HCOs Find Risks & Opportunities in Quest for Reduced Costs & Improved Quality

Groundbreaking report in Mayo Clinic Proceedings examines the implications of the Accountable Care Organization component of the Patient Protection and Affordable Care Act

Rochester, MN, August 2, 2012 – Many health care systems across the US have declined to participate in the Centers for Medicare and Medicaid Services' (CMMS) Accountable Care Organization (ACO) program, developed under the Patient Protection and Affordable Care Act (PPACA), to improve efficiency and quality of health care delivery. In a groundbreaking collection of commentaries in the current issue of Mayo Clinic Proceedings, representatives of six leading health care organizations write about the challenges of reducing health care costs while improving health care quality. They further explain why they did or did not choose to participate in one of the two models now operational at CMMS.

"The US Supreme Court's decision upholding the constitutionality of the Patient Protection and Affordable Care Act provides some security for the fates of the Medicare ACO programs and the private sector's parallel initiatives– although political rally cries for repeal of the Act continue to be raised in the build-up to the 2012 election," comments David Ballard, MD, MSPH, PhD, Baylor Health Care System, Dallas, TX, Health Care Policy Section Editor for the journal. "Regardless of the ultimate outcome, we should not ignore the current opportunity to learn from these activities and health care organizations' experiences implementing (or not implementing) them. Such study can inform future national and global economic initiatives aimed at lessening health care costs and waste and improving health care value."

The debate over the PPACA has focused primarily on individual coverage, but experts believe that the most critical issue in health care is delivery system reform. "To put it simply, effective access for tens of millions of Americans is at risk – not to mention most other public priorities and middle class jobs in a global economy – if we fail to improve the efficiency with which high-quality care is delivered," says Len M. Nichols, PhD, of the Center for Health Policy Research and Ethics, George M. Mason University, Fairfax, VA, a contributor to the special report.

ACOs are groups of physicians, hospitals, and other health care providers that are willing to assume responsibility for the care of a clearly defined population of Medicare beneficiaries. If an ACO succeeds in improving care and reducing costs, they receive a share in the savings achieved for Medicare. The CMMS created two ACO programs, the Pioneer Model, with 32 registered organizations, and the Medicare Shared Savings Program (MSSP), with 27 registered organizations. The basic difference is that the Pioneer program has a greater degree of financial risk and reward. "Many highly regarded health systems developed concerns after initial

enthusiasm about the MSSP ACO model as a mechanism for accelerating their efforts to reduce costs while improving health care quality," notes Dr. Ballard.

Robert G. Porter, JD, MBA, and Amanda P. Tosto, RN, MS, of St. Louis-based SSM Health Care, consider the lack of beneficiary engagement in the CMMS ACO models to be a serious design flaw in the program. "The rule provides for invisible enrollment, meaning each beneficiary is enrolled on the basis of their claims history without regard for their actual preferences. This type of enrollment isn't consistent with SSMSL's transition to a patient-centered model of care that is based on the development of a transparent partnership among health care professionals, patients, and their families to ensure that decisions respect the patient's wants, needs, and preferences," they say.

Baylor Health Care System would like to file for Medicare Shared Savings ACO designation, but cannot. The program requires patient attribution via the tax identification number of the physician. Many of Baylor's physicians practice in groups that include non-Baylor physicians, with the entire group sharing a single tax ID. Therefore, Baylor would become financially responsible for the patients of physicians who are not part of the ACO. Health Choice, LLC, in Memphis, TN, had concerns about retrospective patient attribution and administrative complexity.

In contrast, the Atlantic Health System has already begun to see benefits from the formation of its ACO. Author David J. Shulkin, MD, of the Morristown Medical Center and Atlantic Health System ACO, Morristown, NJ, explains that in New Jersey's fragmented health system, patients have a 25% greater chance of staying in an intensive care unit and 75% greater use of specialists than the national average. "New Jersey needed a catalyst for change," Dr. Shulkin notes, "and the MSSP presented us with just that option."

The Atlantic Health ACO consists of four geographically based pods, each consisting of a hospital, physicians, and other community-based organizations in the region. Clinical navigators collaborate with primary care physicians to identify patients with short- and long-term care needs and guide them through planned pathways of care. Sixteen "Centers of Excellence" incorporate multidisciplinary approaches to care management. The Cardiac Success program has achieved 4% to 6% 30-day all-cause readmission rates, compared to the national average of 20-25%, by incorporating protocol-based approaches. "Little by little, New Jersey's fragmented health care system is being replaced with coordination and integration," Dr. Shulkin says.

Ascension Health will use its two Pioneer ACOs, Seton Health Alliance ACO and Genesys Physician Hospital Organization, to teach the rest of its large system about both medical and financial management as well as strategies for engaging physicians around values and shared business goals. Creagh E. Milford, DO, and Timothy G. Ferris, MD, MPH, of Partners HealthCare in Boston, MA, cite key differences from the health care reforms of the 1990s that influenced the decision to participate as a Pioneer ACO, including the preservation of patient choice and improved technology and electronic health records.

Dr. Nichols comments that none of the organizations represented in this special report think that the goals of the PPACA or the ACO experiments are misguided, and in fact there is a groundswell of parallel incentive realignments in the private sector as well. For example, Baylor has formed the Baylor Quality Alliance to develop a clinically integrated delivery organization, and is creating disease-management, population-management care delivery protocols and pathways. The BQA expects to sign an ACO contract with the Baylor Health Center System Employee Benefit Plan, and is in discussions with several Medicare Advantage plans and commercial plans.

In an interview with Dr. Ballard, Carl E. Couch, MD, MMM, of Baylor Health Care System, notes that the recent Supreme Court ruling on the PPACA confirms that the country is headed in this direction. "Regardless of the decision and the potential political implications this fall in terms of sustaining or overthrowing the act, the fundamental problems remain. Health care still costs too much and the trajectory of the costs is unsustainable. And we still have serious quality problems that can be best addressed by physicians and hospitals committing themselves in an accountable way to improve them. We have the same work to do whether the law is here or not."

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