Key ACO Principles
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?

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

ACOs can strengthen ongoing reform efforts
- Medical home
- Episode, readmission initiatives
- HIT

ACOs can operate in conjunction with current payment structures
- FFS
- Bundled payments
- Partial/full capitation

Confusing aims
Absence or poor measurement
Wrong financial incentives
Fragmented care
Key Elements of an ACO

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
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**

![Graph showing spending over years]

- Spending
- Year: -3, -2, -1, 0, 1, 2, 3
- ACO Launched
- Projected Target
- Actual
- Shared Savings
Wide Range of Payment Models

<table>
<thead>
<tr>
<th>Level 1</th>
<th>Asymmetric Model</th>
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<tbody>
<tr>
<td>Continue operating under current insurance contracts/coverage models (e.g., FFS)</td>
<td></td>
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<tr>
<td>No risk for losses if spending exceeds targets</td>
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<tr>
<td>Most incremental approach with least barriers for entry</td>
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<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>
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<table>
<thead>
<tr>
<th>Level 2</th>
<th>Symmetric Model</th>
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<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>
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<tr>
<td>At risk for losses if spending exceeds targets</td>
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<tr>
<td>Increased incentive for providers to decrease costs due to risk of losses</td>
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<tr>
<td>Attractive to providers with some infrastructure or care coordination capability and demonstrated track record</td>
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<tr>
<th>Level 3</th>
<th>Partial Capitation Model</th>
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<tr>
<td>ACO receives mix of FFS and prospective fixed payment</td>
<td></td>
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<tr>
<td>If successful at meeting budget and performance targets, greater financial benefits</td>
<td></td>
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<tr>
<td>If ACO exceeds budget, more risk means greater financial downside</td>
<td></td>
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<tr>
<td>Only appropriate for providers with robust infrastructure, demonstrated track record in finances and quality and providing relatively full range of services</td>
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Goals of Patient Assignment Method

**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

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<tr>
<th>Beginning</th>
<th>Intermediate</th>
<th>Advanced</th>
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<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>
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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

<table>
<thead>
<tr>
<th>Carilion Clinic</th>
<th>Norton Healthcare</th>
<th>HealthCare Partners</th>
<th>Monarch HealthCare</th>
<th>Tucson Medical Center</th>
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</thead>
<tbody>
<tr>
<td>Roanoke, VA</td>
<td>Louisville, KY</td>
<td>Torrance, CA</td>
<td>Irvine, CA</td>
<td>Tucson, AZ</td>
</tr>
<tr>
<td>- Integrated Delivery System</td>
<td>- Integrated Delivery System</td>
<td>- Medical Group &amp; IPA</td>
<td>- Medical Group &amp; IPA</td>
<td>- 3 Independent Physician Groups + Community Hospital</td>
</tr>
<tr>
<td>- ~750 Providers</td>
<td>- ~270 Providers</td>
<td>- &gt;1,200 employed and affiliated PCPs</td>
<td>- &gt;2,500 contracted, independent physicians</td>
<td>- Virtually Integrated ACO Model</td>
</tr>
<tr>
<td>- 37,000 Medicare Patients Assigned</td>
<td>- 20,000 Medicare Patients Assigned</td>
<td>- &gt;3,000 employed and contracted specialists</td>
<td>- ACO will cover Orange County</td>
<td>- ~80 Providers</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>- 7,000 Medicare Patients Assigned</td>
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Large Group

Fully Integrated System

Smaller Group

Multiple Independent Provider Groups
# Brookings-Dartmouth ACO Learning Network

## 2009-10 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

## 2010-11 Network
- 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

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<thead>
<tr>
<th>Implementation-focused webinars</th>
<th>Focus on key ACO design features, as well as critical topics ranging from legislative and regulatory issues to in-depth case studies</th>
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<tr>
<td><strong>Exclusive Member-Driven Conferences</strong></td>
<td>Emphasize practical, solution-oriented discussion—driven by member leadership and participation—and will provide excellent opportunities for learning, growth, and networking</td>
</tr>
<tr>
<td><strong>Brookings-Dartmouth ACO Newsletter</strong></td>
<td>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</td>
</tr>
<tr>
<td><strong>New Website</strong></td>
<td>Serve as a one-stop shop for all ACO-related news, materials and updates</td>
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<tr>
<td><strong>Implementation Groups</strong></td>
<td>Propose, help create, and join a group to receive more sophisticated and tailored ACO solution-oriented strategies</td>
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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 Exec19 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
ACCOUNTABLE CARE ORGANIZATION
LEARNING NETWORK

Brookings-Dartmouth
ACO Learning Network
www.acolearningnetwork.org

Engelberg Center for Health Care Reform at Brookings
http://www.brookings.edu/health