North Carolina Medical Society

Leadership in Medicine

ACO Summit

August 7, 2010

10:30 a.m. – 2:30 p.m.

North Carolina Medical Society
Leadership in Medicine

Douglas D. Sheets, MD

President, NCMS

North Carolina Medical Society
Leadership in Medicine

L. Allen Dobson, Jr., MD

First Visiting Scholar
Engelberg Center for Health Care Reform
Brookings Institute

ENGELBERG CENTER for
Health Care Reform
at BROOKINGS

THE DARTMOUTH INSTITUTE
FOR HEALTH POLICY & CLINICAL PRACTICE
Where Knowledge Informs Change

Advancing Accountable Care

North Carolina Medical Society

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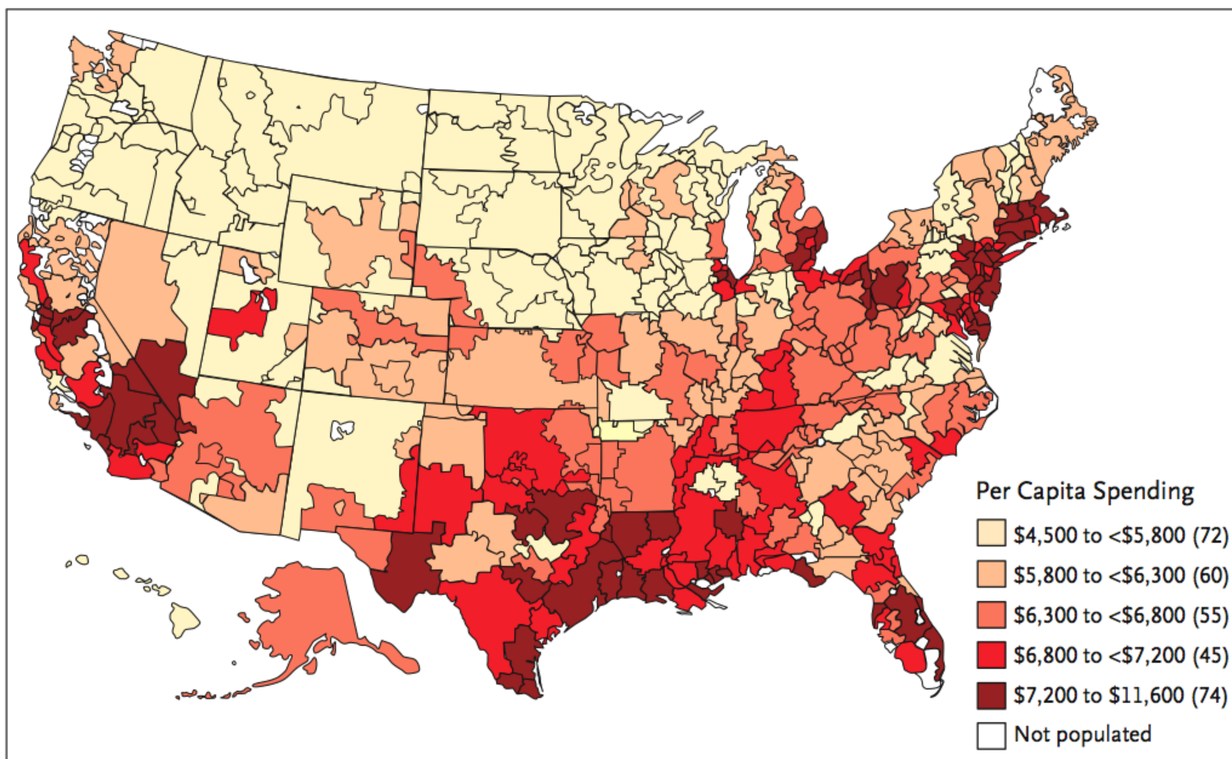
Three Fold Variation in Per Capita Spending

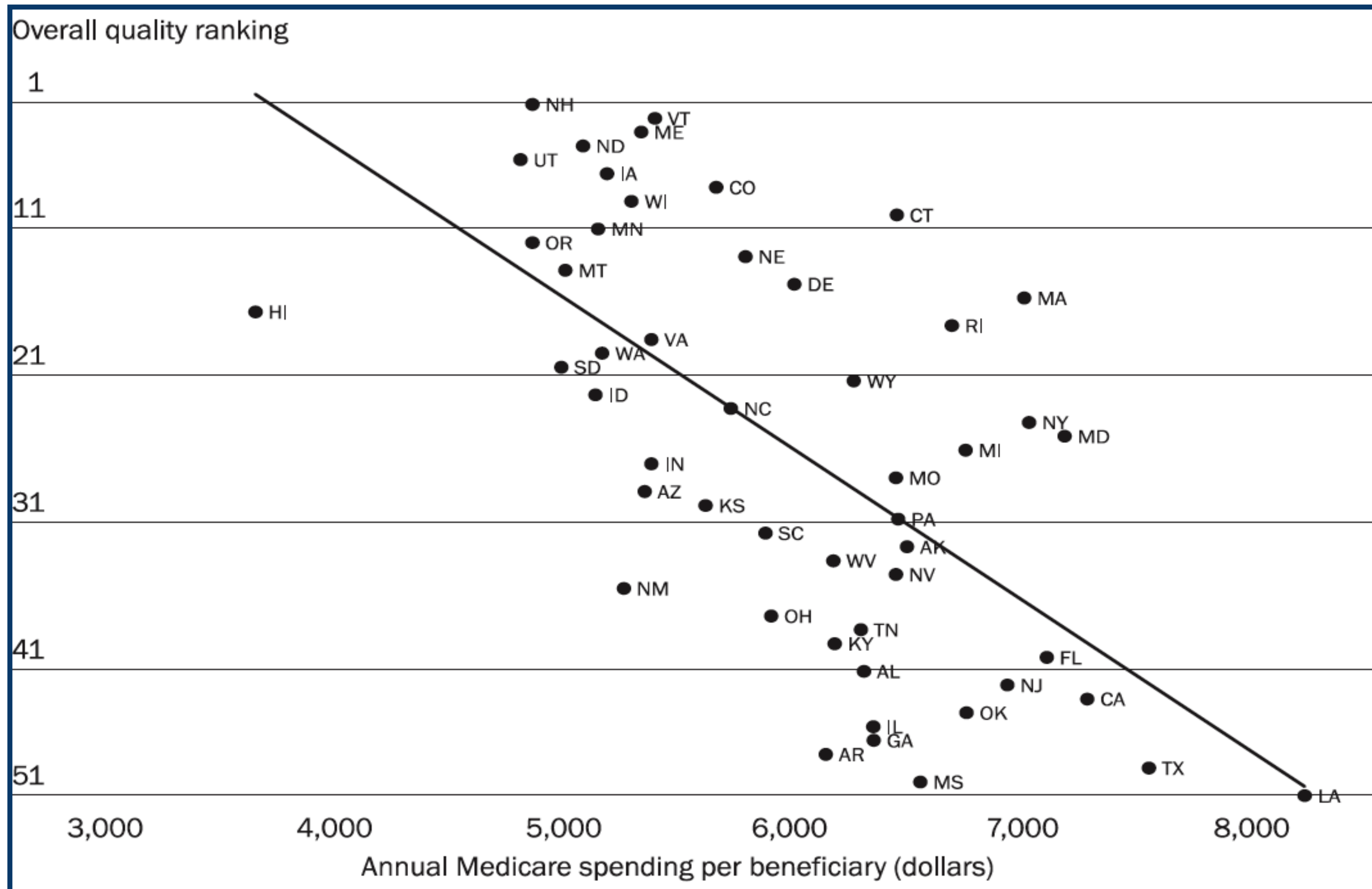


Medicare Spending per Capita, According to Hospital Referral Region, 2003.

Data are from the Dartmouth Atlas of Health Care. Numbers in parentheses are the numbers of hospital referral regions with that level of per capita spending.

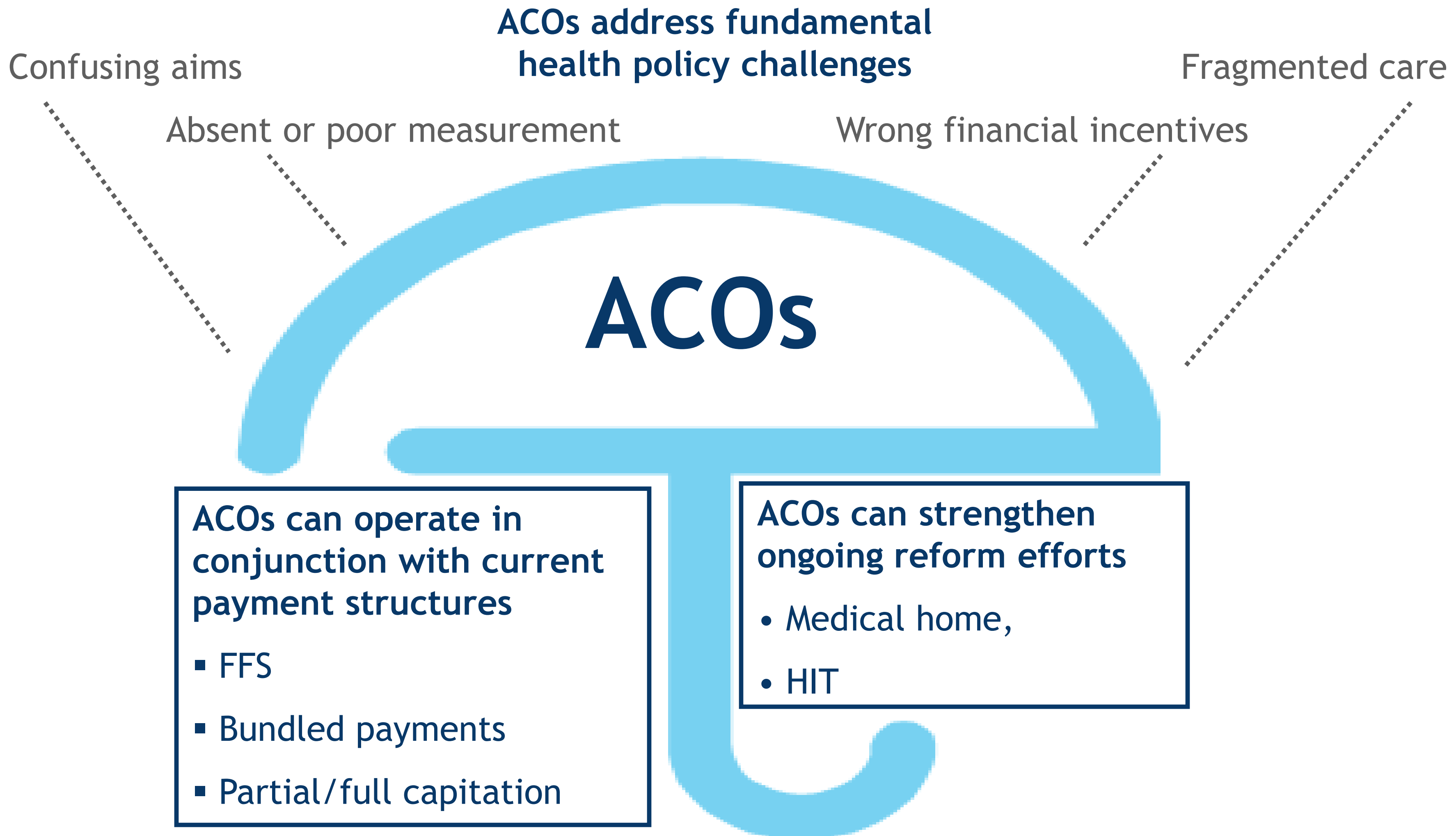
Peter Orszag, N Engl J Med, 2007

Higher Healthcare Spending is Not Associated with Better Quality

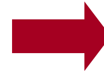
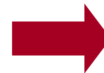


Source: Baicker et al. Health Affairs web exclusives, October 7, 2004

ACO Reform Consistent With Other Reforms



Accountability, "Systemness" & Incentives

Core Principles		Key Design Elements
Clarify aims to emphasize better health, better quality care, lower costs – for patients and communities		▪ Pay for better value – improved overall health while reducing costs for patients
Better information that engages physicians, supports improvement, and informs consumers		▪ Provide timely feedback to providers ▪ Require providers to report on utilization and quality
New model: It's the system - Establish organizations accountable for aims and capable of redesigning practice and managing capacity		▪ Establish robust HIT infrastructure ▪ Implement cost-saving and quality-improving medical interventions ▪ Evaluate performance at the system level
Realign incentives – both financial and clinical – with aims		▪ Restructure payment incentives to support accountability for overall quality and costs across care settings

Local accountability is the goal

- Currently, there is little accountability for creating unnecessary capacity, practicing “high intensity” medicine, or providing lower quality care.

- Current proposals (bundled payments, chronic disease management, pay-for-performance) do not promote accountability for cost, quality and capacity.

Healthcare is practiced in local markets

Number of Medicare Beneficiaries in Network	Percent of Total Beneficiaries	Number of Local Networks	Patient Loyalty to Local Network
Under 5,000	21.7%	3109	63.6%
5,000 -10,000	26.2%	936	70.8%
10,000 –15,000	20.5%	430	72.9%
15,000 +	31.5%	371	75.6%

Illustrative purposes only using 2004 physician data on hospital use; ACO proposal involves no requirements for hospital-based affiliations. From Elliott S. Fisher, Douglas O. Staiger, Julie P.W. Bynum and Daniel J. Gottlieb, Creating Accountable Care Organizations: The Extended Hospital Medical Staff, Health Affairs 26(1) 2007:w44-w57.

ACOs Differ But Share a Few, Key Elements

1

Can provide or manage continuum of care as a real or virtually integrated delivery system

2

Are of a sufficient size to support comprehensive performance measurement

3

Are capable of internally distributing shared savings payments

Important Caveats

- ACOs are not gatekeepers
- ACOs do not require changes to benefit structures
- ACOs do not require patient enrollment

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Comparison of Different Payment Models

	FFS	Capitation	ACO
Payment Model	Providers are paid per service. Incentive to increase volume.	Providing fixed, "upfront" payments unrelated to volume of services changes incentives, which can raise concerns about "stinting". Monthly payments can help finance infrastructure and other improvements.	Reduces incentives to increase volume and can work with other reforms that promote coordinated, lower-cost quality care.
Requires patients to enroll with specific providers	No – Patients are not assigned.	Yes –Patients must enroll with designated provider (who receives fixed payment regardless of utilization).	No – Patients can be assigned based on previous care patterns.
Strengthens primary care/fosters care coordination	No – Little incentive to support primary care or care coordination.	Yes – Can provide incentives to support primary care and care coordination efforts.	Yes – Provides incentives to support primary care and care coordination efforts.
Fosters accountability for total per-capita costs and improved quality	Little incentive to manage total per-capita costs or improve quality	Strong accountability for per-capita cost; however, can lack clear link to improved quality.	Accountability for costs in the form of shared savings with eligibility for shared savings linked to meeting quality measures.

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How are Patients Assigned to the ACO?

Providers sign agreement to participate with ACO

- Defined by the ACO
- PCPs must be exclusive to one ACO
  - Limits concerns about selection and dumping
- Specialists can be part of multiple ACOs

Patients are assigned to their PCP based on the majority of their outpatient E&M visits

- Uses data from insurer

Goals of Patient Assignment Method

Unique provider assignment for every patient (no enrollment by patients)

No "lock in" of patients to the ACO (not a gatekeeper model)

Patients are assigned based on where they received their care in the past

Minimize "dumping" of high risk or high cost patients

Important Caveats

- The method is **not** meant to establish individual provider accountability
- Accountability for assigned patients lies with the ACO, **not** the individual provider
- Physicians are part of the ACO **system** of care
- Even providers affiliated with only one ACO can refer patients to non-ACO providers

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ACO is Responsible for all Patient Expenditures

Expenditures Attributed to ACO

Patient Expenditures

PC P 1

Patient Expenditures

Patient Expenditures

ACO

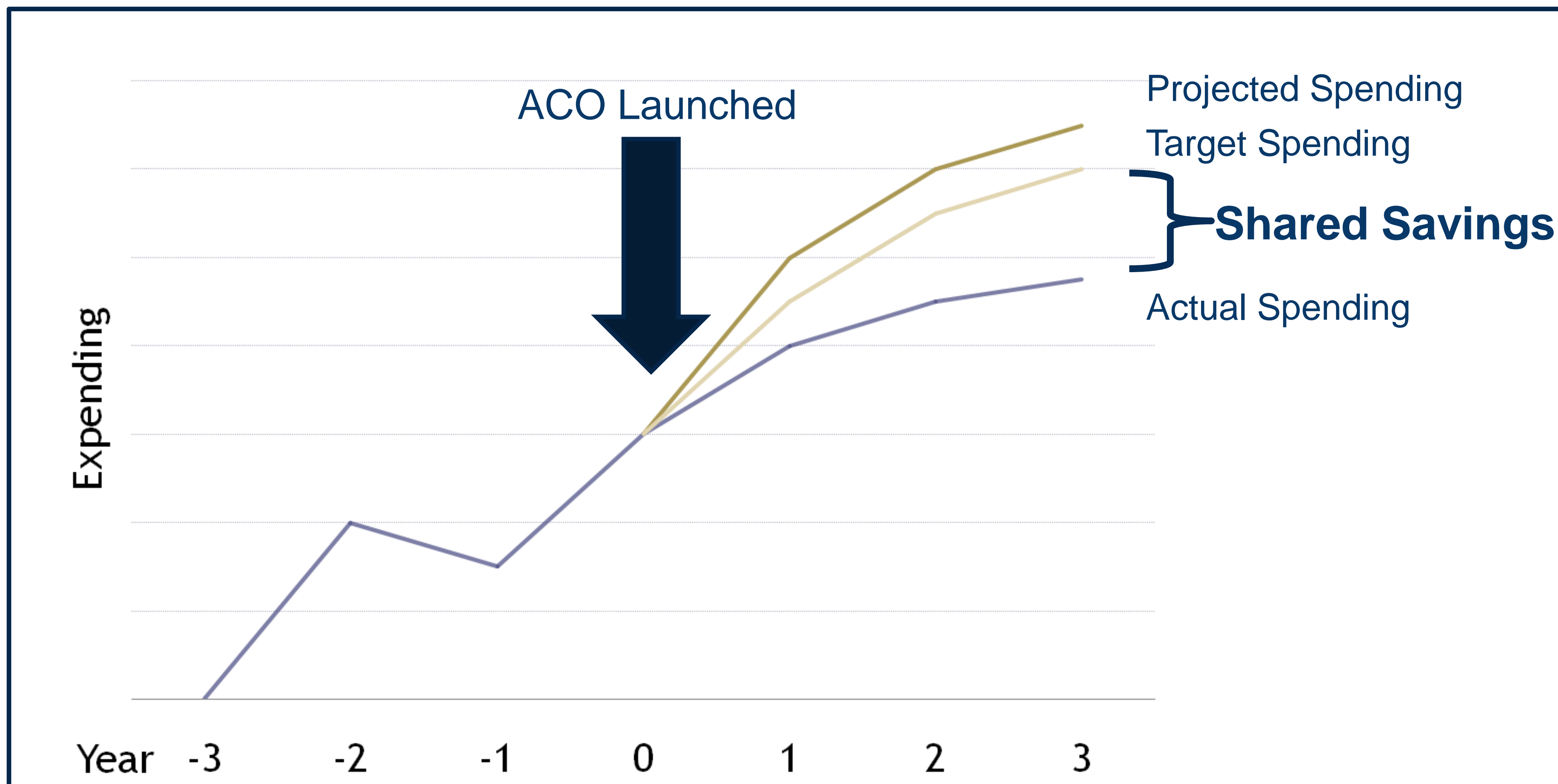
Patient Expenditures

PC P 2

Patient Expenditures

Patient Expenditures

Savings Based on Spending Targets



Performance Payment Framework

ACOs offer a wide range of approaches

Level 1
Asymmetric shared-savings

- Continue operating under current insurance contracts/coverage models (e.g., FFS)
- No risk for losses if spending exceeds targets
- Most incremental approach with least barriers for entry
- Attractive to new entities, risk-adverse providers, or entities with limited organizational capacity, range of covered services, or experience working with other providers

Level 2
Symmetric Model

- Payments can still be tied to current payment system, although ACO could receive revenue from payers and distribute funds to members (depending on ACO contracts)
- At risk for losses if spending exceeds targets
- Increased incentive for providers to decrease costs due to risk of losses
- Attractive to providers with some infrastructure or care coordination capability and demonstrated track record

Level 3
Partial Capitation Model

- ACO receives mix of FFS and prospective fixed payment
- If successful at meeting budget and performance targets, greater financial benefits
- If ACO exceeds budget, more risk means greater financial downside
- Only appropriate for providers with robust infrastructure, demonstrated track record in finances and quality and providing relatively full range of services

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Meaningful Measures; Strategically Deployed

	Current	ACO Model	Impact
Level of Measurement	Individual	ACO (System-Level)	Reduces fragmentation and silos of practice; and, provides an assessment of care because many providers contribute to a patient's care over time.
Types of Measures	Process	Outcomes, Patient Experience, Efficiency	Better data for patients to make choices about providers better data for providers to make changes; Increased accountability for resource use.
Measurement Focus	Individual Provider Accountability for Process	Care Coordination, Shared Decision Making, Capacity Control	Organizational support for managing and improving care; better patient engagement
Provider Focus	Discrete Patient Encounters	Overall health of the population	Shared accountability for the continuum of care.

Beginning, Intermediate, & Advanced

Over time, measures should address multiple priorities, be outcome-oriented, and span the continuum of care

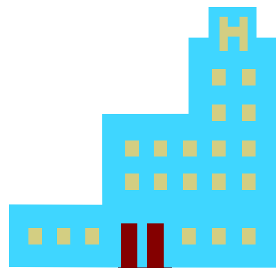
Beginning	Intermediate	Advanced
• ACOs have access to medical, pharmacy, and laboratory claims from payers (claims-based measures) • Relatively limited health infrastructure • Limited to focusing on primary care services (starter set of measures)	• ACOs use specific clinical data (e.g., electronic laboratory results) and limited survey data • More sophisticated HIT infrastructure in place • Greater focus on full spectrum of care	• ACOs use more complete clinical data (e.g., electronic records, registries) and robust patient-generated data (e.g., Health Risk Appraisals, functional status) • Well-established and robust HIT infrastructure • Focus on full spectrum of care and health system priorities

Specialists Are Key Component of an ACO

Accountable Care Organization

Primary Care

Hospital



Specialists

Other Possible Components:

- Pharmacists
- Home Health
- Mental Health
- Rehab Facilities

Integrating Specialists in ACOs

- **Coordination between PCPs and specialists is often inadequate**
  - Leads to inappropriate care (duplication of tests, inefficient referrals, delays, etc…) and potentially worse outcomes
- **Support for preventing complications in specialty care and reducing costs is often inadequate**
  - Leads to difficulties in implementing steps to prevent complications, tracking patients' outcomes, identifying device safety problems, etc
- **Successful ACOs (i.e., those achieving lower total costs and higher quality across the full spectrum of care) will promote more effective specialist care and PCP-specialist coordination and higher-value specialty care**
  - Use of Patient Registries, EHRs, etc… that provides actionable, timely data
  - Performance measures that accurately reflect specialists care are basis for financial support for these goals
  - Internal payment models that support specialist-PCP coordination will help specialists move away from a FFS reimbursement model towards paying for performance
- **Specialists can choose whether to become part of an ACO**
  - Specialists can decide whether to be contracted, employed, exclusive, or not participate at all (but still able to provide services to ACO patients)

Performance Measurement Critical for Effective Support for Specialty Care

- Measures should evolve over time to increasingly address multiple priorities, be outcome-oriented, and span the continuum of care
- Payments should be linked to measures as the basis for moving away from FFS and towards a more value-based reimbursement system – for example…
  - Pay-for-performance based on disease registry participation now
  - Coordination with meaningful use payments
  - Increased emphasis on more comprehensive, outcome-oriented measures (complication rates, patient experience, episode-based cost measures)
  - Allows increasing emphasis on patient-level payments (as in ACO) and episode-based payments (within ACOs or Medicare) and thus more financial support for steps that improve quality and efficiency at patient level

Initial ACO Measures – Claims-Based

ACO Impact	ACOs have access to medical, pharmacy, and laboratory claims from payers
Care Effectiveness/ Population Health	– Cancer Care Screenings – Diabetes care (LDL and H1c tests, eye exams, etc.) – Coronary Artery Disease care (LDL test)
Safety	– High-risk medication for the elderly – Appropriate testing for patients using high-risk medications
Patient Engagement	
Overuse/ Efficiency	– Imaging for low back pain (in absence of "red flags") during first 30 days – Inappropriate antibiotic prescribing – Utilization rates of select services (e.g., C-section)

Intermediate ACO Measures – Key Clinical and Patient Experience Information

ACO Impact	ACOs use specific clinical data (e.g., electronic laboratory results) and limited survey data
Care Effectiveness/ Population Health	– Immunization rates for children and adolescents – Patients with diabetes whose blood sugar (H1c) are in control – Patients with diabetes or ischemic vascular disease whose lipids (LDL) are in control – Patients with hypertension whose blood pressure are in control
Safety	– "Never events" in hospitals
Patient Engagement	– Physician instructions understood (CAHPS) – Care received when needed (CAHPS)
Overuse/ Efficiency	– Episode-based resource use - linked to quality measures for common medical (e.g. diabetes, AMI) and common surgical conditions (e.g. hip replacement)

Advanced ACO Measures – Comprehensive Patient-Focused Electronic Data

ACO Impact	ACOs use more complete clinical data (electronic records, registries, etc.) and robust patient-generated data (Health Risk Appraisals, functional status)
Care Effectiveness/ Population Health	– Comprehensive health risk summary score (BMI, blood pressure, cholesterol, smoking, exercise, alcohol) – Stage-specific quality of life and functional outcomes for common cancers – Quality of life and functional outcomes for common conditions (e.g. AMI, hip replacement, diabetes)
Safety	– Hospital infection and risk adjusted mortality rates – Outpatient medication errors
Patient Engagement	– Care plans – patient activation and engagement in chronic/ other conditions – Preference sensitive conditions – level of information communicated regarding patient choice (e.g., knee surgery) – Patient-preferences – adherence to design and execution of care plan (e.g., advanced directives)
Overuse/ Efficiency	– Episode-based resource use – linked to quality of life, functional and patient engagement measures for common medical (e.g. diabetes, AMI) and surgical conditions (e.g. hip replacement)

Payments Within an ACO

- **Specialists can develop payment distribution contracts within an ACO that support improved patient-level outcomes and cost reductions achieved by specialists**
  - Key issue in effective ACO planning is identifying evidence-based ways that specialists and hospitals can achieve savings with quality improvements
  - May include steps to improve referrals from primary care (e.g., "care coordination" payment replacing some of fee-for-service reimbursement – tied to reducing cost trends associated with volume/intensity of specialist referrals)
  - May include increased payments related to fewer complications/ lower costs in specialty care (e.g., lower cost per episode, lower complication rates, etc.)
  - Reforms in Medicare FFS payments to reinforce these payment reforms?

Next Steps for Specialists

- **Best Practices for Specialty Coordination with Medical Homes**
  - Optimal/efficient referrals, without unnecessary costs or delays
- **Best Practices for Surgical Procedure Registries/Patient Tracking for Improving Care – and Supporting Meaningful Performance Measurement**
  - Near real-time
  - Provides critical information for improving patient care (e.g., identifies opportunities to improve coordination, avoid complications, determine safety problems, etc.)
  - Consistent production of performance metrics to document improvements in care
- **Medicare FFS Payment Reforms to Support These Goals**
  - Beyond SGR and FFS
  - Possibly some payments for coordinating orthopedic care plus some evidence-based practice/ outcome-related payments?
  - Coordination with upcoming additional payments for meaningful use, pay-for-reporting, etc

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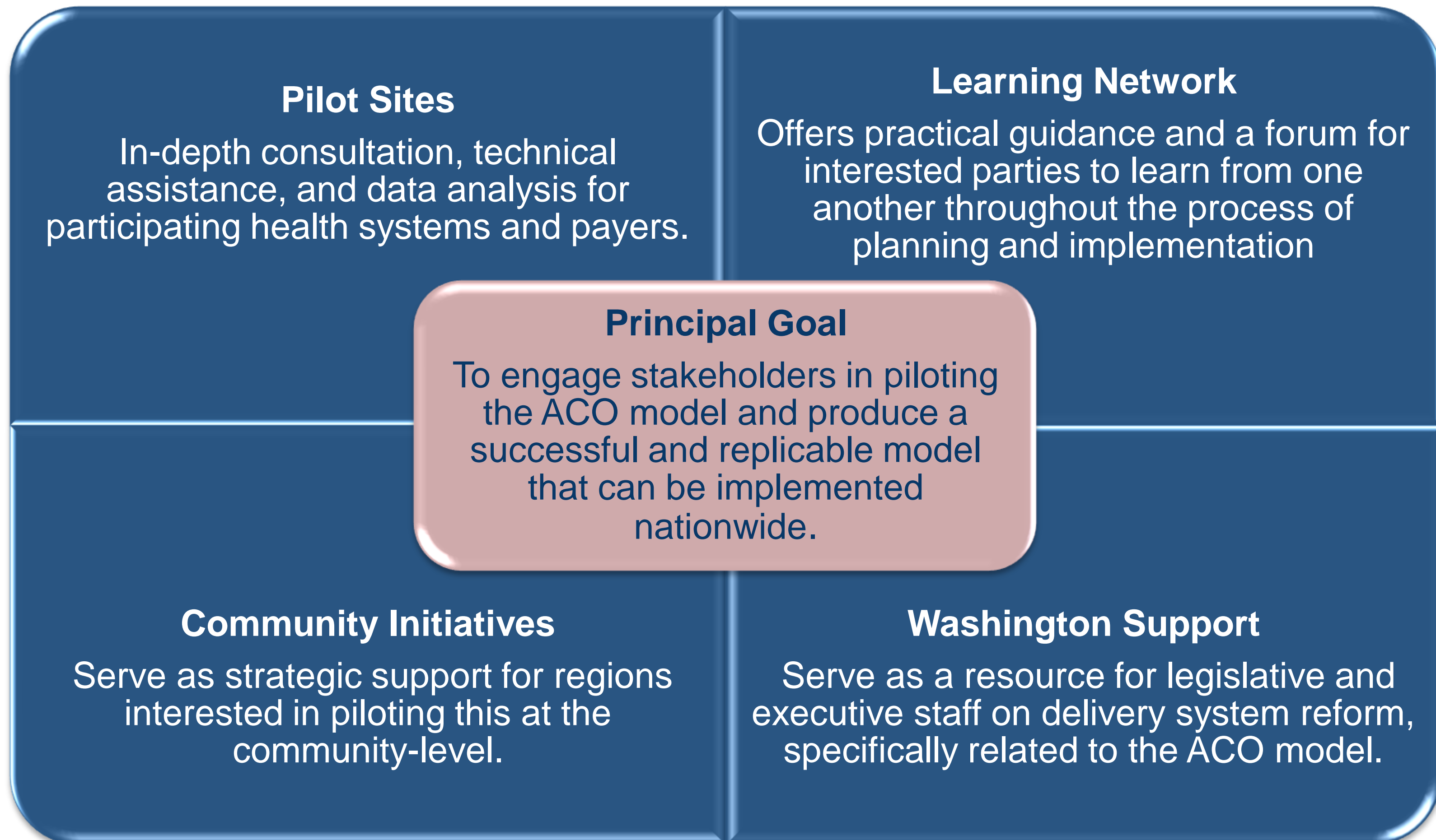
Brookings-Dartmouth ACO Collaborative



ACO Pilot Sites

Carilion Clinic Roanoke, VA	Norton Healthcare Louisville, KY	Tucson Medical Center Tucson, AZ
• ~900 Providers • 60,000 Medicare Patients Assigned	• ~400 Providers • 30,000 Medicare Patients Assigned	• ~80 Providers • 10,000 Medicare Patients Assigned

Large Group Small Group

Low Competitive Environment Highly Competitive Environment

Fully Integrated System Multiple Independent Provider Groups

Private-Sector ACO Examples: Brookings-Dartmouth Pilot Sites

Monarch HealthCare Based in Irvine, CA	**HealthCare Partners** Based in Torrance, CA
• Medical Group & IPA • >800 PCPs • >2,500 contracted, independent physicians • ACO will cover Orange County	• Medical Group & IPA • >1,200 employed and affiliated PCPs • >3,000 employed and contracted specialists • ACO will cover LA County

Large, highly integrated provider systems operating in highly competitive environment

Medicare Physician Group Practice (PGP) Demonstration Program

- The PGP Demo was legislatively mandated in 2000 as a five-year shared savings/quality improvement demonstration with Medicare
  - **Billings Clinic;** Billings, MT
  - **Dartmouth-Hitchcock Clinic;** Bedford, NH
  - **The Everett Clinic;** Everett, WA
  - **Forsyth Medical Group;** Winston-Salem, NC
  - **Geisinger Health System;** Danville, PA
  - **Marshfield Clinic;** Marshfield, WI
  - **Middlesex Health System;** Middletown, CT
  - **Park Nicollet Health Services;** St. Louis Park, MN
  - **St. John's Health System;** Springfield, MO
  - **University of Michigan Faculty Group Practice;** Ann Arbor, MI

PGP Demonstration Results

- **Year 1**
  - All demos improved clinical management of diabetes; two demos achieved benchmark performance on all 10 diabetes measures
  - Two demos shared in savings ($7.3 M in payments)
- **Year 2**
  - All 10 demos continued to improve quality scores
  - Four demos shared in savings ($13.8 M in payments)
- **Year 3**
  - All 10 demos continued to improve quality scores
    - Years 1-3: Average of 10% on diabetes, 11% on CHF, 6% on CAD, 10% on cancer screening, 1% on hypertension
  - Five demos shared in savings ($25.3M) for achieving 2% per year reductions in spending growth below “control” populations

Medicare "646" Demo: Indianapolis

- The Indiana Health Information Exchange (IHIE), through its Quality Health First (QHF) Program, is a community-wide quality measurement and P4P health information exchange made up of a coalition of physician practices, hospitals, employers, private and public payers, and public health officials
- Multi-payer program includes several components:
  - A comparative performance reporting and tracking system that provides participating physicians with information on the extent to which the care complies with evidence-based practice guidelines
  - A pay-for-performance incentive system that uses information on adherence to treatment guidelines and practice efficiency to distribute savings that are achieved through better care management
- Demonstration waiver authority has added Medicare to the list of participating private and public payers and will allow the IHIE to qualify for a portion of Medicare savings if spending reductions are achieved

Medicare "646" Demo: North Carolina

- The North Carolina Community Care Networks (NC-CCN) is a non-profit organization made up of regional health care networks of community physicians, hospitals, health departments, and other community organizations
- Under the MHCQ demonstration, NC-CCN will test the impact that a physician-directed care management approach will have on care quality and efficiency:
  - Enhanced provider fees for medical homes and use of technology to support care coordination and evidence-based practice
  - Regional physician pay-for-performance program supported by a common set of quality measures
- Demonstration waiver authority expands the program population to the dual eligible and general Medicare FFS population and will provide NC-CCN with the opportunity to qualify for a portion of Medicare savings if spending reductions are achieved

Key Challenges for ACOs

- Will "critical mass" of providers join?
  - Enough assigned patients?
- Will payers agree to participate?
  - Will payers support Level I ACOs, or only deal with existing, integrated systems ready for Level II or III?
- Adequate financing for ACO start-up costs?
  - Infrastructure, IT, analysis, limiting ER use, etc.?
- Adequacy of performance measures, patient assignment algorithm, and budgeting methodology?
  - "Good enough" to get started? How to improve?
- Can ACOs change patient behavior & provider culture?
  - No enrollment, no "lock-in", no change in benefits?
  - Modest financial incentives, at least in Level I?
- Potential to increase provider concentration and power?

Why ACOs Might Succeed (Over Time)

- Broad, flexible system built on essential core principles
  - Lots of local variation possible within ACO concept
- 3 ACO Levels permit tailoring to different circumstances
  - Broadly applicable throughout the country, with "Training Wheels" for newly formed Level I ACOs
  - Level II offers more reward/more risk (but still limited)
  - Partial Capitation for highly sophisticated entities, extending their model to FFS Medicare and PPOs
- Pathway to fundamentally shift incentives from FFS revenue centers to population health & accountable care
- Opportunity to change clinical and business environment
  - Timely data and analysis
  - Working collaboratively as part of a system of care

Why would providers participate?

- Improved professional working environment
- Realization that at some point volume and intensity will not be able to be increased further
- Understanding that the care currently being delivered is not in the best interest of the patient
- Knowledge of continued reform attempts by all healthcare stakeholders to improve quality and bend the cost curve

How do ACOs reduce expenditures?

Through systematic efforts to improve quality and reduce costs across the organization:

- Using appropriate workforce (increased use of NPs)
- Improved care coordination
- Reduced waste (i.e. duplicate testing)
- Internal process improvement
- Informed patient choices
- Chronic disease management
- Point of care reminders and best-practices
- Actionable, timely data
- Choices about capacity

ACOs in Health Care Reform Law

- Beyond Pilots
  - Wide range of provider groups meeting certain criteria can implement an ACO outside of traditional CMS demonstration process through shared savings program
- Payment Models
  - Legislation supports a broader range of Medicare ACO payment models then those in current Medicare shared savings demonstrations
    - One-sided and two-side/symmetric shared savings models
    - Range of “partial capitation” models can be established to replace a portion of fee-for-service payments
- New evaluation methods
  - New law authorizes pre-post budget projection approach that uses actuarial methods based on historical spending and utilization data to develop quantitative target to track ACO performance

ACOs in Health Care Reform Law

- Medicare shared savings program starting January 1st, 2012 (Section 3022)
  - Qualifying Medicare ACO requirements:
    - Willingness to be accountable for quality, cost, and overall care of Medicare fee-for-service beneficiaries for a minimum of 3 years
    - Have a formal legal structure to receive and distribute shared savings
    - Have at least 5,000 assigned beneficiaries with sufficient number of primary care ACO professionals
    - Report on quality, cost, and care coordination measures and meet patient-centeredness criteria set forth the Secretary
- Center for Medicare and Medicaid Innovation (CMI) to be created in CMS to test payment and delivery models by January 1st, 2011 (Section 3021)
  - $10 billion authorized for FY2011 to FY2019

North Carolina Medical Society

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Questions?

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Chair, NCMS ACO Work Group

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Questions?

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ACO^2: Alternative Corporate Options for Accountable Care Organizations

Steve Shaber and Kim Licata

Poyner Spruill LLP

Raleigh, North Carolina

August 7, 2010

North Carolina Medical Society ACO Summit

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EPIGRAM

And don't throw the past away
You might need it some other rainy day
Dreams can come true again
When everything old is new again

"Everything Old Is New Again"
Peter Allen

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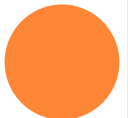

Alternate Epigram

With a bit of a mind flip
You're there in the time slip
Let's do the Time Warp again

"The Time Warp"
The Rocky Horror Picture Show
Richard O'Brien

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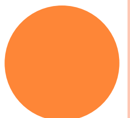
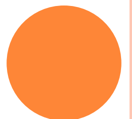


Debate on What Providers Must Be in an ACO to Participate in Shared Savings

- At present, there is NO required composition of an ACO. There may be ACOs focused on particular aspects of care (physician services, acute care, full service)
- "All ACOs should have a strong base of primary care. Hospitals should be encouraged to participate . . . [b]ut in contrast to others' definitions, we believe that this need not be an absolute requirement for ACOs."
  - Elliott Fisher et al., *A National Strategy to Put Accountable Care Into Practice*, HEALTH AFFAIRS, May 2010, at 983.
- "[S]ome think that local hospitals must be included in an ACO. However, others think . . . we should allow separate outpatient and inpatient ACOs to develop. . . ."
  - Kelly Devers, *Can Accountable Care Organizations Improve the Value of Health Care?*, URBAN INSTITUTE, Oct.2009, at 4.



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Introduction to Accountable Care Organizations

- Accountable Care Organizations under health care reform are entities that will become accountable for the overall cost and quality of health care services delivered to patients.
- Inherent in the concept of an ACO is that greater accountability will be encouraged through incentive payments or new forms of payments to the ACOs.

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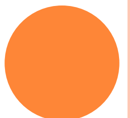
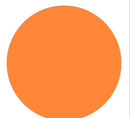


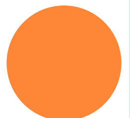
Eight Required Elements

- Legal Organization
- 3 Year Commitment
- 5000 Beneficiaries
- Accountable for Quality & Cost of Care
  - Can collect and provide information
  - Can provide administration and clinical care
  - Offers evidence based medicine and coordinated care
  - Is patient centered
- The key is that CMS wants physicians (and other providers) to tell the Agency what works. We know what doesn't work!



Compensation – Options

- Shared Savings.
  - ACO is eligible for "shared savings" payments (i.e. bonus payments) if:
    - it meets quality and performance standards and
    - the ACO's estimated Medicare costs are a certain percentage below a benchmark set by the Secretary.
- Capitation & Partial Capitation.
  - Secretary can choose to limit the capitation or partial capitation model to ACOs that are highly integrated systems of care and to ACOs capable of bearing risk.
- Other Payment Models Authorized by HHS.



The Stark law, Anti-Kickback Statute, and Anti-trust Considerations

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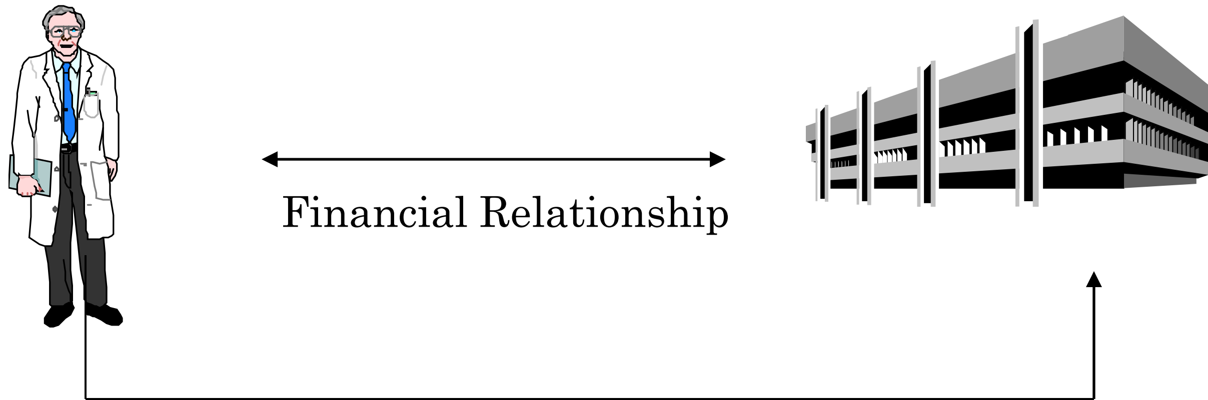
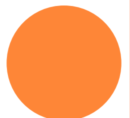
THE STARK STATUTE AND REGULATIONS



Referral of DHS for Medicare or Medicaid patient

- Under Stark, a physician is prohibited from referring Medicare patients to an entity for designated health services for which Medicare would otherwise pay, if the physician (or an immediate family member of the physician) has a financial relationship with the entity.
- Stark is violated when the financial relationship does not fit a statutory or regulatory exception. Stark is a technical, bright-line statute, intent is irrelevant!



The Anti-Kickback Statute

- The Anti-kickback statute prohibits the knowing and willful solicitation, offer, payment, or receipt of any remuneration, whether direct or indirect, overt or covert, in cash or in kind, in return for or to induce:
  - Referring or influencing the referral of an individual for the furnishing of any item or service;
  - Purchasing, leasing or arranging or recommending for the purchase, lease or ordering of any item or service.
- Paid in whole or in part under any federal health program.
- Basis for civil and criminal liability; also leads to liability under other federal statutes (False Claims Act, Civil Monetary Penalties).
- As Stark has exceptions, Anti-kickback has Safe Harbors

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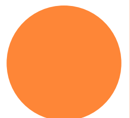

Anti-Trust Law & Safety Zones

- Financial Integration is allowed where there is Limited Market Power
  - *Arizona v. Maricopa County Medical Society*
  - *Statement 8*

- Clinical Integration is allowed where Clinical Benefits Justify Anticompetitive Bargaining
  - Revised FTC *Statement 8*

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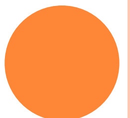

Gainsharing as a Predictor of ACO Treatment

- Gainsharing is profit sharing between hospitals and physicians where FFS remains but a percentage of the cost savings gets passed on to the physician
- The OIG has previously approved gainsharing arrangements on a case-by-case basis because of:
  - Substantial Structure
  - Accountability
  - Quality Controls and
  - Other Safeguards

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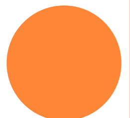

Based on statutory guidance

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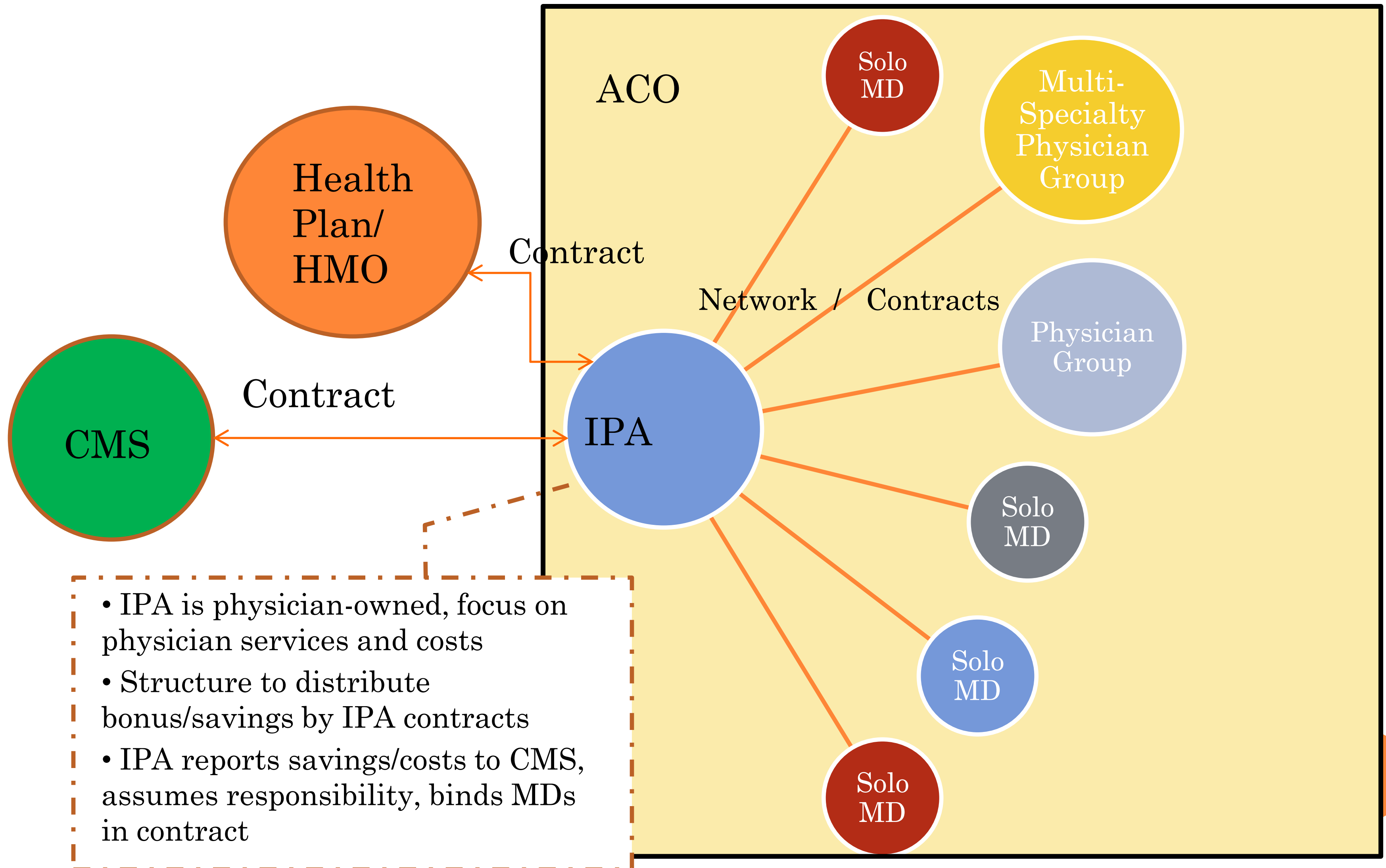
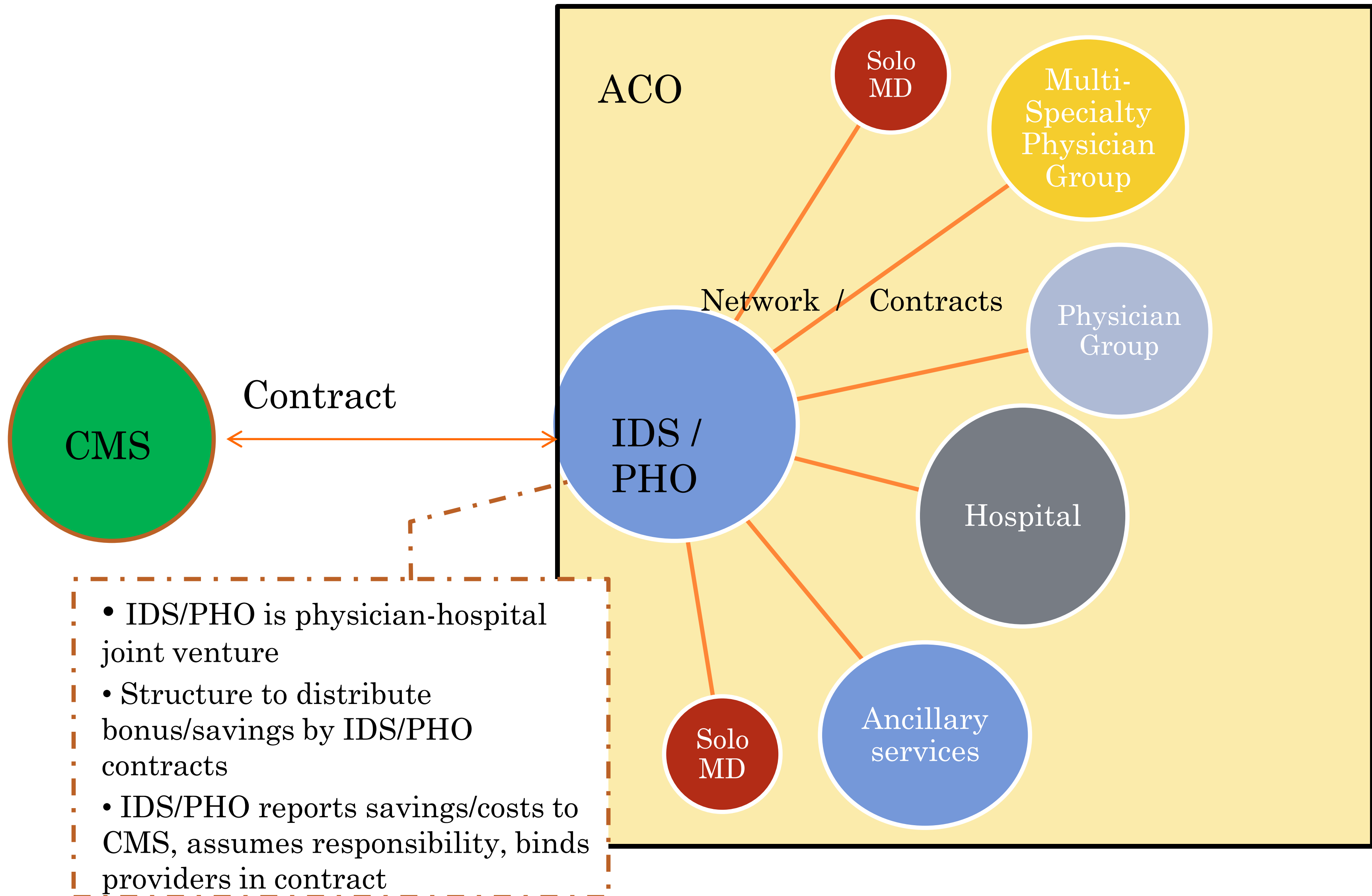
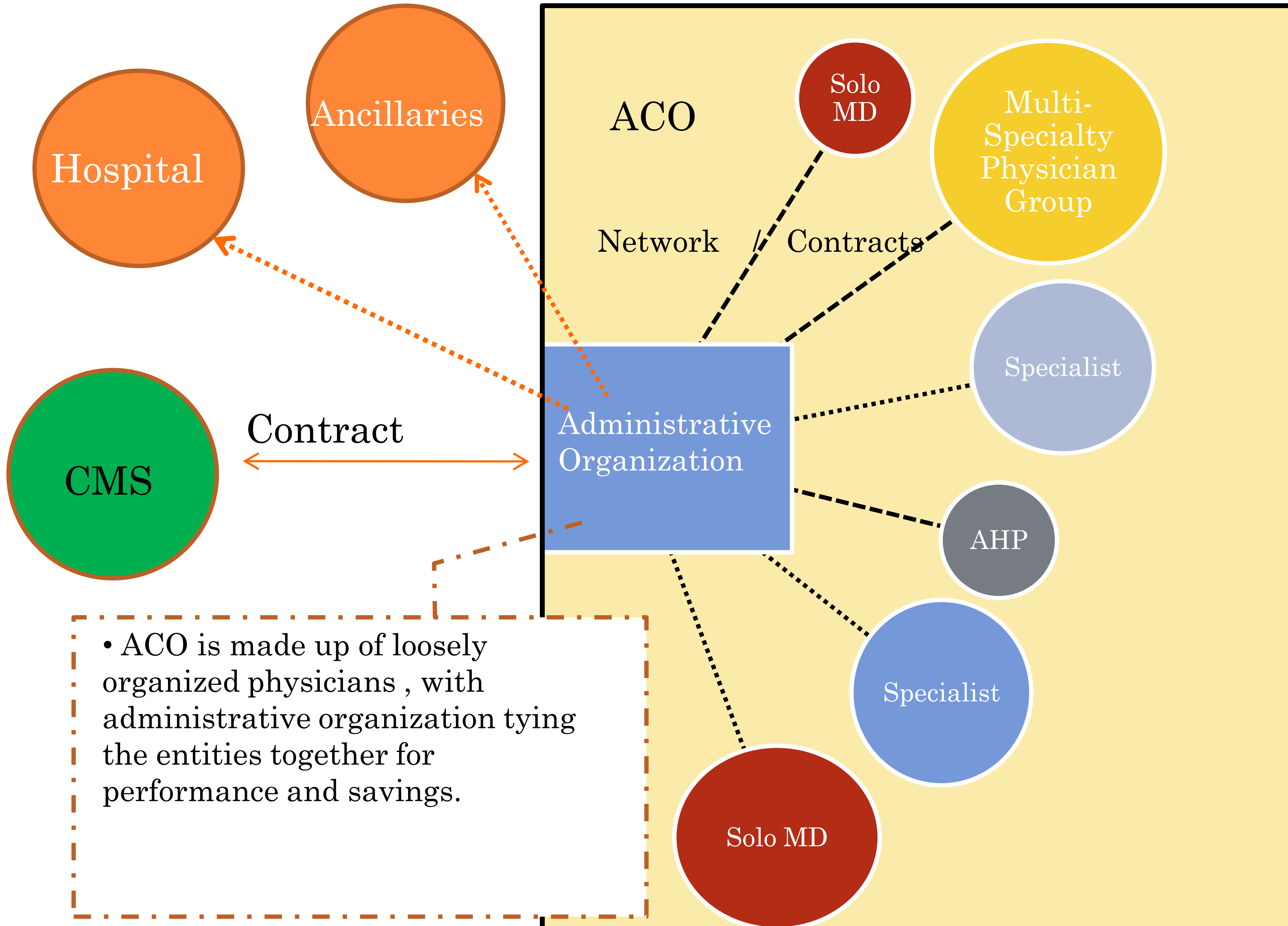
IPA as Basis for an ACO



IDS or PHO as Basis for an ACO



ACO of Loosely Organized Physicians and Physician Organizations



THE BEAUTY OF WAIVERS

- The PPACA allows the government to grant waivers
- Waivers could eliminate possible Stark, AKS, Anti-Trust, and organization problems
- The regulations will (we hope) clarify this

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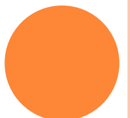

Held on June 24, 2010

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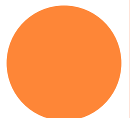
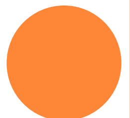
Highlights from the Open Door Forum

- Focus of Open Door Forum was to solicit opinions and experience from industry representatives, particularly physicians, to educate CMS on potential options for ACOs.
- CMS is asking physicians to tell the Agency how ACOs can work to be successful where past entities (i.e., HMOs) have failed to contain costs and promote quality care.
  - Physicians are in the driver's seat if they organize and provide comments to CMS.
  - If physicians do not take on this role, someone else (with potentially different interests) will.
  - Participants speaking at forum ranged from solo practitioners to large industry groups.
  - Additional opportunities for input are planned.



Highlights from the Open Door Forum

- CMS agrees that various organizational models meet the requirements of an ACO (IPAs, Multispecialty Groups, Hospital Medical Staff Organizations, PHOs, Organized/Integrated Delivery Systems, among others).
  - Statutory provisions identify several potential models and allow CMS to specify more details in regulation.
  - Models used can be loosely organized or more structured so long as the goal of cost containment and savings are achieved with accountability for care.
- Physician-led organizations (Mayo Clinic, Cleveland Clinic, Gunderson) have gained respect and notice for clinical <u>and</u> operational excellence.



Final Thoughts, Questions, & Contact

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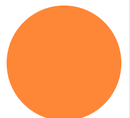

North Carolina Medical Society

Leadership in Medicine

Questions?

North Carolina Medical Society
Leadership in Medicine

Julian D. "Bo" Bobbitt, Jr., JD

Smith Anderson

TOWARD THE SUCCESSFUL ACO – WHY PHYSICIAN-TO-PHYSICIAN COORDINATION IS BOTH ITS GREATEST CHALLENGE AND OPPORTUNITY

North Carolina Medical Society ACO Summit
August 7, 2010

Presented by

Julian D. ("Bo") Bobbitt, Jr., J.D.

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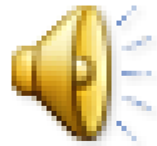
Context and Recap

- ACO trend not dependent on federal health care legislation



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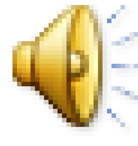

Audio #2

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Context and Recap (cont'd.)

- Quick Review of Critical Competencies for ACO Success
  - Robust system-wide HIT infrastructure
  - Aligned financial incentives – payment for value, not volume
  - Infrastructure and legal structure tailored to setting
  - Clinically reliable performance measurement
  - Locally appropriate and prioritized performance metrics and benchmarks – physician-led but part of multi-disciplinary team
  - Ability to integrate care across time, settings, disciplines, providers, and geography

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Why Is Developing a Culture of Collaboration the Greatest Challenge to ACO Success?

- Unprecedented Scale
  - It will dwarf any partnership, relationship, trust, and interdependency building activities in the history of medicine
  - "Clinical transformation is the linchpin of ACOs' success, and it does not happen automatically by simply changing payment arrangements and measuring performance." Mark McClellan, A National Strategy to Put Accountable Care Into Practice, *Health Affairs*, May 2010

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Why Is Developing a Culture of Collaboration the Greatest Challenge to ACO Success? (cont'd.)

- Alien to scientific training and clinical decision-making skills of physicians
- Alien to fee-for-service win/lose v. win/win negotiation habits
  - The # 1 Challenge according to Deloitte – "[P]hysicians' culture of independence and autonomy will have to be addressed…. The relationships between primary care providers and specialists have the potential to be an issue…." Accountable Care Organizations: A New Model for Sustainable Innovation, Deloitte Center for Health Solutions, 2010.

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Why Is Developing a Culture of Collaboration the Greatest Challenge to ACO Success? (cont'd.)

– The # 1 Challenge according to Navigant – "For many organizations, today's biggest challenge is not *physician-hospital* integration, but its precursor condition, physician-physician integration. Health care leaders eager to move forward are confronting a confusing, redundant, or underdeveloped physician leadership architecture that does not support the organization of an integrated patient-centered, outcome-focused, organized delivery system…." Accountable Care Organizations & Payment Reform: Setting a Course for Success, Navigant Consulting, 2010.

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Why Is Developing a Culture of Collaboration the Greatest Challenge to ACO Success? (cont'd.)

- Hardest, compared to the other Essential Competencies for ACO Success
  - Others are tangible system, structure, and HIT components
  - This one is a largely unquantifiable and immeasurable cultural transformation

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Why Is Developing a Culture of Collaboration the Greatest Opportunity for ACO Success?

- A rare and possibly the last chance to regain control of the physician/patient relationship. Who better than you to design how care should be delivered? Leveraging effect of system design on health care improvement.
- A few physician champions can “move the dial.
- NC already a national leader in physician-driven ACO success.

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Why Is Developing a Culture of Collaboration the Greatest Opportunity for ACO Success? (cont'd.)

- Awareness half the battle. Toolkit for win/win collaboration development available. Physicians who reflexively retreat to their silos in resistance to change will never avail themselves of it. This and other physician-led ACO summits and communications are key and in motion.
- Basic Economics – When it comes to dividing up the shared savings "pie," so to speak, if there isn't a substantial pie of overall savings, it doesn't matter how well you or your specialty performed.

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Why Is Developing a Culture of Collaboration the Greatest Opportunity for ACO Success? (cont'd.)

- New physician leadership architecture emerging:
  - Ability to develop strong teams and shared culture
  - Ability to mediate stakeholder priorities
  - Ability to clearly, regularly, and consistently communicate vision, strategy, and direction to internal and external shareholders
  - Ability to change when necessary
  - Ability to innovate

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"Discussions about employment, independence, autonomy, control, power, and balance of authority—which have been producing far more heat than light—are being replaced by conversations about clinical integration, standardization, reliability, consistency, and shared leadership and influence." Accountable Care Organizations & Payment Reform: Setting a Course for Success, Navigant Consulting, 2010.

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Summary

This is hard; it takes physicians far away from their comfort zones; it will dwarf anything before it—but it is absolutely essential to ACO success according to principles of the medical profession. Will enough North Carolina physician champions emerge to effect this change in time?

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Thank You!

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North Carolina Medical Society
Leadership in Medicine

D. John Godehn, MD

Crescent PPO ACO Exploratory Committee Chair

"The Crescent PPO Experience"

Building an Accountable Care Organization
for
Western North Carolina

"Bottom Up"
or
"Top Down"
???

John Godehn, MD
NCMS ACO Summit
August 7, 2010

Accountable Care Organization "Basics"

- ACOs are increasingly seen as an answer to unsustainable increases in Health Care costs

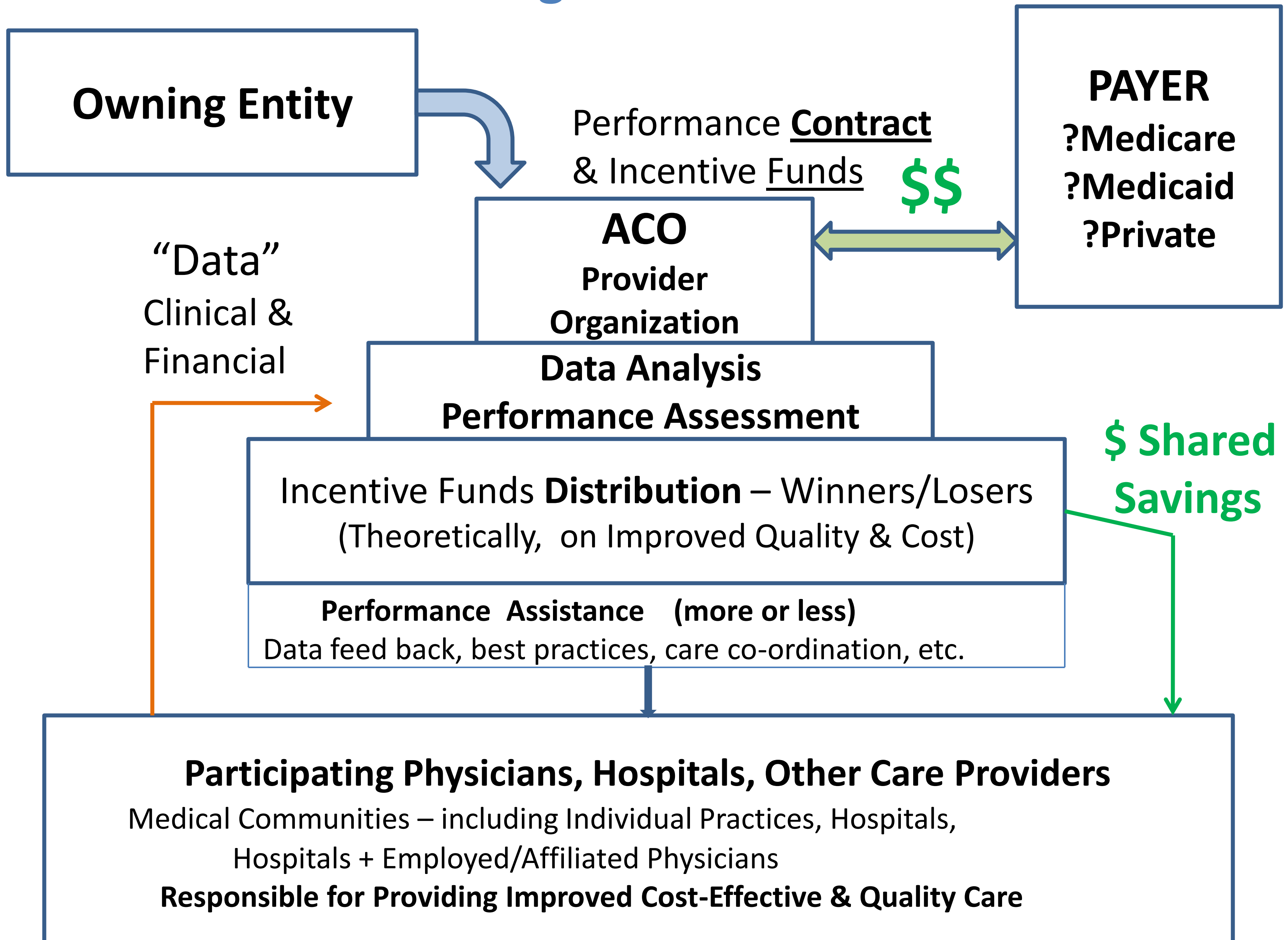
- ACOs will likely transform the System of Health Care Delivery in the US

- ACOs will likely change relationships: Payers vs Providers vs Providers

- ACOs are Provider Organizations that a Payer contracts with to provide care for a defined population.
  If the ACO meets "cost and quality contractual requirements", the ACO gets a "financial reward" that it "shares" with ACO participants [with "the devil" in the details]

- Payers like ACOs – They transfer liability for quality and cost control, along with politically difficult decisions, to Providers

- Providers (esp. large Regional Health Systems) like ACOs – They allow their "system owned ACO" to control the health care management, control performance data analysis,
  control money flow, and control care access in a region


Accountable Care Organization Structure
Owning Entity
Performance Contract
& Incentive Funds
$$
PAYER
?Medicare
?Medicaid
?Private
ACO
Provider
Organization
"Data"
Clinical &
Financial
Data Analysis
Performance Assessment
$ Shared
Savings
Incentive Funds Distribution – Winners/Losers
(Theoretically, on Improved Quality & Cost)
Performance Assistance (more or less)
Data feed back, best practices, care co-ordination, etc.
Participating Physicians, Hospitals, Other Care Providers
Medical Communities – including Individual Practices, Hospitals,
Hospitals + Employed/Affiliated Physicians
Responsible for Providing Improved Cost-Effective & Quality Care

ACO Performance

Quality and Cost-Effectiveness Improvements

Ultimately Achieved at the Individual Provider Level

(How to get everyone on board?)

Strategic Goals may include:

- Better co-ordination of care
- Better chronic disease management
- Reduce unnecessary admissions
- Accurate, cost efficient diagnosis
- Most cost effective therapeutics
- Stimulate healthier lifestyles

Tools could include:

- Clinical data analysis and "feedback"
- Support best practice guidelines
  - Patient Centered Medical Homes
  - Systematic care coordination
  - Well structured and fair incentives
  - Public support for healthier living

True Test of an ACO / The Bottom Line: Outcomes

How well the ACO can encourage and support individual physicians, hospitals, and medical communities to reach Dr. Don Berwick's "Triple Aim" of:

1) Better Care – Better Quality and Better Cost-Effectiveness
2) Healthier Communities – With Reduction in Preventable Disease
3) Better Costs – With Reduced Per Capita Expenditures

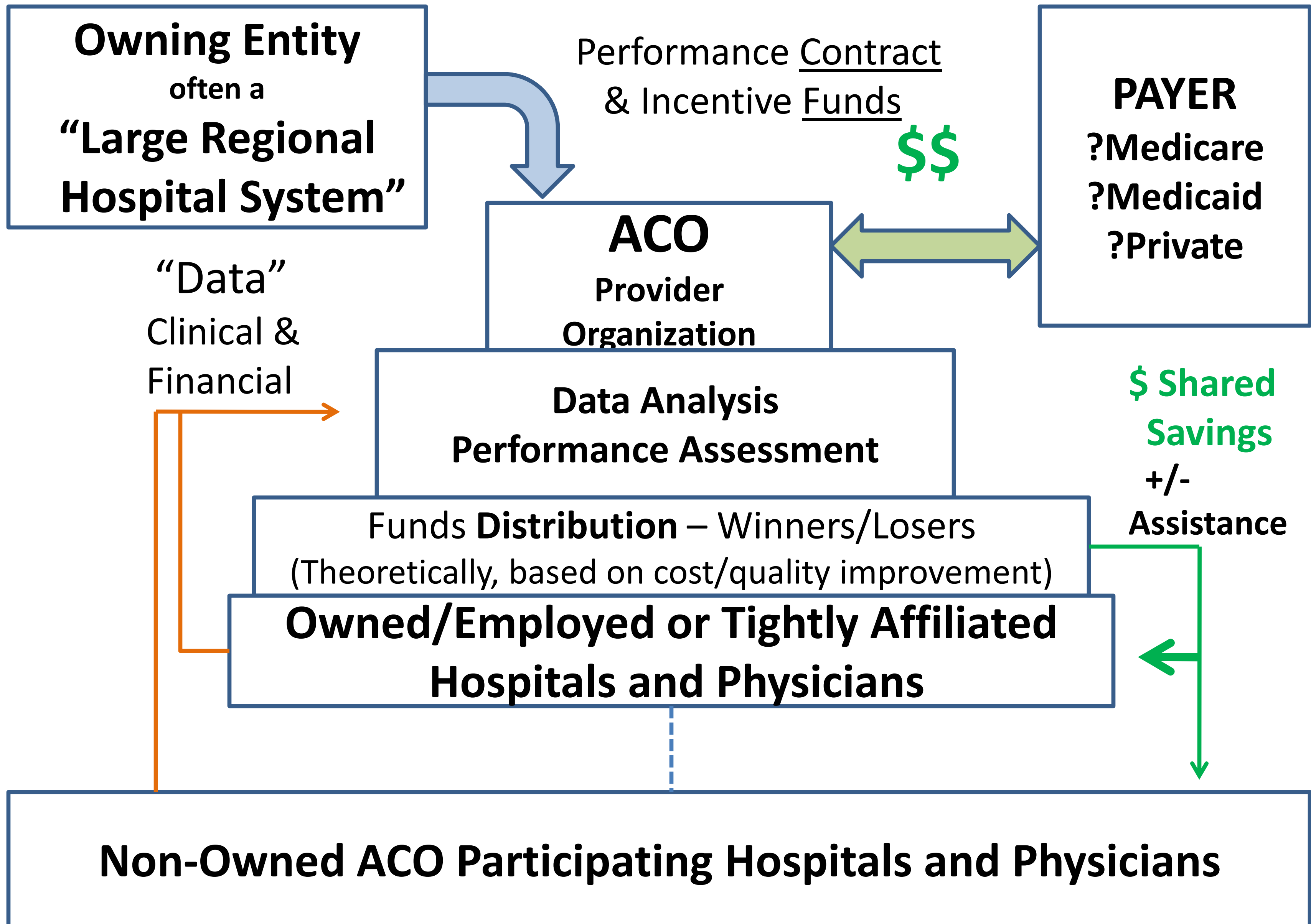
ACO Organizational Structure Design

Hopefully, ACOs will be designed for
improvement of health care and to benefit patients

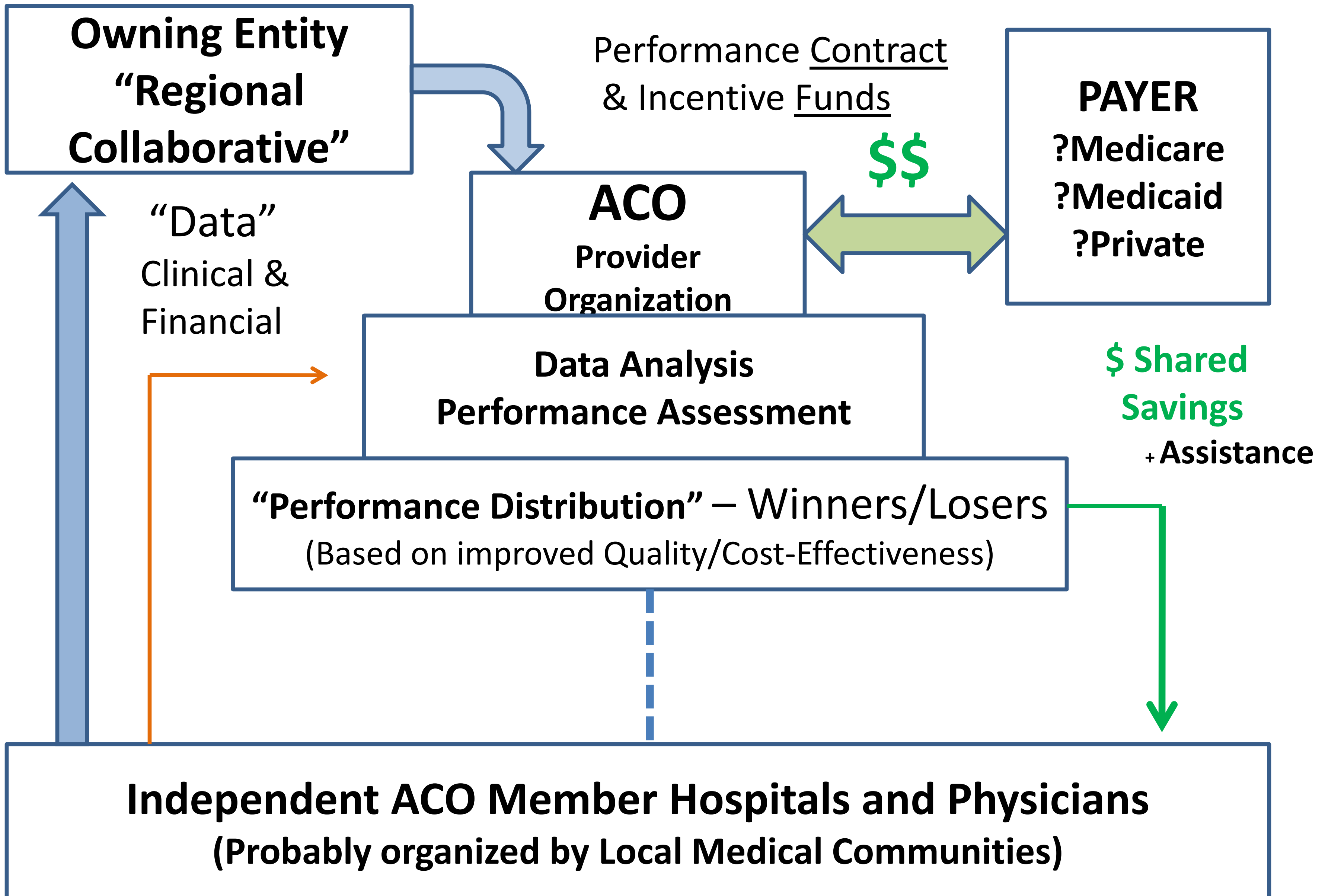
But sometimes there is the tendency to design around
Power, Control, and the Flow of Money

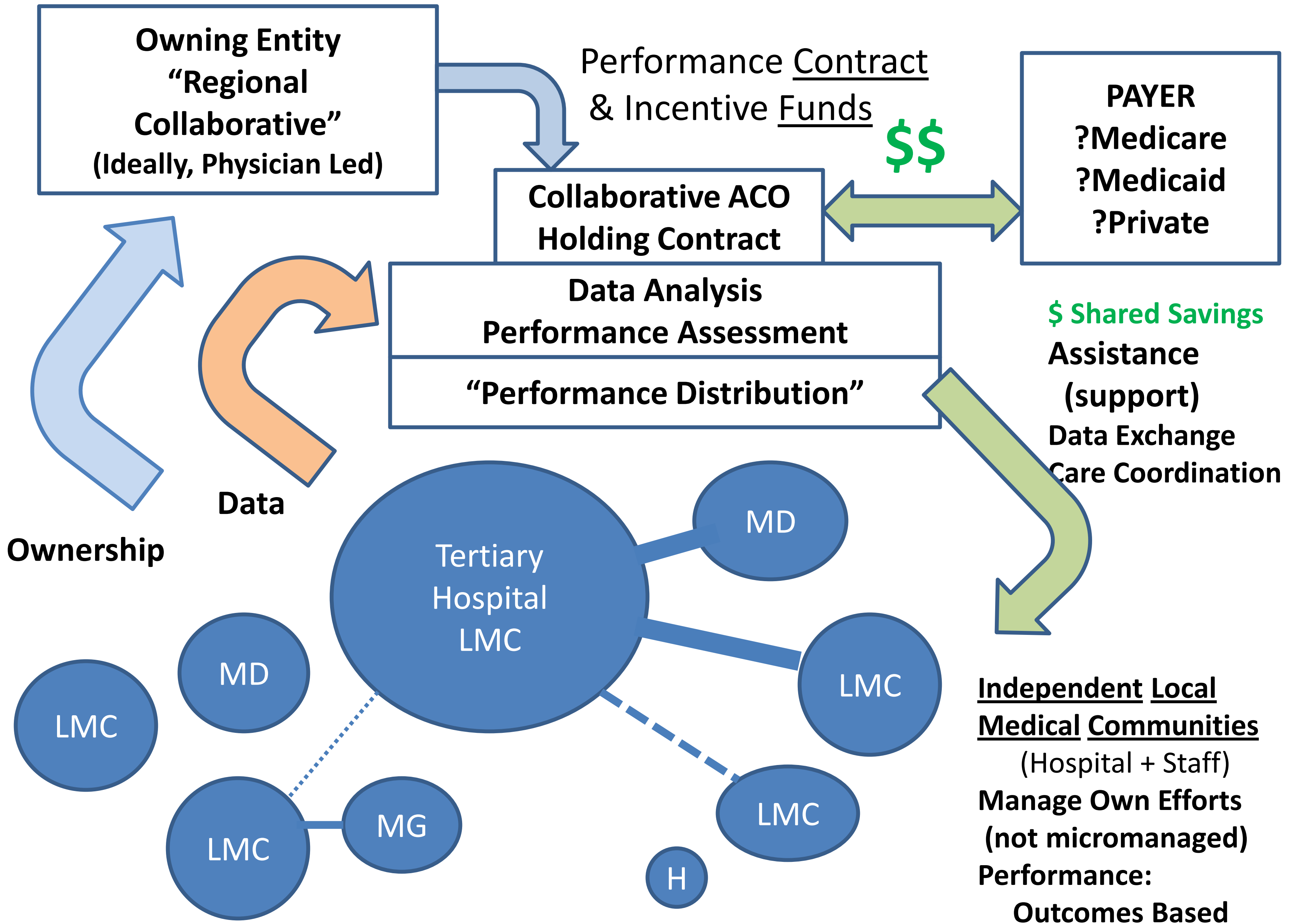
So Ask:

Who Owns the ACO ?
Who Benefits from the ACO Structure?
Who Controls the ACO-Payer Contract ?
Who Controls Data & Performance Analysis ?
Who Controls "Shared Savings" Distribution?
Who Controls Provider Participation in the ACO?
How Are Participating Physicians and Hospitals
Involved in ACO Decisions?


"TOP DOWN" ACO
Owning Entity
often a
"Large Regional
Hospital System"
Performance Contract
& Incentive Funds
$$
PAYER
?Medicare
?Medicaid
?Private
ACO
Provider
Organization
"Data"
Clinical &
Financial
Data Analysis
Performance Assessment
$ Shared
Savings
+/-
Assistance
Funds Distribution – Winners/Losers
(Theoretically, based on cost/quality improvement)
Owned/Employed or Tightly Affiliated
Hospitals and Physicians
Non-Owned ACO Participating Hospitals and Physicians

"BOTTOM UP" ACO




"BOTTOM UP" ACO
Owning Entity
"Regional
Collaborative"
(Ideally, Physician Led)
Performance Contract
& Incentive Funds
$$
PAYER
?Medicare
?Medicaid
?Private
Collaborative ACO
Holding Contract
Data Analysis
Performance Assessment
"Performance Distribution"
$ Shared Savings
Assistance
(support)
Data Exchange
Care Coordination
Data
Ownership
Tertiary
Hospital
LMC
MD
LMC
MD
LMC
LMC
MG
LMC
H
Independent Local
Medical Communities
(Hospital + Staff)
Manage Own Efforts
(not micromanaged)
Performance:
Outcomes Based

ACO Performance

Quality and Cost-Effectiveness Improvements

Ultimately Achieved at the Individual Provider Level

(Getting All On Board with a Common Vision and Effort)

"Top Down ACO"

more likely

Controlling
Micromanaging

Reduced "Buy In" with possibly less productive effort

Monopoly - One Controls all; so Limited options

But, easier to manage; more predictable

Strategic Goals include:

- Better co-ordination of care
- Better chronic disease management
- Reduce unnecessary admissions
- Accurate, cost efficient diagnosis
- Most cost effective therapeutics
- Stimulate healthier lifestyles

Tools can include:

- Clinical data analysis &"feedback"
- Support guidelines & best practices
- Patient Centered Medical Homes
- Systematic care coordination
- Well structured and fair incentives
- Public support for healthier living

"Bottom Up ACO"

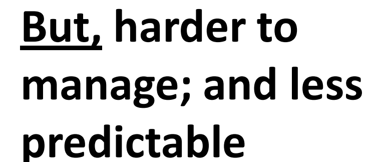
more likely

Collaborative
Macromanaged

Better "Buy In" with possibly more productive results

Independent communities with Provider options

But, harder to manage; and less predictable



Crescent PPO, Inc
Organization

(Potentially a Regional "Collaborative" ACO)

Non-Profit "Messenger Model" PPO; Includes most Physicians & Hospitals of WNC

Formed in 1999, when leaders of IPAs, PHOs & Hospitals of WNC came together

Board - 10 Physicians, 5 Hosp. reps, 2 Employer reps – from across WNC

Covers 16 Western NC Counties – Pop. ~ 750,000

15 Hospitals, including 740 bed tertiary Mission Hospital

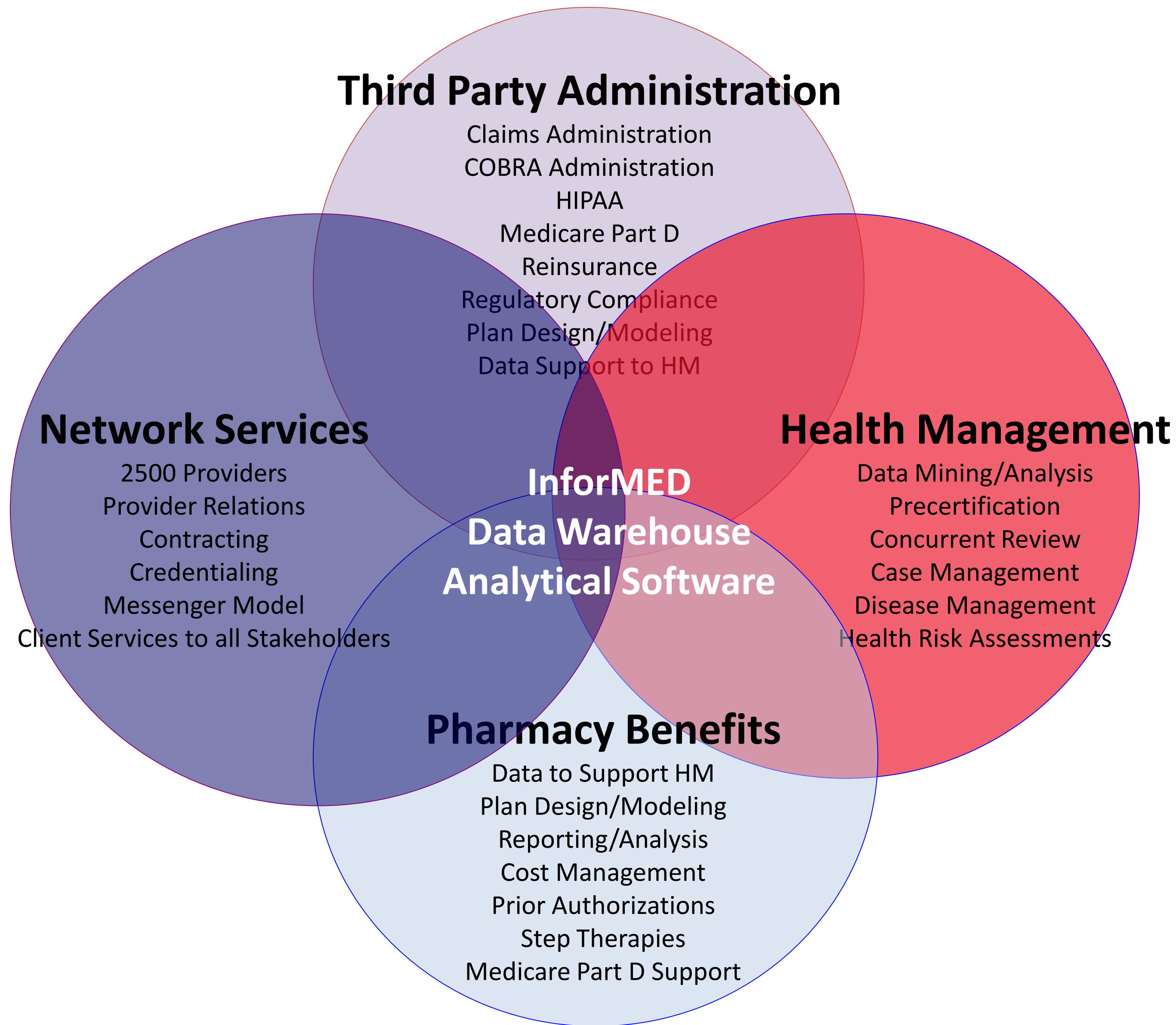
1,900 Physicians – all specialties

Covers many Employer Plans of WNC, about 36,000 covered lives

Crescent Positioned to become an ACO for WNC
("Bottom Up" Collaborative Type)

- Collaboratively owned by Physicians & Hospital Providers of WNC
- Physician led, but Partnership from Hospitals and Employers of WNC
- Core organizational infrastructure in place for an ACO
- Reputation for Competence, Fairness, Neutrality, Collegiality, and Collaboration with WNC Providers – able to serve as a trusted party for Data Analysis & Distribution of "Shared Savings"
- Able to support Local Medical Communities (Hospital & Physicians)
- Has administrative, contracting, and medical management expertise
- Has "third party administrative capability" – owns a TPA
- Affiliated Health Information Exchange (HIE) capability with Data Link; presently a hospital data exchange, plans to broaden capability
- Experience/Capability with Data Analysis and Performance Evaluation
- Experience/Capability with Case Management & Quality Improvement

Crescent Service Lines



Collaborative Crescent ACO

Crescent, Inc.
"Regional Collaborative"
(Physician Led)

Performance Contract
& Incentive Funds

$$

PAYER
?Medicare
?Medicaid
?Private

Crescent WNC ACO
Holding Contract

Data Analysis
Performance Assessment

"Performance Distribution"

$ Shared Savings
Assistance
(support)
Data Exchange
Care Coordinate

Ownership

Data

Mission

H

MD Group

H

H

H

H

MD Group

H

= **Independent Local Medical Community**
(Hospital + Physician-Led Medical Staff)

Challenges for Crescent Becoming a Regional ACO

- **Limited Capital and Administrative Staff in the Crescent Organization**
  - •However, only a "lean" organization needed; capital/capacity in LMCs
  - •Crescent's purpose: To provide coordination, not to micromanage.
  - •Some functions, ie. sophisticated data analysis, could be outsourced
- **How to provide a "Tight" Organization for ACO Payer Contracting**
  - •Presently, providers can choose limited time in particular PPO contracts, ACO contracting will require firm, longer term commitments
- **The Challenge of "Herding Cats" in a Collaborative Organization; and Getting all Providers to agree on Vision & How to Share Risk/Loss/Gain**
  - •Crescent has history of fair collaboration and collegial interactions
  - •Remind all: "Hang Together, or Hang Separately – and fracture WNC"
- **How to deal collaboratively with various health system "affiliations"**
  - •Affiliations include Mission Health System, Carolinas Health, Adventist
  - •A coherent WNC medical community in everyone's interest, esp. patients
- **Mission Health System intentions ? – a major Partner, or "The ACO"?**

Mission Health System's Consideration:

"Is it better to be the Major Partner in a Regional Collaborative ACO,
or better to be 'THE' Regional ACO?" - Mission seems moving to the latter

- **Mission appears rapidly gearing up to become a Regional ACO for WNC**
- **Mission recently hired a new CEO**
  Ron Paulus, MD – presently VP for Operations/Innovations-Geisinger
  MD from U of Penn (with honors); MBA from Wharton (with honors)
  Founder and CEO (along with Dr. David Brailer) of CareScience,
  the HIT forerunner to the RHIO concept; sold to Premier, Inc.
- **Mission recently became part of the "Premier ACO Collaborative" Project**.
  Premier 's ACOC provides tools (data metrics, best practices, etc) and the sharing of ACO development concepts among large member Health Systems around the country (ie. Geisinger, Henry Ford, etc) – Thus, provides support for large health systems to build their "top down" ACOs.
- **Mission has several medical groups and hospitals in its Health System**
  and is closely affiliated with several other hospitals in WNC
- **Mission is holding a "Regional Conference" in the next few months**
  to try and bring WNC providers on board for a Mission led ACO
  (? a "pure top down" model or "federated collaborative top down" model)

So Where Are We with an ACO for Western North Carolina?

Crescent is actively exploring developing a "bottom up"
Collaborative ACO Model for WNC, built around Crescent PPO

Mission is actively exploring developing a "top down"
regional health system controlled ACO Model for WNC,
built around The Mission Health System

Mission is an outstanding health system, but will the providers of WNC be comfortable in a "top down" ACO model?

It is likely in the next few months, the Physicians and Hospitals of Western NC are going to have to decide
which horse to support, which horse to ride.

We will see!

[Postscript: I think physicians are divided. If one has an attractive position with a major health system, the choice between hanging with fellow physicians in a collaborative, or hanging with the "health system," may be difficult .]

North Carolina Medical Society

Leadership in Medicine

Questions?

North Carolina Medical Society
Leadership in Medicine

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Community Care of North Carolina

Community Care of NC

NCMS ACO Summit

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Lawrence M. Cutchin, MD, FACP

Musical Chairs

- Health Planning Councils
- Health Systems Agencies
- HMOs
- PSROs
- PPOs
- IPAs
- PHOs

We all know

If you ignore your health and it will go away.

We all know

You can’t build and maintain muscle without exercise.

We all know

You can’t accumulate knowledge without study and effort.

So need to recognize that

In today's world you can't expect to be granted authority to impact change in the way health care is delivered if you don't assume responsibility for assuring the best outcome at the best price.

CCNC Origins

- 1988 ORDRHD Wilson County Demonstration Project
- Medicaid Waver obtained to allow expansion of the concept across NC as Access I and later Access II
- By 1998 Carolina Access included 9 networks and 20 primary care practices and continued to demonstrate savings
- 1998 Community Care Program initiated

CCNC Current Status

- State-wide- CCNC present in all 100 counties
- CCNC Networks are a public private partnership with a majority of NC physicians, hospitals, health departments and other providers to improve care locally
- Currently over 1 million NC Medicaid recipients are enrolled
- Provides advanced primary care (a medical home) for every Medicaid patient (4200 primary care physicians)
- All our academic medical centers and largest health systems are involved
- Every network provides a local organization to provide care managers, pharmacists, medical directors and other professionals to improve local healthcare delivery
- Represents a 10 year investment by NC and has been recognized nationally as a best practice
- Many states are actively developing models based on CCNC
- CCNC is in the national spot light!

Community Care Networks

- Not for profit
- Physician led
- Board must have physicians, hospital, health dept, social services represented
- Medical Management committee representing majority of primary care practices (medical homes)
- Accountable for quality and cost in their geographic region (Medicaid)

System Wide Quality Initiatives

- Asthma Disease Management
- Diabetes Disease Management
- Pharmacy Management
- Emergency Department Utilization Management
- Case management to High Cost/High Risk Patients
- Heart Failure

Individual Network Quality Initiatives

- Assuring Better Child Development
- Chronic Obstructive Pulmonary Disease Care
- Improved Access to Non-Emergent Care
- Improving Pediatric Access Through Collaborative Care
- Diabetes Disparities
- Medical Home/ED Communication
- Assisting Primary Care Physicians in Providing Patient Behavioral Health Care
- Co-Location of medical and behavioral health care within the same practice setting

Key Current CCNC Resources

- Contract with the State of NC to Manage Medicaid Care Quality and Cost
- Local Care Managers (#400)
- Local Medical Directors (#30)
- Primary Care Access for All Patients (4200 PCPs)
- Clinical Pharmacists Locally (#18)
- Central Staff Focused on Clinical Program Support and Implementation (#28)
- Data Center Providing Quality and Care Management Data to Networks and Practices

Complimentary NC Assets

- AHEC
- NCHQA
- NCHIE
- BCBS,SEHP and MedCost represent a majority of insured
- DHHS /ORHCC
- Strong Foundations

What CCNC Needs to be More Effective

- Organized Involvement of Specialists
- Stronger Analytic Staff Support
- IT Capability to Provide Risk Adjusted Performance Reports
- Predictive Modeling Systems
- Financial Capacity and Infrastructure to Engage in Risk Contracting

How it Works Now

- The state identifies priorities and provides additional financial support through an enhanced PMPM payment to community networks and physicians
- Networks pilot potential solutions and monitor implementation (physician led)
- Networks voluntarily share best practice solutions and best practice is gradually spread to other networks
- The State provides the networks access to data
- The State does an every 2 yr retrospective evaluation of the cost savings and effectiveness of the program (Mercer Eval).

The Results

- Quality: CCNC performance in the top 10% nationally in HEIDIS measures for diabetes, asthma and heart disease compared to managed care organizations
- Cost savings: from 2003-2007 CCNC has saved $ 568 million for AFDC and $400 million for ABD based on Mercer Evaluations

Opportunities

- 646 demo
- Beacon Grant
- RECs
- SEHP changes (Active Health)
- Multi-payer Advanced Primary Care Demonstration
- ACOs

646 Counties

Exempt

Intervention

Holdouts

Ashe
Alleghany
Surry
Stokes
Rockingham
Caswell
Person
Granville
Vance
Warren
Northampton
Gates
Currituck
Camden
Pasquotank
Perquimans
Chowan
Hertford
Bertie
Halifax
Franklin
Nash
Edgecombe
Martin
Washington
Tyrrell
Dare
Wilkes
Yadkin
Forsyth
Guilford
Alamance
Orange
Durham
Wake
Wilson
Pitt
Beaufort
Hyde
Watauga
Mitchell
Avery
Caldwell
Alexander
Davie
Davidson
Randolph
Chatham
Johnston
Greene
Madison
Yancey
Buncombe
McDowell
Burke
Catawba
Iredell
Rowan
Lee
Harnett
Wayne
Lenoir
Craven
Pamlico
Haywood
Swain
Graham
Jackson
Henderson
Rutherford
Polk
Cleveland
Lincoln
Gaston
Cabarrus
Stanly
Montgomery
Moore
Mecklenburg
Cherokee
Clay
Macon
Transylvania
Union
Anson
Richmond
Scotland
Hoke
Cumberland
Sampson
Duplin
Jones
Onslow
Carteret
Robeson
Bladen
Pender
Columbus
New Hanover
Brunswick

Updated: October 1, 2009

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Access II and III Networks

Legend

- AccessCare Network Sites
- AccessCare Network Counties
- Access II Care of Western North Carolina
- Access III of Lower Cape Fear
- Carolina Collaborative Community Care
- Carolina Community Health Partnership
- Community Care of Wake / Johnston Counties
- Community Care Partners of Greater Mecklenburg
- Community Care Plan of Eastern Carolina
- Community Health Partners
- Northern Piedmont Community Care
- Northwest Community Care Network
- Partnership for Health Management
- Sandhills Community Care Network
- Southern Piedmont Community Care Plan

Is CCNC an ACO?

- Regional networks
- Responsible for assigned population
- Focused on quality and costs
- Not for profit
- Medical Homes

What is missing?

P4P, clinical integration legal benchmark

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Questions?

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Wrap-Up

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HEALTH SYSTEM REFORM resource center

New Health System Reform Law

Final Health System Reform Law (includes Reconciliation Bill Language) (PDF - 907 pages)

- NEW! Health System Reform Overview (PowerPoint) - NCMS presentation that spells out implications of new health care reform laws and the timeline for implementation.
- NCMS Analysis of How Health Reform Will Affect the Medicaid Program in North Carolina (PDF)
- Demonstration and Pilot Programs Included in the Patient Protection and Affordable Care Act of 2010 (PDF)

ACO Information & Resources

- Current NCMS Draft ACO Policy (PDF)
- Medicare "Accountable Care Organizations" Shared Savings Program – New Section 1899 of Title XVIII (PDF)
- CMS Forum Summary 7/1/10 (PDF)
- AMA ACO Resources
- ACO Excerpts from the Patient Protection and Affordable Care (PDF)

NCMS on Health Reform

NCMS Focus on HSR

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ACO Information & Resources Available