Providing high-quality patient care while controlling medical costs is the holy grail of healthcare. For more than two decades, HealthCare Partners (HCP), a physician-led healthcare delivery organization with staff-model medical groups and independent practice associations (IPAs) in California, Nevada, and Florida, has embraced that goal through a commitment to both clinical excellence and coordination of patient care. HCP has been highly engaged in the national dialogue on accountable care, and was recently selected to participate in the Pioneer Accountable Care Organization (ACO) Program, an initiative of the Centers for Medicare & Medicaid Services (CMS).

HCP believes the ACO model, which focuses on care coordination across providers and healthcare settings, is a compelling approach. “In the fee-for-service world, care is often fragmented and utilizes resources unnecessarily,” said Jamie Phillips, HCP’s Vice President of Regional Operations. “This adds confusion to the whole patient experience. We believe applying coordinated care principles to the Medicare fee-for-service population leads to better care for the patient. That is essentially what we have been doing with our Medicare Advantage population for many years.”

The Pioneer ACO Model

An ACO consists of medical groups, hospitals, long-term care facilities, and other providers and suppliers that have banded together to coordinate care for the patients they serve. The Patient Protection and Affordable Care Act (PPACA) contains provisions for an ACO initiative centered on Medicare fee-for-service (FFS) beneficiaries; this has led to the development of the Shared Savings Program, the Advanced Payment ACO Model, and the Pioneer ACO Model (see Table 1, page 34), which are all administered by the Center for Medicare & Medicaid Innovation (CMI).
Like the other ACO initiatives administered by CMI, the Pioneer ACO Model aims to test payment arrangements that lead to improved care, reduced waste, and cost-savings to Medicare. In contrast to the Shared Savings Program, however, the Pioneer ACO Model was designed specifically for high-performing health systems with proven skills in coordinating care across multiple treatment settings and managing patients with complex medical needs. Although the Pioneer ACO Model is associated with a higher degree of risk for the participating organizations, the savings potential is also greater. Additionally, it allows providers to move relatively quickly from a shared savings to a population-based payment model.

That approach was attractive to HCP. “We wanted to rapidly, rather than gradually, get to a sharing of risk and being accountable for the population,” said Phillips. “The shared savings version didn’t allow us to get there as aggressively as we wanted.”

Applicant ACOs were permitted to choose among five payment options, including a 50, 60, or 70 percent shared savings model in year one and a 60, 70, or 75 percent shared savings model in year two. ACOs that have met the minimum criteria for savings in years one and two will transition to a partial or full population-based payment model in year three. If an ACO is successful, program participation may be extended for two additional years using the year three payment model. The quality of care provided by the ACOs will be evaluated using 33 performance measures; organizations that do not meet specific quality benchmarks will be ineligible to share in the generated savings. Each Pioneer ACO aims to include at least 15,000 Medicare FFS beneficiaries (5,000 in the case of rural ACOs). Thirty-two organizations were selected to participate in the Pioneer ACO Model, which began in January 2012.

The HCP Pioneer ACO
The HCP Pioneer ACO in California currently includes 30,000 Medicare FFS beneficiaries. Two-thirds of the beneficiaries are seen by HCP IPAs. The initial subset of participating IPA providers includes 685 primary care providers and 153 specialists. The HCP staff-model medical group, which employs 700 physicians practicing out of 60 clinics and offices, sees the remaining third of the Pioneer patients. The HCP groups in Florida and Nevada were also selected as Pioneer ACOs and have separate agreements with CMI; those ACOs include 12,000 and 21,000 Medicare FFS beneficiaries, respectively.

A HCP steering committee provides policies and guidance to the Pioneer ACO. Separate working teams coordinate patient messaging, provider engagement, medical management, meaningful use of electronic health records (a required component of Medicare ACOs), and other tasks. Most teams were already part of HCP’s operating structure, and it is anticipated that they will be able to incrementally absorb much of the work related to the Pioneer ACO patients.

In this first year of the Pioneer program, HCP is focusing on provider and patient engagement and adding program resources where needed. Recruiting IPA providers to participate in the ACO took place through a focused effort that was made easier by the fact that many were already taking advantage of HCP’s existing clinical programs and patient management tools. The participating IPA and group physicians believe the program to be an important step to improve Medicare FFS measures, reduce waste, and slow the cost trend.

Meeting year one patient engagement goals was challenging, since identifying and contacting eligible patients was a multi-step process. Once HCP identified participating providers in early 2012, CMI had to analyze the utilization records of the associated patients and apply algorithms to align patients and providers. Accurate attribution of a patient to a given primary care provider is critical, since it identifies who is responsible for coordinating the patient’s care and affects provider-specific reports on performance measures. CMI also requires the ACOs to use specific protocols and materials to inform patients about the program and offer them the opportunity to opt out of sharing their health information with the ACO. On the whole, beneficiary response has been positive, and HCP anticipates that the ACO population will grow as the program moves forward.

In the ACO model, access to care is “without walls.” Medicare FFS beneficiaries remain free to see any provider they wish, whether or not that provider is part of the ACO. Thus, ACOs have a strong incentive to keep patients engaged with their organization and satisfied with their providers in order to manage their care and control costs. Meeting patient needs will therefore be critical to an ACO’s
HealthCare Partners’ Care Coordination Model

**Episodes of Care**

**CARE MANAGEMENT**
- Home Care Programs
- High-Risk Clinics
- CHF Program
- COPD Program
- Ambulatory Care Mgt.
- Diabetes Program (Registry)
- CKD
- CAD

**PAY-FOR-PERFORMANCE**
- Clinical Metrics
- Patient Satisfaction
- IT Functionality
- Efficiency Measures

**Star and ACO**

**Information Technology and Systems**
- Medical Informatics
- Physician Information Portal (point of care)
- POP-Patient Online Portal
- Data Warehouse
- EMR
- Business Systems
- Transparency of Reporting

**Ambulatory Care Sites**

**Hospitals and SNFs**

**UM**
- Management of Inpatient Bed Days
- Transplant
- Out of Area
- ER
- Referrals (HCP Connect)

**Clinicians**

**Patient**

**Patient**

**Patient**
In the fee-for-service world, care is often fragmented and utilizes resources unnecessarily. This adds confusion to the whole patient experience. We believe applying coordinated care principles to the Medicare fee-for-service population leads to better care for the patient. That is essentially what we have been doing with our Medicare Advantage population for many years.”

–Jamie Phillips, Vice President of Regional Operations, HealthCare Partners

Tools and Tactics
HCP has a track record of effectively and efficiently managing patient care, one of the characteristics that made it eligible to be a Pioneer ACO. For example, among Medicare beneficiaries, HCP’s rate of hospital admissions is about a third lower than the national average and its 2010 30-day readmission rate was 13.9 percent in California, 14.0 percent in Nevada, and 14.8 percent in Florida, compared to a national average of 19.6 percent. Several strategies and tools have been critical to reducing these high-cost events and will be utilized to coordinate the care of Pioneer ACO patients and promote higher patient and family member satisfaction.

On the technology side, a comprehensive data warehouse aggregates administrative, financial, and clinical data for multiple uses, including identification and stratification of high-risk and high-cost patients. The Physician Information Portal, a secure Web-based platform, is a point-of-care tool for sharing patient medical history, medications, allergies, lab results, procedures, vital signs, and referrals among HCP providers caring for the patient. Providers can view outstanding action items and track the patient’s encounters throughout the health system. The portal also contains performance metrics aggregated at the regional, office, and provider levels, allowing a provider to track and compare his or her own performance on measures of quality and care coordination. A clinical decision-support platform is being developed that will systematize clinical guidelines for ready access and permit HCP providers to monitor related referral practices. Finally, a patient portal is available to medical group patients for scheduling appointments, viewing lab results, requesting prescription refills, and sending secure messages to their providers. This tool will be rolled out to IPA patients in year two of the ACO performance period.

Population health management lies at the heart of accountable care. Existing strategies at HCP include disease management (DM) programs for costly conditions: diabetes, congestive heart failure, coronary artery disease, asthma, and chronic obstructive pulmonary disease (COPD). The DM care teams manage symptoms; provide care coordination, follow-up, and education; and monitor patients and expedite access to care after hospitalizations. These programs can have a significant impact. In a one-year evaluation of a patient-centered, COPD management program that included training in self-management skills, nurse telephonic outreach, and an action plan for symptom exacerbation, HCP observed a 34 percent reduction in costs and a 46 percent ROI.

Additional services are provided to high-risk patients to better coordinate care across multiple providers and foster treatment adherence and self-management skills. HCP recently opened five comprehensive care centers in which multidisciplinary teams stabilize and manage high-risk patients. It also has a home-visit program for seniors. Both strategies help prevent unnecessary hospitalizations.

A long-standing commitment to evidence-based inpatient care has been another important cost-containment strategy. HCP directly employs hospitalists, who provide clinical services to hospitalized patients, keep PCPs abreast of patient status, and strive to reduce unnecessary utilization. To prevent readmissions, they meet with PCPs and skilled nursing facility physicians to develop comprehensive post-discharge care plans. Given HCP’s successes to date in managing population health among Medicare Advantage Plan enrollees, it anticipates achieving its Pioneer program success. Specific patient interventions will bring to life the benefits of the ACO’s enhanced care coordination. In addition to physician letters and front office education, HCP plans to use videos and social media to inform and engage patients. Patient satisfaction surveys are included in the Pioneer ACO performance measures and, along with retention rates, are part of HCP’s data-driven clinical model.
### Key Features of the Pioneer ACO Program

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<thead>
<tr>
<th>Length of agreement</th>
<th>Three years, with possible extensions to fourth and fifth years</th>
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<tbody>
<tr>
<td>Medicare fee-for-service beneficiaries</td>
<td>15,000 beneficiaries minimum (5,000 for rural ACOs). Beneficiaries are prospectively identified and aligned with a PCP. New beneficiaries have 30 days at the start of the year to opt out of healthcare data sharing. CMS provides historical claims data to aid in risk management and care planning.</td>
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<td>Alignment with provider</td>
<td>Both MD and non-MD PCPs are allowed; alignment with certain specialists is allowed if less than 10 percent of the beneficiary's care is from a PCP.</td>
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<td>Health information technology</td>
<td>ACO must show meaningful use of electronic health records by 50 percent of PCPs by the start of year two.</td>
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<td>Performance-based contracts</td>
<td>ACO must enter into performance-based contracts with other payors, such as insurers and employer health plans. More than 50 percent of the ACO's revenues must be derived from such payment arrangements by the end of year two.</td>
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<tr>
<td>Performance metrics</td>
<td>Quality scores are based on 33 measures in four domains: patient experience (CAHPS), care coordination/patient safety, preventive health, and at-risk population.</td>
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<td>Payment model</td>
<td>ACOs choose from among five payment options that include:</td>
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<td><strong>Year one:</strong> One-sided or two-sided risk; shared savings/losses of 50-70 percent, depending on option</td>
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<td><strong>Year two:</strong> Two-sided risk; shared savings/losses of 60-75 percent, depending on option</td>
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<td></td>
<td><strong>Year three:</strong> Population-based payment of 50 percent of expected Part A and B revenue or 100 percent of expected Part B revenue (plus shared risk for remaining care not covered by the population-based payment) or 100 percent of expected Part A and B revenue, depending on option</td>
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<td></td>
<td>For all options, minimum savings rate requirements and sharing and loss caps apply. Quality scores affect payment eligibility and amounts.</td>
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**Sources:**
Meeting Challenges

The IPAs are critical to HCP’s Pioneer ACO. Much of the company’s efforts in managing the ACO will center on supporting the IPA providers and patients with the more robust tools and infrastructure commonly used on the medical group side. The Physician Information Portal will be expanded to include FFS beneficiaries and give IPA providers access to additional layers of clinical and performance data. Gaining access to third-party laboratory data, which is needed in order to have a complete clinical picture of IPA patients, presents difficult technical issues that need to be solved.

Although HCP’s hospitalists take care of medical group FFS patients, the practice is less prevalent on the IPA side. Many IPA providers see their own patients in the hospital, and encouraging the use of HCP’s hospitalists and discharge teams will require further dialogue with the IPA providers. IPA leadership and collaboration has been important during year one of the Pioneer ACO and will be even more so during years two and three.

The ACO model gives HCP responsibility for coordinating the care of FFS patients, who are free to go outside the ACO. Thus, one of its biggest challenges is to make the patient experience so extraordinary that patients do not want to go anywhere else. Straightforward steps, such as having someone who sets up appointments as part of post-discharge planning, can create patient satisfaction, and the IPA physicians also see this as a value-added service. HCP will be looking at a number of proactive strategies for keeping FFS patients satisfied with their patient experience and engaged with the organization.

Moving Forward

As a healthcare delivery organization that embraces care coordination principles and is participating in the accountable care model, HCP recognizes that there are several organizational components that increase the likelihood of success:

- The commitment and infrastructure needed to improve the quality and coordination of patient care grows out of strong physician leadership and a culture that supports clinical excellence.
- Improving the management of population health is data driven, and requires an appropriate investment in technology infrastructure.
- The ACO model requires thinking beyond the walls of the organization and finding new ways to engage stakeholders, providers, vendors, and patients.
- The organization has to be in it for the long haul. These programs take time and investment and may not show an immediate return.

The Pioneer ACO model is consistent with HCPs’ longstanding mission to be the role model for integrated and coordinated care and to lead the transformation of the national healthcare delivery system to assure quality, access, and affordable care for all. The multilayered and collaborative strategies of accountable care require rethinking and retooling current approaches, but the model may prove to be a major step forward in improving the quality, experience, and affordability of healthcare.

References