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Next Steps for ACO Implementation

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.
Origins – Why ACOs?

Barrier

Confusion about aims – what we’re trying to produce

Fragmented delivery system, with no accountability for capacity, quality or costs.

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

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

Principles

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

Foster integration and accountability for the full continuum of care – and for the capacity of the local health system

Better information that engages physicians, supports improvement; informs consumers

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

• Considerable technical work for successful implementation: data, effective measurement, financial modeling (including risk issues)

• High-level organizational leadership

• Lack of coordination of public and private payers on models and measures

• Risk that ACOs will reinforce trends toward provider concentration with market power

• Limited consumer engagement in model development and performance reporting

• Tension between need for national models and diversity of local markets

• Need to achieve critical mass of participation for providers to be engaged

• Uncertain financial viability of shared savings model on its own
Organizational Tasks

• Achieving shared vision of leadership team and governing boards to support move toward accountable care
  – Tucson Medical Center board composition
  – Support from state/local political leaders and private alliances

• Understanding market position and developing strategy to work with other providers and with national and local payers required for alignment and necessary critical mass
  – Advocate Health Care alignment of physicians, hospitals and payers
  – “California model” – diverse organizational models; good payer alignment

• Identifying and managing technical and legal issues that must be addressed to participate
  – Issues with federal and state laws, including fraud/abuse and HIPPA/Privacy, must be addressed but can be managed
  – Advisory opinion opportunities with FTC, building on past guidance about clinical integration
  – Same network of providers in ACO can create a parallel organization under Medicare Part C
Organizational Tasks

• Taking advantage of other payment / policy reforms aligned with principles of accountable care to help absorb start-up costs and start down the path
  – Prometheus payment
  – Patient-Centered Medical Homes
  – Meaningful use incentives for health information technology

• Developing administrative and clinical capacities to implement programs to transform practice: informatics, care management, coaching, etc.
  – Informatics: Cost-effective data warehouses, disease registries (Intelligent Health, Advocate)
  – Leadership training: Advocate Health Care, Institute for Healthcare Improvement, The Dartmouth Institute
  – Quality initiatives available on the web (Norton Healthcare)

• Learn from others
  – Brookings-Dartmouth ACO Pilots, CAPG, “Twinning”
  – State and regional quality measurement organizations
Moving Forward

• Advance technical work required for successful implementation, with participation of all key stakeholders: eligibility criteria, performance measures, strategically coordinated payment reforms

• Support actual implementation: early pilots, public-private alignment, rapid learning, successful leadership methods, and adaptation of models from current initiatives, including Brookings-Dartmouth, Premier, AMGA, others

• Promote effective policy steps: federal-state coordination, rulemaking, and further policy actions to promote promising directions on accountable care
Federal and State Policy Initiatives – Synergies

• Medicare ACO Program – Starting 2012
  – Listening session later this month, regulations late 2010/early 2011
• HIT Meaningful Use Payments – Starting 2011
• Medicare Pay for Reporting via Electronic Registries – Available Now
• Center for Medicare and Medicaid Innovation – reinforcing payment reforms – Starting 2011
  – Including “Innovation Zones”
• Comparative Effectiveness Research (Patient-Centered Outcomes Research Institute)
  – Priority to evaluate ACOs and other major payment/policy reforms
• State and Regional Reform Initiatives
Brookings-Dartmouth Learning Network Steps to Support Federal/State Action

• Identify Best Practices for Consistent Metrics on Quality, Cost
  – Faster and more meaningful access to needed data
  – Broader, national support for community goals
• Pilot Implementation Now, with Private/State and Local Partners
  – Collaborations with measurable record, critical mass may encourage CMS/HHS support
  – Strategies and templates for working with states
• Coordinated CMS/HHS Interaction
  – Increased technical knowledge base and impact
• Research/Evaluation Capabilities to Promote Support for Implementing Pilots
  – Evaluation methods for private, CMS use
  – Comparative effectiveness research on care reforms, impact of care