Accountable Care Organizations
Aligning Acute and Post-Acute Care

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Focus is shifting to integration of services, population-based accountabilities and new models of payment. And new payment models are forcing change quickly!
Care Transitions and Reducing Hospital Admissions

The New Currency of Health Care Reform
ACOs

123 new ACOs in Medicare have been announced. Over **370 Programs** with more than **5.3 million** Medicare beneficiaries.
Medicare offers several ACO programs, including:

**Medicare Shared Savings Program (cms.gov)** - For fee-for-service beneficiaries

**ACO Investment Model** - For Medicare Shared Savings Program ACOs to test pre-paid savings in rural and underserved areas

**Advance Payment ACO Model** - For certain eligible providers already in or interested in the Medicare Shared Savings Program

**Pioneer ACO Model** - Health care organizations and providers already experienced in coordinating care for patients across care settings
ACO Goals

• Improve the safety and quality of patient care while lowering costs
• Promote shared accountability across providers
• Increase coordination of care
• Invest in infrastructure and redesigned care services
• Achieve better health and better care at lower costs

Medicaid and private payers increasingly launching both Accountable Care Organizations and “alternative” contracts
Accountable Care Organizations

- Allows for some leverage in *shared savings* between hospitals and “network providers”
- Applies to only fee-for-service patients
- Includes accountability for quality as well as cost savings – 33 quality measures on *care coordination, patient safety, preventive health, improved care for at-risk populations, and pt/caregiver experience*
The ACO Hypothesis

• Changes in Reimbursement and Rules Will Incent Care Delivery System Redesign resulting in...
  – Populations that are healthier longer
  – Fewer avoidable services
  – Efficient care delivery
  – Sustainability of the Medicare program
Tools ACOs Will Use

- Informatics / Analytics
- Care Coordination
- Discharge Placement
- Utilization Management
- Wellness & Prevention
ACOs Demographics: 338 MSSP and 23 Pioneer
5.6M ASSIGNED BENEFICIARIES IN 47 STATES PLUS DC AND PR

Regional Variations in Adoption Exist

- 338 MSSP and 23 Pioneer
- 5.6M assigned in 47 states plus DC and PR
- Average of 13k per ACO
- 92% of Beneficiaries in 10 markets
- Chicago: Highest # of Beneficiaries in ACOs (1M)
- Boston: Highest % of Medicare Benes in ACOs (23.4%)
- Atlanta: Highest # of ACOs (91)

Federal ACOs are Predominantly Physician-led

FEDERAL ACOS ATTRIBUTE BENEFICIARIES TO PHYSICIANS

<table>
<thead>
<tr>
<th>ACO Reported composition</th>
<th>(multiple responses may apply to an ACO, MSSP only)</th>
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<tbody>
<tr>
<td>Networks of Individual Practices</td>
<td>194</td>
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<tr>
<td>Group Practices</td>
<td>133</td>
</tr>
<tr>
<td>Hospital/Professional Partnerships</td>
<td>100</td>
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<tr>
<td>Hospital employing ACO professionals</td>
<td>63</td>
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<tr>
<td>Federally Qualified Health Center</td>
<td>30</td>
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<tr>
<td>Rural Health Clinic</td>
<td>18</td>
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<td>Critical Access Hospital</td>
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Modest Initial Pioneer Results

Pioneer Performance Year 1 Results

32  Pioneer ACOs participated in PY1
13  ACOs achieved shared savings totaling $76M
  2  ACOs had shared losses totaling $4M

Pioneer Performance Year 2 Results

23  Pioneer ACOs participated in PY2
11  ACOs achieved shared savings totaling $68M
  3  ACOs had shared losses of nearly $7M

US$ MILLIONS

Savings to Medicare  |  Shared Savings to ACOs  |  Shared Losses
$33  |  $41  |  $76  |  $68

Source: CMS ACO Financial Results
ACO: Accountable care organization; MSSP: Medicare Shared Savings Program; PY: Performance Year; GPRO: Group Practice Reporting Option; FFS: Fee-for-Service
*Only 5 MSSP ACOs are at-risk for shared losses (Track 2)
Modest Initial MSSP Results

<table>
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<tr>
<th>MSSP Year 1 Results (Cohorts 1-3)</th>
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<td><strong>220</strong></td>
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<td><strong>52</strong></td>
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<tr>
<td><strong>1</strong></td>
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<tr>
<td><strong>6</strong></td>
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<td><strong>$383M</strong></td>
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OTHER OBSERVATIONS

- 92 MSSP ACOs have at least one hospital participating
- MSSP ACOs had better-than-average quality on 17 of 22 GPRO measures compared to Medicare FFS providers
- Even with these results, it is too early to draw definitive conclusions about the success or failure of MSSP and Pioneer ACOs

ACO: Accountable care organization; MSSP: Medicare Shared Savings Program; PY: Performance Year; GPRO: Group Practice Reporting Option; FFS: Fee-for-Service

*Only 5 MSSP ACOs are at-risk for shared losses (Track 2)
How will Long Term Care Fit In?

(AKA, what are some new ways for hospitals and LTC to partner?)
Risk-Bearing Entities Will Look to Decrease Variation in Post-Acute Spending

73% of the regional variation in Medicare spending is due to variation in post-acute care spending

LTACH: Long-Term Acute Care Hospital; IRF: Inpatient Rehabilitation Facility; SNF: Skilled Nursing Facility; HHA: Home Health Agency

How will Long Term Care Fit In?

SHORT TERM

• Hospitals and other payors are looking for contracted vendors
• Initial criteria will be ease of contracting, price and utilization measures
• 30-day readmissions become a key currency
• Many have little understanding of required competencies / measures of high quality LTC – that is YOUR story to share
ACO Network Development

How often are post acute services utilized?
Which post acute providers are receiving our patients?
How often are our patients readmitted from the post acute care setting?

Scorecard Elements:
What is your volume of service?
What types of patients do you admit (payor source and clinical characteristics)
What pharmacy do you contract with?
How are transfers to the ED communicated?
What hours do you accept admissions?
How many LPN, RN, etc on staff?
All cause readmission rates
Nursing Home Compare annual rating
Medical directorship quality
Overlap in physician presence
PAC involvement in system sponsored programs and meetings
How will Long Term Care Fit In?

LONG TERM

• “Mature ACOs” and hospital systems will learn that LTC is a key partner in their success
• “Never admissions” are better that decreased re-admissions in shared savings models
• LTC providers will need to address strategies to integrate information and manage well care transitions
• Quality must be transparent and measured beyond utilization of events
Lessons from Massachusetts

• Coalition of hospitals, nursing homes and other post-acute providers, hospitalists, NH medical directors and insurers
• Developed standards and performance expectations for both NHs AND hospitals
• Domains include:

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<td>Admission Processes</td>
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<td>Med Reconciliation</td>
<td>Care Systems</td>
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New Opportunities for Home Health: Complex Patient Experts

Alignment with Physician Group Practices:
1. Medical Homes
2. Improve quality-based payments
3. Reduced Hospitalizations

Potential Revenue beyond Traditional FFS Medicare
1. Not limited to “home bound”
2. Risk-sharing
3. Population-based payments

Alignment in ACOs and Bundled Payments:
1. Care Coordination
2. Self-management support
3. Connection to HCBS