Accountable Care Organizations in the Era of Healthcare Reform

Interview with Mark B. McClellan, MD, PhD

Under the Patient Protection and Affordable Care Act (PPACA) of 2010, Medicare providers, including physician groups and hospitals, will soon have the option to form accountable care organizations (ACOs) to improve quality and efficiency. ACO participants may share financial gains generated from improved clinical and economic performance, provided that quality goals and patient safeguards are met. Through future regulations, the Centers for Medicare & Medicaid Services (CMS) must implement the ACO option no later than January 1, 2012. In this interview, Dr. Mark B. McClellan, former CMS Administrator and US Food and Drug Administration Commissioner, discusses the extraordinary implications of the new ACO option for improving patient care and reducing unnecessary costs.

Kip Piper, MA, FACHE: You and your colleagues were influential in developing the ACO concept and successfully persuading Congress to make ACOs an option in Medicare. Are you surprised by the tremendous interest in ACOs since enactment of the PPACA this year?

Mark B. McClellan, MD, PhD: There has been a real expansion of interest in ACOs recently, and some of that is not surprising. The key ideas behind accountable care have been around for a while. CMS has implemented some Medicare demonstration programs previously that potentially use ACO concepts, and a number of private payers and providers have been working on ACO implementation as well. I have been a bit surprised by the breadth of interest. It is a reflection of how seriously providers and payers are taking the healthcare reform law.

However, unlike many of the other provisions on payment reform, ACOs will be a real part of Medicare as of 2012, if not earlier; not a pilot, not a demo, but a part of the Medicare program. That may be contributing to the interest too. And finally, there is growing interest in making sure that payment policies fit together to add up to getting better value, getting higher quality, and avoiding unnecessary costs. That’s contributing to the interest in ACOs. It is a confluence of factors, and in retrospect I should not be so surprised by the intense interest in the ACO model.

Piper: What are some of the factors critical to successfully implementing an ACO?

McClellan: One is a critical mass of providers who are willing and able to meaningfully take accountability for the well-being of a population of patients. This includes a primary care network and other types of healthcare providers, maybe even some providers who are involved in things that are not traditionally thought of as healthcare, such as wellness programs and population health management. But the key thing is that there is a critical mass of providers who are willing to work together and are able to take meaningful steps to get to better health for those beneficiaries.

Second, there also is a need for a critical mass of payers. There needs to be enough reform in the way payments work so that steps that traditionally do not make much financial sense—such as promoting better coordination of care, taking steps to reduce complications and readmissions, and exchanging information effectively—make more financial sense. And that takes enough of the payer community to get behind the effort as well.

Having both providers and payers simultaneously jump together is a challenge, but there is certainly a growing number of examples of ways to do it successful-
ly. In the end, the success of ACOs is going to depend on actually reforming care so that costs are lower and results are better. It’s not just a matter of getting the critical mass (of providers and payers), but actually having meaningful steps that can be taken. These steps can take a little time, and certainly some effort, to reform the way healthcare works, which requires a commitment of time, effort, and expertise to meaningfully redesign care.

**Piper:** How does the ACO model fit in context with other major reforms, most notably bundled payment, global and episode-based payment reforms, and the medical home model?

**McClellan:** There is a tendency now to look at what is in the healthcare reform legislation and what is being tried in the private sector and states around the country as basically throwing a lot of spaghetti against the wall and seeing what sticks. That is the wrong way to look at these reforms. They all have a common goal of improving care delivery, making it better so that patients are healthier, and making it more efficient so that costs are lower. The best strategy for an organization is to view these as part of an overall approach to getting that result. So, for example, it can actually be easier to implement an ACO successfully by pairing it with a medical home reform.

We are seeing many examples of this around the country, where the providers get the support they need for coordinating care and spending more time on patient management by the upfront investment needed to support a meaningful medical home. Payers get some accountability that, by taking these steps (or as they take these steps upfront to support reforms and care delivery), they are going to be able to see what the ultimate consequences are for health and for costs on the back end. That is what an ACO provides. So these reforms can truly reinforce each other. The best way to approach payment reform is as pieces that add up to a more comprehensive and effective whole.

**Piper:** Long-term, which form of payment do you expect will work most effectively with the ACO model—shared fee-for-service savings, partial capitation, or some other form of global payment?

**McClellan:** What we have seen in some early adopters is movement toward having less payment depend on fee for service. But that is not necessarily going to be the outcome. I can imagine some long-term arrangements where ACOs are operating at a regional level or across a diverse range of providers, where fee-for-service reimbursement may remain a substantial part of payment. The main thing is that ACOs involve setting up a different kind of tracking system for payments than you get with fee for service.

In the most basic form of ACOs, with shared savings, in addition to tracking the volume and intensity of services for traditional fee-for-service payments, the organization and its payers will also track some meaningful results for the population of patients being served and per-capita spending. If there are any savings compared with fee-for-service costs, those provide an additional source of reimbursement for the providers.

As people get more used to thinking about things that they can do to improve care and to work on improving those patient-focused performance measures rather than just the fee-for-service billing, you can imagine more weight going to this patient-focused payment approach, and it can be gradual. In some examples, it may start out with shared savings. Then, as the providers get more used to working together in this kind of explicit goal-oriented way, as they identify some further steps that they can take together to improve performance, and as they get more comfortable with an explicit patient-level focus, you can imagine putting more weight on the ACO payment model as opposed to fee for service.

So maybe reducing the fee-for-service payment by 20% across the board or for primary care services and putting that money into a partial capitation fund would enable the organization to do more to reform care than it can with the resources from shared savings alone. Different organizations may come out in various places. The whole point is to try to support incremental steps that are not too disruptive in the short-term, but that over time could lead to more fundamental improvements and care.

**Piper:** A few skeptics question the readiness of provider organizations in areas such as governance, physician relationships, coordination, health information technology (HIT), and performance measurement. How do you respond?

**McClellan:** Yes, this is hard, especially in the status quo, where it is very difficult for many healthcare providers and provider organizations. Their payment rates are being squeezed. They are facing new reimbursement and regulatory pressures because of rising healthcare costs. Unfortunately, I do not see the status quo getting better. So although this is a real challenge, there are some unique opportunities to support the move toward a different kind of payment, in which providers get better support for delivering better care, not just more squeezes. It makes now a really good time to consider moving forward on addressing these very hard challenges.

For example, there is the federal HIT initiative, with Medicare and Medicaid incentive payments for adop-
tion of electronic health record (EHR) systems and meaningful use of EHRs. The objectives of the meaningful use standards are tied directly to improving patient care. This sounds a lot like the goal of accountable care. There are some payments now and over the next few years in Medicare for physicians and other healthcare providers for reporting on performance. That is easier to do if you have an information system in place and if you are actually developing and using information systems to improve care.

CMS now has 2 tracks for performance reporting. One is the traditional “fill out another claim form” approach, which is burdensome on providers and does not help improve quality. The other is to submit information from systems used to improve care at the patient level as a registry-based submission to CMS. An increasing number of provider organizations are doing that.

There are also other opportunities in terms of medical homes and other payment reforms that can collectively add up to a significant amount of support for addressing things such as governance, effective information technology (IT) use, and improving physician relationships and coordination. But those opportunities are not going to be around forever. I think the next few years are probably the best time to take advantage of all of this support for building up systems that help providers do what they want to do, which is get better results for their patients at a lower cost.

Piper: ACOs have been discussed mostly in terms of hospitals and physicians. Does the ACO model hold promise for other combinations of healthcare providers?

McClellan: Yes, it does. It is essential to have a network of primary care physicians within an ACO. But there are certainly a lot of opportunities to expand broadly beyond specialist hospitals and other types of traditional healthcare providers. For example, we have heard from a number of communities that already have public health initiatives in place. They want to expand these initiatives to use wellness programs and school-based programs to support ACO goals.

State Medicaid programs are finding that if they can expand the support from ACOs and Medicaid to areas like community-based mental health services, they can document some significant reductions in medical costs related to mental illnesses. There are issues that could be addressed through support of care in the community but that are not part of traditional healthcare delivery. I think ACOs actually make it easier to move toward less-traditional forms of delivering care and toward preventing complications and keeping people well. That’s because all these steps in the absence of an ACO run the risk of payer concerns that they may just lead to higher costs and more expenditures. Therefore, some reluctance. With the accountability of the ACO model, it becomes easier to bring in other types of providers, other types of services that may not even be traditional healthcare to get the better results and lower costs.

Piper: The Engelberg Center for Health Care Reform, at the Brookings Institution, provides practical solutions to achieve high-quality, innovative, affordable healthcare. What else is the Engelberg Center working on?

McClellan: Well, this is sort of high noon for healthcare reform implementation. A lot of people think that the big issues are not coming until 2014, but implementation of reform is under way now. And so we are not only trying to help with effective implementation around accountable care, quality and value, and healthcare payments, but also on other issues, such as evaluating other types of payment reform and other things that may not be viewed as within the traditional reform but probably should be.

For example, we are doing work with a network of health plans and EHR systems on developing a better surveillance capability in this country for monitoring the safety of medical products. We have got an IT infrastructure now, incomplete as it is, that could provide much more timely information on potential safety problems. So we need to take steps to use that.

Of course, healthcare reform is never done. So we are following up on some of our earlier work on bending the curve in healthcare, with ideas that may be considered in the next round of healthcare reform. The President has a commission on deficit reduction that will report later this year. In 2011, unquestionably there will be more healthcare legislation related to implementation of the new law, funding it, and perhaps building on it. So we are trying to provide some useful guidance for all of that too.

What a lot of these projects have in common is a recognition that private sector leadership is needed for real reform in healthcare, and for making our public-private system work better, but that this needs to be aligned with effective federal, state, and local government policies to support shared goals. And one of the things we have tried to do here at the Engelberg Center—as a neutral, expert-oriented think tank—is to help bring together these different perspectives in practical ways to make progress on the big challenges of reform in all of these areas.

Reference