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Accountable Care NEWS

The Road to Sustainable Health Communities

By Todd C. Cozzens, Chief Executive Officer, Optum Accountable Care Solutions

There is a great deal of debate circling around hospital system boardrooms, within the Beltway, and among healthcare experts about how accountable care organizations (ACOs) will evolve. Whatever the opinion, it seems all parties agree that the current system of volume-based, fee-for-service care is unsustainable – that there simply isn't enough money to go around to keep this inefficient system alive.

So no matter how you define what an ACO is or will be, there will inevitably be new models of care where the interested parties beyond the health insurer, hospital system, and physician will take on more risk and be compensated more and more on outcomes, not on individual transactions.

The goal of these new models of care is to achieve Sustainable Health Communities – "sustainable" because the current system is simply unsustainable; "health" because it is no longer about the care of sick patients anymore, but how to prevent illness and encourage wellness and preventive care; and "community" because it will really take the entire community to evoke change – from hospital-employed and independent physicians to pre-acute and post-acute care facilities.

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What to Do about Accountable Care: Defining Success in a Post-Managed Care World

By Philip L. Ronning, Principal, Ronning Healthcare Solutions

Accountable care is a phenomenon – or perhaps more precisely a *noumenon*. Managed care was initially resisted, but accountable care has been embraced even though it has not been adequately explained or defined. Oddly, "managed care" was in its simplest, earliest forms, simply "contracting for care" yet the implications of managed care since 1984 can be seen to include hospital integration and physician aggregation – the forming of delivery system components into enterprise-level economic entities capable of marshalling capital resources and clinical volume. It is unfortunate that the success of managed care in commoditizing care led to the excesses that have regulators on the verge of nationalizing healthcare.

In spite of all the activity, the only thing certain is that accountable care signals the end of the *Age of Managed Care*. It can be argued successfully that managed care did not, in fact, result in care being managed and that we are only now serious about managing care. Regardless of the label, the strategies and structures employed since the mid-1980's, called here managed care, have failed and are in the process of being deposed and displaced.

The passing of the *Age of Managed Care* puts us on the threshold of something that remains to be defined but which promises new challenges and opportunities. Healthcare must begin deliberating what the intermediate future holds and what must be done to position organizations to meet the challenges of the future.

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Editor's Corner

Raymond Carter, Senior Editor, *Accountable Care News*
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We have assembled a distinguished group of national opinion leaders on ACO issues representing a broad range of constituencies to help guide this publication. Each month we will introduce a different member of the Advisory Board. This month we are pleased to feature Jill H. Gordon, JD, MHA.

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Jill Gordon is a health law and life sciences attorney representing hospitals, long-term care facilities, medical groups, and other entities affiliated with the health care industry. Jill also represents a number of emerging growth companies in the medical device and biotech fields. She primarily counsels clients on transactional and regulatory matters including forming and operating joint ventures and other alliances; structuring mergers and acquisitions; entity formation and financing; and negotiating agreements such as physician contracts, leases, management arrangements, and managed care contracts. In addition, Jill advises clients on physician self-referral (Stark law), anti-kickback, licensing and certification, and other health care compliance matters.

Practice Highlights

- Serves as outside general counsel to health care providers, including advice in the areas of hospital-physician contracting, physician recruitment and physician practice sales and acquisitions, management contracts, managed care contracting, and space and equipment leasing
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Professional and Community Activities

- *Accountable Care News*, editorial advisory board (2011)
- American Health Lawyers Association, editor of the Physician Organizations Practice Group e-Newsletter (2007)
- California Bar Association: Chair, Health Law Committee of the Business Law Section (2010-2011); Vice Chair of Education (2009-2010)
- Legal Aspects of the Enterprise Task Force, Healthcare Information and Management Systems Society (HIMSS) (2008-2010)
- Learning Rights Law Center, Board Member and pro bono attorney (2008-present)
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- The Alliance for Children's Rights, pro bono attorney (2001-present)
- The Health Care Innovator's Forum, editorial advisory board (2010-present)
- Women Lawyers of Los Angeles, Board Member (1998-2003)

Professional Recognition

- Named as one of "America's Leading Lawyers for Business" in Healthcare (California) by Chambers USA, 2010, 2011
- Selected to "Southern California Rising Stars," *Law & Politics* and *Los Angeles Magazine*, 2004-2010
- Named as one among 12 recipients nationally, Nightingale's Healthcare News' Outstanding Healthcare Transactional Lawyers for 2004

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JD, Washington University in St. Louis School of Law; MHA, Health Administration, Washington University in St. Louis School of Medicine; AB, Liberal Arts, Sarah Lawrence College.

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Information Technology Infrastructure Provides a Foundation for Accountable Care Organizations

By Gary Zegiestowsky

As the buzz around Accountable Care Organizations (ACO) continues to grow, providers are seeking more information about what an ACO is, how it is structured, what the incentives are, and how all the players in the healthcare process will be aligned in order to create and sustain a successful ACO. One thing is certain, the advent of healthcare reform will require a health information technology (HIT) infrastructure that integrates all the moving parts of an ACO: hospitals, physicians, labs, outpatient centers, claims, and analytics. In this emerging environment, the need for accessing information and exchanging data is critical to ongoing operations and cost-efficient performance.

The alignment of primary care physicians with specialists, hospitals, health plans, and other industry stakeholders, however, poses many challenges. Federally enacted legislation considers an ACO to be a coordinated group of providers – teams of physicians, hospitals, and others healthcare suppliers -- that agree to manage the quality, cost, and overall care of an assigned population of beneficiaries. In fact, the "Shared Savings Program" of the Patient Protection and Affordable Care Act – one of the measures adopted in the new legislation – includes a number of reforms designed to reward these ACOs for lower growth in healthcare costs while meeting quality care standards that put patients first, improve care coordination and patient safety, enhance preventative health, and better deal with at-risk populations and the frail elderly.

Changing the Equation

The United States spends about $2.5 trillion a year on healthcare, more per person than any other advanced nation. Yet, Americans lag behind in some common measures of health and well-being. Researchers estimate that as much as one-third of U.S. spending goes for services that are not really needed. As it stands now, ACOs are intended to replace the traditional fee-for-service Medicare setting, where problems have long persisted in coordinating care among multiple physicians for beneficiaries who might have as many as five chronic conditions. These patients are more often than not subjected to redundant care, and are at increased risk for medical error and hospital readmission that could have been avoided if services had been aggressively communicated and synchronized among physicians, providers, and suppliers of ancillary services.

When Congress found a way to incorporate ACOs as a major tenet of the sweeping 2010 healthcare reform law, it envisioned doctors and hospitals joining forces to prevent a great deal of careless oversight and to prevent blunders like patients doubling up on their medications or failing to follow through on treatment. By developing operable ACOs, the Department of Health and Human Services estimates that Medicare could save as much as $960 million over three years. If the idea succeeds in Medicare, the plan is expected to spread quickly to employer-provided health insurance.

Pros and Cons

Advocates for ACOs believe today's technologies have reached a level that can help better inform patients about the proper course of action for treatment, identify those procedures that aren't necessarily needed, or recommend alternative methods of care. Critics, on the other hand, are afraid ACOs won't be used as they were intended because providers and insurers are inherently incompatible. Both might be able to make more money if the existing, limitless fee-for-service Medicare system remained in place. However, the government believes this framework puts clinical and administration practices at odds, thereby eroding patient care and escalating costs while further illuminating the fragmented debate over why there are inefficiencies in the delivery of healthcare today.

There's another potential problem. A network of providers – doctors and hospitals – may acquire monopoly power in its community and start raising prices. The Justice Department has countered by saying providers that control more than 30 percent of the share of the market for a given service in a community would face scrutiny for anti-trust concerns. Those ACOs with a market share of 50 percent or more would undergo a mandatory review before the network could be approved. For those in-between, the department has made a list of undertakings to avoid or face possible questions from the government.

Sooner, Rather than Later

Make no mistake about it, no matter how much anyone thinks they will or will not save, or how much anyone does or does not know about them, ACOs are coming – and sooner rather than later. The Department of Health and Human Services (HHS) issued its final details in March 2011, and requirements for measuring quality, assigning beneficiaries, and incentive sharing are being ironed out in pilot studies across the country.

Despite legal challenges to the law, many providers have begun enthusiastically gearing up for ACOs, and some have already received a call or an invitation to join one. ACOs must provide services for at least 5,000 Medicare beneficiaries for a period of three years. Under the new rules, ACOs will have no control over the beneficiaries for whom they are responsible. Instead, the Centers for Medicare and Medicaid Services (CMS) will assign them responsibility for its beneficiaries who received most of their primary care from providers in the ACO. Those beneficiaries, however, would be allowed to see any Medicare provider they wanted.

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IT Infrastructure Provides*….continued*

Sound Familiar?

If this all sounds like managed care, ACOs are, in truth, based on the HMO models first proposed about 15 years ago, the last time a significant push was made to reform the healthcare delivery system. At that time, those models didn't catch on because there were few incentives for doctors to participate. Instead, in an effort to preserve revenue streams, many providers attempted to protect or expand market share through acquisition.

In their haste, many of these practices were overpriced, offered little patient choice, and often resulted in massive failures in quality and access to care. Times have changed, as has the healthcare environment. Insurers and the government are now dramatically cutting reimbursements to providers. That means providers have to become a lot more efficient, especially with Medicare beneficiaries. So, doctors and hospitals may have little choice but to be more amenable to a balanced approach between quality and activity as opposed to prior capitation models, where care providers received fixed, pre-arranged, monthly payments per patient enrolled in a plan.

Putting IT to Work

Most providers have been left to their own devices to sort out any confusion or uncertainty surrounding ACOs. And if they have learned anything by now, they know effective ACOs will be all about data. The trouble is that many of these providers remain years away from having the electronic health records (EHR), data management, personal health records, and HIEs to successfully operate as ACOs. Even in their primitive stages, ACOs will need to acquire HIT infrastructure with all of the above, including advanced support for data standards and connectivity that have become available only within the last two years.

EHR infrastructure captures necessary patient data that support a patient centered approach to care-related transactions such as e-prescribing, and provides clinical and financial decision support that helps guarantee that evidence-based medicine is delivered and that providers are aware of ACO quality and efficiency goals. The infrastructure should be able to manage the risk of the populations empanelled to the overall exchange. The system must be able to collect enough information to include the actuarial and financial risk analytics which will give a clear picture of how risk and clinical care are linked. Only when risk and clinical care are integrated can a truly patient centered approach emerge, because only then will providers have the proper incentive and proper tools to be able to deliver quality care in an effective and efficient way.

HIE as an Infrastructure for ACOs

There are two basic HIE designs within the market today. One revolves around patient portability, the other around patient centeredness. Patient portability models facilitate the transfer of patient data from one health provider to another giving them the information they need to care for the episode of care in question. Patient centric models either physically aggregate or virtually aggregate data so that all information about the patient is visible to healthcare providers at any given time to diagnose and treat their patients.

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IT Infrastructure Provides*….continued*

ACOs require a patient centric approach to HIE because of a high affinity to both the patient and local geography in which business is conducted, and the requirement to gather data for analysis to manage the risk associated with the enrolled patient base. Having an HIE platform that is patient centric yet capable of patient portability is the ultimate architecture to support such initiatives.

Finding the Right Fit

One study suggests that 39 percent of all healthcare organizations will launch an ACO by next year (2012). So, change will take time. But, medical thinking doesn't always turn on the dime. Few healthcare organizations have adopted the core applications needed for an ACO, and many questions surrounding reform remain unanswered. Yet the vast majority of providers believe the state of healthcare in America has evolved to a point where change needs to take place. Anyone hoping for this change needs to engage patients, employers, and healthcare providers. The foundations of effective healthcare structures of tomorrow are being set in place today. Attracting new patients, retaining existing ones, improving employee productivity, increasing physician satisfaction and loyalty, and engaging the community, we must build upon these structures and move them forward.

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The Road to Sustainable*…continued*

Many harken back to the bad old days of managed care when they hear about the idea of hospitals and doctors uniting to take on risk-bearing responsibility. However, a closer look at the industry dynamics reveals that the move toward Sustainable Health Communities is a completely different phenomenon. Driven by the unsustainability of the current economic model, and the existence of much more data to track and manage performance, we need to move away from siloed care and into an integrated approach.

CMS has taken a crack at defining what it believes is a viable structure for this kind of collaborative care model – and while it's helped fuel debate and spawned a big movement toward creating private/public models that are more focused on outcomes, some of the key rules that CMS put out in its first version have been viewed as unworkable by many healthcare experts. We'll see if they listened well as the comments come in and the rules are finalized in November. I predict we will see a much more tenable set of final regulations.

To successfully build and operate a Sustainable Health Community, all constituents involved need to recognize that each community is unique – from its population's demographics, (Is it elderly, poor, obese, multi-lingual, etc?), to its level of hospital/physician group sophistication (Are they technology enabled? How are they communicating with the local community?), to other variables such as – how many payers are currently serving the area? Is there an existing health information exchange (HIE) or regional health information organization (RHIO)?

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The Road to Sustainable*…continued*

Because of all of these varying factors, each integrated Sustainable Health Community care model needs to be designed, built, and operated with the specific needs of each community in mind.

Regardless of the model selected, Sustainable Health Communities will, in fact, represent a seminal cultural shift which I firmly believe will be a big step toward modernizing the healthcare ecosystem to drive better population health. It won't be a smooth shift and there will be many starts and stops. There are some health systems that are very prepared for this change, with executives that have managed risk-bearing, fully capitated systems in the past, and ones that have no experience at all and will need a great deal of guidance.

The Five Flavors of Collaborative Care

There are five "flavors" of collaborative care models developing in this very early market and several hybrid models that will likely begin to surface as the industry evolves. Each model reflects the structure that makes the most sense for the particular setting, balancing risk and reward for all involved constituents as well as their preparedness. These flavors include:

(1) *The Medicare CMS-based ACO*. Although currently in a state of flux, this model has the lowest downside, modifying fee-for-service and slowly layering in pay-for-performance. And, while there are shared savings and some bonuses for clinical process improvements, the model doesn't go nearly far enough in terms of shared risk for providers. There also isn't downside protection against a lot of hospitals' fixed costs.

(2) *The Provider Employee Model*. With this model, health systems "pilot" a collaborative care structure by just taking on the risk of their own employees. The overall risk level is expected to be relatively low, due to a controlled population and direct access to the covered population for communications, education, and screening. Several of the larger hospitals and health systems – some with up to 30,000 self-insured employees -- are currently in the early stages of this model. After the testing/trialing phase where they'll manage the population, monitor physician performance, and watch patients closely on a longitudinal basis, these health systems will likely move on to other "flavors" of collaborative care models.

(3) *Payer/Provider Realignment*. This model is usually found in areas where the performance of the health system is below the national benchmarks, prompting the payers and providers to work together in a more collaborative fashion than in the past in an effort to improve outcomes. This could be a single payer and multiple providers, or realignment within a limited population, and may offer no limited gain share.

(4) *Expansion of Existing Risk*. Many health systems across the country already share and bear risk. Some have their own health plans, while others have certain physician groups in risk-capped contracts. These entities want to expand these models and form full Sustainable Health Communities within a three to five-year timeframe.

continued

The Road to Sustainable*…continued*

As they see the potential rewards, they can therefore position themselves to take on more risk. Some organizations have been doing this for a while and, although there aren't many in this country, there are enough to make it a model to consider.

(5) *Comprehensive*. This is the full risk model for a large population – the "holy grail," if you will, of healthcare. It involves collaborative participation of multiple providers and multiple payers, potentially including Medicare/CMS, but private payers as well. It engages the community of independent and hospital-employed physicians. This model will evolve over time and it's likely we'll see many more of these launch in 2013 and 2014.

When you compare these models to the current proposed CMS ACO, they allow for the ability to scale to various-sized populations and to design customized shared savings arrangements, based on the community's specific demographics and needs. They can also involve many more patients and take on a much larger part of the provider population.

These models offer a number of advantages, and will likely foster much more innovation through creating various structures and arrangements specifically designed for a given area's particular characteristics. That said, the CMS-defined ACO model is a viable one that many health systems will need to adopt due to competitive pressures.

Again, while health systems will pursue various collaborative care models, they should all share the common goal of creating a Sustainable Health Community.

The Three Tenets: Intelligent, Connected, Aligned

An effective Sustainable Health Community is based on three components: intelligence, connectivity, and an emphasis on alignment – where all participants operate together, in synchronicity, to produce a system that generates better outcomes for everyone.

The intelligence piece focuses on building a data and analytical infrastructure, since data is the one constant that cuts across the entire health system. This is information in the form of clinical, financial, administrative, and proprietary data gathered from all parties – from the doctor's patient files to extensive patient (longitudinal) data, to clinical best practice information from payers.

By supplying the right sophisticated analytics, organizations can create actionable intelligence to inform all health system processes, operations, and clinical activities at the point of decision-making or point of care.

Connectivity efforts focus on building a comprehensive technology infrastructure that connects all participants across a Sustainable Health Community to share critical information and measure performance.

This includes installing electronic health records (EHRs) and building HIEs that provide access and real-time exchange of patient information – and then connecting these tools and systems into enterprise technologies that can integrate often disparate systems across a Sustainable Health Community.

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What to do about Accountable Care*…continued*

Answering the question, "What comes next?" necessarily involves an examination of the elements of the past delivery system that worked, but also those elements that have failed. What is not working? What is causing the current malaise? Why the need for health care reform legislation and the call for providers to be *accountable*? We know that a reduction in cost will occur during this new age; it simply must. At stake is whether this reduction comes as the result of innovation or regulation.

To prepare for the unfolding future, we propose the evolution of a *new common sense*. Common sense is the mental model or framework of assumptions, often referred to as a paradigm, that we use to make decisions -- and more importantly, judgments. A paradigm that has shifted is easy to recognize, but while the paradigm is shifting there is first no sense that it is shifting, nor is there clarity as to the extent and size of the shift. A new common sense involves 1) recognizing that the context[1] is changing and 2) thinking beyond or past current management fads that the shift immediately produces. Capturing and continuing the successes of the past will require not simply reaction, but anticipation and adaptation as well. A fad is a reaction not an adaptation. Adapting requires recognition and integration of new ideas into an individual's and an institution's character – its myths, assumptions, and expectations.

This new common sense will be based upon both understanding the historical context and defining the emerging context. This new context promises to be troubling, as it foreshadows a redefinition of success. Growth and profitability in healthcare, the standards of success in American business, will at best be diminished as the dominant twin standards by which we judge ourselves and others judge us. Replacing the culturally imbedded need for growth with new metrics surrounding value, expanded indicators of quality, and yet to be defined measures of population health will be most difficult.

These metrics of success in the post-managed care world have not yet been clarified, and success will be clouded by now imperfect measures of results not completely controllable. Population health, one of the tenets of accountable care, is just such a measure. The new common sense then will require a new language with which to communicate about success and new metrics to track progress. This effort should begin now even with the limited information currently available.

Defining Success in a Post-Managed Care World

Western culture has defined success simply as "more." Whether seen as either the deadly sin of greed or the fuel of capitalism, it is the prevalent force. Interestingly, it was around the time of the birth of the *Age of Managed Care* that the conversion to the corporate model began and *administrators* became *executives* and the mentality clearly changed from guiding an institution to running an enterprise. So too, the goals of healthcare became more growth- and profit-oriented, and competition became economically motivated (market share and profits) rather than professionally driven (excellence and reputation). The future holds a necessary redefinition of success. The passage of the Affordable Care Act signals the *end of more*. Turning away from more and its easy, quantifiable metrics will challenge us all, but failure to do so effectively and to redefine success will surely lead to nationalized healthcare. The country cannot and will not pay for more. The responsible approach to the accountable care frenzy should involve these components.

1. **Asking "What's Next?"** – Exploring aspects of the emerging environment now revolving around the phrase "accountable care" is essential. It is so very difficult to look past the seductive products, promises, and promotions of vendors, as idea merchants seek to sell their next potion of progress. It is just too easy to allow these others to do the heavy lifting of thinking, seeking seminar as opposed to sweat lodge solutions. The end of an era brings with it the need for a new mental model, a new common sense. The early challenge of old, broken assumptions leads to advantage. Early adopters buy fads, leaping at change, making decisions based on anachronistic assumptions and expectations. *Early adapters* are those who look past the fad to determine if it is the result of some underlying structural movement and don't simply buy the surface change but instead *plan to change*. Early adapters outplay early adopters much like the tortoise bests the hare. Surfacing and exposing the constructs which frame the current mental model is a difficult but necessary task in gaining insight into what comes next and how to prepare for the future[2].
2. **Divining the Delivery System** – The "delivery system" is an abstraction describing the complex adaptive system that produces population-level results. It belongs to no one, is controlled by no one, and cannot be held accountable. It is influenced by all providers, and responsibility for the results it produces must be accepted, at some level, by all providers. Fiduciary responsibility requires an institutional focus; community responsibility demands a delivery system focus. This is a paradigm shift that can be predicted but which envisions a common sense no one has evolved. Nevertheless, this thinking is required, and accountability cannot be realized without embracing delivery system thinking.

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[1] *Context* as used here refers to aspects of the environment, the surroundings that provide the meaning for activities and events

[2] See "Parsimony: Accountable Care's Big Idea," a white paper, Accountable Care News, June, 2011.

What to do about Accountable Care*…continued*

3. **Managing to Become Accountable** – Combining these elements will provide the basis for addressing the questions about how the challenges developing under the rubric of "Accountable Care" must change the organizations central to the delivery system. The graphic below demonstrates a tool to guide this dialogue.

Population's Health	PCP Involvement	Utilization Excellence	Population Costs	Value Measurement
How do we define our population?	How can we increase PCPs' involvement?	How do we measure utilization?	How do we measure population costs?	How do PCP's experience value?
How do we measure population health?	What can PCPs' do to generate revenue?	How do we contribute to the "Triple Aim"	How do we minimize readmissions?	How do specialists experience value?
How do we improve population health?	How do we integrate the PCMH?	How can we retard utilization?	How do we limit capacity?	How do patients experience value?
How do we compete on our results? On value?	How do we involve PCP's in their patients' care?	How do we communicate our procedure appropriateness?	What do we do to decrease non-program costs?	How do payers experience value?

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In this graphic you will find the five goals distilled from my analysis of the accountable care literature. Below each of the goals are questions that must be asked in order to begin the process of responding to the emerging but unnamed new age of healthcare and modifying personal, programmatic, and institutional strategies. Answering these questions will result in a strategic construct that can then be factored into incremental strategic planning.

Central to this step is grappling with the difficult question of what success may look like in the future to various stakeholders and determining how or, perhaps if, the institution will respond to the challenges of these new parameters. Initial acceptance of these new ideals will be difficult. Payers, providers, patients, community, and board members will no doubt conflict over the new definitions and priorities. This potential conflict is one reason why an early definition and analysis of the implications of change are so important.

4. **Setting Accountable Strategies**. There are a host of proposed strategies for accountable care, enough to confuse and confound. Many are managed care solutions repackaged with the accountable care label. The framework established through this "Managing to Become Accountable" process and framework can be used to evaluate the various available strategies – payment reform, information technologies, physician recruitment, facility planning, care management systems, etc. Determining and prioritizing those that are appropriate and necessary come next. Both the framework and the strategies will need to be monitored and adjusted through feedback loops in the future.

Redefining success requires envisioning a *brave new world*. Not the naive misunderstanding of Miranda in Shakespeare's The Tempest where the phrase first appears or Huxley's sardonic prediction for society in his book of the same title. Instead healthcare needs a blend of Huxley's skepticism with Miranda's innocence as we envision and invent the future. But we must not simply hope for a brave new world, we must bequeath it to the next generation.

"O wonder!"

Philip L Ronning is a healthcare consultant, futurist and educator. He has written eight books published by the American Hospital Association, written over 130 articles, and given more than 100 national presentations on healthcare topics. He can be reached at philronning@ronninghcs.com.

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*T*hought Leader's *C*orner

Each month, *Accountable Care News* asks a panel of industry experts to discuss a topic of interest to the accountable care community. To suggest a topic, send it to us at info@accountablecarenews.com.

Q. "What are the IT opportunities and pitfalls for ACOs going forward?"

"Every stakeholder in the healthcare system will benefit greatly from the volumes of data that will become available through ACOs. These entities will grant payers and clinicians insight into a broader view of a single patient's status and care plan – as well as provide information about populations of patients. This volume of data will enable providers, payers, and patients alike to prevent and manage diseases more effectively .

To paraphrase an old adage, however, with great data comes great responsibility. Healthcare professionals need to ensure the data they review are complete and up to date. If they rely upon partial or inaccurate information, clinical and care management decisions will be compromised. As ACOs are developed, they must deploy technology that supports interoperability – even among disparate systems – and that harmonizes various formats and nomenclatures so the resultant data sets are meaningful and actionable.

Further, ACO leaders must look for real-time reporting in their technology systems. If caregivers must wait for information or make decisions from last week's data, the industry will have made no progress at all."

Joel Diamond, MD
Chief Medical Officer
dbMotion
Pittsburgh, PA

"On average, there are about 100 relevant components – across multiple providers – to a person's medical history. This may include previous medical procedures and tests, medication allergies and prescription dosage – the information needed to ensure the best possible care is received without duplication of effort. But a doctor may have access to only 10 or 20 of these critical pieces. As a result, people are treated episodically by providers who only have access to a limited amount of necessary clinical information.

For providers to truly achieve accountable care across the continuum, they need to be linked with the same information about a person's medical history. They need to be talking to one another, linking data in a meaningful way that allows them to develop treatment plans while ensuring everything they do is complementary.

We need to mirror what we're trying to build across healthcare nationwide – a system that is coordinated and integrated, where communication is dramatically improved and we aren't repeating or replicating. The HIT needed to manage information is out there. We need to use it to shape our data and turn it into actionable insights that improve outcomes and lower costs for each individual."

Keith J. Figlioli
Senior Vice President of Healthcare Informatics
Premier Healthcare Alliance
Charlotte, NC

"One of the critical success factors for ACOs will be the requirement to provide well coordinated care that minimizes or eliminates the fragmentation that is so common and drives up costs today. We will need to craft information management processes that provide the business rules for health IT, and this could well include standards and requirements for unique patient identifiers that allow for collection and integration of health information across organizational boundaries. Such identifiers would provide easier linking of health information, facilitate coordination of care based on the patient's whole story, and allow information to be created and aggregated in ways that support providers' efforts to manage risk and improve quality."

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American Health Information Management Association (AHIMA)
Chicago, IL

*T*hought Leader's *C*orner

"ACOs have several choices when it comes to IT including: (1) Build their own data center and purchase analytic tools to build a linkage with HIE and EMR, and add the staff to manage a 10,000 member ACO and you are looking at $7 to $10 million just for administration, plus additional people for medical management (double what most providers are now doing); (2) Seek the expertise of companies that have already obtained all of the hardware and software, have the licenses, and can connect and market it to physician organizations on a per member per month basis. This business outsourcing means no maintenance or staffing costs and no hardware to buy. The real opportunity here is to have several non-competing physician IPAs and medical networks in a given region share the overhead of setting up their own ACO management company; (3) Partner with an insurance company that promises to do all of this for the providers through a subsidiary corporation (HMOs cannot be ACOs). Contracts like these which have worked state that the provider is at risk to hire and manage the software and hardware leased to them. This has some advantages but also gives some providers sleepless nights by having the insurance company connected to the practices and hospital mainframe.

What makes sense would be for providers to share overhead for the insurance and underwriting function as long as they understand three things: (1) There are limits to the customization of systems. To get scalability may mean to follow standards for reports etc; (2) Hospitals or physicians forming large cartels as a super ACO may run into antitrust problems, as the goal of the shared savings strategy is to have competing provider organizations. Better to have separate organizations sharing a central processing center; (3) Another reason a super ACO may be a problem is sharing risk pools. Some have envisioned one big pool but that is not how risk scores work. One may have two very good partners that toe the mark and create bonuses, but adding a third partner who does not do this makes the other two partners lose their bonus regularly and subsidize the low quality provider.

In all first drafts of business plans there is a discussion of the vision. Remember, if the ACO seeks to go after the commercial market, there are additional TPA costs, licenses, and reporting. Or if the ACO leads to the Medicare Advantage license there are many more hoops to jump through, so building the system that has these capabilities will avoid having to replace or jerry-rig a system just at the time when capital is needed elsewhere.

The truth lies somewhere between these options. As has been done before, we could build an outsourcing strategy as we begin and eventually bring data systems in house as they are needed. Things we have learned in building our own systems for several HMOs and ACOs is that vendors do change. After the acquisition of a small software vendor by a large vendor, costs go up and protection of your data may leak out unless specific provisions are put into your contract. Even de-identified aggregated data has a value for competitors and analysis, so it is very important that the client control the vendor, not the other way around."

William DeMarco, MA, CMC
President & Chief Executive Officer
Pendulum HealthCare Development Corporation and DeMarco & Associates, Inc.
Rockford, IL

"There is an enormous amount of opportunity opened up by the "accountable care" movement, especially in health care IT (HIT). ACOs accentuate the need for collaboration among multiple health care stakeholders – namely, the patient, providers, and payers. On a smaller scale, we'll need to first coordinate between provider groups, such as primary care physicians, specialists, hospitals, and pharmacists. HIT is the tool needed to facilitate this interaction and information sharing, and I expect to see significant technological advances as the industry makes strides toward coordinated care. Technology – used to enable the unprecedented level of communication required of an ACO – will help us in our quest to lower costs, while increasing quality of care.

Of course, health care organizations hoping to form an ACO, or similar care model, will face an uphill battle in regard to HIT. The potential pitfalls are numerous and can be difficult to navigate – from gaining multiple stakeholder buy-in on a specific, coordinated care platform, to upgrading all participants to the appropriate level of technology, to funding and provider alignment. AltaMed Health Services has made great strides in becoming a patient-centric, collaborative organization and was the first organization to be surveyed by the Joint Commission as a Primary Care Medical Home. We've gone through many challenges related to HIT, but the results are worth it. Advice we can offer to groups hoping to pursue a coordinated care model includes identifying a strong executive leader to guide their partners and defining clear objectives that are measureable and demonstrate incremental value in order to support continued funding. Certainly consider each stakeholder an equal player in the creation and eventual operation of an accountable care organization, but do not fall into the common trap of 'design by committee.' "

Martin Serota, MD
Vice President and Chief Medical Officer
AltaMed Health Services
Los Angeles, CA

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*T*hought Leader's *C*orner

"This is a very relevant question. Many believe that the most urgent need is for delivery side infrastructure such as electronic record systems. However, delivery side infrastructure may enable a provider to be accountable, but it does not create accountability.

What is most lacking, and critical for accountability, is more appropriate payment technology. Current systems fail to connect value received with payment. Except for the work by PROMETHEUS PAYMENT®, most are event or process based.

In order to effect change, we need to create, and payers need to adopt, flexible payment systems that are goal-based. Further, these systems must be respectful of the regional context. Goal-based payment can generate usable accountability to the purchasers of healthcare. New cooperative partnerships between payers and providers are an additional benefit, providing the capability to solve problems. A new goal-based payment system is entering the pilot phase in Oregon this summer."

Michael Rohwer
Chief Executive Officer
Performance Health Technology Ltd.
Salem, OR

"First and foremost, ACOs face the challenge of patient/member attribution. It can be difficult to determine who is responsible for the quality and efficiency of care for patients because many see more than one provider. To define a cohort of shared patients, health plans and delivery systems need to collaborate to align their data warehouse and reporting and analysis systems. They also may need to develop new algorithms for detecting patterns in the data to determine who will be accountable for each patient. If ACOs do not invest enough time and resources to put the right systems in place, they won't be able to properly manage patient/member attribution, which is essential for creating a strong foundation to align clinical resources around those patients who need it most and to track interventions and their effectiveness.

Because patients get care from multiple providers, ACOs have the opportunity to federate and partner with tertiary providers to share patient data more effectively through a regional health information exchange (HIE). ACOs can get a more holistic clinical view of their patients and have access to timely, accurate, clinical patient data though an HIE, enabling better coordination across key points in the care delivery continuum. Having expanded information about their patients through an HIE-connected medical record may also help ACOs connect with and engage their patients in new ways. It would be beneficial for ACOs to tap into the proliferation of new data and communication channels to reach their patients who adopt new technology, such as a health care app on a smart phone, appointment reminders via text message, or online health support groups. These technologies can positively influence behavior and help create 'sticky connections' (i.e., sustained and valuable linkages) with their patients."

Peter Bristol
Chief Information Officer
Network Health
Medford, MA

"First and foremost, it is vital for organizations to fully recognize that robust IT will be essential going forward. Organizations today have a great opportunity to start leveraging the technology they have put in place these past several years – such as enterprise master patient index/registry, EHRs, and analytics capabilities (data warehouse and related tools). By utilizing emerging tools like patient portals, personal health records, HIEs, and health risk assessments, ACOs can truly begin to enhance patient engagement.

However, it is important to remember that an integrated delivery network with diverse provider models (e.g., independent practice associations and multispecialty medical groups) will face major challenges in coordinating processes to ensure a collaborative face to the patients. Just as collaborative care will be difficult, ACO leaders need to understand that retrospective assignment under the general ACO model will also be challenging, especially regarding IT support. In order for this to take place, IT applications will need to mirror the melding of the diverse models into this collaborative view. Lastly, as providers enter into multiple ACO models, be it Medicare and/or multiple commercial plans, it is key to remember that the expansion of required performance indicators and potential variation in indicators will entail a considerable ramp-up of analytics capabilities."

William A. Spooner
Senior Vice President and Chief Information Officer
Sharp Healthcare
San Diego, CA

INDUSTRY NEWS

Cost-Saving Groups Embraced by Healthcare Providers

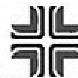
According to *USA Today*, healthcare providers who must face the harsh reality of rising healthcare costs are embracing the concept of ACOs. Currently there are between 60 and 80 health care organizations that use private accountable care models. This number is expected to rise to 100 next year, 200 the year after, and between 500 and 1000 within three years.

California Health Alliance Saves $20 Million in 2010

In 2010, Blue Shield of California, Catholic Healthcare West, and Hill Physicians Medical Group succeeded in saving $20 million by reducing costs for 41,500 Blue Shield HMO policyholders who were served by Hill Physicians and whose physicians were affiliated with CHW.

ACOs Require Improved Infrastructure

A report published by the Commonwealth Fund in July states that providers currently have an infrastructure which is not good enough to take on and manage risk successfully, although some payors will provide infrastructure and other support to providers.



St. Joseph and Blue Shield of CA Form ACO

St. Joseph Health System of Orange, California, and Blue Shield of California, based in San Francisco, have announced that they will come together to set up an accountable care organization involving 30,000 Blue Shield HMO members in Orange County.

The Road to Sustainable…*continued*

This will offer all constituents a holistic view of consumer health and resources which has been sorely lacking in most current models. The alignment of needs and incentives among all participants is, by far, the most critical element of a Sustainable Health Community. It's the most essential element for success and, yet it is also the most difficult to achieve.

Previous health reform efforts have focused primarily on financial engineering and have largely failed to align with the disparate economic interests of health system participants, the new and innovative forms of clinical and medical engineering, and the populist perspective that health care should be focused on care and not cost. The level of positive change in our health system that all parties want to achieve can only result and be sustained if all parties assume some level of risk and benefit from the rewards.

This means primary care practices are aligned with specialists and hospitals and, together, share accountability for the quality and costs of care. Multiple payers are successfully partnered with providers and patients to align benefits, design products, develop networks, measure results, and share risk. Patients and consumers are active participants in their care and share accountability with providers and payers. Payers and providers partner with patients to achieve the triple aim of better care for individuals, better health for populations, and a lower growth of expenditures. All are encouraged to align with financial arrangements that include shared savings incentives and payment reforms.

The New Era of Integrated Care Has Begun

Last month, Optum partnered with the Tucson Medical Center and local physicians in that region, to create the nation's first Sustainable Health Community. Based on a collaborative care model in which hospitals, physicians, residents, employers, and others will share in the risk and rewards of making the health system work better for everyone, this new model will help hospitals, participating physicians, and health plans collaborate to better coordinate care, improve quality and, ultimately, increase consumers' satisfaction with the health system. Key components of the Tucson alliance include the development of four Office Centers of Excellence to provide the analytics needed to determine areas in need of change, progress measures, and management of the critical information and connectivity required; use of advanced health data and analytics capability to ensure information is available to support decisions at the point of care and share information among all involved parties; and shared risks and rewards for the participating physicians.

It will be fascinating to watch the birth and evolution of this innovative new approach – this Sustainable Health Community – in Tucson and elsewhere. I believe it will be the first of many, as it has become increasingly clear that a major shift in how our health care system operates is sorely needed and the pieces are now in place for us to move toward a true vision of Sustainable Health Communities throughout this country.

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Accountable Care News

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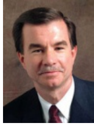

Catching Up With …

Harold D. Miller has been working at both the regional and national levels on initiatives to improve the quality of healthcare services and to change the fundamental structure of healthcare payment systems in order to support improved value. Miller organized the Network for Regional Healthcare Improvement's national Summits on Healthcare Payment Reform in 2007 and 2008. He talks about shared savings, the ACO Pioneer Model, and downside risk…

Harold D. Miller

- President, Future Strategies LLC; Strategic Initiatives Consultant, Pittsburgh Regional Health Initiative; Adjunct Professor of Public Policy and Management, Carnegie Mellon University's Heinz School of Public Policy and Management
- Served as the Facilitator for the Minnesota Health Care Transformation Task Force in 2007 and early 2008
- Master of Science in Public Management and Policy from the Heinz School at Carnegie Mellon University

Accountable Care News: *Which payment models would you like to see employed by health systems as they become ACOs?*

Harold Miller: Payment reforms should be designed to support the specific ways health systems want to improve care delivery, not the other way around. For example, a major focus for most ACOs should be reducing the rate at which people with chronic diseases are admitted to the hospital. Many studies have shown that encouraging patients to call their doctor when they first start experiencing symptoms, improving access to primary care practices on evenings and weekends, and having nurses make home visits to help educate patients can dramatically reduce ER visits and hospitalizations. But the current fee for service system doesn't pay for phone calls, nurse care managers, etc., yet it pays every time the patient ends up in the ER or hospital. The solution is obvious: pay for better chronic disease management in return for physicians accepting accountability for reducing ER and hospitalization rates. Seven health plans in the State of Washington started doing this with primary care practices earlier this year. The only major payer that's not participating is Medicare. CMS could improve care for Medicare beneficiaries and save money in the process by paying to support "accountable medical homes" across the country. Another major opportunity is reducing hospital-acquired infections. Tens of thousands of people still get infections in hospitals every year even though we know infections can be completely eliminated with appropriate protocols. But under current payment systems, hospitals lose a lot of money when they prevent infections. The solution is to pay for care that has a warranty, the same way we pay for products and services in every other industry, so that hospitals make more money when they have lower infection rates rather than the other way around. These types of payment changes are authorized by the Affordable Care Act, both for ACOs and for less integrated providers, but CMS hasn't implemented them. If CMS and commercial health plans would make these payment models available, it would help many physician practices and hospitals transition toward being ACOs far more effectively than the shared savings model.

Accountable Care News: *Besides waiting on CMS to issue rules and regulations, what can be done to reduce costs and improve quality?*

Harold Miller: People should stop waiting for CMS rules and regulations and start proactively identifying opportunities to reduce costs and improve quality and then defining the payment changes they need to implement those opportunities. Rather than merely soliciting comments on shared savings regulations or inviting ideas about generic payment models, CMS should indicate a willingness to support any physician practice, hospital, or health system that brings forward a specific plan for improving patient care in a way that will save money for Medicare, and both CMS and private health plans should move quickly to make payment changes to help a provider implement any such plan.

Accountable Care News: *What are your thoughts on the ACO Pioneer Model?*

Harold Miller: The Pioneer Model includes a number of significant improvements over the proposed shared savings regulations, including the ability for ACOs to know in advance who their patients are, the potential for patients to voluntarily join an ACO, and a shift from fee-for-service to population-based payment in the third year. However, for the first two years it's still a pure shared savings model – a pay-for-performance bonus/penalty built on top of the flawed fee-for-service system – when providers need more fundamental payment reforms right away. There's no reason that CMS shouldn't make changes in upfront payments in the first year if a provider is willing to take accountability for increases in costs (i.e., "downside risk").

Accountable Care News: How much upside and downside risk would you incorporate to make an ACO model attractive to providers while at the same time requiring serious efforts to reduce excess capacity and unnecessary medical activity?

Harold Miller: Trying to define one-size-fits-all percentages of "upside and downside risk" is a prescription for failure. Any ACO will be able to control 100% of some costs and 0% of other costs (e.g., care delivered by out-of-state providers), but the magnitude and types of those costs will differ from community to community and even between ACOs within the same community. This is particularly true in Medicare, since there will be no changes in the underlying benefit design.

We should help and encourage providers of all sizes and types to tackle the costs that they can, and not penalize them for the costs they can't control. CMS and other payers should work with providers to define the types of costs that should be included and excluded from risk, rather than just tweaking the percentages under the generic shared savings/loss model.

Accountable Care News: *How likely is it that we will see the more aggressive payment models, like full capitation, gain traction after the official launch of Medicare ACOs?*

Harold Miller: There are a number of physician groups and IPAs around the country that have both the ability and willingness to enter into a capitation-type payment structure for Medicare fee-for-service beneficiaries right now, but CMS hasn't made that option available. CMS could save money immediately by pursuing this approach, and in the process it could also help other prospective ACOs better understand how to manage costs for this population.