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Wheels up for accountable care organizations

Suppliers and providers alike have been anticipating the arrival of accountable care organizations, or ACOs, since the Affordable Care Act was signed into law in March 2010. Given the Supreme Court's decision this summer to uphold the law, it's a good bet that ACOs will not only arrive on the scene, but stay here as well.

Accountable care organizations are teams of doctors, hospitals, and other healthcare providers and suppliers that will coordinate and (ideally) improve care for Medicare patients. If an ACO saves money by getting beneficiaries the right care at the right time – for example, by improving access to primary care so that patients can avoid a trip to the emergency room – the ACO can share in those savings with Medicare. ACOs that fail to meet quality standards cannot share in program savings, and over time, will be penalized.

In October 2011, the Department of Health and Human Services announced two initiatives – the Medicare Shared Savings Program and the Advance Payment model – designed to help providers form accountable care organizations. Two months later, in December, HHS named 32 healthcare organizations that will participate in the Pioneer Accountable Care Organization initiative. Then, in May 2012, the Centers for Medicare & Medicaid Services selected the first 27 accountable care organizations to participate in the Medicare Shared Savings Program.

More recently, in July 2012, CMS announced that 88 new organizations had entered into agreements with Medicare to participate as accountable care organizations. The 88 ACOs brought the total number of organizations participating in Medicare shared savings initiatives to 153, including the 32 accountable care organizations participating in the testing of the Pioneer ACO Model, and six Physician Group Practice Transition Demonstration organizations. In all, as of July 1, more than 2.4 million beneficiaries were receiving care from providers participating in Medicare shared savings initiatives, according to CMS.

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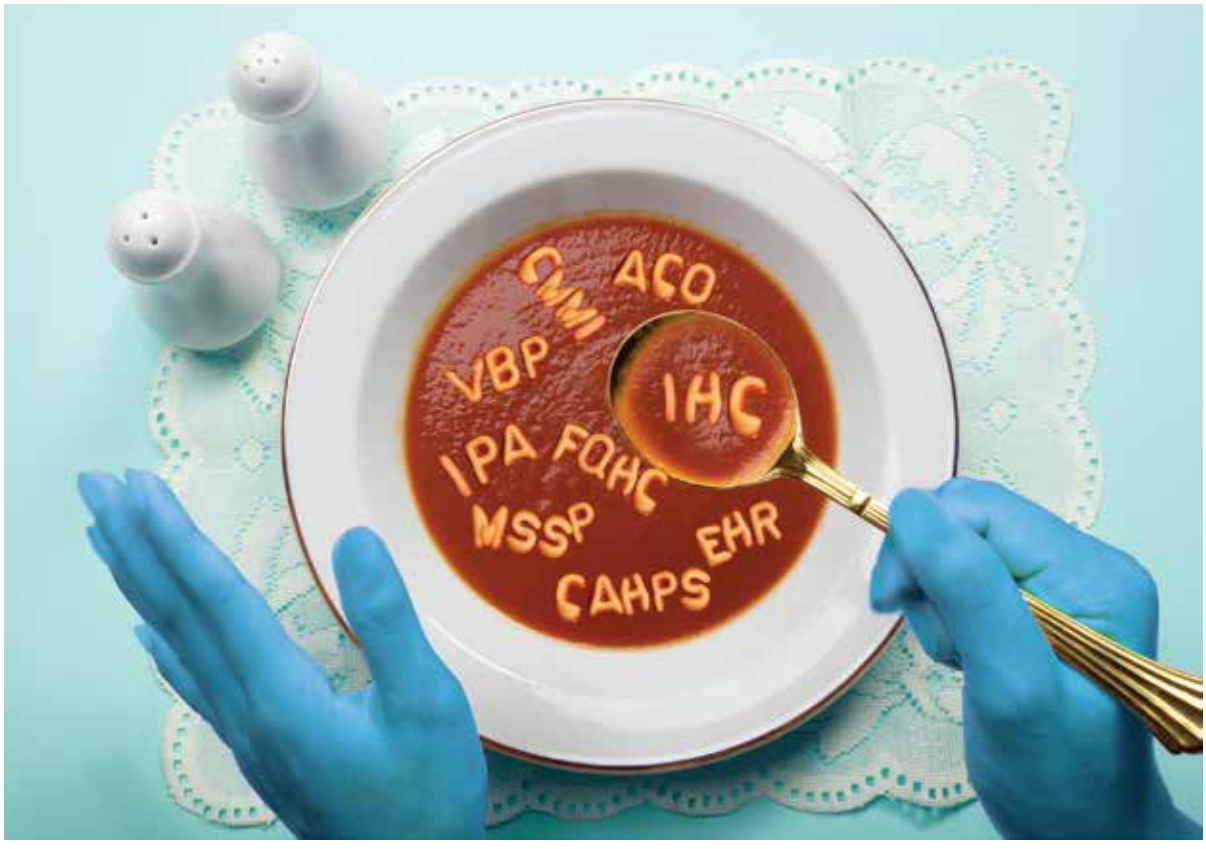

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Wheels in motion

With all the wheels in motion, could the ACO train have been stopped had the Supreme Court overturned the Affordable Care Act? The answer is "no," at least according to two ACO executives with whom the *Journal of Healthcare Contracting* spoke.

"Our work would have continued had the Supreme Court struck down the Act, because of our strong desire to improve quality and reduce costs for our patients [regardless of] what type of coverage they carry," says Rita Potter, director of managed care, The Nebraska Medical Center. The medical center and neighboring Methodist Health System formed the Accountable Care Alliance, an ACO, in January 2010, two months prior to the signing of the Affordable Care Act. "The market pressures are going to continue to push us as providers to be more cost effective," she says. The Accountable Care Alliance stirred interest among supply chain executives earlier this year when it signed a deal with three vendors of cardiac rhythm management devices.

"We started our efforts two years ago, and we had no idea what would happen politically then," says Potter. "The new venture has provided a mechanism and momentum to share best practices together. Had the Supreme Court overturned the entire law, we would have continued, due to the fact that cost and quality pressures are still present in our market from our commercial payers. The [Accountable Care Alliance] still would be a viable option."

"The new venture has provided a mechanism and momentum to share best practices together. Had the Supreme Court overturned the entire law, we would have continued, due to the fact that cost and quality pressures are still present in our market from our commercial payers."

– Rita Potter, director of managed care, The Nebraska Medical Center.

Prepared for any change

Glenn Smith, program manager for Physician Health Partners, a primary-care-based accountable care organization in Denver, Colo., echoes Potter's determination. "Many of the care and quality initiatives in the Affordable Care Act are things we're been working on for quite some time," he says. "We were prepared for many of

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these changes and would have continued to develop new programs either way."

Physician Health Partners collaborates with more than 300 primary care providers, both physicians and midlevel providers, in the Denver metro area, and approximately 600 specialists. For the ACO model, the organization is partnering with two IPAs – Primary Physician Partners and South Metro Primary Care – with the goal of collaborating to improve patient care while lowering associated costs.

"Our organizational mission would not have been affected if the Affordable Care Act had been repealed," says Smith.

"Physician Health Partners has provided patient resources and care management services to the Medicare Advantage population for over 10 years through our longstanding risk contract. The Pioneer ACO has allowed us to utilize our existing clinical programs and physician resources to provide Medicare fee-for-service beneficiaries with the same high quality, well-coordinated care that we have shown lowers the cost of healthcare and decreases duplication of services.

"Because much of our infrastructure existed before the Pioneer ACO, we are now really focusing on adding resources to care for this expanded population and continue to develop programs and resources for patients to receive better health outcomes. In addition, the Pioneer ACO program was already funded and supported by the CMS Innovation Center. We didn't anticipate the program changing based on the outcome from the Supreme Court."

"Because much of our infrastructure existed before the Pioneer ACO, we are now really focusing on adding resources to care for this expanded population and continue to develop programs and resources for patients to receive better health outcomes."

– Glenn Smith, program manager for Physician Health Partners

Quality measures

As a Pioneer ACO, Physician Health Partners will be held accountable to a number of quality measures. "But it's not a new philosophy or initiative for our physicians," says Smith. "When we analyzed our independent practice association quality measures and then added the 'meaningful use' quality metrics for electronic health record systems, we found very few ACO measures that didn't align with at least one of these existing programs. Had the Affordable Care Act been overturned, there may have been two or three fewer metrics for 2012. We anticipate many of the metrics to continue to align across programs.

"We have been making huge strides as a Pioneer ACO by identifying patients across the continuum of care that have gaps in their care and are working to close those gaps to provide them with better care," says Smith. "With the Pioneer ACO structure, it will also allow commercial payers to work more closely with physician groups to improve the healthcare delivery in all populations. We are excited to see what possibilities lay ahead for our company, the physicians and the patients we serve in Colorado." **JHC**

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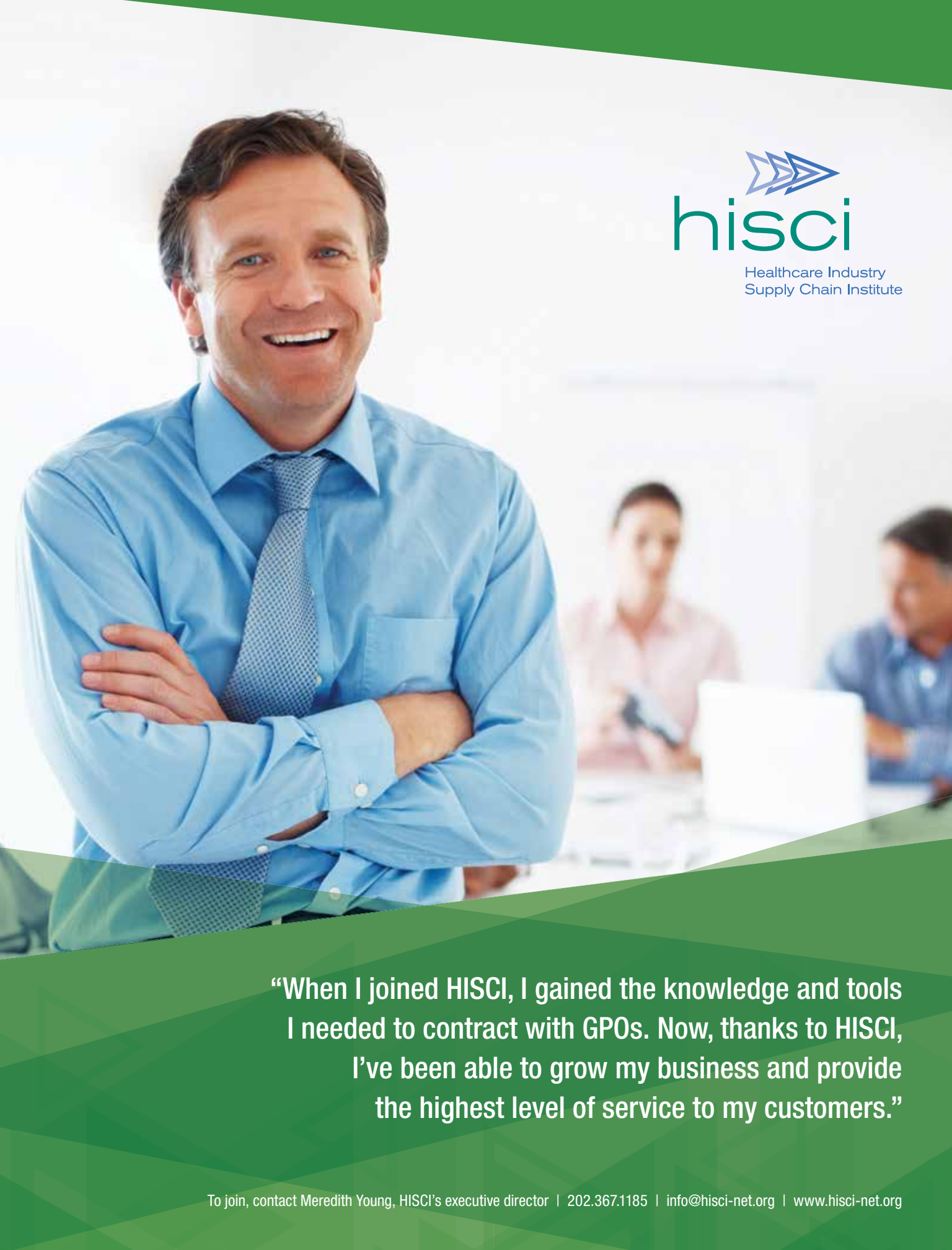
 *Calculations based on these sources; sample calculations available upon request. 1. Computers, Informatics, Nursing: September/October 2009, Volume 27, Issue 5, pages 318-323, Connected Care: Reducing Errors Through Automated Vital Signs Data Upload, Smith, Laura B. MSN, RN; et al. 2. Automated Vital Sign Documentation for Medical Surgical Units: Saving Time and Increasing Accuracy: Fact or Fairytale?, Meg Meccariello, RN MS; Jennifer Johnstone, RN MS, Presented at The Nursing Management Congress 2008 Las Vegas, NV. 3. Vital signs measurement frequency estimates from "Lippincott's Textbook for Nursing Assistants: A Humanistic Approach to Caregiving," Pamela J. Carter, 2007, page 292. 4. Hospital beds (most recent) by country estimates from NationMaster.com, www.nationmaster.com/graph/hea_hos_bed-health-hospital-beds. 5. Population, Source: U.S. Census Bureau, Population Division.

No Stopping NOW

The reform train probably would have kept rolling regardless of how the Court ruled

It's full steam ahead for healthcare reform. But chances are, reform would have moved forward regardless of how the Supreme Court had ruled this summer on the Affordable Care Act, though the pace might have been affected, according to those with whom the *Journal of Healthcare Contracting* spoke. And reform will no doubt continue regardless of what happens in the November election, too, they say, adding there's too much at stake for it to grind to a halt.



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In many ways, the Affordable Care Act, with its many programs, sets the stage for the transition of what the healthcare industry will look like for the next decade, says Keith Kosel, vice president, VHA IMPERATIV™, a program designed to help VHA members manage population health on a broad scale

"Think about the challenges we have today – quality issues and escalating cost," he says. "Those issues are going to be at the forefront regardless of whatever legislation is passed or overturned by the Court, or whatever the election results are in November. The solutions coming forward from the Affordable Care Act – accountable care organizations, the move toward bundled payments, reduction in payment for readmissions and healthcare-acquired infections – those things are likely to have survived any challenge by the Court."

"Think about the challenges we have today – quality issues and escalating cost. Those issues are going to be at the forefront regardless of whatever legislation is passed or overturned by the Court, or whatever the election results are in November."

– Keith Kosel, vice president, VHA IMPERATIV™

As a nation, as much as one-third of our healthcare dollars are spent on care that is unnecessary and even inappropriate, says Kosel. "That's care that's not value-added and, in many cases, actually harmful to the patient. If we were able to address just that one-third of healthcare spending, you could divert those funds to better use.

"We know quality issues are continuing. We know that the escalating trend of healthcare expenditures are soon to become really problematic from an economic standpoint. I don't think you could argue with either of those points, though you might disagree about how prescriptive the solution should be."

As a rule, the Democratic approach is to be more prescriptive, the Republican approach a little more open-ended, he says. "But whether you're Republican or Democratic, we have to get to the same end point in this journey, and that end point is some kind of population health management, coupled with a global/capitated payment model, which would move us away from volume-based [reimbursement]. I think we're all in agreement on that."

True, some of the funding for various programs, such as those emanating from the Centers for Medicare and Medicaid Innovation Center, might have slowed down had the Supreme Court overturned the Affordable Care Act. "But the general direction, the intent, to incentivize hospitals to improve their quality and safety, followed by a stick that would penalize them [for failing to do so], is a process that is going to go forward regardless of who is in the White House or what the Court says. It's a matter of how quickly those programs would come to fruition."

Bipartisan support

"Measures such as hospital value-based purchasing, the creation of Medicare-based accountable care

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"The impact of market consolidation, which is blurring the traditional lines between our acute-care and ambulatory markets," remains one of the most important trends affecting the healthcare community,

– Steve Meyer, President and CEO, Welch Allyn

organizations and national pilots to test the effectiveness of bundled payments are important policy levers that are moving healthcare forward, and each of these enhancements has strong public and bipartisan support," says Blair Childs, senior vice president of public affairs, Premier healthcare alliance. "Similarly, the creation of the CMS Innovation Center and increased investment in the development of quality measures are also necessary to increase transparency, reduce care variation and avoid unnecessary healthcare costs."

But the future of such programs would have been cloudy had the Supreme Court struck down the Affordable Care Act, says Childs.

"The administration asserted that it would do what it could to maintain high-priority pilot [programs] with existing (pre-ACA) demonstration authority and funds," he says. "This would likely have proven difficult, however, with the removal of the $10 billion of funding allocated to the Center for Medicare and Medicaid Innovation and the removal of that agency's authority to implement pilots that are not necessarily budget-neutral at the outset. The administration would have also lost the authority to expand pilots into program-wide policies if they prove successful on cost or quality metrics. The administration did specifically reference the Pioneer ACO program, for example, as a pilot that it intended to continue regardless of the Court's decision."

Future grants and pilot programs would likely have been delayed, perhaps indefinitely, had the Supreme Court struck down healthcare reform, he continues. "The administration suggested it would focus on maintaining existing programs to prevent disruptions. We also believe that, by launching them first, the administration implicitly bestowed higher priority status to the programs already in place."

Market consolidation

"The impact of market consolidation, which is blurring the traditional lines between our acute-care and ambulatory markets," remains one of the most important trends affecting the healthcare community, says Welch Allyn President and CEO Steve Meyer. And there's no doubt that the Affordable Care Act has hastened some of these changes.

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"Payment changes, such as the Medicare Shared Savings Program, Pioneer [accountable care organizations], bundled payments and value-based payments are driving hospitals and physicians to better manage patients across the continuum of care, particularly patients with chronic diseases, frail elders, and high cost/high risk populations. The number of mergers and acquisitions in the healthcare market increased substantially between 2010 and 2011, resulting in the formation of larger integrated systems of care. Acute care systems are purchasing physician practices as a way of better managing patient care, reducing inappropriate admissions and reducing readmissions. From the physician perspective, the administrative burdens of healthcare reform are having a significant impact on their practices."

That said, a decision by the Supreme Court to throw out the Affordable Care Act would have had a significant impact on Welch Allyn and its customers, Meyer believes. "[The Affordable Care Act] has been in place for two years, and it has triggered transformational change in the healthcare market. Increased reimbursement for primary care physicians, insurance coverage for people with pre-existing conditions, and [accountable care organizations] are just a few areas of significant change."

Had the Supreme Court overturned the law, however, "providers' existing feelings of uncertainty would have been compounded, which would have had a detrimental effect on their willingness to invest and innovate," he says. "Having said this, I believe there still remains a high level of uncertainty as [healthcare reform] moves forward.

"There is much change yet to come, and many will still have challenges understanding, implementing and adapting to a new mindset. I believe this is the biggest change to how our healthcare system is managed in a generation."

Had the Supreme Court overturned the law, however, "providers' existing feelings of uncertainty would have been compounded, which would have had a detrimental effect on their willingness to invest and innovate."

'A little chaos, and great opportunity'

"The Supreme Court decision has opened the door to an uptick in activities by hospitals and health systems as they prepare for changes to payment and care delivery models," continues Meyer. "Clinical integration will be a key area of focus, leading to increased activity related to hospital purchases of physician practices and an increased emphasis on physician/hospital alignment.

"Large physician groups, however, will have leverage, and they may prefer to align with large medical groups rather than hospitals. Insurers are already moving more aggressively into care delivery through joint ventures with or acquisitions of hospital systems," continues Meyer.

"Finally, there will be a greater focus on listening to 'the voice of the patient.' It is a time of great change, a little chaos, and great opportunity." JHC

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Whatever works…or doesn't

Studies on the comparative effectiveness of procedures and technologies will continue in wake of Supreme Court's decision.

Comparative effectiveness research, and its cousin, technology assessment, have been around for quite some time. Using these techniques, researchers attempt to find evidence-based answers to the question, "What procedures (and related products) produce the best patient outcomes?" It's a simple question, but answers can be tough to find. Nor is the healthcare community, or lawmakers, always receptive to the findings of such research. The Supreme Court decision this summer to uphold the Affordable Care Act kept the door open to comparative-effectiveness studies; now it's up to the healthcare community to decide where to take them.

One survivor of the Court's decision is the Patient-Centered Outcomes Research Institute, or PCORI. Created by the Affordable Care Act, PCORI is intended to fund research that will provide patients, caregivers and clinicians with the evidence-based information needed to make better-informed healthcare decisions. PCORI has sought to include patients in every step of the process. "Our legacy will include standards for research that anyone can use to address the health outcomes that matter to patients," it says on its website.

PCORI considers its mission to include research that will help patients and caregivers communicate and make informed healthcare decisions. Its research is intended to answer questions such as:

- "Given my personal characteristics, conditions and preferences, what should I expect will happen to me?"
- "What are my options and what are the potential benefits and harms of those options?"

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- "What can I do to improve the outcomes that are most important to me?"
- "How can clinicians and the care delivery systems they work in help me make the best decisions about my health and healthcare?"

"It is, in its own way, a very radical perspective, because almost all of healthcare has been created from a provider perspective," says Jeff Lerner, PhD., president and CEO of ECRI Institute, Plymouth Meeting, Pa. "'These are things we do to and for patients,' and that includes the research end of it. It's quite radical to turn that around and ask, 'What do patients think of all this, and what are their needs?"

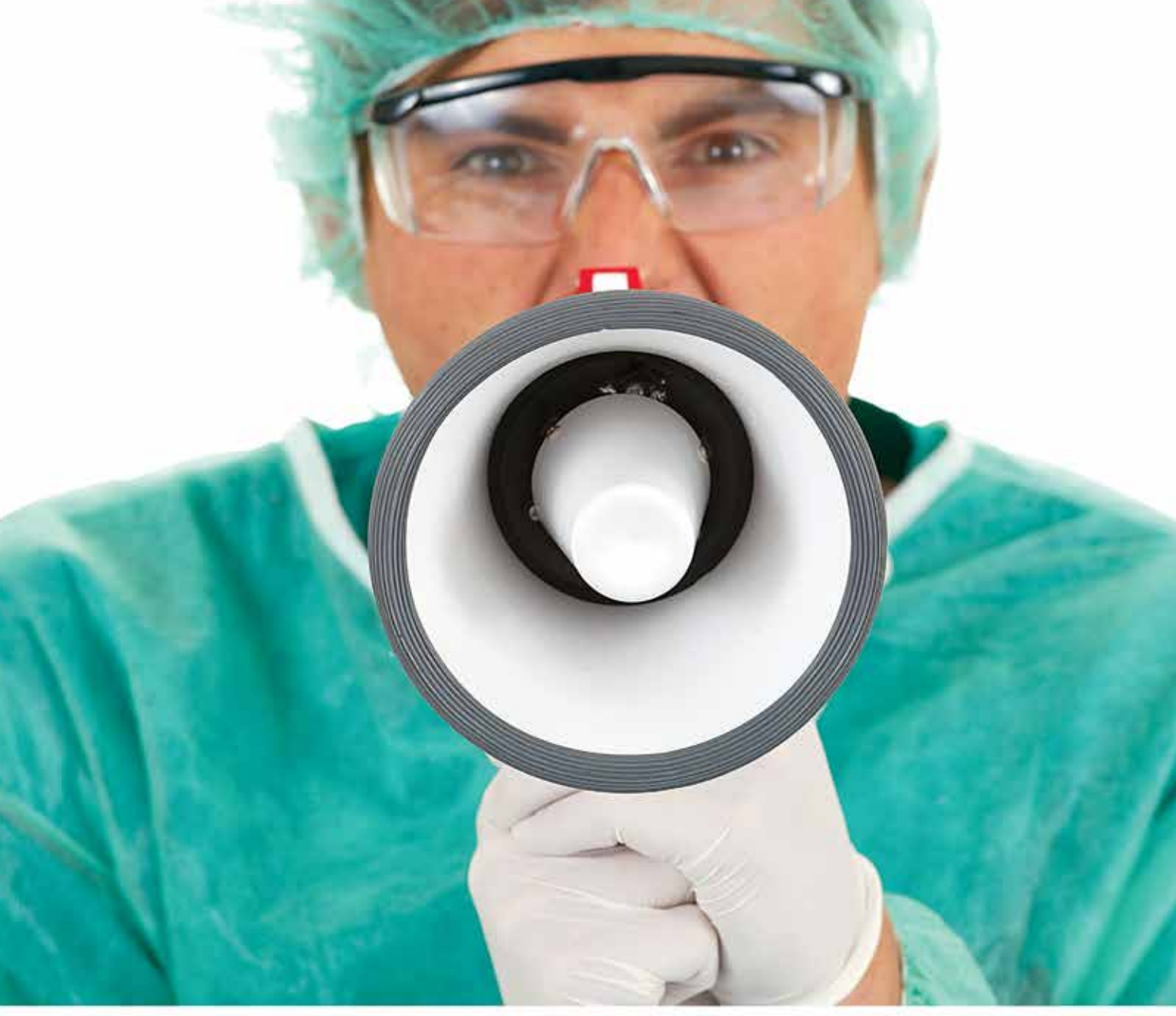
"If you think about patient-centered research, going directly to patients and finding out what matters to them is important."

– Ann-Marie Lynch, executive vice president, health care delivery and payment policy, Advanced Medical Technology Association

To answer these questions, PCORI has pledged to consider in its research people's preferences, autonomy and needs, including their beliefs in and preferences surrounding survival, function, symptoms, and health-related quality of life. It has also pledged to incorporate a wide variety of settings and diversity of participants.

Reflecting [this pledge], PCORI has prioritized five research areas, and is allocating funding to each:

- Assessment of prevention, diagnosis, and treatment options: Comparing the effectiveness and safety of alternative prevention, diagnosis, and treatment options to see which ones work best for different people with a particular health problem.
- Improving healthcare systems: Comparing health system-level approaches to improving access, supporting patient self-care, innovative use of health information technology, coordinating care for complex conditions, and deploying workforce effectively.
- Communication and dissemination research: Comparing approaches to providing comparative effectiveness research information, empowering people to ask for and use the information, and supporting shared decision-making between patients and their providers. Research should take into account the health literacy of individual patients.
- Addressing disparities, that is, identifying potential differences in prevention, diagnosis or treatment effectiveness, or preferred clinical outcomes across patient populations and the healthcare required to achieve best outcomes in each population. Such research would include strategies to overcome barriers (e.g., language, culture, transportation, homelessness, unemployment, lack of family/caregiver support) that may adversely affect patients and is relevant to their choices for preventive, diagnostic and treatment strategies or their outcomes.
- Accelerating patient-centered outcomes



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research and methodological research. Improving the nation's capacity to conduct patient-centered outcomes research, by building data infrastructure, improving analytic methods, and training researchers, patients and other stakeholders to participate in this research.

True to its pledge

Thus far, PCORI has remained true to its pledge to involve patients in its decision-making processes, notes Ann-Marie Lynch, executive vice president, health care delivery and payment policy, Advanced Medical Technology Association, or AdvaMed. Its decision-making processes have been open to the public, via the web and other means.

"If you think about patient-centered research, going directly to patients and finding out what matters to them is important," says Lynch. And what matters to them may go beyond what has currently been considered relevant from a clinical perspective.

Chandra Branham, AdvaMed's vice president, payment and health care delivery policy, points to one hypothetical example offered by PCORI in its proposed methodology report. On the one hand, you have a treatment that can be delivered once a week by injection at the clinic, vs. one that can be delivered in a daily pill by the patient in his or her home. A patient-focused study would consider not just the clinical outcomes related to the injection and the pill, but other factors, such as the logistics of the patient getting to the doctor's office every week.

Traditionally, comparative assessment research looks at Technology X vs. Technology Y, or one technology vs. no intervention at all, says Lynch. And PCORI will conduct such research. "But that's a very small window to look through when you're thinking about patient care," she says. "You can have a great product or drug, but if the patient isn't taking it, or if there's no follow-up care [after discharge from a hospital], their outcome won't be appropriate." That's why PCORI is devoting 20 percent of its funding toward research on improving healthcare systems.

Traditionally, comparative assessment research looks at Technology X vs. Technology Y, or one technology vs. no intervention at all.

PCORI will fund research into other non-clinical issues as well, such as optimum ways to communicate and disseminate research findings. "Many improvements to care never make it out of the research community," points out Lynch. So, PCORI will fund research into the best ways to communicate research to patients and caretakers. In addition, the organization will fund studies on how to address disparities of care, such

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as certain patients' inability to access preventive care or treatments. And PCORI will also fund research into ways to accelerate patient-centered outcomes research.

"From an analytical and overarching perspective, we see this as very positive, because it truly recognizes there are many parts of the overall patient experience [from which] patient-centered outcomes research can benefit," says Lynch. "It's important that PCORI recognizes this, so much so that they have built it into their planning."

More than a bump in the road

Had the Supreme Court overturned the Affordable Care Act and with it, PCORI, the impact would have been significant, if only because of the funding that has been committed to patient-centered outcomes research, says Lerner. It is a field in which ECRI has long been invested, however, he says.

"We pushed for patient-related evidence-based medicine in the early 1990s," he says. "So I would have to say we were an extremely early proponent of the approach." But it hasn't always been a smooth road.

For example, when ECRI questioned the effectiveness of bone marrow transplantation in breast cancer patients in the 1990s, it was criticized from many quarters. "People were so convinced the technology worked, there was not a single controlled study of it," he says.

Technology assessment itself has faced a tough road for several decades, says Lerner. In fact, in the mid-1990s, the Office of Technology Assessment was one of the few agencies that lost its funding, after 23 years of work. "It's a very interesting conundrum, overall, because you think to yourself, 'Why is it so controversial to provide objective, evidence-based information?' What we're doing at ECRI ought to be considered mundane, but it's not."

Had the Supreme Court decision overturned the Affordable Care Act, and with it, PCORI, "you would have been left with more traditional comparative effectiveness research." Granted, traditional research has been moving toward incorporating the patient perspective, though not on the scale of PCORI, he adds.

"We pushed for patient-related evidence-based medicine in the early 1990s. So I would have to say we were an extremely early proponent of the approach."

– Jeff Lerner, PhD., president and CEO, ECRI Institute

All that said, Lerner is cautiously optimistic about PCORI's work. "The results of its first pilot funding look good, but you need to wait and see the actual quality of the research that comes out of it. This is a real first test of the concept. A real field test." And he hopes ECRI will be involved. The organization is applying for funding for research on shared decision-making.

"The real challenges for PCORI lie ahead, despite the Supreme Court decision," he adds. "What you haven't seen yet is, 'How do the various elements of the healthcare community or industry react when the data start to come out?' That's when the rubber will meet the road." **JHC**

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By Robert T. Yokl

Checklists Can Safeguard Your Value Analysis Process Integrity

How to get your VA teamwork done right the first time, every time.

Pilots do it. Surgeon's and architects too. That is employing checklists to ensure the integrity, quality and consistency of their work. Yet, I have not observed even one value analysis team using checklists to safeguard the integrity of their value analysis process – unless they have been trained and facilitated by my firm. Even now that we have value analysis software to automate our client's value analysis process, we still provide them with checklists to make sure there is consistency and reliability built into their value analysis process.

The reason we do this is that no matter how expert you or your VA team members are in your value analysis process, checklists will improve your outcomes. We all tend to veer off course, skip a critical step, or fall asleep at the switch if left to our own devices. Checklists are critically important for your VA project managers for helping them manage the depth, breadth and scope of their projects. I remember one VA project manager who was studying lab reagents and spent weeks visiting other hospitals' labs when there was no reason for her to do so. A checklist would have hopefully put a halt to this excessive behavior.

After a quick search of our library of checklists, I discovered that we have checklists for the selection of VA team members and VA team leaders (5 pages), orientation for new VA team leaders and team members (1 page), VA project managers study guide (8 pages), pre-meeting preparation (1 page), and post-meeting critique (1 page) that we have been

transform

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providing our clients. I see these five checklists as your foundation to ensure your value analysis process integrity. Without a checklist, how would you know if you or your VA team members skipped, took a shortcut or forgot a critical step in your value analysis process?

I remember one VA project manager who was studying lab reagents and spent weeks visiting other hospitals' labs when there was no reason for her to do so. A checklist would have hopefully put a halt to this excessive behavior.

Here are three guidelines for writing your own checklist, based on Dr. Atul Gawande's bestselling book *The Checklist Manifesto*:

1. A checklist is not a set of instructions. The role of a checklist is to help identify and correct common mistakes and critical errors. It isn't meant to be a policy and procedure manual, but instead a set of guideposts to keep you and your VA team members on the right course each and every time.

2. A checklist should be simple, measurable and communicable. It should manage actions and communicate in simple terms that can be measured. For example, in the Understanding Phase of our Value Analysis Funneling™ process we ask our project managers in our VA Project Manager checklist: What are you trying to accomplish? This should immediately communicate the correct response of slowing down and thinking about a clear objective for their value analysis study.

3. Test, re-test and refine your checklist. Measure its efficacy, look for items to cut, and areas to be more explicit. The best checklists are short, concise and understandable.

We all like the freedom to do our own thing. However, if you want to safeguard your value analysis process' integrity you will need multiple lists of "To Do's" for you and your VA team members to note, check and remember in every phase of your value analysis process. This is how you get your VA teamwork done right the first time, every time. **JHC**

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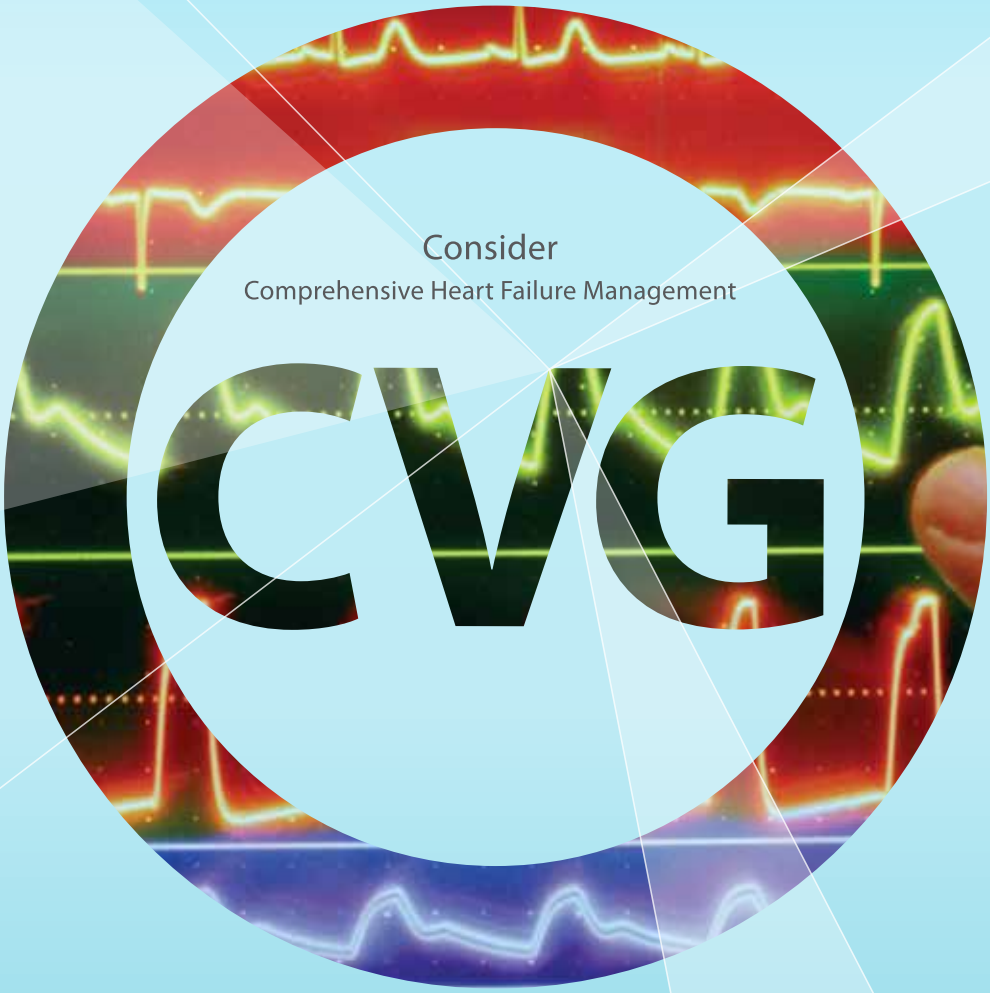

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