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Accountable Care NEWS

Driving out Costly Clinical Variations in Care

by Joe Guerriero

Ever wonder why one physician may be able to spend less but get better results? Or why average Medicare spending per patient costs $6,781 in Bend, Ore., but a whopping $12,090 in Corpus Christi, Tex.?[1]

Disparities like these have long plagued the healthcare industry, leading to inefficiencies, waste and poor outcomes. In fact, estimates show $158 to $226 billion is wasted each year on overtreatment alone.[2] Inconsistencies in clinical processes can also prolong common health problems and delay a patient's return to health.

When patients take longer to heal and require excessive tests and treatments, it further drives up costs and reduces potential revenue for accountable care organizations (ACOs) and other providers that bear financial risk.

With more providers moving toward outcomes-based payment models that focus on value over volume, having the right tools to ensure the consistent application of effective treatments and expected recovery times is more important than ever. The system-wide use of evidence-based, clinical guidelines, along with recovery duration tables and analytics, can help providers return patients to health faster while also empowering them to benchmark, monitor and improve their overall clinical and financial performance.

(*continued on page 4)*

In This Issue

The Keystone of Accountable Care: A Proactive Approach to Patient and Family Education

by Lori C. Marshall, Ph.D., MSN, R.N.

(*This article first ran in the April issue of* Medical Home News.)

Patient and family education (PFE) is a keystone of accountable care. PFE is often under-resourced because the return on investment is not immediate or easy to measure short term nor part of the usual tactical metrics analyzed with outcomes.

Here are five important considerations necessary to create meaningful and effective PFE programs. Undertaking them will leverage the least expensive proactive resources to ultimately avoid the high-cost reactive resources.

1. **It is imperative for healthcare providers to build interdependent, not dependent, relationships with those under their care.**

Far too often, dependencies are created that do not foster self-directed learning, which is an important foundation of self-care management in a patient's healthcare journey. Each discipline must recognize its contribution to the overall long-term outcome. How a discipline views the purpose of its role drives subsequent interactions with patients and families.

For example, physical and occupational therapists, child life specialists and respiratory care practitioners tend to initiate caregiving relationships from the perspective that they are a temporary resource. They are there to help a person regain function by transferring knowledge and skills; however, physicians and nurses, particularly those working in hospital settings, tend to cultivate more dependent relationships.

(continued on page 5)

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What's On Your Mind?

We continue our op-eds and brief reports from the field this month with a commentary from Tim Koxlien on telehealth.

Tim Koxlien
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Telehealth: A Godsend for 56 Million Rural Americans, Accountable Care Collaboration

Who among us has not at times these days yearned for the pastoral, picturesque rolling hills and valleys of rural America where the air is fresh, the sun is bright, the water is pure and you can hear the quietude?

But as we may think about returning to rural America, we often are unaware of the difficulties in finding adequate healthcare for the 56 million Americans living in rural areas.

In the past, rural healthcare was inadequate and often unavailable.

I grew up in that atmosphere in rural western Wisconsin in a small town called Whitehall on the hills and coulees just east of the Mississippi River. My family of five was essentially healthy, and we seldom were in need of healthcare; however, with a largely agriculture-based economy, the health and welfare challenges to farm families were much greater than for those in urban areas.

Working the fields and in the barns, often utilizing dangerous mechanized farm equipment, rural residents confront more incidents of work-related injuries—higher than those experienced by their urban brethren.

Most rural family incomes were lower than city dwellers, and few had employer-provided health insurance. Most farm families were larger than average, compounding the situation. In addition, extended families were often bigger and more closely knit, as were my Norwegian relatives in western Wisconsin.

To complicate matters, there seldom was a healthcare provider nearby. Families had to drive sometimes 50 miles to get to a clinic or possibly even further to a rural hospital in a small town that had limited service and might have closed down due to a lack of funding or patients.

About 11% of physicians practice in rural America despite the fact that roughly 20% of the U.S. population lives there.[1] There was a greater risk of automobile accidents on the long drives to obtain medical assistance, particularly at night or during winter when county roads could be treacherous.

Slowly but surely, rural telehealth has been gaining traction in rural America to accommodate the environment and its challenges. Its arrival has brought some significant advances in patient outcomes and a healthier population.

Progress in recent years has been noteworthy but not without challenges. In some cases, state medical board and federal bureaucrats have been notably dragging their feet on reimbursement by the Centers for Medicare & Medicaid Services (CMS).

The situation I've described is an obvious healthcare problem; yet, most urban Americans are unaware of the rural crisis. While lamenting the decline of rural healthcare, some media, including the respected PBS *NewsHour* in two recent segments on rural health hospital closings, completely missed one of the bright spots that are offering a realistic and relatively rapid part of the solution—telehealth.

The very effective American Telemedicine Association (ATA) describes telehealth as "the use of medical information exchanged from one site to another via electronic communications to improve a patient's clinical health status. Telemedicine includes a growing variety of applications and services using two-way video, email, smart phones, wireless tools and other forms of telecommunications technology."

(continued on page 7)

How Did We Get Here? The Evolution of Medicare's Quality Reporting Programs

by Chris Emper

(This is second in a series of articles; the first one on Medicare's Physician Fee Schedule rule appeared in the February 2016 issue of Accountable Care News*. The third article in the series will appear in the July issue of* Accountable Care News *and will focus on MACRA).*

The 2016 full-year reporting period for Medicare's quality reporting programs officially began last Jan. 1. Physicians have 10% of their 2018 Medicare payments "at-risk" in these programs. In practical terms, this means that physicians who fail to satisfy he 2016 reporting requirements for Medicare's three quality programs that affect Physician Fee Schedule (PFS) payments—the Medicare Electronic Health Record Incentive Program, the Physician Quality Reporting System and the Physician Value-Based Payment Modifier—will be paid $0.90 instead of $1.00 for every service they bill under the PFS in 2018. This financial impact and the complexity of these programs begs the question: How did we get here?

Medicare Electronic Health Record (EHR) Incentive Program. Created by The Health Information Technology for Economic and Clinical Health (HITECH) Act in 2009, the program uses a combination of incentive payments and penalties to encourage the meaningful use of certified electronic health record technology (CEHRT). Marking the shift from incentives to penalties, 2015 was the first year that Medicare penalized providers who failed to comply with the program. As prescribed by law, Meaningful Use (MU) penalties have been increasing each year and as with the other quality reporting programs, CMS applies penalties based on a performance year two years prior to a payment year (i.e., 2016 performance will determine 2018 payment.)

Physician Quality Reporting System (PQRS). Originally authorized by The 2006 Tax Relief and Health Care Act but amended by subsequent laws, the PQRS program uses incentive payments and penalties to promote the reporting of quality measures by eligible professionals. While 2014 was unfortunately the final year for Medicare physicians to receive PQRS incentives, 2015 was the first year PQRS penalties applied for noncompliance. The PQRS penalty in 2015 was 1.5%, but the penalty for 2016 and all subsequent years is 2%.

Physician Value-Based Payment Modifier (VBM). The newest of the three programs, (VBM), was created by The Affordable Care Act (ACA) in 2010, to adjust payments downwards or upwards based on cost and quality. The VBM is based on and aligned with PQRS reporting and creates two groups of Medicare-eligible professionals (EPs): those subject to the PQRS penalty and those that are not. The first group of EPs—those who fail to satisfy PQRS reporting requirements—will receive an additional penalty under VBM; however, the impact and application of the penalty is being phased in by year and practice size.

The second group of EPs under VBM—those who do satisfy PQRS reporting requirements—will be subject to additional adjustments under the VBM's quality-tiering system. Quality tiering is a complex scoring system that evaluates the performance of physicians on their PQRS quality measures and a cost measurement. From there, it adjusts payments up or down based on performance relative to one's peers. As with other CMS programs, the application and impact of the quality-tiering system has been phased in by year and practice size.

The Impact

As the saying goes, sometimes "a picture says a thousand words," so it might be easier to understand the financial impact of these programs visually with the chart below that outlines potential penalties associated with these programs by performance and payment year.

Performance Year	Payment Year	MU Penalty	PQRS Penalty	VBM Penalty	Total Penalties
2013	2015	1-2%*	1.5%	1%**	3.5-4.5%
2014	2016	2%	2%	2%**	6%
2015	2017	3%	2%	4%**	9%
2016	2018	4%***	2%	*4%***	*10%*

Notes and Exceptions

**The 2015 MU penalty will be 2% for EPs who were subject to 2014 eRx payment adjustment. Also, EPs who demonstrate MU for the first time in 2014 will avoid both the 2015 and 2016 MU penalties.*

***The 2015 VBM penalty will only apply to physicians in group practices of 100 or more; the 2016 VBM penalty will only apply to physicians in group practices of 10 or more; the 2017 and 2018 VBM penalty will apply to ALL physicians, but the penalty for physicians in practices with less than 10 physicians will be 2%.*

****For 2018 and subsequent years, if more than 75% of EPs achieve MU, the MU penalty will be 3%; if less than 75%, the MU penalty will increase by 1% each year up to a maximum of 5%.*

(continued on page 4)

How Did We Get Here?*....continued from page 3*

And what comes after the 2016 performance/2018 payment year? The Merit Based Incentive Payment System (MIPS). As a result of The Medicare Access and CHIP Reauthorization Act (MACRA) of 2015, CMS is expected to consolidate the penalties for these three programs for the 2017 performance period into a single incentive and penalty program: MIPS.

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Driving out Costly Clinical Variations in Care*....continued from page 1*

Why Variation Happens

Even though some degree of clinical variation is expected and appropriate based on the unique needs of patients, problems occur when these variations lead to unwarranted or duplicative diagnostic interventions and treatment. To effectively address these issues, drive out waste and succeed in value-based care, providers must first get a handle on why this fragmentation is taking place. When outcomes—not volume—are the desired goal, it is essential to have visibility into how process variations may impact both quality and cost of care.

By gaining a better understanding of the root causes behind clinical variations in care, ACOs and other risk-bearing providers can formulate an effective strategy for promoting greater consistency across an enterprise. Some of the most common causes of clinical variations include:

- **Differences in professional opinion**. In most cases, diagnosing and treating patients are based more on a provider's instinct, opinion or preference about sticking with tradition than on concrete data. Because each provider may have his/her own unique set of opinions, it's no surprise that treatments for the same exact illness or injury can vary greatly.
- **Patient preferences**. At times, patient preferences, such as a desire to postpone or avoid surgery, might conflict with medical evidence and lead to adverse outcomes. Conversely, some patients might opt for elective procedures and incur additional costs for treatments that are not medically necessary for their condition based on the most recent evidence.
- **Medicalization**. When non-medical problems become defined and treated as medical disorders, the potential for variations in care typically increases. Common health and life problems, such as low back pain, are often poorly understood and can lead to intense investigation and treatment experimentation. The end result is often unnecessary expense, patient discomfort and prolonged treatment.
- **Rapid growth of medical data**. In recent years, the number of clinical trials, studies and journal articles has increased exponentially, generating massive amounts of new medical data on the latest procedures, medications and other advances. Sorting through this information is a monumental task, making it extremely challenging for physicians to apply consistent approaches to diagnosis and treatment.

While healthcare providers have little control over patient preferences, they can address the challenges of differing professional opinions, medicalization and the rapid growth of medical data through widespread adoption and use of evidence-based, clinical guidelines at the point of care.

A recent study found that nearly one-third of opioid prescriptions paid for by employers are abused, meaning patients continue their use longer than 90 days or seek prescriptions from multiple providers.

The Value of Evidence

Unlike approaches rooted in tradition or experimentation, evidence-based, clinical decision support increases treatment consistency and strengthens care coordination. Studies show more coordinated, evidence-based care could reduce healthcare costs by $90 to $110 billion dollars annually.[3] By establishing a consistent framework for clinical decision making, treatment planning and patient communication, evidence-based guidelines enable all care team members to use the same terminology and processes for treating a range of conditions, illnesses and injuries.

When evidence-based guidelines are used in combination with illness and injury duration tables, providers could also better engage patients in their recoveries and provide accurate estimates of how long it might take to return to health based on data and expert clinical consensus. With objective duration information in hand, physicians could set realistic expectations for patient recoveries and avoid common missteps, such as unnecessary activity restrictions and wasting time and resources on treatments unlikely to contribute to recovery.

For example, over-prescribing of opioids is a growing national concern. A recent study found that nearly one-third of opioid prescriptions paid for by employers are abused, meaning patients continue their use longer than 90 days or seek prescriptions from multiple providers.[4] By employing an evidence-based approach, providers can help to prevent opioid abuse. Prescribing opioids for the correct phase of treatment, such as the acute, post-surgery phase, rather than for long-term pain management can make a notable impact.

(continued on page 5)

Driving out Costly Clinical Variations in Care

….continued from page 4

When providers have access to the most up-to-date medical evidence at the point of care, they can make more informed decisions that lead to better outcomes. Electronic medical record (EMR) integration can make intelligent clinical decision support tools and content available to physicians and other care team members where and when they are needed most. As physicians consider a patient's treatment using guidelines, having access to recent tests and procedures eliminates unnecessary duplication and facilitates better coordination. In addition, each person who interacts with a patient can present a consistent treatment plan.

When point-of-care tools are built on a robust analytic framework, ACOs can then measure clinical performance against real-world, case data and established recovery duration guidelines at the diagnostic group or code level. These measures can help guide an organization's process improvement efforts by giving providers the ability to evaluate and compare their performance against their peers. With this data-driven insight in hand, it's possible to assess and adjust specific treatment protocols. For example, examining recovery durations based on variables, such as age, gender or comorbidities, can uncover opportunities for improvement and promote more efficient use of resources in the future.

In addition, analytics can reveal where best practices for treatment planning and management need to be implemented, where treatment inconsistencies persist and which high-risk patients demand proactive interventions and management.

Organizations that demonstrate how the use of proven, evidence-based clinical guidelines, recovery duration tables and analytics helps individuals return to full health and activity faster will have a strong differentiator in their respective market. This differentiator can help attract new agreements with third-party payers or self-funded employer health plans, ultimately allowing ACOs to expand market share and generate more revenue.

Making an impact

For healthcare organizations that have already formed ACOs or are in the planning stages, clinical variations in care represent both a challenge and an opportunity. By taking advantage of the right combination of evidence-based guidelines, recovery duration tables and analytics to identify and address these costly inconsistencies in clinical processes, providers can make significant strides toward achieving sustainable cost reduction and realizing better outcomes. With greater visibility into opportunities for process improvement, ACOs can promote more efficient, effective treatments, while also strengthening care coordination, increasing patient engagement rates and bolstering the bottom line.

[1] "Total Medicare Reimbursements Per Enrollee, by Adjustment Type." The Dartmouth Atlas of Health Care. 2016.
[2] "Reducing Waste in Health Care." Health Policy Briefs. *Health Affairs*, Dec. 13, 2012.
[3] Kayyali B, Van Kuiken S, Knott D. "The Big Data Revolution in Health Care: Accelerating Value and Innovation." McKinsey Company. January 2013.
[4] Goldberg S. "Abuse of Employer-Paid Opioid Prescriptions Widespread." *Business Insurance*. April 20, 2016.

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The Keystone of Accountable Care

….continued from page 1

Nurse leaders must harness the power of numbers to drive accountable care. Particularly on the inpatient side, nurses comprise the largest composition of hospital staff and professional discipline in healthcare and deliver more care than any other healthcare discipline.[1] Exploring further, the nursing scope of practice was always meant to embody the "handing off of knowledge," but the changes in work practice continue to encourage dependency.

Transfer of knowledge tends to be nurse-dependent, with some nurses having greater competency and interest in PFE. Some nurses are better at seeing the bigger picture. PFE cannot take a backseat to task or process functions of a professional role. Role clarification via a health systems approach will strengthen and connect disciplines efforts, including nursing, to outcomes of care.

2. It is important to use a PFE framework to guide efforts.

A PFE framework has several important benefits. A framework creates a shared mental model of key PFE concepts, including definitions and terminology. It begins with articulating a philosophy about patients and families as learners, and then defining what constitutes PFE within a health system. Example philosophies are: "We believe patient and families are leaders of their journey," and "We believe patients and families must be developed as self-regulated learners."

Definitions of PFE can have a narrow focus, such as discharge education. They can also contain a range of situations, such as new diagnoses, consents and procedures, medications, treatment options and self-care management at home. A global concept of "anything needed to support participation in care and informed decision making" can also define PFE.

Once PFE is defined, concepts can be organized and connected with other concepts in a meaningful way. Goals and outcomes are specified when these concepts are articulated.

A framework guides a healthcare provider to work in partnership with a patient and family for setting goals, developing a plan and negotiating resources to support knowledge transfer. A framework links tools, resources and learning experiences to gain knowledge or sustain goal-directed behavior.

(continued on page 6)

The Keystone of Accountable Care

....continued from page 5

Above all, a PFE framework helps to hardwire a proactive mindset. Healthcare providers must have a plan and rationale for doing what they are doing. In the same way a treatment plan guides care, an education plan guides knowledge and skill transfer. Cost of care increases when healthcare providers engage in patient education without a plan only to find their approach does not work.

3. **It is essential to recognize opportunities to align PFE efforts across the health system.**

Opportunities begin with understanding what is in place in one's health system. Specifically, these are the committees, councils, people, system and processes intended to support PFE. Important questions to ask include: What resources are in place? Are these resources working in parallel? Who is leading the work and how is it strategically tied to a health system's priorities?

This is the infrastructure that supports content development and oversight, provision of education and policies/procedures and evaluation, as well as tracking and monitoring outcomes. A well-designed health system's PFE policy incorporates the framework and clarifies expectations, roles and responsibilities. It also ties in the committees, settings and reporting accountabilities.

4. **Invest in well-designed patient education documentation processes and systems that are embedded within the electronic health or medical record**.

This area alone can have a significant impact on cross-continuum, care coordination and reduce care costs. PFE documentation requires forward thinking. A design element that is critical to accountable care is capturing discrete data fields for future use in outcomes measure, making wise choices based on EMR functionality. While a health system might not currently analyze data or look at relationships between PFE data elements and readmission rates, visits to the emergency department or missed clinic appointments might spur them to analyze data in the future.

Another critical design recommendation is to build interprofessional tools that cross episodes, encounters and the care continuum. Start with service lines because the relationship between care settings is easier to visualize. When PFE documentation tools cross episodes of care, it reduces rework and promotes continuity. Design PFE documentation to leverage standardized terminology and content sections, while limiting free text entries to comments and other options.

5. **Make a firm organizational commitment to adopt a broader accountability paradigm.**

Along with other important cultural values, health systems must cultivate the proverbial forest and tree thinking. Accountable care is most successful when healthcare providers view their roles not only in the moment but also in the consciousness; there is something bigger and broader next.

"Next" could mean one unit to another or one level of care to another; it is recognizing there is another place in a patient's healthcare journey that follows.

One role that requires the greatest support and focus is that of the bedside nurse in the hospital. Shift work has provided a better working environment and continuity in a given day. The concept of a "primary nurse," whose core function is to embrace the big-picture thinking, is rolled into the expectation that every nurse would own that planning and coordination responsibility on his/her shift; however, this is not the case. These roles have been formalized into hospital-based, care coordinators or nurses who manage care in outpatient settings.

Consider that nearly 75% of all nurses in the United States work in hospitals and clinic settings, and only 6.4% are working in a home.[2] However, WHO estimates that 70% to 90% of medical care is performed in the home setting.[3] This bears a reminder to ensure nurses working in hospitals and clinics in direct care roles remain explicitly connected to care coordination models in order to retain the knowledge, skills and big-picture thinking inherent in the care coordination role function.

In conclusion, a health system approach can positively impact patient and families. When PFE isn't effective, it can increase the length of hospital stays, delay discharges and increase readmissions and more visits to the emergency department.[4] As leaders and stewards of accountable care, nurses need to become champions who focus on creating relevant and meaningful patient and family programs. It is imperative that they invest time to evaluate PFE programs, people and resources at their health systems. Nurses must step back and objectively evaluate their organization's view of patient and families and its capacity for self-care management, and then be willing to advocate for change.

[1] "Nursing Fact Sheet." American Association of Colleges of Nursing. 2011.

[2] "Infographic—The Future of Nursing." Institute of Medicine. 2011.

[3] Berwick D., Nolan T, Whittington J. "The Triple Aim: Care, Health, and Cost." *Health Affairs*. 2008; 27(3):759-769.

[4] "The World Health Report 2000—Health Systems: Improving Performance." World Health Organization. 2000.

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Telehealth: a Godsend for 56 Million Rural Americans*….continued from page 2*

Telehealth service providers see the technology as a strong inducement for collaboration and cooperation through the entire continuum of a patient's healthcare.

By definition, telehealth requires close coordination at all levels of care, from the patient and the attending physician at a local level to the specialist and tertiary hospital many miles away, as patient treatment progresses.

The statistics show that patient outcomes are improved, lives are saved and costs are reduced. Telehealth can be a win-win-win proposition for all involved.

As of 2015, 47 states and Washington, D.C. provide reimbursement for some form of live video in Medicaid fee-for-services.

Many—but not all—of the medical community and government regulators and lawmakers recognize telehealth and telemedicine as effective antidotes to the growing healthcare needs of rural and urban families.

A study conducted by KPMG[2] shows that one-fourth of healthcare providers offer telehealth and telemedicine services. The study says the programs "are financially sustainable and are improving efficiency, patient volumes and loyalty by filling gaps in medical specialties or helping chronically ill patients…

"Telehealth…is gaining credence in urgent care settings from mobile devices…retail clinics or for psychiatric assessments in an emergency department." It notes that telemedicine "has a long history in radiology and for remote, underserved patient populations where specialists are needed for their clinical expertise, but it is gaining greater use."

Digital broadband accessibility, complexity of the Federal Communications Commission (FCC) Universal Service Fund—a system of telecommunications subsidies and fees managed by the FCC to promote universal access to telecommunications services in this country—uncertain Medicare reimbursement, opposition from some state medical boards, lack of parity for telehealth services across state boarders, archaic laws and regulations have been encountered in recent years.

However, progress is being made by the telehealth industry and medical profession to change those restrictions. CMS encourages states to use telemedicine, e-visits and other innovative technological solutions to meet network requirements. Coincidentally, the federal agency is finally liberalizing its reimbursement policies for telehealth and telemedicine.

CMS and the director of the Congressional Budget Office have speculated that telehealth's economic impact has yet to be proved but at the same time, ATA has reported that most of the peer-reviewed research about cost effectiveness of telemedicine based on large sample sizes and following sound scientific rigor, consistently find that telemedicine saves patient, provider and payer money when compared with traditional approaches to providing care.

Meanwhile at the state level, a number of state medical boards, legislatures and regulators have been aggressively moving telehealth policy and procedures along. State regional contracts make it easier for physicians and healthcare providers to work across state lines under one license.

As of 2015, 47 states and Washington, DC, provide reimbursement for some form of live video in Medicaid fee-for-services.[3]

There's no doubt that telehealth is a godsend for rural families.

[1] "Meeting the Primary Care Needs of Rural America: Examining the Role of Non-Physician Providers." National Conference of State Legislatures. 2016.

[2] "A Quarter of Healthcare Providers Make Strides in Telemedicine/Telehealth: KPMG Poll." KPMG. May 12, 2016.

[3] "State Telehealth Laws and Medicaid Program Policies." Center for Connected Health Policy. March 2016.

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If you would like to join the Accountable Care News LinkedIn Group, click here to check out the group. It's an opportunity to network, exchange information and follow current developments with other professionals interested in ACO-related initiatives and issues.

Mari Edlin, a graduate of Stanford University and a long-time San Francisco Bay Area freelance writer specializing in healthcare, serves as editor of *Accountable Care News*. She invites you to submit ideas for bylined articles and opinion pieces on accountable care issues, and case studies illustrating successes with the ACO model. Mari can be reached at MLEdlin@comcast.net.

Thought Leaders' Corner

Each month, we ask a panel of industry experts to discuss a topic of interest to the accountable care community.

Q. What Are Your Criteria for Labeling a Commercial Payer/Provider Collaboration an "Accountable Care Arrangement" Versus Other Types of Payment for Value or Alternative Payment Structures?

First and foremost, it's important to note that care delivery transformation will only happen if payment models change. Alternative payment models include varying financial arrangements between payers and providers (from bonus payments for quality, shared savings and bundled payments to full-risk arrangements) except traditional fee-for-service payments.

Alternative payment models move providers closer to being fully accountable (full risk or capitation) for a population of individuals. To be successful requires collaboration, which means working together to achieve a common goal. In the case between a payer and a provider, it means working together to achieve the Triple Aim (better care, better experience and keeping costs affordable).

There are varying levels of collaboration, from sharing of data about consumers between a payer (i.e., claims) and a provider (i.e., EHR, clinical) to sharing workflow (between payers and providers) to manage the health and episodic care of individuals. For example, when a consumer is accessing care outside a provider's network, a payer notifies an ACO in real time to enable a care team to coordinate and help manage a consumer's experience and health.

When negotiating alternative payment models, keep in mind who the payer is. Of all the payers (government; private, traditional insurance carriers; and self-insured employers), the latter has the most flexibility to collaborate with providers to pull the lever that is most important in engaging consumers in taking personal accountability in actively managing their health.

Tricia Nguyen, M.D.
Executive Vice President, Population Health
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There are many definitions used in healthcare business and policy discussions that touch on the concept of "accountable care." It can be an organization, a payment arrangement or encompass a variety of different characteristics. In the commercial accountable care environment, there are different perspectives on what the term means and how an arrangement between a provider and payer is designed.

In my view, a commercial payer/provider collaboration is an accountable care arrangement when it is broader based rather than focusing solely on reimbursement and payment. Instead, an accountable care arrangement takes into consideration as a key element not just the reduction of cost through alternative pay arrangements such as bundled payments or capitation; its design and purpose is broader, focusing on quality outcomes and the health of the members involved.

Mechanisms, such as bundled payments, capitation or patient- centered medical homes are means to the larger goal of the accountable care arrangement, which is to actually improve the health outcome of the members it serves. In addition, providers and payers bear two-sided risk in terms of the upside and downside, financially succeeding when health quality is improved and costs are lowered and accepting financial losses when those objectives are not met.

Deborah Dorman-Rodriguez
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Thought Leaders' Corner

While the definition of a Medicare Shared Savings Program is very clear, the definition of a shared savings program for direct provider employer contracting is not as strict, but it can have benefits. There are several private pay ACOs in operation, with one of the largest ones being in the San Francisco area with the Pacific Business Group on Health. Commercial ACO contractual obligations include:

- Reporting well-known datasets between provider and payer, patient satisfaction assessed in the Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CAHPS) and risk-adjustment classification.
- A collaborative sharing of eligibility and paid claims information.
- Quality reporting on a group, as well as on a provider specific basis.
- Shared baseline costs.
- Design of a reimbursement system for paying physicians based on value not volume.
- A serious attempt at building a framework for clinical improvement for primary and specialty care physicians.
- Ability to represent inpatient care facilities, home health, rehabilitative care and related mid-level services in a network.
- An organized provider entity that can be accountable for the actions of a network, its participants and staff.

In most of these arrangements, there is an agreement to move forward to a shared-risk model in three to five years depending upon how mature the employer and provider data are and how effective the network is at predicting its actual versus estimated costs.

Many employers have tried to do something like this by getting a bare minimum of data from a third-party administrator and an actuarial study that estimates costs for a normal health population, while others pick one or two elements of a contract like this and hope to do a complete job later. A passive employer usually doesn't see any change, and a provider holding back the savings only assures itself there will not be any shared savings.

In some cases, employers will take the lead at splitting out part Parts A and B costs by negotiating with physicians and hospitals on a specialty basis that represents the best outcomes for their patient populations. This makes other providers not on the network measure up to the employer's best practices or else lose patients. These types of accountable health networks can save 18% to 20% for employers who agree to build benefit incentives to see preferred providers and ask patients to pay an increased percentage on the out-of-network physicians.

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Industry News

IRS Ruling Is Obstacle to Healthcare Networks Promoted by Obama

WASHINGTON, D.C.—A ruling by the IRS creates a significant obstacle to a new type of healthcare network that the Obama administration has promoted as a way to provide better care at lower cost, industry lawyers and providers say.

Healthcare markets are rapidly changing as independent doctors and hospitals race to form networks, known as accountable care organizations (ACOs), in which they coordinate care for patients. The doctors and hospitals have financial incentives to keep patients healthy and to control costs, and they can share in the savings if they meet performance goals.

The new entities, which now cover more than 28 million people, according to Leavitt Partners, a healthcare consulting firm, help manage care for Medicare beneficiaries, people with employer-sponsored insurance and consumers who buy coverage through online marketplaces under the Affordable Care Act.

In its recent ruling, the IRS denied a tax exemption sought by an ACO that coordinates care for people with commercial insurance. The tax agency said the organization did not meet the test for tax-exempt status because it was not operated exclusively for charitable purposes and provided private benefits to some doctors in its network.

The name and location of the organization, formed by a nonprofit healthcare system, were not disclosed. The ruling does not affect ACOs formed solely to participate in Medicare, but it could affect similar entities serving privately insured patients.

(continued on page 10)

Industry News

IRS Ruling Is Obstacle*…continued from page 9*

Many ACOs coordinate care for both Medicare beneficiaries and privately insured patients.

Melinda R. Hatton, senior vice president and general counsel of the American Hospital Association, says the ruling "appears to be a serious obstacle for nonprofit hospitals striving to coordinate care for their communities."

In a letter asking the tax agency to reconsider its position, Hatton says, "The IRS ruling is in conflict with the direction that the Department of Health and Human Services has given to the hospital field."

It is, she says, imperative for the government to make clear that hospitals can participate in ACOs without "incurring the catastrophic loss of their tax-exempt status."

The IRS acknowledges that the organization in question was trying to increase the quality of care, lower costs and improve the health of the community—the Triple Aim championed by President Obama.

But, it says, the organization has also negotiated agreements with insurers on behalf of doctors, and that is not a charitable activity nor one that directly benefits the community as a whole.

NAACOS Releases ACO Cost, MACRA Implementation Survey

WASHINGTON, D.C.—(PR Newswire-U.S. Newswire)—The National Association of ACOs (NAACOS) has released the results of its sixth ACO Survey available at http://www.NAACOS.com. This survey focuses on ACO operational costs, ACOs' ability to take on downside risk and the recently released Centers for Medicare & Medicaid Services (CMS) proposed rule implementing provisions of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA).

The survey answers key questions about ACOs such as: how much are ACOs investing, how much and how quickly are they able to assume two-sided risk and how do ACOs feel about track one being excluded from CMS's proposed list of advanced alternative payment models?

The survey included Medicare Shared Savings Program (MSSP) ACOs that started between 2012 and 2016 and involved both NAACOS member and non-member ACOs. Out of the 433 current MSSP ACOs, 144 from 40 different states completed the survey.

"This study raises very serious concerns about the long-term viability of the Medicare ACO program under the current risk models and proposed MACRA policies. We are hopeful the Administration will recognize the importance of ACOs in achieving the Health and Human Services' value-based payment goals and adopt broader criteria for Advanced Alternative Payment Models under MACRA," says Clif Gaus, president/CEO of NAACOS.

Pharos Innovations, ProMedica Partner to Reduce Avoidable Hospitalizations, Readmissions

Pharos Innovations, a technology-enabled services provider in the patient engagement and care model redesign field, has partnered with ProMedica Health Network (PHN), an accountable care organization (ACO) that is physician-led to provide patients the right care at the right time and right place. PHN strives to align providers with high-quality, integrated and efficient care. The Pharos' programs supplement the ACO's existing care navigation resources to reduce avoidable hospitalizations and 30-day readmissions for PHN's at-risk Medicare patients, initially targeting individuals with heart failure, chronic obstructive pulmonary disease and diabetes.

"We are excited to be working with ProMedica Health Network to help them enhance their best-in-class care model by engaging a larger number of patients who are at risk for future hospitalizations," says Randall Williams, M.D., CEO of Pharos Innovations. "Our proven track record of helping patients stay healthier and take charge of their own self-care allows our healthcare partners to reduce avoidable utilization and costs to achieve their financial goals."

The Pharos program leverages technology that is simple and familiar to patients. Patients self-report their health status, providing care coordinators with real-time information to intervene before symptoms escalate.

"This new technology-enabled model will permit our care navigators to have greater visibility into a larger number of patients without sacrificing care quality," says Dee Ann Bialecki-Haase, M.D., president of PHN.

MedAxiom, Magellan Health Launch Cardiovascular-Specific, Accountable Care Initiative

NEPTUNE BEACH, Fla.—(Business Wire)—MedAxiom, the nation's leading cardiovascular performance community committed to improving business and patient care outcomes, and Magellan Health, a leader in the most complex areas of health, have launched a strategic initiative created to support cardiovascular programs as they develop cardio-vascular-specific, accountable care organizations (ACO).

MedAxiom and Magellan will collaboratively engage with large cardiology practices across the country to develop innovative management capabilities that leverage value-based, reimbursement models, while establishing greater strategic positioning with payers in the market.

(continued on page 11)

Industry News

MedAxiom, Magellan Health*…continued from page 10*

Through this initiative, MedAxiom and Magellan will:

- Engage with cardiovascular ACO provider groups to analyze economic costs of care and identify areas of practice that can either improve quality or reduce unnecessary costs of healthcare.
- Work to assess program readiness and assist in program development opportunities to successfully manage risk.
- Work with selected cardiovascular physician groups to develop and implement best practice guidelines and procedures for billing and coding, including appropriate workflows, documentation and payer interaction.

Catching Up With*…continued from page 12*

Physicians need and want the necessary skills to successfully navigate the new healthcare but like anyone experiencing rapid, broad change, they can feel vulnerable and distrusting. No one likes to be subordinated—physicians included—and we risk doing so if we do not adequately recognize healthcare is a clinical activity largely driven by the decisions physicians make. Physicians are aware and cautious about their role as leaders of healthcare transformation. Regardless of how this all turns out, their world and work will be different. Success will require physician leadership, engagement and a sense of ownership for the outcomes and performance of their healthcare systems.

Accountable Care News: *Are alternative payment models being accepted by the healthcare industry? Are some proving to be more effective than others?*

Mark Werner: Overall, it is becoming increasingly understood that new payment models need to be linked to value creation—outcomes and experiences—not just the volume of services rendered. However, the challenge remains in divining the journey from the current reimbursement state to the payment environment of tomorrow. Healthcare providers and systems need new revenue models that are better aligned with value-based care, and different operating platforms for population health accountabilities. While new payment models are accepted, healthcare providers have yet to sufficiently reconcile the necessary synergies with revenue models, clinical care models and operations. It is too early to say that one value-based payment model is proving more effective. This is due in part to the fact that each model is configured differently from the next and focused on varied patient populations. That being said, there is emerging consensus pressing providers toward global payments and sub-global payments for discrete service lines and episodes of care.

Accountable Care News: *How is your organization managing population health?*

Mark Werner: At the Chartis Group, we have developed a comprehensive framework for population health management (PHM) that begins with the creation of a clear and compelling vision and value proposition designed to unify the organization's leadership and clinicians. We believe that PHM must be based in a strong understanding of the patient populations that a healthcare provider serves and convey a clear value proposition to each of those populations.

Engagement of both patients and providers in efforts to address patient self-management, assure robust plans of care, close gaps in care, leverage technologies and enhance access to care are critically important, as is the use of strong data management and analytics to create actionable insight into care improvement and reductions of clinical variation. We believe PHM must build from a culture of engaged and aligned physicians who embrace teamwork, shared success, transparency and a patient-centered approach.

Accountable Care News: *One of your many accomplishments has been creating a joint venture between a large academic health system and a regional health plan. What were the objectives behind this partnership and how successful has it been? Why is integration so important?*

Mark Werner: Clinical integration refers to the planned and purposeful care of a defined population of patients with accountability for clinical outcomes, efficiency of care and consistent practice standards that advance quality and address unintentional clinical variation. It is a hallmark of population health management. Through clinical integration, physicians work together to establish consensus-driven best practices, leverage their shared learning, build on the insights of clinical analytics and consistently eliminate patient harm. As such, clinical integration is fundamental to ACOs, clinically integrated networks and to the success of all forms of value-based payments.

In regards to the joint venture, our main objective was to establish a strong foundation for PHM by leveraging complementary capabilities of each partner. Health plans bring strong analytics into medical expense drivers, variation in clinical care, risk profiles of patients and aspects of health management. Academic health systems can inform evidence-based practice, address the complexities of new and emerging treatments and manage their provider networks directly in a goal-oriented, accountable fashion. Both have shared incentives to improve quality, reduce cost of care and assure a patient-centered, excellence service experience. Fulfilling the promise of such a joint venture requires each party has a clear vision and value proposition, as well as a willingness to align economics and advance new care models together.

Catching Up with ...

Mark J. Werner, M.D., CPE, FACPE, is national director of clinical consulting for The Chartis Group, a healthcare, advisory services firm. In his role, he focuses on enterprise physician alignment, medical group performance, adoption and change management, performance innovation, population health, provider-payor relationships and the translation of strategy into clinical operations. Dr. Werner also leads the Chartis Physician Leadership Group.

- Chair, Board of Directors, American Association for Physician Leadership
- Former Chief Clinical Innovation Officer, Fairview Health Services
- Former President/Chief Physician Executive, Carilion Clinic
- Former Chief Clinical Officer, Medica Health Plan
- Former Member, American Academy of Pediatrics' Committee on Child Health Financing
- Led one of the first accountable care organizations (ACOs)
- National Presenter/Advisor on ACOs, population health, clinical integration, value-based payment and other topics
- B.A. degree, biochemistry, Phi Beta Kappa and magna cum laude, Rice University
- Medical degree, Alpha Omega Alpha honors, Vanderbilt School of Medicine

Accountable Care News: *Are accountable care organizations (ACOs) delivering the value they promised when first introduced? Please discuss their current benefits and challenges since their initiation in 2011.*

Mark Werner: The ongoing ACO experience is very valuable, making important contributions to our understanding of value-based care and how we most appropriately and effectively continue to transform this industry. Actual results—in terms of quality of care, cost of care and patient experience—remain mixed; however, it is clear that improvements in quality outcomes have benefited the most from ACOs' ability to promote evidence-based medicine, manage variation in care across providers and apply data analytics. There is no doubt ACOs are creating some of the strongest improvements in quality outcomes we have ever seen, particularly for those health outcomes included in CMS' ACO measure set.

Reductions in cost of care are considerably more mixed. Most ACOs reduce costs, but not to the target levels desired by CMS and other key stakeholders. This is likely related to the degree in which ACOs understand the key medical expense cost drivers of their patient populations and the rigor with which clinical interventions are deployed. It is important to know the specific risk profile, medical expense drivers and clinical opportunities for improved care in order to address the medical expense trend. Implementing clinical interventions purposefully and with discipline remains a common challenge for ACOs.

ACOs' current benefits stem from their ability to bring clinicians together with accountability for performance, to provide the tools and infrastructure to understand their current clinical variation and gaps and to systematically transform clinical models. ACOs are tremendous learning labs for core capabilities—physician leadership and engagement, data analytics and care management—needed to successfully manage populations of patients. Their greatest challenges center around limited experience of physician leadership and the lack of necessary management structures and resources through which physicians assume accountability and manage care delivery.

Accountable Care News: *What are the main concerns of physicians today—value-based reimbursement, deploying technology, empowering and engaging patients? How well are physicians embracing healthcare transformation?*

Mark Werner: Physicians are finding that the fundamentals of medical practice are changing rapidly and in ways for which they are often unprepared. Physicians have long practiced as "individual contributors" but now, must work in teams, take accountability for outcomes, collaborate with others to establish more rigorous practice standards, embrace new technologies and utilize data and analytics as never before. In many respects, the playing field between physicians and patients is being leveled.

Sufficient data management and insight to create actionable analytics are a must for value-based care. Physicians see technology as both a solution with vast potential and a disruptor of current care models. They're concerned that those driving technology innovations lack sufficient understanding of clinical medicine. And while they understand the rationale for payment reforms, it remains unclear how to navigate the journey from fee-for-service to new payment models without overly disrupting today's medical practice.

(*continued on page 11)*