

Accountable Care NEWS

Operationalizing Accountable Care: People, Processes, and Technology for Bridging the Care Gap

By Daniel J. Marino, President & CEO, Health Directions

Healthcare technology leaders often talk about turning data into information. The idea is to use data management tools and quality outcomes to create a source of insight into a healthcare organization's past performance and its current direction. For accountable care organizations, turning data into information is an important first step – but it is not enough.

ACOs need to turn information into action. The goal is to use information to improve outcomes for individual patients, improve population health, and deliver care in the most cost-effective way. In terms of the recently finalized Medicare Shared Savings Program rules, ACOs need to bridge the gap between existing patient care outcomes and quality as defined by the 33 measures.

The key to bridging this “care gap” is to create an infrastructure of people, processes, and technology that can translate information into targeted care interventions. How do you build this infrastructure? A close look at groundbreaking ACOs shows that leading organizations are focusing on three areas – enhanced information systems, focused clinical programs, and proactive outcomes management.

Information Systems: Beyond Connectivity

For the past several years, healthcare IT leaders have been emphasizing *connectivity* – the need to link provider information systems to speed up and improve communication.

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Health Care Innovation Zones: An ACO for AMCs?

By Julie Schulz, MD, Consultant, Sg2

As we watch accountable care organization (ACO) fever rise – spiking again after the Centers for Medicare & Medicaid Services (CMS) released the final rules on October 20, 2011 – academic medical centers (AMCs) are left wondering what their role will be in a coming “ACO era.” Health care innovation zones (HIZs) have gotten significantly less media attention than ACOs, but present a compelling model for AMCs to consider. HIZs are 1 of several pilot projects that will be managed by the Center for Medicare and Medicaid Innovation (CMI). HIZs are fundamentally ACOs with AMCs at their heart, combining the unique advanced care expertise, data research capabilities, and physician training competencies of academic hospitals in partnerships with nonacademic organizations, including community providers and public and private payers.

House of Representatives Bill

Specifics about HIZs are sparse in the Patient Protection and Affordable Care Act (PPACA), and CMS has not yet released additional details. However, a House bill proposed in 2009 by US Representative Allyson Schwartz (D-PA) and developed with input from the Association of American Medical Colleges served as a template for HIZ language and provides hints as to how HIZs may be implemented. In the bill, an HIZ is defined as a partnership arrangement in which an AMC leads and coordinates care with other hospitals, primary care providers, outpatient care, recovery and rehabilitation facilities, public health, community services, and Medicare and private payers. In addition, the bill dictated that HIZs must:

- Identify a specific geographical zone and estimate the size of the patient population that could be cared for within the HIZ.

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Accountable Care News

1101 Standiford Avenue, Suite C-3
Modesto, CA 95350

Phone: 209.577.4888

Fax: 209.577.3557

info@accountablecarenews.com

www.AccountableCareNews.com

Editor's Corner

Raymond Carter, Senior Editor, *Accountable Care News*

Pierce Conran, Editor, *Accountable Care News*

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Erratum: An online version of this issue incorrectly attributed the interview on page 12 to John Goodman. In fact the interview was with NCPA Senior Fellow Devon Herrick. We apologize to Dr. Goodman and Dr. Herrick. Ed.

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 Mark Werner, MD.



Mark Werner, MD, CPE, FACPE

Chief Clinical Integration Officer
Fairview Health Services
Minneapolis, MN

Dr. Mark Werner is currently Chief Clinical Integration Officer at Fairview Health Services in Minneapolis, MN. In this role he provides strategic vision and direction for the development of a physician led integrated care network across a 600 member multi-specialty group, some 1200 independent physicians within a contracted network, and the 700 faculty members of the University of Minnesota School of Medicine. Clinical integration efforts are focused on producing both a high-value system of care dedicated to quality, patient experience, and efficient use of resources and a world-class academic health center in partnership with the University of Minnesota. He holds system-wide accountability for quality, patient safety, clinical informatics, and patient experience initiatives. In addition he oversees medical staff management and clinical research and education.

Prior to his current role, Dr. Werner was President of Carilion Clinic Physicians and Executive Vice President and Chief Medical Officer for the Carilion Clinic. In that capacity he led Carilion's transformation from a hospital operating company to a physician-led integrated clinic. He served as the executive lead, in collaboration with the Brookings Institute and the Dartmouth Center for Health Policy Research, on a national ACO pilot project and was involved in planning and developing the Virginia Tech Carilion School of Medicine and Research Institute.

Dr. Werner received his undergraduate degree in biochemistry with honors from Rice University and his medical degree with honors from Vanderbilt University School of Medicine. He completed his residency in pediatrics at Vanderbilt before completing a fellowship in Adolescent Medicine at Cincinnati Children's Medical Center. Dr. Werner also completed a program in medical management at Carnegie Mellon University and is a member of numerous professional organizations and serves on the Board of Directors of the American College of Physician Executives.

Subscribers' Corner

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ACOs: A Call to Arms for Payers?

By Gary M. Austin, Principal and Co-Founder, TranzformHealth

These are the times that try men's souls". When Thomas Paine wrote those illustrious words at Christmas, 1776, the country was in a deep crisis, fighting for its very survival. By almost anybody's standards, we're in a crisis that threatens the very survival of our Nation. Dysfunctional partisan politics, economic threats from abroad, unchecked immigration, a financial system out of control, and scores of other topics are challenging our very core.

Amongst the largest drivers of this duress is health care. Be it the "perverse incentives" alignment of the current system; the lack of "sanity" in delivery setting and model; the disparities and biases inherent in the system due to race, gender, financial situation, employment status, and scores of other attributes; to the oligopolistic positions of both payers and delivery organizations in many markets, the US health care system is in need of a fundamental overhaul. Virtually no one thinks that the system as it exists today should remain intact.

The rise of the Internet is the catalyst for this change. In virtually every other industry, the Internet has created substantial, fundamental transformation. Be it retail, media, transportation, military, manufacturing, or a host of other industries, the Internet has exponentially increased the volume of information, the speed of information transfer, and deep supply chain integration, and it has caused massive disintermediation of players. Arguably, healthcare, education, and energy are the next industries in line for transformation.

Payers are a core component of the current healthcare system. If they are to remain a core component of the system, however, they have to adapt to the "New, New" that the Internet has created. Amazon, Apple, Expedia, eBay, Progressive Insurance, and scores of others all massively disrupted existing players in other industries; now it is time for the Internet to massively disrupt healthcare. And traditional payers are right in the Internet's bullseye. Disliked (often hated) by consumers, seen by many as a non-value added cost driver, and infused with bureaucracy, payers need to either radically transform or die.

I believe that within three years, the end of 2014 (AKA Internet time) we will see the following:

- A new wave of mergers and acquisitions by payers of payers. Payer is a game of scale, and the big will get bigger faster. They have huge capital reserves, know how to buy and integrate, and have market pressure to accelerate them. Any regional payer who gets into financial difficulty or has significant market penetration will be fair game. United, CIGNA, Humana, and Aetna are all poised to acquire, and the 39 Blues could well be down to 25 in short order with Highmark and HCSC leading the way.
- A wave of new, potentially highly disruptive entrants specifically focused on the retail market that will explode in 2014 when the exchanges come online. This is the legacy payer's Achilles heel, and they are extremely vulnerable here. If successful acquiring individual business, these "retail payers" will then point their sights on the small business market, which is extremely price sensitive. As an aside, those disruptive entrants that exhibit early success will be well positioned to be acquired at rich multiples by the national payers.
- Most payers shedding "care management operations" within their walls as a core competency, and paying a kicker to their provider network to assume that responsibility. Operationally, that may play out as the delivery entity hiring its own care management personnel, or the payer placing payer personnel directly into the delivery entity. Real-time analytics will make this service far more valuable at the point of care rather than as an afterthought.
- Accountable Care Organizations (ACOs), or similar constructs will be either underway or announced for in excess of 50% of the delivery marketplace, with delivery marketplace defined as delivery entities either composed of or bundled together (IPA, PHO...) greater than 25 FTE's. While "single shingle docs" will still exist, the vast majority will have their practices acquired by ACO entities, or they will disband and become ACO FTEs. This has happened in every other cottage industry, from travel to legal to retail. There's no reason to think that healthcare will be any different.
- Those entities that make substantial investment in health IT, especially focusing on (a) connectivity, (b) analytics, and (c) social media will make a substantial leapfrog over their non-connected, non-analytical, non-social competitors. And if you don't have the capital to invest, you won't be able to play the game.

Think about it. If you are a consumer, to whom would you rather go? The provider with whom you can schedule your appointment online, with whom you can text for questions, who sends you reminders and alerts for needed services and meds, or the one where you have to wait 20 minutes on the phone to then schedule a callback tomorrow when the doctor is free. Once accountable care takes hold, payers still focused on fee-for-service products cannot compete. The free flow of information, publicly accessible quality reporting, an open pricing model, and direct delivery entity-patient connectivity will destroy this model within a few short years. And if you're not an integral part of it by then, you're disintermediated. Other than specialized boutique entities, business has been disrupted time and time again by the Internet.

Payers, as George Washington said, consider this your "call to arms". Either take the accountable care lead immediately or risk acquisition, disintermediation, or substantial loss of market. Of course, there's always room for one last buggy whip manufacturer.

Gary M. Austin is the principal and co-founder of TranzformHealth. He can be reached at (585) 967-3562 or gaustin@tranzformhealth.com

Health Care Innovation Zones ...continued

- Coordinate a group of clinical entities capable of providing inpatient, outpatient, post-acute, and preventive care.
- Engage community and clinical care leaders in designing the HIZ plan.
- Leverage information technology (IT) to coordinate care across facilities and geography.
- Collect and report quality data to continuously maintain or improve the quality of care.
- Provide comprehensive services to at least 50% of the population in the HIZ.
- Collect and submit data on changes to medical education that reflect changes in how health care is delivered.

As of the writing of this post, it is unclear how (and if) HIZ pilot projects will be funded. Although the fate of HIZs is uncertain, they share much in common with ACOs, which require a strong foundation of primary care. However, most AMCAs have traditionally emphasized tertiary and quaternary care. Future ACOs (and HIZs) will likely give AMCAs the role of a “center of excellence” for patients who require specialty care beyond the scope of what community ACOs can provide. Thus, AMCAs could have multiple contracts with different ACOs that refer to the AMC for tertiary and quaternary care. A surefire strategy for AMCAs in the short- to mid-term includes the following actions:

Strengthen core competencies as “centers of excellence.” Take a disease-based approach to determine in which service lines, procedures or specialties your AMC excels – not every AMC can be a center of excellence in everything! Invest in these areas for sophisticated, high-margin care and strengthen the referral networks that bring in patients for these services.

Learn to partner with primary care providers and post-acute care providers. AMCAs should establish a coordinated, collaborative approach to transitioning patients between sites of care. Tools to improve coordination include:

- A service culture in which both the patient and the referring physician are seen as high-value clients of the AMC.
- An electronic medical record that interfaces with both the primary care office and the AMC.
- Nurse navigators and patient coordinators who facilitate communication between sites of care, providers, and patients.
- Clear guidelines for primary care and community sites on how to perform tests such as biopsies, imaging studies, and other first-line treatments prior to transferring patients to the AMC. Primary care/community health sites and AMCAs should develop these guidelines together.
- Clear referral pathways specifying to which provider the patient will be referred.
- Clear guidelines for post-acute care and effective communication regarding patients’ care plans.

Anticipate major organizational and cultural changes needed for AMCAs to become ACOs or HIZs. Faculty practices that are unified with university hospitals and clinics will be in a better position to coordinate care and avoid interdepartmental conflict than organizations with fragmented leadership. AMCAs will have to negotiate alignment strategies that balance the needs and goals of faculty, non-faculty employed physicians, and independent physicians aligned with the AMC network. Meaningful clinical quality incentives (financial and nonfinancial) will have to be developed for faculty, whose current incentives heavily favor research and grants.

AMCs Making ACO News

AMC interest in ACOs and HIZs varies considerably by organization. A few AMCAs are aggressively pursuing ACO and ACO-like networks, while many are adopting a wait-and-see approach and others are sitting firmly on the sidelines. Interest, however, has picked up significantly in the last few months. Two examples include:

- Montefiore Medical Center, the university hospital for the Albert Einstein College of Medicine, is actively positioning itself to become more accountable for the cost and quality of care. Montefiore’s 4-hospital system has maintained positive operating margins despite the fact that 80% of its volume comes from Medicare and Medicaid patients. It has done this by building an integrated system that includes 21 primary care clinics, multiple physician-led quality improvement initiatives, and a health IT system that tracks patient data across the care continuum. This integration has allowed Montefiore to efficiently deliver care to 150,000 enrollees in capitated contracts from both government and private payers, laying the groundwork for potential transformation into an ACO.
- Johns Hopkins Medicine’s plan to develop an ACO places it in a unique position because it already has an insurance plan, affiliated primary care groups, community hospitals, and 2 recently acquired regional hospital centers. In addition, Johns Hopkins has been participating in innovative payment models, such as PACE (Program of All-Inclusive Care for the Elderly), a capitated program that provides outpatient senior care. Hopkins also has created a virtual, multidisciplinary Center for Innovative Medicine to promote patient-centered approaches to care delivery.

In planning for the long-term, AMCAs should partner with (but not necessarily acquire) primary care providers and begin piloting care delivery models, payment models (eg, bundled payment), and care coordination strategies. Taking a data-driven approach to pilots is a helpful way to incrementally redesign care. Ultimately, metrics will make AMC partnerships more accountable for the care of patients in the community. AMCAs should focus on areas such as hip replacements, cardiac surgery, and high-risk obstetrics, in which the AMC has the means and opportunity to decrease utilization of expensive services. Regardless of the partnerships that emerge, a strong System of CARE (Clinical Alignment and Resource Effectiveness) provides the best foundation for any 3-letter acronym of the future.

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Operationalizing Accountable Care ...continued

But while connecting systems is critical, better communication itself will not deliver accountable care. The real need is not just sharing information but *shaping* it. Leading ACOs are developing IT systems that organize information for the clinic, structure it for population management, and help drive performance outcomes.

Technologically, the key system is a Health Information Exchange (HIE). However, it is important to understand how leading organizations are using HIE capabilities. An HIE is not just an interface engine, it is a tool for structuring and sharing information. Think of the difference between a conventional telephone (a tool for transmitting information) and a smartphone (a tool for organizing information and using it in different ways). Like a smartphone, an HIE provides powerful capabilities for exchanging, assembling, and managing data.

Leading ACOs are coupling HIEs with an array of supporting systems to organize data into high-value clinical and financial information. Chief components include:

- An Enterprise Master Patient Index (EMPI) that assembles patient information from network EMRs and databases, creating a longitudinal record for every patient within a care population;
- A clinical data repository that collates patient information by diagnosis, enabling ACOs to effectively manage disease categories and improve population outcomes;
- A customer relationship management (CRM) tool to support patient outreach, content management of patient education materials, and patient-focused call center activities; and
- A business intelligence system with data warehouse and analytic capabilities, allowing ACOs to manage financial and cost data in detail.

The key to bridging this “care gap” is to create an infrastructure of people, processes, and technology that can translate information into targeted care interventions. How do you build this infrastructure? A close look at groundbreaking ACOs shows that leading organizations are focusing on three areas – enhanced information systems, focused clinical programs, and proactive outcomes management.

Clinical Operations: Targeting the Biggest Opportunities

The quality movement is an important driver of the accountable care paradigm, but an ACO cannot target “quality” in general as its sole aim. Leading ACOs have developed operational processes for identifying the biggest quality/cost opportunities and applying targeted interventions to improve outcomes.

- One critical discipline is risk stratification. Every healthcare population is a continuum of low-, moderate-, and high-risk patients. Prominent ACOs have developed expertise in using EMR data, disease registries, and business intelligence analytics to identify patients in the critical *high-risk* and *moderate-high-risk* categories.
- Another basic discipline is clinical integration. Several organizations have gained attention for their success at bringing together multidisciplinary provider/administrator teams to improve care for high-cost diseases. Note the practical focus of these initiatives. Successful clinical integration programs use evidence-based information to create well defined clinical care pathways. Just as important, they create roles, structures, and tools to make sure care plans are executed at the point of care.

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Operationalizing Accountable Care ...continued

How does it all work together? Consider how an effective ACO might structure an effort to improve care for congestive heart failure (CHF) patients:

First, a collaborative group develops a care model. The model might include (1) an evidence-based plan for stratifying patients by heart function measures and risk factors, (2) a baseline track of scheduled appointments and tests, (3) pathways for medical management and interventional care, (4) patient education goals for home monitoring, and (5) a panel of clinical outcomes metrics, including hospitalization/surgery rates.

Second, the program identifies top risk groups. As a starting point, the initiative might focus on two cohorts: CHF patients with recent hospitalizations (high-risk) and non-hospitalized CHF patients who have hypertension and high BMI (moderate-high-risk). Based on care model protocols, the program would identify concrete interventions aimed at two goals – preventing readmissions for high-risk patients and keeping moderate-high-risk patients from progressing to high-risk status.

Third, the program uses care coordinators to keep patients on appropriate care pathways. Nurse navigators or care coaches monitor CHF patients to make sure physician appointments and labs are up to date and lab results fall within appropriate ranges. They also call patients periodically to check up on medication compliance and provide coaching on home monitoring.

Fourth, point-of-care tools are incorporated into overall IT systems. Physician EMR systems include alerts and flow sheets that drive agreed-upon CHF protocols and help support evidence-based decision making about heart medications at the point of care.

Fifth, a patient portal provides further support for the care plan. Patients in the program can go online to enter daily values for heart rate, blood pressure, and weight. Care coordinators use this data to tailor patient coaching. The portal could also feature CRM tools to push key information to patients, such as appointment reminders for patients who have not seen a physician in six months.

Data: From Reporting Outcomes to Managing Outcomes

The final rule for the Shared Savings Program cut reporting requirements in half for Medicare ACOs. Easing outcomes reporting will make the program more manageable for many organizations. In the long term, however, ACOs will need to embrace outcomes data, not see it as an obstacle.

Leading ACOs are going beyond *reporting* outcomes and putting tremendous energy into *managing* outcomes. The most advanced organizations have developed capabilities for managing results within four slices of data:

- *Clinical data* provides a current health outcome snapshot for a specific ACO population. For example, a core data point for an ACO's diabetic population might be the percentage of patients with good A1c control. Nationwide benchmarks (such as HEDIS data) provide a quality denominator.
- *Quality data* measures the organization's success (or failure) in delivering protocol-defined interventions to a given population. For instance, an important ACO quality metric might be the percentage of diabetics with poor A1c control who received follow-up evaluations and appropriate medical management.
- *Financial data* provides information required to identify the total cost of care for populations and individual patients. For example, to effectively manage diabetic patients in the high-risk group, the ACO would need to capture full cost information on provider encounters, hospital admissions, ED visits, lab costs, etc.
- *Claims data* supplies information on all patient services and interventions, not just encounters generated by ACO providers. Say a diabetic patient within an ACO is hospitalized for hyperglycemia while vacationing in another state. Encounters and claims for these services take longer to come in, but it is important to capture this data to get a complete picture of care and costs and identify the patients that "leak" out of the ACO.

The final rule for the Shared Savings Program cut reporting requirements in half for Medicare ACOs. Easing outcomes reporting will make the program more manageable for many organizations. In the long term, however, ACOs will need to embrace outcomes data, not see it as an obstacle.

The key to managing all of these data components is monitoring outcomes and responding proactively. In leading ACOs, outcomes management is the "return loop" of a process improvement cycle. Programs use clinical data to identify the top health issues within disease populations. Quality data provides a precise measure of the effectiveness of processes and interventions and guides specific improvement efforts. Detailed financial information (including complete claims data) provides the opportunity to manage high-cost patients in the same way an organization manages high-cost diseases – with lower-acuity interventions designed to prevent patients from progressing to higher-acuity needs.

Translating Goals into Reality

As accountable care enters its formal launch phase in 2012, finding ways to bridge the gap between current care and quality/outcomes goals will be critical to success. The key is to focus on more than just connectivity, quality, and reporting. Groundbreaking organizations are operationalizing accountable care by developing processes for translating high-value information into high-impact clinical interventions and better outcomes in costs and patient care.

Daniel J. Marino is the president and CEO of Health Directions, a national consulting firm that provides business solutions for healthcare organizations. He can be reached at (312) 396-5400 or dmarino@HealthDirections.com.

Thought Leader's Corner

Q. "Could the Comprehensive Primary Care Initiative be a vehicle for smaller physician groups in particular to enjoy some of the benefits of an ACO model without having to create the infrastructure?"

"The ACO initiative, even after the recent simplification of the final rule, leaves a gaping hole in the way the government plans to address the need to transform healthcare into a collaborative and more efficient system by effectively excluding small practices due to high administrative and clinical thresholds. The newly announced Comprehensive Primary Care (CPC) initiative, although currently limited to 5-7 selected localities, offers a seemingly viable option to incentivize coordinated, community-based quality care on a broader basis than Medicare ACOs while lowering the barriers for participation. Moreover, the CPC initiative calls for participation of all payers in a locale, thus ensuring a broader implementation that better mimics the delivery of care in the community while maximizing the financial incentives, including shared savings, for community-based providers. Considering that solo and small practice physicians still provide health services to a large chunk of our population, this is a practical and realistic approach that is hinged on successful coordination between multiple players. However, the relatively limited planned implementation may be shadowed by the ACO initiative."



Gai Elhanan
CMIO
Halfpenny Technologies
New York City, NY

"The Comprehensive Primary Care Initiative does offer providers from individual and small practices the opportunity to participate in a shared-savings, coordinated-care environment without the burden of joining a larger integrated physician group or health system, but infrastructure challenges similar to those faced within an ACO remain. With primary care physicians serving as the hub of patient care, for example, providers and payers will need to tightly coordinate patient activities and the services they receive – much like an ACO. It will be difficult to manage these processes on paper, and physicians often cite the high cost of HIT infrastructure as a barrier to such new models of care. Smaller practices, especially, will struggle with the costs, workflow challenges, and lost productivity often associated with collaborative HIT initiatives. To overcome this intimidating hurdle, providers and payers alike can look to web-based portals and similar solutions that will allow information exchange and care management with limited start-up and maintenance cost. In the case of the Comprehensive Primary Care Initiative, payers and primary care physicians are hopeful that they can work together toward a solution so that the very best practices are able to participate in the program, regardless of their size."



Gene Boerger
Vice President of Product Development
Emdeon
Nashville, TN

"I do not believe this will be possible without additional infrastructure. Too many requirements of the program lie outside of the reality of a primary care practice. The nature and location of the infrastructure needed is the real question."

Community organizations composed of networks of smaller providers can create the necessary infrastructure. The infrastructure can be centralized, lightweight, and patient-problem focused. In Oregon, this is taking the form of Coordinated Care Organizations now mandated by the state. These organizations create opportunities for additional funding and a more effective restructuring of healthcare.

An additional benefit of a community organization is a consistent management approach. This will reduce the impact to the program when members move from one plan to another."



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

Thought Leader's Corner

"The Comprehensive Primary Care Initiative would provide a unique opportunity for a primary care practice to create a population-based healthcare practice that's primarily focused on patient care rather than on creating financial savings. Although the PCP group would need to develop the required fundamental care elements, it could receive direct payment from CMS and/or the participating payers to mitigate that cost. This contrasts with the requirements of an ACO, in which participants are required to fund their own infrastructure investments from any future shared savings that they may generate, or from their own internal capital. In addition, the participation of payers other than Medicare can create a larger group of patients over which the fixed infrastructure costs can be recovered. Finally, there's no apparent down-side risk to participants as is present in some ACO models.

When compared to an ACO, the primary disadvantage of this program for PCPs is the reduced ability to generate shared savings payments. However, the direct payments for care management may outweigh the potential financial gain from shared savings. The initial program is offered to payers, so PCP groups won't be eligible to participate unless payers in their market are selected by CMS, and the details of the program will depend on the proposals of those payers and therefore won't be known until the payers have been selected. Also, PCPs participating in this program will not be able to participate in an ACO or other shared savings program. For physicians whose principal interest is patient care, this program will be an attractive alternative."



Jonathan Pearce
Principal
Singletrack Analytics, LLC
Marlton, NJ

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

Accountable Care Organization eNewsletter

<http://www.healthcarenewsletters.com/archive.html>

MedeAnalytics Accountable Care Organization Center

<http://www.medeanalytics.com/healthcare-analytics-solutions/accountable-care-organizations.html>

Optum Insight Accountable Care Organization Resources

<http://www.ingenix.com/Accountable%20Care%20Organizations/Resources/>

Accountable Care Organization Legal Resources

<http://www.healthlaw-blog.com/2011/04/aco-accountable-care-organization-resources/>

INDUSTRY NEWS



Optum Brings Together Dedicated Team to Help Health Systems Rapidly Build and Implement Accountable Care Organizations

Optum has introduced its Accountable Care Solutions business to enable hospitals, physicians, and health plans to better coordinate patient care, enhance care quality and financial performance, and, ultimately, increase consumers' satisfaction with the health system. Since its formation earlier this year, the Accountable Care Solutions team now includes more than 700 experienced professionals across Optum's businesses, including the recent addition of Carol Corporation, a consulting firm with specialized expertise in care redesign and clinical performance management services. This team leverages Optum's broad portfolio of health information technology, consulting, and population health management capabilities to help health systems across the country design, build, and operate new models for collaborative care, balancing risk, and reward for all constituents in their markets.



Minnesota Payer-provider ACO Reports First Year Savings of \$6 Million

A one-year-old accountable care organization established by Allina Hospitals & Clinic and payer HealthPartners has reported that it reduced medical cost by \$6 million in 2010 and reduced the medical cost trend to 3 percent compared with 8 percent in 2009. The ACO, called the Northwest Metro Alliance, launched last year and provides healthcare services for more than 27,000 people in the northwest suburbs of the Minneapolis-St. Paul metropolitan area. Its focus is on attaining the "triple aim" of health reform – improving the patient experience of healthcare, improving patient health, and decreasing costs.

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INDUSTRY NEWS



HHS Releases Final Regulations For ACOs

Physician and hospital groups applauded the changes in the final ACO rule announced by officials at the Centers for Medicare and Medicaid Services. The administration is betting the new design will entice scores of health care providers to form into an untested health care model next year. "We have been able to fine tune and improve the rules for a range of stakeholders, providers and patients," said Dr. Donald Berwick, the CMS administrator, in a conference call with reporters.



Final ACO Rule Holds Great Possibilities for Health IT

Compared with the draft rule on accountable care organizations (ACOs) that the Centers for Medicare & Medicaid Services (CMS) issued last March, the final rule has made it significantly easier for ACOs to qualify for the Medicare shared savings program in the area of health IT reports Fierce Health IT. What CMS has done, in effect, is to recognize that healthcare organizations are in a variety of stages on their road to electronic perfection. Yet that doesn't mean that the less technologically advanced groups aren't trying to provide accountable care that lowers costs and raises quality.



Analytics Vendor Analyzes ACO Rule

MeDeAnalytics Inc., a vendor of health care business intelligence software focusing on performance management to improve clinical, financial and operational outcomes, has published a free white paper summarizing the final Medicare Shared Savings/Accountable Care Organization rule.



Shared-Savings Rules Get Nod from AMGA

The revisions that federal officials undertook in the recently issued final version of the Medicare Shared Savings Program from an earlier version drew praise from a national advocacy group for large physician practices.



Health Access Solutions Provides Technology Platform for Anthem's First Commercial ACO in Northern California

Health Access Solutions, offering its Web-based multidisciplinary Coordinated Care Platform™, announced today that the use of health information technology software was a key factor in Anthem Blue Cross' decision to choose the Individual Practice Association Medical Group of Santa Clara County (SCCIPA) as the provider partner for the first accountable care organization (ACO) in the northern California market. The Health Access Solutions Coordinated Care Platform enhances communication and collaboration among SCCIPA physicians which is critical to the success of any ACO.



The ACO Race Is On: Navigating the Terrain

The final CMS rules include a 622 page preamble that is a model of transparency. Section by section, the preamble describes the originally proposed rules and their rationale, the public comments received in response, and the CMS response to the comments. In each case, CMS lays out possible alternative rules, their advantages and disadvantages, and the reason for its final decision.



Employers Look to ACOs to Increase Value, Keep Costs in Check

A new report from human resources consulting firm Aon Hewitt and healthcare consulting firm Polakoff Boland says employer interest in accountable care organizations is ramping up as they seek new ways to continue offering healthcare benefits to employees. "Seventy-seven percent of employers are unlikely to exit healthcare management when health insurance exchanges become available starting in 2014," the study authors noted. "This finding indicates that employers intend to remain 'in the game' of offering healthcare benefits for the foreseeable future. Sixty-five percent of respondents have expressed interest in exploring the use of ACOs as an option for providing healthcare benefits to their workforce."

INDUSTRY NEWS



AtlantiCare Announces Launch of Accountable Care Organization

AtlantiCare, an integrated care delivery system in southeastern New Jersey and a 2009 recipient of the Malcolm Baldrige National Quality Award, announced today that it is launching AtlantiCare Health Solutions, an accountable care organization (ACO), which is expected to enroll groups of people in 2012.

David Tilton, the system's president and chief executive officer, said AtlantiCare will operate its accountable care network through AtlantiCare Health Solutions, Inc., a New Jersey nonprofit corporation. AtlantiCare's range of health and wellness services, its distinctive chronic care management capabilities, and both independent and employed physicians as well as payer partners will participate in the ACO. Tilton also noted that AtlantiCare Health Solutions will have a separate governing board with physicians accounting for the majority of its members.



First Pioneer ACO Accepted; Banner Health to Decide on Contract

Banner Health could be the first accountable care organization (ACO) under the Pioneer ACO program, if it chooses to accept the Centers for Medicare & Medicaid Services (CMS) contract, reports the Phoenix Business Journal today. CMS accepted the application of Arizona's largest health system as the first in the ACO experiment on a governmental level, and Banner Health has until mid-November to decide, according to the article.

Health Care Innovation Zones ...continued

Sources: Berkowitz SA and Miller ED. Accountable care at academic medical centers—lessons from Johns Hopkins. *N Engl J Med* 2011;364:e12(1)–e12(3) [Epublication ahead of print]; Kastor JA. Accountable care organizations at academic medical centers. *N Engl J Med* 2011;364:e11(1)–e11(3) [Epublication ahead of print]; Sg2 Interview With Montefiore Care Management Organization, February 2011; Chase D. Montefiore Medical Center Case Study. The Commonwealth Fund: October 2010; HR 3664: Healthcare Innovation Zone Pilot Act of 2009.

Dr. Julie Schulz is a Consultant with Sg2. This article first appeared on Sg2's Online Community and is reprinted with permission. Sg2 is a health care intelligence and information services company whose data-driven systems,

Health Care Innovation Zones ...continued

business intelligence, and educational programs deliver growth and clinical performance improvement solutions across the care continuum. Sg2 works with more than 1,200 hospitals and health care organizations in the US and around the globe. For more information, visit www.sg2.com.

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Devon Herrick: The American Medical Group Association reported to CMS that nine-in-ten of its members will probably not participate in the ACO program because of the reporting requirements and financial disincentives. CMS has since relaxed some of the regulations.

Accountable Care News: *You have been critical of the approach taken to health care reform by the Obama Administration. Where do you think they missed the mark and how would you approach the problem of the uninsured?*

Devon Herrick: The first step should be to repeal the individual and employer mandates then offer a generous tax subsidy to individuals and families to obtain insurance on their own. This would allow them the freedom and flexibility to adjust their benefits and cost-sharing in order to control costs.

Senator Coburn and Representative Paul Ryan have proposed similar ideas. A tax credit would provide every family with the same subsidy regardless of family income.

The single biggest health insurance problem for most Americans is the lack of portability. If history is a guide, 80% of the 78 million baby boomers will retire before they become eligible for Medicare. Two-thirds of them have no promise of postretirement health care from an employer. If they have above-average incomes, they will receive little or no tax relief when they try to purchase insurance in the newly created health insurance exchange. To make matters worse, the ACA appears to encourage employers to drop the postretirement health plans that are now in place.

The first solution is to allow employers to do something they are now barred from doing: purchase tax-free, personally-owned, portable health insurance policies for their employees. Such insurance travels with the individual — from job to job and in and out of the labor market. Employers could continue to subsidize employee coverage; but the coverage would be individually-owned.

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

Devon Herrick: I began my career as a health economist as an accountant for a health care system, doing accounting for a chemical dependency center and an ambulatory surgery center, both owned by Baylor Medical Center in Dallas.



Catching Up With ...

Devon M. Herrick, PhD is a senior fellow and health economist at the National Center for Policy Analysis (NCPA). He is a leading expert on 21st century medicine, including the evolution of Internet-based medicine, consumer driven health care, and key changes in the global health market. He was among the first to identify and publish in-depth studies on medical tourism, telemedicine, and "shopping for drugs" strategies. Dr. Herrick concentrates on a variety of critical health care issues, such as health insurance and the uninsured, patient empowerment, and trends in state health policy reform.

Devon M. Herrick, PhD

- Senior Fellow, National Center for Policy Analysis, Dallas, TX
- Previously a research assistant at the Bruton Center for Development Studies at the University of Texas at Dallas
- Writes regularly on health policy for the NCPA and other research organizations and is a contributing editor of *Health Care News* and a regular contributor to *NABE News*
- His comments have appeared in hundreds of newspapers nationwide as well as on television and radio
- Received a PhD in Political Economy and a Master of Public Affairs from the University of Texas at Dallas with a concentration in economic development
- Dissertation research examined patient empowerment through empirical analysis of the Internet and disease advocacy
- BA with a concentration in finance from Oklahoma City University and an MBA from Amber University
- BS in accounting from the University of Central Oklahoma

Accountable Care News: *What is the National Center for Policy Analysis' role in the shaping of ACOs?*

Devon Herrick: The National Center for Policy Analysis had no direct role in shaping Accountable Care Organizations (ACOs), though we have always tried to educate policy makers, the public, and Congress on the right way to reform Medicare by getting the incentives right. ACOs and other recent Washington initiatives are examples of a much larger trend: Washington telling the medical community how to practice medicine. We are about to usher in the era of big brother medical care – even though a recent study finds little relationship between the inputs Medicare wants to pay for and patient outcomes, such as patient survival.

Pay for performance initiatives are widely considered the latest Holy Grail in health care reform. But, to date, the latest pilot programs have shown little evidence that paying doctors and hospitals for performance improves quality and lowers costs.

Accountable Care News: *Given their current form, how would ACOs need to change to deliver on their promise of better quality and lower costs?*

Devon Herrick: ACOs are one of the latest proposed concepts to slow the growth in Medicare spending. As part of the health reform bill, backers expect ACOs to raise the quality and lower the cost of patient care. Detractors, on the other hand, describe them as "HMOs on steroids."

The system would be better served by providing an incentive for providers to offer new, customized solutions. For several years now, scholars have been calling for a radical change in how Medicare pays doctors and hospitals. Instead of having Medicare set millions of prices for predetermined packages of care, we should allow providers the opportunity to compete based on quality of care by repackaging and repricing their services. Medicare should accept these repackaged services provided (1) the total cost to government does not increase, (2) quality of care does not decrease, and (3) the provider proposes a reasonable method of assuring that (1) and (2) have been satisfied.

Instead of maximizing against reimbursement formulas, doctors and hospitals would be encouraged to discover more efficient ways of providing care, enabling them to make more money for themselves as long as they save taxpayers money and patients don't suffer.

Accountable Care News: *Why do you think it is that major groups like the Mayo Clinic, the Cleveland Clinic, and Geisinger Health System, have rejected the current ACO model?*

Devon Herrick: During the health care debate, the Mayo Clinic, the Cleveland Clinic, Geisinger Health System, and Intermountain Healthcare were repeatedly touted as models for a new health care delivery system. Now, they have something else in common: All four have declined to apply for the ACO "Pioneer" program that was tailor-made by the Obama administration to reward such organizations.

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