BROOKINGS | QUALITY. INDEPENDENCE. IMPACT.

# Moving Toward Accountable Care

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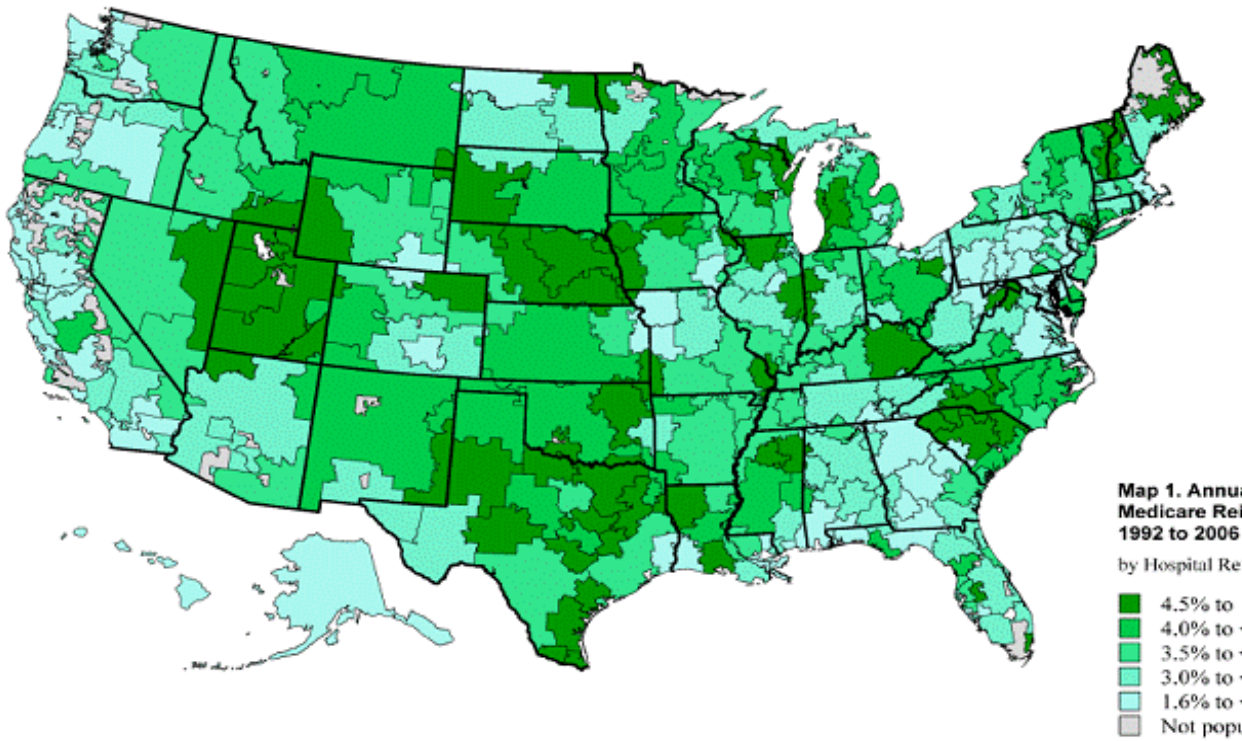
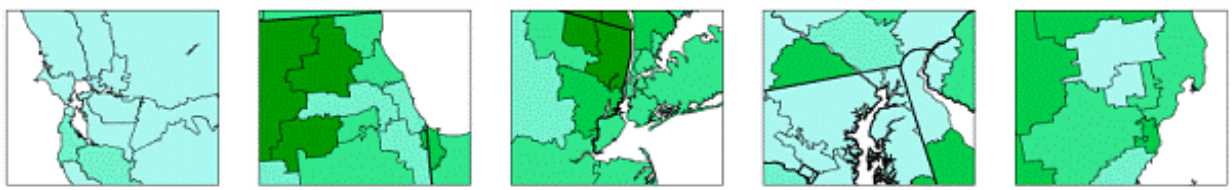
# Regional variations in growth of per capita Medicare spending, 2006




The Dartmouth Atlas Project, "Policy Implications of Variations in Medicare Spending Growth" (February 2009).

THE DARTMOUTH INSTITUTE FOR HEALTH POLICY & CLINICAL PRACTICE
*Where Knowledge Informs Change*

# Research on causes of regional variations

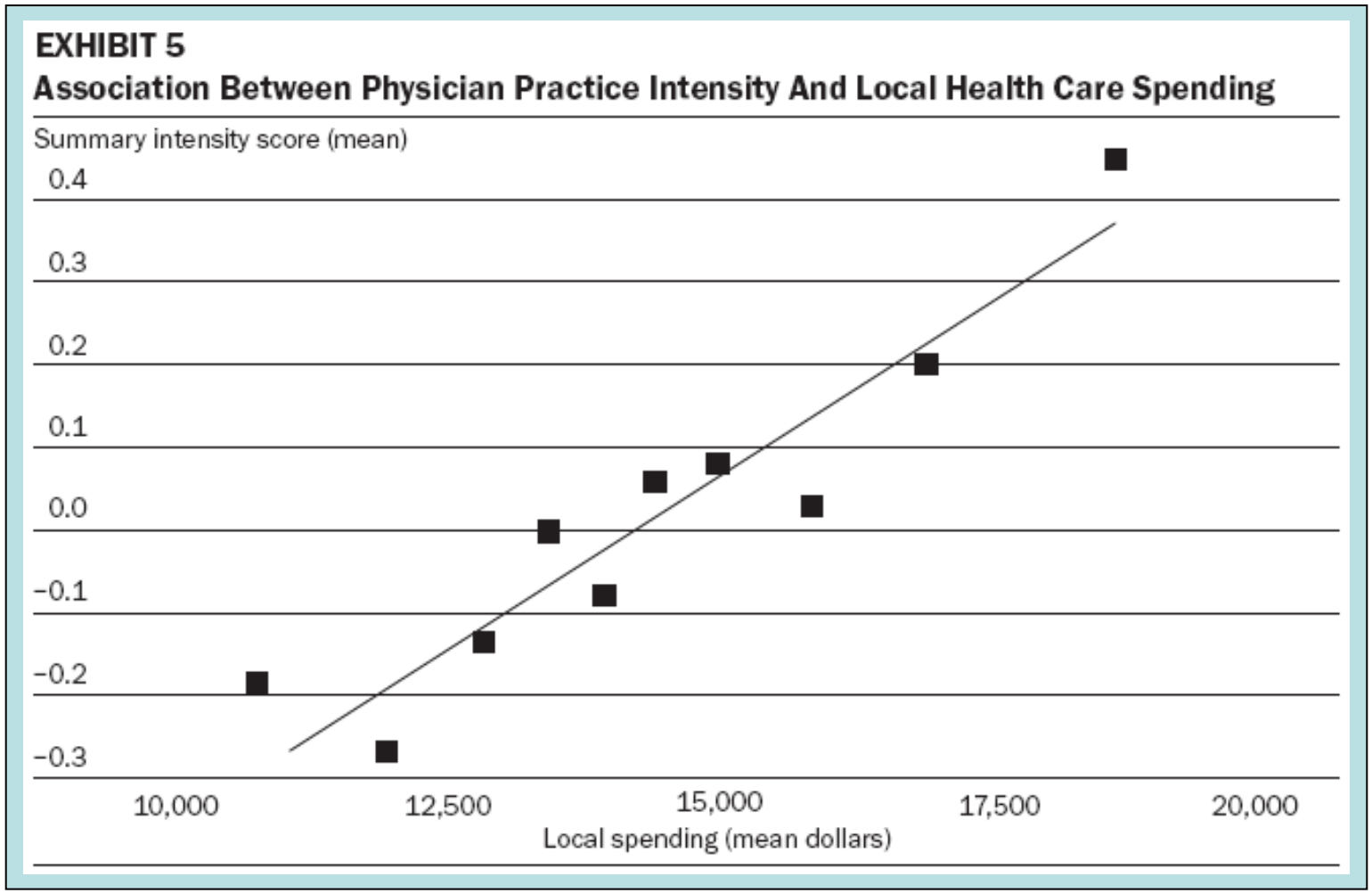
**For a patient with well-controlled hypertension and no other medical problems, when would you schedule the next visit?**

**Other "guideline free" decisions used in intensity index**

| | |
|---|---|
| **Referral to specialist** | reflux, angina |
| **Diagnostic testing** | cardiac ultrasound, chest CT |
| **Hospital admission** | angina, heart failure |
| **Admission to ICU** | heart failure |
| **Referral to palliative care** | heart failure |

Sirovich et al. "Discretionary Decision Making By Primary Care Physicians And The Cost Of U.S. Health Care." Health Affairs, 27, no. 3 (2008): 813-823.

# Research on causes of regional variations

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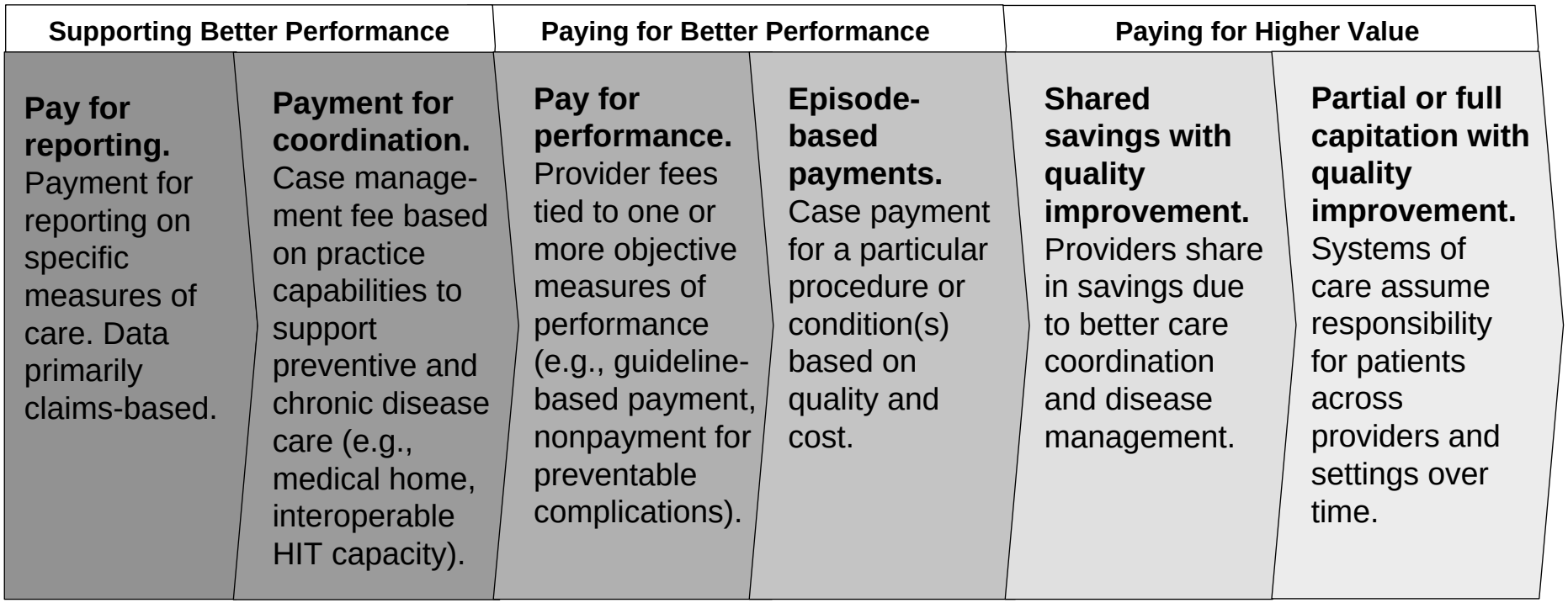
# Key elements of delivery system reform

- **Local accountability for quality and cost across the care continuum**
  - » Reforms should "build in" expectations of cost containment and quality improvement
- **Feasible across diverse practice types/organizational settings**
  - » Reforms should be flexible to allow for variation in the strategies that local health systems use to improve care
- **Shift payments from rewarding volume and intensity to increasing value**
  - » Payments should encourage collaboration and shared responsibility among providers and consistent incentives/measures from payers
- **Help consumers make better decisions**
  - » With increased accountability on the part of providers must come greater transparency for consumers

# Evolution of payment reform

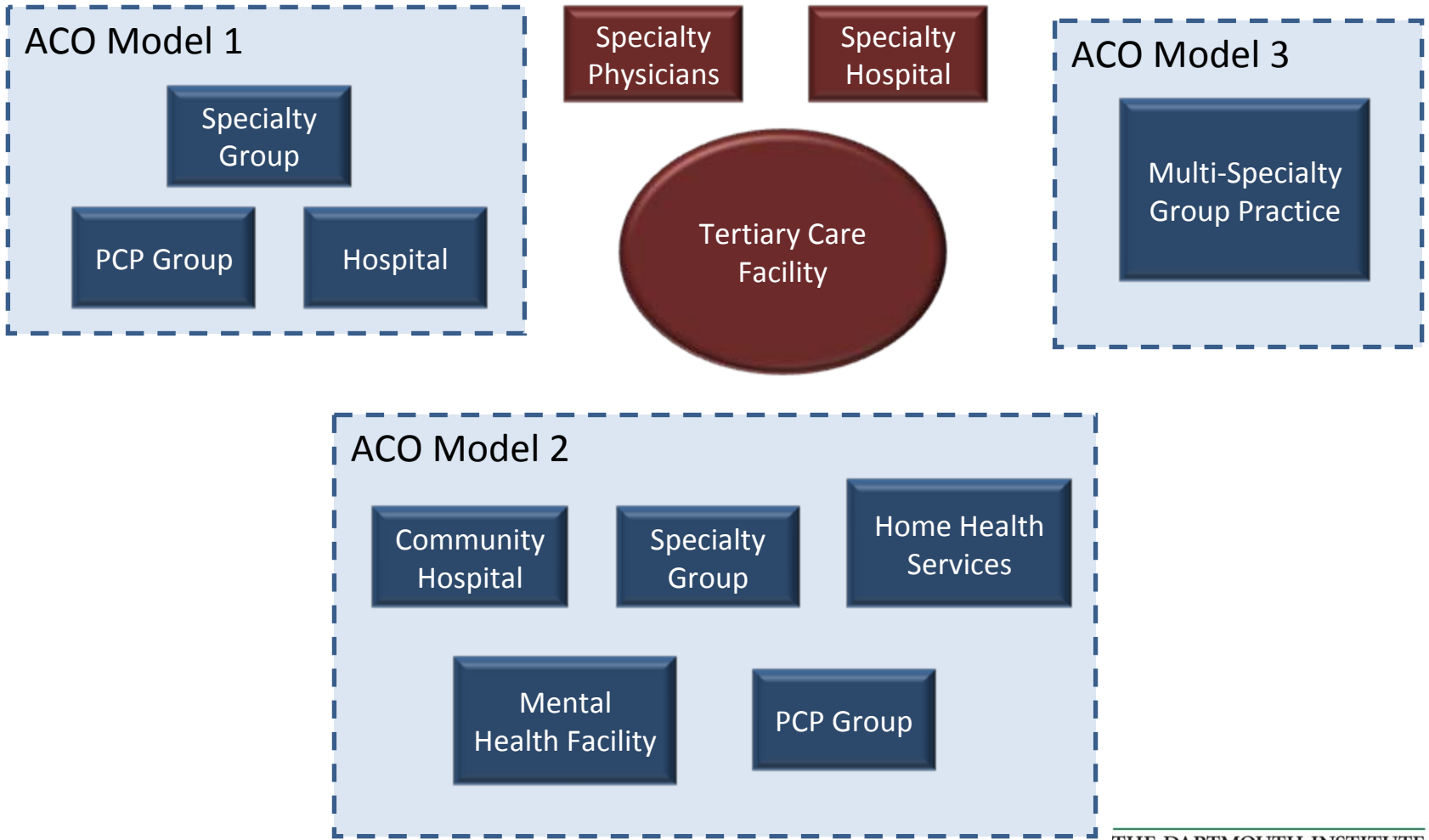
Past and Emerging Models of Accountability in Provider Payments



# Accountable Care Organizations

- ACOs are collaborations to assume responsibility for overall patient care, across providers and settings.
- Key features of ACOs:
  - Voluntary provider participation
  - Local accountability for cost, quality, and capacity across the continuum of care
  - Payment incentives (e.g., shared savings) and related organizational support gives providers the support needed to improve care and slow cost growth
  - Performance measurement to ensure that appropriate care is being delivered and that cost savings are not attributable to limitations on necessary or appropriate care

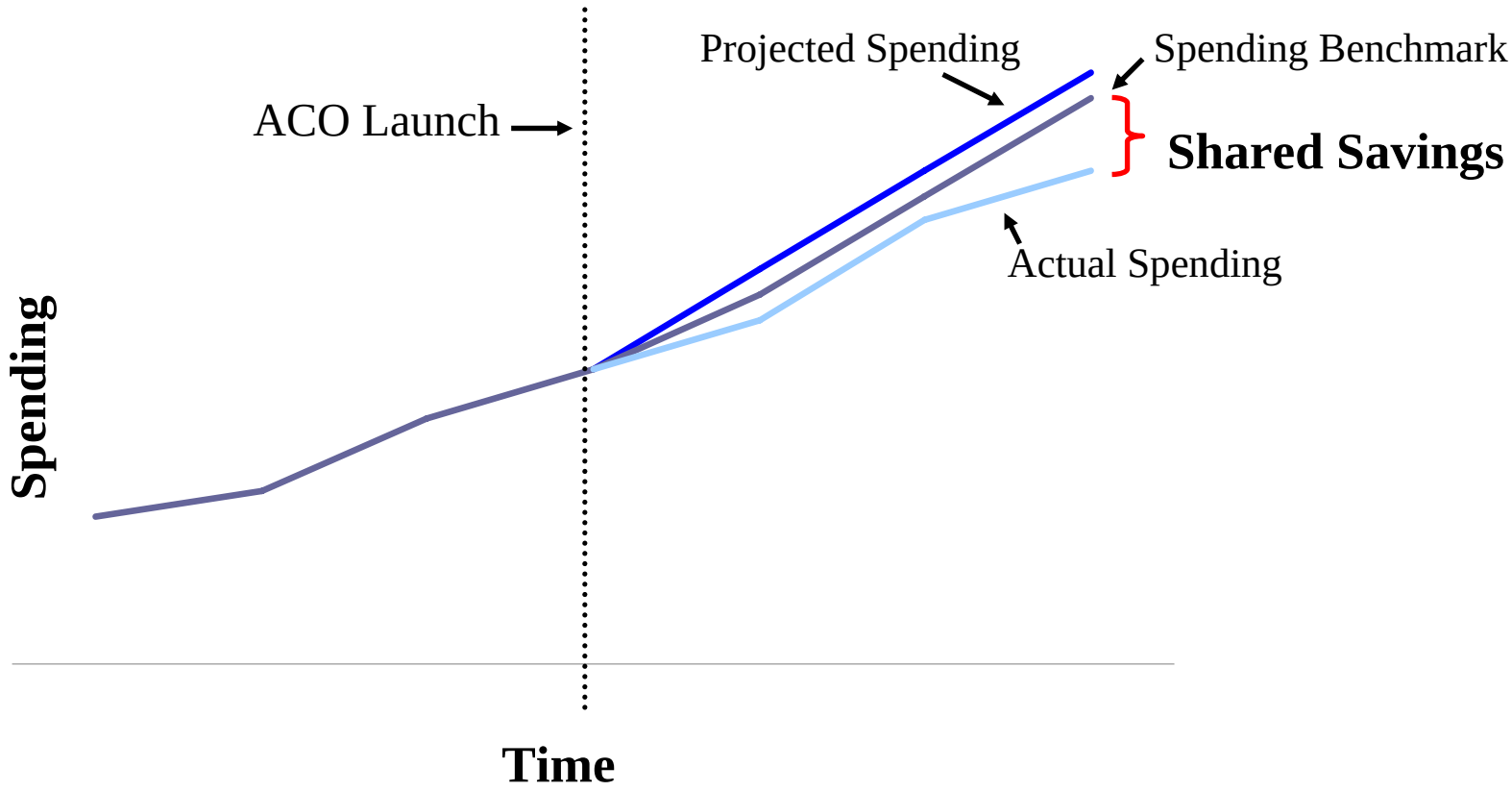
# ACOs can be configured in different ways



# Some ACO Issues

- **ACO Structure:** Established governance structure and broad (voluntary) physician and payer participation. Ideally participation by Medicare.
- **Measures:** Well-established performance measures relevant to multiple payers/populations. Included measures become more sophisticated over time.
- **Payment Incentives:** Participating payers agree to adopt their own provider payment incentives that at a minimum involve QI and may include cost savings and efficiency; incentives based on performance across specified populations.
  - » Over time, ACO payment incentives can transition from "one-sided" shared savings to two-sided risk, partial capitation, and further reforms
  - » Beneficiary incentives also possible (e.g., differential copays)
- **Performance reporting:** Providers, payers, and consumers receive regular, risk-adjusted reports about performance with benchmarks.
- **Complementary reforms:** ACOs are compatible with, and can be reinforced by, other reforms including bundled payments, care coordination, chronic disease management, pay-for-performance, incentives to prevent re-hospitalizations, etc.

# Initial Shared Savings Derived from Spending Below Benchmarks



# Steps for Initial ACO Implementation

1. Local providers and payers agree to pilot ACO reform
2. ACO provides list of participating providers to payers
3. Patients are "assigned" to ACOs (e.g., based on preponderance of E&M codes)
4. Actuarial projections about future spending are based on last 3 years
5. Determine/negotiate spending benchmark and shared savings
6. ACO implements capacity, process, & delivery system improvement strategies
   - e.g., reducing avoidable hospitalizations, coordinating care, health IT
7. Progress reports on cost and quality are developed for ACO beneficiaries
8. At year end, total and per capita spending are measured for all patients (regardless of whether they received care from ACO providers)
9. Savings under the benchmark is shared between providers and payers

# ACOs and Health Care Reform

- Potential element of health care reform
  - CBO Budget Options ("Bonus-eligible organizations")
  - President's Budget
  - Senate Finance reform options
- Can be reinforced by other delivery reform incentives
  - Health IT and ERx incentives, payment incentives for reporting or performance
  - Update-related incentives for care coordination
- Brookings/Dartmouth ACO Collaborative
  - ACO "Learning Network"
  - In-depth technical assistance for ACO pilots
  - Support for building large-scale infrastructure for "rapid learning" pilots