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Accountable Care NEWS

Demystifying Accountable Care for Patients

By Jenn Riggle, Associate Vice President and Director of Healthcare Social Media, CRT/tanaka

One of my favorite descriptions of accountable care organizations (ACOs) compares them to the mythical unicorn, "a fantastic creature that is vested with mythical powers. But no one has actually seen one."

There are people in D.C. who believe that ACOs promise to improve the quality of health care by focusing on the needs of patients and linking payments to outcomes. However, there's still a lot of confusion about what these systems will look like and whether the financial rewards for moving to this model of care might be limited.

Historically, hospitals have been focused on the care given inside their walls. But with ACOs, there is new emphasis on patient care that is given post discharge. Why? Because beginning in 2012, hospital reimbursement will be tied with readmission rates. This means that it's not enough for hospitals to provide great clinical care; they also need to work with primary care physicians, home health aides, pharmacists, and other caregivers to manage patients' medications and ensure that patients follow their discharge instructions.

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In This Issue

Analytics for ACOs[1] - A Framework for Strategy and Due Diligence

By Jonathan Pearce, Principal, Singletrack Analytics, LLC

The health reform act has given new life to integrated healthcare delivery systems. While the Medicare ACO model may be attracting fewer participants than originally anticipated, some commercial payers appear to be preparing updated models of their managed care contracting processes, hoping that more advanced provider groups will create successful relationships.

One of the key differences between 21st century ACOs and the managed care organizations of the 1990s is their ability to integrate and analyze data. Electronic health records may ultimately provide a key source of data, although their implementation is still in process. Better database and visualization software, combined with more cost-effective hardware solutions, enhances the ability of these organizations to rapidly load, analyze, and disseminate other types of data.

This article provides the framework for an ACO or other integrated healthcare delivery system to design its analytics function, understand the relevant issues, and structure its approach.

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[1] Although the term "ACO" commonly refers to the Medicare contracting organizations created by the health reform legislation, the types of analytics necessary will be applicable to any risk contracting organization. Therefore, an ACO in this article refers to "any contracting organization", whether contracting with Medicare or another payer. The data availability and requirements will vary depending on the type of contract, but the metrics, systems, and skill sets will be similar across all of these organizations.

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Editor's Corner

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

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

William DeMarco is the President & Chief Executive Officer of DeMarco & Associates, Inc., a national, independent healthcare consulting firm specializing in healthcare delivery system redesign and transformation. Mr. DeMarco is recognized as a leader in the research, design and implementation of community based health plans. Since his involvement in several startup health plans in Minnesota in the early 1970s, he and his team of management consultants, clinical specialists, and reimbursement analysts have assisted employers and physicians in developing better relationships with insurers up to and including developing local solutions to deliver and finance care. He is currently involved with assisting special needs plan startups and expansions as well as other Medicare and Medicaid program development activities.

Mr. DeMarco is a well-known author, having written or contributed to over a dozen books on managed care topics. He holds a master's degree in organizational development from DePaul University. He a past faculty member of Loyola Law School's graduate program and was recently awarded the Follomer Bronze award from the Healthcare Financial Management Association for his outstanding service and contributions to HFMA chapters and members.

As an accomplished speaker on a variety of topics including reimbursement, marketing, and management issues, he has received high marks for offering entertaining and insightful workshops and seminars. He is a regular presenter for such audiences as Medical Group Management Association, HFMA, VHA, AHA, Quorum, NMHCC, and AHIP.

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Subscribers can also network and discuss ACO issues with other health care professionals, review job opportunities, respond to posted questions and comments and more in the LinkedIn Accountable Care News Group. This is an active community of members with a wide variety of experiences and expertise to share on ACO issues. To join the group, simply go to http://www.linkedin.com/groups?gid=3066715

ACO e-Poll on Medicare Shared Savings Program Provisions June 2011

Accountable Care News conducted a survey on involvement, assessment, impact, and perception of the Medicare Shared Savings Program provisions. Survey participants typically have a more active interest in accountable care issues.

We asked participants to respond to seven items:

1. *Please categorize your organization*.
   - Provider
   - Other (Includes Plans as well as other organizations)

2a) *Is your organization involved with ACOs (operating/developing/contracting with/providing services to)?*
   - Yes
   - Not Yet But Plan To
   - No

2b) *If You Answered "Yes" or "Plan To" to 2a: Do you anticipate potentially being involved with the Medicare Shared Savings Program?*
   - Yes
   - No

3) What is your overall assessment of the ACO Proposed Rules issued by CMS in April?
   - Generally Positive
   - Generally Neutral
   - Generally Negative
   - Unsure

4) *What is your overall assessment of the ACO Antitrust Proposed Rules issued by FTC/DOJ in April?*
   - Generally Positive
   - Generally Neutral
   - Generally Negative
   - Unsure

5) *How will the May Center for Medicare & Medicaid Innovation Announcement for a Pioneer ACO Model and potential up-front funding impact ACO development for the Shared Savings Program?*
   - Significantly
   - Moderately
   - Small Impact
   - No Impact
   - Unsure

6) *How would you categorize your current overall perception of ACOs and their potential to achieve their stated objectives?*
   - Very Positive
   - Somewhat Positive
   - Skeptical
   - Negative
   - Unsure

Here's what we found:

- Of respondents, almost 84% are or plan to be involved with ACOs. Providers were slightly more likely to answer that they are or plan to be involved with ACOs at 87.5% as compared to other

continued

ACO e-Poll *…continued*

Organizations, of which 80% are or plan to be involved with ACOs. Of those who are currently involved with ACOs, providers were almost 10 percentage points behind other organizations.

- Of those who are or plan to be involved with ACOs, in no case was a majority of respondents planning to be involved in the Medicare Shared Savings Program.
- The overall assessment of the ACO proposed rules issued by CMS in April was generally negative with 65.6% of respondent answering that way. Providers had a more generally negative assessment of the proposed rules than other organizations by 20 percentage points.
- Only 14% of respondents had a generally positive assessment of the ACO antitrust proposed rules issued by FTC/DOJ in April. 20% of other organizations had a positive assessment while only 8.3% of providers did. More than one in five were unsure.
- A majority of respondents thought the May Center for Medicare & Medicaid Innovation announcement for a pioneer ACO model and potential up-front funding would have a moderate to small impact on ACO development for the Shared Savings Program. Again, one in five were unsure.
- A slim majority of respondents had a skeptical or negative overall perception of ACOs and their potential to achieve their stated objectives. Just under 50% of respondents from other organizations had a somewhat to very positive perception of ACOs and their potential while under 36% of providers did.
- By region, respondents from the West were far more likely (66.6%) to have a skeptical or negative perception of ACOs and their potential to achieve their stated objectives but interestingly were also most likely to be or plan to be involved with ACOs. Respondents from the Mountain region were far more likely (also 66.6%) to have a positive perception of ACOs and their potential, although none of them were currently involved with ACOs. Respondents from the Central region were most likely to be currently involved with ACOs.
- Overall a majority of respondents who are currently involved in ACOs had a somewhat or very positive perception of ACOs and their potential to achieve their stated objectives. Of respondents who are not or plan to be involved in ACOs, majorities of both had a skeptical or negative perception of ACOs and their potential.
- Respondent's overall assessment of the ACO proposed rules issued by CMS in April was not affected by whether or not they anticipate potentially being involved with the Medicare Shared Savings Program.
- The sample was Providers 52%, Other 48% (N=93)

ACO e-Poll *...continued*

Results:

Organizations Involved with ACOs

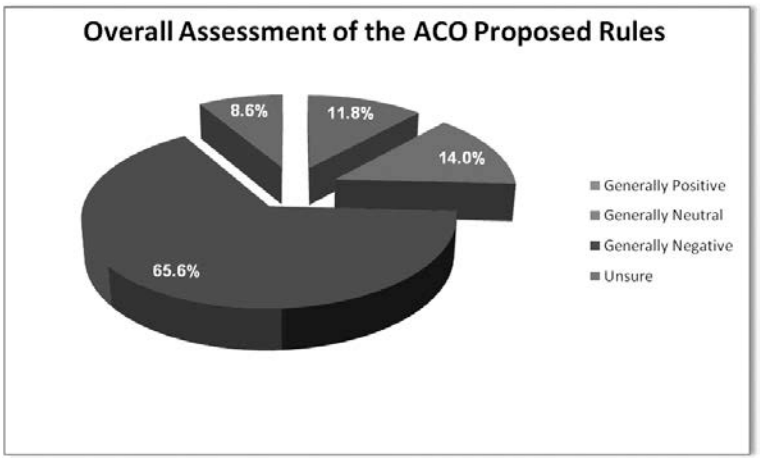
Response	Other	Provider	Overall
Yes	54.3%	60.0%	57.3%
No	45.7%	40.0%	42.7%
Total	100.0%	100.0%	100.0%

Of those who are or Plan to Be Involved with ACOs: Those That Anticipate Potentially Being Involved with the Medicare Shared Savings Program

Response	Other	Provider	Overall
Yes	48.9%	39.6%	44.1%
Not Yet But Plan To	31.1%	47.9%	39.8%
No	20.0%	12.5%	16.1%
Total	100.0%	100.0%	100.0%

Overall Assessment of the ACO Proposed Rules Issued by CMS in April

Response	Other	Provider	Overall
Generally Positive	20.0%	4.2%	11.8%
Generally Neutral	22.2%	6.3%	14.0%
Generally Negative	55.6%	75.0%	65.6%
Unsure	2.2%	14.6%	8.6%
Total	100.0%	100.0%	100.0%



Overall Assessment of the ACO Antitrust Proposed Rules Issued by FTC/DOJ in April

Response	Other	Provider	Overall
Generally Positive	20.0%	8.3%	14.0%
Generally Neutral	31.1%	33.3%	32.3%
Generally Negative	26.7%	37.5%	32.3%
Unsure	22.2%	20.8%	21.5%
Total	100.0%	100.0%	100.0%

How the May Center for Medicare & Medicaid Innovation Announcement for a Pioneer ACO Model and Potential Up-Front Funding Will Impact ACO Development for the Shared Savings Program

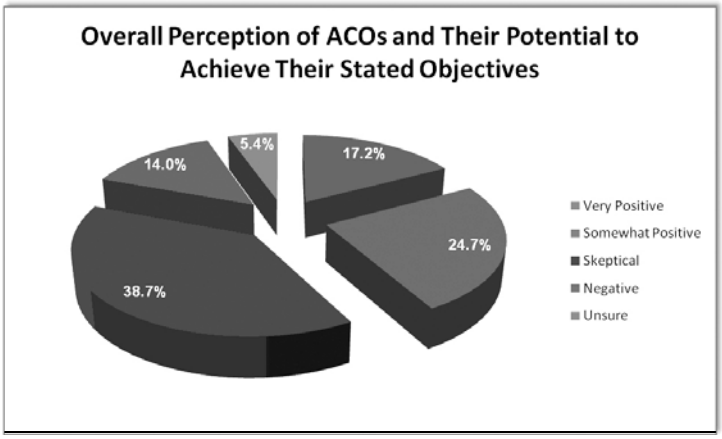
Response	Other	Provider	Overall
Significantly	6.7%	10.4%	8.6%
Moderately	35.6%	18.8%	26.9%
Small Impact	28.9%	25.0%	26.9%
No Impact	6.7%	27.1%	17.2%
Unsure	22.2%	18.8%	20.4%
Total	100.0%	100.0%	100.0%

continued on page 5

ACO e-Poll *…continued*

Current Overall Perception of ACOs and Their Potential to Achieve Their Stated Objectives

Response	Other	Provider	Overall
Very Positive	15.6%	18.8%	17.2%
Somewhat Positive	33.3%	16.7%	24.7%
Skeptical	37.8%	39.6%	38.7%
Negative	8.9%	18.8%	14.0%
Unsure	4.4%	6.3%	5.4%
Total	100.0%	100.0%	100.0%



Response	Central	Eastern	Mountain	West	Unknown	Overall
Very Positive	25.0%	14.6%	33.3%	13.3%	10.0%	17.2%
Somewhat Positive	16.7%	36.6%	33.3%	20.0%	0.0%	24.7%
Skeptical	37.5%	31.7%	0.0%	53.3%	60.0%	38.7%
Negative	12.5%	14.6%	0.0%	13.3%	20.0%	14.0%
Unsure	8.3%	2.4%	33.3%	0.0%	10.0%	5.4%
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Current Overall Perception, by Region, of ACOs and Their Potential to Achieve Their Stated Objectives

Organizations Involved with ACOs, by Region

Response	Central	Eastern	Mountain	West	Unknown	Overall
Yes	54.2%	46.3%	0.0%	26.7%	50.0%	44.1%
Not Yet But Plan To	25.0%	36.6%	66.7%	66.7%	40.0%	39.8%
No	20.8%	17.1%	33.3%	6.7%	10.0%	16.1%
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Response	Yes	Not Yet But Plan To	No	Overall
Very Positive	24.4%	10.8%	13.3%	17.2%
Somewhat Positive	29.3%	18.9%	26.7%	24.7%
Skeptical	31.7%	45.9%	40.0%	38.7%
Negative	9.8%	18.9%	13.3%	14.0%
Unsure	4.9%	5.4%	6.7%	5.4%
Total	100.0%	100.0%	100.0%	100.0%

Current Overall Perception of ACOs and Their Potential to Achieve Their Stated Objectives, by Organizations Involvement in ACOs

Those That Anticipate Potentially Being Involved with the Medicare Shared Savings Program, by Overall Assessment of the ACO Proposed Rules Issued by CMS in April

Response	Generally Positive	Generally Neutral	Generally Negative	Unsure	Total
Yes	14.0%	16.3%	65.1%	4.7%	100.0%
No	9.4%	12.5%	68.8%	9.4%	100.0%
N/A	11.1%	11.1%	61.1%	16.7%	100.0%
Overall	11.8%	14.0%	65.6%	8.6%	100.0%

Demystifying Accountable Care*…continued*

Whether or not ACOs become adopted, the good news is that hospitals are moving toward an accountable care model that does a better job of coordinating patient care, both pre- and post-discharge. The goal is that patients receive the right care while in the hospital but that the care doesn't end there. Hospital staff will work with patients, family members, and caregivers to help prevent patients from developing complications and being readmitted to the hospital.

The question is: How can hospitals talk to their patients about accountable care in a way that is meaningful to them?

In many ways, ACOs are a natural extension of the pay for performance, clinical improvement, and physician alignment initiatives that have been around for years. Whether it's creating an environment that makes patients feel special or providing the best clinical care, hospitals have always been focused on improving quality. Pursuing an accountable care model is yet another example of how hospitals are taking efforts to improve quality. However, it's important to keep in mind that patients' eyes may glaze over when you talk about things like "clinical transformation" or "evidence-based medicine." While these terms may be meaningful to people who work in health care, they sound like gibberish to those outside the industry. Instead, clinicians need to tell patients that with accountable care, hospitals are taking patient care to a new level.

Here are some key areas that hospitals should focus on when talking to patients about accountable care:

Disease management

The Patient Protection and Affordable Care Act (PPACA) has established benchmarks for hospital readmission rates. Initially, the government will track readmission rates for congestive heart failure, heart attack, and pneumonia. Hospitals that don't meet these benchmarks will see a 1 percent decrease in their reimbursement. However, by 2014, the government will also track the readmission rates for other conditions, including: chronic obstructive pulmonary disease (COPD), coronary artery bypass surgery, and coronary angioplasty. More importantly, penalties for high readmission rates will increase to 3 percent. With this new focus on accountable care, hospitals will have a new reason to work with their patients to help them manage chronic diseases.

Discharge planning

According to *The New England Journal of Medicine* (April 2, 2009), 1 in 5 elderly patients is readmitted to the hospital 30 days after discharge. With this move toward accountable care, hospitals are putting new emphasis on discharge planning. Finding the resources to help patients manage their care at home can be a complicated process.

Hospitals can do simple things, such as developing a checklist, to help improve discharge planning. Some key topics that should be discussed include:

- Make sure patients get the follow-up attention they need to keep their conditions under control
- Schedule follow-up appointments for patients before they're discharged

continued

Demystifying Accountable Care*…continued*

- Coordinate patient coaching so patients and caregivers understand their roles
- Review the patient's medications to make sure there is no duplication

Quality

Another way you can make accountable care real for patients is to explain that it's another extension of your hospital's ongoing quality improvement efforts. Consider developing a quality section on your hospital's website that not only posts your hospital's quality data, but also explains what it means. It should also incorporate patient feedback and testimonials as well as highlight industry recognition that your hospital, staff, and physicians have received. If you're not already doing so, consider using patient testimonials in your marketing and advertising materials to bring your story to life. But keep in mind, patient testimonials can tend to look alike. It's important to find ways to differentiate your marketing materials and make them uniquely your own.

Electronic medical records

There is often poor communication between specialists, hospitalists, primary care providers, and patients or their caregivers. The main reason for this lack of communication is because there's no easy way to share patient information. Not only do different departments in a hospital have different IT system, but the same is true for organizations and caregivers outside of the hospital. This means that patient information can get lost or simply not get shared with all caregivers.

Electronic medical records can help simplify this process by providing all caregivers with access to up-to-date patient information. This will make it easier for caregivers to determine if patients are following their discharge instructions and whether there have been changes in their care plans.

Your physicians

With accountable care, physicians assume greater accountability for improving clinical quality and lowering costs. This falls right in line with hospitals' employing physicians as part of their physician alignment strategies. Be sure you work with your physicians to help them find meaningful ways to explain accountable care to their patients. In addition, be sure to include your doctors in videos that highlight new procedures or clinical issues. These can be posted on your website, Facebook page, and YouTube page. Not only do these videos help build your hospital's credibility and increase your website's search engine optimization (SEO), but they also help position your physicians as thought leaders. ACOs and accountable care promise to transform the way hospitals deliver care by encouraging health care providers to work together. However, there's still a lot of uncertainty about what this model will look like, how it will work, and what sort of financial impact it will have on hospitals. That's why some hospitals (i.e. Mayo Clinic, Cleveland Clinic and Aurora Health) have spoken against ACOs.

Take a stand and tell your patients that your hospital firmly believes that accountable care is the right thing to do because you've always been committed to improving the quality of patient care.

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Demystifying Accountable Care*…continued*

Moving to an accountable care model is another example of how you're evolving to meet patient needs.

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Analytics for ACOs*….continued*

THE RIGHT DATA

Data for these organizations will come from many diverse sources. For Medicare ACOs, CMS is expected to provide some level of claims-based historical data. While this data will ultimately be helpful in that it is expected to contain all data relevant to the ACO's population, it may not provide timely, actionable data for population health management. Instead, data should be obtained directly from as many providers as possible, and especially from the primary care physicians whose patients become the ACO's population.

These providers may also provide lab results, patient registries and surveys, health and functional status information, and other data in a form that can be integrated into a single organized database. Assessing the availability of PCPs to provide data must be a critical part of the due-diligence process when recruiting PCPs, since PCPs who can't provide data on their patients are essentially operating outside of the control of the ACO.

Obtaining data from employed physicians may also be more challenging than anticipated. Our recent experience with obtaining data from a large group of hospital-owned physicians turned up many diverse sets of data that were created by each physician group's staff, who were unfamiliar with the process of extracting data from their billing system. Assembling a usable data set from these groups required repeated requests to get the right set of data, which then required significant editing and manipulation to convert to a usable form. Creating a repeatable, timely and consistent process for obtaining this data must be a high priority, and shouldn't be "assumed away" during the strategic planning process.

These organizations must also develop and implement robust data governance plans. Data governance defines the ownership, data definitions, business rules, metrics, quality assurance processes, and other components that prevent misunderstanding and lack of consistency and responsibility for data; and ultimately that facilitate the use of the data. Successful data governance depends on robust business rules that define metrics and processes. These rules may appear straightforward but often have complexities that aren't obvious. It takes coordination among the clinical, financial, and analytics teams to develop comprehensive rules that create consistent results.

THE RIGHT METRICS

ACOs will require an entirely new set of metrics. In addition to the utilization-based metrics in use for decades, providers now must become intimately familiar with population-based metrics of the kind used by health plans.

continued

Analytics for ACOs*….continued*

Population-based metrics

The critical metric denominators will change from "per admission" to "per member per month (PMPM)", as in "admissions PMPM". No longer does an increase in utilization create a financial advantage – now it's creating a cost to the ACO that will decrease your "shared savings" or increase your shared loss. ACO managers must refocus on these new metrics and understand their new significance to financial success.

Disease markers and risk metrics

In the draft regulations, CMS indicates that it will compute risk adjustments during the benchmark period, but will apply those same risk adjustments to the assigned population during the demonstration period. Since this risk stability is unlikely to occur because of patient turnover, there are two major reasons for ACOs to monitor the risk adjustments of their patients throughout the demonstration period. First, patient severity is a key driver of cost. If patient severity in the ACO is increasing and not accommodated by CMS through adjustments to the baseline costs, it's highly likely that the ACO's costs will increase despite any cost containment efforts. The ACO must monitor these severity changes and make revisions to its patient care cost budgets in order to maintain reasonably accurate estimates of shared savings and losses.

In addition, the risk scoring process itself identifies members who have various chronic diseases, and in some cases differentiates among the severities of those diseases. This is critical information for assigning these members to the appropriate disease management program. There are other methods of identifying these patients, but the clinical groupings are a byproduct of the "grouper" used for risk adjustment, and they provide a consistent and well-defined method of identifying and monitoring these types of patients.

Quality metrics

Medicare ACOs will be required to report on numerous quality metrics. While a full discussion of the IT requirements for quality measurement is beyond the scope of this article, ACOs must develop processes to monitor metrics that are available from claims and billing data, and develop systems to collect metrics that don't result from existing systems and therefore will require new data collection processes.

THE RIGHT TOOLS

Traditional healthcare IT tools will generally not be useful for ACO reporting because much of the data to be collected and integrated won't be coming from typical healthcare systems in the usual way. "Meaningful use" for EHR systems primarily focuses on getting data into EHR systems; the challenge for an ACO will be to get data out of those systems so that it can be integrated and reported. Instead of using HL7-based data, ACOs will be dealing with reading "flat" text files containing claims data from CMS and the billing systems of physicians and other providers. They'll also need to import data from desktop databases that have been cobbled together to record the myriad of new quality measures that require data that has never been previously collected.

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Analytics for ACOs.....*continued*

To capture and manipulate this data ACOs will need to look towards the conventional database integration tools from vendors such as Microsoft and Oracle, and find IT staff members trained in their use. Computer infrastructure will also be required, as will a variety of dashboards, reports, and free-form analytical tools to present the information to the ACO team and allow them to perform their own analyses.

THE RIGHT TEAM

ACOs are focused on creating multidisciplinary teams. Finance people will need to understand clinical terminology. Physicians will need to interact with other physicians and healthcare professionals far more frequently than before. The ACO analytics team will need a broader skill set than has been necessary in any other type of healthcare organization. These teams must understand the vocabulary of healthcare data; terms such as ICD-9 code, NPI and NDC identifiers, and the differences between incurred and paid dates. The teams must also be able to load, validate, and report on data from a wide variety of different data sources and formats. Team members must be sufficiently skilled to be able to develop complex metrics from this data, such as identifying diabetics who haven't received HbA1c tests within a prescribed time interval, or determining whether patients discharged to a post-acute care facility have a lower readmission rate than those discharged to home. Perhaps most challenging, they need to understand the thought processes of the end users (clinical, financial, and operational) so that they can take the lead in creating the business rules and definitions for the end users, who frequently aren't able to conceptualize these issues in sufficient detail. Failure to develop comprehensive business rules leads to the "I gave you want you asked for – it's not my fault if it's not what you wanted" result, which will be immensely debilitating to an organization. The ACO analytics staff must have sufficient knowledge of these issues to be able to create the right answers using the right process, delivered in the right way.

THE RIGHT MINDSET

The objective of this article is to highlight the important factors in planning and implementing an effective ACO analytics team. The right mindset is to recognize the significance of analytics to the success of the ACO, and to direct the necessary resources to the planning and execution of this function. Analytics provides the information for planning patient care, the feedback loop for evaluating what's working, and the retrospective evaluation of the ACO's efforts. Without effectively utilizing the new tools of analytics, ACOs may find themselves revisiting the failures of the managed care organizations of two decades ago.

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Thought Leader's *Corner*

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

Q. "How might the proposed antitrust guidance affect ACO engagement?"

"We see this blown way out of proportion by employers and insurance companies who are concerned that these ACOs will be a repeat of the PHOs and IPA networks that pushed reimbursement rates higher as cartels and in turn disadvantaged purchasers and consumers in the marketplace by forcing them to pay higher premiums.

If CMS remains firm in granting ACO designations to markets with competing ACOs, the FTC should be able to enforce its network definitions from 1966 that have been the rule of thumb for every IPA, PHO, and ACO like Alliance for decades.

In a nutshell, the group of providers must offer a community benefit such as clinical integration or financial integration to meet the FTC and DOJ definitions and must not be a dominant network or exclude providers without reason. In addition, providers cannot fix prices or collude to boycott payers. Anti-competitive behavior will be rewarded with an investigation as we have seen in Chicago, Indianapolis, and soon in Milwaukee. Because the ACO framework includes clinical and financial integration through its definition, the provider group that is established as a formal group practice or a group without walls managing risk arrangements will have a distinct advantage over hospitals and some independents that are awaiting final regulations to THEN do something. The concept of clinical and financial integration are perquisites for the ACO business. This means antitrust guidelines would be met by the definition of integration BEFORE the ACO application request is even submitted. This is truly a game changer, and the competitive value of being one of the few clinically integrated groups in your service area holds political and economic value."

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

"The prospect of federal antitrust review will create a bias toward 'Copperwelded' applicants in the MSSP and Pioneer programs. Adding non-Copperwelded participants to an ACO adds a risk of uncertainty and cost to the application process.

Like every other policy, this policy of trying to qualify non-Copperwelded ACOs to operate in the commercial market as a condition of the Medicare shared savings program may have unintended consequences. One of those may be to provide additional impetus to providers to become part of Copperwelded systems."

Mark E. Lutes
Member of the Firm, Epstein, Becker & Green
Washington, DC

"The proposed ACO antitrust guidance from CMS provides a leading indicator for how the government will treat accountable care organization applications. ACOs that take up less than 30% of their market will be in the 'safety zone'; those that consolidate 30%-50% of the market will have the option of a review by the Federal Trade Commission and the Department of Justice; those assuming greater than 50% of their market will undergo mandatory review. In other words, the guidance has merely made explicit what most healthcare professionals implicitly understood: the government wants to encourage ACO development, but not to the extent that it promotes monopolistic behavior that adversely impacts the marketplace.

Since the antitrust review and ACO review go hand in hand, the real limiting factor to ACO engagement may be whether organizations are willing and able to meet all the qualifications and guidelines outlined in the 429 pages of ACO regulations. Thus, the larger obstacle for nascent ACOs remains their ability to meet stringent requirements by CMS for coordinating care across entities, improving health outcomes, and reducing cost growth. Those entities aspiring to become ACOs will likely continue to pursue that goal regardless of the antitrust guidance. Similarly, if the quality metrics are seen as unreachable, or the structural requirements are seen as too restrictive and financially prohibitive, there may not be significant ACO engagement regardless of antitrust status."

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

Thought Leader's Corner

"Antitrust monitoring and enforcement is important and necessary. However, the proposed guidelines envision as problems what we see as creative solutions. They ignore the gorilla that is already in the room and driving prices up.

The proposal seems focused on collaborations of otherwise independent providers. Shared savings requires collaboration, and this proposal threatens to punish that. Savings are hard to generate. The potential savings are unlikely to result in the kind of market manipulation the proposal would guard against. I worry that a group of physicians might be reluctant to collaborate on improving care to reduce hospital admissions if they first must get approval or be subject to antitrust complaints. A local hospital operating a 'natural' monopoly in the same community appears to be unaffected by the antitrust proposal. Ironically, the hospital may protect its own monopoly by using the proposal to control competing interests.

A Congressional Research Service report for congress (R41588 published January 11, 2011) shows what many know from experience: commercial rates are high because of price, not utilization. The antitrust proposal does nothing to address existing monopolies. In addition, fear and complexity are driving many providers to surrender to the delivery systems that are creating the problem. Overt integration is ignored by the proposal while collaboration is targeted. For ACOs to succeed, we need more collaborating networks and less monopoly. The alternative will produce more of what we already have: high prices, low quality, and some excellent documentation of improvement."

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

INDUSTRY NEWS

Scripps

Scripps Readying ACO Network

Scripps Health has announced that it will form a partnership with North American Medical Management to create an ACO-like Integrated Care Network with 14 physician groups in the San Diego area.

Robert Wood Johnson Foundation

Robert Wood Johnson Deems Shared Savings Principles Too Harsh

The Robert Wood Johnson Foundation believes that the proposed rule for shared savings is too stringent and is now urging CMS to soften the principles in order to appease organizations that fear financial risk in ACOs.

OPTUM™

Tucson Medical Center Bands with UnitedHealthcare to Form ACO

The Tucson Medical Center, along with local physicians, is partnering with Optum, part of UnitedHealthcare, to create a sustainable health community based on the ACO model. TMC has also submitted a letter of intent for the Pioneer ACO Model.

AHIP
America's Health Insurance Plans

AHIP Wants ACOs Held to Health Plan Standards

In this letter to CMS, America's Health Insurance Plans is urging CMS to make sure ACOs are held to the same standards as health plans. These standards include financial requirements, network requirements, disclosure requirements, and quality improvement requirements.

AMGA

ACO Savings Overestimated According to AMGA

According to the American Medical Group Association, the estimates for ACO savings are too high. The provider group believes that in reaching the projected $510 million in savings, ACOs will be strained and may not effectively meet their objectives.

AdvaMed
Advanced Medical Technology Association

Medical Device Companies Warn Against ACOs Scaling Back on Quality

AdvaMed is worried that ACOs may incentivize physicians to use lower-cost devices and scrimp on quality care. In a letter to CMS, they requested oversight of ACOs so that technology adopters will not get penalized.

INDUSTRY NEWS

ACO Regs Could Soften Ahead of Launch

Many organizations have expressed their concerns over CMS' proposed ACO regulations and now it seems there is a chance that the rules could amended or be made less stringent. HHS Secretary Kathleen Sebelius has said that her department was looking into the 1200 comments and seeking to strike some sort of balance between those and the idea of bending the cost curve while still improving patient care.

CMS Extends Application Date for Pioneer Model

During a national conference cal, the Centers for Medicare and Medicaid Services clarified the specifications of the ACO Pioneer Model and also extended the due dates for the letter of intent and final application to June 30 and August 19, respectively.

Majority of Seniors May Receive Care From ACO Beyond 2012

HealthLeaders-InterStudy reports that 2011 could be the last year the majority of seniors will receive care from physicians not organized in a system of care. According to the recent *National MCO Analyzer: Medicare,* Accountable Care Organizations (ACOs) are a central part of the Medicare-related provisions in the Affordable Care Act and have received the most attention from the healthcare industry. In addition, Medicare Advantage plans are jockeying to improve their quality ratings and risk scores in order to attract members and achieve better reimbursement.

10 Questions on Clinical Integration and ACOs

Eric Nielsen and James Smith of The Camden Group answer ten frequently asked questions on clinical integration and accountable care organizations. They include queries on specialists, PCPs, and who will control ACOs**.**

AMA Wants Significant Change in Proposed Rule

The American Medical Association is urging CMS to significantly amend its proposed ACO regulations before they go into effect in early 2012. They would like to see CMS take more time to finalize the rules in order to forge reform which will comply with the initial objective of ACOs.

Catching Up With*…continued from page 12*

Accountable Care News: *The current ACO debate about the CMS models runs the whole gamut from savings only with no downside risk to full risk capitated models. How confident are you that ACOs will save Medicare money in the long run and how much "skin in the game" should providers have in order to play?*

Alain Enthoven: I'm not at all confident about the ACO model as currently conceived. For one thing, the doctors most likely to play and succeed, the AMGA, looked at this and 93% of them said "we don't want to play". I think that if they did play, then the problem would be with the shared savings model. I don't think it provides a powerful incentive. You're still in the fee-for-service context, maybe not even creating any savings at all, and there would be no penalty for that.

On the other hand, the providers may look at that and say "If we make 'savings', that means a reduction in revenues, so what the government is saying to us is: cut revenue by a million dollars and we'll give you back half a million". That's very different from the managed competition model, in which if you don't improve your quality and cut your costs, then you're going to lose members and patients.

Accountable Care News: *As a long-time student of the health care marketplace, what research agenda would you recommend for CMS around ACOs?*

Alain Enthoven: As well as keeping careful track of who contracts and who doesn't and how they perform, I'd like to see them try to understand the characteristics of the good performers and shape that knowledge into best practice recommendations that can be promulgated. They should try some innovations. There seems to be an ideological block among leading members of the authorship of PPACA against letting consumers keep the savings if they choose a less costly health plan. They think people will be forced for economic reasons to choose inferior care.

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

Alain Enthoven: One thing people might not know is that I am the proud grandfather of 17 grandchildren. When I look at this whole thing, I think about them. They are my descendants and I love them. Ten of them live in California, and I think of the poor state of public finance and what will happen as a result of that. I worry about the continued out-of-control healthcare spending which will lead to reducing their educational opportunities.

We can't go on paying for Medicare by borrowing from the Chinese. If we had wall-to-wall competing organizations like Kaiser Permanente, high quality health care could cost us half of what it does. A good 30%-40% of spending is wasteful, I would like to see that money saved and invested in educational opportunities for my grandchildren.

Catching Up With …

Alain C. Enthoven, MPhil, PhD Alain C. Enthoven is an American economist known as the "father of managed competition". He is currently the Marriner S. Eccles Professor of Public and Private Management, Emeritus, at the Stanford Graduate School of Business. He talks about the differences between managed care of the 1980s and today, his skeptical view of the current ACO concept, the CMS proposed rule, a research agenda, and his grandchildren.

Alain C. Enthoven, MPhil, PhD

- Served as Deputy Assistant Secretary of Defense (1961-1965), and as the Assistant Secretary of Defense for Systems Analysis (1965-1969).
- Received his BA from Stanford University in 1952, an MPhil from the University of Oxford in 1954, and a PhD from MIT in 1956. He was a RAND Corporation economist between 1956 and 1960.
- Is a member of the Institute of Medicine, a fellow of the American Academy of Arts and Sciences, and is a former Rhodes Scholar.

Accountable Care News: *The notion of an "accountable care organization" -- an integrated provider entity competing in the marketplace on quality and price -- looks an awful lot like your "managed competition" model of the 1970s. How are they alike and how are they different?*

Alain Enthoven: The accountable care organization idea grew out of a recognition that to get improvement there has to be accountability for quality and cost, and providers have to see that they would be better off by improving quality and improving cost. Back in the 70s I was thinking mainly of prepaid group practices like Kaiser Permanente and Group Health Cooperative as well as IPAs (Independent Practice Association). There is a big difference between that and accountable care organizations as they are now defined. Back on the East coast, where people are not as familiar about what we have out here, there is an idea that the American people don't want to lock in to one or another delivery system. That is, that you join an HMO and agree that over the following year you will get all of you care from the providers contracting with that HMO or doctors to whom they refer you. With the managed care backlash, people interpreted that as meaning that the American people didn't want it. I dispute that conclusion. If you look at the experience, say, of State of California employees, or University of California employees, or Stanford employees, or State of Wisconsin employees, what you see is this: when given the opportunity, and if you can keep the savings, very high percentages of people prefer to choose a less costly model of care in which they can keep the savings compared to open-ended fee-for-service.

With the ACO there is no lock-in, and the care organization doesn't know exactly for whom it is responsible. People who are ascribed to an ACO are free to go anywhere they want. I think that is not workable and a misreading of history. The problem is that ascribed patients may go out of the system for their most costly episodes, which is when they are most likely to travel somewhere else, and then the ACO would be charged with the expenses they generate somewhere else. That is very different from what you see around here with Kaiser Permanente. They know who their members are, and they can pursue them: "Madame, you have not had your mammogram yet, please come in and get it, we believe it is important for your health." Because if they are going to be responsible for their members, they want to be able to contact them and persuade them to come in and get the services they need. On the other hand, it is a two way commitment with the lock-in. The patient commits their body to this organization, and the organization in turn has a reciprocal obligation to see to it that the patient gets good care. I believe that the open-ended ACO is going to be ineffective.

Accountable Care News: *ACOs are clearly going to be in the care management business (and some would say they look like 1980s managed care warmed over). What do we need to know and do differently about "managing care" to be successful in today's environment?*

1980s managed care, as practiced by the insurance companies, is what I call carrier HMOs, I distinguish between delivery system HMOs and carrier HMOs. By that I mean: here is an HMO, I want to go and see it and grasp its essence. If it's a delivery system HMO, what you find is a medical group, possibly an affiliated hospital system, and they are providers. On the other hand, with a carrier HMO, let's say I'm with the Anthem HMO, what I find is an insurance company. In the carrier HMO, the problem is that it contracts with solo, autonomous doctors and it contracts with consumers who have the HMO contract. The consumers, since they are all insured, they want it all; and the doctors, since they're on fee-for-service solo practice, they want to deliver al. Then the 'managed care' company gets in the middle and tries to act as the traffic cop. I think this is a losing proposition for an insurance company, because an insurance company doesn't have the credibility and acceptability with patients to do so.

Now I'm not saying they are necessarily all bad, I realize that they have a lot of data and know some things that doctors need to know. ACOs are supposed to be provider organizations, so when you ask where's the ACO, I want to go and see it. And what you'll find is a hospital and a list of doctors on their staff. It's not going to be like the carrier HMOs warmed over because it's supposed to get at the idea of being a delivery system. The government is trying to say we want doctors and hospitals to get together, practice teamwork, and deliver quality, cost-effective care. What we need is genuine teamwork. What has to be overcome is the culture of autonomy in medical practice. We also need information sharing and incentives alignment. You didn't have any of these in the carrier HMO.

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