Succeeding as an ACO: A 6-Step Guide for Health Care Organizations

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Executive Summary

If you're a health care system, hospital or provider, chances are you feel some pressure to form or join an Accountable Care Organization (ACO). An ACO is a group of doctors and/or hospitals that voluntarily assumes responsibility for the *quality* and the *cost* of health care for a defined population of beneficiaries.

The number of ACOs has risen dramatically in recent years. Some research supports the effectiveness of the ACO model in improving the cost and efficiency of care without sacrificing quality. However, there are important concerns about ACOs, such as questions about whether ACOs are equipped to transform physician behaviors on the scale that will be needed, an ongoing disagreement about clinical quality standards, and concerns about whether that patient participation is voluntary.

No matter how these issues are resolved, the new health care reality demands that providers deliver quality care while controlling costs. Use these six steps to bring success to your organization in the new reimbursement landscape:

1. Understand Your Costs

2. Reduce Out-Migration from Your Network

3. Maximize Pay-for-Performance Reimbursement

4. Identify Early Opportunities for Utilization Reductions

5. Support Chronic Care and Disease Management

6. Predict Who Will Develop Issues

The Rise of Accountable Care

Spurred by the Affordable Care Act (ACA), health care organizations are under pressure to improve the safety, affordability and quality of patient care. More than ever before, providers are expected to deliver value—that is, improved quality with controlled costs—through reductions in overuse.[1]

To shape this transition, the Department of Health and Human Services (HHS) released new rules under the ACA to help doctors, hospitals and other providers better coordinate care in the form of Accountable Care Organizations (ACOs). ACOs provide a framework for rewarding providers—in both the public and private sectors—that ensure that patients, especially the chronically ill, get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors.[2]

The number of ACOs has grown dramatically. As of February 2013, Leavitt Partners' Center for Accountable Care Intelligence estimated that 428 ACOs exist in 49 states, more than double the number at the start of 2011.[3]

Despite their proliferation, especially among physician-led organizations, ACOs are in the early stages of development. There are important, unanswered questions about how to measure quality in an ACO, how to calculate financial rewards for participating providers, and even how to determine the ACO structure will be viable in the long term.

These are serious issues that need to be addressed. However, whether or not your organization decides to enter the ACO space, and regardless of the ACO program's ultimate success, health care organizations must prepare to take on increasing amounts of financial risk. The American Medical Association points out that medical groups and health care organizations "will need to participate in systems requiring more communication, care coordination and quality measurement reporting."[4]

The health care landscape is evolving. As health care shifts towards new payment models, your health care organization should consider a logical progression of six steps, presented here, to successfully navigate the change to come.

What Is an ACO?

ACOs are groups of doctors and/or hospitals that voluntarily assume responsibility for the *quality* and the cost of health care for a defined population of beneficiaries. The payers establish a framework whereby provider groups agree to care for a population of patients with the goal of reaching or surpassing predetermined cost and quality benchmarks. If the ACO manages to meet all the quality benchmarks and the population's cost of care is below the established threshold, the ACO is able to share in all or part of the savings (the difference between the actual cost and the benchmark cost). Some contracts add additional incentives for reaching even higher quality goals.

Figure 1. Health care organizations must prepare for increasing amounts of financial risk
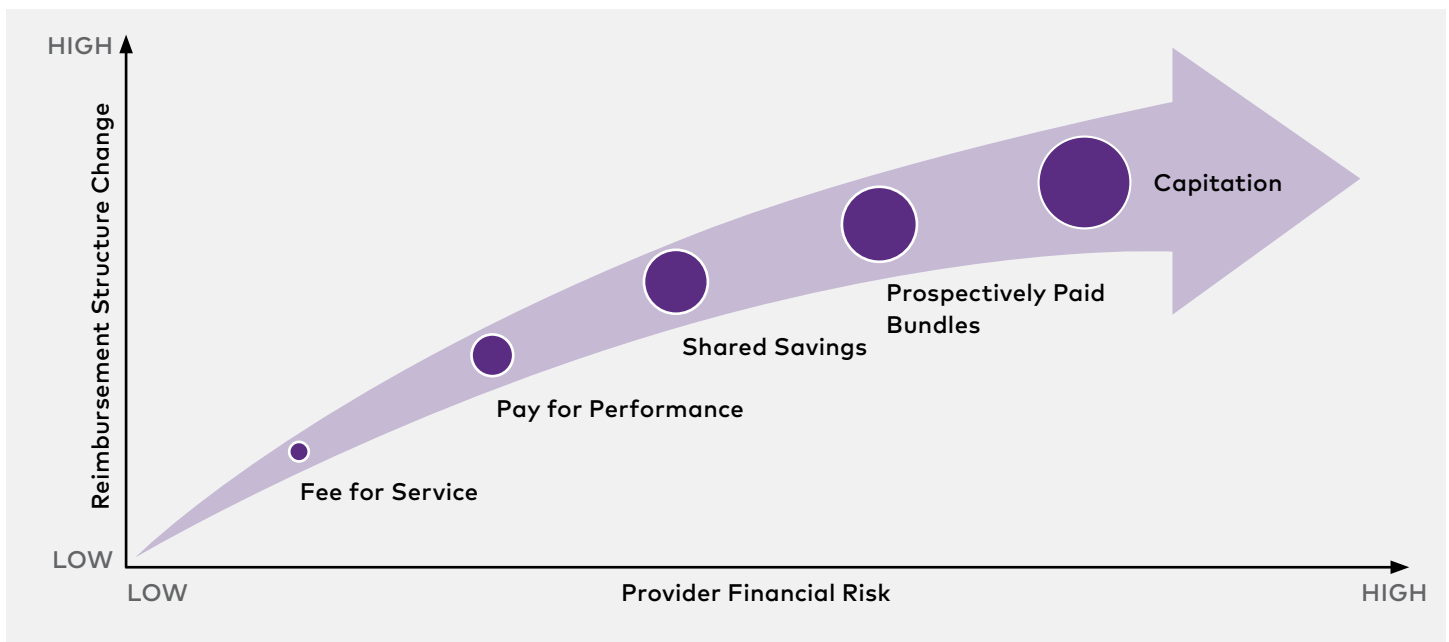
There were 428 ACOs in the U.S. as of February 2013, including both Medicare and private ACOs, and every state but Delaware had at least one ACO.[5]

ACOs have been established by The Centers for Medicare and Medicaid Services (CMS) and by private payers. In either case, providers are eligible for bonuses based on savings and outcomes.

Currently, ACO specifications are flexible enough to accommodate a range of provider organizations, including fully integrated health care systems, multi-specialty group practices, physician hospital organizations and independent physician associations.

ACOs in the public sector

Under CMS, ACOs agree to manage all of the health care needs for a minimum of 5,000 Medicare beneficiaries for at least three years. CMS established 33 quality measures on care coordination and patient safety, appropriate use of preventive health services, improved care for at-risk populations, and patient and caregiver experience of care. Federal savings from this initiative could be up to $940 million over four years.[7]

More than half of the U.S. population lives in areas served by ACOs, according to new analysis by Oliver Wyman. Currently, 52 percent of U.S. patients live in primary care service areas served by ACOs. Additionally, at least 28 percent of U.S. patients live in areas served by two or more ACOs. All together, ACOs now cover 37 million to 43 million Medicare and non-Medicare patients.[6]

The first 32 Medicare ACOs, called "Pioneer ACOs," were announced in 2011 and comprised organizations already operating with coordinated care principles.[8] For the first year, Pioneer ACOs received payments for reporting data on the 33 metrics, including data on how many patients received mammograms or were readmitted 30 days after discharge.[9] In 2012, no payments were linked to clinical outcomes.[10] In 2013, providers were scheduled to move from pay-for-reporting to pay-for-performance, but requested extra time to reexamine the terms under which they would be evaluated.[11]

The Medicare Shared Savings Program (MSSP), designed for organizations new to risk-based reimbursement, rewards ACOs that lower growth in health care costs while meeting performance standards on clinical quality and patient-centered care. To date, the federal government has approved nearly 260 ACOs in the MSSP.[12]

Commercial risk opportunities

Alongside the CMS-backed plans, commercial insurers began offering risk-based contracts for providers. One such program, established long before the CMS initiatives, was the Blue Cross Blue Shield of Massachusetts Alternative Quality Contract (AQC), which served as a model for payment reform. While most commercial risk contracts include similar combinations of quality incentives, shared savings, or full capitation, and small budget adjustments for medical inflation, some have moved to partial capitation (bundled payments), retainer agreements, in-kind services and subsidies provided by payers, or have limited themselves to upside pay-for-performance incentives.[13]

Operating as an MSSP or working with private payers does not require an exclusivity agreement, and many ACOs simultaneously contract with private payers and CMS.[14] Additionally, many state Medicaid programs, either directly through the state Medicaid office or via a Medicaid managed care plan, are negotiating accountable care agreements with providers.[15]

Are ACOs Here to Stay?

Despite the rapid growth of the ACO model and some initial successes, most ACOs are in the early stages of transformation to true accountable care. Many ACOs have begun to evolve their clinical processes, incentive models, and reporting and data infrastructure, but few have transformed all of these areas.

In fact, according to a recent analysis by consulting firm Oliver Wyman, "It is clear that many of the organizations that currently call themselves ACOs fall short of being 'real' ACOs in some respects."[16] For example, this group points out, "[o]f the 89 providers approved as ACOs in the most recent round, only five are taking on both upside and downside risk. The remaining 84 could simply tweak their current models, run as predominantly fee-for-service enterprises, and hope for the best."[17] That is, if these ACOs create any savings, they get to share in them; if not, there's no penalty.

In addition, there are some critical concerns about the ACO program that need to be addressed. These include:

- *ACOs may not be equipped to transform physician behaviors on the scale that will be needed.* In a recent *Wall Street Journal* article, experts wrote that "many proponents of ACOs believe that doctors automatically will begin to provide care different from what they have offered in the past" but that "[s]uch a profound behavior shift would likely require re-education and training."[18] For example, physicians will need to employ evidence-based protocols more often to determine optimal treatment. Doctors will also have to find ways to move some care to lower-cost sites of service, such as more surgeries in ambulatory clinics instead of hospitals.[19] These experts argued that physicians need to be re-educated and retrained to provide care in an ACO, but even after that effort, "the result would be uncertain."[20]

- *Disagreement about documenting clinical quality standards.* Most of the ACO Pioneers disagree with the CMS approach to appraising quality. Their concerns include the lack of data available to determine appropriate quality benchmarks, the setting of flat benchmarks, or using benchmarks higher than standards set in commercial contracts and in Medicaid.[21] Whether this is due to inadequate information technology or insufficient agreement with established standards is unclear, given that the majority of providers in commercial risk in Massachusetts seem to have been successful in similar commercial programs.[22]

- *Concern that patient participation is voluntary, so there's no real incentive for participation.* Under Medicare plans, patients are free to choose providers inside or outside an ACO. This freedom of choice could create problems for ACOs seeking to satisfy financial and administrative requirements.[23] It also reduces the control that an ACO has over patient flow.[24] In addition, patients can opt out of sharing their medical history or claims data with the organization, which can be a detriment to the ACO responsible for their care.[25]

One particular concern is that market consolidation under large hospital-based health systems—including the acquisition of independent and small-practice physicians for the purpose of gaining market influence—is increasingly prevalent. Additionally, smaller practices are often excluded from forming ACOs due to structural impediments such as regulatory bias and staffing constraints.

Despite these important issues, experts studying the ACO movement agree that ACOs are a viable approach for organizations looking to transition to new payment models. For example, the Oliver Wyman report stated that "[w]e cannot ignore how the ACO movement has already earned the confidence of...sophisticated players across the healthcare system. They see more than just a buzz word or an impending government-sponsored trend; they see an attractive bottom line."[26]

"'The growth and dispersion of accountable care organizations continues as the American health care system searches for value,' said Leavitt Partners CEO Rich McKeown. 'While the success or failure of the ACO movement remains an open question, if ACOs meet their quality and cost benchmarks, the ACO model may become the dominant form of health care in the United States over the next decade.'"[27]

Why ACOs Are Important for Your Organization Now

There are three reasons why the ACO model should be on your radar now:

1) Long-standing goals, new tools and flexibility

Efforts to incent providers to address the cost-effectiveness of health care delivery are not new. The concept has been around for decades, in the form of prepaid health plans, health maintenance organizations (HMOs), physician-hospital organizations (PHOs), and independent practice associations (IPAs). However, current ACO initiatives are different from prior efforts in several important respects. See Table 1.

Table 1. ACOs have key differences that could support their ultimate success over earlier models

Historic Cost Containment (e.g., HMOs)	New ACO Model
Focus on prevention and lower utilization	Focus on improved management of chronic conditions and appropriate utilization[28]
Standard structure and governance	Flexible structure and governance
Measures of service utilization drove management and pricing decisions	Physicians are accountable for the outcomes and expenditures of their assigned population and are tasked with collaboratively improving care to reach agreed-upon cost and quality targets
Providers are not rewarded or penalized for meeting quality, and cost targets	Can distribute bonuses when targets are met, as well as levy penalties when targets are missed
Patients required to stay in-network	Patients not required to stay in-network
Held to national benchmarks derived from aggregate data	Rewarded for achieving gains against its own baseline, to help control national spending while taking into account the wide variation in regional populations and practices

One of the biggest differences between today's health care environment and reforms of the past is a greater ability to capture, analyze and share data—especially clinical data. Health information technology (HIT), such as electronic health records (EHR), practice management solutions and other systems, have become more affordable, powerful and simple to use, allowing organizations to track costs and outcomes that directly impact compensation within the ACO. When data is fully accessible across the financial and clinical spectrum, organizations can identify and target patients for outreach, intervene to improve health and reduce utilization, track compliance and performance against contractual quality goals and published guidelines, and support alignment between care and quality managers. This kind of data is essential to the integration necessary for success as an ACO.

2) Increasing physician involvement

Here's another reason you should pay attention to ACOs now: There's been a dramatic change in the structure and governance of new ACOs. First, the number of ACOs launched by non-hospital organizations (IPAs and large medical groups) has increased rapidly. Second, even hospital organizations are including physician-leadership in their ACO governance models.

Physician-led ACOs now outnumber hospital-led ACOs by 202 to 189, according to a new report.[30] These organizations are significant in that, theoretically at least, they can reduce hospital expenses to zero and boost profits without substantially changing their business models. Hospital-organized ACOs must manage decreases in hospitalization more carefully in order to maintain revenue in the face of declining volume.

The Pivotal Role of PCPs

Under the HMO model, primary care providers (PCPs) served as "gatekeepers," limiting access to care. In the ACO model, PCPs provide basic outpatient services and coordinate care for patients who choose to see them. PCPs are also central to the patientcentered medical home (PCMH) concept. PCMH is a method of aligning health plans and providers to create greater value than in the fragmented fee-for-service system.[29]

In the Medscape Business of Medicine 2012 report, only 8% of physicians were either in an ACO or planned to be in an ACO within a year.[31] However, in 2013, 24% of physicians in the study were either in an ACO or planned to be in one in the coming year.[32]

Why the rapid growth in physician-led ACOs? First, as a result of ACA and related guidelines, physicians are under increasing pressure to coordinate care and form ACOs. Second, experts have pointed out that physicians may be able to gain market leadership if they move first into the ACO space.

According to the authors of a *New England Journal of Medicine* article, "If physicians come to dominate [the ACO market], hospitals' census will decline, and their revenue will fall, with little compensatory growth in outpatient services, since physicians are likely to self-refer."[33] However, the authors also point out that in "geographic areas where the physician base is fragmented and physicians are unlikely to collaborate or where there are already well-established hospital-based health systems, hospitals are likely to dominate."[34]

It is too early to determine whether, in the long run, ACOs will be predominantly physician-run or hospital-run, and which will fare better. It is clear, for now, that physicians understand that they must adapt to the changing environment, and they are rapidly entering the ACO market.

3) Early evidence suggests potential for success

Providers, researchers and industry stakeholders have expressed mixed opinions on whether ACOs will achieve their goal of improving quality while lowering costs.

But there is some evidence that the ACO model can be effective.

According to CMS, all 32 Pioneer ACOs earned incentive payments for their first-year reporting accomplishments.[35] In addition, Pioneer ACOs performed better overall than fee-for-service Medicare for all 15 clinical quality measures for which comparable data were available.[36] First-year results also showed that the Pioneers slowed cost increases. On average, costs for the more than 669,000 Medicare beneficiaries in Pioneer ACOs increased by just 0.3 percent in 2012, compared with 0.8 percent growth for Medicare fee-for-service beneficiaries. But only 13 Pioneers produced enough savings to share with CMS—yielding gross savings of $87.6 million in 2012, saving about $33 million for Medicare.[37]

Legal Considerations for ACOs

"Consolidation of health care services within a market carries a high risk of monopolistic behaviors with resulting higher costs and controlled access. On the same day that CMS published the proposed rules for ACOs, the Justice Department and the Federal Trade Commission also published rules that allow a certain level of consolidation and market share for health care organizations."[39]

While early results were promising, nine Pioneers chose not to continue in the program for year two. Seven intended to transition to lower-risk MSSP programs, and the other two planned to leave the Medicare accountable care model entirely. However, these organizations remain committed to improving health care quality and containing cost growth; they simply decided to use their ACO investments for less risky or commercial ACO-like arrangements.[38]

The Commonwealth Fund's study of the Alternative Quality Contract (AQC), launched by Blue Cross Blue Shield of Massachusetts in 2009 also found that global payment programs that combined risk-sharing with pay-for-performance bonuses may be effective at controlling health care spending and improving quality.[40] In the study, 11 participating physician groups (1,600 primary care physicians and 3,200 specialists) achieved average two-year savings of 2.8%.[41] The authors concluded that savings resulted largely from reduced spending for procedures, imaging and lab tests.[42] The greatest savings were from reduced costs for enrolled patients with the highest health risks.[43] Ten of the 11 participating physician groups spent below their 2010 targets, earning a budget surplus payment.[44] And all groups earned a 2010 quality bonus.[45]

A March 2013 Commonwealth Fund report, exploring the experiences of seven ACOs, found that the most advanced ACOs saw reductions or slower growth in health care costs and had anecdotal evidence of care improvements.[46] The ACOs in the report that had been at financial risk long enough to see results have cut costs, primarily from reduced hospitalizations, lower spending per hospitalization and reduced spending on specialty and ancillary care.[47] Newer ACOs lacked enough financial data to cite concrete results, but some saw improvements in utilization rates, such as fewer inpatient days, lower length of stay and greater patient engagement.[48]

Another study, from the Dartmouth Atlas Project and The Dartmouth Institute for Health Policy and Clinical Practice, highlighted the potential benefits of the ACO model for dual-eligible patients (those covered by both Medicare and Medicaid).[49] Looking at the Medicare's Physician Group Practice Demonstration (PGPD), the study found that the participating health systems achieved their savings largely by reducing hospital stays.[50] An accompanying analysis of quality indicators also showed that quality of care did not decline.[51]

Position Your Organization to Succeed as an ACO

As health care organizations consider ACO requirements, many realize that the process of creating or joining an ACO addresses the capabilities they need to thrive in the post-reform environment. Many organizations are shifting from "Should we be an ACO?" to "What should we do to be ready?"[52]

Use the following checklist as a starting point to determine whether you have the level of business and clinical intelligence necessary to succeed in the new health care reality.

Figure 2. Assess ACO readiness: A checklist for health care organizations

Costs

Do we understand the true costs of care for our population?
- We may know how much we are charging, but what about the costs of care delivered outside our organization?
- Do we have access to payer data on the entire population of designated beneficiaries across the continuum?

Which costs can and should we try to reduce?
- Do we have access to data to identify opportunities to lower costs?
- Are there opportunities for new partnerships at lower costs of care?

How will we make this change happen?

Quality

Do we have the ability to track quality measures?
- Do we have access to clinical data, such as lab and test results, medical history, medications, procedures and other information typically found in EHRs?
- Do we have a data set that can be used to benchmark performance and drive improvement?

How will we influence providers on these measures?
- Do we have processes to standardize care and promote evidence-based medicine?
- How will we establish appropriate incentives for providers in the group?

What tools do we have to engage patients?
- Do we have services like a 24-hour nurse hotline, expanded urgent care and next-day appointments?
- How will we engage patients through annual wellness visits, patient portals and shared decision making?

Do we have the capability to share and access clinical and financial data outside the organization?

Does our organization's culture support physician alignment and leadership?

ACOs: 5 Questions and Answers for Independent Practices

Question #1:

Q: Do we have to join an ACO in order to stay in business?

A: Probably not. However, it may be difficult in some regions to negotiate better payer rates without participating in new incentive-based contracts. The American College of Physicians, the American Medical Association and other professional groups have been encouraging practices to look into creating ACOs and becoming leaders in reform. However, patients can choose to see any provider, and your long-term patients will probably stay with you no matter what you decide about the ACO model. If you want to participate in an ACO, but not sell your practice, consider joining, or starting, an IPA affiliated with a local ACO.
(Source: American Academy of Family Physicians. FAQs about ACOs.)

Question #2:

Q: How can we make ourselves attractive to ACOs that are forming?

A: Primary care practices should consider the patient-centered medical home (PCMH) as an essential component of any ACO. Primary care provides access, disease prevention, disease management and care coordination services that leverage overall cost savings for the system. According to the American Academy of Family Physicians, "Moving your practice to the PCMH model is a great way to assure that you can demonstrate both quality and efficiency to any ACO in your community seeking primary care services."
(Source: American Academy of Family Physicians. FAQs about ACOs.)

Specialists (especially independent specialty practices) should determine how they can demonstrate value to ACOs and partner with them to lower the overall cost of care. For example, moving procedures from the hospital to the office or an ambulatory surgery center (ASC) represents startling opportunities for ACOs to reduce the cost of care. Independent practices should ask if their EHR is sufficiently "wired" to participate in meaningful care coordination. Is turnaround time on consultations acceptable? Are you able to return consults and procedure reports in electronic form? Are you able to capture and demonstrate the quality of the specialty-based care you provide?

Question #3:

Q: How can we take advantage of risk-based reimbursement models without joining an ACO?

A: In the short term, good coding and billing procedures and attention to accounts receivable are critical. Longer term, you should be making changes and installing the systems suggested by the PCMH model so that you can respond quickly as incentives change.

Question #4:

Q: How can we avoid making costly investments in health care information technology (HIT) that won't work in the ACO model?

A: Your practice needs HIT solutions that give providers the right information at the right time, don't require large up-front expenses, allow for choice and independence and enable interoperability in the event there are other entities to collaborate with. Cloud-based, service-model solutions can meet these kinds of requirements. Cloud-based HIT systems are strong enablers of interoperability among a wide range of systems because: (1) all information is stored in a secure site and accessed via the Internet, (2) the cloud vendor can provide a care management system to harmonize data from multiple sources (e.g., EHRs, practice management, stand-alone HIE platforms), and (3) creating interfaces for participating providers is more cost effective, since an electronic connection only needs to be built once from the cloud architecture to each trading partner. Cloud-based solutions enable a single source of truth for appropriate users on the network. Providers can choose the EHR that works best for them while benefitting from true integration with vendors, partners and others in the network.

Question #5:

Q: If we join an ACO, what changes should we be prepared for?

A: In an ACO, providers' attention must shift to the management of *all patients across the entire spectrum of health*. This will be a major transformation for most physicians. For example, providing patient-centered care might translate into extended hours, open-access scheduling and the opportunity to request refills and appointments online. ACO-related initiatives will require changes in staffing, staff roles and clinician workflow and scheduling. According to the American Medical Group Association, "[t]o effectively manage population health, practices must reengineer their workflow and adopt health IT automation tools that will enable them to reach out to patients who need services, and keep track of their population in the most efficient way."
(Source: American Medical Group Association.)

A Tactical Approach to ACO Success

Once you have assessed your readiness for an ACO-like payment structure, there is a logical flow of steps to move through to attain ACO success.

1. Understand your costs

Understand your total medical expenditure (TME) and cost drivers across your population of patients under contract. Relying on payers to report costs and quality to providers is insufficient. Access to payer claims-based data is essential to understanding the total cost of care delivered by providers inside and outside the ACO, and to accurately attribute the costs of interventions to rendering providers.

2. Reduce out-migration from your ACO network

Pay yourself, rather than a competitor, for care you can provide. It makes no sense for your ACO to pay a competitor for services you can provide. While it is unlikely your ACO *can* provide everything to your beneficiaries, make every effort to reduce "leakage" of services you can perform. For example, establishing or increasing after-hours care can go a long way to reducing ED visits. Understanding where costs are high outside your network may reveal opportunities for new lines of business, or the establishment of new contractual relationships. Providing cost and quality transparency to providers in your ACO will help them make the best decisions for patient care.

3. Maximize pay-for-performance reimbursement

Monitor your population directly against contracts and get every dollar available by closing gaps in care. Depending on the payer contract, pay-for-performance will be either "upside" (higher rewards for better care) or "downside" (declining or no reimbursement at the end of the contract year). Proper screening of and managing the primary health needs of a patient population saves money by keeping chronic diseases in check and by helping patients avoid expensive hospital or emergency room visits. You should identify a vendor that can support your ACO with the tools and knowledge necessary for complete reporting, tracking and benchmarking of your financial and clinical performance. You'll need to know where you're doing well, and where you can improve.

4. Identify early opportunities for utilization reductions

Target reductions where there are clear opportunities for savings. Under new contracts, 30-day readmissions, the occurrence of "never events" in hospitals and the development of complications are increasingly uncompensated. Gaining control of and reducing these events is critical to reducing needless expenditures. It also makes sense to reduce durable medical equipment expense by utilizing lower-cost suppliers. In situations where you must refer patients to out-of-network services, utilizing higher-quality, lower-cost providers is essential. Physician-led ACOs may benefit from reducing inpatient utilization and partnering with a hospital that can give them attractive financial terms.

5. Support chronic care and disease management

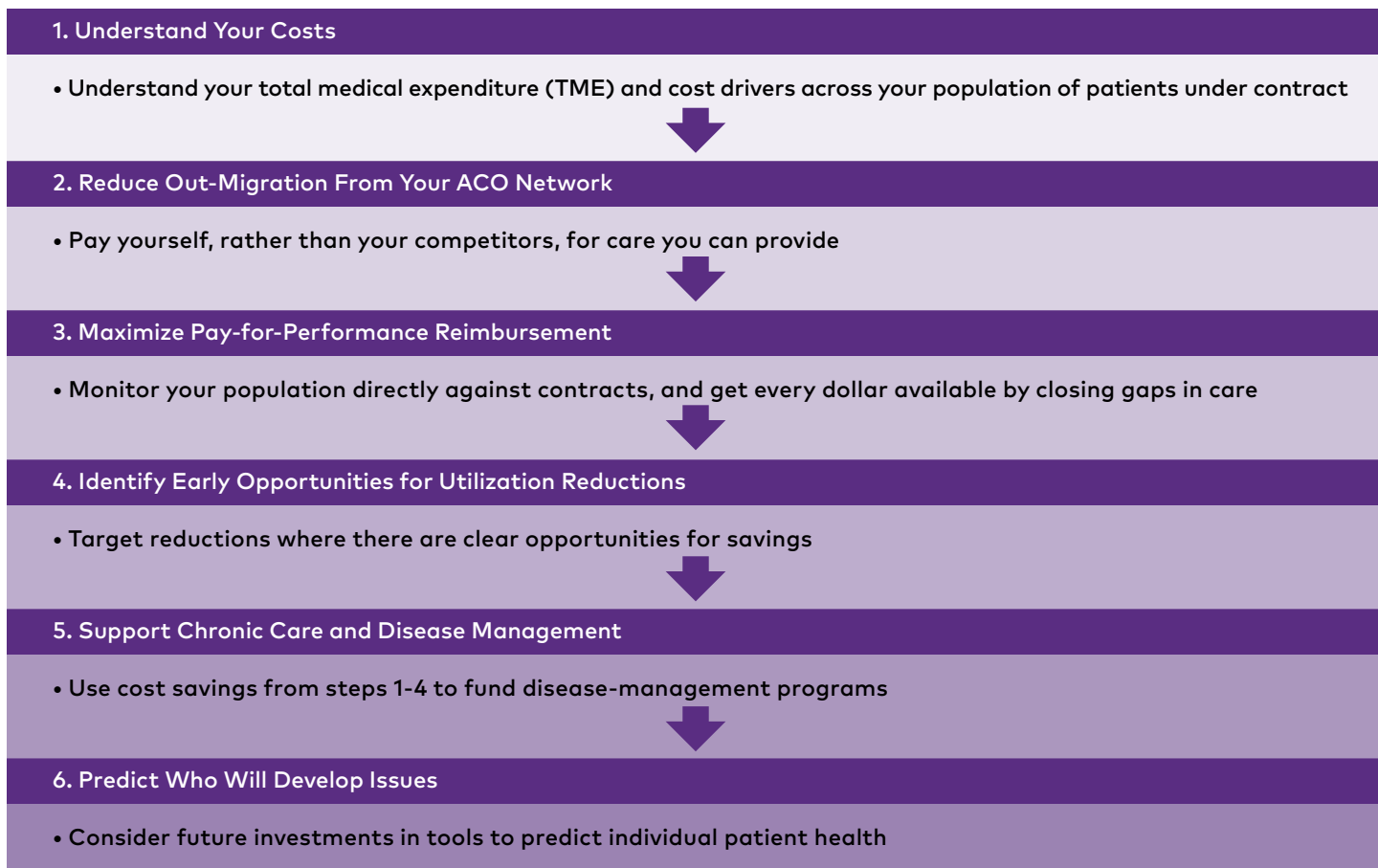**Use cost savings from steps 1 through 4 above to fund disease management programs.** The establishment of care-management or disease-management programs can be an expensive proposition, and the cost reductions obtained through these efforts frequently take years to accrue. If disease management is part of your strategy, fund these initiatives through cost reductions from the steps above first. Once care management is implemented, it is essential to target patients with meaningful opportunities for cost reduction. For example, the vast majority of diabetic patients will not contribute to substantial costs, so diabetes programs should be targeted at patients who are heavy users of ED or hospital services. Conversely, substantial costly programs aimed at patients in the pre-terminal stages of chronic illness are rarely successful at reducing costs. Many of these patients would be better served by appropriate referral to hospice care.

6. Predict who will develop issues

Consider future investments in tools to predict individual patient health. The current market for population tools emphasizes predictive analytics to identify patients who will develop issues and require higher spending. Purchasers looking for population health tools commonly confuse risk-adjustment (the normalizing of costs and outcomes based on the number and severity of co-morbid conditions) with predictive analytics. Predictive analytics is an emerging field of big data, utilizing complicated algorithms and statistics. While it is essential to utilize risk adjustment to compare providers and determine budgets, the ability to predict outcomes on a per-patient basis is in its infancy and is unlikely to lead to substantial improvement in outcomes or reduction in expenses. Mature ACOs that have gained control of items 1 through 5 above may justify a pilot of predictive analytics. However, until these tools are better-tested, their benefit remains unproven and unlikely to justify the expense.

Figure 3. Six tactics for ACO success

1. Understand Your Costs

- Understand your total medical expenditure (TME) and cost drivers across your population of patients under contract

2. Reduce Out-Migration From Your ACO Network

- Pay yourself, rather than your competitors, for care you can provide

3. Maximize Pay-for-Performance Reimbursement

- Monitor your population directly against contracts, and get every dollar available by closing gaps in care

4. Identify Early Opportunities for Utilization Reductions

- Target reductions where there are clear opportunities for savings

5. Support Chronic Care and Disease Management

- Use cost savings from steps 1-4 to fund disease-management programs

6. Predict Who Will Develop Issues

- Consider future investments in tools to predict individual patient health

Moving Forward: Do You Have the Right Tools?

Having strong HIT and electronic health records (EHR) systems is the backbone of providing coordinated, accountable care; data ties into every aspect of ACOs, from categorizing high-risk patients to collecting patient data to tracking health improvements.[53] However, having an effective, sustainable HIT solution requires more than just data reporting. *To succeed, you need actionable insight into your financial performance and your population's health.* Without clear visibility across your network—and the ability to influence behavior at the point of care—revenue goals and care outcomes become increasingly difficult to achieve.

Therefore, when selecting or upgrading your information technology, including an EHR system, it is essential to judge that technology on two principles. First, does the technology support *clinical process improvement*? Does it support delegation of care across care teams? Does it support streamlining workflow within the practice? Does it "wire" your practice to the ACO and other trading partners? Does the system integrate well with other platforms?

Second, does your HIT help improve *clinical effectiveness*? Is data on gaps in care available to clinicians, and are those gaps addressed directly in the clinician's workflow to ensure success?

To progress through the tactics for ACO success, your organization needs HIT solutions that:

- Insert quality measures into the clinical workflow—where staff can act on them at the point of care;

- Align and engage providers across the spectrum of clinical, technical, cultural and financial coordination;

- Are nimble enough to change as quickly as the health care industry, crossing the chasm between fee for service and risk, and resulting in success under any future payment scenario;

- Have long-term economic sustainability; and

- Appropriately engage patients in their own care.

Cloud-based services and software offer the most cost-effective, flexible and robust solutions for hospitals and health care organizations moving toward true accountable care. A cloud-based services vendor offers a combination of software, networked knowledge and back office support with low up-front costs. What's more, this kind of solution can quickly adapt to future payment models and many other changes to come.

> A three-pronged approach to health IT— software, knowledge and work—is the hallmark of a co-sourced, cloud-based service.

Cloud-based services can help your organization:

Coordinate care across the ACO

Cloud-based software provides an easy-to-use framework to manage and ensure consistent workflows, from scheduling patient encounters to billing and order management. Since a single instance of software exists in the cloud, the vendor can make regular updates to the network instantly available to all clients. This rapidly effects change and drives results by offering a single source of "truth" including:

- A central source of revenue-cycle knowledge

- Key performance indicators by location, department or role

- Population health tools, such as identification of cohorts to be targeted for outreach

Continually updated, cloud-based services also make it easy for providers to do business with your facilities. They get an instantly updated, streamlined order process, you get full visibility into order patterns, and patients get a better experience. That's because the cloud offers a single, shared instance of software that is continually updated.

Ensure appropriate measurement and reporting of financial and clinical data

Since the cloud enables interoperability across different systems, a cloud-based services vendor can provide services that track compliance and performance against contractual quality goals and published guidelines—by patient, provider or practice. The cloud can normalize all payer data sources into standardized service categories so that you can see trends over time and against budget. It can also

integrate data from disparate EHRs to support alignment between care and quality managers. This will help transform your population health data into a single source of actionable insight, with a consolidation of clinical and claim data from across your network.

Support patient engagement and satisfaction

Cloud service providers can build patient web portals for your ACO, improving patient communication by giving patients the ability to request appointments, view and update their personal information, request prescriptions, receive test results and read patient education material suggested by you–all instantly and securely. When patients are empowered to do more, they can make better decisions and have higher satisfaction with their care.

Add intelligence without cost

The cloud-based network's services and software are infused with continually updated intelligence. That means fresh information is embedded directly into the user's workflow. Without added cost, your organization has access to expert research to capture new revenue opportunities, along with industry benchmarks and best practices, which help your enterprise to run at its full potential. The collective knowledge amassed in the cloud gives health care organizations instant access to the latest payer and clinical rules. You get better visibility and transparency into business processes, with targets for improving your organization's workflows and cash flows, translating into increasing value over time.

Be prepared for the future

The element of co-sourced, cloud-based services that offers the most value is the "work" component. That is, the cloud-based vendor can offer built-in, behind-the scenes support to research and anticipate changes, such as Meaningful Use Stages 2 and 3, the conversion from ICD-9 to ICD-10, and 16 million new beneficiaries in Medicaid by 2019[54] —all without extra cost. It has the people and processes already in place to optimize collections, eliminate workflow inefficiencies, aggregate disparate data, and provide deep visibility into your business processes, clinical activity and referral patterns. Your organization has access to expert research to capture new revenue opportunities, along with industry benchmarks and best practices, which help your organization to run at its full potential. You get better visibility and transparency into business processes, with targets for improving your organization's workflows and cash flows, translating into increasing value over time.

New Models, New Perspective

athenahealth is a company focused on making health care work as it should. athenahealth's flexible, cloud-based services deliver real-time clinical and financial visibility, a requirement in today's evolving health care landscape.

With a proven integrated health care solution, we help you realize your strategic vision and thrive in a rapidly changing environment. You get seamless integration across your care community—easily scaled for your growth.

The challenge of transitioning to an ACO requires leaders to shift to "network" strategies that address the entire continuum of care: identifying and targeting patient populations, achieving clinical integration across your network and leveraging data no matter where it lives in your care community. To succeed, you need actionable insight into your financial performance and your population's health. Without clear visibility across your network—and the ability to influence behavior at the point of care—revenue goals and care outcomes become impossible to achieve.

About athenahealth

athenahealth is a leading provider of cloud-based, Best in KLAS* electronic health record (EHR), practice management, and care coordination services to medical groups and health systems. Our mission is to be the most trusted service to medical caregivers, helping them do well by doing the right thing. To learn how our services can help your organization, contact us at 866.817.5738 or athenahealth.com/hospitals.

athenaOne℠

Increase your network's productivity with our integrated suite of cloud-based services, helping improve performance while keeping providers focused on patient care. athenaOne includes our Best in KLAS practice management and EHR services, plus a comprehensive patient communications solution. With our cloud-based software, networked knowledge, and back-office service teams that take on practices' most burdensome work, athenaOne improves every step of the workflow. Providers stay up-to-date and prepared for every industry change, from ICD-10 to Stage 2 Meaningful Use.

* Practice management (1-10 physicians & 11-75 physicians); and ambulatory EHR (1-10 physicians), as reported in the 2012 Best in KLAS Awards report.

Endnotes

1. Alice G. Gosfield, J.D. Making Clinical Integration Work. *Medical Economics.* June 25, 2011. Available at: http://medicaleconomics.modernmedicine.com/news/making-clinical-integration-work.

2. Centers for Medicare & Medicaid Services. Accountable Care Organizations (ACO). Available at: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ACO/index.html?redirect=/aco/.

3. Leavitt Partners. (2013, February 20). Accountable Care Organizations have more than doubled since 2011. Available at: http://leavittpartners.com/2013/02/accountable-care-organizations-have-more-than-doubled-since-2011/.

4. American Medical Association. Accountable care organizations. Available at: http://www.ama-assn.org/ama/pub/physician-resources/practice-management-center/practice-operations/business-models/accountable-care-organizations.page.

5. Leavitt Partners. (2013, February 20). Accountable Care Organizations have more than doubled since 2011. Available at: http://leavittpartners.com/2013/02/accountable-care-organizations-have-more-than-doubled-since-2011/.

6. Oliver Wyman. http://www.oliverwyman.com/media/ACO_press_release(2).pdf

7. Centers for Medicare & Medicaid Services. (2013, January 10). More doctors, hospitals partner to coordinate care for people with Medicare. Available at: http://www.cms.gov/apps/media/press/release.asp?Counter=4501&intNumPerPage=10&checkDate=&checkKey=&srchType=1&numDays=3500&srchOpt=0&srchData=&keywordType=All&chkNewsType=1%2C+2%2C+3%2C+4%2C+5&intPage=&showAll=&pYear=&year=&desc=&cboOrder=date.

8. Kliff, S. (2013, March 6). Hospitals want to delay a key Obamacare program. *Washington Post.* Available at: http://www.washingtonpost.com/blogs/wonkblog/wp/2013/03/06/hospitals-want-to-delay-a-key-obamacare-program/.

9. Ibid.

10. Ibid.

11. Ibid.

12. Japsen, B. (2013, February 18). Half Of U.S. Patients Can Access Obamacare's 'Accountable Care Organizations'. Available at: http://www.forbes.com/sites/brucejapsen/2013/02/18/half-of-u-s-patients-can-access-obamacares-accountable-care-organizations/.

13. Muhlestein, D. (2013, February 19). Continued growth of public and private accountable care organizations. *Health Affairs Blog.* Available at: http://healthaffairs.org/blog/2013/02/19/continued-growth-of-public-and-private-accountable-care-organizations/.

14. Ibid.

15. Ibid.

16. Gandhi, G. & Weil, R. (2012). The ACO surprise. Oliver Wyman. Available at: http://www.oliverwyman.com/media/OW_ENG_HLS_PUBL_The_ACO_Surprise.pdf.

17. Ibid.

18. Christensen, C., Flier, J. & Vijayaraghavan, V. (2013, February 18). Christensen, Flier and Vijayaraghavan: The coming failure of 'accountable care'. *The Wall Street Journal.* Available at: http://online.wsj.com/article/SB10001424127887324880504578296902005944398.html.

19. Ibid.

20. Ibid.

21. Kliff, S. (2013, March 6). Hospitals want to delay a key Obamacare program. Washington Post. Available at: http://www.washingtonpost.com/blogs/wonkblog/wp/2013/03/06/hospitals-want-to-delay-a-key-obamacare-program/.

22. See Song, Z., Safran, D.G., Landon, B. E. Landrum, M.B., He, Y., Mechanic, R.E. et al. (2012). The 'Alternative Quality Contract,' based on a global budget, lowered medical spending and improved quality. *Health Affairs.* Published online July 11, 2012. Available at: http://mn.gov/health-reform/images/The-Alternative-Quality-Contract-HealthAffairs.pdf.

23. Medical Society of Virginia. (2012, February). Accountable care organizations: What physicians need to know. Available at: http://www.msv.org/MainMenuCategories/Advocacy/Health-Reform-Federal-Issues/Health-Reform-Federal-Issues/Accountable-care-organizations-QA--.aspx.

24. Ibid.

25. Christensen, C., Flier, J. & Vijayaraghavan, V. (2013, February 18). Christensen, Flier and Vijayaraghavan: The coming failure of 'accountable care'. *The Wall Street Journal.* Available at: http://online.wsj.com/article/SB10001424127887324880504578296902005944398.html.

26. Gandhi, G. & Weil, R. (2012). The ACO surprise. Oliver Wyman. Available at: http://www.oliverwyman.com/media/OW_ENG_HLS_PUBL_The_ACO_Surprise.pdf.

27. Leavitt Partners. (2013, February 20). Accountable Care Organizations have more than doubled since 2011. Available at: http://leavittpartners.com/2013/02/accountable-care-organizations-have-more-than-doubled-since-2011/.

28. Nielsen, E. & Smith, J. (2011, June 9). Top 10 clinical integration, ACO physician questions. The Camden Group for HealthLeaders Media. Available at: http://www.healthleadersmedia.com/page-3/PHY-267181/Top-10-Clinical-Integration-ACO-Physician-Questions.

29. Nielsen, E. & Smith, J. (2011, June 9). Top 10 clinical integration, ACO physician questions. The Camden Group for HealthLeaders Media. Available at: http://www.healthleadersmedia.com/page-3/PHY-267181/Top-10-Clinical-Integration-ACO-Physician-Questions.

30. Pittman, D. (2013, April 14). More Docs Joining Forces in ACOs. MedPage Today. Available at: http://www.medpagetoday.com/MeetingCoverage/ACP/38440.

31. Medscape News Today. Physician Compensation Report: 2013. Available at: http://www.medscape.com/features/slideshow/compensation/2013/public.

32. *Ibid.*

33. Kocher R. & Sahni, N.R. (2010, December 10). Physicians versus hospitals as leaders of accountable care organizations. *New England Journal of Medicine*, 363:2579-2582. Available at: http://www.nejm.org/doi/full/10.1056/NEJMp1011712.

34. *Ibid.*

35. Centers for Medicare & Medicaid Services. (2013, July 16). Pioneer Accountable Care Organizations succeed in improving care, lowering costs. Available at: http://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-Releases/2013-Press-Releases-Items/2013-07-16.html.

36. *Ibid.*

37. *Ibid.*

38. Leventhal, R. and Hagland, M. (2013, July 16). Nine ACOs to leave the Pioneer program. Healthcare Informatics. Available at: http://www.healthcare-informatics.com/news-item/breaking-news-nine-acos-leave-pioneer-program.

39. American Academy of Family Physicians. FAQs about ACOs. Available at: http://www.aafp.org/practice-management/payment/acos/faq.html.

40. See Song, Z., Safran, D.G., Landon, B. E. Landrum, M.B., He, Y., Mechanic, R.E. et al. (2012). The 'Alternative Quality Contract,' based on a global budget, lowered medical spending and improved quality. *Health Affairs*. Published online July 11, 2012, at 7-8. Available at: http://mn.gov/health-reform/images/The-Alternative-Quality-Contract-HealthAffairs.pdf.

41. *Ibid.* at 2.

42. *Ibid.* at 7.

43. *Ibid.* at 4.

44. *Ibid.* at 7.

45. *Ibid.*

46. Silow-Carroll, S. & Edwards, J.N. (2013, March). Early adopters of the accountable care model. The Commonwealth Fund at 3. Available at: http://www.commonwealthfund.org/~/media/Files/Publications/Fund%20Report/2013/Mar/1673_SilowCarroll_early_adopters_ACO_model.pdf.

47. *Ibid.* at 19.

48. *Ibid.*

49. Colla, C.H., Wennberg, D.E., Meara, E., Skinner, J.S., Gottlieb, D., Lewis, V.A., et al. Spending differences associated with the Medicare Physician Group Practice Demonstration. *JAMA*. 2012;308(10):1015-1023, 1019-20.

50. *Ibid.* at 1020.

51. *Ibid.*

52. The Cornerstones of Accountable Care. Available at: http://www.healthleadersmedia.com/content/256694.pdf.

53. Punke, H. (2013, March 15). 3 ACO Readiness Strategies. Becker's Hospital Review. Available at: http://www.beckershospitalreview.com/hospital-physician-relationships/3-aco-readiness-strategies.html.

54. The Kaiser Family Foundation. (2010, August). Explaining health reform: Benefits and cost-sharing for adult Medicaid beneficiaries. Available at: http://www.kff.org/healthreform/upload/8092.pd

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