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AMERICAN ACADEMY OF
FAMILY PHYSICIANS

STRONG MEDICINE FOR AMERICA

Objectives

1 Describe impact of ACO on Family Medicine

2) Elaborate on the role of AAFP members in the payment & delivery models pertinent to Family Medicine

3) Evaluate the ACO in the context of health care reform, Patient Centered Medical Home and impact on Family Medicine.

Abbreviations

- Accountable Care Organizations (ACO)
- Feds
  - Center for Medicare & Medicaid Services (CMS)
  - Health & Human Services (HHS)
- Patient Centered Medical Home (PCMH)
- Per-member-per-month payment (PMPM) or per-patient-per-month
- Fee-for-Service (FFS)

President Obama signs Affordable Care Act (ACA) 3/2010

Push for ACA

- Control health care costs
  - This was #1 priority for many
  - Question has been how best to do this
- Expand health insurance coverage
- Improve health

Incentives from ACA

- Community-based care funds grants
- Programs to keep patients at home
- Initiates payment reforms and pilots for PCMH,
- ACO’s and bundled payment models

Budget-Based Payment

- Attempts to shift delivery from volume to value
  - Away from FFS
- Capitation
- Shared savings
- Bundled

Capitation

- Prospective global payment
- Risk falls to provider
  - FFS risk is with payer
- Payment for patient includes:
  - Complications
  - Utilization extremes
- Managed Care is example

Episode-Based

- Bundled payment synonym (sometimes)
- Payment is bundled= single payment
- Specific condition
- All setting
- Provider has all the risk but less exposure due to limited time

What is an ACO?

- Takes concept of PCMH "neighborhood"
- PCMH are foundational to success
- Assume responsibility for defined population
- **Financial risk and savings issues**
  - **Must understand risk adjustment**

Why the push for ACO?

- Attempt to move to new model
- Away from traditional fee-for-service
- Control costs
- Achieve quality markers

PCMH Neighborhood

- PCMH primary care based
- Expanded with:
  - Subspecialists
  - Mental Health
  - Support services
  - +/- hospital

ACO Payment Structures

- Medicare contracts
- Medicaid (dual eligible)
- Private insurance contracts
- Degree of provider integration predictor of ACO formation
  - Integrated hospital systems and larger PC groups increased ACOs.

Health Affairs. Oct 1013

Types of Payment Structures

- Shared savings
  - FFS is basis
- Capitation
- Bundled/ DRG
- Pay for Performance
  - Bonus or increased differential on top of FFS

Shared Savings Options

- Upside or both upside & downside
  - Retrospective adjustments to payments based on cost and quality
  - 2 sided= provider repays if cost overruns but gets share of savings if costs are less than predicted
  - 1 sided= shares in savings if any, but less $$ than 2 sided formulas since there is less risk

Payment Issues

- Risk of penalties if miss savings targets
- Acuity of patients
- 3 year baseline formula for spending target
- Have to calculate the start-up cost
  - Staff support, IT

Quality measures- CMS

- 33 NQF measures in 4 areas:

1. Care coordination and patient safety
2. Preventive care
3. Patient experience
4. Care for at risk populations

Quality Markers

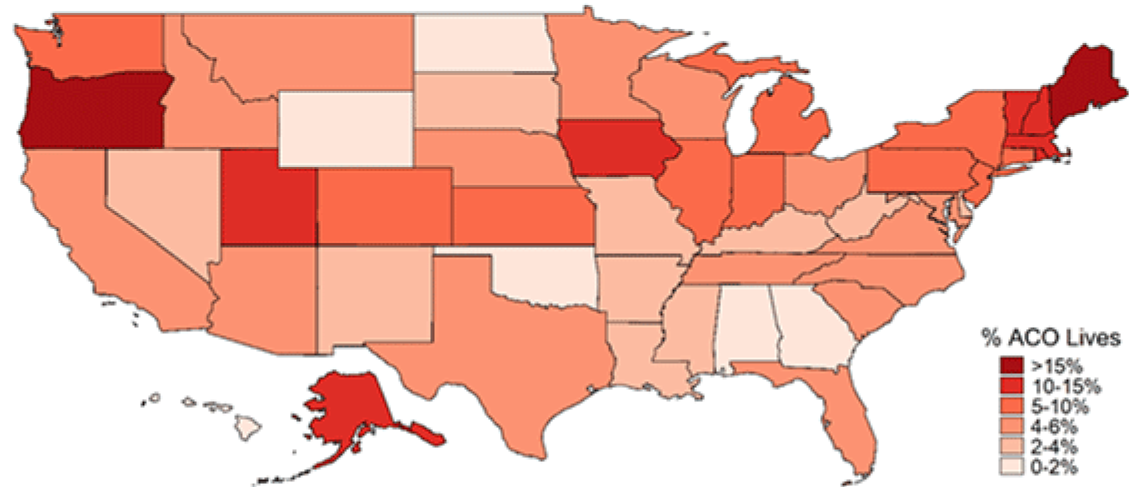
- HEDIS measures
- Inpatient hospitalization & readmissions
  - Usually ambulatory care-sensitive (CV, DM)
- Patient satisfaction
  - May not be indicative of either quality of care or predictive of cost expenditures or savings

Fenton JJ, Jerant AF, Bertakis KD, et al. The cost of satisfaction: a national study of patient satisfaction, health care utilization, expenditures, and mortality. Arch Intern Med 2012;172:405–11.

Medicare Program

- 366 ACOs after 4 rounds of Medicare Shared Saving Programs (MSSP) contracts
- 606 including public & private ACOs
- Minimum of 5,000 beneficiaries
- 3 year commitment
- Adhere to same basic coverage as set in ACA rules

ACO Penetration



ACO in NM

- Accountable Care Coalition of New Mexico, LLC
- GPIPA ACO
- Presbyterian Healthcare Services

ACO Structure Options

- Physician led/owned- predominant
- Hospital system
- Non-profit community organization
- Practice management companies

JAMA The Journal of the American Medical Association

May 14, 2014, Vol 311, No. 18 >

Viewpoint | May 14, 2014

Health Reform and Physician-Led Accountable Care

The Paradox of Primary Care Physician Leadership FREE

Farzad Mostashari, MD, MPH[1]; Darshak Sanghavi, MD[1]; Mark McClellan, MD, PhD[1]

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JAMA. 2014;311(18):1855-1856. doi:10.1001/jama.2014.4086.

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Physician Leadership in ACOs

- 51% physician led, 33% physician + hospital
- 78% majority on governing boards
- 40% physician owned

First National Survey Of ACOs Finds That Physicians Are Playing Strong Leadership And Ownership Roles

Health Affairs June 2014

Physician Led ACO Examples

- Wilmington Health, NC
  - Medicare Shared Savings
  - BCBS

ACO impact for FM

- Opportunity for income but also for financial risk depending on structure
- Need to determine how savings are shared- Who gets what cut of the pie
- Very difficult (impossible) for solo without other integration but doesn’t require hospital centric platform, just more common

ACO Implications for Patients

- Attempts to balance cost savings with quality & patient outcomes
  - Reaction to prior managed care & incentive to withhold care to control costs
- Emphasis on integration of care, communication, prevention
  - Most realize cornerstone is adequate network of primary care

Vulnerable Populations

- High- risk clinical populations
  - CHF, DM, mental health issues, etc
- High-risk social populations
  - Poverty, illiteracy, etc
- Opportunity to target interventions with greatest reward either in cost savings (decreased ER/hospital $) or increased quality

Cautions & Challenges

- Defined patient population- “attribution”
- Management of “drift” outside network
  - Penalties to pts for this?
- Data is mandatory

  “big data” but also **actionable** patient level
- Support to act on this data

Data

- Attribution of patients
  - Prospective vs performance year methods
- Track by population and by individual and their provider group
- Requires current claims data- Medicare, Medicaid, private insurance

Patient Engagement

- Critical component for ACO and any intervention
- Yet this is elusive

Summary

- ACO likely to propagate further
- Resources available to evaluate plan to determine if wise move:
  - cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/index.html
  - AMA, AAFP, Most state medical societies
  - Health Affairs, Commonwealth Fund, Kaiser Permanente Foundation

Resources

Quality Measures and Perf ×

www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Quality_Measures_Standards.html

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Home > Medicare > Shared Savings Program > Quality Measures and Performance Standards

Shared Savings Program

- ACOs in Your State
- CMS Regional Office Contacts for ACOs
- Financial and Assignment Specifications
- Frequently Asked Questions
- Medicare Shared Savings Program ACO Fast Facts
- Medicare Data to Calculate Your Primary Service Areas
- Program News and Announcements
- Quality Measures and Performance Standards
- Shared Savings Program ACO Agreement
- Shared Savings Program Application
- Statutes/Regulations/Guidance

Quality Measures and Performance Standards

Quality data reporting and collection support quality measurement, an important part of the Shared Savings Program. Before an ACO can share in any savings generated, it must demonstrate that it met the quality performance standard for that year. There are also interactions between ACO quality reporting and other CMS initiatives, particularly the Physician Quality Reporting System (PQRS) and meaningful use. The sections below provide resources related to the program's 33 quality measures, which span four quality domains: Patient / Caregiver Experience, Care Coordination / Patient Safety, Preventive Health, and At-Risk Population. Of the 33 measures, 7 measures of patient / caregiver experience are collected via the CAHPS survey, 3 are calculated via claims, 1 is calculated from Medicare and Medicaid Electronic Health Record (EHR) Incentive Program data, and 22 are collected via the ACO Group Practice Reporting Option (GPRO) Web Interface.

Narrative Specifications for all 33 Measures

Coming Soon In this section we will post a document with narrative measure specifications for the 33 quality measures for the 2014 reporting period, as well as release notes that indicate changes to the specifications since the 2013 reporting period. For reference, the narrative measure specifications for all measures for the 2013 reporting period can be found in the section Prior Reporting Years' Documentation, below. The sections below contain links to additional documentation with details specific to some measures.

ACO GPRO Measures

Visit the GPRO Web Interface page for ACO GPRO measures documents related to the 2014 reporting period, including: narrative measure specifications; supporting documents; measure flows; XML specifications; and training videos, as well as Q&A resources. This web site will be updated periodically before and during the reporting period as these and other resources are made available.

Administrative and Claims Based Measures

In this section, we provide Measure Information Forms (MIFs) that include technical specifications for ACO claims-based and administrative measures for the 2014 reporting period.

- ACO #8 Risk Standardized All Condition Readmission [PDF, 372KB]
- ACO #9 – Prevention Quality Indicator (PQI): Ambulatory Sensitive Conditions Admissions for Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults [PDF, 259KB]
- ACO #10 – Prevention Quality Indicator (PQI): Ambulatory Sensitive Conditions Admissions for Heart Failure (HF) [PDF, 257KB]
- *Coming Soon* ACO #11 – Percent of Primary Care Physicians Who Successfully Qualify for an EHR

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