Accountable Care

Where are we now? Where are we going?

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Dartmouth Medical School

Director, Center for Population Health
Director for Population Health and Policy
The Dartmouth Institute for Health Policy
and Clinical Practice
Houston: We’ve got a problem
Origins
Vermont, Maine, then Dartmouth

Small Area Variations in Health Care Delivery

A population-based health information system can guide planning and regulatory decision-making.

John Wennberg and Alan Gittelsohn

Recent legislation has extended planning and regulatory authority in the health field in a number of important areas. The 1972 amendments to the impact of regulatory decisions on the equality of distribution of resources and dollars and the effectiveness of medical care services.
Variations in supply-sensitive care
Is More Always Better?

Variations in spending largely due to “supply-sensitive care”
Variation in price and illness-adjusted spending largely due to avoidable use of the hospital as site of care; specialist visits; imaging and tests
Higher use of these services is not, generally, better.
There’s lots of waste.

(2) Baicker et al. Health Affairs web exclusives, October 7, 2004
(3) Fisher et al. Health Affairs, web exclusives, Nov 16, 2005
(4) Skinner et al. Health Affairs web exclusives, Feb 7, 2006
Variations in supply-sensitive care
Is More Always Better?

Why the variation?
Not preferences, malpractice, or payment system
Capacity important, but explains less than half of the spending differences
Judgment – in “gray area” decisions -- is critical
Why clustered regionally?  Local components: capacity and culture

“…a culture that focuses on the wellbeing of the community, not just the financial health of our system.”

Jeff Thompson, MD
CEO Gunderson-Lutheran
La Crosse WI

“Here … a medical community came to treat patients the way subprime mortgage lenders treated home buyers: as profit centers.”

Atul Gawande
Recent insights
Both volume and price are important

Michael Chernew:
Prices are important determinants of spending in under 65

MedPAC:
Hospitals under pressure to keep costs down are able to do so
There are many low cost, high quality hospitals
**It is possible to reduce unit costs and thus prices**
What have we learned?
The underpinnings of accountable care

Underlying problem

Confusion about aims: is it about money or something more?

Poor data, unengaged patients leaves practice unable to improve; choices driven by physician opinion

Flawed conceptual model. Health is produced by face-to-face visits with physicians. More is always better.

Wrong incentives reinforce model, reward fragmentation, induce more care and entrepreneurial behavior.

Key principles

Clarify aims: Better health, better care lower costs – for patients and communities

Better information, shared decision-making supports improvement and enables informed choice

New model: It’s the system. Establish organizations accountable for aims and capable of redesigning practice, eliminating waste and managing capacity

Rethink our incentives: Realign incentives – both financial and professional – with aims.
The new policy environment
Consensus on aims and measures

Emerging alignment on aims

National Quality Strategy: “three part aim”
- Improving health
- Better care: safe, reliable, patient centered (informed choice)
- Lower costs – through improvement (not rationing)

Performance measurement – a critical lever

National Quality Forum “Episode Measurement Framework”

Key notions

Core issue: how did the patient do over the relevant time-course?

Value is multidimensional: outcomes, risks, quality, costs

Requires integration and organizational accountability – over time
The new policy environment
Consensus on aims and measures

At Risk

Acute Care

Rehab

Recovery

Population at Risk

1st Prevention (no known CAD)

2nd Prevention (CAD no prior AMI)

2nd Prevention (CAD with prior AMI)
Advanced Care Planning

PHASE 1

PHASE 2

PHASE 3

PHASE 4

Onset

Episode begins – onset of symptoms

Risks reduced
Good function
Informed choice
Minimal cost

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The new policy environment
Consensus on aims and measures

At Risk

Population at Risk
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Acute Care

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Recovery

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Informed choice
Minimal cost

Traditional model
Autonomy
Individual Responsibility

New model
Accountability
Shared Responsibility

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The new policy environment
Growing understanding of the science of health care delivery

**Microsystem**: front-line unit where patient and family interact with clinician to produce value for a specific condition: e.g. office practice, inpatient unit,

**Key elements:**
Flow is clear and well defined
Microsystems are linked
Measurement is integrated
Professional work is redefined: Involves care and improvement

![Figure 7-2: Percentage of Intermountain Healthcare System Diabetic Patients with Glycolated Hemoglobin (HA1C) > 9%, June 1999–March 2006](image)
The new policy environment
Affordable Care Act -- delivery system reforms

Independent Payment Advisory Board
Recommends changes to slow spending growth if target exceeded
Overturning recommendations requires supermajority

Prevention and Wellness
Prevention fund ($7b 2010-2015; $2b per year thereafter)
Community transformation grants
Annual Wellness Visit

Delivery and payment system reform
Health Information Technology – EHRs, HIE,
Comparative Effectiveness Research Institute
Accountable Care Organizations (Section 3022)
Center for Medicare and Medicaid Innovation (CMMI)
Requires testing of diverse new delivery and payment models
Specifically: Shared decision-making; High Value Health Care
“Successful” models are to be implemented by Secretary

Commitment to value based payment
Payment Reform
Episode / Bundled Payments

Theory
Single payment for episode (e.g. total knee replacement), encourages collaboration and integration to improve care

Strong interest – especially among referral centers
Early evidence promising
High Value Healthcare Collaborative up and running

High Value Healthcare Collaborative

<table>
<thead>
<tr>
<th>Baylor Health Care System</th>
<th>Beaumont Hospital</th>
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<tbody>
<tr>
<td>MaineHealth</td>
<td>Scott &amp; White Health Care</td>
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<tr>
<td>Sutter Health</td>
<td>UCLA Health System</td>
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<td>University of Iowa Health Care</td>
<td>Virginia Mason Medical Center</td>
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<td>Cleveland Clinic</td>
<td>Dartmouth Hitchcock</td>
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<td>Denver Health</td>
<td>Intermountain Healthcare</td>
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<td>Mayo Clinic</td>
<td>The Dartmouth Institute</td>
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Limitations:
Few outcome measures yet available;
Boundaries contentious;
Incentive to provide more episodes remains
Linkage to shared decision making needed
Payment Reform
Medical Home

Theory:
New payment to support core (currently unfunded) primary care functions – and redesign of practice

Evidence
Better care, lower costs;
Strongest effects within integrated systems
Many health plans and employers supporting adoption

MEDICAL HOMES: A SOLUTION?
By Robert J. Reid, Katie Coleman, Eric A. Johnson, Paul A. Fishman, Clarissa Hsu, Michael P. Soman, Claire E. Trescott, Michael Erikson, and Eric B. Larson

The Group Health Medical Home
At Year Two: Cost Savings, Higher Patient Satisfaction, And Less Burnout For Providers
Payment Reform
Medical Home

Theory:
New payment to support core (currently unfunded) primary care functions – and redesign of practice

Evidence
Better care, lower costs;
Strongest effects within integrated systems
Many health plans and employers supporting adoption

Limitations:
Leaves responsibility largely on shoulders of primary care clinicians
No incentives for specialists or hospitals to support improvement
Most initiatives lack accountability for overall costs
Payment Reform
Accountable Care Organizations: Early initiatives

**Alternative Quality Contract (MA Blue Cross Blue Shield)**
- **Global payment** (limited risk) with strong quality incentives (10% income)
- **Technical support**: data tools, feedback, collaborative improvement
- **Promising results**: strong participation

**Physician Group Practice Demonstration (CMS)**
- **Providers**: ten systems, diverse locations,
- **Results**: all achieved savings, but only half received bonus payments

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<thead>
<tr>
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<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
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<tbody>
<tr>
<td>Quality metrics</td>
<td>7/10</td>
<td>25/27</td>
<td>28/32</td>
<td>29/32</td>
</tr>
<tr>
<td>achieved by all sites</td>
<td></td>
<td></td>
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<tr>
<td>Total savings</td>
<td>9.5 million</td>
<td>17.4 million</td>
<td>32.3 million</td>
<td>38.7 million</td>
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<tr>
<td>Savings distributed</td>
<td>7.3 million</td>
<td>13.8 million</td>
<td>25.3 million</td>
<td>31.7 million</td>
</tr>
<tr>
<td># of sites achieving</td>
<td>2</td>
<td>4</td>
<td>5</td>
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Payment Reform
Accountable Care Organizations under the Affordable Care Act

Principles:

Diversity: support collaboration across continuum of care as a real or virtually integrated local delivery systems

Performance measurement – to ensure focus on improving care

New payment models: fee-for-service foundation, total cost accountability, shared savings, graduated risk bearing

No beneficiary “lock-in”

Section 3022: Medicare Shared Savings Program

National program, to begin January 1, 2012
Draft regulations released March 31, 2011

Center for Medicare and Medicaid Innovation

Pioneer ACOs – greater rewards, multi-payer, required risk bearing
Advanced Payment ACOs – CMS provides up-front capital
Others expected: Medicaid, dual eligibles
Lots of interest
Frequency of news articles mentioning ACOs

= # Unique instances ("Accountable Care" OR "Accountable Care Organization" in "All News Sources – English" in LexisNexis Academic Search, Conducted 2/17/2011)
Serious concerns
CMS proposed rule for ACOs has many worried

Strengths worth noting:
- Coordinates with other federal agencies
- Strong focus on improving care
- Acknowledges principle of phasing in requirements
- Commits to making data available and useful

But problems are apparent:
- Too burdensome
- Potential rewards small and uncertain, making risks loom large
- Important issues left unaddressed

Many – including DH – highly and publicly negative
Many moving forward
Current ACO sites

Private Sector
★ = Brookings-Dartmouth
★ = Premier
★ = CIGNA
★ = AQC (9 organizations in MA)
★ = Other private-sector ACOs

Public Sector
★ = Beacon Communities
★ = PGP, MHCQ
(1) It's not just a contract, it's a journey

Social and Cultural Development

Organizational Capacity

Toward Accountable Care

- Collaboration
- Shared Community Values
- Clarity and Focus of Shared Aim
- Local Multi-Stakeholder Governance
- Advancing Performance Measurement
- HIT: Health Information Exchanges & Data Support
- Payment Model Experience
- Local Regulatory & Competitive Market

Capacity of Partners and Stakeholders
National, State, Local

Structure of Payer-Provider Contracts

- Hit: EHR & Registries
- Care Management
- Care Improvement
- Performance Measurement
- Payment Models Medical Home, Episode, ACO
- Patient Engagement and Assignment
- Local Multi-Stakeholder Governance
- Organizational Structure
- Governance and Leadership

Social and Cultural Development

Organizational Capacity

(1) It's not just a contract, it's a journey
(2) It's not us against them, it's a partnership

<table>
<thead>
<tr>
<th>Managed Care Era</th>
<th>Accountable Care</th>
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<tr>
<td>Risk badly managed: plans shifted risk to providers, many failed.</td>
<td>Shared risk: use sound actuarial principles, sharing risk and rewards</td>
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<tr>
<td>No measures of quality allowed some to ignore quality or stint on care</td>
<td>Transparent measurement ensures focus on improvement</td>
</tr>
<tr>
<td>Rewards for cost cutting. Financial incentives focus on savings only.</td>
<td>Payment for improvement. Share of savings contingent on improvement.</td>
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<tr>
<td>Beneficiary lock-in created fear of stinting &amp; poor quality (gate-keeping).</td>
<td>Choice: no need to lock patients in -- “The best fence is a good pasture”</td>
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Health plans driving cost savings

Providers, plans & patients working together to improve care and reduce costs
Pilot site visits -- preliminary findings:
Shared identity fosters cooperation, influence
Loss of identity – a primal threat

Independence a key element of MD identity

ACOs emphasizing shared identity of physicians as independent practitioners within collaborative model – working toward common aim

“This is the first time in my career in medicine, since I started practicing in 1974, that I see things lining up right for the patient”

-Dr. Palmer Evans, Tucson Medical Center
Might it work?
Real progress on best practices on technical issues

Design of ACO Contracts
Organizational requirements
Patient assignment
Setting financial benchmarks
Risk adjustment
Performance measures
Funding up-front costs
Payment models

Care Transformation
Governance structures
Clinical leadership
HIT, registries, analytics
Care management
Quality improvement
Clinician engagement
Distribution of internal rewards
Might it not?
Another way to package business as usual
Each man is locked into a system that compels him to increase his herd without limit – in a world that is limited. Ruin is the destination toward which all men rush…

Avoiding the tragedy of the commons
Elinor Ostrom

Traditional view
Common pool resources create social dilemmas
Only two possible solutions:
  Treat as private goods: create private property rights
  Treat as public goods: government regulation

Might there be a third way?
Are there examples of how local communities have managed to sustain a common pool resource?

Indeed

Beyond Markets and States: Polycentric governance of Complex Economic Systems
Avoiding the tragedy of the commons
Managing common pool resources

Design Principles
Defined boundaries, known “appropriators”
Those affected help establish rules
Monitoring, graduated sanctions, conflict resolution mechanisms
“Nested” structures (practices, integrated systems, regions)

Processes that contribute
Communication
Relationships, trust
Recognition of shared interests
Focus on problem solving

Stewardship as a core value
**Stewardship**
In integrated delivery systems

**ACOs should seek:**
- Reduce volume (e.g., avoidable hospital stays); reduce capacity
- Reduce unit costs (LEAN e.g., Denver Health, Virginia Mason)
- Refer wisely to low cost / high quality providers

**Referral centers should seek**
- To provide high quality, low cost episodes
- To use specialists as wisely as possible (e.g., Intermountain)
- To reduce regional duplication (collaborate where possible)

**Brookings-Dartmouth ACO pilots:**
- Tucson: “Cash for Clunkers”
- Roanoke: Should we collaborate on specialty surgery?

**Geisinger Health System:**
- Medicare spending fell by 13% relative to US (92-06)
- Teachers given $7,000 raise (over 3 years)
Stewardship
In regions

“How Will We Do That?”
May 26-27, 2010

Grand Junction, CO
Tallahassee, FL
Cedar Rapids, IA
Portland, ME
Grand Rapids, MI
Cedar Rapids, IA
Manchester, NH
Newark, NJ
Buffalo, NY
Rochester, NY
Asheville, NC
Bend, OR
Everett, WA

Key elements:
Structure to convene key stakeholders
Shared aims, accountable to community
External constraint – (Everett, WA)
Use of data to drive change
Physicians as partners in leadership
Reduced use of hospital (Asheville)