Systems in the Act, Trying Out ACOs

BY MARK CRAWFORD

Catholic health care leaders are experimenting with accountable care organizations (ACOs) as a method of delivering higher quality care at lower cost. The concept has come to the forefront thanks to the Patient Protection and Affordable Care Act that includes ACOs as one of several Medicare programs expected to reduce the cost of health care.

The law makes ACOs a permanent Medicare option for group practices, physician associations and hospital partnerships. An ACO must commit to a three-year contract to serve an assigned Medicare population of at least 5,000 patients. It must also have a formal legal structure in place to receive and distribute shared savings. However, myriad other important details have yet to be worked out by the Department of Health and Human Services (HHS) by Jan. 1, 2012.

According to the Congressional Budget Office, implementing the ACO model is expected to save Medicare $5 billion during the next eight years.

"Health-care spending in the U.S. rose 5.7 percent in 2009, up to $2.5 trillion," said Steve Ronstrom, chief executive of Sacred Heart Hospital in Eau Claire, Wis., which is laying the groundwork for launching an ACO in the near future. "ACOs will help hospitals become more efficient and cost-effective by coordinating all care a patient receives, both inside and outside the hospital, within a certain region," he said. "For example, in my part of Wisconsin, an ACO might serve 800,000 to 1 million people and bring hospitals, physicians and other providers together into a coordinated system that's more efficient, productive and safer."

Instead of receiving payment through the traditional fee-for-service Medicare system, ACOs will be eligible to receive from Medicare a percentage of the cost savings they have generated through integrated delivery of health care and by shifting the financial risk to health care providers. Because compensation is tied to *quality* of care

Q: How does an ACO differ from your typical HMO plan?

A: The answer lies in accountability and flexibility. An ACO by definition is accountable, and the responsibility for outcomes lies directly with the providers rather than an insurance company. Providers will be accountable and evaluated on their efficiency, effectiveness, quality and convenience of care (i.e., outcomes). This is a big change for the industry and a major differential from the traditional HMO, where the payment structure does not necessarily align with the required accountability of the system.

— Kevin Fickenscher, MD, executive vice president of international health care for Dell Perot Systems

(outcomes) rather than to *quantity* of care, hospitals, clinics and physicians in ACOs are much more likely to collaborate to deliver the best possible care at lower costs.

HOSPITAL ADMISSIONS DOWN

After running a successful pilot "micro-ACO" program for several years, Sisters of Providence Health System in Springfield, Mass., has decided to implement the model on a larger scale.

"We are proving this ACO model can work with smaller practices and independent physicians," said Mark Fulco, senior vice president of strategy and marketing for Sisters of Providence. "We first tested the model as a partnership with an associated practice in 2007. We are now building a better infrastructure, have aligned our financial incentives and are establishing the partnership as a legal entity with not-for-profit status."

According to Fulco, the key to a thriving ACO is robust care management, supported by highly functional administrative, clinical and information systems. "This has allowed us to dramatically reduce costs by focusing more on high-quality, efficient, inpatient care, well-coordinated outpatient care and the cost drivers of chronic conditions," he said.

Fulco said the Patient Protection Act provides no specific guidance about how savings are supposed to be shared, "other than a broad requirement that an ACO entity must be capable of accepting and distributing payments to providers."

"In our ACO model, the savings are divided per the contract and agreements between the ACO providers," he said via e-mail. "There are 2 distinct 'pools' of funds — the Hospital Services Fund and the Medical Services Fund — that are used

WHAT IS AN ACCOUNTABLE CARE ORGANIZATION?

Accountable care organizations are collaborations among groups of physicians, hospitals and other providers whose goal is to achieve higher quality health care while demonstrating reductions in overall spending growth for their defined patient population.

According to the National Accountable Care Organization Summit, "The ACO model is highly flexible and can be organized in a number of ways, ranging from fully integrated delivery systems to networked models within which physicians in small office practices can work effectively together to improve quality, coordinate care and reduce costs. They can also feature different payment incentives ranging from 'one-sided' shared savings within a fee-for-service environment to a range of limited or substantial capitation arrangements with quality bonuses."

ACOs are a mechanism to transition from paying for volume and intensity to paying for value, and they are compatible with a range of other payment reforms to improve quality, such as medical homes and bundled payments.

According to David Harlow, attorney and founder of The Harlow Group LLC, (www.harlowgroup.net), a health care law and consulting firm in Newton, Mass., the Patient Protection and Affordable Care Act requires ACOs to:

- Have a formal legal structure to receive and distribute shared savings
- Have a sufficient number of primary-care professionals for the number of assigned beneficiaries (5,000 beneficiaries at a minimum)
- Agree to participate in the program for not less than a three-year period
- Have sufficient information regarding participating ACO health care professionals to support beneficiary assignment and for the determination of payments for shared savings
- Have a leadership and management structure that includes clinical and administrative systems
- Have defined processes to promote evidence-based medicine, report the necessary data to evaluate quality and cost measures (which could incorporate requirements of other programs, such as the Physician Quality Reporting Initiative, electronic prescribing and electronic health records and coordinated care)
- Demonstrate that it meets patient-centeredness criteria

to cover the costs of care provided to the members (assigned patients) included in the plan. Any surplus remaining in the Medical Services Fund is shared by the physician participants; surplus remaining in the Hospital Services Fund is shared between the hospital and physician providers."

Sisters of Providence has found hospital admissions are 202 per 1,000 members/patients of the ACO, compared to 400 per 1,000 members for unmanaged Medicare. Length of stay is 5.6 days compared to 6.2 for unmanaged Medicare, and readmission rate within 30 days is 9.8 percent compared to 20 percent for unmanaged Medicare, Fulco said.

The comparison reflects the ACO's intense care management and disease management, he said. Specially trained home-care nurses work with high-risk individuals who have targeted chronic disease, a program that helps prevent emergency room visits and hospital admissions.

"Most importantly, 99 percent of participants scored their experience as excellent or very good," said Fulco. "As a result we have demonstrated significant financial savings, including an 8 percent surplus in Hospital Services Fund expenses and a 23 percent surplus in the Medical Services Fund."

Ronstrom of Sacred Heart Hospital said, "Right now we're putting everything in place that will be needed for ACO. We are focused on improving care, patient and physician satisfaction and really managing costs."

"A primary care network needs to be established with a focus on physician leadership; it's essential to bring physicians into the mission itself and create physician leaders," he said. "By establishing the right tools, processes and financial incentives it will be much easier to move into an ACO model."

MEDICAL HOMES ARE KEY

Bon Secours Health System in Richmond, Va., also is working to position itself for inevitable changes in health care payments as provisions of the new law rollout. "We have to improve our capacity to see patients and affect a change in their compliance," said Robert Fortini, chief clinical officer for Bon Secours. "Our goal is to deliver care in such a way that primary care practitioners who now manage a panel of 2,500 patients will have a system around them capable of managing 5,000 patients."

To accomplish this, Bon Secours has implemented a medical home model, another cost-saving program recognized by the Affordable Care Act. The medical home model promotes a team-based approach within an individual hospital or system. That patient's personal physician, who maintains the electronic medical records, communicates with all the patient's clinical caregivers and tracks the patient's progress, leads overall coordination of care for an individual patient. "A care team, however, with multiple access points for patient contact [open access, extended hours, nurse visits and a web portal] must be in place to handle the load," said Fortini.

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STEVE RONSTROM

Unlike ACOs, medical homes do not provide incentives to specialists, hospitals and other providers outside the system to share in savings. Medical homes also have no accountability for total per-capita costs; however, they contribute to savings through care coordination and waste elimination, such as redundant radiology orders. "The medical home model is the foundation of the ACO — you need one to have the other," Fortini said.

Bon Secours is focusing on three key strategies to drive improvement: implementation of electronic medical records, clinical standardization and redesign of its delivery system.

"The 'one patient, one record' mantra is critical to the success of many medical home processes," said Fortini. "We have been engaged in an aggressive rollout of [an electronic record keeping and clinical information system] at all of our primary care sites. Our systemwide approach to clinical standardization will reduce variability and improve efficiency. Much of our delivery system redesign is guided by the principles of embedded panel management and case management. For example, we are using embedded case managers called care navigators who are equipped with a

direct phone line and text-enabled beeper for ease of access by patients in need, as well as medical staff."

CHALLENGES AHEAD

Though the ACO shifts responsibility for containing Medicare costs to the providers rather than to insurance companies or other third-party payers, debate continues over exactly how to do so. Plenty of logistical questions remain to be answered in the months before the 2012 rollout on such critical topics as accountability, risk, safe harbor and waivers.

One enormous problems ACOs face will be the lack of enough physicians to make the system work.

Smaller physician practices will be looking for guidance, as they often lack the organizational structure, infrastructure and information technology to establish an ACO. In addition, as pointed out by Elliott Fisher and Stephen Shortell in their October 2010 *JAMA* article, "Accountable Care Organizations, Accountable for What, to Whom, and How," a "robust, comprehensive, and transparent performance measurement system" must be in place for an ACO to be effective. They point out that, ultimately, the survival of ACOs may depend upon the ability of Medicare, Medicaid, health system executives, practitioners and private payers to work together to establish such a measurement system and an evaluation framework that truly advances accountability on all levels.

In organizing ACOs, speed is of the essence. Ronstrom said the clock is ticking. "If you're interested in organizing an ACO, begin planning now," he advised. "Someone else in your region may have already started. ACOs need to be up and running by January 1, 2012, when CMS [the Centers for Medicare and Medicaid Services, a division of HHS], as directed by the [Affordable Care Act], will begin assigning Medicare beneficiaries to these organizations and allowing ACO providers to begin sharing any Medicare cost savings they achieve."

Sacred Heart Hospital is planning to run three ACO pilot projects using different models of physician alignment. The first involves a small group of independent physicians in a medical home; the second, a larger medical group that has an infrastructure in place; and the third, physicians in a midsize group practice. "We will then pick the most successful strategy and use that as our model," said Ronstrom.

One enormous problem ACOs face will be the lack of enough physicians to make the system work. "We don't have enough doctors right now, much less when 32 million newly insured people enter the system under health reform," said Ronstrom. "I believe we need to make it easier for mid-level providers, such as physician assistants and nurse practitioners, to step in for doctors where appropriate. This will involve changing state licensing requirements and increasing positions at professional schools."

"ACOs will require new models of physician-hospital collaboration," said Fulco. "It's critical to create a culture of trust and cooperation between hospitals and physicians, especially regarding running the ACO and aligning incentives. The operational integration of very strong clinical and management systems is essential for generating the improved patient outcomes that will lead to shared savings and a stronger health care system nationally."

"We have faith, we have commitment and we have the patient at the center of our concern — this is what the Sisters of Bon Secours intended in the beginning," added Fortini. "Catholic health care across this country is uniquely positioned to lead this type of critical change because it is so aligned with our mission."

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