Accountable Care Organizations, Bundled Payments and Impact on Anesthesiology

Patricia A. Kapur, MD
Professor and Ronald L Katz MD, Chair
David Geffen School of Medicine at UCLA

Simplified Structure of Health Reform Coverage

Expansion to projected 32 million more Americans from 2014-2019:

- Estimated 16 million into expanded Medicaid programs
- Estimated 16 million able to buy private insurance through state-based exchanges with government subsidies
- Individual and employer mandates
- Insurance Market Reforms – broaden and stabilize private coverage; eliminate pre-existing condition restrictions

Simplified Structure of Health Reform: Payment and Delivery System Transformation

- Delivery/payment reforms & experiments to slow growth rate of health care spending
- Accountable Care Organizations, pilot and demonstration projects
- Comparative Effectiveness Research to make sure the right care gets to the right patient at the right time

CMS Payment and Delivery Reform Efforts

- Readmissions prevention program.
- Medical Homes: All-payer national pilot; Medicaid “health homes”.
- Community-based care transitions programs.
- Federal coordinated care office to better coordinate care of “dual eligibles” (Medicare + Medicaid).

CMS Payment/Delivery Reform Efforts, cont.'

- Bundled payment pilots.
- Value-based purchasing.
- Accountable Care Organizations:
  - Includes private payors and Medicare Shared Savings Program.
  - Provides all levels of care to large numbers of patients.
  - Population-based care; pro-active preventive care.
  - Providers at risk for quality outcomes and cost-effectiveness.

Accountable Care Organizations

1. ACO's forming in private sector between payors, eg: Blue Shield, and healthcare institutions.

2. ACO's in the Medicare Shared Savings Program:

   - "One-sided" option: ACO's not responsible for costs above expenditure target for the first two years; receive lower share of the savings compared to two-sided option.

   - Two-sided option: ACO's share in savings and risk liability for losses beginning in the first performance year.

ACO options, cont.'

3. ACO's under the "Pioneer" and "Transitions" programs from the Center for Medicare and Medicaid Innovation.
   - "Pioneer" program: 15 organizations to be selected; more aggressive quality/savings targets; providers accept more risk.
   - Transitions program for organizations formerly part of the Medicare Physician Group Practice Demonstration; including among others Dartmouth-Hitchcock, Mayo, Geisinger.

ACO's may be a combination of 1 and 2, or 1 and 3

ACO Themes

- Emphasis on care coordination across multiple organizations – not all owned or controlled by the primary organization.
- Systems Practice: mergers, consolidation, acquisition of physician practices.
- Eliminating unnecessary costs
- Living on Medicare rates.

ACO Themes, cont'.

- Chronic care management, Medical Home, and patient-centered primary care.
- 360-degree, 24/7 continuum of care.
- System-wide EMR.
- "Embedded" nurses in primary care practices; telephonic monitoring/case management.

Active Patient Population Management

Resources are spent preventively and supportively to assist people to remain at the lowest levels of resource consumption for their state of health.

A minority of a population needs acute care services, delivered based on systems optimization and outcomes measures.

UCLA Health System Faculty Practice Group

Health Reform May Create Substantial Risks for Academic Medical Centers

Potential Cuts in Graduate Medical Education payments (GME) under Medicare:

- Medicare program provides the primary financial support for graduate medical training of residents and fellows, and also helps to support care of underinsured and uninsured at AMC's and teaching hospitals.
- Residency and fellowship programs exist in 681 institutions; more than 300 sponsor only one residency program, primarily primary care programs in small, often rural locations.
- GME = 2 parts: Direct Medical Education and Indirect Medical Education.
- IME intended to reimburse institutions for higher costs of training residents who are "learning by doing".

Reductions in GME Funding

- The Medicare Payment Advisory Commission (MedPAC) has determined that these Indirect Medical Education (IME) add-on payments are significantly greater than the additional patient care costs that teaching hospitals experience.
- Fiscal Commission, among others, recommended reducing the IME adjustment.
- Current proposal to reduce the IME adjustment by 10 percent beginning in 2013.
- Plan estimated to save approximately $9 billion over 10 years.

Concerns voiced by ACGME, etc.

- Institutions may respond by reconfiguring residency and fellowship programs to meet patient care needs.
- Institutions may add more highly technical subspecialty programs, reduce number of “pipeline” programs.
- Institutions may turn to pharmaceutical or medical device industries to support education and training programs.
- Residents may need to pay tuition for training in some specialty and subspecialty programs.
- Financial pressures on residents may prompt them to forego completion of additional training to enter clinical practice early.
- Institutional faculty support may be reduced.

Challenges for Academic Medical Centers in Patient Care

- Impact of quality and outcomes measures initiatives on payment environment for Medicare, Medicaid, and private pay.
- Need to justify or reduce higher costs.
- Face fundamental choice: cede more routine care to community hospitals and focus on most severely ill patients?
- Make case for differential payment based on severity.
- How to handle the influx of patients as coverage expands in 2014.

The Progression to ACO's…

Penalties for healthcare-acquired conditions.

- "Never" events.

"Value-based" purchasing based on:

- Cost-effectiveness.
- Quality and outcomes measures.

Penalties for re-admissions.

Bundled payments.

ACO's

Goals of CMS “Bundling for Care Improvement” Initiative

Improve overall quality and value:

- Drive physician collaboration through financial incentives as a mechanism to improve efficiency and achieve sustainable results
- Reduce or stabilize growing costs to Medicare for acute care services by maximizing the use of available capacity in high quality providers
- CMS has reported $42.3 million in savings in the current Acute Care Episode (ACE) Demonstrations with substantial increases in clinical quality. $7 million in Co-Insurance costs.

"Acute Care Episode" Bundled Payment Demonstration Results

- After 2 years, the ACE Demonstrations produced impressive results: All participants saw increases/improvements in clinical outcomes.
- Participants saw decreases in cost per case via average length-of-stay and/or supply cost unit price decreases through vendor consolidation.
- One participant realized increased market share from Medicare and commercial plans.
- Further integration by and between the physicians and hospitals lead to other efforts to reduce care costs.

Model 4 –Global Fee Components
Most Similar to Current ACE Demonstration

- Can select DRGs Sponsor wishes to include.
- Episode begins 3 days prior to admission and ends at discharge.
- Paid as a single fee (Part A/B Services) to Sponsor; Physicians paid by Sponsor.
- Minimum discount 3% if DRGs selected are more than current ACE listing; greater discount is expected if Sponsor stays with current ACE scope (28 Cardiac and 9 Ortho DRGs).

Model 4 - Global Fee Components, cont.

- Can keep any savings; must pay back any excess spending (paid to non-participants) within 30-day post discharge period.
- Risk includes related or unrelated re-admission risk.
- Can propose quality measures to report; must still report full set of hospital quality metrics required by CMS.

Common Payment Aligns Goals

Typical Global Fee Arrangements- Model 4 as an Example:

- Sponsor contracts with CMS for a negotiated global fee per DRG.
- Sponsor contracts with physicians at a single fee based upon +/-historical Medicare rates.
- Incentive is developed to meet all CMS mandated Quality/Access/Efficiency metrics.
- Utilize clinical performance protocols to optimize outcomes.
- Hospital savings is the source of any incentive payout to physicians; limited to 50% of total pro-fees paid and 50% of total actual savings.

Typical Model 4 Flow of Funds

- Sponsor agrees to flat rates per episode with all Providers.
- Sponsor sends Bundled Bid to CMS.
- Sponsor bills CMS upon 30 days post discharge.
- Sponsor may pay physicians in any time frame sooner than payment from CMS.
- Physicians submit “No-Pay” claims to CMS for assurance of care delivery.
- Reconciliation by CMS annually to agreed rates.

CMS Bundled Model Application Process

Sponsor must establish:

- Financial model and arrangements.
- Organizational structure and governance.
- Current quality and efficiency metrics at 90th percentile.
- Cost savings opportunities and quality improvement.
- Provider engagement and partnerships.
- Care re-design.
- Marketing plan to beneficiaries.

CMS Bundled Model Application **Selection Criteria and Weights**

- 40 points: Financial Model
  - Overall savings to Medicare.
  - Risk adjustment (if applicable).
  - Anticipated actions that will result in lower spending.

- 25 points: Quality and Patient Centeredness
  - Proposed mechanisms to improve quality and patient experience of care.
  - Proposed quality metrics.
  - Quality assurance and continuous quality improvement.
  - Beneficiary protections.

CMS Bundled Model Application **Selection Criteria and Weights**

- 20 points: Demonstration Design
  - Definition of episode.
  - Level of provider engagement and participation.
  - Care improvement.
  - Design for gain-sharing.

- 15 points: Organizational Capabilities, Prior Experience, and Readiness
  - Financial arrangements.
  - Commitment and credentials of executives and governance bodies.
  - Success and readiness to participate.
  - Partnerships.

CMS Bundled Payment Pilot: What's In It for Hospitals?

- Strengthen service line:
  - Reduction of costs
  - Enhanced operational efficiency
  - Enhance clinical quality
  - Improved patient experience
- Protect current & build future market share
  - Preferred provider status within region
- Build organizational mastery to manage to fixed budget
- Stepping-stone in physician integration, supporting progress toward clinical integration or ACO
  - Alignment in care management
  - Co-management of clinical services

CMS Bundled Payment Pilot: What Is In It for Physicians?

- Potential volume increase.
- Protect current and build future Medicare market share.
- Pay physicians more quickly if in Model 4.
- Co-management of clinical services affecting them.
- Improved quality and patient experience.
- Incentive possible of 150% of Medicare payment.
- Effective and integrated care coordination.

CMS Bundled Payment Pilot: What's in it for Physician Groups?

Medical Groups Can Sponsor a CMS Bundled Payment:

- Increase revenue for Medicare FFS patients.
- Leverage care management tools with a hospital partner.
  - May improve specialty relationships and overall costs of care for all patients.
  - Potentially leverage arrangement for HMO patients with hospitals and contracted physicians.
- Teaming up on a pilot basis in preparation for ACO's with hospitals.

Critical Success Factors Under Bundling

- Physician leadership and co-management
- Targeted education to participants
- Best practices in cost, efficiency and effectiveness
- 90th percentile in quality
- Legal structures able to handle gain-sharing

Opportunities for Anesthesiology with Bundled Payments

- Take a larger role to manage the interventional experience from the decision to provide a procedure, until the patient's care is returned to the longitudinal provider, ie: "Surgical Home".
  - Pre-procedural screening and optimization
  - Pre, intra-, and post-procedural care
  - Critical care, step-down, and pre-discharge care.
  - In- and Outpatient acute & chronic pain management
  - Palliative and hospice care.

Anesthesiology opportunities, cont.'

- Organizationally manage procedural, recovery, critical care, and pain management areas; assure optimum quality and cost-effective productivity and throughput.
- Manage professional staffing expense by utilizing diverse providers, each functioning at the top of their license.
- Become the "go to" acute care resource for the institution, eg:
  - Trauma care.
  - Code and Rapid response teams.
  - Line placement and cardiac rescue imaging.

“We always overestimate the change that will occur in the next two years and underestimate the change that will occur in the next ten.”

Bill Gates Jr.