ACOs and the Role of the Community Clinics and Consortia

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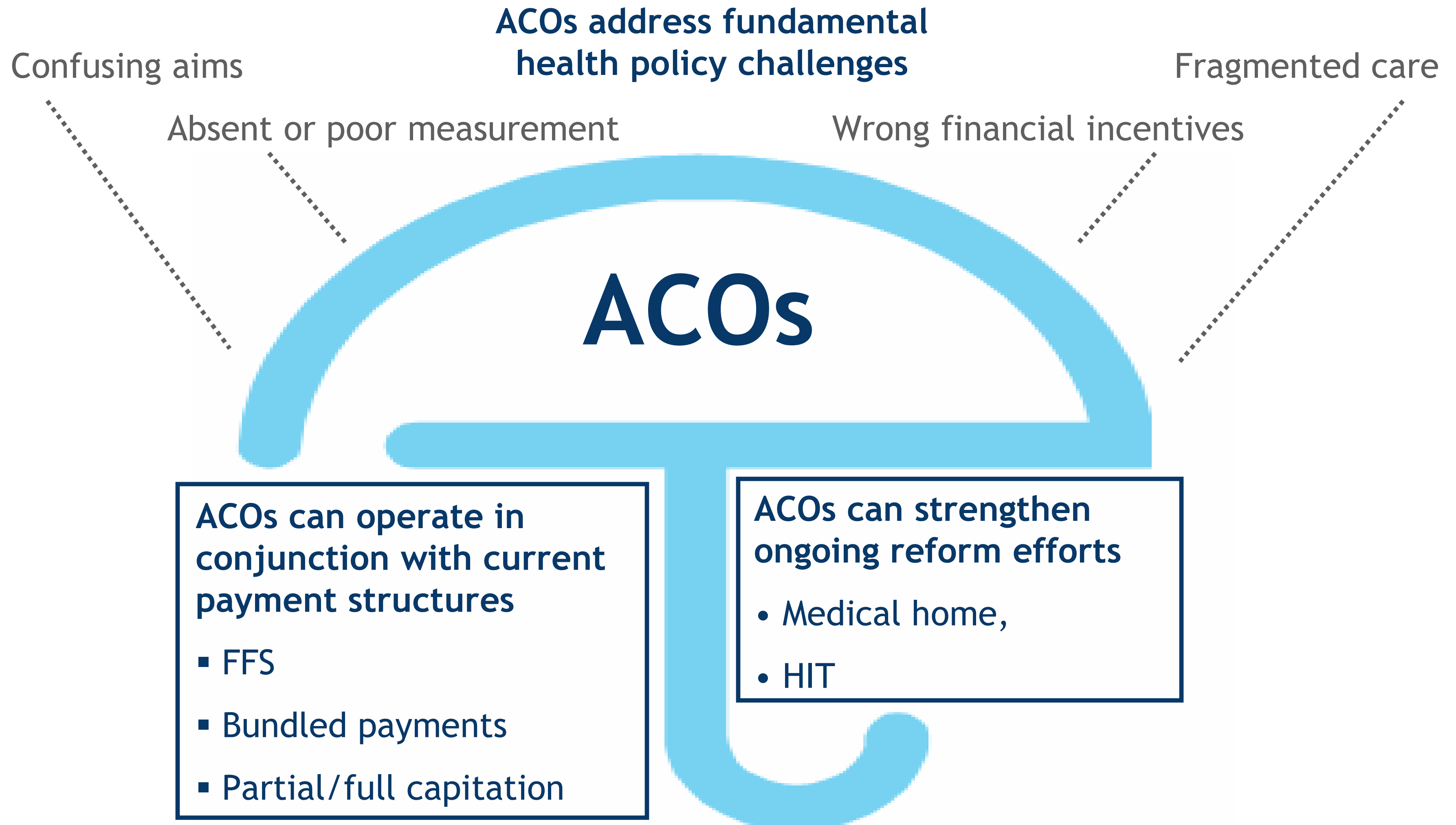
ACO Reform Consistent With Other Reforms



Accountability, “Systemness” & Incentives

Core Principles		Key Design Elements
Clarify aims to emphasize better health, better quality care, lower costs – for patients and communities		▪ Pay for better value – improved overall health while reducing costs for patients
Better information that engages physicians, supports improvement, and informs consumers		▪ Provide timely feedback to providers ▪ Require providers to report on utilization and quality
New model: It’s the system - Establish organizations accountable for aims and capable of redesigning practice and managing capacity		▪ Establish robust HIT infrastructure ▪ Implement cost-saving and quality-improving medical interventions ▪ Evaluate performance at the system level
Realign incentives – both financial and clinical – with aims		▪ Restructure payment incentives to support accountability for overall quality and costs across care settings

ACOs Differ But Share a Few, Key Elements

1	2	3
Can provide or manage continuum of care as a real or virtually integrated delivery system	Are of a sufficient size to support comprehensive performance measurement	Are capable of prospectively planning budgets and resource needs

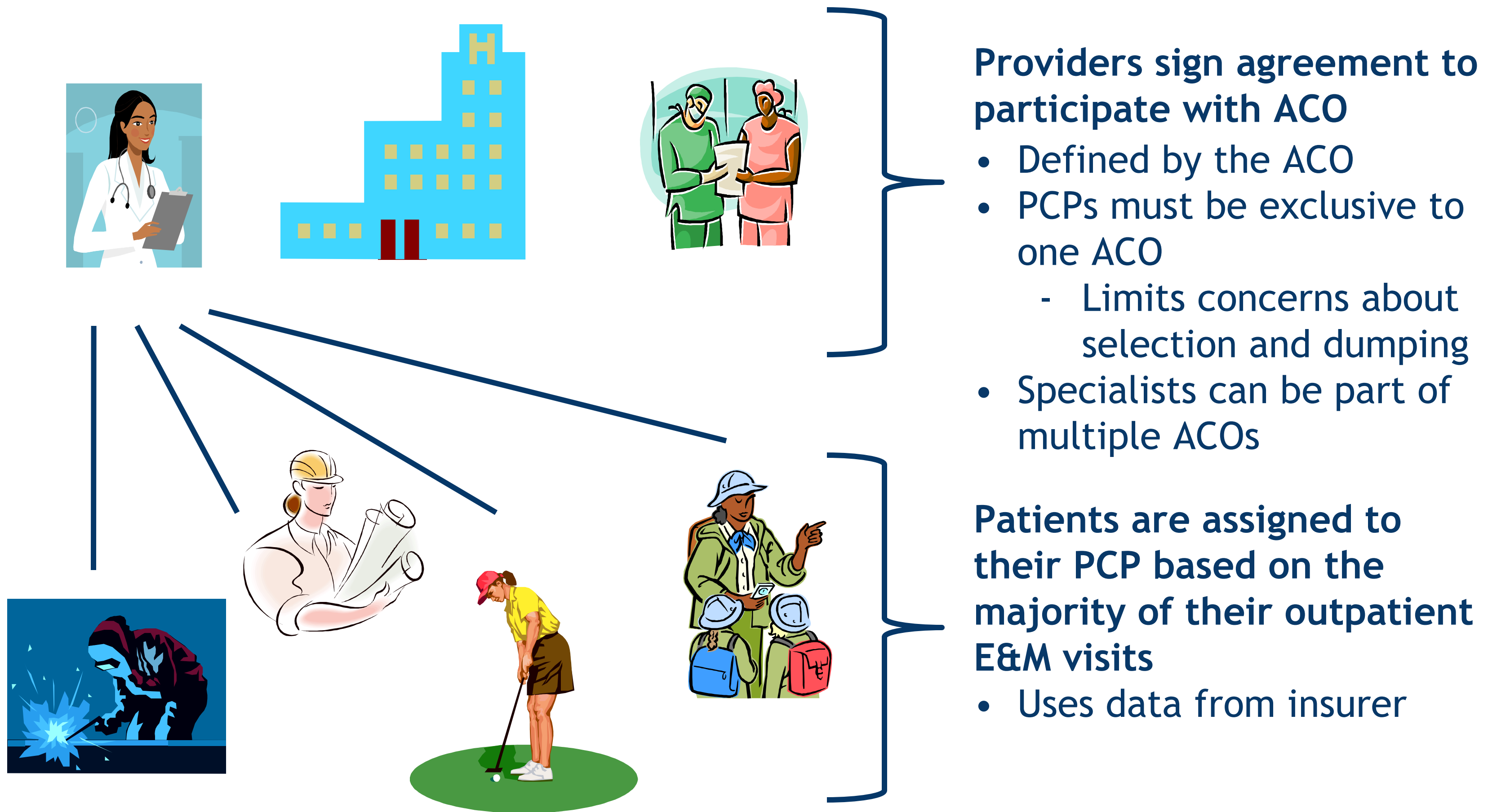
Important Caveats

- ACOs are not gatekeepers and don't have closed networks (e.g., HMO networks)
- ACOs do not require changes to benefit structures
- ACOs do not require patient enrollment

Payer/Provider Requirements

- Sharing savings between payers and providers if performance exceeds both financial and quality targets
- Set financial targets for assigned population based on historical spending and trend using a standardized actuarial methodology
- Use standardized attribution methodology to assign patients to providers exclusively affiliated with that ACO
- Ensure a minimum “risk pool” size to sustain meaningful measurement and acceptable statistical stability
  - e.g., 15,000 commercial, 10,000 Medicaid, or 5,000 Medicare patients
- Use a minimum common core set of quality measures (can add more)
- Provide data feeds to ACOs in a timely manner
- Work with providers on other steps to help the ACO in lowering costs and improving quality

How are Patients Assigned to the ACO?



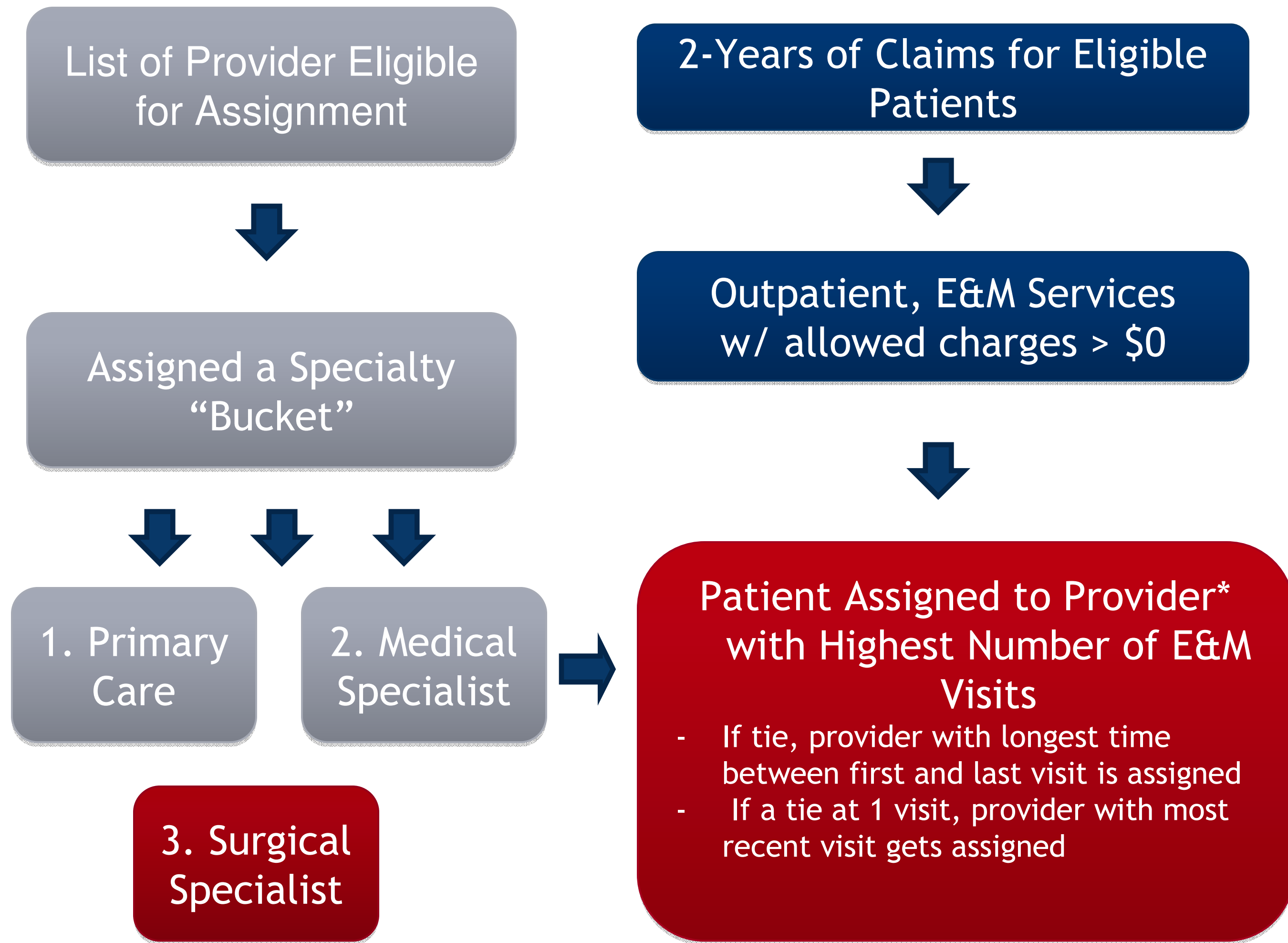
Providers sign agreement to participate with ACO

- Defined by the ACO
- PCPs must be exclusive to one ACO
  - Limits concerns about selection and dumping
- Specialists can be part of multiple ACOs

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

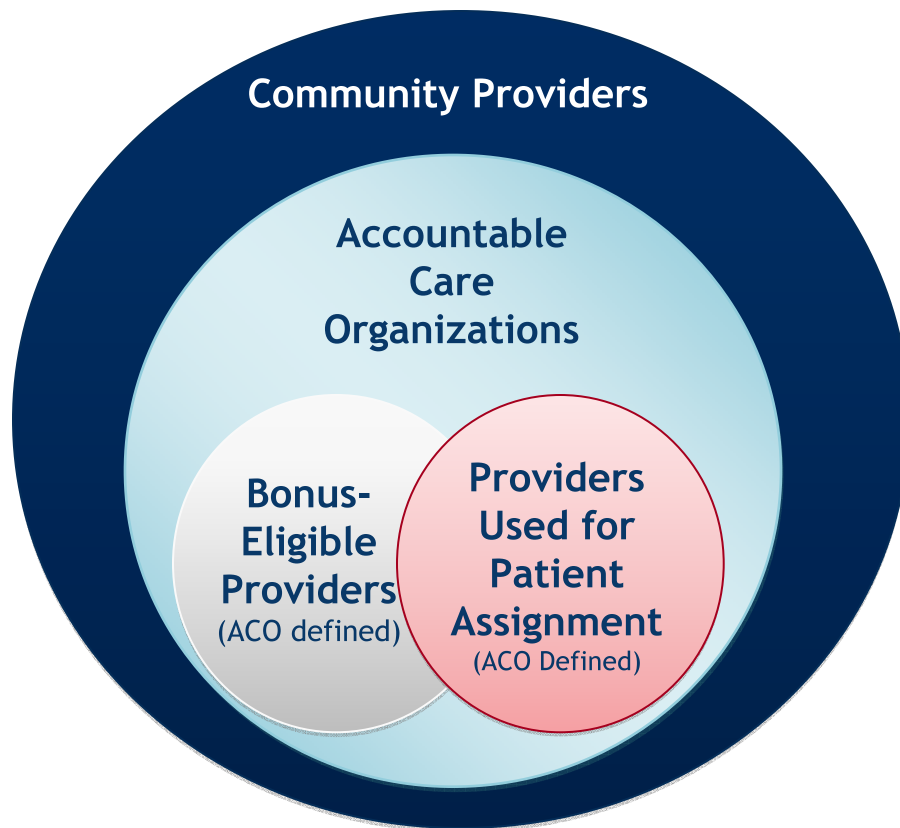
- Uses data from insurer

Patient Assignment Methodology



* PCP(1st), Medical Specialist(2nd), Surgical Specialist(3rd)

Understanding Provider Relationship



Community Providers are not part of the ACO, although they may provide care to ACO patient. Some community providers may have contractual relationships with the ACO or routinely receive referrals, while others may have no relationship with the ACO or be out of area.

ACO Providers: These providers are members of the ACO and, for physicians exclusive to the ACO, can have patients assigned to them. Providers not used for patient assignment may participate in multiple ACOs. ACO members have governance rights.

Bonus-Eligible Providers: Each ACO prospectively determines eligibility for and the allocation of shared savings to ACO members, which could range from a subset to all ACO members. The treatment of providers can vary (e.g., all PCPs could receive bonuses, while only some specialists might), and the amount of bonuses could also vary by provider.

Key Considerations for ACO Providers

- **Patients can only be attributed to providers who are members of one ACO**
  - Allowing patients to be assigned to providers participating in more than one ACO greatly complicates attribution and raises risk selection concerns
- **ACO Membership, Governance, and Referrals**
  - ACO members have governance rights
    - The ACO decides bonus allocation
  - Providers may direct referrals to ACO members and non-members
    - The ACO monitors utilization and can establish referral policies
- **Shared Savings (or Losses)**
  - Timely performance reporting essential for successful ACO
  - The ACO decides how to allocate shared savings bonus among its members
  - For ACOs selecting "symmetric risk" (level II), all ACO members would have fees cut if spending exceeds budget target

Performance Payment Framework

ACOs offer a wide range of 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

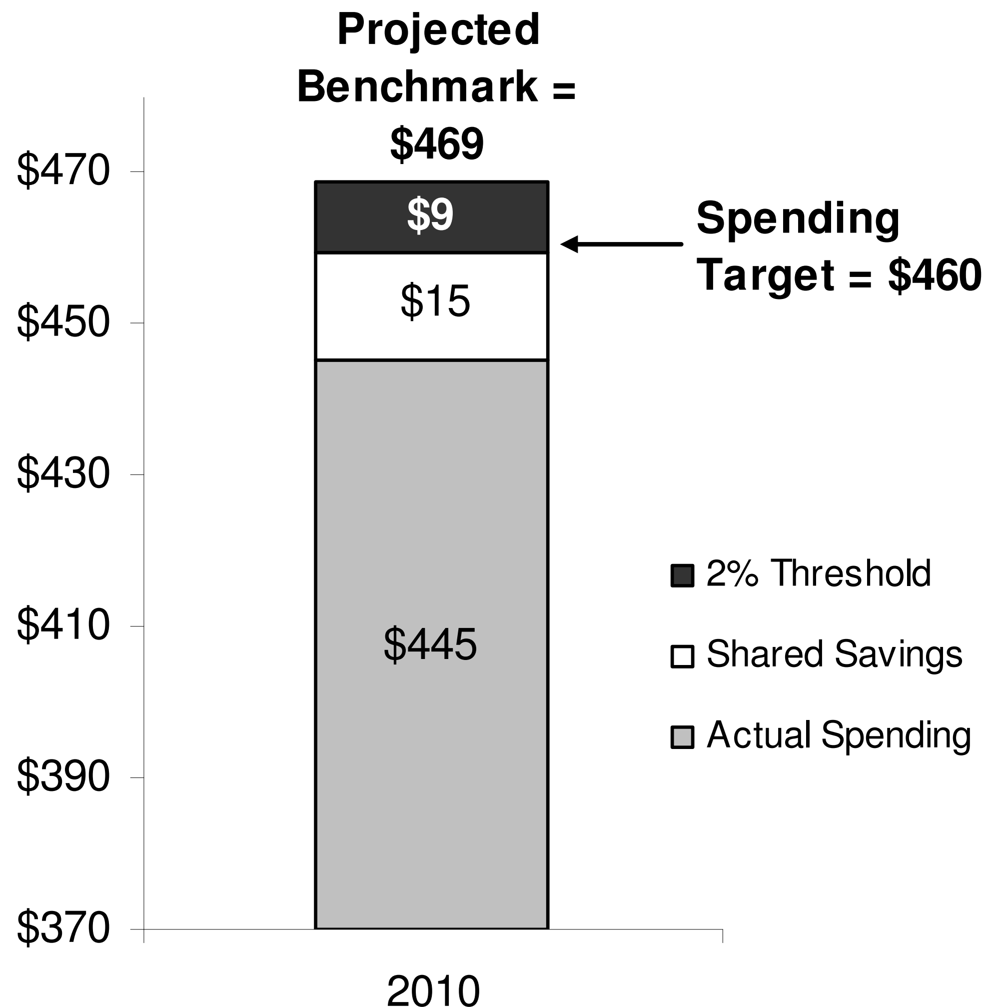
Level 2
Symmetric Model

- 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

Bonus Threshold Model (Asymmetric Model)

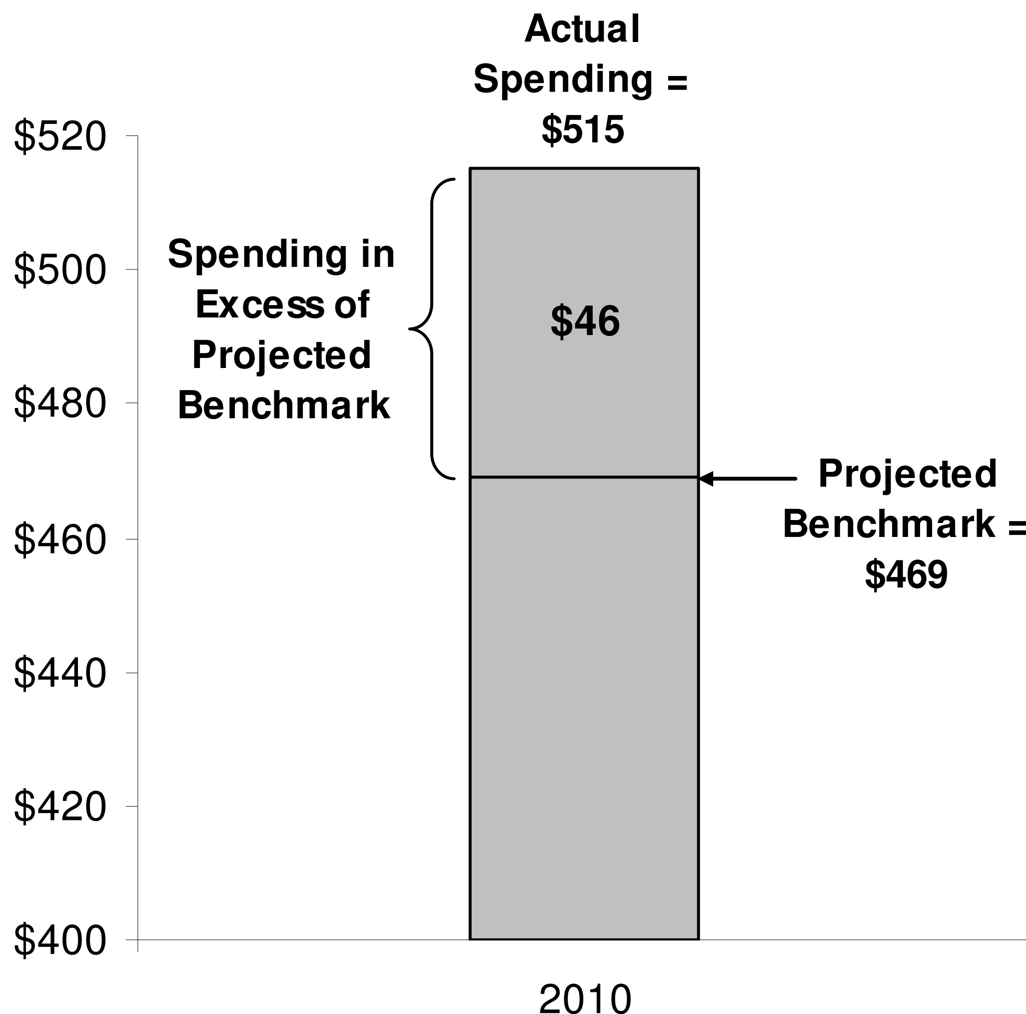


- Project benchmark ($469) in the performance period based on historical baseline data
- ACO reduced PMPM spending by 5% ($24) from benchmark.
- Exceeded 2% ($9) savings threshold resulting in $15 in shared savings
- If 50/50 shared savings, $7.50 (1.5%) would be distributed to ACO, with $7.50 to payer
- Note: No down-side risk if actual spending exceeds benchmark

Key Considerations for Spending Benchmarks

1. Setting expenditure target for ACO
2. Savings Threshold Necessary in Asymmetric Risk (no downside) model
   - Limits bonus payments for savings that happen by chance
3. Percentage of Savings to be Shared by Providers and Payers
   - Negotiated and influenced by type of risk, threshold, etc.
4. Symmetric or Asymmetric Risk
   - Asymmetric (One-Sided) Model
     - ACOs not at risk for any increased costs if actual spending exceeds benchmark amounts
     - ACOs share in savings if actual spending is below the benchmark spending
   - Symmetric (Two-Sided) Model
     - ACOs share in the costs if exceed benchmark spending amounts
     - ACOs may be eligible for greater, first-dollar savings than one-sided models
5. Start-up funding (to finance ACO infrastructure, etc.)

Bonus Withhold Model (Symmetric Model)



- ACOs could opt to have a threshold or not (benefit is access to first dollar of savings; tradeoff is risk of first dollar losses and statistical volatility)
- ACO shares downside risk
- May want to use “risk corridors”
- Assume ACO exceeded the benchmark by 10% ($46)
- Without risk corridors, ACO responsible for 80% of surplus/deficit ($37)
- With risk corridor, losses/ gains limited ($18, if limited to 80% of +/- 5%)

Meaningful Quality Measures

	Current	ACO Model	Impact
Level of Measurement	Individual	ACO (System-Level)	Reduces fragmentation and silos of practice; and, provides an assessment of care because many providers contribute to a patient's care over time.
Types of Measures	Process	Outcomes, Patient Experience, Efficiency	Better data for patients to make choices about providers better data for providers to make changes; Increased accountability for resource use.
Measurement Focus	Individual Provider Accountability for Process	Care Coordination, Shared Decision Making, Capacity Control	Organizational support for managing and improving care; better patient engagement
Provider Focus	Discrete Patient Encounters	Overall health of the population	Shared accountability for the continuum of care.

Beginning, Intermediate, and Advanced Measures

Over time, measures should address multiple priorities, be outcome-oriented, and span the continuum of care

Beginning	Intermediate	Advanced
• ACOs have access to medical, pharmacy, and laboratory claims from payers (claims-based measures) • Relatively limited health infrastructure • Limited to focusing on primary care services (starter set of measures)	• ACOs use specific clinical data (e.g., electronic laboratory results) and limited survey data • More sophisticated HIT infrastructure in place • Greater focus on full spectrum of care	• ACOs use more complete clinical data (e.g., electronic records, registries) and robust patient-generated data (e.g., Health Risk Appraisals, functional status) • Well-established and robust HIT infrastructure • Focus on full spectrum of care and health system priorities

Starter Set of Measures

Domain	Beginning Measures*
Overuse	Low back pain: use of imaging studies
	Appropriate Testing for Children With Pharyngitis
	Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis
	Appropriate treatment for children with upper respiratory infection (URI)
Population Health	Breast Cancer Screening
	Cervical Cancer Screening
	Colorectal Cancer Screening
	Diabetes: HbA1c Management (Testing)
	Diabetes: Cholesterol Management (Testing)
	Cholesterol Management for Patients with Cardiovascular Conditions (Testing)
	Use of appropriate medications for people with asthma
	Persistence of Beta-Blocker Treatment After a Heart Attack
Safety	Annual monitoring for patients on persistent medications
Care Coordination**	30-day all cause (risk-adjusted) readmission rate

* Most are HEDIS measures

** Test measure

ACOs with Community Clinics

- Need
  - In the context of health care reform
    - Must reduce cost from the status quo
    - Must increase Primary Care capacity for:
      - New MediCal enrollees
      - Newly insured subsidized private payer enrollees
- Timing
  - CMS is slated to start new Medicare and Medicaid ACOs on 1/1/12
    - Draft regs possible in late 2010
    - Possible selection of ACO sites by CMS (my guess) in early 2011
  - Health plans may need “new partners” to enroll new subsidized members on 1/1/14 (non-MediCal)
    - Are these new members currently served by Community Clinics?

ACOs with Community Clinics

- Possible ACO organization:
  - One or more Community Clinics to provide professional services:
    - Primary care teams
    - Some specialty services?
  - Specialist referral network?
  - Hospital partner?
  - Health plan partner?
    - For budget and quality measurement analytics
  - State of CA as a partner for MediCal members?

Key Challenges for ACOs

- Will "critical mass" of providers and clinics join?
  - Enough assigned patients?
  - Will there be a Clinic assignment for MediCal members?
- Will payers agree to participate?
  - Will MediCal partner with ACOs? Is it willing to do gain-sharing?
  - Will private payers join to serve newly insured subsidized enrollees?
- Are there enough savings to be found through ACO changes?
- Adequate financing for ACO start-up costs?
  - Infrastructure, IT, analysis, limiting ER use, etc.?
  - Foundation or health plan grants?
- Use of patient assignment algorithm for MediCal enrollees, and budgeting methodology?
  - "Good enough" to get started? How to improve?
  - Use assignment of MediCal members rather than attribution?
- Can ACOs change patient behavior & provider culture?
  - No enrollment, no "lock-in", no change in benefits?
- Roll of the ACO for overall community population health (e.g., for obesity, smoking cessation, vaccinations, etc.)

Why ACOs Might Succeed (Over Time)

- Broad, flexible system built on essential core principles
  - Lots of local variation possible within ACO concept
- 3 ACO Levels permit tailoring to different circumstances
  - Broadly applicable throughout the country, with "Training Wheels" for newly formed Level I ACOs
  - Level II offers more reward/more risk (but still limited)
  - Partial Capitation for highly sophisticated Level III entities, extending their model to FFS Medicare and PPOs
- Pathway to fundamentally shift incentives from FFS revenue centers to population health & accountable care
- Opportunity to change clinical and business environment
  - Timely data and analysis
  - Working collaboratively as part of a system of care