Accountable Care Organizations: An Overview

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Overview

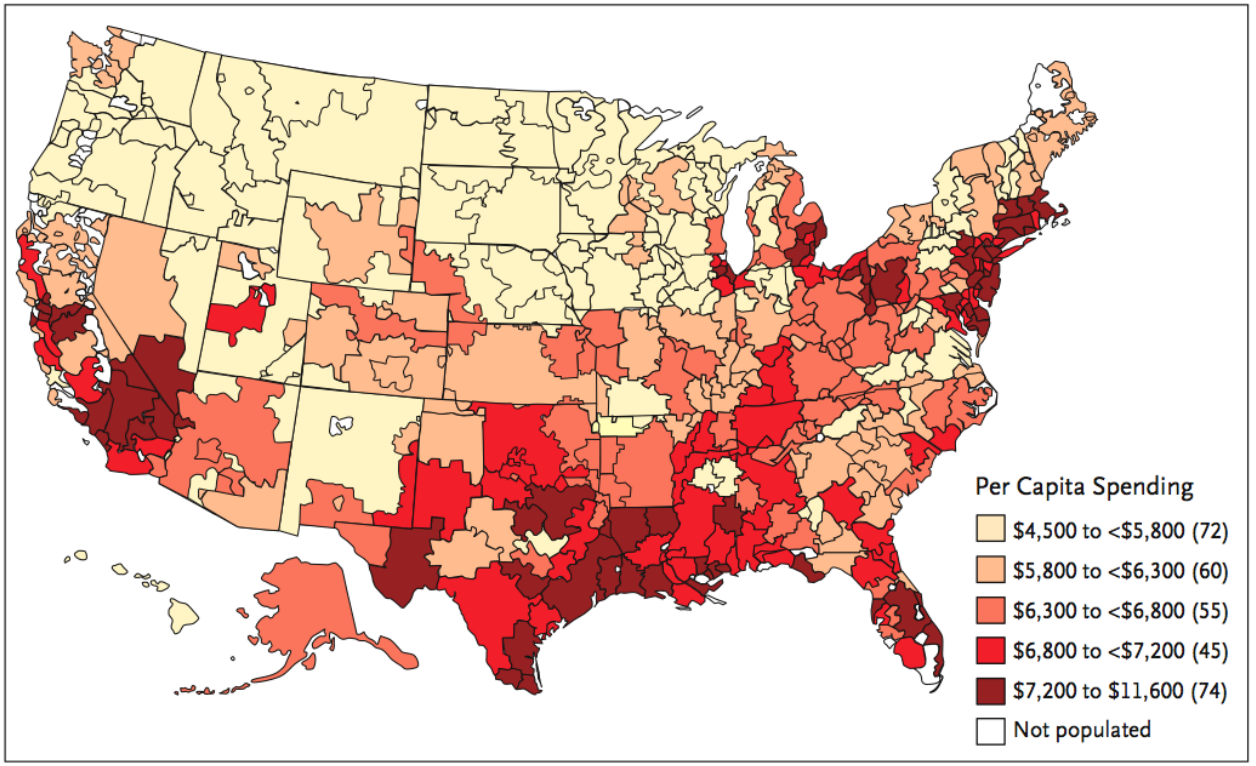
- Motivation
- What is an ACO?
  - Conceptually
  - Starting locally
  - Reimbursement reform
  - The big vision

Motivation

We know the story…

- A complex, fragmented, & confusing system
- Very little coordination
- Very little or no incentive to limit care
- Inadequate data to assess cost-effectiveness , cost growth or utilization trends
- Variations in care with no apparent benefits

Threefold variation in per capita spending

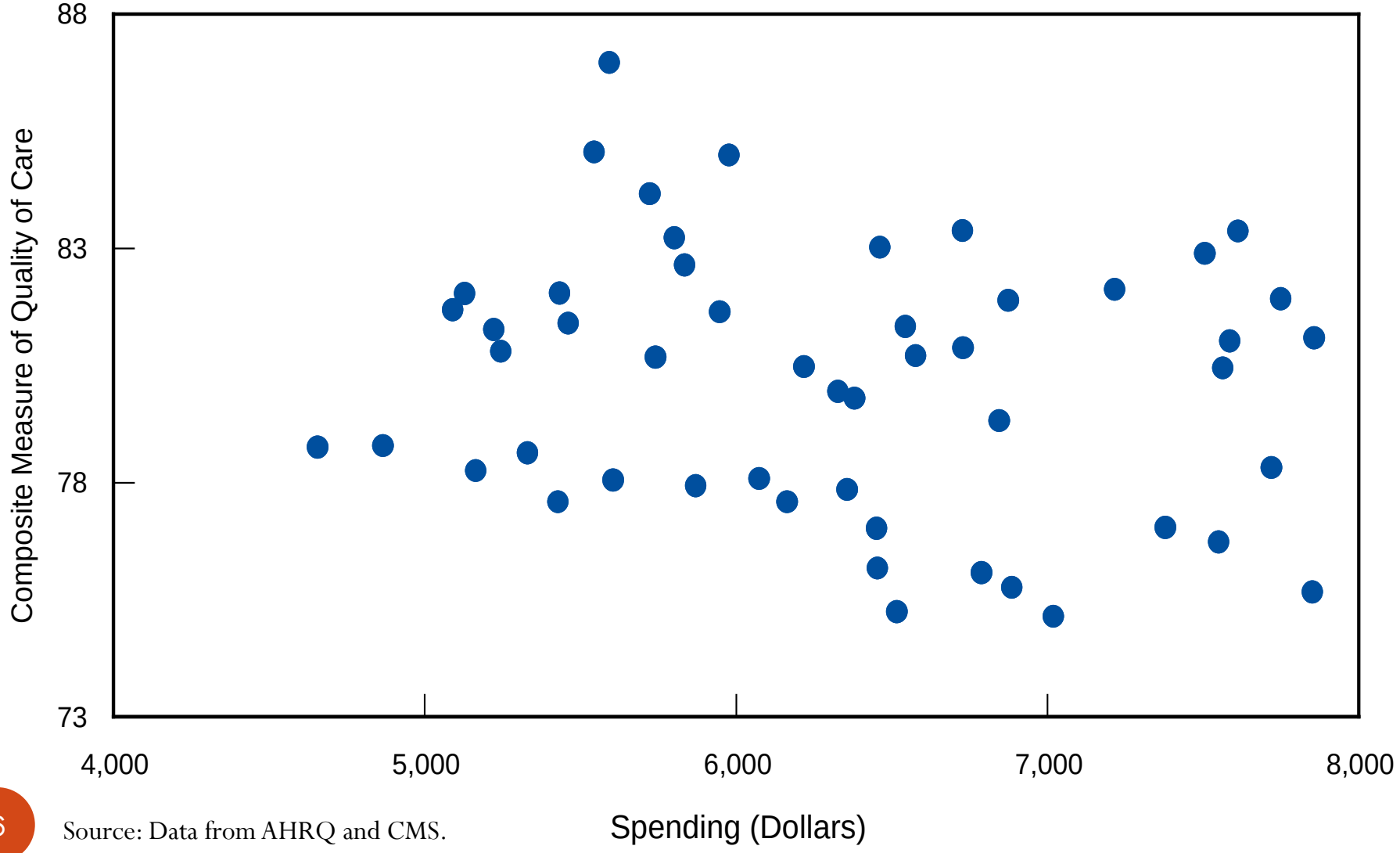


Medicare Spending per Capita, According to Hospital Referral Region, 2003.

Data are from the Dartmouth Atlas of Health Care. Numbers in parentheses are the numbers of hospital referral regions with that level of per capita spending.

Peter Orszag, N Engl J Med, 2007

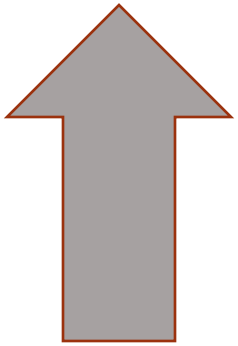
The relationship between quality and Medicare spending, by state, 2004



Source: Data from AHRQ and CMS.

Where is the variation?

More Care in High Spending Regions



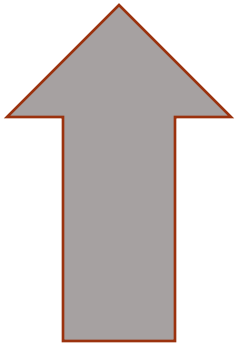
Less Care in High Spending Regions

Examples:
Mammogram, Women 65-69
Pneumococcal Immunization

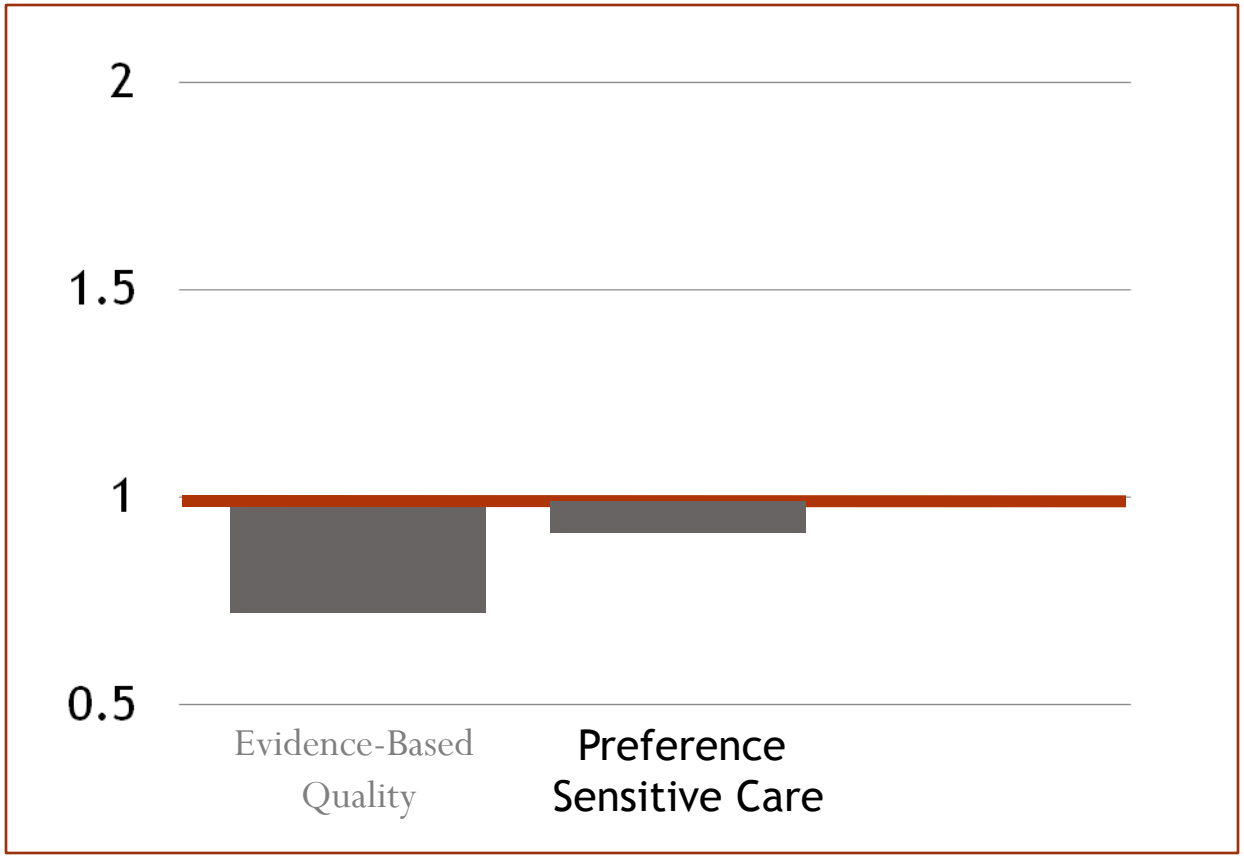
Pap Smear, Women 65+
Aspirin at admission (Heart attack)

Where is the variation?

More Care in High Spending Regions



Less Care in High Spending Regions

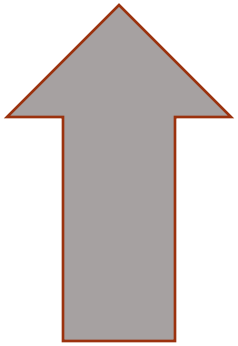


Examples:

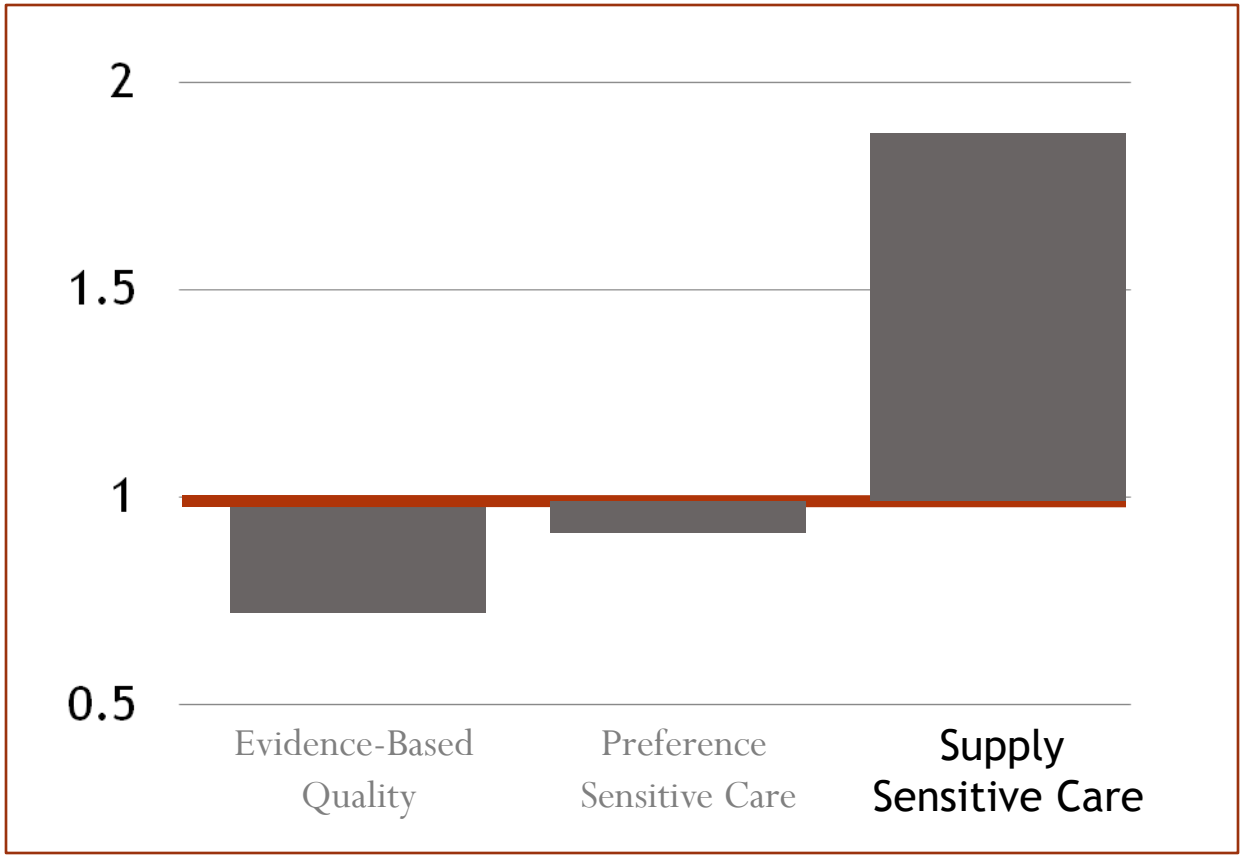
Total Hip Replacement	Total Knee Replacement
Back Surgery	CABG Following Heart Attack

Where is the variation?

More Care in High Spending Regions



Less Care in High Spending Regions



Examples:
Total Inpatient Days/ICU Days
Evaluation and Management (visits)

Diagnostic Tests
Imaging

What is going on?
Key role of local context

- 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

The Accountable Care Organization approach

- Basis: Elliot Fisher & colleagues at Dartmouth
  - *Health Affairs*, 2006
- Three rationales:
  - Performance measurement
    - Population health and per capita costs
  - Local accountability
  - Payment reform
- Substantial/permanent support in House & Senate health reform bills
- A rose is a rose is a rose…
  - Accountable Care Systems
  - Accountable Health Districts
  - Accountable Care Communities

  - The goal: build community health systems

What is an Accountable Care Organization?

Let's cover ACOs in steps

- Conceptually
- Starting locally
- Reimbursement reform
- The big vision

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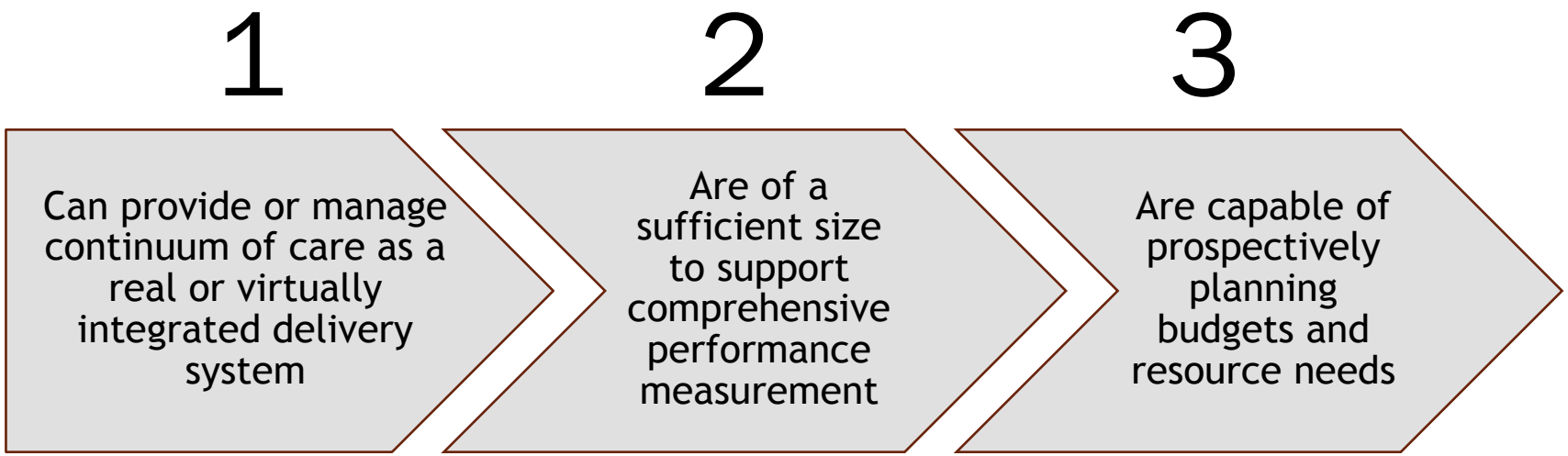
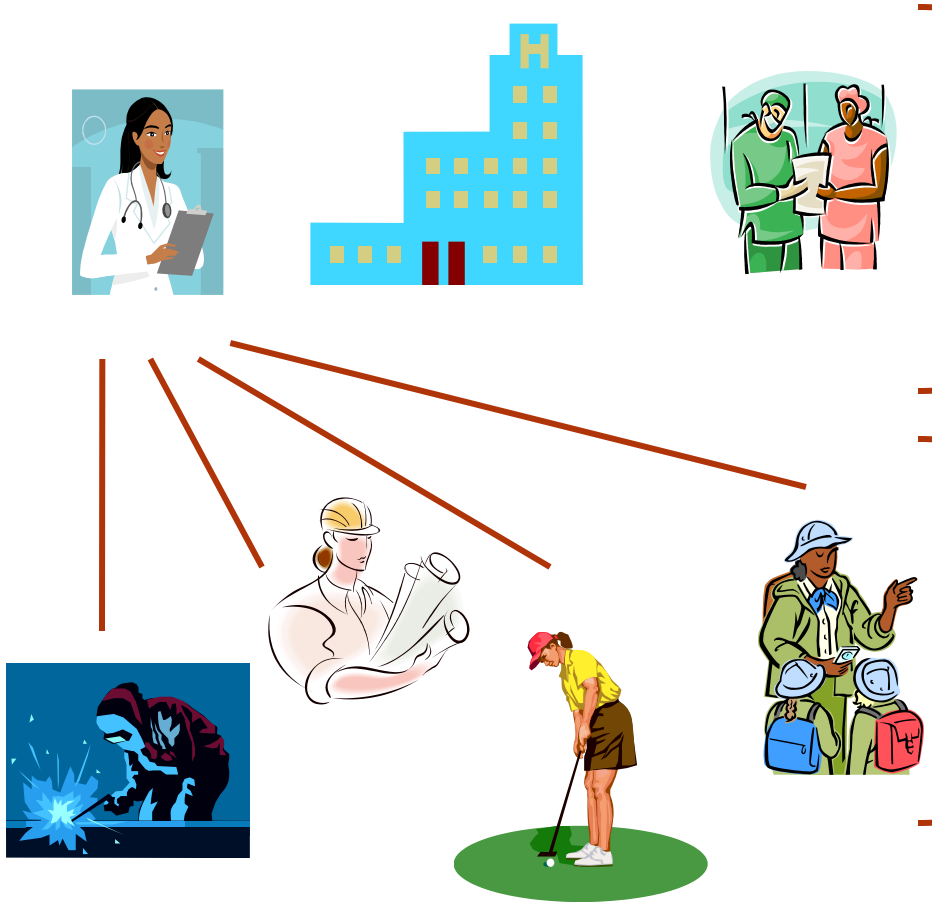
What is an accountable care organization?

- Most patients get most of their care from one or two physicians
- Most physicians admit most of their patients to one or two hospitals
- This empirical relationship creates a virtual network
- We can imagine using claims data to associate patients with a primary care clinic and follow their outcomes (health care quality and expenditures) over time
- We can structure reimbursement to reward primary care clinics for high quality care and low overall spending
- This is the beginning of an "Accountable Care Organization"

ACOs will look very different, but a few characteristics are essential



How are patients assigned to the ACO?



Providers sign agreement to participate with ACO

(PCPs must be exclusive to one ACO; Specialists can be part of multiple ACOs)

Patients are assigned to their PCP based on the majority of their outpatient E&M visits

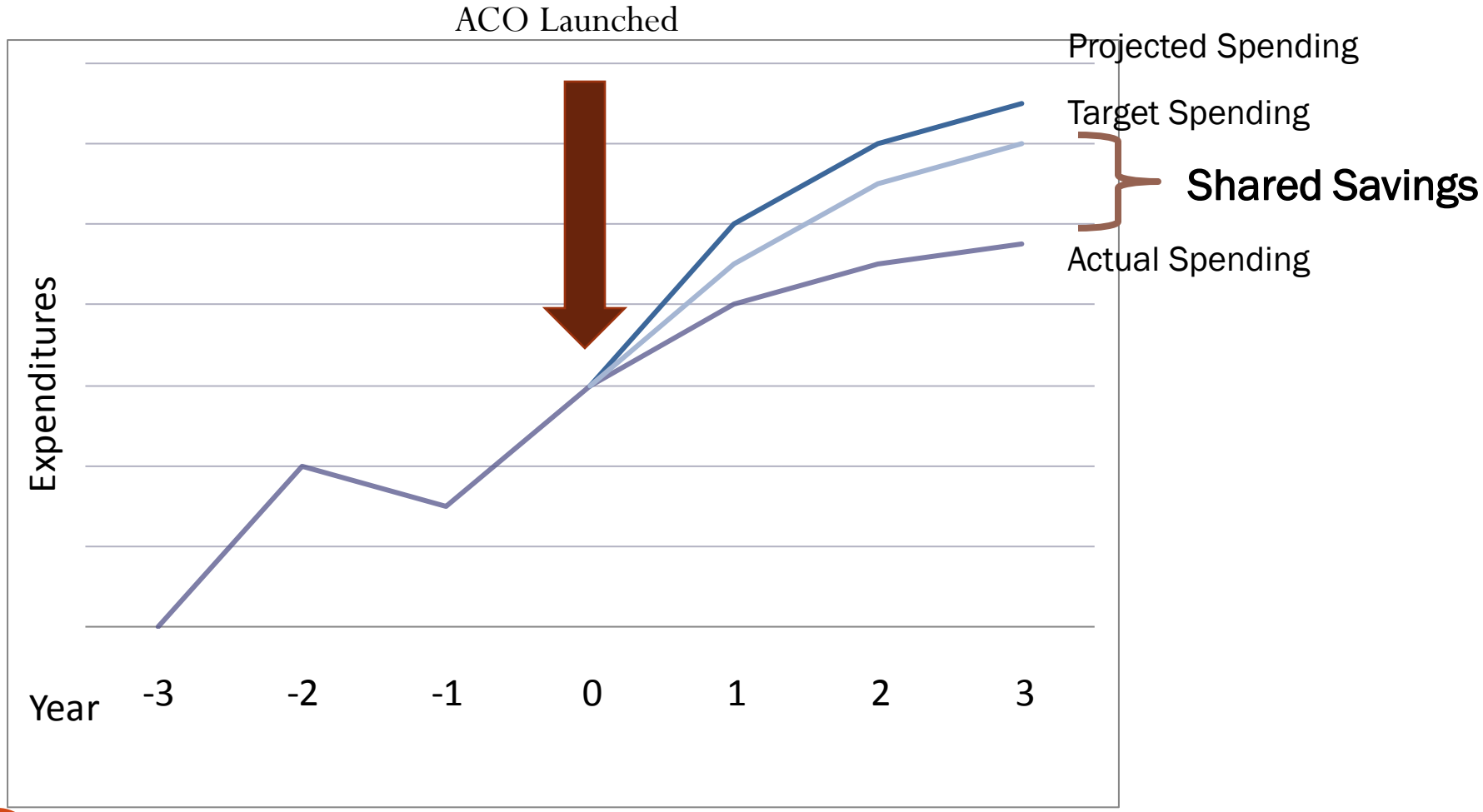
Three components of ACO infrastructure

- Local Accountability for Cost, Quality, and Capacity
- Shared Savings
- Performance Measurement

1. Local accountability

- We know that cost growth is a major challenge to health reform
- Local decisions (MRI purchases, ICU wings, high-tech devices) are a first step in the chain to more-intensive practice patterns and the overuse of services
- ACO-level measures of quality and costs would bring the impact of such decisions to light
- The effects of expansions of acute care facilities or recruitment of additional specialists would be more easily identified
  - The good and the bad
  - Not just a vague pass-through that is built into future premiums

2. Shared savings based on spending targets



3. Performance measurement

- Oregon's development of All Payer All Claims database provides rich set of opportunities for measurement
- Focus: population health and per capita costs
  - Not just outcomes & costs for a selected procedure
- Measures and promotes coordination between physicians, clinics, and hospitals
  - Not just silos
- Opportunities for comparing outcomes different regions (and learning best practices)
- Broad, diverse set of measures possible (public health, too!)

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ACO concepts evolving

- Initial conception (Fisher *Health Affairs*): ACOs generated empirically through data

- In practice: : identify groups of providers (PCPs) willing to voluntarily form ACO
- Then: work with health plans to identify new reimbursement structure
- Then: flip the switch on the SAS patch to create your virtual network

- (Lots of activity here in MN, VT, MA)

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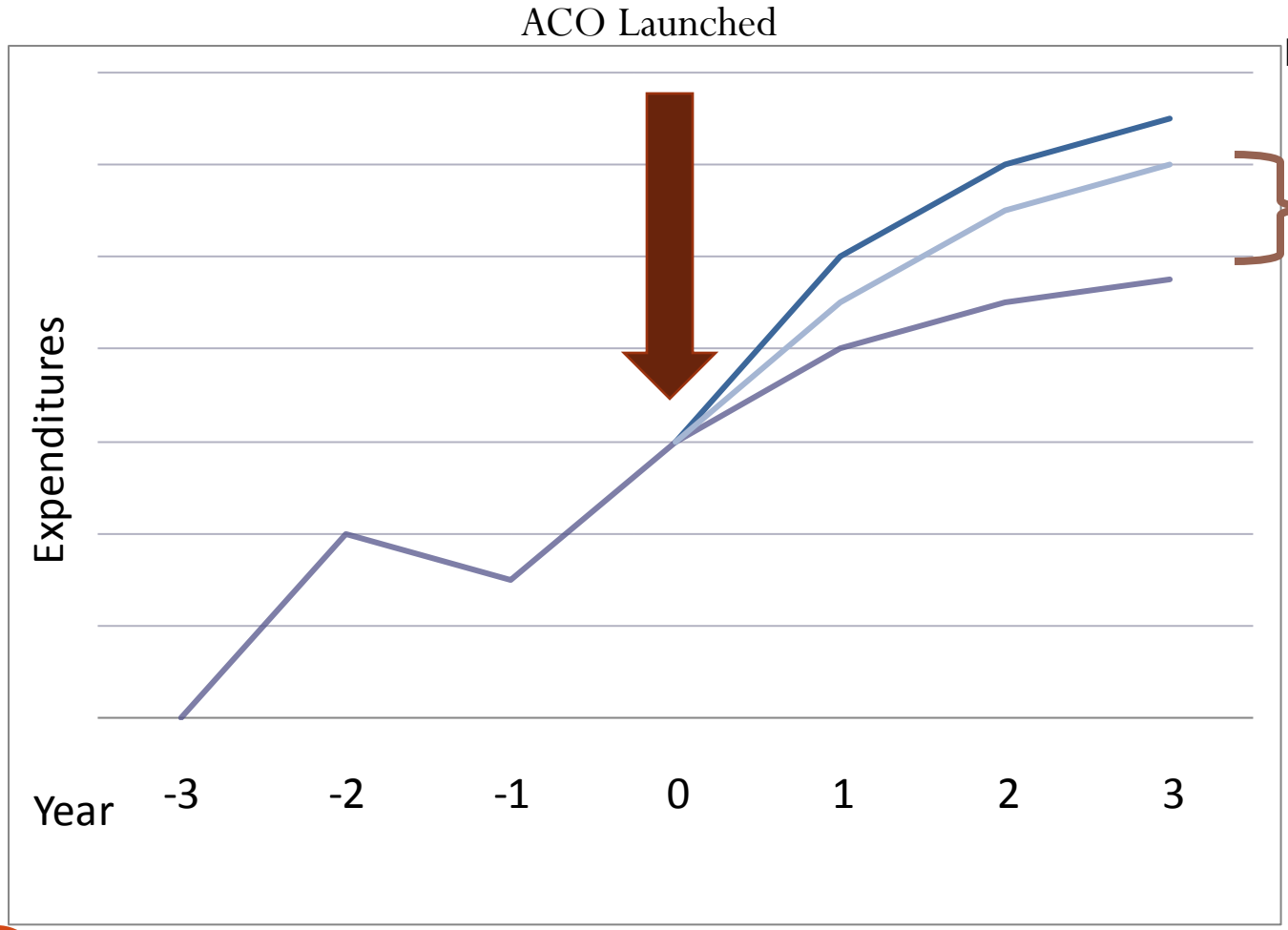
Shared savings: Overview

- The principal features of a "shared savings" model include:
  - Payers and ACOs establish budget targets for the total health spending of ACO's members.
  - Payers may continue to make payments on a fee-for-service basis.
  - At the end of the year, the actual and target spending are reconciled.
  - If the actual spending is less than the target, and if the ACO has performed adequately on access and quality metrics, the ACO, payers, employers, and consumers share the difference ("shared savings").

Shared savings based on spending targets



Changing incentives

- Current focus: revenue growth
  - Often driven by large capital investments with high fixed costs
  - Incentives for more use
    - Extra MRI means more revenue
    - Foregoing MRI means NO revenue
    - Only way to make margins is to use more or charge more
  - Always leads to greater health care spending
- Better focus: spending targets & shared savings
  - Preserves margins
  - 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
  - ACO – not a radical shift
    - Can be implemented in context of fee-for-service payment

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What do primary care practices need to become ACOs?

- Complete & timely information about their patients and the services they are receiving
- Technology and skills for population management and coordination of care
- Adequate resources for patient education and self management
- A culture of teamwork
- Coordinated relationships with specialists and other providers
- Ability to measure and report on the quality of care
- Infrastructure skills for the management of financial risk
- Commitment by leadership to improving value as a top priority

Things in Oregon's favor

- There are only a few states ahead of us
  - VT, MA, MN, PA
  - We can learn from them
    - Brookings/Dartmouth learning collaborative
  - We are still well-positioned for federal reform pilots
- High probability that some type of substantial support for ACOs will come out of federal reform or Medicare
  - Early adopters will benefit
- Very important and complimentary work has been conducted by the Oregon Healthcare Quality Corporation
- The Oregon All Payer All Claims database lays the groundwork for ACOs

Closing thought

"As America struggles to extend health-care coverage while curbing health-care costs, we face a decision that is more important than whether we have a public-insurance option, more important than whether we will have a single-payer system….. the decision is whether we are going to reward the leaders who are trying to build a new generation of Mayos and Grand Junctions. If we don't, McAllen won't be an outlier. It will be our future."

Atul Gawande, M.D.
The NewYorker
June 1, 2009

Thank you…

…and questions?

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