Accountable Care Organizations: Empowering Internists

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Angry? Frustrated? Lost?

MEDICARE RULES REGS

Denied Claim

ICD-10 EMR RVU MOC
The 6% Problem

- Primary Care only directs 6% of costs of medical care.
- Primary care physicians can have the greatest impact on health outcomes for individuals and population in the new "wellness care" system.
- High quality, caring primary care has been under-compensated with reliance on current E and M coding developed for "sickness care" system.
- Primary care in current health structure lack the levers to manage costs, improve outcomes and be well compensated for their intellectual work.
Thesis

- Accountable Care Organizations (ACOs) can re-center primary care.
- Physician Owned ACOs create value for physician and patients as key stakeholders.
- ACO structures can generate PCP income.
- Physician engagement and clinical transformation create success.
(My) Definition of an ACO

❖ "Integrated provider based organization formed for the purpose of contracting with payors, improving value of health care by reducing per capita cost and increasing measurable quality." **

❖ **Hallmarks**: data collection and aggregation, EHR linkages, clinical integration, data analysis and provider engagement, gainsharing, incentive pay for performance and quality gains

❖ **Payors**: Medicare, Commercial insurance, Medicaid, MA programs

**Joshua Lowentritt, MD, CEO, Louisiana Physicians ACO**
MEDICARE SHARED SAVINGS PROGRAM BASICS
How does a Medicare ACO work

- CMS algorithm attributes beneficiaries by clinic /TIN (tax ID number in the PECOS) based on plurality of primary care services.

- PCP attribution 100-200 patients in metro areas with heavy penetration Medicare Advantage, 300-450 in cities with less MA, up to 1300 in small cities, rural areas; some specialists will attribute panels, such as cardiology.

- Nursing home patients will attribute (POS 32).

- CMS calculates benchmark part A and part B spending per beneficiary and specifies target minimum savings rate (MSR), 3-4% to quality for shared savings distribution.

- Track One MSSP, no downside financial risk, receives up to 50% distribution based on meeting MSR and Quality reporting.
How does a Medicare ACO work?

- Year One--pay for reporting -
- Years 2-3--pay for performance, shared savings limited by quality metrics, CAHPS surveys, management of ambulatory sensitive conditions which are scaled and summed up to 100 possible points.
- The medical budget is determined by:
  - 3 year look back period in which every Medicare beneficiary cared for by the group of member physicians, clinics is evaluated to determine if he/she received plurality of care for outpatient services from its clinicians by an algorithm.
  - The budget is determined by actual costs of the attributed patients weighted by prior years.
Savings Ahead
Shared Savings

- CMS calculates savings compared to risk adjusted benchmark
- Must meet minimum savings rate, varies based on size of population, 2.2% - 4%
- Track 1-Potential distribution 50% of savings, up to 10% budget
- Track 2 shares downside risk with higher pay out
- Track 3/ Next Gen ACO - can select risk corridor for higher pay out
Shared Savings Distribution Waiver

- Waives application of the Stark law, gainsharing provisions of the CMP Statute and the federal anti-kickback statute with respect to distributions and use of shared savings by an ACO
- ACO must have participation agreement and remain in good standing
- Distributed to ACO participants, ACO providers/suppliers or used for activities that are reasonably related to purpose of Shared Savings Program
- Payments to physicians cannot be made knowingly to induce the physician to reduce or limit medically necessary items or services
Features of Commercial ACOs

❖ Attribution based on PCPs
❖ Focus on chronic disease patients (HTN, Diabetes, CAD/CHF, CKD)
❖ PMPM fees ($1-15) pay for care coordination of chronic disease beneficiaries, tiering of fees based on quality and cost outcomes.
❖ Pre-defined quality measures, performance goals, defined cost targets
❖ Opportunities for shared savings / gainsharing
❖ Commercial plan payments can help primary care clinics hire patient navigators, enhance staff for wellness that can also benefit Medicare enrollees and others.
What is LPACO?

- Louisiana Physicians ACO (LPACO) is the largest, oldest physician owned, physician governed ACO in the state.
- Developed by early adopter physicians and clinics in 2013.
- In 2017, now in year 4 of participation in the Medicare Shared Savings Program (MSSP).
- Entering commercial gainsharing contracts and Medicaid pilot projects.
- 12 clinic partners, 175 providers, 10,600 Medicare beneficiaries, serving nearly 50,000 Louisianans.
Louisiana Physicians ACO Clinics & Beneficiaries 2017

[Map showing locations of clinics and beneficiaries]
LPACO Members / Governance

- Committed to independent physician directed practice
- Medical society and Hospital local leaders
- Entrepreneurial ethical physicians
- Governed by shared decision making, frequent Board, Committee and Membership meetings
- Transparent governance, finances, goal-setting
LPACO Physician Engagement

- Board members and clinics participate in shared decision making

- All Clinic / Members included in phone meetings 8-12 meetings yearly

- Quality and Clinical Policy Committees function as a Committee of the Whole (COW) with quarterly calls

- Annual Retreat in Baton Rouge in January
LPACO 2017 Annual Retreat
ACO–Keys to Success –1

• Physician and Provider engagement is critical-frequent meetings to develop working relationships, shared decision making, shared goal setting

• "Skin in the game" - ownership, monthly program fees, budgeting, distribution formula

• Create early wins - mine claims data for variance and set simple achievable goals (reduce LTAC, chose HH partners, pick outlier disease states)
## Detailed Inpatient Costs by Level

<table>
<thead>
<tr>
<th>Inpatient Cost Category</th>
<th>Risk and Unit Cost Adjusted Benchmark (Benchmark National Average)</th>
<th>Variance from National Average</th>
<th>Target @ 5% Below National Average</th>
<th>Target @ 15% Below National Average</th>
<th>Q114</th>
<th>Q214</th>
<th>Savings/ (Cost Increase) $M</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient</td>
<td>$5,347 ($4,213 $3,010)</td>
<td>40.0%</td>
<td>$3,628 ($3,303)</td>
<td>$5,506 ($3,398)</td>
<td></td>
<td></td>
<td>($0.49)</td>
</tr>
<tr>
<td>Short-Term Hospital</td>
<td>$3,453 ($2,721 $2,740)</td>
<td>-0.7%</td>
<td>$3,303 ($2,955)</td>
<td>$3,118 ($2,394)</td>
<td></td>
<td></td>
<td>$1.97</td>
</tr>
<tr>
<td>Long-Term Hospital</td>
<td>$973 ($767 $89)</td>
<td>758.7%</td>
<td>$108 ($96)</td>
<td>$1,045 ($740)</td>
<td></td>
<td></td>
<td>($0.43)</td>
</tr>
<tr>
<td>Rehabilitation Hosp or Unit</td>
<td>$675 ($532 $196)</td>
<td>721.1%</td>
<td>$236 ($211)</td>
<td>$736 ($354)</td>
<td></td>
<td></td>
<td>($0.38)</td>
</tr>
<tr>
<td>Psychiatric Hosp or Unit</td>
<td>$366 ($289 $80)</td>
<td>261.7%</td>
<td>$96 ($86)</td>
<td>$354 ($611)</td>
<td></td>
<td></td>
<td>($1.44)</td>
</tr>
</tbody>
</table>

**Use of LTAC, Inpatient Rehab and Inpatient Psych are dramatically higher than national averages are continue to grow.**

**Very good improvement in short-term acute care costs already are being offset by continued growth in LTAC, Rehab and Psych.**

<table>
<thead>
<tr>
<th>Admission Rates by Category (per 1,000 Beneficiaries)</th>
<th>Percent Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Hospitalizations</td>
<td>1.4%</td>
</tr>
<tr>
<td>Short-Term Hospital</td>
<td>-3.8%</td>
</tr>
<tr>
<td>Long-Term Hospital</td>
<td>3.2%</td>
</tr>
<tr>
<td>Rehabilitation Hosp or Unit</td>
<td>-1.5%</td>
</tr>
<tr>
<td>Psychiatric Hosp or Unit</td>
<td>62.2%</td>
</tr>
</tbody>
</table>

**The historically high LTACH, Rehab and Psych costs are being driven by high admission rates.**

Suggest criteria around level of care between SNF, LTACH, IP Rehab and Home Health be developed and communicated.
Clinics – Keys to Success – 2

- Clinical transformation - change patient flow, focus on a few simple changes
- Annual wellness visits - create sticky attribution, meet quality measures, risk assessments
- TCM post acute care visits - this is the highest value service to focus on for savings.
- CCM - next phase for patient engagement and care of complicated patients, vendor vs in-house
- Drive quality metric outcomes, use variance analysis to determine focuses, share best practices
Physicians – Keys to Success – 3

• Liberate the data, share trends, analysis with all providers individually.
• Benchmark providers with unblinded data
• Physicians are competitive, have never seen their utilization data
• All providers have strengths and weaknesses (no provider is last across the board)
• Focus on outliers, avoid judgments, set simple goals
“The treatment of a disease must be completely impersonal; the treatment of a patient must be completely personal.”

—Francis W. Peabody, MD, early 20th century physician
KEEP CALM
ITS CME/MOC TIME
CME/MOC Question 1

- Clinical: Your primary care patient Mrs Jones is 74 yo woman, has Medicare with secondary, is attributed to your ACO, has hip fracture, repaired and discharged. Which of the following is a true statement:
- 1. She must use a home care agency approved by the ACO.
- 2. Her Skilled length of stay care will be limited by ACO Quality Committee Clinical pathway.
- 3. Her orthopedic surgeon must be selected from a list of ACO participating physicians.
- 4. The ACO and its primacy care physician can have financial relationships with the orthopedic surgeon, the home health agency and skilled nursing facility as part of integrated care network.
4. Medicare beneficiaries attributed to ACOs, unlike a commercial HMO or Medicare Advantage plan can receive services from any participating Medicare provider, physicians, health agency, faculty.

• A Medicare beneficiary can receive the same types of care as regular fee for service Medicare with same regulations and qualifications.

• There are broad waivers of Stark rules, gainsharing and anti-kickback regulations for financial relationships between participating Medicare providers, faculties and entities which meet certain tests.

• Source: see final slide
CME/MOC Question 2

- Clinical: You are member of a Track One ACO, with ten thousand patients, with $10,000 risk adjusted benchmark and minimum savings rate of 3%. All of the following are true except:

- 1. After saving $5,000,000 in year one your ACO fails to report clinical quality data, your ACO receives $0 for your shared savings.
- 2. After saving $5,000,000 in year one, your ACO successfully reports clinical quality data successfully, your ACO will receive $2,500,000 as it's shared savings.
- 3. After saving $5,000,000 in year two, report quality measures and CAHPS scores which are scaled and total up to 90 of 100 points, your ACO revives $2,250,000 in shared savings.
- 4. After saving $2,500,000 in year three, report quality measures and CAHPS scores which are scaled and total up to 90 of 100 points, your ACO receives $1,125,000 in shared savings.
CME/MOC Answer 2

4. To receive distribution for all years, an ACO must exceed its Minimum Savings Rate (MSR).

To receive a distribution in year one, an ACO only needs to report data successfully.

To record a distribution in years two and later, an ACO must exceed its MSR, report its quality metrics successfully and its distribution is limited by its total scaled scores in 4 domains.

Source: see final slide
CME/MOC Question 3

- Medicare ACO can be set up a variety of ways. Each of the following is allowed except:
- 1. Practice practice physicians in Alaska, Alabama, Chicago, and New York State who attribute 5,000 or more patients.
- 2. Employed physicians, podiatrists, nurse practitioners, physician assistants working for rural safety next hospital, tertiary medical center and community private practice physicians who attribute 10,000 patients.
- 3. Chain of orthopedic and rehab hospitals physical therapists and its employed and private practice surgeons which attribute 2,500 patients.
- 4. An integrated regional group of primacy care physicians, accupuncturists, dieticians, chelation therapists, masseurs, hypnotists, palm readers, and other allied health providers who attribute 10,000 patients.
3. An ACO must attribute 5,000 or more patients in the three year look back period to be accepted into the Medicare program.

The attribution of patients is determined by outpatient E and M codes, wellness care, including nursing home codes and rural health care management codes by eligible providers (physicians, nurse practitioner, physician assistants, podiatry) regardless of what other types of providers are involved in the business.

The providers need not be in a contiguous geographic area, can be any specialty, any type of employment or corporate structure.

Source: see final slide
The Patient Protection and Affordable Care Act (PPACA) (Pub.L. 111-148) and the Health Care and Education Reconciliation Act of 2010 (Pub.L. 111-152) are collectively known as the Affordable Care Act. Section 1899 is the actual MSSP statute. On CMS' MSSP website (link below) there is a tab on the lower left "Statutes/Regulations/Guidance" that contains a great deal of interpretation of the statute. Happy reading!

http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/index.html?redirect=/sharedsavingsprogram/
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Final Thoughts

• Know your data, cost and quality of care
• Measure and benchmark your practice, clinicians
• Prepare for transition to value based care, no matter your sub-specialty
• Bonus--75% of year one Medicare MIPS requirements are met by Track 1 ACO activity
• Learn about costs, risks, begin to prepare for partial or full capitation models
• Create and share some savings !!!
• Can you afford NOT to participate in these models ?