Accountable Care Organizations: A Viable Model for CAH Participation?

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The Changing Landscape

- **$$** must be squeezed out of current health care expenditures: 20+% of GDP by 2020 is not acceptable
- **Both** price and quantity of services must be reduced
- Changes will happen in the delivery system, fundamental not cosmetic
- For health systems, PRESSURE TO GROW AND SUSTAIN PATIENT VOLUME

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Coincidental Presence of Models for Change (old and new)

- Prevention and population health
- Community well-being
- Bundled payment
- Value based purchasing
- Managed care organizations
- Accountable care organizations

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Demand for services will shift

- Expansion of Medicaid enrollment with some federal help in paying providers, but limited
- Expansion of enrollment in the individual and small group markets
- CAN'T EXPECT CURRENT/HISTORIC APPROACHES TO DELIVERING AND FINANCING CARE TO RESPOND TO THIS SHIFT

Points of Emphasis

- Payment will change
- Numbers of patients will drive success
- Care management will be required
- Capturing share of shrinking dollar

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ACOs are One Means to the End

- Medicare Shared Savings Program
- Pioneer ACOs
- Advanced Payment Model
- Private Sector

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The future is NOW in many places

- Private action: Brookings-Dartmouth learning sites, Premier, CIGNA, Others
- Public Sector: Beacon communities, Practice Group Demonstrations, Medicaid, Medicare
- Urban based, FOR NOW
- But reaching beyond: Carilion System in Virginia

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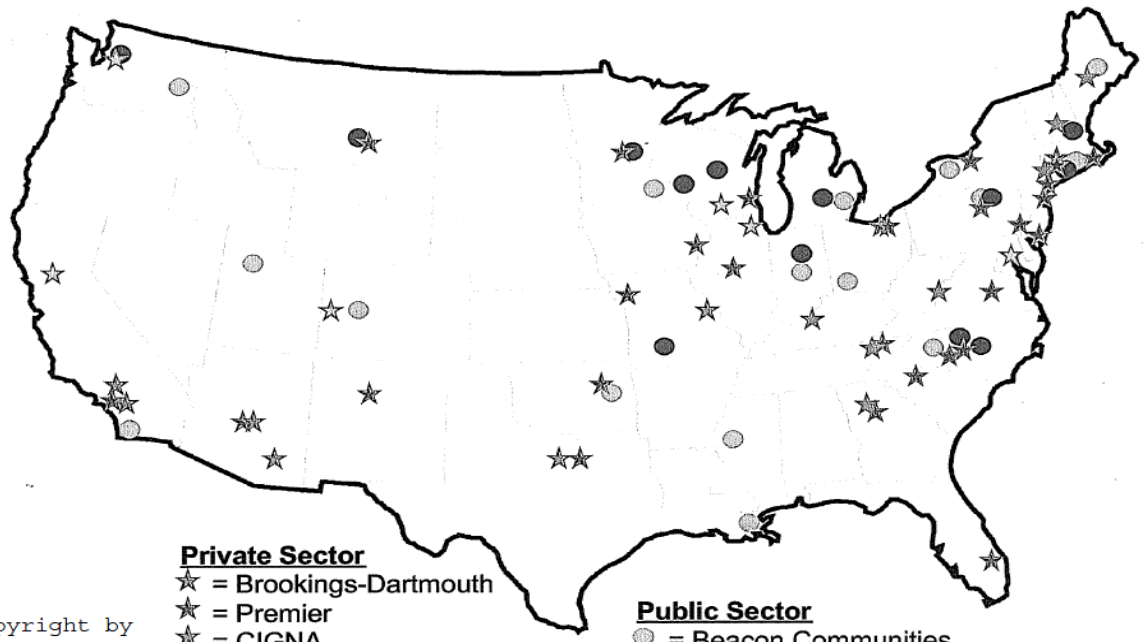
The National Map: Constructed by the ACO Learning Network

Looking back: the obvious progress

Many moving forward with ACOs



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ACO
ACCOUNTABLE CARE ORGANIZATION
LEARNING NETWORK

www.acolearningnetwork.org

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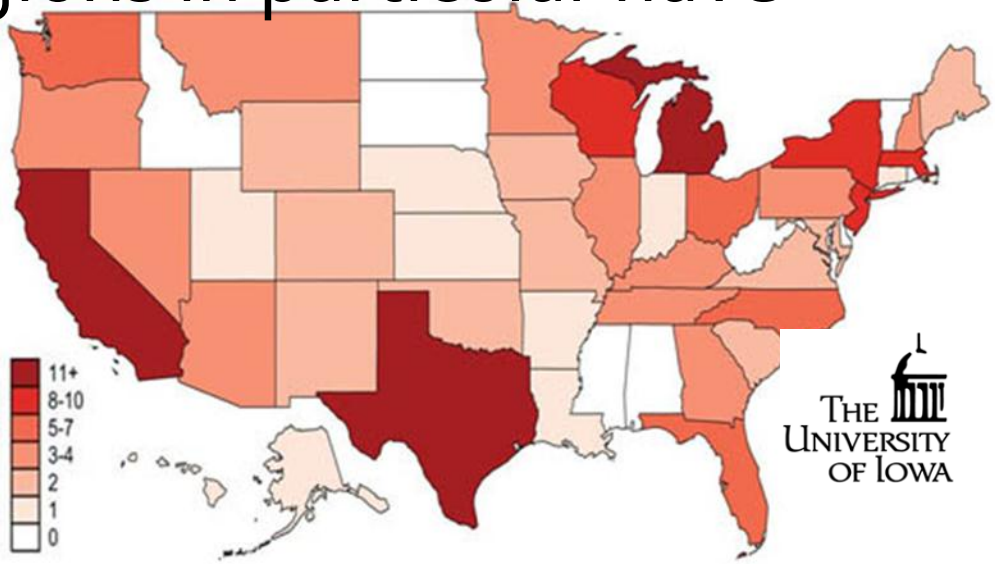
Report from Leavitt Partners in November 2011

- 164 ACOs nationally
- "A clear movement is evolving within the health care industry towards the accountable care model of providing health services."
- "Poorer and rural regions in particular have little ACO growth
- LeavittPartners.com



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ACO Activity in the Northwest

- Washington:
  - 3 ACOs headquartered in hospital systems
  - 3 ACOs headquartered in Independent Practice Associations
  - Oregon:
    - 2 ACOs in hospital systems
    - 1 ACO in an IPA
    - Coordinated Care Organizations

Changes in the MSSP Final Rule

- In Track 1 no transition to risk in third year
- Preliminary prospective assignment of beneficiaries
- 65 quality measures across 5 domains reduced to 33 in 4 domains; 70% threshold in one domain, one measure in each of the others
- Pay for reporting continued for 3 years instead of just 1, in combination with reporting in years 2 and 3

Changes in the Final Rule

- Share on first dollar of ACOs in both models after minimum savings achieved
- FQHCs and RHC eligible to both form and participate in an ACO
- Dropped requirement that 50% of primary care physicians be meaningful users of EHR, but is a quality measure with higher weighting

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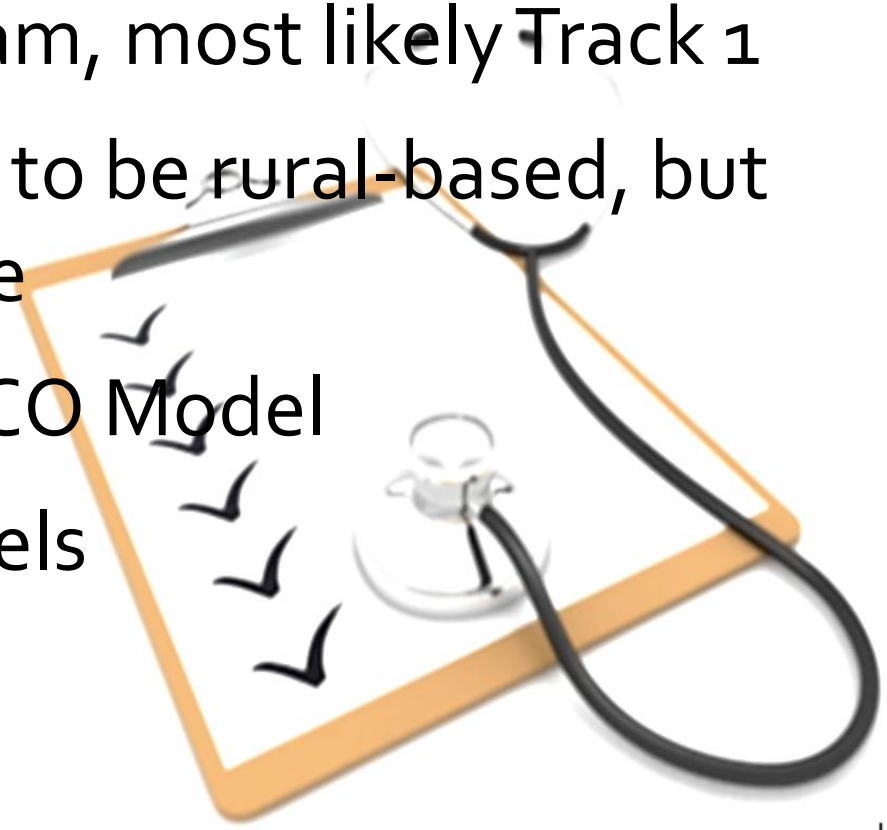
Rural Options

- Shared Savings Program, most likely Track 1
- Pioneer ACOs unlikely to be rural-based, but could be rural-inclusive
- Advanced Payment ACO Model
- Other innovative models



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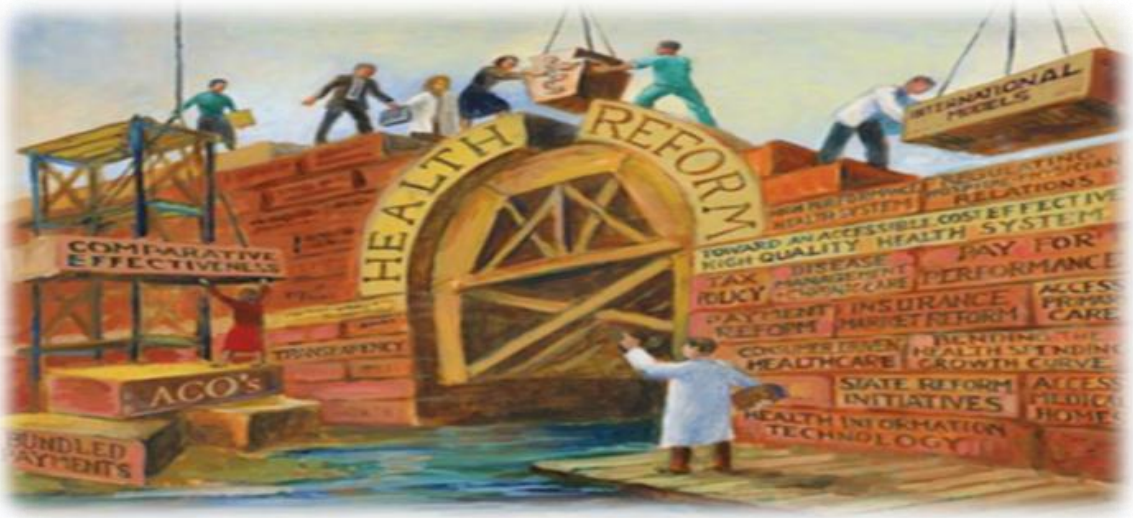
Pioneer ACOs Include

- Central Illinois (including RHCs)
- North Central Iowa
- Eastern and Central Maine
- Northeast Wisconsin



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Advanced Payment ACO Program

- "Designed to provide support to organizations whose ability to achieve the three-part aim would be improved with additional access to capital, including rural and physician-owned organizations."
- CMMI has budgeted $170 million to the Advanced Payment ACO program

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Advanced Payment Program Eligibility

- Only two types of organizations are eligible
  - ACOs without any inpatient facilities and less than $50 million annual revenue
  - ACOs in which only inpatient facilities are CAHs and/or Medicare low volume hospitals and less than $80 million annual revenue
- Co-ownership with health plan not allowed

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Advanced Payment ACO Selection

- April 2012 and July 2012 entries for 3-year contract
- Selection will favor ACOs:
  - With least access to capital;
  - That serve rural populations;
  - That serve a significant number of Medicaid beneficiaries
- Application, Section 6:
  - "Explain how the ACO intends to use the funds awarded as advanced payments from CMS." (Limit of 20,000 characters)

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Advanced Payments

- Upfront fixed payment
  - $250,000 for ACO start-up
- Upfront variable payment
  - $36 per prospectively assigned beneficiary
- Variable monthly payment
  - $8/month per prospectively assigned beneficiary
- ACO can request less

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Payment Recoup

- Advanced payments to be recouped from the ACO's shared savings
  - If savings not enough to recoup advanced payment after 18 months, CMS will recoup in last 18 months of contract
  - CMS will not pursue recoup of savings after 3-year agreement period, unless ACO does not complete the 3-year contract

Rural Configurations

- Primary care role central
- Savings mostly from care management and cost avoidance
- So effects on hospital may be pronounced, especially for inpatient care
- Therefore important for hospitals to be engaged

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Form, Join, Sit?

- Forming even for Track 1 MSSP or Advance Payment Model should be based on combination of patient care and business considerations
- Joining for similar reasons, but also assessing future for integrated services with local base being sustained
- Sit might work for market that has limited appeal to other providers
- Highest risk is "go it alone"

For Further Information

The RUPRI Center for Rural Health Policy Analysis
http://cph.uiowa.edu/rupri

The RUPRI Health Panel
http://www.rupri.org

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