ACCOUNTABLE CARE ORGANIZATION
LEARNING NETWORK

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Key ACO Principles

ENGELBERG CENTER for Health Care Reform at BROOKINGS

THE DARTMOUTH INSTITUTE FOR HEALTH POLICY & CLINICAL PRACTICE
Where Knowledge Informs Change ™

ACO Congress Agenda

Over the next few days the Congress will examine:

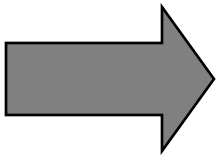
1. How ACOs fit into health care reform
2. How to align physicians, hospitals, and health plans through an ACO to support value-driven care delivery
3. How to structure and implement an ACO to be able to successfully report on quality measures, track population level costs, and reform care

Origins – Why ACOs?

Barrier	Principles
Unclear aims – conflicts about what we're trying to produce	**Clarify aims:** Better health, better care lower costs – for patients and communities
Fragmented delivery system, without accountability for capacity, quality or costs.	**Foster provider accountability** for the full continuum of care – and for the capacity of the local health system
Absent or poor data leaves practice unexamined and presumption that more is better.	**Better information** that engages physicians, supports improvement; informs consumers for best care
Wrong incentives reinforce problems, reward fragmentation, induce preventable complications and inefficient care.	**Move incentives in right direction:** Align financial incentives with professional aims.

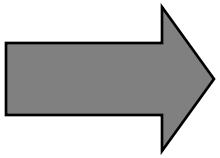
Transforming the System

Implementing an ACO is not going to be easy…



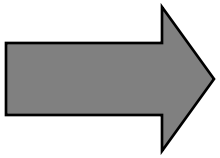
…and will require truly changing the way we approach, deliver, and pay for care.

An ACO is not a repackaging of what we already doing…



…but is a real move away from fragmented system to a more integrated and publicly accountable delivery system.

ACOs are not a panacea and some will fail…



…but they do represent an important step towards a more value-based and accountable health care system.

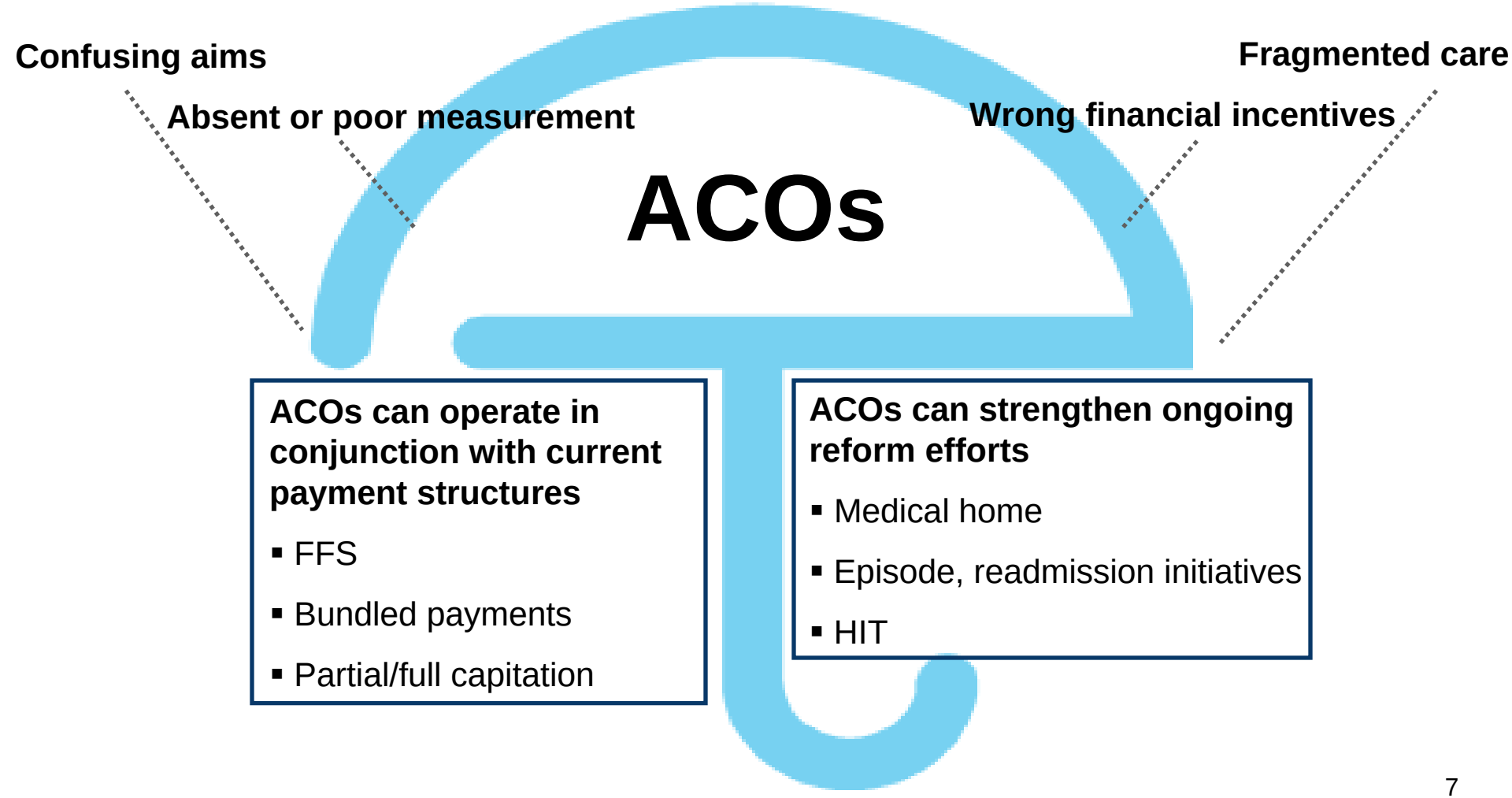
ACOs in the Affordable Care Act

- Part of Medicare – Not Pilot Program
  - Wide range of provider groups meeting certain criteria can implement an ACO outside of traditional CMS demonstration process through shared savings program
  - Can collaborate or build upon private-sector and state-based ACOs
- Evaluation Methods Based on Pre-Specified Benchmarks
  - New law authorizes pre-post budget projection approach that uses historical spending and utilization data to develop quantitative, pre-specified targets to track ACO performance
- Broad Range of ACO Payment Models
  - Broader than current Medicare shared savings demonstrations
  - Benchmark based on projected absolute growth in national per capita expenditures
  - One-sided and two-sided/symmetric shared savings models
  - Range of partial capitation models can be established to replace a portion of fee-for-service payments

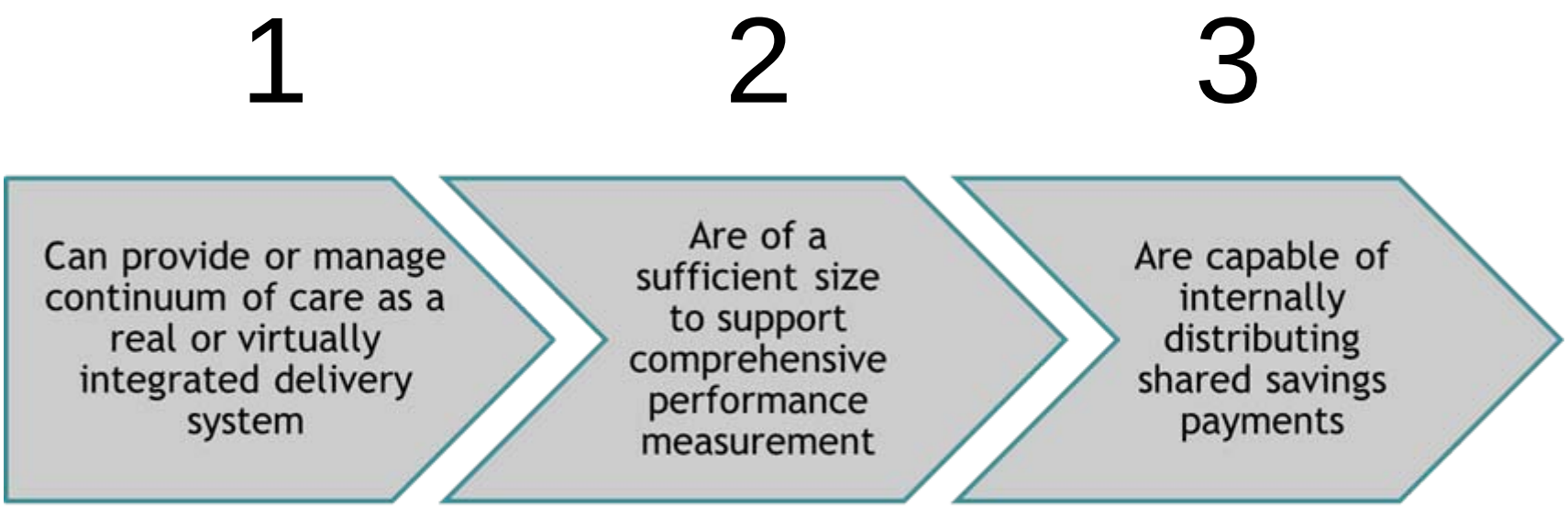
ACOs in the Affordable Care Act

- Medicare Shared Savings Program Starts Jan. 1, 2012 (Sec. 3022)
  - Regulations from CMS expected around December 2010
  - Qualifying Medicare ACO requirements:
    - Willingness to be accountable for quality, cost, and overall care of Medicare fee-for-service beneficiaries for a minimum of three years
    - Have a formal legal structure to receive and distribute shared savings
    - Have at least 5,000 assigned beneficiaries with sufficient number of primary care ACO professionals
    - Report on quality, cost, and care coordination measures and meet patient-centeredness criteria set forth by the HHS Secretary
    - May initially focus on one-sided shared savings models
- Center for Medicare and Medicaid Innovation (CMI) to Evaluate Broad Range of Payment and Delivery Reforms by Jan. 1, 2011 (Sec. 3021)
  - $10 billion appropriated for FY2011 to FY2019
  - ACO and related pilots expected before the start of the 2012 Shared Savings program to test different ACO concepts
- Interaction with Other Payment Reforms
  - Health IT Meaningful Use Payments
  - Payments for Quality Reporting and Improvement
  - Other Medicare Payment Reform Initiatives

ACOs Consistent With Other Reforms



Key Elements of an ACO

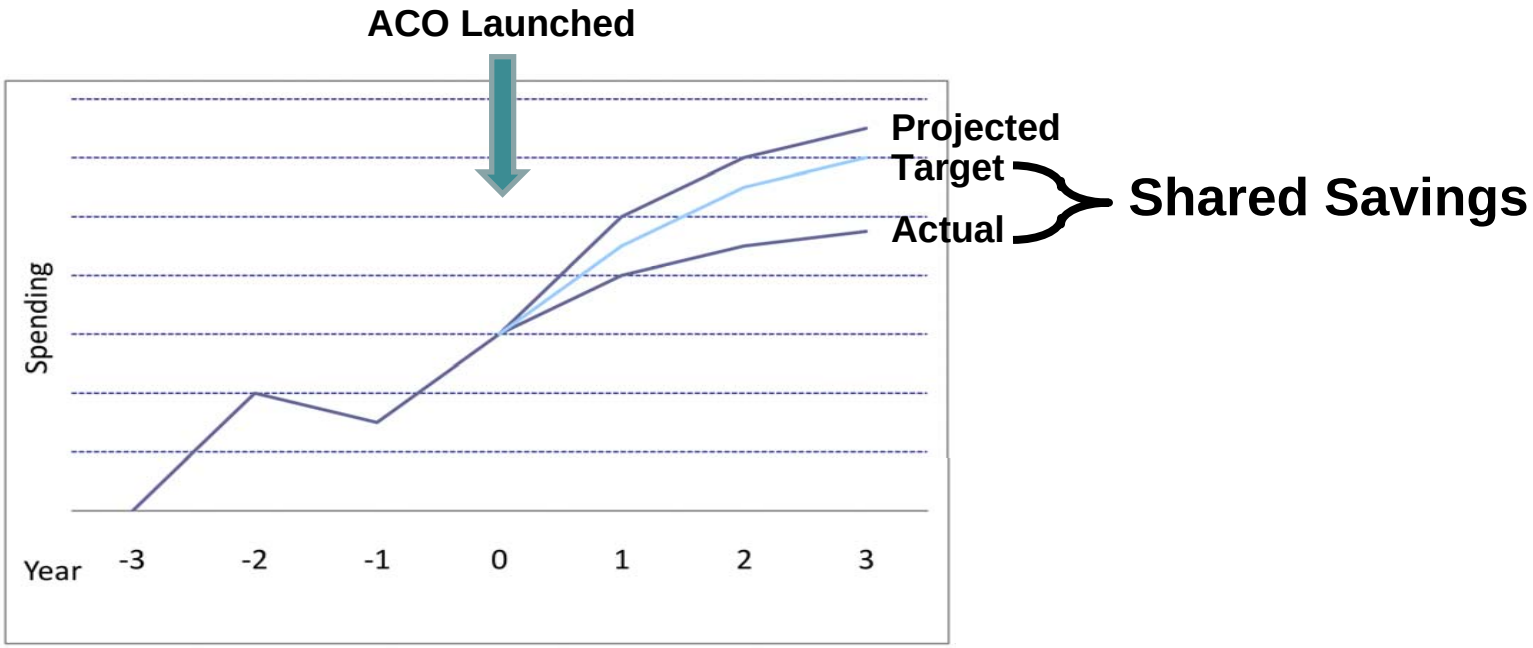


Important Caveats

- ACOs are not gatekeepers
- ACOs do not require changes to benefit structures
- ACOs do not require patient enrollment

Incentives Aligned with Aims

- **New payment model: shared savings if quality targets met**
  - Current per-capita spending for assigned patients determined from claims
  - Spending target is negotiated (private payers) or determined (Medicare)
  - If actual spending lower than target, savings are shared
  - **IF quality targets are also achieved**



Wide Range of Payment Models

Level 1
Asymmetric Model

- Continue operating under current insurance contracts/coverage models (e.g., FFS)
- No risk for losses if spending exceeds targets
- Most incremental approach with least barriers for entry
- Attractive to new entities, risk-adverse providers, or entities with limited organizational capacity, range of covered services, or experience working with other providers

Level 2
Symmetric Model

- Payments can still be tied to current payment system, although ACO could receive revenue from payers and distribute funds to members (depending on ACO contracts)
- At risk for losses if spending exceeds targets
- Increased incentive for providers to decrease costs due to risk of losses
- Attractive to providers with some infrastructure or care coordination capability and demonstrated track record

Level 3
Partial Capitation Model

- ACO receives mix of FFS and prospective fixed payment
- If successful at meeting budget and performance targets, greater financial benefits
- If ACO exceeds budget, more risk means greater financial downside
- Only appropriate for providers with robust infrastructure, demonstrated track record in finances and quality and providing relatively full range of services

Goals of Patient Assignment Method

- Unique provider assignment for every patient (no enrollment by patients)
- No "lock in" of patients to the ACO (not a gatekeeper model)
- Patients are assigned based on where they received their care in the past
- Minimize "dumping" of high risk or high cost patients

Important Caveats

- Accountability for assigned patients lies with the ACO, **not** the individual provider alone
- Physicians are part of the ACO **system** of care
- Providers affiliated with an ACO, even exclusively, can refer patients to non-ACO providers

ACO Provider Roles

- Providers to Whom Patients are Assigned:
  - Deliver primary and preventative care services to ACO patients (e.g., Internal Medicine & Family Practice, Endocrinology; etc…)
  - Expected to have main responsibility for managing total cost and total health of patients
- Other Specialists with Potential for High Resource Use and Care Impact:
  - Manage chronic diseases as well as resource intensive acute events (e.g., General Surgery; Hospitalists; Oncology, Orthopedics; etc…)
- Other Specialists with some Potential to Impact Resource Use and Procedure Quality and Efficiency:
  - Typically do not have an ongoing relationship with patients (e.g., Anesthesiology; Radiology; Emergency medicine, etc…)
- Non-Contracted Providers:
  - Out-of-Area providers or providers in the insurer network but not contracted with ACO who still provide care for ACO patients

Meaningful Performance Measures

Over time, measures should address multiple priorities, be outcome-oriented, and span the continuum of care

Beginning	Intermediate	Advanced
• ACOs have access to medical, pharmacy, and laboratory claims from payers (claims-based measures) • Relatively limited health infrastructure • Limited to focusing on primary care services (starter set of measures)	• ACOs use specific clinical data (e.g., electronic laboratory results) and limited survey data • More sophisticated HIT infrastructure in place • Greater focus on full spectrum of care	• ACOs use more complete clinical data (e.g., electronic records, registries) and robust patient-generated data (e.g., Health Risk Appraisals, functional status) • Well-established and robust HIT infrastructure • Focus on full spectrum of care and health system priorities

Organizational Tasks

- **Achieving shared vision of leadership team and governing boards to support move toward accountable care**
  - *Tucson Medical Center board composition*
  - *Support from state/local political leaders and private alliances*
- **Understanding market position and developing strategy to work with other providers and with national and local payers required for alignment and necessary critical mass**
  - *Advocate Health Care alignment of physicians, hospitals and payers*
  - *"California model" – diverse organizational models; good payer alignment*
- **Identifying and managing technical and legal issues that must be addressed to participate**
  - *Issues with federal and state laws, including fraud/abuse and HIPPA/Privacy, must be addressed but can be managed*
  - *Advisory opinion opportunities with FTC, building on past guidance about clinical integration*
  - *Same network of providers in ACO can create a parallel organization under Medicare Part C*

Organizational Tasks

- **Taking advantage of other payment / policy reforms aligned with principles of accountable care to help absorb start-up costs and start down the path**
  - *Prometheus payment*
  - *Patient-Centered Medical Homes*
  - *Meaningful use incentives for health information technology*
- **Developing administrative and clinical capacities to implement programs to transform practice: informatics, care management, coaching, etc.**
  - *Informatics: Cost-effective data exchanges, disease registries (Intelligent Health, Advocate)*
  - *Leadership training: Advocate Health Care, Institute for Healthcare Improvement, The Dartmouth Institute*
  - *Quality initiatives available on the web (Norton Healthcare)*
- **Learn from others**
  - *Brookings-Dartmouth ACO Pilots, CAPG*
  - *State and regional quality initiatives*

Brookings-Dartmouth ACO Pilot Sites

Carilion Clinic Roanoke, VA	Norton Healthcare Louisville, KY	HealthCare Partners Torrance, CA	Monarch HealthCare Irvine, CA	Tucson Medical Center Tucson, AZ
•Integrated Delivery System •~750 Providers •37,000 Medicare Patients Assigned	•Integrated Delivery System •~270 Providers •20,000 Medicare Patients Assigned •*Operational as of July 2010 with payer partner Humana (ASO populations)*	•Medical Group & IPA •>1,200 employed and affiliated PCPs •>3,000 employed and contracted specialists •ACO will cover LA county	•Medical Group & IPA •>800 PCPs •>2,500 contracted, independent physicians •ACO will cover Orange County	•3 Independent Physician Groups + Community Hospital •Virtually Integrated ACO Model •~80 Providers •7,000 Medicare Patients Assigned

Large Group	⟷	Smaller Group
Fully Integrated System	⟷	Multiple Independent Provider Groups

Brookings-Dartmouth ACO Learning Network

Conceptual → Implementation

2009-10 Network	2010-11 Network
• Focused on defining the ACO model and describing its technical components (e.g., patient attribution, performance measurement, etc.) • Included regular webinars, ACO materials, and discounts to events • Over 100 members including provider groups, payers, and policymakers	• Provides practical leadership on **how to implement an ACO** especially in light of emerging **Federal/state ACO regulations and pilots** • Includes implementation-focused webinar series, exclusive member-driven conferences, Brookings-Dartmouth ACO newsletter, other web-based resources, and ACO implementation groups • Open to all parties interested in advancing accountable care – **1st webinar in late November**

Join the 2010-11 ACO Network

Apply at: www.acolearningnetwork.org

Implementation-focused webinars	Focus on key ACO design features, as well as critical topics ranging from legislative and regulatory issues to in-depth case studies
Exclusive Member-Driven Conferences	Emphasize practical, solution – oriented discussion – driven by member leadership and participation – and will provide excellent opportunities for learning, growth, and networking
Brookings-Dartmouth ACO Newsletter	Provide descriptions of the latest ACO activities, interviews with key policy and thought leaders, takeaways from network webinars, and profiles of organizations – including network members – implementing ACOs
New Website	Serve as a one-stop shop for all ACO-related news, materials and updates
Implementation Groups	Propose, help create, and join a group to receive more sophisticated and tailored ACO solution-oriented strategies

ACO Implementation Group

- **Mission**: To enable IPAs or similarly structured organizations across the country to develop, build, and share knowledge around implementing partial capitation ACOs.
- **Format:** A program format will be developed that is reflective of the needs and issues of the sites. Possible topics include:
  - Organizational and operational structures for general ACO development;
  - Business and clinical operations for coordinated, integrated care delivery; and,
  - Financial management capabilities to support prepayment
- **Expert Faculty:** Brookings-Dartmouth will develop a curriculum and work with CAPG/IHA to select a faculty of executives, senior managers, physician leaders, hospital executives and other experts. Possible faculty include:

- Donald Balfour, MD, CMO, Sharp Rees-Stealy Medical Group
- John Jenrette, MD, CEO, Sharp Community Medical Group
- Bart Asner, MD, CEO, Monarch Healthcare
- Jay Cohen, MD, President, Monarch Healthcare
- Keith Wilson, MD, Med Director, HealthCare Partners
- James Mason, CEO, SynerMed, Inc.
- Rick Shinto, MD, CEO, NAMM California
- Robert Margolis, MD, CEO, Healthcare Partners Med. Group
- Richard Merkin, MD, CEO, Heritage Provider Network
- Jeffrey Burnich, MD, SVP & EO, Sutter Medical Network
- Bill Gil, CEO, Facey Medical Foundation
- Howard Saner, CEO, Riverside Physician Network
- Gloria Austin, CEO, Brown and Toland Physicians
- Patty Page, CEO, Memorial Healthcare IPA
- Sharon Levine, MD, Associate Exec Director, The Permanente Med Group

Moving Forward Now

- **Advance technical work** required for successful implementation, with participation of all key stakeholders: eligibility criteria, performance measures, strategically coordinated payment reforms
- **Support actual implementation**: early pilots, public-private alignment, rapid learning, successful leadership methods, and adaptation of models from current initiatives, including Brookings-Dartmouth, Premier, AMGA, others
- **Promote effective policy steps**: federal-state coordination, rulemaking, and further policy actions to promote promising directions on accountable care

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