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ACOs: Getting More for Less?

The N.J. Medicaid accountable care organization model seeks to save taxpayer dollars while improving health care

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There's a new model on the health care scene: the accountable care organization, or ACO. The premise of an ACO is that aligning the interests of otherwise separately operating, often competing and frustratingly non-communicating health care providers, payers and patients will lower costs while improving access to and quality of health care. If accountability is truly shared among the various parts of the system, then opposing or disjointed facets of the system will create ways to work together to produce the best results.

While it is tempting to dismiss the ACO model as simply renamed physician hospital organizations (PHOs), independent practice associations (IPAs) or closed-panel HMOs of the past, these prior attempts to revise how health care was delivered or reimbursed focused on aligning discrete segments of the health care system. They rarely, if ever, rewarded component parts of the model for the quality and efficiency achieved by the whole. These models pre-dated the health information technology systems we have today, and were developed in an era when volume was viewed as a rational basis for reimbursement.

The interconnected, data-driven, results-oriented health care world of today makes a volume-based payment system seem archaic and ineffective. Moreover, because the consumer cost of health care (as measured by resource use or volume) does not correlate to its quality, figuring out how to spend health care dollars more wisely may actually result in keeping us healthier. See, e.g., Baicker and Chandra, "Medicare Spending, the Physician Workforce, and Beneficiaries' Quality of Care," *Health Affairs* (Millwood), April 7, 2004, http://content.healthaffairs.org/cgi/content/abstract/hlthaff.w4.184.

The Patient Protection and Affordable Care Act, P.L. 111-148 (PPACA or the Affordable Care Act) as amended by the Health Care and Education Reconciliation Act, P.L. 111-152, grapples with complex health care cost and quality issues in a wide variety of ways, many of which have been challenged. The Centers for Medicare and Medicaid Services (CMS) described the Medicare ACO model as set forth in PPACA as follows:

> The Affordable Care Act seeks to improve the quality of health care services and to lower health care costs by encouraging providers to create integrated health care delivery systems. One important delivery system reform is the Medicare Shared Savings Program under section 3022 of the Affordable Care Act, which promotes the formation and operation of accountable care organizations (ACOs).
> http://www.federalregister.gov/articles/2010/11/17/2010-28996/medicare-program

CMS explains that section 3022 allows groups of providers to "work together to manage and coordinate care for Medicare" beneficiaries through an ACO, which can receive payments from Medicare for shared savings if certain quality performance standards are met. According to CMS, the model creates a structure for collaboration among providers to incentivize higher-quality, lower-cost medical care. PPACA outlined the skeletal structure of a Medicare ACO, and CMS recently proposed regulations (http://www.cms.gov/sharedsavingsprogram), putting 427 pages of flesh on the Medicare ACO body.

However, it is likely that individual ACOs — whether created as Medicare ACOs or "commercial" ACOs formed in collaboration with non-government

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third-party payers (such as carriers and self-funded employer plans) — will contain features unique to that ACO's participants and patient population. A common feature of a successful ACO will be its ability to connect and synchronize the interests of the providers, payer(s) and patients. Even a perfectly conceived, carefully constructed, legally impervious ACO will fail to achieve its "patient protection" (or health care quality) and "affordability" goals if its parts fail to work in concert.

The New Jersey Medicaid ACO model was conceived as a way to achieve and reward high-quality, appropriately accessible and affordable patient care in communities in which these traits are most often and obviously lacking. Like many states, New Jersey faces a significant budget crisis. The affordability of the existing Medicaid program, let alone any expansions to the program, is a key concern to the governor, legislators and New Jersey taxpayers. Medicaid beneficiaries often live in poor areas, have poor access to primary care (and fewer resources to find or obtain specialty care), and have greater dependence on local emergency rooms.

The New Jersey Medicaid ACO Demonstration Project (the Project) was introduced as *S2443* by Senator Joseph F. Vitale on Nov. 8, 2010. As introduced, the Project shares elements of the Medicare Shared Savings Program outlined in PPACA, but is applicable specifically to beneficiaries whose care is paid for by the New Jersey Medicaid fee-for-service (FFS) program and who reside within the region covered by the approved (or certified, as described in the bill), regional Medicaid ACO.

The Project would not alter the way in which Medicaid claims are currently paid. Rather, it would allow an additional payment to providers participating in the Medicaid ACO to the extent savings are achieved (and from the savings realized, not from additional or new revenue required to fund the Project) as a result of improvements in access to needed services, achievement of quality standards, and coordination and information-sharing among the various participating providers. The Medicaid ACO would "sit on top" of the existing care delivery and payment system and function as an invisible (to the patient), cohesive layer.

The Project would permit voluntary participation by a Medicaid managed care organization (MCO). The Medicaid MCO would function in a role similar to that of Medicaid FFS, in that its participation would not alter the way in which the MCO currently reimburses providers for services rendered to its members. In addition, the MCO would continue to receive premium payments from Medicaid and operate in accordance with its Medicaid contract. As with the Medicaid FFS program, if savings result from the improvements instituted by the Medicaid ACO, the Medicaid MCO would share those savings with the participating providers.

The Medicaid ACO model was not developed in a vacuum. In the City of Camden, one of the most impoverished cities in the United States, local health care providers worked for the past nine years to build a nonprofit, ACO-type coalition, the Camden Coalition of Healthcare Providers (CCHP), committed to improving the quality, capacity, and accessibility of the local health care delivery system. CCHP's efforts began with the development of a citywide health database that collected claims data from the three acute care hospitals serving the city. The data collected demonstrated the stark reality that Camden residents lacked adequate access to primary care and were using emergency rooms or hospitals at twice the national rate. In a single year, CCHP found that 50 percent of the city's residents used an emergency room or hospital; one resident used emergency room or hospital services 113 times in a year. CCHP's claims data analysis also revealed that the vast majority of these visits were for health needs better addressed or prevented by visits to primary care providers.

The top 10 diagnoses associated with Camden residents' emergency room visits from 2002 through 2007 were due to health conditions better treated in a primary care setting. During the 2002-2007 period, there were 317,791 visits to one of Camden's three emergency rooms. Of these visits, 12,549 were for a diagnosis of an acute upper respiratory infection not otherwise specified (head cold); 7,638 were for a diagnosis of middle ear infection; 7,577 were for a diagnosis of an unspecified virus; 6,195 were for a diagnosis of a sore throat; and 5,393 were for a diagnosis of asthma. The remaining diagnoses on the "top 10" list related to ailments that included fever, chest pain and headache.

The most frequent utilizers of hospital and emergency rooms during this time period, consisting of 1,035 Camden residents, each visited the emergency room or hospital between 24 and 324 times. CCHP identified total hospital charges associated with these patients of $375 million, with actual payments of $46 million (not including charity care reimbursement). The $46 million payment, if redirected to preventative and primary care services, could fund 50 primary care physicians or 100 advanced practice nurses. It would also eliminate an estimated (given that charges do not equate to actual costs) hospital revenue shortfall of $300 million.

CCHP's efforts to reduce emergency room usage began by transforming local primary care offices into patient-centered medical homes using multidisciplinary care teams to target the "top utilizers"; electronic health records and a local health information exchange accessible by all local providers; open-access scheduling; and patient registries. CCHP's success in addressing the health care needs of Camden residents presented a compelling case for creating an ACO model specifically designed to serve a defined group of patients. While not every Medicaid beneficiary resides in a city that resembles Camden, the Medicaid ACO model injects a framework and funding source for collaboration and coordination where it is likely to be most lacking and where targeted improvements are most likely to produce relatively fast, measurable, and positive results. ■