Healthcare Policy Considerations for Accountable Care Organizations: A Business Perspective

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The Affordable Care Act (ACA) makes extensive changes in both healthcare insurance and delivery. While there has been a large amount of public debate about the law, most of that discussion focused on the insurance related aspects. Many other sections of the act have been less publicized, and most US residents have little knowledge of those provisions (Wayne, 2015). This policy experience and analysis paper will look at one of those important sections, specifically the one which establishes Medicare Shared Savings Programs (MSSP's) and Accountable Care Organizations (ACO's). To provide the perspective of a critical, but yet often overlooked stakeholder in the public discourse, an executive of a large healthcare system was interviewed. The paper will begin with some background information on this executive, followed by a description of the policy issues related to ACOs and an analysis of various different potential policy approaches for this area.

Description of Interview

The healthcare leader interviewed for this analysis is Ms. Sarah Patterson, Executive Vice President and Chief Operating Officer (COO), Virginia Mason Health System (VM). VM is a nonprofit organization including a large 336 bed hospital, 460 on-staff primary and specialty care physicians, ambulatory clinics throughout Washington State, and various initiatives to transform healthcare through the VM Institute and the VM management method, which includes concepts adopted from LEAN manufacturing concepts (Virginia Mason, 2015). As the COO, Ms. Patterson is responsible for operations of the clinics and the hospital, as well as Human Resources, Quality / Compliance, Facilities and Pharmaceutical Services. She is a member of the executive leadership team and also has responsibility for the VM management method. Through four study trips to Japan, Ms. Patterson has extensive training in applying the Toyota Production System to healthcare. She has been employed by VM for over 30 years and received her MHA from the University of Washington.

Ms. Patterson was chosen to provide input for this analysis based the leading edge healthcare initiatives that she has helped pioneer at VM. Following the success of applying advanced process management concepts to improve the quality and efficiency of healthcare, VM is now trying to lead their region through new concepts, such as ACO's and other innovative healthcare ideas. Through utilization of their own lobbyist and membership in organizations like the Washington State Hospital Association and the Washington State Medical Association (both of which also employ lobbyists at the state and national level on the behalf of health systems), Ms.

Patterson and VM try to influence the adoption of policy that supports these innovative ideas. Ms. Patterson notes that VM feels it is very important that they work together with these organizations to define the policy agenda (personal communication, July 1, 2015). In fact, the CEO of VM, Dr. Gary Kaplan, has testified multiple times before the US Congress regarding healthcare reform.

The Policy Issue – Population Reimbursement Strategies and ACO's

Some of the most critical aspects of the ACA have not received much attention in the public media (Wayne, 2015). One of the most important of those provisions is Title III, "Improving the Quality and Efficiency of Health Care" (HHS, 2015). Section 3022 of this Title directs the establishment of MSSP's to focus on population based healthcare strategies and to redesign care processes for high quality and efficient delivery (HHS, 2015). The section further defines that providers may align together in some form to create an ACO structure to coordinate care for Medicare beneficiaries. ACO's which meet performance and efficiency standards are eligible for bonus payments (HHS, 2015). This analysis will look at various aspects of ACO's including the populations affected, human and financial costs, key stakeholders, any related healthcare disparities, and current challenges. Through the comments from Ms. Patterson, this discussion of ACO's will be primarily though the business lens of a large provider system.

ACO's are intended to focus on population management and results across a defined population, versus individual patient metrics. While the specific population addressed by ACO's in the ACA are Medicare recipients, Ms. Patterson pointed out that what Medicare does typically drives what private insurance does. As such, there are already numerous "commercial ACO's", and Ms. Patterson believes these will increase. Thus, the population addressed by ACO's may grow to include much of the US. VM did not choose to participate in the initial wave of ACO's due to the complexity and cost issues discussed later in this paper. However, Ms. Paterson indicates VM is now considering forming a Medicare and/or commercial ACO in which VM would be the central coordination point for care and financial risk (VM would be the recipient of a capitated payment and manage all associated expenses). The VM ACO would provide patient services from its own hospital, provider, and ambulatory network, supplemented by partnership agreements to fill any gaps.

To accomplish this, VM or any entity considering becoming an ACO would need to commit a substantial amount of investment. In order to coordinate, track, and measure needed quality and cost

information for any defined population, there must be some level of clinical system and data integration, as well as common processes. The estimates of the cost for this type of infrastructure will vary greatly with the size and type of ACO, but Ms. Patterson indicates it could be $10-$20M+ per large ACO group. The analysis from Menachemi and Collum (2011) agree and suggest EHR associated implementation costs of $15K to $30K per provider in an organization, plus ongoing maintenance costs of $8K-17K per provider.

There are also human cost considerations. While the concepts of population management can potentially improve overall healthcare quality and cost efficiency across a defined group, the individual affects may not be positive in all cases. As an example, Bodenheimer and Grumbach (2012) discussed an HMO company's analysis related to the use of $3.5M in funds. The $3.5M could be used to either procure expensive x-ray dye and save 40 lives or expand cervical cancer screening and save 100 lives. In the real world of limited resources, a population based approach would use the funds for the additional cervical cancer screening. At the macro level, this is terrific, but it is not as positive for the 40 lives lost due to the lack of investment in the better dyes. These types of scenarios could result in healthcare disparities for people with less common or less easily treated conditions, as well as those with other risks and/or various handicaps (AHRQ, 2012).

In addition to the financial and human cost considerations, there are also interesting implications for stakeholders. As Ms. Patterson indicates, insurance companies are concerned about potential disintermediation if large provider groups begin to take on healthcare capitation financial responsibility as fully integrated ACO's. Many industry analysts are suggesting large providers do just that and offer "direct-to-employer" health plans (Hill & Petrick, 2015). To combat that threat, Ms. Patterson indicates some insurance firms are adding nurse case managers and other roles to enhance their ability to perform ACO functions. In essence, there is a possible scenario here where provider groups expand "vertically up" into the space filled by Insurance companies, who expand "vertically downward' into the space filled by providers. Such overlap would not be efficient.

This is an example of one of the current challenges of the ACO concept. According to Ms. Patterson, the flexibility defined by Medicare in terms of potential ACO constructs could actually prevent any large scale movement to the ACO concept. While that flexibility was included to accommodate different stakeholder interests and to hopefully increase participation, a more definitive model(s) may ultimately be required. Ms.

Patterson believes the current large variety of potential types of ACO implementations will limit the level of standardization required for large, national population improvement.

Potential Solutions

Given the highlighted ACO concerns related to the potential healthcare disparities, the cost of investment, and the challenge of the variety of ACO models, different policy actions may be considered. For the potential sub-groups which may be negatively affected by macro level healthcare population management, one solution could be an "exception" process. In such a process, a patient in an ACO group would be able to make an appeal for some action / treatment that does not follow macro population guidelines. This appeal process could go outside of the ACO (to Medicare, as an example, for Medicare recipients) and could be funded from a separate pool to not affect the ACO financial structure. On the positive side, this approach would provide a process for potential solutions, but on the negative side, it would not ensure sub-groups are protected.

With regard to another major issue for ACO's, there needs to be more help for required infrastructure investment. The Health Information Technology for Economic and Clinical Health (HITECH) Act and the ACA do provide some assistance for Information Technology (IT) infrastructure investments, but most of these programs are oriented towards smaller firms (ONC, 2011). As Ms. Patterson explains, while larger firms like hers do have some capacity to make investments, they also still require some help. Additionally, more nationally driven investment and guidelines are required for interoperability among different electronic health record (EHR) systems vendors. Without this, ACO's will be severely limited in their ability to analyze and manage the full healthcare needs of patients (Kellerman & Jones, 2013). Of course, one of the challenges that exist in this area is the competitive postures of EHR vendors, like EPIC, who would rather solve interoperability issues by having all firms migrate to the vendor's specific system.

Finally, since no one is sure of the future of ACO's, Ms. Patterson indicates firms are reluctant to make investments. This is another major area in which policy can help ensure the success of the ACO concept. After additional analysis of the success / failure of the various ACO models to date, the government should enact policy to better standardize the ACO model and measurements (Fisher & Shortell, 2010). Ms. Patterson agrees such policy action would help firms feel more comfortable making investments. She also believes standardization would allow the ACO concept to better achieve its goal of improvements in national healthcare

cost and quality. However, a disadvantage of standardization might be to limit both the innovation and participation in the ACO model (Kreindler et al., 2012).

The solutions discussed would help solve both efficiency and equality of care issues with ACO's, which would be the ultimate measures of success for these policy recommendations. However, these actions require investment above what is included in the ACA (HHS, 2015). To fund these policy initiatives, a portion of the Medicare savings from the ACO's could be used. Since ACO's are new, it is not possible to provide an exact estimate of the savings, but an approximation can be made based on ACO results to date. The 2014 report from the CMS (2014) revealed the current group of 250 ACO's provided over $417 million in annual savings, net of the shared savings returned to the ACO's. Since currently only 10% of Medicare enrollees are in an ACO, an extrapolation of the data suggests that approximately $4 Billion/year might be saved if most Medicare enrollees were in an ACO. Using that estimate, 10% of the savings ($400 million) could be used to address any healthcare disparities, through the recommended exception process. This allocation portion of annual savings would continue indefinitely. An additional 25% of the savings ($1B) could be used annually over the next three years to further support needed IT and other infrastructure investments, especially related to IT data interoperability.

Summary

The ACO provisions in the ACA provide for population driven reimbursement strategies to improve the quality and cost of healthcare. To ensure ACO success, all stakeholders must be considered, and this paper provided the perspective of one of those stakeholders - an executive in a large healthcare system. Through the insight from the executive and additional research, some of the challenges of ACO's related to investments, healthcare disparities, and lack of model clarity were examined and potential solutions were provided.

While performing the analysis, I learned a great deal about the topic and the policy process. The perspective of a business stakeholder was very informative relative to the challenges providers and insurance firms may face. Most consumer media articles do not focus on these groups, but no major changes in US healthcare will occur without them. Thus, their policy needs, such as investment support and clarity, must be considered. It was also very interesting to learn the level of involvement of large provider systems in policy determination and administration – and how much time and money they spend on it. Overall, this analysis increased the understanding of the promises and challenges of ACO's through the lens of a key stakeholder.

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