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ACOs? PCMH? MU? Which Shiny Object?

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ACOs?

- **Secretary for DHHS required by PPACA to: "establish a shared savings program that promotes accountability for a patient population and coordinates items and services under Medicare Parts A and B, and encourages investment in infrastructure and redesigned care processes for high quality and efficient service delivery"[1]**
- **Accountable Care Organizations (ACOs) detailed in CMS Final Rule[2]**

[1]Patient Protection and Affordable Care Act, Section 3022

[2]42 CFR Part 425 Medicare Shared Savings Program: ACOs [CMS-1345-F]

PCMH?

- **"…a healthcare setting that facilitates partnerships between individual patients and their personal physicians, and when appropriate, the patient's family. Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner."[1]**
- **Patient –Centered Medical Home recognition program updated by NCQA to align with requirements for Meaningful Use**

[1]http://www.ncqa.org/tabid/631/default.aspx, accessed 8/1/11

Meaningful Use (MU)

- **ONC Health IT Policy Committee (June, 2009):**
  - We recommend that the ultimate goal of meaningful use of an Electronic Health Record is to enable significant and measurable improvements in population health through a transformed health care delivery system. The ultimate vision is one in which all patients are fully engaged in their healthcare, providers have real-time access to all medical information and tools to help ensure the quality and safety of the care provided while also affording improved access and elimination of health care disparities.
- **Stage 1 - qualified providers receiving payments**
- **Stage 2 - recommendation to defer for 1 year**
- **Stage 3 - in 2015, non-qualifieds will receive reduced reimbursement**

Words of Wisdom?

- **John Halamka (former CIO of Harvard Medical School) now CIO of Beth Israel Deaconess Medical Center:**
- **"will need to reset the team at BIDMC to qualify as an ACO"**
  - Will require substantial improvements in HIT registries, Health Information Exchange, business intelligence
- **BIDMC is one of the most advanced HIT user/innovators in the country.**
  - BIDMC has qualified for Stage 1 Meaningful Use & is receiving payments start

How different will its systems have to be to qualify as an ACO?

CHCs? ACOs?

- **Final Rule specifies that FQHCs can both sponsor and join ACOs under Medicare Shared Savings Program**

- **ACO guidelines will, in part, drive CMS' focus on:**
  - Technology-enabled clinical reporting
  - Financial reporting
  - Outcomes management

ACO Qualification

- To qualify as an ACO, providers must meet numerous requirements:
  - Be a legally formed organization with a defined management structure
  - Have at least 5,000 assigned Medicare beneficiaries in traditional fee-for-service programs
  - Commit for 3 years
  - Provide the data to calculate per beneficiary fee-for-service cost and risk adjusted Minimum Savings Rate (MSR)
  - Report on 33 clinical & population-based performance measures
- Organizations weighing participation due to complexity & cost. Two different risk models with complex guidelines:
  - ACOs eligible for 2%-3.9% shared savings (depending on size) or
  - 2% with possibility of shared loss (payment to CMS) depending on exceeding MSR

Some Real Similarities

- **ACO, PCHM, MU each require some level of:**
  - ePrescribing
  - Medication reconciliation
  - Use of patient registries
  - Reporting of selected PQRI measures
  - Use of information exchange for care coordination
  - Provider to provider communication
  - Provider to patient communication

Overlapping Technology Requirements

- High-speed network (T1, 1.5MB/sec) or higher for HIE & care coordination
- Network monitoring & management tools
- Redundant, modern application server hardware (4GB RAM, >150GB user accessible memory/node, Windows or Linux)
- Redundant information management hardware (at least 1TB storage)

Similarity/Difference Analysis 1

Category	Meaning Use (S1)	PCMH 2011	CMS ACO (3/11)	Remarks
Financial Analysis, Measurement, Business Intelligence	Not aligned	Not aligned	Core qualifying requirement	A primary focus of ACOs
Patient-Caregiver Experience	Not aligned	Somewhat aligned with Access to Care requirements	Core qualifying requirement	Becomes more important in Stage 2-3 MU
Care Coordination	More aligned with Stage 2 team-based practice requirements	Well aligned	Core requirement	Well aligned by Stage 3

Similarity/Difference Analysis 2

Category	Meaningful Use (S1)	PCMH (2011)	ACO (CMS 3/2011)	Remarks
Information Systems	Meaningful use no longer a condition of ACO participation	Somewhat aligned – eSummary, eAccess & 2-way Patient-Provider communication	EHR use retained as a highly weighted quality measure	Blanket requirement for S1 MU, but need details re: enforcement
Educational & Community Resources	Well Aligned with ACO	Well aligned with ACO	Core qualifying requirement	Appears well aligned
Care Coordination	Somewhat aligned, more with S2	Well aligned with ACO, less with MU	Core qualifying requirement	Well aligned by S3 MU

Similarity/Difference Analysis 3

Category	Meaningful Use (S1)	PCMH (2011)	ACO (CMS 3/2011)	Remarks
Clinical Reporting-Patient Safety	Somewhat aligned with PCMH, but not ACO, submission of PQRI to CMS	Submission of PQRI to CMS	Use various PQRI & NQF measures for reporting	CMS to announce rules to integrate PQRI & MU 1/1/2012
At-Risk Populations	Somewhat aligned with PCMH, but not ACO, submission of PQRI to CMS	Submission of PQRI to CMS	Substantial reporting of measures for at-risk populations	Need to assess alignment after CMS PQRI integration rules (2012)

But Wait…

- **The details of comparative reporting & qualification are important, but…**
- **The three programs have very different conceptual and motivational bases:**
  - MU: incentives for adoption & specific use of EHR by CMS providers
  - PCMH: improvement of outcomes through care coordination & shared process with HIT use
    - MU, PCMH more closely aligned
  - ACO: shared RISK & potential shared SAVINGS in fee-for-service Medicare programs with eye toward

This Means…

- **ACO focused on very different goals than MU or PCMH:**
  - ***Cost savings through:***
    - Shared risk models
    - Demonstrated shared savings

    - **Goals require substantial investment in HIT beyond MU/PCMH needs**
  - Financial analysis & business intelligence tools for calculation of MSR & actual risk-adjusted savings
  - Identity proofing & management tools for beneficiary identification & management

Application Suite

- **Practice Management System, integrated with**
- **Certified EHR system with both provider & patient access portals**
- **Secure email capability (NwHIN Direct)**
- **Secure information exchange capability (NwHIN CONNECT)**
- **Secure connection to:**
  - Disease registries
  - Public Health agencies

ACO Requires

- **Financial analysis & reporting software**
  - Calculation of per-beneficiary baseline cost
  - Calculation of Minimum Savings Rate
  - Analysis of actual per beneficiary costs
  - Analysis of aggregate costs
  - Analysis of actual risk-adjusted savings rate vs. MSR
- **Personnel who have relevant skill set and can interact with CMS**

Making It Less Daunting

- Certain IT infrastructure will serve to qualify for all three initiatives
- HCCNs, PCAs & other aggregate-level organizations may provide infrastructure or advise on acquiring & managing it
- Many commercial hosting companies can provide infrastructure

Strategy?

- **Regardless of how it is provided, the relatively close alignment of MU & PCMH allow the same technology infrastructure to support both**
  - Provided that provider to provider & provider to patient portals are available
- **This infrastructure will facilitate addition of financial analysis tools to provide capability for ACO qualification**

More Strategy

- **Does Shared Risk make sense for health centers?**
  - Health Centers already have a good deal of risk associated with their patient population
  - Experience with CHC owned managed care plans
  - FQHCs receive grants under the Health Center Program (Section 330 of the Public Health Service Act) for care of the uninsured and underserved
    - What does risk-adjusted shared savings mean in this context?
- **These are questions, not answers**
  - We'll see if there are answers as there is more experience with shared risk/shared savings models

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