National ACO Summit

Accountable Care Organizations: Core Features and Attributes

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National Perspective: FFS Dominates, Rewards Quantity but Ignores Quality and Systems of Care

ACO Core Principles Permit Diverse Arrangements

Patient Attribution, Shared Savings, Quality Measurement

Will ACOs Work? Challenges & Opportunities
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

<table>
<thead>
<tr>
<th>2006 Spending</th>
<th>92-06 Growth</th>
</tr>
</thead>
<tbody>
<tr>
<td>McAllen</td>
<td>$14,946</td>
</tr>
<tr>
<td>La Crosse</td>
<td>$5,812</td>
</tr>
</tbody>
</table>
Growth in Per-Capita Medicare Spending


- 4.5% to 8.4% (59)
- 4.0% to < 4.5% (52)
- 3.5% to < 4.0% (68)
- 3.0% to < 3.5% (62)
- 1.6% to < 3.0% (65)
- Not Populated
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.
Regional Variations in Care (Medicare)

More Care in High Spending Regions

Less Care in High Spending Regions

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

<table>
<thead>
<tr>
<th>Employer</th>
<th># Lives (Millions)</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>PPO</td>
<td>120 M</td>
<td>68%</td>
</tr>
<tr>
<td>Other</td>
<td>21 M</td>
<td>12%</td>
</tr>
<tr>
<td>HMO</td>
<td>35 M</td>
<td>20%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medicare</th>
<th># Lives (Millions)</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>FFS</td>
<td>34 M</td>
<td>75%</td>
</tr>
<tr>
<td>PPO &amp; PFFS</td>
<td>4 M</td>
<td>8%</td>
</tr>
<tr>
<td>HMO/POS</td>
<td>8 M</td>
<td>17%</td>
</tr>
</tbody>
</table>

- 100+ integrated delivery systems serve 40 million people
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Will ACOs Work? Challenges & Opportunities
## Comparison of Different Payment Models

<table>
<thead>
<tr>
<th></th>
<th>FFS</th>
<th>Capitation</th>
<th>ACO</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Payment</strong></td>
<td>Providers are <strong>revenue centers</strong> rewarded for increased volume.</td>
<td>With fixed payments unrelated to volume, providers are <strong>cost centers</strong>.</td>
<td>Incentives moderated under <strong>shared savings</strong>.</td>
</tr>
<tr>
<td></td>
<td><em>Concerns about overuse to maximize revenues.</em></td>
<td><em>Concerns about “stinting”</em></td>
<td><strong>Seek balance between FFS &amp; capitation</strong></td>
</tr>
<tr>
<td><strong>Patients</strong></td>
<td><strong>Neither</strong> assigned nor enrolled</td>
<td><strong>Enrolled</strong> with specific provider</td>
<td><strong>Assigned</strong> based on previous care patterns.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td><em>No enrollment</em></td>
</tr>
<tr>
<td><strong>Primary care &amp; care coordination</strong></td>
<td><strong>Little reward</strong> for primary care or care coordination</td>
<td><strong>Supports</strong> primary care and care coordination</td>
<td><strong>Supports</strong> primary care and care coordination</td>
</tr>
<tr>
<td><strong>Accountability for per-capita costs &amp; quality</strong></td>
<td><strong>Weak</strong> incentives to manage per-capita costs or improve quality</td>
<td><strong>Strong accountability</strong> for per-capita cost.</td>
<td><strong>Accountability</strong> for costs.</td>
</tr>
<tr>
<td></td>
<td></td>
<td><em>Links to quality vary</em></td>
<td><em>Links shared savings to meeting quality measures</em></td>
</tr>
</tbody>
</table>
# Accountability, “Systemness” & Incentives

<table>
<thead>
<tr>
<th>Core Principles</th>
<th>ACO Key Design Elements</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Achieve</strong> better health, better quality &amp; lower costs for patients and communities</td>
<td>▪ Pay for better value: improve overall health &amp; reduce costs</td>
</tr>
</tbody>
</table>
| **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

1. Can provide or manage continuum of care as a real or virtually integrated delivery system
2. Are of a sufficient size to support comprehensive performance measurement
3. Are capable of internally distributing shared savings payments

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

<table>
<thead>
<tr>
<th>Level 1</th>
<th>Asymmetric shared-savings</th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ Continue operating under current insurance contracts/coverage models (e.g., FFS)</td>
<td></td>
</tr>
<tr>
<td>▪ No risk for losses if spending exceeds targets</td>
<td></td>
</tr>
<tr>
<td>▪ Most incremental approach with least barriers for entry</td>
<td></td>
</tr>
<tr>
<td>▪ Attractive to new entities, risk-adverse providers, or entities with limited organizational capacity, range of covered services, or experience working with other providers</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Level 2</th>
<th>Symmetric Model</th>
</tr>
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<tbody>
<tr>
<td>▪ 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)</td>
<td></td>
</tr>
<tr>
<td>▪ At risk for losses if spending exceeds targets</td>
<td></td>
</tr>
<tr>
<td>▪ Increased incentive for providers to decrease costs due to risk of losses</td>
<td></td>
</tr>
<tr>
<td>▪ Attractive to providers with some infrastructure or care coordination capability and demonstrated track record</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Level 3</th>
<th>Partial Capitation Model</th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ ACO receives mix of FFS and prospective fixed payment</td>
<td></td>
</tr>
<tr>
<td>▪ If successful at meeting budget and performance targets, greater financial benefits</td>
<td></td>
</tr>
<tr>
<td>▪ If ACO exceeds budget, more risk means greater financial downside</td>
<td></td>
</tr>
<tr>
<td>▪ Only appropriate for providers with robust infrastructure, demonstrated track record in finances and quality and providing relatively full range of services</td>
<td></td>
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- 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
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Quality Measures Will Evolve Over Time: Beginning, Intermediate, & Advanced Stages

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

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

**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

- ACO Launched
- Projected Spending
- Target Spending
- Shared Savings
- Actual Spending

Year -3 -2 -1 0 1 2 3
Expenditure
# Measuring Performance in ACOs

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

<table>
<thead>
<tr>
<th>Carilion Clinic</th>
<th>Norton Healthcare</th>
<th>Tucson Medical Center</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Roanoke, VA</strong></td>
<td><strong>Louisville, KY</strong></td>
<td><strong>Tucson, AZ</strong></td>
</tr>
<tr>
<td>~900 Providers</td>
<td>~400 Providers</td>
<td>~80 Providers</td>
</tr>
<tr>
<td>37,000 Medicare Patients Assigned</td>
<td>20,000 Medicare Patients Assigned</td>
<td>7,000 Medicare Patients Assigned</td>
</tr>
</tbody>
</table>

### Environment
- Low Competitive Environment
- Highly Competitive Environment

### Provider Groups
- Fully Integrated System
- Multiple Independent Provider Groups

### Group Size
- Large Group
- Small Group
New Brookings-Dartmouth ACO Pilot Sites

Monarch HealthCare
Based in Irvine, CA
- Medical Group & IPA
- >800 PCPs
- >2,500 contracted, independent physicians
- ACO will cover Orange County

HealthCare Partners
Based in Torrance, CA
- 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