The long and winding road to Accountable Care

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Geisel School of Medicine
The long and winding road

Past      How did we get here?
Present    Where are we now?
Future     What will we do?
Per-Capita 2009 Medicare Spending by HRR (Age, Sex, Race Adjusted)

<table>
<thead>
<tr>
<th>Location, State</th>
<th>Amount</th>
<th>% 10+ MDs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Miami, FL</td>
<td>$16,639</td>
<td>59.4</td>
</tr>
<tr>
<td>McAllen, TX</td>
<td>$14,576</td>
<td>59.0</td>
</tr>
<tr>
<td>Manhattan, NY</td>
<td>$13,453</td>
<td></td>
</tr>
<tr>
<td>Los Angeles, CA</td>
<td>$12,711</td>
<td></td>
</tr>
<tr>
<td>Detroit, MI</td>
<td>$11,647</td>
<td></td>
</tr>
<tr>
<td>Chicago, IL</td>
<td>$11,646</td>
<td></td>
</tr>
<tr>
<td>Philadelphia, PA</td>
<td>$10,640</td>
<td></td>
</tr>
<tr>
<td>San Francisco,</td>
<td>$9,913</td>
<td>26.9</td>
</tr>
<tr>
<td>Cincinnati, OH</td>
<td>$9,388</td>
<td>22.7</td>
</tr>
<tr>
<td>Lebanon, NH</td>
<td>$8,124</td>
<td></td>
</tr>
<tr>
<td>La Crosse, WI</td>
<td>$6,532</td>
<td></td>
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</tbody>
</table>
An additional 1 in 5 patients survive delivering safe, reliable, and effective care. Cost decreases by $20,000 per patient by avoiding unnecessary care (hospital stays, ER visits, duplicate tests).
<table>
<thead>
<tr>
<th><strong>Problem</strong></th>
<th><strong>Solution</strong></th>
</tr>
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<tbody>
<tr>
<td>Confusion about aims</td>
<td>Clarify aims: better health, better care, lower costs.</td>
</tr>
<tr>
<td>Absent or poor data</td>
<td>Provide high-integrity information to patients and clinicians</td>
</tr>
<tr>
<td>Flawed conceptual model</td>
<td>New model: organized systems of care focused on population health</td>
</tr>
<tr>
<td>Wrong incentives</td>
<td>Shift to value-based payment</td>
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</table>
Affordable Care Act
- Investments in public health
- Health information technology
- Expanded coverage
- New payment models

“No Outcome, No Income”
David Nash
Dean, Jefferson School of Population Health
The Transition to New Delivery Models Is Underway

- **Incentives**
  - Volume
  - Value

- **Focus of responsibility**
  - Individual patient
  - Specific encounter
  - Patient and Population Continuum of Care

- **Locus of accountability**
  - Individual provider
  - Single site of care
  - Organization
  - All sites of care

Pay for performance → Episode-based payment → Global payment (no risk) → Global payment (with risk) → Community-based payment

Accountable Care Organizations
Figure 1: Medicare FFS All-Cause, 30-day Readmission Rate
The Randolph Project
Core Ideas
- Population-based virtual budgets
- Real or virtual organizations
- Performance measurement
- Patient choice
- Accommodate diversity
2009: 21 ACOs in the US.
Physician Group Practice Demonstration (10)
Alternative Quality Contract (8)
Brookings-Dartmouth Pilots (3)
2014: 600+ ACOs in the U.S
ACOs cover an estimated 20.5 million lives

- Pioneer: 669,000 (3.3%)
- MSSP: 5.3 million (25.8%)
- Commercial: 12.4 million (60.5%)

Leavitt Partners, 2014
WHAT DO THEY LOOK LIKE?
**WHAT DO THEY LOOK LIKE?**

**Optimus Healthcare Partners, Summit NJ**

<table>
<thead>
<tr>
<th>Organizational Structure</th>
<th>Partnership between two IPAs: Vista Health Systems IPA and Central Jersey Physician Network</th>
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<tbody>
<tr>
<td>Physicians</td>
<td>550 physicians; mostly solo / small office practices; 60+ specialists</td>
</tr>
<tr>
<td>Payer-Partners</td>
<td>Private: Horizon Blue Cross Blue Shield; others pending</td>
</tr>
<tr>
<td></td>
<td>Public: MSSP</td>
</tr>
<tr>
<td>ACO Governance</td>
<td>Four physician-driven committees: (1) quality, (2) finance, (3) medical/management/utilization, (4) credentialing</td>
</tr>
<tr>
<td>Payment Model</td>
<td>Private: PCP care management fees, netted against shared savings Public: Upside only Shared Savings,</td>
</tr>
<tr>
<td>Attributed Patients</td>
<td>Private: 40,000 patients under BCBS contract</td>
</tr>
<tr>
<td></td>
<td>Public: 27,000 Medicare beneficiaries under MSSP</td>
</tr>
<tr>
<td>Anticipated Distribution of Shared Savings</td>
<td>30% to Optimus operations; 70% to providers (mostly physicians); distribution determined by finance committee</td>
</tr>
</tbody>
</table>
WHAT DO THEY LOOK LIKE?

FQHC Urban Health Network
Coalition of 10 independent federally qualified health centers; 40 service sites extending through seven Minnesota counties

Walgreens
Three MSSP ACOs in partnership with health systems and physician organizations in FL, NJ, and TX
Physicians Represent Majority on Governing Board

WHAT DO THEY LOOK LIKE?

- Physician-led: 51% (94%)
- Jointly led by physicians and hospital: 33% (65%)
- Hospital-led: 3% (20%)
- Coalition-led: 6% (80%)
- State, region, or county-led: 1% (50%)
- Federally Qualified Health Center-led: 1% (0%)
- Some other arrangement: 5% (60%)

National Survey of Accountable Care Organizations: Colla et al. Health Affairs 2014
WHAT DO THEY LOOK LIKE?

- Fully developed readmissions program
- Inappropriate ED use program
- All PCPs attested to meaningful use
- Comprehensive care management
- Advanced HIT capabilities
- Comprehensive previsit planning
- Transitions program across settings

National Survey of Accountable Care Organizations: Colla et al. Health Affairs 2014
<table>
<thead>
<tr>
<th>Program</th>
<th>Financial Performance</th>
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</table>
| Physician Group Practice Demonstration| - Small overall savings -- $114 per capita  
- Big savings for duals -- $532 per capita  
- Savings largely in acute care        |
| Pioneer Program                       | - Year One: $147m total; $76m to ACOs  
- Year Two: $96m total; $68m to ACOs  
- Savings overall 0.5%: 0.3% vs FFS 0.8% |
| Medicare Shared Savings Program       | - Year One: $652m total; $300m to ACOs  
- 53 received bonuses; 52 savings; no bonus  
- Savings overall 0.3%                  |
HOW ARE THEY DOING? QUALITY

MSSP Release of final year one results in Sept
220 ACOs launched in 2012 and 2013
Nine failed to report (4 would have received savings)
ACOs better than FFS providers on 17 of 22 comparable measures
Improvement reported on 30 of 33 measures
HOW ARE THEY DOING? PIONEER 2012-2013

Improved on 28 measures
Mean percentile score 71.8 to 85.2

Patient caregiver experience
ACO-1 Getting timely care
ACO-2 How well providers communicate
ACO-3 Patients overall rating of provider
ACO-4 Access to specialist
ACO-5 Health promotion and education
ACO-6 Shared decision-making
ACO-7 Self-rated health and function

Care coordination-safety
ACO-8 Readmission rate (risk adjusted)
ACO-9 COPD/Asthma admission rate
ACO-10 Heart Failure admission rate
ACO-11 PCP - EHR qualification rate
ACO-12 Medication reconciliation
ACO-13 Screening for fall risk

Preventive Health
ACO-14 Influenza vaccination status
ACO-15 Pneumonia vaccination status
ACO-16 BMI index screening
ACO-17 Tobacco use screening and advice
ACO-18 Depression screening and follow-up plan
ACO-19 Colorectal cancer screening
ACO-20 Breast cancer screening
ACO-21 Blood pressure screening and follow-up

At-risk population
ACO-22 BP control in diabetics
ACO-23 LDL control in diabetics
ACO-24 HgB A1c control in diabetics <8%
ACO-25 Daily aspirin with DM and CVD
ACO-26 Tobacco non-use
ACO-27 HgB A1c in poor control
ACO-28 BP control
ACO-29 CVD – LDL control
ACO-30 CVD – Aspirin or other antithrombotic
ACO-31 Beta blocker for CHF
ACO-32 CVD composite
ACO-33 ACE/ARB for CHF or DM
HOW ARE THEY DOING? ALTERNATIVE QUALITY CONTRACT

Song et al. NEJM, Oct 30, 2014
OTHER FINDINGS FROM ONGOING RESEARCH

Easier to succeed in high cost regions

Physician-led ACOs may have edge
  Half of those getting savings were MD led
  But: hospital as part of ACO unrelated to performance

Strategies:
  Focus on high cost patients;
  Behavioral health integration a target; but limited success yet
  HIT use important
  Physician engagement a high priority

Challenges:
  Only 1 of 59 patients in focus groups aware of ACO
  Start up costs
THE CURRENT MOMENT

Value-Based Models Poised for High Growth

Within three years...

78%
Of physician practices expect to have meaningful value-based revenue

49%
Of facility payments is projected to be derived from value-based payment models

Projected Medicare Spending as a Share of GDP, 2013–2085

Source: Medicare Trustees (2012); Social Security Trustees (2012); CEA calculations.
THE CURRENT MOMENT

Republican control of Congress: impact on ACA

Wholesale repeal unlikely;
Vulnerable: employer mandate; medical device tax
Uncertain: CMMI; IPAB

ACOs likely safe – for now

Generally non-controversial and supported by conservatives
Welch-Black ACO Bill
Seen as possible contributor to slower spending growth
Per-bene spending growth averaged 0.8% past two years
Challenges – Technical / Legal

Notice of proposed rule expected “soon”
   Feb 2014 RFI elicited range of ideas
   Broad authority to restructure program

Revisions in play:
   Prospective benchmarks and attribution (many)
   Include NP’s and PA’s in attribution (MedPAC)
   Synchronize ACO and MA benchmarking (MedPAC)
   Attestation and attribution (Premier; Welch-Black)
   Financial incentives for patients to align w/ ACO (Welch-Black)
   Regulatory relief if bearing 2-sided risk (MedPAC; Welch-Black)
   Encourage 2-sided risk, but support continued “on-ramp”
Challenges – to our professions

Top Medicare Doctor Paid $21 Million in 2012, Data Show

By Caroline Chen and Sophia Pearson  |  Apr 9, 2014 7:39 PM ET  |  143 Comments  |  Email  |  Print

A doctor who treats a degenerative eye disease in seniors was paid $21 million by Medicare in 2012, twice the amount received by the next ophthalmologist on a list of 880,000 medical providers released by the government.

The data on the payments was given to the public for the first time today by the Centers for Medicare and Medicaid Services. The list, a detailed account of how $77 billion in federal health-care funds were spent in 2012, showed a wide range in which some top earners were paid.

Giant Healthcare Systems: Higher Prices, Fewer Choices And Impersonal Care

It seems like every day another large hospital system or pharmaceutical company is acquiring or merging with another large entity to form a giant healthcare system that claims “bigger is better.” It reminds us of the big fish
### PGP Demo

<table>
<thead>
<tr>
<th></th>
<th>Savings Achieved</th>
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<tbody>
<tr>
<td><strong>Overall</strong></td>
<td><em>1%</em></td>
</tr>
<tr>
<td><strong>Duals</strong></td>
<td><em>5%</em></td>
</tr>
<tr>
<td><strong>All Systems</strong></td>
<td><em>1%</em></td>
</tr>
<tr>
<td><strong>Marshfield</strong></td>
<td><em>9%</em></td>
</tr>
</tbody>
</table>

|                      | *11%*            |

Kori Krueger, MD  
Marshfield Clinic
The argument in brief

1. The health care system is failing us
2. This need not be so
3. New payment and delivery models offer promise.
4. It won’t be easy
5. But it might be fun
Please help
We are in the field with Round 3 National Survey of Accountable Care Organizations
Thanks!