SCOTTSDALE INSTITUTE

INSIDE EDGE

The Movement to Accountable Care

EXECUTIVE SUMMARY

On January 1, 2012, CMS will begin reimbursing qualified organizations for Medicare patients under an accountable care organization or ACO model. Exactly what this model will look like is still unclear although in its simplest terms an ACO brings together providers and payors in a coordinated effort to be accountable for the care of a patient population. CMS is currently reviewing an avalanche of industry comments to rules the agency proposed on March 31 and is expected to release final rules sometime this fall at the latest. Judging by our interviews for this report, many if not most of the comments to the proposed rules were negative largely because of various clinical, administrative and reporting burdens placed upon ACO participants.

Still, health systems, plans and provider groups are hopeful CMS adjusts the final rules to make it easier to develop an ACO. CMS also offered more flexibility to advanced health systems with an alternative Pioneer Model ACO. And interest remains high. Nearly 1,000 attendees packed the second annual ACO Summit held June 27-28 in Washington, DC, sponsored by the Engelberg Center for Healthcare Reform at Brookings and the Dartmouth Institute for Health Policy & Clinical Practice (visit www.acosummit.com).

For this Inside Edge view on ACOs, we talked to executives at SI member organizations Advocate Health Care, Heartland Health and Sharp HealthCare, SI sponsor OptumInsight (formerly Ingenix) as well as experts at Premier health alliance and The Commonwealth Fund. Federal regulatory efforts to control the soaring costs of the Medicare and Medicaid programs may be driving ACO development but private ACOs are on the rise. How those organizations fare during the next three years will tell the tale of just how accountable we are for our nation's health and wellbeing.

Young and unproven

"While ACOs may be invaluable to successful health reform, the ACO movement is still young and unproven," says Mark Zezza, a senior policy analyst in the program for payment and delivery system reform at The Commonwealth Fund, a New York-based private foundation devoted to promoting a high-performance healthcare system. That was clear, he says, at the June ACO Summit.

"People are still trying to figure out exactly what an ACO is," he says, "but

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you could tell from the audience that there's a lot more agreement on ACO goals and more ACO activity compared to last year's conference," he says.

Mark Zezza, senior policy analyst, Commonwealth Fund

Not surprisingly, there are few if any tested models and therefore few results and lessons learned. However, there are hundreds of healthcare organizations interested or planning to become an ACO, estimates Zezza. At this point most of the initiatives are being driven through the private sector, although there are 10 Medicare-funded Physician Group Practice demonstration sites launched in 2005 that are likely to become Medicare ACOs.

With so much hype and so little certainty as to what will eventually work, the challenge will be to distinguish between real ACOs—those involved in payment systems that hold an organization accountable for care—as opposed to provider groups merely carrying on business as usual under the rubric of an ACO.

"You definitely need payment reform that results in better value," he says, and that includes paying providers in ways that support investments in care innovation and incentivize more efficient and higher-quality care rather than just more care. ACOs will also have to provide meaningful evidence that their innovation efforts and integration with other providers are leading to better quality and efficiency.

Become a self-critical culture

Successful ACOs will require deep clinical transformation in which providers join together to determine how they collectively deliver evidence-based medicine, what patient populations to target, where to cut losses in areas that aren't working and how to disseminate best practices. Such an effort will require strong leadership and governance that ties together the collaborators and facilitates the significant cultural change required to become an ACO. Specifically, the new culture must encourage a self-critical perspective that fosters continual improvement in data sharing and communication with patients. It means providers working with payors in a new way that eschews the traditional win/lose proposition for one that is win-win.

Rapid-cycle learning and performance measurement will rely heavily on deep leveraging of an EHR and those provider groups not used to such IT capability will have to collaborate with other providers who are up to speed.

"Each ACO is going to be a little different because of local market conditions," says Zezza. Some markets may be highly competitive, some more dominated by a single hospital or health system. Aside from the prevailing structure of healthcare providers, markets will differ in state and local laws that affect how providers can work together, prior expe-

WELCOME NEW MEMBER

Oakwood®

The Scottsdale Institute is proud to announce Oakwood Healthcare, based in Dearborn, Michigan, as a new member.

Oakwood Healthcare, a regional healthcare network, is one of the most comprehensive healthcare delivery systems in southeastern Michigan. It operates four acute-care hospitals, several health centers and a vast number of specialty services, including four centers of excellence. More than 1,300 physicians, representing nearly every medical, surgical specialty and subspecialty, are affiliated with OHS and it has 9,500 employees.

continued on next page

rience with integrated delivery systems, the competitiveness of the payor market, socio-demographic characteristics, existing HIT infrastructures and many other factors that will play a major role in how each ACO develops.

Premier collaboration

While many health systems can live with such an outline of accountable care, the devil may be in the details of federal rules.

Barbara Gray, VP, Premier

"There's lots of noise regarding the CMS proposed regulations," says Barbara Gray, VP, Premier healthcare alliance's Accountable Care Collaborative, which assists members in developing accountable care capabilities, including applying for shared savings and the Pioneer program, funded by the Center for Medicare and Medicaid Innovation (CMMI). (Hear more from Ms. Gray at SI's Fall Forum {http://www.regonline.com/SI-2011-Fall-Forum} "Becoming Accountable in Healthcare," Oct. 6-7 at Ascension and St. Vincent's in Indianapolis.) "Some organizations are taking a wait and see approach. Others are saying the bar is set so high that they will focus their accountable care efforts on other markets, for example their own employee health plans. Overall, the proposed regs have dampened enthusiasm for Medicare ACOs," she says.

Organizations are averse to the financial risk and onerous quality measures inherent in the latest rules. From the perspective of CMS and the Medicare program, Gray says, their efforts have stalled. "That said, members of the Premier collaborative are seeking to fast-track their efforts in implementing accountable care operating principles in specific areas such as clinical integration," she says.

Under shared savings the quality measurement requirements are significant, requiring sophisticated informatics capability. That's a big reason why it's critical for a health system to have upfront investment capital. "Otherwise you will struggle to be successful managing population health and delivering care interventions in a focused, cost effective manner."

Another onerous requirement, according to Gray, is that half of primary care physicians in the ACO meet Stage 1 Meaningful Use. Also, under the attribution model, "you don't know which members are assigned to your panel. If you have 2,000 members in your practice and half are Medicare, that's a significant portion." She acknowledges the rationale behind that requirement is the concern that a provider might treat patients differently if they were outside the ACO; however, as a practical matter, changing practice patterns based upon the payor would be a difficult thing to do. "Regardless, if I were a physician participating in an ACO, I would like to know which of my patients were attributed to that ACO."

continued

The organization serves 1 million people in 35 communities in SE Michigan. In 2010, there were:

- 57,640 inpatient discharges
- 188,986 emergency room visits
- 199,754 hospital-based outpatient registrations
- 359,861 ambulatory visits.

Oakwood is the winner of the 2007 Michigan Quality Leadership Award and was named, for the sixth time, one of the nation's top 100 Integrated Healthcare Networks.

Welcome Brian Connolly, CEO, Paula Smith, CIO, and the entire Oakwood Healthcare team.

"We're inescapably in this era of accountability and value."

"Now we're looking at efficiency across the continuum, which is closely aligned with improving quality as well."

Gray encourages health systems to prepare for accountable care in one or more markets (such as your own employee health plan, self-funded employers and commercial health plans. As the Premier ACO framework illustrates, organizations should focus their efforts on delivering healthcare based upon the following major core competencies:

1. People-centered culture and foundation;
2. Health (medical) home framework, focus on primary care;
3. High value network, including clinical integration and coordination of specialty care;
4. Managing population health, including IT capabilities to enable and support;
5. Leadership, including physician leadership and change leadership;
6. Building payor partnerships.

Advocate for accountable care

Oakbrook, Ill.-based Advocate Health Care, a 10-hospital integrated delivery system serving the Chicago and downstate Illinois areas, is betting that the future has arrived and has cast its net into the accountable-care waters. "We're inescapably in this era of accountability and value," says Lois Elia, VP of AdvocateCare, Advocate's new framework for implementing accountable care and reform, whether that future is in Medicare ACOs or other type of accountable payment arrangement.

"We've jumped into the deep end," says Elia, and a centerpiece of that effort is a three-year shared savings program with Blue Cross Blue Shield of Illinois, which accounts for two-thirds of Advocate's managed care business. A quarter of that revenue is under contract for shared savings, which can also be described as a version of pay for performance (P4P).

Advocate Health Care
Inspiring medicine. Changing lives.

Lois Elia, VP, AdvocateCare

A critical and difficult factor of the new ACO rules involves attribution of members to the accountable entity: PPO benefits design typically allows members freedom of choice as to provider and does not penalize insured members for going outside the network, as is often the case under traditional HMOs. Defining attribution is in the eyes of the beholder, she says, but generally involves retrospectively reviewing claims activity to identify the member's most frequently used primary care provider.

That challenges the health system to conduct appropriate risk adjustments for patients while taking responsibility to manage them across the entire continuum of care. "Now we're looking at efficiency across the continuum, which is closely aligned with improving quality as well," says Elia. For example, reducing readmissions improves quality and efficiency at the same time. "The savings supplies the funding to build the

infrastructure for what is essentially a medical home," she says.

Under a traditional HMO, 90 percent of patient care activity is coordinated within the network, while in a PPO only about half is, according to Elia. This creates some unique communications challenges with both physicians and patients.

Choice is a third rail

"Our goal is to make these patients want to come to Advocate for better service and coordination of care, as opposed to perceiving they must coordinate their care through a gatekeeper" like in a traditional HMO benefit design, she says. "One way to increase the 'stickiness factor' with patients is to provide better access. If you are available, then patients will come to you. Choice is the political third rail for Medicare. Anything else [which doesn't involve choice] is an HMO plan."

Whatever the final payment form, Elia is confident that Advocate's organizational and IT infrastructure is in place for accountable care. "We feel we have a really good foundation in place that incorporates a nationally recognized structure for physician alignment."

Marty Manning, president of Advocate Physician Partners (APP), says the first challenge is to make the conversion from a traditional PPO model to one in which it's possible to track patients who receive care at non-Advocate sites of care or with non-APP member physicians, and to do so in a HIPAA-compliant way. New IT systems are available that can view a total patient population using tools like a master patient index (MPI), and identify gaps in care such as when patients fail to fill pharmacy orders. "This is a rapidly evolving field. Some of these systems are adapted from systems that benefits managers used and are now being repackaged for clinical decision support," he says.

Marty Manning, president, Advocate Physician Partners Organization

APP has been in existence since 1995, a time when HMOs were in vogue in the Illinois market. In 2000 the organization began turning its attention to the PPO space, creating one of the nation's first clinical integration programs. Today, over 3,900 of the physicians on the medical staff at Advocate hospitals are members of APP. Of them, over 1,100 are in primary care, with the remainder being in a wide variety of specialty areas. About 1,000 of these physicians are employed by Advocate, but importantly, some 2,900 remain in private practice.

In 2004, those doctors were measured on 36 quality measures; today they're measured on 150 quality measures, including measures related to chronic disease conditions like diabetes, asthma, and CHF, as well as generic prescribing and patient safety measures. "We identify patients through a variety of

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Advocate does not call them bonuses, because the payments often are payment for the extra work it takes to meet the performance measures.

data sources, and place them in a disease registry where they are assigned to a specific physician. For diabetes, for example, we track physician performance on the eight commonly accepted HEDIS measures," says Manning.

Not a bonus

Based on how well those physicians perform, they earn annual incentive payments that can average up to $15,000 per physician. Advocate does not call them bonuses, because the payments often are payment for the extra work it takes to meet the performance measures. "There's no CPT code for managing a patient in a disease registry, but it takes significant time and effort to manage those patients. Our incentives are designed to complement the traditional fee-for-service payment system to acknowledge and adequately compensate physicians for these types of activities." he says.

Advocate's clinical integration program, which involves nine PPO plans reimbursed by commercial insurers, produces an annual report summarizing its results. The 2011 Value Report, the seventh such annual report, is available online at www.advocatehealth.com/valuereport.

A dashboard provides data views into the population, including such key efficiency measures as readmissions, LOS and potentially avoidable readmissions for chronic disease like asthma, ER visits per thousand patients, admits and patient days per 1,000. "What's really critical is that we see some decrease in trend in cost per member per month," says Manning.

"The most important driver of our success is the culture we have created—of both physicians and management. We've been building that culture through our clinical integration program since the early 2000s," he says.

Elia says the culture change requires accepting that healthcare has entered "a new world with new challenges that include population health, population risk, new kinds of predictive modeling, new information technologies—including clinical decision support and disease registry systems—and the ability to coordinate care across the entire continuum."

In planning its Clinical Integration strategy during the last six months, Advocate developed five strategic focus areas:

1. ***Enterprise management***—create a mechanism for better care management in all settings including the hospital, home, skilled nursing facility and doctor's office. With high-risk patients constituting 3 percent to 5 percent of Advocate's total patient population and the health system at risk for those costs, the emphasis is on filling gaps in care, especially in the handoffs between these settings. While an estimated 10 percent of its patients constitute 50 percent of Advocate's costs, a portion of those costs involve end-stage care that is often unavoidable. So the health system is focusing special efforts on

CONGRATS

SI members Advocate Health Care, Partners Healthcare and Spectrum Health were recognized by Thomson Reuters as among the top ten best-performing health systems based on quality of care, efficiency and patient satisfaction.

Way to go!

areas it can generate a return such as the "actionable patients" who can be identified through claims data that could have been prevented by filling gaps in primary care or through patient self-management.

2. ***Primary care access***—another important strategy to prevent patients from ending up in the ED because they get sick at odd hours or on the weekend. Advocate is working closely with primary care physicians to improve such access and is hiring 66 outpatient care managers dedicated to doctors with higher need patients.
3. ***Post-acute care***—the job is not done when the patient leaves the hospital, so coordinated care with SNFs, rehab and long-term care facilities is critical to ensure best outcomes and prevent readmissions. This involves bolstering partnerships with preferred providers and reaching out to those post-acute care sites. With only a few months into a pilot, Advocate is already showing a decline in readmissions. Previous studies show that about three in 10 SNF patients get readmitted to the hospital, which is not good for the patient or the bottom line.
4. ***Data and analytics***—new systems for tracking population health. Advocate, which uses Cerner for its inpatient HIS, is acquiring software that helps manage patients in the outpatient setting and offers predictive modeling capability. The resulting robust data and analytics allows the health system to share with doctors critical care patterns in the wide-open ambulatory sector.
5. ***Market share growth***—the goal is to reduce unnecessary readmissions and ED visits for ambulatory sensitive conditions. Tactics to "backfill" hospital rooms include closer bonding with "splitter physicians" who can choose which hospitals to send their patients. A second strategy is to identify and link those patients to a medical home that cares for them so well that they want to go to Advocate. The approach uses a combination of physician loyalty, unassigned patients and acquisition of new patients.

"The five strategic buckets," says Elia, "builds on the foundation of Advocate Physician Partners' 15-year history of physician/hospital collaboration and alignment of behaviors to drive improved patient outcomes."

Sharp-eyed view of accountable care

Some leading health systems are indeed taking a wait and see stance regarding ACOs.

"When the law was passed last year," says Bill Spooner, CIO at Sharp HealthCare, a San Diego-based integrated delivery system with seven hospitals and a health plan in the greater San Diego area, "we imagined the ACO would be like the managed care business we've been doing for 25 years. When we saw the proposed rules we changed our view."

Specifically, Sharp management is unhappy with the blind attribution model because it would include patients who might not even be identified to

Tactics to "backfill" hospital rooms include closer bonding with "splitter physicians" who can choose which hospitals to send their patients. A second strategy is to identify and link those patients to a medical home that cares for them so well that they want to go to Advocate.

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- Lorin Bird, research manager, Operations, KLAS

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August 3
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- Jerome A. Osheroff, MD, FACP, FACMI, TMIT Consulting, LLC

August 9
Accountable Care Agenda for Quality
- Jane Metzger, principal researcher,Global Institute for Emerging Practices, CSC

August 11
MD cost for EHRs: Research Report Findings
- Lara Sibley, director, CDW Healthcare

August 15
SI-Cerner Users Collaborative No. 34: Explore Sharing of CDS Interventions
- Jerome A. Osheroff, MD, FACP, FACMI, TMIT Consulting, LLC

August 25
CPOE
- Colin Buckley, strategic operations manager, KLAS

continued on next page

the health system or who otherwise can freely seek care out of the network without penalty. As a result, the organization has "backed off" somewhat on its ACO effort, he says, although it is likely to file a letter of intent to become a Pioneer Model ACO, which was proposed in late May.

Bill Spooner, CIO, Sharp Healthcare

Sharp has been caring for patients under capitated managed care but Spooner says the proposed ACO rules keep it under traditional fee-for-service and patients are allowed to choose whatever provider they want. Also, the 65 quality indicators will require Sharp to expend a great deal of effort in building the appropriate monitoring capabilities. "In the ACO model you can go anywhere you want but the health system still has to track quality indicators. How I pull this external data into my analytics will be an interesting puzzle," he says.

Still, Spooner is optimistic about other aspects of the ACO model, especially its emphasis on patient engagement which will involve use of patient portals and other online tools. "That's really a win," he says, noting that Sharp's first-generation patient portal has 50,000 patient registrations. "That will be fun. As we see more and more using such tools there's no question they're happier patients. Why do I want to sit in a waiting room or wait for a person to return my call? Patients ought to have copies of their medical records. I recently sent an email to my physician through a secure portal and it only took him a few minutes to respond. Some of these things are so exciting from a patient perspective."

If the ACO model does win out, it will require a health information exchange (HIE) as its network infrastructure. However, the landscape will have to become a lot clearer before that occurs. "I don't believe the ACO model is firm enough to understand how it would relate to an HIE," says Spooner. The ACO itself will have to have a strong HIE for a group of providers to come together and effectively communicate patient information.

The original ACO rule was focused around the patient's ability to decline to be part of an ACO, "so you wouldn't even know if they went out of network," he says, and yet the ACO must ensure that patient receives the same quality as if she were a member of the ACO, which could prove quite costly in practice.

Despite its misgivings, Sharp will likely become an Pioneer ACO and will continue to participate in a commercial ACO with Anthem Blue Cross. "In that model we know who our patients are," says Spooner.

Accountability in the heartland

"We already have a Shared Savings system for our own caregivers and are growing a commercial ACO offering with Aetna," says Joe Boyce, MD,

CIO and CMIO at Heartland Health in St. Joseph, Mo. The early outcomes for those initiatives include significant changes in patient behaviors, increased cost savings and better awareness, he says. (Hear more from Dr. Boyce at SI's Fall Forum {http://www.regonline.com/SI-2011-Fall-Forum} "Becoming Accountable in Healthcare," Oct. 6-7 at Ascension and St. Vincent's in Indianapolis.)

Joe Boyce, MD, CIO & CMIO, Heartland Health

"The Medicare ACO initiative is a good idea. What's missing in the initial rules is shared savings with the patient, and what we got instead was tons of overhead," asserts Boyce. Heartland, which is self-insured, has given its more than 3,500 employees health savings accounts as part of its ACO program since the first of this year. "That's going very well. The big key is everybody being tightly aligned with incentives. Medicine has been broken because of adversarial incentives between doctors, patients, and payors. When patients and providers have an understanding of the options and chips on the table, they make better informed choices. "

Patient engagement, improved communications, and point-of-care information within an efficient workflow are all critical components of any successful ACO, according to Boyce.

Achieving accountability in care is an imperative and performance measurement is critical to achieving that goal. As a result, tools like data warehousing and CDS will be instrumental to operating an ACO. "How you stop unnecessary, ineffective, improper orders and testing is a question we'd like an answer to," says Boyce in reference to a particular CDS target Heartland would like to deploy under an ACO strategy. "Decisions have to be real time with the patient, with clear prior guidelines, or both docs and patients will perceive this as just another cost-cutting take away."

It's a strategy that is evolving. "Changing the current system is not only necessary, it's critical for the future of our economy. We're trying to invent weapons of mass disruption," he said.

While several local employers have selected the Aetna ACO for coverage, Heartland is marketing the product slowly because of its uncertain financial impact. "This is a very difficult transition, one that changes the whole ecosystem. An ACO plan could hurt if it's poorly planned, mis-communicated, or has inadequate tools, " says Boyce.

Triple aim

Despite the uncertainty, accountable care is our best shot at stanching rising healthcare costs, according to one expert.

"We're at a fork in the road," says Michael Goran, MD, managing director

continued

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Meaningful Use Series
- Erica Drazen, managing director, Global Institute for Emerging Practices, CSC

September 14
Technology Enabling Your ACO
- Mitchell Morris, MD, principle, Deloitte Consulting LLP and Deloitte & Touche LLP
- Robert B. Williams, MD, MIS, director, Healthcare Practice, Deloitte Consulting LLP and Deloitte & Touche LLP

September 19
SI-Cerner Users Collaborative No. 35: Advocate ACO Prep
- Joel Shoolin, DO, Vice President, Clinical Information, Advocate Healthcare

September 22
ICD-10 Get Ready Now: Lessons Learned from Leading Hospitals
- Mark Morsch, VP, Technology , OptumInsight.

September 26
Are Your Implementations Effective … and Safe?
- John R. (Skip) Valusek, PhD, CPHQ, director, Clinical Analytics, HealthEast Care System

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"You're talking about a multi-year path. That's why CMS requires a three-year commitment."

at OptumInsight and a 34-year healthcare industry veteran who's witnessed every trend from managed care to QI to clinical integration. "We have two choices: regulate ourselves out of it by shifting more costs and reducing provider payments or change the way we deliver care."

Building ACOs—a foundational element of what Optum calls "Sustainable Health Communities"—offers an opportunity for providers, payors and patients to achieve the Triple Aim: improved patient care, population health and reduced cost.

Achieving the Triple Aim requires:

1. Information connectivity;
2. An active patient;
3. Connection with the patient;
4. Alignment of all players;
5. Near total change in the care environment, including more primary care doctors, more outpatient care;
6. Ultimately, payment reform.

OptumInsight is assisting a Tucson, Ariz. collaborative spearheaded by the Tucson Medical Center, three local physician groups and UnitedHealthcare to develop the Southern Arizona ACO or SAACO. "Tucson Medical Center was selected as one of the original Brookings Dartmouth ACO demonstration sites and that experience has been invaluable," Goran says.

SAACO plans to develop a separate management services organization to tackle two key tasks: data, including ensuring interoperability among EMRs; and care management, which will involve identifying at-risk patients, for example, managing their care and implementing preventive care strategies.

Goran cites several challenges facing SAACO:

1. Getting physicians willing to participate;
2. Building an infrastructure;
3. Implementation--especially of the IT and care-management infrastructure;
4. Measurement—are we achieving our goals?
5. Distribution of shared savings among participants.

Michael Goran, MD, managing director, OptumInsight

"You're talking about a multi-year path. That's why CMS requires a three-year commitment," he says. SAACO hopes to be accountable for 40,000 members by its third year of operation. Goran says that one strength of the Tucson initiative is that it is multi-payor—focused on both private and government segments. UnitedHealthcare and Medicare are involved from the start, giving the program a broad enough brush to allow for true population health.

Managing those members successfully will require every one of them to have

a personal health record (PHR). "For a patient to have her own record means she will keep track of her health better through tools like alerts and reminders and watching educational videos online. It can change the way we do care by allowing us to do shared decision making. As you move to a patient-centered medical record office visits drop but interactions go up," he says.

Conclusion

No one can argue that all of us, whether a hospital, provider, payor or patient, must become accountable for our care, whether we call it an ACO or some other acronym. In the near term, we'll have to continue to navigate a blend of regulations and private initiatives to cut a clearer path toward this goal.

OptumInsight's Goran is optimistic that CMS has listened to the industry commentary and will ease the final ACO rules and even lengthen the launch period which requires ACOs to start January 2012. "To me, all that urgency is less important than getting the regs right. It's not so much what happens on January 1 but what happens during the three or four years that follow in achieving the Triple Aim."

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