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

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Agenda

- 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

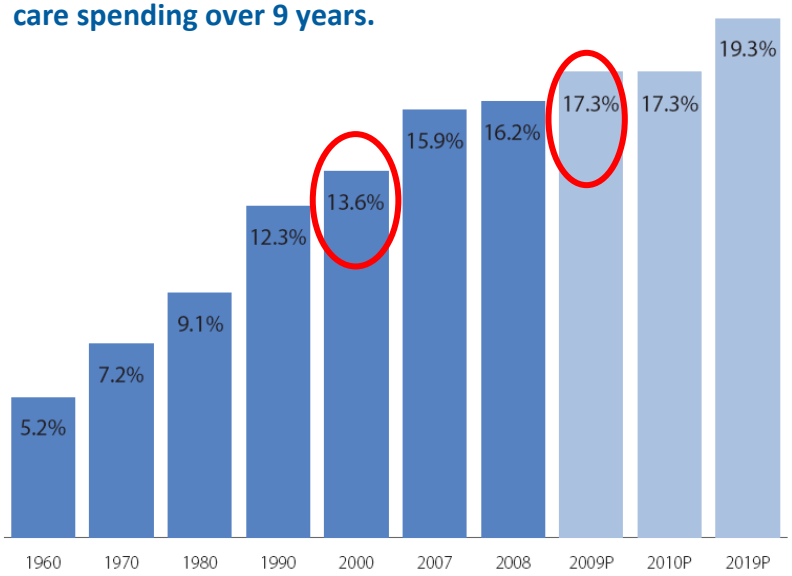
Health Care Reform

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.**



***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.**

AFFORDABLE CARE ACT

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

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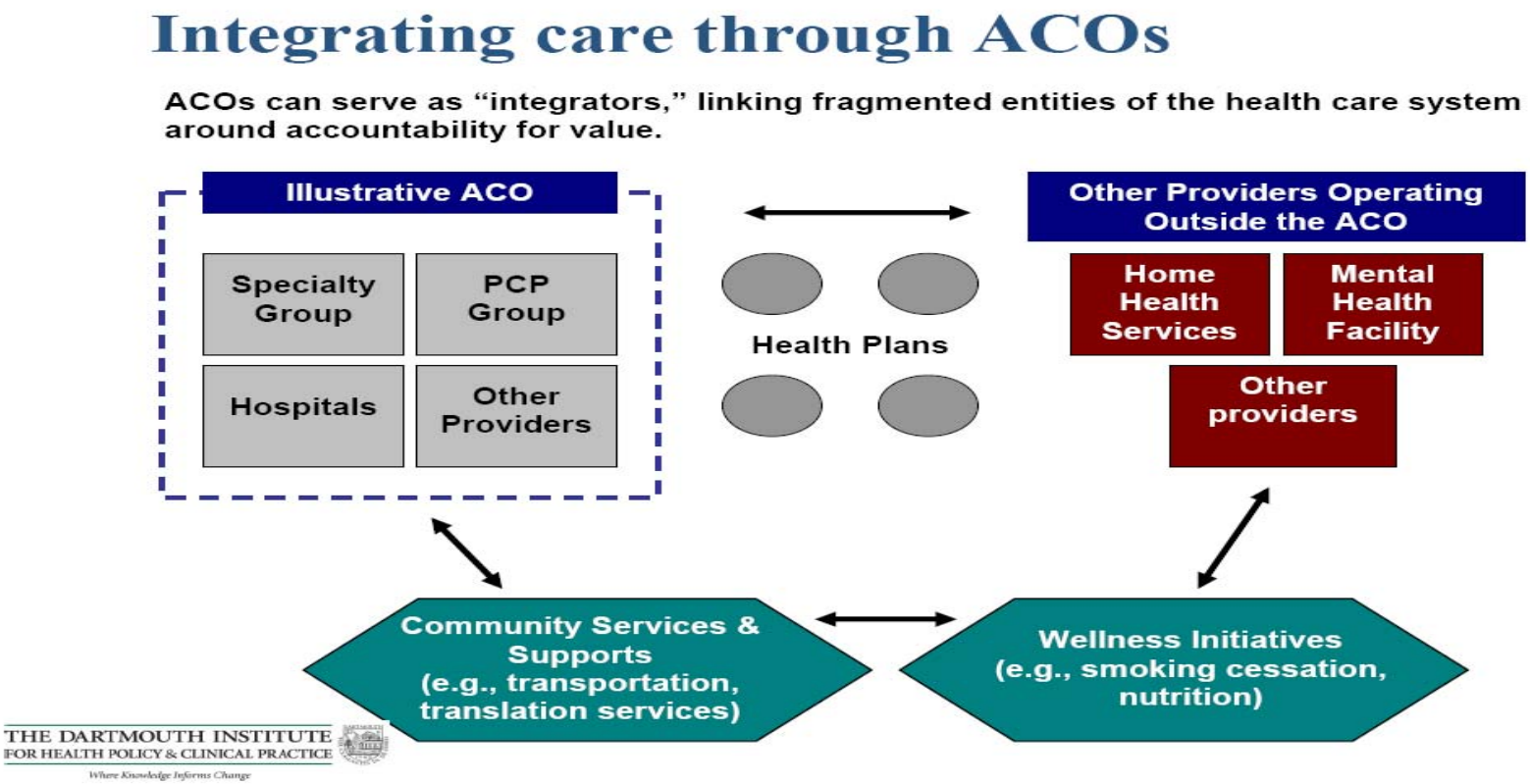
The goal of ACOs is to transform the current health care delivery system

Current System	ACO System
Fragmentation	Integration
Adversarial relationships	Cooperation
Focus on "doing"	Focus on managing a population
One-to-one care	Team-based care
Gatekeeper	System management
Perverse financial incentives	Aligned incentives
Focus on volume/intensity	Focus on ***quality*** and efficiency

Source: Brookings-Dartmouth ACO Pilot Project

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)



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

Understanding the ACO Provider Relationship

Source: Brookings-Dartmouth ACO Pilot Project

Community Providers not part of ACO but may provide care to ACO patient. Some community providers may contract with ACO or routinely receive referrals, while others may have no relationship (or be out of area).

ACO Providers: Members govern ACO and, if exclusive, have patients assigned to them. Other providers may join multiple ACOs.

Bonus-Eligible Providers: ACO prospectively sets eligibility and allocates shared savings. ACOs have discretion to pay bonuses to a subset or all ACO members, varying treatment and amounts (e.g., all PCPs could receive bonuses, while only some specialists might).

Early adopters of the ACO concept have the opportunity to shape the federal government's standards for ACOs going forward

Options for Payment Reform

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

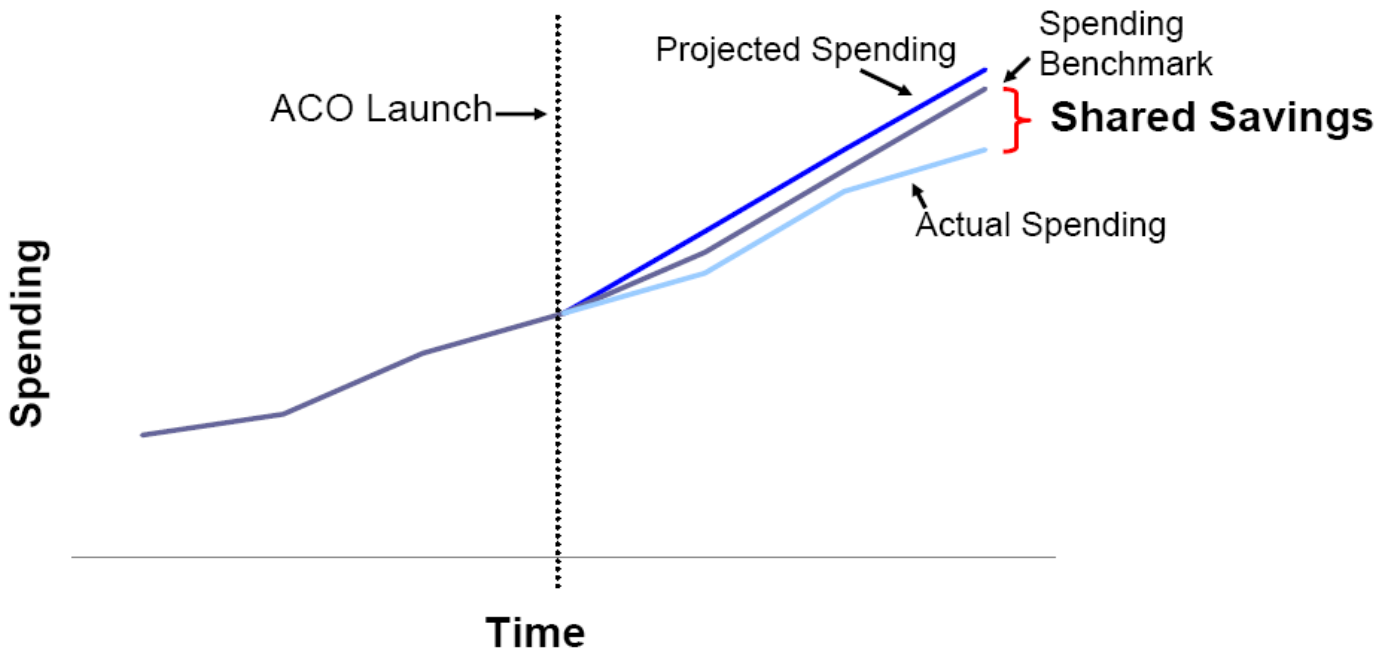
Source: Brookings-Dartmouth ACO Pilot Project

- ***QUALITY 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



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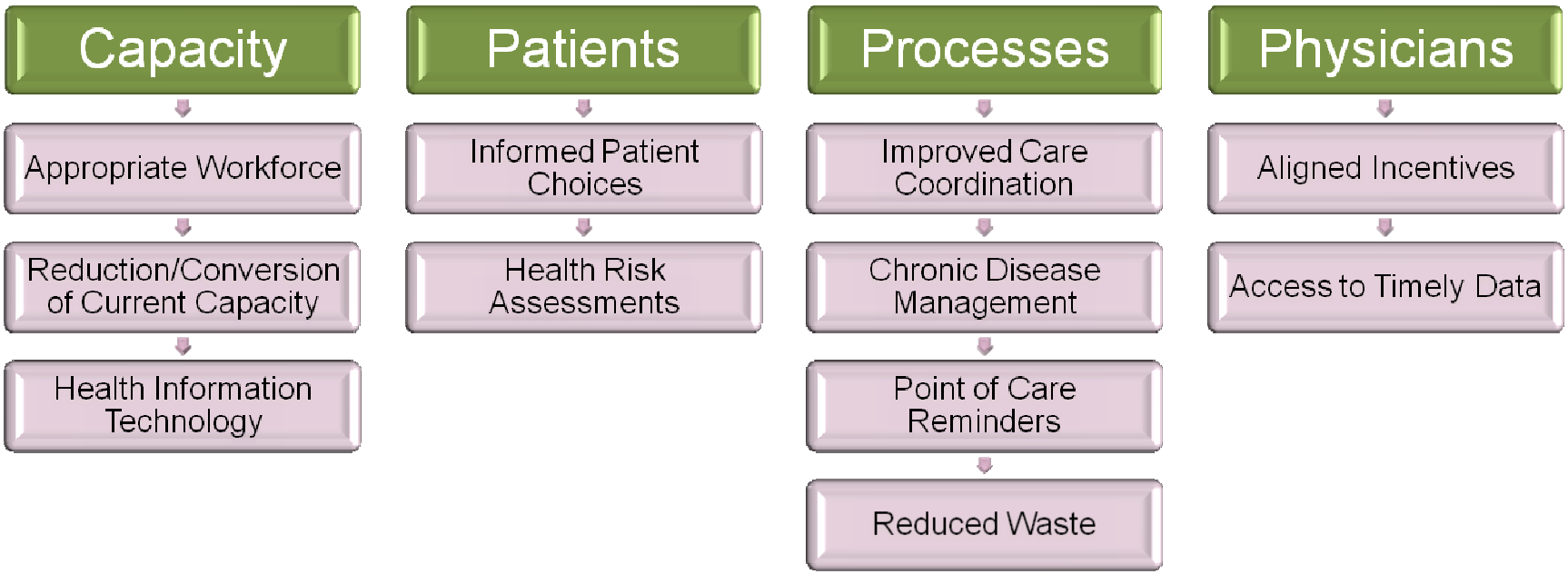
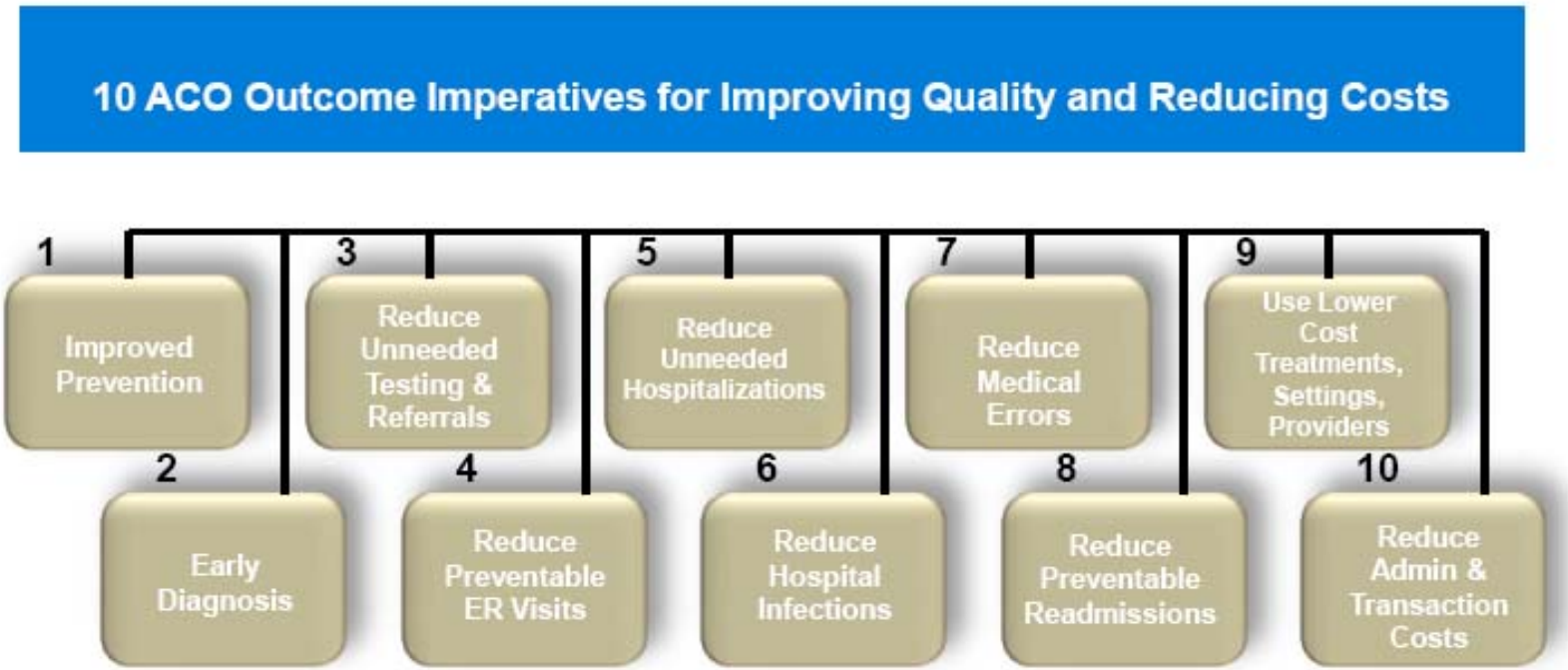
How Do ACOs Reduce Expenditures?

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



Source: Brookings-Dartmouth ACO Pilot Project

Examples of outcomes required to improve quality and reduce costs



Source: How to create Accountable Care Organizations, September 2009, Harold Miller, www.CHQPR.org

Dartmouth-Brookings ACO Pilots

Dartmouth Brookings ACO Pilot sites

Carilion Clinic Roanoke, VA	Norton Healthcare Louisville, KY	Tucson Medical Center Tucson, AZ
• ~900 Providers • 37,000 Medicare Patients Assigned	• ~400 Providers • 20,000 Medicare Patients Assigned	• ~80 Providers • 7,000 Medicare Patients Assigned

CALIFORNIA ACO

Monarch HealthCare Based in Irvine, CA	HealthCare Partners Based in Torrance, CA
• Medical Group & IPA • >800 PCPs • >2,500 contracted, independent physicians • ACO will cover Orange County	• Medical Group & IPA • >1,200 employed and affiliated PCPs • >3,000 employed and contracted specialists • ACO will cover LA County

Data Source: Brookings-Dartmouth ACO Pilot Project

Why pursue development of an ACO?

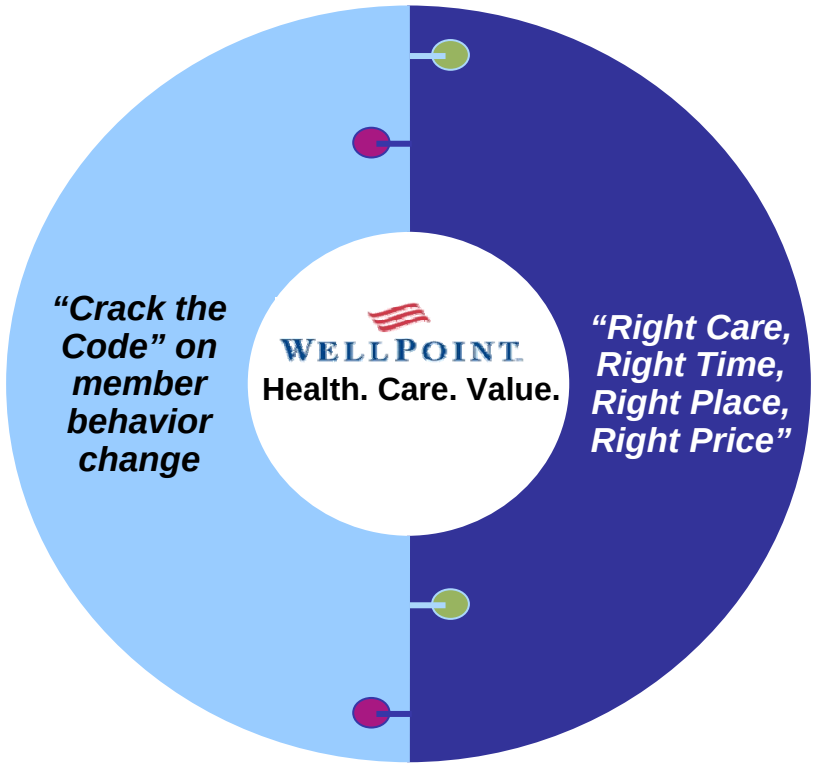
- Anthem is developing ACOs to respond to changes in U.S. health care flowing from the new federal health care reform law.
  - Improve the quality and coordination of health care;
  - Slow the growth of spending

- 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

Creating the best Health Care Value for our customers

Members

- Members are people, not numbers
- A personal, not population approach
- Reward healthy behaviors



Providers

- Pay for value over volume
- Steer members to high value care
- New models for care delivery

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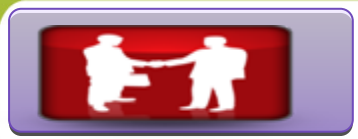
How is an ACO different from the HMO model?

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.

Lessons Learned

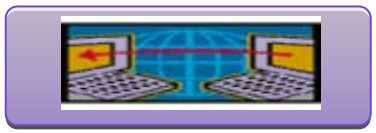


•**Dialogue:** initial step is beginning a dialogue with community physicians/ACO partners.

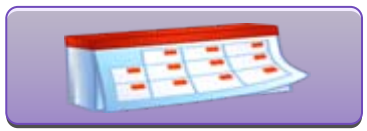
•**Align incentives:** quality improvement and cost reduction require careful discussions.

•**Resources:** carefully assessing the current environment and taking inventory of available resources and identify additional needs.

•**Transparency:** participants commit to the open sharing of performance data across the organization.



•**IT Development:** must involve the IT department early in the process to assure that it has the data and infrastructure needed to support integration.



•**Time:** requires substantial time and ongoing internal and external support.

•**Flexibility:** process of refining and improving ACO performance is ongoing. The ACO is a dynamic organization; Stakeholders must equipped to adapt and execute.

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The Obama Administration's Commitment to Accountable Care

"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

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Conclusion

"***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.

Questions