



# Accountable Care Organizations

Rick Shinto, MD  
Aveta Health Inc.

July 20, 2010



# Health Care Reform- New Models of Care

- Patient Protection and Affordable care Act (PPACA 2010)
  - controlling costs and improving quality
  - Several payment reform pilots
- Growth of new models of Care
  - Medical Homes
  - Patient-Centered Medical Home
  - Accountable Care Organizations
- NCQA and the Medical Home

# Why Accountable Care Organizations?

- ACOs are one response to concerns over the fragmented nature of health care delivery in the US
- Current payment system inefficient
  - Fee-For-Service (FFS)
  - Volume- based structure
  - Incentives lacking in FFS payment systems
- They aim to create incentive for providers to work together more closely by tying at least part of their payments to metrics reflecting care the ACOs as a whole provides for defined groups of people
- Expected estimate of 5\$ billion savings



# What is an ACO?

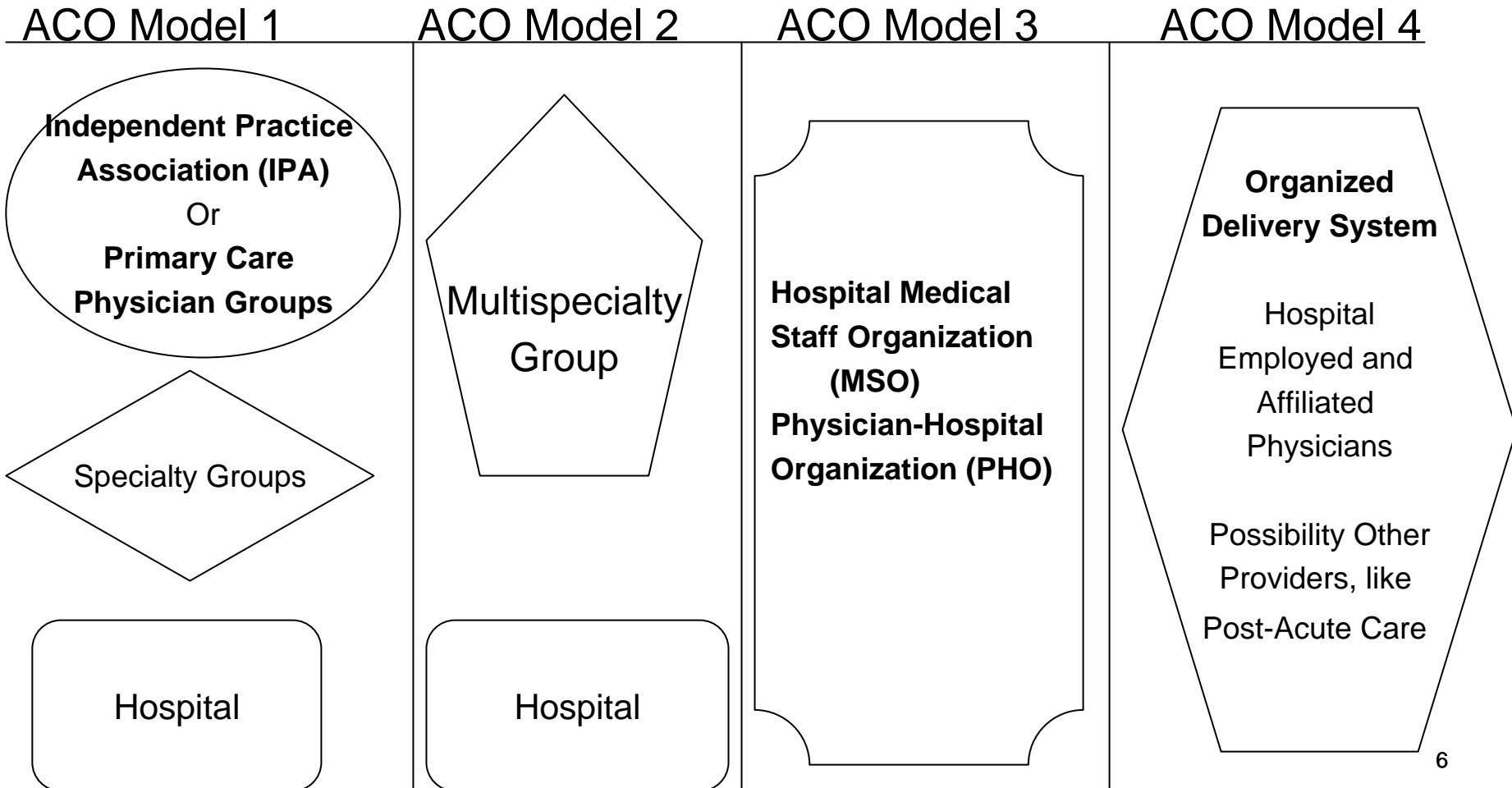
- What constitutes an ACO?
  - Definitive regulations to be rolled out in early 2011
- Accountable care organizations are a method of integrating local physicians with other members of the health care system and rewarding them for their comprehensive coordinated quality efforts
  - They are accountable for 100% of expenditures and care of a defined population of patients
  - Shared saving program (based on benchmarks)
  - Continuum of care- full coordination
  - Promotion of quality
  - Efficient service delivery
- Takes into effect 2012
- Pilot Programs



# Who Can be an ACO?

- Academic Medical Centers
- HMSOs- Hospital Medical Staff Organization
- HPPNs- Health Plans and Providers
- Different Physician Models:
  - Integrated Health System
  - Multispecialty Groups
  - PHOs
  - IPAs

# Possible ACO Configurations, Comprised of Different Provider Organizations in Local and Regional Geographic Areas





# Requirements of an ACO

- Willing to become accountable for quality, cost, and overall care
- Minimum 3 year contract agreement
- Formal legal structure (allow to receive and distribute payments for shared savings)
- PCPs= minimum of 5,000 members
- Have a leadership management structure that includes clinical and administrative systems
- Practice evidence-based medicine
- Report on quality and cost measures
- Patient centeredness
- IT structure
- Have PCPs, specialists and probably hospital
- Different payment model- accept risk

# Accountable Care System Models and Core Capabilities

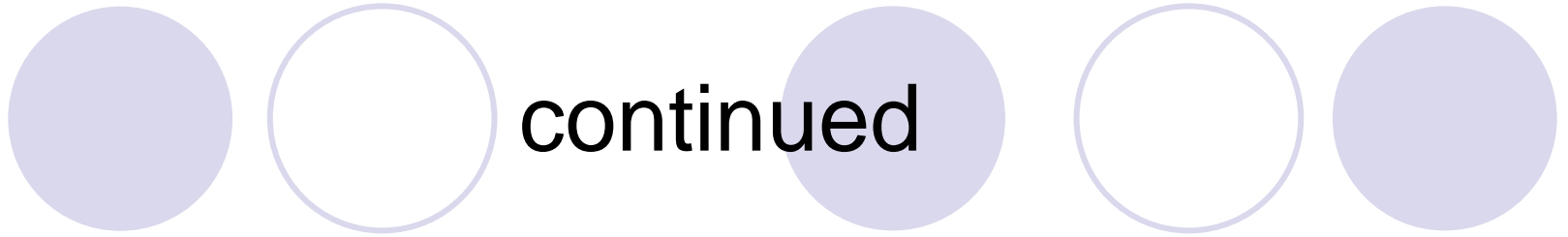
Accountable Care System Models	Redesign Care Process	Teamwork	Care Coordination	Core capabilities Performance Accountability	Information technology	Knowledge Management	Change Management
1. Multi-Specialty Group Practice (MSGP)	High	High	High	High	High	High	Medium
2. Hospital Medical Staff Organization (PHO)	Medium	Medium	High	High	High	Low to Medium	Low to Medium
3. Physician Hospital Organization (IPO)	Medium	Medium	Medium	High	High	Medium	Medium
4. Interdependent Provider Organization (IPO)	Low	Low	Low to Medium	Medium	Low	Low	Low
5. Health Plan Provider Organization/Network (HPPO/HPPN)	Medium	Low to Medium	Low to Medium	Medium to High	Low to Medium	Low to Medium	Low to Medium





# Managing Risk

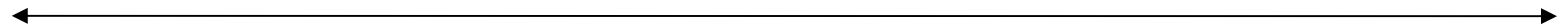
- To manage risk the following are required
  - Information systems
  - Medical management protocols and procedures
  - Contracting with health plans, employers, etc
  - Collection and distribution of dollars
  - Compliance with state and federal
  - Capital pool



- Recommendations

- 3 tier structure of qualification for ACO integration
- Based on degree of financial risk assumed by ACO
- Degree of rewards
  - Level 1: FFS payment with shared savings
  - Level 2: bundled payments ( i.e. AMI, CABG, total knee) and episode of care payments (i.e. asthma, diabetes)
  - Level 3: partial ( for professional and risk shared for hospital care) and global capitation payments

# Alternative Methods of Payment



**Fee for  
Service**

**FFS+  
Shared  
Savings**

**Episode  
Payment**

**Partial  
Comp.  
Care Pmt.  
+ P4P**

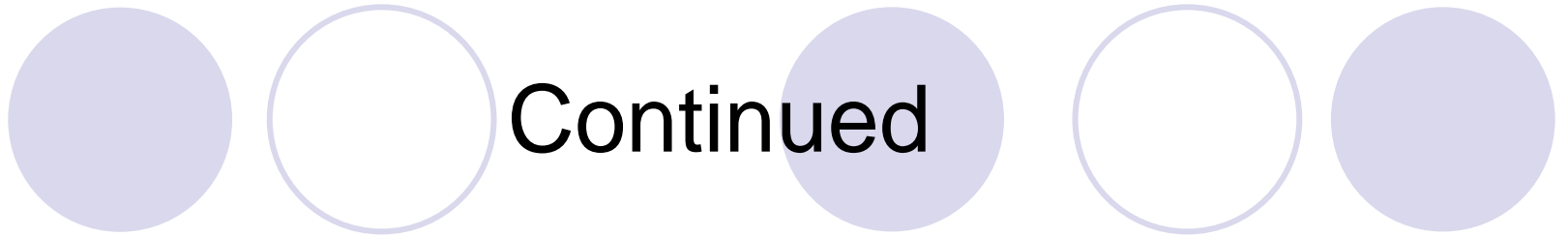
**Comprehensive  
Care (Global)  
Payment**

**Capitation**



# ACO Pilot Programs

- Mayo Clinic
- Geisinger
- Intermountain Healthcare
- Model testing
  - Dartmouth/Brookings Model
    - Carillion Clinic (VA)
    - Norton Healthcare System (KY)
    - Tucson Medical Ctr (AZ)
  - Massachusetts
    - Special commission
    - Capitated payments in ACO
    - Assume risk
    - Pt preferences/ considerations



- Vermont

- Blueprint for health reform
- Enhanced medical home (Dartmouth Model)

- Colorado

- Medicaid consideration
- New pilot
- 60,000 members--- Start winter 2010

- Academic Hospitals

- Baylor System
  - 4500 providers and 13 hospitals
  - Marketing to employers
  - Bundled payment systems
- Robert Wood Johnson Foundation
  - Partnership with Medical School
  - 100-150 providers
  - Linked to 6 hospitals
  - Bonus not determined

# Seven core ACO competencies and associated critical success factors

<b>Core competency</b>	<b>Critical success factors</b>
<b>Leadership</b>	<ul style="list-style-type: none"> <li>● Ability to develop strong teams and shared culture</li> <li>● Ability to mediate stakeholder priorities</li> <li>● Ability to clearly, regularly and consistently communicate vision, strategy and direction to internal and external stakeholders</li> <li>● Ability to change direction when necessary</li> <li>● Ability to innovate</li> </ul>
<b>Governance</b>	<ul style="list-style-type: none"> <li>● Ability to design and execute strategy and management performance goals</li> <li>● Ability to leverage cultural strengths and neutralize cultural challenges</li> <li>● Ability to access and deploy capital efficiently to implement strategy</li> <li>● Ability to recruit and retain competent leadership</li> <li>● Ability to use fact-based planning to engage trustees</li> <li>● Ability to leverage profit with purpose</li> </ul>

# Continued

<b>Operational management</b>	<ul style="list-style-type: none"><li>● Ability to incorporate clinical performance measurements (safety, efficacy, effectiveness, costs, outcomes, satisfaction, productivity, efficiency) to optimize accountability and gain sharing</li><li>● Ability to contract effectively with health plans and employers to leverage capabilities and performance</li><li>● Ability to align supply chain vendors in collective gain sharing and achieve optimal purchasing efficiency</li><li>● Ability to manage regulatory compliance</li></ul>
<b>Clinical management</b>	<ul style="list-style-type: none"><li>● Ability to manage clinical pathway adherence by care teams</li><li>● Ability to redesign and align population-based health management processes with evidence-based guidelines</li><li>● Ability to coordinate care across patient conditions, services, and settings over time</li><li>● Ability to manage patient behavior and implement patient outreach, adherence and self care</li></ul>

# Continued

<b>Infrastructure and IT</b>	<ul style="list-style-type: none"><li>● Ability to build and make effective use of information technologies for health care delivery and administration at provider, patient and system level</li><li>● Ability to integrate systems and aggregate data across multiple sites of care</li><li>● Ability to synthesize data into dashboards for management decision-making</li><li>● Ability to leverage IT infrastructure to reduce paperwork and workflow inefficiency</li></ul>
<b>Risk assessment</b>	<ul style="list-style-type: none"><li>● Ability identify and mitigate the impact of at-risk populations of patients</li><li>● Ability to identify and interdict operational problems that pose risk</li></ul>
<b>Work force</b>	<ul style="list-style-type: none"><li>● Ability to effectively design and allocate a health care workforce</li><li>● Ability to optimize workforce productivity in team-based incentive structure</li><li>● Ability to control fixed and variable costs for workforce through innovation in HR design</li><li>● Ability to manage outsourced relationships and strategic partnerships to cost-effectively enhance core competencies</li></ul>



# Current Federal Considerations

- Patients assigned to ACO based on their PCP
  - Can be voluntary participation (vs. mandatory)
- Open access
- Can see providers outside ACO
- Can switch ACO
- PCPs can belong to only one ACO
- Specialists can participate in more than one ACO
- Bonuses based on cost benchmarks by set by HHS
- Currently only Medicare- commercial insurers seriously being considered
- Set waivers
- Multiple hospital regional area- competition?

# ACO- Legal Considerations

Relevant Laws	Principal Legal Objectives	Potential Design Implications
<b>Antitrust</b>	Avoid market monopolization	<ul style="list-style-type: none"> <li>● Remain within precedent “safety zones” in terms of number of physicians involved</li> <li>● Utilize non-exclusive physician agreements</li> </ul>
<b>Civil Monetary Penalty Provisions of Social Security Act</b>	Do not induce physicians to reduce or limit care provided to Medicare/Medicaid beneficiaries	<ul style="list-style-type: none"> <li>● Focus cost-savings on compliance with principled guidelines (e.g., substituting lower-cost, clinically equivalent drugs and devices)</li> <li>● Build in (and document) monitoring systems for care quality and changes in physician practice patterns (case mix, volume, steerage, etc.)</li> </ul>
<b>Stark and Anti-Kickback</b>	Do not reward physicians for referrals	<ul style="list-style-type: none"> <li>● Ensure complete disconnect between amount and timing of compensation and referrals</li> <li>● Pre-determine any bonus amounts: avoid letting bonus amount fluctuate in a way that could be connected to physician referrals</li> </ul>
	Preserve payment-productivity parity	<ul style="list-style-type: none"> <li>● Reimburse any non-clinical work at fair market value</li> </ul>
	Keep payment within fair market value “safe range “	<ul style="list-style-type: none"> <li>● Compare overall opportunity (base plus bonus) with third-party-verified regional benchmarks</li> <li>● Keep compensation within two standard deviations of industry-wide metrics</li> </ul>
<b>Not-for Profit Tax Exemption</b>	Do not share hospital profit with individuals	<ul style="list-style-type: none"> <li>● Predetermine payout and bonus amounts</li> <li>● Tie bonus payout to specific performance milestones</li> </ul>

# What the FTC is looking for

Clinical  
protocol  
development  
and adoption

Regular care  
reviews  
based on the  
application  
of protocols

Mechanisms  
that will  
ensure  
physician  
adherence to  
protocols

The use of  
common IT  
to ensure the  
exchange of  
relevant  
patient data

# Elements of Clinical Integration

## Governance

- Quality Improvement Committee established to develop and monitor clinical quality
- Action plan development to improve data capture, accuracy and physician performance

## Guideline/Protocol Development for disease states and conditions

- Evidence-based clinical protocols
  - Covering conditions impacting the majority of IPA/PHO patient population
- Ability to identify disease/condition
- Accepted treatment and management

## Care Coordination

- Patient outreach by Care Coordinator
  - Mail and/or telephonic to encourage compliance

## Data

- Ability to collect data related to established guidelines/protocols
- Access to Data – Clinical data repository
  - Access to most current information about patient care

# Clinical Integration Requirements

## Reporting

- Ability to measure compliance with established guidelines/protocols
- Reports need to be at the summary and patient detail level
  - Identification of cases that do not meet compliance with guidelines/protocols

## Incentive Programs

- Quality performance – Protocols
  - Resource/Cost Management
  - Patient Satisfaction
  - Meeting attendance
  - Use of Technology (On-line Patient Disease Registry, EMR)

## Education

- Guideline/Protocol Education
  - Meetings
  - Provider Portal
  - Hard copies
- Training for physicians and office staff

## Credentialing/ Recredentialing

- Selection and retention of high quality provider panel willing and able to follow guidelines/protocols
- Deselection process

# Difference between Medical Homes and ACOs

- **The terms are often used synonymously but they are not the same.**
- **Practices within ACOs would/could function as medical homes**
  - ACOs are integrated delivery systems that are globally capitated to control the cost and quality of care for a population of patients. MedPAC says: “This concept could complement medical homes, which in some cases may be too small to support full accountability, and hospital-physician bundling, which creates no incentive to control the volume of initial admissions.”
- **Medical homes:**
  - Much smaller than ACOs
  - Smaller= not capable of robust measures of outcomes or of being held accountable for full costs of care
  - No incentive to decrease volume of own or other services
  - No incentive for hospitals or specialists to cooperate

# How Does This Work?

## Steps for initial ACO Implementation

- Local providers and payers agree to pilot ACO reform
- Assessment of participants ability to form a viable ACO
- ACO providers list of participating providers to payers
- Patients are “assigned” to ACOs (e.g., based on preponderance of E&M codes)
- Actuarial projections about future spending are based on last 3 years of historical data
- Determine/negotiate spending benchmark and shared savings arrangement
- ACO implements capacity, process, and delivery system improvement strategies
- Progress reports on cost and quality are developed for ACO beneficiaries
- At year end, total and per capita spending are measured for all patients
- Savings under the benchmark is shared between providers and payers