



Advancing Accountable Care in Colorado

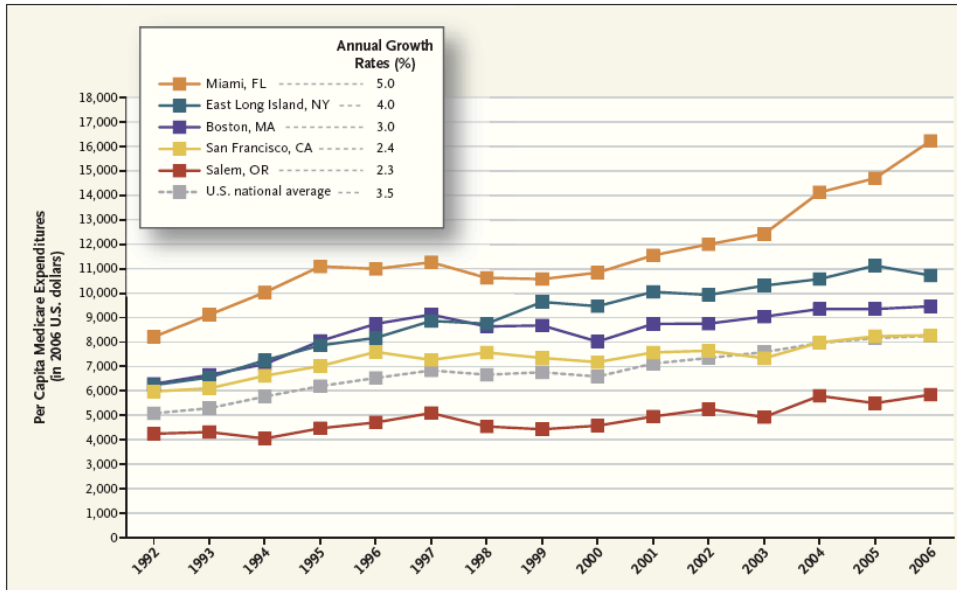
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Per-capita Medicare Spending Trends: 1992 to 2006



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
Miami	\$16,351	5.0
E. Long Island	\$10,801	4.0
Boston	\$9,526	3.0
San Francisco	\$8,331	2.4
Salem, OR	\$5,877	2.3
US Average	\$8,304	3.5

Annual savings now if Long Island had grown at San Francisco rate: \$1 billion
 Projected savings if US grew at San Francisco rate from now to 2023: \$1.4 trillion

What do they get more of?

Effective Care: *benefit clear for all*

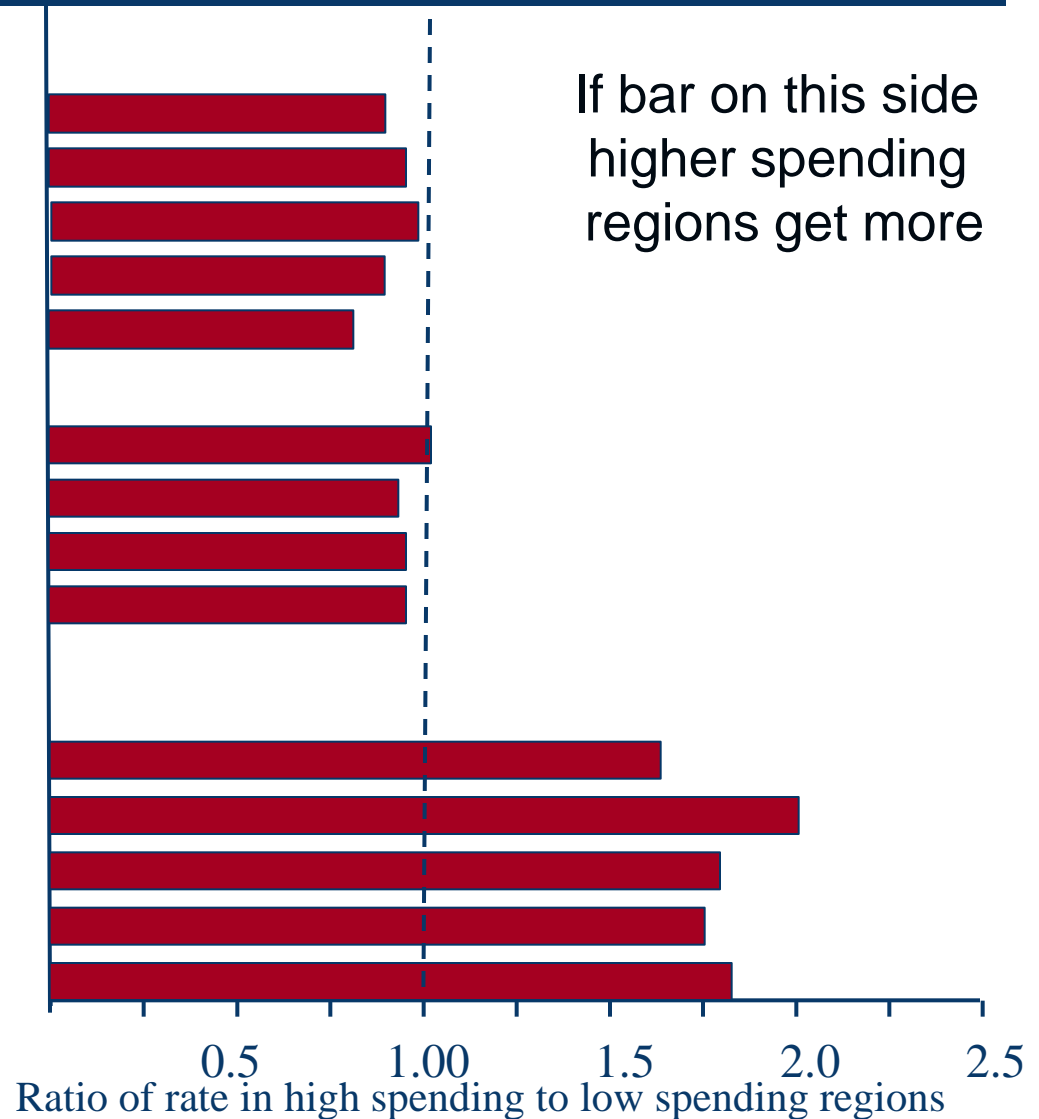
- Reperfusion in 12 hours (Heart attack)
- Aspirin at admission (Heart attack)
- Mammogram, Women 65-69
- Pap Smear, Women 65+
- Pneumococcal Immunization (ever)

Preference Sensitive: *values matter*

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

Supply sensitive: *often avoidable care*

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



Some principles to guide reform

Aims, Accountability, Integration, Incentives

Underlying problem

Confusion about aims – what we’re trying to produce

Absent or poor data leaves practice unexamined and public assuming that more is always 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.

Key principles

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

Better information that engages physicians, supports improvement; informs consumers

New model: It’s the system. Establish organizations *accountable for aims* and capable of *redesigning practice* and *managing capacity*

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

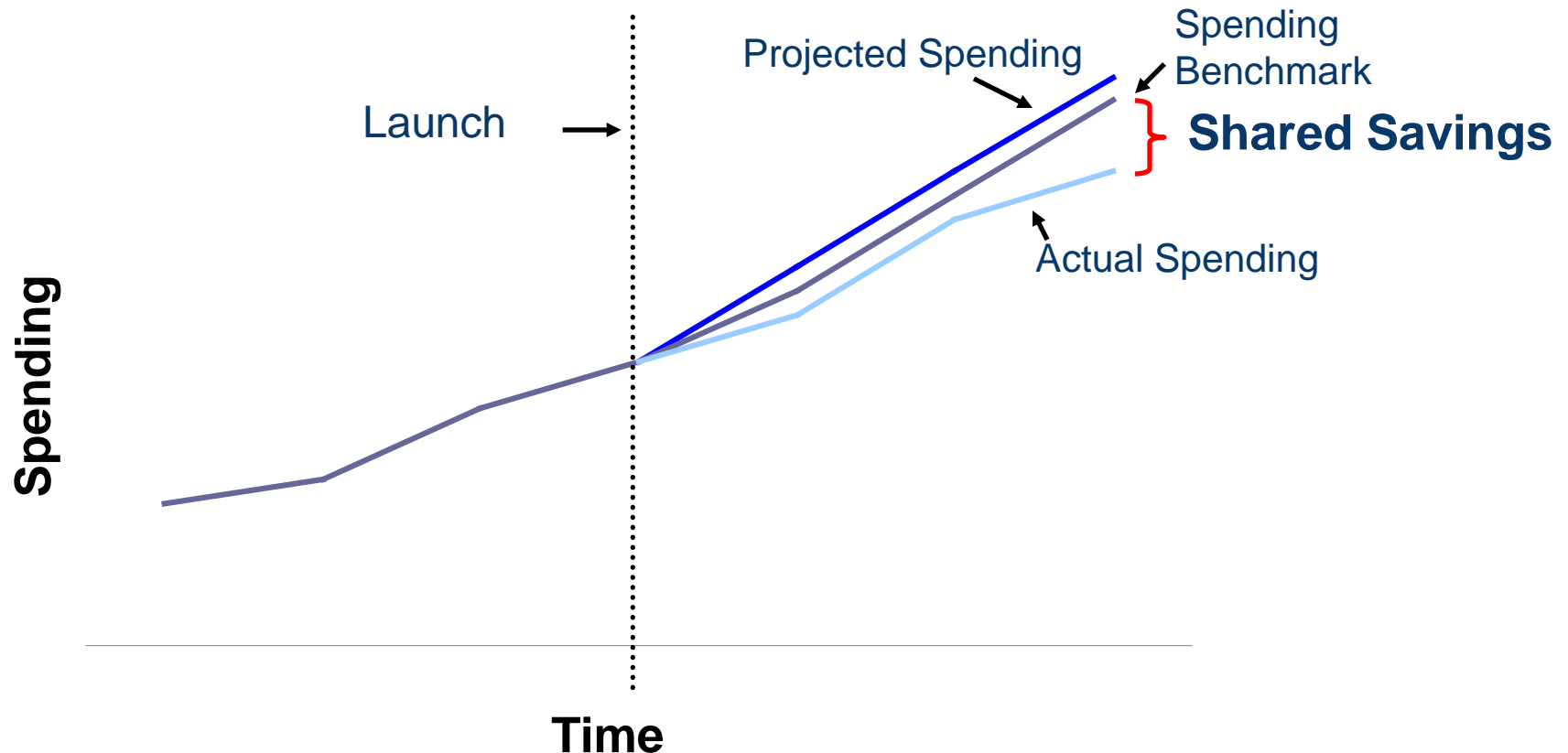
Progression of Payment Reform

Past and Emerging Models of Accountability in Provider Payments

Supporting Better Performance		Paying for Better Performance		Paying for Higher Value	
<p>Pay for reporting. Payment for reporting on specific measures of care. Data primarily claims-based.</p>	<p>Payment for coordination. Case management fee based on practice capabilities to support preventive and chronic disease care (e.g., medical home, interoperable HIT capacity).</p>	<p>Pay for performance. Provider fees tied to one or more objective measure of performance (e.g., guideline-based payment, nonpayment for preventable complications).</p>	<p>Episode-based payments. Case payment for particular procedures or conditions based on quality and cost.</p>	<p>Shared savings with quality improvement. Providers share in savings resulting from better care coordination and disease management.</p>	<p>Partial or full capitation with quality improvement. Systems of care assume responsibility for patients across providers and settings over time.</p>

How Do “Shared Savings” Models Work?

Shared savings derived from spending below benchmarks



Accountable Care Organizations (ACOs)

ACOs are provider collaborations organized around the ability to receive shared-savings bonuses by achieving measured quality targets and demonstrating real reductions in overall spending growth for a defined population of patients.

- **Voluntary Provider Participation:** Established governance structure and broad (voluntary) physician and payer participation. Ideally participation by Medicare.
- **Local Accountability:** Providers, payers, and consumers receive regular, risk-adjusted reports about performance with benchmarks.
- **Payment Incentives:** Participating payers agree to adopt their own provider payment incentives that, at a minimum, involve QI and may include cost savings and efficiency incentives based on performance across specified populations.
- **Performance Measurement:** Well-established performance measures relevant to multiple payers/populations. Measures become more sophisticated over time.
- **Integration with Other Reforms:** ACOs are compatible with and reinforced by other delivery system reforms to ensure coordinated, high-quality care (e.g., consistent with “Triple Aim” goals, compatible with medical homes).

How Do ACOs Reduce Expenditures?

Through systematic efforts to improve quality and reduce costs across the continuum of care

- Timely, actionable data for feedback and improvement
 - Likely enabled by IT and other tools
- Strengthening primary care
 - Access to providers (e.g., extended office hours)
 - Chronic disease management
- Managing care coordination and care transitions
- Informed patient decisions
- Capacity Planning
 - Workforce
 - Infrastructure

ACO Organizational Designs

ACO configurations will vary reflecting the diversity of local markets. However, several characteristics are essential for all ACOs:

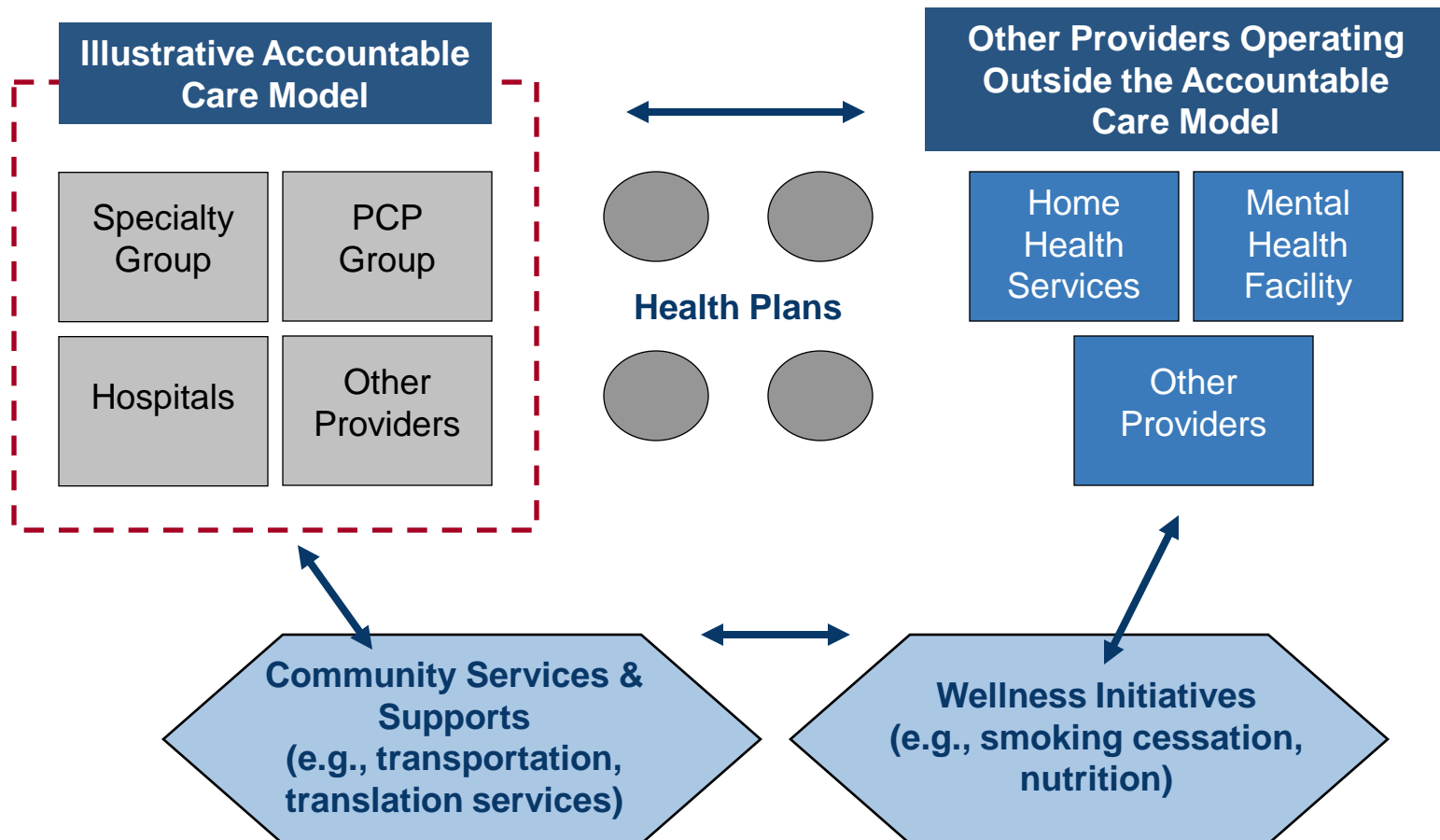
1. Can provide or manage the continuum of care for patients as a real or virtually integrated delivery system
2. Are of sufficient size to support comprehensive performance measurement and expenditure projections
3. Are capable of internally distributing shared savings and prospectively planning budgets and resource needs

Sample of Diverse Organizational Designs in ACO Learning Network

- North Colorado Health Alliance
- United Health Alliance (VT)
- Baylor Health System
- Duke University Med. Center
- Iowa Health System
- Carilion Clinic
- Tucson Medical Center
- Norton Healthcare

Integrating Care Through ACOs

ACOs can serve as “integrators,” linking fragmented entities of the health care system around accountability for value.



How Does This Actually Work?

Steps for initial ACO implementation

- Local providers and payers agree to pilot ACO reform
- ACO provides list of participating providers to payers
- Patients are “assigned” to ACOs (e.g., based on preponderance of E&M codes)
- Actual projections about future spending are based on last 3 years of historical data
- Determine/negotiate spending benchmark and shared savings arrangement
- ACO implements capacity, process, and delivery system improvement strategies
- Progress reports on cost and quality are developed for ACO beneficiaries
- At year end, total and per capita spending are measured for all patients
- Savings under the benchmark is shared between providers and payers

Fostering ACO development

Achieving “Accountable Care” will require coordinated effort

Advancing
Accountable Care

Developing, testing,
and evaluating ACO
model

Supporting
integration & clinical
transformation

Aligning private and
public initiatives

Likely to require:

Technical support

- For ACO model implementation
- For clinical transformation

Public-private collaborative

- To coordinate local, state, federal initiatives
- To advance standards on measures
- To identify barriers and address them

Recent and Emerging ACOs

Lineage of ACOs through Federal Initiatives:

- Medicare Physician Group Practice Demonstration
- Medicare Health Care Quality Demonstration
- Accountable Care Organizations

Physician Group Practice (PGP) Demo

- The PGP Demo was legislatively mandated in 2000 as a 5-year shared savings/quality improvement demonstration with Medicare
 - **Billings Clinic**; Billings, MT
 - **Dartmouth-Hitchcock Clinic**; Bedford, NH
 - **The Everett Clinic**; Everett, WA
 - **Forsyth Medical Group**; Winston-Salem, NC
 - **Geisinger Health System**; Danville, PA
 - **Marshfield Clinic**; Marshfield, WI
 - **Middlesex Health System**; Middletown, CT
 - **Park Nicollet Health Services**; St. Louis Park, MN
 - **St. John's Health System**; Springfield, MO
 - **University of Michigan Faculty Group Practice**; Ann Arbor, MI

Physician Group Practice (PGP) Demo Cont.

- **Summary of Results**

- Year 1

- All demos improved clinical management of diabetes; 2 demos achieved benchmark performance on all 10 diabetes measures
- Two demos shared in savings (\$7.3 M in payments)

- Year 2

- All 10 demos continued to improve quality scores
- Four demos shared in savings (\$13.8 M in payments)

- Year 3

- All 10 demos continued to improve quality scores
 - Years 1-3: Average of 10% pts on diabetes, 11% pts on CHF, 6% pts on CAD, 10% pts on cancer screening, 1% pt on hypertension
- Five demos shared in savings (\$25.3M)

Medicare “646” Demo: Indianapolis

- The Indiana Health Information Exchange (IHIE), through its Quality Health First (QHF) Program, is a community-wide quality measurement and P4P health information exchange made up of a coalition of physician practices, hospitals, employers, private and public payers, and public health officials.
- Multi-payer program includes several components.
 - A comparative performance reporting and tracking system that provides participating physicians with information on the extent to which the care complies with evidence-based practice guidelines
 - A pay-for-performance incentive system that uses information on adherence to treatment guidelines and practice efficiency to distribute savings that are achieved through better care management
- Demonstration waiver authority has added Medicare to the list of participating private and public payers and will allow the IHIE to qualify for a portion of Medicare savings if spending reductions are achieved.

Medicare “646” Demo: North Carolina

- The North Carolina Community Care Networks (NC-CCN) is a non-profit organization made up of regional health care networks of community physicians, hospitals, health departments, and other community organizations.
- Under the MHCQ demonstration, NC-CCN will test the impact that a physician-directed care management approach will have on care quality and efficiency.
 - Enhanced provider fees for medical homes and use of technology to support care coordination and evidence-based practice
 - Regional physician pay-for-performance program supported by a common set of quality measures
- Demonstration waiver authority expands the program population to the dual eligible and general Medicare FFS population and will provide NC-CCN with the opportunity to qualify for a portion of Medicare savings if spending reductions are achieved.

Brookings-Dartmouth ACO Learning Collaborative

- ACO Learning Collaborative programs include:
 - ACO Learning Network
(www.acolearningnetwork.org)
 - Technical Assistance and implementation support sites
 - Policy guidance and assistance in Washington and with states

ACO Learning Network

- The Brookings-Dartmouth ACO Learning Network is comprised of nearly 60 diverse provider systems across the country
- The Learning Network includes:
 - An online forum for providers to exchange ideas and experiences;
 - Monthly webinars on core ACO technical implementation issues (i.e., budget and budget benchmarks; performance and quality measurement; and governance and legal issues);
 - An ACO “tool kit” highlighting practical implementation issues that potential ACO pilots would need to address in the implementation process.

Technical Assistance

- Technical Assistance is provided to three organizations in the process of becoming ACOs:
 - Carilion Clinic, Roanoke, VA
 - Norton Healthcare, Louisville, KY
 - TMC HealthCare, Tucson, AZ
- Core areas of technical assistance includes:
 - Actuarial and budget benchmark development
 - Guidance on payment models
 - Best practices in quality measurement and reporting



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Questions?
