Models of Accountable Care
Medical Home, Episodes and ACOs – Making it work

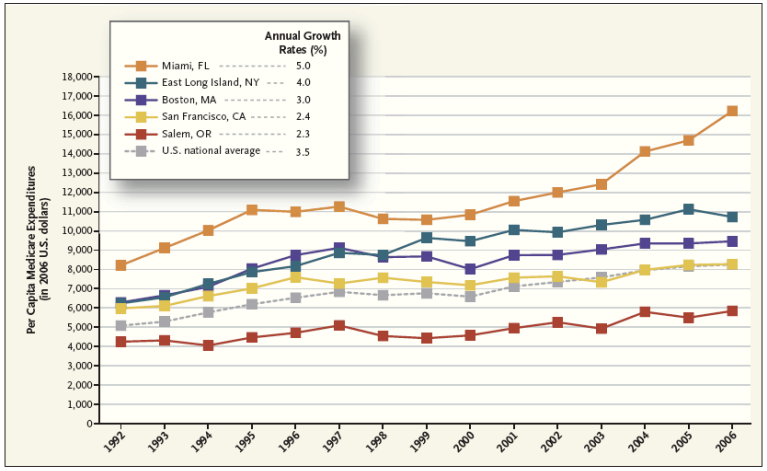
Elliott Fisher, MD, MPH

Director, Population Health and Policy
The Dartmouth Institute for Health Policy and Clinical Practice

Professor of Medicine and Community and Family Medicine
Dartmouth Medical School

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
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**

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

Underlying causes
And principles to help guide reform

What's going on?	What we need: accountable care
Confusion about aims – what we're trying to produce	**Clarify aims:** Better health, better care lower costs – for patients and communities
Limited data leaves practice unexamined, limits learning, and allows public to believe more is better.	**Better information** that engages physicians, supports improvement; informs consumers and policy makers
Flawed conceptual model. Health is produced only by individual actions of "good" clinicians, working hard.	**New model: It's the system.** Establish organizational structures *accountable for aims* & capable of *redesigning practice* and *managing capacity*
Wrong incentives reinforce model, reward fragmentation, induce more care and entrepreneurial behavior.	**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)

Fisher et al. Creating Accountable Care Organizations, Health Affairs 26(1) 2007:w44-w57.

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

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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