ACO Accelerated Development Learning Sessions

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Setting Priorities and Leading ACO Formation

June 20, 2011
1:30–3:30 p.m.

Perspectives, Priorities, and Leadership

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Key Concepts

- Managing a population
- Creating "systems of care"
- Measurement using data for all services provided to beneficiaries
- ACO infrastructure
- Understanding budget risk
- Recipes for success

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Managing a Population

- Focus for an ACO changes from delivering services for patients to managing quality and cost of a population
  - Who is the population?
    - Medicare – attribution using PCP services
    - Private insurance –
      - Attribution, or
      - Enrollment in a “product”
- Longer term investments may now be practical
  - Controlling diabetes, hypertension, smoking, and body weight
  - Investing in extended hours and open scheduling practices
  - Understanding costs and quality of whole episodes of care (e.g., a hip replacement)

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Managing a Population

Service Category	Admissions per 1,000	Length of Stay	Total Utilization per 1,000	Allowed Average Charge	PMPM Claim Cost
Inpatient Facility					
Medical	16.4 Admits	2.91	47.8 Days	$4,150.30	$16.53
Surgical	13.2 Admits	3.45	45.5 Days	$8,957.05	$33.96
Skilled Nursing	1.8 Admits	12.00	21.6 Days	$603.73	$1.09
…	…	…	…	…	…
Total Inpatient	48.1 Admits	3.35	161.0 Days		$62.64
Outpatient Facility					
Emergency Room			104 Cases	$1,342.87	$11.64
Surgery			56 Cases	$3,258.70	$15.21
Radiology					
General			163 Cases	$306.74	$4.17
CT/MRI/PET			27 Cases	$1,313.96	$2.96
…	…	…	…	…	…
Outpatient Total					$45.85
Professional					
Office/Home Visits			2,669 Visits	$63.50	$14.12
Inpatient Visits			137 Visits	$151.78	$1.73
Inptient Surgery			28 Proced	$2,038.94	$4.76
Emergency Room Visits			113 Visits	$172.82	$1.63
Radiology					
General			727 Proced	$92.81	$5.62
CT/MRI/PET			94 Proced	$383.76	$3.01
…	…	…	…	…	…
Professional Total					$53.48
…	…	…	…	…	…
Total Medical Cost					**$250.64**

Source: V. Boyarski, et al., ACOs beyond Medicare, Milliman Healthcare Reform Briefing Paper, April 2011 © 2011 Milliman, Inc.

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Managing a Population

Service Category	% of beneficiaries with claims	Services per user	Services per 1,000 beneficiaries	Expenditure per service	PMPM Claim Cost
Inpatient Facility					
Medical	13%	1.6 Admits	215 Admits	$6,302.65	$123.03
Surgical	7%	1.2 Admits	83 Admits	$16,844.78	$127.40
Skilled Nursing	5%	37.7 Days	1,802 Days	$350.47	$57.41
…	…	…	…	…	…
Total Inpatient					$341.35
Outpatient Facility					
Emergency Room	20%	2.8 Visits	553 Visits	$104.50	$5.26
Procedures	13%	17.0 Proced	2,148 Proced	$92.02	$17.97
Imaging	38%	3.7 Proced	1,400 Proced	$105.98	$13.49
…	…	…	…	…	…
Outpatient Total					$95.35
Professional					
Office Visits	70%	7.7 Visits	5,373 Visits	$52.38	$25.48
Inpatient Visits	18%	15.8 Visits	2,912 Visits	$62.84	$16.64
Inptient Surgery					
Emergency Room Visits	24%	2.0 Visits	470 Visits	$92.87	$3.97
Radiology					
Standard imaging	54%	10.8 Proced	5,823 Proced	$15.62	$8.27
CT/MRI/PET	27%	2.9 Proced	799 Proced	$107.61	$7.81
…	…	…	…	…	…
Professional Total					$187.24
…	…	…	…	…	…
Home health	8%	38.4 Visits	3,170 Visits	$141.50	$40.78
DME	26%				$24.12
Total Medical Cost					$709.87

Source: Centers for Medicare & Medicaid Services, Unpublished Data, 2008

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Creating New "Systems of Care"

- ACO provider networks
  - PCPs as key ACO participating providers
  - Specialists – either:
    - Part of the ACO network as care coordinators (e.g., cardiologists)
    - Outside in the community, receiving referrals
  - Hospital:
    - Sometimes as an ACO participating provider
    - Sometimes as a community provider
    - Tertiary care hospitals for certain procedures
  - Other providers – labs, imaging centers, post-acute facilities, etc.
- "Leakage" to non-ACO providers:
  - How much?
  - For which services?

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“Systems of Care”

- Systems come in many forms, suited to local conditions:
  - PHOs
  - Physician groups
  - Hospitals with employed physician groups, usually also with some community physicians
  - Integrated Delivery Systems (IDSs)
- Key concept:
  - All have a formal organization structure as an ACO
  - All have contractual arrangements for services and payments

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Measurement Using Data

- Multiple data streams
  - Local EMR data
    - Near-real-time data feeds at the clinician's site
    - Possible additional data from local health information exchanges (HIEs)
  - Additional clinical data
    - Lab data feeds
    - Rx data may be possible
  - Payor data feeds
    - Periodic feeds for all claims paid
    - Will include non-ACO claims/services, but with a lag

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Measurement Using Data

- Examples of data analyses tools
  - Quality reporting
    - Quality “scoreboards” by physician (e.g., for CAD or diabetes measures)
    - Registries
  - Cost metrics
    - Actual to target, by specialty service or service type
    - “Drill down” reports by each specialist
    - Referral costs, by episode
    - High-cost cases

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ACO Infrastructure

- Some of the services needed:
  - Claims adjudication (if needed)
  - EHR
  - Utilization management
  - 24/7 nurse hotlines
  - Budget monitoring
  - Measurement reporting
  - Network contracting (depending on the size of the ACO)
  - Patient education and handbooks, etc.
  - Credentialing of ACO providers
  - Quality improvement programs

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ACO Infrastructure

- Where to obtain services:
  - "Make vs. Rent" dilemma
    - More control when an ACO invests funds into some or all of these components
    - Lower (or no) upfront investment to "rent" ACO services from available organizations
      - Some Management Service Organizations (MSOs) have a long history of serving capitated medical groups
      - Some insurers may "rent" their surplus capacity
      - Other single-service organizations (e.g., data reporting or utilization management)

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ACO Infrastructure – Sample Timeline

Activity	Date
Decision to form an ACO	1/1/XX
Inventory internal capability	2/1
Discuss needed services	3/1–4/1
RFP prepared	4/1–5/1
RFP released	6/1
MSO vendors proposals received and reviewed	8/1–9/1
Final MSO terms negotiated	9/15–30
Implementation	10/1–12/15
“Go live” date	1/1/XX+1

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Understanding Budget Risk

- “Budget risk” is holding ACO providers responsible for the cost and quality of care provided to a defined population of patients
- Two main types being discussed:
  - “Bonus only,” where good performance on both quality and cost leads to gain sharing
    - Generally a threshold must be exceeded before payments are made
  - “Upside/downside” risk where the ACO is rewarded for good performance but also may owe a repayment if the budget is exceeded

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Budget Risk

- Based on:
  - Attributed patients
  - Historical patterns of care, as seen in claims data
  - A trend factor to project into the “budget year”
  - Any necessary adjustment for changes in population risk
  - Adjustments for new entrants, deaths, and those leaving the ACO (e.g., people who move out of the area)

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Patient Responsibility

- Patients of an ACO have responsibilities:
  - See their PCP first!   (But not as a gatekeeper)
  - Take actions to maintain their own health
    - Ask questions
    - Listen to and act on directions of the care coordination team
    - Recognize their own role in staying healthy
    - Improve their health literacy

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Recipe for Success

- Formal structure of ACO providers
- Understanding the history of the ACO population
- Focusing on specific clinical intervention tactics
- Measuring quality and cost on a frequent basis
- Teamwork – physicians, RN and other clinicians, hospital staff, payor reps
- Great leadership and vision of a new system!

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