Advancing Accountable Care

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Agenda

1. Overview of national ACO Implementation: growing private and public sector activity
2. Discovering the unicorn: ACO fundamentals
3. Insights from ACO Learning Network members: Preparing for Medicare ACOs
4. Implementation through collaboration: Brookings-Dartmouth ACO Learning Network

Little formal ACO activity just two years ago

[Map showing ACO activity]
Early private-sector effort: Brookings-Dartmouth ACO pilot sites

<table>
<thead>
<tr>
<th></th>
<th>Payer partners</th>
<th>Downside риск</th>
<th>Other clinical transformation &amp; reform efforts</th>
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<tbody>
<tr>
<td>Norton Healthcare</td>
<td>B-D</td>
<td>Y 2</td>
<td>Electronic data feeds and dashboards; ambulatory care reminders; CER pilots</td>
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<tr>
<td>HealthCare Partners</td>
<td>B-D</td>
<td>Y 2</td>
<td>Homebound program; disease registries; MD incentives; care reminders</td>
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<tr>
<td>TMC Healthcare</td>
<td>B-D</td>
<td>Y 2</td>
<td>Level 6 (7) SHR capacity; 2nd year analytics and HIE platform; medical home</td>
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<tr>
<td>Marsh HealthCare</td>
<td>TBD</td>
<td>Y 1</td>
<td>SHR deployment in process; patient registries</td>
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<tr>
<td>Carilion Clinic</td>
<td>TBD</td>
<td>Y 2</td>
<td>Enterprise-wide SHR: P4P, outcome reporting; physician compensation</td>
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*All pilots plan to introduce downside risk within five years.

New momentum from the ACA Passage with the MSSP and ACO Pioneer Models

**Medicare Shared Savings Program**
- Two tracks offering shared savings to ACOs if cost and quality targets are met
- 33 quality measures spread over four domains: Patient/Community Experience, Care Coordination/Patient Safety, Preventive Health, and, At-Risk Populations
- CMS estimates up to 270 ACOs will participate between 2012 – 2015 resulting in $1.5 billion in shared savings payments to ACOs
- First round of applications submitted

**Pioneer ACO Model**
- 32 provider organizations across the country participating in the ACO Pioneer Model, offering accelerated tracks to more financial risk
  - Five different financial models all moving to population-based payments in year 3
- Pioneer Model is meant to inform future changes to the MSSP
### Commercial insurers also moving to accountable care arrangements

<table>
<thead>
<tr>
<th>Payers</th>
<th>Examples of Accountable Care Initiative</th>
<th>Early Results</th>
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<tbody>
<tr>
<td>CIGNA</td>
<td>Cigna Collaborative Accountable Care Initiatives: Engaged in nine accountable care programs including with a primary care practice, a multi-specialty group, and an IDS. Cigna plans to have approximately 30 ACOs launched by the end of 2011.</td>
<td>Reducing the FFS model with a modified global payment model linked to nationally recognized quality metrics.</td>
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<tr>
<td>BlueCross BlueShield of MA AQC: Twelve provider groups are replacing the FFS model with a modified global payment model tied to nationally-recognized quality metrics.</td>
<td>Downward trends in unnecessary visits and an improving medical cost trend.</td>
<td></td>
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<td>UnitedHealthcare</td>
<td>Engagement of community hospitals and low-volume physicians to improve the quality and efficiency of services.</td>
<td>Early Results Examples of Accountable Care Initiative - Reductions in readmission rates while the rates for the rest of the network have increased.</td>
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<tr>
<td>Aetna</td>
<td>Aetna ACOs: Implemented its ACO model in 36 primary care practices across the nation that focus on realigning incentives through shared savings and improving a care management process.</td>
<td>Findings indicate that the cost trend is below the national average while quality has remained high.</td>
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**Payers**

- 12 states passed accountable care legislation in 2011

**ACO implementation is now accelerating across the country**

*Upwards of 150 self-identified ACOs*
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Progression to more accountable payment: Pioneer ACO core payment model

Measuring and supporting better performance

- Core measures
  - Overview: Easily calculable through administrative data or existing patient survey systems
  - Health IT: Implementable without fully functioning and integrated EHRs (e.g., internal web portals, patient registries)
  - Sample Measures: breast cancer screening, hemoglobin A1c testing in patients with diabetes, patient and care giver experience of care, and total per-capita expenditures

- Interim process measures
  - Overview: Require clinical data on evidence-based care processes
  - Health IT: Expanded health IT capabilities from investments in electronic data systems and better access to clinical data
  - Sample Measures: drug therapy for lowering LDL cholesterol, beta-blocker therapy for left ventricular systolic dysfunction, and childhood immunization status

- Longitudinal & Advanced measures
  - Overview: Advanced, patient-reported measures that include functional outcomes and health risk assessment
  - Health IT: Advanced health IT capabilities that likely include an integrated and fully-functioning EHR system
  - Sample Measures: self-reported physical functioning in patients with heart failure, 10-year risk of developing hard CHD, and condition-specific outcome measures

Increasingly Sophisticated Measures Over Time
Wide variety of possible models for ACO implementation

<table>
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<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>
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<tr>
<td>Close 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 groups</td>
<td>Small physician practice working together as a company, 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>Grow eHealth mechanisms for coordinated care (sometimes managed through another partner)</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 governments</td>
</tr>
<tr>
<td>Aligned financial incentives, aligned health IT, EHRs, &amp; well-coordinated team-based care</td>
<td>Developed mechanisms for coordinated care</td>
<td>Many require strong management focused on clinical integration &amp; care management</td>
<td>Individual practices typically serve non-HMO clients or standalone basis</td>
<td>Sometimes in conjunction with health information exchanges or public reporting</td>
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<tr>
<td>E.g., Dartmouth Hitchcock</td>
<td>E.g., Marshfield Clinic</td>
<td>E.g., Tucson Medical Center</td>
<td>E.g., Mount Auburn P/H</td>
<td>E.g., NC-CCN</td>
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Glide path towards payment reforms that reward value

Payment reform is moving towards bundled payments and shared savings.

Multi-payer efforts critical to successful ACO formation

Successful ACOs should build support from private payers, states, and CMS.
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Insights from a Brookings-Dartmouth ACO Pilot Site

Arizona Connected Care (Tucson, AZ)

Commercial Payer-Partner: United Healthcare (Also has applied to the Medicare Shared Savings Program)
Legal entity: LLC
Governance: Hospital will have 30% representation and physicians will have 80%
Payment model: shared savings, no risk in years 1 & 2; transition to risk-bearing in year 3
Patient attribution model: Brookings-Dartmouth prospective method and United Healthcare PCMH Method
Performance measures: Brookings-Dartmouth 35 measures of quality and efficiency
ACO patient population: 23,000 PPO patients and 8,000 MA beneficiaries
ACO physician population: 55 PCPs, 35 specialists

Success factors:
1. Capability to care for a population
2. Effective health information technology
3. Performance Measurement Infrastructure
4. Ongoing learning: “It’s a process not a destination”

Core challenges:
1. Developing a care management infrastructure
2. Adjusting to a new paradigm for hospital care
3. Overcoming legal barriers
4. Engaging physicians

ACO LN Member Pioneer ACO Implementation Plan

Steward Health Care System (MA): “Value (quality, access, cost) is the new paradigm”

Population Identification and Stratification

Analyze population to identify patients health status and drive the most appropriate and effective care interventions

Tailored Care Interventions

Evidence based clinical pathways and protocols to define and deliver the most appropriate intervention for all patients based on their identified health status

Measure & Track Performance

Improve ability to measure population health to the patient level, disease/condition level and physician level

Optimize Care & Physician Communication

IT and communication infrastructure to enable improved care delivery

Patient Engagement

Primary prevention initiatives including cultural compatibility and community education outreach
### Key challenges for successful ACO implementation

<table>
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<tr>
<th>Challenges</th>
<th>Potential solutions</th>
<th>Required ACO Competencies</th>
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| Aligning multi-payer ACOs with other reform initiatives | - Develop a common set of performance measures with a pathway for more sophistication over time.  
- Create harmony between other payment and delivery system reforms.  
- Convene sufficient leadership support towards shared goals between payers and providers.  
- Develop a physician-supported implementation plan to identify costs and quality improvement opportunities.  
- Develop common frameworks and contract templates to reduce costs and uncertainty.  
- Analyze data to understand organizational performance and develop realistic start-up costs.  
- Promote transparency to accelerate learning. | 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 improvement and accountability.  
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 allowing teams comprised of providers to maintain health and prevent costly complications of chronic diseases and major procedures. |
| Catalyzing real leadership from providers & payers | | |
| Reducing start-up costs | | |

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### ACO Learning Network: implementation through collaboration

2009-2010 ACO Learning Network:
- Focused on defining core ACO concepts
- Included webinars, ACO materials, and conference discounts
- Included the release of our ACO Toolkit

2010-2011 ACO Learning Network:
- Shared lessons learned from ongoing examples of ACO implementation
- Identified best practices and strategies from ongoing ACO implementation efforts
- Provided in-depth analysis of emerging Federal and State regulation

2011-2012 ACO Learning Network:
- Focused peer-led work groups on key ACO challenges guided by technical experts and resulting in real actionable ACO implementation tools
- Continued analysis of emerging Federal and State regulation and National ACO trends

Conceptual Implementation
1. Overview and Key Principles of ACOs
2. Organization and Governance
3. Accountability for Performance (e.g. patient attribution, payment models, performance measurement)
4. ACO Infrastructure
5. Health Care Delivery Transformations for Achieving High-Value Health Care
6. Legal Issues for ACOs

Available at: http://www.acolearningnetwork.org/request-aco-toolkit

Overview of the 2011-12 Brookings-Dartmouth ACO Learning Network

Brookings-Dartmouth ACO Learning Network Services

- Enhanced ACO Implementation Webinars
- Member-Driven Conferences
- Implementation Work Groups
- Online Tools and Resources

Clinician-led implementation work groups to address core ACO challenges

- Implementing Performance Measures
- Accountable Care Payment Strategies
- Clinical Transformation
- High-Risk and Vulnerable Populations

Member informed decision-making tools to help ACOs make strategic investments to improve care & lower costs
Thank you

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