News and Publications

De-fragging health care

'Accountable Care Organizations' could revolutionize medicine

July 13, 2011 by William H. Maruca

Few would disagree that the fragmented American system of delivering and paying for health care is dysfunctional. Physicians and hospitals get paid by the office visit, hospital admission or diagnostic test, and nobody is held economically responsible for the outcome of patient care from start to finish.

Largely overlooked in the ongoing health reform debate is whether the diverse players in the health industry can be encouraged to cooperate, coordinate services, control costs and, most importantly, ensure high quality of care.

By next year, a little-noticed provision of the Affordable Care Act of 2010 ("Obamacare" to its critics) may begin to bring accountability to a system with few checks and balances -- if enough health care providers are willing and able to participate.

The health reform law includes a new Medicare Shared Savings program set to take effect in 2012 for qualifying "Accountable Care Organizations." The program is designed to create financial incentives that reward ACOs for reducing spending while maintaining quality.

These new networks will need to develop the infrastructure to track costs and quality indicators, and they haven't been given much time to organize. The jury is still out on whether this program will prove feasible, affordable and sufficiently financially attractive to doctors and hospitals to make a dent in Medicare costs. The good news is that Pennsylvania may be in front of the curve for a change.

Under the Affordable Care Act, an ACO network must include primary care physicians and can include specialists, hospitals and others. An ACO would coordinate all care needed by a pool of at least 5,000 designated Medicare patients and would share the cost savings they achieve over certain benchmarks. Large integrated systems like UPMC or West Penn Allegheny Health System can apply, but networks of smaller, unaffiliated physician groups and independent hospitals may also qualify. Highmark's planned acquisition of WPAHS likely will include efforts to develop an ACO.

ACOs represent an attempt to align all the players who treat a group of patients so they share both the responsibility and the rewards for coordinating services. Currently, doctors face no financial penalty when they order duplicative or unnecessary tests, procedures or medicines, and they may feel pressured to do so by the malpractice litigation environment. Hospitals often bear the costs. Preventive care is a low priority. Too much health data remains embedded in antiquated pen-and-paper charts and forms that cannot be quickly accessed by a care team or easily evaluated for quality and effectiveness. Medication errors and hospital-acquired infections put patients at risk.

Pennsylvania's Health Care Cost Containment Council has been sharing cost and outcome data since 1986. Other efforts in the state and region include the Pennsylvania Health Care Quality Alliance and the Pittsburgh Regional Health Initiative. These organizations, and the cost- and quality-monitoring projects supported by providers and their associations in the state, may give potential ACOs an advantage here that is not shared in other parts of the country.

The ACO model was patterned after the efforts of well-integrated health systems such as the Cleveland Clinic, the Mayo Clinic and Danville, Pa.-based Geisinger Health System. These prototypes have the means to monitor and manage costs and quality that many startups will need to build from scratch -- Geisinger adopted electronic health records more than 10 years ago.

A Medicare pilot program shows promise for smaller ventures. All 10 physician groups that participated met at least 29 of the program's 32 quality goals, most of which were process measures related to coronary artery disease, diabetes, heart failure, hypertension and preventive care. Six of the 10 demonstration sites produced an aggregate of $78 million in cost savings.

Lengthy proposed regulations released by five federal agencies on March 30 spell out what an ACO must do to qualify for shared savings, and these rules are likely to change before they become final. ACOs must be able to "clinically integrate" care, share health information quickly and accurately using modern technology, capture and report on costs, and meet 65 separate quality factors for the Medicare patients they are assigned. Each ACO must commit to a three-year agreement and, unlike most HMO subscribers, patients are free to seek treatment outside the ACO network at no extra cost.

Medicare's initial efforts have been met with resistance, even from the health systems, networks and pilot program physician groups that the government used as templates. The administration is expected to address their concerns by streamlining eligibility criteria and removing unpopular features, such as mandatory risk sharing, in the final rules. A proposed advance funding initiative was announced in May that may help smaller ACOs pay for some of the developmental costs out of expected savings.

Effective ACOs will reduce medical errors, eliminate duplicative tests, empower patients to make better decisions, focus on preventive care and provide physicians with modern tools to help them improve outcomes. Patients may

appreciate the improvements in communication among their doctors and hospitals.

Launching an ACO will be expensive and may force wrenching cultural changes. In the best scenario, ACOs may succeed under the Medicare program and establish a model for private insurers to emulate. Otherwise, they may fail to get off the ground due to formidable capital and technology requirements, political opposition, lack of patient and provider understanding and trust, inadequate rewards, perceived complexity or plain old inertia.