Accountable Care: Capitol Briefing

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Why ACOs?
Address the underlying causes of poor quality, rising costs

Early research
Higher spending due to discretionary use of “supply sensitive care”
More – of this kind of care – is not better.

Why the variation?
Not preferences, malpractice, or payment system (only)
Capacity important – but so is how we use it: local values
Prices are important contributors for commercial populations

“...a culture that focuses on the wellbeing of the community, not just the financial health of our system.”
Jeff Thompson, MD
CEO Gunderson-Lutheran, La Crosse WI

“Here ... a medical community came to treat patients the way subprime mortgage lenders treated home buyers: as profit centers.”
Atul Gawande
## What ACOs?
The principles underlying accountable care

<table>
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<tr>
<th>Underlying problem</th>
<th>Key principles</th>
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<td>Confusion about aims: is it about money or something more?</td>
<td>Clarify aims: Better health, better care, lower costs – for patients and communities</td>
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<td>Absent or poor data leaves practice unexamined and unable to improve; choices uninformed by evidence</td>
<td>Better information that engages physicians, supports improvement; informs consumers and patients</td>
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<td>Flawed conceptual model. Health is produced by face-to-face visits with physicians. More is always better.</td>
<td>New model: <em>It’s the system.</em> Establish organizations <em>accountable for aims,</em> capable of redesigning practice, eliminating waste and managing capacity</td>
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<td>Wrong incentives reinforce model, reward fragmentation, induce more care and entrepreneurial behavior.</td>
<td>Rethink our incentives: Realign incentives – both financial and professional – with aims.</td>
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The current opportunity
Accountable Care

Core Ideas:
- Population-based virtual budgets
- Real or virtual organizations
- Performance measurement
- Patient choice
- Support diverse approaches
The current opportunity
ACOs: Under the Affordable Care Act

Section 3022: Medicare Shared Savings Program
National program, anyone can apply
Draft regulations released March 31, 2011
Final rule released October 20, 2011

Pioneer ACOs
Greater rewards,
Multi-payer, required risk bearing

Advanced Payment ACOs
Physician led with limited capital
Critical access hospitals
CMS provides up-front capital
The current opportunity
Lots of interest
<table>
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<th>The current opportunity</th>
<th>Then vs Now</th>
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<td>Risk badly managed: plans shifted risk to providers, many failed.</td>
<td>Shared risk: use sound actuarial principles, sharing risk and rewards</td>
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<td>No measures of quality allowed some to ignore quality</td>
<td>Transparent quality measurement ensures focus on improvement</td>
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<td>Rewards for cost cutting. Financial incentives focus on savings only.</td>
<td>Payment for improvement. Share of savings contingent on improvement.</td>
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<td>Beneficiary lock-in created fear of stinting (gate-keeping).</td>
<td>Freedom of choice: beneficiaries free to seek care from any provider.</td>
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**Health plans driving cost savings**

**Providers, plans and patients collaborating to improve care**
A complex terrain
Multiple starting points
Multiple participants
Multiple tasks

Toward Accountable Care

Local Context

Capacity of Partners and Stakeholders
National, State, Local

Organizational Structure
HIT: EHR & Registries
Care Management
Care Improvement
Performance Measurement
Payment Models Medical Home, Episode, ACO
Patient Engagement and Assignment

Clarity and Focus of Shared Aim
Shared Community Values
Collaboration

Local Multi-Stakeholder Governance
Advancing Performance Measurement
HIT: Health Information Exchanges & Data Support
Payment Model Experience
Local Regulatory & Competitive Market

Structure of Payer-Provider Contracts

Organizational Capacity

Local Context
Challenges remain
Just another way to package business as usual?

I believe that the fingers controlling those paddles, Dr. Fisher, often use those "gray areas of judgment" as an excuse to shoot the patient back to the triple-score bumpers.”

Geoffrey G. Smith, MD, May 24, 2007 (email)
Challenges remain
What might we do?

Roles for government (or multi-stakeholder initiatives)
*Clarify the goal:* value-based payment & global accountability
*Align policies:* governance, measures, safe-harbor
*Advance accountability:* transparency on costs and quality

Roles for providers?
*Clarify the goal:* triple aim for both patients and community
*Commit to stewardship:* likely to be an ongoing discussion
*Explore where to compete, where to collaborate*
Toward a sustainable health system
A very rough draft

- In communities
  Health and health care are locally produced

Doing the right thing
What works? What doesn't? For whom? Helping patients make wise choices

Doing the right thing - right-
Improvement science Human factors engineering

Getting people to do both
Health policy Catalyzing needed change