Providing Accountability

Accountable Care Concepts for Providers

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ABSTRACT

Health care expenditures in the United States totaled $2.5 trillion in 2009. Researchers estimate as much as 30 percent of those costs, or $750 billion, may have been due to overuse, underuse, misuse, and/or inefficiencies of healthcare services. Another study of the industry estimates that wasteful healthcare spending costs $1.2 trillion annually. The bottom line: Delivery of health-related care may often be inappropriate or unnecessary.

This paper will examine the concept of accountable care and its "Triple Aim"—better health, better care, and lower costs. It will discuss how a shift for providers from a fee-for-service payment model to one that rewards quality rather than quantity is possible through existing and new capabilities. Finally, it will explore some of the core concepts providers may adopt to collaborate in a major overhaul of the healthcare industry.

EXECUTIVE SUMMARY

The United States spent about $8,047 per resident, or 17.3 percent of the nation's Gross Domestic Product (GDP), on healthcare in 2009. That was more than three times the $714 billion spent in 1990, and more than eight times the $253 billion spent in 1980. Spending is expected to rise to $4.5 trillion, or 19.3 percent of GDP, in 2019.[1]

The root causes for high costs in our healthcare system have been largely attributed to a fee-for-service payment model that rewards quantity rather than quality. Researchers estimate that about 30 percent of healthcare costs ($750 billion in 2009) are generated by poor quality because of overuse, underuse, and misuse of healthcare.[2] A spectrum of payment reform options is possible that would enhance providers' ability to collect self-pay and high-deductible bills to reduce their bad debt and A/R days.

The term "accountable care" is often used to describe the desired outcome of health reform, where medical quality is optimized and cost is controlled through new provider organizational arrangements. Medical decisions are based on medical evidence, and providers' reimbursements are based on patient outcomes and the cost-effectiveness of treatments delivered.

In the 2010 Patient Protection and Affordable Care Act (PPACA), The Centers for Medicare and Medicaid Services (CMS) defined the ultimate goal for accountable care as the "Triple Aim"—better health, better care, and lower costs for the overall population.[3] Accountable care concepts may potentially evolve into a number of forms, so long as the "Triple Aim" is achieved. Rules for Medicare ACOs are in the process of being defined.

For the concept of accountable care to take hold, transformation must occur in three key areas—care delivery, payment methods, and health information technology. Technology leaders face added pressure, knowing all three areas are dependent on an infrastructure that can support fluid information exchange to facilitate clinical integration.

Healthcare analysts agree that accountable care requires a strong foundation of coordinated primary care. The patient-centered medical home (PCMH) is fully aligned with the principles of accountable care, and many industry leaders consider the PCMH model to be foundational for successful accountable care. The many care improvement processes that can be implemented in a clinically integrated system of care share several core concepts.

Today's climate is more receptive to reform than it was in the early 1990s. At all levels, care management and care coordination are critical and can be accomplished outside of a Medicare ACO.

1 http://www.fiercehealthcare.com/press-rel; http://www.kff.org/insurance/upload/7670.pdf; http://www.nehi.net/publications/27/clinical_care_a_comprehensive_analysis_in_support_of_system_wide_improvementseases/waste-u-s-healthcare-system-pegged-700-billion; http://www.factsforhealthcare.com/whitepaper/HealthcareWaste.pdf

2 Mechanic, D; *J Health Serv Res Policy.* 2008; 13: 57-58

3 About the Triple Aim, Institute for Healthcare Improvement, http://www.ihi.org/IHI/Programs/StrategicInitiatives/TripleAim.htm

Defining Accountable Care and the Accountable Care Organization

Serious and costly performance problems riddle the U.S. healthcare system. Healthcare expenditures in the United States in 2009 totaled $2.5 trillion, about $8,047 per resident. Researchers estimate that delivery of health-related care may be inappropriate or unnecessary a significant percentage, perhaps as often as half, of the time.

The root causes for high costs in our healthcare system have been largely attributed to a fee-for-service payment model that rewards providers for quantity rather than quality of care. Providers have significant opportunities to eliminate waste and improve quality and access to care by coordinating and integrating care across the continuum.

Because of our current federal and state debt levels, our ability to compete globally, and U.S. consumers' expectations for quality healthcare, there will be reforms to our current system. With its inclusion in the Patient Protection and Affordable Care Act (PPACA), the Accountable Care Organization, or ACO, has become the ultimate — though as yet undefined — goal of reform.

Much confusion exists for providers, and key questions remain unanswered over many key elements of health reform as it pertains to ACOs.

Two basic, but important, points of understanding for providers:

- **What is accountable care?**
- **What constitutes an Accountable Care Organization?**

The term "accountable care" is often used to describe the desired outcome of health reform, where medical quality is optimized and cost is controlled through new provider organizational arrangements. Medical decisions are based on medical evidence, and providers' reimbursements are based on patient outcomes and the cost-effectiveness of treatments delivered.

"Accountable care systems" may involve payer-provider collaborations, where incentives are established to manage the care of a specific patient population, with the goals of improving care, keeping the population as healthy as possible and creating efficiencies that reduce the cost of care.

The Centers for Medicare and Medicaid Services (CMS) has defined "Accountable Care Organization" as a new contracting mechanism with specific rules and regulations, but has not made specific recommendations for how medical care should be delivered. Although some Medicare ACO requirements are stipulated in the PPACA, signed into law in March 2010, a number of rules are still being debated.

While CMS regulations for Medicare ACOs are in the process of being defined, they will likely include restrictions on provider participation, putting physicians in the driver's seat of accountability. CMS will allow primary care physicians to participate in one ACO at a time to assign responsibility for particular Medicare beneficiaries in the ACO.

No such restrictions exist for other providers (e.g., hospitals, pharmacies, etc.), who could provide services to Medicare beneficiaries from more than one ACO.

CMS requires primary care physicians to be at the core of an individual ACO, but all stakeholders (patients, physicians, other providers and payers) must collaborate to accomplish the desired improvements in medical quality, patient outcomes, and cost containment. Because CMS has not made specific recommendations for how medical care should be delivered or paid for, ACOs will be able to experiment with many progressive care delivery and payment models. There are expectations that the drive toward ACOs by CMS will influence adoption of accountable care by the private sector, most likely by public-private collaborative contracting with the same ACOs.

CMS: Physicians are in the driver's seat of accountability.

Basic requirements provider organizations must meet to contract with CMS as a Medicare ACO

- Formal legal structure to receive and distribute shared shavings
- Sufficient number of primary care professionals for the assigned beneficiaries (5,000-beneficiary minimum)
- Participation in the program for at least three years
- Sufficient information regarding participating ACO healthcare professionals as the HHS Secretary determines necessary to support beneficiary assignment and for the determination of payments for shared savings
- A leadership and management structure that includes clinical and administrative systems
- Defined processes to promote evidenced-based medicine, report the necessary data to evaluate quality and cost measures, and coordinate care
- Meet patient-centeredness criteria (to be determined by the HHS Secretary)

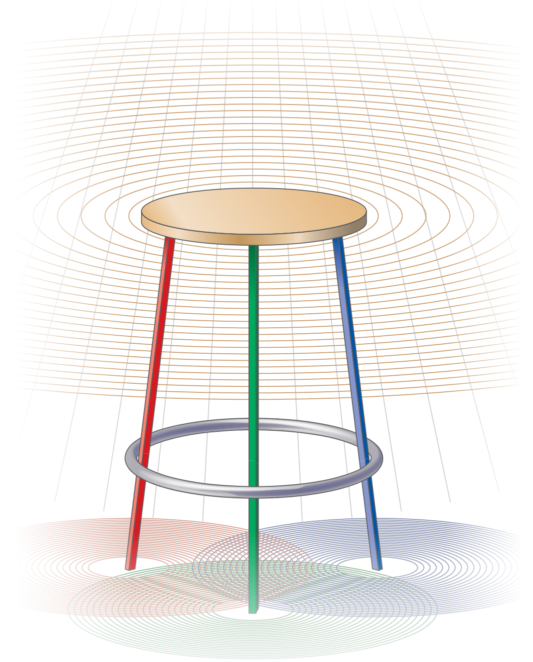
Source: *https://www.cms.gov/OfficeofLegislation/Downloads/AccountableCareOrganization.pdf*

There are many reasons why the climate today is more receptive than it was in the early 1990s.

To lead in this marketplace, hospitals that are part of an ACO will need to reduce overall costs by 15 percent to 20 percent (i.e., subsist at Medicare reimbursement rates for all patients), while simultaneously investing in infrastructure and technology for information management and reporting. Most providers will be forced to assume ever-increasing levels of performance and utilization risk through care delivery and payment reforms. In this environment, patient-centered care, coordination, collaboration, and leveraging clinical data and analytics will be critical to success.

Many are skeptical that we can transform our healthcare system, given failed attempts over the past 30 years to institute managed care approaches. There are doubts whether stakeholders are willing to reduce costs or bridge cultural divides between payer and provider, or specialty care and primary care, or facility care and ambulatory care. But, there are many reasons why the climate today is more receptive than it was in the early 1990s — the cost crisis, improved HIT, experience from past failures, a more active government role, better payer alignment, better population management capabilities, experience in performance management and population risk adjustment, and a different approach to physician alignment.

The intentional lack of specificity in PPACA around ACOs, combined with numerous yet to be promulgated "rules," means uncertainty exists around exactly what an ACO is or will become. ACO concepts may potentially evolve into a number of forms, so long as the "Triple Aim" of reducing cost, improving quality and improving the overall population health is achieved.



Three Fundamental Areas for Reform

For accountable care to take hold, three key aspects of transformation must occur, each interdependent upon the other, as in a three-legged stool:

Care Delivery Reform: First and foremost is the integration of processes that result in an end to the fragmented, siloed care delivery that frequently exists today. Clinical integration and care coordination are key goals in care delivery reform.

Payment Reform: While care delivery reform is the desired end state of accountable care, it is dependent on changing the second variable — the way that care is paid for. Payment reform is essential to spur and sustain a transformed delivery system, as people and systems respond to the incentives inherent in the payment schema.

Health Information Technology: The ability to integrate providers across multiple care settings and to support the complexities inherent in various proposed ACO care delivery models, as well as new and more complex payment systems, requires an infrastructure of health information technology (HIT). Accountable care systems, supported and enabled by HIT, will allow many of the payment and delivery system reforms to flourish.

Given the three-legged interdependency, technology leaders face added pressure knowing success is dependent on an infrastructure that can (a) support fluid information exchange across care settings, (b) aggregate and normalize patient-centric data, (c) empower robust analytics for population health management, and (d) provide shared clinical and financial decision support in point-of-care workflows.

Accountable care systems, supported and enabled by HIT, will allow many of the payment and delivery system reforms to flourish.

Care Delivery Reform: Care Coordination, Care Management, and Clinical Integration

The effective coordination of healthcare services is a key component of high-quality, efficient care. It provides value to patients, professionals and the healthcare system by improving the quality, appropriateness, timeliness, and efficiency of decision-making and care activities.

In the 1990s, hospitals and health systems acquired physician practices primarily to drive in-patient admissions. Little to no effort went into integrating the practices into hospital operations or standardizing care. Today, hospitals are looking to do more than lock in a referral base, and potential acquisition targets want more than a steady paycheck and less overhead.

Still, integration is much harder than acquisition. While a handful of prominent IDNs (Kaiser, Geisinger, Intermountain Health, etc.) and multi-specialty group practices (Cleveland Clinic, Mayo Clinic, Virginia Mason Clinic, etc.) show early strong potential to succeed as accountable care organizations, many aspirants will not succeed unless they can truly standardize and coordinate care across the continuum.

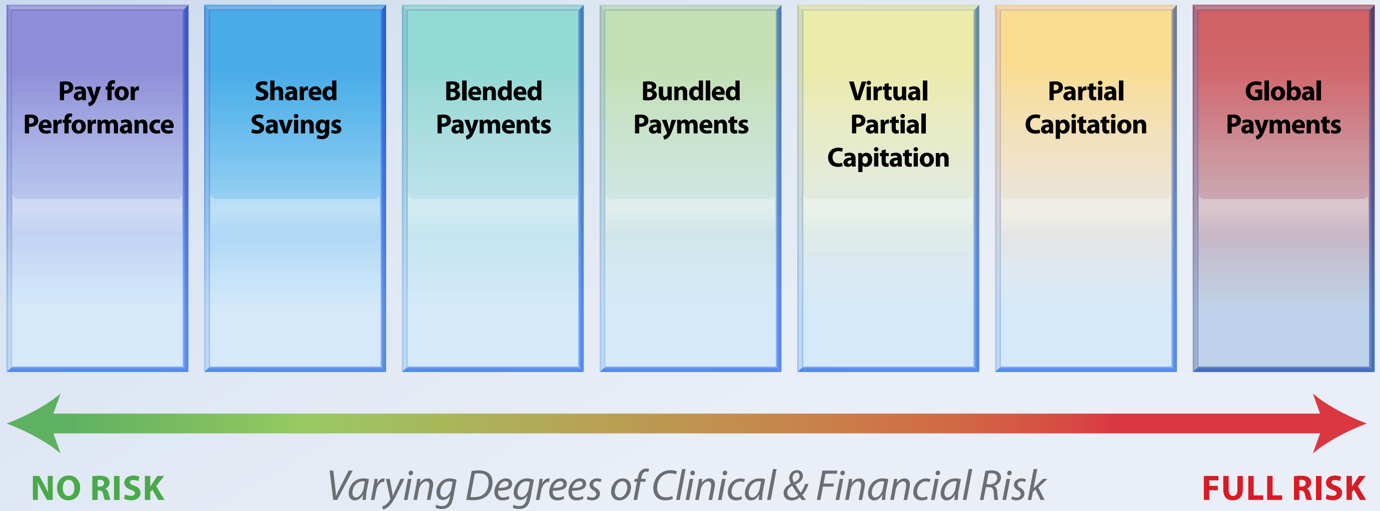
The concept of clinical integration of providers and care provision within an accountable care system is core to this process. Two fundamental operating principles provide its foundation in accountable care:

- Commitment to the regular and timely transfer and exchange of pertinent information — such as medical history, medication lists, lab results, imaging studies, and patient preferences — among everyone involved in a patient's care
- Accountability, which requires:
  - Mutual understanding about the responsibilities of every participant in a patient's care
  - Clarity in regard for everyone's role and extent of responsibility for each aspect of care
  - Clarity as to when, how, and to what degree responsibility is transferred to other care participants during the course of patient care
  - Mutual understanding with regard to the type(s) of patient population (high risk, chronic condition, etc.)

The importance of a primary care "home" for the patient, the use of electronic health records, and health information exchange capabilities across the medical neighborhood become paramount in a clinically integrated care system. Connected providers can better engage in shared decision-making and be held more accountable for agreed-upon care delivery protocols and expectations. They can also implement health promotion and prevention initiatives that manage their patient population more effectively, such as outreach to high-risk patients and chronic disease management strategies.

As a result, primary care medical homes need to be able to connect and exchange information with:

- Hospitals and other acute settings of care
- Outpatient specialists and ancillary service providers
- Nursing homes, home care, and rehabilitation facilities
- Other sub-acute settings
- Laboratories, radiology imaging centers, and other diagnostic facilities
- Retail Pharmacies
- Patients and their families and caregivers



Payment Reform

The current fee-for-service (FFS) model incents providers for volume over quality, and encourages procedural services rather than preventive care. The more interventions one does, and the more expensive they are, the more revenue results. PPACA supports piloting a broad range of payment models. A spectrum of payment reform options is possible, ranging from shared savings, pay-for-performance and bundled payments to partial or full capitation. Each step along this continuum is characterized by greater risk assumption by the provider.

Since risk assumption has raised concerns about creating potential financial incentive to withhold care, increased risk assumption is expected to be tied with performance expectations for quality, outcomes, evidence-based processes, consumer access, and experience. The use of payment methods that are of intermediate risk, lying somewhere between capitation and FFS, or the use of blended payment models that combine various payment methods, are other ways in which risk concerns can be mitigated or used to support an accountable care system early in its clinical integration.

Major types of payment reform, and their affect on providers:

- **Pay for Performance:** Physicians, hospitals, medical groups, and other healthcare providers continue to receive fee-for-service, but are rewarded for meeting certain pre-established quality or efficiency targets for delivery of healthcare services.
- **Shared Savings:** Fee-for-service payments continue, but providers also share in a proportion of savings resulting from reductions in utilization-related costs as long as certain predetermined performance and/or utilization thresholds are met.
- **Blended Payments:** Leaves the fee-for-service system in place, and supplements with a partial capitation (per capita) fee to cover additional activities not included on the fee schedule.
- **Bundled Payments:** Reimburses providers on the basis of expected costs for clinically defined episodes of care. Also known as "case rates" or "episode-based payment," they provide a single payment for all services related to a specific treatment or condition, possibly spanning multiple providers in multiple settings. Bundled payments, said to represent a middle ground between fee-for-service reimbursement and full capitation, should reduce spending by reducing the volume of services provided.
- **Virtual Partial Capitation:** This is partial capitation (a defined budget for a defined group of patients), but the treating providers would bill for individual services rather than receive a pre-payment. Total billings would be compared to the budget, with payments adjusted up or down to reconcile with it.
- **Partial Capitation:** An accountable care system would agree to accept a pre-defined monthly per capita payment during a contracted period to cover all costs of care for a defined subpopulation of patients.
- **Global Payments:** A fixed-dollar payment is made for the care that a population of patients receives in a given time frame, placing the providers at financial risk for the occurrence of medical conditions and the management of those conditions. Payment is adjusted to account for underlying risk of the specific population by contemporary risk adjustment methods such as the Medicare DCG/HCC model used in the Medicare Advantage program and Physician Group Practice Demonstration.[1]

1 https://www.cms.gov/HealthCareFinancingReview/Downloads/04Summerpg119.pdf

Health Information Technology

Since payment reforms are essential to overall reform, it is critical that providers collaborate with payers to negotiate a payment arrangement that both the provider and payer believe will be successful. This will require clinical and financial data that both parties trust, and a level of transparency that is comfortable for all parties while providing sufficient and ongoing performance tracking.

Health IT can provide critical information about the patient across all stages of care. It can support communications among members of the care team, enable more timely and accurate performance measurement and quality improvement processes, and improve a patient's accessibility to the physician practice. Additionally, a patient should be able to easily and simply manage all aspects of financial obligations, leading to increases in self-pay and high-deductible collections, and reduction of providers' bad debt and A/R days.

The ultimate goal of implementing HIT is to create an interconnected "superhighway" that allows health information exchange along with workflow, analytics, decision support, and other technology tools that empower the healthcare team. For example, one of the key requirements of this infrastructure is to enable robust analytics for population health management. The desired result is that healthcare is coordinated and delivered in a more efficient manner anywhere in a system of care.

An accountable care system requires three types of clinical HIT systems: electronic health records, personal health records, and health information exchanges. Each must provide at least some "traditional" core capabilities, such as support of the documentation of a patient's problems and care plan, e-prescribing, and health information exchange that supports the transfer of care summaries and procedure reports between providers.

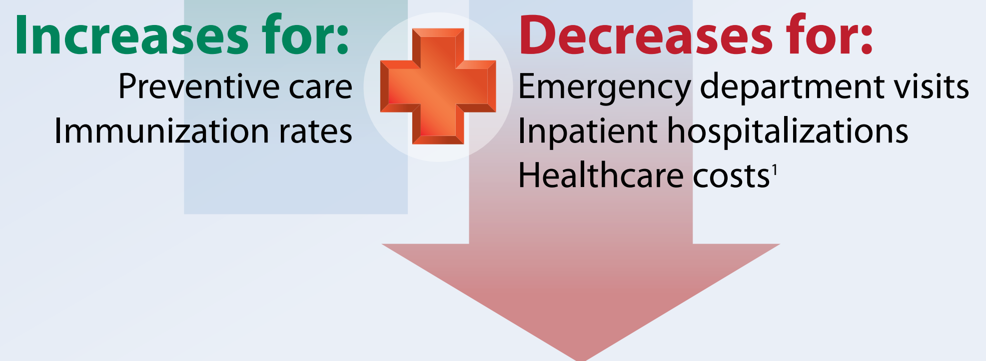
More advanced EHR capabilities are required in a connected accountable care system, ranging from role-based access for practice-based care team members to secure messaging with other providers for consultation and collaboration. The primary purpose of an EHR in this context is to capture data that was otherwise only available in the paper chart. Personal health records will need to provide patients with access to their pertinent data, and provide access to a range of personal health management and health information tools. Robust health information exchange is essential to allow participating providers to routinely share clinical data and communicate with their patients and each other.

Health IT can provide critical information about the patient across all stages of care.

The desired result is that healthcare is coordinated and delivered in a more efficient manner anywhere in a system of care.

Core Concepts for Achieving the Triple Aim

Healthcare analysts agree that accountable care requires a strong foundation of primary care. Improving access to primary care has been shown to improve quality of care and efficiencies in the delivery of care. In general, better access to integrated primary care results in:



The patient-centered medical home (PCMH) is fully aligned with the principles of accountable care. PCMH combines the core tenets of primary care (first contact care for health that is continuous, comprehensive, and coordinated) with the adoption of innovations such as electronic information systems, population-based management of chronic illness, a focus on delivering evidence-based medicine, and continuous quality improvements for the delivery of care. PCMH also focuses on extended access to care for patients (after hours, weekends, secure email and other technology media), and coordination of care across the healthcare continuum.

The Patient-Centered Primary Care Collaborative,[2] a consortium of the nation's four primary care medical associations — the American Academy of Family Physicians, the American Academy of Pediatrics, the American College of Physicians, and the American Osteopathic Association — and more than 800 large employers, insurers, consumer groups, and provider organizations, support the patient-centered medical home model. Many industry leaders consider the PCMH model to be foundational for successful accountable care systems.[3]

1 Contribution of Primary Care to Health Systems and Health" in the September 2005 Milbank Quarterly: Starfield B, Shi L, Macinko J., Milbank Q. 2005;83(3):457-502.

2 http://www.pcpcc.net

3 http://www.nejm.org/doi/pdf/10.1056/NEJMp0909327

Several other concepts help providers track the health of their overall population and improve care processes, and can be implemented in a clinically integrated system of care:

- **Care Coordination:** For patients with chronic conditions, particularly those at high risk of poor outcomes, targeted care coordination using team-based models has improved health outcomes and/or reduced hospitalizations, readmissions, and costs.[1] Guiding those patients to the right setting and providers is critical to improving care coordination across a host of specialists, physicians, pharmacists, nurses, therapists, and other clinicians. A designated care coordinator may:
  - align efforts toward a common care plan
  - ensure sharing of information and perspective
  - enable seamless and effective care setting transitions and positive patient experiences.[2]
- **Clinical Decision Support:** Information presented at the appropriate time enables providers and patients to make decisions based on specific circumstances and reduce errors and/or redundancies. By comparing the information in a patient's electronic record with a set of evidence-based clinical guidelines, an electronic decision support system can, for example, remind a provider that a patient needs recommended immunizations, track a diabetic patient's HbA1c levels, or notify a provider that the medication he or she is about to prescribe may lead to a life-threatening allergic reaction.
- **Evidence-Based Medicine:** Standardized clinical processes, protocols, and guidelines ensure that care processes are uniform, follow known best practices, and improve decisions about when and how to treat. The scientific and medical research community has a wealth of information on how numerous conditions should be treated to get optimal medical outcomes. Where clear outcomes information does not exist, standards of care that use experience and less rigorously defined patient outcome information create a path of diagnosis and treatment.

1 Peikes, Chen, Schore, and Brown , JAMA. 2009, vol 301, no. 6 : 603-618

2 Ibid.

Readmission rates can be improved by implementing new processes and evidence-based transitions of care programs.

- **Care Management:** Care management services involve collaboratively engaging consumers and their support systems to assist in care coordination, to ensure optimal engagement with an appropriate care plan, and to remove barriers to care. These services have traditionally been performed by payers, but may also be effectively provided with a provider-based system or practice.
- **Utilization Management:** Utilization management refers to the use of data and protocols to review and appropriately manage healthcare costs and influence decision-making through case-by-case assessments of the appropriateness of care. UM is traditionally performed by payers using techniques like pre-certification and concurrent review of continued stay, or by hospital staff to review appropriate use of bed allocations. The adoption of utilization risk (or at least the financial incentives to reduce utilization in a shared savings model) will necessitate evolving ACOs to consider adopting similar techniques.
- **Disease Management:** Disease management refers to the use of applications and tools to enhance the individual care of patients with chronic diseases, in which patient self-care efforts are critical to preventing the progression or development of complications. These tools typically allow the monitoring of pre-defined care protocols over multiple care settings.
- **Readmission Management**: Implementation of evidence-based care interventions and protocols can optimize the effective transition of care from one setting to another. Few hospitals currently monitor for readmissions or provide follow-up with discharged patients, resulting in up to 20 percent of discharged patients being readmitted within 30 days. Readmission rates can be improved by implementing new processes and evidence-based transitions of care programs[1]. Accountable care will demand that appropriate transitions happen, and that receiving care teams are ready, willing and able to provide requisite services.
- **Medication Therapy Management:** Non-adherence to medications is responsible for 33 percent to 69 percent of medication-related hospital readmissions, and 20 percent of discharged patients experience an adverse event that is largely medication related.[2] The adoption of specific protocols and technologies for medication reconciliation, and counseling by pharmacists for medications adherence, can significantly improve adherence, reduce adverse reactions, and improve outcomes.

1 Medicare Physician Group Practices: Innovations in Quality and Efficiency, Michael Trisolini, Gregory Pope, John Kautter, and Jyoti Aggarwal, December 2006, accessed electronically 02-Feb-11 at https://www.cms.gov/DemoProjectsEvalRpts/downloads/PGP_Conference_Report.pdf

2 Jencks SF, Williams MV, Coleman EA. Rehospitalizations among patients in the Medicare fee-for-service program. N Engl J Med. Apr 2, 2009;360(14):1418-1428.

- **Prevention and Wellness:** Preventive strategies that target the effects of various lifestyle and occupational factors on individual health should focus on areas the health system identifies as having a significant impact on the overall health of the responsible population. Lifestyle and other patient-desired changes can be most effectively addressed by the primary care practice, but some health systems have collaborated with local governments and employers to define an overall health and wellness strategy for a community.
- **Patient-centric Care:** An actively engaged and empowered patient population must understand their health, their conditions, and their role in health management. Engaging patients and their family/caregivers in a more active and empowered way will require a significant shift in thinking and business for many providers and payers, as well as a reconsideration of staffing resources and competencies to meet the needs of diverse populations.

Accountable Care: Considerations for Providers

- Search is on for new care models that cut costs and prepare for outcome-based payments
- Fee-for-service models may decline, and capitation-like payment could increase, if accountable care takes hold
- Care pathways will be important. Providers need to identify their core capabilities, then fill in gaps to help them deliver a continuum of care
- Organizations have new opportunities to work together to share financial risks and rewards
- Organizations contemplating mergers and acquisitions must weigh benefits and risks of buying versus not buying, and integrating versus owning as a standalone business
- Consumers may need to be convinced of the advantages of accountable care
- Consumers could start seeking more preventive services, especially if given incentive to do so

Source: *Top health industry issues of 2011*, PwC Health Research Institute, December 2010

About This Series

This is the third in a series on healthcare reform, accountable care and Medicare Accountable Care Organizations. There is great complexity and breadth to these issues, and many uncertainties as to how the industry will evolve. How care is delivered and how providers are paid will most certainly change, and healthcare information technology will enable their transformation. Whatever your role in our industry, we hope you can use this document to build your understanding of the rapidly occurring trends and changes in healthcare.

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