

MEMO TO-----OHPB: Public Testimony
FROM*-----Mike Saslow, Ph.D. 
SUBJECT**----Serious Concerns About the Pace of CCO Development
DATE-----Tuesday, October 11, 2011

As the legislative session approaches, I am becoming pessimistic. Here are my observations and impressions, after attending every meeting of every transformation work group:

1. Members of the four transformation work groups are not familiar with the plans of the Governor's HITOC (Health Information Technology Oversight Commission) for HIT (Health Information Technology) and HIE (Health Information Exchange).
2. Members of the four work groups are not aware of how vital system-wide HIT and HIE are for effective CCO implementation. As a member of the HITOC Consumer Advisory Panel, I hope that OHPR will aggressively close this gap.
3. Members of the four work groups have not been presented with a parallel column comparison of CCOs and MCOs, nor have local groups seeking to become CCOs been provided with such important guidance.
4. Many of the local entities seeking to become CCOs are attempting to do so on the backs of existing already overloaded staff, without an explicit and adequate budget commitment to cover appropriate temporary staff and/or consultants for finance, systems redesign, and continuing professional education.
5. An important and persuasive warning article (attached) recently appeared in JAMA. Realistic development of CCOs would be facilitated if OHPR were to require, of each local group seeking to become a CCO, a prompt and detailed narrative response addressing each of the ten explicit potential pitfalls. Otherwise, they are planning in a vacuum and are at high risk of failure.

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**Context: Year Two Biennial Budget assumes substantial savings from effective CCO implementation July 1, 2011. That is what the Governor and Legislature are expecting and counting on. There's lots of work to do!

ONLINE FIRST

Implementing Accountable Care Organizations Ten Potential Mistakes and How to Learn From Them

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ACHIEVING THE TRIPLE AIMS—HIGHER-QUALITY patient-centered care, improving population health, and moderating per capita costs—will require fundamental change in the US health care system.¹ Accountable care organizations (ACOs) as outlined in the Affordable Care Act represent an early initiative in restructuring health care.² Accountable care organizations accept responsibility for the cost and quality of care for defined patient populations. Under the Medicare shared savings program, ACOs will face expenditure targets based on their previous 3 years of Medicare Part A and Part B experience.³ Qualifying organizations can choose between 2 risk arrangements. The first involves upside potential from shared savings in the first 2 years, adding downside risk only in the third year of operation. In the second arrangement, organizations share a greater percentage of the savings but are responsible for downside risk from the beginning. The shared savings program will require organizations to conduct quality improvement initiatives, care coordination, performance measurement, and public reporting.

To succeed, organizations contemplating participation in ACOs will need to develop and improve organizational capabilities necessary to meet program requirements. Hospitals and physician organizations will need to forge new relationships and take on new responsibilities. Success will require adaptation and change, learning quickly from mistakes, and developing an ability to transfer knowledge among participating entities. This will require ACOs to become learning organizations that can comprehend and expand what works and move to correct things that do not.⁴

In this commentary, we discuss 10 potential mistakes that organizations may experience in becoming ACOs whether with Centers for Medicare & Medicaid Services (CMS) payment or working with private payers.

Overestimation of Organizational Capabilities

1. **Overestimation of Ability to Manage Risk.** This is perhaps the major lesson to be drawn from the experimentation with capitated managed care in the 1990s.⁵ Organizations frequently overestimate their abilities, particularly when potential rewards are at stake. Some physician organizations have the ability to manage and measure ambulatory

care. Some hospitals have the ability to manage and measure inpatient care. But the Medicare shared savings program and many private payer demonstrations require a single risk bearing entity, the ACO, to manage the entire care continuum. The challenge will be to merge hospital and physician capabilities, an exercise with which most health care organizations have little experience. Estimates of the start-up cost of developing these capabilities vary widely from \$1 million³ to \$12 million per ACO.⁶

2. **Overestimation of Ability to Use Electronic Health Records.** Implementation of electronic health records will be more challenging than most believe, despite financial support offered by CMS and others. Most clinicians are inadequately trained and supported in the use of electronic health records. This will hinder the ability to report on the cost and quality metrics required for ACOs. Even with adequate support, implementation of electronic health records systems can disrupt practices for 6 months or more.⁷ Incompatibility among hospital and physician information systems is a further impediment to achieving the goals of integration.

3. **Overestimation of Ability to Report Performance Measures.** Experience with pay-for-performance programs suggests the challenge of collecting, analyzing, and reporting performance data. For most ACOs, reporting capability will evolve slowly over time even with the technical assistance provided and will depend on the ability of electronic health records to reliably document the delivery of clinical care.

4. **Overestimation of Ability to Implement Standardized Care Management Protocols.** The goal of protocols is to eliminate variation and complexity in the care delivery process that do not add value. For protocols to work, clinicians must be substantially involved in their development, data must exist to assess protocol implementation and outcomes, and the protocols must allow for tailoring to individual patient needs and preferences.⁸ This takes time and, in the haste to qualify as an ACO, there is the temptation to shortchange the degree of involvement needed.

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Failure to Balance Interests and Engage Stakeholders

5. Failure to Balance the Interests of Hospitals, Primary Care Physicians, and Specialists in Creating Governance and Management Processes to Adjudicate Differences. Historically, relationships between hospitals and physicians often have been strained. Whether new incentives will mitigate or exacerbate conflicts and whether sufficient managerial and clinical leadership exists to deal with the challenges are empirical questions. Participants may view ACOs simply as an opportunity to achieve greater market power rather than to improve the overall value of care delivered.⁹

6. Failure to Sufficiently Engage Patients in Self-care Management and Self-determination. Patients and family members can provide considerable care particularly in managing multiple, complex chronic conditions. Patients need to be both considered a key part of the care team and educated about taking responsibility for their health and health care with support of friends and family members. Many potential ACOs have little experience with this degree of patient engagement.

7. Failure to Make Contractual Relationships With the Most Cost-Effective Specialists. Unlike primary care physicians, specialists are not required to limit their activity to a single ACO under the proposed rules. Nor are patients confined to a single ACO. Thus, referral relationships become critically important to overall ACO performance. They need to be sufficiently broad to meet the needs of patient populations being served yet sufficiently concentrated to promote mutual investment and use of the most cost-effective specialists. Entrenched relationships with high-cost specialists will be a stumbling block for some ACOs.

8. Failure to Navigate the New Regulatory and Legal Environment, Understanding the "safety zone" for exemption from antitrust, Stark antikickback legislation, and related regulatory and legal constraints to the formation of ACOs will be challenging. Compliance with new regulatory requirements will require unprecedented levels of transparency and cooperation among hospitals, physician organizations, and payers.

9. Failure to Integrate Beyond the Structural Level. Structural and contractual mechanisms may be in place to provide more coordinated care, but ACOs may lack the change management and implementation skills required to improve care delivered to patients. Improvement will require engaging a wide spectrum of health professionals in the change-management process and aligning shared interests and rewards.

Failure to Recognize Interdependencies

10. Failure to Recognize the Interdependencies and Therefore the Potential Cumulative "Race to the Bottom" of the Above Mistakes. Overestimating an organization's ability to manage risk (the first mistake) will be exacerbated by the other mistakes, particularly the failure to implement electronic health records, which will affect the ability to develop and report performance measures and will result in

less learning from feedback. This in turn will be made more difficult by the challenge of balancing interests among hospitals, primary care physicians, and specialists. This constellation of potential shortcomings will result in failing to engage patients, develop contractual relationships with cost-effective specialists, navigate the regulatory and legal barriers, implement standardized care management protocols, and manage change necessary to improve care integration for patients. The net result may be failure to reduce preventable hospital readmissions, eliminate admissions for ambulatory care-sensitive conditions such as asthma and diabetes, reduce inappropriate emergency department use, and improve the overall patient experience of care.

The Way Forward: Measurement and Management

Although strategies exist for addressing each of these potential mistakes, such strategies are unlikely to be universally generalizable. Rather, solutions will need to be adapted to local contexts and experience. For this to occur, organizations need robust learning systems to help them avoid these potential mistakes, learn from those that occur as quickly as possible to take corrective action, and anticipate future challenges.¹⁰ Two factors will be key. The first is collective leadership by CMS, private payers, hospitals, physicians, and other health professionals to promote learning systems. The second is the development of a mature performance measurement system to provide rapid feedback about what works in different local environments. What is not measured cannot be managed, but what is measured must still be managed. Management and measurement hold the keys to ACO success or failure.

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