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HOW TO CREATE ACCOUNTABLE CARE ORGANIZATIONS

*EXECUTIVE
SUMMARY*

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How to Create Accountable Care Organizations

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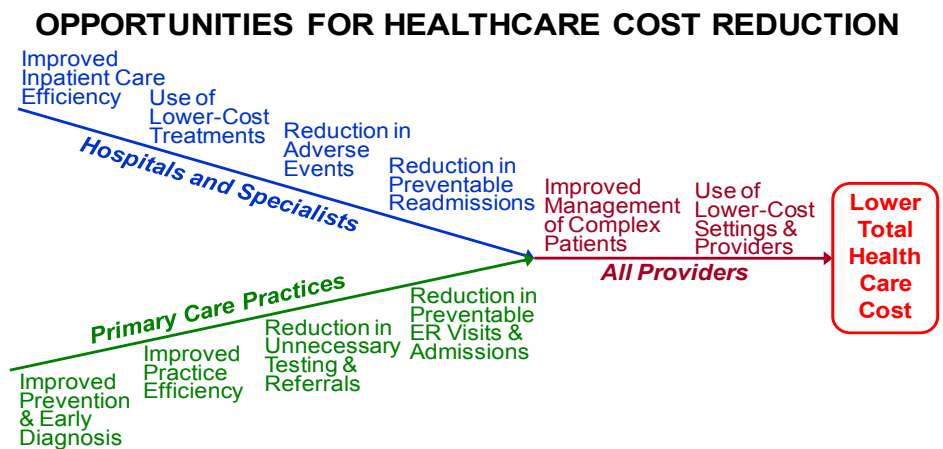
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EXECUTIVE SUMMARY

HOW TO CREATE ACCOUNTABLE CARE ORGANIZATIONS

WHAT WOULD ACCOUNTABLE CARE ORGANIZATIONS BE ACCOUNTABLE FOR, AND WHAT WOULD THEY DO DIFFERENTLY?

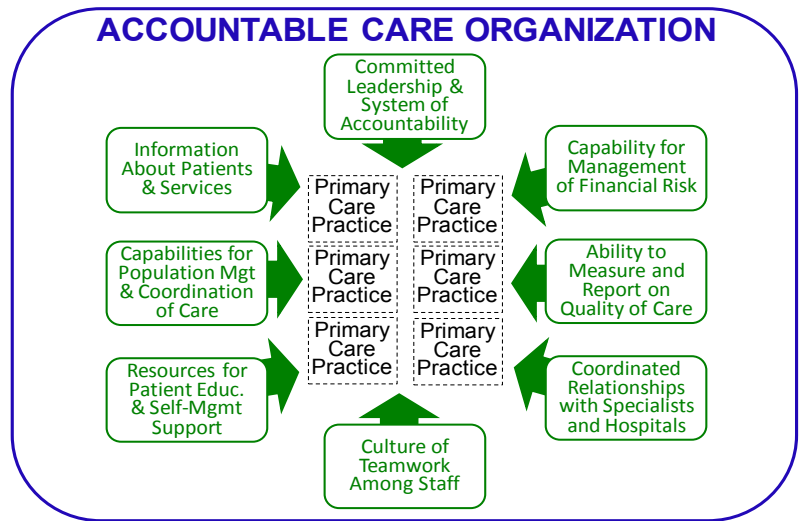
- The goal of Accountable Care Organizations should be to reduce, or at least control the growth of, healthcare costs while maintaining or improving the quality of care patients receive (in terms of both clinical quality and patient experience and satisfaction). There are many opportunities that exist for improving quality and reducing healthcare costs without the need to ration care. These include improved prevention and early diagnosis, reductions in unnecessary testing and referrals, reductions in preventable emergency room visits and hospitalizations, reductions in infections and adverse events in hospitals, reductions in preventable readmissions, and use of lower-cost treatments, settings, and providers.
- Although Accountable Care Organizations should accept greater accountability for reducing costs, they should not be expected to take on insurance risk, i.e., the risk associated with whether the patients who come to them are sick or well (unless they choose to do so). Insurance plans should continue to manage insurance risk, and Accountable Care Organizations should manage performance risk, i.e., the ability to successfully treat an illness in a cost-effective way.
- Accountable Care Organizations should not be expected to take responsibility immediately for all possible opportunities for cost reduction. They can be accountable for total costs and make significant impacts on those costs just by pursuing a subset of the many opportunities for cost reduction.



WHAT KINDS OF ORGANIZATIONS CAN SERVE AS ACCOUNTABLE CARE ORGANIZATIONS?

- To the maximum extent possible, an organization's ability to serve as an Accountable Care Organization should be determined by its success in improving outcomes – controlling costs, improving quality, and providing a good experience for patients – not on its organizational structure or even the specific care processes it uses. In the short run, since outcomes can only be known after the fact, some structural and process criteria are needed to define which organizations have the greatest probability of success.
- The core of an Accountable Care Organization is effective primary care. Although the majority of healthcare expenditures and increases in expenditures are associated with specialty and hospital care, some of the most important mechanisms for reducing and slowing the growth in specialty and hospital expenditures are prevention, early diagnosis, chronic disease management, and other tools which are delivered through primary care practices.
- In order for primary care practices to become an Accountable Care Organization, they will need to have at least eight things:
 - 1) Complete and timely information about patients and the services they are receiving;
 - 2) Technology and skills for population management and coordination of care;
 - 3) Adequate resources for patient education and self-management support;
 - 4) A culture of teamwork among the staff of the practice;
 - 5) Coordinated relationships with specialists and other providers;
 - 6) The ability to measure and report on the quality of care;
 - 7) Infrastructure and skills for management of financial risk;
 - 8) A commitment by the organization's leadership to improving value as a top priority, and a system of operational accountability to drive improved performance.

- Efforts to help primary care practices become more effective, such as the tools of Patient-Centered Medical Homes, the Chronic Care Model, etc., are helpful, but not sufficient. In order to create a successful Accountable Care Organization, primary care practices must add the capability to manage both cost and quality outcomes. Moreover, not all of the standards in current Medical Home accreditation programs may be necessary to success as an Accountable Care Organization.



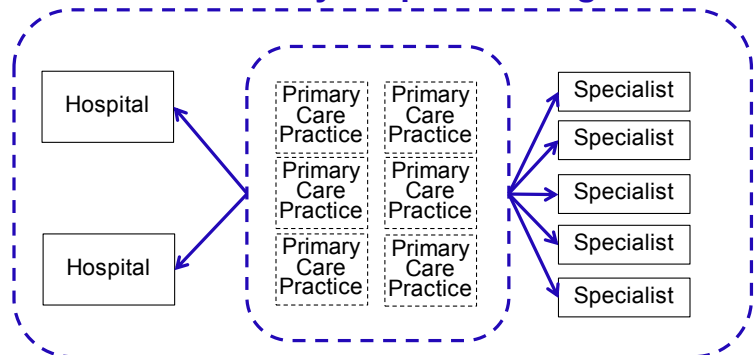
- Small primary care practices that work together through organizational mechanisms such as an Independent Practice Association (IPA) have a better ability to form an Accountable Care Organization if the number of participating physicians and their organizational structure gives them:

- 1) The ability to manage and coordinate patient care;
- 2) The ability to manage financial risk associated with the costs of patient care; and
- 3) The ability to measure cost and quality in a statistically valid way.

- It is undesirable to require or encourage all physicians in a geographic area to form a single Accountable Care Organization. Participation should be voluntary – based on a commitment to success. There are advantages to having multiple Accountable Care Organizations in a region, but also some additional challenges, and the best approach will vary from region to region.

- Specialists will continue to play an important role in patient care, but their roles relative to primary care will need to be rationalized and better coordinated, and the volume of referrals to specialists will need to decrease in most regions. Although an Accountable Care Organization will need to have effective working relationships with specialists, specialists do not necessarily need to be part of the Accountable Care Organization itself.

Accountable Care Requires Coordinated Relationships, Not Necessarily Corporate Integration



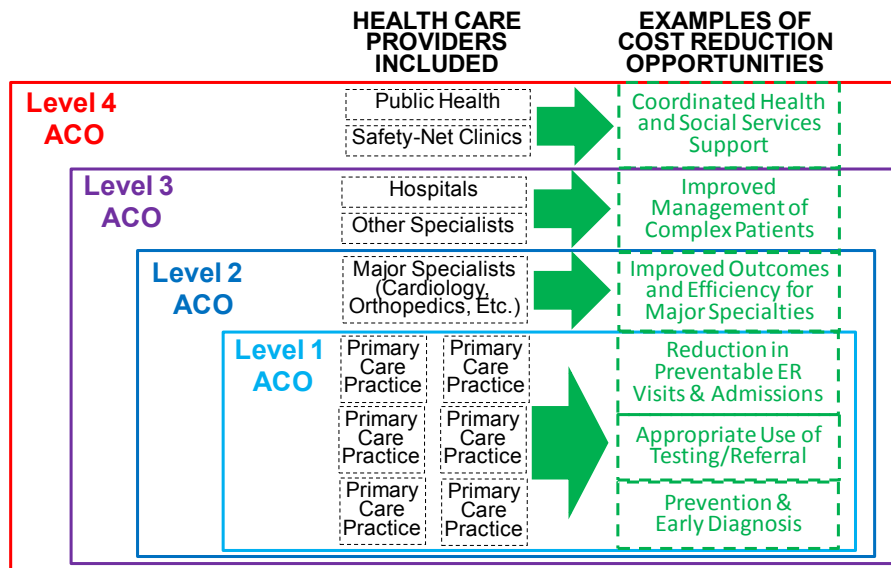
- It can be very advantageous to have a hospital included in an Accountable Care Organization if the hospital is committed to the goals of reducing total costs and improving quality. However, Accountable Care Organizations should not be *required* to include a hospital, since the interests of hospitals and physicians may be in conflict in the early stages of development of Accountable Care Organizations.

- Integrated Delivery Systems could serve as an ideal model for Accountable Care Organizations if they have true clinical integration and a commitment by their leadership to fulfill the vision of an Accountable Care Organization.

- Since providers in different parts of the country differ dramatically in terms of size, clinical and corporate integration, and skills in managing costs, there is no single definition of “Accountable Care Organization” that will work everywhere. Four different levels of Accountable Care Organizations (ACOs) should be considered:

- Level 1 ACO: Primary care practices functioning together through an IPA or other organizational mechanism and focusing on prevention and improvement of care for ambulatory care-sensitive conditions.
- Level 2 ACO: Primary care practices and frequently-used specialties, working together through an IPA or multi-specialty group practice, and focusing on prevention and improvement of care for ambulatory care-sensitive conditions and common specialty procedures.
- Level 3 ACO: Primary care practices, specialists, and hospitals, working together through an integrated delivery system or other organizational mechanism, and focusing on all or most opportunities for cost reduction and quality improvement.
- Level 4 ACO: Healthcare providers, public health agencies, and social service organizations working jointly to improve outcomes for a very broad patient population, including homeless individuals and the uninsured.

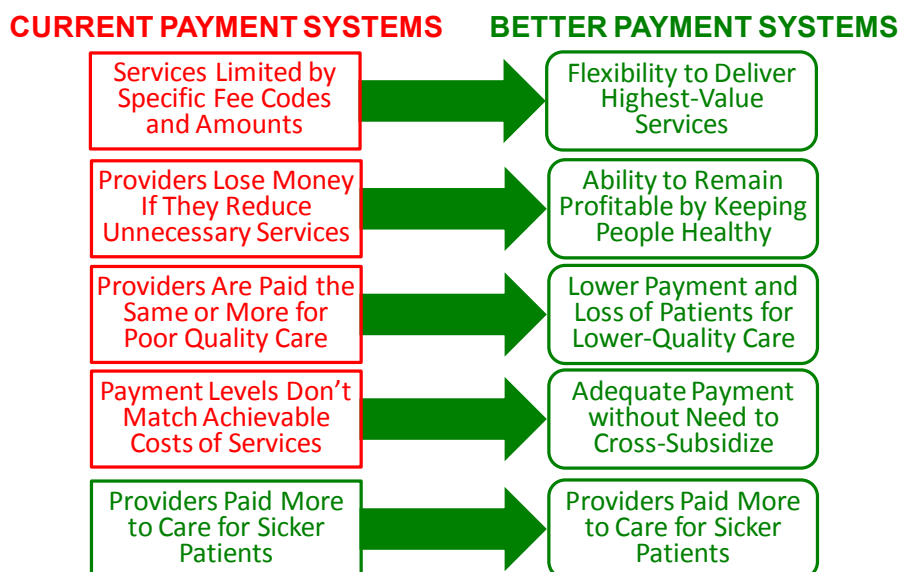
DIFFERENT FORMS OF ACCOUNTABLE CARE ORGANIZATIONS

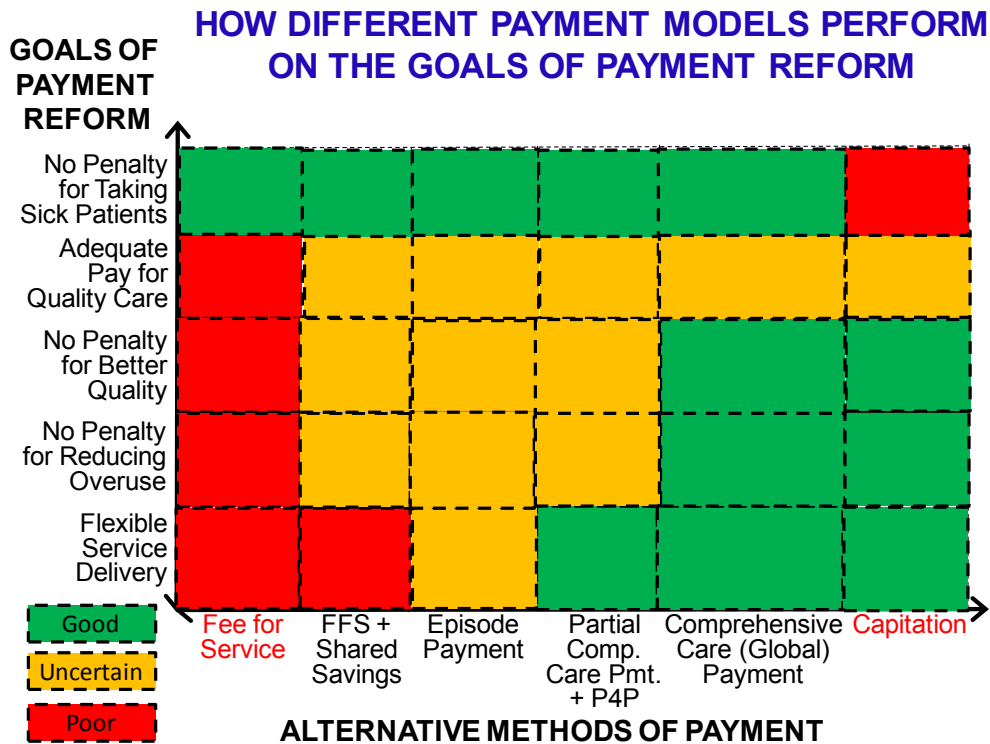


WHAT PAYMENT REFORMS ARE NEEDED TO SUPPORT ACCOUNTABLE CARE ORGANIZATIONS?

- Payment systems need to be changed significantly to support Accountable Care Organizations (ACOs). Payment reforms should achieve five goals:
 - 1) Provide the ACO with the flexibility to deliver the right services to patients in the right way at the right time;
 - 2) Enable the ACO to remain profitable if it keeps people healthier or reduces unnecessary services;
 - 3) Pay the ACO more for high-quality care than for low-quality care, and encourage patients to use higher-quality ACOs;
 - 4) Pay the ACO adequately, but not excessively, to cover the costs of the services it provides for all of its patients; and
 - 5) Avoid penalizing the ACO for caring for sicker patients (unless the sickness was caused by the ACO itself).
- Offering arbitrarily defined “shared savings” to an ACO is not sufficient to encourage the formation of ACOs and to enable ACOs to truly transform the way they deliver care. To be effective, shared savings would need to be based on net savings (including unreimbursed costs of changes in care delivery) and combined with other payment changes.
- A properly-structured Comprehensive Care Payment (or global payment) system can achieve all of the goals of payment reform, as long as it is structured so as to avoid the problems of traditional capitation payment systems.
- Episode-of-Care Payment can serve as both a transitional payment reform and as an important long-run component of an overall payment system.
- Hybrid payment models (e.g., partial comprehensive care payments with bonuses and penalties based on savings and quality) can also be used as a transitional payment reform.
- In addition to implementing new payment *methods*, effective mechanisms for setting appropriate payment *levels* will also be needed. The appropriate mechanisms will vary from region to region and provider to provider, depending on the structure of local healthcare markets.

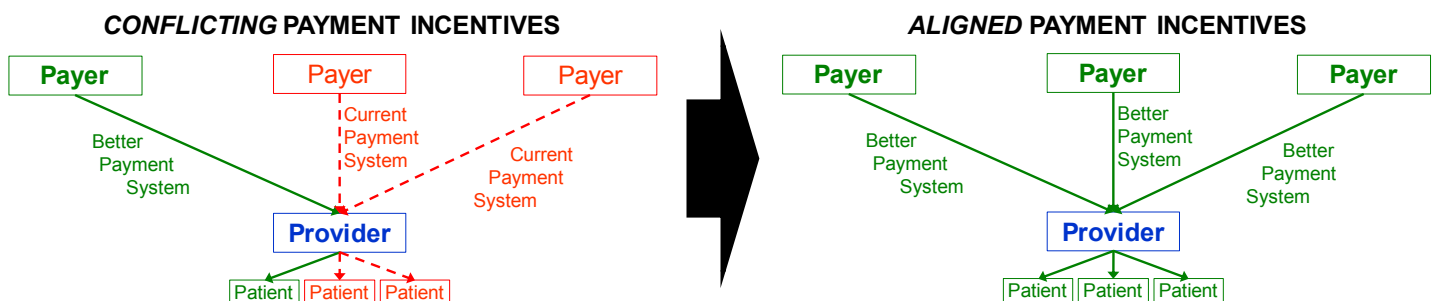
GOALS OF PAYMENT REFORM





WHAT SHOULD COMMUNITIES DO TO ENCOURAGE AND SUPPORT THE DEVELOPMENT OF ACCOUNTABLE CARE ORGANIZATIONS?

- Comparable changes in payment systems should be made by all payers, but as a minimum, changes need to be made by the payers that provide health insurance coverage for a majority of an Accountable Care Organization’s patients so that the ACO has the resources and ability to change the way it cares for all patients. Medicare needs to have the flexibility to change its payment systems to match the changes local payers make.
- The outcomes and measures of success for Accountable Care Organizations should be defined by the community they serve, rather than by individual payers. States, Regional Health Improvement Collaboratives, large payers, and consortiums of payers can play a key role in building consensus among payers and providers on what the standards for success should be and on the appropriate transitional paths.
- It is critical to build support among consumers and patients for changes in care delivery and payment, and to have consumers actively engaged in achieving the desired outcomes, rather than trying to hold Accountable Care Organizations solely accountable for improving quality and reducing costs without adequate patient support and involvement.
- Other changes in laws and policy would be helpful in encouraging and supporting Accountable Care Organizations, such as malpractice reform, changes in accreditation processes, and modifications to anti-trust laws and gain-sharing laws.



HOW CAN THE TRANSITION TO ACCOUNTABLE CARE ORGANIZATIONS BE FACILITATED?

- It is unreasonable to expect healthcare providers in most parts of the country to successfully accept full accountability for costs and quality quickly or in a single step. Transitional approaches will be needed.
- Support should be made available to willing providers to help them get started, including coaching and technical assistance, information on their current costs and quality, shared services for improved care management, financial resources to support changes in care, and financial modeling to help in taking on financial risk.
- A multi-year process for transitioning to full accountability should be used, such as focusing initially on subgroups of patients and subsets of costs. Measures of success should be based on absolute standards of performance, relative performance compared to other providers, and improvement relative to a provider's own baseline.
- Special attention should be given to underserved communities and consumers to ensure they participate in and benefit from improved care delivery.
- Payment changes should also transition over time in ways that support the transitional changes in care processes. Since initial payments will be based on the fee-for-service system, reforms to the current fee-for-service system, particularly its support for primary care, should be a high priority.
- Medicare should encourage and participate in regionally defined Accountable Care Organization initiatives by waiving Medicare requirements and changing payment rules to match what other major payers in the region, including commercial payers and Medicaid, are doing.

MEDICARE SHOULD PARTICIPATE IN PAYMENT AND DELIVERY SYSTEM REFORMS INITIATED BY STATES AND REGIONAL HEALTH IMPROVEMENT COLLABORATIVES



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