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Accountable Care NEWS

Medicaid and Pediatric Accountable Care Organizations: A Case Study

By Steve Allen, MD, MBA, Chief Executive Officer, Nationwide Children's Hospital

"While discussion around Accountable Care Organizations has centered on the creation of adult ACOs through Medicare, the Patient Protection and Affordable Care Act of 2010 also authorizes the creation of Medicaid ACO demonstration projects, including a pediatric ACO project. The provision authorizes participating state Medicaid/CHIP programs to allow pediatric providers to form ACOs and receive incentive payments from savings generated by their ACO.

The law's inclusion of pediatric ACOs reflects:

- First, recognition that pediatric care is a critical intervention point for shifting from a culture of acute care to a culture of prevention.
- Second, appreciation for the different market forces in pediatric healthcare.

Bending the Cost Curve through Pediatrics

One of the goals of ACOs is improving the "health of the community," which takes on different dimensions in pediatrics. Preventive care is the centerpiece of pediatrics and more so in light of the realization that most chronic illnesses begin in childhood. Pediatric care is a community activity: a parent or guardian is primarily responsible for a child's care, but schools and child care programs are involved, too. Pediatric care is not about getting one person to do the right thing, but often two or more.

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A National Model for Accountable Care: Scott & White Healthcare

By Robert W. Pryor, M.D., MBA, Chief Operating Officer and Chief Medical Officer , Scott & White Healthcare

Accountable Care Organizations (ACOs), progeny of the Patient Protection and Affordable Care Act of 2010, reside in a place of prominence in discussions between providers and payers, policy makers and patient advocates, the government and the health care industry. Given the recent focus on ACOs and how to structure health care organizations around this model, it would be understandable if patients are left with the impression that ACOs are a new phenomenon.

There are integrated health care delivery systems that emulate the ACO model. Scott & White Healthcare, a non-profit, collaborative, physician-led health system headquartered in Temple, Texas, has been operating essentially as an "ACO" for more than a century. It is also the only fully integrated group practice model health system in the state of Texas.

Many of the fundamentals of ACOs, as outlined under the Patient Protection and Affordable Care Act, are reflected in the way Scott & White has always functioned.

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ACOs are a promising model because they have the potential to make prevention financially sustainable through either partial or full capitation. Moreover, because they are comprehensive, ACOs may allow innovative organizations to experiment with more efficient delivery models beyond a physician's office—such as school or child care-delivered preventive services, or health promotion linked with Women Infant and Children (WIC) clinics.

The Unique Market for Pediatric ACOs

Pediatric ACOs will operate in a different market than adult ACOs. More than half of America's children live in low-income families, and an estimated 28 percent of US children through age 18 are insured by Medicaid or CHIP programs. This number is expected to rise dramatically. Because Medicaid reimburses pediatricians at just 72 percent of the Medicare rate, many pediatricians lose money with every Medicaid patient they see, and as a result, they restrict access. The percentage of physicians accepting new Medicaid patients fell from 51.1 percent in 1996-1997 to 40.2 percent in 2008.

Chronic illness care also differs from pediatric settings to adult care. For an adult practice, chronic illness prompts most visits. Consequently, adult medical home practices may employ patient advocates and educators. In pediatrics, multiple practices might share members of a medical home team, such as a diabetes educator, because no practice alone has sufficient numbers of chronically ill patients. While CMS considers 5,000 patients an acceptable minimum for participation in a Medicare ACO, in a pediatric ACO, the same number may be insufficient to generate savings through economies of scale and better patient engagement and self care.

Finally, pediatric health care markets are characterized by regional groupings of pediatric specialists that often take on accountability for subspecialty care in conditions like cystic fibrosis, sickle cell, burn care and neonatology. In contrast, the adult specialty system features greater regional competition. It is likely that pediatric ACOs will need to have almost all pediatric specialists in a region as participants except in the very largest cities.

Some providers have taken advantage of local market opportunities and modeled their organizations with all the characteristics of an ACO, to better coordinate care while improving safety and quality. One such organization is Nationwide Children's Hospital in Columbus, Ohio, which is a potential model for other pediatric ACOs.

Nationwide Children's Hospital's Partners for Kids: An ACO Case Study

In 1994, Nationwide Children's Hospital along with community pediatricians and subspecialists created Partners for Kids (PFK). PFK is a physician-hospital organization with governance shared equally between the hospital and representatives of physician primary and specialty practice groups. The majority of PFK physicians work under a salaried model as hospital or practice partners, while the remaining physicians are community practitioners. Non-employed community physicians receive Medicaid fee-for-service rates plus incentive payments.

Since 2005, Nationwide Children's Partners for Kids network has operated as a pediatric ACO covering more than 285,000 low-income children in Central (urban) and Southeastern (rural) Ohio.

Through a capitated arrangement with three mandated Medicaid managed care plans, Partners for Kids is paid a set fee per child through Medicaid, and held responsible for managing their care. While the insurers retain a percentage of the Medicaid premium for claims processing, member relations and management functions, Partners for Kids carries the business risk for clinical and financial outcomes.

The true test of the ACO model is its ability to improve pediatric care. Recent PFK data are promising.

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- Read about the case experiences of health systems already involved with informal accountable care models
- Keep pace with evolving financial, operational, and strategic requirements and considerations for ACO creation and operation

A National Model for Accountable Care *….continued*

Accountability

Making providers accountable for both quality and cost savings is among the expectations specified in the Patient Protection and Affordable Care Act. Put another way, accountable care means providing safe, timely and efficient care. As a coordinated care system, Scott & White has demonstrated its ability to deliver the highest quality care with an efficiency that lowers cost throughout a continuum of care, from outpatient to inpatient to long-term care to hospice and home care. Our system has been cited in an often-quoted study by the Commonwealth Fund that analyzed cost-effective care in relationship to quality.

We have learned that providing accountable care means providing patient-centered care in the right place at the right time. It is also about focusing on quality outcomes such as reducing hospital readmissions for patients with chronic conditions. Reducing hospital readmissions by improving care is another way Scott & White aims to keep costs down. About 20 percent of hospitalized Medicare patients are readmitted to the hospital within 30 days, according to a 2009 study in the *New England Journal of Medicine*. That equates to approximately $17 billion per year. Scott & White has designed a "care transitions" initiative aimed at saving older patients a return trip to the hospital. And in half of the cases, patients don't see a doctor between stays. After patients are discharged, we assign them a transition coach and a trained social worker that stops by to review their medications and helps the patient better identify symptoms that may signal the need to call the doctor for at-home help.

> ***We have learned that providing accountable care means providing patient-centered care in the right place at the right time.***

Leadership and Management

Scott & White is one of the country's largest multi-disciplinary group practice systems comprised of a clinical and administrative structure with over 12,000 employees, more than 1,200 physicians, scientists and health care providers, 12 hospitals and hospital partners, and more than 60 clinics located throughout the Central Texas region. This integrated system of care supports our goal of providing the right care, at the right place, at the right time. It also aids Scott & White physicians in their ability to conduct seamless hand-offs of patients from one provider to the next, minimizing the risk for medical error while maximizing patient satisfaction.

Evidence-Based Medicine

At the core of academic medical centers is the ability to inform health care delivery through the type of discovery that enhances evidence-based medicine. The role of evidence-based medicine in impacting patient care is noted among one of the expectations of the Patient Protection and Affordable Care Act. As the principal clinical partner for the Texas A&M Health Science Center College of Medicine, Scott & White has embraced research and is data-driven in achieving the quality outcomes that help manage cost and care.

Technology has also played an important role not only in impacting our ability to manage cost, but also in facilitating the coordination of patient care. Scott & White is unique in Texas in utilizing an electronic medical record (EMR) for over 15 years. Moving to more uniform application of EMR systems is one of the stated goals of the Patient Protection and Affordable Care Act. At Scott & White, a patient's medical record can be accessed by any provider at any Scott & White location throughout the Central Texas region. Having a long-established EMR allows us to avoid duplication of testing while also empowering our patients to become involved in their own care.

Patient-Centered Care

Creating a patient-centered medical home can impact quality, health and cost and can be an important step in alignment with the ACO model. The link was recently affirmed in a joint statement by the American Academy of Pediatrics, the American College of Physicians and the American Osteopathic Association. The groups assert ACOs cannot be successful "if they are not based on primary care and the patient-centered medical home, because that's where we're going to get the care coordination, cost savings and quality of care that we're interested in."

The medical home concept fits well with the Scott & White mission to provide the most personalized, comprehensive and highest quality patient care, enhanced by medical education and research. Our system possesses two key components to establishing a medical home: the right team to deliver care and support patient self-management; and the right information technology such as EMR and electronic prescribing.

Another component in forming "the right team" in a medical home is compensation based on healthier patient outcomes. Other models of patient care typically incentivize physicians to order additional tests and procedures. This "fee-for-service" system reimburses hospitals and doctors by how much they do to patients, not necessarily for making them healthier in the long-term. At Scott & White, our physicians are salaried and do not have that incentive. Because we don't function on a fee-for-service system, we're able to keep costs down and provide the patient with the best possible care.

Scott & White also makes use of patient panels to receive direct and candid feedback from those we treat. Using technology to enhance tracking of our performance with patients is something we recognize will strengthen our efforts to establish an exemplary medical home. We have teams in place to help identify other tools and processes that will take us even farther down the path leading to a patient-centered medical home.

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Medicaid and Pediatric ACOs *….continued*

- Access. Over the past five years, Partners for Kids has increased access to physicians for children enrolled in the Medicaid program by 200 percent. Higher up-front Medicaid fees have allowed the partnership to grow from 109 physicians to 334, while increasing capacity by 300,000 visits. The partnership also monitors when and where all 285,000 children are due for checkups and immunizations.
- Pre-term births. Partners for Kids physicians participate in a program called Ohio Better Birth Outcomes, in which clinicians, researchers, community agencies, and OB/GYN providers collaborate on prematurity prevention. Over the past two years, those efforts have expanded prenatal home visiting programs, high-risk prenatal visits, and access to family planning services.
- Hospital length of stay. These efforts resulted in fewer NICU admissions and reduced average NICU length of stay both in the largest county, Franklin County and across Central Ohio. From March-June of 2009 to February-March of 2010, the average number of NICU days per 1,000 members fell by 54 days.
- Quality. Partners for Kids through Nationwide Children's Hospital has collaborated with seven other Ohio pediatric hospitals on four initiatives to improve quality. Over the past 10 months, the program has reduced surgical site infections, reduced overall adverse drug events, and saved $3.08 million.

For additional information about Nationwide Children's Partners for Kids, go to www.NationwideChildrens.org/aco.

Lessons Learned

What lessons have we learned the past five years? Among others:

First, identify your local business opportunity. Our ACO began for practical reasons: a number of Medicaid managed care plans went bankrupt and hospitals lost substantial amounts of money. We recognized that if we adopted a fully capitated model, we would eliminate the solvency risk as an issue because we would get paid up front—and assume the risk for care. Once we made that financial decision, other plans got involved, and Partners for Kids took shape around its ability to impact care.

Second, identify specific opportunities to improve care and save money. Accountable care requires both. In our market, we recognized that some money had already been wrung out of the system, but there were specific conditions with poor coordination and inefficiencies driving costs: such as asthma, pre-term births, and Attention Deficit Hyperactivity Disorder (ADHD). By taking on full financial and clinical risk, we were better able to coordinate local care and reduce costs.

Third, do a strong internal survey and be frank about your weaknesses. We considered creating our own HMO. Ultimately, we determined that we didn't have the expertise to manage claims processing, member eligibility, and related challenges. So, we stayed with our strength—clinical work—and pursued a cooperative model instead of a competitive one, partnering with our three local Medicaid managed care plans.

Fourth, to change from a fragmented to an integrated culture, you have to listen more than you talk. Our relationship with our physicians is becoming a true partnership with shared dialogue. We are learning to share our ideas, and ask for frank feedback: it allows us to take ownership of PFK together. Our medical home participation rate is much higher than we would have expected—honest dialogue is the reason.

Fifth, recognize there will be tension about how fast savings will be realized, and how big those savings will be. Savings never accrue as fast as you'd want them to. We learned in our pilot studies to reduce pre-term births that any early savings had to be reinvested immediately in community hotlines, clinical services, and improved infrastructure—those things that allowed us to improve follow-up and have a greater local impact.

Conclusion

After just five years, Nationwide Children's Hospital's Partners for Kids has improved outcomes, improved quality, and increased access.

CMS is expected to issue regulations on Medicare Shared Savings Program and ACOs by December 31, 2010. It is unclear whether regulations for pediatric ACOs will be included. Since pediatric accountable care has not been subjected to the kind of demonstration projects that Medicare experienced in the five-year Physician Group Practice, CMS should fund the first round of pediatric ACO demonstrations.

Pediatric ACOs promise to improve quality, cost, and safety for all children participating in Medicaid, while yielding lessons for improving the health of commercially-insured children. They are an important part of the long-term solution to our health care challenges.

Thought Leader's Corner

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 three most significant obstacles (in order of priority) to ACO implementation in the short term?"

In working with hospitals, medical groups and health plans, it is striking how their respective business interests hinge on mission and values, market position and strategic intent. For hospitals, three issues surfaced repeatedly this month within the context of collaboration with payers and physician organizations:

1. Revenue growth is up, but margins are decreasing each quarter. Should we embark on something new like an ACO and, if so, what should be the magnitude of effort and resources? Is there a compelling business case to change (e.g., cut costs, raise quality, gain market share)?

2. Should we just stick to our knitting as a high-performance acute care center and continue focusing on quality? Or, does our commitment to quality patient outcomes mean that we need to be in the continuum of care business -- outside the hospital walls -- in order to avoid unnecessary admissions, readmissions and complications? That would mean making hard decisions about community-based services ("make, buy or partner") and level of capital investment.

3. ACOs do not include typical gatekeeper functions (open access model). What will influence patient behavior in relation to utilization and lifestyle choices that impact health, utilization and costs (e.g., diabetes, heart disease)? Without the safety net of a gatekeeper, risk and uncertainly increase. Who is going to shoulder this added risk? For example, are payers willing to share the added risk by putting more money on the table and delegating more case management functions with providers?

These types of real-world issues – call them obstacles or opportunities – make ACO development and multi-party collaboration challenging. However, each thorny issue represents an opportunity for further dialogue and clarity among stakeholders about their accountable cares objectives.

Peter Boland
Managing Partner
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The first and most important obstacle is perceptual. Too many see this problem as ensuring that delivery systems have systemic competence. This is a distraction from the more fundamental need of accountability. It concerns the capability of being accountable and is not accountability itself. Accountability depends first on understanding what it is we want.

The second obstacle is the first task of accountability, specifically developing measurable performance standards. For many, the perception is that this has been achieved with Evidence Based Medicine (EBM). However, EBM is a set of working hypotheses around which scientific inquiry and discussion proceeds. While EBM should be used to develop standards, a standard serves a different role. Standards are the tools by which we measure results.

The third obstacle is the absence of operational process to convert measurable results or standards into accountability. The obvious and easiest realm for this is the payment model. Yet, many payers and purchasers seek to abdicate their role in accountability. They prefer simple delegation to large corporate entities operating under global budgets. This is the opposite of accountability. It will simultaneously reduce competition and transparency. The history of corporate monopoly says it will also increase cost. There is no inherent nobility in healthcare to prevent this.

Look to retailers to see accountability in action. Large retailers like Wal-Mart do not become competitors by being big and buying in large quantities. They drive cost down by being able to manage the detail of their operations and inventory. Effective detail management enables them to buy in volume and compete across the entire spectrum of their market.

The hope driving ACO formation is genuine accountability. That requires attention to what accountability is and a commitment to develop the tools and methods to create it. The Prometheus® payment model (www.prometheuspayment.org) is a good example of one approach. The work on "Program Oriented Payment" at PH Tech is another.

Michael Rohwer
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*T*hought Leader's *C*orner *…continued*

1. Too much reliance on Section 3022 of the Affordable Care Act.

Section 3022 is an important provision, and it provides one avenue for testing and learning on the pathway to accountable care. It should not, however, be viewed as the "end all and be all" of achieving the triple aim goals of accountable care - better care, better health, and lower cost. Section 3022 provides for a shared savings model (although partial capitation and other payment methodologies are also authorized), which is only one of many approaches to payment reform. We need to test multiple payment and delivery reform models in the years ahead in both the public and private sectors and not get too caught up in any single approach at this early stage.

2. Failure to find innovative solutions in the ACO market power debate.

There is a legitimate and important policy debate going on regarding how to incentivize care coordination without unduly reducing competition in provider markets. We will need to look for solutions that allow for sufficient ACO size and scale to achieve improved quality and greater cost efficiency while still promoting and supporting multiple ACOs or ACO-like entities in most health care markets. This is not an easy task, of course, but the application of evidence-base measures with new payment models and new payer-provider contracting approaches can help us find innovative ways to achieve cost savings and to appropriately allocate them among purchasers, payers, providers and consumers. Failure to do so will put more onus on government to regulate both provider and payer prices and to regulate contract provisions.

3. Over-focus on ACO structure and under-focus on clinical transformation.

The ultimate goal of accountable care is to improve patient outcomes and patient satisfaction while also achieving greater cost efficiencies. The key to achieving this goal is enhanced coordination of care among diverse providers through the application of evidence-based clinical protocols and transparent measurement and reporting. While ACO formation and ongoing structural, operational and legal issues related to ACOs are important, it is this transformation in clinical care that must remain the overriding focus of ACO development.

Doug Hastings
Chair of the Board of Directors
Epstein, Becker & Green, P.C.
Washington, D.C.

In increasing order of difficulty:

- Sufficient data systems to measure and improve performance—Being accountable for financial and clinical results requires huge amounts of data and sophisticated analysis. Few organizations coming out of a fee for service environment are prepared for these requirements. Organizations will spend an enormous amount of money and effort over the next decade developing these systems and knitting them into a coherent whole.
- Finance and governance structures—How is cost allocated? What are the legal structures necessary to make collaborations acceptable given existing antitrust law and enforcement? How does a board composed of diverse stakeholders make decisions to take contracts or reject them? All of these questions need answers before an ACO can take a payment. They are especially difficult against a historical backdrop of low trust, as is the case with hospital/physician relationships in many parts of the country.
- Scarcity of clinical leadership—What we are really looking at here are fundamental changes in the way people buy care, provide care, and consume care. While all three of these changes are difficult, changing the way we provide care is possibly the most challenging, as the existing system has been pretty lucrative for providers, reinforcing the status quo. There are probably too few clinicians invested in ending this way of doing business currently. And yet, history shows that imposing radical change from without clinical leadership within has generally been unsuccessful. I think systems intent on winning in the next round need to start now to develop a cadre of clinical leaders with a different set of skills. Among these skills: managing to a budget, process re-engineering, change management, and leading through influence/indirect authority. This requires identifying and grooming a cohort characterized by humility and a philosophy of service.

As usual, the biggest challenges and potential wins have to do with changing people's feelings and attitudes.

Jay Want
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*T*hought Leader's *C*orner*…continued*

1. Lack of governance structure that provides control over physician behavior. Governance can take many forms but must be structured so as to establish and hold individual physicians accountable for meeting performance expectations. Physicians must provide significant input for establishing the expected behaviors along with other ACO participants (hospitals, etc). The physician leadership group will need strong professional management skills.

2. Lack of buy-in from all ACO participants that utilization must be reduced. The mind set and behavior of provider churning and filling hospital beds is contrary to the efficient management of medical utilization required to meet population cost and quality targets. Fewer hospital admissions, procedures and specialty services will impact hospital and physician revenue unless accompanied by an increase in base population volume and/or control of leakage outside the ACO provider network. Provider compensation models must be aligned with the projected utilization reduction.

3. Failure to produce a realistic financial and utilization analysis for the ACO population budget. An actuarial cost model that depicts detailed utilization and unit cost on a population basis is critical for setting targets and determining resources needed to meet targets. The actuarial cost model must in turn be connected to the "corporate" financials.

Kathryn V. Fitch, RN, MEd, MA
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1. Legal. As it currently stands, the anti-kickback law, Stark law, and civil money penalties statute -- particularly the way the latter prohibits payments to reduce or limit services -- and their State law counterparts, raise significant issues when it comes to an ACOs or other providers' payments to physicians to incent them to treat patients in order to save money and improve care. Antitrust, patient privacy, and other laws present different challenges. That's why it's important for DHHS to offer us meaningful waivers to compliance with the first three laws, and for the FTC to support the formation and operation of ACOs.

2. Electronic health records. ACOs will require providers to capture, measure, and report clinical and other data like never before. This will require new approaches in health information technology, and deep pockets.

3. Culture of patient treatment. Can providers and care givers of different stripes actually work together to provide patient services along the full continuum of care, with their collective eye focused always on patient-centeredness? A tall order. Leadership and governance among physicians and other providers will be key.

Dennis Diaz
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1. Timing of transition: It is very difficult to change the delivery model (and culture) from volume to value prior to the business model changing substantially and at a critical mass of payers – yet changing the business model abruptly without delivery system capabilities will result in immediate failure. The delivery and payment models need to co-evolve strategically and briskly to avoid a prolonged transition period of conflicting models. I now close many of my presentations with a picture of the "push-me-pull-you" creature with which many of us are feeling kinship these days.

2. Competition versus integration: I don't see any way around the fact that the most seamless, efficient, effective care systems are integrated or at least tightly aligned across the entire continuum of services – yet are simultaneously disparaged as a price leveraging instrument. We have to find a new paradigm for agreeing upon a high-level measurement of value according to the triple aim of quality, experience, and overall cost of meeting a population's needs over time. We will not get to where we need to be by continuing the price-volume arguments.

3. Leadership bandwidth (relates to #1): Keeping our organizations running smoothly and successfully continues to be a full time job with new fires to put out every day (regulations, relationships, reimbursement pressures, etc.). As the saying goes, "culture eats strategy for lunch every day" but I would add that daily operations can eat what's left of strategy for breakfast and dinner if you're not careful.

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*T*hought Leader's *C*orner*…continued*

1. In my opinion, the most significant obstacle to ACO implementation is the ability to have in place the infrastructure to manage utilization, coordinate care delivery, and promote quality care delivery. This infrastructure is necessary for an ACO to be successful but it will require a significant financial investment. ACOs will need information systems capable of sophisticated medical management tools such as reporting for chronic disease management, high-tech radiology management, and hospital utilization review. The ACO infrastructure will also need to be able to collect and distribute the income, monitor patient adherence, and track compliance with regulatory requirements. The investment will not only be in the infrastructure but in the financial and actuarial expertise needed to monitor and analyze the results. Historically, these functions have resided in the health plan. However, the ACO will need to build these capabilities or purchase them from the health plan in order to receive. This will require significant financial and resource investment in the short term.

2. Another obstacle to ACO implementation is successfully aligning incentives through the payment mechanism. Establishing a payment mechanism with enough upside reward to attract the critical mass of providers needed yet with enough downside risk to change behavior will present significant difficulties. Any reduction in medical costs will certainly result in reduced income to certain providers. Payment mechanisms that utilize financial rewards but not financial downside risk have traditionally not been as effective as those that include both upside and downside financial risk. However, ACO payment methodologies that include significant penalties may have difficulty attracting providers. Additionally, many ACOs will receive reimbursement from different payers utilizing different payment mechanisms and incentives, which will increase the burden of understanding the contacts and gaining provider buy-in.

3. Determining a patient attribution method will also be a new challenge. Depending on benefit design, the amount of services a patient receives within the ACO may vary significantly. The provider will have limited control over patient behavior and where the patient receives care. Establishing a patient attribution methodology that holds the provider accountable for patients only where the provider is able to coordinate care delivery presents a challenge. The process is transparent to the patient and assigning patients too aggressively may result in a provider held accountable for patients where he has limited ability to coordinate care. This could result in distorted financial results for a provider and ultimately provider dissatisfaction.

Susan Pantely
Principal and Consulting Actuary
Milliman
San Francisco, CA

1. Getting health plans and providers to align on the cost and quality equation by moving to new, non fee-for-service-based payment models

The health care system needs to deliver and reward better, more coordinated care. However, getting there requires a cultural shift for health plans and providers. Health plans and providers must collaborate to create new, innovative partnerships that support better health outcomes, results-based financial rewards, and fiscal sustainability, while reducing system waste and duplication.

2. Implementing cost and quality data-sharing measures

Health care data cannot exist in a silo. Health plans and providers must invest in and support connectivity and data-sharing in a transparent, accurate, current, and easy-to-understand way. Health plans and providers must treat data as a shared asset to optimize the partnership, best manage performance, and improve health outcomes.

3. Ensuring ACOs are physician-driven

As the pulse of the health care system, physicians have a critical role in making and driving health care decisions — decisions of their own and of their patients through shared decision making — that directly affect health care quality and cost. Physician insight and leadership is vital to driving coordinated, efficient, cost-effective health care, and promoting the inherent value of an ACO.

Christina Severin
President
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*T*hought Leader's *C*orner*…continued*

The top 3 obstacles to ACO implementation out of the many challenges to be overcome? My choices are based on my belief and experience that if incentives are correctly aligned, organic innovations to solve other problems can and will emerge. In the absence of alignment, it is almost impossible for the other changes needed to improve value in health care to occur.

1. ACOs form, but don't perform. Anticipated early versions of ACO payment incentives are likely to be directionally correct but unlikely to be sufficient to create the needed burning platform for change. Change will come when there are compelling financial incentives across a critical mass of payers. Shared savings plans make it safe for providers to sit back and wait because there is no immediate downside while the upside is uncertain and far in the future. Once the right organizational incentives are in place, these must be translated throughout the organization and network to individual physicians, other care team members and management to be effective.

2. Funding and managing the transition. Even the most well intended ACO wannabes are struggling with how to get from here to there. Hospitals committed to bond covenants requiring minimum margins can ill afford to cannibalize their profitable business lines, which need to move from profit to cost centers to achieve improved total cost of care performance. Unless there is substantial reallocation of underlying RBRVS payment structures to primary care coupled with reimbursement for care management fees, it is hard even for vertically integrated systems to invest in the population management activities that will make them successful ACOs and almost impossible for more virtual organizations. Furthermore, the change in incentives must be accompanied by a change in culture—from provider centric, to patient centric; from do more, charge more, to value based care. There is much work to be done building trust among primary care, specialists and hospitals who have little or no experience working collaboratively or thinking about patients from a population health standpoint.

3. Consumers aren't on board. The most powerful weapon for change is the consumer and their purchasing behavior, yet ACO rules aren't really considering patient incentives. With respect to patient market share, there is no advantage to ACOs who deliver the most cost effective, highest quality care. Consumers believe "more is better" and are likely to mistrust provider efforts to direct them to only use services that actually have value. Making consumers more accountable for their choices of providers, treatments and lifestyle by moving to premium or benefit differentials for provider choice, immediate incentives for lifestyle improvements and value based benefits with better coverage for proven treatments will be essential to making the ACO market effective, yet these changes aren't discussed in conjunction with ACOs. Creating consumer incentives to use more efficient providers is the best lever to make sure provider consolidation serves to deliver value rather than excessive market power.

Making the changes needed to be a successful ACO requires no small leap of faith for providers. The result may be that many ACOs will initially organize and excessively consolidate for self-defense but can't/won't make the necessary investments in change. This is of particular concern because if done correctly, ACOs should be able to drive dramatic improvements in value, but if organizations create ACOs in name only and don't perform, policymakers are likely to conclude that they didn't work and move on to some other idea.

Ann Robinow
President
Robinow Health Care Consulting
Minneapolis, MN

1. The need for clear guidance. From the regulations that will determine the requirements for Medicare ACOs to the application of antitrust and fraud & abuse laws to these new organizations, there remain a large number of unanswered questions. This obstacle, fortunately, could be significantly reduced as the government pronouncements are published.

2. The scope of services to be managed. If ACOs are held responsible for all health care items or services for a defined population, from mental health to DME, it will require significant infrastructure to manage.

3. The uncertainty of the reward. ACOs are premised upon a shared savings concept. The amount of savings that ACOs can reasonably be expected to generate, the allocation of those savings among the Payor and other participants and the cost of participating in the ACO to the providers are very difficult to predict.

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INDUSTRY NEWS

AHA Requests CMS For Clarity On ACO Implementation

The American Hospital Association (AHA) is asking the Centers for Medicare & Medicaid Services (CMS) to allow flexibility in the implementation phase of accountable care organizations. The group stated that "We believe CMS should allow different configurations of provider organizations to enter the shared savings program to see what works and what does not work well".

In their letter to CMS, the AHA identified seven “must-haves” and three “must-not-haves” in the move towards accountable care. The whole document can be downloaded at http://www.aha.org/aha/letter/2010/101118-let-fishman-blum.pdf. (cmio.net, November 29, 2010)

Do ACOs Really Have the Power To Cut Costs?

The *Wall Street Journal* reported that some critics are asking whether accountable care organizations will help cut costs by operating more efficiently. Because of the need to hire more physicians and add doctor practices to coordinate care, emerging ACOs will run the risk of raising costs, even more so as hospitals grow through new mergers and acquisitions. Typically, hospitals generate more revenue from outpatient facilities and imaging as opposed to physician-owned clinics.

Karen Ignagni the chief executive of America's Health Insurance Plans believes that "If ACOs are a recipe for more consolidation and price increases, that will take us in the wrong direction". The worry from the insurers side is that larger hospital groups will have the dominance in the marketplace to force private payers to pay more.

The Billings Clinic of Billings, Montana, which is a not-for-profit that includes a hospital, is getting ready to become an ACO. At 41%, Medicare stand as a large part of the clinic's revenue. In an earlier Medicare pilot program hospital read-missions for 500 heart failure patients was reduced by 35% - 43%, resulting in a saving of $3 million over three years.

CMS deputy administrator Jonathan Blum said that "We want the program to create incentives, both clinical incentives and payment incentives, that encourage providers to provide better and more low-cost care". CMS is also ready "to ensure that our payment rules don't produce unintended consequences for private payers". (Wall Street Journal, November 28, 2010)

MedPAC Warily Approves of Accountable Care Organizations

While accountable care organizations have the potential the improve quality and contain costs in the Medicare fee-for-service program, the Medicare Payment Advisory Commission believes that they must be structured in a very particular fashion in order to be effective.

In their letter to CMS, MedPAC stated that ACOs should not only receive bonuses for savings made and improved quality, they must also be set up to pay for overruns if they do not meet their spending goals.

Additionally MedPAC says in the letter that ACOs could also help Medicare patients “receive more coordinated care and become more engaged with their care management, particularly if beneficiaries are informed when they are assigned to ACOs.”

MedPAC also advises that “Receiving higher quality care, improved care coordination, enhanced after-hours access, and greater engagement in their own care should be meaningful improvements from the beneficiaries’ perspective, and having the provider describe them would increase the beneficiaries’ trust in the value of those benefits". (CQ HealthBeat News, November 22, 2010)

Group of Lawmakers Ask CMS To Let Specialists Form ACOs

A bipartisan group of 17 House lawmakers has asked the CMS to allow specialists to form accountable care organizations, as long as those specialists also provide primary care. Recently, a Congressional Research Service report introduced the idea of specialty ACOs.

According to the healthcare law, "The Secretary shall determine an appropriate method to assign Medicare fee-for-service beneficiaries to an ACO based on their utilization of primary care services provided ... by an ACO professional".

The lawmakers, led by Reps. Joseph Crowley (D-NY) and Mike Rogers (R-MI), understand this to mean that the HHS has the power to allow professionals from any specialties that provide "significant primary care services to Medicare patients" to form ACOs. (HealthPolicyNewsStand.com, November 29, 2010).

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A National Model for Accountable Care *….continued*

Looking Ahead

As the next CEO and President of the organization, I believe Scott & White already has a solid foundation in providing accountable care. Our present CEO and President Dr. Alfred B. Knight built on a tradition and reputation for quality that has established Scott & White as a national model of care, one that enables us to provide the very best care to our patients.

None of us knows exactly what is on the horizon with health payment reform and the changes that will accompany it. What we do know is that lower cost, high quality care and outcomes as well as transparency will be at the forefront. We will all have to develop the appropriate systems for measuring outcomes more efficiently and passing the benefits onto the patient. Adaptability will also be another key component.

I am eager to take on this challenge and work with our leadership team, many of them recruited from the country's largest, most well-respected multi-disciplinary health systems. While the Federal Government may change its definition of an Accountable Care Organization, the principle of physicians coming together to provide the best care for the patients they serve has been a tradition dating back to our organization's founders Arthur Scott, M.D., and Raleigh White, M.D. Though medicine has changed scientifically and the delivery of care has evolved, our basic tenets of care have never changed. Scott & White Healthcare has believed in and practiced accountable care for over 100 years. We invite others to follow in our footsteps.

CATCHING UP WITH *…continued from page 11*

AM: We applaud NCQA for taking the initiative to establish preliminary quality standards absent the clarity and direction that CMS Medicare regulations will ultimately provide. The standards provided a major start and gave the industry some direction at an important early stage, especially with clearly defined outcome benchmarks. We anticipate there may be some evolutionary developments; for example, the industry is seeking guidance on which steps to follow to successfully achieve the outcomes – and whether those are based on the results of predictive modeling or other industry-standard tools that are now available.

ACN : *What do you think might be the timeline and likelihood of ACOs bending the cost curve?*

AM: Before we can talk about bending the cost curve, I think we need to acknowledge the significant effort it will take for all participants to fully bend their minds around the concept of patient-centric care. The cultural changes that are required are just as significant as the investment in the health system. That said, the cost to restructure the system is going to be significant; we anticipate the upfront costs between now and 2014 will bear returns in the latter half of the decade. But the implementation process needs to be completed first, and we can't take our eye off the fact that cost, while critical, is just one-third of the Triple Aim objective.

ACN : *Finally, please tell us something about yourself that few people would know.*

AM: Health care has been both my career and passion for 28 years, and I have always been focused on being an active patient advocate, whether in a consulting capacity or as a hospital COO. What I also enjoy doing is meeting with local community groups to help them understand health legislation – taking the thousand-plus pages of legislation and helping people understand what's truly in it for them as a community and as an individual. After all, we're all consumers of health care. When I've helped someone understand the personal implications and opportunities of health reform, I really feel like I've accomplished something with my day.

Selected Accountable Care Web Sites and Resources

Brookings-Dartmouth ACO Learning Network
https://xteam.brookings.edu/bdacoln

The Commonwealth Fund
http://www.commonwealthfund.org/ - Enter 'Accountable Care' in the search box for multiple results

The Urban Institute
http://www.urban.org/index.cfm - Enter 'Accountable Care' in the search box for multiple results

Health Reform GPS – Navigating the Implementation Process
http://healthreformgps.org/- Enter 'Accountable Care' in the search box for multiple results

The Camden Group – ACO Resource Center
http://www.thecamdengroup.com/aco-resource-center.php

Premier Inc. - ACO Collaboratives
http://www.premierinc.com/quality-safety/tools-services/ACO/index.jsp

AMGA – ACO Resource Center
http://www.amga.org/AboutAMGA/ACO/index_aco.asp

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http://www.healthcareenewsletters.com/archive.html

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Catching Up With …

Anne McCune, Senior Vice President, Coordinated Care, Ingenix

Anne M. McCune is the senior vice president of Strategy and Governance at Ingenix Consulting. McCune has more than 27 years of management consulting and health care executive experience, helping academic medical centers, health plans, medical schools, children's hospitals, health systems and cancer centers drive growth and greater efficiency. Previously, she was the founding managing director at Three-Sixty Advisory Group LLC, where she served as an adviser to a broad range of health care boards and executives. Prior to that, she served as senior vice president and chief operating officer for Children's Hospital and Research Center Oakland in Oakland, Calif., and City of Hope Cancer Center in Duarte, Calif.

Anne McCune
- Juris Doctor - Loyola University, Chicago
- Bachelor's Degree - Sociology and Cultural Area Studies - College of Wooster, Ohio
- Speaker at many national and international meetings, including International Forum on Quality and Safety in Healthcare, American Practice Assembly, Medical Group Management Association, Health Financial Management Association and National Association of Healthcare Access Management.

Accountable Care News: *How will the incoming regulations most likely impact ACO implementation?*

Anne McCune: The creation of ACOs represents the most sweeping change to health care in our time. While some cynics suggest that accountable care organizations are simply a new twist on HMOs, the fact is that we have never before effectively addressed the issues of cost containment and quality of care at the same time. While the regulations will likely provide clarity on the operations and governance of ACOs, the mandate for coordinated, patient-centric care is already clear from the original legislation. Smart organizations are already talking about what steps they can take now to prepare, rather than waiting for the release of regulations.

ACN : *Which kind of structures may be the most suitable for the operation of an accountable care organization?*

AM: The time-honored concept that all health care is local means that ACO structures must be flexible enough to meet the needs of the specific community. There's no one-size-fits all approach; rather, the ideal structure will be designed to create local, sustainable health communities. This doesn't mean that each community will need to build its delivery model from scratch; there are a growing number of care models that can be replicated in communities from coast to coast – some designed by large physician groups and others managed by hospitals and health systems.

The more pressing matter is to ensure that ACOs are designed to achieve progress against the "Triple Aim" objectives, which are to improve quality, lower costs, and improve patient satisfaction.

ACN : *What do you see as the most pertinent market issues and drivers behind ACO creation?*

AM: The main driver behind ACOs may simply be that the nation's health care system is ready to synthesize the best practices that have emerged from a quarter century of trial and error. Advances in health information technology make it easier to measure quality and costs, assess an organization's need to accept risk, operate more efficiently, reduce errors and design more acceptable value-based payments. ACOs weave these elements together to provide a cohesive approach that will require health care providers, health plans and individual patients to come together in a way that is truly unprecedented – but that will bring tremendous improvements in care delivery.

ACN : *What are the most important elements of successful ACO development and execution?*

AM: We believe that there are five guiding principles to consider:

1. ACOs should be set up with the objective of creating local sustainable health communities. We feel strongly that solutions to transform the health delivery system depend on the context that emerges at the local level.
2. ACOs should be designed with the purpose of achieving progress against the Triple Aim objectives of improved quality, lower costs and improved patient satisfaction. All three goals must be met concurrently to achieve success.
3. Incentives alone won't achieve the Triple Aim results. Instead, root cause ecosystem factors must be addressed: the technology infrastructure, improved use of health intelligence, change management and modern transaction processes.
4. Both patient and care team experience must be drivers of the design of ACOs. Patients have a central role in the ACO, with access to robust clinical programs that include wellness, prevention, chronic care, disease management and the like. With improved care comes increased responsibility and accountability for one's own well-being. Taking ownership of your health is a concept that will be new to many.
5. ACOs should maximize the benefits of integration without stagnating competition. ACOs and payment reform together should encourage and promote care provider collaboration, while enhancing consumer choice and competition.

ACN : *The recent NCQA standards for ACOs did not include expertise in predictive modeling and patient risk stratification or experience with managing risk (financial reserves, IBNR). What do you make of this?*

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