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Accountable Care Organizations and Patient Centered Medical Homes

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Goals of the Presentation



- Explain ACOs and PCMHs in the context of health reform
- Lay out the statutory and structural foundations of ACOs and PCMHs
- Show the relationship between ACOs and PCMHs
- Offer some policy considerations around ACOs and PCMHs

Topics to Be Covered



1. Health Reform Legislation
2. Accountable Care Organizations
3. Patient Centered Medical Homes
4. Health Homes



Health Care in the U.S.



- Ever changing field
- Always searching for the “holy trinity”: cost, access, quality
- Historical examples: health insurance, Medicare, Medicaid, HMOs, CQI, MCOs, P4P
- Among the latest: Electronic Health Records (EHRs), Accountable Care Organizations (ACOs) and Patient Centered Medical Homes (PCMHs)

ARRA and PPACA on EHRs and ACOs



- ARRA HITECH push for EHRs
- PPACA (H.R. 3590) amends §1899 of SSA, ACO incentives under Medicare by 1/1/12
- PPACA includes Pediatric ACO Demonstration Project: authorizes States to offer incentives through Medicaid and CHIP, 1/1/12 – 12/31/16
- HHS Secretary to issue Notice of Proposed Rulemaking this year

Accountable Care Organization



- Term attributed to Dr. Elliott Fisher (Dartmouth Atlas Project), 2006
- Shifts locus of accountability from individual provider to collective entity, from per unit payment to outcomes
- Network of physicians and other providers working together to improve quality and reduce costs for defined patient population
- Reflects reality that physicians connected to hospital often already function as informal network and patients tend to stay within network for most care

ACO Implications for Cost and Quality



- Public and private payers hold system accountable for high-quality care while reducing unnecessary cost
- ACO that improves performance financially rewarded
- Virtuous cycle of improved care management, further rewards, steady evolution toward fully coordinated system
- No good examples yet; mixed results in limited experiments (Physician Group Practice demo project)
- CBO estimates \$5B Medicare ACO savings first eight years

ACO Statutory Entities



- Physicians and other professionals in group practices
- Physicians and other professionals in networks of practices
- Partnerships or joint venture arrangements between hospitals and physicians/professionals
- Hospitals employing physicians/professionals
- Other forms the Secretary deems appropriate

Exhibit 1. Accountable Care System Models and Core Capabilities

<u>Accountable Care System Models</u>	Redesign Care Processes	Teamwork	Care Coordination	<u>Core Capabilities</u>			
				Performance Accountability	Information Technology	Knowledge Management	Change Management
(1) Multi-Specialty Group Practice (MSGP) ^a	High	High	High	High	High	High	Medium
(2) Hospital Medical Staff Organization (HMSO) ^b	Medium	Medium	High	High	High	Low to Medium	Low to Medium
(3) Physician Hospital Organization (PHO) ^c	Medium	Medium	Medium	High	High	Medium	Medium
(4) Interdependent Provider Organization (IPO) ^d	Low	Low	Low to Medium	Medium	Low	Low	Low
(5) Health Plan Provider Organization / Network (HPPO/HPPN) ^e	Medium	Low to Medium	Low to Medium	Medium to High	Low to Medium	Low to Medium	Low to Medium

^a 17-26 percent of practicing physicians in groups of 100 plus including institutionally based; 35 percent in groups of 20 plus

^b Almost all 718,000 practicing physicians

^c Estimated 37 percent of practicing physicians; see text

^d 48% of office-based in solo or 2 person partnership; 89% in arrangements of 10 physicians or less; 38% members of IPA's

^e 38% members of IPA's



EXHIBIT 1

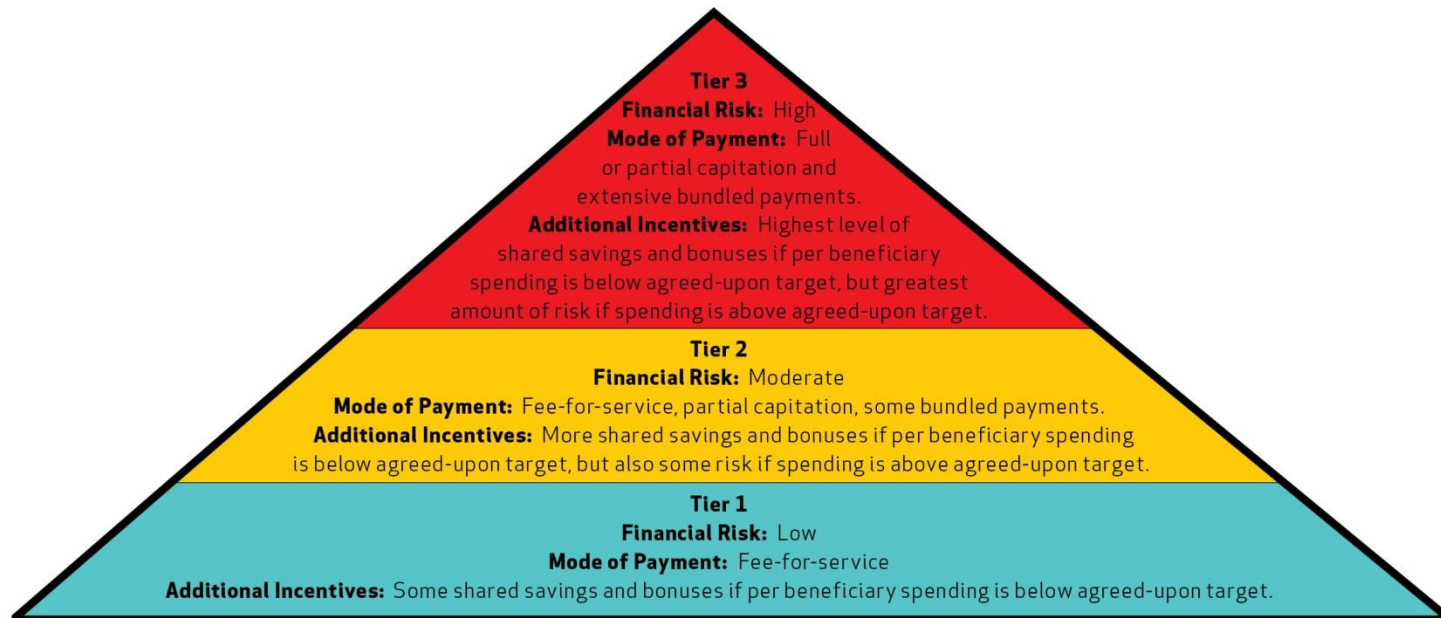
Delivery Systems That Could Become Accountable Care Organizations

Model	Characteristics	Current Examples
Integrated delivery systems	<ul style="list-style-type: none"> • Own hospitals, physician practices, perhaps insurance plan. • Aligned financial incentives. • E-health records, team-based care. 	Geisinger Health System Group Health Cooperative of Puget Sound Kaiser Permanente
Multispecialty group practices	<ul style="list-style-type: none"> • Usually own or have strong affiliation with a hospital. • Contracts with multiple health plans. • History of physician leadership. • Mechanisms for coordinated clinical care. 	Atrius Health (eastern Massachusetts) Cleveland Clinic Marshfield Clinic Mayo Clinic
Physician-hospital organizations	<ul style="list-style-type: none"> • Nonemployee medical staff. • Function like multispecialty group practices. • Reorganize care delivery for cost-effectiveness. 	Advocate Health (Chicago) Middlesex Hospital (Connecticut) Tri-State Child Health Services (affiliated with the Cincinnati Children's Hospital Medical Center)
Independent practice associations	<ul style="list-style-type: none"> • Independent physician practices that jointly contract with health plans. • Active in practice redesign, quality improvement. 	Hill Physicians Medical Group (northern California) Monarch HealthCare (southern California)
Virtual physician organizations	<ul style="list-style-type: none"> • Small, independent physician practices, often in rural areas. • Led by individual physicians, local medical foundation, or state Medicaid agency. • Structure that provides leadership, infrastructure, resources to help small practices redesign and coordinate care. 	Community Care of North Carolina Grand Junction (Colorado) North Dakota Cooperative Network



EXHIBIT 2

Three Tiers Of Accountable Care Organizations And Possible Characteristics



ACO Statutory Requirements



- Shared governance
- Legal structure to receive/distribute shared savings
- Leadership and management structure includes clinical and administrative systems
- Adequate patient/provider ratio
- Minimum 5000 patients (Medicare fee-for-service parts A and B)
- ACO agrees to participate for at least three years
- Provide DHHS-determined information regarding participating providers, cost, quality

ACO Statutory Requirements (cont'd)



- Promote evidenced-based medicine
- Patient engagement and patient-centeredness (*e.g.*, patient/caregiver assessments, individual care plans)
- Coordinate care, especially through health IT
- Cannot also be under “independence at home” or 1115A pilot
- Other less comprehensive payment models possible
- CMS exploring ACO contracts with Physician Group Practice demonstration project providers

ACO Quality Requirements



- Likely will measure:
 - Clinical processes and outcomes
 - Patient and, where possible, caregiver experience
 - Utilization
- CMS may raise standards over time, introduce new measures
- Must be met to receive payment
- Consider tie to CMS QIOs, other like organizations

ACO Reporting Requirements



May include:

- Care transitions across settings
 - Hospital discharge planning
 - Post-hospital discharge follow-up
- PQRI-related
 - E-prescribing
 - EHRs
 - Eligible for additional incentive payments

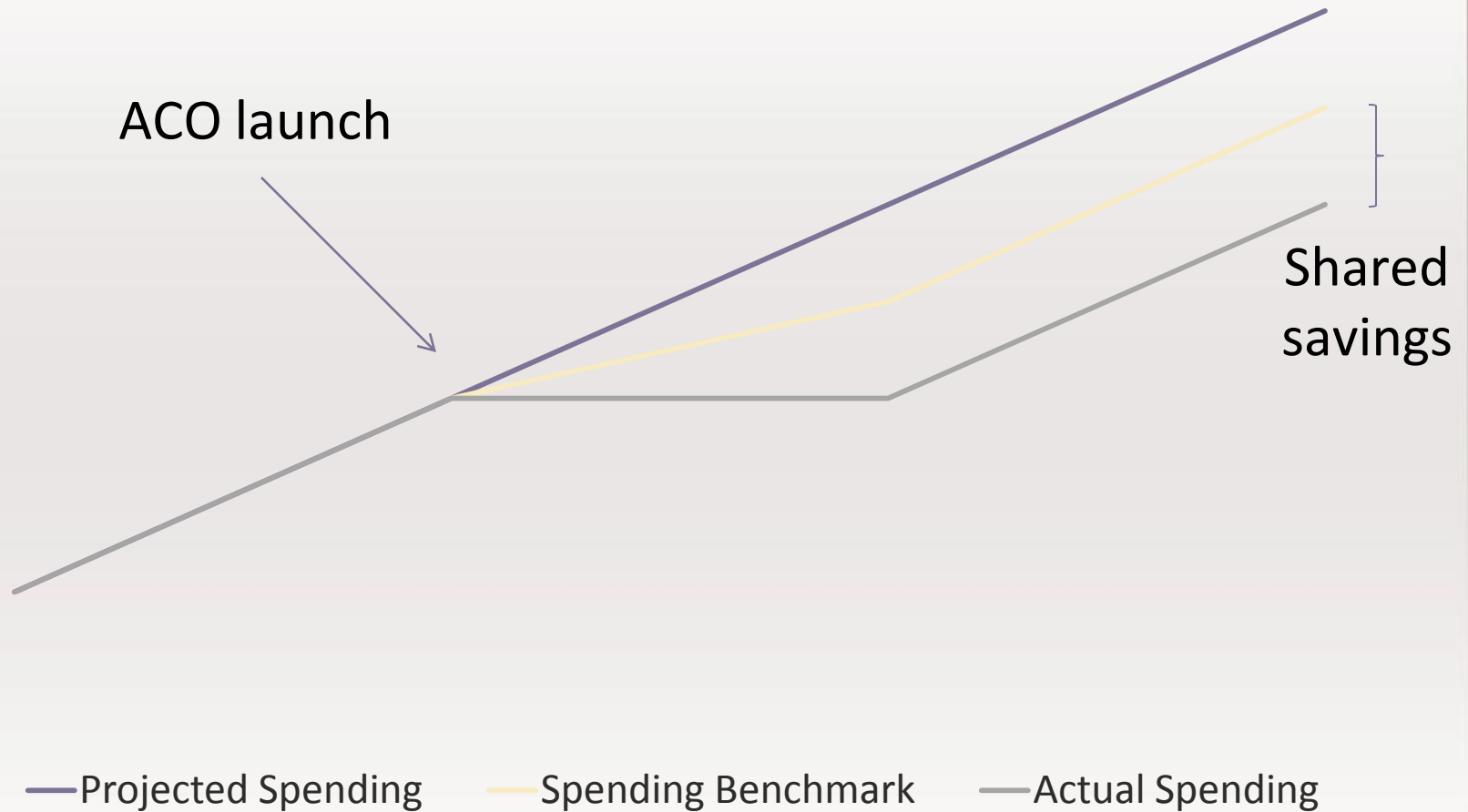
Payments to ACOs



- Continue to receive routine payments, plus
- If estimated average per capita expenditure is at least x percent below adjustable benchmark, as determined by
- Most recent available three years of comparable expenditures, then
- A percent of that percent up to a specified limit, but
- No penalty for failure to meet savings target



Spending Before and During an ACO



Other ACO considerations



- Secretary to determine how to assign patients to ACO
- Assignment invisible to beneficiary and will not affect benefits or choice of doctor
- Patients free to come and go at will
- If avoid high-risk patients, sanctions (including termination as an ACO)
- Is a new concept that will evolve over time

Pediatric ACO Demonstration Project



- States apply to DHHS for authorization to allow pediatric ACOs similar to §1899 ACOs
- Five year window (1/1/12 – 12/31/16), ACO must participate minimum three years
- Care guidelines developed by Secretary in consultation with States and providers
- ACO enters agreement with State to achieve savings eligible for incentive payment
- Medicaid and CHIP

Challenges for ACOs



- Current fee-for-service model entrenched; volume maximizers reluctant to change
- Smaller practices lack IT and administrative infrastructure
- Antitrust and other legal hurdles
- Monopolies could cause failure to realize savings
- Up front incentives needed for some

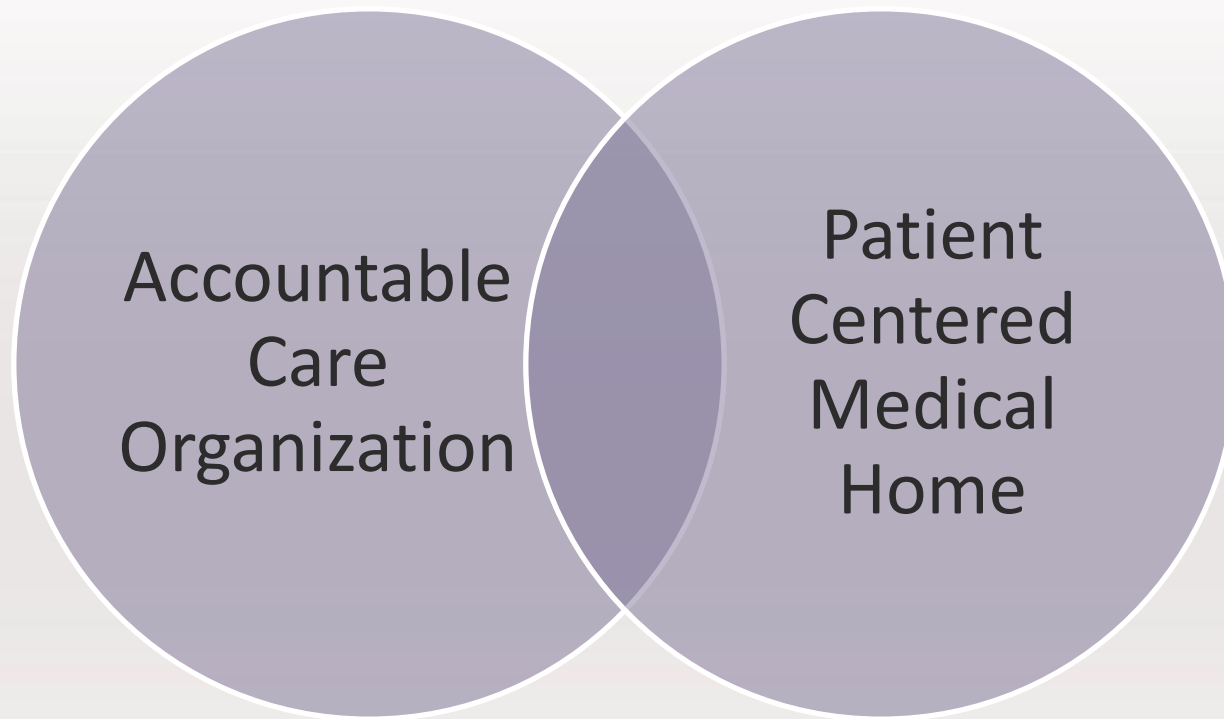
Challenges for ACOs



- Determining benchmark thresholds
- Determining savings distribution methodology among providers
- Not a closed system: efficiency leaks out, cost leaks in
- Maintaining or improving quality while cutting costs
- Measuring quality



- An ACO is built on physician practices that may be organized as PCMHs
- The ACO is the medical neighborhood for the PCMH
- ACO and PCMH models are complementary
- >20% of US population (~65MM) live in officially designated primary care shortage areas





- NCQA standards
 - Reflects principles developed by
 - American College of Physicians (ACP)
 - American Academy of Family Physicians (AAFP)
 - American Academy of Pediatrics (AAP)
 - American Osteopathic Association (AOA)
 - New standards expected 1/11
- Joint Commission to begin accrediting Primary Care Homes in 2011



- >100 demonstration projects have already tested effectiveness of PCMHs
- Thirty-one states planning or implementing PCMH pilots within Medicaid or CHIP
- Twelve states have developed PCMH initiatives involving multiple payers
- CMS developing Medicare-specific demonstration (2010)
- Medicare to participate in multi-payer projects in up to six states (2011)
- VA has begun shifting clinics to PCMH model; transition expected completed by 2015

Health Affairs



- Private payers supporting PCMH include
 - Aetna
 - CIGNA
 - Empire BlueCross BlueShield
 - Group Health Cooperative
 - Independent Health
 - Geisinger Health Plan
- Payment model
 - Ongoing fee-for-service payments
 - Fixed (typically monthly) case management fee
 - P4P bonus payments

PCMH defined (§3502)



A model of care that includes

- Personal physicians
- Whole person orientation
- Coordinated and integrated care
- Safe and high-quality care through evidence informed medicine, appropriate use of health information technology, and continuous quality improvements
- Expanded access to care
- Payment that recognizes added value from additional components of patient-centered care

PPACA on PCMHs (1)



- Secretary, through AHRQ, to establish Primary Care Extension Program (PCEP) employing Health Extension Agents to assist primary care providers (PCPs) to implement PCMHs
- Competitive grants to States for PCEP State Hubs to assist PCPs to implement PCMHs
 - Hubs to include state health department; Medicaid agency; Medicare administrator; schools training primary care providers; others
 - Mandatory involvement of local entities as PCEPs
 - 6 year program or 2 year planning grants
 - \$120MM in 2011 and 2012, \$TBD in 2013 and 2014

PPACA on PCMHs (2)



- Secretary to implement grants or contracts to establish community-based interdisciplinary, inter-professional teams (“health teams”) to support PCMHs
- Secretary, with quality experts and stakeholders, to develop guidelines for health plans to report to Health Benefit Exchanges their efforts to financially reward PCMHs
- New CMS Center for Medicare and Medicaid Innovation (CMI) to test effect of new service delivery models such as PCMHs on cost and quality
- Monthly performance bonuses to Medicare Advantage plans that promote PCMHs (starts 2014)

PPACA on Health Homes



- State option to provide Health Homes (HHs) to Medicaid enrollees with chronic conditions begins 1/1/11
- Extra payments for providing HHs
- \$25MM for planning grants to States (with required match) also available beginning 1/1/11

Health Home definitions



- Chronic conditions include
 - Mental health condition
 - Substance use disorder
 - Asthma
 - Diabetes
 - Heart disease
 - Being overweight
- Health Home means individual or team providing
 - comprehensive care management
 - care coordination and health promotion
 - comprehensive transitional care, including appropriate follow-up, from inpatient to other settings
 - patient and family support (including authorized representatives)
 - referral to community and social support services, if relevant
 - use of health information technology to link services, as feasible and appropriate

Challenges for PCMHs



- Healthcare system and medical culture inertia or opposition
- Structure/definition
- Upfront costs; involvement of facilitators
- Concomitant payment model change (ACO?)
- Patient expectations
- Name? HHS: Advanced Primary Care Practice

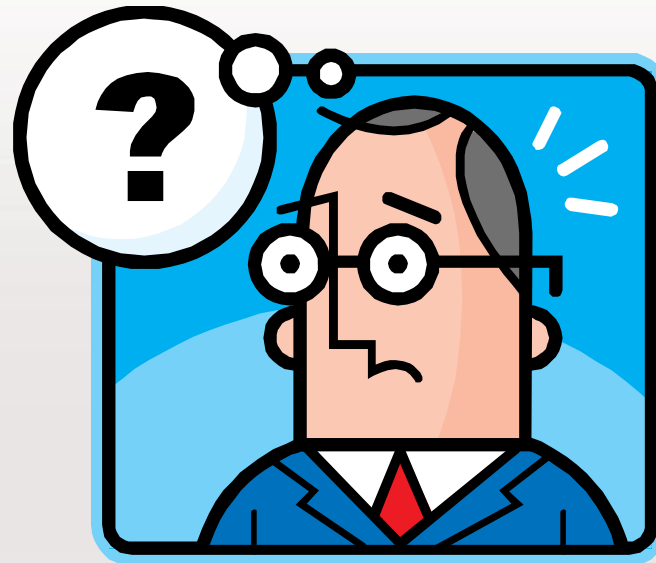


- "Health Policy Brief: Accountable Care Organizations," *Health Affairs*, July 27, 2010
- Shortell, Casalino and Fisher, "How The Center For Medicare And Medicaid Innovation Should Test Accountable Care Organizations," 29, no. 7 (2010): 1293-1298
- Cohen, "A Guide to Accountable Care Organizations, and Their Role in the Senate's Health Reform Bill," *Health Reform Watch*, March 11, 2010
- Brookings-Dartmouth ACO Learning Network, "Overview of the Accountable Care Organization (ACO) Model," March 2009
- "Medicare Physician Group Practice Demonstration," CMS, August 2009

Resources



- [“Health Policy Brief: Patient-Centered Medical Homes,”](#) *Health Affairs*, September 14, 2010
- NCQA, [Physician Practice Connections[®] - Patient-Centered Medical Home[™]](#)
- CMS, [Details for Medicare Medical Home Demonstration](#)
- PCPCC, [Patient Centered Medical Home](#)

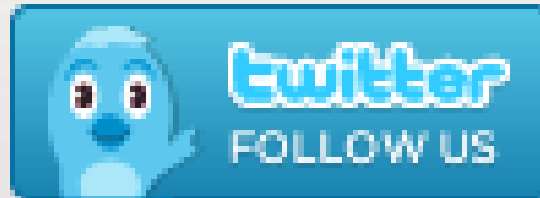


Questions??

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