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Value-Based Change: Accountable Care Organizations as a Method of Healthcare Reform

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Abstract

In the past, there have been several attempts to overhaul the healthcare system. Despite this, the healthcare system in the United States has been relatively the same for over a hundred years. Consumers are at the forefront of a major push for a better healthcare system that meets all of their needs without emptying their bank accounts, restricting access to services and providers, communicating in unclear and insufficient ways, and requiring consumers to jump through hoops of complex processes. This project analyzes value-based reimbursement by way of accountable care organizations and coordinated healthcare as a front-running alternative healthcare model currently being explored.

Changing healthcare demands innovative, affordable adaptations to better serve consumers. The Centers for Medicare and Medicaid Services Innovation and programs like the MassHealth ACO pilot program are building a foundation for the future of the healthcare industry by branching away from the old system, and creating new and innovative methods of delivering high value, high quality healthcare.

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Introduction

The term healthcare is used globally as a single word and as two separate words with no official differentiation between them. This analysis will use the one word option, healthcare, as both a noun and an adjective, unless in a quotation or reference from an outside source.

Healthcare is all efforts administered by licensed professionals to promote, maintain, and restore positive overall physical, emotional, and mental well-being. This is a combination of definitions of the term 'healthcare' from a variety of sources such as the American Medical Association, The World Health Organization, Oxford English Dictionary, Market Business News, and Healthcare.gov. All of these definitions boil down to the same idea, positive overall well-being for individuals and communities. Unlike many aspects of the industry, the definition of what healthcare is, seems to be generally agreed upon with variations of the same idea appearing over and over again. If the broad understanding of healthcare is, at the most basic level, the same across industries, then why is the execution so inconsistent? What is the most effective way to reform the current system to better connect with this basic goal of healthcare? To understand where the healthcare industry needs to go, it is important to have a clear picture of where it has been. This analysis will focus on the United States healthcare industry using Massachusetts as an on-the-ground example.

Fee-for-service is a style of healthcare where providers are paid by insurance companies and/or government agencies based on the number of services they provide or perform such as tests, office visits, and procedures. Each of these services get billed independently of one another, delivering rewards for a high quantity of services while leaving behind a confusing,

expensive, and limiting experience for the consumer with little control over their healthcare. This is where the majority of the United States healthcare industry lives today.

In 2017, between 86% and 95% of U.S. healthcare providers were still being paid for each individual test, procedure, and treatment they provided (Pearl, 2017).

> For its many users, healthcare's fee-for-service reimbursement methodology is like an addiction, similar to gambling, cigarette smoking and pain pill abuse. Doctors and hospitals in the clutches of this flawed payment model have grown dependent on providing more and more healthcare services, regardless of whether the additional care adds value. (Pearl, 2017, para. 1)

During the 20th century, this system worked for the United States because medicine was rudimentary and could offer fewer solutions to consumer needs (Thomson & Guthrie, 2017). Today, medicine has advanced significantly, offering multiple procedures, tests, and/or medications for what seems like every ailment. However, these advancements come at a price.

Consumer Standpoint

In the United States, 1 in 10 people delay getting their medical needs met because of worry over the cost (Claxton, Sawyer, & Cox, 2019). Not getting treated when you have a medical need is a risky game to play with your health and your bank account. Maybe the problem will go away on it's own, or maybe it will get worse, costing you more overall. The United States is the only developed country on earth, of which there are 50 according to the Human Development index, that does not have universal healthcare (Amadeo, 2019). This lack of universal access in the U.S. means that consumers must make decisions based almost exclusively on economic factors rather than their acute and long term health needs. The many

recent attempts to overhaul healthcare in the U.S. indicate that the current system is expensive and ineffective.

History of Healthcare and Overhaul

In the past, there have been several attempts to overhaul the U.S. healthcare system. It is important to recognize previous efforts to change a system imbedded so deeply in our society. Change never comes easily and healthcare is not different. In fact, we have been using the same fee-for-service system in the U.S. for over a hundred years (Pearl, 2017). In 1933, the New Deal under President Roosevelt gave some attention to healthcare but ultimately focused on retirement benefits and unemployment insurance, leaving healthcare on the backburner. The Fair Deal under President Truman called for medical care to be a human right by law, only to be defeated by a war-time economy (Fair Deal, 2017; Hoffman, 2009; New Deal, 2009). From there, the Great Society under President Johnson pushed through the formation of Medicare and Medicaid services which provided health coverage to the elderly and the poor ("Evaluating the Success," 2014; Hoffman, 2009). The Health Security Act under the Clinton administration called for universal coverage, employer and individual mandates, competition between private insurers, and was to be regulated by government to keep costs down. However, the complex plan totalled over 1400 pages and failed to gain popularity (Hoffman, 2009; Mariner, 1994). More recently, the Affordable Care Act, often referred to as the ACA or "Obamacare," was established under President Obama with the goal of making affordable health insurance available to more people, expanding the medicaid program, and supporting innovation in the healthcare industry (United States, 2010). Through the ACA, the idea of healthcare based on quality instead of quantity was formally introduced.

ACA and Care Coordination

Grown from seeds of the Affordable Care Act, value-based reimbursement is a model of healthcare where physicians are paid based on the quality and efficiency of the care they provide. Pieces of the ACA still exist today, fueling a shift away from a fee-for-service model of healthcare into a new system called value-based reimbursement. A value-based style of healthcare encourages a team centered approach across specialities, with a strong focus on coordination and communication. Value-based reimbursement promotes a holistic strategy to caring for consumers, getting back to the root of the industry; to promote, maintain, and restore positive overall physical, emotional, and mental well-being. A strategic focus on value forces change at every level of a healthcare organization, creating an entirely new picture of consumer healthcare experiences. Because value-based reimbursement rewards physicians and healthcare organizations based on the quality of outcomes instead of the quantity of services, there is a particular emphasis on preventive care. Physicians and organizations are able to find new and more innovative ways to keep consumers healthy, preventing the need for excessive services later in life. In order to do this effectively, healthcare organizations, community partners, and physicians need to operate as coordinated teams instead of in individual silos.

Care coordination means deliberately organizing activities and sharing information among all participants concerned with consumer care, to achieve an overall safer and more effective care experience. The goal of coordinated care is to ensure that consumers get the right care at the right time, while avoiding unnecessary or duplicated services and high costs. Coordinated care gives control back to the consumer, creates an organized, efficient space for providers to deliver care, and increases ease of communication from provider to provider, and

provider to consumer. Coordinated care brings all necessary parties out of their silos and together at the table for consumer health needs.

An increasingly popular method for implementing value-based reimbursement and coordinated care is the creation of accountable care organizations or ACOs. ACO's are networks of doctors, hospitals, and other healthcare providers who come together to give coordinated, high-quality care to their Consumers. Current trends in healthcare show that this delivery method combined with value-based contracts are a promising basis for the future of the industry (McClellan et al., 2010). ACOs allow groups of providers to deliver better care at a lower rate.

Seven Pilot Programs

Since the implementation of the Affordable Care Act in 2010, ACOs and healthcare centers nationwide have been stepping into the ACO arena through pilot programs created by the Centers for Medicare and Medicaid Services (CMS). There are 7 overarching ACO programs through CMS, each catering to a different payment style or degree of experience in various care coordination activities. All of the information about these programs comes from the Centers for Medicare and Medicaid Services website.

Shared savings program. The Centers for Medicare and Medicaid Services Shared Savings Program is designed specifically for ACOs that follow a fee-for-services payment model. In this program, providers and suppliers are offered the opportunity to create an ACO which will be held accountable for the quality, cost, and consumer experience of an assigned Medicare fee-for-service population. It is important to note that through this program, an ACO is formed as the beginning stage of their participation in the program. Other programs are available

for pre-existing ACOs. The Shared Savings Program allows ACOs to select an arrangement that best fits their organization(s) specific needs and abilities.

Pioneer ACO model. The Pioneer ACO Model was created for health care organizations and providers that already practiced care coordination techniques between healthcare settings. This program allowed provider groups to move from the shared savings payment model to a population-based payment model. This population-based payment model was designed to work alongside private payers by providing incentives to improve quality and health outcomes for Consumers as well as achieve cost savings for Medicare, employers, and consumers. This program ran from 2012 through 2016 and was the first step to a long but necessary reform process currently developing in the United States.

Next generation ACO model. The Next Generation ACO Model is the step after the Shared Savings Program and the Pioneer ACO Model. This program builds upon existing experience by setting predictable financial targets and allowing providers and beneficiaries a greater opportunity to coordinate care to meet those goals. This all works toward the ultimate goal of attaining the highest quality standards of care. This program launched in January of 2016 and will run through December of 2020.

Advance payment model. The advanced payment model was designed for physician-based and rural providers who have come together voluntarily, not in a structured ACO, to give coordinated high quality care to the Medicare consumers they serve. Through this program, participants received monthly payments used to invest in their care coordination infrastructure.

ACO investment model. The ACO Investment Model is an advanced, pre-paid shared savings model specifically designed to be tested in rural and underserved areas. Pre-existing ACOs can can join the Medicare Shared Savings Program using the Advanced Payment Model. ACOs in this program are able to test pre-paid shared savings, encourage new ACOs to form in rural and underserved areas, and transition into arrangements with greater financial risk. This program stretches the ACO model to fit more complex healthcare arrangements.

Comprehensive ESRD care model (CEC). The CEC is a program specifically for Medicare beneficiaries with End-Stage Renal Disease (ESRD). This program aims to identify, test, and evaluate new ways to improve care for this particular population. CMS will partner with health care providers and suppliers on a new payment and service delivery model that provides person-centered, high-quality care. This program is a way for CMS to see if Accountable Care Organizations created for a specific health condition can function successfully.

Vermont all-payer ACO model. The Vermont All-Payer ACO Model is designed to test if population health activities for the entire state can be coordinated under one payment structure. This program incentivizes value and quality with a strong focus on health outcomes in an effort to transform healthcare for all of Vermont.

The variety in these programs prove there is not just one method of payment or healthcare style that works for everyone and every location. CMS is attempting to pilot a variety of programs to determine the most effective ways to move the country toward systems focused on value and quality in healthcare. There are benefits of both fee-for-service and value-based reimbursement. These models impact the way people at every level of the system do their jobs,

from consumers to insurance companies and everyone in between, creating real change from the ground up.

Simply making adjustments to the current fee-for-service system would make it very easy to fall back into familiar habits built by over a hundred years of routine in services (Pearl, 2017). In order make the kind of radical change the United States healthcare system needs, we need think outside of the box that has been keeping us in place for so long and these pilot and trial programs through CMS are a promising way to begin exploring that process.

Massachusetts Example

A deep dive into healthcare reform provides us with a clearer picture of what an accountable care organizations structure can look like within a statewide framework. MassHealth is the title under which Massachusetts Medicaid and Children's Health Insurance Programs fall.

Massachusetts applied for a Medicaid 1115 Demonstration Waiver to extend their healthcare services. The Medicaid 1115 Demonstration Waivers allow states to receive additional flexibility to design and improve their programs. Waivers may provide federal authority for states to expand eligibility to individuals and use innovative service delivery systems that improve care, increase efficiency, and reduce costs (MassHealth, 2019).

This Massachusetts' 1115 Demonstration Waiver allowed MassHealth to provided two accountable care organization healthcare plans in addition to their other programs not involved in this ACO pilot program. These plans are available for five year demonstration beginning July 2017 through June 2022. MassHealth members who fit the criteria of being under the age of 65, not having another form of healthcare, living in a community that is not a nursing facility, and

being covered by one of four other MassHealth programs are eligible to receive services through this program. About 1.2 million of the 1.8 million total MassHealth members are eligible to enroll in ACO plans. At the start of the pilot in 2016, 17 healthcare organizations across the state signed on to participate in the pilot launch of this potential new system.

Changing healthcare demands innovative, affordable adaptations to better serve consumers. The Centers for Medicare and Medicaid Services Innovation and programs like the MassHealth ACO Pilot Program are building a foundation for the future of the healthcare industry by branching away from the old system, and creating new and innovative methods of delivering high value, high quality healthcare.

Literature Review

Despite all of the attention healthcare has received over the last several years, proposed reforms have not gone far enough to amend the instability of the current system and the rising cost of healthcare. Factors such as the aging population and 21st century technological advances have been major barriers to prior reform efforts coming to fruition. There is a shift in today's healthcare climate that has brought a receptivity to new systems and ideas in an effort to change what is widely agreed upon is a broken system (Davidson, 2010; Khazan, 2018; Mcglynn, et al., 2003). Consumers are at the forefront of a major push for a better healthcare system that meets all of their needs without emptying their bank accounts, restricting access to services and providers, communicating in unclear and insufficient ways, and requiring consumers to jump through hoops of complex processes.

Advocates for a systemic change recognize that the fee-for-service healthcare model encourages “over utilization and fragmentation” causing physicians and consumers alike to be blinded from the financial excess that unnecessary or duplicated services create (Hodgin, 2018). Too often, because there is little or no communication from one healthcare center or provider to another, the same services occur multiple times raising the cost for insurance companies and consumers. The Centers for Medicare and Medicaid Services (2017) report cost being the number one complaint about the current healthcare system, above inadequate service, malpractice, and accessibility.

According to Saad (2010), 3 in 10 Americans, put off or delay seeing a doctor for their health needs because of the cost. The extreme costs of healthcare is causing overall population health to suffer. When a consumer ignores a health issue because they cannot afford to go to the doctor, those issues often end up getting more serious and costing more for the consumer over time. Those enrolled in medicare or medicaid programs are the least likely consumers to put off or delay care. Because of this, it makes sense to test alternative payment models, such as value-based reimbursement, with the group of consumers who are most likely to use it, Medicaid consumers. With this in mind, it makes sense that ACOs were introduced in the Centers for Medicare and Medicaid Services Innovation as well as room for growth and development of other ideas (United States, 2010).

Piloting programs aimed at redesigning the healthcare industry creates an opportunity to collect and analyze data. This data becomes foundation each program is built from. Collected data gives us an inside look into how consumers, providers, and coordinators function within a system. For example, what do consumer-physician relationships look like? In a coordinated care

structure, it is a partnership where consumer and physician can work as a team, along with nurses, physician assistants, pharmacists, and other healthcare providers, to manage medical problems and prevent new ones from forming (Veatch, 1991). The goal is to pilot this idea and collect data to prove that this kind of relationship is possible in a new value-based system where achieving and maintaining good health is significantly less expensive than correcting or managing poor health. Popular data collection methods include surveys, questionnaires, interviews, and focus groups.

Value-Based Reimbursement

In 2005, a group of healthcare providers, calling themselves the Physician Group Practice Demonstration, combined services creating a style of "shared saving", the early phases of what would develop into the emerging value-based system we are looking at today (Kautter et al., 2012). In this early system, providers still received fee-for-service payments but also received bonus payments if their efforts to improve care coordination lowered overall health spending and improved performance. Medicare built upon this framework and, in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, formed the Medicare Healthcare Quality Demonstration. This five year demonstration focused on examining "health delivery factors that encourage the delivery of improved quality in patient care" (United States, 2003).

Value-based reimbursement, is a financial structure designed to provide payment to healthcare providers and collaborators based on the quality of the care provided as opposed to the quantity like in a fee-for-service system. Providers gain rewards for being effective healthcare professionals and for improving efficiency and innovation in the field. The overall goal of this value-based care model is three-fold; better care for individuals, reduced healthcare

costs, and improved population health management strategies (Porter, 2010). Providers from all areas of the industry, including primary care physicians, surgeons, pharmacists, and mental health professionals, would need to come together to treat consumer health needs. Payment for any services provided is dependent on the quality of healthcare as opposed to the quantity of services.

A value-based system benefits all stakeholders of the healthcare industry such as providers, consumers, and insurance companies. A 2017 survey from the Council of Accountable Physician Practices (CAPP) found that consumers believe consumer-provider relationships are the single most important factor in quality care (Gomez, 2017). A focus on quality care would enhance the provider-consumer relationship to meet this standard. Provider quality is another area that benefits from this value-based system. In a value-based world, providers are able to have engaging and meaningful interactions with consumers, which allows them to administer the best possible services (Heath, 2017). Providers are given the time and resources to be proactive with consumers, preventing healthcare issues in the future as well as finding innovative ways to treat chronic conditions more efficiently (McClellan et al., 2017). Rather than healthcare costs rising, leaving improvements in care as a casualty of the system, payment is issued with quality of care as the standard. How health data is analyzed also plays a role in the care providers improved experience. In a value-based care system, data is analyzed across a care providers entire organization as opposed to getting trapped in siloed archives of information, never to be found or utilized again. This information is critical in identifying specific health risks and providing validity to the organization's overall operations ("How Value-Based", 2019).

The value-based reimbursement model puts consumers at the center of the healthcare experience. They are able to build stronger relationships with their care providers, gain transparency of price and quality information that healthcare organizations were previously not required to provide, and have a better care experience when considering time, money, and quality of care ("How Value-Based", 2019). All of this gives the consumer more control over their care, better care overall, and a more positive experience in the healthcare system. Consumer outcomes and quality of care are the standards by which all other factors stem. Value-based care focuses on consumer outcomes and improved quality of care through specific measures, such as reducing hospital readmissions and improving preventative care. In order to measure consumer outcomes, reporting criteria and methods needs to be clearly defined across the industry.

National Reporting and Criteria

The United States has reached a stage in the transformation of the healthcare industry where a national reporting system is necessary. The value-based reimbursement system further supported by an accountable care organization model of healthcare delivery, is a strong platform to begin moving in that direction (Fisher & Shortell, 2010; McGlynn et al., 2003).

> To create a national healthcare system that provides efficient, effective care of a consistently high quality to all Americans, regardless of their geographic location, a standardized system of evidence-based performance measurement and reporting must be established, applying the principles of quality improvement to the American healthcare system. (National Quality Forum, 2018, para. 2)

The main challenge of creating this structure is addressing all six key areas of the healthcare system. Safety, effectiveness, consumer-centeredness, timeliness, efficiency, and equity are the top priorities for the quality reporting standards to measure (Institute of Medicine, 2001). Currently, much of the attention and hope for a system that works is directed at value-based reimbursement.

Moving forward, federal leadership is going to be essential in ensuring evaluation and performance measures meet all six of the defined criteria, with special consideration for the three that are currently most lacking, consumer-centeredness, efficiency, and equity (Institute of Medicine, 2006). This leadership will be critical in the coordination of the currently unstable healthcare system. The major challenges facing the success of performance measurement and reporting systems are identifying national goals that consider healthcare delivered differently in all areas of the country, and building capacity to accomplish these goals within a system that is focused on the consumer (Institute of Medicine, 2006). Without a national reporting system in place, value-based reimbursement and accountable care organizations could fail to build support, ultimately leaving the current healthcare industry broken.

Accountable Care Organizations are a newer healthcare delivery model, currently being piloted by the Centers for Medicare and Medicaid Services. ACO's are required to submit data to the United States Secretary of Health and Human Services, who uses the data to evaluate and ideally improve the quality of the care delivered through them (Burke, 2011). Accountable care organizations are a promising way to keep this value-based care system from failing due in part to the built-in evaluation and reporting processes across organizational boundaries.

Accountable Care Organizations

Though there are hundreds of proposed models to reform healthcare, there are only a few that have garnered national attention. The ACO or Accountable Care Organization model is one of them. This model could not only improve overall population health and the consumer care experience, but do so in a cost efficient way that allows all stakeholders in the healthcare industry to benefit (Pimperl, 2018; McClellan et al., 2010). The interest in this particular model has risen dramatically since the Affordable Care Act was passed in 2010 establishing a Center for Medicare and Medicaid Innovation, encouraging new pilot programs:

> There is created within the Centers for Medicare & Medicaid Services a Center for Medicare and Medicaid Innovation (in this section referred to as the 'CMI') to carry out the duties described in this section. The purpose of the CMI is to test innovative payment and service delivery models to reduce program expenditures under the applicable titles while preserving or enhancing the quality of care furnished to individuals under such titles. In selecting such models, the Secretary shall give preference to models that also improve the coordination, quality, and efficiency of health care services furnished to applicable individuals defined in paragraph (4)(A). (United States, 2010, p. 271)

This statute introduced the concept of an accountable care organization.Today, there are seven pilot programs encompassing hundreds of participating healthcare institutions. The United States Secretary of Health and Human Services supported the ACO model as a leading option in healthcare reform and launched pilot projects across the country to test their effectiveness. (Centers for Medicare, 2019).

An ACO is a group of doctors, hospitals and other health care providers who work together to coordinate your care. This group, is jointly responsible for providing quality, coordinated care to those their consumers. Ideally, ACOs will allow physicians, hospitals, and other clinicians and healthcare organizations to work more effectively together to both improve quality and decrease spending (Fisher & Shortell, 2010). Figure 1 gives a clear picture of the progress the healthcare industry can make through the adoption of accountable care organizations and coordinated care. The current healthcare system is siloed and fragmented while the new system has stronger connections across organizational boundaries. The future system shows the possibility for smooth, connected, cohesive healthcare should the industry continue moving in the direction of holistic, quality, valued focused healthcare.

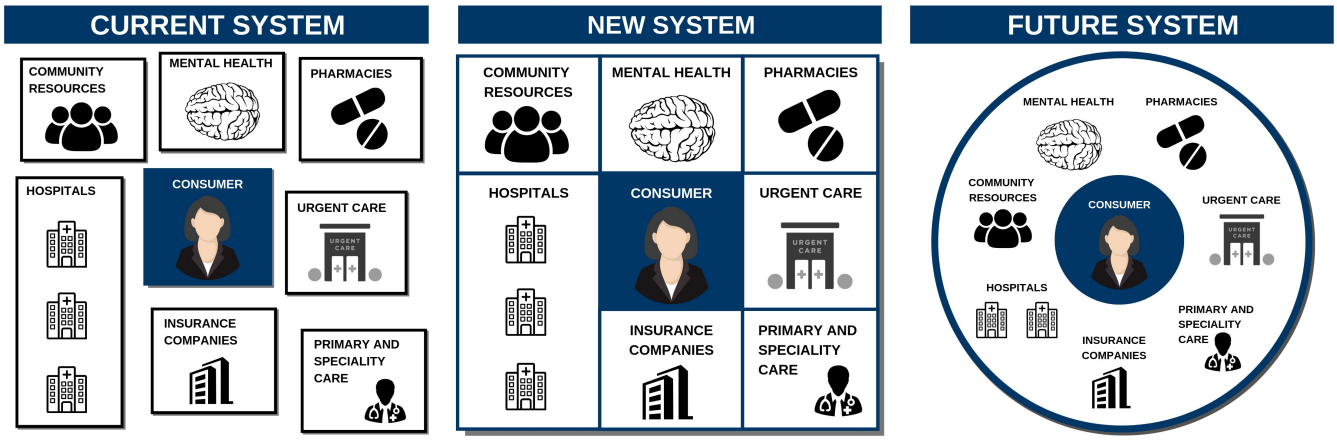

Figure 1. The progression of the United States healthcare industry.

ACOs are designed for smooth communication that can be implemented across systems, including fee-for-service system and value-based reimbursement. Regardless of the payment

style, ACOs follow the same basic principles (Tara, 2014). First, they must be provider-led organizations with strong ties to primary care and other critical physician relationships. This principle simply requires an organization to be established in their community. Second, these costs and related payments are dependent on improvements in care procedures resulting in overall lower expenditures. This principle enforces the responsibility for not only quality, coordinated consumer health outcomes, but also for the associated costs across a continuum of care for the ACOs population of consumers. Third, all improvements in care are evaluated through performance measures that meet best practices by constantly changing to ensure reduced costs are primarily the results of innovation and efficiency in care and not impeding outside factors (McClellan et al., 2010; Pimperl, 2018). If there is a drop in the number of readmissions ACOs want that data to get credited to improved care techniques. Accurate data and evaluation is key in determining the future of healthcare and more specifically of the accountable care organization model. According to the National Association of ACOs, over 20% of all people receiving services through Medicare are currently being served by an accountable care organization (Holder, 2018).

ACOs engage large populations of consumers in shared decision making regarding their diagnoses, therapies, and other healthcare choices, as well as ensuring consumers have the right information at the right time during their care (Berwick, 2011). These interactions will ideally improve the overall experience for consumers who are often left with questions and no sufficient platform to ask them. It is also common for consumers to get lost in the shift from one service or physician to another. Accountable care organization models, specifically ones that employ a coordinated care method, aim to eliminate this consumer burden resulting in more accurate and

frequent communication from physician to physician, physician to consumer, healthcare center to healthcare center, and so on.

ACOs have the ability to provide and manage, with consumers, the continuum of care across different institutional settings. From one healthcare provider to another, from building to building, healthcare can remain consistent and smooth (Pimperl, 2018; Shortell et al., 2015). ACOs also have strong administrative capacity in regard to budgets and resource allocation. Because of the increased size of an organization when it becomes part of an ACO, there is access to more resources, allowing for stronger planning and implementation of projects, processes, and procedures. ACOs also have the have the financial capacity to support comprehensive performance measurement data. This is achieved through through more dedicated staff time or contracts with outside resources (McClellan et al., 2010).

According to Health Affairs, a leading journal of health policy, initial results from pilot programs across the country show improvements in just the first year or two. The journal has tracked the growth of accountable care organizations from their inception. At the end of the first quarter in 2018, they were tracking around 1,000 ACOs serving over 32 million consumers. Health Affairs report that the overall number of ACOs and ACO contacts has continued to grow annually since the initial pilot in 2012 (Muhlestein et al., 2018). Consumers who are served by an ACO report improvements in access to care and care coordination where consumers who are served by other plans did not. However, both groups reported equal satisfaction in other areas such as interactions with physicians and physician ratings (Mcwilliams et al., 2014). Preliminary results have shown a greater shared savings and higher consumer and physician satisfaction from

ACOs with more years of experience in using the model (Pierce-Wrobel & Micklos, 2018). This trend is attributed to a focus on innovation and efficiency.

Many of these improvements are connected to the wider spread use of coordinated care. Within an ACO, coordinated care allows consumers health needs to be communicated to a physician sooner in the care process, resulting in a safer and more effective care, and a better experience for the consumer. The Institute of Medicine describes coordinated care as a key strategy to improving effectiveness, safety, and efficiency in the healthcare industry, areas that are currently lacking in our fee-for-service landscape (Craig, Eby, & Whittington, 2011). Coordinated care can improve outcomes for consumers, providers, and payers (Care Coordination, 2015).

Without specific coordinated care plans and procedures in place at every healthcare organization, the industry easily falls back into a fragmented, siloed system (McClellan et al., 2010). Accountable care organizations are attempting to improve coordination from one care provider to another. Success for ACOs and other models of healthcare reform are hinged on their ability to build partnerships with other healthcare organizations and providers. Unfortunately, there is little information yet on how effectively or to what extent ACOs are developing these crucial partnerships (Lewis et al., 2017). Massachusetts is a strong example of how ACOs can coordinate care with an ACO as well as with the local community.

MassHealth - ACO Pilot Program

MassHealth, Massachusetts Medicaid program serves approximately 1.2 million of the 1.8 million total MassHealth members. There are two types of ACO plans available to eligible

members, the Accountable Care Partnership Plan and the Primary Care ACO Plan. The following information on each plan was gathered from the MassHealth website.

Accountable care partnership plan. An Accountable Care Partnership Plan is an ACO partnered with a single managed care organization(MCO) to create a full network that includes primary care physicians, specialists, behavioral health providers, and hospitals. This partner MCO, usually associated with an insurer, handles the financial and administrative tasks such as assembling a network of providers and paying for services. This type of plan involves a capitation fee which is a fix monthly amount per member used to manage their total cost of care, and as incentives to meet quality standards (Seifert & Love, 2018). Thirteen of the 17 ACOs in Massachusetts MassHealth ACO Pilot Program fall under the Accountable Care Partnership Plan style of ACO.

Primary care ACOs. Primary Care ACOs contract with different stakeholders such as MassHealth itself or multiple MCOs at a time for network and administrative functions. Primary Care ACOs use the MassHealth statewide provider network for their consumer care options and receive fee-for-service payments from MassHealth or an MCO. These payments get measured against an annual cost target and the Primary Care ACOs share in those savings or losses. Because fee-for-service is not based on value, this style of plan also has added incentives to meet quality standards.

Both of these plans have the option of risk-adjusted payments. This means ACOs receive larger payments if they have members have greater care needs. This risk-adjustment style of payment helps mitigate ACOs from limiting care and/or avoiding members with greater or more specialized needs, factoring in social determinants of health, for the purpose of having stronger

reported health outcomes (Seifert & Love, 2018). Because of the willingness of Massachusetts to pilot a new style healthcare delivery and reporting system, the state will have a strong basis to build their healthcare infrastructure from in the future. Massachusetts has put a significant focus on the restructuring of their healthcare systems. This has created stronger relationships with some areas of the community but more tense relationships with others.

Community Partners

Currently, much of the ACO environment is unstable, similar to musical chairs. Who an ACO chooses to align with can make or break community organizations ability to get clients in their doors. The consolidation of organizations to expand capacity and build financial life jackets is a major trend in the industry today. The bigger and more efficient you are, the more attention you get therefor there are more opportunities available for your organization to join an ACO as a key public health agency or community partner (Costich, Scutchfield, & Ingram, 2015). The goal of value based reimbursement and ACOs is to improve safety, effectiveness, consumer-centeredness, timeliness, efficiency, and equity while focusing on the whole person, creating a holistic healthcare industry. Community partners help meet the needs of the whole person.

Behavioral health (BH) and long-term services and supports (LTSS) community partners are community-based affiliates that work with MassHealth ACOs and MCOs to provide coordinated care to members with extraordinary needs. Behavioral health community partners provide supports for significant behavioral health needs, including serious mental illness and addiction. Long-term services and supports community partners provide services for complex

LTSS needs, such as children and adults with physical and developmental disabilities and brain injuries.

Community partners are able to supplement services, provided by ACOs and MCOs, for consumers. This attracts community attention and helps community partners build relationships. Because community partners are not contracted members of ACOs they are able to provide services as a partner with multiple ACOs and/or MCOs at a time. This means more financial opportunity and allows community partners to remain competitive in the industry and in their communities. When the program is fully implemented, MassHealth predicts that community partners will help to support between 55,000 and 60,000 MassHealth members.

Opponent and Proponent Arguments

Opponent arguments. In his 2018 article "What is the Perfect Fee-for-Service System?", Matthew Hahn, MD argues that changing the fee-for-service model simply fills in some holes while digging others. There are advantages to a high volume, fee-for service style of healthcare. Though there are consumers that may only need one physical a year, there are also consumers that need frequent attention for complex or chronic health conditions. A high-volume system encourages physicians to provide that kind of care because more hours or more procedures means more money. Whether this is ethical or not, the outcome is the consumer gaining facetime with their care provider whenever they need it. The ability to easily make same-day appointments is a benefit to consumers that could disappear should the fee-for-service system be eliminated. Busy practices that fill up their daily appointments sometimes days or

weeks in advance have little incentive to fit in those same-day appointments. For consumers with chronic needs, this becomes a barrier to their care.

Hahn is not alone is arguing against value-based reimbursement and ACOs. Rita E. Numerof, Ph.D., is a strong believer that an ACOs have an unfair competitive advantage over the rest of the industry in its service area. Numerof (2011) argues that ACOs create a monopolization of the market, shutting out many existing programs and organizations, and eliminating the competitive factors that drive innovation. Independent practitioners and small to mid-sized practices can lack the infrastructure, technology, or other resources needed to succeed on their own. Moving forward, they may find themselves competing against similar practices that have either joined ACOs or been acquired by larger organizations, and are therefore under less pressure both monetarily and clinically, to improve efficiency and quality. Large systems like ACOs are then able to stake their hold on major portions of their markets, resulting in less competition and no need for coordinated communication, creating a system similar to the one we currently have.

According to Goldsmith (2009), in the 1990's, hospitals and physicians believed that the Clinton health reform strategy would force them into healthcare plans that allowed flat fee payments for each consumer it covers, also known as a capitated contract. This unrest created a similar environment as what we are seeing today with like-organizations merging to make themselves more desirable and cost effective. This happened in the 1990's out of a desire for control over the money stream in healthcare plans. Today, we are seeing it as a response to the value-based reimbursement trend and accountable care organizations. In the 1990's these

mergers were a terrible failure. Today, mergers are being implemented at a higher rate than in the last 20 years (RevCycle Intelligence, 2018).

Proponent arguments. ACOs have an uphill battle to fight to achieve their main objectives of high-quality, low costs, and improved overall population health. However, according to Timothy Vogus and Sara Singer (2016) in their article "Creating Highly Reliable Accountable Care Organizations*"* it is possible for ACO's to provide care in "a nearly error-free manner". To do this, ACOs need to mimic highly reliable organizations (HROs). HROs are organizations characterized by their ability to manage complex, fast paced environments while maintaining steady reliability over long periods of time. For example, aircraft carrier flight decks and nuclear power control rooms. By studying these HRO practices, regulations, policies, and standards, ACOs could better inform their practices and support the development and implementation of a new kind of healthcare. If our society can develop structures that support some of the most efficient and streamlined functions in the world, why can't we accomplish the same for our national health? Vogus and Singer believe that healthcare should be taken as seriously as our national safety. Taking a highly privatized industry like healthcare and attempting to make it public and accessible is no small feat. Vogas and Singer argue that ACOs can be the change the healthcare industry needs, as long as the implementation and development is approached with the care and attention the industry deserves.

ACOs improve the healthcare industry through health information technology (IT) and health information exchange (HIE), shared responsibility, and consumer safety (Bates, 2015). ACOs are able to promote efficient IT and HIE which allows providers to communicate with other organizations and physicians with ease, improving the overall care coordination for

consumers (Dullabh, Hovey, & Ubri, 2015). Additionally, one agency or organization is never solely responsible for the fees accrued by the whole system. Shared risk means shared responsibility among ACO participants to be as efficient as possible and to provide high quality care to consumers throughout their entire care journey. Joining with other providers means more eyes and ears, more knowledge, and better population health control leading to better care for the consumer and more stability and confidence for the providers. In addition to consumers receiving better overall care, they also have access to more choices, greater benefits, and far improved accuracy of diagnoses from their providers and healthcare plans (Bates, 2015).

A key part of garnering cost savings is through reducing emergency room visits and hospital admissions by way of preventive care. Accountable care organizations are set up to encourage just that. There have been questions about the reality of accountable care organizations because of initial reports failing to show much cost savings. However, according to Ted Schwab, Managing Director at Huron Healthcare, immediate critics have overlooked that this ACO movement has been an organizing force throughout the healthcare industry and, for the first time, has hospitals, doctors, pharmacists, and so many more care providers under the same umbrella, in the same space. In a 2015 interview Schwab said:

> If you think about where the industry has been for the last hundred years, it's been a mom-and-pop fragmented industry. Now you have hundreds of organizations with folks at least talking to each other. It's going to take a while. We're at the very beginning of this movement but I could not be any more encouraged. (Gruessner, 2015, Interview section, para. 1)

Hospitals, doctors, pharmacists, and many other healthcare professionals are finally talking about efficiencies, clinical protocols, and ways to save costs like they never have before.

Conclusion

The United States has leaned over the edge of a major healthcare reform. The road to an affordable, high quality, value-focused healthcare industry is long. However, through the adoption of value-based payments to accountable care organizations applying a coordinated method of care, the United States healthcare system has begun to collect data and see positive results in the piloting of new programs. With stronger communication, coordination, information exchange, and capacity, the accountable care organization model of healthcare is shaking up the industry and pushing us in the direction of an innovative, affordable healthcare system that better serves consumers. The mold is not one-size-fits-all, and there are many obstacles to overcome, such as evaluation and reporting methods, market monopolization, and taking this method from medicare to standard healthcare plans. However, the initial results from ACO pilot programs across the country paint a promising picture of the future of the United States healthcare industry.

Recommendations

Short Term Recommendations

ACO coalition meetings. A systemic change as disruptive as healthcare reform can cause friction across industries. Organizational and industry change often induce a panic, pushing those involved in the change, such as employees or consumers, to put their guard up to

protect themselves. A common reaction to change is to retreat, siloing your work and rejecting collaboration and communication. This, combined with the threat of accountable care organizations cornering the market, creates a competitive atmosphere, leading us right back into fragmented, expensive healthcare. Creating ACO Coalitions with the goal of gathering key figures from multiple ACOs together, could help to combat this tense, sometimes aggressive atmosphere. These coalitions have the flexibility to be grouped by size, geographic location, or style of ACO, and would help foster camaraderie and support form one organization to another. Having a structured platform to work through the struggles of implementing a new healthcare model with others who are experiencing similar obstacles would not only support continued growth but would also improve care delivery, innovation, and transparency for consumers, physicians, and employees. Care delivery, innovation, and transparency are cornerstones of a value and quality focused healthcare model. Additionally, an ACO Coalition is an ideal space to work on developing solutions to industry-wide goals such as a uniform evaluation and reporting process. Furthermore, an ACO Coalition meeting would create an opportunity for representation by the federal government to be available to the healthcare community participating in the programs the Centers for Medicare and Medicaid Services Innovation created. This representative(s) would be able to answer questions and gain information about how the trial phases of the CMS ACO models are developing.

Pilot programs for specialized services. Using MassHealth Community Partners as an example, community organizations are able to provide specialized services, such as behavioral health or long-term services and supports. However, these organizations run the risk of being overlooked or underutilized in their service areas. Community organizations need the

opportunity to run pilot programs, demonstrating their capacity to function as community partners. These pilot programs give the healthcare community a clear picture of their resources. Community partners will be able to collect data to supports their programs and services, not only helping to combat the ACO power shift, but also making them more competitive in grant applications and other funding processes outside of the ACO arena. This would respond to one of the most common complaints about the accountable care model, the fear of ACOs cornering the market and controlling the industry, leaving many community resources out of luck. It is important to utilize existing resources whenever possible to prevent unnecessary duplication of services, save money, and stimulate communities.

Long Term Recommendations

Non-clinical inclusion. Accountable care organizations and value-based reimbursement puts a strong emphasis on holistic and preventive healthcare techniques. In a value-based system or in an accountable care organization, the stream of information and communication is built to be more efficient across a continuum of consumer care activities. This means consumers spend less time on unnecessary services and more time with their doctor focusing on holistic, preventive approaches to their health. With this in mind, it seems like an oversight to disclude basic preventive health businesses and organizations in accountable care organizations.

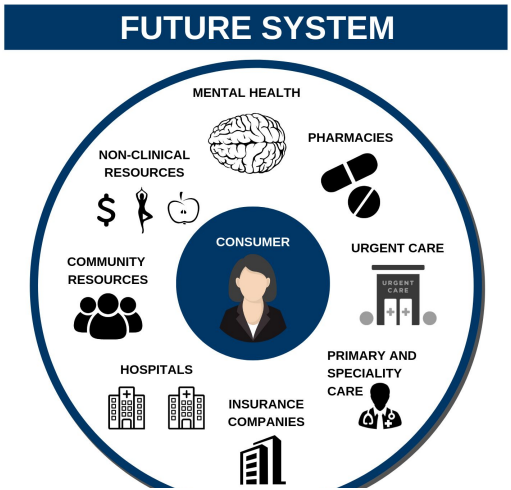

Figure 2. The potential for non-clinical inclusion in future versions of accountable care organizations.

For example, gyms, yoga or pilates studios, financial counselors, and nutrition coaches would validate accountable care organizations focus on preventive healthcare while emphasizing all of the social determinants of health. Your health would be in your control, with referrals and class or admission fees included in or supplemented by your healthcare plan. If the focus of this new system is on holistic health, then these additions would provide an easy and affordable pathway to strong overall population health and community engagement activities.

Accountable care community centers. Once non-clinical businesses and organizations have been included in accountable care organizations or simply within the overarching value-based reimbursement model, the next logical step would be to put these options under one roof. This idea is similar to a community center for an ACO. Having your gym, yoga or pilates studio, nutrition coach, financial counselor, or other non-clinical healthcare options in once space along with a drop-in clinic for your non-emergency healthcare needs would make healthcare easy to access and the system simpler to maneuver through. Having these resources in one space, coordinated communication across your healthcare organization, and your providers focused on

quality and value would make healthcare for the whole person possible. This idea is similar to health collaboratives but with non-clinical inclusion. A health collaborative is a group of providers that work together to provide the integrated care to their clients. Though there are hundreds of health collaboratives across the country, a small percentage of them included both clinical and non-clinical partners to serve population health in the way an accountable care organization could do with the same model. This offers the opportunity for more partnerships across industries. Eventually, to achieve holistic population health, the healthcare industry will need to partner with other industries. Over time the lines between these industries will blur and healthcare will mean something much larger and more encompassing than it does today. What it all comes down to is utilizing our resources to create the healthiest people possible in the most efficient, logical, and affordable way. Changing healthcare demands innovative, affordable adaptations to better serve consumers.

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