

# Accountable Care Organizations and the Role of Non-Clinical Support

Care Transitions & ADRC Training

November 30, 2011

Presented by: G. Joseph Sample, M.P.A., M.A.

Iowa Dept. on Aging

Iowa Aging and Disability Resource Center Project Director



IOWA DEPARTMENT ON AGING

# What is the Accountable Care Organization (ACO)?

- ▶ CMS-1345-F
  - A legal entity (organization) formed by one or more providers/suppliers who are Medicare-enrolled
  - ACO provider/supplier
    - Entity/organization Enrolled in Medicare
    - Eligible to bill Medicare for beneficiary services
    - Partners work together to manage/coordinate care for Medicare beneficiaries

# What is the Accountable Care Organization (ACO)?

- ▶ Managed payment system
  - Provider payment
  - Delivery system reform
- ▶ Local entity and a related set of providers
  - Eligible physicians, group practices, other professionals
  - Individual practice networks
  - Partnerships/joint ventures b/t hospitals and ACO professionals
  - CAHs (specific to §413.70(b)(3))
  - RHCs
  - FQHCs
  - **OTHER**

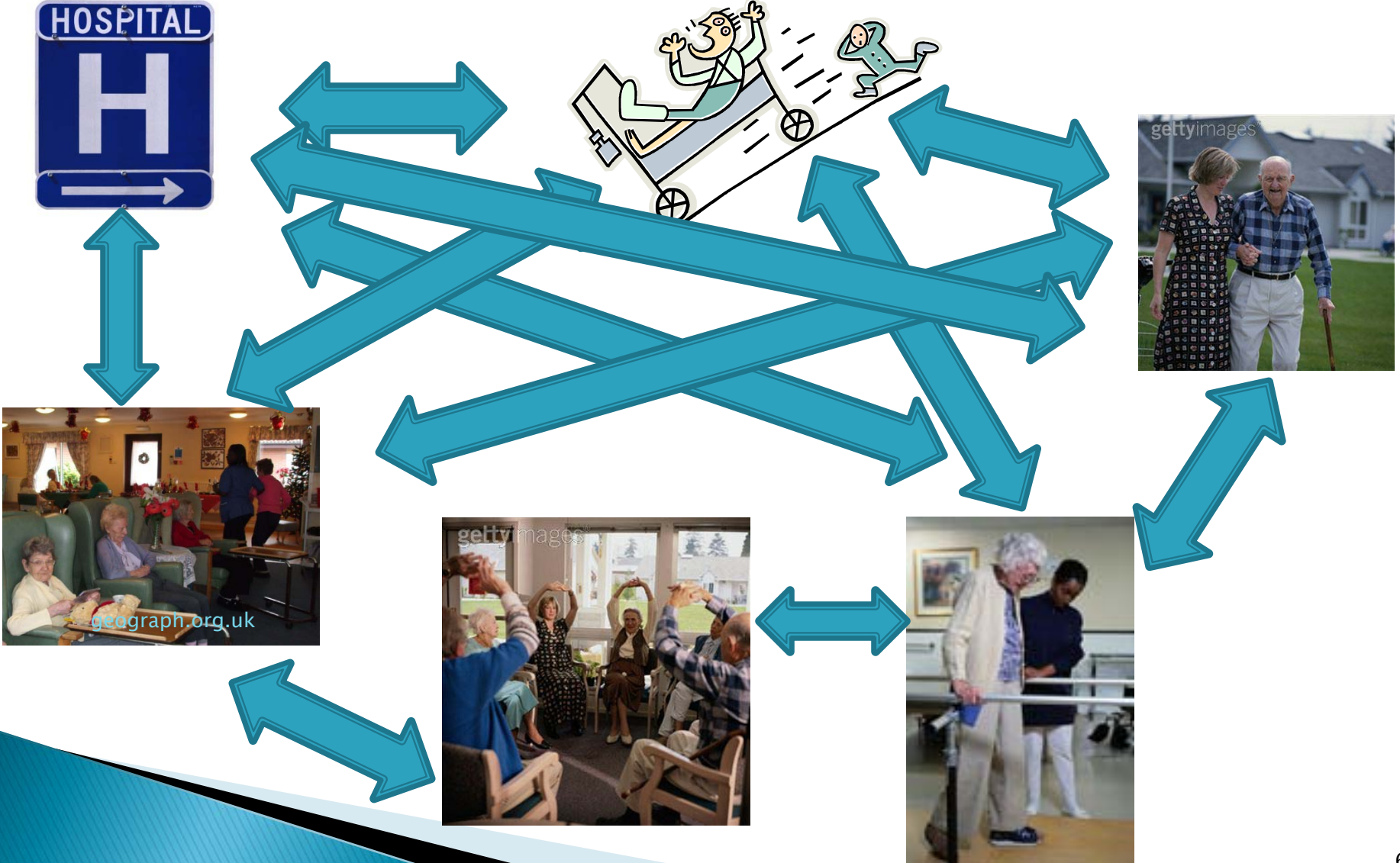
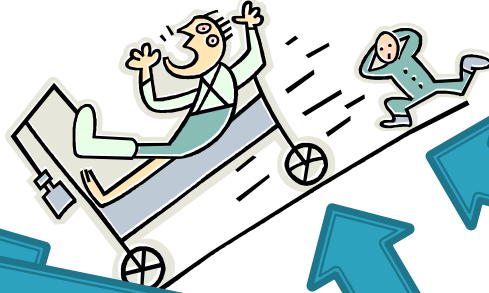
# Putting 'accountable' in the ACO

- ▶ Shared risk
  - Repay shared losses owed to CMS
- ▶ Shared reporting
  - Quality performance standards by all ACO partners
- ▶ Shared revenue
  - Receive/distribute shared savings
- ▶ Shared governance
  - Oversight and direction
  - Transparent governance process
  - Have fiduciary duty
  - Must be separate/unique when multi-organizational partnership
    - 75% control held by partnerships

# Putting 'accountable' in the ACO

- ▶ Leadership/management
  - Clinical and administrative systems
- ▶ Beneficiaries
  - At least 5,000 assigned beneficiaries
- ▶ Patient-Centeredness
  - Promote **evidence-based medicine**
  - Adopt a focus of patient centeredness
  - Establish quality measures to fulfill this

# Care Transitions





# ACOs, Care Transitions, HCBS

## Clinical Care Coordination

- ▶ Medical needs based
- ▶ Follows physician directions
- ▶ Includes fee-for-service items

## Home/Community Supports

- ▶ Nutrition
  - Is there food in fridge?
  - Have provided meals been eaten?
- ▶ Falls Prevention
  - \$19B industry
  - Rugs and Rails
- ▶ Chronic Disease Mgmt
- ▶ Family Caregiver Support
- ▶ Access to community programs

Partnerships and coordination will ensure the entire patient is supported to:

- reduce inappropriate hospital readmissions
- Improve quality of care

# Aging and Disability Resource Centers (ADRC)

- ▶ No-wrong door approach to accessing long-term community care supports and services
- ▶ Pillar Programs
  - Information/Referral & Access
  - Options Counseling
  - Person-Centered Care Transitions
  - Streamlined Eligibility

# Conclusion

- ▶ Identify partners that enhance your system
  - Clinical Expertise
  - Home–Community Based Services Expertise
  - Service Access Points (ADRCs)
- ▶ Determine the value of your service
- ▶ Make your service invaluable through quality and partnerships

## Comparison of Payment Reform Methods (adapted from Cohen, J.T., *Health Reform Watch*, March 11, 2010; Fisher et al., 2007)

	ACO (Shared Savings)	Primary Care Medical Home	Bundled Payment	Partial Capitation	Full Capitation
Strengths- Weaknesses	<ul style="list-style-type: none"> <li>•Makes providers accountable for total per-capita costs</li> <li>•Does not require “lock-in”</li> </ul>	<ul style="list-style-type: none"> <li>•Supports primary care physicians coordination of care</li> <li>•Not accountable for per-capita costs</li> </ul>	<ul style="list-style-type: none"> <li>•Promotes efficiency &amp; care coordination</li> <li>•Not accountable for per-capita costs</li> </ul>	<ul style="list-style-type: none"> <li>•“Up front” payment to improve processes/systems</li> <li>•Only accountable for specific aspects</li> </ul>	<ul style="list-style-type: none"> <li>•“Up front payment” to improve processes/systems</li> <li>•Requires “lock-in”</li> </ul>
Strengthens primary care?	Yes—incentive to focus on disease mgmt. Strengthened by medical home	Yes—allows for better care coordination and disease management	Yes/No—Only for bundled payment items	Yes—if primary care is included in model for systems improvement	Yes—“up front” payment for systems improvement
Fosters coordination	Yes—significant incentive	No—specialists, hospitals not incentivized	Yes—limited within bundle	Yes—strong incentive	Yes—strong incentive
Removes payment incentives to increase volume	Yes—adds incentive based on value, not volume	No—no incentive to decrease volume	No—outside the bundle	Yes/No—restricted within capitation	Yes—very strong efficiency incentive
Providers bear risk for excess cost	No—risk shared across partners	No—no risk to increase volume	Yes—within episode	Yes—only for outside services	Yes—providers responsible for costs > payment
Requires “lock-in” of patients to specific providers	No—assigned based on previous care patterns	Yes	No	Yes	Yes

Accountable Care Systems Models and Core Capabilities (adapted from Cohen, J.T., *Health Reform Watch*, March 11, 2010; Shortellet al., 2009)

Accountable Care System Model	Redesign Care Processes	Teamwork	Care Coordination	Performance Accountability	Information Technology	Knowledge Management	Change Management
Multi-Specialty Group Practice	High	High	High	High	High	High	Medium
Hospital Medical Staff Organization	Medium	Medium	High	High	High	Low-Medium	Low-Medium
Physician Hospital Organization	Medium	Medium	Medium	High	High	Medium	Medium
Interdependent Provider Organization	Low	Low	Low-Medium	Medium	Low	Low	Low
Health Plan Provider Organization/ Network	Medium	Low-Medium	Low-Medium	Medium-High	Low-Medium	Low-Medium	Low-Medium

# General References

- ▶ <http://www.aging.iowa.gov>
- ▶ <http://www.lifelonglinks.org>
- ▶ <http://www.iowahealthylinks.org>
- ▶ CMS Accountable Care Organization Decision
  - [http://www.ofr.gov/OFRUpload/OFRData/2011-27461\\_PI.pdf](http://www.ofr.gov/OFRUpload/OFRData/2011-27461_PI.pdf)

Joe Sample

[joseph.sample@iowa.gov](mailto:joseph.sample@iowa.gov)

515-725-3335

