The Pioneer ACO: A Strategy for Population Health Management

By Emily Brower

"P"opulation health management" and "accountable care organization" (ACO) have become buzz words in the healthcare industry as of late, but when they work in tandem, they can be an effective way for organizations to meet the triple aim to improve quality, improve patient experience, and decrease costs. ACOs are a valuable strategy to move clinical management beyond targeted population health approaches to a population health strategy.

Population health management is an approach to care that moves beyond traditionally reactive individual patient, transaction-based medicine to caring for a group of patients proactively over the long term and across the care continuum. This is an approach that reaches back to the early days of Atrius Health.

The medical groups that comprise Atrius Health built robust care management tools and processes decades ago. And, unlike many other organizations that dismantled much of their managed care infrastructure in the 1990s, the Atrius Health groups maintained those resources and, most importantly, the mindset, allowing for the development of an accountable care organization that takes responsibility for population health.

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Nationwide Rural ACO Reduces Costs in MSSP by Harnessing Data

By Lynn Barr

Based in Nevada City, California, the National Rural Accountable Care Consortium (the Consortium) is unique in the Medicare Shared Savings Program (MSSP) in that we are the only rural-based nationwide Accountable Care Organization (ACO), with fifty-two participating provider organizations from Texas, California, Washington, Iowa, Indiana, Missouri, Oregon, Illinois and Michigan.

This geography-spanning structure was necessary due to our participants’ limited financial resources and Medicare patient population sizes. Our members also faced a lack of experience with population health management and value-based payment models. The leaders from our founding organizations recognized that the fee-for-service and cost-based reimbursement payment models we were accustomed to were changing, so we would have to find ways to get more of the premium dollar in the coming years in order to remain financially viable.

We determined the best way to achieve that goal and better manage the patients who are driving our largest costs was through improved care coordination supported by information technology tools. As we learned, not all population health management technology was equipped to serve a unique ACO like ours. With Lightbeam Health Solutions implemented, the ACO was able to reduce avoidable admissions and emergency department visits, while expanding our overall patient population and improving MSSP care quality metrics.

Overcoming Early Obstacles. The origins of the Consortium, which formed as a MSSP ACO in 2013, date back to 2009. I was working as a chief information officer at a rural critical access hospital (CAH) leading an initiative in California to help one-third of the state’s CAHs implement electronic health record (EHR) systems. These systems added significant cost, only a part of which was being paid for by Medicare.

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Editor's Corner

Raymond Carter, Senior Editor, Accountable Care News

We will continue with our op-eds and brief reports from the field beginning with the February issue, but as is my tradition I always like to pause and thank all those who contributed special opinion pieces or reports for this space (so I do not have to!), as well as those brave souls willing to disclose a bit of personal information that few people knew as part of the back page interview. Do not misunderstand -- I also deeply appreciate the authors who contribute the feature articles for this publication, as well as the many Thought Leaders who enrich the commentary section. You are legion, and I thank you all. Ed.

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A Pioneer ACO Firefighter Visit Program to Prevent Hospital Readmissions

By Roxanna Gapstur, PhD

Every year, the western Minneapolis suburb of St. Louis Park gets nearly 5,000 calls to 911. Nearly three out of four of these calls are for medical emergencies. With each of these calls, generally three emergency crews respond: fire, ambulance, and police. There are many times that these calls are for patients recently discharged from the hospital. The problem might be a fall due to weakness or a mix-up in medications related to their recent hospitalization.

A little more than a year ago, St. Louis Park Fire Chief Steve Koering was thinking about these types of calls and recognized an opportunity for firefighter emergency medical technicians to interact with patients before they needed emergency help. This could allow community members to stay healthier in their homes, and possibly head off a severe medical condition that would force them to be hospitalized.

With the passage of the Affordable Care Act, hospitals are also thinking about what they can do to prevent the need for visits to the hospital. One incentive is a provision in the ACA that requires hospitals to prevent patients with certain conditions such as pneumonia from being readmitted within 30 days of discharge. Failure to do so could result in decreased payments by the Centers for Medicare and Medicaid Services.

Koering met with leaders from Park Nicollet Methodist Hospital, a Pioneer Accountable Care Organization, and together developed a plan for firefighters to conduct home visits. Methodist Hospital knew that the first 72 hours after discharge are a critical time for potential readmissions. So the following May, the hospital and the fire departments of Minneapolis, St. Louis Park, and Minnetonka (another suburb west of Minneapolis) launched a three-month pilot program to visit patients in their homes within 24 to 72 hours after they are discharged from Methodist.

A main focus is on helping patients understand their discharge instructions after they leave the hospital. The reality is that when patients are getting ready to leave the hospital, they are more focused on going home and not on what medications to take or what trouble signs to watch out for. In addition, patients may be in pain, on medications, and disoriented from their hospital stay. Recognizing this, the EMT’s help patients understand the answers to the following questions:

- Do you know what medication to take?
- Do you need a medication pill holder to help organize your pills?
- Do you have a follow-up visit scheduled with your doctor?
- Do you know what symptoms to be aware of and who to call if you experience them?

With the patient’s discharge diagnosis in hand, the firefighters check the patient’s blood pressure and heart rate, evaluate whether their pain is controlled, if their breathing is labored, and what their general level of comfort is. In addition, they use the Physical Environment Assessment Tool (P.E.A.T.) to assess home safety to determine whether patients need social services. The P.E.A.T. scale looks at 16 criteria, such as whether there is heat and water, clutter or biological waste present in the home, if the person lives with others, or if there are signs of neglect and abuse. A score of 36 reflects a very safe living situation. The average score for patients in the pilot is 34 and a score of 22 or less may indicate a need for interventions.

Checking on food security is a unique aspect of Methodist’s firefighter home visits. Firefighters not only ask, but with the patient’s permission, check cupboards and refrigerators to see if patients have enough food in the house for the next few days. They also check to see if homes have working smoke and carbon dioxide detectors and that the house does not have any safety hazards such as throw rugs or electrical cords that could cause falls.

If any problems are found, the firefighters can call the patient’s care team or they can connect patients with community services such as food shelves, home meal delivery, transportation, and help getting prescriptions filled. They can also supply smoke and carbon monoxide detectors, and mount them appropriately for the patient. The firefighter concept is a new twist on a growing trend for community partnerships that focus on preventive rather than emergency medicine. Community paramedic programs, for example, involve regular visits to patients’ homes to help them with post-hospital treatment plans for serious diseases such as congestive heart failure (CHF) and pneumonia.

Unlike community paramedic programs, this firefighter program involves one visit after a hospital discharge. Both programs aim to identify any health problems proactively and whether there are things in the home environment that might negatively impact health or medical condition. Where community paramedics provide ongoing care, the firefighter home visit program fills a gap between hospital discharge and their primary care follow-up appointment, or when follow up care begins such as a home health nurse visits.

There is no cost to patients or health plans for the recommended firefighter visits, which take an average of 30 minutes. Hospitals or fire departments are not currently reimbursed by Medicare or health plans for these visits. But programs like this could help hospitals in relation to the ACA incentive to prevent readmissions and also become a new source of revenue for fire departments.

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A Pioneer ACO Firefighter Visit Program...continued from page 3

The hope is that proactively scheduling medical calls with patients at-risk of a medical emergency could reduce the number of acute admissions, and medical calls to 911. Payers may also begin to recognize the visits as a cost effective part of a patient’s overall care plan.

There is proposed legislation in Minnesota that would establish certification for Community Emergency Medical Technicians, who would visit patients after hospital discharge. It also would allow state reimbursement for those services under Medicaid. Methodist Hospital recommends that all patients get the visits, although they are voluntary. Patients must opt-in to receive them. In the first five months of the pilot, about seven in ten patients opted in, but Koering predicts that number will grow as more providers become familiar with the program and are able to talk to their patients about the benefits of the visits.

Between May and November, fire department crews have visited more than 194 patients. Of these, firefighters helped connect ten patients to social/community services, referred seven patients to food shelves, identified 20 cases where additional care was needed from the patient’s medical team, and replaced 52 smoke detectors or batteries. About sixty percent of patients are female. The oldest patient was 100 years old and the youngest was 11.

The firefighter visit pilot was originally scheduled to last 90 days. Early success led to an extension to the end of December, and this past fall two more fire departments (Eden Prairie and Hopkins) joined the program. Firefighters from all five cities have been trained to conduct patient visits. Leaders from all organizations involved expect the program to continue in 2015.

Now hospital and fire officials will continue to assess the program. Metrics they will consider include:

- the cost of the visit
- if fire fighters have been to a home in a 911 response before the visit
- whether the visit likely prevented a readmission
- the readmission rate
- patient satisfaction

The post-discharge firefighter home visit program is one of several initiatives that Park Nicollet Methodist Hospital has implemented after being named a Pioneer Accountable Care Organizations by CMS. In September, CMS announced that Park Nicollet was one of 11 Pioneer ACOs to earn a bonus for meeting or exceeding 33 quality measures in 2013. In addition to the firefighter pilot program, other initiatives include a care consultant program that provided home visits to patients with multiple illnesses that decreased hospital visits by 15 percent and an after-hours call program for frail elderly in nursing homes that avoided trips to the emergency room and reduced medical costs by $2 million in 2013.

Roxanna Gapstur, PhD is Senior Vice President, Chief Operating Officer and Chief Nursing Officer of Park Nicollet Methodist Hospital in St. Louis Park, MN. She may be reached at 952-993-5010.

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Population health management processes and protocols at Atrius Health began with a focus on preventive care, using tools such as best practice alerts through its electronic health record (EHR), Epic®, and practice-based population managers who reach out to individual patients to ensure that certain patient populations receive preventive services.

Managing patient health in this manner aligned well with chronic disease management programs for high-risk diseases such as patient with diabetes. Specific guidelines were developed and a population management approach was put in place.

Using a payer-blind, population health approach, Atrius Health analyzes integrated claims and EHR data to stratify the population, detect gaps in care, and identify opportunities to improve outcomes. Because Atrius Health began as a system of associated but independent medical groups, it functions as a laboratory of sorts -- each group treats slightly different populations in slightly different ways and with slightly different approaches. This allows us to look within Atrius Health to identify which practices produce the best outcomes for certain patient populations and then together design initiatives to implement system-wide improvements. We engage clinical, care management, clinical informatics, and operational experts with a passion for care improvement to understand the gaps and develop innovative programs to close those gaps. Most importantly, we thoroughly measure and revisit initiatives to ensure continual improvements in how we care for patient populations.

Despite the difficulties that exist in taking full financial risk and outcomes accountability for patients that can receive care outside of the Atrius Health system, the organization believes in the ACO model. Thus, when the opportunity arose to work with the Center for Medicare & Medicaid Innovation (CMMI) as part of the Pioneer ACO program, it was a natural opportunity to develop a more robust population health approach for a broad population. Atrius Health saw participation in the program as the first step to creating one model of care for all of our Medicare-eligible beneficiaries.

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The Medicare population is complex because it has high clinical needs, significant visit volume, more acute care and more care transitions. Much of the volume and care happens outside of the Atrius Health practices, by many unaffiliated physicians and facilities. Prior to participating in the Pioneer ACO model, we did not have access to claims data for our traditional Medicare fee-for-service patients, and so had limited tools to coordinate their care.

The claims data we received for our traditional fee-for-service Medicare patients aligned to Atrius Health through the Pioneer model realigned the fragmentation of care that existed for these patients. Once we were able to integrate that data into our population health tools and strategies, we could focus our work. To start, we developed interventions to manage high-risk patients and high-cost events. The Atrius Health ACO team developed an algorithm to identify its highest risk patients and create a high risk roster. The roster tools and workflows were built on the earlier work described above that focuses on patients with specific diseases or risks -- such as diabetic patients -- but is disease agnostic, since most of the high risk patients have multiple chronic diseases. Primary care teams conduct a standardized "roster review" using a whole patient approach to understand the many clinical and social challenges the patient faces, and the many providers involved in their care. That 360 degree review takes place with input from many disciplines surrounding primary care -- case management, social work, clinical pharmacy, geriatrics -- to develop a comprehensive plan of care. Several of the practices have developed relationships with the local elder services agencies so that care plans include community resources (e.g. Meals on Wheels) to support patients at home.

While our initial, rapid interventions focused on the top of the population health pyramid, we were also diving into more preventative approaches that would reduce health risk in the population as a whole. These preventative measures aligned well with the ACO quality measures: falls risk assessments, depression screening, and medication reconciliation. For example, after a literature review and speaking with experts in the field, we set a goal to assess risks for falls for all Medicare-eligible patients annually. A group worked together to choose the most appropriate assessment tool, and build that into our Epic EHR. Practice teams tested and shared workflows and training so that medical assistants across Atrius Health could implement the tool when a patient appeared for a visit, document the result in a standardized way, and inform the physician so that a plan could be developed for that patient. Experience and data collected by our affiliated home health agency, which had been assessing falls risk in the home as part of their standard work, also feeds into the workflows for documentation and referral, as do assessments provided by our skilled nursing facility partners. The new processes and tools support all Atrius Health patients over age 65, regardless of payer or site of care.

To ensure effective population health interventions that pulled from and fed into innovations in the Atrius Health practices, Atrius Health developed workgroups made up of physicians, case managers, clinical informatics, and operational staff from across the Atrius Health system of care. Once a month, the workgroup members and other leaders come together for "ACO Day," to review performance, compare best practices, look at changes in the Pioneer model, plan for the future, and discuss new initiatives, developments, successes and barriers. The individual workgroups then break out into group sessions to dive into their individual topic areas:

**Geriatric Care Model Workgroup.** The high-risk roster reviews discussed above developed from the geriatric care model workgroup. The individuals in this group were tasked with looking at how to develop a comprehensive care plan for individuals with multiple chronic diseases. They determined a need existed to aggregate the high-risk patient’s care teams in order to develop one plan of care, not just for a specific disease like diabetes or COPD, but for the patient’s overall health. Additionally, this team has developed a set of tools and training to support advanced care planning for high-risk patients. The goal of this work is to help patients understand their prognosis and elicit their goals and wishes for care as their illness advances, documented in such a way that their wishes can be respected and followed across care settings.

**Post-Acute Workgroup.** As part of better managing high-cost events, understanding the care our patients were receiving at skilled nursing facilities (SNF) was an immediate priority. Upon review of the data provided by Medicare, we learned that Traditional Medicare patients were more dispersed at facilities across the state, many without any connection to or support from the Atrius Health practices. This workgroup developed stronger coordination with our SNF partners, which included developing shared expectations for care and communication, tracked through of a number of transparent cost, quality, and patient experience measures. Regular forums with SNF leaders support continued improvements in care and coordination for patients during a SNF episode.

**Care Management Workgroup.** This group is tasked with developing systems and tools to improve longitudinal case management for our highest risk patients in coordination with the Geriatric Care Model workgroup, as well as improving and transitions of care for all patients. The team identifies and shares best practices and develops tools to document and support care as patients transition across settings. Another significant focus of this group is integrating care with Atrius Health’s home health agency and hospice affiliate, VNA Care Network & Hospice. We have moved from a referral relationship, where primary care and home health operate in parallel, to a model where home health nurses are members of the integrated care team, our “boots on the ground” bringing a unique perspective and set of care management tools to the care system.

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While the work can at times seem daunting and the list of initiatives endless, we have made some terrific progress. In 2013, Atrius Health achieved the highest scores in New England on the 33 ACO quality measures set by CMS and the second highest quality scores of any Pioneer ACO in the country. In addition, we maintained a low total cost of care among Pioneer ACOs as compared with our local market.

We’ve learned through this process that, in addition to improving care across the Atrius Health practices, our ability to partner with other parts of the delivery system is key to our success. For example, partnering with hospitals to improve transitions of care is key to managing high risk patients and high costs events. Implementing an effective strategy to work with skilled nursing facilities yielded early results in reducing costs and speeding patient recovery.

Our Medicare population health strategy has provided tremendous insight into how we can improve care for any patient population. We can apply this set of tools and the rigorous approach to close any clinical gap. As we integrate clinical programs across Atrius Health, we continue to look at what other “high-stakes” or “high-opportunity” populations would benefit from the population health strategy. For example, early data and conversations with other delivery systems have identified younger adults with severe and persistent mental illness and children with high-risk conditions as potential beneficiaries of this model.

There is an incredible power and momentum that develops when you move out of a payer-based approach and focus on care driven by population needs. It’s a leap of faith to take this approach, and requires a strong appetite for risk, but when implemented in a way that looks at all pieces of the triple aim -- cost, quality and experience -- care will improve and costs will decrease. The ACO model demonstrates that organizations can provide the right care for patient populations while decreasing costs overall. The work is satisfying to the providers, and improves patient care. There really is no turning back to transaction-based medicine once you’ve felt the rewards of the population health approach.

Emily Brower is Executive Director of Accountable Care Programs at Atrius Health in Newton, MA. She can be reached at Emily_Brower@atriushealth.org.

Nationwide Rural ACO Reduces Costs …continued from page 1

We resolved that we would not only adopt these systems, but that we would use them to improve care, lower cost, and get paid more to do it. Dozens of programs were being introduced by the Center for Medicare and Medicaid Innovation (CMMI), but rural providers either didn’t have the right case mix, enough volume, or the infrastructure to participate in most of them. None of the California rural providers, and only a fraction of other rural providers, were participating in any of the programs.

We determined that MSSP participation was the only feasible program for our rural organizations. Importantly, it paid for managing population health, and we had fixed populations that we cared for throughout the majority of their lives. However, the costs of starting and running an ACO, which costs millions of dollars, was not a challenge any one of us could overcome on our own. Furthermore, only one applicant had enough beneficiaries to form its own ACO, so collaboration was essential. Nine brave CEO’s -- Tim Putnam, David Ameen, Steve Barnett, Christine Baumgardner, Melanie Van Winkle, Jim Suver, David Hill, and Lee Barron -- started the first National Rural ACO in 2014, quickly followed by many more.

Discovering New Population Health Tools. Since none of the ACO members were experienced with using claims data for population health management, choosing from the wide array of software tools was a significant challenge. After considering several vendors, the Consortium adopted a population health management strategy, but was forced to abandon the initiative after investing six hundred thousand dollars due to the vendor’s inability to deliver the promised functionality or respond adequately to our unique needs. While a frustrating experience, it helped better focus our selection process for the next system we implemented, which has better served the needs of our organization.

A key feature we sought in our second population health management system was that the analytic tools must be simple to use for care coordinators and other clinicians working with this type of technology for the first time. The reports generated from the data analysis also had to be easy to understand for the physicians and clearly verifiable against information from their charts.

We found our replacement system based on a recommendation from an ACO leader who we contacted after reading about him in an article. The population health management system he recommended offered the following key features we desired, in addition to the ease-of-use and reporting tools:

- Combined clinical, claims and demographics data in its warehouse so we could perform more timely and reliable analyses
- Normalized data from the ACO’s different EHR systems and documentation methods so analysis and reporting was consistent and reliable
- Applied MSSP quality measures and business logic to our data so the reports generated were relevant to the ACO program and to building market share for our customers
- Delivered real-time predicative reporting to facilitate more efficient care interventions for high-risk patients

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The system also served our hospitals’ entire patient population, not only MSSP-attributed patients. As we later learned, addressing care gaps of non-attributed patients improved our care quality metrics and increased overall revenue by aligning patients with much-needed care.

**Data Analysis on a Micro- and Macro-level.** The primary users of the tool are care coordinators who serve each participating community and concentrate on engaging individual high-risk patients. The population health management tool identifies patients with gaps in their care relative to evidence-based guidelines, MSSP and HEDIS measures, or other metrics. The technology also helps coordinators identify those patients most likely to need additional support.

For example, it ranks patients by utilization. Thanks to the data capture and analysis, one of our participating hospitals identified a patient who had visited its emergency department 84 times in one year, but had not yet received any intervention to address this behavior.

With a consolidated view of the patient’s clinical, claims, and social data, providers were able to determine that the over-utilization was motivated not by medical conditions, but rather social factors, namely the recent death of his wife. Patient support staff was able to align the patient with mental health counseling services and social support available through his church. Since then, that patient has not returned to the emergency department.

On a Consortium-wide level, the administration leverages the population health management tool to analyze data and deliver reports identifying cost and quality issues that require improvement, which may not yet be detected at the individual facilities.

**Reducing Admissions, but not Revenue.** In addition to addressing the frequent emergency department visitors, the Consortium has also improved other care quality metrics in the MSSP program in the nine months since it began using the population health management tool.

Hospital admissions have reduced by 14 percent across the ACO, and emergency department visits are down by 5 percent. Participating hospitals were also able to reduce admissions among Chronic Obstructive Pulmonary Disease (COPD) patients by 38 percent after educating participating physicians about recently changed best practices.

Through the population health management tool, the Consortium discovered that physicians were prescribing older, less effective medications to treat COPD, even though there was substantial evidence demonstrating the efficacy of newer, more effective treatments. We were certain that physicians would not be receptive to administrators simply demanding they modify their prescribing habits, so instead, the Consortium offered an education program for physicians about newer COPD management protocols, using data from Lightbeam to gain credibility. Their response to the outreach, as indicated by the improved metrics, was clearly positive.

Although avoidable admissions have decreased, which potentially helps improve our revenue under the MSSP payment model, overall patient volume for the participating organizations has increased. Due to improved preventive and follow-up care, as well as effective high-risk interventions, organizations are treating more patients before an adverse event or complication occurs. Many of these patients may have gone undetected and avoided care before the population health management software was implemented. This improved level of service also builds loyalty with patients.

**Continuous Improvement through Data Analysis.** The Consortium continues to learn more about population health management and explore how our information technology tools can support these efforts. Based on our experience in 2014, the Consortium plans to reach out to skilled nursing and other long-term care facilities to explore how they can more efficiently use resources involving our ACO’s patients after they are discharged from our participating hospitals.

We are confident that the analysis and reporting will be advantageous for us in helping these facilities identify their contribution to the overall costs and encourage new behaviors while still supporting safe, high-quality evidence-based care.

This type of provider outreach is another example of how access to timely insights of clinical and claims data analysis is crucial to managing patients throughout the continuum of care, not just within the walls of the National Rural Accountable Care Consortium’s facilities. Even when providers are separated by states and time zones, collaborative care and continuous improvement is possible through information technology.

Lynn Barr is the founder of the National Rural Accountable Care Consortium, based in Nevada City, California. She may be reached at lbarr@nationalruralaco.com.

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Q. “What is the greatest challenge facing the ACO movement in 2015?”

“Market credibility. The #1 challenge facing ACOs is costs, not quality and not access. While there is anecdotal information on how selected services can be better managed (value versus volume), there is little evidence that ACOs have played a major role in achieving significant savings to date.

The operative word here is ‘significant’ since incremental improvement in care delivery falls short of the magnitude of savings needed by employers. It takes more than just moving the needle in the right direction. What customers (employers and payers) need are clinical partners that have the commitment and capacity to significantly reduce medical spend as their core business objective.

Employers are relying more and more on high deductible health plans to limit their financial risk since health plans (and ACOs) have had limited success in reducing costs and rates. With deductible levels ranging from $1,500 to $10,000 a year, financial risk is now being transferred to patients. Without the ability to reduce costs through mechanisms like ACOs, employers will continue to implement deductible levels that will present liquidity issues for employees/patients seeking care through accountable care systems. When patients cannot meet high deductible thresholds, providers are faced with turning patients away or being saddled with bad debt and accounts receivables.

The business reality is that ACOs need to be far more aggressive at reducing costs to earn the trust of employers who cannot afford current price levels. ACOs have yet to demonstrate they have the mettle to meet this challenge.”

Peter Boland, PhD
President
Boland Healthcare
Berkeley, CA

“Accelerating the development and implementation of financial models that incorporate shared risk between payers and providers, while achieving quality goals. Pay-for-performance and shared savings only models will not drive the necessary health system transformation in the long run.

Certainly, we will need to continue to encourage start-up and early stage ACOs. But arrangements with existing ACOs, particularly in markets where capitation is not commonly found, need to move forward along the risk continuum. The new Proposed Rule for the Medicare Shared Savings Program, with its introduction of an additional two-sided shared savings and loss model (Track 3) is an effort in this direction by CMS. Private payers and providers should be more aggressive in 2015 in developing their own more advanced shared risk arrangements, which must be fair to both sides to work.”

Doug Hastings
Chair Emeritus of the Board of Directors
Epstein, Becker & Green, P.C.
Washington, D.C.

“The greatest challenge is still physician alignment. Whether you are an insurer setting up a private ACO or a hospital or physician network trying to set up a Medicare MSSP, the ability to align very different philosophies of practice, attitudes toward government, skillful practice management, and desire for revenue stabilization are but a few important issues to address in building or contracting with a network.

The new model of care (actually it has been around since the 60’s) requires some fundamental understanding of risk and reward, and many physicians have had (or think they have had) a bad experience with managed care and risk so they are gun shy about jumping into ACO contracts without the sponsor taking some risk.

If the physicians themselves are the sponsor, this takes time and some false starts to get going, but those who stay the course have the opportunity to learn successful risk management and will be years ahead of the doubters and late adopters.”

William DeMarco MA CMC
President & Chief Executive Officer
Pendulum HealthCare Development Corporation and DeMarco & Associates, Inc.,
Rockford, IL
"I believe that the greatest challenge facing the ACO movement in 2015 is still skepticism on the part of the ACO participant. Not many ACOs have truly embraced the model to the point where their participants are practicing medicine differently."

Chris Sawyer
Founder
The Aiki Health Initiative
Fountain Valley, CA

"Physician alignment and the ability to transform physician care models is most definitely a challenge. Beyond the technology, business and clinical workflows are impacted by the need to redesign processes and coordinate efforts between ACO professionals to maintain compliance with the new regulations. It’s like the analogy of one who has never driven to buy and begin using a car. The culture shock and belief in new methods of care over what is known may stifle progress."

Deborah Leyva, RN, BSN, MSHI
Healthcare Informatics Independent Consultant

"In 2015 I believe many ACOs that were started in an ‘upside only’ environment will need to grapple with the question of readiness for at least some downside risk -- not just in theory but in reality to commit in 2016+.”

Katherine Schneider, MD, MPhil., FAAFP
President and CEO
Delaware Valley Accountable Care Organization
Radnor, PA

"Will the ACO section of the Affordable Care Act and the rules implementing it become a target of the Republican Congress? Some of the less politically high-profile changes the GOP wants to see in the ACA may well end up in ‘can’t veto’ legislation. ACOs fit in that category of ‘insiders care, the public doesn’t much.’ If the status quo prevails, other challenges will predominate in the ACO movement. If it doesn’t, whatever Congress does moves to the top of the list. The culture shock and belief in new methods over what is known may stifle progress."

Michael L. Millenson
President
Health Quality Advisors, LLC
Highland Park, IL

“I think policy is inhibiting provider success and participation in government ACO programs, which are essential to the ACO movement. CMS’s MSSP provides an important model to transition from Medicare’s fee-for-service to one that incented value and population health. Our alliance members are pleased with some of the proposals to remove serious hurdles, but we believe that CMS needs to do much more.

For one, CMS should really work to improve the one-sided risk model. It actually proposes to reduce the already inadequate shared savings payments for ACOs extending their contract under Track 1 from 50 percent to 40 percent in year 4, stepping payment down an additional 10 percent for each subsequent contract period. This will impede participation and inadequately recognizes the financial and transformational contributions made by participating providers. We’re looking forward to working with the agency to further refine the program rules."

Wes Champion
Senior Vice President
Premier Consulting Solutions
Charlotte, NC
CMMI 2nd Report to Congress Touts ACO Savings

As required by the Affordable Care Act, CMMI issued its second report to Congress on its 22 innovation initiatives, this one covering the period November 1, 2012 through September 30, 2014. CMMI estimates that over 2.5 million Medicare, Medicaid, and CHIP beneficiaries are or soon will be receiving care furnished by more than 60,000 providers participating in its payment and service delivery models.

With respect to ACOs, the report noted that Pioneer ACOs generated total program savings of $87 million in their first year of operation with savings to the Medicare Trust Funds of nearly $33 million. They also performed better than comparable providers in Medicare FFS on all 15 clinical quality measures for which comparable data are available.

There are currently 35 Advance Payment ACOs encompassing a total of 301,000 aligned Medicare beneficiaries with a three-year performance period.

CMS Announces 89 New MSSP ACOs

On December 22 CMS announced that 89 new ACOs will join the Medicare Shared Savings Program, bringing the total number of MSSP ACOs to 405, serving more than 7.2 million beneficiaries. When combined with the Innovation Center’s 19 Pioneer ACOs, CMS will have 424 ACOs serving over 7.8 million beneficiaries. MSSP ACOs improved on 30 of the 33 quality measures in the first 2 years and outperformed group practices reporting quality on 17 out of 22 measures. Together with the Pioneer model ACOs, they generated combined total Medicare program savings of $417 million.

Analysis: ACO Contracting with Public/Private Payers

The December 12, 2014 issue of the American Journal of Managed Care included a cross-sectional analysis of the National Survey of Accountable Care Organizations (n = 173) on ACO contracts with public and private payers and private payer contract characteristics. Most ACOs had only one ACO contract (57%). About half had a contract with a private payer, the most common being an upside-only shared savings model (41%), although most private contracts included some form of downside risk (56%). Most of these made shared savings contingent upon quality performance (79%), some included bonus payments for quality (39%), and most included upfront payments, such as care management payments (56%) or capital investment (17%). Public ACOs were fewer in number but more likely to include both downside risk and upfront payments.

Humana Touts Results from its 2013 ACO Programs

Humana reports that 2013 data on quality, outcomes, and cost from its ACO programs serving about one million Medicare Advantage members show a number of measureable improvements. ACO providers under a value-based reimbursement model had an average HEDIS Star score of 4.25 compared with providers not in an ACO, who averaged 3.65. ACO population health improvements included 7 percent fewer emergency department visits and 4 percent fewer inpatient admissions than among the control groups. Screening and monitoring of patients also improved, with an 8 percent boost in providing medication reviews for older patients.

Health Net, John Muir Launch New ACO

Health Net of California and John Muir Health have formed an ACO serving Health Net members utilizing John Muir Health’s medical centers and physician network in Contra Costa, Solano, and Alameda counties. The ACO will focus on promoting patient engagement and improving the patient experience through care management, wellness, and prevention programs, including health coaches and use of patient-centered medical homes.

Walgreens Cuts Ties with Two ACOs, Starts a Third

Walgreens has ended its partnership with two of the three ACOs it formed in 2013 – Advocare Walgreens Well Network, which was formed with New Jersey physicians and exceeded its spending mark, and the Scott & White Healthcare Walgreens Well Network in Texas, which did not achieve any savings. Walgreens’ third ACO, the Diagnostic Clinic Walgreens Well Network in Tampa Bay, Florida, which achieved nearly $1.6 million in Medicare savings in 2013, will apparently remain in place. Walgreens has also started a new ACO partnership in Arizona with Arizona Priority Care, an affiliate of Heritage Provider Partners.

KLAS Rates Deloitte Top ACO Strategy Firm

KLAS evaluated seven ACO consulting firms against three categories – strategy development, readiness assessment, and implementation – based on interviews with 41 health care organizations working to implement value-based care models. The report, ACO Advisory Services 2014, named Deloitte Consulting, LLP as the top firm for strategy development and readiness assessment.
Accountable Care News: The U.S. has long lagged behind other industrialized counties in terms of IT adoption and the ratio of primary care to specialist physicians. How does the U.S. now compare given the push for meaningful use and accountable care? What are we teaching and what are we learning from other countries in this area?

Mark McClellan, MD: Different countries are starting from very different places, but in our work outside of the US, we’ve found lots of examples of ways to improve care and lots of efforts to reform payments to health care providers to support those changes. Accountable care can help in all these cases, by shifting payments from provider silos to a more direct focus on patients. For example, health networks in Mexico and India are using mobile health technology to identify at-risk patients diabetes and to engage patients in their treatment regimens. The low- and middle-income country settings show that mobile health can be done in resource constrained areas, and do not require the use of smartphone technology. It can be as simple as an integrated, cloud-based program with text messaging to continuously monitor a patient’s vitals. Integrated care systems in Spain and Italy are using coordinated IT systems to target chronic, complex patient care and financial incentives to reward an entire team’s performance. Furthermore, in Germany, care teams are measured against standardized, risk-adjusted measures for a particular condition, which facilitates continuous improvement. To make these programs sustainable, these care reforms need patient-level payments to the collaborating team of providers, with accountability for overall costs as well as quality.

Accountable Care News: Notwithstanding some success, particularly on the quality front, there is nonetheless fairly widespread provider discontent with a number of features of the Medicare ACO model. If you could wave a magic wand, what would you change to give providers a better chance at success in both improving quality and managing cost?

Mark McClellan, MD: I think the recent Medicare proposed rule for the next version of the Medicare ACO program has highlighted many key areas where the program might be improved. I applaud the proposals to make the program more predictable and to reduce the uncertainty facing ACOs, for example by highlighting improved ways of data sharing. Along with that, the proposal rightly gives ACOs more time to move toward taking on more financial accountability for their patients – financial risk – but it also aims to create a clearer and more feasible pathway for ACOs to transition to two-sided risk over time. I’ve heard positive reception to CMS’ proposal to waive a number of existing requirements for ACOs that move into two-sided risk, including relief from Medicare rules designed for fee-for-service regulation, such as restrictions on paying for hospitalizations for patients from SNFs (skilled nursing facilities), paying for telehealth, and paying for home health for the non-homebound. But the proposed rule left many of these issues open for broad comments, which means that a lot depends on the comments and how CMS responds to them.

I do want to emphasize the importance of reducing uncertainty wherever possible for ACOs to make it easier for them to know what they can do to reform care and still make ends meet in the program. CMS has mentioned some proposals for calculating, adjusting, and updating benchmarks, but has not taken a firm stand on which one to adopt. We think it’s very important for ACOs and others to comment on these proposals in order to ensure that financial benchmarks better account for regional variation and an ACO’s performance over time.

ACOs also need better and more timely data. CMS appears open to providing ACOs with additional data elements needed for population health management, but has not specified in great detail what these elements may include. This is again an area that ACOs can offer meaningful comments to the proposed rule. CMS could also foster the sharing and dissemination of best practices via a web portal or other ACO-to-ACO interactions, particularly as the program continues to grow and ACOs gain greater experience.

Accountable Care News: ACOs need a proper network in order to be successful, but what looks like a “value” network to them may just look like a “narrow” network to Medicare and PPO patients who have been used to freedom of choice. How do ACOs effectively communicate the value proposition to their members?

Mark McClellan, MD: Patient engagement and activation is one of the most critical areas where further progress is needed, and where many ACOs would like to do more. It’s easy to understand the fear of “narrow networks,” but remember that Medicare ACOs do not directly limit patient choice. This is why it’s important to create clear value for patients who use the ACO providers, and to pay careful attention to communicating this value to patients. Beyond that, the more that patients engage with their providers and track their health and health improvement opportunities, the more health benefits are possible. One major barrier to this outreach right now is that Medicare ACOs are limited in the kind of materials they can provide to patients; these restrictions might be modified in the future.

Another way to not only communicate, but also show, the value of an ACO is to enable patients as well as providers to share in the savings from engaging with the ACO to improve their care. Many private insurance plans are trying reduced copays or deductibles for choosing ACO providers, or rebates for patients that successfully adhere to medications, or additional discounts for patients who take other health improvement steps. Medicare should consider further reforms like these that support patient engagement.

Accountable Care News: Finally, tell us something about yourself that few people would know.

Mark McClellan, MD: I think many people know that I’ve got a background in economics and in medicine. One thing most people don’t know is that I didn’t start out that way. I was an English major in college, with a focus on American literature in the 1920s, including some physician writers. Health policy by way of Sinclair Lewis and William Carlos Williams.
Catching Up with...

Mark McClellan, MD, PhD is a Senior Fellow and Director of the Health Care Innovation and Value Initiative at the Brookings Institution in Washington, DC. Within Brookings, his work focuses on promoting quality and value in patient centered health care. A doctor and economist by training, he is a former administrator of the Centers for Medicare & Medicaid Services (CMS) and former commissioner of the U.S. Food and Drug Administration (FDA). He talks about his own expectations for ACOs, physician-led vs. hospital-led ACOs, the U.S. vs. other countries regarding integrated care models, needed changes in the Medicare ACO models, communicating the ACO value proposition to patients, and himself.

Mark McClellan, MD, PhD
- Senior Fellow and Director of the Health Care Innovation and Value Initiative at the Brookings Institution, Washington, DC
- Former Administrator, Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health & Human Services
- Former Administrator, Food and Drug Administration (FDA), U.S. Department of Health & Human Services
- Former Senior Director of Health Care Policy, The White House and member of the Council of Economic Advisers
- Co-director, Bipartisan Policy Center’s Leaders’ Project on the State of American Health Care; co-chair, Robert Wood Johnson Foundation Commission to Build a Healthier America;
- Chair, FDA’s Reagan-Udall Foundation; co-chair, Quality Alliance Steering Committee; board member, National Quality Forum‘; member of the Institute of Medicine; research associate, National Bureau of Economic Research
- BA from University of Texas at Austin, MPA from Harvard University, PhD in economics from MIT, MD from Harvard-MIT Division of Health Sciences and Technology; residency in internal medicine at Boston’s Brigham and Women's Hospital

Accountable Care News: When the Affordable Care Act was being drafted, you were in the forefront of those supporting financing and program flexibility for testing the ACO model. Have your expectations been met thus far?
Mark McClellan, MD: I think ACOs have helped lead the shift in health care payment from a focus on provider services to a focus on patient-centered care. At the same time, truly reforming care is hard work, and there’s a lot more that needs to be done to build on the results so far, to get to much more affordable, high-quality care. On the Medicare side, the MSSP and Pioneer ACOs are achieving significantly more quality of care in most measurable dimensions compared to the rest of fee-for-service Medicare. These ACOs were also able to save Medicare over $417 million in their first year, as well as earn shared savings payments of $460 million. Those numbers are only a small part of Medicare spending, but coupled with the quality improvement that ACOs are achieving, and the fact that Medicare baseline spending was flat during this time, it’s a promising start. In addition, few ACOs have seen their spending increase so much that they would owe money back to Medicare, and some ACOs have achieved substantial savings. The challenge now in Medicare is to learn more about what the successful ACOs are doing, and to take other steps to reduce the uncertainty and the challenges of moving toward a true focus on person-centered, lower-cost care. Another 90 organizations just joined the Medicare ACO program this year.
On the private-insurance side, even bigger reforms in ACO payment and delivery are occurring. Many of these ACOs appear to be implementing larger changes in care and larger shifts away from fee-for-service payment, with notable increases in quality and larger cost savings, such as the recently-reported experience of the Alternative Quality Contract at Massachusetts Blue Cross. And 19 states are now in the process of implementing ACOs in their Medicaid programs, including steps to coordinate behavioral health and social services.
There are now over 600 accountable care arrangements in all part of the country, with a growing number of physician-led ACOs, indicating that accountable care reforms are not just for large hospitals and integrated health systems.

Accountable Care News: You and Aledade CEO Farzad Mostashari, MD recently released a toolkit for physician-led ACOs. Do you expect these ACOs to out-perform their hospital- and system-led counterparts over time?
Mark McClellan, MD: More than half of MSSP participants are now physician-led and early results from Medicare suggest that they are performing as well, if not better, than their hospital and system-led counterparts. Not surprisingly, with the smaller sizes, there is wider variation in terms of financial performance across physician-led organizations. But in an analysis done by our ACO Learning Network, compared to larger ACOs, we found that Medicare ACOs with less than 8,000 Medicare beneficiaries on average achieved bigger early savings relative to their financial benchmarks. As we emphasized in our recent ACO Learning Network toolkit, Adopting Accountable Care: An Implementation Guide for Physician Practices, we think these organizations have some distinct advantages in reforming care. These physician-led ACOs often consist of one or just a few primary care physician groups or practice associations. Increasingly these ACOs are engaging with specialists, but primary care remains their focus. This focus on primary care means that the ACO can leverage relatively larger savings from reducing unnecessary hospitalizations and ED visits, and using other specialty services more efficiently. In many cases, the size of these ACOs means their clinicians are closer to the quality improvement initiatives and new clinical care approaches.
These physician-led ACOs also face significant challenges, many of which we highlighted in the toolkit. The challenges include things like identifying and managing high-risk patients, developing high-value referral networks, getting event notifications even when interoperable electronic records are not available, and engaging patients. While the reforms are challenging for physician groups that are already stretched, we’ve found lots of successful examples of how to do these things to enable early success.

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