How Does an ACO Work?

The PEC “Explainer” Series

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A Deceptively Simple Definition

ACOs Allow Providers to Assume Risk for Total Cost of Care

What an ACO Is…

Accountable Care Organization

“Accountable Care Organizations (ACOs) are groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high quality care to their Medicare patients.

When an ACO succeeds in both delivering high-quality care and spending health care dollars more wisely, it will share in the savings it achieves for the Medicare program.”


…And Is Not

HMO (Or any specific insurance product)

An ACO may contract with a payer (Medicare, commercial, etc.) but is not itself an insurance vehicle

Patient Centered Medical Home

Providers in an ACO may structure their practices as PCMH, but an ACO can be made up of different practice types

Physician-Hospital Organization

PHOs and ACOs are related, however PHOs exist mainly for managed care contracting, and not care coordination
What is an ACO?

Contracting Mechanism That Allows Providers to Share in Cost Savings

Provider-Led Organization
Primary care physicians are mandatory; other specialties and providers (e.g., hospitals, post-acute care facilities) are included as necessary

Quality- and Value-Based Payment Incentives
Reimbursement may be capitated, but is more typically traditional fee-for-service; participants are rewarded for reducing total population cost over a defined time period

Sophisticated Performance Measurement
Rigorous quality and cost reporting requirements require more than a basic information infrastructure

Definition in Brief: Accountable Care Organization
An organizational structure through which clinical providers can take risk for the total cost of care for a defined population of patients.

Source: McClellan M et al., “A National Strategy to Put Accountable Care into Practice,” Health Affairs, 2010, 29, No. 5: 982-990; Advisory Board interviews and analysis.
PCPs are Mandatory, Other Providers As Needed

Accountable Care Organization

Order of Physician Partnership Priority

Primary Care
- Internal Medicine
- Pediatrics
- Family Medicine
- Hospitalists

Community-Based Medical Specialists
- Cardiology
- Medical Oncology
- Endocrinology
- OB/GYN

Proceduralists
- General Surgery
- Cardiac Surgery
- Neurosurgery
- Orthopedics

Hospital-Based Non-Admitting Specialists
- Radiology
- Anesthesiology
- Pathology
- ED Physicians

Community Contractors
- Dermatology
- Ophthalmology

Partner to Create Effective Care Management Enterprise
“ACO Care Managers”

Partner to Create Efficient Procedural Enterprise
“ACO Proceduralists”

Attribute #1: Provider-Led Organization

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Source: Advisory Board Interviews and Analysis
Redefining Provider Roles Across the Care Team

APs, Physicians Both Must Be Utilized More Effectively

**Common Team-Based Staffing Model**

- Physician involved in each patient visit, providing care or checking AP work

**Ideal Team-Based Staffing Model**

- Patients requiring physician attention

Source: Medical Group Strategy Council interviews and analysis.
CMS Requires Reporting, Performance Across 33 Metrics, 4 Domains

**Patient/Caregiver Experience**
- Getting Timely Care, Information
- Provider Communication
- Patient Rating of Provider
- Access to Specialists
- Health Promotion and Education
- Shared Decision Making
- Health Status/Functional Status

**Preventive Health**
- Influenza Vaccine
- Pneumonia Vaccine
- BMI Screening
- Tobacco Screening
- Depression Screening
- Colorectal Cancer Screening
- Breast Cancer Screening
- Hypertension Screening

**Care Coordination/Patient Safety**
- Readmission Rates, All Conditions
- COPD Admissions
- Heart Failure Admissions
- PCP MU¹ Bonus Eligibility
- Medication Reconciliation
- Fall Risk Screening

**At-Risk Populations**
12 Specific Clinical Indicators for Patients With:
- Diabetes
- Ischemic Vascular Disease
- Hypertension
- Heart Failure
- Coronary Artery Disease

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¹ Meaningful Use

Source: [http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Quality_Measures_Standards.html](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Quality_Measures_Standards.html); accessed April 13, 2014
ACOS Require Robust IT Infrastructure

Five Core Competencies of ACO-Capable IT Infrastructure

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<th>Purpose</th>
<th>Example</th>
<th>Improving Clinical Care</th>
<th>Adapting Administrative Infrastructure</th>
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<td>Network Interconnectivity</td>
<td>Data Warehouse</td>
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<td>Clinical Knowledge Management</td>
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<td>Patient Activation</td>
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<td>Financial Operations</td>
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<td>Population Risk Management</td>
<td>Claims-Based Analytics</td>
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Purpose:
- Transparency into patient utilization, health status across entire continuum of care
- Support for evidence-based medicine, decision support, cost and quality analytics
- Engagement of patients in health outcomes, mitigation of risky behaviors
- Visibility into cost of care and operational efficiency
- Risk-segmentation of patient panel to ensure right care in the right setting

Source: Advisory Board interviews and analysis.
Mechanics of a Shared Savings Contract

Applying Total Cost Accountability to Fee-for-Service Payments

Shared Savings Payment Cycle

1. **Assignment**
   Patients assigned to ACO retrospectively based on primary care services provided

2. **Billing**
   Providers bill normally, receive standard fee-for-service payments

3. **Comparison**
   Total cost of care for assigned population compared to risk-adjusted target expenditures

4. **Bonus**
   Bonuses (based on share above minimum savings threshold) or penalties levied based on variance of expenditures from target, quality performance

5. **Distribution**
   ACO responsible for dividing bonus payments (or possible penalty payments) among stakeholders

Source: Advisory Board interviews and analysis.
## Degree of Daily Change Depends upon Specialty

Primary Care Likely to See More Operational Changes than Specialists

<table>
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<th>Primary Care</th>
<th>Specialists</th>
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<td><strong>Transition to Team-Based Care</strong></td>
<td><strong>Quality Measurement and Reporting</strong></td>
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<tr>
<td>• Physician as team leader                                                   • Move from process to measurements to outcomes where possible</td>
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<tr>
<td>• Variety of clinical and non-clinical team members</td>
<td><strong>Acute Care Episode Cost Management</strong></td>
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<tr>
<td><strong>Primacy of Patient Engagement</strong></td>
<td>• Reduce post-procedure complications and readmissions</td>
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<td>• Proactive identification of and outreach to high-risk patients</td>
<td>• Utilize site of service with best value</td>
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<td>• Detailed understanding of motivational factors</td>
<td><strong>Protocol development with PCPs</strong></td>
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<tr>
<td><strong>Expansion of Patient Access</strong></td>
<td>• Reduce unnecessary tests and referrals</td>
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<td>• Extended hours</td>
<td>• Eliminate gaps in care</td>
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<td>• Partnerships with retail clinics, urgent care</td>
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<td>• Virtual visits, patient portals, self-service options</td>
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## Physician Implications for ACO Participation

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<th>Physician Type</th>
<th>Advantages of ACO Participation</th>
<th>Disadvantages of ACO Participation</th>
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| Primary Care   | • Bonus potential for improving quality and reducing total health care spend  
• Capital support for infrastructure investments  
• “Practice medicine the way I’ve always wanted to” | • Reporting and infrastructure requirements may be prohibitive for smaller practices  
• Attribution methodologies are imperfect at best  
• Success depends upon data availability and timeliness |
| Specialist     | • Bonus potential for improving quality and reducing total health care spend  
• Increased referrals from ACO PCPs | • Single ACO may not produce sufficient volumes; multiple ACO participation logistically complex  
• Potential for reduced utilization/demand in certain procedural specialties |
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