The Impact of Accountable Care Organizations on Healthcare Delivery, the Primary Care Physician and the Medicare Patient

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Accountable Care Organizations: Increase Quality, Decrease Costs

- 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.”

- Section 3022 of the Patient Protection and Affordable Care Act’s Medicare Shared Savings Plan (MSSP)
- Formal legal structure (management and legal)
- 5,000 beneficiaries for 3 years
- Quality measures that reduce cost to receive payment
- System for evaluating the health needs of the population

What Comprises an ACO?

Accountable Care Organization

- Hospital
- Specialists
- Primary Care
- Integration of Specialists
- Patients

- Appropriate use of resources
- Strong Base of Primary Care
- Patient-centered care
Why ACOs?

- **Problems**
  - **Cost** - general Medicare
  - **Cost** - chronic illness
  - Decline in **quality**
  - Decrease in **workforce**
  - **Access**
The Problem: Medicare Cost

- The rising cost of healthcare and the stability of Medicare:
  - In 2010 47.5 million were covered by Medicare ¹
    - 39.6 million aged 65 and older, and 7.9 million disabled
    - Next twenty years the Medicare population is expected to double
  - 23% of mandatory federal spending ²
    - 2nd only to Social Security
  - Medicare is not financially sustainable ³
    - By 1990 Medicare was seven times over budget and currently is growing each year by twice the cost-of-living - 7% versus 3% per year.
  - Medicare participants may see a reduction in benefits

Problem: Cost of Chronic Illness

• Leading cause of death and disability in the US

• 75% of total US health spending

• 66% spending increase over the past 20 years is linked to chronic disease

• Medicare patients with chronic conditions have more office visits

Federal Spending

Source: (left) http://www.hhs.gov/asl/testify/2008/04/t20080401c.html; (right) http://dpc.senate.gov/docs/fs-111-1-100.html
## Healthcare Spending is Expected to Increase

<table>
<thead>
<tr>
<th>Year</th>
<th>National Health Expenditures (NHE)</th>
<th>NHE as Percentage of GDP</th>
<th>NHE Per Capita</th>
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</thead>
<tbody>
<tr>
<td>2004</td>
<td>$1,855,400,000</td>
<td>15.6%</td>
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<td>2005</td>
<td>$1,982,500,000</td>
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<td>2006</td>
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<td>2007</td>
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<tr>
<td>2010</td>
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<td>17.5%</td>
<td>$8,388.70</td>
</tr>
<tr>
<td>2011</td>
<td>$2,709,800,000</td>
<td>17.4%</td>
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</tr>
<tr>
<td>2012</td>
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<td>$9,039.60</td>
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<tr>
<td>2013</td>
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<td>17.3%</td>
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<td>2014</td>
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<td>2017</td>
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<tr>
<td>2018</td>
<td>$4,297,600,000</td>
<td>19.3%</td>
<td>$12,941.20</td>
</tr>
<tr>
<td>2019</td>
<td>$4,571,500,000</td>
<td>19.6%</td>
<td>$13,652.50</td>
</tr>
</tbody>
</table>

*Source: 2010 Office of the Actuary, CMS*
Problem: Quality

- If the U.S. could reduce mortality to the average rate achieved in the three top-performing countries, there would be fewer deaths.

Preventable Deaths* per 100,000 Population in 2002-2003 (19 Industrialized Nations, Commonwealth Fund)
(* by conditions such as diabetes, epilepsy, stroke, influenza, ulcers, pneumonia, infant mortality and appendicitis)

Problem: Workforce = Access

• The Association of American Medical Colleges (AAMC) predicts a shortage of approximately 21,000 primary care physicians (PCPs) in 2015.¹

• Population growth and aging will increase family physicians’ and general internists’ workloads 29% between 2005 and 2025.²

• Initial estimates: shortage of 35,000–44,000 primary care physicians for adults by 2025.³

Most Plausible Scenario

- Utilization rates will rise;
- Shift in work schedules;
- Moderate growth in GME (27,600 new residents per year), and
- Increase in productivity.

Most plausible demand: 950,000
Most plausible supply: 800,000

Shortage: 159,300

Medicare Visits to Primary Care

Map 1. Average annual percent of Medicare beneficiaries who had at least one visit to a primary care doctor among hospital referral regions (2006-07).

Rates are adjusted for age, sex and race using the indirect method, with the corresponding population as the standard. The standard population is the U.S. resident noninstitutional population age 65 to 99 with Medicare Parts A and B enrollment and no HMO enrollment during the measurement period.

Medicare and Primary Care

- The Medicare population makes up approximately 15% of the U.S. population.¹

- 48.1% all ambulatory medical care visits were made to primary care physicians in office-based practices.²

- From 1978 to 2008, for patients aged 65 and over, the percentage of visits that were to primary care decreased from 62 percent in 1978 to 45 percent in 2008.³

Fewer PCPs caring for the Medicare population

- 83% of doctors accept Medicare (CMS).\(^1\)
- 15% of AOA members did not participate in Medicare.\(^2\)
- 19% of AOA members did not accept new Medicare patients.\(^2\)
- 13% of family physicians did not participate in Medicare in 2009 (AAFP).\(^2\)

ACO: Structure

- Maintain consistent quality measures;
- Increased awareness of capital & operational planning;
- Utilize existing relationships and strengthen PCP infrastructure;
- Sustainability and expand resources.
Opponents: Accountable Care Organizations

• Concerned about the CMS rules and regulations
  - American Medical Group Association (AMGA)
  - Premier Healthcare Alliance (PHA)
  - Federation of American Hospitals (FHA)
Opponents: Accountable Care Organizations

- Limited Health Information Technology (HIT)
- Inability to access adequate funding
- Limited physician coverage
- Demographic variances
- Patient and healthcare professional education
- Barriers between administration and medical staff
Proponents: Accountable Care Organizations

- American Hospital Association (AHA)
- American Osteopathic Association (AOA)
- American Medical Association (AMA)
- American Academy of Family Physicians (AAFP)
- American Academy of Pediatrics (AAP)
Proponents: Accountable Care Organizations

- Will help drive healthcare delivery reform by **reducing costs and increasing quality**.

- Facilitates **coordination and cooperation** among providers.

- **Improves beneficiary outcomes** and increases value of care.
Unintended Consequences

- **Exclusion of Providers**
  - Solo or small primary care practices will be excluded because of their size
  - Loss of the physician: retirement, lack of participation
  - Mid-levels

- **Role of costs**
  - Start-up financing (higher cost)
  - Data mining: quality measures that need to be documented and reported

- **Patient Accountability**
ACO (PPACA): Opportunity

- Estimated Medicare savings: $170 million and $960 million over the next three years.¹

- Provide an opportunity for improved quality.²

- Reduce redundant, unnecessary and inappropriate medical care.³

- Integrate quality care & accountability.⁴

- Act as a care organization “model”

Recommendations: ACOs

- ACO models that allow greater participation by smaller primary care practices.
- Improved financing mechanisms and start-up costs.
- Greater flexibility in the criteria used to qualify practices for participation in an ACO.
- “Right size” the quality measures to make them more reasonable for smaller groups.
- Reduce the data burden and patient load.
- Broaden waivers to facilitate necessary up front investments such as electronic health records.
ACOs: Concluding Thoughts

- ACOs provide an opportunity for all healthcare providers to contribute to the reduction in the escalating costs of healthcare.
- Emerging consensus: Better health, better care, lower costs.
- The time is now…Federal support for change:
  - Comparative Effectiveness Research (CER)
  - Health Information Technology (HIT)
  - Coverage expansion
  - Commitment to value-based healthcare
QUESTIONS
References


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