

Accountable Care NEWS

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

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

Will 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*¹:

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.”

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ACO Development: What’s in it for Nurses?

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

The 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?

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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. "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. "



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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."



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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. "



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"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,
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