



Nuts and Bolts of Accountable Care Organizations

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Health Care Reform

- Need for Universal Access
- Regulatory Reform of Individual's Insurance
- Reform of Finance
- Reform of Delivery System

Paul Ginsburg, PhD

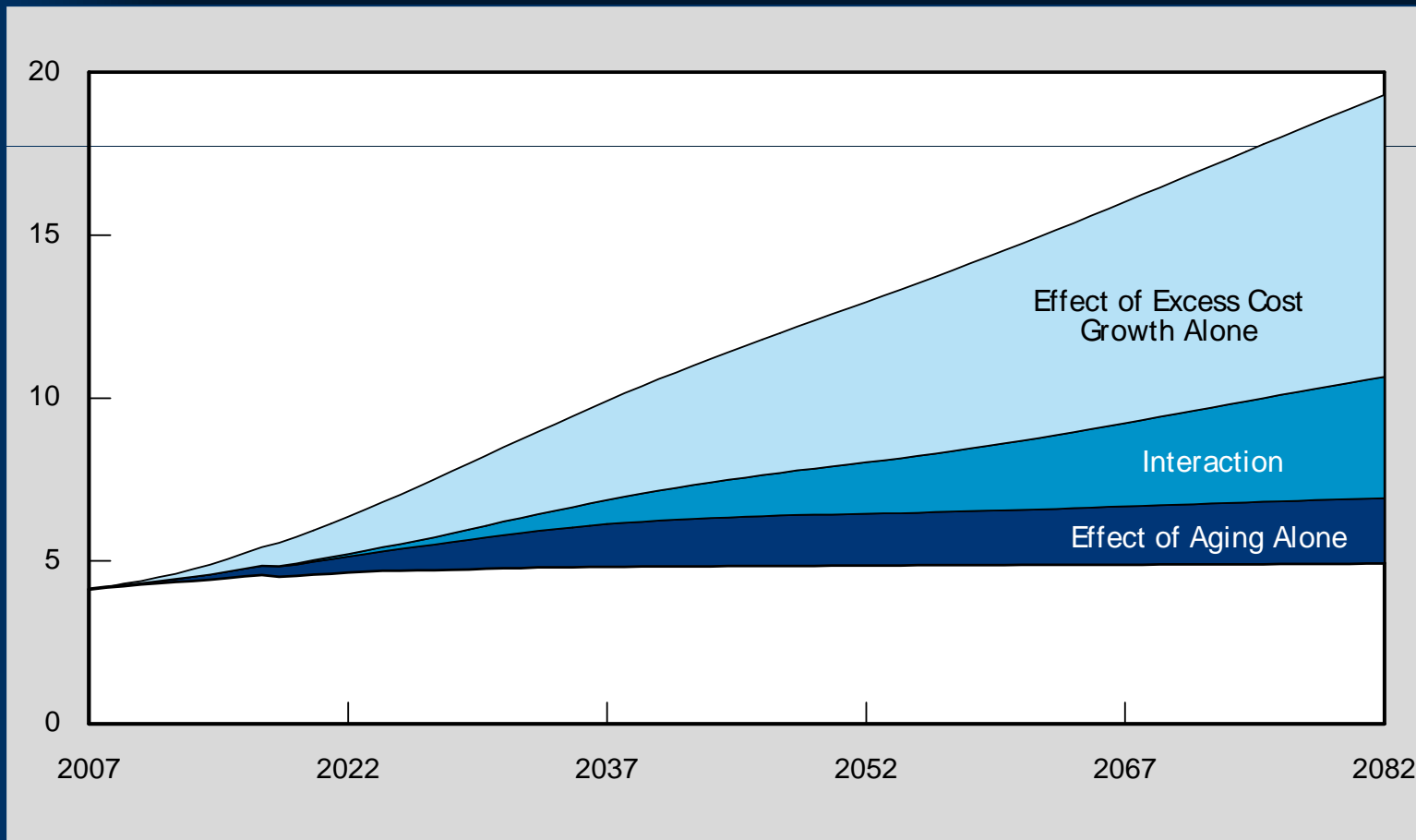
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Sources of Growth in Projected Federal Spending on Medicare and Medicaid

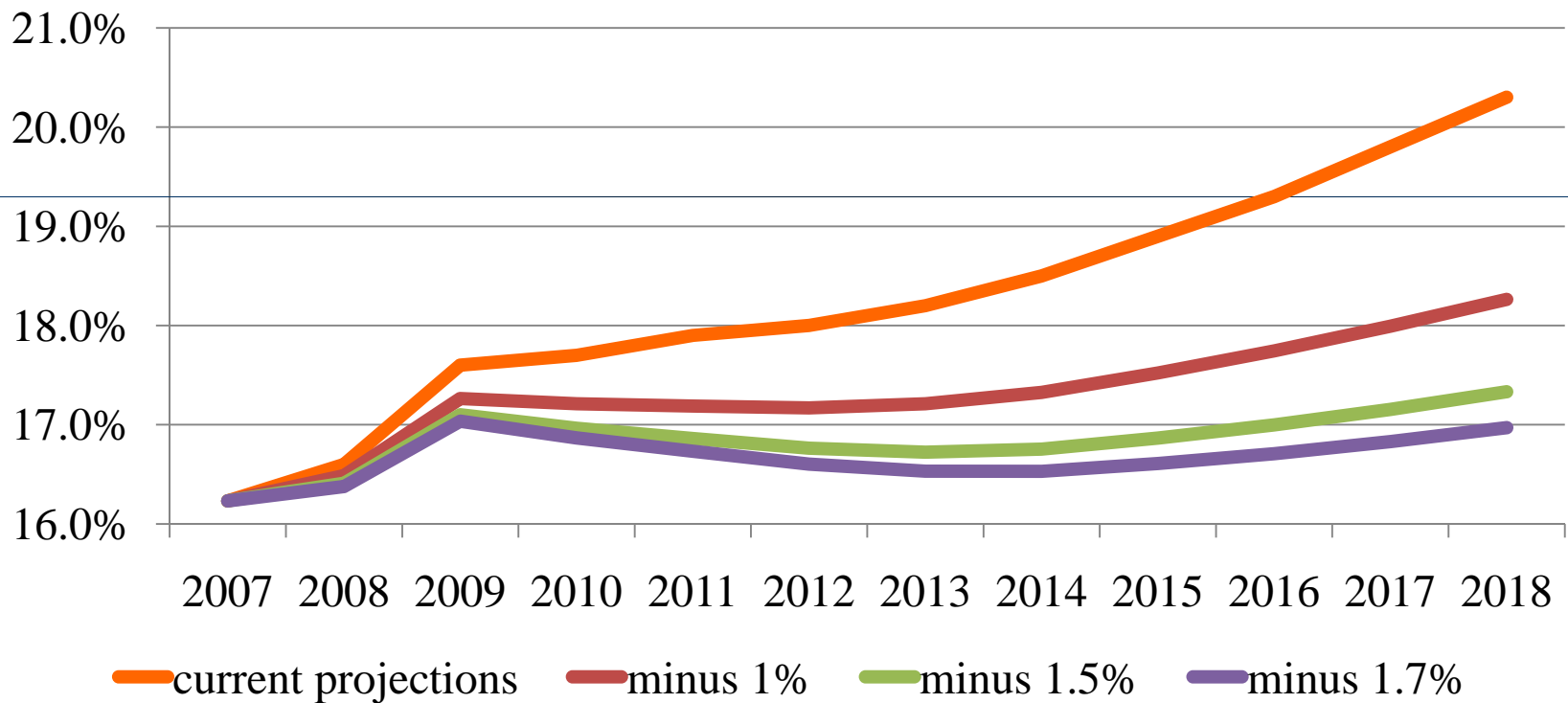
Percentage of GDP



Cost Containment

Potential associated with bending the cost curve

National Health Expenditures as a Percentage of GDP



The government alone cannot fix it!

What can our government do?

Create Taxation

Regulate / Deregulate

Centralize/Decentralize

Create Oversight

Spend Your Money

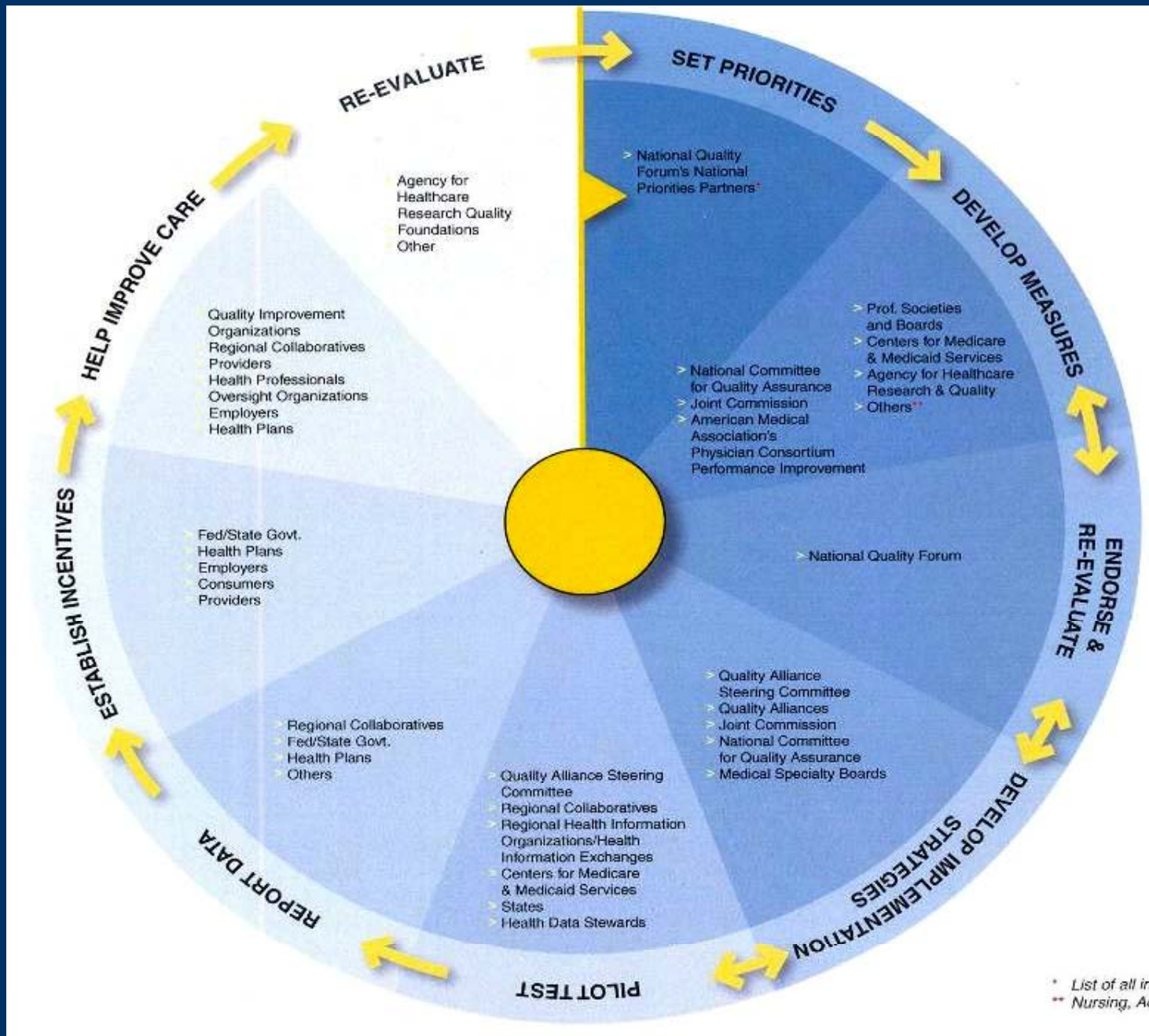


National Strategy for Quality Public-Private Partnership

It's a Trinity:
Quality Care
Affordable Care
Healthy Communities

From Current State to Future State





* List of all inv
 ** Nursing, Aca

Delivery System Redesign Payment Reform

- Accountable Care Organizations
- Medical Home / Independence at Home
- Episodes of Care
 - Procedure Specific Bundles
 - Condition Specific Bundles

Governing the Common

Elinor Ostrum

Non-Zero Sum

Logic of Human Destiny

Robert Wright

Health Reform and Economic Recovery Legislation

- Increases payments for prevention and primary care (and general surgery); supports medical homes
- Moves from pay-for-reporting to pay-for-performance/value-based purchasing
- Reduces payment for healthcare-acquired conditions and for preventable hospital readmissions
- Begins pilot program for bundling
- Creates accountable care organizations
- Establishes Medicare and Medicaid Innovation Center
- Creates new organization and provides funding for comparative effectiveness research funding (\$1.1 billion)
- Funds Health Information Technology (net \$19 billion)
 - Promises Medicare & Medicaid financial incentives totaling a net \$14 to \$27 billion over 10 years for eligible professionals (EPs) and eligible hospitals

Could These Be Game Changers?

Medicare Shared Savings Program: Accountable Care Organizations (ACOs)

- ◆ A new permanent (and optional) program that begins 1/1/2012
- ◆ Widely viewed as an approach that could improve the quality and efficiency of healthcare
- ◆ Interest in ACOs is extremely high, especially among hospitals and health systems
 - A major question is the extent to which physicians will want to partner with hospitals versus participate on their own as in the PGP demo
- ◆ Modeled on Physician Group Practice Demonstration, now completing 5th year
- ◆ Beneficiaries are assigned to an ACO but may continue to receive services from any physician or provider
- ◆ CBO scored 10-year savings of \$4.9 billion

ACO: What is It?

- ◆ CMS: “An organization of health care providers that agrees to be accountable for the quality, cost, and overall care of Medicare beneficiaries who are enrolled in the traditional fee-for-service program who are assigned to it”
 - Must have a formal legal structure to receive and distribute shared savings
 - Must have defined processes to (a) promote evidence-based medicine, (b) report the necessary data to evaluate quality and cost measures, and (c) coordinate care
- ◆ Assignment to an ACO will be “invisible to the beneficiary, and will not affect their guaranteed benefits or choice of doctor. A beneficiary may continue to seek services from the physicians and other providers of their choice, whether or not the physician or provider is part of an ACO”
- ◆ Assignment methodology to be specified by CMS; based on which ACO professionals provide “the bulk of primary care services” to a particular fee-for-service Medicare beneficiary

ACOs in Health care reform

◆ Eligible Groups of Providers:

- ACO professionals in group practice arrangements
- Networks of individual practices of ACO professionals
- Partnerships or joint venture arrangements between hospitals and ACO professionals
- Hospitals employing ACO professionals
- Such other groups of providers of services and suppliers as the Secretary determines appropriate
- Note: providers operating under a section 1115A waiver or independence at home medical practice pilot program are not eligible to participate

Key Elements of Accountable Care Model



- **Local Accountability**

- Foster provider accountability for quality and per capita cost for their patient population

- **Standardized Performance Measurement**

- Increased accountability on the part of providers should be accompanied by improved incentives and information for consumers

- **Payment Reform**

- Transition payments from rewarding volume/intensity to increasing value
- Payments should encourage collaboration and shared responsibility among providers and consistent incentives from payers

The ACO is the overarching structure within which other reforms can thrive

Accountable Care Organization

Patient Shared Decision Making

Bundled Payments

Partial Capitation

Tiered Benefit Design

Patient Engagement

Health Information Technology

Focus on Primary Care (Medical Home)

Accountable Care Organizations

ACO configurations can vary, reflecting the diversity of local health care markets

Integrated delivery systems, Physician-Hospital Organizations, Independent Practice Associations (IPA), physician group practices, regional collaborations

Several characteristics are essential for all ACOs:



1. Can provide or manage the continuum of care for patients as a real or virtually integrated delivery system

2. Are of sufficient size to support comprehensive performance measurement and expenditure projections

3. Are capable of internally distributing shared savings and prospectively planning budgets and resource needs

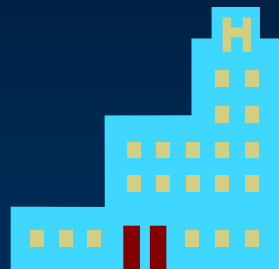
What providers comprise an ACO? It varies.

Accountable Care Organization

Primary Care



Hospital



Specialists



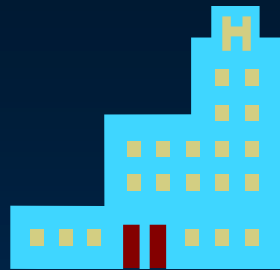
**Other Possible
Components:**

Home Health

Mental Health

Rehab Facilities

No Lock In: Patient assignment to ACO



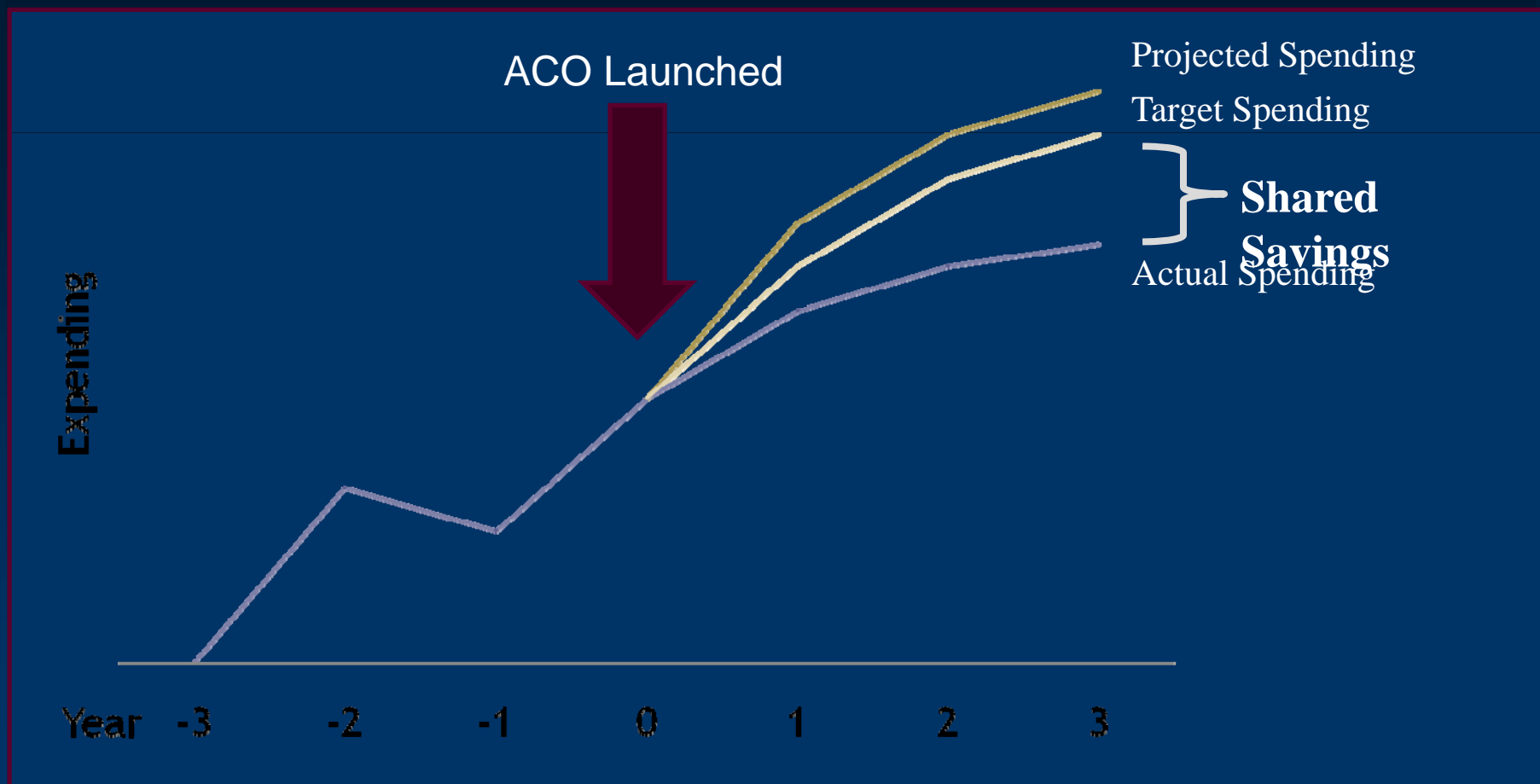
Providers sign agreement to participate with ACO

(PCPs must be exclusive to one ACO; Specialists can be part of multiple ACOs)



Patients are assigned to their PCP based on the majority of their outpatient E&M visits

Calculating savings based on spending targets



Multiple initiatives within the ACO model:

\$800M (Target Expenditures)

- \$160M (20% Capitation)
 - \$365M (Traditional Fee for Service Payments)
 - \$115M (Bundled Payments for Specific Conditions)
 - \$150M (PMPM Payments for Medical Home)
-

\$10M (Available Shared Savings if Quality Targets are Met)



\$8M to the Providers



\$2M to the Payers

Payment Frameworks: Many approaches

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

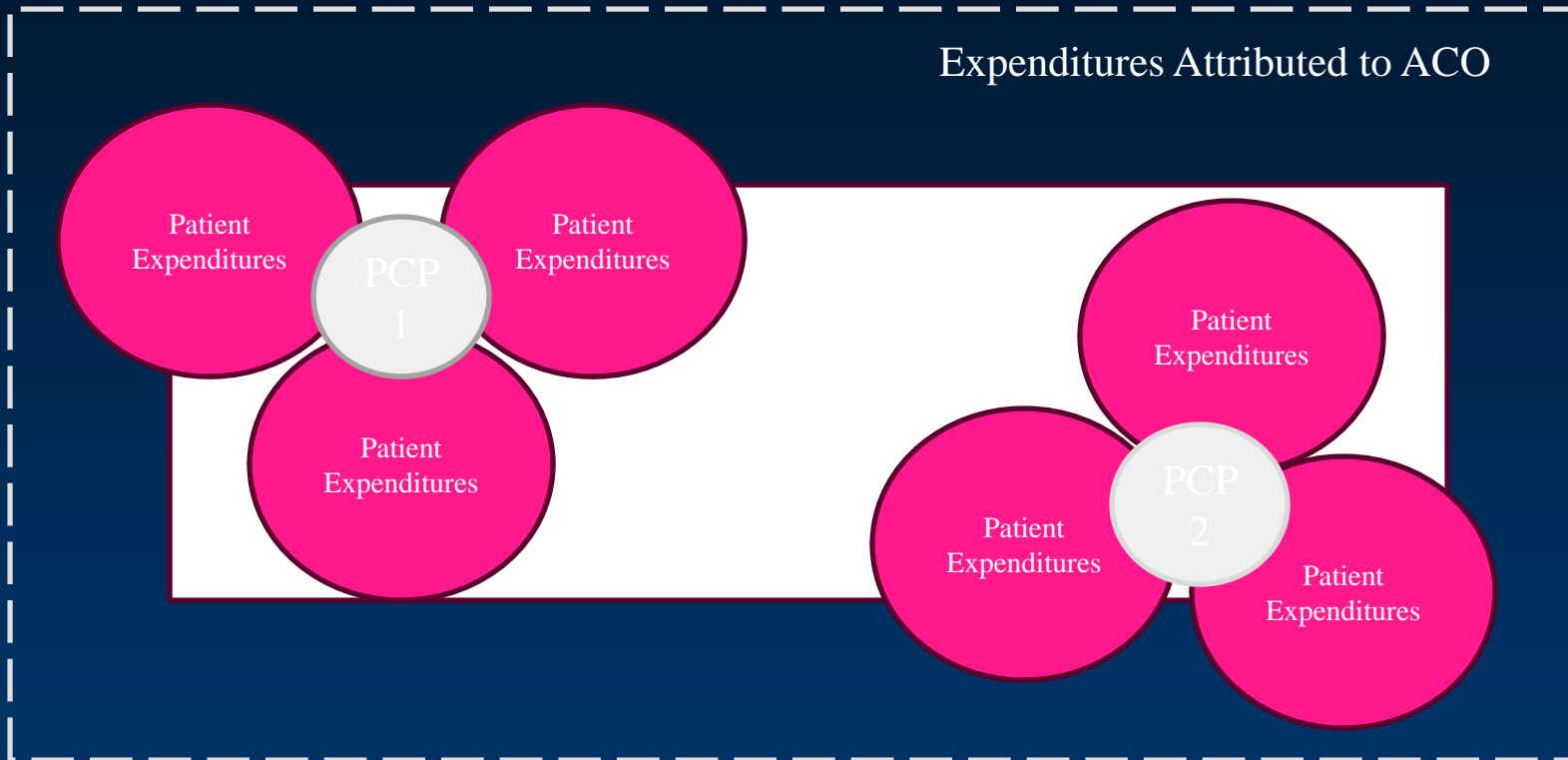
Level 2 Symmetric Model

- 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

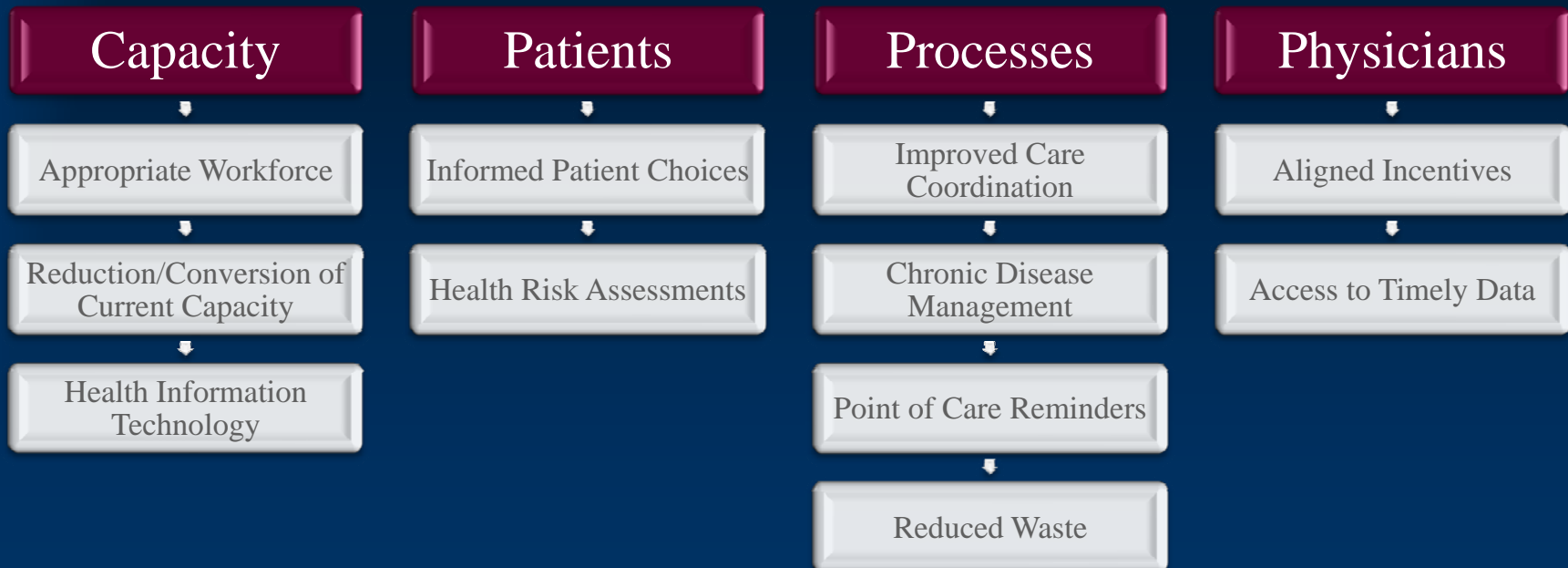
- ACO receives mix of FFS and prospective fixed payment
- If successful at meeting budget and performance targets, greater financial benefits
- If ACO exceeds budget, more risk means greater financial downside
- Only appropriate for providers with robust infrastructure, demonstrated track record in finances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

ACO is responsible for all patient expenditures

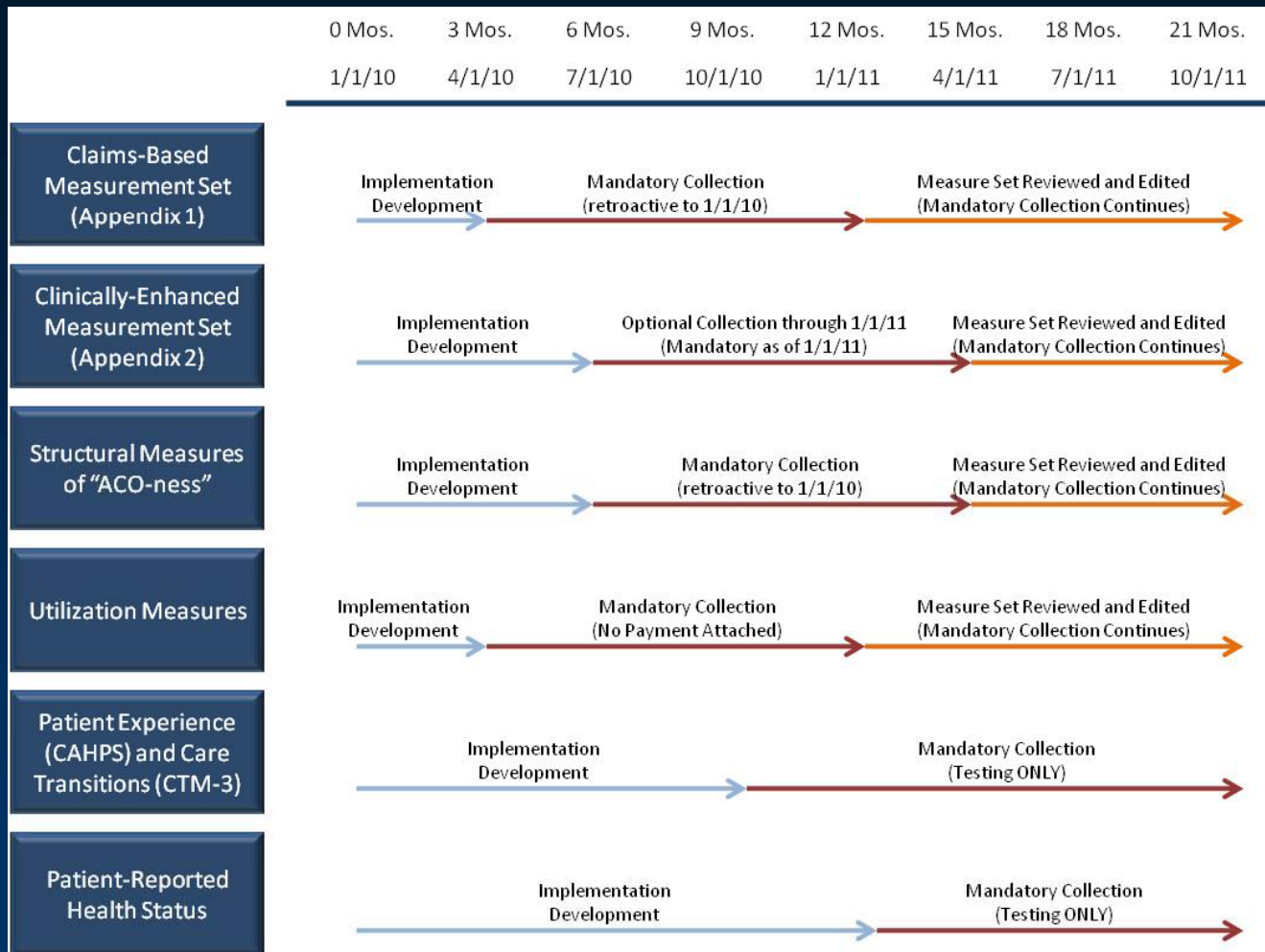


How do ACOs reduce expenditures?

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



Performance Measurement Timeline



How Does This 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 ACOs (e.g., based on preponderance of E&M codes)
- 4. Actuarial projections about future spending are based on last 3 years of historical data
- 5. Determine/negotiate spending benchmark and shared savings arrangement
- 6. ACO implements capacity, process, and delivery system improvement strategies
- 7. Progress reports on cost and quality are developed for ACO beneficiaries
- 8. At year end, total and per capita spending are measured for all patients
- 9. Savings under the benchmark is shared between providers and payers

Brookings-Dartmouth ACO Collaborative

Pilot Sites

In-depth consultation, technical assistance, and data analysis for participating health systems and payers.

Learning Network

Offers practical guidance and a forum for interested parties to learn from one another throughout the process of planning and implementation

Principal Goal

To engage stakeholders in piloting the ACO model and produce a successful and replicable model that can be implemented nationwide.

Community Initiatives

Serve as strategic support for regions interested in piloting this at the community-level.

Washington Support

Serve as a resource for legislative and executive staff on delivery system reform, specifically related to the ACO model.

ACO Pilot Sites – Round 1

Expectations of Dartmouth-Brookings ACO Pilot Sites

1. Willingness to work with multiple payers,
2. Use of the Dartmouth patient assignment methodology,
3. Willingness to participate in a global per capita shared savings model
4. Standardized collection of the ACO performance measurement starter set,
5. Membership and active participation in the ACO Learning Network, and
6. Commitment to the pilot for a minimum of 5 years.

Carilion Clinic

Roanoke, VA

- ~900 Providers
- 37,000 Medicare Patients Assigned

Norton Healthcare

Louisville, KY

- ~400 Providers
- 20,000 Medicare Patients Assigned

Tucson Medical Center

Tucson, AZ

- ~80 Providers
- 7,000 Medicare Patients Assigned

ACO Pilot Sites

Carilion Clinic Roanoke, VA

- ~900 Providers
- 60,000 Medicare Patients Assigned

Norton Healthcare Louisville, KY

- ~400 Providers
- 30,000 Medicare Patients Assigned

Tucson Medical Center Tucson, AZ

- ~80 Providers
- 10,000 Medicare Patients Assigned

Large Group



Small Group

Low Competitive Environment



Highly Competitive Environment

Fully Integrated System



Multiple Independent Provider Groups

Better Care, Lower Costs, Better Health,

Current System

- ◆ Fragmentation
- ◆ Adversarial Relationships
- ◆ Focus on “doing”

- ◆ One-to-one care
- ◆ Perverse financial incentives
- ◆ Focus on volume/intensity

ACO System

- ◆ Integration
- ◆ Cooperation
- ◆ Focus on managing a population
- ◆ Team-based care
- ◆ Aligned incentives
- ◆ Focus on quality, efficiency, and value





