

# Accountable Care NEWS

## ACO Strategy: Plan for “Open Platforms,” not “Walled Gardens”

By Vince Kuraitis, JD, MBA, Principal, Better Health Technologies LLC

**W**ill ACO information technology (IT) models be walled gardens or open platforms? i.e., will ACO IT platforms focus on exchanging information and workflow within the provider network of the ACO, or will they also be able to exchange information and workflow with providers outside the ACO network?

While this issue might not yet be bright on the radar screens of ACO leaders, it's destined to become a top ACO operational and strategic concern.

### The View from the Clinical Trenches: ACOs Will Need Open IT Platforms

Mike Cummins, M.D., Associate Chief Medical Information officer at 750-physician Marshfield Clinic in Wisconsin, makes the clinical case for an open ACO IT approach in a recent article in *Healthcare Informatics*<sup>1</sup>:

There will be an emphasis on transfer-of-care summaries and how to facilitate information sharing across the full continuum of care, he said. “For instance, you will have to work into care management plans the notification of home health agencies,” Cummins added. “In an ACO model, you will have to have methods in place to communicate all this information to providers who are not part of your own organization. People will have an option to see providers outside an ACO, so you will need to be able to transfer care summaries and discharge summaries outside the ACO.”

*continued on page 6*

### In This Issue

- 1** ACO Strategy: Plan for “Open Platforms,” not “Walled Gardens”
- 1** ACO Development: What’s in it for Nurses?
- 2** Editor’s Corner
- 3** Do You Have ACO Fever? Five New Year’s Resolutions for Health System CEOs
- 5** Subscriber’s Corner
- 8** Thought Leader’s Corner
- 10** Industry News
- 12** Catching Up with.... Jack Cochran, MD, FACS

## ACO Development: What’s in it for Nurses?

By Susan E. Strzelczyk, RN, Senior Analyst, SG2

**T**he Patient Protection and Affordable Care Act (PPACA) will challenge hospitals, health systems, payers, and physicians to assume increased accountability for patient outcomes, quality care, and decreased cost. Sg2, a health care analytics company headquartered outside of Chicago, has been helping organizations interpret the legislation and plan for the new health care landscape. In discussing what accountability will look like -- its structure and its associated care delivery models and payments -- we have just begun to address the largest providers of health care: nurses.

The PPACA provides a unique opportunity for nurses to enhance care delivery and encourage care redesign with the goals of increasing clinical efficiency and taking cost out of the system. New and developing care models, including group visits, e-visits, and telemedicine, will enable clinicians to interact with patients more regularly to encourage proper medical management of common ailments. There is a growing emphasis on the ability to provide high-quality, lower-cost, patient-centered care through palliative services. Growth in this area will increase nurses’ opportunities to offer symptom management and discuss advance directives. Moreover, the importance of patient self management during the next decade will increase patient education requirements of nurses.

These changes are expected as the industry prepares for another sweep of nursing shortages. The aging workforce combined with the projected increase in newly insured patients will strain the health system to continue to provide high-quality care. Care redesign and the accompanying clinical efficiency encouraged in an accountable care organization (ACO) framework will decrease the strain on nurses and have the potential to postpone the nurse shortage. So what exactly does an ACO mean for nurses? How will it change care delivery?

*continued on page 4*

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## Editor's Corner

Raymond Carter, Senior Editor, *Accountable Care News*  
Pierce Conran, Editor, *Accountable Care News*

As announced last month, we have assembled a distinguished group of national opinion leaders on ACO issues representing a broad range of constituencies to help guide the publication. This month we are pleased to introduce Dr. Larry Casalino.


**Lawrence P. Casalino, MD, PhD, MPH**

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Dr. Lawrence Casalino is the Livingston Farrand Associate Professor of Public Health and Chief of the Division of Outcomes and Effectiveness Research in the Department of Public Health at Weill Cornell Medical College. Previously, he worked for 20 years as a full-time family physician in private practice, obtained a Ph.D. in Health Services Research at the University of California, Berkeley, and served on the faculty at the University of Chicago. He is the recipient of an Investigator Award in Health Policy Research from the Robert Wood Johnson Foundation. He has served on numerous national committees, as Chair of the Academy Health Annual Research Meeting, and as the John Fry Fellow at the Nuffield Trust in London. He has worked with the Federal Trade Commission on issues related to clinical integration and has published extensively on ACOs and other topics related to physicians, hospitals, and health plans.

Dr. Casalino completed a B.A. degree in philosophy from Boston College and an M.D. from the University of California at San Francisco. After a general internship at Santa Clara Valley Medical Center in San Jose, California, he worked from 1980 to 2000 as a family physician in private group practice in Half Moon Bay, California. During this period he held Attending Physician appointments at Mills-Peninsula Hospital in San Mateo, CA; at Seton Medical Center in Daly City, CA; and at Seton Medical Center Coastsides in Half Moon Bay, CA. From 1984 to 1986, he was Medical Staff President at the latter hospital. During the 1990s, while continuing in his medical practice, he earned an MPH and a PhD in health services research, with an emphasis on organization theory, institutional sociology, and institutional economics, from the University of California at Berkeley.

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# Do You Have ACO Fever? Five New Year's Resolutions for Health System CEOs

By Tony Miller, Chief Executive Officer, Carol Corp.

**A**dvice: resist the ACO fever. Don't fall victim to the herd mentality. With much still unknown about Accountable Care Organization (ACO) requirements, following the ACO pack is not a strategy. At best, it's a flawed tactic.

One size will not fit all. Strengths, weaknesses, and priorities vary. And, as the saying goes, culture eats strategy for breakfast. In redesigning care and realigning incentives, each hospital and health system will have a unique journey to value-based, accountable care.

To help health system CEOs stay focused in this incredibly challenging environment, here are five key suggestions for 2011:

## 1. Be Intentional with Your Accountable Care Strategy:

In 2011, verify your strengths and weaknesses by accumulating and analyzing performance data on total cost of care, quality, and patient experience to help you understand where you are best positioned to compete and where to prioritize the changes you need to make.

Each organization will have a unique journey to manage and master change. You do not have to make a decision right now, but you do need a firm understanding of your assets, culture, competitive position, and a baseline understanding of how you would do under various payment scenarios. It is never too early to assess your population health management capabilities and to look ahead financially by modeling various payment scenarios for 2015 and 2020.

**Sample Strategic Question:** If you were paid a fixed amount annually to care for a patient with diabetes, what would happen to your financial performance?

## 2. Find Your True North:

Reset your compass so that everything you do – every decision that is made – is done from the perspective of Patient Value: quality, affordability, increasing access, and patient experience. The future requires a laser-like focus on optimizing Patient Value. Whether you become an ACO, or participate in an ACO, or whether the whole ACO concept crumbles, long-term financial success is dependent on delivering differentiated Patient Value.

Patient Value is not the same as hospital or physician value. It's performance that matters to patients' lives, using resources in a way that keeps health care affordable for your patients, and creating an experience that doesn't add to their problems, but actually supports them in their time of need.

**Sample Strategic Question:** Do you know how many of the patients who received back surgery from your organization in the past 24 months are living with less pain today than prior to surgery?

## 3. Make Money on Medicare:

Recognize that today's profit center is likely tomorrow's cost center. Initiate shared savings programs that incent high-quality clinicians to become efficient stewards of resources and work toward achieving profitability at Medicare rates. Demonstrate your health system's commitment to resource stewardship. For example, allocate capital in light of how it will help or hinder you in a payment environment that rewards value. Develop a parallel capital planning process with the assumption that everything is a cost center not a profit center and approve only projects that make sense under both fee for service and value-based payment.

**Sample Strategic Question:** Should you invest in a Da Vinci Machine or develop a new chronic care coordinator team to assist in the management of your high risk employees?

## 4. Make New Friends:

If you are a hospital, your future depends on genuine, positive, patient-centered collaboration with physicians and other care team members.

If you are a physician organization, you also need to play nice with others. You don't need to own everyone and everything, but you do need to find ways to align and work together. Therefore:

- Confirm your organization's role in the market now and determine if that is the right place to be long term. One size does not fit all – not everyone needs to be or lead an ACO. There is a need for both ACO conveners and those who will participate with an ACO.
- Spend time with health plans as well, especially off cycle. Change is tough for them too. Explore new ways to contract for your private sector business that are consistent with the emerging incentives from CMS and other public payers.
- Get to know the purchasers as well, both the employers and consumers. Also, build relationships with your state Medicaid agency, state health exchange, your local employer group on health, and consumer groups. They are your market and you need to understand their issues in order to create new opportunities to work together.

*continued on page 4*

## Do You Have ACO Fever? ...continued

**Sample Strategic Question:** What percent of your revenues are either directly or indirectly controlled by separate legal entities from your own, and are those entities likely or unlikely to partner with you to develop an ACO?

### 5. Lead Through Prototypes:

Merely creating a new corporate shell called an ACO is not a guarantee of success, financial or clinical. To execute on the ACO or a value-based payment model, you must identify resources to fund the transition, redesign care to improve patient experience and efficiency, and realign incentives up, down, and around the organization. These changes take time and rely on leadership, culture change, and technical skill throughout every part of your organization.

You'll soon face the dilemma of living in two payment worlds simultaneously. So create a prototype environment to isolate your change efforts. This will help you contain the positive and negative effects to an isolated portion of your organization, learn objectively about capabilities, uncover needs, and effectively focus improvement efforts. The know-edge acquired through prototyping is essential to leading both your organization and your market through these uncertain times.

**Sample Strategic Question:** If a large self-insured employer in your market asked you to enter into a long term financially lucrative deal to deliver disease management services to its employees, how would you respond?

Rarely have health system executives faced such a daunting environment of market and policy change. The ACO model holds great promise, but CEOs should avoid falling prey to herd tactics or cookie-cutter processes. Survival and success are possible – with the right strategy and strong leadership, all committed to advancing Patient Value in a new financial paradigm.

*Tony Miller is the Chief Executive Officer of Carol Corporation, based in Minneapolis, MN. He can be reached at info@Carol.com.*

## ACO Development: What's in It for Nurses? ...continued

The answer is threefold. First, nurses can expect increased responsibility for coordination across the care continuum. Next, nurses should anticipate greater accountability for hospital-acquired conditions (HACs). Lastly, nurses with advanced degrees can look forward to becoming "accountable care providers" within the ACO framework. Together, these components will help nurses lead care redesign in our health system's move toward accountable care delivery.

### Care Coordination

With a move away from volume-driven care toward outcomes-driven care, as well as new financial and quality incentives to keep patients out of the acute care setting, nurses will be required to take on more responsibility to coordinate care throughout the care continuum. This will start in primary care settings and will be emphasized through the growing use of the medical home model for patients with chronic diseases. Coordination must continue in the hospital and throughout the discharge process. Growing relationships with post-acute care providers and the threat of readmission penalties will require enhanced discharge planning. This may require the development of new care coordination by patient type (elective, occasional, perpetual, or complex critical) and disease to both manage acute care utilization and improve patient engagement. Remote monitoring technology will support the care team to ensure a safety net for care based on a patient's risk profile for readmission or relapse. Health plans and nurse case managers at the plan level have already begun preparing for the post-2014 marketplace. They have created models varying in size and scope that encourage clinical accountability through care coordination. Regardless of a patient's position along the care continuum, nurses will be accountable for improved quality of care through successful care coordination.

### Hospital-Acquired Conditions

The Centers for Medicare & Medicaid Services no longer pays hospitals additional dollars for 12 HACs if the HACs (which include the subset category of hospital-acquired infections) were not present on patient admission. Prevention of several of these conditions, including pressure ulcers, intravenous catheter sepsis, and catheter-associated urinary tract infections, falls largely on the nursing staff. Not only do these conditions have the potential to impede clinical performance and dramatically increase costs, but they also will be associated with financial penalties. In an effort to link payment to quality outcomes, the PPACA stated that hospitals in the top quartile of HACs will face overall reductions in Medicare payment by 1% starting in fiscal year 2015. The HAC data also will be made public at that time. Nurses in all settings must assume responsibility for their quality metrics to prevent HACs and the financial penalties associated with them.

*continued on page 5*

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## ACO Development: What's in It for Nurses?...continued

### Advanced Practice Nurses (APNs) as Accountable Care Providers

An APN's ability to act as an accountable care provider depends on the scope of practice as defined by state regulations. In states with broader scopes of practice that allow APNs to function independently, APNs will face similar opportunities and challenges as physicians in terms of ACOs. This means APNs will have the ability to participate in shared savings models, take on increased clinical risk for patients, or exert greater control over care delivery to control costs and improve quality. This effect will be amplified for APNs working in primary care and medical home models; primary care extension is expected as millions more Americans will gain access to the health system via the insurance mandate starting in 2014. In order to participate in an ACO, APNs must be offered a fair share of the cost savings and/or monthly stipends for additional time spent coordinating care for their patients. Extensive ongoing education and data sharing will be required to encourage both physicians and APNs to participate in the new model. The extent to which APNs will participate depends chiefly on the specific scope of practice and ACO model (from virtual to fully integrated) in their care environment.

### Key Considerations

Regardless of whether an organization pilots an ACO, gears up for the Medicare Shared Savings Program, or cautiously waits to see how ACOs develop in its local market, the principal underpinnings of ACOs -- assumption of clinical risk, improvements in quality care, and decreases in costs -- will be required of all organizations as we move through Medicare reform. Therefore, all nurses will be required to enhance their overall accountability and become true patient advocates by:

- Enhancing patient and family education
- Identifying patients at risk for 30-day and multiple readmissions
- Increasing use of telemedicine and telemonitoring devices
- Ensuring timely care coordination through targeted communication between hospital and community-based case managers and providers
- Designing new care delivery models that focus on active care coordination and clinical/financial effectiveness
- Creating a patient-centered self-management approach through assessment of patient engagement, access to education/peer groups, and leveraged technology
- Empowering patients and families to engage in their plan of care and manage their expectations

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*Sources: Hastings DA. The timeline for accountable care. BNA's Health Law Reporter. www.bna.com. Published March 25, 2010. Accessed December 2010; Sg2 Special Report: Accountable Care Organizations 2010; Sg2 Report: Innovative Care Delivery Models Compendium, 2009.*

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## ACO Strategy: Plan for “Open Platforms” .....continued

Also, because patient involvement is a key part of ACOs, the IT infrastructure will have to support patients signing off on their care plans and document their progress toward reaching goals, he noted. That will involve some type of self-management tools and personal health record access to their own data.

...He sees the need for a new type of system, probably outside the EHR, that can bridge organizations, allow for risk assessment and analytics and reach down into tools for day-to-day management. That's a tall order.

However, for many ACOs, the likely “default” choice will be Walled Garden IT.

Why? While Dr. Cummins makes an intuitively appealing case for open ACO platforms, it's likely that many ACOs will default to walled gardens – they will primarily only be able to share information within the ACO network. Why?

1. ACO Technology is Highly Immature. The Advisory Board has developed a list of 12 IT capabilities necessary for the success of ACOs:

- EMR Capability (Inpatient and Ambulatory)
- Access Management
- Enterprise RCM
- Remote Monitoring/Disease Management Support
- HIE/Web Services Support
- IT Physician Engagement
- Payer Integration
- Decision Support
- Unified Communications
- IT Infrastructure
- Enterprise Data Warehouse/Business Intelligence Data Marts

ACOs will evolve at different speeds and trajectories. Few ACOs will have all these capabilities when they open for business.

2. Architecture Isn't at the Top of the List of ACO Issues. A report by PwC issued in June 2010 — *Designing a Health IT Backbone for ACOs* — found that providers are all over the map in thinking about IT requirements for their ACO.

*Have you considered the IT requirements of an ACO?*

No — 26%  
Yes — 74%

*(If “Yes”) How do you plan to address the IT requirements of an ACO?*

Use existing internal systems — 39%  
Utilize a planned local/regional HIE once developed — 19%  
Through an existing local/regional HIE — 15%  
Partner with another organization (e.g. a large IDN, a payer-driven initiative, community EHR, etc.) — 12%  
Build own new IT infrastructure, systems — 11%  
Other 4%

PwC concluded:

Most ACO discussions remain internally focused despite concerns about accessing external data.<sup>2</sup>

3. Reflexive Data Hoarding. It's been the history of the healthcare system stakeholders NOT to share patient data – many have viewed data as a competitive asset. ACOs will require a 180 degree shift in culture, systems, and thinking.

4. Capital Costs. Many ACOs – particularly smaller ones – will be working off of bootstrapped budgets. They won't have sufficient capital to spend on IT.

5. IT Vendor Misinformation. Beware of existing EHR vendors and others who will say: “Our IT system has the capabilities to serve ACOs”. There's a big difference in thinking of an EHR as a *foundation* for ACO IT vs. being *everything* for ACO IT.

### **There are Compelling Strategic Advantages to Open Platform ACO IT**

There are many reasons for ACOs to anticipate needs for the broadest possible sharing of patient clinical information:

1. Many Physicians and Clinical Service Providers Will Not Be In Your ACO Contracting Network. Yet, these providers will have demands for your clinical data and will be able to contribute data back to your ACO members. What are examples? Long-term care facilities, specialists, home health agencies, behavioral health providers, health plans, and many others.

2. Expect Significant Patient Leakage (Migration) Out of Your ACO Network. The Medicare Savings ACO likely will have little or no restriction on patient choice of providers. Thus, anticipate that much patient care will be provided by clinicians or institutions that are not part of your ACO contracting network.

*continued on page 7*

## ACO Strategy: Plan for “Open Platforms” ....continued

The size of this problem will be proportional to the size of your ACO. A small ACO (as few as 5,000 Medicare patients) should anticipate significant leakage. How significant? We don't know, but a recent article published in *Annals of Internal Medicine* sheds light. The study found that the typical primary care physician needs to coordinate care with 229 other physicians working in 117 different practices.<sup>3</sup>

3. Expect Patient Demands for Sharing Records. As ePatient Dave deBronkart points out, more and more patients will be saying “Gimme my damn data...and give it to me NOW and ELECTRONICALLY”.

4. Minimize Anti-Trust Concerns. The Federal Trade Commission has made clear that a major concern is ACOs being used to consolidate provider market power, reduce competition, and raise prices. The ACO that shares data broadly looks much more like an organization focused on clinical integration and less like an organization that is trying to gain market power through controlling data.

5. Expect Continuing Government Pressure for Broad Data Exchange. Dr. David Blumenthal, National Coordinator for Health Information Technology, wrote in November 2009:

*...we cannot support arrangements that restrict the secure, private exchange of information required for patient care across provider or network boundaries. Some of these arrangements may improve care for those inside their walls. But ultimately, they have the potential to carve the nation up into disconnected silos of information, and thus, to undermine the vision of a secure, interoperable, nationwide health information infrastructure, which the law requires us to establish.*<sup>4</sup>

6. Achieve ACO Efficiency and Cost Savings. The more care providers with whom you are able to transact electronically, the less money your ACO members will need to spend on paper, fax, and phone communication.

7. Differentiate Your ACO. Open IT ACOs will be attractive to patients, community physicians, community support services, and payers.

8. Reduce Risk of Malpractice Liability. The parameters of competition in health care are changing. The paradigm for success is becoming: having the “best” data is foundational for patient care, analytics, predictive modeling, and targeted patient interventions. We can anticipate that the availability of electronic data will change the standard of care in communities. You don't want to have to answer questions such as “Doctor, why didn't you share your medical record electronically with providers that you KNEW your patient was seeing.” Or “Doctor, why DIDN'T you have access to this information that was in the patient's health record?”

9. Reduce Reliance on Your Local Health Information Exchange (HIE). In many communities, existing or planned HIEs are still immature — many aren't yet up and running, they won't include all providers, and they initially will share limited types of information.

In some communities HIEs might be a satisfactory solution. However, here are some questions to ask:

- Has the local HIE developed a critical mass of subscribers who want to share data?
- Is there substantial enough overlap between membership in the HIE and membership in the ACO network?
- Has the local HIE developed a sustainable business model? What happens when government funding runs out?
- How much and what types of information are actually being shared?
- Even if we get data out of the HIE, how do we turn that data into actionable information for individual patients and for population health? Do we have appropriate clinical decision support and analytical capabilities?

10. It's the Right Thing To Do. Consider how you would want your loved ones (parents, spouse, children) cared for? Would you want appropriate access to their digital medical record information restricted in any way because of local care provider choice of IT architecture?

### Plan for Open Platforms, Not Walled Gardens

The success of ACOs will require a different mindset – think of your ACO as a platform for care collaboration among community providers. The temptation around ACO IT might be to skimp or hoard... but the winning long-term strategy will be to share information broadly.

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<sup>1</sup> "What are the IT Requirements of Accountable Care Organizations?", Healthcare Informatics, <http://www.healthcareinformatics.com/ME2/dirmod.asp?sid=&nm=&type=Publishing&mod=Publications%3A%3AArticle&mid=8F3A7027421841978F18BE895F87F791&tier=4&id=DEF4AFA9DEBD40A593E8DB6F6ABF1794>

<sup>2</sup> <http://www.pwc.com/us/en/health-industries/publications/designing-a-health-it-backbone-for-acos.jhtml>

<sup>3</sup> "Primary Care Physicians' Links to Other Physicians Through Medicare Patients: The Scope of Care Coordination," *Annals of Internal Medicine*, Vol.150 no. 4, 236-242, Feb. 17, 2009, <http://www.annals.org/content/150/4/236.abstract>

<sup>4</sup> The HITECH Foundation for Information Exchange, November 12, 2009, [http://www.healthit.hhs.gov/portal/server.pt?open=512&objID=1406&parentname=CommunityPage&parentid=0&mode=2&in\\_hi\\_userid=10741&cached=true11](http://www.healthit.hhs.gov/portal/server.pt?open=512&objID=1406&parentname=CommunityPage&parentid=0&mode=2&in_hi_userid=10741&cached=true11)

## 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](mailto:info@accountablecarenews.com).

### Q. "What are the Pros and Cons of Having Downside Risk in the ACO Model?"

"An organization will have to weigh several pros and cons when deciding whether or not to incorporate downside risk in their ACO structure. The decision will be driven by organizational goals, culture, and the level of maturity of the healthcare system. The following are some of the pros and cons to consider:

#### Pros:

1. Providers without downside risk will often achieve more favorable financial results under the current system, without sharing in any savings. Therefore, the incentive to coordinate care and change behavior is minimal, at least from a financial perspective. Thus, downside risk offers a stronger incentive to work toward the common goals of the ACO.
2. The foundation of the ACO model is more efficient, high quality healthcare. Without downside risk, providers that achieve these goals may be compensated lower than providers that do not achieve these goals; that result is contrary to the ACO principles.

#### Cons:

1. Providers that do not have experience with risk contracts as well as providers that have had previous negative experiences with risk contracts may be reluctant to enter into an ACO model with downside risk. An ACO model without downside risk may encourage these providers to join the ACO.
2. ACOs will require many features that take time to develop such as an investment in infrastructure and providers learning to collaborate in new ways. These features may take time to establish. An ACO model may be established without downside risk as a transition period as the ACO builds the infrastructure and knowledge to accommodate downside risk.
3. The prior managed care backlash was driven by the consumer's perception that medical care was withheld for financial gain. ACOs having downside risk may result in a similar backlash from consumers. "



**Susan E. Pantely, FSA, MAAA**  
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"ACO downside risk offers health plans and providers larger positive financial opportunities for improved performance, while simultaneously creating consequences for performance shortcomings. Health plans and providers must work together to customize fair, balanced, and mutually beneficial ACO downside-risk arrangements.

If ACO entities are to be truly accountable for patient care, health plans and providers must each have a stake in the outcomes. By design, ACO downside risk ensures health plans and providers are equally accountable for, and invested in, successful outcomes by tying compelling financial incentives to positive outcomes. With more to lose, yet more to gain, health plans and providers will engage in collaborative, "we're in it together" partnerships that motivate change, embrace innovation, and help both succeed.

However, ACO downside risk is not a one-size-fits-all proposition. Providers must assess their appetite for risk and their risk readiness. Bearing an unfair proportion of risk — controllable or uncontrollable — could cause providers to disengage from the health plan or compromise patient care quality to meet financial incentives. Transitioning to ACO downside risk requires a certain amount of readiness and a sometimes steep learning curve.

Providers must have the infrastructures in place to effectively bear risk and assume some of the responsibilities a health plan traditionally holds. Simultaneously, health plans must be able to transition these responsibilities at the same pace to avoid duplication and redundancy.

ACO downside risk cannot be just about delegating risk, but rather about health plans and providers working collaboratively to build customized solutions to achieve balanced and mutually successful results."



**Christina Severin**  
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Medford, MA

**Thought Leader's Corner**...continued

"An Accountable Care Organization (ACO) is a group of healthcare providers working together to provide coordinated care, sharing in the risk and rewards of providing that care, and ultimately improving the delivery of healthcare while minimizing overall costs.

In order to meet this mandate, ACOs need several key components:

1. Broad participation across a range of healthcare providers and the ability to impose clinical standards.
2. Infrastructure, including IT and HR resources, to effectively coordinate care.
3. Access to capital and the ability to deploy innovative financing mechanisms allowing for a migration away from Fee-for-Service medicine and its volume-over-value payment philosophy.

This final point is the most essential. As long as providers are paid for delivering services independent of value or cost savings, then the aspirations of healthcare reform and ACOs cannot be realized. That said, the new financing mechanisms at the heart of PPACA-endorsed CMS pilot programs suggest a range of tolerance between upside and downside risk. The blend of "carrot" versus "stick" incentives ultimately used by an ACO rests on assumptions about competing interests.

At the micro level, incorporating downside risk into an ACO gives its management team greater governance flexibility and more levers to pull to motivate behavior change. It also provides greater incentives to ACO groups to rein in costs. Without downside risk, these groups may choose to ignore potentially elusive bonus payments and focus on driving volumes in order to achieve partial cap or remaining FFS payments. At the macro level, ACOs that take downside risk are spreading responsibility for poorly delivered care across the system, rather than forcing it all onto CMS, which could exhaust the government wallet and will to facilitate this transition. Thus, shared downside risk makes the long-term viability of the ACO concept more tenable.

Downside risk, however, poses challenges to the nascent ACO. Most notably, discouraging provider adoption. Some providers may choose to stay with the imperfect FFS system rather than accept potential downside risk via an ACO. Moreover, the notion of an ACO accepting risk is predicated on that organization having access to data to make informed decisions. A critical, albeit oft overlooked, component of ACO development is empowering managers with information necessary in making effective risk management decisions. While the future of the ACO remains uncertain, the need for financial innovation – and corollary financial risk management tools – is clear. The healthcare cost improvement imperative is so acute that, should downside risk prove successful, it may very well become a frequent component of emerging healthcare payment models. "



**Jordan Bazinsky, MBA**  
Vice President of Science and Technology  
Verisk Health  
Waltham, MA

"The ACO has been described as a mythical unicorn, which all can describe but no one has ever seen. But in California, we believe we have a pretty good sense of its existence and fundamentally believe that chasing unicorns is imperative in order to reduce the rising cost of health care as a threat to the economy and consumers because of unaffordability. Accountable care organizations can and must work, and California strongly backs them.

California has led the nation in capitated payments to medical groups and independent practice associations to manage risk for professional services, and in a number of instances, even global risk. We fundamentally believe that downside risk can stimulate innovation, putting "skin in the game" to provide improved care at a lower cost, and pushing ACOs to better manage patient risk and find ways to make it more predictable and manageable. Risk-bearing entities in California, aka "ACOs," are largely committed to delivering better care at a lower cost for their patients, and are making significant investments in health information technology and clinical infrastructure to integrate their care with their contracted partners at every level of the patient experience. Those that are successful are reducing the costs of care, and produce a better patient experience via treatment, coaching, and follow-up coordination. As a result of managing risk in a capitated structure, California's HMO premiums have historically been lower by double digits than those in the rest of the country.

However, there are significant downside risks to ACOs, as currently structured in health reform. The way the ACO provisions are currently framed, patients who end up in an ACO will be assigned to them based on an "attribution logic," and patients in ACOs will not know they are in them, although the federal Department of Health and Human Services is working on a requirement for notification. While there are assurances that this can be managed, it represents a bizarre impediment from the outset. Many also believe that the "shared savings" approach to downside risk will yield few replicable and scalable models to prove the success of payment reform. There is also the historic hazard of taking downside risk: guessing wrong on the division of financial responsibility. Predicting and pricing that care is a really sophisticated line to walk, trying to take into account issues such as the composition of the patient population, which could put the care delivery model and finances in jeopardy.

*Cindy A. Ehnes, Director,  
California Department of Managed Health Care  
continued on page 10*

## Thought Leader's Corner...continued

continued...

" Being too aggressive with taking risk could, of course, cause the ACO to fail, leaving patients without a medical home and providers without payment.

California has experienced the fallout of failure associated with unbridled downside risk and, through successfully addressing these risks, now finds itself among the leaders of the ACO movement. California already has strong oversight provisions on licensing and financial solvency of risk-bearing organizations. To ensure consumer protection and a level playing field, the DMHC will be examining the business models of ACOs and other new practice models to see whether the organization accepts pre-paid or capitated payments, and therefore triggers the need for DMHC licensure. The DMHC will offer an expedited review of potential licensees, so that they can enter the market quickly."



**Cindy A. Ehnes, Esq.**  
Director  
California Department of Managed Health Care (DMHC)  
Sacramento, CA

## INDUSTRY NEWS



### CMS Receives Comments on ACO Regulations

The Centers for Medicare and Medicaid Services is busy at work creating the regulations for accountable care organizations, which are set to launch in January 2012. To date, CMS has received 417 sets of comments from numerous providers, payors, and others in the healthcare field after issuing its request on November 17. The key issue on people's minds was how ACOs will be structured. According to [amednews.com](http://amednews.com), other questions raised included: How should patients be attributed, and how should their experience, along with that of their caregivers, be assessed? What aspects of patient-centeredness are important? What quality measures should be used? What other payment models should be considered?

One reason attributed to the high volume of responses was concern from medical societies that the legislation and various economic pressures are making small, independent medical practices an unsavory proposition. Legal issues such as continuing worry over how antitrust will be dealt with, along with anti-kickback, Stark laws, and civil monetary penalties were high on most agendas. The regulations are expected at some point during February.

MONTEFIORE



### EmblemHealth and Montefiore Medical Center of New York City to Research ACO Model

In the expansion of its contract with EmblemHealth, Montefiore Medical Center will explore the possibility of an accountable care organization arrangement. Montefiore currently manages the care of 90,000 EmblemHealth patients through its Care Management subsidiary and will continue to do so under the new arrangement, which became active on January 1st. Through this new agreement, both parties have committed to improved care and reduced health care costs.



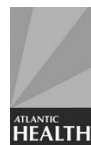
### Banner Health®

#### Banner Health Looking Into ACOs

Banner Health is in serious discussions with various private insurers that are at the forefront of payment delivery reform about the possibility of implementing the accountable care organization model.

President and Chief Executive Officer Peter S. Fine is worried that many in Arizona may perceive this as a by-product of last year's health reform act and thus may not be worth due consideration. Fine argues that ACOs will be moving ahead, health reform or not.

The main question driving these discussions is timing and how quickly the model could come into action. Key to this would be an integrated network of hospitals, physicians, and other providers as a means of support.



#### Atlantic Health Forms New ACO

Atlantic Health, a two-hospital system in New Jersey, has formed an accountable care organization to raise patient care quality, reduce costs, and streamline health care delivery. Atlantic Health previously experimented with new methods of improving quality and controlling costs by participating in the Medicare Gainsharing trial.

Atlantic's ACO is expected to enroll patients by January 2012. According to *Modern Physician*, roughly 100 independent physicians and about 200 doctors employed by the system will participate in the ACO.

# INDUSTRY NEWS



## Parrish Medical Center and MDI Viewpoint Analytics Create New Accountable Care Organization

The Parrish Medical Center, along with the Community Health Network of Florida, an integrated delivery network, have partnered together and are jointly implementing MDI's Viewpoint Analytics healthcare technology in their move towards forming an accountable care organization.



## Austin Hospital Systems Drive Towards Accountable Care

Austin's two largest hospital systems, Seton Family of Hospitals and St. David's Healthcare, have been buying private physician practices in an effort to align more closely with doctors for over a year in anticipation of accountable care organizations. The local Scott & White is already seen by many as a successful example of accountable care.



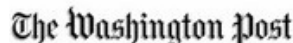
## Is Consolidation a Danger to Health Care Cost Control?

Merrill Goozner of the *Fiscal Times* reports that consolidation of the primary players in the health care industry - insurers, hospitals, and physician practices - could lead to monopolies that may conspire together to charge prices to employers and consumers that will circumvent cost measure controls.

*continued*

## Is Consolidation a Danger...continued

The Center for Medicare and Medicaid Services (CMS) is already fearing that a number of groups may try to recoup Medicare losses and thereby undermine short term savings gained by Medicare as private insurers raising their rates would lead to a rise in a region's health care bill and ultimately force Medicare to augment its own rates.



## Health Plans and Providers Clash Over Proposed ACO Regs

*The Washington Post* reports that the provisions for ACOs in the Patient Protection and Affordable Care Act were loosely written by legislators who were expecting regulators to fill in the gaps. Now CMS is working to come up with the regulations and answer such questions as: How will the quality of care be assessed? How will beneficiaries be attributed to ACOs? Who will be in charge of an ACO? What will ensure that ACOs do not become so large as to dictate their prices to health plans?



## Vista Health System IPA and Central Jersey Physician Network IPA Partner to Create ACO

On December 21st, Vista Health System IPA (VISTA) and Central Jersey Physician Network IPA (CJPN) announced the formation of Optimus Healthcare Partners LLC, an accountable care organization. 650 physicians will work together to shepherd patients through the continuum of care. According to *Modern Healthcare*, this move was motivated by the need to counter the rapid growth of a larger medical group in the region.

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## Catching Up With ...

**Jack Cochran, MD, FACS, Executive Director, The Permanente Federation, LLC**

Dr. Jack Cochran became Executive Director of The Permanente Federation in 2007. He began his career with the Colorado Permanente Medical Group in 1990 as Chief of Plastic Surgery and founder of its Plastic Surgery Department. He has participated in many of Kaiser Permanente's health reform efforts, including its EHR, the largest successful non-governmental clinical information systems deployment in the world. He talks about patient expectations, financial alignment, The Triple Aim, and himself.

### Jack Cochran, MD, FACS

- Executive Director, Permanente Foundation; Board of Directors, AMGA (2007-Present)
- Colorado Permanent Medical Group, Chief of Plastic Surgery (1990-1997), CPMG Executive Medical Director (1999-2007)
- Previously at Exempla Saint Joseph Hospital, served terms as Chief of Plastic Surgery, Chair of Surgical Services, and President of the medical staff
- Member, Board of Directors for the American Medical Group Association (AMGA) and the Alliance of Community Health Plans (ACHP), and member of the Advisory Board of the Global Health Group
- Board certified in otolaryngology and plastic and reconstructive surgery
- MD degree, University of Colorado; Residencies at Stanford University Medical Center and University of Wisconsin Hospital

**Accountable Care News:** When ACOs get underway in 2012, how will patients feel about being part of one?

**Jack Cochran:** Nobody wakes up in the morning saying, "I haven't been a patient for awhile. Maybe that's something I'd like to do today." Let's not forget that being a patient is an involuntary act. So patients are the vulnerable ones, and it is critical that they feel a sense of trust with an ACO and especially with their physicians. Based on our 60-year experience, we have learned that individuals need to choose their providers because this choice marks the beginning of a long-term, meaningful partnership. Effective ACOs will have reached out to patients to help them understand the benefits of care coordination and other quality and convenience features that are part of ACOs.

**Accountable Care News:** What does Kaiser Permanente hope to see in the incoming regulations from CMS?

**Jack Cochran:** We hope to see regulations that are clearly patient-centered and that focus on how integration and coordination can provide patients with excellent care and better outcomes. ACOs should form and organize around the needs of patients and their experience. Along the same lines, the regulations should ensure aggregation for the purpose of patient-centered clinical integration rather than for creating market power and negotiating leverage.

**Accountable Care News:** How difficult will it be for new ACOs to achieve a significant degree of financial alignment?

**Jack Cochran:** Financial alignment is one of the critical dependencies for ACOs. While challenging, it is more easily achieved when organizations have a strong foundational alignment around mission and values. We have found that population-based, prospective payment fosters joint accountability in financing and health care delivery and creates an incentive to keep patients healthy and to deliver care in the most appropriate setting, be it home, ambulatory, or inpatient.

This type of aligned incentives allows physicians, clinical, and administrative staff to work as a team and share responsibility in achieving performance and process improvements to deliver high-quality care.

**Accountable Care News:** How much potential do ACOs have to reduce healthcare costs?

**Jack Cochran:** If ACOs are founded on the right core principles, this should naturally create opportunities for improvements in quality and care management and place appropriate attention on resource stewardship and costs. It begins with organizations making the ACO principles and the "Triple Aim" a priority, after which they will be able to put continuous effort into implementation and execution in reducing healthcare costs. We can improve in many areas that will save lives, reduce suffering, and reduce costs. Preventable hospital readmissions are an example of how patients fall through the cracks in a fragmented healthcare system. CMS estimates that \$12 billion in Medicare and Medicaid readmission payments each year could be avoided if we improved coordination. Clearly, there is room for improvement.

**Accountable Care News:** From the perspective of an Integrated Delivery System, what do you see as the crucial steps for building an ACO?

**Jack Cochran:** Based on our experience, the foundational elements that must be in place for an ACO to thrive are clear: an agreed upon mission; visionary leadership; aligned structure and incentives; integrated information technology; and performance improvement. Physicians or other organizations that come together to form ACOs will need a common foundation and a culture of accountability to practice successfully in this model. Organizations must design effective and well-balanced governance structures. Organizations will need visionary leadership to drive execution and clinical excellence. They need to create a strong sense of shared responsibility and commitment to the mission. To manage care effectively for a population of patients across disparate organizations, providers will need to share patient information and report on performance metrics for clinicians, teams, and the organization overall. Aligned incentives are crucial in bringing providers together toward these shared goals and responsibility. Often when I speak about our experience in practicing the core ACO principles, I hear, "You can do that because you're Kaiser Permanente." My response, "We couldn't do it until we did it." As we continue on our journey of continuous improvement and learning, we work on these foundational elements every day.

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

**Jack Cochran:** Every year I volunteer in Arusha, Tanzania for a week performing cleft lip and cleft palate surgeries. It's been one of the most rewarding experiences of my life. The volunteer work has also helped me to realize that you can find mentors everywhere. I've gained a greater awareness and appreciation for bringing back and sharing learnings.