



# A Medicare ACO Model

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# What You Will Learn

1. The building blocks for a successful ACO
2. How you can reduce costs
3. The competitive factors you are likely to encounter

# Our Shared Savings Calculation for 2014

- Assigned beneficiaries: 15,603
- Per Capita Expenditures Benchmark: \$13,099
- Total Benchmark Expenditures: \$198,546,103
- Total Actual Expenditures: \$192,081,207
- Total Savings: \$6,464,895
- Minimum Savings Rate: \$5,312,845 or 2.7%

# Our Shared Savings Calculation for 2014

- Quality Performance Sharing Rate: 50%
- Our Quality Score: 89%
- Our Final Sharing Rate:  $89\% \times 50\% = 44.7\%$
- Our Shared Savings: \$2,890,804
- Sequestration Adjustment: \$57,816
- Net Earned Performance Payment: \$2,832,988



# What Demographics and Utilization Worked in our Favor\*

- Average Age: 75.9 years versus group of 71.7 years
- Average Risk Index of 24.34 versus 17.17 for group
- Our inpatient PMPM costs were 10% above norm while our utilization was 10% below norm.
- Our ER PMPM costs were 2% above norm while utilization was 23% below norm

\*Data provided by Verisk and Premier Inc.

# Where is Risk Accounted for in the Calculations?

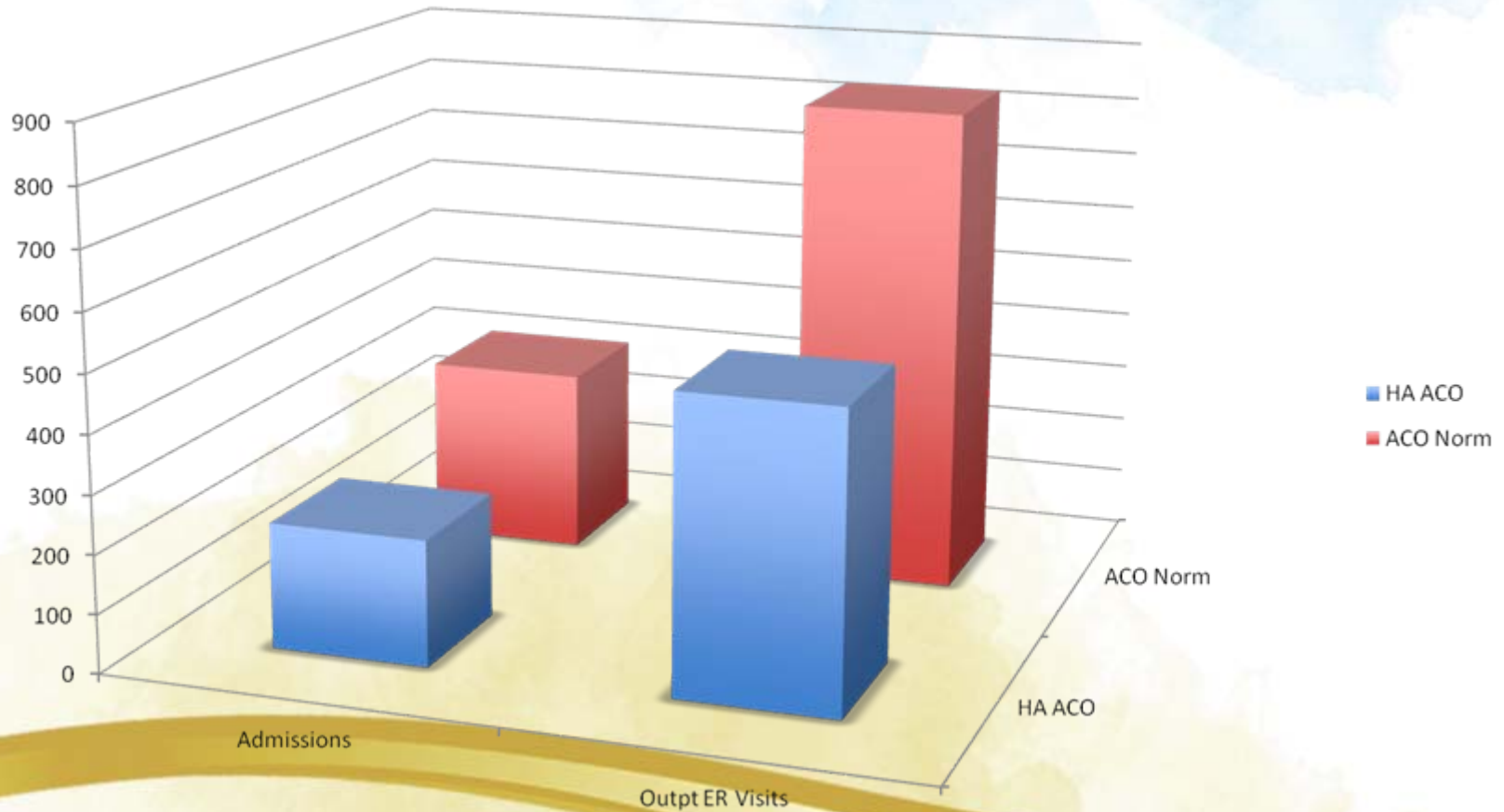
- Risk scores:  $>1$  and applied at multiple levels:
- CMS-HCC scores, Demographic scores, Risk Ratios, then renormalized
- Each one applied to the benchmark year and the performance year, to newly assigned and to continuously assigned beneficiaries.
- Finally, the CMS Office of the Actuary (OACT) adds a FFS growth increment



# Conclusion

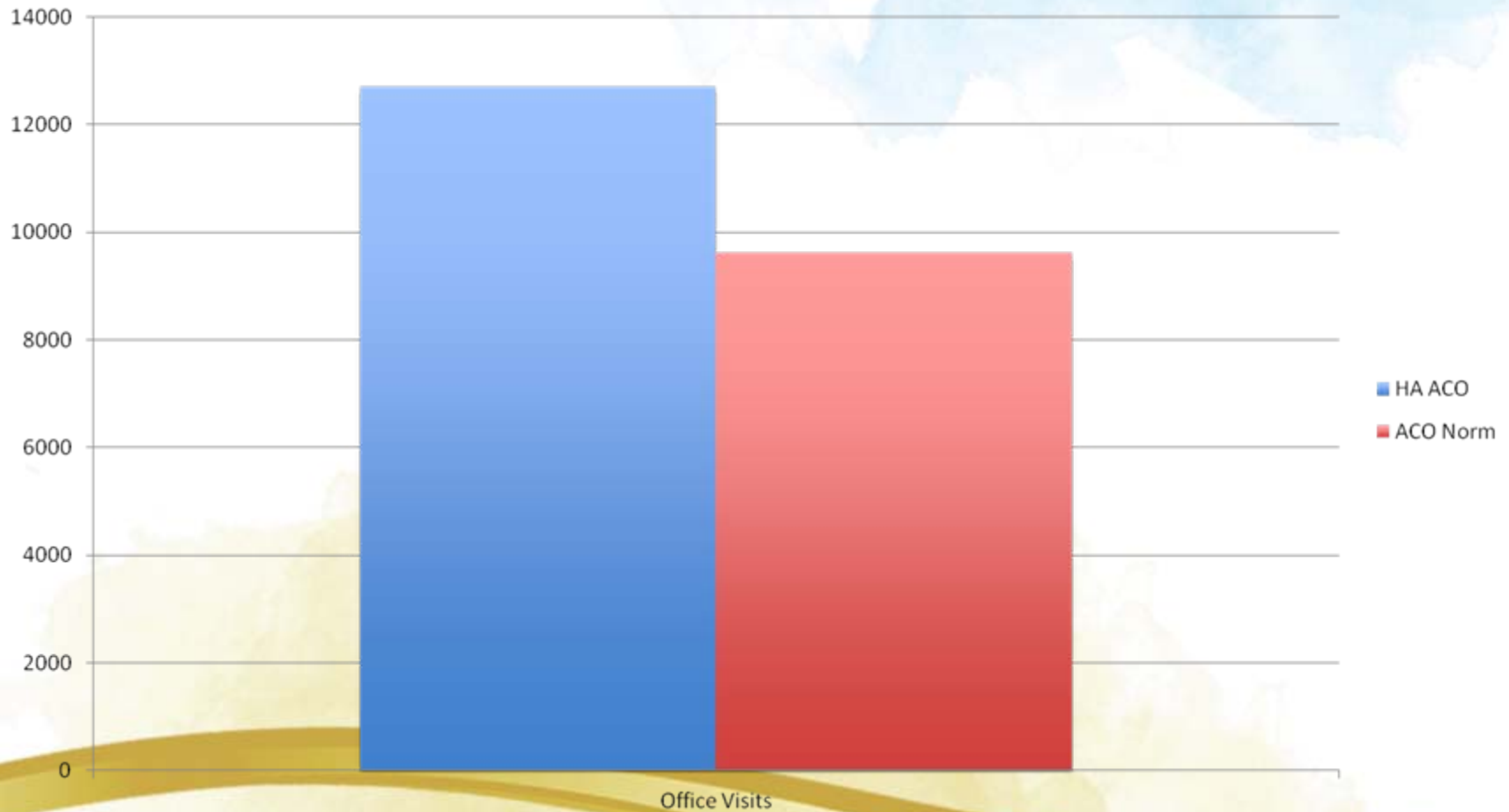
- Our costs are higher because, in part, our risk index is so much higher than the norm.
- Yet our utilization numbers are significantly below expected for such a high risk index.
- This means that the physicians are taking cost-efficient care of very high risk patients. This is primarily responsible for our savings.

# Admissions and Outpt. ER Visits





# Office Visits



# Review of Utilization that made a difference

- Total admissions per 1000: 274.1 (us) vs. 316.8 (group)
- ER visits per 1000: 641.9 (us) vs. 835.0 (group)
- Urgent care visits per 1000: 44.2 (us) vs. 53.8 (group)
- Total office visits per 1000: 13,210.8 (us) vs. 9,631.7 (group)
- The relative increase in office visits accounts for greater attention to the patients in order to avoid hospital admissions, ER visits, and urgent care visits.



# Next Question—Is the care suffering?

- The answer is a definite NO as demonstrated by the average care gap index (CGI). For our ACO, the CGI is 4.80 while the CGI of 4.96 is higher for the group of ACOs being monitored.
- In summary, our ACO is taking care of much higher risk patients but because of more efficient care we are generating a savings while providing excellent care.
- This is a tribute to the physicians, care coordinators, office nursing staff, and other providers in the offices. This message needed to get out to the ACO providers in each ACO practice.

# Prime Opportunity for reducing PMPM spend

- Top process identified for improvement by PMPM spend
  - Skilled nursing facilities: \$135.60 PMPM or \$28,323,645 per year
  - We can break down the data by SNF and by referring provider
  - Also, break down by admissions, readmissions, length of stay, cost per day, etc.

\*Data provided by Verisk and Premier Inc.



# Disease Prevalence Reports Opportunity

- CHF, COPD, and diabetes as expected will be targets for more and more attention to deal better with high risk scores, care gaps, admission and readmission rates, and use of outpatient facilities.
- High ordering of CT scans and MRIs will get our attention

# Ultimate Opportunity: physician reports

- Individual physician reports will be prepared to show rates of admissions, readmissions, adjustments for patient risk scores, quality of care gaps, and efficiency. The reports will permit individuals to compare their results with their peer group as a whole.



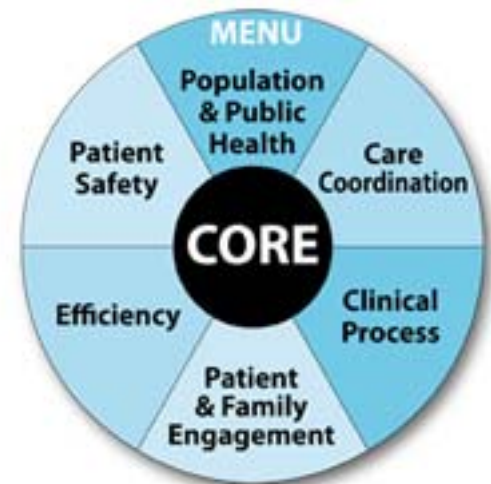
	A	B	C
1	\$2,330,000	\$4,1570,150	\$2,259,950
2	\$1,900,400	\$8,2373,000	\$2,180,950
3	\$3,710,020	\$1,200,950	\$1,423,000
4	\$9,500,000	\$1,000,440	\$930,950
5	\$5,670,200	\$7,980,000	\$1,770,350
		\$2,100,090	\$1,150,440
		\$3,423,000	\$1,900,400
		\$1,900,400	\$3,710,020

# How did it happen?

- Practice selection for membership
  - Patient-Centered Medical Home (PCMH) recognition by National Committee for Quality Assurance (NCQA)
- Nurse Care Coordinator for large practices
  - Relate to high-risk patients

# How did it happen?

- Awareness that compliance with the 33 quality measures determines whether all or part of any potential savings accrues to the practice
  - Use Health Endeavors to assist





# How did it happen?

- Identified a data analytics company
  - First step was a false step
  - Second step was with Premier and Verisk Health, and later with Milliman
- Verisk pointed out that our population risk score was very high—24.34 versus 17.17
  - CMS then determined that our historical benchmarks would be relatively high.

# How did it happen?

- ACOs with higher initial benchmark expenditures are more likely to save money
  - Need to consider regional variation in determining benchmark expenditures and utilization of resources.
- Option: Certify as ACO by NCQA

# Process versus Outcome Measures

- Donabedian: Structure, Process, Outcome
- Process measures current activity
- Outcome measures an end result
- Outcome-orient process measures
- Non-physician factors that affect outcome
  - Patient lifestyle, other diseases, socio-economic status, job,

# Quality Measures in the Future

- International Consortium for Health Outcomes Measurement's (ICHOM) standardized outcome set examples
  - Coronary artery disease
  - Hip and knee osteoarthritis
  - Heart failure
  - Breast cancer

# ICHOM - Coronary Artery disease

- Acute Complications of cardiac surgery or interventional cardiology
- Patient reported health status: angina, dyspnea, depression, functional status, HRQoL
- Cardiovascular disease progression: reinfarction, stroke, heart failure, renal failure, need for revascularization procedure
- Survival: overall survival

# Internal Competition & Challenges

- Track 1 – the most popular Track, eventually
  - Track 2 and Track 3
  - Next Generation
- Regionalizing the historical benchmark
  - 35% >> 75%
  - Winners and Losers



# External Competition & Challenges

- Bundled Payment for Care Improvement (BPCI) initiative
- Comprehensive Primary Care initiative (CPC)>>CPC+
  - Track 1 and Track 2: care management fee and performance-base fee PBPM
- Medicare Advantage plans







# In summary, what did we learn?

- It's step by step –
  - pick the doctors who get it,
  - hire your care coordinators,
  - focus on the low hanging fruit like decreasing hospital admissions and increasing office visits,
  - Make sure they know the 33 quality measures
  - Line up a decent data analytics firm
- Then, you are on your way to a successful ACO

For Questions, please call or  
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