

A Medical Neighborhood

Accountable care organizations could solve some of health care's biggest problems, but they're largely untested.

BY MEGAN FOREMAN

Improving how we care for patients while controlling escalating costs are the two toughest issues in health care.

An approach some think may address both is the use of accountable care organizations, in which a range of medical providers work together to manage a patient's medical needs. Some backers think the approach could help states control Medicaid costs and provide better care.

Accountable care organizations are similar to medical homes, but on a larger scale—a medical neighborhood. In an ACO, all providers—from the primary care doctor to the specialist to the hospital—have a stake in improving the health of patients.

The goal of coordinating care is to ensure patients get the right care at the right time in the right setting. This may mean more convenience for patients: Extended office hours, same-day appointments, and a 24/7 call-line staffed with professionals who can give patients advice and triage health concerns. States save money when the majority of patient care happens in a primary care setting. For example, Colorado estimates it spends \$50 million a year on emergency room care for nonemergency situations. A 2009 survey indicated 87 percent of Medicaid clients who used ER services were never seen for that condition in a primary care setting.

Colorado, a leader in developing the model, is setting up regional ACOs to serve the state's Medicaid beneficiaries. The state is currently testing its new system—called Regional Care Collaborative Organizations—with 60,000 Medicaid clients in a small number of counties. The program is set to expand to include all Medicaid beneficiaries in July if the test group meets its budget and patient care goals. Colorado hopes to save up to \$14 million a year once the program is fully implemented.

“Community health centers and medical homes are critical to coordinating care,” says Colorado Senator Betty Boyd (D), chair of the Health and Human Services Committee. “If you have a medical home, you're more apt to get the most appropriate care because the provider knows what's going on in your health life, and you are less likely to overuse the system.”

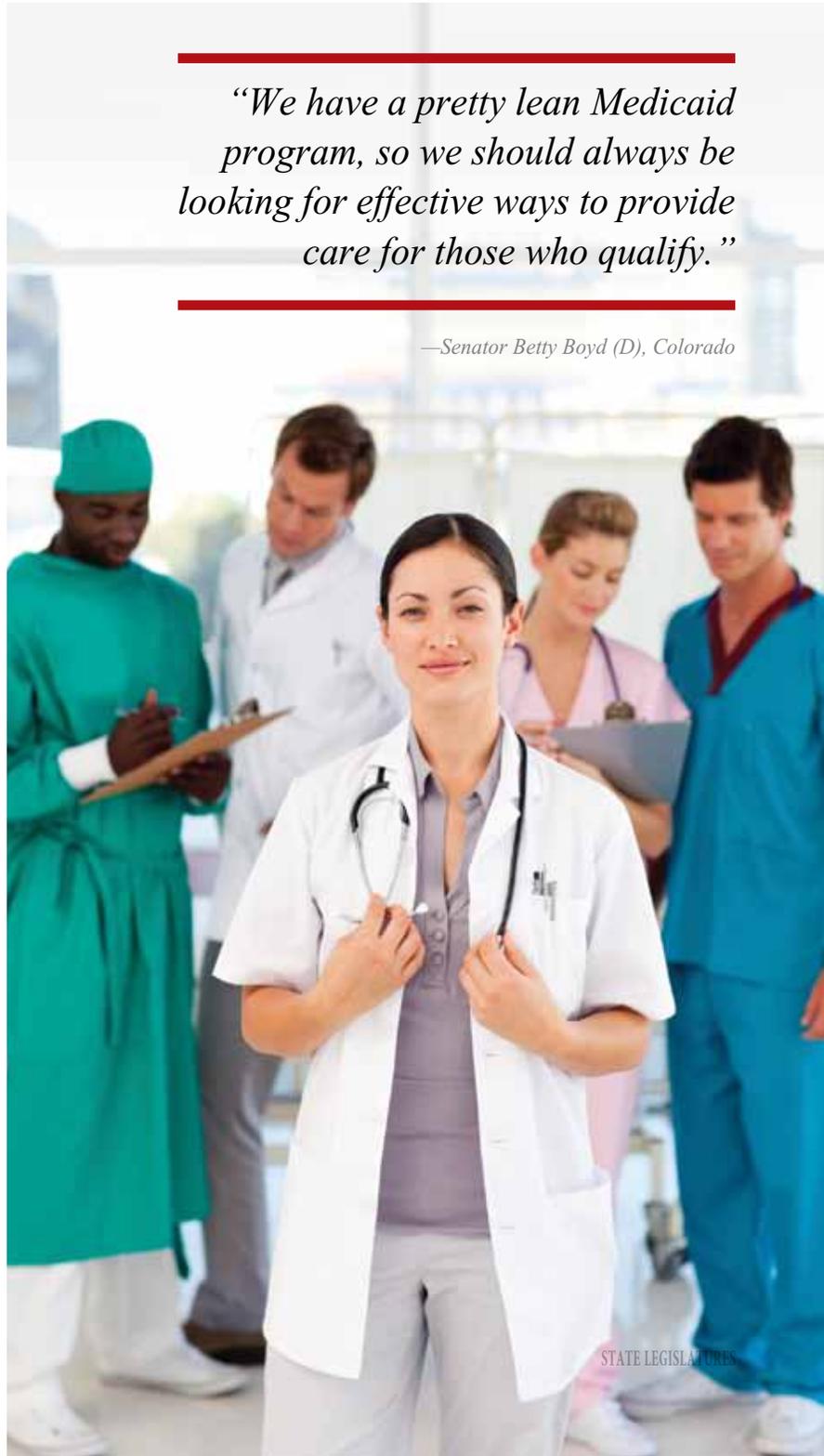
Pilot programs are just beginning to test the



Senator
Betty Boyd (D)
Colorado

“We have a pretty lean Medicaid program, so we should always be looking for effective ways to provide care for those who qualify.”

—Senator Betty Boyd (D), Colorado



Supporting ACOs

State policymakers can speed the development of accountable care organizations by getting involved in these areas, according to the National Academy for State Health Policy.

- ◆ **Data.** States are on the forefront of health information technology and health information exchange development. These systems promise to change the way health care is provided. States can be the keepers and sharers of vast amount of claims data as well, which helps systems budget and track performance measures.
- ◆ **Designing and promoting new payment methods.** Medicaid and others are experimenting with payment reform. Rather than the current fee-for-service model, states are trying to create incentives to focus on results over volume in pilot projects.
- ◆ **Accountability measures.** State payments are tied to quality performance measures, which will allow ACOs to track their progress and ensure accountability.
- ◆ **Supporting the medical home model.** Almost every state has legislatively moved the medical home model forward, in an effort to provide patients a “first stop” for all their medical needs. This initial, money-saving step is the foundation upon which ACOs can be built.

ACO model and the data on their effectiveness is still to come. For this reason, some lawmakers think the timing is wrong to experiment with new approaches, especially with looming deadlines for federal health reform. Some are concerned that ACOs inevitably will lead to even larger health care organizations.

Potential Cost-Savings

For most patients, their benefits package will stay the same under ACOs. The consumer will find that little about their health care experience changes, except maybe some added conveniences. The major differences will be on the provider side, as payment models change drastically. The accountable care model fundamentally changes the financial incentives for health care providers.

The prevalent fee-for-service model rewards volume. Primary care doctors, specialists and other providers are not paid to prevent problems or help patients maintain a certain level of wellness.

ACOs turn the compensation model on its head by creating an incentive for treating illnesses and diseases early, providing more primary care, managing chronic diseases well, avoiding redundant and expensive tests, and cutting down on hospital readmissions.

The organizations do this by having providers and payers agree on a single budget for all the health services a certain group of people use in a year. They also establish a series of goals, such as reducing the number of hospital-acquired infections and increasing the number of patients able to manage their own illnesses. The budget and goals are determined through an analysis of claims to ensure the risk is tolerable for the providers and the quality goals are achievable.

Accountable care organizations share the savings among all the providers if they meet goals for patient health and cost containment.

“ACOs are really a tangential aspect of the Affordable Care Act. Sure, we’d like to look at it, but we’re struggling just to get some basic intellectual capital on the ACA.”

—Representative Mark McCullough (R), Oklahoma

Accountable care organizations “embody the financial and quality care relationship states want to have with providers,” says Andrew Allison, Arkansas’ Medicaid director and president of the National Association of Medicaid Directors. “They are potentially the ideal [way] to align the financial impact with medical decision making.”

State Role

Lawmakers can play a role in helping accountable care organizations be successful.

“The state can provide structure and support for ACOs and ensure that whoever comes into the [Medicaid] system is routed to the most efficient level of care,” says Boyd.

Massachusetts, Minnesota, North Carolina, Oregon, Vermont and Washington join Colorado on the list of states that have taken long-term action to develop the ACO model. Many states have established pilot projects, reformed data and payment systems, invested in health information technology and exchange, restructured their Medicaid provider systems, and integrated the medical home model into service delivery.

“I’m proud Colorado is moving forward and thinking creatively about how to provide services for Medicaid beneficiaries,” Boyd says. “We have a pretty lean Medicaid program, so we should always be looking for effective ways to provide care for those who qualify.”

Who’s in the Driver’s Seat?

Federal health reform created several pilot programs to test ACOs as a way to deliver health care to Medicare beneficiaries. The experience in those projects—both successes and failures—will give policymakers concrete data on what works.

“Medicare has the burden of leadership, and ACOs are its new payment model of choice,” says Allison. The question is whether states, after four years of deep fiscal pain, have the flexibility to take a chance on an unproven approach in their Medicaid programs.

Oklahoma Representative Mark McCullough (R) and his colleagues are deeply concerned about implementing the Affordable Care Act and ballooning Medicaid costs. He says they don’t have time to pay attention to more “exotic” ideas.

Accountable care organizations “are really a tangential aspect of the Affordable Care Act. Sure, we’d like to look at it, but we’re struggling



Representative
Mark
McCullough (R)
Oklahoma

“ACOs embody the financial and quality care relationship states want to have with providers.”

—Andrew Allison, Arkansas’ Medicaid director and president of the National Association of Medicaid Directors.

gling just to get some basic intellectual capital on the ACA,” McCullough says. “We’re opposed to it, but we have to prepare for what’s coming. It’s really hard because there is so much public opposition and [health reform] is so complicated.”

Reform on the Fly

Accountable care organizations may hold the promise of addressing all that’s wrong with the U.S. health care system, but they remain more of a concept than a concrete model. Even in Colorado and other states where pilot projects are underway, there is not enough data to draw firm conclusions about how well the approach contains costs or improves patient health.

“How long have ACOs been around?” McCullough asks. “It’s hard to pass judgment at all. The jury is still out, but some of the early data show that ACOs do not produce the cost savings it was hoped they might.”

Even advocates agree creating an ACO in a vastly complex health care system is like changing the battery while the car is going 80 mph. Payers and providers are entering into contracts while the business model is being developed and tested.

States that embrace ACOs as their business model are making purchasing decisions worth millions of dollars, essentially “picking winners,” Allison says. “The taxpayers aren’t interested in picking winners, they’re interested in outcomes, like quality and cost-efficiency. Patients want to see these outcomes, too.”

Creating an ACO requires a large-scale remodeling of the system that already is in

place. There is concern that it will lead to even larger hospital systems and provider groups that will eventually hold huge market shares and run afoul of anti-trust laws.

“The systems ready to be ACOs are large, integrated health care systems,” says Allison.

“This is an economy of scale. To be successful in the ACO’s risk-based payment models, and achieve team-based care, a system must have a large number of patients, functioning health information technology, and a solid infrastructure. This scale means market power.”

SEARCH

www.ncsl.org



Searching for NCSL resources and information is now a whole lot easier. See for yourself at www.ncsl.org.

