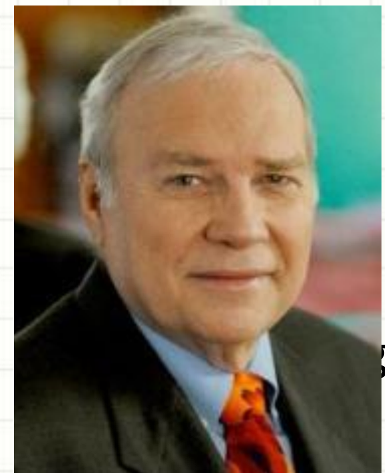
Physicians ACO

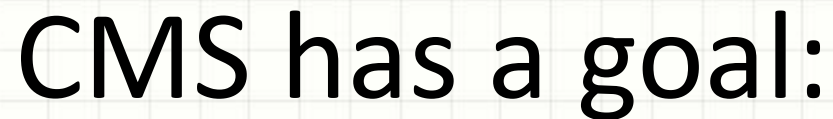
Don
McCormick
President



go

Why Congress and CMS want ACOs

Cost of health care is too high
Quality of health care is too low
Evidence for both conditions is undeniable
Congress passed a law to address the problems
CMS has been instructed to make the needed changes

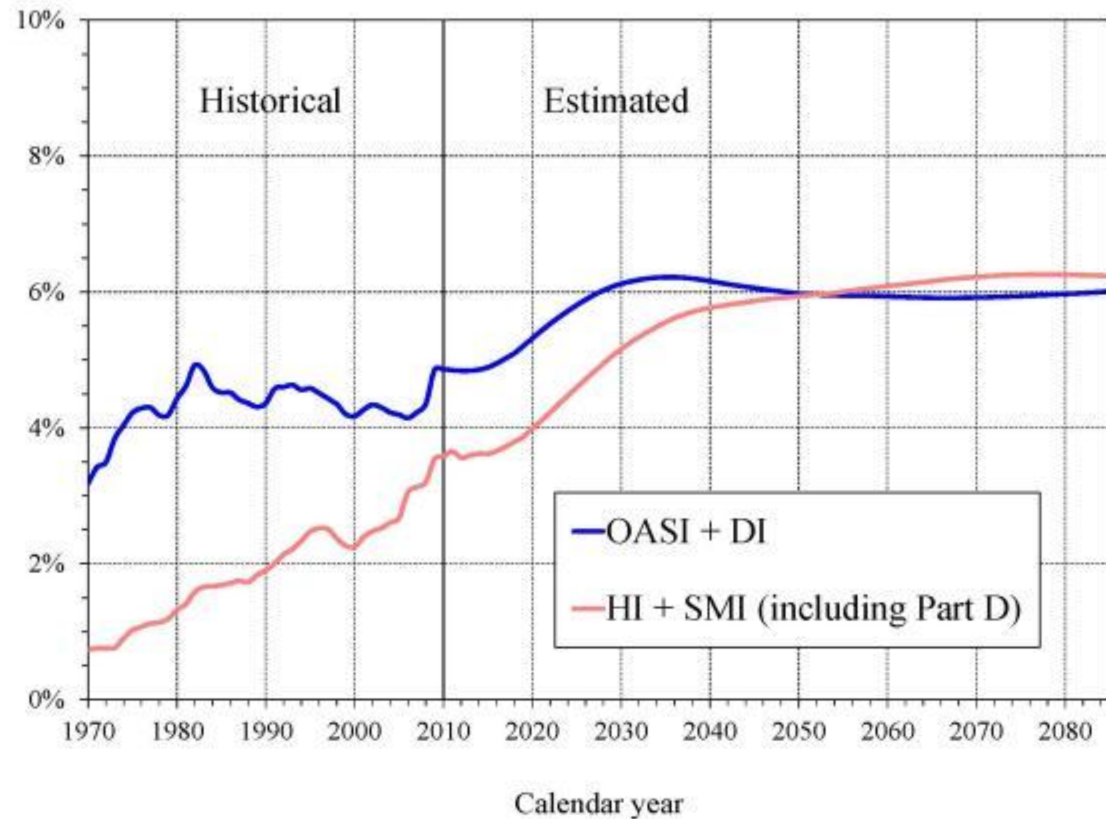


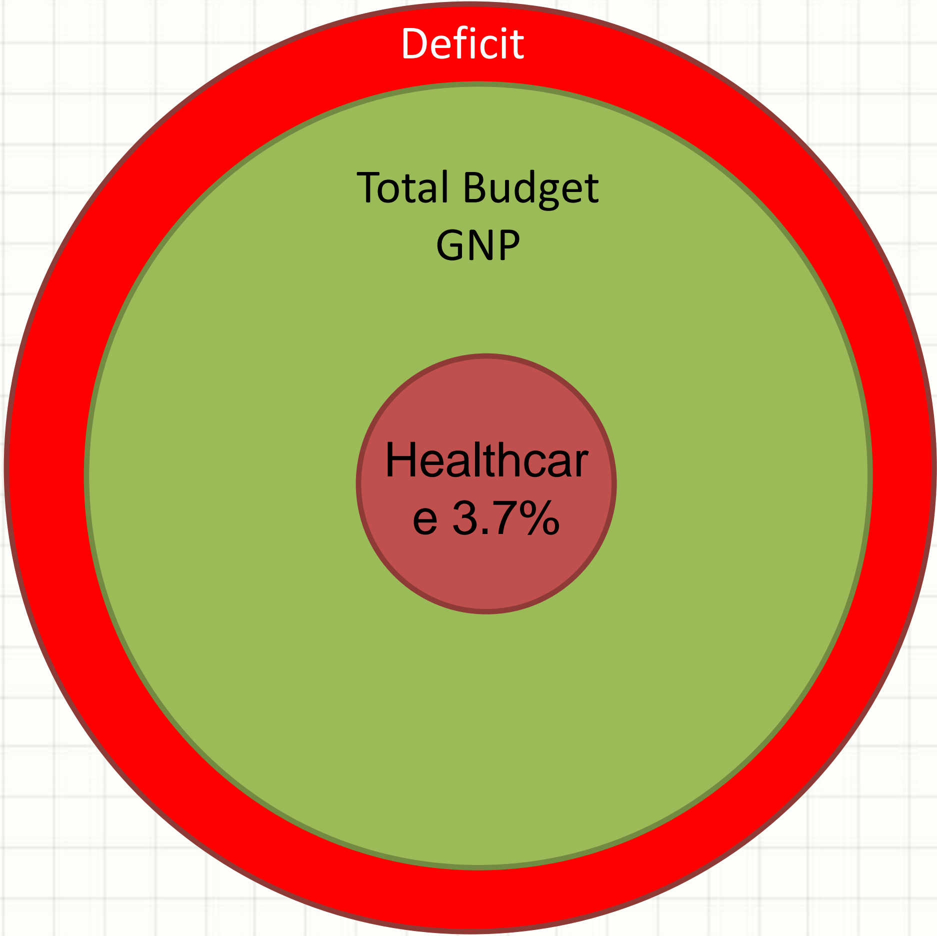
CMS has a goal:

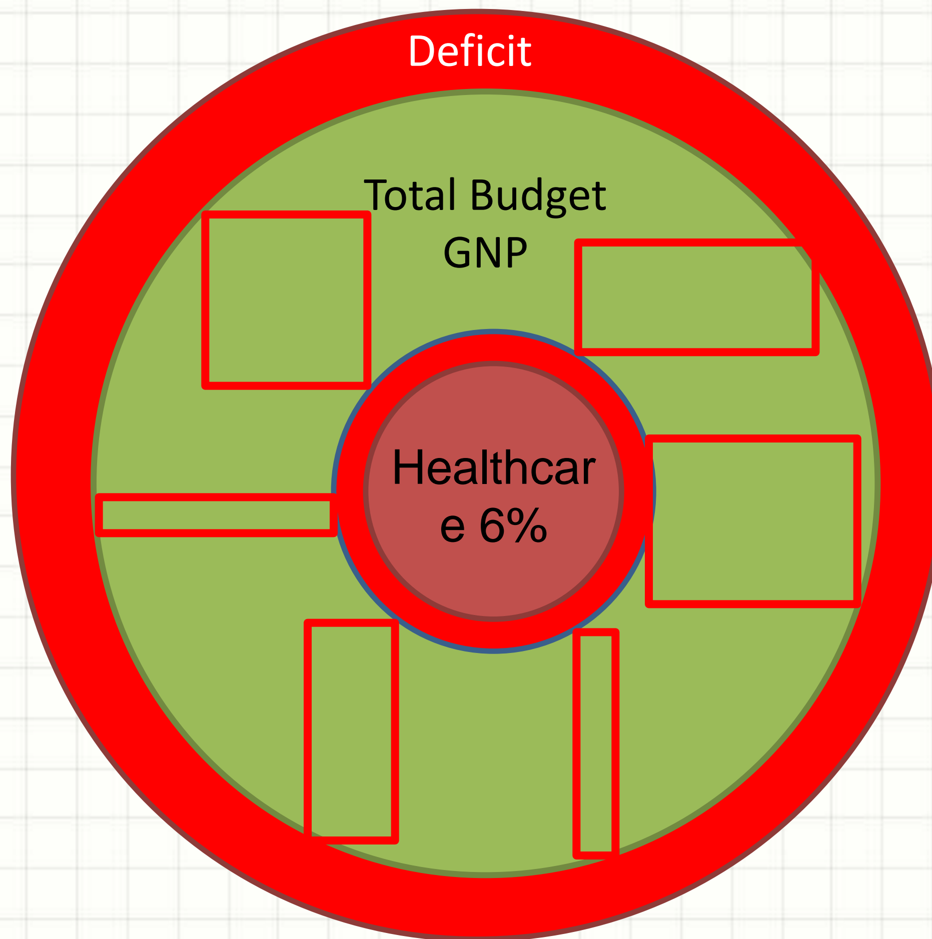
1. Better Health Care
2. Better Health
3. Lower Costs

Cost Evidence

The average cost per patient was $12,288 per year in 2011 or about 3.7% of the GNP.




Deficit
Total Budget
GNP
Healthcar
e 3.7%

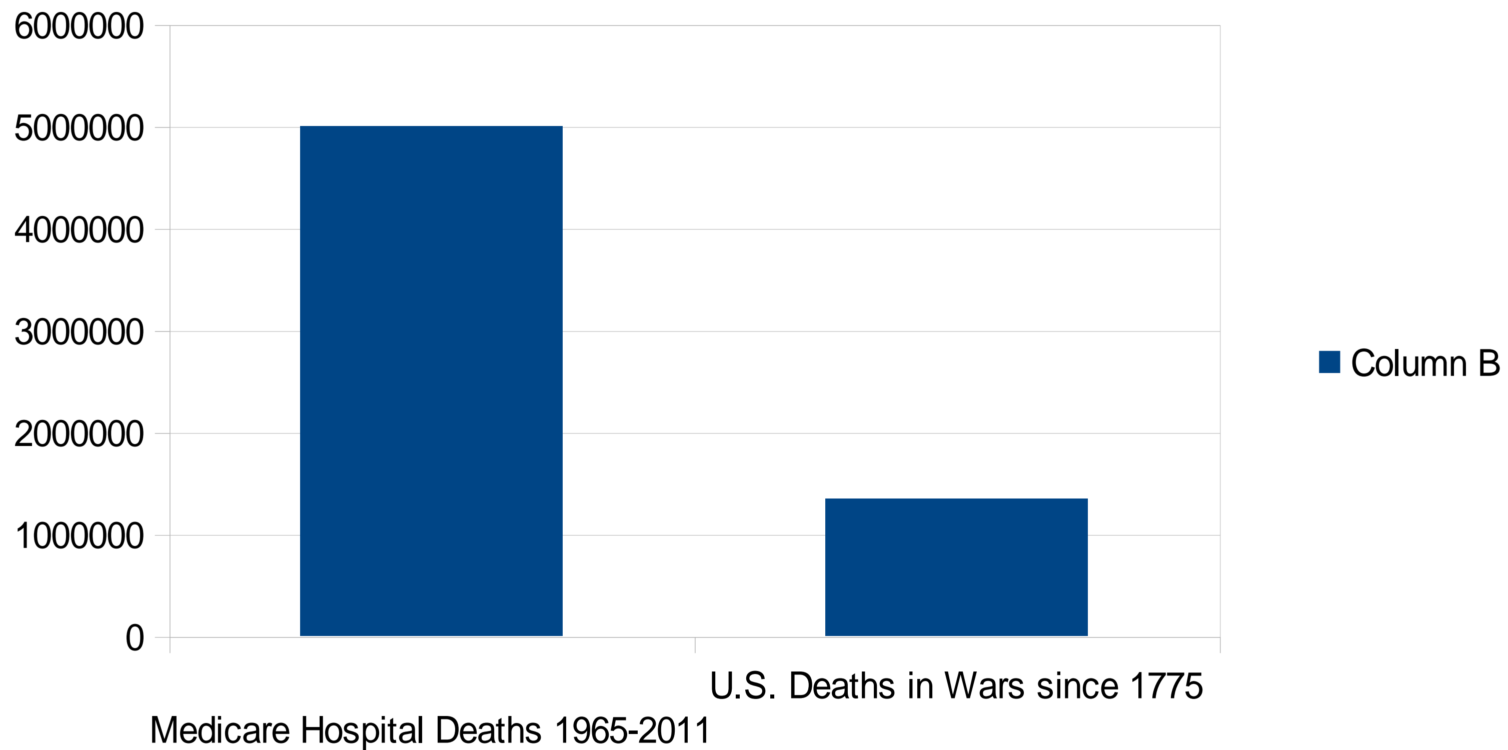

Deficit
Total Budget
GNP
Healthcar
e 6%

Quality Evidence

Department of Health and Human Services
Office of Inspector General
November 2010

13.5% of Medicare beneficiaries had adverse events during hospital stays
13.5% of additional Medicare beneficiaries had events that resulted in temporary harm
44% of the events were clearly or likely preventable
Added cost was 3.5% of Medicare's expenditure for inpatient care.
In 2009 that added Cost was 4.4 billion dollars
1.5% of Medicare beneficiaries experienced events that contributed to their deaths (projected to be about 15,000 per month for the total Medicare admissions)

7 of 12 related to medications
2 of 12 from bloodstream infections
2 of 12 involved aspiration
1 of 12 from ventilator-associated pneumonia


6000000
5000000
4000000
3000000
2000000
1000000
0
Column B
U.S. Deaths in Wars since 1775
Medicare Hospital Deaths 1965-2011

1. Changes in reporting and accountability for care

&

2. In accord with the Patient Protection and Affordable Care Act:

ACOs.

The Congressional Budget Office Recommends that CMS make Health Care Providers:

1. Gather timely data on the use of care, especially hospital admissions.
2. Improve its capability to provide programs with timely data on their patients' use of services.
3. Focus on transitions in care settings
4. Provide education and support to patients in transition to decrease hospital admissions.
5. Use team-based care by encouraging collaboration between care managers and physicians.
6. Target interventions toward high-risk enrollees to limit the costs of intervention.
7. Program's fees and bonuses must be smaller than its reductions in regular Medicare expenditures.

Memo from
Congressional Budget Office

In the past **two decades**, CMS has conducted two broad categories of **demonstrations in Medicare's fee-for-service program** aimed at:

1. Enhancing the quality of health care and
2. Improving the efficiency of health care delivery.

The evaluations show that most programs have not reduced Medicare spending:

Nearly every program involving disease management and care coordination, spending was either unchanged or increased relative to the spending that would have occurred in the absence of the program.

When the fees paid to the participating organizations were considered, programs in which care managers had substantial direct interaction with physicians and significant in-person interaction with patients were more likely to reduce Medicare spending than other programs, but on average even those programs did not achieve enough savings to offset fees.

Company Logo

What does the **CMS** contract proposal ask of the **ACO** providers?

CMS's Expectations of a Contracted ACO

1. Actively promote evidence-based medicine
2. Provide integrated health care with individualized personal care plans
3. Implement care plans that embrace CMS goals: Better Health Care, Better Health, Lower Cost
4. Coordinate referrals for control of patient outcomes
5. Manage admissions and discharges within DRG guidelines
6. Cooperate to assure against unnecessary admissions and unwarranted early discharges
7. Make utilization review and peer review consistent and regular
8. Communicate with PCPs, care coordinators, and attending physicians every day on hospitalized patients.

CMS's Expectations of a Contracted ACO (cont.)

9. Develop a plan for patient/caregiver engagement that is structured, managed and resourced like a major organizational project.
10. Implement the plan using accountability and integration into existing systems and structures.
11. Assess the activities, goals and objectives in an open and transparent way from organizational goal, to Board involvement, to front-line providers and staff, and to patients and caregivers.
12. Evaluate activities based on data collected from Patient Health Assessment Records where the elements of the personalized Care Plan are identified and formulated.
13. Deploy Certified Electronic Health Records.
14. Support health information data exchange leading to coordination of care among practices, easing care transitions and allowing access for patient health information via online patient portal access.
15. Build the ACO participants' capacity for change.

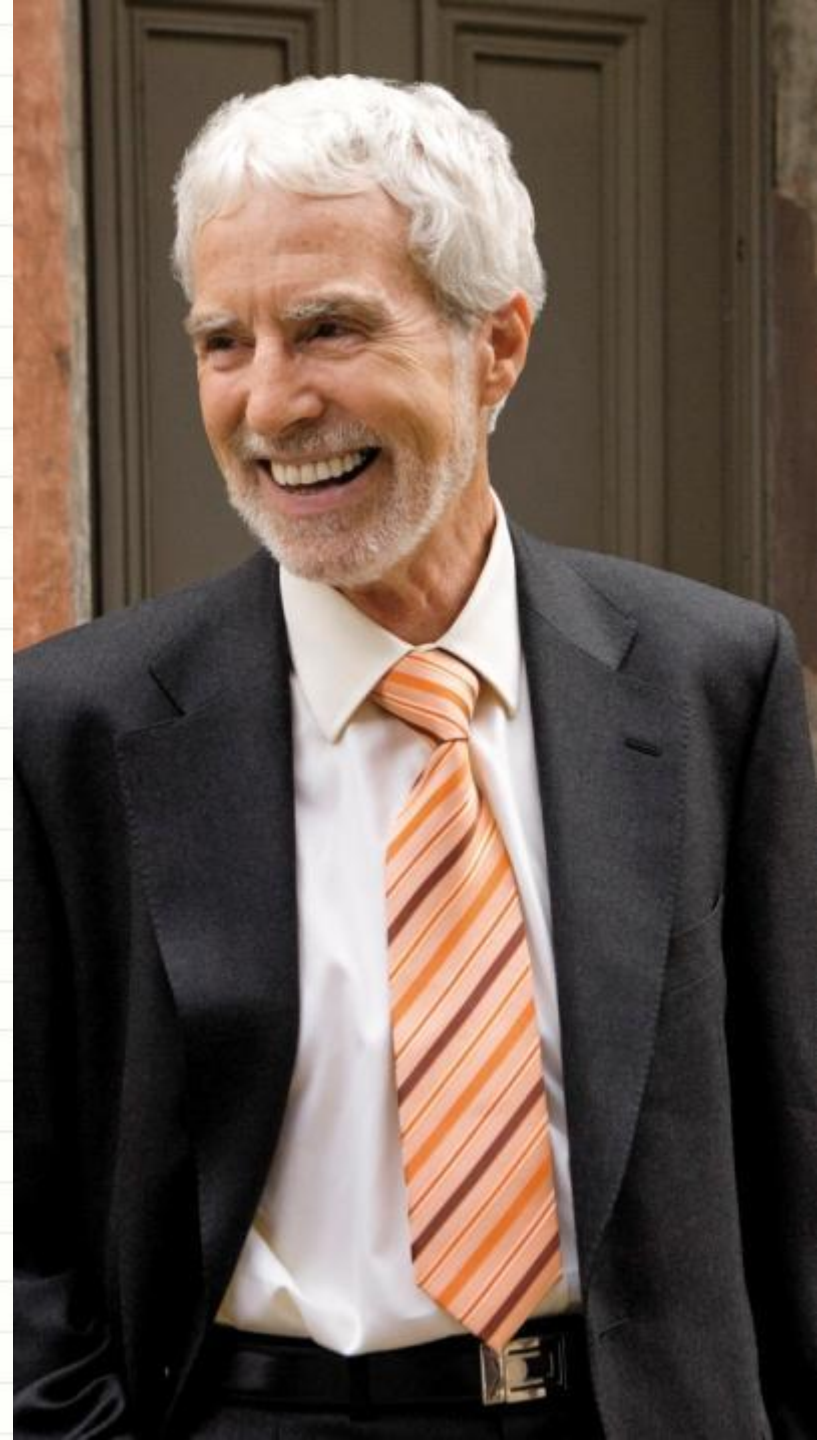
CMS's Expectations of a Contracted ACO (cont.)

16. Bring colleagues together to appraise the organizational and professional barriers to change.
17. Identify barriers to action, triggers, opportunities and pressure points relevant to making evidence work on the ground with patients.
18. Identify effective practice teams through the facilitation of learning and sharing among care teams
19. Develop effective care coordination teams by critically engaging with the field support staff to guide the implementation of processes and systems
20. Train practice staff in new processes to develop expertise in patient care and coding
21. Train community health workers to contribute to dissemination and adoption of effective health practices.
22. Make providers compliant by having strong Quality Assurance Committees that can correct bad care and reward good care.

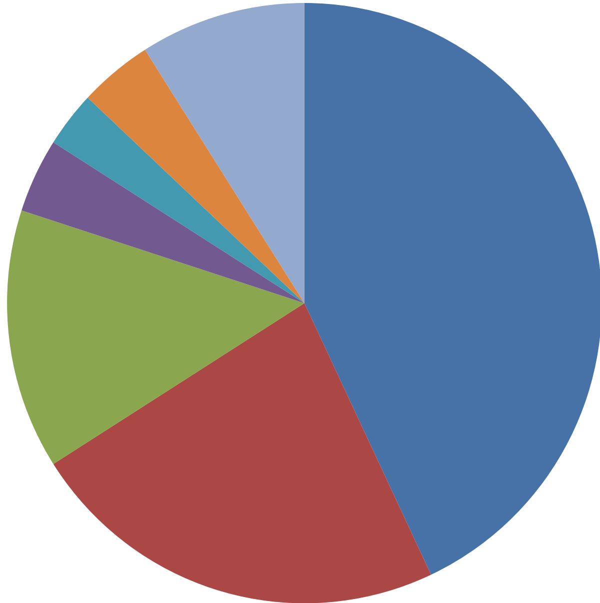
Is an ACO a zero sum game?

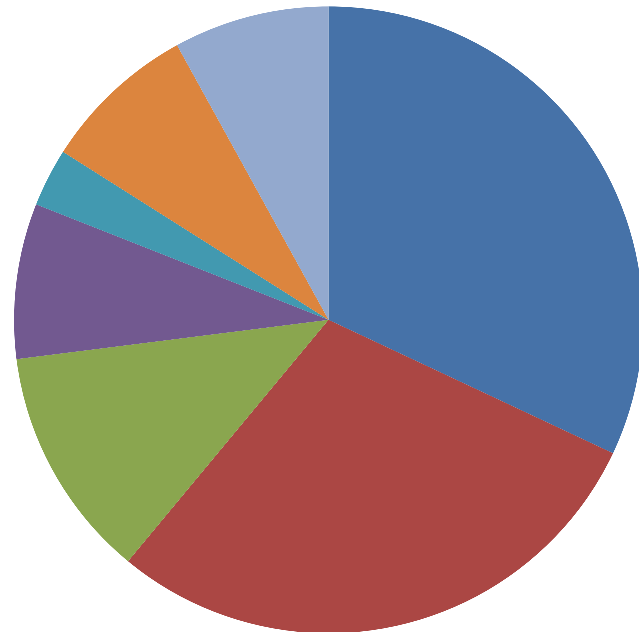
"A zero sum game is a situation in which a participant's gain or loss of utility is exactly balanced by the losses or gains of other participants."

We think it is.



Hospitals





- **Physicians**

Is this what the zero sum game will be like?

“When you're out in the woods with your friends and you're chased by a bear, you don't have to run faster than the bear. You just have to run faster than your friends."

Questions

These are the questions we have as we begin Physicians' ACO:

What are the logistics of moving an ACO from where it is to where it ought to be?

Is there freedom for patients in selecting medical care providers?

How do patients avoid the trap door of the emergency room and find the front door of a medical home?