Accountable Care Organizations

A path forward to improving quality, reducing costs

Wisconsin Legislature
February 18, 2009

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The Dartmouth Institute for Health Policy and Clinical Practice

Rethinking health care

Out of crisis, opportunity?

Three crises

- Population health
- Affordability, access, quality
- Professional integrity

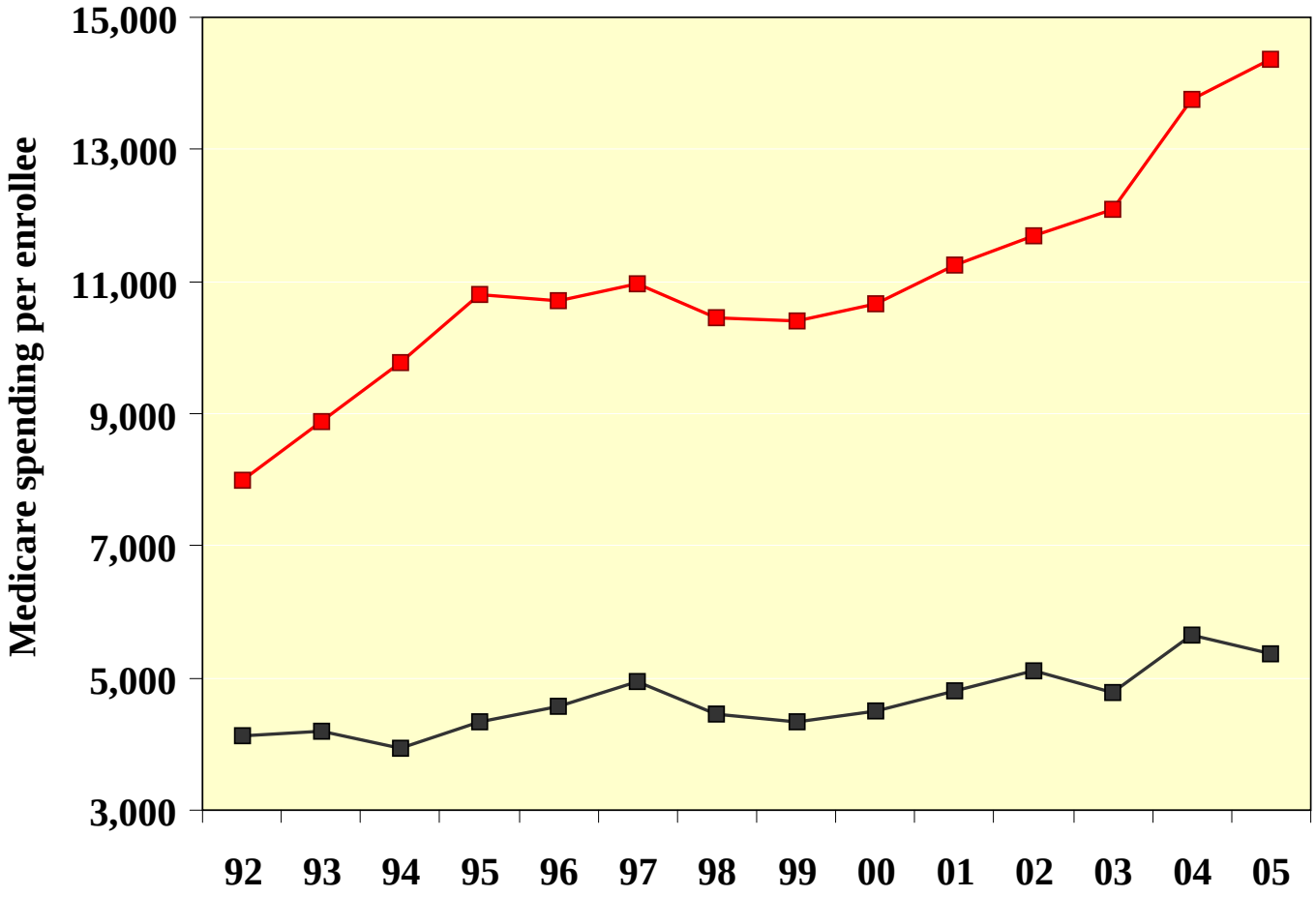
What we've learned over the past 10 years

- Marked variations in spending – and in growth – across regions

Per-capita Medicare Spending

Trends: 1992 to 2005

Note: US GDP per capita growth 92-05: 2.02%



Annual growth rate	
Miami	**4.61**
Salem, OR	**2.03**

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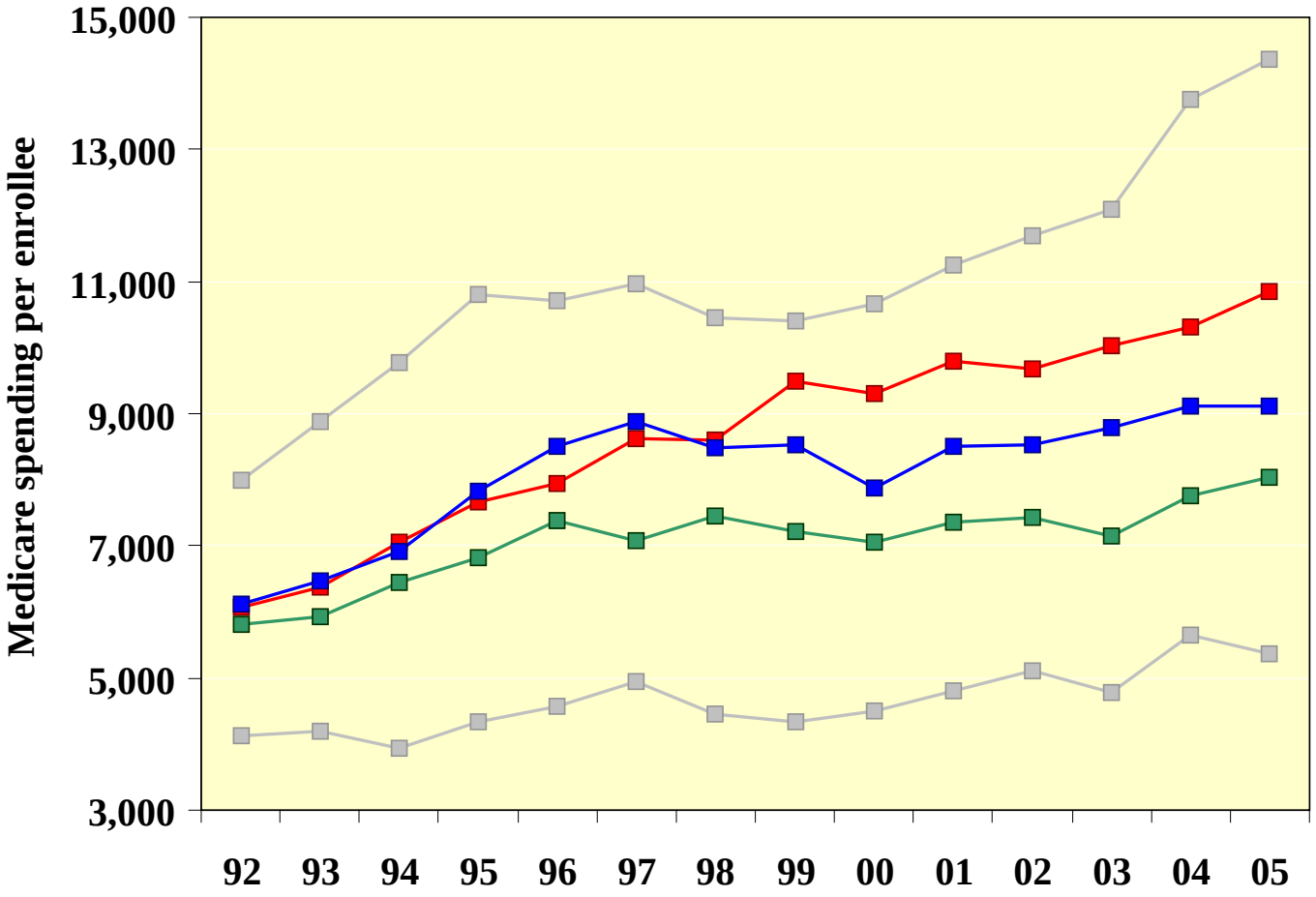

Annual growth rate	
Miami	4.61
E. Long Island	4.58
Boston	3.13
San Francisco	2.52
Salem, OR	2.03

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Per-capita Medicare Spending

Trends: 1992 to 2006 -- Wisconsin

Hospital Referral Region	1992 Level	2006 Level	Increase	Annual Growth Rate
Wausau	3,841	8,127	4,286	5.5%
Green Bay	3,345	6,810	3,465	5.2%
Neenah	3,583	6,790	3,207	4.7%
Milwaukee	4,636	7,578	2,942	3.6%
Marshfield	3,802	6,603	2,801	4.0%
Appleton	3,699	6,180	2,480	3.7%
Madison	3,945	6,416	2,471	3.5%
La Crosse	3,414	5,812	2,398	3.9%
United States	5,110	8,304	3,193	3.5%

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- Where is the money going? *Supply-sensitive services*

What do high spending regions get?

Use Rates in High vs Low

Effective Care: ***technical quality***

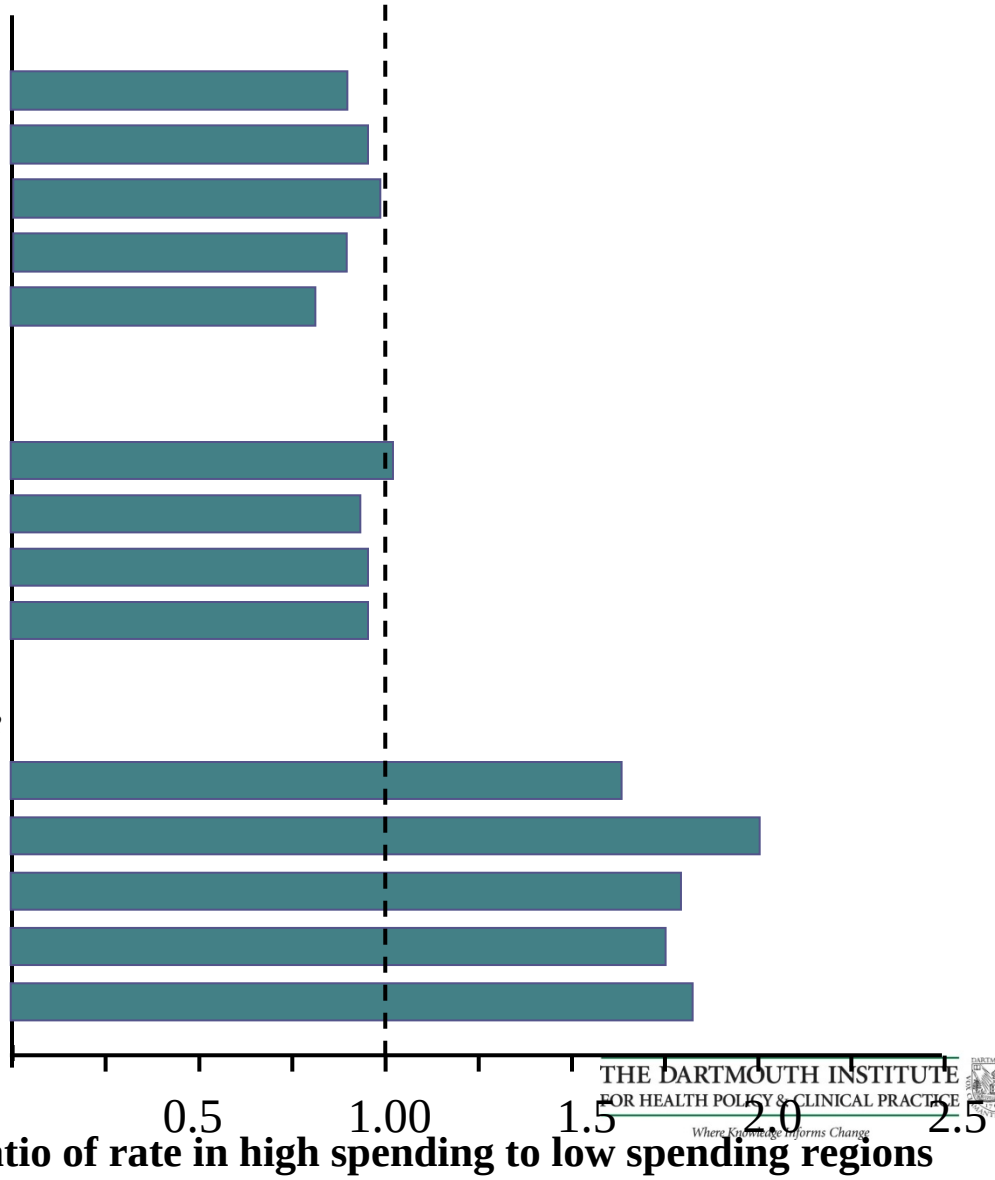
- Reperfusion in 12 hours (Heart attack)
- Aspirin at admission (Heart attack)
- Mammogram, Women 65-69
- Pap Smear, Women 65+
- Pneumococcal Immunization (ever)

Preference Sensitive Care: ***elective surgery***

- Total Hip Replacement
- Total Knee Replacement
- Back Surgery
- CABG following heart attack

Supply sensitive services: ***often avoidable care***

- Total Inpatient Days
- Inpatient Days in ICU or CCU
- Evaluation and Management (visits)
- Imaging
- Diagnostic Tests



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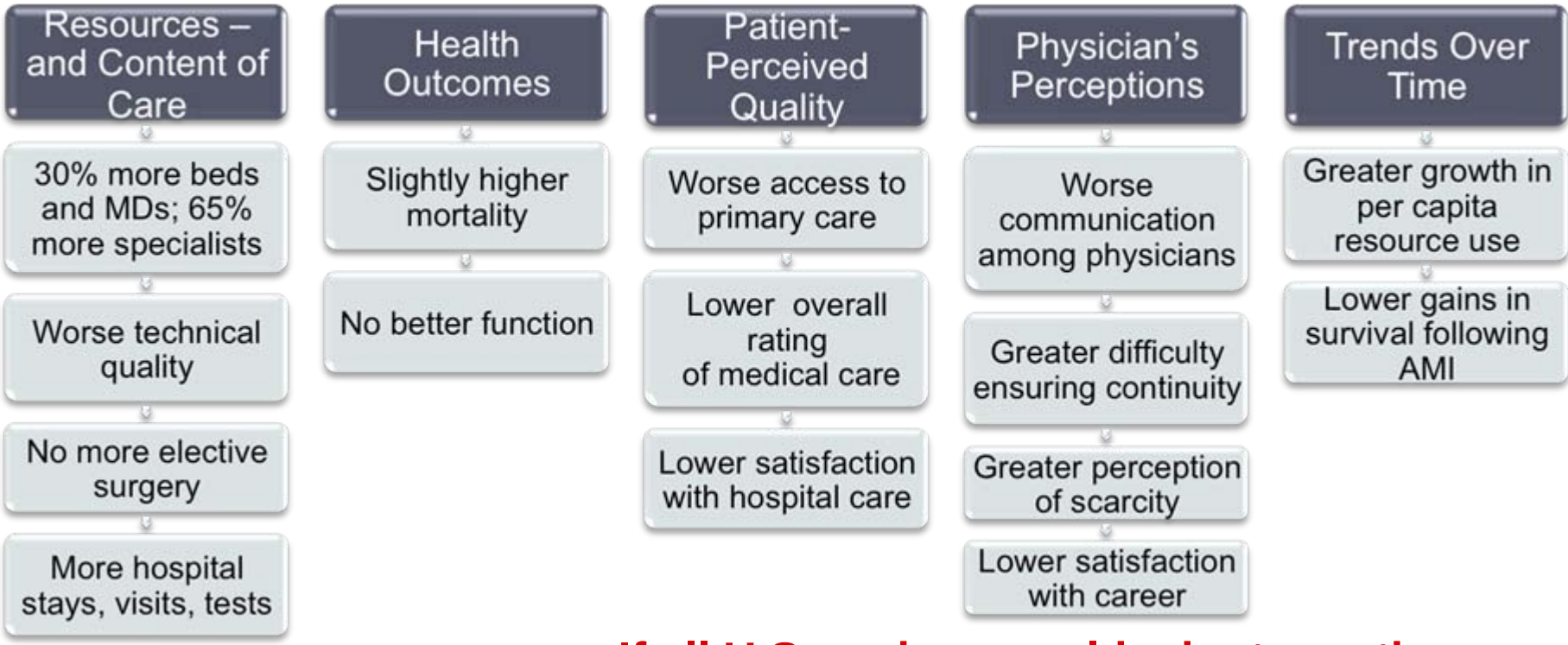
- Where is the money going? *Supply-sensitive care*
- *More supply-sensitive care isn't better.*

What do high spending regions get?
The paradox of plenty



If all U.S. regions could adopt practice patterns of most conservative fifth of US, Medicare spending would decline by 30%

(1) Fisher et al. Ann Intern Med: 2003; 138: 273-298
(2) Baicker et al. Health Affairs web exclusives, October 7, 2004
(3) Fisher et al. Health Affairs, web exclusives, Nov 16, 2005
(4) Skinner et al. Health Affairs web exclusives, Feb 7, 2006
(5) Sirovich et al Ann Intern Med: 2006; 144: 641-649
(6) Fowler et al. JAMA: 299: 2406-2412

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- *More of this kind of care isn't better.*

What's going on?

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The challenge of "gray area" decision-making

Evidence is an important – but limited – influence on clinical practice

Physicians practice in settings where capacity and local social norms exert powerful influence

- Current payment system ensures existing capacity fully utilized
- Income pressures (price cutting) motivate: purchase of new technology; recruitment of new specialists; referral of more complicated patients
- Acceptable professional behavior varies

  (Specialist referral in S. California or NYC)
  (Ownership of CT/MRI in N. Carolina or Idaho)

Differences in practice are invisible to providers

Just the gray areas?

capitalize on imaging opportunities in urology

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NEW: Quick Start Package

To get you started quickly, we will prepare your personal **"CT Quick Start Package for Urology."** Simply use the Quick Checks #1-4 and we will customize your personal information package with these features:

- Product brochures

	Procedures Per Day	Days Per Month	Average CPT	Income	FMVL Cost	ROI* Per Month	ROI for 5 Years
A	1.8	20	$220	$7,950	$7,950	Break Even	Break Even
B	5	20	$220	$22,000	$7,950	$14,050	$843,000
C	10	20	$220	$44,000	$7,950	$36,050	$2,163,000

Sample computation – Basic SOMATOM Spirit configuration, based on a 5-year Fair Market Value Lease (FMVL). Prices will vary with additional options. Please consult your Siemens Account Executive for details.
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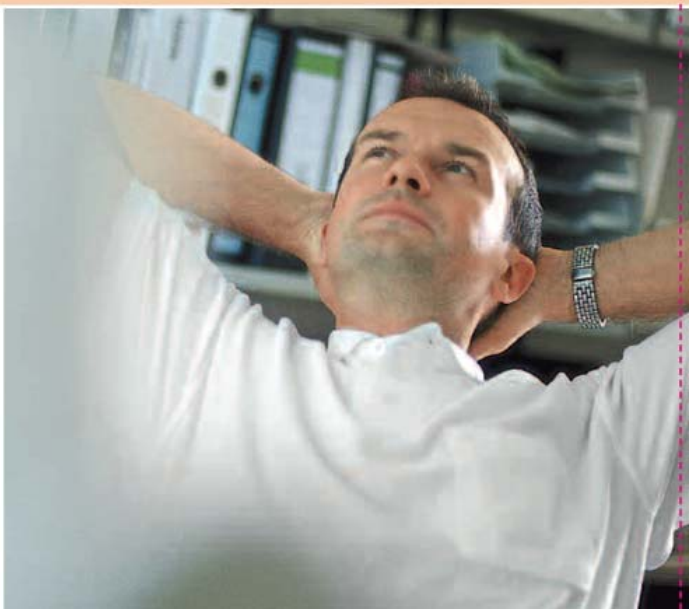
Business Development Manager Your local Siemens Sales Representative will be your personal contact partner. He or she will listen to your plans and advise you on the right products and solutions. In addition, he or she will introduce the right specialist at the right time and prepare the appropriate system quote.

Project Manager Your local Project Manager is responsible for assessing your site and supporting the installation process.

Financial Analyst Your Financial Analyst will prepare a business pro forma and calculate income, expenses, and profitability. He or she will also show you Siemens financing solutions that meet your financial and administrative needs.



Just the gray areas?

“These marketing ploys are wildly successful across the entire country. Patients are viewed as the ball in a pinball machine, popped back and forth, ringing up profits, until finally they escape past the paddles and can no longer render income. I believe that the fingers controlling those paddles often use those "gray areas of judgment" as an excuse to shoot the patient back to the triple-score bumpers.

Geoffrey G. Smith, MD, Casper Medical Imaging, PC
May 24, 2007 (email)

An aside

What's going on with access to care?

Access to care: what we know

- Access to hospitals and specialists WORSE in higher spending regions
- Massachusetts reports "crisis" in availability of physicians

What's the likely explanation?

- Primary care physicians: must keep schedule full to break even; more efficient to see "easy" patients: result – close to new patients; refer to specialists; send sick patients to ER.
- Specialists: increased referrals from primary care MDs and from other specialists

Worrisome anecdotes:

- Some physicians report that at least half of their visits are unnecessary
- S. Florida endocrinologist describes breakdown of primary care

Moving forward

Address the underlying causes of rising costs, poor quality
Shift focus from "health care" to "health"

Underlying cause	Key principles
Failure to recognize key role of local system (capacity, local social norms) as a driver of cost and quality	**Organizational accountability:** Foster the development of local systems accountable for the overall cost and quality of care
Assumption that more is better Equating less care with rationing	**Measurement:** (1) Comparative effectiveness (2) comprehensive performance measures
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

Organizational Accountability

Foster Accountable Care Organizations (Systems)

Essential attributes of an Accountable Care Organization

- Provides (or can effectively manage) continuum of care as a real or virtually integrated local delivery system
- Sufficient size to support comprehensive performance measurement

Potential Accountable Care Organizations

- Integrated delivery systems
  - (Mayo Clinic, Intermountain Health Care)
- Physician-Hospital Organizations / Practice Networks
  - (Middlesex Health System, Academic medical centers)
- Regional Collaboratives
  - (Rochester, NY; Indianapolis, IN)

Would entail little disruption of practice

- All physicians practice within easily defined “Physician-Hospital Networks”, which provide 70% or more of the care to their patients.

Fisher et al. Creating Accountable Care Organizations, Health Affairs 26(1) 2007:w44-w57.

Organizational Accountability
Performance measurement and improvement

Performance measurement more tractable at ACO level

- Can include all physicians who contribute to care within frame of measurement immediately – with adequate sample sizes
- More practical (5000 entities, vs 500,000)

Allows shift to meaningful measures

- Health outcomes, patient experience, care coordination, costs
- Important structural measures:
  - Traditional – electronic health records, CPOE
  - New dimensions: transparency on incentives, conflicts of interest

Establishes locus of accountability and organizational support

- *No other logical candidate for decisions on capacity*
- ACOs could finance electronic health records, provide decision support, feedback, quality improvement

Organizational Accountability

Support for quality improvement, non-punitive professional feedback

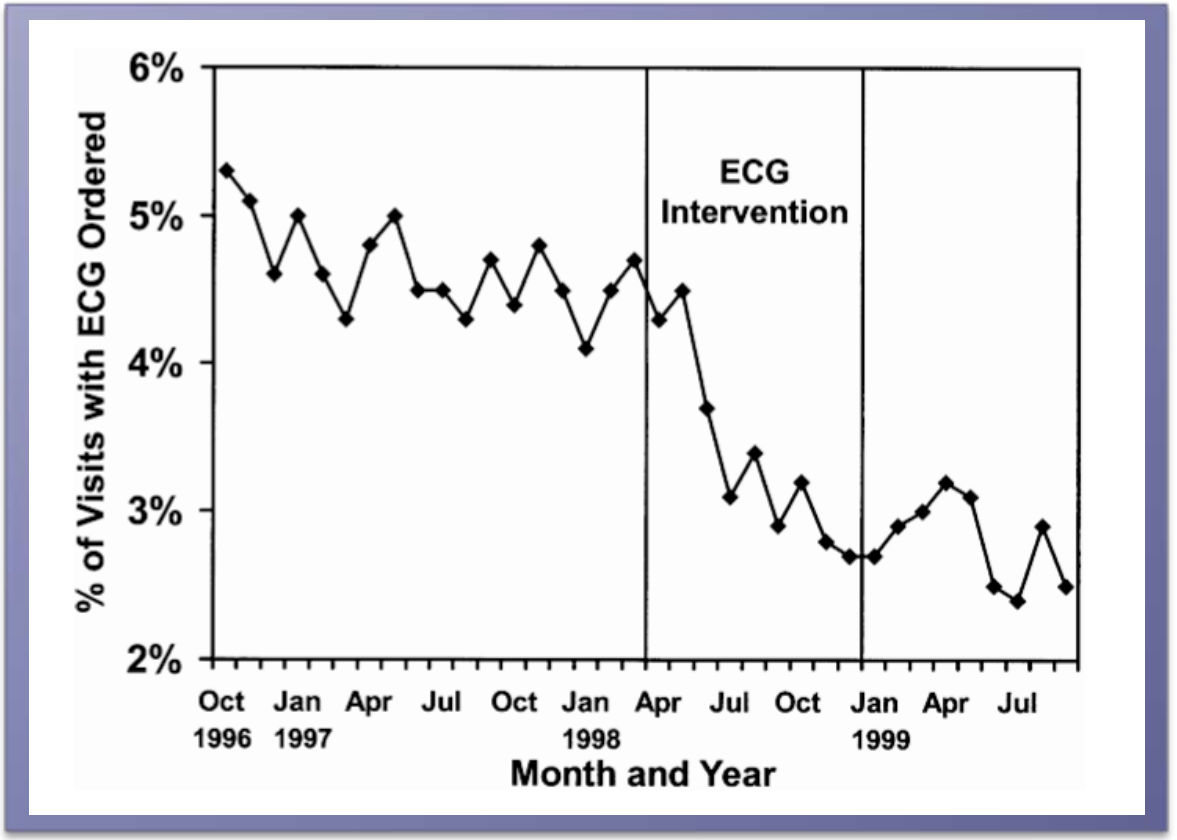
Massachusetts General Hospital

Variation in proportion of visits with EKG ordered

Physician level (n = 117)
Low: 0.0%
High: 24.6%

Practice level (n = 10)
Low: 1.0%
High: 8.1%

Impact of Individualized Feedback and Education.



Stafford RS Am J Heart 2003, 145:979-85.

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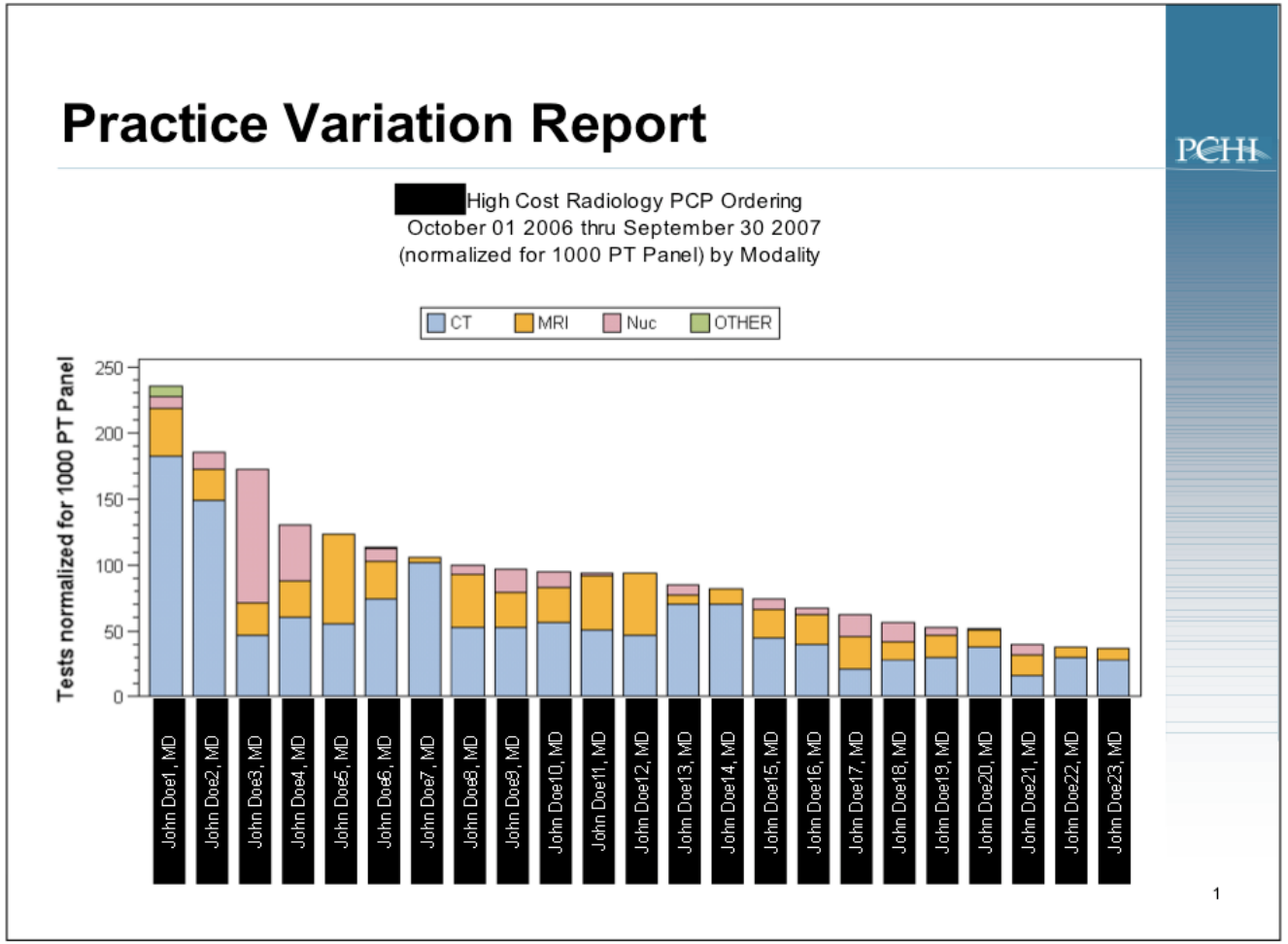
Organizational Accountability

Support for quality improvement, non-punitive professional feedback



May 29, 2008 Presentation at Federal Trade Commission
Tom Lee, MD (Partners Healthcare System) (with permission)

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Payment reform

The critical element

Current payment system has two effects

- Fosters unprofessional behavior in some
- Presents serious barrier to aligning care with our values

Long-term: reward improved care and outcomes & lower costs

- Capitation – or other means with population-based cost accountability
- Medical home, P4P, and bundled payments will NOT constrain overall cost growth. (But can help if *within* population-based cost accountability)

Short term -- Shared savings models

- Establish target growth rate
- Reward ACOs that achieve spending growth below target (if quality benchmarks met)

Shared-savings
What is current evidence?

Physician Group Practice demonstration

- Shared savings payments if groups achieve target savings and meet quality goals
- Within 2 years, most quality benchmarks achieved by all groups; almost all achieved some savings; almost half received shared savings payments in each year

Dartmouth experience – a new conversation

- Growing internal support for primary care & “medical home”
- System beginning to focus on improving “population health”
- Interest in all-payer model – essential to fully reorient system (Current incentives to increase volume in < 65)

Why would anyone want this?

Reforms must meet interests of key parties

Physicians and hospitals

- Offers alternative that allows realignment of work and values
- ACO model allows adaptation of private practice to integration
- Allows personal incomes to be preserved while total revenues fall (achieving savings for patients and payers)
- *Better than the threatened alternative of draconian price cuts*

Patients and consumers

- No lock-in required (but incentives to choose PCP would help)
- System-level measurement allows more rapid implementation
- Offers possibility of real savings (maybe more than capitation)
- *Better access to care*: if unnecessary "revenue-driven" visits eliminated, access to both specialists and primary care physicians should improve (preliminary evidence from medical home pilots highly relevant)

What about other reforms?

Comparison of current payment reforms

	Primary Care "Home"	Episode Bundled Payments	Global Shared savings	Full Capitation
Strengthens primary care directly or indirectly	**Yes**	**No**	**Yes**	**Yes**
Fosters coordination among participating providers	**No**	**Yes (for some)**	**Yes**	**Yes**
Removes payment incentives to increase volume	**No**	**No**	**Yes**	**Yes**
Fosters accountability for total costs of care	**No**	**No**	**Yes**	**Yes**
Requires providers to bear risk for excess costs	**No**	**Yes (within episode)**	**No**	**Yes**
Requires "lock-in" of patients to specific providers	**Yes**	**No**	**No**	**Yes**

Barriers

And what we might do

Without all-payer participation, savings may not occur

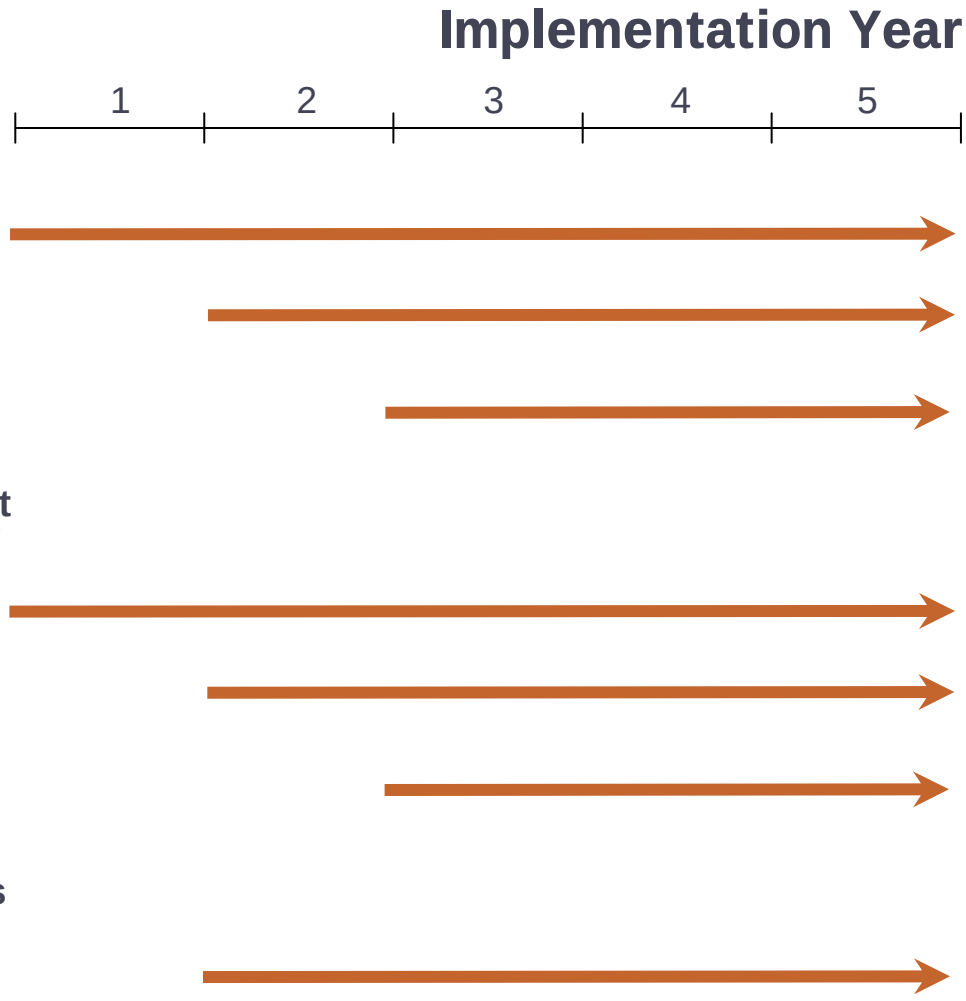
- Temptation may be to increase utilization (and maximize income) from any patients not participating in shared savings program
- Solution: support for state and local development of all-payer ACO – shared savings models

Proliferation of often conflicting reforms: quality measurement, P4P, medical home, e-health, etc

- Establish clear long term goals: integration, EHRs, systematic quality and outcome measures, global shared savings
- Align interim steps with long term goals

Moving forward

Align interim steps with long-term goals



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Focus short-term efforts on aggressive pilot testing and evaluation of new payment models

A riddle for would-be health care reformers:

Q: How is a kilowatt-hour of electricity like a day in the hospital?

A: Nobody wants either

Insights from the energy industry

Utility industry rewarded for producing energy.

- Result: only interested in building power plants.
- Reforms require new structure to reward “end-use efficiency”: light, heat, cold beer – at lowest cost.

Key principles of energy reforms

- Population-based accountability for end-use goals.
- Payment reform: (1) Decouple profits from volume
  (2) Shared savings
- Performance measurement

California per-capita electricity use FLAT, while Gross State Product rose by 82%

Insights from the energy industry – how applicable to health care?

Providers now rewarded for producing services.

- Result: focus on high margin services; volume growth.
- Reforms require new structure to reward "end-use efficiency": health promotion, restoring health / function; quality of life – at lowest cost.

Key principles of *health care delivery system reform*

- Population-based accountability for end-use goals *(health)*.
- Payment reform: (1) Decouple profits from volume
  (2) Shared savings
- Performance measurement

Imagine if health care costs were flat for the next 10 years