

# Models of Accountable Care

Medical Home, Episodes and ACOs - Making it work

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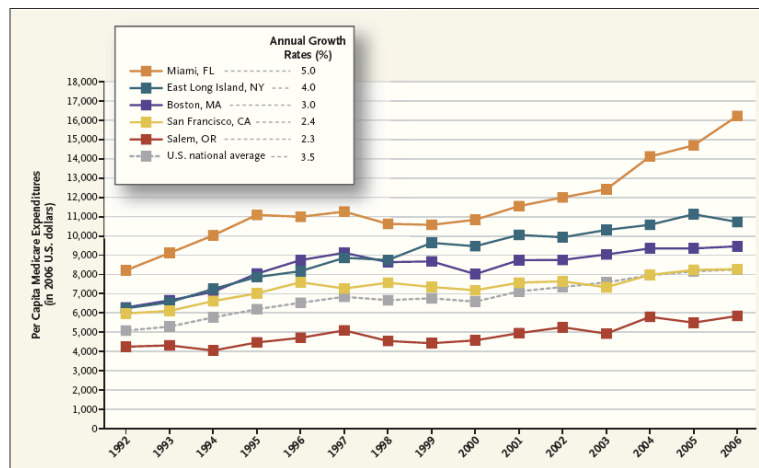
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# The challenge

Uneven quality, rising costs, fragmented care



Annual Growth Rates of per Capita Medicare Spending in Five U.S. Hospital-Referral Regions, 1992-2006.

Data are in 2006 dollars and were adjusted with the use of the gross domestic product implicit price deflator (from the Economic Report of the President, 2008) and for age, sex, and race. Data are from the Dartmouth Atlas Project.

	Per-Capita Spending	Annual Growth Rate
<b>Miami</b>	<b>\$16,351</b>	<b>5.0</b>
<b>E. Long Island</b>	<b>\$10,801</b>	<b>4.0</b>
<b>Boston</b>	<b>\$9,526</b>	<b>3.0</b>
<b>San Francisco</b>	<b>\$8,331</b>	<b>2.4</b>
<b>Salem, OR</b>	<b>\$5,877</b>	<b>2.3</b>
<b>US Average</b>	<b>\$8,304</b>	<b>3.5</b>

	Inpatient Days	Specialist visits	Primary care visits	PCP / Spec visits	Percent w/10+ MDs
<b>Miami</b>	29	56	41	0.72	51
<b>East Long Island</b>	32	42	41	0.97	50
<b>San Francisco</b>	19	27	31	1.13	32
<b>Boston</b>	20	24	29	1.21	39
<b>Salem</b>	12	15	20	1.30	18

# Underlying causes

And principles to help guide reform

## What's going on?

**Confusion** about aims – what we're trying to produce

**Limited data** leaves practice unexamined, limits learning, and allows public to believe more is better.

**Flawed conceptual model.** Health is produced only by individual actions of “good” clinicians, working hard.

**Wrong incentives** reinforce model, reward fragmentation, induce more care and entrepreneurial behavior.

## What we need: accountable care

**Clarify aims:** Better health, better care lower costs – for patients and communities

**Better information** that engages physicians, supports improvement; informs consumers and policy makers

**New model: It's the system.** Establish organizational structures *accountable for aims & capable of redesigning practice and managing capacity*

**Rethink our incentives:** Realign incentives – both financial and professional – with aims.

# An opportunity

We got a lot of what we asked for

## National consensus on key elements has already been achieved

***Aims -- National Priorities Partnership:*** population health, patient engagement, safety, care coordination, end-of-life care, & overuse

***Measurement Framework:*** how patients do over time: health risks, health outcomes, patient experience, total costs

## Reform should advance new delivery & payment models

***Leadership & support:*** National strategy (2011); Innovation Center (2011)

***Primary care:*** Medical home pilots in Medicare; Medicaid

***Episode (bundled) payments:*** readmissions reduction program (2012); National bundled payment demonstration (2013)

***Accountable Care Organizations:*** Community-based collaborative care networks (2011); National shared savings (ACO) program (2012)

# New Models of Care and Payment

## Bundled payments -- Medical Home

### **Episode (bundled) payments:**

**Single payment** creates incentive for providers to work together to improve care and reduce costs within the episode

**Examples:** inpatient and post acute care; major elective procedures

**Challenges:** requires organization and measures; may not reduce costs

### **Patient-centered medical home**

**Practice redesign** to support core functions of primary care: enhanced access; pro-active care management of population; team-based care

**Payment reform** to support currently non-reimbursed activities

**Examples:** evidence from integrated systems promising

**Challenges:** may not reduce costs; free standing medical home leaves responsibility to primary care MD

# New Models of Care and Payment

## Accountable Care Organizations

### Theory

*Organization:* A provider organizations that can effectively manage the *full continuum of care* as a real or virtually integrated local delivery system

*Performance measurement* – to ensure focus on demonstrably improving care and lowering costs

*Aligned financial incentives:* establish target spending levels; shared savings – under fee-for-service or partial capitation;

### Potential ACOs

Integrated delivery systems – academic medical centers

Hospitals with aligned (or owned) physician practices

Physician networks (e.g. California Medical Group model)

Community health systems (e.g. rural or critical access hospitals)

# New Models of Care and Payment

## Accountable Care Organizations: early evidence

### **Physician Group Practice demonstration**

10 multispecialty group practices; quality benchmarks, spending targets  
All met quality targets, all achieved savings for Medicare; most got bonuses

### **Multi-payer site: Geisinger Health System:**

Medicare spending fell by 15% relative to US (92-96)  
Teachers given \$7,000 raise (over 3 years)

### **A key mechanism: redesign (not rationing)**

Population-based specialist care: Intermountain, Dartmouth, Kaiser

### **Initiatives underway at state and local level**

Brookings-Dartmouth pilots underway in five sites (VA, KY, TX, CA)  
Learning network with 60+ health systems  
Some states moving forward to support all-payer models

# New Models of Care and Payment

## Accountable Care Organizations: a risky moment

**Everyone wants to be -- or already claims to be -- an ACO**

### **Legitimate concerns**

Consumers – stinting on needed care

Payers – a path toward greater market power and higher prices

Policy makers – “not as easy as you think”

*It may not work*

### **Barriers to success**

**Design issues are real:** organizational standards; performance measures; payment models; risk adjustment (technical support required for each)

**Context will matter:** lessons learned in one site may not apply elsewhere

**Local, state & federal efforts may** conflict (so too private payer reforms)

**Clinical transformation will be necessary:** and not easily led or learned

# New Models of Care and Payment

## Accountable Care Organizations: moving forward

### **How might we increase the odds of success? Answer 3 questions**

*Accountable to whom?* To patients, consumers, communities, payers

*Accountable for what?* Better care, better health, lower costs,

*Accountable how?* Transparency on performance, financial incentives, and where “savings” are going.

### **Strategies that might help: support innovation and learning**

**Shared “core” measures; diverse models (“bottom up, top down”)**  
measures should work at all levels: individual, PCMH, ACO, community  
e.g. avoidable health risks; health outcomes, patient experience, costs

**Ongoing evaluation and learning: Establish action-learning collaboratives:** that require reporting on both performance and contextual factors (supports learning and implementation)

**National public-private effort to coordinate and align reforms**