

Accountable Care Organizations: What We Know For Now

*Presented to the Nashville Academy
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Part 1:

BACKGROUND



Background

- PGP in 2005
- MedPAC Report 2009
- Patient Protection and Affordable Care Act (“PPAC” or “ACA”) 2010
 - CMS Center for Innovation beginning in 2011
 - Demonstration Projects beginning in 2012
 - New Payment Models
 - Waiver of Antikickback and Stark requirements

PPACA on ACOs

- Payment – fee-for-service to risk approach for meeting goals; achieving savings
- Incentives – integrated approach to care, especially chronic disease
- Incentives - focus on savings rather than on delivering more care



Center for Innovation

- Section 3021 establishes the Center for Medicare and Medicaid Innovation (CMI)
- Goal is to address deficiencies in care with poor clinical outcomes and unnecessary expenditures
- Reimbursement to groups of providers rather than individuals to promote care coordination
- Other innovation



Demonstration Projects

- Payment Bundling
- Medical Home
- Gainsharing



Payment Model Options

- Shared Savings
- Partial Capitation
- Flexibility to use payment model that Secretary determines will improve quality and efficiency
- Bundled payments covering an episode of care (physician, hospital, rehab, etc.)

Part 2

REQUIREMENTS OF ACOS



Requirements of ACOs

- Formal legal structure to distribute/share savings
- Capability to treat minimum of 5000 Medicare patients
- 3 year or more participation
- Track quality and cost data
- Promote evidence-based medicine
- Other patient-centered criteria TBD

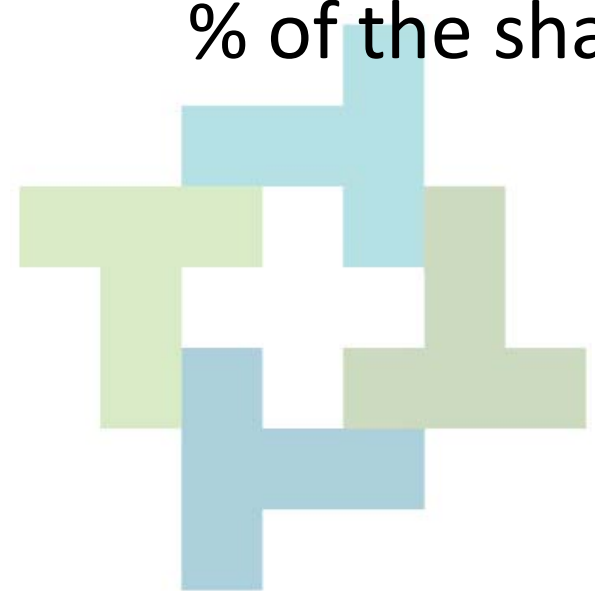
Legal Structure

- Physicians and others in group practices
- Networks of physician practices
- Partnerships or joint ventures between hospitals and physicians
- Hospitals employing physicians
- Other forms that the Secretary may approve



How ACOs Work

- Providers continue to submit claims and be paid individually
- If benchmarks are met, ACO receives back end % of the shared savings



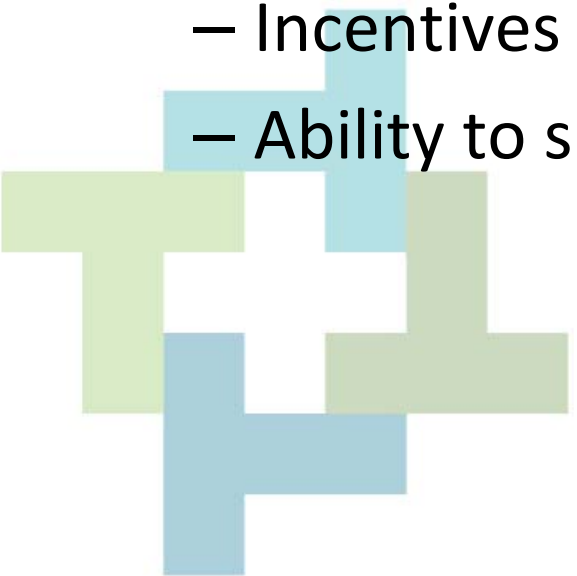
Distribute/Share Savings

- Quality benchmarks to be established
 - Most recent 3-year experience Parts A and B
- Savings in expenditures for beneficiaries may be shared; computed in 12 month periods
- Quality benchmarks not yet determined but will likely focus on chronic disease, readmissions, and more



Requirement: Track Quality

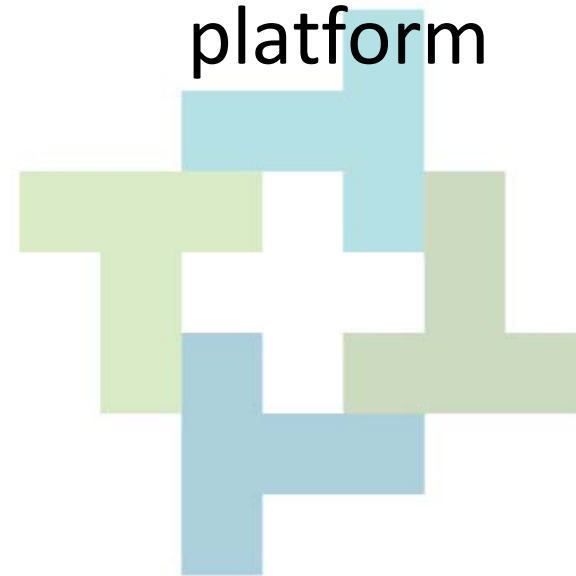
- Rules to identify benchmarks due Fall 2010
- No reimbursement cuts if quality benchmarks are not met
- Tracking expected to be via EHR
 - Incentives available for meaningful use
 - Ability to share information





Requirement: Track Quality

- Clinical processes and outcomes
- Patient and caregivers perspectives on care
- Utilization and costs
- Connectivity among providers as to EHR platform

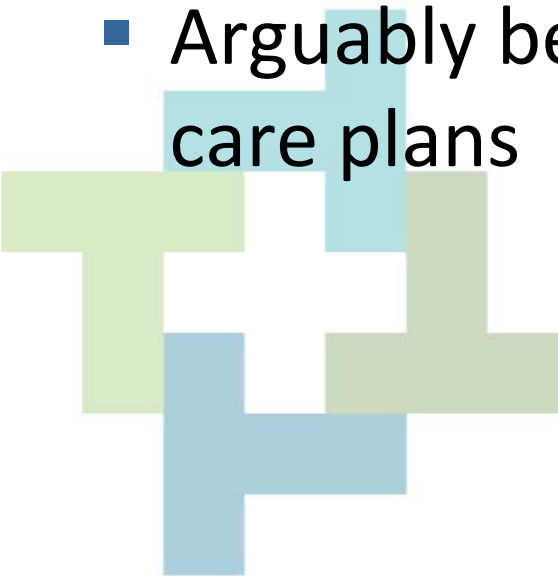


Part 3:

PROS AND CONS OF ACOS



ACOs: Pros

- Promotion and funding for EHRs
 - Acceleration of use of best practices
 - Access to specialists, especially for Medicare patients
 - Arguably better care through use of individual care plans
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ACOs: Cons

- Lack of administrative or judicial appeals of the Government's determinations
- Opportunity for hospitals to control physicians
- Opportunity to squelch competition
- Possession of large market share
- Incentive based
- Ever increasing quality standard improvements
- Non-compliant patients punish ACO

Part 4: What We DON'T Know:

QUESTIONS ABOUT ACOS



Questions

- Can ACOs control patient choice so that all services are provided in-network?
- How are intervening medical conditions treated? New episode?
- Whose/What data is used for rate determination?
- How will cost of benchmarks be determined?
- What rules govern patient selection and underutilization?

Questions

- Calculation of risk-adjusted payments for age and health status
- Extent as to payment incentives for copays, deductibles, in-network differentials
- Effect on supplemental policies
- Provider credentialing and risk sharing
- Will adequate relief be afforded under Stark, anti-kickback and antitrust laws?

Part 5: Preparing for ACOs:

WHAT PHYSICIANS SHOULD BE DOING NOW





Transition Issues to ACOs

- Capability to accept bundled payments
- EHRs and interconnectivity
- Line up potential partners/alliances



Physician Considerations

- In or Out?
 - Age
 - Employment
 - Affordability of EHRs
 - Loss of Medicare/Medicaid provider status



EHR Assessment

- TMA Resources

- Angie Madden, Director of E-Health Services,

- angie.madden@tnmed.org

- Comprehensive online resources at

- www.tnmed.org/ehealth/

- Selection
 - E-Prescribing Resources
 - Research and Quality Initiatives
 - News and other links

What Should TMA Do?

- ✓ Education and vetting of EHR vendors
- ✓ Educate members on ACOs
 - Make members aware of pitfalls of employment
 - Advocate for physician-friendly standards in rules
 - Monitor the pilots; communicate what works and what does not

What Should TMA Do?

- Study the formation of a CO-OP
 - Small local health plan via contract with local TPA
 - Provider network
 - Client base
- ✓ Assign steering task to committee or form new steering committee with broad expertise
 - What else?

