Accountable Care Organizations
Why? How? And where are we?

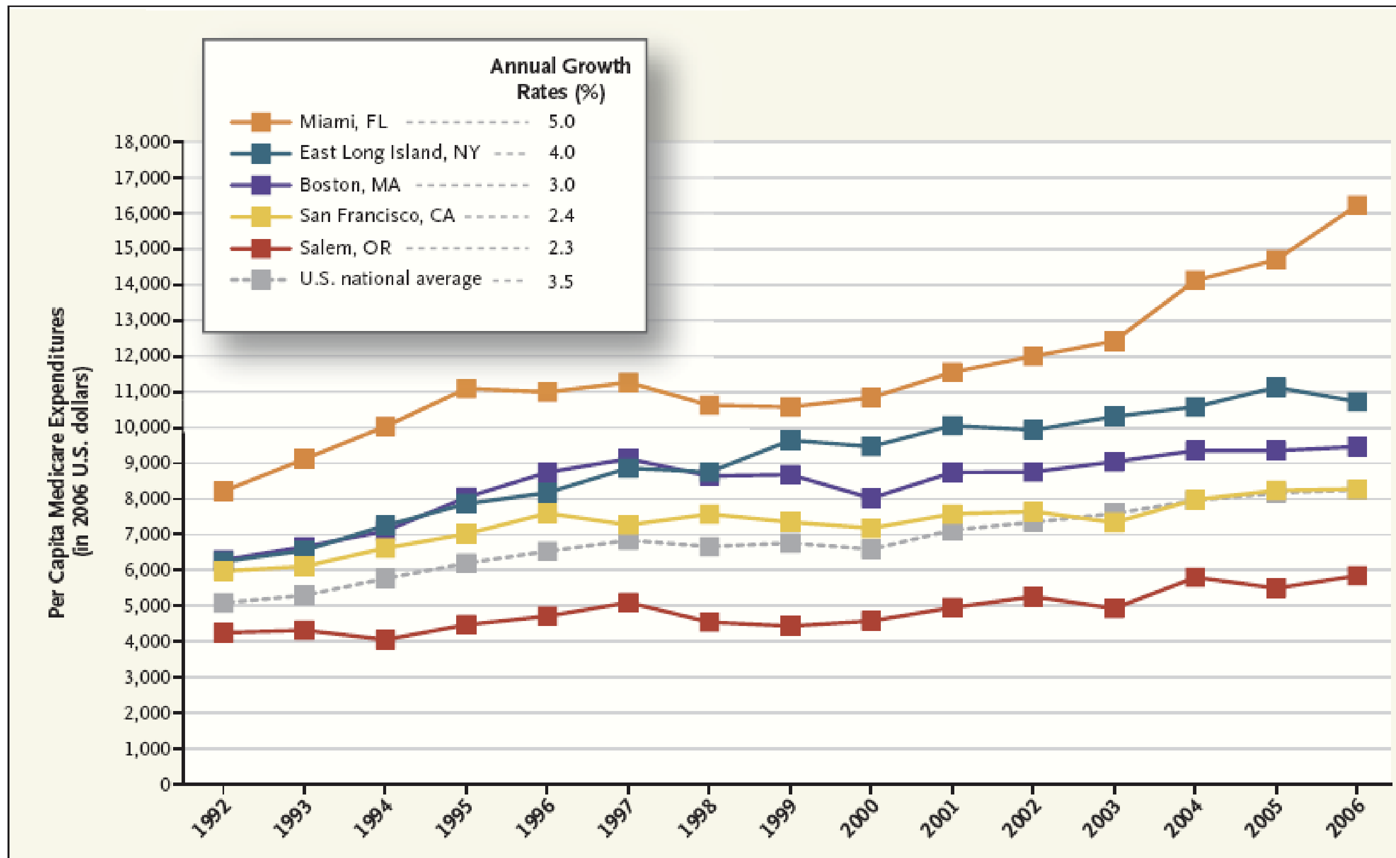
National Hospital Payment Reform Summit

September 16, 2009

Elliott Fisher, MD, MPH

The Dartmouth Institute for Health Policy and Clinical Practice

Annual Growth Rates
Per Capita Medicare Spending



Source: Slowing the Growth of Health Care Spending: Lessons from Regional Variation
Fisher, Skinner, Bynum, New England Journal of Medicine, February 26, 2009

What Does Higher Spending Buy?

	Rate of Avoidable Admissions[1]	Physician Visits[2]	Per-beneficiary spending on imaging	Ratio Primary Care to Specialist visits[2]	Percent seeing 10 or more MDs[2]
Miami	95	106	$1434	0.72	51
E. Long Island	75	91	$1388	0.97	50
Boston	81	59	$864	1.20	39
San Francisco	52	64	$687	1.12	32
Salem	44	38	$512	1.30	18

Notes

1. Ambulatory Care Sensitive Hospitalizations per 1000 Medicare beneficiaries
2. Utilization during last 2 years of life, Medicare beneficiaries with serious chronic illness.

And more isn't better.

ENGELBERG CENTER for Health Care Reform at BROOKINGS

Sources: E.S. Fisher et al, *Annals of Internal Medicine* 138, no. 4 (2003): 273-287. K. Baicker et al, *Health Affairs* web exclusive, 7 Oct 2004. E.S. Fisher et al., *Health Affairs* web exclusive, 16 Nov 2005. J.S. Skinner et al, *Health Affairs* 25, no. 2 (2006): w34-w47. B.E. Sirovich et al, *Annals of Internal Medicine* 144, no. 9 (2006): 641-649. F.J. Fowler et al, *JAMA* 299, no. 20 (2008): 2406-2412.

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

Moving forward

Addressing the underlying causes of rising costs, poor quality

Underlying problem	Key principles
Lack of support for improvement, care management and coordination.	**Organizational support:** Develop virtual or real integrated systems to support practice.
Failure to recognize role of local system (e.g. capacity) as cost-driver.	**Organizational accountability:** Foster accountability for total costs – and capacity.
Assumption that more is better. Equating less care with rationing.	**Measurement:** Comprehensive performance measures: outcomes, patient experience.
Payment system that rewards more care, increased capacity, high margin treatments, entrepreneurial behavior.	**Payment reform:** foster accountability for capacity – and behavior: capitation or global shared savings.

Evolution of Payment Reform

From Incremental Reporting Bonuses to More Comprehensive and Integrated Population-Level Reforms

Supporting Better Performance		Paying for Better Performance		Paying for Higher Value	
Pay for reporting. Payment for reporting on specific measures of care. Data primarily claims-based.	Payment for coordination. Case manage-ment fee based on practice capabilities to support preventive and chronic disease care (e.g., medical home, interoperable HIT capacity).	Pay for performance. Provider fees tied to one or more objective measures of performance (e.g., guideline-based payment, nonpayment for preventable complications)	Episode-based payments. Case payment for a particular procedure or condition(s) based on quality and cost.	Shared savings with quality improvement. Providers share in savings due to better care coordination and disease management.	Partial or full capitation with quality improvement. **Systems of care assume responsibility for patients across providers and settings over time.**

Key Elements of Accountable Care Model

- **Local Accountability**
  - Foster provider accountability for quality and per capita cost for their patient population
- **Standardized Performance Measurement**
  - Increased accountability on the part of providers should be accompanied by improved incentives and information for consumers
- **Payment Reform**
  - Transition payments from rewarding volume/intensity to increasing value
  - Payments should encourage collaboration and shared responsibility among providers and consistent incentives from payers

Accountable Care Organizations

ACO configurations can vary, reflecting the diversity of local health care markets and preferences of participants;

Integrated delivery systems, Physician-Hospital Organizations, Independent Practice Associations (IPA), physician group practices, regional collaborations

---

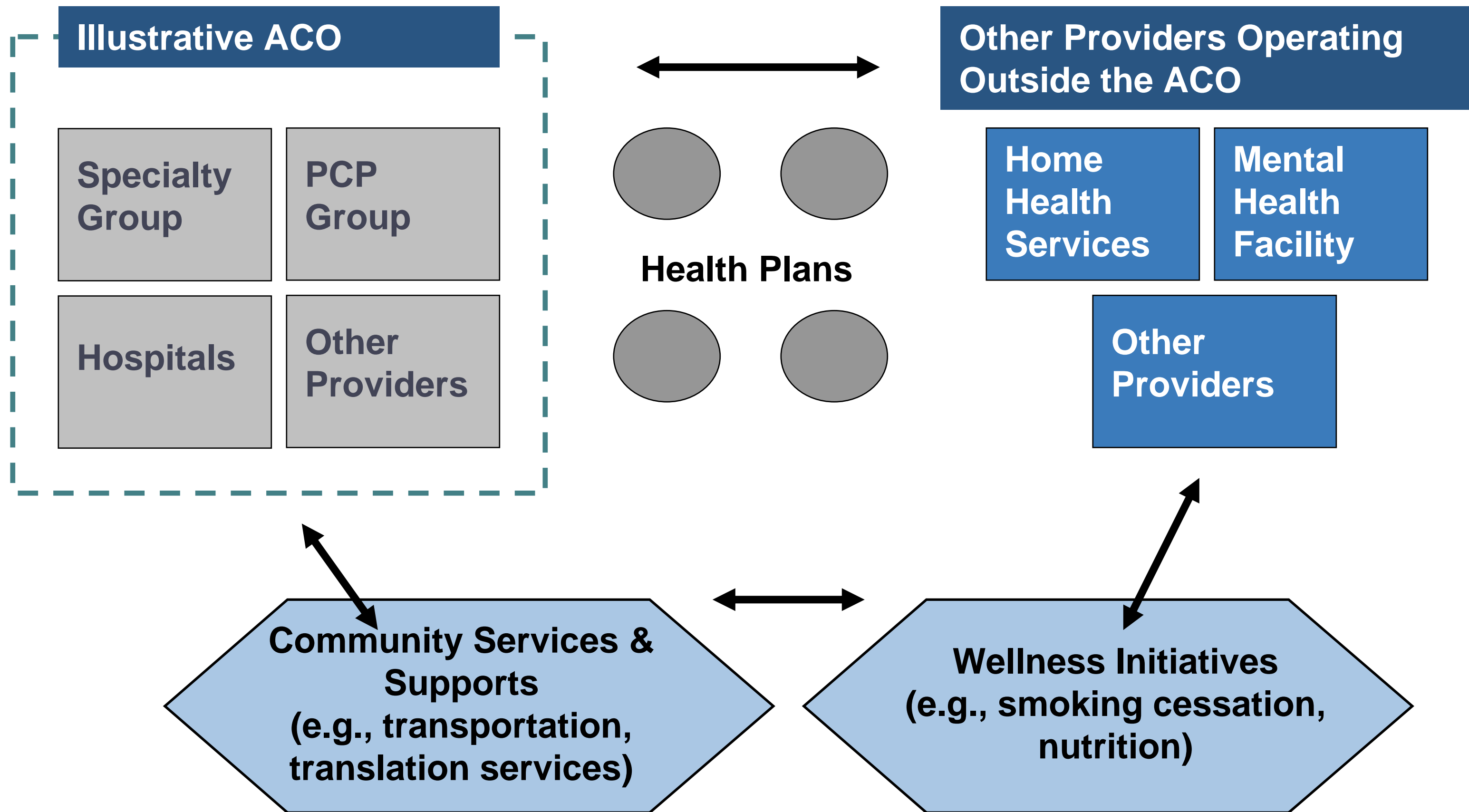
Several characteristics are essential for all ACOs:

1. Can provide or manage the continuum of care for patients as a real or virtually integrated delivery system

2. Are of sufficient size to support comprehensive performance measurement and expenditure projections

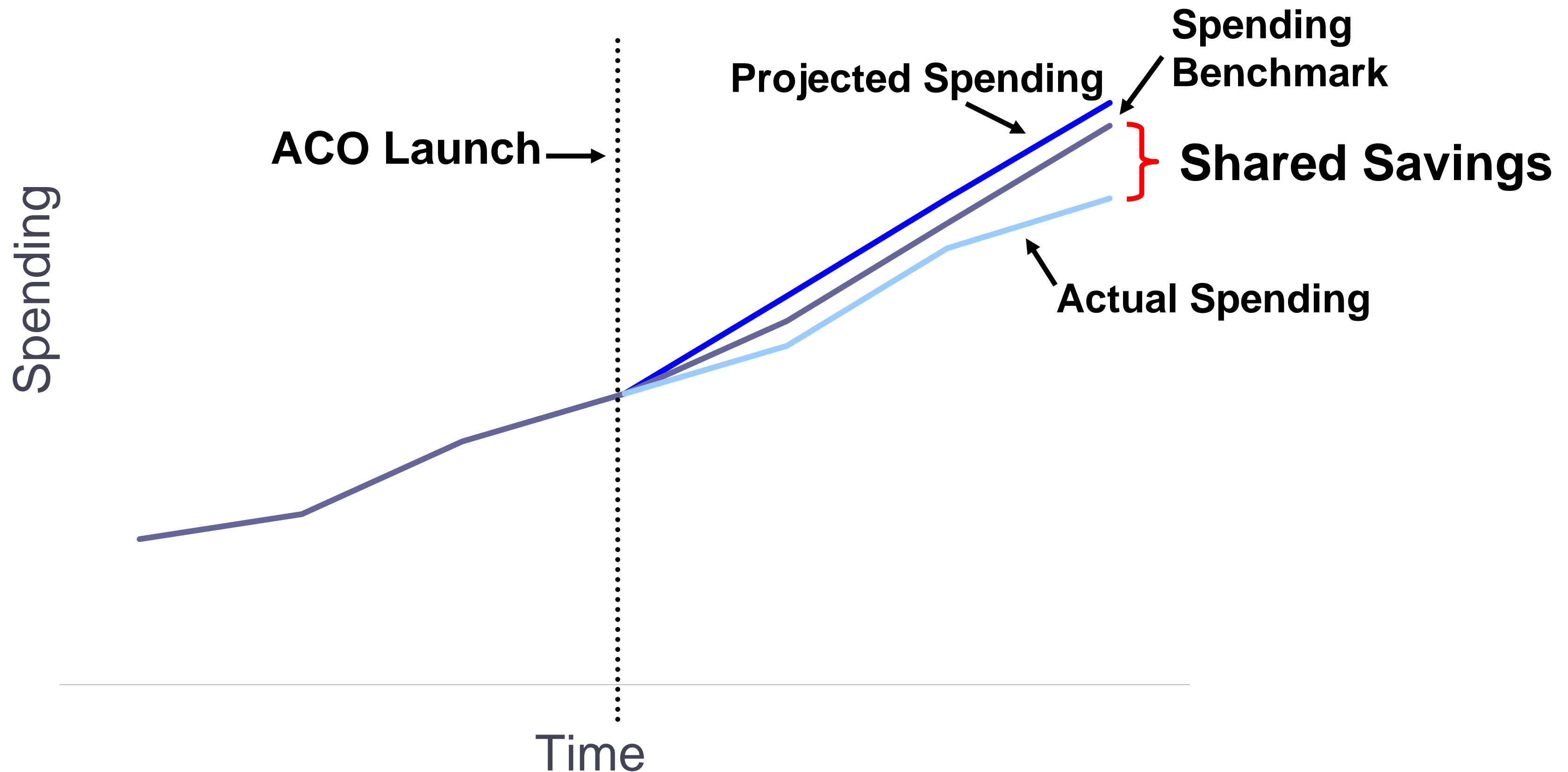
3. Are capable of internally distributing shared savings and prospectively planning budgets and resource needs

Integrating Care through ACOs



"Shared Savings" Model

Initial shared savings derived from spending below benchmarks

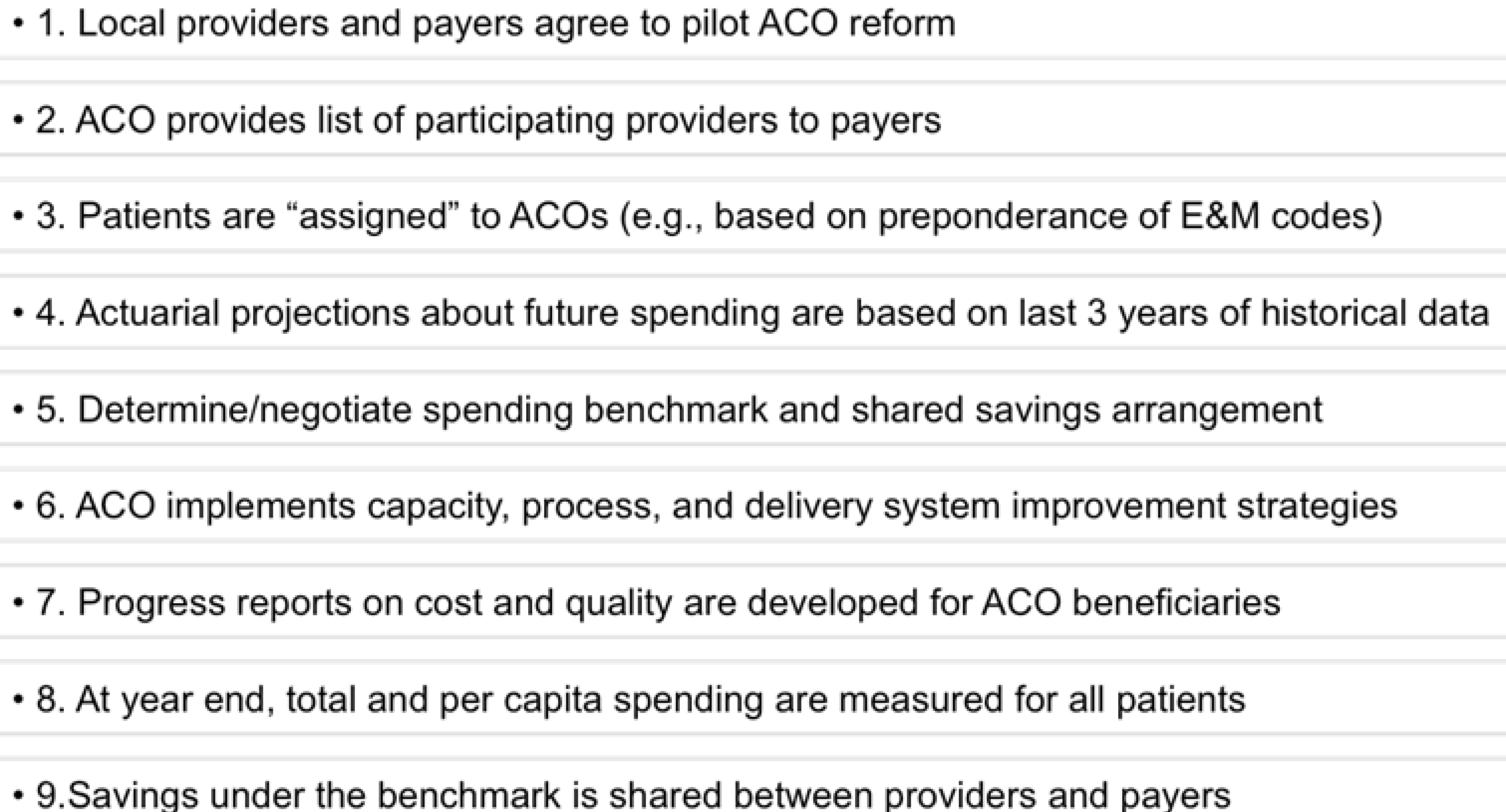


ENGELBERG CENTER for
Health Care Reform
at BROOKINGS

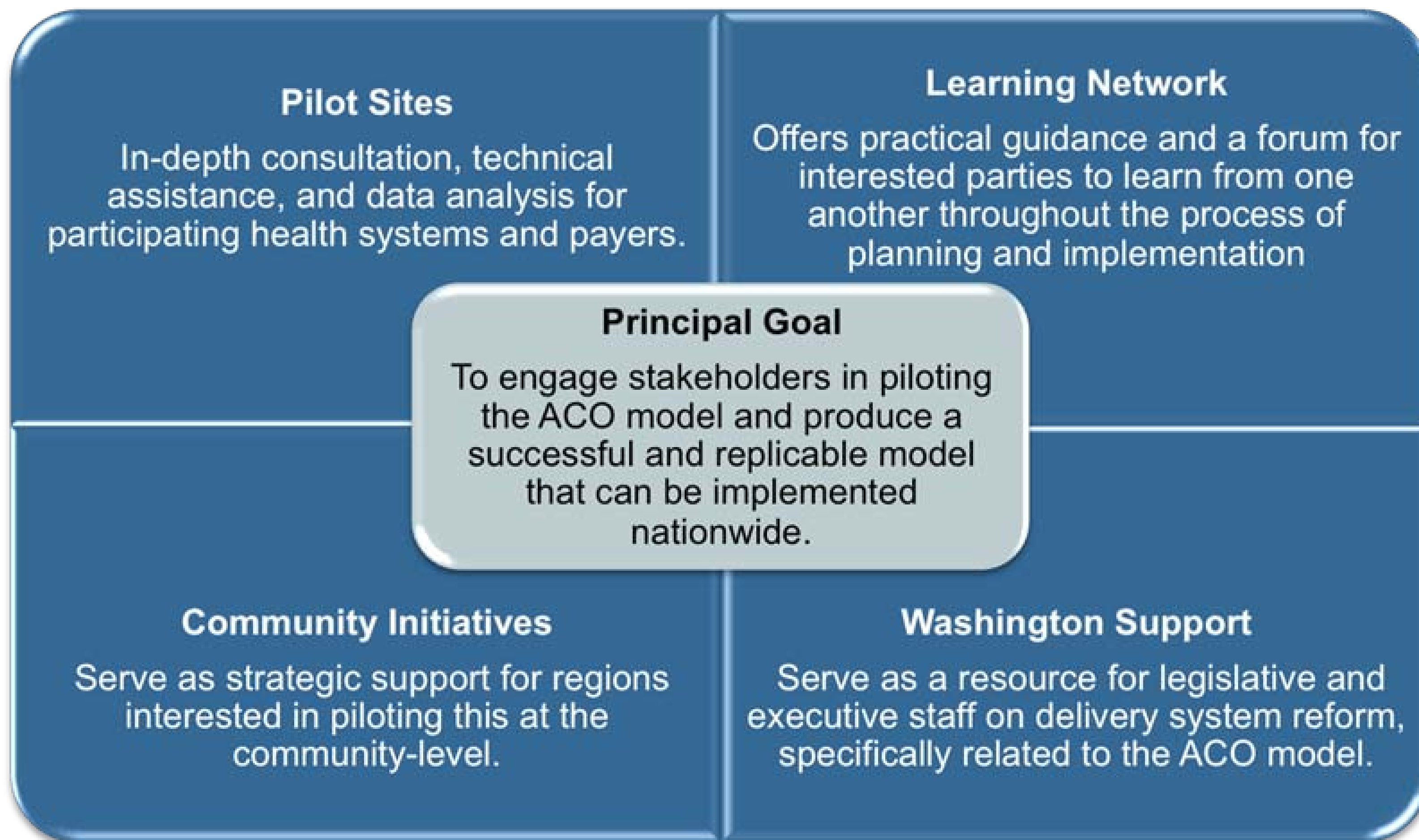
THE DARTMOUTH INSTITUTE
FOR HEALTH POLICY & CLINICAL PRACTICE
Where Knowledge Informs Change

How Does This Work?

Steps for initial ACO implementation



Brookings-Dartmouth ACO Collaborative



Current Status

ACOs accepted as component of current bills

- Support for extensive pilots, rapid expansion in House bills
- Senate Finance Committee expected to support

Initiatives are now at state and local level

- Brookings-Dartmouth supporting pilot development in multiple sites
- Pilots to start January 2010 in two (or more) sites
- Learning collaborative began in September, 25+ sites
- Massachusetts, VT moving forward

Challenges

- Developing common framework for private payers and Medicare
- Support for evaluation, learning, feedback
- Support for local systems to allow / ensure success