National ACO Summit

Accountable Care Organizations: Core Features and Attributes

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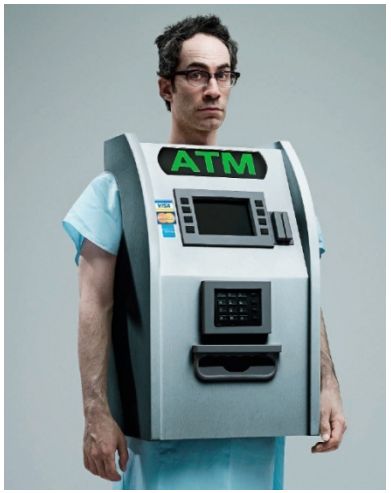
FFS: Unsustainably Expensive & Unfair

"the federal budget is on an unsustainable path . . . rising costs for health care . . . will cause federal spending to increase rapidly under any plausible scenario . . ." (*The Long-Term Budget Outlook,* CBO, 2009)



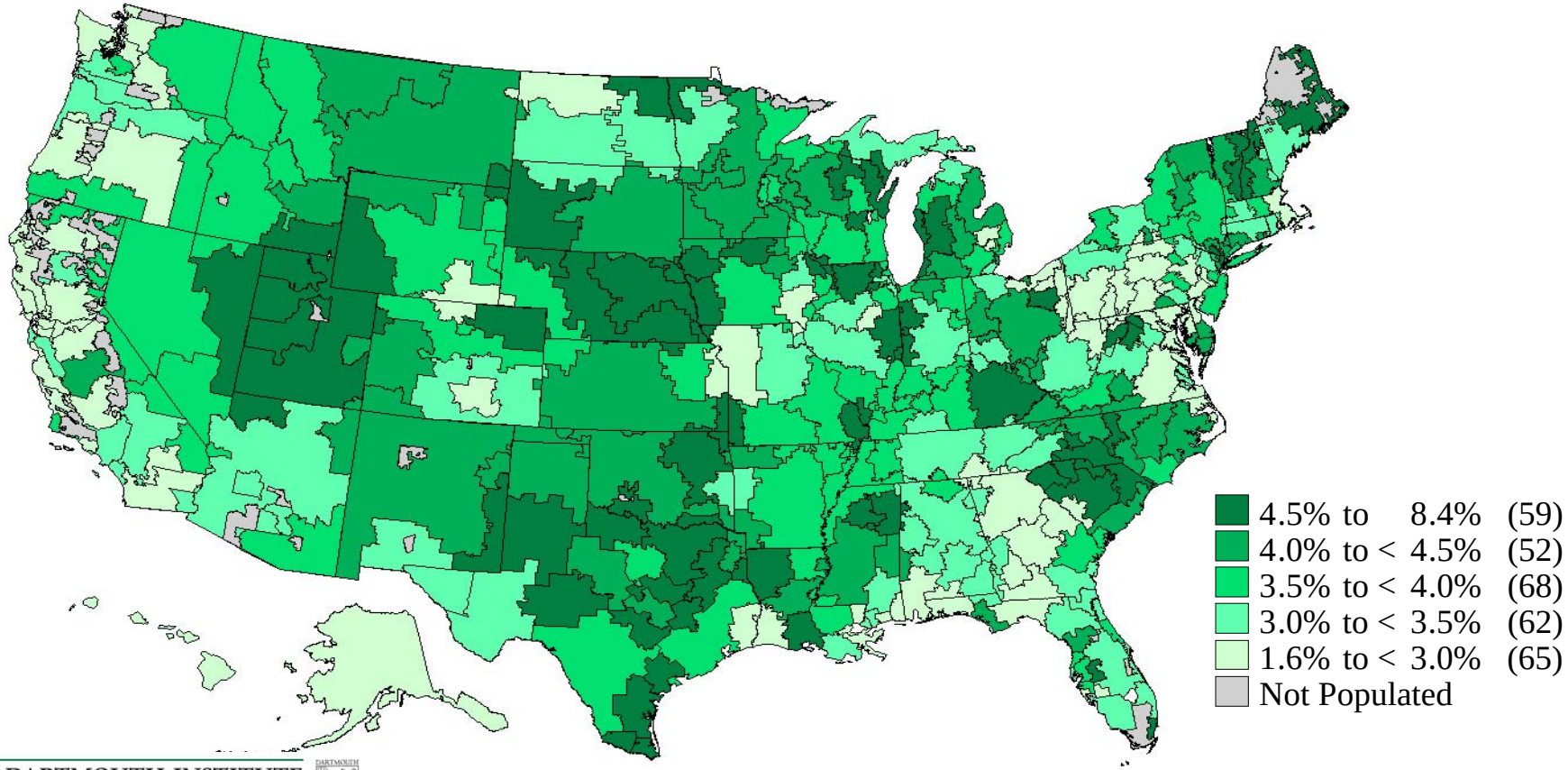
"Here … a medical community came to treat patients the way subprime mortgage lenders treated home buyers: as profit centers."

Atul Gawande

	2006 Spending	92-06 Growth
McAllen	$14,946	8.3%
La Crosse	$5,812	3.9%

Growth in Per-Capita Medicare Spending

Average annual inflation adjusted growth rates (1992-2006) result in 3-fold variation in spending ($6K—$17K, 2006)



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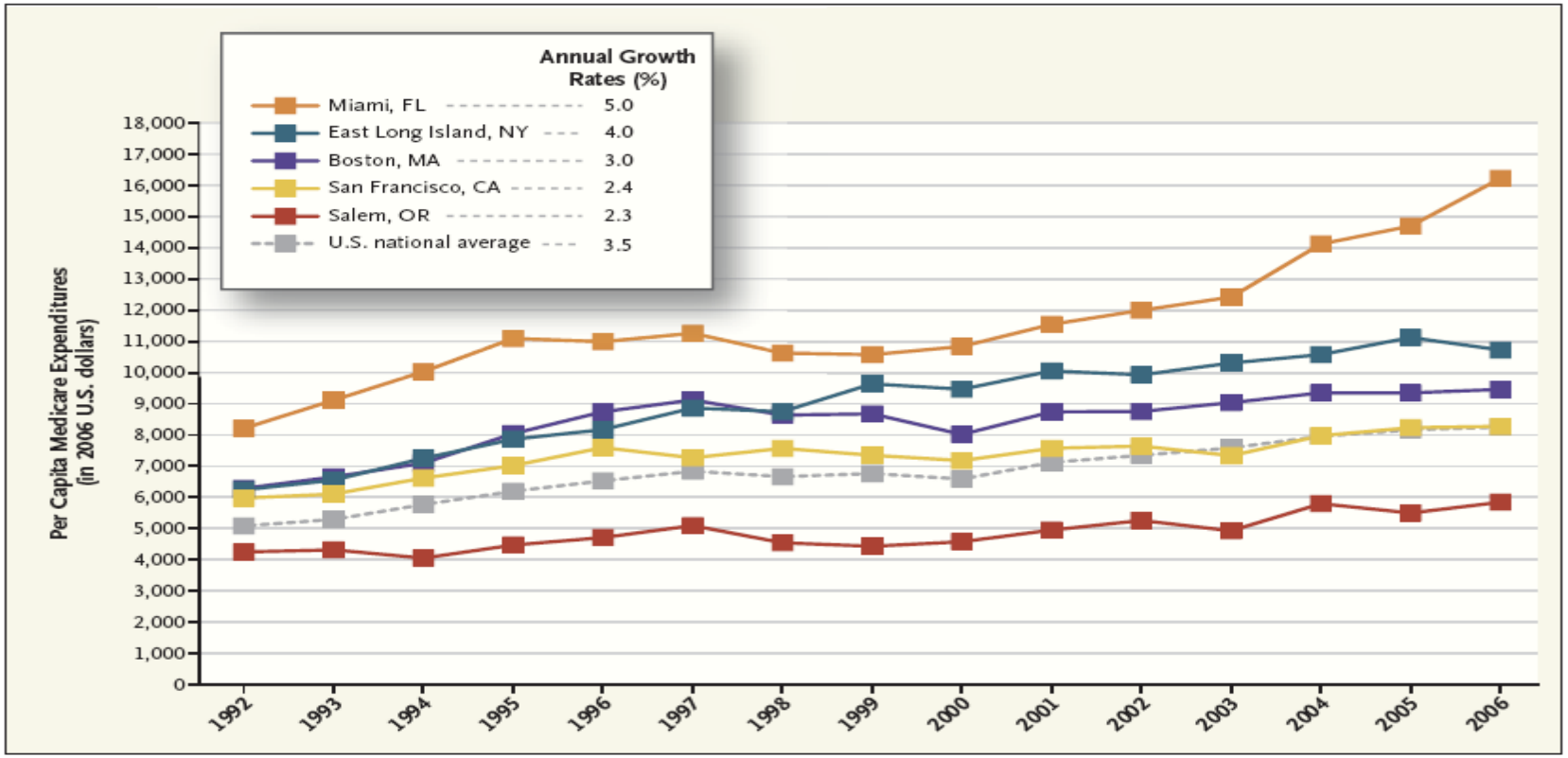
Medicare: Tale of 5 Cities



Annual Growth Rates of per Capita Medicare Spending in Five U.S. Hospital-Referral Regions, 1992–2006.

Data are in 2006 dollars and were adjusted with the use of the gross domestic product implicit price deflator (from the Economic Report of the President, 2008) and for age, sex, and race. Data are from the Dartmouth Atlas Project.

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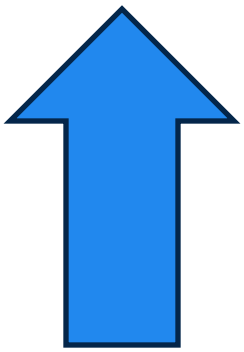
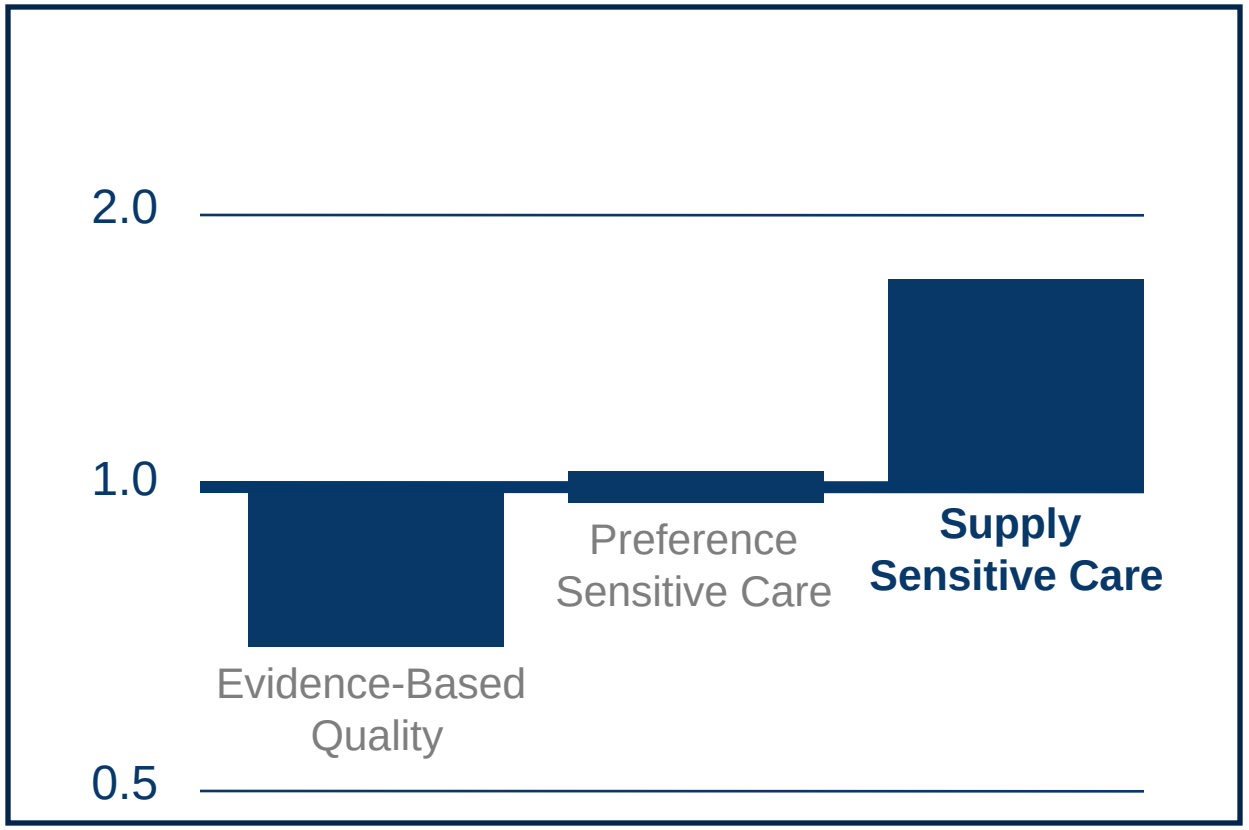
Regional Variations in Care (Medicare)

More Care in High Spending Regions



Less Care in High Spending Regions



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Includes rates of:
Inpatient Days
Imaging & Diagnostic Tests
Inpatient Days in the ICU
Evaluation & Management Visits

N.B. Self-reported health status & income explain about 25% of variation

National Perspective on HMOs & POS

	# Lives (Millions)	Percent
Employer		
PPO	120 M	68%
Other	21 M	12%
HMO	**35 M**	**20%**
Medicare		
FFS	34 M	75%
PPO & PFFS	4 M	8%
HMO/POS	**8 M**	**17%**

- 100+ integrated delivery systems serve 40 million people

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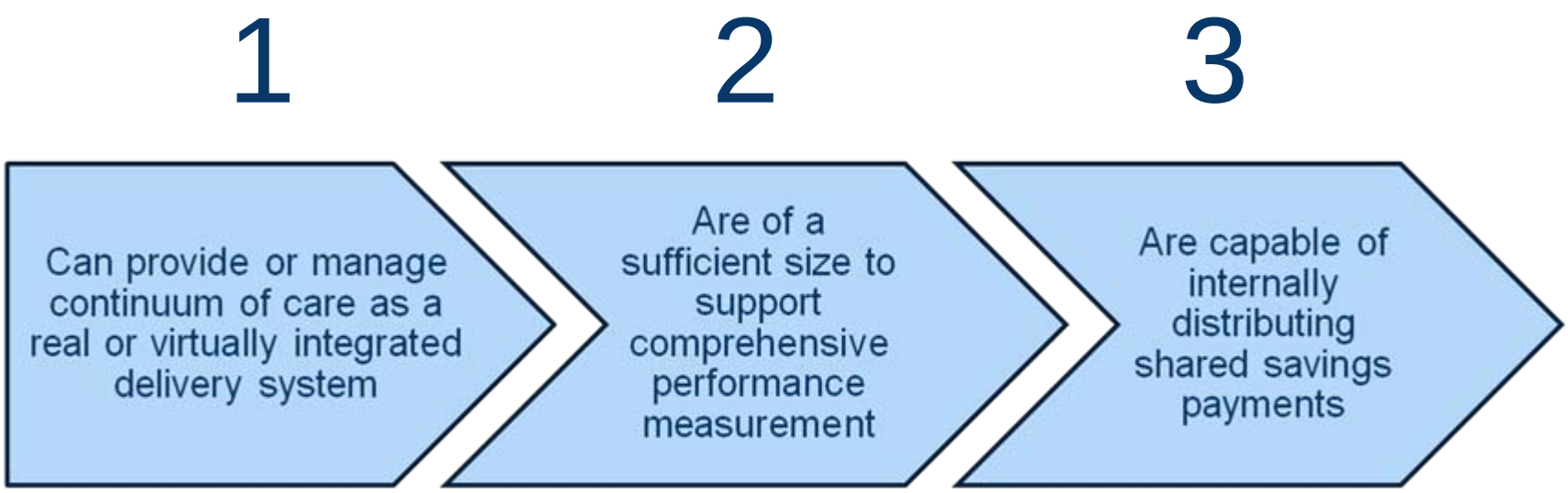
Comparison of Different Payment Models

	FFS	Capitation	ACO
Payment	Providers are **revenue centers** rewarded for increased volume. *Concerns about overuse to maximize revenues.*	With fixed payments unrelated to volume, providers are **cost centers.** *Concerns about "stinting"*	Incentives moderated under **shared savings.** ***Seek balance** between FFS & capitation*
Patients	**Neither** assigned nor enrolled	**Enrolled** with specific provider	**Assigned** based on previous care patterns. *No enrollment*
Primary care & care coordination	**Little reward** for primary care or care coordination	**Supports** primary care and care coordination	**Support**s primary care and care coordination
Accountability for per-capita costs & quality	**Weak** incentives to manage per-capita costs or improve quality	**Strong accountability** for per-capita cost. *Links to quality vary*	**Accountability** for costs. *Links shared savings to meeting quality measures*

Accountability, "Systemness" & Incentives

Core Principles	ACO Key Design Elements
Achieve better health, better quality & lower costs for patients and communities	▪ Pay for better value: improve overall health & reduce costs
Better information that engages physicians, supports improvement, and informs consumers	▪ **Tools**: timely feedback to providers ▪ **Reporting**: require utilization and quality data from providers
New model: It's the system - Establish organizations accountable for aims and capable of redesigning practice and managing capacity	▪ Establish robust HIT infrastructure ▪ Implement cost-saving and quality-improving medical interventions ▪ **Evaluate performance of systems**
Realign incentives – both financial and clinical – to support accountability for costs and quality across care settings	▪ Restructure payment incentives to avoid extremes of FFS "revenue centers" & capitation "cost centers"

ACOs Vary Widely But Share Key Elements



Important Caveats

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

3 Payment Levels Permit ACOs to Vary Widely

Level 1
Asymmetric shared-savings

- 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

Quality Measures Will Evolve Over Time: Beginning, Intermediate, & Advanced Stages

Multiple priorities, outcome-oriented, and span the continuum of care

Beginning

- 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)

Intermediate

- 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

Advanced

- 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

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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 assigned based on where they received their care in the past	Minimize “dumping” of high risk or high cost patients

Important Caveats

- Patients assigned by plurality of outpatient E&M visits (PCP-1st; Medical Specialist-2nd; Surgical Specialist-3rd)
- For patient assignment, PCPs must be exclusive to one ACO (to minimize concerns about selection & dumping); Specialists can be part of multiple ACOs
- The method is **not** meant to establish individual provider accountability
- Accountability for assigned patients lies with the ACO, **not** the individual provider
- Physicians are part of the ACO **system** of care
- Even providers affiliated with only one ACO can refer patients to non-ACO providers

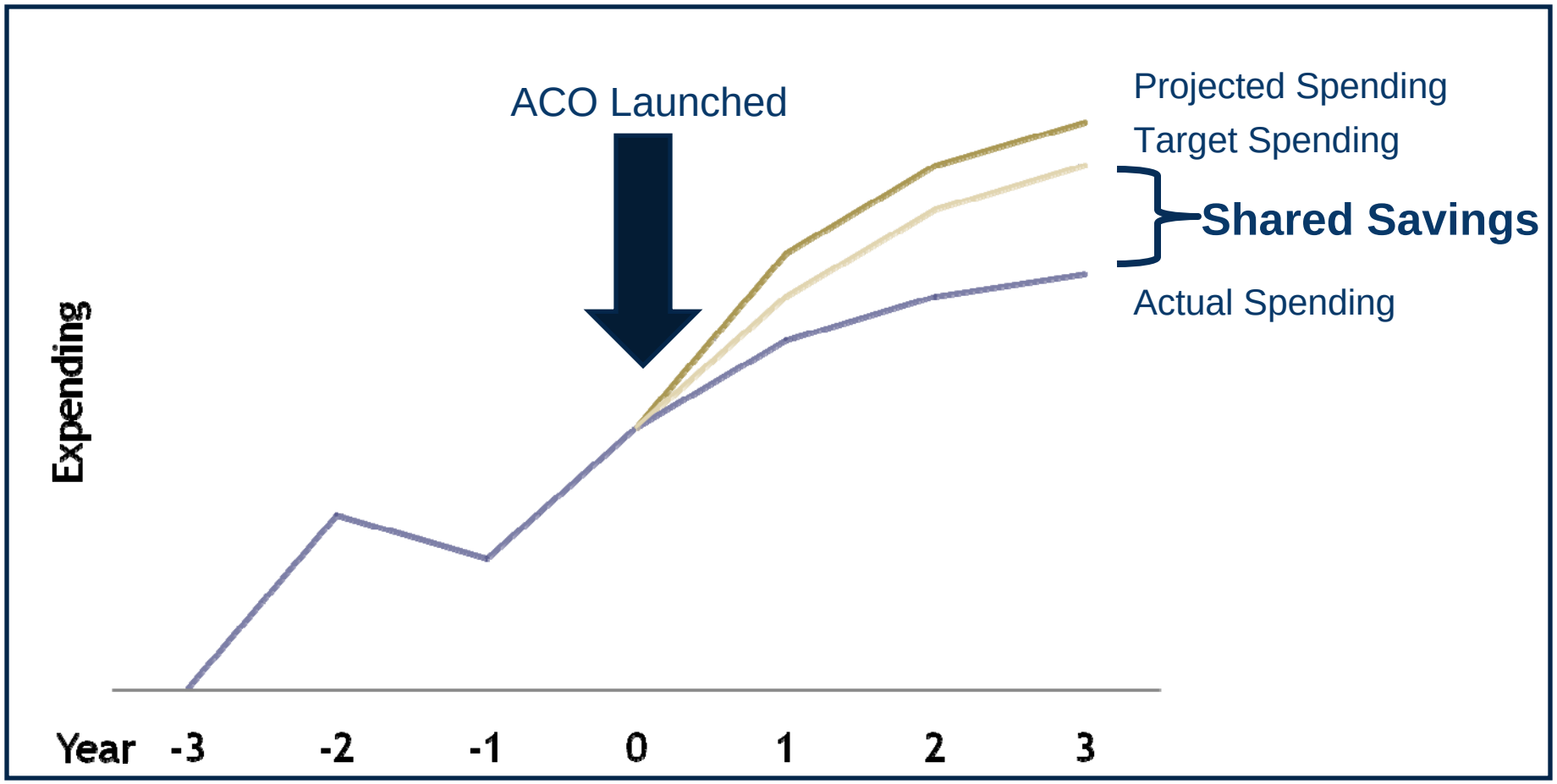
Understanding ACO Provider Relationship

Community Providers not part of ACO but may provide care to ACO patient. Some community providers may contract with ACO or routinely receive referrals, while others may have no relationship (or be out of area).

ACO Providers: Members govern ACO and, if exclusive, have patients assigned to them. Other providers may join multiple ACOs.

Bonus-Eligible Providers: ACO prospectively sets eligibility and allocates shared savings. ACOs have discretion to pay bonuses to a subset or all ACO members, varying treatment and amounts (e.g., all PCPs could receive bonuses, while only some specialists might).

Savings Based on Spending Targets



Measuring Performance in ACOs

	Current	ACO Model	Impact
Level of Measurement	Individual	ACO (System-Level)	Reduces fragmentation and silos of practice; and, provides an assessment of care because many providers contribute to a patient's care over time.
Types of Measures	Process	Outcomes, Patient Experience, Efficiency	Better data for patients to make choices about providers better data for providers to make changes; Increased accountability for resource use.
Measurement Focus	Individual Provider Accountability for Process	Care Coordination, Shared Decision Making, Capacity Control	Organizational support for managing and improving care; better patient engagement
Provider Focus	Discrete Patient Encounters	Overall health of the population	Shared accountability for the continuum of care.

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Initial Brookings-Dartmouth ACO Pilot Sites

Carilion Clinic Roanoke, VA	Norton Healthcare Louisville, KY	Tucson Medical Center Tucson, AZ
• ~900 Providers • 37,000 Medicare Patients Assigned	• ~400 Providers • 20,000 Medicare Patients Assigned	• ~80 Providers • 7,000 Medicare Patients Assigned

Large Group	⟷	Small Group
Low Competitive Environment	⟷	Highly Competitive Environment
Fully Integrated System	⟷	Multiple Independent Provider Groups

New Brookings-Dartmouth ACO Pilot Sites

Monarch HealthCare Based in Irvine, CA	**HealthCare Partners** Based in Torrance, CA
• Medical Group & IPA • >800 PCPs • >2,500 contracted, independent physicians • ACO will cover Orange County	• Medical Group & IPA • >1,200 employed and affiliated PCPs • >3,000 employed and contracted specialists • ACO will cover LA county

Large, highly integrated provider systems operating in highly competitive environment

Key Challenges for ACOs

- Promote development of new systems of accountable care
  - No adverse affects on existing systems providing accountable care
- Lower costs while improving population health
  - Measure both quality and financial performance

Key Challenges for ACOs (con't)

- Will "critical mass" of providers join, with enough assigned patients?
- Can ACOs promote forming new systems of care, without adversely affecting existing (integrated) systems?
- Will payers support Level I ACOs, or only focus on integrated systems ready for Level II or III?
- Financing for ACO start-up costs? (e.g., Infrastructure, IT, analysis, limiting ER use, etc.)
- Can ACOs change patient behavior & provider culture with Level I or II incentives & NO enrollment, "lock-in" or benefit changes?
- Potential to increase provider concentration and power?
- Other legal obstacles (e.g., Stark, corporate practice of medicine)?

Why ACOs Might Succeed (Over Time)

- Broad, flexible system built on essential core principles
  - Lots of local variation possible within ACO concept
- 3 ACO Levels permit tailoring to different circumstances
  - "Training Wheels" for Level I entities (no risk)
  - Level II offers more reward but adds (limited) risk
  - Partial Capitation allows proven entities to add FFS Medicare & PPOs
- Pathway to begin fundamental shift from FFS to population health & accountable care
- Create more provider systems ready to contract with managed care plans
- Opportunity for providers to change clinical & business environment
  - Requires timely data, analysis & working as a **system** of care
- Facilitates successful capitated systems serving FFS & PPO patients