

Can Accountable Care Organizations Improve Population Health? Should They Try?

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THE NUMBER OF ACCOUNTABLE CARE ORGANIZATIONS (ACOs) increased rapidly during 2012. There are now more than 250. This increase is likely to accelerate: commercial health insurers are signing ACO-like contracts with health care organizations, and the return of President Obama to the White House, as well as the Supreme Court ruling upholding the Affordable Care Act (ACA), have removed uncertainty about the Medicare ACO program. The goals for ACOs are well known: to control health care costs, to drive quality in health care, and to improve population health.

But what does improving population health mean? The word “population” is used only once in the much-cited section 3022 of the ACA, which created the Medicare Shared Savings ACO program: “[a shared savings program] . . . that promotes accountability for a patient population.” This sentence sets the tone for the meaning of population health as applied to ACOs—implying that it is the health of the Medicare beneficiaries attributed to a health care organization, not the health of all people living in an ACO’s geographic area. The final Centers for Medicare & Medicaid Services (CMS) rule for ACOs uses the phrase “population health” 15 times; although not formally defined, it appears to have the same meaning conveyed in the ACA.

Many ACOs appear to interpret their responsibility for population health in medical terms—that is, as a responsibility to provide preventive care for all their patients and care management for their patients with serious chronic diseases. This is a major step forward from the traditional model in medical care, which has been to focus on whatever patients appear in the physician’s office, while the patient is in the office. However, it falls far short of working to improve the health of the population in a geographic area.

Population health depends not only on medical care, but also on social services, the public health system, and, crucially, on socioeconomic factors (eg, housing, education, poverty, and nutrition). Being clear about what is meant by population health is crucial; attempts are being made in the United States to draw attention to population health and ways of measuring it within communities/geographic areas.¹⁻³

Talking about ACOs as if they are focusing on improving population health—as opposed to improving medical care for their populations of patients—leads to a lack of clarity about what ACOs are doing and about population health and may divert attention away from social and public health services and from socioeconomic factors critical to health. It would be unfortunate if ACOs, which have been conceived in idealistic terms, were to result in a narrowing and medicalization of the phrase “population health.”

Currently, ACOs lack the incentives and, in most cases, the capabilities to be responsible for population health defined as the health of everyone in their geographic area. ACOs will be challenged to improve medical care and to cooperate with social service organizations for their own population of patients. Many ACOs are small, and few if any have the expertise, authority, and incentives to act effectively in the areas of public health, social services, and socioeconomic determinants of health. The 33 CMS metrics for ACOs do not have a clear link to geographic population health. The patients “attributed” to an ACO generally represent a relatively small fraction of the people in a geographic area, and attribution may change from one ACO to another as often as annually. This gives ACOs little incentive to focus on the health of everyone in the communities in which they are located, or even on long-term determinants of health in the patients for whom they are accountable in the present.

Population health should be clearly defined, and not used loosely in relation to ACOs. When population health is clearly defined, it becomes possible to think more specifically about what needs to be done to improve it, whether and how ACOs can help, the types of organizations with which ACOs will need to cooperate, and the incentives that ACOs—and other organizations—will need to improve the health of the population in their geographic area.

Recently, experts have begun suggesting that ACOs should cooperate with other organizations in improving the health of the entire population in their geographic area.⁴ A report from University of California, Los Angeles Public Health argues that the health care system version 1.0 focuses on acute reactive medical care; version 2.0 on chronic disease man-

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agement; and version 3.0 on addressing population health involving medical organizations and public health agencies working collaboratively to focus on primary prevention for an entire geographic community.⁵ At present, although ACOs use the language of “population health,” they mainly represent a 2.0 system—aiming to reduce costs associated with chronic disease management of their patients. Fisher, one of the pioneers of the ACO movement, and colleagues make a similar argument for accountable health communities in which ACOs would cooperate with other organizations to improve geographic population health.⁶

These are difficult issues. Should ACOs be given incentives to improve the health of the population in their geographic area? Who would give these incentives? Should there be incentives for accountable health communities, and, if so, who would provide them? It will only be possible to have this debate if the phrase population health is used clearly, and not as a vague way of referring to what ACOs are currently doing.

Some ACOs have some incentives to cooperate with other organizations in trying to improve the health of the population in their geographic areas. To the extent that an ACO is very large, and has ACO-like contracts with payers in addition to Medicare (ie, commercial health insurers and/or Medicaid), it may have more incentive to improve population health in its area. Many ACOs are based in nonprofit hospitals, which have to comply with a community benefit reporting requirement to maintain tax-exempt status. In addition, under the ACA, such hospitals have to perform a community health needs assessment and report on what they are doing to address those needs.⁶

George Orwell argued that by choosing one’s language with care, “one can think more clearly, and to think clearly is a necessary first step. . . .” It is not merely a semantic issue, of little importance, if ACOs are described, or self-

described, as working to improve population health when what they are really doing is improving medical care for their own patients. If the good name of population health continues to be used in this way, it will be difficult to understand what ACOs are doing, what tasks they are not doing but should be done, who can do these tasks, how performance on these tasks should be measured, and how and for whom incentives should be created.

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