



***FAQs: Clinical Integration and
Accountable Care Organizations (ACOs):
What Physician Leadership, CEOs and Trustees
Need to Know Before They Get Started***

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as interviewed by Dudley Morris, Senior Advisor, BDC Advisors***

The Patient Protection and Affordability Act set a national agenda for improved access, improved health care status, and affordable costs, which will impact all healthcare providers in the next decade. The Department of Health and Human Services (HHS) has identified “Accountable Care Organizations” (ACOs) as a core strategy for reform and plan to begin moving providers into ACOs by the start of 2012. HHS strategy is to fundamentally transform the core business model of health care from the current state (in which more units of service – MRIs, procedures, bed days and office visits – equals more income for the provider) to a future state of bundled payments tied to the quality of care.

Some health system leaders are avoiding any change to their strategy, arguing that this is a repeat of the 1990s when the industry prepared for capitation and vertical integration that never happened. Other system executives seek to be among the first to be designated an ACO. However, premature transition to a complete vertical integration may be too extreme.

While a handful of health systems - Kaiser Permanente, Sharp Rees Stealy, Cleveland Clinic and Geisinger Healthcare - seem well equipped to manage care for large, defined populations (the end goal for Accountable Care Organizations), these organizations are unique and difficult to replicate. A move to become the next Geisinger would be a “bet the farm” strategy for most systems.

There is an alternative. A significant number of mainstream organizations, such as Advocate Physician Partners (APP) in Chicago, have developed broad integrated networks of hospitals and physicians. APP successfully manages capitation and fee for service products without vertical integration. While each of these mentioned systems employs physicians – physician employment is not the key to their success. Nor is ownership of a health plan. APP allows physicians to remain independent and yet participate in contracts

that improve the quality and efficiency of patient care (the very goals of HHS). By focusing on *clinical integration* first, they have built the foundation needed for accountable care, established partnership relations with health plans to manage risk, and created data links to the end users of health care services to provide performance-based measurement of population-based health care delivery.

As health systems face the challenging strategic choice offered by the road to accountable care - deciding whether to enjoy the status quo of fee for service products, keep the middle ground and consider strategic options, or move more decisively towards ACO development – clinical integration with physicians in the community provides an affordable bridging strategy that will benefit the organization in both the fee for service world of today, and “ACO” or value based payment future.

To meet the needs of the organizations beginning this process, and those further along the road to accountable care, *Advocate Physician Partners (APP)* and *BDC Advisors*, the national health care consulting firm, recently announced the formation of **CI-Now**, a new company that will assist health care organizations in building and successfully managing a clinically integrated network.

CI-Now will provide a set of tools, technologies, best practices and support for hospital systems and physician groups seeking to accelerate the design and creation of a clinically integrated network, ultimately beginning their journey to an ACO.

With the assistance of its business partner APP, BDC Advisors has prepared a list of Frequently Asked Questions -- ‘FAQs’-- about ACOs for physicians, executives, and board members who must decide how to position their organizations in the accountable care environment. **CI-Now** founders Rick Wesslund, Chairman and Founder of BDC Advisors and Lee Sacks, MD, CEO of Advocate Physician Partners (APP) respond to the interview questions posed by Dudley Morris, Senior Advisor, BDC Advisors.

1. What is an Accountable Care Organization?

Rick: The concept of an ACO emerged in the health care legislation in 2009, but as I remember the term was originally coined in 2006 by Dartmouth professor Elliot S. Fisher, M.D. in an article he published in Health Affairs on *Creating Accountable Care Organizations: The Extended Hospital Medical Staff*. Over the years Fisher has done pioneering research in shifting the focus of the health care system from simply “delivering care” to “improving health and reducing suffering”. In its purest form an ACO would have a set of hospitals and physicians in a coherent local delivery system accept joint responsibility for the quality and cost of health care for a defined population. Conceptually, this is reminiscent of integrated delivery systems of the 1990’s which were set up to accept capitation and manage care, but which frequently failed because of weak clinical integration and poor risk management. When properly organized, ACOs will offer members the ability to embrace the emerging financial

mechanisms such as bundled payments, pay for performance, gain sharing and perhaps most importantly the Medicare Shared Savings Program which is scheduled to kick off in 2012.

Lee: To succeed in the current environment providers will need to achieve a significant level of clinical integration before contracting with health plans, sharing the benefits with its physicians, or participating in the Shared Savings Program. Successful clinical integration is the cornerstone of accountable care. APP accomplishes this through our network of 3,500 physicians – some directly employed and others independent community practitioners. After decades of work we have the organization and information systems in place to measure the quality of care and appropriately reward physicians who are efficient providers. We have accelerated performance throughout the system by sharing exemplary practices. Quality is infectious - in the last five years we have recorded significant improvements in outcomes across a broad range of disease categories and have increased the generic drug use rate by 20%, saving over \$50 million. It's a formidable job, however, and you need to be realistic about the resources that are going to be required.

2. Why should we be interested in Clinical Integration and ACO's? Do we really need one?

Rick: The strategic decision to form an ACO takes a major commitment of resources. Bundled payments and capitation are on the horizon, and there will be significant Medicare penalties for readmissions for several large DRG groups in the future for organizations that don't develop ACO capabilities. The success a number of our long-term clients have had in measuring outcomes improvements has allowed them to strengthen partnerships with health plans that have improved the business environment. And it has paid off in that health plans will support incentives for measurable improvements in cost and outcomes.

Lee: I think the major question is how could anybody not be invested in clinical integration? Clinical integration is all about improving care coordination for the benefit of our patients and measuring and reporting our quality and efficiency performance. Hospitals have done a good job in improving *inpatient* quality, with less success on the *outpatient* side. Private practices report very few performance measures, so most systems have major gaps in their care continuum since nine out of 10 Americans still receive their care from solo or single specialty practices. If we need to pull off a 'triple play' to improve health status, cost and the patients' experience, then we will need to invest in the systems and organizational structure to do so. Finally, our physicians like the system because it makes it easier for them to demonstrate the quality of care they provide and simplifies their quality reporting requirements.

3. Where are the successful models? Who can we learn from?

Rick: There are literally dozens of different types of ACOs ranging from clinically integrated networks that sell to health plans, up to provider sponsored health plans that have all the health plan functions integrated with the provider functions. The most prevalent models will probably be an outgrowth of the large integrated systems such as Allina, Advocate, and Partners or physician-led organizations such as the Carillion Clinic Health System in Norfolk. **CI-Now** will make that business experience available to organizations aspiring to become ACOs by providing them a package with the systems, protocols, care patterns and operating protocols needed to build a successful ACO, and perhaps most importantly we have the capability to provide the consulting, training, and technical expertise organizations will need to tailor these systems to their needs and integrate them into the systems they already have.

Lee: We launched a successful APP Symposium three years ago that is now attended by nearly 500 individuals from organizations around the nation. Our **CI-Now** venture with BDC Advisors is the next logical step to take our experience and share our programs, systems and protocols with organizations working to become ACOs. We believe this package, coupled with our ongoing technical assistance, will shorten the development time and greatly reduce risks for organizations in the current environment. It is all about creating the “Four Pillars”: optimizing clinical outcomes, enhancing patient experience, creating a culture of committed physicians, and securing funding for our futures.

4. How do we decide where to start?

Lee: The prerequisite for any ACO is a clinically integrated network that ties together all the clinical components needed to serve a given population. APP, for example, serves a population of more than one million people in the Chicagoland market. Participants in the network work together to collect and analyze performance data, develop clinical protocols, and contract with health plans for pay for performance (P4P) contracts. The first step is collecting sufficient clinical data and generating the performance metrics that can be used in contracting and then constructing the action plans needed to improve initiatives.

Rick: Once the network is up and operating other health plan functions such as member service portals, plan design, and transaction processing can be added. In the final stage the ACO operates as a unified care manager for its defined population, either commercially insured or Medicare beneficiaries for whom the ACO is the care manager.

5. What are the requirements for Physician Membership?

Lee: Generally they are fairly standard - collecting and sharing clinical data from the practice, working on clinical improvement efforts, a willingness to adopt common information systems, participating in pay for performance contracts, and abiding by ACO requirements for clinical practice. Most at-risk medical groups and IPAs require primary care practitioners to be exclusive because without this they cannot manage care and provide a unique product. Specialists are generally allowed to contract with multiple ACOs until the ACOs' patient base is large enough to sustain their practice directly.

6. How Will Physicians Benefit From Joining?

Lee: ACOs have the ability to deliver a superior product to the market. APP allows our medical staff to document the quality and cost effectiveness of their results in a relatively simple and straightforward manner. Moreover, our organization provides physicians with the ability to participate not only in multiple contracts with different health plans, but in P4P and bundled payment contracts with CMS in the future. Our focus on clinical integration has also improved our physicians' ability to manage chronic diseases and reduce medical errors while also improving professional collegiality among our medical staff - an important intangible benefit.

7. Do we really need to Act Now?

Rick: Boards and their CEOs are facing one of the most challenging strategic choices imaginable: maintain their current business model or begin the transformation into an Accountable Care Organization. Standing still, however, is perhaps the weakest strategic choice available since this fall CMS will begin to promulgate new ground rules for payment. Providers who do not invest in the infrastructure for members to integrate care will be unable to embrace the emerging payment methodologies such as medical homes, gain sharing, and pay for performance.

Lee: I don't think there is much choice. Most hospital systems will need to start migrating towards an ACO now. It will require passion and commitment but it will also take rapid enough payment reform to provide a critical mass of value based payment systems to support the effort.

8. How long does the process take and what resources are required?

Lee: We have been working on the process of developing a clinically integrated network ---the backbone of any ACO---for nearly a decade, and have invested significant resources in the process. By taking advantage of what **CI-Now** has to offer, it is possible to complete the transition to an ACO in a condensed timeframe. However, the clinical

integration journey is a significant undertaking that will require a million dollar plus investment.

Rick: The major upfront investment is probably in clinical systems, and fortunately informatics is an area where many health systems have made significant investments in the past few years. The other critical factor is physician alignment and most large health systems now have substantial experience in the employment of physicians and the management of their practices so they do not have to do it all from scratch. But I agree with Lee that depending on the starting point it will be a three to five year undertaking requiring significant financial resources.

9. What are the major pitfalls or “death traps” that could significantly slow or stop the transformation to an ACO?

Rick: **CI-Now** has developed a detailed road map for the transformation of a hospital system into an ACO starting with a strategic business plan to respond to reform and concluding with financial transformation away from fee for service to direct and risk contracting. Failure to have a clear vision and appreciation of the complexity of the process will be a major roadblock for many; others may be derailed by failure to communicate a compelling vision to various organizational constituencies or not having the skills to contract effectively with physicians through employment or network participation.

Lee: For me, having a clear, shared vision; physician leadership; and a strong management team are the key success factors needed at the start. An effective clinical integration program requires an organizational commitment and participation beyond staff dedicated to day-to-day program administration. Without that, and without the appropriate financial commitments, the process can be delayed at any number of points along the way.

In addition, a well-organized method of communication needs to be put in place to support sharing of an individual physician’s performance against established goals. The success of the program will be bolstered by a structured mechanism to evaluate performance and target improvement opportunities—and to identify and share activities viewed as best practices.

10. What is the most appropriate organizational structure?

Rick: The Affordable Care Act has identified four different kinds of organizations from physicians and other professionals in group practices or networks of practices, to organizations that are partnerships or joint ventures between physicians and hospitals, to hospitals that employ physicians. The Act leaves the door open for the Secretary to fund any other kind of organization that he may find appropriate. BDC Advisors is

betting that the most appropriate form of organization will involve hospitals and physicians *and a partnership with one or more health care insurers who will have the capacity to appropriately and carefully share risks with providers* since this is likely to be an increasingly important element of the ACO equation.

Lee: I think it is particularly important to have all governance---boards, quality, utilization management, credentialing---with a 'multi-specialty' composition so that the ACOs' physicians can regularly work through conflicts between specialties, particularly since the discussion may involve the need to transfer income from specialists to primary care physicians. Primary care physicians will eventually need their own sub-group or council, but we recommend a multispecialty governance composition which provides the most effective launch for an organization.

11. What new financing will be available?

Rick: Most experts seem to agree that the most important component of the reform law is the Medicare Shared Service Program which is due to be launched in 2012. Under this program Medicare beneficiaries who are enrolled in the traditional fee for service program will be "assigned" to ACOs which meet certain quality standards, and will thereby be eligible for a cut of any cost saving resulting from the treatment of these patients, assuming they meet specified quality performance standards set by the government. CMS plans to promulgate new regulations this fall, which will further define the ACO and the Medicare Shared Service Program, but at the moment it is confusing. To quote CMS: "Assignment means those beneficiaries for whom professionals in the ACO provide the bulk of the primary care services." CMS goes on to say that assignment will be "invisible to the beneficiary, and will not affect their guaranteed benefits or choice of doctors," and further that beneficiaries can continue to go to any physician they choose whether or not the physician or provider is part of an ACO.

Lee: Hopefully more will be revealed in the fall of 2011. It would appear, however, that only ACO organizations with a large number of primary care physicians with significant *existing* patient panels, and sophisticated electronic infrastructure, will be in a position to participate. The legislation states that there must be a sufficient number of primary care physicians to cover at least 5,000 beneficiaries, but this is probably at the low end of patients needed for an ACO to be economically viable.

Rick: Medicaid is another matter and since the bulk of new patients eligible for care will come through Medicaid, ACOs may need to strike separate deals with each state if the shared services agreements are to cover these newly insured patients. Private insurance companies are another matter, though groups such as Advocate Physician Partners and others have already worked on shared saving agreements with insurers for help to bend the cost curve. The participation of insurers has been somewhat

overlooked in the excitement over ACOs and BDC Advisors believes that the ability to manage risk is likely to become increasingly important in the future, and is a skill that is beyond the capability of most aspiring ACO organizations.

For more information about developing clinical integration please contact Neal C. Hogan, PhD, neal.hogan@ci-now.com.

View the Advocate Physician Partners 2010 Value Report at <http://www.advocatehealth.com/body.cfm?id=439>