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Accountable Care NEWS

Provider-Sponsored Health Plans as a New Accountable Care Entity

By Phil Kamp

As market competition among healthcare providers continues to increase, so too does the confusion around accountable care. The industry has spent significant time defining accountable care, debating whether or not this time it will actually stick, and even outlining various levels of financial risk.

But, hospital executives are still struggling to take the plunge. They're wrestling with questions like, "How much risk is the right level for my hospital?" and "How far along the risk-sharing spectrum will my clinicians and board of directors be willing to go?"

After weighing the various levels of value-based care, providers will readily begin to understand that "risk" is less risky than most perceive. In fact, taking on more risk can yield even more benefit.

For many providers, creating and offering their own health plan is the best route to achieving the competitive advantage promised by the shift to pay-for-performance and value-based care.

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In This Issue

Being Accountable For Good Preventive Care

By James L. Holly, MD

The plaque arrived on April 23, 2013 and read: "Texas Physician Practice Award presented to Southeast Texas Medical Associates, LLP for Providing Exceptional Preventive Health Care Services using Health Information Technology." This was awarded by The Texas Physician Practice Quality Improvement Award Committee, which is made up of the TMF Health Quality Institute (Texas' CMS Quality Improvement Organization), the Texas Medical Association, and the Texas Osteopathic Medical Association. Because our Nurse Practitioners are also included in the award, SETMA has recommended expanding the sponsoring organizations to include the Texas Nurses Association.

The Committee commented, "Congratulations on this significant accomplishment, which illustrates your commitment to delivering quality care to all patients. Your award demonstrates that SETMA has an exceptional team." "Quality care to all patients" is one of the major goals of healthcare reform and one of the foundational principles of an ACO. This award is also an affirmation of SETMA's decision in 2000 to begin tracking quality metrics performance and our 2009 decision to begin public reporting of performance by provider name. The results are now posted on SETMA's website www.setma.com under Public Reporting for 2009-2013.

The value equation is at the heart of the quality process, i.e., value equals quality divided by cost. Value can be increased by quality improvement and/or by decreasing cost or both. In its March Brief the Commonwealth Fund tied payment reform to accountability for improved care. The recommendation was that providers and ACOs should be eligible for additional payment if practices participate in "a high-value accountable care organization," "bundled payment arrangement," or "other innovative model of health care delivery."

Also in March the Commonwealth Fund addressed accountability for quality in a paper entitled, *Early Adopters of the Accountable Care Model: A Field Report on Improvements in Health Care Delivery* http://www.healthreformgps.org/wp-content/uploads/aco-3-14.pdf.

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Editor's Corner

Raymond Carter, Senior Editor, *Accountable Care News*

This year on the Editor's Page we will be featuring "Reports from the Field" – short commentaries on key developments affecting ACOs, progress reports from those in various stages of implementation, or key lessons learned during an ACO journey. Did you try something that worked really well? Or something you tried that just didn't turn out the way you had envisioned? Any sage advice for those brave souls who follow you? Pithy commentary on what you see in the field? We will host our own mini ACO learning collaborative right here, 500 words at a time. Here is Dean Coddington:

Phil Dean C. Coddington
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ACOs: A Wolf in Sheep's Clothing?

In a new book, *Political Malpractice*, Stan Hupfeld, the former CEO of Integris Health System in Oklahoma City, refers to accountable care organizations (ACOs) as being similar to the discredited HMOs of the 1980s and early 1990s. A former CEO friend, who sent me Stan's excellent book, noted that he often hears ACOs referred to as "a wolf in sheep's clothing." We heard similar comments when the concept of an ACO was first introduced four or five years ago. For example, one of our partners said she could not see the difference between the old-fashioned primary care gatekeeper of the early HMOs and the patient-centered medical home. We see them as quite different.

In recent presentations on ACOs, we have used the following chart to show the major differences between ACOs and tightly managed care, which usually means HMOs.

ACOs and Managed Care: Major Differences

ACOs	Managed Care (HMOs)
1. Patient-centered medical home	1. Gatekeeper
2. Retrospective review	2. Prospective review
3. Risk-adjusted payment based on performance	3. Capitated payment with no risk adjustment
4. Focus on patients with chronic diseases	4. Focus on population as a whole
5. General availability of electronic health record	5. Paper medical records

For me, the ACO focus on those with chronic disease (#4) is a key difference. The HMO approach did not normally differentiate among subscribers. It treated a 27-year old indestructible male the same as a 59-year-old female with chronic obstructive pulmonary disease (COPD). As we know, the big dollars to be saved in health care are in doing a better job of managing the health care of patients with chronic illnesses, such as diabetes, COPD, or congestive heart failure. On #3, the CEO of a primary care network that also accepts financial risk for specialty care told us that without risk adjustments in the Medicare population of the Medicare Advantage product, it would be impossible to make money on capitated payment. "With risk adjustment, we love taking care of older, sicker patients." Risk adjustment was not part of most early HMOs.

How would you describe the differences, and do the differences bode well for the future of ACOs? I think they do.

Dean Coddington can be reached at DCoddington@mcmanisconsulting.com. This piece originally appeared essentially as is in the April 4 issue of the HFMA Healthcare Finance Blog and is reprinted by permission.

Pitfalls for Managed Care Organizations in the Medicaid Managed Care Expansion – A Cautionary Tale for the Medicaid ACO

By Danyell Jones

The movement to expand Medicaid managed care is trending across the nation with the creation and formation of new Managed Care Organizations (MCOs), including some new Medicaid ACOs. The managed care expansion is occurring with rapid speed in such states as Kansas, North Carolina, Louisiana, and Mississippi. In other states, such as Texas and Nebraska, managed care for the State's Medicaid population is expanding with a concentration now going beyond urban centers to even the most rural outposts of the state. The movement has been sparked by States looking to control healthcare costs prior to the 2014 expansion of Medicaid enrollment and by the growing interest in Accountable Care Organizations beyond Medicare and the commercial sector.

Though plans vary widely based on State, the overall crux of the movement would allocate a fixed cost for care of its patient populations by the State to these MCOs. The MCOs would then be responsible for the provision of care through a network of providers within this budget, or liable for financial overages is the budget is exceeded, putting the MCO "at risk." With large financial responsibility, a changing healthcare environment, and the need to ensure that patients are not only pleased with care – but delighted -- MCOs are looking for winning implementation strategies and lessons learned from other organizations which have already made the change.

This article will explore some of the most common managed care implementation pitfalls and how they can be avoided with careful planning, ensuring that MCOs initiate operation in a responsive manner that increases satisfaction among providers and enrollees and improves functional efficiency from an internal perspective, beginning with understanding the change. While the context here is Medicaid managed care , many of the same MCO pitfalls will apply to organizations seeking to become Accountable Care Organizations (ACOs) in the Medicare or commercial markets.

MCO Pitfall 1: Care Authorizations and a Shifting Culture of Care

Gone are the days when patient wants dictated care. In the MCO environment care provided will need to meet medical necessity criteria, and it will have to be shown to be the most effective way to provide care that achieves the best end outcome for the patient. This can constitute a significant philosophical change in the way that care is authorized, which can be compounded by a community which may see care that they are accustomed to receiving denied due to lack of meeting medical necessity criteria (MNC).

Solutions

- Ensure that all parties involved (MCO internal staff, providers, enrollees) are aware of what MNC is and the part that it plays in care authorization.
- Ensure that the MNC your organization utilizes is being applied in a standardized way, and bolster this understanding with intensive training.
- Bolster authorization decisions with person-centered planning focusing on "what's important for" the Patient vs. "what's important to" the patient.
- Educate patients and their families regarding service authorizations; emphasize the effectiveness of alternative levels of care and that the overall goal is the best treatment for the best outcome.
- Work with clinical committees and patient advocacy groups to explore the change, approve authorization standards, and obtain buy-in.

MCO Pitfall 2: Readiness Complexity for Transitioning/Expanding an MCO

The changes needed to transition to an MCO, or to expand an existing MCO for a different patient population or geographic region are complex and impact all areas of the organization. The scope of the change can become enormous, and there will be critical issues to address across the organization – many of which have their own unique obstacles and deadlines. To avoid these issues consider the following:

- *Transitional Project Management* -- designate a project manager for the entire transition/expansion with a singular focus on implementation and do not append this role to any others.
- *Knowledge* -- require the entire leadership team to become intimate with the upcoming changes and do not silo knowledge between clinical leaders and non-clinical leaders or you will miss the big picture.
- *Business Process Engineering* – have work flow meetings and select an unbiased facilitator to dive down to the ground level to identify where departmental overlap occurs. Ensure that you know how hand-offs will occur between departments and diagram everything.
- *Rates and Budgets* -- establish your budgets early and collaborate with the clinical team and the claims team for risk management monitoring so that you can stay ahead of the curve.

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Pitfalls for Managed Care Organizations*...continued*

MCO Pitfall 3: IT Requirements

IT requirements and systems can be a costly and time consuming investment. IT systems can also vary widely in their capabilities and operational processes, while vendors can vary significantly in the level of customer and ongoing support that they provide.

Solutions:

- An IT System should only be chosen after a thorough evaluation which includes clinical, executive, and IT members of the organization
- Customer Support should be considered before making a final decision, and the following questions should be considered:
    - How responsive will the vendor be to our needs?
    - How available is the vendor?
    - How are system modifications or errors handled?
    - What is the level of implementation support provided?
- Minimize changes -- don't always choose the luxury model; choose the IT systems model that will meet your MCO contract requirements and has some efficiencies.
- Require the leadership team to be active participants in the development of reports.
- Test, Test, Test- this will build confidence in the process flow and help you to identify issues.

MCO Pitfall 4: Provider Network Changes

Transitioning from a fee-for-service environment, or from an open provider network to a closed network, is a large scale change for providers. The process involved -- including applications, credentialing, and contracting -- can also be time consuming from an MCO perspective. To make the change a fluid one, consider the following:

- Begin the application process as early as possible for providers and establish timelines for actions to occur. Ensure that you decide when you will change strategies for obtaining applications and announce everything to providers so that they are aware of the information.
- Know your providers -- is there an organization that provides care to a large segment of your members? Is there a provider who has a specialty that is singular in a geographic area? Ensure that you know your providers, taking into consideration specialists, volume, and geography to cover the needs in your area appropriately.
- Contracting -- again, the contracting process can be time consuming, and providers are looking for a fast response. Route provider contracts as soon as the application process is complete and have dedicated staff who are responsible for oversight of the process internally
- Credentialing -- MCOs expecting to do credentialing in-house should expect to dedicate significant resources for accomplishing the task. Consider outsourcing the credentialing process as it is often laborious and unfamiliar to MCO staff.

Call centers at newly formed or expanded MCOs have been plagued with tremendous call volumes in go-live testing. A lack of education for call center members mean that mixed messages can be passed on to patients/members as well as providers.

MCO Pitfall 5: Call Center Volume and Staffing

Call centers at newly formed or expanded MCOs have been plagued with tremendous call volumes in go-live testing. A lack of education for call center members mean that mixed messages can be passed on to patients/members as well as providers. To avoid these pitfalls consider the following:

- Separate call centers into two specialties -- one that deals with members, and one for providers.
- Write call guides for staff to follow and execute solid workforce management practices ensuring that there are strong flows in place for Call Center staff to follow in order to obtain answers.
- Remember -- different answers from within and organization will lead callers to "answer shop" and "no" answers will lead to complaints.

MCO Pitfall 6: Appropriately Managing with Data

Data is crucial for MCOs, but organizations often lack experience gathering data or are unfamiliar with what kind of data they need. Additionally, data available may not be Impactful, meaning that it may not be something over which the MCO has control.

- When utilizing data for decision making, remember that you need a baseline of at least one year of data. Making decisions based on initial data without a baseline can cause your organization to become over-reactive and miss long tail trends.
- Analyze where you will source the data to ensure that it will be accurate and meaningful.

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Pitfalls for Managed Care Organizations*…continued*

- Ensure that Quality Improvement initiatives are developed around data that you can actually impact as an MCO. For instance a Quality Improvement Project focused on inpatient stays may not be a good idea because the MCO has limited control over this.

In the end, whether transitioning or expanding an MCO, the road will be a long one, but with careful planning and learning from the implementation challenges of others, you can best position your organization for implementation success. Whether embracing the change, or bracing for the impact of it from a long term perspective, the bottom line is that Managed Care is here to stay, and the biggest mistake about managed care is the idea that transition can be avoided.

Danyell Jones is the Senior Vice President of Marketing for BHM Healthcare Solutions, based in St. Louis, MO. She can be reached at dajones@bhmpc.com.

Accountable Care with a Competitive Edge*…continued*

The Benefits of Provider-sponsored Health Plans

A provider-sponsored health plan is a powerful enabler of accountable care and offers several key benefits:

1. *Increased market pene*tration – Through a provider-sponsored plan, health systems have an increased opportunity to keep services within the system. When patients see a provider outside the network, it is often because a primary care physician referred them outside the system or didn't convince them to stay within the network. In a provider-sponsored plan, incentives are created so that primary care keeps patients within the system, encouraging collaboration and care coordination. With more patients staying within the system, health systems improve market share and remain competitive.
2. *More effective population health management* – A provider-sponsored health plan enables health systems to understand the needs of their patient base better and design plans that deliver more customized care. Critical decisions around what care to provide and what to pay for are both under the health system's own control. With more tightly integrated clinical and financial performance data and metrics, health systems are in a better position to improve outcomes and lower costs around specific patient populations.
3. *Higher financial reward* – Providers who offer health plans will be in a better position to meet the goals of true value-based care – better alignment of incentives, population health, increased clinical coordination, and first dollar capture. Because a certain amount of hospital costs are fixed – beds, facilities, staff – the costs of incremental care is often less for a provider organization than for a traditional payer. For example, an episode of care might cost an outside payer $50k. However, provided the health system has capacity, their out of pocket costs are limited to the variable costs associated with providing care – often less than 30% of total amount billed. Furthermore, up to 15 percent of an insurance company's cost is administrative. Recent studies suggest that provider-sponsored plans are more efficient, paving the way for the health system sponsored payer to offer lower premiums or additional incentives, or to pass through the savings.

Provider-Sponsored Health Plans – Where to Begin

For hospitals and health systems thinking about forming a provider-sponsored plan, the first thing to think about is a risk feasibility study. Providers should consider:

- Network of physicians -- what other providers will be participating? How strong is our primary care base?
- Local payer reaction -- will the independent payers still be willing to work with them, and if not, can they function without those contracts?
- Market position and local competition -- with which patients or in which geographies does the provider have a competitive edge?
- Community reaction -- what will consumers and employers say to a provider-sponsored plan?
- Regulatory environment -- is there legislation that prevents or makes it difficult for provider sponsored plans to realize their potential?
- Costs and financial position -- does the provider organization have the cash and bond rating to allow it to set aside the necessary reserves?

Once providers understand their market position, they are going to need to incorporate services that enable them to take on the role of the payer. This means adding a range of new responsibilities – claims payment, customer service, insurance reporting, and other administrative operations. There are a wide variety of tools and services that providers can utilize today to develop a provider-sponsored plan without relying on private insurers. For example, advances in technology and predictive modeling have evolved to where providers can apply proven actuarial analysis without having the armies of actuaries that traditional insurance companies employ. This visibility into financial risk and the ability to account to it is readily available to providers.

The thought of stepping into the payer's shoes may seem overwhelming to providers, but for many hospitals and health systems the rewards far outweigh the risks – and will put them ahead of the game when it comes to accountable care.

Phil Kamp is CEO of Valence Health, based in Chicago, IL. He may be reached at PKamp@valencehealth.com.

Being Accountable for Good Preventive Care…continued

The Triple Aim and Integrators of Care

Increasingly, health plans and particularly Federal programs are requiring evidence of quality performance with reimbursement tied to that evidence. In 2007, the Institute for Healthcare Improvement (IHI) enunciated The Triple Aim for the future of healthcare which is: improved health, improved care, lower cost. IHI identified "integrators" of health as the organizations which would move healthcare by pursing healthcare transformation and innovation. Three of those "integrators" have defined sets of quality measures which must be met in order to receive the maximum reimbursement; they are:

1. *Medicare Advantage* - STARS Program - 53 Quality Metrics (This is not to be confused with IHI's STAARS Program, which is working to decrease hospital readmissions.)
2. *Patient-Centered Medical Home* - National Quality Forum endorsed measures - 10 required by NCQA
3. *Accountable Care Organizations* - 33 defined quality metrics

There is significant overlap in these requirements, and SETMA reports on numerous quality measures and groups of measures -- NCQA, PCPI, AQA, HEDIS, NQF, Guidelines Advantage, Core Measures (Hospital), Bridges to Excellence for multiple disease processes, PQRS, Joslin, SETMA Developed Measurement Sets and STARS, and ACO measurements.

SETMA's Quality Metrics Philosophy

SETMA's philosophy with regard to quality metrics has the following eight elements:

1. Quality metrics are not an end in themselves. Optimal health at optimal cost is the goal of quality care. Quality metrics are simply "sign posts along the way." They give directions to health. And the metrics are like a healthcare "Global Positioning Service": they tell you where you want to be, where you are, and how to get from here to there.
2. The auditing of quality metrics gives providers a coordinate of where they are in the care of a patient or a population of patients.
3. Statistical analytics are like coordinates along the way to the destination of optimal health at optimal cost. Ultimately, the goal will be measured by the well-being of patients, but the guide posts to that destination are given by the analysis of patient and patient-population data.
4. There are different classes of quality metrics. No metric alone provides a granular portrait of the quality of care a patient receives, but all together, multiple sets of metrics can give an indication of whether the patient's care is going in the right direction or not. Some of the categories of quality metrics are: access, outcome, patient experience, process, structure, and costs of care.
5. The collection of quality metrics should be incidental to the care patients are receiving and should not be the object of care. Consequently, the design of the data aggregation in the care process must be as non-intrusive as possible. Notwithstanding, the very act of collecting, aggregating, and reporting data will tend to create a Hawthorne effect.
6. The power of quality metrics, like the benefit of the GPS, is enhanced if the healthcare provider and the patient are able to know the coordinates while care is being received.
7. Public reporting of quality metrics by provider name must not be a novelty in healthcare but must be the standard. Even with the acknowledgment of the Hawthorne effect, the improvement in healthcare outcomes achieved with public reporting is real.
8. Quality metrics are not static. New research and improved models of care will require updating and modifying metrics.

SETMA's Clinical Decision Support

The following are screen shots of our MA STARS and our ACO Quality Metrics tools. The legend is:

- If the measure applies to the patient and has been done, it is in black
- If the measure applies to the patient and has not been done, it is in red.
- If the measure does not apply to the patient, it is in grey.

If a provider wishes to review the content of each metric, he/she can click on "view" and it will show what it takes to fulfill the metric. This makes it possible for the provider, at the point of service, during the office visit, to measure their own performance for whatever "integrator" of care in which the provider is working.

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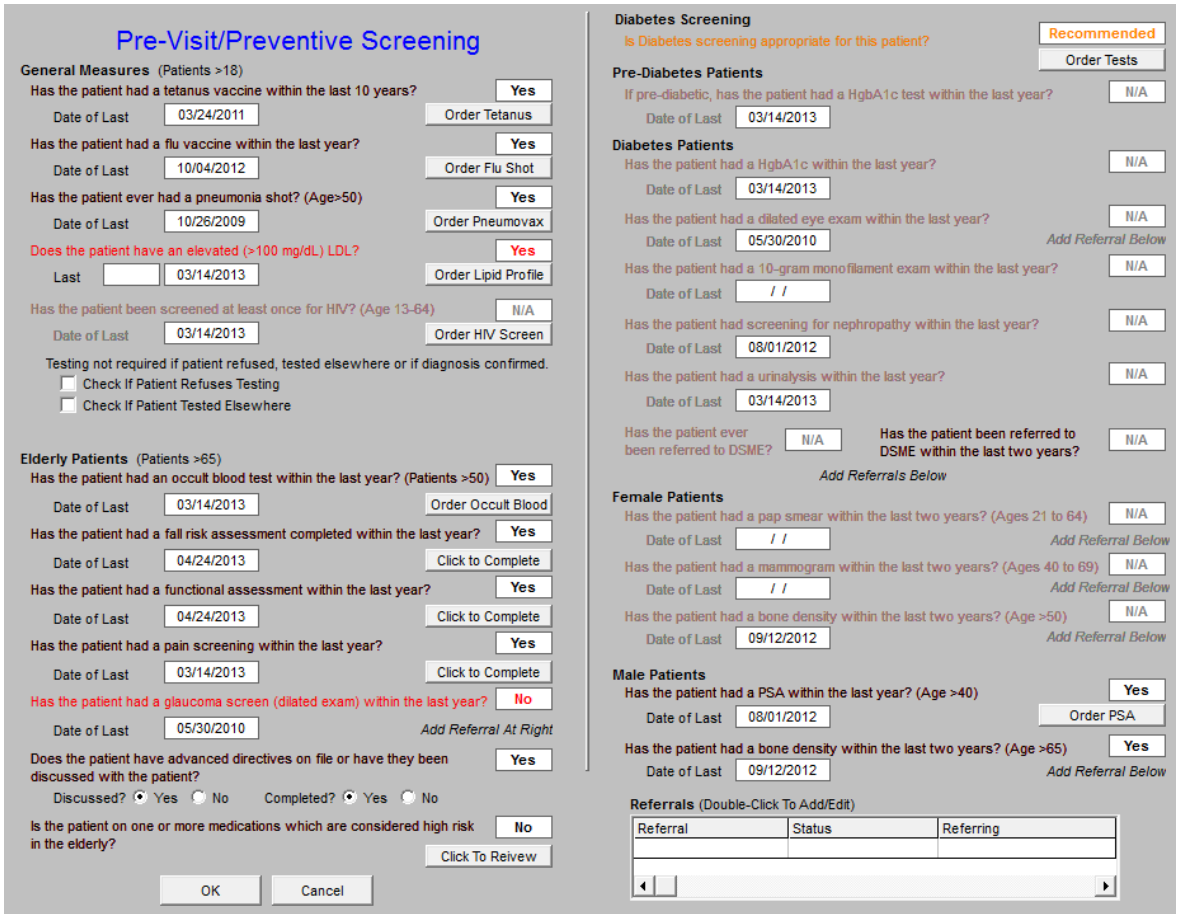
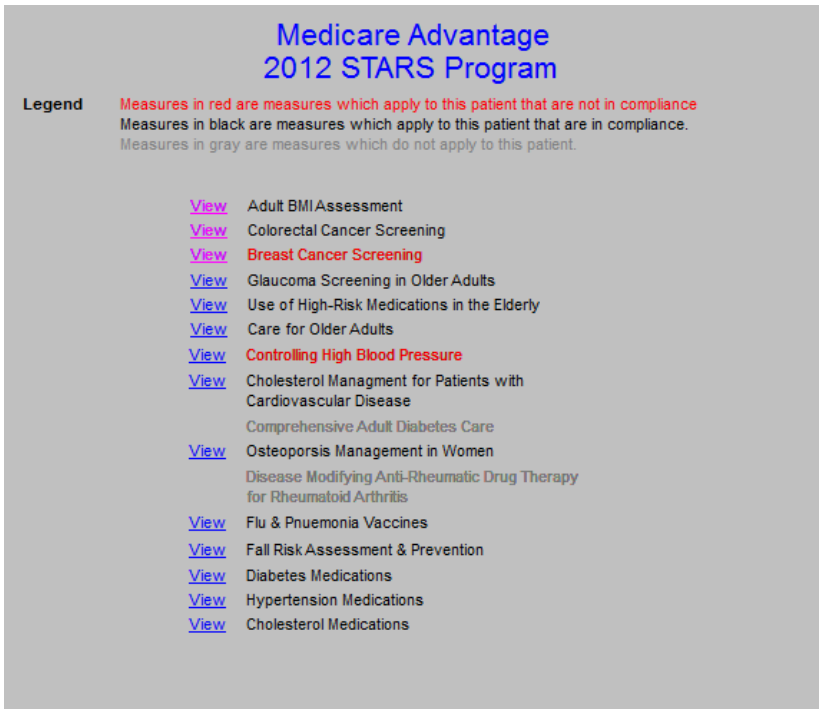
Subscribers' Corner

Subscribers can access an archive of current and past issues of *Accountable Care News*, view added features, change account information, and more from the Subscriber web site at www.AccountableCareNews.com. Subscribers can also network and discuss ACO issues with other health care professionals, review job opportunities, and more in the LinkedIn Accountable Care News Group. To join, go to http://www.linkedin.com/groups?gid=3066715.

Being Accountable for Good Preventive Care…continued

This CDS tool is for general preventive and screening functions.





This is the tool for the Medicare Advantage STARS Program

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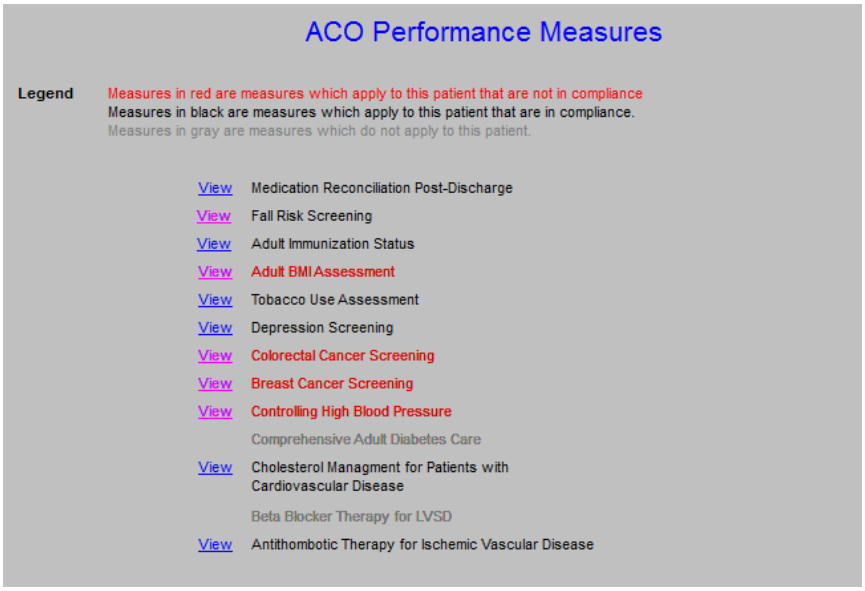
Being Accountable For Good Preventive Care...continued

This is for the ACO Quality Metrics requirements



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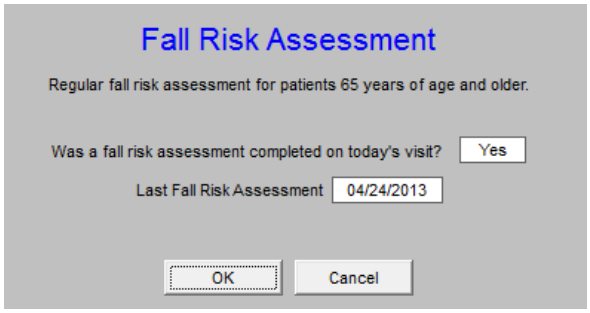

Why not cheat?

- If you are going to be given a test, and
- if you are given the test questions beforehand, and
- if the test is an open-book examination, and
- if there is no time limit for the test,

Why not "cheat?" Look up the answers before the test so that you know what your performance is before you go into the test. Don't wait until an insurer or an ACO measures your HEDIS performance, or your performance on an ACO measurement set. Know your performance beforehand by measuring yourself. Know your performance at the time you see a patient.

Of course, ethically, there is no "cheating" in this context. The test is not measuring what you know, but it is measuring what you have access to and what you pay attention to. The test is not measuring what you remember, but it is measuring what you are reminded of. Consequently, if you have Clinical Decision Support tools (CDS) which remind you of what needs to be done and if you have CDS tools which allow you to measure your own performance at the point of care, it is obvious that you can consistently improve your performance.

Being accountable for good preventive care? That's easy, which makes the future of ACOs and other "healthcare integrators" bright.

James (Larry) Holly, MD is CEO of SETMA in San Antonio, TX and also Adjunct Professor of Family & Community Medicine at the University of Texas Health Science Center, San Antonio School of Medicine and a Clinical Associate Professor in the Department of Internal Medicine at the Texas A&M Health Science Center School of Medicine. He can be reached at Jholly@setma.com.

Thought Leaders' Corner

Each month, *Accountable Care News* asks a panel of industry experts to discuss a topic of interest to the accountable care community.

Q. "CMS and the Pioneer ACOs seem to have come to an understanding regarding payment for performance for ACOs (vs. pay for reporting), based on a set of quality metrics. But the larger question is: how quickly should purchasers move providers to performance-based payment given that any set of metrics will be a somewhat imperfect measure of 'quality'?"

"The time to move to performance-based payment was yesterday, let alone today. The notion that quality metrics are imperfect is only true in a few instances. For the most part there are very good proxies for patient outcomes. For example, the lack of complications such as readmissions, ambulatory care sensitive emergency department visits or hospitalizations, patient safety failures, and others are all indications that the patient's care has few, if any, significant defects. And since these defects are financially and physically costly, reducing them will also reduce costs of care.

We're spending 18% of the GDP on health care, and it now consumes 30% of an average family's income. The agents of the status quo who benefit from this heavy taxation of US residents have long argued that measures of quality are so imperfect that they should not be held accountable to those metrics. And the 'Pioneers' went whining to CMMI that the metrics they needed to achieve were too hard. How about the burden on the family that can't afford to pay for its kids' college education? Do we continue to pander to the fleecers or start helping those being fleeced? So yes, it's time to move to performance-based payment."

François de Brantes
Executive Director
Health Care Incentives Improvement Institute
Newtown, CT

"Performance measurement in clinical quality and care experience are essential elements of accountable care. Providing a balance to the incentives for cost-efficiency, performance measures assure providers, payers, and patients that accountable care is not simply cost-cutting. Quality measurement continues to improve as national and specialty organizations create, test, and monitor new measures that use rich clinical data only now becoming available in EHRs. In the meantime, the healthcare delivery system needs to continue the adoption of performance measurement requirements in order to promote investments in quality infrastructure, patient experience initiatives, and developing a culture of transparency and continuous learning. Key issues will be about how each quality measure is specified, benchmarked, and refined over time, and success will require ongoing dialogue, patience, and collaboration among trusted partners."

Donald W. Fisher Ph.D., CAE
President and Chief Executive Officer
American Medical Group Association
Alexandria, VA

"It is essential for payers to take action to reinforce the 'from volume to value' message but to do so with an understanding that, unlike Marshall McLellan who said 'the medium is the message,' here the payer message is the medium to make known that the times are not a changin', they have changed and there are no magic slippers to take us back to Payer Kansas. The benefit to patients and payers will be neither immediate nor significant savings (see the work of Jha, Ariely and others) but rather a softening of the soil for future change once the methods and measurements are improved so that (risks and) rewards can be increased."

Philip L. Ronning
Principal
Ronning Healthcare Solutions
Newberg, OR

Thought Leaders' Corner

"The National Association of ACOs (NAACOS) strongly supports pay for performance based on fair and empirically determined quality metrics that compare ACOs to fee-for-service performance. The determinants and the level of performance selected by CMS will demonstrate the reasonableness of the numeric goal for each measure. The 33 CMS ACO metrics combined with their latest decision to include the GPRO data in the setting of benchmarks is an important step. However, ACOs are extremely concerned about a proliferation of different quality metrics from each different purchaser and believe CMS and other payers should establish a process for aligning their requirements. NQF is a useful process for vetting the accuracy and reliability of the measures, and ACOs should have a role there too. Also, we are moving to a state where there may be too many metrics for purchasers to choose from and not enough empirical validation of benchmarks within those measures. Our greatest fear is that ACOs will be buried in an avalanche of differing metrics by payers and be forced to spend their resources reporting care instead of improving care."

Clif Gaus
CEO
National Association of ACOs
Bradenton, FL

"Today, value-based payment remains unproven. This creates an opportunity to implement new measures of performance that will be more meaningful to consumers, clinicians, health systems, purchasers, and policy makers. As we move forward with different models of delivery and payment, a common measures framework is needed to support data-driven assessments of which systems deliver the most value.

To demonstrate effectiveness, measures must assess costs, health outcomes, and care experiences in a way that is easily understood and valued across entities. Measures should also guard against unintended consequences, such as stinting on care or 'cherry picking' to avoid high-cost patients, which could undermine ACO's goals and lead to public backlash. Premier is focusing on a set of meaningful ACO measures for more widespread use. However, we must start testing these measures now to determine whether they are effective at accurately assessing functional health, health risk, patient experience, and total per capita costs."

Wes Champion
Senior Vice President
Premier Consulting Solutions
Charlotte. NC

Industry News

MedPAC Chair Renews Call for Beneficiary ACO Savings

At the April meeting of the Medicare Payment Advisory Commission (MedPAC), the Commission Chair, Glenn Hackbarth, expressed support for Medicare beneficiaries being able to share in any savings generated by ACOs. This could shield ACOs from criticism that they were making money by denying medically necessary care, an oft-cited criticism of HMOs during the early days of managed care. MedPAC had in fact made this suggestion to CMS when the initial ACO regulations were being developed.

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CMS Maintains Pioneer ACO Pay-for-Performance

CMS Center for Medicare and Medicaid Innovation (CMMI) Director Richard Gilfillan, MD has announced that CMS will not change the Pioneer ACO metrics to a report-only mode for FY 2013, as a large group of Pioneer ACOs had demanded under the threat of withdrawal from the program. Gilfillan said there was enough data from 200 ACOs, including the Medicare Shared Savings Program participants, to make valid measurements. However CMS did say that it would accelerate efforts to "speed up the collection and application of data to these important quality metrics to ensure that they are as accurate as possible."

Cooper University Health Care Launches New ACO

Camden, NJ-based Cooper University Health Care has acquired a 20% stake in AmeriHealth, New Jersey and will form a new health plan accountable care model

ACO Leaders: Pharma Could Do More re Costs

A new Oliver Wyman survey of 200 physicians in value-based delivery models found that 61% believed that branded drugs could help reduce the total cost of care if used appropriately; but only 37% supported or strongly supported the statement that "Pharmaceutical companies have the capabilities to reduce the total cost of care and improve patient outcomes." The disconnect stems from the pharmaceutical industry's lack of emphasis on how drugs can impact the total cost of care for a disease episode. Industry analysts expect that to change.

Truven Health Analytics Lists Top 15 Systems

Truven Health Analytics' recently released fifth annual survey lists the top 15 health systems based on eight measures of quality, patient perception of care, and efficiency. All five of the big systems (more than $1.5 billion in total operating expenses) are well known ACOs: Advocate Health Care, Oak Brook, IL; Banner Health, Phoenix; Memorial Hermann Health System, Houston; OhioHealth, Columbus; and Scripps Health, San Diego.

Brookings Report Calls for ACO-like MCC System

A new report from Brookings calls for creation of a Medicare Comprehensive Care system that builds and extends the ACO model to a fully capitated payment system for integrated provider networks that would also meet quality of care and efficiency standards.

Catching Up With *…continued from page 12*

Gov. Leavitt: (continued) One thing to note is that the Medicaid ACO programs vary as much as the states' respective political makeups. Case in point: Utah has taken a very hands-off approach whereas Oregon is much more proscriptive in its approach, including some pretty stringent cost-reduction requirements.

Accountable Care News: *You have been an outspoken proponent of States creating and managing their own health insurance exchanges, but only 18 apparently plan to do so. With many of the new commercial ACOs now coming into play by virtue of partnerships between national plans like Aetna and Cigna, are the Federal exchanges in particular going to be a boon or a nightmare for local and regional ACOs?*

Gov. Leavitt: The question is: how many carriers will participate on a specific state FFM (Federally Facilitated Marketplace)? We are hearing from some states, like North Carolina, that carriers will be very reluctant to participate. For example, we have heard that Aetna will not participate on FFM in their states.

However, participating carriers can create and offer plan products on any marketplace model that would/could funnel consumers into ACOs. Exchanges in general, federal or state, will be a boon to ACOs; perhaps not in the startup year but assuredly in coming years. This is because plans with competitive prices and consumer satisfaction will be the most successful on exchanges. You have a lot of new lives, especially lower income and younger populations that will encounter high premiums. It follows that plans on exchanges (plans that are able to offer more competitive prices by delivering more efficient care in narrower networks) will capture more business (plans that are more likely to contract with ACOs).

Accountable Care News*: Finally, tell us something about yourself that few people would know.*
Gov. Leavitt: I am an avid golfer and have played nearly my entire life, but I didn't get my first hole-in-one until my 60th birthday.

Catching Up with …

Gov. Michael Leavitt is the founder and chairman of Leavitt Partners, where he advises clients in the health care and food safety sectors. In previous roles, he served in the Cabinet of President George W. Bush as Administrator of the Environmental Protection Agency and as Secretary of Health and Human Services. He also served as Governor of Utah from 1993-2003. He talks about the characteristics of ACOs that will succeed or fail, performance metrics, Medicaid ACOs, ACOs and the Federally-run health insurance exchanges, and himself.

Gov. Michael Leavitt

- Founder and chairman, Leavitt Partners
- Advisor, Romney for President Campaign
- Secretary, U.S. Department of Health and Human Services (2005-2009)
- Administrator, U.S. Environmental Protection Agency(2003-2005)
- Governor of Utah (1993-2003)
- Bachelor's degree in economics and business from Southern Utah University

Accountable Care News: *According to your Center for Accountable Care Intelligence, you count 428 total accountable care organizations in the US as of January 10, 2013, and the number continues to rise. Clearly some will flourish and some will fail. What do you think are the characteristics of those who succeed and those who don't?*

Gov. Leavitt: There are 5 key attributes of successful emerging delivery models. Organizations that succeed will share common core values, principles and structure components. These include:

1. Governance Structure: Fosters a commitment to providing care that puts people at the center of all clinical decision-making, the ability to interface with payers and the ability to manage a culture of change among providers and patients.
2. Health IT: For care coordination, outcomes measurement and payment distribution.
3. Payment Structure: To align stakeholder incentives and pay individual providers based on value.
4. Sufficient Capital: To invest in infrastructure and hold more accountability.
5. Efficient Care Model: To manage the continuum of care, have established relationship along the care continuum and prevent acute events.

Successful organizations will also embody characteristics of strong leadership with a progressive institutional culture, and they'll have experience dealing with risk. I suspect they'll become very good at gathering, reviewing and making decisions based on the very best health care intelligence -- something we at Leavitt Partners call collaborative IQ.

If organizations fail, it will be because of the following:

- Inability to manage risk (financial)
- Inability to manage populations (clinical)
- Taking on ACO contracts without making necessary internal changes
- Unable to get physicians on board
- Unable to create strategies to affect patient behavior
- Poor communication between providers and administrators

Accountable Care News: *Performance metrics is still a somewhat imperfect science, and the recent discussions between the Pioneer ACOs and CMS on paying for "quality" highlight the inherent tension in a purchaser wanting to pay for results and a provider wanting to make sure the metrics are valid and fair. Is it better to push ahead since providers will adjust their behavior or wait until a set of performance measures are fully vetted?*

Gov. Leavitt: There needs to be a balance between moving forward while vetting the metrics. This can be done by using the best metrics that currently exist coupled with low-payment risk for the providers. Over time, the metrics will improve and the provider risk can increase. We will develop better quality metrics through an iterative process that requires pushing ahead to some degree. This will allow organizations to gain experience as the innovation takes place, rather than sitting around waiting for the industry to work out the kinks.

Accountable Care News: *Dr. Jeff Brenner and the Camden Coalition were arguably the first to begin constructing what is a Medicaid accountable care organization, and now a growing number of States are experimenting with different ACO and CCO models. Can these new models make a real dent in the Medicaid cost curve?*

Gov. Leavitt: Two things stand out among characteristics people hope will separate new models from managed Medicaid: increased use of quality metrics and increased scope of services covered. The hope is that:

1. Quality metrics will counterbalance the incentive to simply reduce/deny care.
2. Care coordination can be motivated by broadening the scope of covered services and connecting the payment arrangement to the performance of multiple providers.

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