
Accountable Care Organizations and The Medicare Shared Savings Program

Population Health Management, Enabled by Information Technology, Will Be Critical To Success

The Patient Protection and Affordable Care Act (PPACA) of 2010 focuses mainly on regulating health insurance and expanding coverage. But the legislation also addresses the role of the healthcare delivery system in health spending growth. In this area, the law's major thrust is to change how providers are paid. Among the approaches that Congress authorized the government to test is one that involves "accountable care organizations" (ACOs), which are healthcare provider groups that are designed to be accountable for the cost and quality of care.

Specifically, the PPACA authorizes the Centers for Medicare and Medicaid Services (CMS) to launch a shared-savings program with ACOs in 2012. Under this approach, an ACO that meets specified quality goals will be able to split with CMS any savings that surpass a minimum level.¹

CMS has not yet spelled out the details of this program or defined exactly what an ACO is. But the agency has said that, to qualify for the shared-savings program, an ACO must consist of providers and suppliers that "work together to manage and coordinate care for Medicare fee-for-service beneficiaries." Among the organizations that might qualify are large group practices, independent practice associations (IPAs), physician-hospital organizations (PHOs), and integrated delivery systems.²

This shared-savings program, which is not a pilot, potentially affects all patients covered by traditional Medicare. As a result, the ACO provision has generated strong interest among group practices and healthcare organizations. The ACO initiatives of a few commercial insurers are also attracting national attention. Some of the latter involve financial risk,³ and others are limited to gain-sharing.⁴ But, due to its sheer size, the Medicare ACO program is getting the lion's share of interest.

The ACO concept dovetails with other new reimbursement methods that payers are piloting, including payment bundling and patient-centered medical homes. Further down the road, it's likely that shared savings will transition to some type of payment bundling and, eventually, global capitation (a fixed payment for all care provided to each patient). But right now, the government and private insurers are proceeding with caution, because they know that the vast majority of providers are not ready to assume that much financial risk. Moreover, there are questions about how much limitation on provider choice the public is willing to accept.

Whichever direction the reimbursement changes take, they will require providers to do population health management (PHM). In the case of ACOs, the reasons are transparent: These organizations must manage the full spectrum of care and must be accountable for a defined patient population.⁵ Unless an ACO is capable of tracking the health status of and the care provided to every one of its patients, it is unlikely to produce significant savings or meet the quality benchmarks of CMS. And when organizations take on financial risk, it is absolutely essential for them to learn how to prevent illness and manage care as well as possible. The more risk that providers assume, the better they have to be at managing their populations' health.

THE ACO ENVIRONMENT

While experts have been discussing ACOs since 2006,⁶ relatively few organizations across the country have partnered with health plans to implement the concept so far. One reason is that most insurance companies, especially in the eastern half of the U.S., are reluctant to offer global capitation contracts. Also, gain-sharing between hospitals and physicians is still fairly uncommon, having only recently emerged from a regulatory deep freeze.⁷ In addition, health policy expert Jeff Goldsmith points out,⁸ hospitals and independent physicians have moved further apart in recent years as medical and surgical specialists have pulled more services out of the hospital into their offices, imaging centers, and ambulatory surgery centers.

But other trends are moving in the opposite direction. Hospitals are employing more and more physicians, including specialists.⁹ They are doing so partly for competitive reasons and partly because they believe that they will need to have physicians' cooperation when reimbursement methods change. The Federal Trade Commission, meanwhile, has given a handful of IPAs and PHOs approval to negotiate insurance contracts because they are clinically integrated and are therefore able to improve the quality of care.¹⁰ Many healthcare systems are moving toward clinical integration with their physicians, whether or not the latter are employed. And the spread of healthcare information technology is expected to accelerate this process.¹¹

Currently, the biggest ACO experiment in the country is the "alternative quality contract" of Massachusetts Blue Cross and Blue Shield.¹² This is actually a global capitation agreement with two features that differentiate it from the old HMO risk contracts: First, participants can qualify for graduated quality incentives, and second, the insurer pledges not to reduce their budgets in future years. In return, the contract holders promise to gradually cut cost growth to the rate of inflation.

Nine organizations currently participate in the Blues' alternative quality contract. They range in size from the six-hospital Caritas Christi chain in Boston to the physician-hospital organization of Lowell General Hospital in Lowell, Mass. The PHO includes numerous small physician practices that are in the process of clinical integration. They managed to do well in the first year of the contract by hitting quality goals and garnering incentives from the Blues.¹³

Other IPAs and PHOs that are gearing up to become ACOs include the Greater Rochester (NY) IPA, Advocate Health Care in Chicago, Brown & Toland in San Francisco, Hill Physicians in San Ramon, Calif., and Monarch Healthcare in Orange County, Calif. Hill is participating in a three-way pilot involving Catholic Healthcare West and Blue Shield of California.¹⁴ Monarch is engaged in a different kind of ACO pilot with Anthem Blue Cross and Healthcare Partners, a multistate physician group and IPA based in Los Angeles.¹⁵ Unlike the Blue Shield experiment, which involves the California Public Employees Retirement System (CalPERS) and is focused on reducing HMO costs by sharing financial risk, the Anthem-Monarch-Healthcare Partners pilot focuses on PPO members and shared savings. The participants hope that, by applying managed-care techniques in a fee-for-service setting, they can reduce costs and improve quality. In this respect, their approach is very similar to that of Medicare.

The Anthem pilot is one of several being conducted across the country under the aegis of the Engelberg Center for Health Care Reform at the Brookings Institution and the Dartmouth Institute for Health Policy and Clinical Practice. The leaders of those research organizations—Mark McClellan, M.D., and Elliott Fisher, M.D., respectively—are among the founders of the ACO movement. They have formed the Brookings-Dartmouth ACO Learning Network to promote the concept to healthcare organizations.¹⁶

Some observers question whether ACOs can succeed in most areas unless hospitals take the lead in organizing them. Yet there is nothing in the CMS regulations that requires hospitals to lead or even be a direct participant in ACOs. The only requirements are that ACOs include primary-care physicians and serve at least 5,000 Medicare patients each.¹⁷ But because an ACO must coordinate care across all care settings, it must secure the cooperation of one or more hospitals. So, while physician organizations and hospitals would both prefer to be in charge, they will have to learn how to work together.

Some experts doubt that a shared savings program that offers only rewards without risk will get physicians' attention and motivate them to change how they practice. They also wonder how patients will react to the idea of having a personal physician coordinate all of their care, when the patients are used to going to any physician they want to see. These observers view the Medicare approach as a first step toward partial or full capitation of healthcare organizations.¹⁸

GROUP PRACTICE DEMONSTRATION

These are valid points, but the history of Medicare's Physician Group Practice (PGP) demonstration¹⁹—an important precursor of the shared-savings program--offers some reasons to hope that large provider groups will be able to use CMS' shared- savings approach in constructive ways.

The PGP pilot, which involved 10 large groups and healthcare systems, began in 2005 and ended in March 2010. CMS paid the participants up to 80 percent of Medicare's savings from inpatient and outpatient care in excess of 2 percent of historical costs. Half of the bonuses were based on efficiency, and the other half came from meeting quality targets. While CMS has not yet released details of how it will share savings in its ACO program, in formulating its reform legislation in 2009, the Senate Finance Committee proposed that Medicare split the savings 50-50 with ACOs.²⁰

By the end of the second year of the PGP pilot, all of the groups hit most of the quality benchmarks for three chronic conditions. Four of the participants earned a total of \$13.8 million. In the third year, five groups netted a combined \$25.3 million.²¹

Each participant used different techniques to improve care and reduce costs. For example, the Dartmouth-Hitchcock Clinic in Bedford, N.H., focused on the use of electronic registries and patient education, while the Everett Clinic concentrated on improving primary care and radiology services, as well as the handoffs between inpatient and outpatient care settings. But all of the participants, in their own ways, were trying to upgrade their ability to manage population health.

The Everett Clinic (TEC), a large multispecialty group in Washington State, netted some of the shared savings in the second year of the pilot, but not in the third. (No data is available yet on the fourth and fifth years.) TEC successfully reduced the cost of imaging services and improved its understanding of how to manage high-cost subpopulations who need complex care. But the clinic also encountered some significant obstacles, including difficulty in correlating health risk scores with cost-effectiveness; the retrospective nature of the model; problems in getting non-TEC providers to cooperate; and difficulty

in persuading patients to use their primary care physician as a care coordinator.²²

Despite these issues, TEC plans to qualify as an ACO for Medicare's shared-savings program in 2012. The group's leaders believe that budgeting is the future of healthcare and that ACOs could be a key driver of that transition.

POPULATION HEALTH MANAGEMENT

U.S. healthcare costs much more per capita than the systems of other advanced countries but does not deliver better results.²³ The reasons are well known: The U.S. has a fragmented, chaotic care delivery system; healthcare providers are incentivized to provide high service volume rather than high-quality care; we have too few primary-care physicians and too many specialists; and our system is provider-centered rather than patient-centered.²⁴

To turn the healthcare system around, policy makers and health policy experts are focusing on population health management (PHM)—a key goal of ACOs. PHM has been defined as a healthcare approach that emphasizes “the health outcomes of individuals in a group and the distribution of outcomes in that group.” It addresses not only longitudinal care across the continuum of care, but also personal health behavior that may contribute to the evolution or exacerbation of diseases.²⁵

Among the key characteristics of health organizations that conduct PHM are an organized system of care; the use of multidisciplinary care teams; coordination across care settings; enhanced access to primary care; centralized resource planning; continuous care, both in and outside of office visits; patient self-management education; a focus on health behavior and lifestyle changes; the use of interoperable electronic health records; and the use of registries and other tools essential to the automation of PHM.²⁶

Today, the main practitioners of PHM are group-model HMOs like Kaiser Permanente and Group Health Cooperative of Puget Sound; large integrated delivery systems like Intermountain Healthcare, Geisinger Clinic, and the Henry Ford Health System; and the Veterans Affairs Health System and the Military Health System.²⁷ But if ACOs gain traction, they could help spread population health management to many other providers.

Whether the financial incentive is shared savings or global budgets, ACOs have a strong motive to maintain health, prevent disease, and control chronic conditions so that they don't lead to ER visits and hospitalizations. To achieve these goals, ACOs will have to stress non-visit care and disease management, including home monitoring of the sickest patients. They will have to build care teams that are capable of tracking patients' health status and ensuring that they receive recommended care. And they will have to incentivize providers to work with patients to improve their health behavior and their compliance with care plans.

ACOs share many of these objectives with patient-centered medical homes, the subject of a future white paper. For example, a physician whose practice serves as a medical home must coordinate care, improve patient self-management skills, track the services provided to patients, and maintain contact with patients between visits. Medical homes are also expected to use electronic tools such as EHRs and registries.²⁸ The primary-care practices that serve as medical homes are generally much smaller than ACOs and may lack the ability to induce specialists and hospitals to cooperate with them.²⁹ Nevertheless, a practice that qualifies as a medical home has gone a long way toward being able to function within an ACO. An effective ACO must not only take excellent care of patients who present for care, but must also try to monitor and stay in contact with people who do not have contact, or rarely have contact, with healthcare providers. The importance of

communicating with this segment of the population is profound, because it includes many individuals who will become sick and need acute or chronic care at some point in time. Therefore, an ACO that proactively addresses the health needs of this cohort will be able to control costs better than one that doesn't.

IMPORTANCE OF TECHNOLOGY

To be successful, an ACO must be clinically integrated, which means that physicians and other providers must communicate and exchange key clinical information. Up to now, this has been very difficult, because most clinical data is locked up in paper files that are inaccessible to providers outside of a particular hospital or practice. Even the delivery of lab results is still done mostly by fax, courier or mail.

Electronic health records (EHRs) are crucial to clinical integration. Not only can they make it easier for caregivers to document and retrieve patient data, but they also hold the key to health information exchange with other providers. Although only about 20 percent of physicians and 10 percent of hospitals have even basic EHRs,³⁰ adoption is beginning to accelerate, partly as a result of the HITECH provisions of the American Recovery and Reinvestment Act (ARRA) of 2009. Under this law, eligible professionals who demonstrate "meaningful" use of qualified EHRs may receive government subsidies of up to \$44,000 from Medicare or \$64,000 from Medicaid over five years.³¹

As the amount of digitized health information increases, however, most EHRs are still incapable of exchanging data; even interfaces with labs and hospitals remain problematic, mainly for financial reasons. The government is funding health information exchanges (HIEs) through the states, but these are still in their infancy. To achieve clinical integration, ACOs will have to form seamless electronic networks; consequently, we can expect these organizations to create or further develop local HIEs that will enable data exchange between disparate EHRs.

AUTOMATION TOOLS

EHRs, however, often have drawbacks for performing population health management. They are not designed for tracking populations, providing actionable reports on care gaps, or sending alerts to patients.³² ACOs will need not only EHRs, but also supplemental technologies that automate the work of monitoring, educating and maintaining contact with the patient population.

These tools, which should be used in conjunction with EHRs, include electronic registries; multiple outreach and communications methods; software that can stratify a population by health status; and health risk assessment programs that trigger alerts and provide educational materials to patients. Automated PHM tools ensure that the routine, repetitive work of managing population health is done in the background, freeing up doctors and nurses to do the work that only they can do.

For example, registries can be programmed to generate reports on the care gaps of patients for care coordinators and care managers in practices. The care managers can use the information to prepare care teams for patient visits and to ensure that patients are receiving recommended services across the continuum of care. By automating patient communications, registries combined with outreach tools also make it easy to send alerts to every patient who needs to be seen for follow-up.

These supplemental technologies can also aid ACOs in managing population health at the macro level. A sophisticated rules

engine can integrate disparate types of data with evidence-based guidelines, generating reports that provide many different views of the information. For example, the entire patient population could be filtered by payer, activity center, provider, health condition, and care gaps. The same filters could be applied to all patients with a particular condition to find out where the ACO needs to improve its care for that disease.

ACO management could also use this type of information to pinpoint where the coordination of care is breaking down. For example, if an unusual number of patients with a particular condition were being readmitted to the hospital, that might indicate a problem with outpatient follow-up.

Another important determinant of population health is the degree to which patients are coached on improving their health behavior. Automation tools can also help in this area. For example, when a patient fills out a health risk assessment online or in a practice computer kiosk, that patient can receive educational materials tailored to his or her condition and can be directed to appropriate self-help programs for, say, smoking cessation or losing weight.

CONCLUSIONS

Largely because of the reform law's authorization of a Medicare shared-savings program, accountable care organizations (ACOs) are generating excitement among healthcare providers. If ACOs become widespread, they could become a powerful force for establishing population health management as the primary approach to quality improvement and cost containment in the U.S.

To do PHM properly, ACOs must use a range of information technologies. These include not only electronic health records, but also supplemental technologies that automate the routine work of tracking, educating, and communicating with patients. These tools will make it possible to do PHM comprehensively and cost-effectively, allowing ACO members to benefit economically from shared-savings, bundled-payment and global capitation programs.

Many healthcare organizations will try to become ACOs if the financial opportunity is sufficient. But only the ACOs that achieve clinical integration and learn how to do population health management will succeed. Therefore, information technologies, including automation tools, are essential components of ACO success.

ABOUT THE AUTHOR



Richard Hodach, MD, MPH, PhD
Chief Medical Officer

Dr. Richard Hodach is the Chief Medical Officer of Phytel. Dr. Hodach has long been recognized as an advocate of integrating IT with the practice of medicine. Before joining Phytel, Dr. Hodach, a board-certified neurologist, was the senior vice president, chief medical officer at Matria Healthcare, where he provided strategic direction and clinical expertise in the development of evidence-based, patient-centric population health products. He also has served as medical director and vice president of Medical Affairs at Accordant, where he developed the medical concept and structure of Accordant's patient-centric website and converted disease management programs into web-enabled disease management tools. He co-founded MED.I.A. (Media Interactive Applications), a company that designed, developed and produced medical interactive educational materials to be used by patients in their doctor's office. Dr. Hodach has a PhD in Pathology and an MD with Board Certification in Neurology and Electrodiagnosis, as well as a Master's Degree in Public Health.

ABOUT PHYTEL

Phytel creates consistent and sustainable patient engagement through automated coordinated care tools and services that extend the reach of the physician beyond the office. This results in improved quality outcomes and increased profitability. Phytel's outreach solution combines an electronic registry utilizing evidence-based protocols triggering outbound messaging to patients who are in need of preventive and chronic disease care. By increasing compliance with physicians' treatment plans, our services substantially improve patient compliance with recommended care, leading to better patient outcomes and assisting our clients in reaching their quality and financial goals.

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