

Accountable Care Organizations *How Will They Change Cost and Quality*

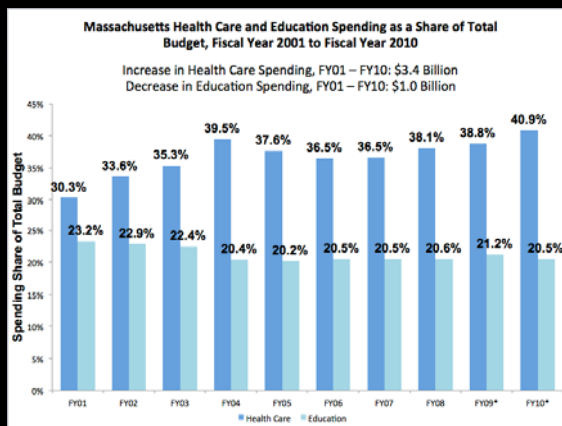
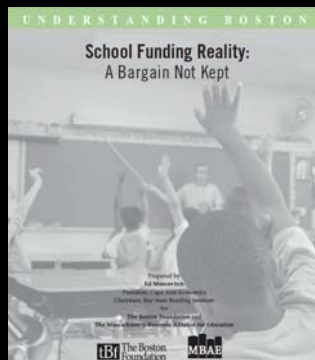
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Director for Population Health and Policy
The Dartmouth Institute for Health Policy
and Clinical Practice



Houston: We've got a problem



Origins

Variations in Medicare Spending and Quality

Initial study

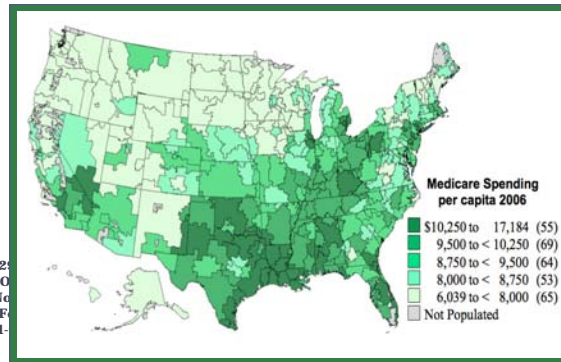
1 million Medicare beneficiaries: AMI, cancer, hip fracture
 Followed for up to 3 years after initial admission
 Compared content, quality and outcomes of care across regions of differing spending levels

Per-capita Spending (1996)

Low (pale): \$3,992
 High (green): \$6,304

Difference: \$2,312
 (61% higher)

- (1) Fisher et al. Ann Intern Med: 2003; 138: 273-298
- (2) Baicker et al. Health Affairs web exclusives, Nov 2003
- (3) Fisher et al. Health Affairs, web exclusives, Nov 2003
- (4) Skinner et al. Health Affairs web exclusives, Feb 2004
- (5) Sirovich et al Ann Intern Med: 2006; 144: 641-648
- (6) Fowler et al. JAMA: 299: 2406-2412



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Variations in Medicare Spending and Quality

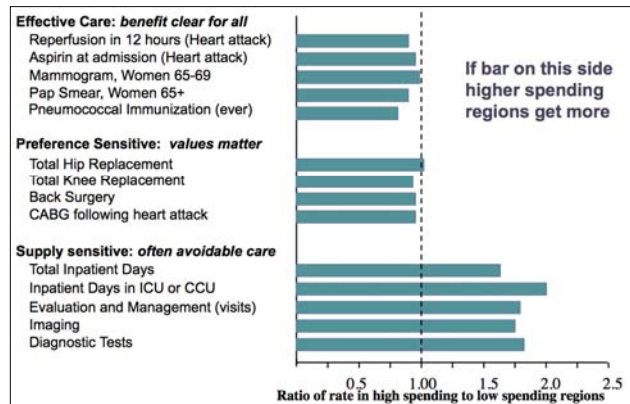
Content of care:

Excess spending due to greater use of hospital, visits (mostly specialist)
 diagnostic tests and imaging

Ratio of utilization
 rates in first year of
 follow-up

Risk adjusted, all 3
 cohorts combined
 unless otherwise
 shown

- (1) Fisher et al. Ann Intern Med: 2003; 138: 273-298



Origins

Variations in Medicare Spending and Quality

Quality and outcomes of care:

No evidence that greater use of these services (e.g. more frequent readmissions, visits or tests) led to better outcomes
 Greater spending growth does not lead to greater gains in AMI survival.
 Physicians in high spending regions perceived quality to be worse
 Patients did not report better care

Health Outcomes	Physician's Perceptions	Patient-Perceived Quality
No gain in survival	Worse communication	Lower satisfaction with hospital care
No better function	Greater difficulty ensuring coordination	Worse access to primary care
	Greater perception of scarcity	No less sense that care is rationed

- (1) Fisher et al. Ann Intern Med: 2003; 138: 273-298
- (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
- (5) Sirovich et al Ann Intern Med: 2006; 144: 641-649
- (6) Fowler et al. JAMA: 299: 2406-2412

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Subsequent research

Underlying causes of variations in Medicare spending

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

Origins Subsequent research

Underlying causes of variations in Medicare spending

Prices matter – and are under provider control

Chernew: Prices are important determinants of spending in under 65

MedPAC: Hospitals under pressure to keep costs down do so
It is possible to reduce unit costs and thus prices

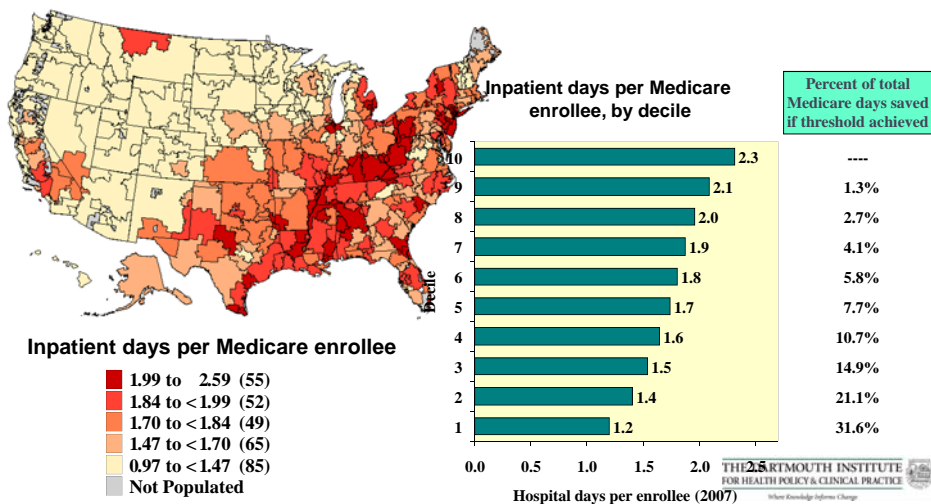


Geographic Correlation Between Large-Firm Commercial Spending and Medicare Spending

Michael E. Chernew, PhD; Lindsay M. Sabik, BA; Amitabh Chandra, PhD;
Teresa B. Gibson, PhD; and Joseph P. Newhouse, PhD

Origins Substantial savings are possible

Potential savings from reducing excess hospital utilization



Origins

The underpinnings of accountable care

Underlying problem

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

Absent or poor data leaves practice unexamined, and unable to improve; choices uninformed by evidence

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 that engages physicians, supports improvement, informs consumers and patients

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.

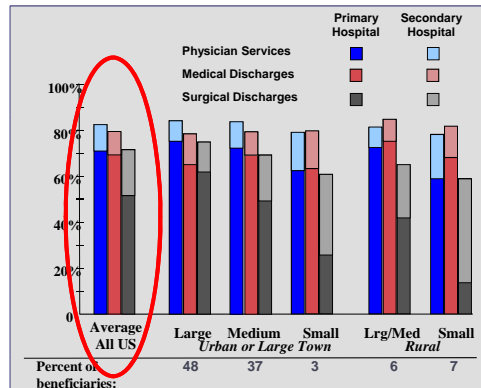
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Moving toward population-based payment reform

The Randolph Project



Assigning Ambulatory Patients and Their Physicians to Hospitals: A Method for Obtaining Population-Based Provider Performance Measurements
Julie P W Bynum, Enrique Bernal-Delgado, Daniel Gottlieb, and Elliott Fisher

Fostering Accountable Health Care: Moving Forward In Medicare

Real savings to the Medicare program could occur within five years with only modest changes in providers' spending behavior.
by Elliott S. Fisher, Mark B. McClellan, John Bertko, Steven M. Lieberman, Julie J. Lee, Julie L. Lewis, and Jonathan S. Skinner

Origins

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: over two thirds of MA MDs participating

Physician Group Practice Demonstration (CMS)

Providers: ten systems, diverse locations,

Results: all achieved savings, but only half received bonus payments

	Year 1	Year 2	Year 3	Year 4
Quality metrics achieved by all sites	7/10	25/27	28/32	29/32
Total savings	9.5 million	17.4 million	32.3 million	38.7 million
Savings distributed	7.3 million	13.8 million	25.3 million	31.7 million
# of sites achieving shared savings	2	4	5	5

Where are we now?

Accountable Care Organizations under the Affordable Care Act

Principles:

Acknowledge 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

Draft regulations released March 31, 2011

Final rule released October 20, 2011

Center for Medicare and Medicaid Innovation

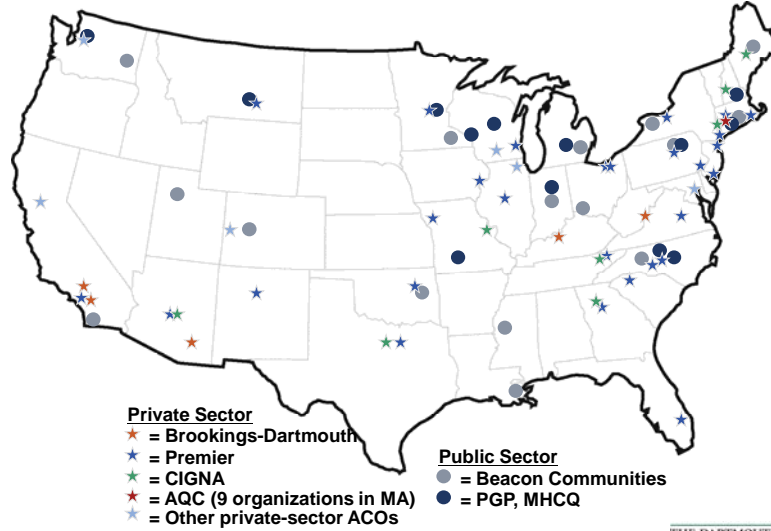
Pioneer ACOs to be announced imminently:

Greater rewards, multi-payer, required risk bearing

Advanced Payment ACOs – CMS provides up-front capital

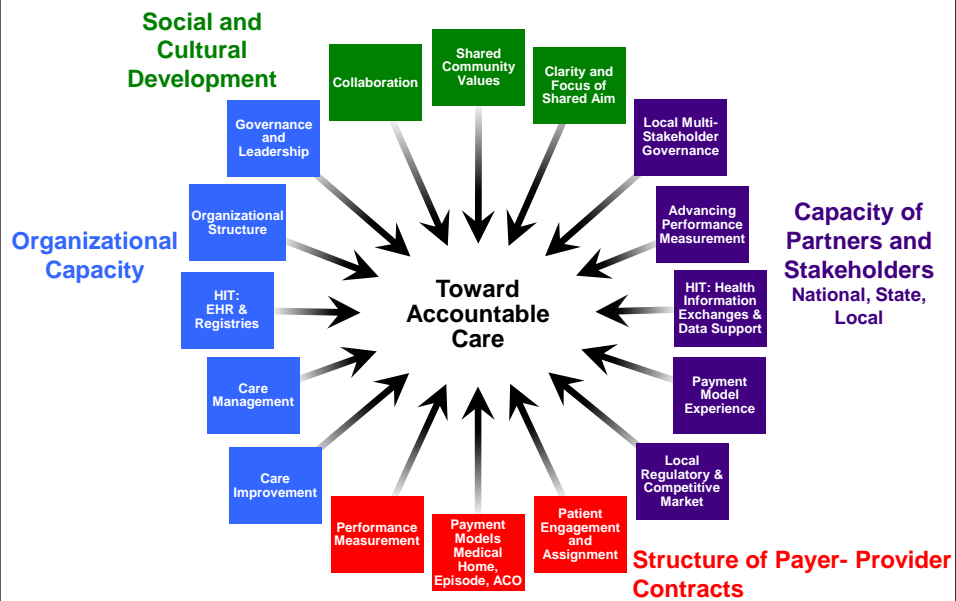
Many moving forward

Current ACO sites



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(1) Its not just a contract, it's a journey



(2) Its not us against them, it's a partnership

Managed Care Era

Risk badly managed: plans shifted risk to providers, many failed.

No measures of quality allowed some to ignore quality or stint on care

Rewards for cost cutting. Financial incentives focus on savings only.

Beneficiary lock-in created fear of stinting & poor quality (gate-keeping).

Health plans driving cost savings

Accountable Care

Shared risk: use sound actuarial principles, sharing risk and rewards

Transparent measurement ensures focus on improvement

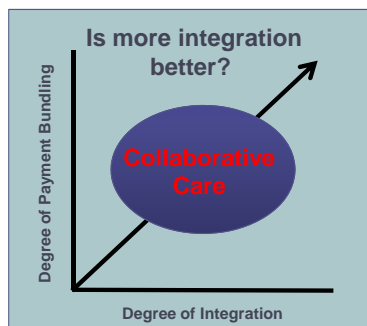
Payment for improvement. Share of savings contingent on improvement.

Choice: no need to lock patients in -- "The best fence is a good pasture"

Providers, plans & patients working together to improve care and reduce costs

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(3) A collaborative model that respects professional identities



Pilot site visits -- preliminary findings:

Loss of identity – a primal threat
Shared identity fosters cooperation, influence

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

Medicare ACO regulations

Major revisions

Proposed Rule

- High administrative burden and implementation costs
- Too much financial uncertainty with limited upside
- Lacked a clear pathway to accountability over time
- Insufficient alignment with other public and private payers and initiatives

Final Rule

- Fewer, but better, quality measures
- Greater financial rewards
- Shared savings only model
- Less burdensome governance and structural requirements
- Revised beneficiary assignment approach
- “Advance Payment Model” to help provide up front capital for smaller physician groups
- Streamlined antitrust and anti-fraud rules and guidance

The road ahead

Challenges are real

Scope of change required – and diversity of contexts

Social: governance, leadership, team development, patient engagement, care management, care improvement

Technical: Health information exchange, EHRs, registries, analytics, quality measurement, feedback reports

➔ **Learning networks, technical support, educational resources**

Lack of timely and useful data; conflicting measures

Even those with EHRs are blind to care provided elsewhere

Little information about quality or cost of care at referral sites

Performance measures often not useful for care management

➔ **Timely provision of public and private data, in consistent formats**

➔ **Alignment of performance measures across all payers**

The road ahead

Challenges are real

Overcoming transition costs

Initial infrastructure and organizational costs can be substantial

CMS estimated: initial (\$29 - \$157m); continuing (\$63 - \$342)

- **CMS addressed: greater share of savings, advanced payment ACO**
- **AQC has many approaches: in-kind, quality payments, some direct**
- **multi-payer ACOs would allow costs to be spread broadly**

Gaining consumer support

Name is a challenge

If consumers fear (or experience) stinting; model will be rejected

- **Include measures meaningful to consumers**
- **Maintain consumer choice**
- **Consumer participation in governance and operation**
- **Innovative benefit designs**

The road ahead

Challenges are real

Need to track and learn from early experience

Remarkable diversity of organizations and settings

Impact of reforms on ACO, non-ACO and community populations uncertain

Risk that we will fail to learn. Wrong question: does model work?

Better question: what works? how? for whom?, in what contexts?

Needed to inform both policy and practice

- **All-payer resource use, cost and quality tracking**
- **Survey emerging ACOs / medical groups**
- **Coordinate evaluation initiatives**

Unrealistic expectations

Many already disappointed that CMS program “starting small”

Model risks being rejected if we give it inadequate time to succeed

- **Recognize that this is a marathon, not a sprint**

Perhaps the biggest challenge

Just another way to package business as usual?



Animated Short: The Amazing Health Care Arms Race

Posted by Gregory Warner on September 13, 2011 5:06 AM



A medical mecca rises in suburban Detroit

By Gregory Warner
Marketplace, Thursday, September 15, 2011

I believe that the fingers controlling those paddles, Dr. Fisher, often use those "gray areas of judgment" as an excuse to shoot the patient back to the triple-score bumpers."

Geoffrey G. Smith, MD, May 24, 2007 (email)

The Tragedy of the Commons

The population problem has no technical solution; it requires a fundamental extension in morality.

Garrett Hardin

At the end of a thoughtful article on the future of nuclear war, Wiesner and York (7) concluded that: "Both sides in the arms race are . . . confronted by the

sional judgment. . . ." Whether they were right or not is not the concern of the present article. Rather, the concern here is with the important concept of a

Science

"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..."

Garrett Hardin. *Science* 1968; 162:1243-8.



Avoiding the tragedy of the commons

Managing complex economic systems

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

Neither is efficient if local knowledge is important



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

Elinor Ostrom: American Economic Review, June 2010, pp 1-33

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Avoiding the tragedy of the commons

Managing complex economic systems

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



Alanya

Avoiding the tragedy of the commons

Perhaps: regional initiatives to improve health and health care

Acknowledge nested structures and build on them

- Physician Practices – redesign (evidence); monitoring (gray areas)
 - Use knowledge to support care provision in lowest cost setting
- ACOs / Hospitals: re-engineer and downsize: (increase margin, decrease costs)
- Referral Centers: low cost, high quality episodes

Develop local multi-stakeholder “polycentric governance” structures

- Develop shared aims
- Where is collaboration needed? Where is competition constructive?
- Manage the conversation about reducing capacity; workforce transitions
- Use data to monitor resource use, costs, prices
- Use social capital to motivate stakeholders and gain consumer support
- Align community and provider efforts to improve health

Avoiding the tragedy of the commons

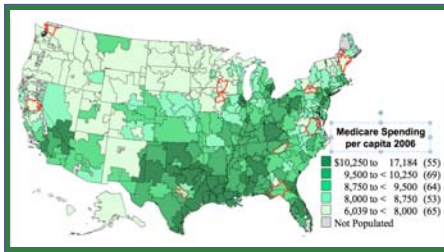
Perhaps: regional initiatives to improve health and health care

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

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

Key elements:

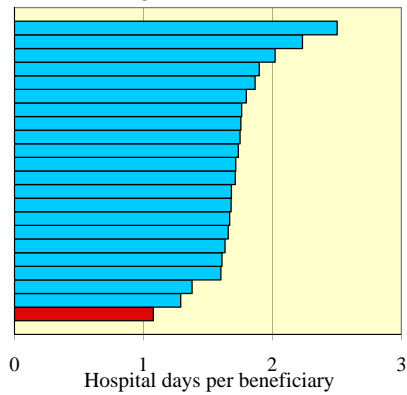
- Structure to convene key stakeholders
- Shared aims, accountable to community
- External constraint – (Everett, WA)
- Use of data to drive change
- Physicians as partners in leadership
- Reduced use of hospital (Asheville)



Avoiding the tragedy of the commons

Perhaps: regional initiatives to improve health and health care

**Inpatient days per beneficiary
MA Hospital Service Areas**



Potential savings? 39% of inpatient days

Topics to consider:

- Who could convene the discussion?
- Who will monitor cost, use & margins?
- What services should be consolidated?
- Which teaching hospitals should merge?
- What workforce do we need?
- How will consumers be engaged?
- How will savings be shared to promote community and population health?