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Healthcare Brand Management

"A Conversation About Accountable Care"

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What is an Accountable Care Organization?

- According to the Centers for Medicare and Medicaid Services(CMS) an ACO is:

"An organization of health care providers that agrees to be accountable for the quality, cost, and overall care of Medicare beneficiaries who are enrolled in the traditional fee-for-service program who are assigned to it."

What are the basics?

- Three key concepts apply:
  - ACOs will have strong primary care capabilities and be accountable for quality and costs of the patients they serve
  - Assertive care management and accurate measurement of quality and cost reduction goals
  - Payments and incentives aligned to quality care and cost reduction

How may a healthcare entity become an ACO?

- Collectively speaking they must:
  - Contract with CMS for 3 years and service 5,000+ Medicare beneficiaries
  - Be accountable for quality, cost and care of beneficiaries, feature a process for evaluating their health needs, potentially operate under a capitated payment/fixed funding pool
  - Have a defined administrative, clinical and legal structure, a certain number of primary care providers and likely feature a hospital and other care facilities
  - Be responsible for issuing savings to providers and not service other Medicare shared savings plans
  - Effectively assess, treat, measure and improve care/reduce costs

What else may they need?

- They need accurate billing and clinical systems to continually assess/tabulate patient care and costs.
- Extensive information sharing conduits with doctors, nurses and pharmacists to coordinate and deliver highly effective yet economic care on a daily basis
- Successful adoption/implementation of evidence-based medicine measures
- Have provisions in place to work with patients individually

How did the ACO idea come about?

- Medicare and other payers have been looking for an alternative to the Fee-For-Service model, which reimburses based on numbers of patients but not the level of care or cost management of them

- The ACO-model initiative originates from the 2003 Medicare Prescription Drug, Improvement, and Modernization Act

  - It is part of the provisions to explore alternative ways to deliver high care/low cost healthcare other than the current U.S. healthcare delivery system

What can they be compared to?

- Geisinger, Intermountain Healthcare, Kaiser Permanente and Mayo Clinic have served as “role models” in how optimum patient care, physician accountability and economic performance can be achieved

- Pilot programs were conducted in Arizona, Kentucky, New Jersey, Massachusetts, Vermont, Virginia and Texas to gather data and working knowledge of the concept before it rolled out in 2012

Do all healthcare entities have to become ACOs?

- No, the ACO initiative is optional
- Academic, community and government healthcare facilities and organizations are continuing to operate according to their individual business models and may choose not to participate in the ACO initiative during the initial 3-year run beginning 2012
- 32 Pioneer ACO plans were initially approved to operate in the United States

- Allina Hospitals & Clinics
Minnesota, Western Wisconsin
- Atrius Health
Eastern and Central Massachusetts
- Banner Health Network
Phoenix, Arizona Metropolitan Area
- Bellin-Thedacare Healthcare Partners
Northeast Wisconsin
- Beth Israel Deaconess Physician Organization
Eastern Massachusetts
- Bronx Accountable Healthcare Network (BAHN)
New York City (Bronx) and Westchester County, New York
- Brown & Toland Physicians
San Francisco Bay Area, California
- Dartmouth-Hitchcock ACO
New Hampshire, Eastern Vermont
- Eastern Maine Healthcare System
Central, Eastern and Northern Maine
- Fairview Health Systems
Minneapolis, Minnesota Metropolitan Area
- Franciscan Alliance
Indianapolis, Central Indiana
- Genesys PHO
Southeastern Michigan
- Healthcare Partners Medical Group
Los Angeles and Orange Counties, California
- Healthcare Partners of Nevada
Clark and Nye Counties, Nevada
- Heritage California ACO
South Central and Coastal California
- JSA Medical Group, division of HealthCare Partners
Orlando, Tampa Bay and surrounding South Florida

32 Pioneer ACO Plans

- Michigan Pioneer ACP
Southeastern Michigan
- Monarch Healthcare
Orange County, California
- Mount Auburn Cambridge Independent Practice Association
Eastern Massachusetts
- North Texas ACO
Tarant, Johnson and Parker counties in North Texas
- OSF Healthcare System
Central Illinois
- Park Nicollet Health Services,
Minneapolis, Minnesota Metropolitan Area
- Partners Healthcare
Eastern Massachusetts
- Physician Health Partners
Denver, Colorado Metropolitan Area
- Presbyterian Healthcare Services-Central New Mexico Pioneer ACO
Central New Mexico
- Primecare Medical Network
Southern California, San Bernardino and Riverside Counties
- Renaissance Medical Management Company
Southwestern Pennsylvania
- Seton Health Alliance
Central Texas , including Austin and 11 counties
- Sharp Healthcare System
San Diego County, California
- Steward Health Care System
Eastern Massachusetts
- TriHealth, Inc.
Northwest Central Iowa
- University of Michigan
Southeastern Michigan

What's the difference between Shared Savings and Pioneer Programs?

- The Shared Savings Program implements a legislative obligation established in the Affordable Care Act to create a structure for groups of healthcare providers to become ACOs

- The Pioneer ACO Model tests effectiveness of a payment plan:

  - If a plan is successful, they will show a profit and qualify for a share of the savings they have earned through successful care/cost management of the Medicare beneficiary patients they treated

  - Depending upon the minimum savings threshold (which may be from 2% to 3.9%),CMS will return some of the savings (as much as 60%) to the ACO to reward its providers

Is it a good idea to become an ACO?

- It could prove to be successful and be an important conduit for providers and managed care to get focused access to the Medicare patient population
- Some ACOs may become stronger as inherent healthcare systems by employing more physicians, caring for more patients and doing it more cost effectively than other healthcare providers in their marketplace
- It may prove to provide better patient care and be the wave of the future in the delivery of healthcare in the United States

Why would an organization not participate?

- Significant investments are required to develop and implement an ACO including:
  - Patient care/clinical protocol development and tracking
  - Physician group contracting and coordination of care between doctors, nurses, pharmacists and other providers
  - Information technology
  - Risk-sharing capability and resources
- There is no guarantee the ACO model will be effective or patient care/savings will result in real financial return

What happens if an ACO is not successful?

- They will not be eligible to earn additional funds through the shared care/cost savings incentive
- They will still be required to participate in the program for the duration of their contract with CMS
- Depending upon their arrangement with CMS, they may have to pay a certain amount of the coverage costs back to the government in a “risk sharing agreement”

What do physicians think of ACOs?

- Some do not believe they will be fairly reimbursed for delivering high levels of quality care and cost savings by the ACO they are affiliated with
- Certain physicians believe it may drive them to alter how they normally treat patients and potentially under treat patients to keep costs down
- Physicians maybe engaged by the program if it suits their practice management style and stabilizes their income/reimbursement
- Other physicians may not have a choice if they are employed by a healthcare organization participating in the program

What does managed care think of ACOs?

- Conceivably, improved care means lower costs and in the long run, MCOs could realize greater margins/less risk
- If quality of care and cost reduction goals are not met, ACOs could be overly burdened with clinical, financial and technical operating structures unable to deliver results
- Some managed care plans are concerned about the leverage sizable healthcare systems have against them in an ACO arrangement and in their commercial plans as well

What do healthcare manufacturers think of ACOs?

- ACOs are another administrative/contracting structure for them to strategically/tactically account for
- If their product is part of the standard of care which an ACO adopts, they are in a good position, if they are not, then they have less access to the providers/patients in the ACO plan
- For products to be considered as part of the standard of care, they will have to clinically demonstrate they can deliver cost-effective care and/or reduce their prices for a stronger economic position within treatment protocols

What may Medicare patients think of ACOs?

- It is still too early to tell as each of the pilot programs operates differently and patient care experiences are in early stages

- Conceptually:

  - If patients have access to physicians they prefer, receive better care, experience less issues with medical records and incur less out-of-pocket costs, they will embrace the ACO model and it will be expanded beyond Medicare into commercial sector applications

  - If they experience restrictive access to care, administrative issues, increased costs or confronted with overly cost-based treatment considerations , ACOs will be associated with the unpopular, rigid staff model HMOs of the early 90s which fell into disfavor

What about Healthcare Brand Management?

- There are a number of opportunities to engage the ACO initiative:
  - Professionally recognized prescribing/treatment protocols and key indications may position a brand over another and achieve optimum access
  - Potential for Comparative Effectiveness Research (CER) and Health Economics Outcomes Research (HEOR) applications present themselves but will require additional funding by pharmaceutical manufacturers
  - Pull-through promotion and clinical presentations must champion the brand's ability to parallel the care/cost goals of the ACO's protocols
  - Additional market segmentation and contracting strategies will be required
  - Fluid communication, web-based brand/clinical information sharing is key

What is the outlook?

- Ongoing clarification of the legislation and enhancements made in implementation/operation could steer ACOs in different ways
- Those healthcare systems choosing not to participate may selectively adopt certain ACO methodologies/principles to enable themselves to operate more efficiently, then promote their performance and eventually formalize their ACO status later
- The limited number of ACOs participating will clearly and quickly determine the success of the concept
- The Federal government will closely assess progress and seek an optimum, ongoing arrangement

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