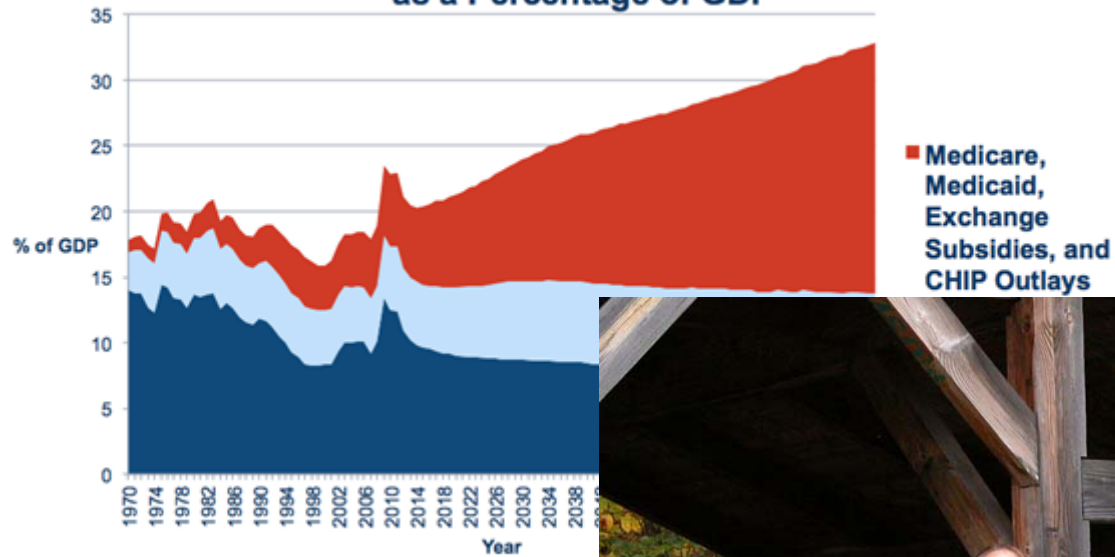# The long and winding road to Accountable Care

Elliott Fisher, MD, MPH
Director, The Dartmouth Institute
John E. Wennberg Distinguished Professor
Geisel School of Medicine

CBO Long-Term Federal Spending Projections as a Percentage of GDP
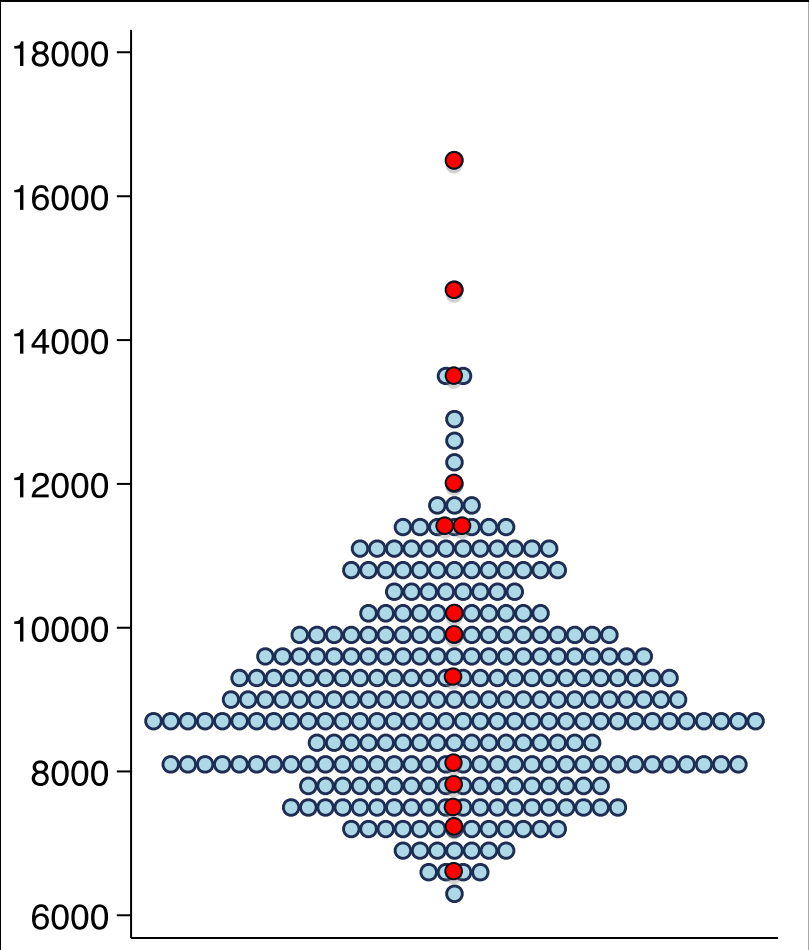
The long and winding road

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)

% 10 + MDs

City	Spending	% 10 + MDs
Miami, FL	$16,639	59.4
McAllen, TX	$14,576	59.0
Manhattan, NY	$13,453	
Los Angeles, CA	$12,711	
Detroit, MI	$11,647	
Chicago, IL	$11,646	
Philadelphia, PA	$10,640	
San Francisco,	$9,913	26.9
Cincinnati, OH	$9,388	22.7
Lebanon, NH	$8,124	
La Crosse, WI	$6,532	

An additional 1 in 5 patients survive

Delivering safe reliable, and effective care

Figure 1: Hip Fracture Risk-Adjusted Spending ($1,000) and One-Year Mortality, 2007-09 by Hospital (N > 300)

Cost decreases by $20,000 per patient

Avoiding unnecessary care
(hospital stays, ER visits, duplicate tests)

Problem	Solution
Confusion about aims	Clarify aims: better health better care, lower costs.
Absent or poor data	Provide high-integrity information to patients and clinicians
Flawed conceptual model	New model: organized systems of care focused on population health
Wrong incentives	Shift to value-based payment

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

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

Accountable Care Organizations
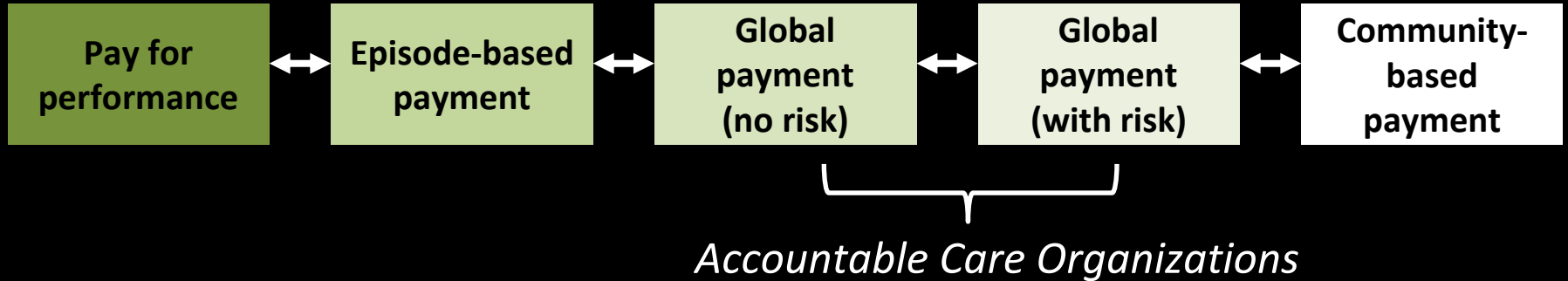
Incentives	Volume →	Value
Focus of responsibility	Individual patient Specific encounter →	Patient *and* Population Continuum of Care
Locus of accountability	Individual provider Single site of care →	Organization All sites of care

Figure 1: Medicare FFS All-Cause, 30-day Readmission Rate[7]
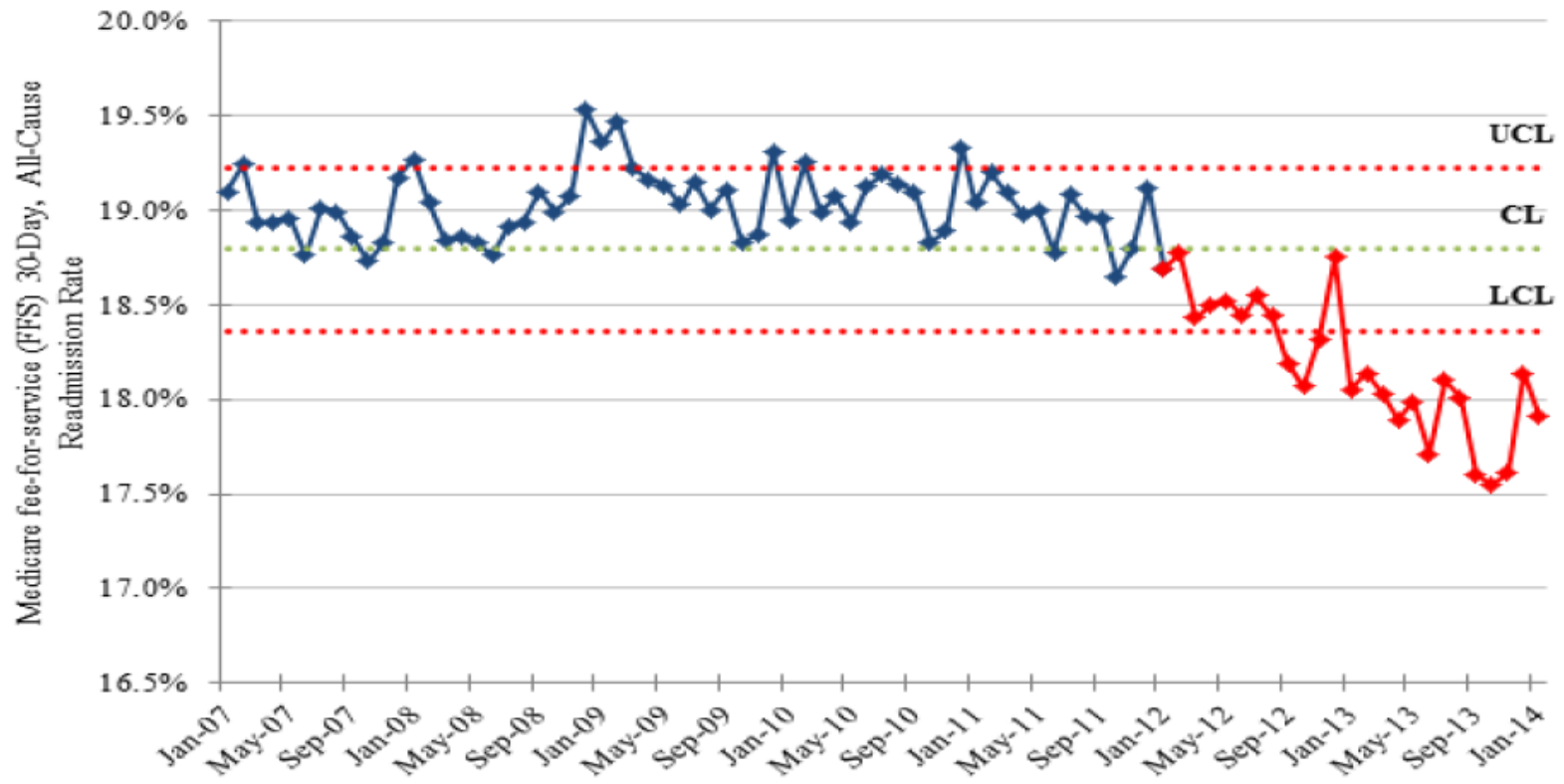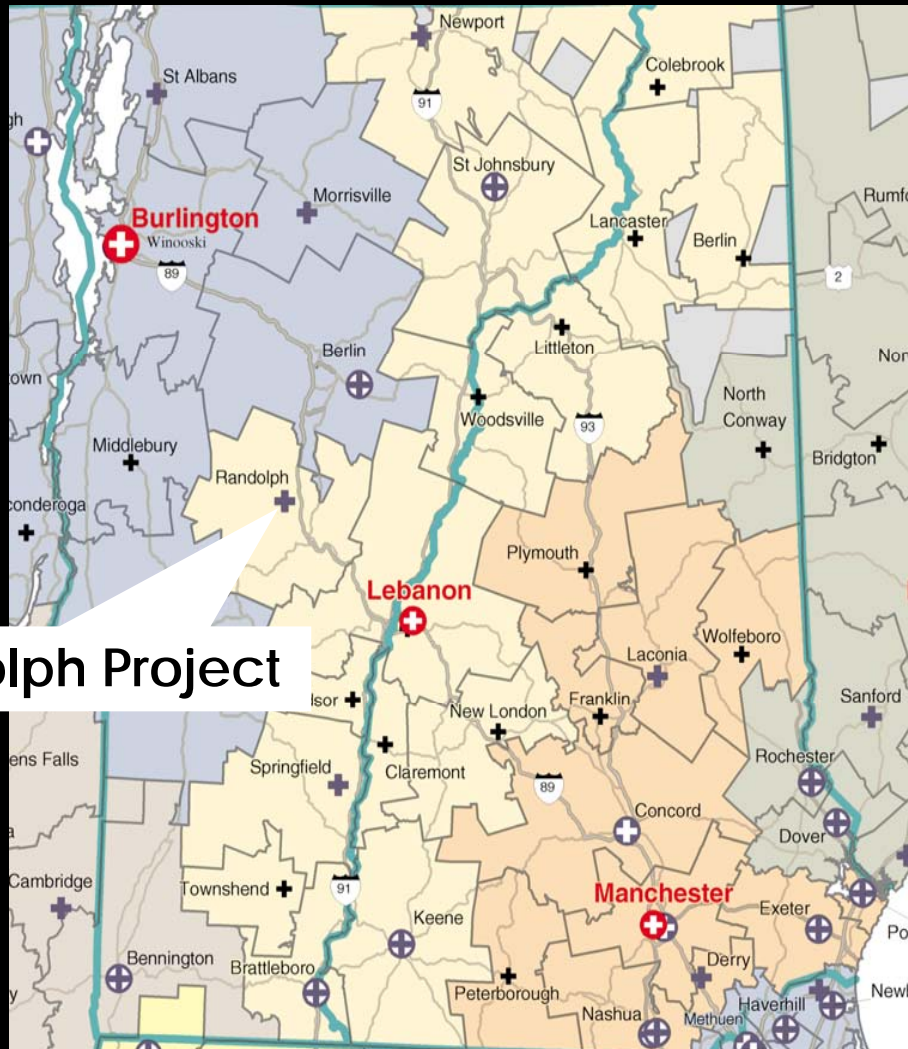
The Randolph Project

Core Ideas
- Population-based virtual budgets
- Real *or* virtual organizations
- Performance measurement
- Patient choice
- Accommodate diversity

MARCH 2010

REPORT TO THE CONGRESS

Medicare
Payment Policy

HOSPITALS & PHYSICIANS

Creating Accountable Care
Organizations: The Extended
Hospital Medical Staff

A new approach to organizing care and ensuring ac

by Elliott S. Fisher, Douglas O. Staiger, Julie P.W. Byr
Gottlieb

The NEW ENGLAND JOURNAL *of* MEDICINE

Perspective

NOVEMBER 10, 2011

Making Good on ACOs' Promise — The Final Rule
for the Medicare Shared Savings Program

Donald M. Berwick, M.D.
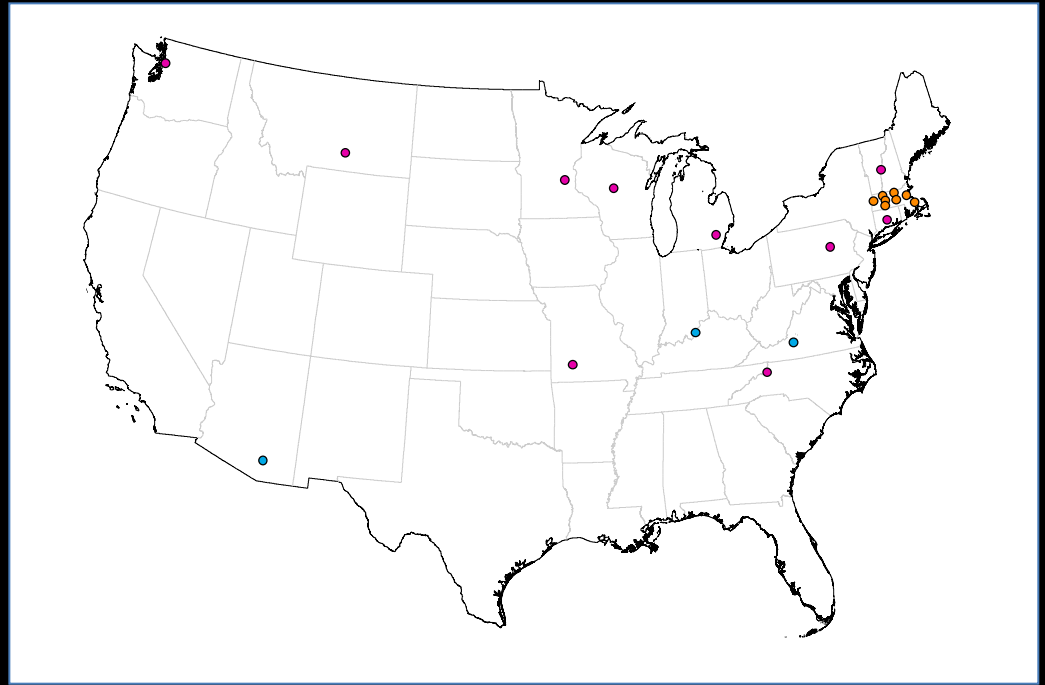
2009: 21 ACOs in the US.
   Physician Group Practice Demonstration (10)
   Alternative Quality Contract (8)
   Brookings-Dartmouth Pilots (3)

% ACO lives
- >15%
- 10-15%
- 5-10%
- 3-5%
- 1-3%
- .5-1%
- .1-.5%
- 0-.1%
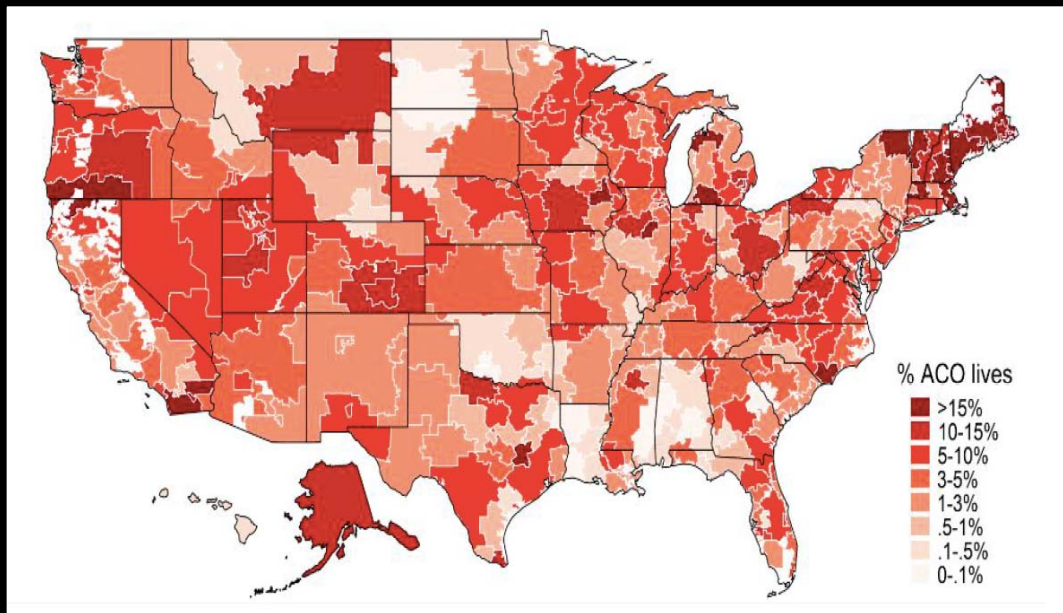
2014:   600+ ACOs in the U.S

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?
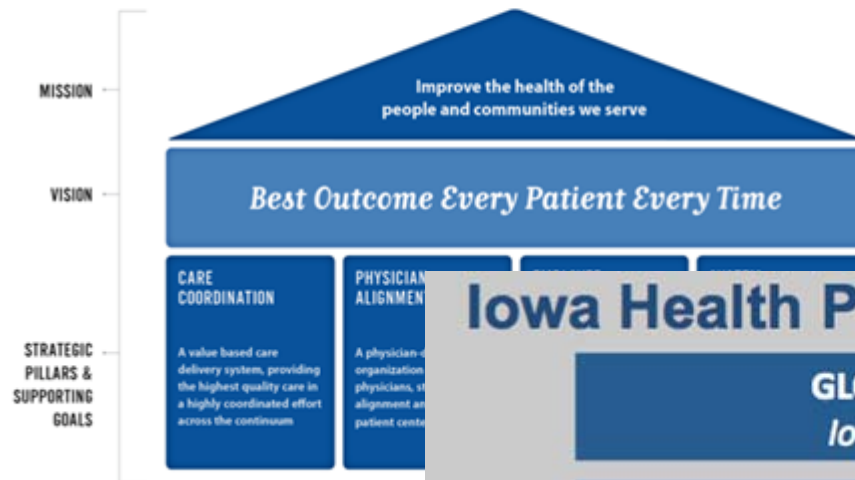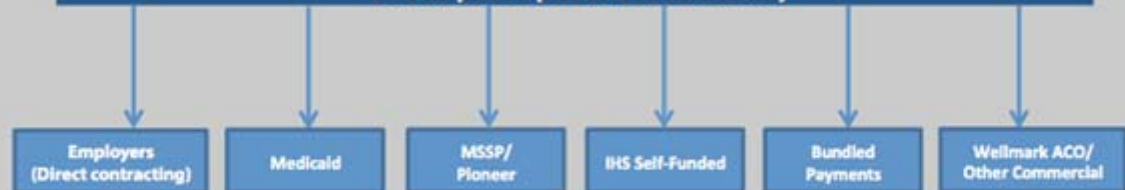
WHAT DO THEY LOOK LIKE?

Optimus Healthcare Partners, Summit NJ

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

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

Three MSSP ACOs in partnership with health systems and physician organizations in FL, NJ, and TX

WHAT DO THEY LOOK LIKE?

Physicians Represent Majority on Governing Board

Category	Proportion of ACOs	Physicians Represent Majority on Governing Board
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%

Proportion of ACOs

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

10%   20%   30%   40%   50%

National Survey of Accountable Care Organizations: Colla et al. Health Affairs 2014

HOW ARE THEY DOING?   FINANCIAL PERFORMANCE

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
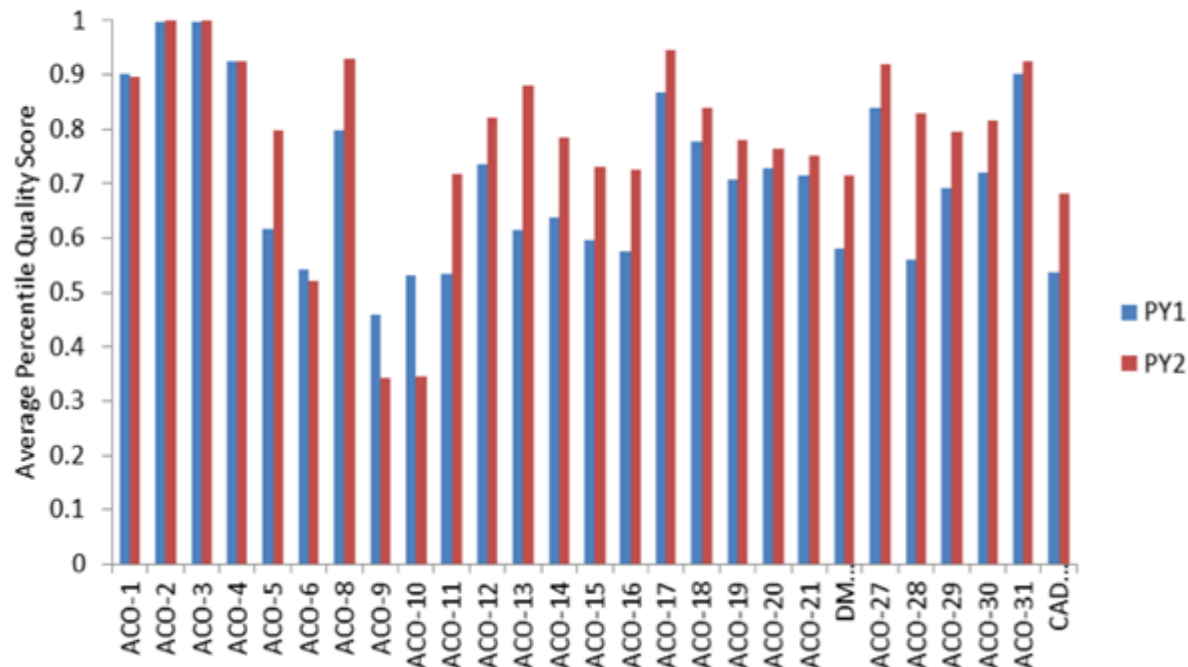
    220 ACOs launched in 2012 and 2013

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

Average Percentile Score for Each Quality Measure
Peformance Year 1 vs. Performance Year 2

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
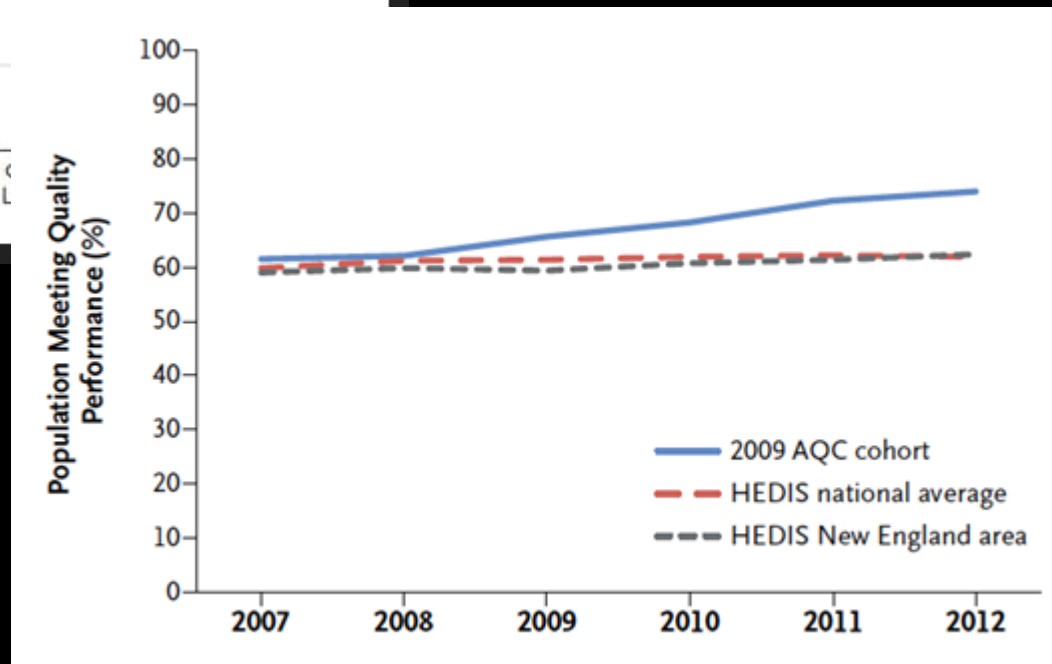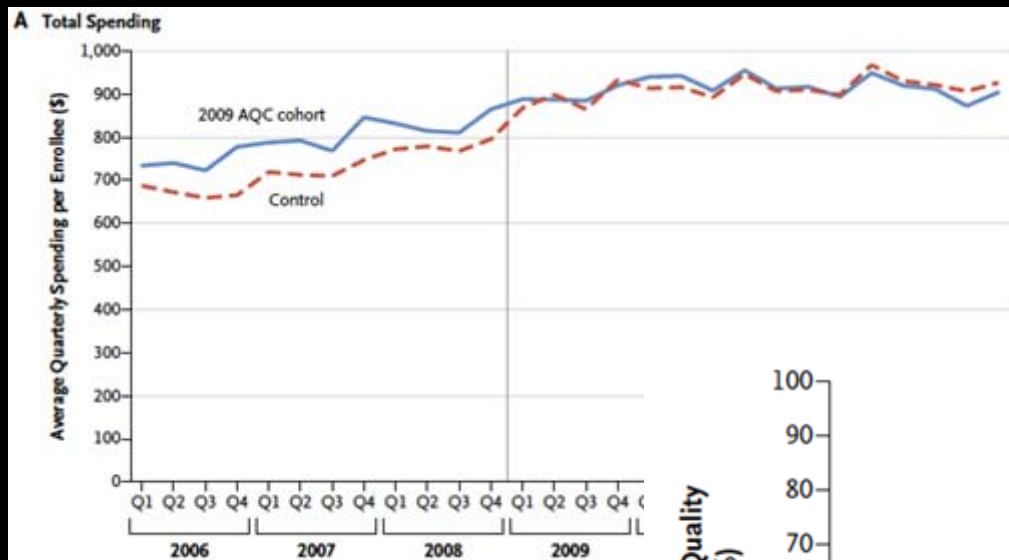
OTHER FINDINGS FROM ONGOING RESEARCH

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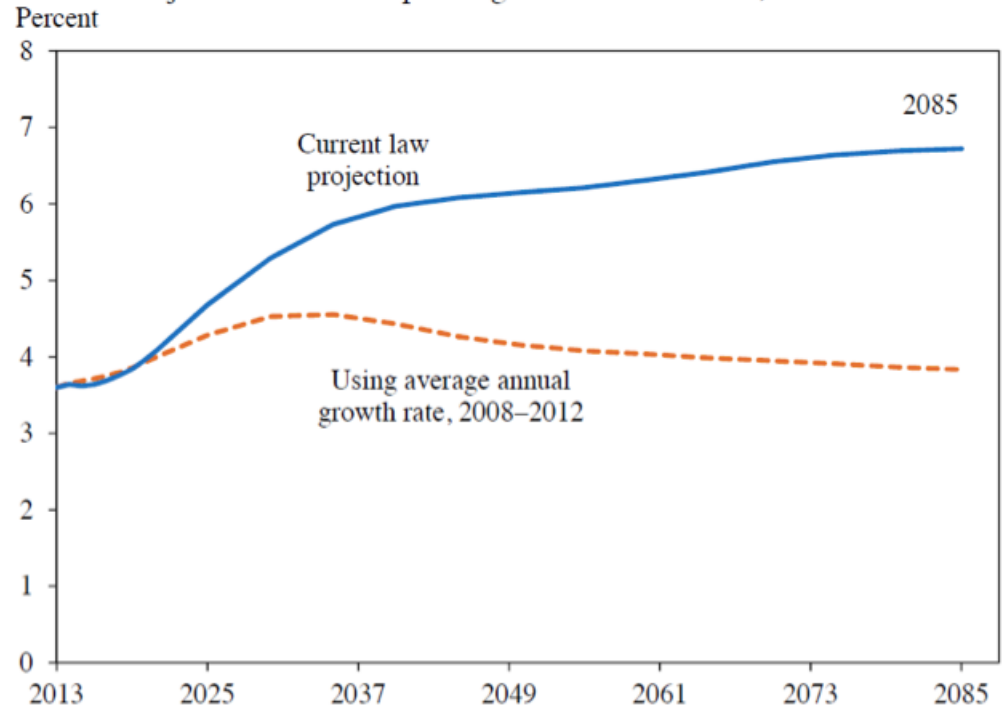Of physician practices expect to have meaningful value-based revenue

49%
Of facility is projecte derived fro based pa

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

Current law projection

Using average annual growth rate, 2008–2012

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

Photographer: Mar...

Forbes ▾

Report: 97% Of Mobile Malware Is On Android. This Is The... *Active on Twitter* 🐦 ▾

THE PHYSICIANS FOUNDATION

Louis Goodman and Tim Norbeck, Contributor

We provide the physician perspective on key U.S. healthcare issues

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OP/ED 1/22/2014 @ 11:05AM | 2,617 views

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

+ Comment Now   + Follow Comments

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

Share

Phil Bretthauer

Lincoln Wallace

Tammy Bennett

Kori Krueger, MD
Marshfield Clinic

PGP Demo

Savings Achieved

	Overall	Duals
All Systems	1%	5%
Marshfield	9%	11%

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!