

# Accountable Care Organizations



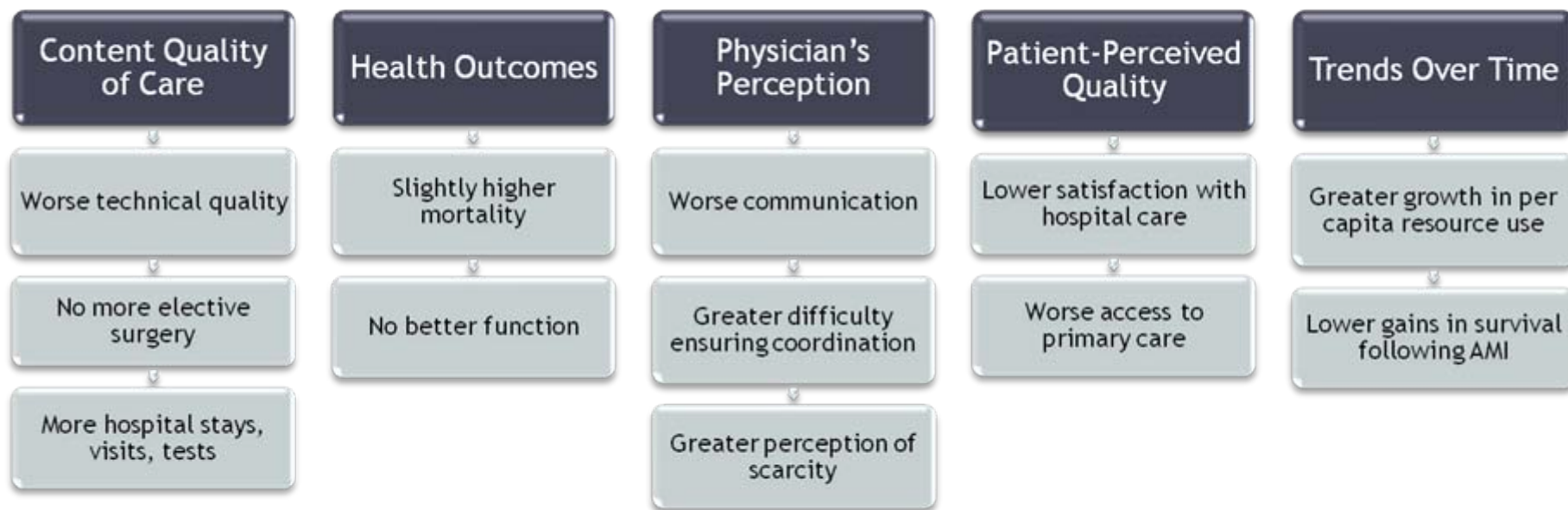
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# How can the best medical care in the world cost twice as much as the best medical care in the world?

Spending and resource use chronically ill, last 6 months of life	UCLA Medical Center	Massachusetts General Hospital	Mayo Clinic (St. Mary's Hospital)
Total Medicare spending	50,522	40,181	26,330
Hospital days	19.2	17.7	12.9
Physician visits	52.1	42.2	23.9

# What do higher spending regions get?



- (1) *Ann Intern Med*: 2003; 138: 273-298
- (2) *Health Affairs* web exclusives, October 7, 2004
- (3) *Health Affairs*, web exclusives, Nov 16, 2005
- (4) *Health Affairs* web exclusives, Feb 7, 2006
- (5) *Ann Intern Med*: 2006; 144: 641-649

# What is going on?

## Attributes of US Health Care

- Assumption that more is better
- Inadequate information on risks and benefits
- Growing tension between science and professionalism -  
- and -- market approach (health care as a commodity)
- Conflicts of interest are widespread, even in academic medicine

# What is going on?

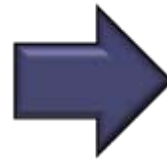
Focus on the underlying causes of rising costs

## Underlying Cause

Lack of accountability for key local determinants of quality, costs and health outcomes

Assumption that more care is better care

Payment system that rewards more care, increased capacity, high margin treatments, and entrepreneurial behavior



## General Approach

Foster development of local organizations (delivery systems) accountable for care (with incentives to limit future growth): ACOs

Balanced information on risks / benefit, and strategic performance measures

Reform of payment system (long term), shared savings as interim approach

# What is going on? Underlying causes of variation

## Patient Preference

Minor differences across regions

## Malpractice Environment

Explains less than 10% state differences in spending

## Capacity & Payment System

Capacity is strong correlated, but explains less than 50%

Payment system ensures that all stay busy

## Clinical Judgment

No difference in decisions with strong evidence

More likely to intervene in gray areas

# What is going on?

## Key role of local context

- Clinical evidence and principles of professionalism are a critically important, but limited, influence on clinical decision-making.
- Local organizational context and policy environment profoundly influences decision-making
- Payment system ensures that capacity is fully utilized
- Physicians adapt to available resources: more referrals, more admissions, more ICU stays.

**Consequence:** reasonable individual clinical and local decisions lead, in aggregate, to higher utilization rates, greater costs, and inadvertently worse outcomes

# Overview of ACO Proposal

Organizational Accountability

Performance Measurement

Shared Savings

Strategic Approach to Long-Term Goals

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# Key attributes of an ACO

- **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
  - Capable of prospectively planning budgets and resource needs
- **Potential Accountable Care Organizations**
  - Integrated delivery systems and hospitals
    - (Mayo, Virginia Mason, Group Health)
  - Physician-Hospital Organizations / Practice Networks
    - (Middlesex Health System)
  - Regional Collaboratives  
(Rochester, NY)

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# Performance Measurement

- 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 to audit, vs 500,000)
- Quality accountability should emphasize patient-level results and care coordination, including:
  - Key structural measures (e.g. medical home, e-prescribing, EHRs)
  - Clinical registries with care outcomes
  - Patient experience and care coordination
- Establishes a viable locus of accountability and needed resources
  - No other logical candidate for decisions on capacity
  - ACOs would have resources to finance electronic health records for associated physicians and implement quality improvement initiatives

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# Shared savings approaches help in the interim

- Key notion: establish target growth rate; reward ACOs that achieve spending growth below the target
- Theory being tested in the Physician Group Practice demonstration
- Has important advantages:
  - Preserves fee-for-service payment (good for patients and MDs)
  - Provides incentive to avoid increases in capacity (and to reduce capacity where feasible); and to improve care in domains previously ignored: care coordination, end-of-life
  - Can be done with existing claims data

# Integration would require little disruption of current practice

Number of Medicare Beneficiaries	Percent of Beneficiaries	Number of Hospitals	Average Primary Loyalty	Average Primary and Secondary Loyalty
Under 5,000	23.1%	2850	59.3%	75.1%
5,000 -10,000	26.5%	864	73.3%	82.2%
10,000 - 15,000	20.6%	395	75.6%	83.3%
15,000 +	29.8%	324	76.9%	83.7%

Illustrative purposes only using 2004 physician data on hospital use; ACO proposal involves no requirements for hospital-based affiliations. From Elliott S. Fisher, Douglas O. Staiger, Julie P.W. Bynum and Daniel J. Gottlieb, *Creating Accountable Care Organizations: The Extended Hospital Medical Staff*, *Health Affairs* 26(1) 2007:w44-w57.

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# A Roadmap to Quality and Cost Accountability in Medicare

Implementation Year



Support coordination & integration

Timeline clarifies long-term goals



Long-term goals reduce wasteful investments

# Loyalty rates in Oregon are higher than the national average

Number of Medicare Beneficiaries	Percent of Beneficiaries	Number of Hospitals	Average Primary Loyalty	Average Primary and Secondary Loyalty
Under 5,000	36.7%	40	65.9%	80.6%
5,000 -10,000	33.5%	9	78.3%	86.4%
10,000 - 15,000	27.8%	5	86.6%	89.7%
15,000 +	0	0	0	0

# Data for Portland HRR

Hospital Name	Number of Beneficiaries	Number of Physicians	Primary Loyalty	Primary & Secondary Loyalty
ADVENTIST MEDICAL CENTER	4140	88	73%	81%
COLUMBIA MEMORIAL HOSPITAL	2410	24	78%	81%
GOOD SHEPHERD MEDICAL CENTER	2300	26	71%	78%
LEGACY EMANUEL HOSPITAL & HEALTH CTR	2025	49	60%	71%
LEGACY GOOD SAMARITAN HOSP & MED CTR	5060	128	69%	78%
LEGACY MERIDIAN PARK HOSPITAL	6650	100	72%	81%
LEGACY MOUNT HOOD MEDICAL CENTER	2410	42	65%	79%
MID-COLUMBIA MEDICAL CENTER	3140	31	86%	88%
NORTH LINCOLN HOSPITAL	2110	13	37%	56%
OHSU HOSPITAL AND CLINICS AND DOERNBEC	3720	158	66%	72%
PROVIDENCE MILWAUKIE HOSPITAL	2235	54	66%	75%
PROVIDENCE NEWBERG HOSPITAL	825	24	71%	78%
PROVIDENCE PORTLAND MEDICAL CENTER	9970	243	77%	81%
PROVIDENCE SEASIDE HOSPITAL	1375	16	46%	60%
PROVIDENCE ST VINCENT MEDICAL CENTER	11020	261	75%	80%
SAMARITAN PACIFIC COMMUNITIES HOSPITAL	2345	18	70%	78%
SILVERTON HOSPITAL	1735	33	75%	90%
TUALITY HEALTHCARE	3865	82	84%	90%
WILLAMETTE FALLS HOSPITAL	2745	50	74%	81%
WILLAMETTE VALLEY MEDICAL CTR	3200	49	82%	87%

# Next Steps

- Work with congress to promote ACO approach:
  - CMS to pursue rapid implementation of pilots,
  - Careful design of measurement framework to serve as roadmap
  - Integration of medical home pilots into ACO framework
- Establish and support learning collaborative of organizations and regions willing to work on design and implementation of successful models

# Appendix Slides



# What defines an ACO?

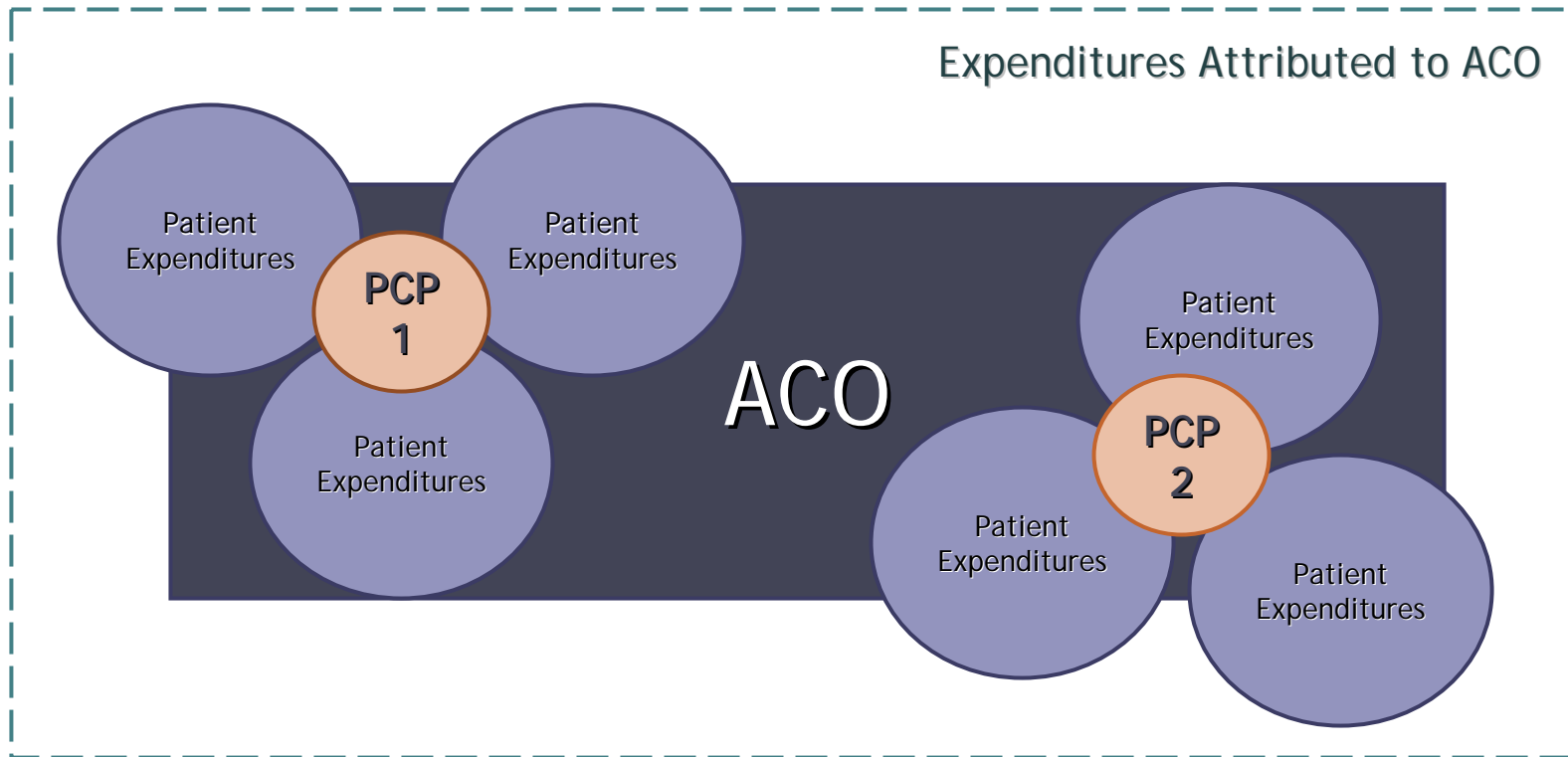
- Legally constituted entity that can receive Medicare payments and has arrangements in place for sharing bonus payments
- Ability to specify physicians voluntarily participating within the ACO and meet performance reporting requirements.
- Minimum of 5000 Medicare beneficiaries must be assigned to ACO

# Assigning Beneficiaries to ACO

- No registration by population
- Patients with at least one E&M service in the previous year will be assigned to an ACO based on the largest share of E&M services from exclusive ACO providers, measured by number of ambulatory visits
- Results in a unique assignment for the patient
- Assignments revisited on an annual basis

# Calculating ACO Spending

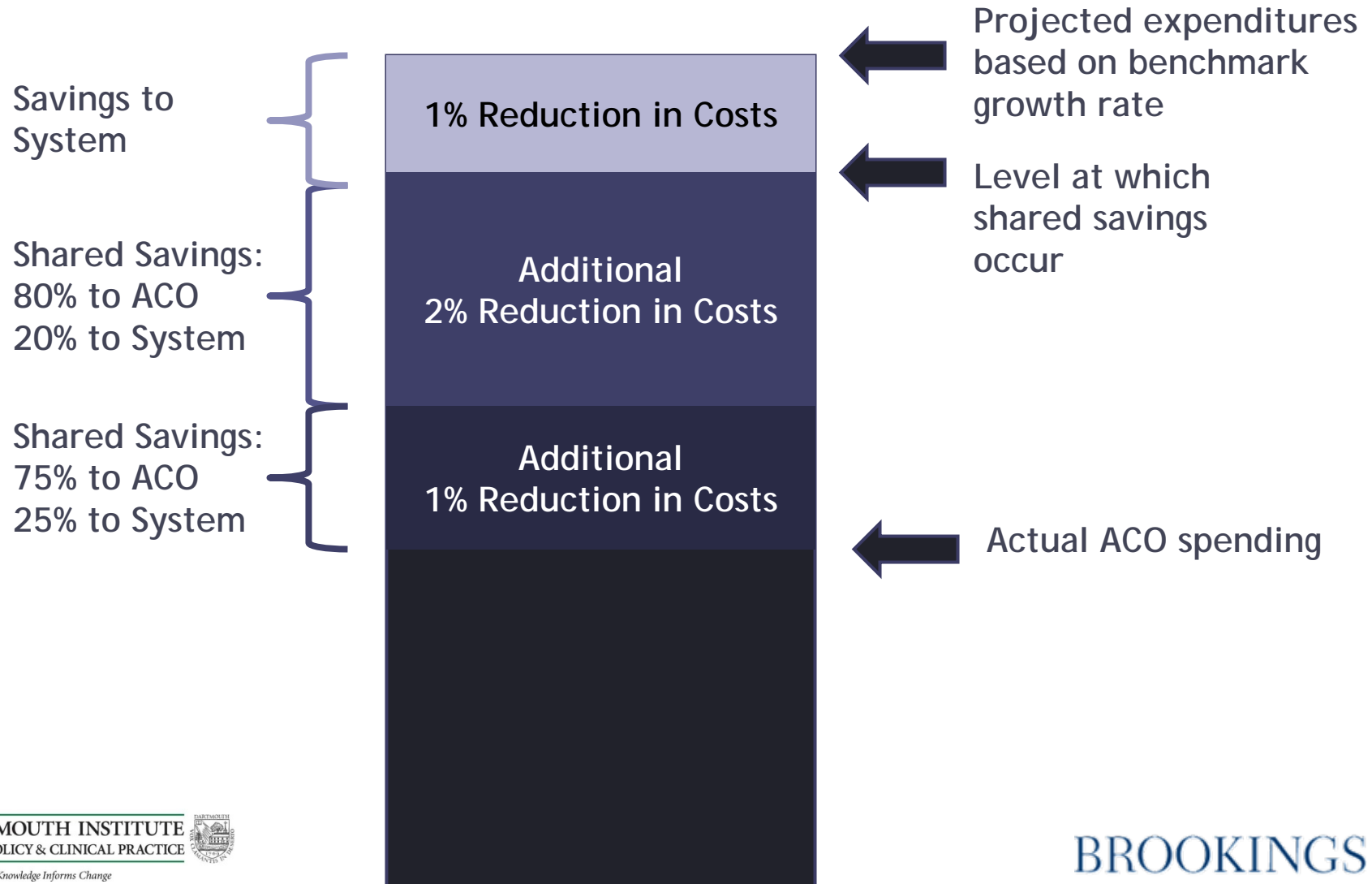
For patients assigned to an ACO (based on receiving the largest share of their evaluation and management visits from a particular ACO's unique provider), all physician and hospital allowed charges will be used to calculate ACO spending.



# Shared Savings are based on spending benchmarks

- Actuaries make spending projection
- Benchmark requires % savings below *projected* growth
  - Baseline -- ACO specific per-beneficiary spending
  - Benchmark = Baseline + Projected growth - Y% (e.g. 2%)
  - Projection / Benchmark could be national, regional, or ACO-specific
- Shared savings payments based on performance relative to benchmark over 2 yrs (based on rolling average of 8 quarters of data, with partial payments in first year of program)

# Example of Shared Savings Allocation



# Overview of Shared Savings Approach

