Accountable Care Organizations
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Some Context

CBO Long-Term Federal Spending Projections as a Percentage of GDP

Source: 2011 CBO Long-Term Budget Outlook
## Accountable Care and Health Care Reform

<table>
<thead>
<tr>
<th>Barrier</th>
<th>Principles</th>
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<tbody>
<tr>
<td>Health care payments do not promote optimal health care decisions</td>
<td>Clarify aims to advance better health, better care, and lower costs</td>
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<tr>
<td>Fragmented delivery system does not promote accountability for capacity, quality or costs</td>
<td>Foster provider accountability for the full continuum of care – and for the capacity of the local health system</td>
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<tr>
<td>Absent or poor data leads to under-informed health care decisions</td>
<td>Better information that engages providers, supports improvement; informs consumers for best care</td>
</tr>
<tr>
<td>Non-aligned payments reinforce problems, reward fragmentation, induce preventable complications and inefficient care</td>
<td>Pay more for better, more efficient care by aligning financial incentives with professional aims</td>
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What is an ACO?

• ACO’s are “provider-based organizations that take responsibility for meeting the health care needs of a defined population with the goal of simultaneously improving health, improving patient experience and reducing per capita costs”

• Fundamentally, they are entities capable of accepting accountability for clinical/quality and financial outcomes

• By intent, they should enable better coordination and integration of care across providers/sites of 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 exclusive patient enrollment
Core Competencies for Accountable Care

1. **Governance and leadership** focused on the resources and project management required to implement new models of care

2. **Health IT** that supports measurement for both improvement and accountability – starting with simple systems for tracking patients and progressing to electronic health records

3. **Care coordination** – especially for the frail elderly or for those with multiple chronic conditions – across clinicians and sites of care

4. **Care improvement programs** that allow teams comprised of nurses, pharmacists and other health professionals to maintain health and prevent costly complications of chronic diseases and major procedures
Wide Range of Possible ACO Designs

<table>
<thead>
<tr>
<th>Integrated Delivery System</th>
<th>Multispecialty Group Practice</th>
<th>Physician-Hospital Organization</th>
<th>Independent Practice Association</th>
<th>Regional Collaborative</th>
</tr>
</thead>
<tbody>
<tr>
<td>One or more hospitals &amp; large group of employed physicians</td>
<td>Strong physician leadership</td>
<td>Joint venture between one or more hospitals &amp; physician group</td>
<td>Small physician practices working together as a corporation, partnership, professional corporation or foundation</td>
<td>Independent or small providers</td>
</tr>
<tr>
<td>Insurance plans (some cases)</td>
<td>Contract with multiple health plans</td>
<td>Vary from focusing contracting with payers to functioning like multi specialty group practices</td>
<td>Often contract with health plans in managed care setting</td>
<td>Leadership may come from providers, medical foundations, non-profit entities or state government</td>
</tr>
<tr>
<td>Aligned financial incentives, advanced health IT, EHRs, &amp; well-coordinated team-based care</td>
<td>Developed mechanisms for coordinated care (sometimes arranged through another partner)</td>
<td>Many require strong management focused on clinical integration &amp; care management</td>
<td>Individual practices typically serve non-HMO clients on a standalone basis</td>
<td>Sometimes in conjunction with health information exchanges or public reporting</td>
</tr>
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</table>
The Evolving ACO Landscape: Current Pilots

**Medicare PGP**
- 10 integrated multispecialty provider groups testing care reforms for Medicare beneficiaries under a shared-savings payment model (started 2005)

**Brookings-Dartmouth**
- Initially five provider groups, ranging in size, type, and geography, implementing shared savings programs with commercial payers, with additional sites in process

**Premier**
- Roughly 25 “ACO ready” Premier provider systems working to implement shared savings programs within 1-2 years

**Medicare MHCQ (“646”)**
- Builds on the PGP Demo by testing a similar payment and quality improvement model in multi-stakeholder organizations that include but are not limited to physician groups
The Evolving ACO Landscape: Current Pilots

- Brookings-Dartmouth Pilot
- PGP, MHCQ and regional ACO pilots
- Premier Implementation Group
- ONC Beacon Site
- AF4Q Pilot Sites

Others in process …
The Evolving ACO Landscape: On the Horizon

Medicare Shared Savings Program
- Established by ACO, with draft regulations promulgated April, 2011. CMS reviewing (considerable) feedback. Final regulations expected later this year

Pioneer
- CMS Innovation Center program, intended to pilot advanced models for ACOs with ~30 organizations based on applications (currently under review)
The Brookings-Dartmouth Pilots

Quick Facts:
• Pilots include two integrated delivery systems (IDSs); two independent physician organizations (IPAs); and a physician-owned hospital system (PHO)
• Revenues ranging from $0.4-2.5 Bn
• Initial ACO attributed population up to 40K
• Negotiations with Anthem, UnitedHealth and Humana
<table>
<thead>
<tr>
<th>Payor partners</th>
<th>Performance measurement</th>
<th>Downside risk*</th>
<th>Other clinical transformation &amp; reform efforts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Norton Healthcare</td>
<td>HUMANA</td>
<td>B-D</td>
<td>✓</td>
</tr>
<tr>
<td>HealthCare Partners Medical Group</td>
<td>Anthem</td>
<td>B-D</td>
<td>✓</td>
</tr>
<tr>
<td>TMC Healthcare</td>
<td>UnitedHealth Group</td>
<td>B-D</td>
<td>✓</td>
</tr>
<tr>
<td>Monarch HealthCare A Medical Group, Inc.</td>
<td>Anthem</td>
<td>IHA</td>
<td>✓</td>
</tr>
<tr>
<td>Carilion Clinic</td>
<td>TBD</td>
<td>TBD</td>
<td>✓</td>
</tr>
</tbody>
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*All pilots plan to introduce downside risk within five years
B-D = Brookings-Dartmouth Measures; IHA = Integrated Healthcare Association
## Lessons Learned from ACO Pilots

<table>
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<tr>
<th>Develop a process</th>
<th>Secure ongoing commitments</th>
<th>Distinguish risk from uncertainty</th>
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<tr>
<td>• Use data to inform a move towards value and identify payer-partners to initiate implementation process</td>
<td>• Commit to ongoing adjustments to the ACO contract – from both payers and providers</td>
<td>• Develop realistic estimates of ACO start-up costs</td>
</tr>
<tr>
<td>• Develop an implementation plan that identifies opportunities to improve care delivery and population management</td>
<td>• Harmonize the assets of both payers and providers</td>
<td>• Analyze past data to understand organizational performance</td>
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<tr>
<td>• Launch initiatives that reinforce payment changes (PCMHs, episode-based payments)</td>
<td>• Receive commitments from the payer for: timely data, management of insurance risk, and possibly sharing of performance risk</td>
<td>• Align on clear and realistic expectations for both quality and cost improvements</td>
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</table>
Successful ACOs should build support from private payers, states, and CMS.

ACOs should build on (and capitalize on) other reforms: PCMH, HIT.
Payment Reform: The Other Side of the Coin

**Aligned Performance Measures**
- Quality (Including Impact on Outcomes, Population Health)
- Cost/Efficiency Impacts

**Value-based payment reform**

**Aligned Payment Reforms**
- HIT Meaningful Use
- Payments for Reporting/
- Medical Homes
- Episode Payments
- Accountable Care
- Others

**Aligned Reform Priorities and Support**
- Timely data for patient care
- Supportive health plan, specialty providers, hospitals

**Sufficient Scale**
- Sufficient capital to provide time, effort, and technical support for real delivery change (payers, providers- including physicians, equity)
- Strategy for using and augmenting Federal payments
- Systemwide leadership: regional collaborations; business groups; states; Federal government?
Moving Toward “Paying for Value”

- “Fee for value” reforms
  - Pay for participation/pay for reporting
  - HIT meaningful use payments
  - “Value modifier” and other coming Medicare reforms

- Medical Home Payments
  - Bundled payment for primary care
  - Accountability for structural/process features (registries, office capabilities)… and better results

- Episode Payments
  - Specialty care, other “bundles” of care
  - Move from FFS payments toward better support for identifiable improvements in quality and efficiency (examples in all types of specialty care)
The Need for Clinical Leadership

- Decisions by physicians and other clinicians are primary determinants of health care spending and quality
- SGR and FFS payments for physician services not sustainable – but reforms will require physician support
- Key features for sustainable payment reform
  - Driven by clear evidence of better quality and lower overall costs
  - Some accountability for achieving better results - and thus new kinds of shared risk for physicians and their organizations
- Leadership and capital (time, investments) needed
  - Integrated systems and specialized groups
  - Health plan support: Aetna, Cigna, United...
  - Other capital investors
  - Hospitals?
**Challenges**

- Aligning multi-payer ACOs with other reform initiatives
- Catalyzing real leadership from providers & payers
- Reducing start-up costs

**Potential solutions**

- Develop a common set of performance measures with a pathway for more sophistication over time
- Create harmony between other payment and delivery system reforms
- Commit sufficient leadership support within organization and trust toward shared goals between payers and providers
- Develop common frameworks and contract templates to reduce costs and uncertainty
- Promote transparency to accelerate learning

**Accountable Health Care**

ACOs: Coordinated networks of providers with shared responsibility to provide the highest value care to their patients
ACO Learning Network (www.acoLearningNetwork.org)

2009-2010 ACO Learning Network

• >60 provider & payer organizations
• Focused on defining core ACO concepts
• Included webinars, ACO materials, and conference discounts

2010-2011 ACO Learning Network

• >125 organizations from across the health care spectrum
• Share lessons learned from ongoing examples of ACO implementation
• In-depth analysis of emerging Federal and State regulation

Implementation-focused webinar series
Member-Driven Conferences
ACO Newsletter
Web-based resources