SPARKING CONVERSATIONS IN HEALTH CARE

Summer 2011

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AGE OF ACCOUNTABILITY **LESSONS FROM CMS**

HEALTH I.T. FRAMEWORK FOR REFORM

THE ACO VISION **FACTORS FOR SUCCESS**

OPTUMInsight™

A New Beginning



For more than a decade, Ingenix has been providing practical solutions for the complex issues our clients encounter across the health ecosystem. I am pleased and proud of the reputation we have established under that name.

However, just as the general landscape of health care is transforming to improve access and emphasize collaboration, we, at Ingenix, are aligning our health care services to provide greater understanding and access to our company's full range of capabilities. To reflect this increased coordination, we are unifying our health care services under the Optum brand. Going forward, Ingenix will now be known as OptumInsight™. In addition, Prescription Solutions will become OptumRx™ while OptumHealth™ will retain its name. I am excited about this next step in the evolution of our company, and I truly believe this will help us better connect with our clients to address their needs.

As Ingenix transitions to become OptumInsight, we thought it only fitting to refresh *Ignite* by implementing a redesign, both for the print publication and the supplementary website. In addition, we recognize the importance of social media platforms for engaging our readership and will be launching a LinkedIn page in the coming months.

> "We are aligning our health care services to provide **greater understanding and access to our company's full range of capabilities**"

In this new issue of *Ignite*, we continue our discussion of ACOs with a focus on physician buy-in. We outline five factors needed to attain ACO benefits and address physician concerns about patient attribution, provider profiling, payment and member engagement. Also, read our analysis of initiatives set by the Centers for Medicare & Medicaid Services (CMS) to improve health outcomes and lower costs.

We've added some new sections to *Ignite*, as well. In coming issues, you will find a Q&A with respected health care thought leaders, an analysis of the latest findings we've researched at OptumInsight, and ideas and guidance from one of our specialists about navigating the new, and often unpredictable, health care industry.

For more information on some of our featured topics, I encourage you to visit ignite.optuminsight.com to find Web exclusives, including a podcast interview with Anthony Shih of The Commonwealth Fund.

As you flip through the pages of this issue and navigate through our website, I hope you enjoy the new look and feel and walk away with even more insight into the important health care topics our specialists address. And, as always, I look forward to the conversations that ensue.

Sincerely,

Andy Slavitt
CEO, OptumInsight

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Summer 2011
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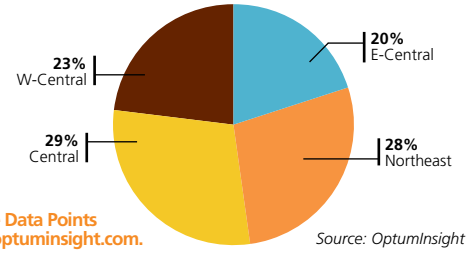
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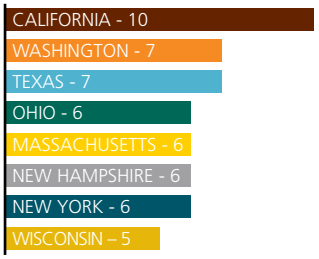
DATA POINTS
Where are ACOs most prevalent?

ACOs BY REGION



Source: OptumInsight

STATES WITH THE MOST ACOs:



Learn more in the Data Points section of ignite.optuminsight.com.

Q&A

Making the Case for ACOs

By Kim Ribbink



Improving the delivery of health care, while seeking the outcomes of accountable care organizations (ACOs), requires some fairly significant changes in how health care providers function. Even before ACOs are officially established, many hospitals, physicians and payers are becoming advocates for the types of changes ACOs will require. These supporters welcome a shift away from the fee-for-service, silo-type activities that have prevailed within the industry for so long.

To gain insight into how hospitals, physicians and payers are working to advance health care outcomes, *Ignite* spoke with two proponents of collaboration and enhanced coordination of care: Stephen Rosenthal, president and CEO of CMO, The Care Management Company of Montefiore Medical Center, and Justin Chang, MD, chief of emergency services at Kaiser Permanente, Colorado, and medical director of the Exempla St. Joseph Hospital Emergency Department. Together, they make the case for a new model.

IGNITE: WHAT NEEDS TO CHANGE IN THE WAY HEALTH CARE IS DELIVERED TO ACHIEVE THE DUAL ACO GOALS OF BETTER OUTCOMES AND REDUCED COSTS?

Rosenthal: Health care is often fragmented, with practitioners paid on a fee-for-service basis and everyone trying to maximize their silo. Health care reform seeks to move away from silos to focus on the continuum of care. We view that continuum as much broader than just what happens during the medical experience.

Chang: One, you have to have a wide variety of care providers willing to work together toward a common goal of better outcomes for patients. Two, you have to have the support networks behind all these providers, meaning chronic care coordinators, case management, nursing, even dietary. Electronic medical records are key to efficiency so all these individuals can share information regarding patients in real time.

IGNITE: HOW DO YOU DEFINE PARTNERSHIP IN THE CONTEXT OF THE ACO MODEL?

Rosenthal: Our partners are the other health systems and major insurance companies in our region, and we hope to collaborate to create a regional approach to managing the health of the population we service. We are looking to work with two other major hospital systems in the Bronx, N.Y. We will also participate with community health centers, known as federally qualified health centers in our region, which are where the population enters the system, as well as nursing homes, mental health community-based organizations and so on.

Chang: Kaiser Permanente has established a large, multi-specialty group that is salaried, as opposed to being paid on a fee-for-service basis, and is aligned around organizational objectives. The physicians in our group utilize the same electronic medical records; we order the same items in the same way; and this helps the network monitor groups for outcomes.

IGNITE: WHAT APPROACHES ARE YOU TAKING TO MANAGE YOUR PARTNERSHIPS OR THE WAY YOU COORDINATE CARE?

Rosenthal: We are connected to a health information exchange, which helps us understand what services patients get in different facilities. The more we know about the patient's health care experience, the more effective we can be in providing that patient the right service at the right time and, perhaps, at the right cost.

Chang: It's about having physicians in key locations partnering with each other and using the same electronic records, with support personnel who oversee the patient's overall health and



> "We view that continuum of care as **much broader than just what happens during the medical experience.**"

manage the transitions. That's the beauty of an integrated ACO, because it's during the transitions that most medical errors, readmissions, dropped medications and wrong information occur.

IGNITE: WHAT FURTHER STEPS NEED TO BE TAKEN TO CREATE A MORE COLLABORATIVE ENVIRONMENT TO IMPROVE HEALTH OUTCOMES?

Rosenthal: Transparency is important so health care practitioners can compare their performance to their peers. Full public health awareness can change outcomes on a population level. If your community has a high level of obesity, you can have a much more significant impact if you're talking to the community as a whole, providing education and awareness about health hazards. On the clinical side, we must start to insist on a clear methodology for using and monitoring best practices in clinical guidelines and dealing with gaps in care.

Chang: Systems, policies, procedures and protocols must be patient-centric, not physician-, hospital- or insurance-centric. That's my litmus test. ■



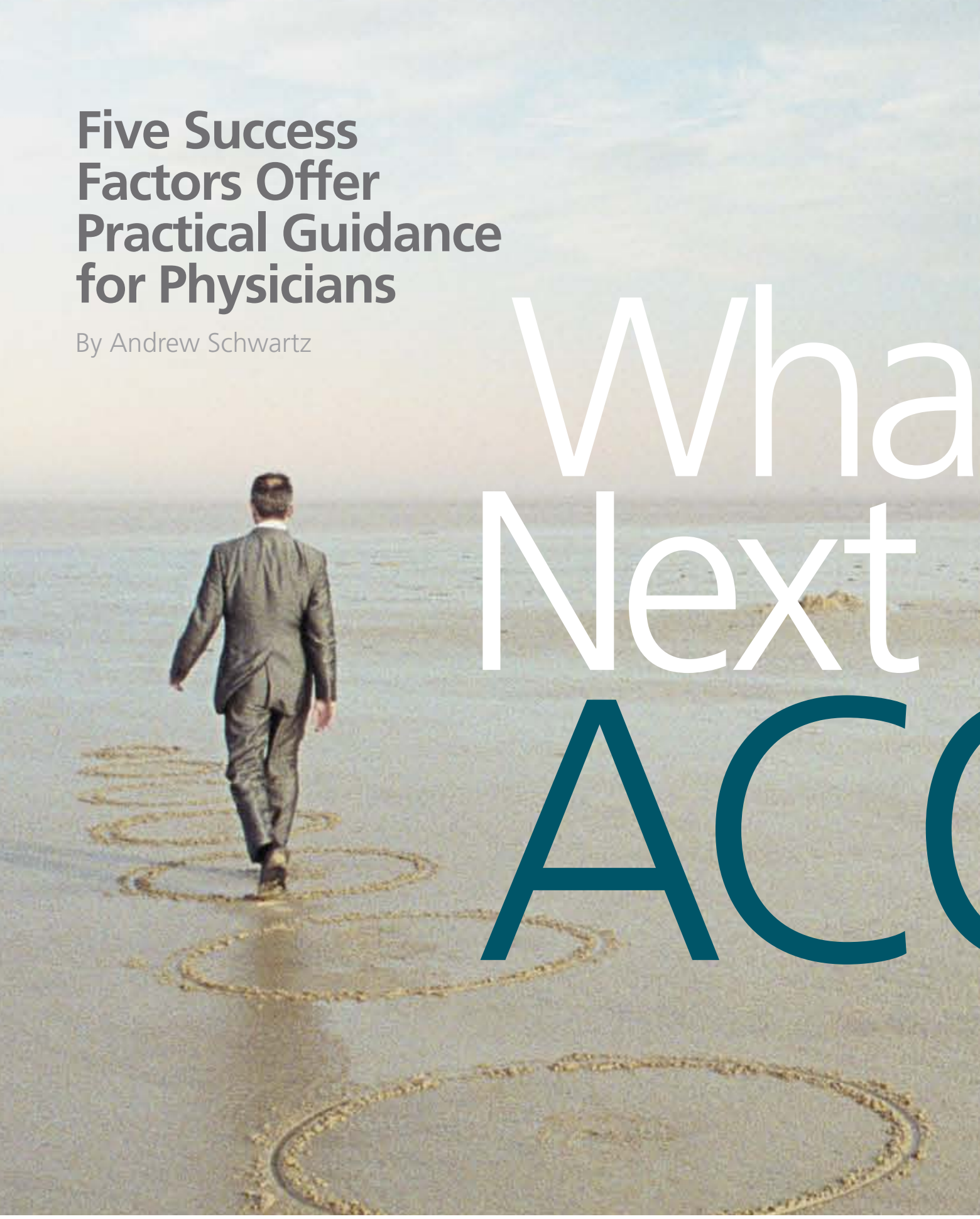
Stephen Rosenthal, president and CEO of CMO, The Care Management Company of Montefiore Medical Center



Justin Chang, MD, chief of emergency services, Kaiser Permanente, Colorado, and medical director, Exempla St. Joseph Hospital Emergency Department

Five Success Factors Offer Practical Guidance for Physicians

By Andrew Schwartz





When the Centers for Medicare & Medicaid Services (CMS) released proposed regulations for its Shared Savings Program (Medicare fee-for-service accountable care organizations), it took one step forward in what could be a transformation of the U.S. health system. Though the proposed rules will stoke existing concerns about Medicare ACOs, they do begin to flesh out a vision where health care stakeholders work together to achieve enduring community health. The next step—ensure those stakeholders have buy-in.

"Addressing flaws in our current system and successfully building out the ACO vision demands strong physician engagement, as they and their patients are the first line of defense in managing health and health care," says Anne McCune, managing director of strategy and governance at OptumInsight. "When physicians are highly engaged in system change, it not only benefits the health of the entire community, but it should benefit physicians, as well."

Realizing those benefits, however, depends on a rigorous ramp-up process that addresses physician concerns in four key areas: patient attribution, provider benchmarking, payment and member engagement. This is true, McCune says, whether a physician group wants to participate in the CMS Shared Savings Program or in private shared savings or accountable care models, which OptumInsight calls Sustainable Health Communities (see page 6).

THE RAMP-UP PROCESS

According to McCune, creating a rigorous ramp-up process is not something every physician organization should aggressively pursue for 2012. "When you look at the most prominent ACO-type pilots, they consist of highly organized physician groups of at least 250 physicians that have significant market share, a large degree of clinical integration and the advanced technology to engage patients and manage risk and population health," McCune says. "There has been very limited pilot activity with highly distributed small physician practices, despite the fact that 85 percent of physician groups in the U.S. consist of three physicians or less."

Nevertheless, there are incentives in the CMS-proposed regulations and in the general movement toward the accountable care model that should motivate any physician practice to begin making changes to achieve the triple-aim objectives of better care for individuals, better health for populations and slower growth in costs through improvements in care.

- *Income Preservation/Shared Savings:* Income preservation is hardly the sexiest of incentives. But because some version of the ACO model is the direction health care delivery is moving, every physician group and hospital must begin devising ways to preserve their income under the new models. In the CMS program, participating physician groups will have the option to receive their regular fee-for-service Medicare payments without having to

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assume any risk for the first two years of a three-year commitment—and they can earn shared savings by meeting quality and efficiency targets. That said, lower reimbursements, complex metrics to achieve shared savings, language in the proposed regulations that warns against improper incentives, and the failure of most groups in the less stringent Medicare Physician Group Practice Demonstrations to achieve any savings over three years all set the bar for shared savings quite high.

That's why some market-led models are exploring other physician revenue sources, such as reimbursement for e-visits, care coordination and enhanced opportunities within pay-for-performance formulas. "But even in these situations, physicians should be careful," says David Plocher, MD, vice president of health management and clinical excellence at OptumInsight. "Our research shows that the biggest lift will come for groups whose practice patterns show considerable practice variability. Those practices will have to do a lot of work to meet quality targets in any of the existing models."

- *Enhanced Control:* "Particularly in the private models, physicians could enjoy more control over how they get paid and what they get paid for; pre-authorizations may disappear," Plocher says. But he notes that physicians will also assume a new level of responsibility for efficient, economic-minded care.
- *Prestige and Market Share:* Physicians who participate in shared savings models and deliver on the promise of improved care could garner prestige in their community, which translates into increased market share. But they must be able to document superior, patient-centric care and be savvy about making patients, potential patients and referring physicians aware of their achievements.

FACTORS FOR SUCCESS

To achieve physician buy-in and attain ACO incentives, organizations should follow five critical success factors:

1 Focus On, Motivate and Deliver Exemplary Primary Care

The proposed CMS regulations encourage most ACOs to have a core group of outstanding primary care providers who function as, or in ways similar to, a patient-centered medical home (now known as an advanced primary care practice). Market-led models also recognize that a "home for health" is the key. Therefore, physician groups must be able to use data and benchmarks to confidently assess the strengths and weaknesses of their primary care physicians, particularly in managing population health.

The data-driven assessment should be paired with a qualitative exploration of the factors that facilitate outstanding care and improved wellness and prevention, including:

- Expert engagement of individuals in wellness and preventive care programs
- Efficient, economic clinic visits that make full use of physician extenders and connectivity with data supplied by electronic health records (EHRs), pharmacies, labs and payers
- Exemplary management of chronic conditions and end-of-life care, which are both a significant focus for the quality measures CMS has proposed

In addition, although there are no funds in the proposed CMS regulations specifically slated for primary care enhancements, there is nothing stopping the market-led models. For example, payment methodologies could motivate further improvements in primary care. "Advanced groups can move quickly to global capitation, which will be the easiest to administer—though that doesn't preclude the need for transitional models, like bundled payments, with some organizations," Plocher says.

2 Rigorously Identify Partners and Set the Scale

"If an organization is prepared to assume risk, it still must carefully define a service catchment area, strong potential partners and, in the case of private models, the population demographic they want to serve—Medicare, Medicaid or commercial," Plocher says. This demands a clear understanding of the region's patient population. In addition, organizations must measure their practices' patterns against those of competitive specialists and hospitals in the region.

"Benchmarking and analysis drive partner selection and gap analysis for ACO-type readiness," says Pamela Friedman, vice president of strategy and governance at OptumInsight. "They an-

SUSTAINABLE HEALTH COMMUNITIES

On March 31, 2011, CMS defined ACOs as structures that "create incentives for health care providers to work together to treat an individual patient across care settings—including doctors' offices, hospitals and long-term care facilities. The Medicare Shared Savings Program will reward ACOs that lower growth in health care costs while meeting performance standards on quality of care and putting patients first. Patient and provider participation in an ACO is purely voluntary." The 429 pages of proposed regulations focused largely on providers—physicians and hospitals—while carefully defining many of the requirements for participation, patient attribution, payment models and a host of other elements.

The OptumInsight concept of a Sustainable Health Community, however, aims to ensure all stakeholders—physician, hospital, patient, pharmacy and payer—are involved in, and accountable for, optimizing the health of individuals and entire communities of people. Most of the efforts toward this goal will be market-led, rather than government-led, and how groups get there is more open-ended than what CMS is proposing.

swer questions, such as: What dictates a go/no-go decision on an ACO? And if you're not ready, how quickly can you or your partners get there? It is also a head start on determining patient attribution, payment methods, provider profiling and individual engagement should groups decide to move ahead."

3 Negotiate Partnerships

Once partners and scope have been identified, groups must negotiate agreements with their chosen hospitals, specialists and, perhaps, ancillary care organizations. Private models also must determine ways to partner with the region's health plans and/or insurers.

These arrangements are tricky because, to keep both providers and patients engaged and effective in improving health and lowering costs, groups must often balance conflicting needs and incentives.

Hospitals

"Hospitals offer opportunities for savings and improved care through reduced ER visits, reductions of medical errors, reduced length of stay and reduction of readmits," McCune says. "Yet the majority of the savings at all PGP (Physician Group Practice) pilot sites occurred in outpatient services; four of the six PGP hospital-based system pilots achieved no savings, and this has everything to do with incentives."

The agreements must incent hospitals to communicate with ACO physicians when a patient is admitted and to aggressively manage inpatient and transitional care. Also, hospitals should consider how they can refocus their business. For example, are there ways to convert unused beds into specialty outpatient services that support the ACO?

Specialists

Deciding on specialty partners depends on the region's patient profile, but in most cases, primary care practices should look first to cardiologists, endocrinologists and oncologists.

"Their chronically ill patient populations need extensive care that can become exorbitant when not managed properly," Plocher says.

He notes that in many cases, these integrated delivery models also are likely to include rheumatologists and OB/GYNs as well as skilled nursing facilities and visiting nurse associations.

Payers

Participation in CMS-certified ACOs will not change underlying fee-for-service coverage; shared savings will be calculated and distributed after the fact. "But in Sustainable Health Communities, there are opportunities to collaborate with private payers on creative incentives and to leverage payer expertise in areas that will be new to providers," Friedman says.

Some payers have already begun working with physician groups to:

- Create new, value-based benefit designs
- Subsidize investments in the necessary technological tools
- Create educational and marketing materials that will encourage members to join and remain with the ACO and engage in preventive care, wellness and chronic care management programs



"THE BIGGEST LIFT WILL COME FOR GROUPS WHOSE PRACTICE PATTERNS **SHOW CONSIDERABLE PRACTICE VARIABILITY.**"

4 Form a Management Services Organization

Every ACO or Sustainable Health Community needs a carefully conceived governance structure.

"The new models need strong medical and executive leadership," says Michael Goran, managing director of provider alignment at OptumInsight. "This requires training a new generation of leaders that can measure performance and create a culture that understands how to improve the care of individuals and improve the health of populations while efficiently managing costs."

Governing boards for both CMS and private shared savings models should oversee a management services organization (MSO) that has real responsibilities and power. It should:

- Hold the reinsurance arrangement (for private models only)
- Stratify members

- Profile providers
- Assume medical management functions
- Distribute bonus payments (and, eventually, penalty withholds) as part of its role as joint contract holder with payers
- Work with legal counsel to manage anti-trust and other regulatory concerns

Effective MSOs also must sensitively engage in delicate negotiations on the details of patient attribution, payment distribution and technology investment. "Trust is critical," McCune says. "The MSO must respect physicians' professionalism by ensuring they are still in control of treatment choices and create clear communication channels and a transparent management, data and evaluation structure—including reliable risk and severity adjusters—that ease concerns about how payment and investment will occur."

5 Make Wise Investments in Data, Technology and Expertise

The proposed regulations make clear that information technology and expertise in the use of data—particularly population health data—will be core competencies of ACOs that successfully manage risk and population health.

At a minimum, the technology and expertise should include:

- EHRs, or at least what are known as EHR-lite solutions, pharmacy benefit management (PBM) tools and, in most cases, the ability to discover and share information through health information exchanges (HIEs) or regional health information organizations (RHIOs)
- Trustworthy risk and severity adjusters that enable apples-to-apples patient comparisons
- Provider-facing tools that: 1) deliver accurate, in-depth provider profiles to prompt redesign efforts that reduce practice variation, and 2) identify members headed for trouble to prevent costly hospitalizations. These go hand in hand with the expertise to implement effective care coordination programs
- Reliable actuarial projections that predict cost drivers so the ACO can align cost and clinical concerns and identify areas that most demand attention

How the ACO engages this technology and expertise depends on its size and where it operates. A small ACO in the CMS program—say, one clinic, one hospital—may need to look to the Center for Medicare and Medicaid Innovation or meaningful use incentives for necessary investments.

In a Sustainable Health Community of similar size, in an area where one payer has 70 percent market share, the provider group may be able to work with the payer to rent access to the payer's programs that can stratify patients and measure provider performance.

"On the other extreme, a large, multi-clinic, multi-hospital system in a state with no dominant payer will have to run its own analytics," says Colleen Thilgen, vice president for strategy and governance at OptumInsight. "In most cases, they can license software from reputable vendors and adapt it to their own needs."

ADDRESSING PHYSICIANS' BIGGEST CONCERNS

These five success factors can help deliver a satisfactory return on investment because, together, they address physicians' four biggest concerns:

- *Patient Attribution:* Because patient participation in the CMS program is voluntary, it will be based on retrospective assignment. "Retrospectively, a reconciliation should reflect the opportunity the ACO actually had to influence patients' care," Thilgen says. "This means having the data, tools and expertise to understand how and why patient leakage (working with providers outside the ACO) occurred."

  In contrast, some Sustainable Health Communities may have the leeway to do a more pure prospective attribution because they are not prevented from "locking" patients in. "A commitment by both physicians and patients enables the ACO to better engage the patient in health risk assessment, health improvement and shared decision-making programs," Thilgen says. "Strong primary care providers and enhanced technology tools optimize the commitment."
- *Provider Profiling:* Both in the ramp up to any ACO-type model and throughout the process, understanding provider practice patterns helps uncover where to reduce practice variation and meet quality goals. "Increasingly sophisticated analytical software can draw on integrated administrative claims and lab and pharmacy data, as well as from clinical data in EHRs, to help physicians understand where change must occur," Thilgen says.

  "But the software must be accompanied by the MSO employ-



> WITH PATIENTS FREE TO MOVE IN AND OUT OF THE ACO AT WILL, **ATTRACTING MEMBERS AND KEEPING THEM ENGAGED IN THEIR OWN CARE AND WELLNESS BECOMES PARAMOUNT.**

ing face-to-face meetings with physicians and the creation of a process that encourages physician buy-in—one that builds in the time and conditions for change to happen," Plocher says.

- *Payment:* While the CMS ACO program retains fee-for-service payments for the initial three years, the CMS Innovation Center is considering various payment reforms, many of which are likely to appear in private Sustainable Health Communities.

  "In Sustainable Health Communities, payment distribution will be most challenging in this transitional period, where groups will choose from bundled payments, shared savings or global capitation," Plocher says.

  Processing the much-talked-about bundled payments, for example, will require most organizations to update their existing revenue cycle payment technology to address questions, such as: What triggers the bundle? Is every patient visit over a period of time tied to the bundle? When multiple providers submit multiple claims at multiple times, how do the provider and insurer indicate or understand what is part of the bundle?
- *Member Engagement:* "With patients free to move in and out of the ACO at will, attracting members and keeping them engaged in their own care and wellness becomes paramount," McCune says. "Patient-focused Web portals along with educational programs make it easier for patients to do that."

  In addition, organizations will need to ensure smooth transitions in care, and they should deploy patient identification tools and skilled case managers to target the right patients and make the necessary personal connections, McCune says.

  Commercial Sustainable Health Communities, not limited by CMS regulations, also can use reduced member copays and other reductions in member liability to motivate members to obtain care from the ACO.

Clearly, there are many challenges that accompany the pursuit of an ACO or Sustainable Health Community. Nevertheless, these models are the future of health care, and there are strategies to help attain effective results. OptumInsight consultants agree that the key is to keep stakeholders engaged and execute a focused ramp-up process.

"While physicians can, to some degree, choose the pace they want to move, it seems unlikely they can choose the direction," McCune says. "Understanding the success factors and building them into future planning is essential." ■

ENGAGING THE PHYSICIAN COMMUNITY TO CONNECT DISPARATE EMRs

Since 1993, Utah Health Information Network (UHIN), a state nonprofit organization, has been working to improve the administrative side of health care through the use of electronic data interchange. Over the past three years, UHIN has been trying to ensure clinical standardization, as well, by creating a health information exchange (HIE) for Utah. UHIN membership includes 90 percent of Utah medical providers, so physician buy-in was key to a successful launch.

"UHIN was fortunate as we already had a relationship with the providers through our administrative exchange," says Teresa Rivera, chief operating officer at UHIN. "With that established relationship, we were able to request provider participation as we moved into the clinical exchange."

In fact, providers helped create the request for proposal and choose a vendor for the HIE system—Axolotl's Elysium® Exchange. This strategy was mutually beneficial. The physicians could take ownership of the process rather than have a system forced upon them, and the discussions that took place surrounding the HIE selection allowed UHIN to gain further insight into clinical concerns. Equally important, the support of the current Clinicians Committee has furthered the adoption of the clinical exchange among the providers' peers.

"The Clinicians Committee has helped us prioritize projects, determine user roles and customize the product," Rivera says. "Their support is critical to the success and growth of the clinical exchange."

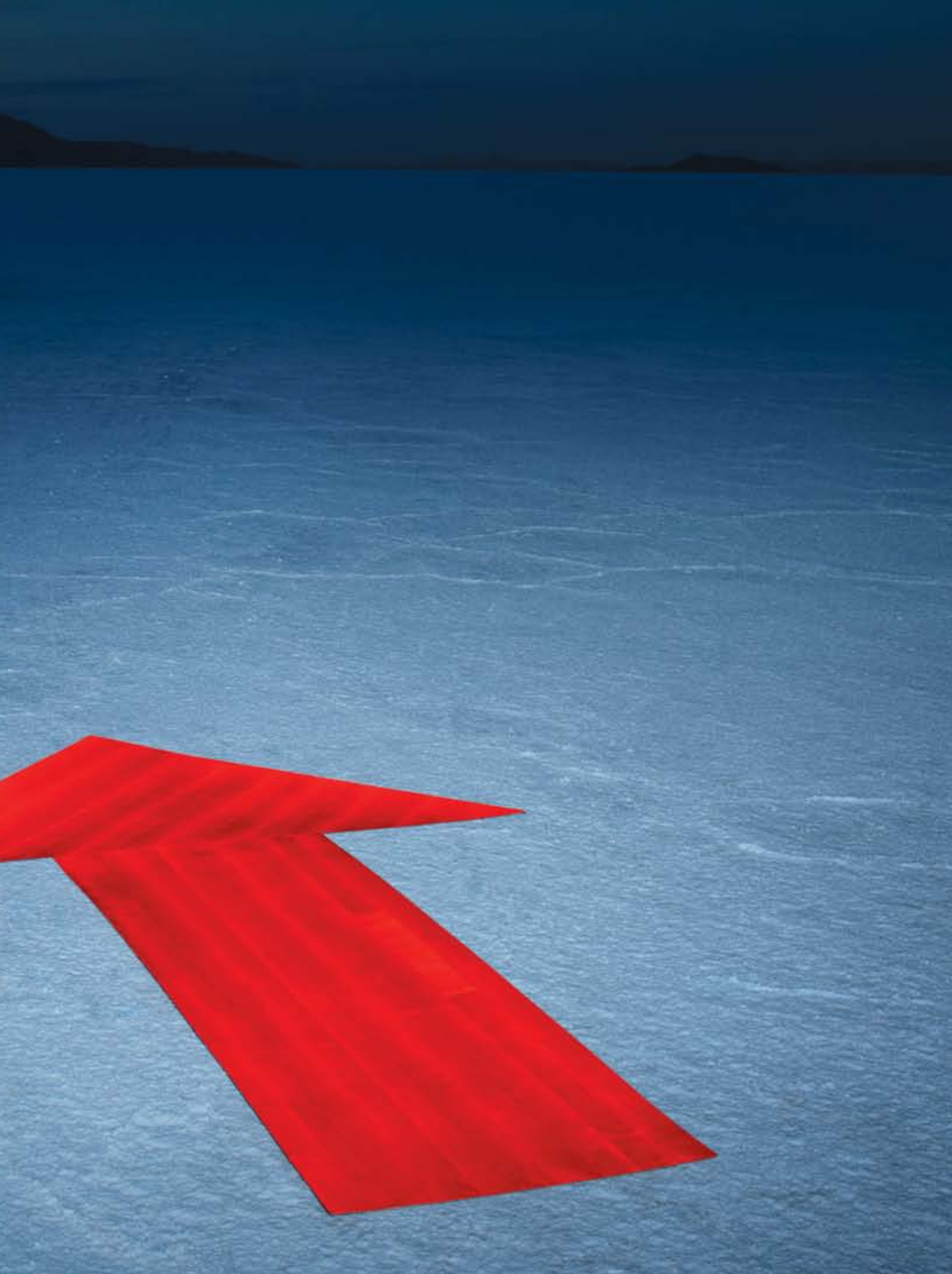
Since implementation, Axolotl's Interoperability HUB (I-HUB) has allowed for adoption of a single, virtual patient record and connected disparate EMRs throughout the state. With this process in place, UHIN has further plans to improve the exchange of information by creating an immunization registry and funneling insurance eligibility through its clinical exchange. *– Katherine Osos*



The POWER of IT to Transform Health Delivery

As the accountable care organization model comes into focus, so does the requirement for a robust health information infrastructure

BY DOUGLAS CLARK





Momentum is building in health information technology (IT)—pulled onto the national stage as the government has created the models and incentives to update the technology infrastructure upon which the health care system relies. In April 2011, the Office of the National Coordinator for Health Information Technology released its Federal Health IT Strategic Plan, which spells out the strategy for meeting national health IT goals through 2015. The release of these guidelines coincided with the proposed rules for accountable care organizations (ACOs) and the disbursement of Medicare incentive payments to providers who qualified as meaningful users of electronic health records (EHRs)—a critical component in the new health care era.

Underlying Framework for Reform

Among other goals, health reform aims to fix a system that is characterized by fragmented and disconnected care. And the government, as well as private industry, plans to implement initiatives to address these challenges. At an Institute for e-Health Policy forum in Washington, D.C., Sen. Sheldon Whitehouse (D-R.I.) called health IT "the underlying framework on which the Affordable Care Act's payment reforms, pilot projects and other delivery system reforms will have to be built." Indeed, as delivery system reforms roll out over the coming months and years—and as health systems increasingly form partnerships to evolve from fee-for-service payment models to value-driven models—organizations will look for new ways to engage with patients, analyze initiatives and report data, and electronically connect with other providers.

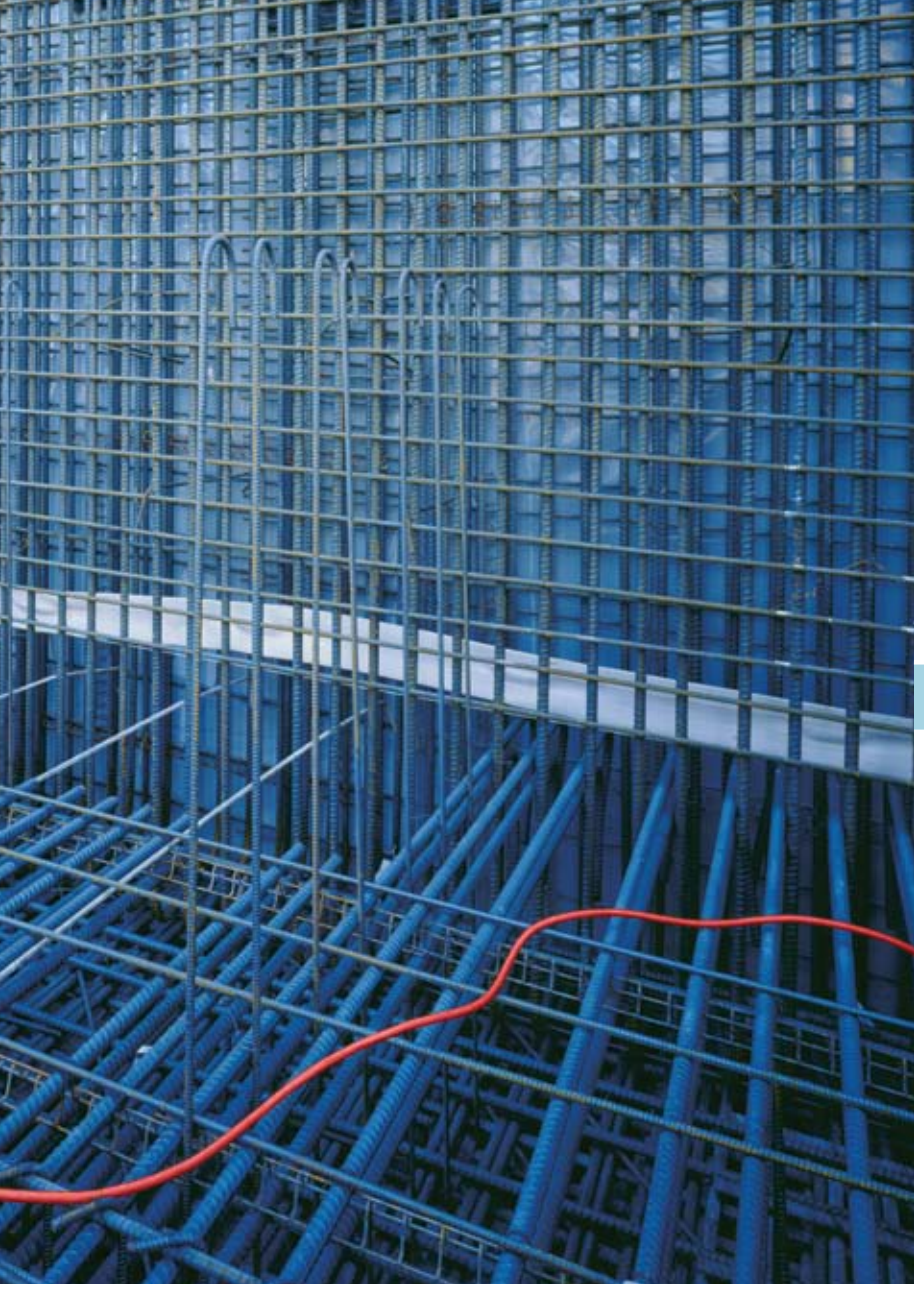
At the macro level, organizations will need to collaborate with each other to manage population wellness and to develop the infrastructure and processes needed to exchange population-level health data. Such an exchange will identify patterns of care across populations, target fraud and abuse, identify variations in care, and develop powerful learning tools to deliver better and more personalized care. Of course, this all hinges on data that is anonymous, secure and private. Recent government actions to put teeth into the Health Insurance Portability and Accountability Act (HIPAA) with the Health Information Technology for Economic and Clinical Health (HITECH) Act underscore the importance of data privacy and security.

Sustainability of such a transformed system of health delivery requires that participants and trading partners be aligned, connected and intelligent.

Alignment demands clear strategies and goals shared by providers and payers in support of lower costs, improved outcomes and better quality of care. Cooperation at this level also requires alignment of incentives, which gets into equitable strategies for sharing cost, revenue and potential bonus payments.

To be connected means the system must offer the ability to share relevant portions of a patient's medical record with authorized providers in a timely, secure and efficient manner.

And intelligence suggests the skillful application of information during the process of delivering care so that it is simultaneously safe, efficient and accessible. This involves the ability to focus on what is important now while identifying factors that merit focus in the near- and long-term.



> The most fundamental change for health organizations will be to **create a system that is built around an accessible and broad view of health.**

To meet these three requirements, organizations will need to focus their IT investments and operational priorities on: 1) a holistic view of coordinated care, 2) analytics that improve care and control cost, and 3) partnering with patients through technology.

A Holistic View of Coordinated Care

The most fundamental change for health organizations will be to create a system that is built around an accessible and broad view of health. Since payment for most providers today is based on individual procedures or consultations, attention is narrowly focused on these moments in a patient's care. Under the ACO model, however, providers are given the incentive to take a holistic view of patient health. ACOs will be paid based on how well they manage the health of their defined population (attributed patients) over time. Providers will need to rely on many of the tools and techniques that payers have been using for years to identify high-risk situations and promote effective, coordinated care that improves outcomes and lowers costs.

To make coordinated care a reality, providers need to begin with clinical integration—the ability to selectively share relevant data about a patient among various authorized providers in a secure and efficient manner. Technology enablers of this capability include EHR, health information exchange (HIE), home monitoring, portals, etc.

While all of these technologies exist, they are not frequently deployed in consort—let alone across a larger metropolitan area or geographic region. Take EHR, for example. Even though EHR software may provide access to all physicians working within a health delivery system, that flow of information immediately breaks down outside the system. Dan Kinsella, managing director at OptumInsight, comments on one example: "The classic case is a primary care physician who's been seeing a patient for years and may use Application A as his EHR. When the patient develops a heart problem, he is referred to a cardiologist who may use Application B [for EHRs]. Today, the gap between the two systems is filled by faxing the records or having the patient transfer them

from one doctor to the other. A true HIE would make these records available so that the cardiologist could see a complete patient history, avoid duplication of tests and so forth. It's this 'white space' between specialists and primary care or between surgeon and rehabilitation. That's the greatest challenge."

Beyond connecting physicians within their own exchange, providers will have to link to additional types of HIEs—including regional and statewide HIEs—to access and share clinical data with other institutions, including outside providers, imaging centers, public health agencies, schools and community pharmacists.

One example of a successful regional HIE is the Rochester Regional Health Information Organization (RHIO), which was created in 2006 and shares information among 20 health care organizations, including hospitals, reference labs, insurance providers and radiology practices. Of particular note, the Rochester RHIO was designed to share medical imaging in a faster, fully updated fashion. This is in contrast to the slow and sometimes unreliable means of sharing that many hospitals use, which include transmitting files manually, using disparate archiving systems and having patients transport their own test results. Furthermore, the organization sought to eliminate unnecessary exposure to radiation and the costs of redundant exams. Today, the RHIO serves more than 1.6 million patients and allows providers to access medical records and test results easily, regardless of where in the network the data originated.

Also important to providing coordinated care is the task of integrating scheduling and referral procedures. Although clinical data must be available to all who need it, it is equally important that patients see the proper doctors in a timely manner for seamless care. Integrated scheduling and referrals will be crucial to ACOs, as well, to keep patients within the system whenever appropriate. Otherwise, patients who seek outside treatment oblige the provider to pay for outside care.

Analytics That Improve Care and Control Cost

Sources of reliable data are a challenge for the ACO model. But claims data for the attributed population is a viable starting point. Several states have created "all payer" claims databases in an effort to establish the context for population health analytics. Although analysis of patient data was once a task for payers, under the ACO model, providers will find data analytics essential to controlling costs and improving care.

ACOs will need to use data to develop initiatives aimed at specific segments of the member population that are historically high users of the health care system. Patients with chronic conditions, such as diabetes or heart disease, are frequently the initial focus of disease management programs. Over the long term, population health can drive benefits related to early detection, intervention and management—usually at lower overall cost, higher member satisfaction and improved population health status. Such programs often include educational events, community support groups and ongoing monitoring and treatment programs. By applying algorithms to patient records and claims data, providers will be able to identify high-risk patients so they can prioritize care management interventions.

With the ability to look at data in aggregate, metrics will become a powerful tool for improving quality of care. Providers will need to use data to benchmark performance against accepted practices to deliver evidence-based care. "We're no longer in a position of 'do no harm.' It's up to us to look for ways to act that will bring about positive effects for patients," says Mark Crockett, MD, president of the emergency care division of Picis and attending physician at Advocate Good Samaritan Hospital.

> "**Being able to track patients, outcomes and specific treatments will also help ACOs determine the metrics needed** for understanding which physicians are deviating from the standard of care."

Examples of metrics that currently can be used to carry out evidence-based care are limited. "If we do better on the few metrics we have that are truly evidence based, patients will benefit significantly at a much lower cost," Crockett says. In addition to applying existing metrics, ACOs will be able to take advantage of growing stores of data over time to begin developing clinical models and establishing a broader set of evidence-based guidelines.

Being able to track patients, outcomes and specific treatments will also help ACOs determine the metrics needed for understanding which physicians are deviating from the standard of care. And for optimal results, immediate feedback and constant connectivity will be the goal. Crockett emphasizes the importance of making findings available to physicians as soon as possible. "It won't work to tell doctors that they were performing sub-optimally six months ago," he says. "The sooner data is made available, the sooner doctors can react and give good care at a lower cost. I don't believe anyone objects to being accountable for something that is good quality for the patients and profitable for the hospital."

Partnering with Patients Through Technology

"Under the ACO model, the patient is no longer just a patient but a member of the community," Kinsella says. Providers will need to build a new kind of relationship that extends well beyond the exam room or hospital bed. To make the relationship work, providers will again find themselves in territory that once belonged to payers as they work to encourage patients to take a more active role in their own health care.

For the consumer, this may mean more active participation in health decisions and engagement in shared decision making with providers. The assumption is that this model will drive better engagement, activation, satisfaction, increased accountability for health and, ultimately, higher patient satisfaction.

A good example of a consumer-centered health program is the Eastern Maine HomeCare (EMHC) Telehealth program, which was funded under the Beacon Community Program—a major project of the U.S. Department of Health and Human Services' Office of the National Coordinator for Health Information Technology (ONC). It provides funding to 17 select communities throughout the United States that have made inroads toward developing secure, private and accurate systems of EHR adoption and HIE.



Designed to engage patients through technology, Telehealth has become a tool that EMHC uses as part of its overall plan of care for patients with chronic diseases and some hospice patients. Patients "self report" certain data to Telehealth nurses each day, so clinical changes can be handled in real time. The clinical nurse calls patients with clinical "red flag" data and provides consultation over the phone or determines next-level intervention. To date, EMHC has seen a significant drop in the percentage of hospitalizations and emergency department visits—and conversely, it has been able to get high-risk patients to the hospital for care when appropriate.

Beyond collaborative decision making, considerable relationship building can be enabled through other types of technologies, including Web portals and social media platforms. Borrowing from the example of payers, providers also may choose to use call centers with consulting nurses. This would encourage members to turn to the ACO with their health questions and concerns.

For situations where a chronic illness or high-risk condition is involved, some providers will benefit from software and equipment that allow health to be monitored from the home. This could be particularly useful in dealing with elderly patients and might include blood pressure or weight-monitoring equipment that transmits results to the provider. For a variety of patients, additional tactics could include e-visits, video chats or other technologies that improve efficiency, lower costs and improve patient health.

Because customer feedback will be an important measurement in how well an ACO is performing (thus affecting financial compensation), providers will need to ensure patient satisfaction. Often, satisfaction is directly related to how informed and involved a patient feels. Using Web portals and other tools, providers will need to make sure patients have easy access to their own medical records.

The health care industry is undergoing another period of transformational change. And many providers are already on the path to adopting some of the most critical technology needed. The real proof will be finding ways to use technology so that it serves end goals. Whatever strategy an organization takes, the ability to be connected, intelligent and aligned will determine success. There are undoubtedly many challenges in the ACO model for providers. But for a number of institutions, embracing the new model represents a real opportunity to further develop evidence-based medicine and manage the overwhelming costs—both financial and social—of some of the country's great health issues. ■

New ACO regulations initiate the movement toward collaborative care

CMS Spotlight

By Kim Ribbink

Even before the Affordable Care Act was signed into law in November 2010, the Centers for Medicare & Medicaid Services (CMS) has been at the forefront of initiatives aimed at improving health outcomes and lowering costs.

The agency made its intentions clear in 2005 with the release of a key document: "Roadmap for Implementing Value Driven Healthcare in the Traditional Medicare Fee-for-Service Program."

"It is important to develop the tools necessary to create rational approaches to lessen healthcare cost growth and to identify and encourage care delivery patterns that are not only high quality, but also cost-efficient," the roadmap states. Reaching these goals, CMS emphasized in the document, will require working collaboratively with multiple stakeholders to promote clinical and financial accountability.

"This document is a strategic piece from CMS that gives a framework to a whole variety of things that have since been put in place," says Sharman Stephens, vice president at the Lewin Group, a health care policy consulting firm. The recent release of proposed regulations for accountable care organizations (ACOs) gives those goals further impetus. But according to Stephens, ACOs are just one of many tools.

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Over the past five years, CMS has put in place a host of measures intended to determine whether plans and providers are meeting quality standards. These measures include the Five-Star Quality Rating System—established in 2006 as CMS' payment system for the managed care setting—and the Physician Quality Reporting System (PQRS)—established in 2007 as the Physician Quality Reporting Initiative (then renamed and updated in December 2010) for the Medicare fee-for-service setting.


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What is clear in all these initiatives is that, in this new era of accountability, the role of both providers and payers is evolving. "The shared savings that the ACOs are projected to deliver will be the incentive for good, coordinated care to bend the cost curve and improve outcomes so everyone can benefit equally—obviously centric to the patient," says Scott Howell, MD, national senior medical director at OptumInsight. "The word 'accountable' is what's driving this."

Fragmented Outcomes

One of the biggest barriers to improving health care is fragmentation of the payment and delivery system, or a failure to align payer and provider incentives, says Anthony Shih, MD, executive vice president for programs at The Commonwealth Fund, a private foundation to improve health care. "Many payers have their own pay-for-performance program and their own set of measures and clinical topics, none of which make up the majority of a practice's income," Shih says. "So there isn't a clear message as to what the practice needs to focus on, what the most important measures are, and there is limited assistance on what they should do to improve quality and performance."

Several large demonstration projects that sought to overcome this issue of fragmentation have had mixed results, says Eric Cahow, senior director of health care solutions at OptumInsight.

Cahow cites three examples:

- The Integrated Healthcare Association's (IHA) California initiative, which ultimately brought together nine insurers and covered 200,000 beneficiaries and 300 provider groups
- Massachusetts Health Quality Partners' (MHQP) Medicaid all-payer pay-for-performance initiative
- Minnesota Senior Health Options' (MSHO) Medicaid collaborative

The California example showed only modest gains, while the Massachusetts initiative showed no statistical difference in improvement between participating and non-participating providers. The Minnesota multi-stakeholder collaborative, on the other hand, was a success. This was primarily due to the fact that it was a Medicaid program with clear leadership by a government entity, Cahow says.

The poorer performance of the first two examples is telling because these were gold-standard programs with large populations, and the multiple stakeholders involved in the design were aligned. What it suggests, according to Cahow, is that the incentives associated with pay for performance are not guaranteed to create momentum. Also, he says that measurements, in and of themselves, are insufficient to generate change. "An organization can only effectively manage so many measures at a time," he says. "Those measures that receive focus should receive real improvement; it's likely those

CMS has taken steps to unify the payment systems around **a core set of measures that will harmonize provider and payer activities.**

measures that do not receive focus will languish."

Nevertheless, Stephens says the use of measurements has been shown to be beneficial. "Public reporting of measures and the measurements themselves have been shown to improve quality on the provider side and, at the same time, because we're at a point in health care where we're trying to make consumers more responsible for the choices they make, measurements also give information to the consumer," she says.

The challenge for CMS, and indeed all health care participants, is how to drive better performance.

A Unified Response

Improving health outcomes will depend on far more than simply a collaborative exercise between payers—whether Medicare or the commercial sector—and providers in pay-for-performance initiatives. It also will rely on harmonizing the system for measuring performance, experts say.

For example, CMS has taken steps to unify the payment systems around a core set of measures that will harmonize provider and payer activities, Cahow says. In addition, CMS has worked to align the ACO regulations with meaningful use measures for certified electronic health record (EHR) technology. "CMS is making very clear its stated objective to create one measurement system," Cahow says.

The inclusion of robust performance measures in the proposed ACO regulations also sends a clear message to providers as to what CMS deems to be desirable performance, Shih says. "The decision by CMS to tie the proportion of the shared savings available under the new ACO program to performance on those measures is a big deal because the law only required that minimum standards be set," he says.

These efforts are not confined to CMS. There also has been a shift in how the Healthcare Effectiveness Data and Information Set (HEDIS) is being used, from its historic purpose—to report activities across clinical components—to using it to identify gaps in care and prompt a response, says Stephen Wood, vice president of government and strategies at OptumInsight.

Beyond the use of measurement tools, enabling technologies and processes to accompany the payment system will be paramount. For example, efforts around EHR not only enhance the provision of care from providers but also promote patient engagement. Equally, processes must be in place to support real-time reporting, such as having personnel in the provider's office receiving reports and reaching out to individuals needing more care. That role must be further supplemented with a nurse manager or clinical manager to educate patients about their disease and how to manage it.

"More robust comparative effectiveness information is needed to help inform both providers and patients about the best medical treatment choices for a given patient situation," Shih adds.

In addition, patient-centered medical homes have been invaluable in improving health outcomes—in both the private and public sectors—and are regarded by many as essential to the core infrastructure of ACOs.

Leading the Way

The steps taken by CMS, in particular the agency's robust measures on ACOs, are expected to have a domino effect in the commercial sector. "CMS is sometimes a leader, sometimes a follower on these initiatives," Cahow says. "But because of their heft, they can move markets and accelerate adoption of a concept."

Shih adds that the proposed rules for the ACO program will greatly accelerate other payer efforts to create similar incentive programs and encourage providers to organize into ACOs. But both CMS and other payers need to be willing to grant rewards for desirable provider behavior without making the providers jump over onerous hurdles. Payers also need to offer technical assistance to providers to help them identify and adopt more efficient and effective best practices.

"On the provider side, they need to be willing to work with payers to figure out how to use the tremendous amount of resources in our health care system—we're talking $2.5 trillion and growing—to get better care and slow the rapid rise in cost growth," Shih says.

Yet while payers and providers are striving to work together more collaboratively, their relationships remain fragile. And if the desired outcomes fail to materialize, these fragile relationships will be at risk.

Shih, however, remains optimistic. "I do see providers and payers working together toward shared goals through incentives that support the delivery system reforms that both parties want," Shih says. "For instance, the providers want to become patient-centered medical homes, and the payers, in turn, are offering a different payment structure to providers to support that organizational model."

The future is hopeful, but the next few years will determine whether past disappointments can be avoided in this new age of accountability. ■



JOHN G. NACKEL, CEO, OPTUMINSIGHT, CONSULTING

Opening the Door to Reform

By John G. Nackel, PhD, FACHE, CEO
OptumInsight, Consulting

The clash between payers and providers over where the power of the accountable care organization (ACO) system lies is somewhat inevitable, but one thing remains clear—true reform requires lowering costs and aligning incentives with care outcomes. To achieve that goal, the regulations proposed by the Centers for Medicare & Medicaid Services (CMS) addressed one of the most contentious aspects of our health care system—reimbursement. Currently, physicians and hospitals are reimbursed for what they do without consideration for whether it was necessary or whether it improved care. Such a process is unsustainable.

We must revamp health care to address this underlying flaw and achieve what are known as the triple-aim goals: better care for individuals, better health for populations and slower growth in costs. We applaud CMS for advancing the concept of ACOs to address these aims. It was not an easy step to take given our enormously complex health care system and stakeholder views that often struggle to find common ground.

"The final regulations need to better reflect **successful, market-led models.**"

At OptumInsight, we are following the CMS request to encourage market-wide discussion and comment on the draft regulations. For our part, we are pleased that they contain:

- The welcome overlap of ACO standards with established initiatives, including the EHR Incentive Program, eRX Incentive Program, Physician Quality Reporting System and meaningful use standards
- A focus on primary care as well as provisions that help physicians and hospitals collaborate to form ACOs and align care coordination and transitions of care
- Standard, objective performance measures that bring together claims and clinical data to simplify data collection and reporting



- Varying participation levels for different organizations, including payers and management service organizations that can supply needed expertise and financial backing
- Encouragement for bringing actionable information to the provider at the point of care
- Transparency via public reporting of ACO performance and independent reviews of shared savings
- Waivers that recognize how ACO-driven clinical integration might conflict with some existing regulatory frameworks
- Caps on shared loss to ensure reasonable risks

Despite these encouraging points, we are concerned about other elements in the draft that could deter motivated and high-performing organizations from pursuing CMS-sponsored ACO status and perpetuate some of the misaligned incentives. We believe the final regulations need to better reflect successful, market-led models that offer genuine insight into issues affecting the scalability and long-term sustainability of the ACO concept. Among other things, these



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organizations and their early successes and challenges demonstrate that it is critically important to:

- Align objectives, incentives and workflows across all stakeholders: physicians, hospitals, pharmacies, professional services, multiple payers and, especially, patients/members within a local community
- Transform hospital incentive structures so they can be more active participants and supporters of the ACO concept
- Implement cash flow solutions through financing, revenue cycle and cost management to fund the multi-year investment required
- Ensure longitudinal, actionable intelligence—real-time at the point of clinical decision-making
- Support the time, resource and skill set requirements needed for physicians to address their patients' chronic and complex care needs, including pharmacy services, behavioral health, community resources and more
- Engage the patient/member, regardless of health care coverage, to be an active participant in his or her own health and wellness

The weakness or absence of these pieces in the proposed regulations does not diminish the importance of the ACO concept, nor should it discourage any stakeholder from moving in the direction that CMS intends. A select few may even be ready to participate fully. See "What's Next for ACOs" (page 4), where we share some of what we've learned about the factors necessary for moving toward the ACO ideal.

But without modifications to the proposed regulations, we believe the ultimate role of the CMS Shared Savings program will be to act as a springboard for a model that will drive deeper and more lasting change—something we are building in regions across the country called Sustainable Health Communities (SHCs).

The vision for this model is similar to ACOs, with a SHC goal of creating efficiencies to keep cost increases under control while optimizing quality. The main difference is that with SHCs, all participants work in harmony to achieve enduring community health, and all stakeholders (particularly consumers) engage equally toward population health. All are connected. All are aligned. And all share both risk and reward.

While challenging, we believe this goal is nearer than it may seem, and we are in close pursuit. We hope you'll join us. ■



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Optum is an information and technology-enabled health services business platform serving the broad health marketplace, including care providers, plan sponsors, life sciences companies and consumers. Its business units – OptumInsight, OptumHealth and OptumRx – employ more than 30,000 people worldwide who are committed to enabling Sustainable Health Communities.

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