FEATURE STORY

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accountable care
are you ready?

A readiness assessment is a critical first step in a strategy to develop an ACO.

AT A GLANCE

Ten steps are required to develop an ACO that can thrive in the emerging healthcare environment:
> Assess readiness for accountable care.
> Assemble the right project team.
> Create a legal and organizational framework for an ACO.
> Form the right leadership team.
> Strategically align human capital.
> Ensure minimal operational requirements are met.
> Assess all dimensions of financial readiness.
> Integrate IT to the point of "meaningful use."
> Strengthen partner relationships and business networks.
> Engage the community as an ally.

Accountable care organizations (ACOs) have been described as having three fundamental characteristics:[a]
> They are able to deliver and manage the continuum of care across a range of settings, particularly ambulatory and inpatient settings
> They can plan budgets and resource needs prospectively
> They have a large enough patient population to support "comprehensive, valid, and reliable performance measurement" (which the Centers for Medicare & Medicaid Services [CMS] has set at 5,000 Medicare beneficiaries for its demonstration program)

These characteristics are reminiscent of the capabilities needed to manage "at-risk" payment arrangements in the 1990s era of managed care. The primary difference is that while "at-risk" payment in the 1990s was driven by commercial payer organizations, this time around it is a mandate from CMS.

The proposed ACO regulations issued March 31, 2011, aim to give more structure to the initial proposal around ACOs and give more specific guidance around issues such as participation eligibility, governance requirements, the savings options (ACOs must pick one of two options), assignment

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a. Devers, K., and Berenson, R., "Can Accountable Care Organizations Improve the Value of Health Care by Solving the Cost and Quality Quandaries?" *Timely Analysis of Immediate Health Policy Issues*, Urban Institute, October 2009.

of beneficiaries, quality measures/performance, marketing, the role of HIT, quality and reporting requirements, start and antikickback waivers for ACOs, and IRS guidance regarding ACOs.

Much of the prior literature surrounding ACOs deals with the core competencies needed for a successful ACO. But other important considerations remain, chief among them being the need for organizations to assess their readiness to successfully participate in CMS's Medicare Shared Savings Program as ACOs. This assessment starts with having a clear understanding of the requisite competencies of the key players who would participate in the ACO.

Key Players

The ACO model designed by CMS is deliberately flexible, allowing a variety of existing provider organizations the opportunity to participate. Examples of organization types include independent practice associations, multispecialty group practices, physician-hospital organizations, and integrated delivery systems (IDSs). However, the suitability of different provider groups varies depending on the required competency.

The American Hospital Association (AHA) has assembled a list of 11 competencies from the prevailing academic literature:[b]
> Leadership
> Organizational culture of teamwork
> Relationships with other providers
> IT infrastructure for population management and care coordination
> Infrastructure for monitoring, managing, and reporting quality
> Ability to manage financial risk
> Ability to receive and distribute payments or savings
> Resources for patient education and support
> Ability to disseminate best practices aggressively
> Linkages to public health/community resources

b. *Accountable Care Organizations*, AHA Research Synthesis Report, American Hospital Association, June 2010 (www.aha.org/aha/content/2010/pdf/09-26-2010-Res-Synth-Rep.pdf).

Among the competencies required for ACO success, two are key—an organizational culture of teamwork and the ability to manage financial risk—because they could have the greatest impact in truly reforming health care.

> Participation in a multi-stakeholder health information exchange

Among the competencies required for ACO success, two are key—an organizational culture of teamwork and the ability to manage financial risk—because they could have the greatest impact in truly reforming health care. They also are among the most difficult in terms of physician adoption because physicians have a long-standing history of autonomy and aversion to taking on financial risk.

Based on the AHA's ACO competency criteria, it would seem IDSs are best positioned to deploy ACOs. In particular, these vertically integrated healthcare systems are able to align the incentives of the physicians with those of the organization, and therefore may be able to cultivate the environment of teamwork necessary to successfully implement accountable care. Moreover, IDSs such as Kaiser-Permanente already bear financial risk.

The exhibit on page 94 illustrates three tiers of organizational models for ACOs. Organizations fall into a given tier based on their readiness to assume financial risk.

IDSs rest on top of the pyramid in Tier 3. Providers in this tier should be able to realize results that produce the greatest impacts, both financially and in terms of better care delivered to patients. The question posed to competitive organizations in Tiers 1 and 2 is whether and how they can move up the pyramid.

In Tier 2's blended model, a greater portion of the financial risk is shifted to healthcare providers. These providers typically have mechanisms to effectively administer "at-risk" payment methodologies, such as bundled payments and partial capitation. Because of their improved ability to contain cost, providers at this level are gradually moving away from the fee-for-service model in Tier 1.

In Tier 1's fee-for-service model, payers are still responsible for a portion of payment. Although the prospect of taking costs out of the system is unmistakably attractive, the increasing market power and subsequent bargaining leverage of healthcare providers is a concern.
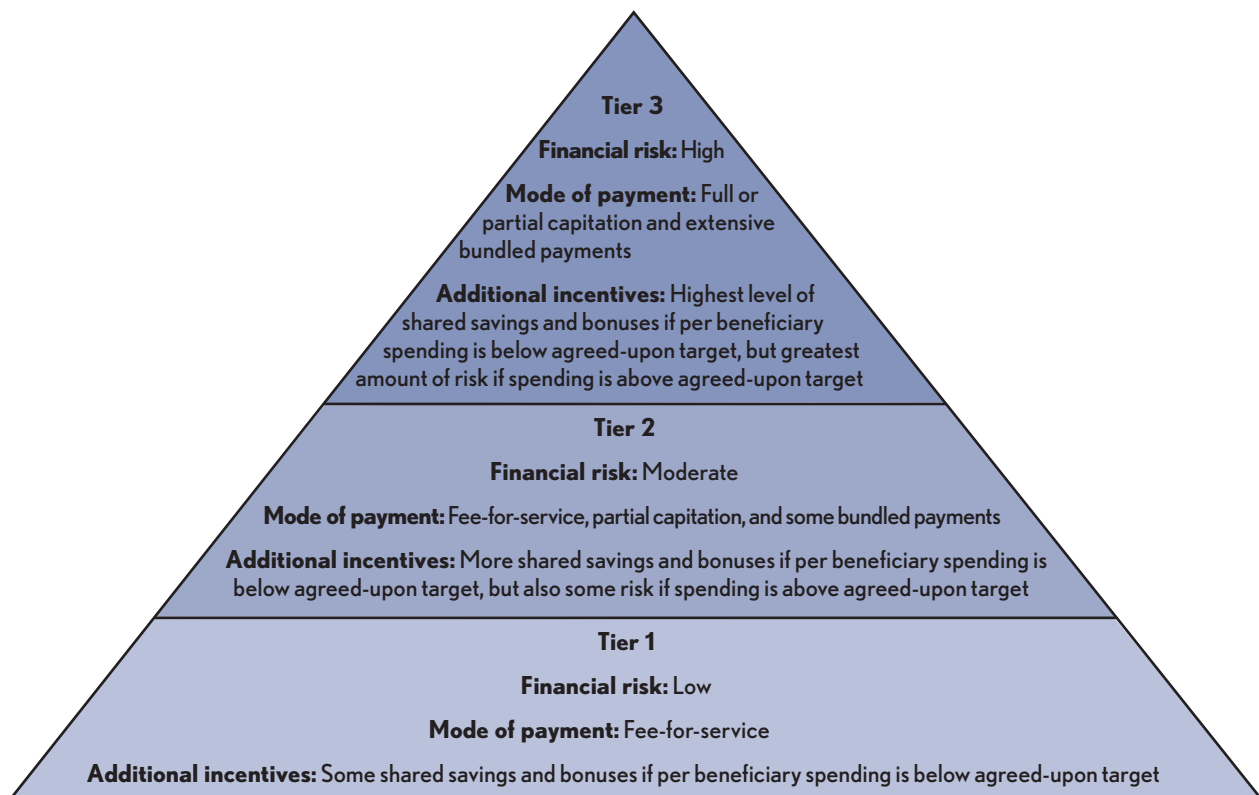
The final group affected by ACOs is the patients themselves. Patients who receive the majority of care from ACO-affiliated providers would be considered "assigned" to that ACO. Currently, there is no enrollment requirement for participants, who may not even know the ACO exists.

According to a health policy brief issued by *Health Affairs* and the Robert Wood Johnson Foundation, "Critics of this approach believe that patients should have a choice about participating in an arrangement that could reward providers for reducing services" ("Accountable Care Organizations," July 27, 2010, www.rwjf.org/files/research/66449.pdf). If, at some point, patients must enroll, ACOs may face a backlash and fate similar to that experienced by health maintenance organizations, where consumers do not want to have their choices limited.

Revenue Considerations

The core purpose of an ACO is to improve patient care by providing accountability and continuity in healthcare service. Costs should be reduced as a matter of course as redundant efforts are eliminated (e.g., readmissions) and the focus shifts from reactive disease and acute episode management to proactive health and wellness over.

THREE TIERS OF ACCOUNTABLE CARE ORGANIZATIONS

Tier 3
Financial risk: High
Mode of payment: Full or partial capitation and extensive bundled payments
Additional incentives: Highest level of shared savings and bonuses if per beneficiary spending is below agreed-upon target, but greatest amount of risk if spending is above agreed-upon target

Tier 2
Financial risk: Moderate
Mode of payment: Fee-for-service, partial capitation, and some bundled payments
Additional incentives: More shared savings and bonuses if per beneficiary spending is below agreed-upon target, but also some risk if spending is above agreed-upon target

Tier 1
Financial risk: Low
Mode of payment: Fee-for-service
Additional incentives: Some shared savings and bonuses if per beneficiary spending is below agreed-upon target

Source: "Health Policy Brief: Accountable Care Organizations," *Health Affairs*, July 27, 2010 (available at www.healthaffairs.org). Used with permission.

With the proposed ACO regulations, CMS will evaluate the savings an ACO generates through the coordination of care and pass part of those savings along to the ACO, assuming it exceeds a minimum savings rate and certain quality standards and that it maintains its eligibility to participate in the Medicare Shared Savings Program (MSSP). (To read more about how an organization may choose to participate in the VBP program, go to www.hfma.org/hfm.)

A more pressing question for organizations considering deploying an ACO is how any savings (or losses) will be distributed equitably within the organization. It also remains uncertain whether these financial incentives will be enough to motivate healthcare providers, although we have historically seen commercial payers follow Medicare's lead and can only assume that they will be able to coerce physicians because they are holding the purse strings.

IT: A Key Success Factor

At an operational level, fledgling ACOs will need to consider key success factors, including technology infrastructure, resources for patient education, team-building capabilities, strong relationships with physicians and other providers, and the ability to monitor and report quality data. Many provider organizations are currently focusing on assessing and developing the core capabilities and competencies that all ACOs should possess, regardless of the subtle distinctions CMS ultimately makes in defining them. IT is a key enabler of ACOs, and the rollout of ACOs goes hand-in-hand with the 2009 Health Information Technology for Economic and Clinical Health (HITECH) Act and its emphasis on "meaningful use."

In its June 16, 2010, recommendation to the Department of Health & Human Services Health IT Policy Committee, the committee's Meaningful Use Workgroup defines the term *meaningful use* as follows:

> We recommend that the ultimate goal of meaningful use of an electronic health record [EHR] is to enable significant and measurable improvements in population health through a transformed healthcare delivery system. The ultimate vision is one in which all patients are fully engaged in their health care, [and] providers have real-time access to all medical information and tools to help ensure the quality and safety of the care provided while also affording improved access and elimination of healthcare disparities.

As such, healthcare IT will be essential to capturing performance and quality metrics, sharing information among healthcare providers, and giving line-of-sight to consumers/patients.

10 Steps to Launching and Sustaining an ACO

All of these considerations are integral components of the deliberations and actions required of a healthcare organization if it is to successfully develop and sustain an ACO. Viewed from an overall perspective, achieving this end involves 10 basic steps.

1. Assess readiness for accountable care. The first step in any strategic planning initiative is to assess the organization's strengths and weaknesses, as well as any opportunities and threats that may exist, both internally and externally to the organization. With an understanding of the financial, organizational, and operational capabilities required to successfully launch and sustain an ACO—as discussed above—an organization can develop an actionable plan to execute against the strategy. Anticipating the remaining nine steps should also assist an organization in assessing its organizational readiness for accountable care, both for a Medicare ACO in the short term and, ultimately, for the move toward a commercial ACO designed to succeed on health insurance exchanges.

Before performing the readiness assessment, the organization should conduct preliminary research on ACOs and their alignment with the organization's strategic objectives. The organization's readiness then should be evaluated from the following perspectives:
> Legal (e.g., What's the existing shared legal entity? Do you have a Taxpayer Identification Number?)

> Financial (e.g., Do you have adequate financial reserves to undertake an ACO? How do you plan to disburse the shared payment savings among ACO participants?)
> Operational, including IT (e.g., What are your current managed care reconciliation procedures? Where are you in terms of implementing EHR and meaningful use?)
> Clinical (e.g., How does your organization currently disseminate best practices? What quality programs do you currently have in place? What utilization management tools/practices are you currently employing?)
> Organizational (e.g., What is your current governance/leadership structure? How has your organization typically handled large, enterprisewide changes? How will you align the physician's incentives with your ACO?)

2. Assemble the right project team. This team should combine the organization's leadership and the expertise of the organization's key stakeholders. Guiding the process should be a steering committee charged with designating the base team members, as well as the project management office (PMO), which will perform the actual work of creating the ACO. Depending on the size of the organization, the PMO is effectively one or two project managers who are quarterbacking the execution of the project. The base project team will then create a project charter authorizing the PMO and project team and provide official notice to the organization, by means of an enterprisewide communication plan, that the project is under way. Within healthcare organizations specifically, it is important to include both clinical and administrative functions on the team.

In short, the project team should include representatives from:
> The C-suite
> Legal counsel
> Clinical departments, including the clinical leadership team, primary care, and subspecialties
> Administration, including human resource, operations, and finance and revenue cycle
> Nursing

3. Create the legal and organizational framework for an ACO. The steering committee and project team will be required to obtain the approvals for the formation of the ACO. Internal constituents such as physician shareholders, community members, parent boards, and even county health organizations may need to sign off for the ACO formation to move ahead. External organizations may also require filings, notifications, and approvals (e.g., premerger notification by the Federal Trade Commission, certificate of need by state planning agencies, and insurance certification by state departments of insurance). The PMO will need to manage the timeline considerations carefully, as some approvals may take more than 60 days.

As noted previously, multiple forms of ACOs are possible, including large IDSs, physician–hospital organizations, multispecialty practice groups

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What Is an ACO?

The term *accountable care organization* (ACO) came to prominence with Elliot Fisher, MD, director, center for population health, The Dartmouth Institute for Health Policy and Clinical Practice, Lebanon, N.H., who used the term to describe a health system partnership between physicians and hospitals with the ability to provide and manage patients across the continuum of health care from acute inpatient care, to ambulatory outpatient care, and possible post-acute care. In theory, the ACO would thus improve quality and reduce costs in healthcare delivery. The concept originated as a response to rapidly increasing cost of care without a commensurate improvement in health outcomes (i.e., quality of care).

Recently, ACOs have been in the limelight because of their role in the healthcare reform legislation passed in March 2010. The inclusion of ACOs was predicated on the notion that they would be able to improve quality and control skyrocketing healthcare costs to the tune of $5 billion, according to the Congressional Budget Office (CBO). More specifically, in accordance with the Affordable Care Act of 2010, the Centers for Medicare & Medicaid Services (CMS) encourages the creation of ACOs and has issued proposed rules for an organization's participation as an ACO in the Medicare Shared Savings Program, as described in the legislation. Although the industry still awaits the final rules, the Affordable Care Act has stated that ACOs should be able to share in the resulting savings under the program—as long as quality benchmarks are maintained—beginning in January 2012.

The key to effectively driving the necessary operational change in an organization is to pursue a broad range of focused performance improvement activities.

cite the need for a collaborative team culture and financial incentives for physicians to promote quality rather than quantity.

At a high level, organizations can use three types of practices to strategically align human capital with goals of an ACO:[c]
> Motivation-enhancing practices (e.g., regular

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c. Gardner, T.M., Moynihan, L.M., Park, H.J., and Wright, P.M., "Beginning to Unlock the Black Box in the HR Firm Performance Relationship: The Impact of HR Practices on Employee Attitudes and Employee Outcomes," CAHRS *Working Paper Series*, Paper 75, 2001.

with or without hospital ownership, independent practice associations (IPAs), and virtual interdependent networks of physician practices. The project team will need to give careful consideration to which organizational structure will work best for the organization in meeting the objectives of improving quality of care and decreasing costs, while also allowing for effective measurement of results and disbursement of payments.

In short, key considerations for organizational design include:
> Governance structure
> Ability to hit quality and cost metrics
> Ability to manage payments effectively

4. Form the right leadership team. The current literature around ACO formation often refers to the need for organizations to possess strong physician leadership and an effective governance structure. This is true not only through the formative stages of the ACO, but also in the ongoing day-to-day operations. As with the project team and steering committee, a cross-functional team of administrative, clinical, and executive participants will be essential to sustaining financial and clinical results for the long run.

5. Strategically align human capital. Because ACOs are, by and large, a significant paradigm shift for most healthcare professionals and providers, the project team should also take steps to ensure the alignment of the human capital with the ACO's strategy. For example, recent studies on ACOs

Regulatory Considerations for ACOs

The Federal Trade Commission (FTC) and the Department of Justice (DoJ) released a joint "Proposed Statement of Antitrust Enforcement Policy" regarding accountable care organizations (ACOs) in coordination with CMS's proposed rule. The statement is intended to clarify how both of these agencies will apply antitrust laws to ACOs, with the intention of maximizing and fostering as much innovation as possible while minimizing exposure for consumers through reduced competition that could result in higher prices and lower quality of care.

Specifically, the FTC and DoJ will evaluate ACOs that meet the CMS eligibility requirements under the Rule of Reason. Additionally, the statement clarifies that ACOs will be liable for review with respect to not only Medicare, but also with private-sector contracting.

In their statement, the DoJ and the FTC effectively define three categories of ACOs based on market share in the participants primary service area (PSA). ACOs with less than 30 percent market share are in a safety zone where if common services are not provided, the aforementioned agencies will not challenge the ACOs. For ACOs with market shares of 31 to 49 percent, guidance is provided to help ACOs avoid anti-competitive behavior, although these ACOs would not be required to undergo a mandatory review. ACOs with market share greater than or equal to 50 percent of a PSA are mandated to undergo a review.

In terms of Stark, antikickback and civil monetary penalties for ACOs, the Office of Inspector General (OIG) has proposed waivers for all three. That is to say the Stark Law, the antikickback statute, and the civil monetary penalties law will not apply as they relate to distributions of shared savings received by an ACO under the Medicare Shared Savings Program, or the distribution of those savings within the ACO.

These were much-needed clarifications and should help fledgling ACOs navigate regulatory hurdles more effectively.

performance feedback, individual and group incentives, and pay for performance)
> Empowerment-enhancing practices (e.g., information sharing, participation in decision making, and grievance procedures)
> Skill enhancing practices (e.g., recruiting, election testing, and onboarding and continuing education)

6. Ensure minimal operational requirements are met.
This step entails reducing cost by streamlining business processes, and improving quality by enhancing clinical care pathways. Simply put, before developing or executing any tactical plan, an organization should ensure that it will be able to optimize, accelerate, and sustain performance. The key to effectively driving the necessary operational change in an organization is to pursue a broad range of focused performance improvement activities.

As an example, if an ACO's objective were to decrease cases of ventilator-acquired pneumonia (VAP), the project team would need to:
> Identify stakeholders who will be accountable for executing tactical level plans (e.g., executive sponsor, such as the chief clinical officer; ICU nurses; internal medicine physicians; and/or respiratory technicians)
> Identify and define priorities (e.g., reduce number of cases of VAP, decrease costs coming from rehospitalization or increased length of stay, and ultimately reduce ensuing mortality)
> Define key performance indicators and link them to tactical plans that, in turn, are aligned with strategic goals (e.g., VAP rate, linked to tactical plans for handwashing, oral hygiene, common suction protocol, closed suction system, saline lavage, which are aligned to the more strategic goals of staff education, colonization reduction, and aspiration avoidance, ultimately leading to reduction in VAP)
> Integrate best practices (i.e., leverage industry standard practices from leading practitioners, and visit other organizations that are known to have demonstrated good results with reducing VAP rates)

> Develop dashboard and reporting capabilities to allow for routine tracking of performance (e.g., web-based performance management tools)
> Implement mechanisms to communicate results (e.g., post results in visible places so all stakeholders can see progress and feel accountable, publish in employee newsletter, design public relations campaign to raise awareness)

7. Assess all dimensions of financial readiness. As noted previously, different provider types, whether they be IPAs or IDSs, will have varying degrees of financial readiness to pursue an ACO strategy. But regardless of the provider type, a financial readiness assessment should be performed, including review of the following:
> Payment methodology and rates of all service lines by payer contract
> Contract language terms and conditions by payer contract
> Rate variance between contracted rates and "area average" benchmark rates
> Mechanism to support bundled payment of episodes of care
> Ability to receive and distribute payments or savings
> Historic performance of revenue cycle functions (i.e., billings, accounts receivable follow-up, and denial/underpayment management)

8. Integrate IT to the point of "meaningful use." If all of an ACO's provider participants—whether they be acute care hospitals, primary care physician offices, or outpatient clinics—are to deliver the most appropriate level of care to a patient, every one of these entities will require access to the patient's file. Moreover, the high volume of patient data accessible in a fully integrated EHR will enable the use of predictive analytics to drive clinical decisions, help identify trends, and benchmark data.

To move the organization closer to full IT integration, the project team will need to give close consideration to the following IT elements:
> EHR system
> IT infrastructure for population management and care coordination

> IT infrastructure for monitoring, managing, and reporting quality
> Capitation management system
> Telemedicine and/or other remote healthcare management system(s)

In fact, a requirement of the recently proposed regulations for ACOs is that 50 percent of an ACO's primary care providers must be "meaningful EHR users" by the beginning of an ACOs second year in the MSSP ACO program.

As an additional IT concern, the team should assess the organization's ability to aggressively disseminate best practices.

9. Strengthen partner relationships and business networks. Traditionally, providers have contended not only with lack of coordination of care among providers across the healthcare continuum, but also with an adversarial relationship with payers. As we see more integration among the network of providers and payers, the relationships grow more intricate and continuous. This interaction will evolve into a more collaborative relationship among all parties, ultimately resulting in reduced cost, improved quality, and increased access within the healthcare continuum. Moreover, providers in an ACO can immediately begin identifying business processes that are currently an administrative burden for both providers and payers. Simplification of these business processes would reduce the degree of coordination required between both parties.

The project team and organizational leadership should assume a leading role in building a more collaborative relationship with payers. Examples of ways in which they promote this greater level of collaboration include:
> Educating the provider community on the MSSP and the importance of accountability
> Participating in health information/insurance exchanges
> Fostering increased clinical collaboration and coordination across the care continuum
> Reducing administrative complexity and costs within payer and provider relationship

10. Engage the community as an ally. By engaging and educating the community, providers can increase patient awareness of how care will be delivered in this new post-reform environment, thereby encouraging them to shift their approach toward health and wellness from treatment and prevention. The community should be made to understand the weak correlation that exists between "more care" and higher quality outcomes. Over time, as the community becomes more knowledgeable about the factors contributing to their health, utilization of health resources will diminish as the overall health of the community improves.

Effective ways to educate and engage the community include:
> Offering fitness evaluations/programs and nutritional counseling
> Disseminating educational materials, such as home toolkits and brochures
> Developing wellness/prevention programs targeted toward employer groups

Moving Forward

Throughout the 1990s, we saw ineffective attempts to integrate physician practices and implement "at-risk" payment methodologies such as capitation. Those experiences brought considerable wisdom to today's healthcare leaders. Looking at past failures, it's not surprising that many healthcare leaders believe the ACO movement is simply another fad that will come and go. Unfortunately, leaders who adhere to this

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view have influenced a number of provider organizations to adopt a "wait-and-see" approach.

What these leaders have not taken into account is that, after almost 20 years, there has been a tremendous advancement in healthcare administrative/clinical technologies, allowing providers and payers to monitor utilization and quality much more closely. The convergence of advanced healthcare technologies, improved business processes, and wisdom from the managed care movement of the 1990s has created a perfect opportunity for provider organizations to successfully execute at the tactical level to get ahead of the ACO curve.

Organizations with foresight realize that they need to execute these steps now. Organizations that have yet to begin preparing to lead or to be a part of an ACO risk being unable to maximize payment from Medicare come January 2012. ●

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