



Reviewing the Landscape and Defining the Core Competencies Needed for a Successful Accountable Care Organization

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Chapter 1 – Introduction

This paper defines the core competencies needed to develop and implement an Accountable Care Organization (ACO), based on the current available knowledge about how ACOs will operate.

The analysis will first look at what issues within the healthcare industry are driving the development of this model. The three main areas that will be addressed are a focus on the individual provider, lack of coordination of care and disease management.

A definition of the ACO model will follow, along with an assessment of how the model will address these issues. This section will focus on the vision for the ACO model, potential structures, and how the payment model will function.

Challenges the model will encounter will then be addressed. These will be assessed from the perspective of the respective stakeholders (hospitals, physicians and consumers), as well as challenges related to payments, the impact of federal and state laws, and challenges to the overall, long-term viability of the model.

Next, a handful of current ACO initiatives will be reviewed. This will look at information related to federal legislation, initiatives occurring in different states, and an overview of the work being done by The Accountable Care Organization Learning Network, a joint initiative of the Brookings Institution and the Dartmouth Institute for Health Policy and Clinical Practice, which is operating a pilot program for ACOs.

This will be followed by recommended steps for facilitating the development of the model and the payment system for the model, along with the potential issues in the implementation of ACOs. This analysis will largely focus on the implementation of ACOs who are contracting with private payers, and not Medicare, though the process for developing a Medicare ACO should be similar.

The white paper analysis will conclude with a list and explanation of the core competencies needed to successfully develop and implement an ACO.

Chapter 2 - Issues with Current System

There are three, somewhat overlapping issues that are driving change in healthcare towards a more accountable, quality-oriented, and cost-effective model:

Focus on the Individual Provider

Monitoring and payment systems in today's healthcare environment focus on the individual provider. Because care is focused on the individual provider, there is poor coordination of care, and the transitioning of consumers between providers leads to significant gaps in quality.

These gaps in quality are best demonstrated by Medicare spending, which can vary up to 300% within different regions of the United States while showing no tangible benefit in quality for the higher-spending regions. Utilization of medical services is ever-increasing, largely due to a fee-for-service payment system that inadequately provides incentive to the individual provider for minimizing cost, leading to increasing waste and cost. This fee-for-service system leads to consumers being moved through practices at a quicker pace in order to generate more volume, and takes away any incentive to manage disease by coordinating correct delivery of care.

Lack of Coordination of Care

With multiple providers located in different settings, all given incentive to generate volume and order the most expensive treatments possible, coordination of care suffers. Lack of adoption of the requisite information technology is also an issue. This lack of coordination of care results in poor diagnoses, unnecessary and redundant treatments and higher admission rates, but is a financial boon to the providers on a fee-for-service model.

Lack of Disease Management

Seventy-five percent of all US healthcare spending is for the management of chronic diseases related to COPD, congestive heart failure, depression and diabetes. Lack of management of these conditions can lead to such cost-increasing events as hospitalization or readmission, ER visits, ICU usage, excessive ancillary usage and over-medication.

The Accountable Care Organization is gaining traction as a realistic model for addressing these issues and others. ACOs help ensure providers are adequately compensated while utilization is decreased. And the quality measures help ensure patient care is not negatively impacted.

Chapter 3 – What is an ACO?

Vision

Goals

An Accountable Care Organization (ACO) can have numerous and varying definitions. At its highest level, the vision for it would be a provider-centric organization which focuses on **three** main goals for a specific population of consumers:

- **Reducing Cost** – through enhanced preventative care and disease management which will result in reduced preventable readmissions and other avoidable usage of hospital or ambulatory services; as well as creating economies of scale and avoiding the duplication of services that currently exists in today's industry.
- **Improving Quality** – through coordination of care and the existence of quality-related, rather than volume-related, incentive programs, as well as defining best practices through experience and evidence-based medicine.
- **Developing Skills and Resources** – to meet the cost and quality goals in the present and future as the healthcare industry moves forward.

For an ACO, these goals will be applied to a group of consumers who are assigned to that ACO. While these consumer populations will usually be broad and cover a wide range of demographic bases, there may be opportunities for more specialized ACOs that focus on specific demographic subgroups in the future.

In addition to these consumer-focused goals, the ACO will also need to focus on three additional administrative-related goals, which are:

- **Developing Information Technology Infrastructure** – to track data related to quality and cost within that consumer population, and to collect and mine clinical and claims data to develop support for evidence-based protocols within the ACO, as well as assist in the overall coordination of care.
- **Developing Payer Contracting Strategy** – to ensure the ACO is properly reimbursed for care that it is managing, as well as making sure the performance standards for each payer don't create an administrative burden for the collection of data related to those standards.
- **Allocating Payments** – Developing the ability to accept and appropriately allocate some form of capitated payment or incentive payments from a payer or multiple payers related to the care of that consumer population and the associated cost of that care.

ACOs vs. HMOs

Previous models, such as HMOs have attempted to do this very same thing. However, ACOs differ from HMOs on several key points:

- HMOs relied on insurance companies to provide accountability for patient care. Under the ACO model, quality and efficiency will be more in the hands of the providers.
- An ACO will be able to directly contract with a large, self-insured payer or payers regarding the quality and cost goals for which it will be responsible; whereas, HMOs had the added cost of being the middle-man between the consumers and the providers.
- The provider arrangement for ACOs will be much more flexible than under an HMO.

Structure

Delivery System

At its most basic model, an ACO only needs to have primary care physicians, possibly a hospital and some level of specialty care. However, any type of provider or provider organization can theoretically join, such as health systems, physician groups, ambulatory care centers (surgical or medical), post-acute care providers, and federally qualified health centers, among others. The providers at these organizations will need to be supported by personnel resources such as care managers and discharge planners, to provide some of the needed resources to track patient data related to the coordination of care.

It seems unlikely that many primary care-only ACOs will be formed. The administrative burden in terms of cost and time will likely be too great. In addition, the specialty care that will inevitably be a part of a patient's care will have to either be contracted with or paid for by the ACO, creating another barrier.

Whatever the provider component of the ACO, it will need to develop a legal entity for those providers. That entity, to the legal extent necessary, will need to be clinically and financially integrated to allow for joint contracting under federal anti-trust laws.

Any number of existing models, or a hybrid of these models, may serve as the provider entity for the ACO. Ultimately, the arrangement will depend on local needs and resources. Some of the existing models which might be considered include:

Independent Practice Associations (IPAs) – A group of independent physicians or a contractor of independent physicians that can jointly contract with payers.

Physician Hospital Organizations (PHOs) – Similar to an IPA, but includes one or more hospitals along with physicians, and shares some of the hospital's administrative capabilities with the physician practices in that group.

Multispecialty Groups (MSGs) – Practices with primary care and some specialty physicians.

Hospital Medical Staff Organizations – Medical staff of a hospital, including non-physician, licensed, professionals that provide patient care, which is responsible for the quality of services offered to the hospital's patients.

Integrated Delivery Systems – A system of providers contracting with other providers and/or purchasing other providers, negotiating contracts for services with one another, and/or forming legal affiliations as a group.

Extended Hospital Medical Staff – A "virtual" model in which the practices that are most closely connected to an acute care hospital, even if they are non-affiliated, are defined as "extended staff."

These models will almost certainly change going forward. Many of them are comprised of loosely affiliated physicians and were created out of self-preservation rather than as a pro-active shift in healthcare delivery. Whatever type of provider arrangement model is used, it must be a legal entity which is actuarially stable (if accepting risk), which is clinically integrated, and which has or can acquire the ability to collect and report performance data.

Large health systems with a large primary care base and multiple disciplines are well-positioned for the ACO model. Smaller hospitals and/or independent physician practices may need assistance with the administrative responsibilities required, and will require time to work through a transition phase. These responsibilities will include:

- Addressing changes in the payment mechanism
- Establishing formal financial and organizational structures to support internal governance
- Integrating the delivery of care
- Developing and establishing clinical guidelines
- Providing for utilization analysis and risk management
- Measuring group and individual performance measurement
- Overseeing quality improvement
- Other activities specific to that ACO

Measurement of Performance

Paramount for an ACO is the ability to manage performance effectively and as efficiently as possible. In creating an efficient monitoring system for performance measurement, the following considerations should be taken:

- A single “quality of care” measure does not exist. It is likely, especially in the developmental phase of ACOs, that individual payers will use multiple quality measures. This will add to the expense and difficulty as ACOs create systems to measure performance.
- For the performance data collected to be statistically valid, a statistically significant amount of data must be collected and measured against the different quality measures. However, if different payers use different quality measures, the population that applies to each of the separate measures will be reduced. For an ACO to develop a statistically significant baseline for expected costs from three-plus years of historical data, experts recommend a patient base of at least 5,000 Medicare patients or 15,000 privately insured patients.
- Similarly, errors and/or incomplete records in data systems can suggest problems within the delivery system that do not exist, or hide problems that do exist.
- Safeguards must be put into place to make sure performance measurements are risk-adjusted for patient acuity levels and other risk factors, so that providers are not incented to avoid patients that may negatively impact their performance measures.
- Most systems in place now that measure performance do so from fee-for-service billings, and only measure service utilization. The measurement of quality requires full implementation of EHR systems. It will be important to consider the effect of the transition to EHR when establishing performance criteria.
- When measuring performance benchmarks, the ACO will have to establish at what level its member providers will be compensated for reaching a quality goal. The ACO may require that a threshold be hit (e.g. 90% of patients given X) or they may judge their providers’ performance against one another (e.g. must be in top 25th percentile of providers in giving patients X).

While these are not all of the considerations that need to be taken into account, these issues, at a minimum, must be addressed when developing a performance measurement system.

Payment Models

While ACO pilots are just now under way to test the payment systems that will accompany this new model, some conclusions can be drawn about what types of payments can be expected. Different types of payments will likely be used to address both cost and quality.

Addressing Cost

To address cost, one of two approaches will be taken:

1. Some form of shared savings arrangement, in which a fee-for-service model will still be used, but will be supplemented with a bonus for keeping costs for the consumer population below a previously determined benchmark. While easier to implement than a capitated payment model, this model will face challenges. It asks physicians to forgo the safety of a fee-for-service payment based on volume generated by that physician's practice for the promise of an incentive payment based on quality and cost goals being met by a network of physicians, whom the physician may or may not trust to meet those goals. This will likely be the first step for most ACOs, as it represents the smallest departure from the status quo, and has the least amount of risk for the providers; albeit with the lowest reward. This is the type of payment system any eventual Medicare ACO payments will likely be structured as.
2. Some form of a modified or full-risk capitation. This type of payment will remove the incentives to generate volume that a fee-for-service system creates, while rewarding providers for improving health and avoiding unnecessary services. These payments will have to be risk-adjusted so as not to provide a disincentive for treating consumers with greater health risks.

Addressing Quality

To further address quality, an incentive payment for reaching certain thresholds or a disincentive for not meeting thresholds will have to be used. An ACO could earn incentive payments by reporting yearly on quality indicators, clinical processes, consumer satisfaction, utilization, cost, and outcomes. These quality goals will serve as a supplement to the cost goals in the ACO, and will provide a check against the inadequate provision of services for the patient.

The Center for Medicare and Medicaid Services will be responsible for developing federal payment guidelines, but individual private payers will develop their own guidelines for payments and incentives for quality.

Chapter 4 - Challenges

Hospitals

Financial Pressures

ACOs present a potential risk to hospitals, as the ACO goal of reducing utilization is in opposition to the hospital's business model. Also changes in payment structure to adjust for this may lag behind decreases in revenue for the hospital. This will result in a need for hospitals to focus on lean management and other techniques for reducing cost and waste while maintaining quality.

Lack of Primary Care Physicians

Currently, approximately 31% of U.S. physicians practice primary care, while only 25% of current medical school residents are training in primary care. Should the ACO model succeed the demand for physicians in primary care is going to explode, creating gaps in coverage and straining providers to meet the need for primary care physicians. Primary care physicians will be relied upon to do the heavy lifting in regards to controlling costs, mainly through preventative care, early diagnosis of disease, and disease management. With primary care already in short supply in terms of manpower throughout most of the country, the additional demands from ACO-related activities will be difficult to meet.

Provider groups looking to form ACOs should be aware of their primary care needs. In addition, these groups should consider expanding their use of mid-level providers and other physician extenders to create additional primary care capacity within their network.

One potential ray of hope for primary care is, in the long-term, the types of payments associated with this model should allow ACOs to increase primary care compensation through quality and cost incentives, which will in turn drive more young physicians into the specialty. However, this will not be a quick change, and in the interim, ACOs should make other plans to fill their primary care needs.

Physicians

Culture

The ability of physicians to change their professional behavior will be one of the biggest keys to the success or failure of ACOs. Successfully meeting the cost and quality criteria within an ACO will require a cultural shift away from the professional autonomy and individual responsibility by which most physicians operate.

Competing Incentives

No matter the setup of an ACO, physicians will be presented with competing incentives related to their compensation. Under a shared savings arrangement, which uses a fee-for-service model, the physician will have to choose between receiving a more certain payment for producing volume, or a less-certain, but potentially higher, payment for improving quality and reducing utilization. A capitated payment will provide better alignment of incentives; however, it is unlikely that all of a physician's patients will be part of the same ACO, thus creating the same volume vs. cost/quality questions. In addition, the practice management systems that most physicians have are designed to track fee-for-service related data, and have limited ability to measure the type of data needed for cost and quality measurement. The cost and resources needed for retooling and relearning these systems will provide a disincentive for the physicians to embrace an ACO.

Independence

While larger physician groups or vertically-integrated hospitals and health systems are set up well to begin developing an ACO, there are significant difficulties for independent physicians.

First, a group of small, independent providers would have a hard time developing a large enough consumer base to generate statistically significant comparisons of cost and quality data. As stated earlier, the Dartmouth Center for Health Policy has noted that a Medicare ACO would require 5,000 lives to meet the thresholds needed to generate significant data. This 5,000 Medicare patient threshold would eliminate most independent primary care practices in most states, and would necessitate multiple groups joining together to form the ACO. Without a hospital or larger partner, this could create very cumbersome administrative duties.

Second, the risk to independent physicians of a new reimbursement model that increases financial risk is a major roadblock. In addition, these smaller practices generally do not have the capability to review historical data and determine improvement opportunities.

Consumers

Perception of Level of Care

Managing the consumers' perceptions of, and satisfaction with, their care is another challenge that will be faced by ACOs. Above all, consumers will likely pushback against the implementation of an ACO if they feel that their choice in providers or services is being restricted, or if they believe the change to an ACO will result in their receiving less care or "budget" care. Consumer dissatisfaction with care under the HMO model will likely transfer over to the ACO model until the consumer understands that their choice will not be limited and they will still receive the same, or better, level of care as before.

Health Management

In addition, consumer education about health management will become more important than ever, as ACOs strive to improve disease management and prevent avoidable inpatient admissions, ER usage, and other services that will negatively impact ACO performance.

Long-Term Sustainability

What Happens as Waste is Removed from the System?

Physicians' financial incentives must be aligned with the ACO's long-term goals of removing over-utilization of services, and to increasing the quality of patient care. However, this creates a paradox, as the model, if successful, will negatively impact most of the provider incentives that the ACO's payment model is designed to create.

However, it is also likely that as information technology capabilities increase, and physician culture changes, a new host of issues that an ACO will be equipped to manage will come to the forefront, and provide new incentive targets for the ACO's payment model. These incentives might be structured around improvement in clinical outcomes, regardless of cost-impact, or for holding future expected cost increases below expected levels.

Payments

Inappropriate Payment Levels

For many of the services delivered by providers, current payer fee schedules are not based on actual cost data. Most payer rates are based on some percentage of Medicare, which itself is fraught with numerous over and underpayment issues. As ACOs contract with payers, there is some danger in these payment issues being carried forward.

Along the same lines, overpayments for some procedures potentially have affected past utilization of those procedures in order to drive up profitable volume. This scenario will create an unrealistic historical picture of what utilization is appropriate.

A further challenge will be adapting payments over time to accommodate more expensive treatments, ushered in by advancements in technology and drugs that are proven to provide better, albeit more expensive, care.

Allocating Payments

Allocating payments will also be a challenge. Within an ACO model, providers will face different readmission and other cost-inflating risks for treating patients with different acuity levels. In addition, as the ACO is able to prevent some readmissions, ER care, etc., the historical, pre-ACO, cost structure will become less and less relevant. Over time, higher value services will draw more volume, while previous high-margin but lower-value services lose volume. This will result in an ongoing adjustment of payment allocations to ACO participants, to make sure providers do not fall into financial distress due to a shift in services.

Additionally, there are some services over which the ACOs will have limited cost-control, and therefore will make allocating the payment received by that ACO difficult.

If, for instance, in a smaller community there is only one radiation oncology or anesthesiology group which is not part of the ACO, the ACO will be somewhat at the mercy of that group's prices. That could reduce the share of the payment made to other providers. In this situation, it will be up to the physicians participating in the ACO to bring those service's costs under control through peer pressure and other mechanisms.

Another possible situation is that a consumer might seek services outside of his or her ACO, but the ACO will still be responsible for coordinating that patient's care and paying that provider for its services. In this case, a disproportionate share of the payment may go to the out-of-ACO provider. The patient's insurance benefit design will be an important measure for keeping as much of that patient's care within the ACO as possible.

Length of Payment Contracts

Administrative costs for the startup of an ACO are significant, and will require a substantial capital investment. Thus, contracts for payments should be encouraged to be longer rather than shorter, in order to encourage the ACO to make the appropriate investment in preventative care, which, in the long-term, will be best for the ACO and the payer.

Coordination of Payers and ACO in Developing a Multi-Payer Agreement

The administrative tasks related to collecting and reporting cost and quality data against pre-determined benchmarks will be an arduous task for an ACO. If the ACO's contracts with payers call for multiple sets of data to be collected and reported in order to determine compensation, the ACO may be overwhelmed administratively or financially by the complexity of such reporting.

Risk Adjustment

Unlike the capitation system used in the 1990s, the modified capitation payment structure used for payments to ACOs should provide an adjusted payment based upon insurance risk and differing acuity. Without some sort of insurance risk adjustment, providers will be punished for treating higher-acuity patients while seeking out lower acuity ones.

Impact of Federal and State Laws

Several federal and state laws have applications to ACO formation and operations. These are briefly discussed below:

Anti-Trust Laws

Federal anti-trust laws prohibit separate and competing providers from conspiring together to negotiate contracts for payment when they are not to some extent clinically or financially integrated. Any attempt to do so by providers who have not developed a formal legal structure may be construed as price-fixing. While all the providers in the ACO do not have to be in the same practice or same hospital, having a separate legal entity which focuses on quality measures within the network is likely one way of meeting anti-trust scrutiny (*HSG does not provide legal advice, please seek the advice of qualified legal counsel related to this information*). To meet clinical integration criteria, an ACO must engage in data collection and analysis while providing management services to, as well as oversight of, provider practices. With these criteria in place, an ACO will likely be able to negotiate with payers on behalf of the network without any anti-trust issues.

STARK (Anti-Fraud) and Anti-Kickback Laws

STARK laws potentially come into play with providers in an ACO referring to any “designated health services (DHS)” within the ACO. There has been little guidance from the OIG in terms of what quality and pay for performance arrangements can legally be done to make sure no anti-fraud or anti-kickback statutes are triggered by the formation of an ACO. Similar to the federal level, many states have their own anti-kickback laws which will potentially impact the ability to distribute payments among a group of providers.

Reserve Requirement Laws

For risk-bearing entities, in some states, reserve requirements must be met. This may potentially limit initial efforts for self-insured clients.

CHAPTER 5: Current ACO Initiatives

Federal Initiatives

Accountable Care initiatives are happening at the federal level, with both the House and the Senate including language in their respective versions of healthcare legislation recognizing ACOs as a tool for transforming the way healthcare operates within the United States.

The final version of the Patient Protection and Affordability Act (PPAC) makes limited references to ACOs under “Section 10307 Improvements to the Medicare Shared Savings Program.” Past versions of the legislation have referenced ACOs and related systems in more depth, with a focus on the following:

1. Expanding quality measure reporting for physicians and other providers
2. Paying for hospital performance on quality measures
3. Testing for patient-focused delivery and payment models through CMS
4. Development of a national quality improvement strategy related to patient care and delivery
5. An acknowledgement of the need for a formal legal structure that would allow distribution of incentive payments to the participants of an ACO
6. Through a pilot program, testing bundled payments for providers across the continuum of care
7. Disincentives in Medicare payments for preventable readmission

State Initiatives

Many states, in either public, private or a public/private partnership, have developed or are developing ACO-related initiatives. The following are anecdotal accounts of news items related to these efforts:

In New Jersey, Robert Wood Johnson (RWJ) is developing an academic-health-center-related ACO with 100-150 primary care practices that have received level-1 recognition in the National Committee for Quality Assurance's (NCQA) Patient-Centered Medical Home recognition program. This ACO will focus on integrating with the hospital's inpatient hospitalist service to reduce length-of-stay, increase efficiency, reduce redundancy and unnecessary procedures, and develop the feedback process to primary care physicians.

In Vermont, the state is performing ACO pilots, and is scheduled to expand to an increased number of pilot sites in 2010. The savings gained from this program will be reinvested in the state's network of community hospitals.

In Massachusetts, a task force has recommended moving completely away from Fee-for-Service and moving towards implementing a global payment system, with similar goals to an ACO.

In Pittsburgh, the Pittsburgh Regional Health Initiative (PRHI) is developing pilot programs for the clinical side of an ACO, while bypassing the legal and revenue-sharing questions that accompany the development of an ACO. PRHI will work with payers to develop quality and cost data that will be used to measure the effectiveness of the ACO, and will focus on just the chronic conditions that are most often the cause of readmissions to the hospital: CHF, COPD, Depression, etc. They hope to use these results to demonstrate the effectiveness of the arrangement, not only to other providers, but to commercial payers who would benefit from a reduction in readmissions.

In Texas, the Baylor Healthcare System is attempting to move its 13 hospitals and 4500+ physicians to an ACO-type structure by 2015.

In Nebraska, the Nebraska Medical Center and Methodist Health System are creating an "Accountable Care Alliance," where the focus will be to share best practices of each of the hospitals to reduce costs and increase quality and efficiency.

In New Hampshire, the state has created a "Health Services Cost Review" Commission that will review and approve or disapprove hospital rates and rate schedules, assess and tax hospital income, and most relevantly, will be required by law to promote new systems of payment and structures of care like Medical Homes and ACOs.

Brookings-Dartmouth Institute

The Accountable Care Organization Learning Network, a joint initiative of the Brookings Institution and the Dartmouth Institute for Health Policy and Clinical Practice, has developed an ACO Pilot Project, with the goal of creating a replicable model for ACOs.

The three institutions involved are Carilion Clinic in Roanoke, VA, Norton Healthcare in Louisville, KY and Tucson Medical Center in Tucson, AZ.

Carilion Clinic is a seven-hospital system that has a goal of being a “physician-centered” organization, rather than a hospital that employs physicians. Carilion will use its own databases to identify historical spend rates for its consumer populations and then set a target cost reduction goal. Patient care will be coordinated through its’ EHR system and inpatient hospitalist service.

Carilion also will be operating a Medicare Advantage Plan, under the name Carilion Clinic Medicare Health Plan, which will offer a range of plan designs. The goals of the plan will be similar to that of the ACO, with increased wellness and preventative care that should lead to quality outcomes and cost reductions.

Norton Healthcare is a five-hospital system, with almost 1400 staffed beds, and 400 employed providers. Thirty percent of the system’s physicians are employed by Norton. Of this provider base, 149 of its PCPs, along with 35 nurse practitioners and 109 specialists will be participating in the ACO pilot.

While Norton has significant experience in the back-office administrative functions required for an ACO, they will have to collaborate with other organizations to develop the predictive modeling functions needed to create realistic payment models and incentives. Norton is using a steering committee to guide this process, with involvement from clinical leadership, their board of trustees, and management. Humana is also participating with Norton in this ACO pilot.

Tucson Medical Center is a 676-bed tertiary hospital that has, within the last 15 years, operated as a fully-integrated PHO. As opposed to the other two participants, Tucson’s ACO will be more collaborative with independent providers, specialists and ancillary services, rather than more vertically integrated with physicians and providers affiliated with the system. United Healthcare of Arizona is participating with Tucson Medical Center in this program, and has sophisticated payer business systems that can be leveraged to supply the data needed for the pilot program. UHC of AZ also administers the hospital’s self-insured employee program, which covers approximately 9,000 lives

In addition to the ACO pilot, Tucson is participating in a number of other initiatives. A Patient-Centered Medical Home Program, Pay-for-Performance and Gain-Sharing Models, EHR and HIE initiatives, and advanced care transition models.

Chapter 6 - Facilitating the Formation of an Accountable Care Organization

Facilitating the Development of Administrative Capabilities

Provider Selection

Providers being considered for inclusion in a developing ACO must be able to meet the quality standards that the ACO will set in place and must be committed to the philosophy of the ACO and the delivery model. The providers must be willing to participate in the systems that will create improvements in quality and cost measurements, including use of evidence-based medicine, practice management software and EHR. The “appropriate” provider mix for the ACO should also be considered.

Evaluation of Historical Data

Initial discussions and planning will focus on historical data for the projected consumer population, including utilization, payment rates, and how payments will be structured. In addition, the providers should receive assistance in developing financial models in order to project their performance and be able to evaluate payment rates.

Development of Capabilities to Serve as an ACO

Providers of all shapes and sizes will need help developing the capabilities (or enhancing existing ones) needed to successfully serve as an ACO and manage the related payments.

Providers will need assistance in:

- Developing a vision of the ACO’s structure, provider components, IT platform and other elements
- Developing resources to get timely information about their consumers and the services those consumers are receiving from other providers, both in and out of the ACO
- Developing the technology and skills needed among both providers and administrative personnel to manage an entire population’s health and coordinate that care properly
- Developing infrastructure and skills to manage the financial risk inherent in the ACO model

Providing External Support

As the first ACOs are developed, providers will likely have issues adjusting their care processes and administrative systems to respond to quality, rather than volume, initiatives. The time, capital and other resources needed to reinvent these processes will not be immediately affordable for most providers. External support to these providers will be helpful in the following areas:

- **Coaching** on how to change operations to improve quality and lower cost.
- **Information** about the current costs and outcomes associated with their patients to define targets for outcomes. Providers will need outside help in working with payers to get, and more importantly, process this type of information. The complexity of this task will be exacerbated if the ACO is contracted with multiple payers.
- **Shared Services** among smaller providers for services that have not been historically used in a fee-for-service model, but will be more important as the shift is made to coordination of care among providers. Discovering which services could be shared, and how they can be effectively implemented will be important.
- **Financial Modeling** will be necessary to understand the payment levels that can be sustained by a successful ACO.

Encouraging Physician Leadership

Physician leadership will be crucial in the development of the ACO model, the implementation of the model, and the execution of that model.

Because the current fee-for-service system does not encourage or reward coordination of care between providers, new relationships must be built, and a new cooperative trust must be developed among providers.

Once in the ACO, it will be physicians, not administrators or insurers, who are responsible for working together to execute the improvements in quality and reductions in cost that the model demands. Discussions regarding best practices and evidence-based medicine, rates, and acceptable utilization all will likely be facilitated by physician leaders.

Facilitating the Development of Payment Models

Payments to ACOs should give providers the maximum amount of flexibility to structure and deliver healthcare services in the most efficient and effective manner. When this efficient and effective process results in consumers receiving high-quality, appropriately-costed healthcare, the payment system should reward the provider. However, the providers should also be held accountable for costs and outcomes that are within their control.

Establishing the Proper Payment Levels

There are significant downsides to capitated payment levels in the ACO being set too low or too high. Payments set too low will result in the ACO being forced to under-provide care, or face financial losses. Payments set too high will not provide significant incentive for the ACO to coordinate care to improve quality and reduce costs. Payments should be adequate to cover the achievable costs of the services needed by patients whose care is to be covered by the payments.

In the transitioning process from fee-for-service, payers should consider increasing primary care fees to adequately compensate primary care physicians for their increased responsibilities. In addition, as noted earlier, payers should consider agreeing to multi-year agreements to allow ACOs the security to make investments in the requisite information technology needed to coordinate care.

Importance of Proper Payment Allocation

Even with the capitated payment amount set correctly, how that payment is allocated will be decided at the ACO level. Improper allocation of the payment among the providers will have significant downside, similar to an inappropriate payment level. If a provider is receiving too low an allocation, that provider will not likely be able to deliver adequate care. If it is too high an allocation, that provider will have incentives for overutilization or overinvestment. Payment allocations to all providers will need to be periodically reviewed as services are improved.

In addition, providers who are not part of the ACO, but who serve the ACO's consumers, will have to be paid an adequate and appropriate rate for services delivered to those consumers. This could apply to a provider a consumer has chosen to use, and whose insurance plan covers that choice, or, as referenced earlier, this may include an ancillary or other provider who is not part of the ACO, but is the only provider in the area that provides a certain service.

Finally, beyond patient care, providers have responsibilities in medical education, research, and other societal needs and those must be addressed within the payment system, either through the payments made to those providers, or via separate payments to those providers.

Potential Issues

In facilitating the formation of an ACO, the following issues to be avoided were identified in the article “*Creating Accountable Care Organizations in Massachusetts*,” by Harold D. Miller, Executive Director of the Center for Healthcare Quality and Payment Reform and the CEO of the Network for Regional Healthcare Improvement. This is not a comprehensive list of Mr. Miller’s potential ACO issues, but instead a look at those most applicable to the formation of ACOs:

- Paying providers less than the reasonably achievable costs of delivering necessary, high-quality services to patients based on their healthcare conditions and other needs; Encouraging unnecessary duplication of facilities and services
- Expecting healthcare providers to reduce or deny services that consumers have been promised under their health insurance benefits
- Holding healthcare providers accountable for outcomes without adequate resources or incentives to ensure patient adherence
- Putting healthcare providers at risk for unpreventable variations in patient conditions and outcomes
- Expecting healthcare providers to perform functions currently delivered by health insurance plans without adequate resources to do so or sufficient time to develop those capabilities
- Expecting healthcare providers to deliver services or perform functions for which an adequate workforce or effective technology is not available
- Imposing unnecessary or excessive new administrative burdens that increase providers’ operating costs without corresponding benefits in terms of the quality or costs of patient care

Chapter 7 - Core Competencies Needed for the Creation and Implementation of an ACO

To successfully meet the ACOs goals of reducing cost, improving quality, developing the systems to measure performance, contracting successfully with payers, and allocating payments appropriately, many core competencies will be needed.

In this chapter is a list of those competencies that will be needed; generally grouped by relative priority. In addition, the entity that should be primarily responsible for developing that competency has been included, along with any other entities (if any) that will play a consultative role.

The provider entity that will form and administer the ACO will be defined as the “provider” in the section below.

Many of these competencies cannot be developed by the provider organization alone. Many issues will require working with an organization with expertise that relates to that competency’s area, usually the payer aligned with the ACO. In each case, this organization will be referenced as the “**strategic partner.**”

Exhibit 2, at the end of this white paper, provides a visual display of competency development ownership.

First Year of Development

Define and Implement Performance Measures

Primary Responsibility: Strategic Partner

Description: ACOs will have to work with payers to define the performance measures to be benchmarked and measured, and which will be most important to improving patient outcomes. Once defined, the ACO will have to assure that the data is collected, benchmarks and expectations are defined, and that systems are developed and implemented to assure the targets are achieved.

Accounting Validation for Payments to Physicians

Primary Responsibility: Strategic Partner

Description: The capability to evaluate performance and define incentive payments, in a manner that is understood by physicians, will be crucial to aligning physicians' incentives with the goals of the ACO.

Education and Training

Primary Responsibility: Strategic Partner

Description: In addition to physicians, hospital staff and administrative staff related to the ACO need to be educated on their responsibilities and how they tie into achieving the goals of the ACO. The strategic partner can help by developing content and curriculum, so that it does not have to be re-created by each hospital network. Over time, the strategic partner can train each hospital system to take over these functions.

Claims Processing

Primary Responsibility: Strategic Partner

Description: The ability to adjudicate claims efficiently, effectively, and with a customer-friendly explanation of benefits is a key competency requirement. Key to this will be the development of information systems with the ability to report monthly, quarterly and other timeframes as required. This will not be a requirement for Medicare ACOs.

Prioritizing Target Savings Opportunities

Primary Responsibility: Provider

Consultative Role: Strategic Partner

Description: To achieve the most efficient results in terms of benefits from the ACO, the target areas that present the greatest savings opportunities must be identified and prioritized. The strategic partner should be involved in the data review and analysis for determining potential impact of savings in each area.

Legal Compliance

Primary Responsibility: Provider

Description: The ACO must be able to address how it will be compliant with anti-fraud, anti kickback, and anti-trust legislation, while being aware of potential Medicare fraud, restraint of trade, and other legal issues.

Plan Design

Primary Responsibility: Provider

Consultative Role: Strategic Partner

Description: The development of the plan design for enrollees in the ACO will be an important feature in reducing out-of-network utilization, among other things. Designing the plan to encourage the consumer to be cost-and-quality-conscious in their healthcare decision making will reduce the burden on the administrative and provider levels in the ACO to manage consumer behavior. The strategic partner's role will be to make recommendations. This will not be applicable to an eventual Medicare ACO.

Wellness Services

Primary Responsibility: Provider

Consultative Role: Strategic Partner

Description: Wellness services that engage the consumer in management of their health and increase personal accountability must be part of the ACO.

Development and Management of ACO Governance Structure

Primary Responsibility: Provider

Consultative Role: Strategic Partner

Description: The development and management of the ACO governance structure is a critical competency. At a minimum the governance structure will be responsible for establishing policy and procedures related to the ACO, along with physician payment criteria. The entity will be comprised of physicians, administrators and the community at large; the proportions of which will be determined on an individual basis. This will be a requirement for Medicare ACOs.

Define and Assemble Appropriate Provider Mix

Primary Responsibility: Provider

Description: It is essential to have an appropriate mix of primary care and specialist physicians, who individually deliver enough care to the ACO patient population to affect its quality and cost objectives. Physicians who are a part of the ACO are most likely to follow the defined guidelines and be influenced by the payment incentives related to its performance benchmarks. However, not all physicians who will serve the ACOs patient population will have enough patients in the ACO to be influenced by the payment incentives, and thus should likely remain outside the ACO. For example, a particular subspecialist may serve 500,000 patients in a suburban area. For an ACO with a patient population of 10,000 lives, the subspecialist's ACO patient base will be approximately 2% of his or her total patient base, and will be unlikely to change his or her practice patterns because of the ACO's incentive payments.

Assembling Appropriate Primary Care Physician Base and Care Model(s)

Primary Responsibility: Provider

Description: To support the activities of the ACO, as well as meet its minimum requirements, primary care physicians will have to be integrated into the ACO as the base for coordination of patient care. In addition, the ability to evaluate and develop different primary care models (such as the medical home model, or other physician-extender-heavy model) to meet the needs of the patient base, as well as the supply and availability of primary care resources, will be important.

Development of Provider Payment Model

Primary Responsibility: Provider

Consultative Role: Strategic Partner

Description: Developing a payment model that provides incentive for appropriate utilization and achievement of ACO goals is essential. Once the payment model is developed, implementation of the model and monitoring its success will be the next competency needed. The information system must capture accurate data that is easily translated into simplified reports to which the physicians can trust and relate (i.e. cost per physician, cost per procedure, and cost per plan).

Electronic Health Record (EHR) Implementation

Primary Responsibility: Provider

Description: The ability to coordinate the implementation and usage of an electronic health record in the hospital and provider practices will play a key role in the coordination of patient care. Over time, an EHR will allow for more physician-led disease management, as well as reducing utilization by removing redundant and/or unnecessary care.

Second Year of Development

Disease Management Capabilities (Next Generation)

Primary Responsibility: Strategic Partner initially, transitioning to Primary Care Physicians

Description: A disproportionate percentage of the premium dollar goes towards managing patients with chronic conditions such as diabetes or COPD. Two elements are essential to this capability: First, a predictive modeling/data mining system can help identify patients with these conditions, or at risk for these conditions. Second, support systems that help patients follow their individualized plan of care can increase patient compliance and therefore control incremental growth in the cost of care.

Utilization Management Capabilities (Next Generation)

Primary Responsibility: Strategic Partner initially, transitioning to Primary Care Physicians

Description: Management of utilization will be important to ensuring that each patient receives the medically necessary and appropriate level of care, while receiving it in the most cost-efficient manner possible. This management could include services such as pre-certification before inpatient admission, discharge planning, and case management.

Information Technology (Cost Reporting, Quality Measurement, Care Coordination)

Primary Responsibility: Strategic Partner

Description: Developing the information technology competencies to coordinate, deliver and measure the care provided is critical to the function of an ACO.

Enhancement of Evidence-Based Protocols

Primary Responsibility: Provider

Consultative Role: Strategic Partner

Description: In order to deliver care that drives down cost and improves quality, evidence-based protocols, or best practices, will have to be developed and implemented across the network of providers in the ACO. This will be done through mining data related to care of the population, and showing where variation exists in terms of care or cost. It will also be done by understanding the latest research and incorporating those findings into care decisions. Physicians will need to be educated as to why each protocol is effective and shown evidence that the protocol works in meeting the ACO's goals.

Third Year of Development

Consumer Education

Primary Responsibility: Strategic Partner

Consultative Role: Provider

Description: Consumers who are assigned to an ACO will have to be educated on its' goals and how care will be delivered to meet those goals. It is possible that ACOs will be viewed as restricting patient choice, or delivering sub-standard care because they will be receiving “less” care. It is important that consumers be educated to realize that this will not be the case. In addition, consumers need to play an active role in their own health management, and the decisions they can make to improve their own health and reduce unnecessary utilization.

Sales and Marketing of Services

Primary Responsibility: Strategic Partner

Description: Resources will have to be developed to promote the ACO model. These resources will be targeted at increasing awareness of the benefits the ACO model can provide for payers, which will include employers.

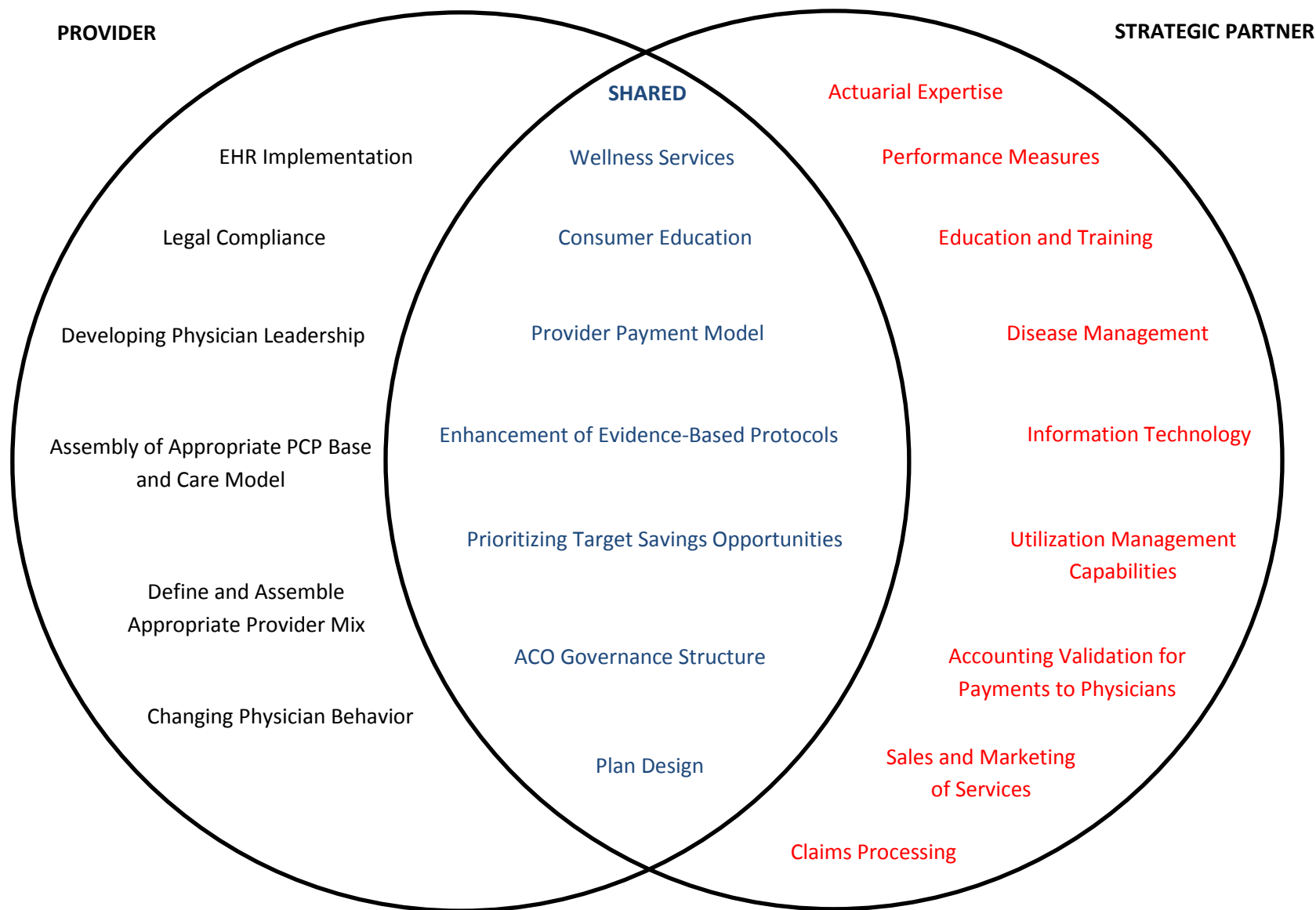
Exhibit 1

Brookings-Dartmouth Steps to ACO Implementation*

1. Local payers and providers agree to pilot ACO reform
2. ACO provides list of participating providers to payers
3. Consumers are “assigned” to physicians (e.g. based on preponderance of E&M codes)
4. Actuarial projections about future spending are based on last 3 years of historical data
5. Determine/negotiate spending benchmark and/or shared savings arrangement
6. ACO implements capacity, process and delivery system improvement strategies
7. Progress reports on cost and quality are developed for ACO beneficiaries
8. At year end, total and per capita spending are measured for all consumers
9. Savings under the benchmark is shared between providers and payers

**From presentation given on October 6th, 2009 at The Accountable Care Organization (ACO) Learning Network, a joint initiative of the Brookings Institute and the Dartmouth Institute for Health Policy and Clinical Practice; Slide 23*

Exhibit 2 - Core Competency Ownership



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