Toward a high performing health system

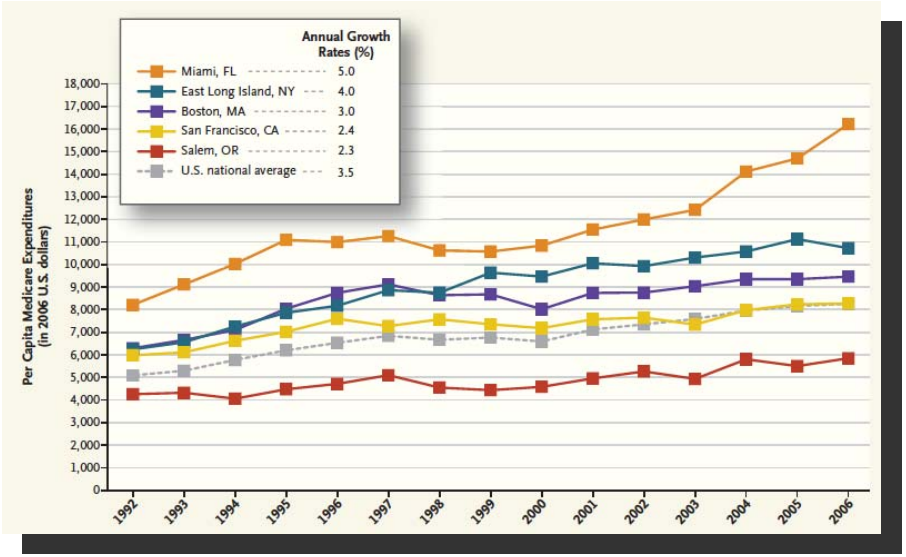
Accountable Care: Past, Present and Future

Elliott Fisher, MD, MPH
Director, The Dartmouth Institute for Health Policy and Clinical Practice
John E. Wennberg Distinguished Professor, Geisel School of Medicine

June 10, 2016

Looking back

Origins: variations in spending across regions and academic centers



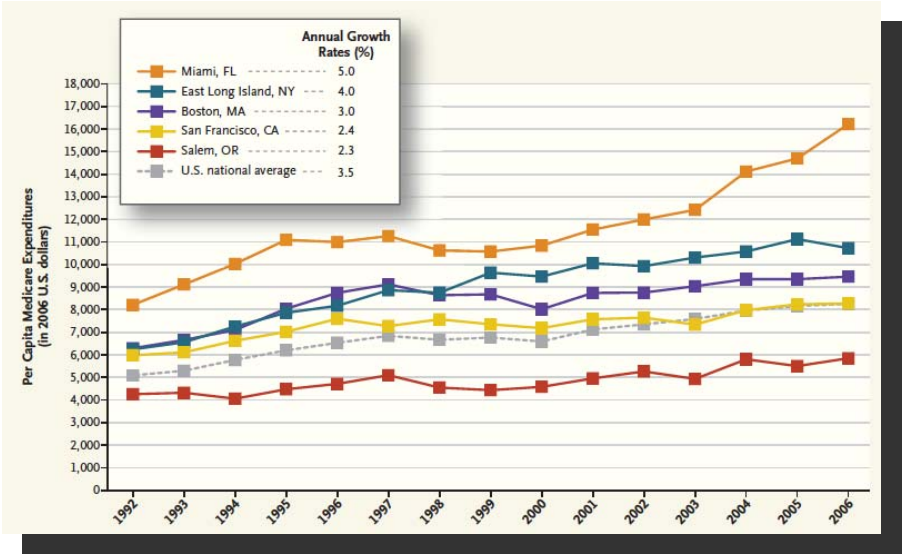
Spending and resource use chronically ill, last 6 months of life	NYU Langone Medical Center		Mayo Clinic (St. Mary's Hospital)	
	2001-05	*2014*	*2001-05*	*2014*
Total Medicare spending	$57,716		$28,763	
Hospital days	31.2		12.0	
Physician visits	76.9		23.9	

How can the best medical care in the world cost twice as much as the best Medical care in the world?

Uwe Reinhardt

Looking back

Origins: variations in spending across regions and academic centers



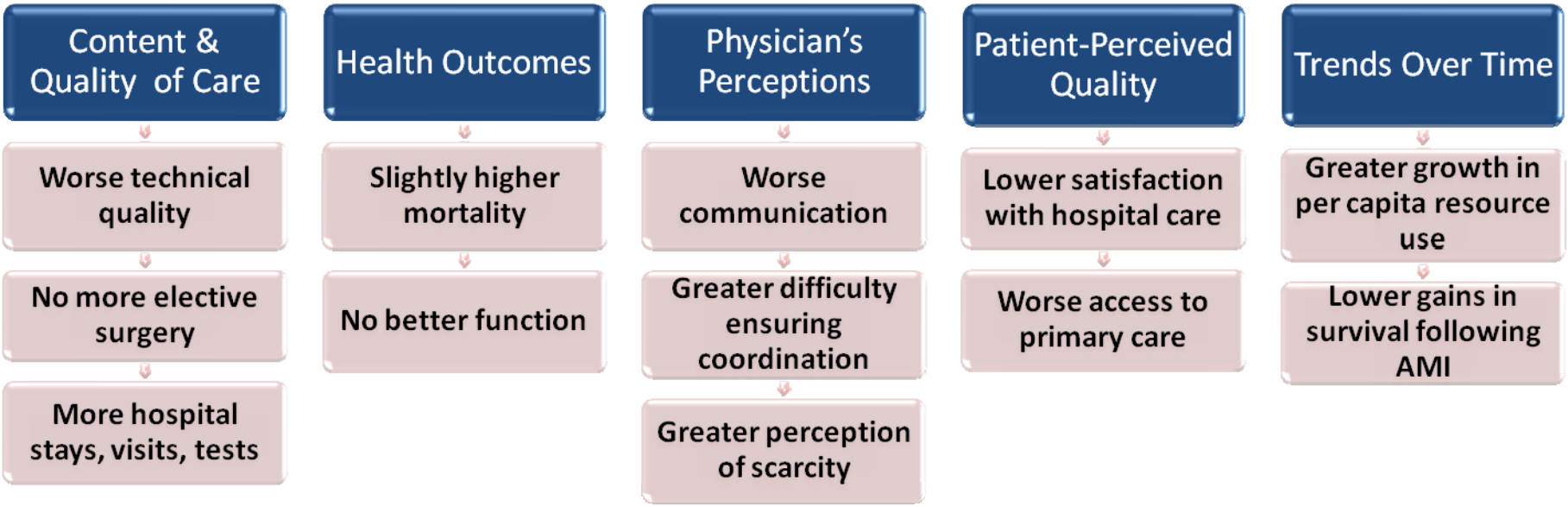
Spending and resource use chronically ill, last 6 months of life	NYU Langone Medical Center		Mayo Clinic (St. Mary's Hospital)	
	2001-05	*2014*	*2001-05*	*2014*
Total Medicare spending	$57,716	$71,706	$28,763	$39,505
Hospital days	31.2	15.6	12.0	9.8
Physician visits	76.9	47.8	23.9	20.9

How can the best medical care in the world cost twice as much as the best Medical care in the world?

Uwe Reinhardt

Looking back

Origins: no evidence of benefit from greater use of discretionary care



(1) Ann Intern Med: 2003; 138: 273-298
(2) Health Affairs web exclusives, October 7, 2004
(3) Health Affairs, web exclusives, Nov 16, 2005
(4) Health Affairs web exclusives, Feb 7, 2006
(5) Ann Intern Med: 2006; 144: 641-649

Looking back

Original theory – how might we improve health system performance?

Problems needing attention

Rising costs; overuse of supply-sensitive care

Quality uneven

Patient care fragmented and poorly coordinated

Original theory:

Organizations accountable for defined population (all patients; all their needs)

Focus on total cost of care: create incentives to reduce capacity and overuse

Provider leadership – central role for physicians

Collaborative model: across continuum of care; with payers as partners

Meaningful measures of quality, rewards for improvement

Flexibility: but with goal of fully integrated care and single business model

Health Affairs 28, no. 2 (2009): w219–w231

Where are we now?

What is the current evidence

ACO growth continues

ACO contracts increasing – public and private payers;

Penetration varies across US

Impact on costs

Overall savings small, highly variable

Some have achieved year on year savings; others nothing

AQC shows increasing savings over time.

Impact on quality

Technical quality improving substantially across almost all ACOs

Patients report better overall quality and access to care

Interesting findings

Spillover effects for Medicare beneficiaries cared for by commercial ACOs

Focus important: Savings greatest among high-cost, high risk populations

Discretionary care? ACOs are reducing (a) hospitalizations, (b) ER utilization; (c) low value care

Where are we now?

How should we interpret the evidence?

Surprises:

- Degree of behavior change observed is substantial, given weak incentives
- Reduction in low value care contrasts with “blunt” instrument of cost-sharing
- Spillover effects point to changes in both clinical and system behaviors

Perhaps there is something about ACOs & health professional leadership?

- New payment models enable physicians to do the right thing
- Physician judgment is essential to good decision-making at point of care
  - Few decisions are black or white; most are in “gray areas”
- Organizational support is essential for redesign of care
  - Care-transitions programs
  - Integration of behavioral and medical services
  - Partnerships with other organizations

Where are we now?

Challenges

Prices remain a problem – for privately insured patients

Consolidation continues, perhaps accelerated by ACOs

And – there is remarkable variation in prices across US

	Private Spending		Medicare Spending	
High Private, High Medicare	Actual	Rank	Actual	Rank
Manhattan, NY	$4,152	272	$13,576	304
Napa, CA	$5,516	306	$10,117	233
High Private, Cheap Medicare				
La Crosse, WI	$4,272	285	$6,844	1
Rochester, MN	$4,564	296	$7,433	14
Cheap Private, High Medicare				
San Bernadino, CA	$2,543	6	$11,189	276
Tacoma Park, MD	$2,966	40	$10,130	235
Cheap Private, Cheap Medicare				
Dubuque, IA	$2,573	9	$7,243	5
Rochester, NY	$2,196	3	$7,285	8

Cooper et al, NBER 2015

Where are we now?

Challenges

Prices remain a problem – for privately insured patients

Consolidation continues, perhaps accelerated by ACOs

And – there is remarkable variation in prices across US

Most patients remain in the dark

Few are aware that they are in an ACO

ACOs struggling with approaches to "patient engagement"

Technical challenges are substantial

Benchmarks; timing of transition to risk; how much risk;

Regulatory relief, malpractice reform;

Implementation and alignment of MACRA reforms: MIPS, definitions of APMs

Relationship of episodes and bundles to ACOs

"Social" challenges

What to do about weak incentives

Complexity of changes -- distraction

Persistent schisms: primary care vs specialists; hospitals vs physicians

How might we strengthen incentives?

Be clear about where we are going – and align programs toward that goal

Continue transition toward two-sided payment models and capitation

- Next-Gen model
- MSSP Track 3
- APMs under MACRA

Accelerate public and private payer alignment

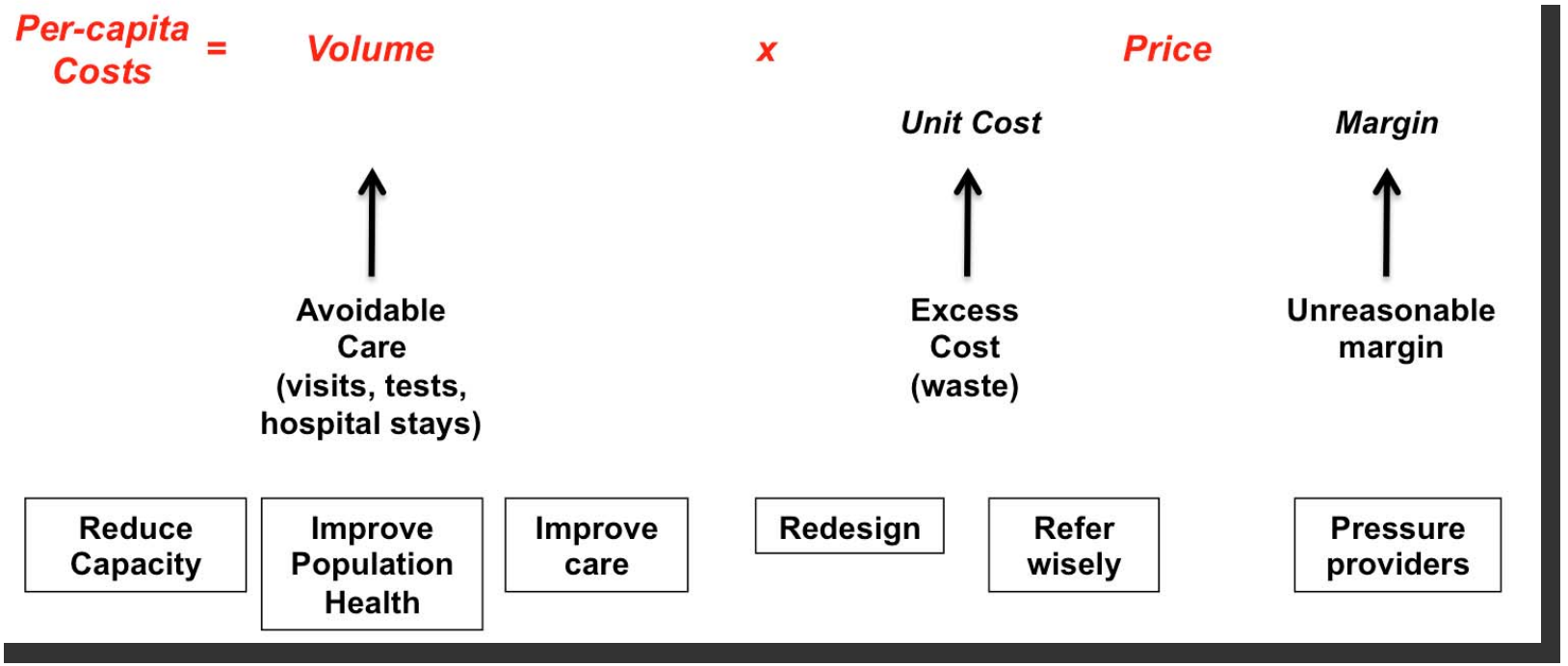
- Having all-payer model may be more important than two sided risk
- Not getting a reward can be framed as a loss

Align episode-based payment with total cost of care accountability

- Episodes helpful: engage specialists and hospitals in managing to a budget
- Challenge: they don't solve the volume problem
- Solution: end-game must have episodes managed within total-cost of care incentive

How might we strengthen incentives?

Think about all elements driving costs – and address each one



Remember why we are here

The challenges we faced 10 years ago remain:

Health care continues to crowd out important social spending

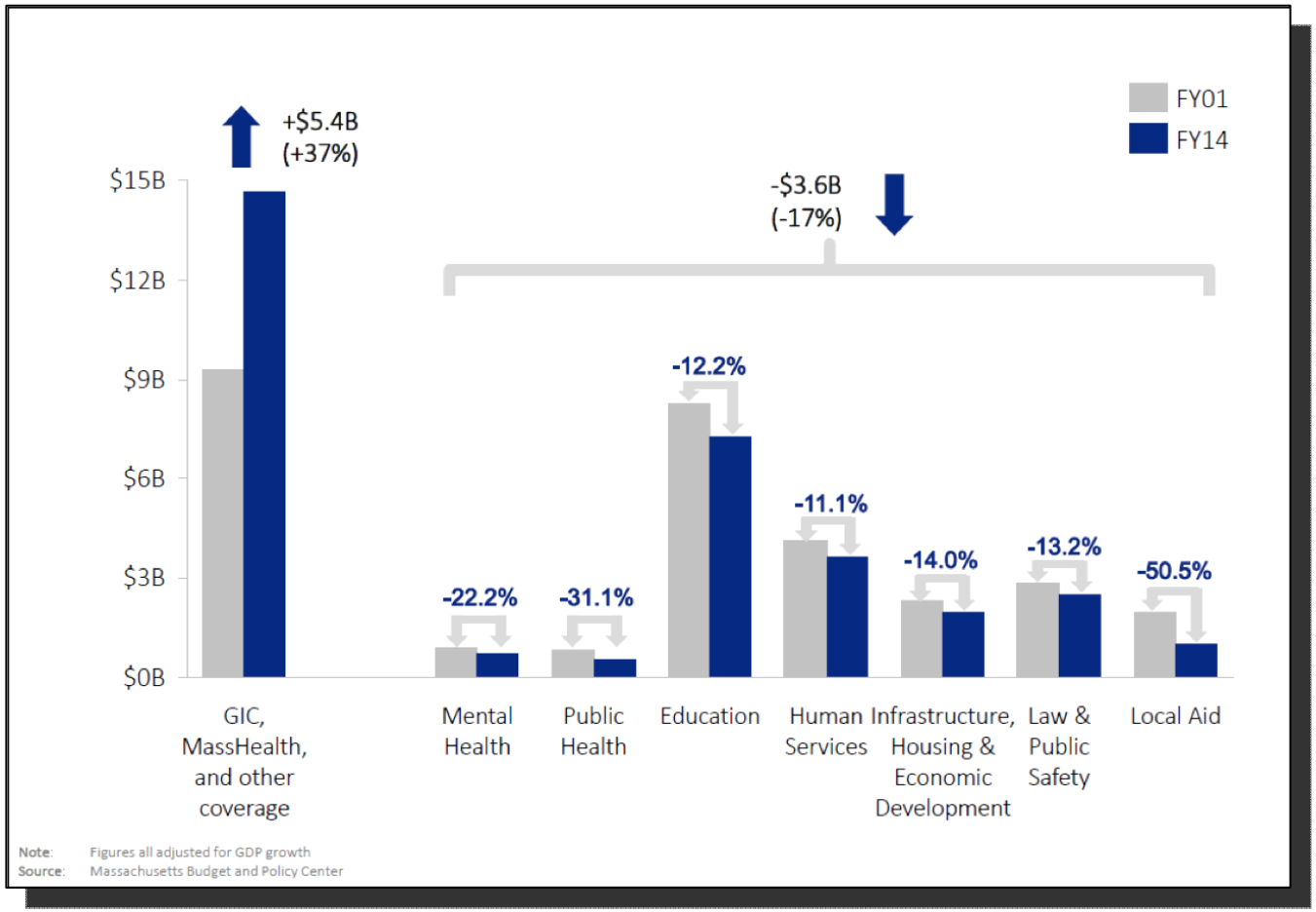


Figure thanks to Tim Ferris

Remember why we are here

It is possible to do better

Some systems are making substantial progress

Optimus: Reducing costs each year for past 4, with shared savings

Tucson: year over year reductions; finally receiving shared savings bonus

Why is it working?

Data: on quality and cost of care – and how to improve both

Physicians: want to provide great care to their patients

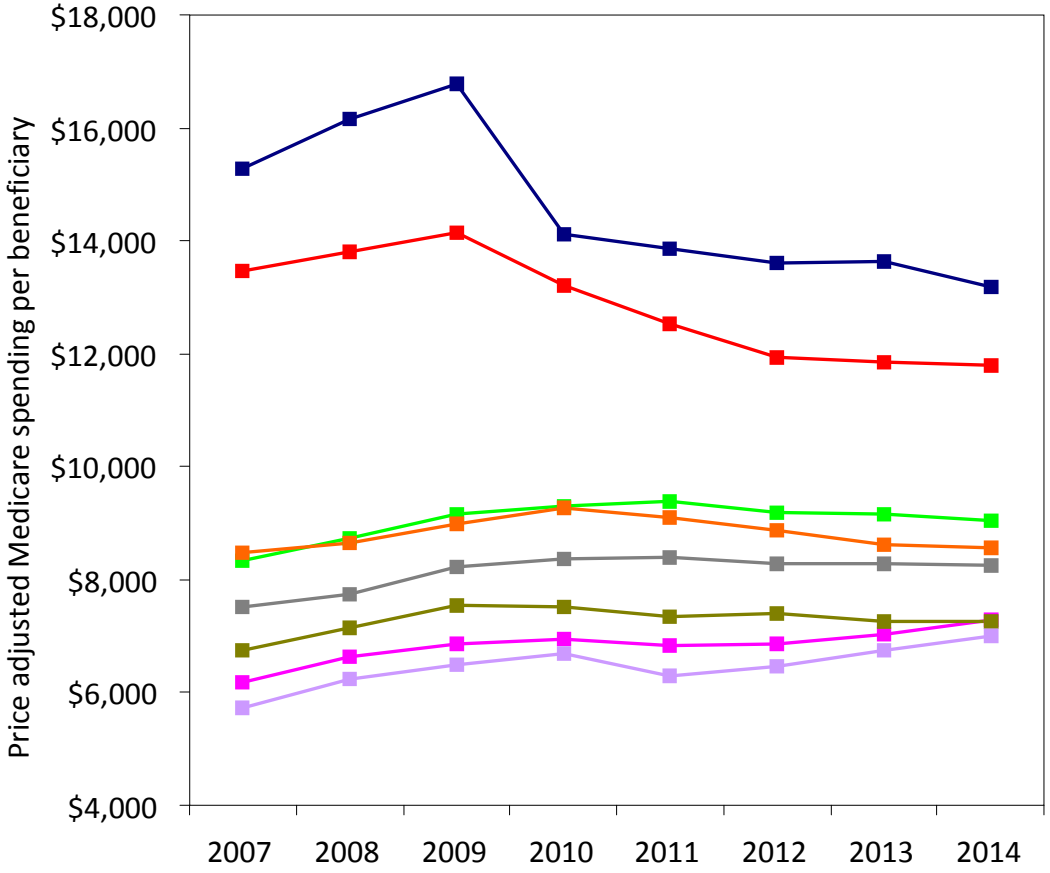
Threat? Distraction

Jim Barr

Pal Evans

Remember why we are here

It may be working – in some places



	Average annual growth rate	
	2007-10	2011-14
Miami, FL	-2.6%	-1.6%
McAllen, TX	-0.7%	-2.0%
Boston, MA	3.6%	-1.2%
Worcester, MA	3.0%	-2.1%
Springfield, MA	3.5%	-0.6%
Rochester, MN	3.8%	2.0%
Tucson, AZ	3.6%	-0.4%
La Crosse, WI	5.1%	3.5%
United States	4.0%	-0.3%

Remember why we are here

Redesigning care can give our patients back their lives