Accountable Care Organizations (ACOs)

Pantea Ghasemi, USC Pharm.D. Candidate 2015
Sarkis Kavarian, UOP Pharm.D. Candidate 2015

Preceptor Dr. Craig Stern
Pro Pharma Pharmaceutical Consultants, Inc.
April 13, 2015

PRO PHARMA
PHARMACEUTICAL CONSULTANTS, Inc.

Objectives

1. Definition and Principles of ACOs
2. Affordable Care Act
3. ACO Programs and Models
4. ACO Quality Measures
5. ACO Stakeholders
6. Challenges for the Future
7. Summary

PRO PHARMA
PHARMACEUTICAL CONSULTANTS, Inc.

Definition & Principles of ACOs

- Definition: A **network** of physicians, hospitals, and other healthcare professionals that share financial and medical responsibility for providing **coordinated care** for patients
- Principles
  1. Better overall health through **higher-quality care** and **lower costs** with a focus on patients
  2. Establish provider organizations accountable for achieving better results for all of their patients at a lower cost
  3. Align financial, regulatory, and professional incentives to achieve better health through higher quality care, lower costs
  4. Valid performance measures that support provider accountability for aims and support informed and confident patient care choices

Affordable Care Act (ACA)

- Initial Guidelines for Establishment
  -Under Medicare Shared Savings Program (Section 3022 of the Patient Protection ACA) on March 31, 2011
- Authorizes Center for Medicare and Medicaid Services (CMS) to create Medicare Shared Savings Program (MSSP)
  -Allows establishment of ACO contracts with Medicare by January 2012
- ACO must:
  1. Define processes to promote evidence-based medicine and patient engagement
  2. Monitor and evaluate quality and cost measures
  3. Meet patient-centeredness criteria and coordinate care across care continuum

ACO Programs & Models

1. Medicare Shared Savings Program
2. Advance Payment Model
3. ACO Investment Model
4. Comprehensive End Stage Renal Disease Initiative
5. Pioneer ACO Model
6. Next Generation ACO Model

Medicare Shared Savings Programs

- Established by section 3022 of the Affordable Care Act as a **new approach to the delivery of health care** and a key component of the Medicare delivery system reform initiatives
- Purpose:
  - Facilitates the coordination and cooperation among providers to improve the quality of care for Medicare Fee-For-Service (FFS) beneficiaries and reduce unnecessary costs
  - Creates **financial incentives** for ACOs that lower growth in health care costs while meeting performance standards on quality of care and putting patients first
- Eligibility:
  - Eligible providers, hospitals, and suppliers may participate in the Shared Savings Program by creating or participating in an Accountable Care Organization (ACO)
  - Each ACO must agree to accept responsibility for at least 5,000 Medicare Fee-For Service beneficiaries to be eligible to participate
  - If application is approved, the ACO must sign an agreement to participate in the Shared Savings Program for at least 3 years

Advance Payment Model

- Purpose:
  - Designed for physician-based, **smaller practices and rural providers with less access to capital** to participate in the Shared Savings Program
  - Selected participants in the Shared Savings Program will receive **advance payments** that will be repaid from the future shared savings they earn
  - CMS will recoup these advance payments from an ACO's shared savings
- It was initially only made available to ACOs who began participation in the Medicare Shared Savings Program on April 1, 2012 or July 1, 2012 but now it accepts ACOs as of January 2013
- Payment Method:

  Selected participants will receive upfront and monthly payments to invest in their care coordination infrastructure
  1. An **upfront, fixed payment**: Each ACO will receive a fixed payment
  2. An **upfront, variable payment***
  3. A **monthly payment of varying amount** depending on the size of the ACO*

  *Each ACO will receive a monthly payment based on the number of its historically-assigned beneficiaries
- This model will test:
  1. Whether providing an advance (in the form of up-front and monthly payments to be repaid in the future) will **increase participation** in the Shared Savings Program.

  2. Whether advance payments will allow ACOs to improve care for beneficiaries and generate Medicare savings more quickly, and **increase the amount of Medicare savings**.

ACO Investment Model

- Purpose:
  - Builds upon the Advance Payment Model to encourage new ACOs to form in **rural and underserved areas** and current Medicare Shared Savings Program ACOs to transition to arrangements with greater financial risk
- Participation will be limited to **2 distinct groups**
  - New Shared Savings Program **ACOs joining in 2016** - offering pre-payment of shared savings in both upfront and ongoing per beneficiary per month payments
  - ACOs that joined Shared Savings Program **starting in 2012-2014** - encourage progression to higher levels of financial risk, ultimately improving care for beneficiaries and generating Medicare savings
- Payment Methods:

  - ACOs that will begin participating on January 1, **2016** will receive three types of payments:

  1. *An upfront, fixed payment:* Each ACO receives a fixed payment.
  2. *An upfront, variable payment:* Each ACO receives a payment based on the number of its preliminarily prospectively-assigned beneficiaries
  3. *A monthly payment of varying amount depending on the size of the ACO:* Each ACO receives a monthly payment based on the number of its preliminarily prospectively-assigned

  - **ACOs** that began participating before January 1, **2014** will receive two types of payments:

  1. *An upfront, variable payment:* Each ACO receives a payment based on the number of its preliminarily prospectively-assigned beneficiaries
  2. *A monthly payment of varying amount depending on the size of the ACO:* Each ACO receives a monthly payment based on the number of its preliminarily prospectively-assigned beneficiaries

Comprehensive ESRD Care Initiative

- Purpose:
  - The **first disease-specific** Accountable Care Organization (ACO) model designed by CMS to identify, test, and evaluate new ways to improve care for Medicare beneficiaries with ESRD

  - These beneficiaries constituted 1.3% of the Medicare population and accounted for an estimated 7.5% of Medicare spending, totaling over $20 billion in 2010

- CMS will partner with groups of health care providers and suppliers – **ESRD Seamless Care Organizations (ESCOs)** – to test and evaluate a new model of payment and care delivery specific to Medicare beneficiaries with ESRD

- Participating ESCOs will be clinically and financially responsible for all care offered to a group of matched beneficiaries, not only dialysis care or care specifically related to a beneficiary's ESRD

Pioneer ACO Model

- Center for Medicare and Medicaid Services (CMS) Innovation Center Initiative as a part of the Affordable Care Act (ACA) 2010
- Purpose:
  - Allow provider groups that are **already experienced in coordinating care** for patients to move more rapidly **from a shared savings** payment model **to a population-based** payment model
  - Designed to work in coordination with private payers by aligning provider incentives, which will improve quality and health outcomes for patients across the ACO
  - Reduce cost for Medicare, employers and patients
- Payment Methods:
  - Shared savings payment policy with generally higher levels of shared savings and risk for Pioneer ACOs than levels currently proposed in the Medicare Shared Savings Program (in the **first 2 years**)
  - Participating ACOs that have shown a specified level of savings over the first two years will be eligible to move a substantial portion of their payments to a population-based model (in **year 3**)

Next Generation ACO Model

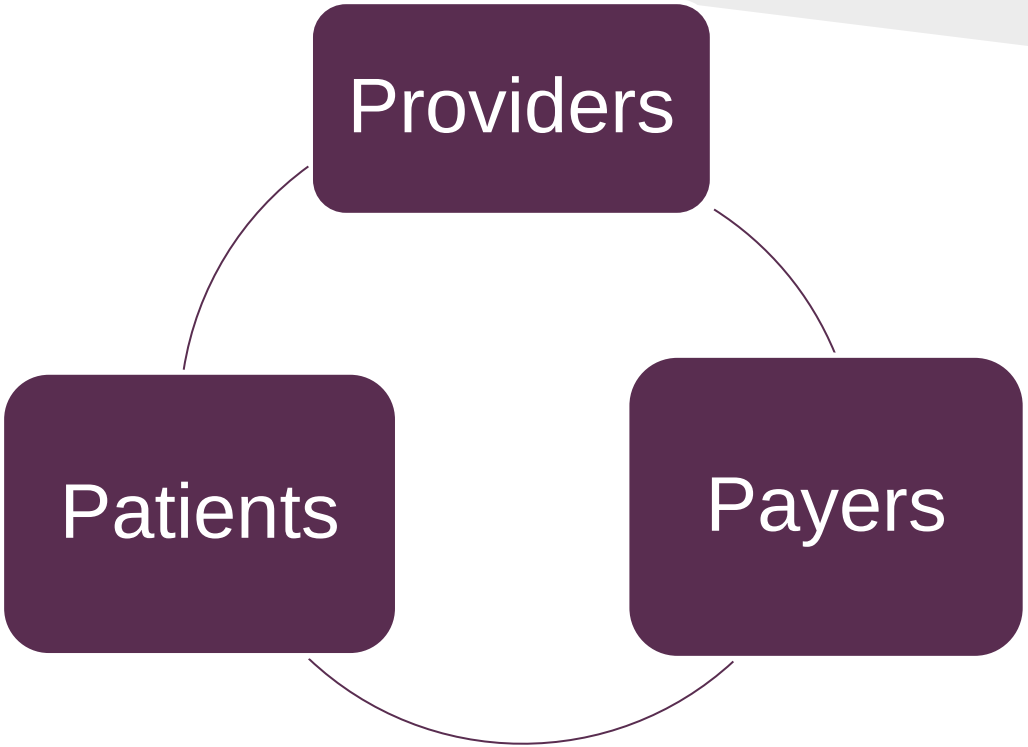
- Purpose:
  - Builds upon experience from the Pioneer ACO Model and the Medicare Shared Savings Program(Shared Savings Program)
  - Offers a new opportunity in accountable care
    1. Predictable financial targets
    2. Enables providers and beneficiaries greater opportunities to coordinate care
    3. Aims to attain the highest quality standards of care
  - Allow provider groups to assume **higher levels of financial risk and reward**

- This model tests:
  - The strength of financial incentives for ACOs, coupled with tools to support better patient engagement and care management, in improving health outcomes and lowering expenditures for Original Medicare fee-for-service (FFS) beneficiaries
  - Included in the Next Generation ACO Model are **strong patient protections** to ensure that patients have access to and receive high-quality care

ACO Quality Measures

- To address the goal of improving healthcare quality, CMS has established **five domains** in which to evaluate the **quality of an ACO's performance** (with corresponding drug therapy-related performance measures):
    1. Patient/Caregiver Experience
    2. Care Coordination/Transitions
        - Medication reconciliation post-discharge from inpatient-facility
    3. Patient Safety
    4. Preventative Health
        - Influenza immunization
        - Pneumococcal vaccination
        - Cholesterol management for patients with CV conditions
    5. At-risk population/frail, elderly health
        - Diabetes Mellitus - aspirin use
        - Heart Failure - beta-blocker therapy, ACE-Inhibitor or ARB therapy, Warfarin therapy for patients with AFIB
        - Coronary Artery Disease - antiplatelet therapy, beta-blocker therapy, ACE-I/ARB therapy, LDL-cholesterol lowering therapy
        - Chronic Obstructive Pulmonary Disease (COPD) - bronchodilator therapy
        - Osteoporosis management in women who have had a fracture
        - Monthly INR readings for patients on Warfarin

ACO Stakeholders



ACO Stakeholders - Providers

- Network of Providers
  - Hospitals
  - Physicians
  - Other healthcare professionals
  - Health departments
  - Social security departments
  - Safety net clinics
  - Home care services

ACO Stakeholders - Payers

- Primary payer: the **federal government** (i.e. Medicare)
- Other payers:
  - Private insurances
  - Employer-purchased insurance
- Roles of Payers:
  - Help ACOs to achieve higher quality care and lower expenditures
  - **Collaboration** among payers to align incentives for ACOs and create financial incentives for providers to improve healthcare quality

ACO Stakeholders - Patients

- Primarily: Medicare beneficiaries

- Other patients: the homeless and uninsured (within larger and more integrated ACOs)

Challenges for the Future

1. Forming **multispecialty** groups since there are **income disparities** between specialties and multiple ways that physician can be paid

2. **Size** of patient population
   - Medicare Shared Savings provision proposed **minimum of 5,000** but this may be too small
   - The larger the population, the easier it is to measure outcomes

3. **Lack of consistent** measures
   - Quality measures from different providers and hospitals requested by various payers may differ

4. **Legal issues** must be addressed to allow for ACO collaboration and integration, such as Sherman Antitrust law, Anti-kickback laws, and physician self-referral Stark Laws

Role of Pharmacist

- 32% of adverse events leading to hospitalization are due to **medications**
- Treatment and management of **chronic diseases** cost health care system over $1 trillion
- Pharmacists' roles:
  - -Medication Therapy Management
  - -Medication Reconciliation after hospital discharge
  - -Drug utilization review and identifying gaps in care
  - -Provide education on medication adherence

Summary

1. ACOs are responsible for the health care of **large populations** and managing **health care cost** within the entities (providers, hospitals), not just for a single practice.

2. The **Pioneer model** and **Medicare Shared Savings program** are designed in a way to provide some incentives in order to get providers to provide care in an ACO setting (i.e more provider involvement).

3. The different payment models are simply ways providers will be paid in an ACO program.

4. ACOs have many **challenges** pertaining to serving large populations; the coordination of care among different providers presents challenges within itself.

5. The **role of pharmacists** iscritical and they need to start taking on responsibility in order to lower health care cost and continue to provide better care for the population especially in this new evolving ACO setting.

References

1. American College of Osteopathic Family Physicians. Accountable Care Organizations Fact Sheet. American College of Osteopathic Physicians. Updated 2010. http://www.acofp.org/Practice_Management/ACO/Medical_Home
2. American Hospital Association. (2011). "The Work Ahead: Activities and Costs to Develop an Accountable Care Organization." American Hospital Association. 2011; 1-17.
3. Centers for Medicare & Medicaid Services. Advance Payment Accountable Care Organization (ACO) Model. Updated January 10, 2013.
4. Centers for Medicare & Medicaid Services, Center for Medicare & Medicaid Innovation. Pioneer Accountable Care Organization Model: General Fact Sheet. Updated September 12, 2012.
5. Centers for Medicare & Medicaid Services. Comprehensive ESRD Care Model Fact Sheet. Updated April 15, 2014.
6. Department of Health and Human Services, Centers for Medicare & Medicaid Services. Medicare Shared Savings Program: Accountable Care Organizations; Proposed Rules. 76 Fed. Reg. 67 (April 7, 2011).
7. Department of Health and Human Services, Centers for Medicare & Medicaid Services. Summary of Final Rule Provisions for Accountable Care Organizations under the Medicare Shared Savings Program. HHS; April 2014.

Thank You!

Any Questions?

PRO PHARMA
PHARMACEUTICAL CONSULTANTS, Inc.