ACCOUNTABLE CARE ORGANIZATION (ACO): Long-term commitment to a new vision

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Medical Director
February 9, 2011
Physician Reimbursement

“There are three ways to pay a physician, fee for service, capitation, and salary, and they are all bad.”

James Robinson, UC Berkeley,
Salary and capitation – little incentive to increase productivity or quality
Fee for Service – incentive to produce more units regardless of quality
• Health Care Reform
• What is an ACO?
• Why pursue development of an ACO?
• How is an ACO different from the HMO model?
• Lessons Learned
• Questions
UNSUSTAINABLE SPENDING
- Health care grows ~17.3% of the GDP in 2009

National Health Spending as a Share of GDP, 1960–2019*
- 2000 to 2009 represents a 21% increase in health care spending over 9 years.

AFFORDABLE CARE ACT
- Calls for the creation of separate ACO demonstration projects within the Medicare Program by January 1, 2012.

*Selected rather than continuous years of data shown. 2010 and 2019 are projections. Data Source: Centers for Medicare and Medicaid Services (CMS), Office of the Actuary.
“The Administration hopes that delivery system reforms that are identified during the Accountable Care Organization demonstrations will eventually replace the fee-for-service system that produces haphazard quality, fosters the use of unproven interventions, and increases costs.”

Ezekiel Emanuel, MD, PhD
White House Adviser for Health Policy
August 14, 2010

“CMS will support ACO learning networks. Authenticity matters, those who seek to protect the status quo won't be tolerated.”

Don Berwick, MD
CMS Administrator
October 5, 2010
“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)

- By aligning provider incentives and putting quality first, ACOs will play a pivotal role in health care reform impacting all stakeholders-providers, payers and patients.
Patient Protection and Affordable Care Act (ACA)

• President Obama calls for a comprehensive overhaul of the U.S. health care system to combat rising health care cost.
  ▪ Patient Protection and Affordable Care Act (PPACA) passes in March 2010
    ➢ Three major health care payment reform provisions under PPACA:
      ❖ Accountable Care Organization (ACO)
        ✓ Section 3022 calls for the creation of separate ACO demonstration project within the Medicare Program by January 1, 2012.
      ❖ Patient Centered Medical Home (PCMH)
        ✓ Section 3502 grants or contracts to establish community health teams to support the PCMH.
      ❖ Bundle Payments
        ✓ Section 2704 establishes a demonstration program to allow states to use bundled payments to promote integration of care around hospitalizations starting January 1, 2012.
Why pursue development of an ACO?

• ACOs are a response to changes in U.S. health care flowing from the new federal health care reform law.
  ▪ Improve the quality and coordination of health care;
  ▪ Slow the growth of spending

• California is the optimal site for development of an ACO because the HMO delivery model is already in place.
  ▪ Existing provider infrastructure makes it easier to develop related processes
The goal of ACOs is to transform the current health care delivery system

<table>
<thead>
<tr>
<th>Current System</th>
<th>ACO System</th>
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<tbody>
<tr>
<td>Fragmentation</td>
<td>Integration</td>
</tr>
<tr>
<td>Adversarial relationships</td>
<td>Cooperation</td>
</tr>
<tr>
<td>Focus on “doing”</td>
<td>Focus on managing a population</td>
</tr>
<tr>
<td>One-to-one care</td>
<td>Team-based care</td>
</tr>
<tr>
<td>Gatekeeper</td>
<td>System management</td>
</tr>
<tr>
<td>Perverse financial incentives</td>
<td>Aligned incentives</td>
</tr>
<tr>
<td>Focus on volume/intensity</td>
<td>Focus on quality and efficiency</td>
</tr>
</tbody>
</table>

Source: Brookings-Dartmouth ACO Pilot Project
Adoption of Payment Reform Models: Why?

- Current crisis in primary care recruitment and retention
- Aging population & increased prevalence of chronic diseases
- Current system emphasizes episodic treatment for acute care and more care, not better care; Capitation led to less care
- Rising healthcare costs and gaps/variations in quality and safety

- Need for better coordination of care among providers; care coordinated by a personal physician associated with better outcomes, especially in many chronic diseases
- Disease management as currently exists yielding mixed results; DM activities most successful when integrated into a physician practice
- Decreased patient, provider and employer satisfaction
Defining an Accountable Care Organization (ACO)

- **ACO**: Group of primary care providers, specialists and/or hospitals and other health professionals who manage the full continuum of care and are accountable for the overall **quality of care** and **costs** for a defined population. (Medicare Payment Advisory Commission)

**Integrating care through ACOs**

ACOs can serve as “integrators,” linking fragmented entities of the health care system around accountability for value.

![Diagram showing the integration of various health care providers through ACOs](image-url)
Forming an ACO - What does it need to include?

Basic Features

- **Provider Group** willing to become accountable for the quality, cost and overall care of fee-for-service beneficiaries.
- **Legal structure** that allows organization to receive and distribute payments for shared savings based on PQRI and other measured achievements.
- **Sufficient Primary Care providers**
- **Clinical processes and benchmarks** that promote evidence-based medicine and patient engagement.
- **Technology infrastructure** to enable reporting on quality and cost measurements, coordinated care, remote patient monitoring, clinical outcomes, patient experience, caregiver experience of care and utilization among other measures.
- Leadership and management structure that includes **clinical and administrative systems**.
How are ACOs Structured?

ACO Model 1
- IPA or PCP Group
- Specialty Group
- Hospital

ACO Model 2
- Multi-specialty Group
- Hospital

ACO Model 3
- Hospital
- Medical Staff Organization (MSO) or Physician-Hospital Organization (PHO)

ACO Model 4
- Organized Delivery System
  - Hospital
  - Employed and Affiliated Physicians
  - Possibly Other Providers, like Post Acute Care

Devers & Berenson, 2009, RWJF and The Urban Institute, *Timely Analysis of Immediate Health Policy Issues*, Figure 1
Possible ACO Configurations, Comprised of Different Provider Organizations in Local and Regional Geographic Areas
How will an ACO work?

**Steps for initial ACO implementation:**

1. Local providers and payers agree to pilot ACO reform.
2. ACO provides list of participating providers to payers.
3. Patients are “assigned” to ACO (e.g., based on preponderance of E&M codes or other attribution methodologies).
4. Actuarial projections about future spending are based on previous historical data.
5. Determine/negotiate spending benchmarks and shared savings.
6. ACO implements capacity, process and delivery system improvement strategies (e.g., reducing avoidable hospitalizations, coordinating care, health IT).
7. Progress reports on quality and cost are developed for ACO beneficiaries.
8. At year end, total and per capita spending are measured for all patients (regardless of whether or not they received care from an ACO provider).
9. Savings is shared between providers and payers for meeting quality thresholds and performing under benchmark.

Data Source: Brookings-Dartmouth ACO Pilot Project
### Options for Payment Reform

<table>
<thead>
<tr>
<th>Simple Shared Savings</th>
<th>Shared Savings + Symmetrical Risk</th>
<th>Shared Savings + Partial Capitation</th>
</tr>
</thead>
<tbody>
<tr>
<td>• No risk for spending over the benchmark</td>
<td>• Split of shared savings is 80/20, with symmetrical risk (withhold)</td>
<td>• 10%-50% capitation on ACO patient expenditures</td>
</tr>
<tr>
<td>• 2% threshold before savings can be distributed</td>
<td>• Good option for established ACOs</td>
<td>• Shared savings split of remaining 50% – 90% based on risk relationship</td>
</tr>
<tr>
<td>• Shared savings split of 50/50</td>
<td></td>
<td>• Good option for advanced systems</td>
</tr>
<tr>
<td>• Likely, a time-limited option</td>
<td></td>
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</table>

Source: Brookings-Dartmouth ACO Pilot Project

**QUANTITY FIRST**

- **ACO PROVIDERS MUST MEET QUALITY THRESHOLDS IN ORDER TO QUALIFY FOR SHARED SAVINGS.**
Shared Savings Model

How do “shared savings” models work?

Initial shared savings derived from spending below benchmarks

- ACO Launch
- Projected Spending
- Spending Benchmark
- Actual Spending

Spending vs. Time

Shared Savings

The Dartmouth Institute
For Health Policy & Clinical Practice
Where Knowledge Informs Change

How Do ACOs Reduce Expenditures?

Through systematic efforts to **improve quality** and **reduce costs** across the organization:

- **Capacity**
  - Appropriate Workforce
  - Reduction/Conversion of Current Capacity
  - Health Information Technology

- **Patients**
  - Informed Patient Choices
  - Health Risk Assessments

- **Processes**
  - Improved Care Coordination
  - Chronic Disease Management
  - Point of Care Reminders
  - Reduced Waste

- **Physicians**
  - Aligned Incentives
  - Access to Timely Data

Source: Brookings-Dartmouth ACO Pilot Project
Examples of outcomes required to improve quality and reduce costs

1. Improved Prevention
2. Early Diagnosis
3. Reduce Unneeded Testing & Referrals
4. Reduce Preventable ER Visits
5. Reduce Unneeded Hospitalizations
6. Reduce Hospital Infections
7. Reduce Medical Errors
8. Reduce Preventable Readmissions
9. Use Lower Cost Treatments, Settings, Providers
10. Reduce Admin & Transaction Costs

Source: How to create Accountable Care Organizations, September 2009, Harold Miller, www.CHQPR.org
Health maintenance organizations (HMOs) share commonalities with the ACO concept as they were also large-scale attempts to improve health care delivery and payment. However, ACO differs in that they are:

1. **Long term partnerships with providers.** The ACO partnership with HealthCare Partners and Monarch will be for five years.

2. **IT Connectivity.** Including health information exchanges to enable care coordination across a designated population is critical. Shared information will allow physicians treating any patient to have an up-to-date picture of how the patient’s condition is progressing, no matter which physician is managing the care at any point in time.

3. **Coordination.** Enabling physicians, hospitals and health plans to work together to achieve quality and cost improvement.

4. **Collaborative Relationships.** The collaborative nature of the program moves away from traditional managed care contracting. Each party is committed to each other’s success.

5. **Improved Quality/Shared Savings.** Used in the Brookings-Dartmouth ACO Pilot Project and Medicare ACO program, where providers who meet predetermined *quality* and/or *utilization* targets qualify to share in any savings.

6. **No Gatekeeper.** Care is coordinated and patients are followed closely by the ACO providers, working to keep them well, yet there are no restrictions to specialists when needed.
### Dartmouth-Brookings ACO Pilots

#### Dartmouth Brookings ACO Pilot sites

<table>
<thead>
<tr>
<th>Clinic</th>
<th>Location</th>
<th>Providers</th>
<th>Medicare Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carilion Clinic</td>
<td>Roanoke, VA</td>
<td>~900</td>
<td>~70,000</td>
</tr>
<tr>
<td>Norton Healthcare</td>
<td>Louisville, KY</td>
<td>~400</td>
<td>~90,000</td>
</tr>
<tr>
<td>Tucson Medical Center</td>
<td>Tucson, AZ</td>
<td>~80</td>
<td>~50,000</td>
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#### CALIFORNIA ACO

<table>
<thead>
<tr>
<th>Monarch HealthCare</th>
<th>Based in Irvine, CA</th>
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<tbody>
<tr>
<td>Medical Group &amp; IPA</td>
<td>&gt;800 PCPs</td>
</tr>
<tr>
<td>&gt;2,500 contracted, independent physicians</td>
<td>ACO will cover Orange County</td>
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</tbody>
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<table>
<thead>
<tr>
<th>HealthCare Partners</th>
<th>Based in Torrance, CA</th>
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<tbody>
<tr>
<td>Medical Group &amp; IPA</td>
<td>&gt;1,200 employed and affiliated PCPs</td>
</tr>
<tr>
<td>&gt;3,000 employed and contracted specialists</td>
<td>ACO will cover LA County</td>
</tr>
</tbody>
</table>

Data Source: Brookings-Dartmouth ACO Pilot Project
Patient Centered Medical Home - Growing support for Payment Reform in Primary Care

The PCMH is based on studies that show the value of care coordinated by a personal physician using systems-based approaches. 

Patient-centered primary care has been implemented successfully in other nations that have better overall quality scores and lower costs. Within the U.S., states that rely more on primary care have better quality, lower overall Medicare costs and lower utilization.

Effective care coordination in the ambulatory setting can reduce hospital admissions and re-admissions for chronic illnesses (such as diabetes, CHF).

Starfield, presentation to Commonwealth Fund Roundtable on Primary Care, October 2006
Commonwealth Fund, Chartbook on Medicare, 2006
Dartmouth Atlas, Fall, 2006
Haven’t we seen this before? ACOs vs. HMOs

Designer’s Perspective

- Some similarities w/delegated (full risk) models in CA that have had some success.
- Main difference is that in capitated HMOs prior, there was reduced attention paid to patient satisfaction/ experience. Focus was on reducing UR to make $$. 
- **ACO is first attempt to link quality and patient satisfaction to opportunity for shared reward/$$ is fundamental difference.**
- ACO entities are owned / run by physicians not payers
- Accountability moving from the Health Plans to the Providers
Conclusion

When you talk about paradigms – shift happens
Framework for change proposed – some enacted into the ACA
Not universally embraced – further change is likely
Desired trajectory is enhanced coverage, improved quality with lower cost trend
End Game – high quality affordable health care
Changes in framework must meet these goals
Collaboration amongst purchasers, payors, providers is essential for success
Conclusion

There are major opportunities for improvement
   ▪ We must close the quality chasm and reduce variation in health care

Purchasers want value for their premium dollar
   ▪ Health care dollars are not limitless and must be spent wisely

Quality measurement is imperfect
   ▪ We need consistent standards
   ▪ We need measures that address specialty care

Quality improvement requires multiple strategies beyond P4P, including new reimbursement models

Collaboration amongst purchasers, payors, providers is essential for success
ACO – Unintended Consequences and Barriers

- Providers asking to exclude members who go out of ACO
- Antidote - tiered copays, tiered premiums, default attribution – opt out penalty, provide information to influence choice
- No downside risk
- AHA – no member satisfaction survey
- Danger of Strong Provide System Monopolies
- Antidote – anti-trust regulations and transparency of pricing, don’t allow “most favored nation status”
- Physician – ACO formation – 75% of office based physicians practice in groups of 5 or fewer
- Potential conflict between PCPs and SCPs