

Diabetes and Accountable Care Organizations: An Accountable Care Approach to Diabetes Management

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The need for health care delivery and payment reform in the United States is quite apparent, as evidenced by the fact that health care costs and expenditures continue to rise while the overall health of the population continues to decline. Rising expenditures can be partially attributed to the increasing prevalence of chronic disease. U.S. health care spending exceeded \$2.5 trillion in 2009.¹ An estimated 75% of these expenditures were associated with the treatment of chronic disease.² Almost two-thirds of the growth in spending has been linked to Americans' worsening health habits, particularly the epidemic rise in obesity.³

Obesity is a risk factor for the development of a number of chronic conditions, including diabetes. More than 25.8 million people living in the United States have diabetes, including an estimated 7 million who are undiagnosed.⁴ The yearly direct cost of diabetes care has been estimated to be \$116 billion, plus an additional \$58 billion for indirect costs, including disability, work loss, and premature mortality.⁴

Currently, the U.S. health care system is structured to pay for the treatment of chronic conditions like diabetes rather than for the prevention of these diseases.³ Improved health and cost savings will not be achieved unless incidence rates of chronic disease and associated comorbidities are reduced. New comprehensive models of care that

engage patients in health promotion and disease prevention must be implemented to improve the health of the U.S. population and reduce health care costs.

The accountable care organization (ACO) concept is being promoted as a means to slow the growth of health care spending while improving quality of care. The overall managed care concept has been re-introduced by Elliott Fisher at the Dartmouth Institute for Health Policy and Clinical Practice and Mark McClellan of the Brookings Institute, who envision ACOs as an alternative care and payment methodology that will reward provider organizations for reducing Medicare spending growth in individual hospital service areas.⁵ Fisher and his colleagues are advocating ACOs as a means to realign payment incentives to better support health care providers and to meet the demonstrated need for greater integration and coordination within the health care delivery system. The implementation of ACOs could help shift the payment system from a focus on volume and intensity to a focus on value and performance.⁶

As part of the Affordable Care Act of 2010, the Centers for Medicare & Medicaid Services (CMS) is promoting experimental reimbursement and care models such as the ACO Shared Savings Program as a means to improve the quality of care for Medicare beneficiaries and reduce unnecessary costs. Although

formal guidelines for participation in the Shared Savings Program (expected to begin by 1 January 2012) have not been released, CMS is defining an ACO as "an organization of health care providers that agrees to be accountable for quality, cost, and overall care of Medicare beneficiaries who are enrolled in the traditional fee-for-service program who are assigned to it."⁷

Attributed beneficiaries are those for whom the professionals in the ACO provide the bulk of primary care services. However, beneficiaries will not be aware of their attribution and may continue to seek services from the providers of their choice, whether or not those providers are part of the ACO. This could limit the ACO's ability to control costs.

Organizations that may become ACOs include physicians and professionals in group practices or networks of practices; partnerships or joint venture arrangements between hospitals and physicians/professionals; and hospitals employing physicians/professionals. To participate in the Shared Savings Program, ACOs must have a sufficient number of primary care professionals to provide services for at least 5,000 beneficiaries and the ability to report data on cost and quality for Medicare fee-for-service beneficiaries. ACOs that participate in CMS Shared Savings Program and meet specified quality performance standards will be eligible to receive a share of any savings if the

actual per capita expenditures of their assigned Medicare beneficiaries are a sufficient percentage below their specified benchmark amount.⁷

Much debate has occurred over how ACOs should be defined and whether these arrangements can eliminate costs while improving quality of care. Proponents of ACOs argue that ACOs will assist “physicians, hospitals, and other clinicians and health care organizations to work more effectively together to both improve quality and slow spending growth”⁸ and that ACOs have “the potential to overcome the fragmentation and volume orientation of the fee-for-service system so that the right incentives are in place to foster health and wellness, instead of payment for treating illness.”⁹

Although it is apparent that the value proposition for health care delivery lies in improving health in relation to the cost of care delivered, it is unclear whether ACOs as defined by CMS will be able to achieve improved health or reduced costs. The CMS Shared Savings Program does not provide an evidence-based model for improving patient care, but does employ financial incentives that may encourage providers (based on the percentage of the physician reward) to work together to develop innovative ways to improve health outcomes for patients.

Critics argue that ACOs will cause cost-shifting, as hospitals will merge with other hospitals to avoid risk of loss, thus creating provider dominance that will raise costs in the private sector.¹⁰ ACOs will require collaboration between physicians and hospitals, a relationship that has been marked in the past by competition for control of lucrative services such as ambulatory surgery. Indeed, the track record for provider-led managed care efforts is poor; hundreds of hospitals and hospital-

physician organizations attempted to contract with insurers on the basis of capitation in the 1980s and 1990s and failed completely because of inadequate resources, weak governance, and inability to control the use of services and contain expenses.⁵

Stakeholders in the U.S. health care reform movement have agreed that health care transformation will require “improving population health, engaging patients in making decisions and managing their care, and improving safety and care coordination.”⁸ Although the CMS Shared Savings Program could lead to improvement in cost-effective health care delivery, little emphasis has been placed on formally engaging the patient in the production of health to reduce the consumption of health care services. This polarity was cogently articulated by Victor Fuchs more than 35 years ago in his classic book *Who Shall Live? Health, Economics, and Social Choice*.¹¹ The concept of patients’ production of their own health and their accountability for that health must be central to any discussions and policies related to health care reform.

We have taken such an approach through our South Dallas health initiative for an economically disadvantaged population through the Baylor Diabetes Health and Wellness Institute (DHWI), a joint partnership between the Baylor Health Care System and the City of Dallas Parks and Recreation Department. The DHWI is open to the community and encourages member involvement in the prevention, as well as the treatment, of diabetes. Members engage in education and exercise programs that teach participants how to develop and maintain healthy lifestyles.

DHWI programs teach skills related to the American Association of Diabetes Educators’ seven health care behaviors: Health Eating,

Being Active, Monitoring, Taking Medication, Problem Solving, Reducing Risks, and Healthy Coping.¹² Participating members have an assigned diabetes educator to accompany them on their journey toward good health. A multidisciplinary team provides care within the DHWI and works in concert with lay health care workers and community partners to create a coordinated approach to wellness for each member. We believe that this approach will lead to reduced illness episodes, with the financial benefit of fewer Emergency Department visits and hospitalizations. The DHWI is one of the Baylor Health Care System strategies as part of the accountable care movement that focuses on population management within neighborhoods as a segmentation tactic to better customize for individual patient needs. The Quality Health Care Alliance has mapped 10 strategies that are patient-centered, integrating care across providers with a heavy emphasis on clinical data systems that can track patients throughout the continuum of care as well as manage patient relationships. These strategies represent an important shift from the fee-for-service model to overall patient management, with the goal of achieving optimal cost-effectiveness given finite resources.

This nontraditional approach to care proactively seeks to engage patients in all aspects of care and in health promotion to improve their health. It is designed to reduce health care spending rather than simply shifting risk that is primarily financial from the existing reimbursement system to ACOs, the former being reminiscent of the per-member, per-month pricing models (i.e., capitation payment) that evolved during the era of increased

propagation of health maintenance organizations in the mid-1970s.

The value proposition for ACOs and the accountable care movement must emphasize promotion of health that will either prevent or mitigate the effects of chronic conditions such as diabetes. Patients need to be included in that equation for real benefits to be realized. Health care reform must include structures that include incentives for better patient health created by health care providers and patients themselves.

We think the DHWI and its engagement of patients with diabetes and patients at risk for developing the disease has greater applicability to overall chronic illness and is a great model that should be a component of the ACO and accountable care movement. Certainly, an important question to be answered is, "Who will do this important work?" The DHWI can be a model that emphasizes the required collaboration between expert centers and traditional care, and it can be a model that demonstrates how care is delivered in areas where primary

care is in short supply but demand is great.

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