Few would dispute the merits of the goals for improvement in patient care quality, efficiency and access that form the bedrock of the Patient Protection and Affordable Care Act. Less clear, however, is how best to accomplish these reforms.

Over the next several years, the Centers for Medicare & Medicaid Services will pilot new configurations that include accountable care organizations (ACOs). Some providers have already immersed themselves in the initial stages of ACO development. Many others have yet to begin.

The ACO model has drawn notice from policymakers, providers, physicians and payors for its emphasis on shared responsibility in increasing value, eliminating waste and reining in spending for defined populations of Medicare beneficiaries. This approach, also known as the shared savings program, calls for more focus on reviewing utilization, streamlining processes and reducing costs. The intent of the model is for the savings generated by this shared accountability to flow back to patients and to the providers and physicians who serve them.

“We all came to healthcare with a calling of sorts, and we all want to provide the best care possible,” says consultant James R. Smith, FACHE, senior vice president, The Camden Group, Rochester, N.Y. Smith leads the firm’s ACO development and clinical integration services. “With reform, we’re talking about (providing optimal care) on a population basis, of thinking not only of the individual, but whether we are deploying the right resources in the
right way and at the right time for large groups of patients. If we add 30 million-plus people to the ranks of the insured, the true measure of success will be whether we can do this more cost effectively at quality and service levels that are even better than what we have today.”

Smith notes that health reform creates the new ability for providers to care for more people in a way that increases the safety and effectiveness of care. “It’s exciting to think about whether we can do this better and how we can create value, measure it and generate sufficient resources to care for those who will be insured for the first time or who have been underinsured,” he adds. “The good news is that this is our opportunity.”

Michael Nugent, director in the Healthcare Practice and leader of the Managed Care and Payment Reform team for Navigant Consulting Inc., Chicago, advises providers to start getting their financial and infrastructure ducks in a row regarding ACO development. No need to wait for an ACO government mandate—there is already plenty to do, he says.

The following road map can help organizations set a course for ACO development.

Establish Long-Term Goals
“One of the common mistakes we see in ACO model development is a narrow focus on short-term governance and organizational issues without a long-term view to the ultimate goals of value and efficiency,” Nugent says. Chief financial officers have an excellent leadership opportunity to keep their organizations focused on these goals and ensure that ACO planning does not occur in a vacuum. The CEOs’ most important task in this regard is to communicate the why and how behind reform’s economic realities.

“We can no longer shift our cost increases every year to the market,” Nugent says. “There is a limit to purchasers’ ability to afford 6 to 12 percent annual healthcare cost increases. That means we have to think differently about how we configure our assets and manage costs in order to deliver care at a lower price point.”

The Camden Group’s Smith notes that as healthcare delivery shifts from a volume-based to a value-based system, CFOs will need to begin thinking about how to measure and evaluate government and commercial payor incentive programs and to provide the appropriate information to caregivers so they can actually manage that care.

“Their (CFOs’) investment has to be in the clinical systems, financial systems, data warehouses, disease registries and real-time reporting capabilities needed to measure results and identify problems quickly,” says Smith.

Examine Internal Business Operations
The next step is focusing on the patient’s needs related to affordability, service and quality, Nugent asserts. The process requires a willingness to open the organization to self-scrutiny. “Every hospital needs to put a mirror up and say, ‘How am I going to make the underlying concepts real? Where am I going to save 10 percent or more on costs short term versus long term, while improving quality and service?’” he says.

A good starting point for the self-examination Nugent advocates is to run some basic revenue and cost benchmarks across the continuum of care, including fixed and variable costs and utilization. These analytics should look at untapped margin opportunities including supply standardization and reductions in clinical variance and avoidable costs.
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“There is a lot of money holed up in supply and process standardization opportunities, reductions in length of stay, avoidable readmissions and management of post-acute care,” says Nugent. “Providers have a substantial opportunity to reduce avoidable costs and complications—including intensive care unit and emergency department utilization—by aggregating specific patient cohorts and focusing on care transitions both in and out of the hospital.”

Most hospitals have already achieved standardization around some major supplies such as orthopedic or cardiac implants. But many have yet to mine standardization for all it’s worth. “There are enormous opportunities if providers can work with their top payors to share savings for standardizing supplies and reducing variation,” says Nugent.

Providers are approaching payors with sizeable savings opportunities in supplies, Nugent says. Payors, in turn, are working with providers to create an alternative “value-based” fee schedule that provides hospitals and physicians with a bonus in return for standardizing clinically equivalent products. This process also lowers the cost of services.

As a result, physicians and hospitals benefit because they are buying equipment and supplies at a lower cost. Health plans benefit from hospitals’ bulk purchasing from one or two vendors instead of five or six, and patients benefit in reduced out-of-pocket costs of care, according to Nugent.

Employ Patient-Centered Clinical Integration
According to a 2009 study published in the *New England Journal of Medicine*, about 20 percent of hospitalized Medicare patients are readmitted within 30 days. A major issue facing providers is how to manage the clinical variance at the root of many of these readmissions—for which Medicare soon will no longer pay.

Nugent illustrates how providers can address this issue through the example of a major provider that devoted an entire year to eliminating the sources of variance within its hospitals and other clinical settings in the delivery of cardiac care. The organization ran analytics to identify practice variation in specific types of care and supply and resource utilization.

“They went beyond the claims data,” Nugent says. “They had physician assistants shadow their cardiac surgeons for a few weeks to understand how these doctors really do their jobs. And they acquired indisputable observational data as a result. Then they married that data with the clinical protocols of the American College of Cardiology so they could identify the practices that did and did not make sense. That extra effort eventually enabled them to win buy-in from the medical staff, and this buy-in allowed them to re-engineer processes and address the cost side of variation.”

Nugent advises that health systems and hospitals that may not have achieved the level of clinical integration or physician engagement of this large provider should study their own billing and claims data and electronic medical records information to identify avoidable costs and readmission rates before payors do this to them. “Then engage payors in looking at clinical variation together,” says Nugent.

Do More With Less
Payors are targeting 3 to 5 percent annual medical cost increases within a few years—half of what providers are getting today. Ratcheting up utilization to compensate for these lower reimbursement rates obviously is not
a realistic or healthy option, notes Nugent. The solution is to reconfigure operations by using existing physical capacity more efficiently and by standardizing them.

“Do you really need eight operating rooms?” Nugent asks. “Do you really need to build a new hospital to optimize your value for the dollar versus the competition? Maybe you should be thinking about adding some hospitalists, nurse practitioners or physician assistants instead of a new building.”

Hospitals need to look at their long-term strategic capital plans as well—or what Nugent calls their “big buckets of spend.” “Evaluate those big-time expenditures with cost and quality in mind,” he says.

**Develop a Strategic Margin Plan With Physicians, Payors**

Hospitals need to maintain a 4 to 5 percent margin in order to fund depreciation, and bondholders demand that type of financial margin performance, notes Nugent. As a result, CFOs’ hands are tied when a health plan informs them they’ll get only a 2 percent rate increase instead of the budgeted 8 or 10 percent increase. The solution is to develop a “strategic margin plan” that reduces costs, improves productivity and optimizes revenue by standardizing care and negotiating higher payments for better performance.

“The hospitals that do this are going to be in a better position to get whatever rate increases the payors can ante up,” says Nugent. “That’s new money.” Nugent cites the recent example of a large health system and health plan that have negotiated a $30 million bonus that will be shared among the system’s 800 physicians.

**Explore Consolidation**

To maintain your margin under a softer top line, look at ways to consolidate and reconfigure excess physical capacity to reach underserved patient populations, Nugent suggests.

“There are significant pockets of excess supply in healthcare,” says

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**Provider Perspective: Early in the Journey**

**Catholic Health East, Newtown Square, Pa.**

Catholic Health East, which includes 34 acute-care hospitals and dozens of other facilities in 11 eastern states from Maine to Florida, began its ACO journey more than a year ago. The organization’s current ACO focus is to develop standard order sets around evidence-based medicine and determine how the system’s and its physicians’ IT systems will integrate across the continuum of care. The relationship the hospital has with the medical staff is absolutely tantamount to the success of an ACO, according to John C. Johnson, FACHE, executive vice president of ministry operations for Catholic Health East.

“Credibility and transparency in that regard are critical,” he says. “That doesn’t mean, however, everyone has to agree about everything. But you have to have a fair exchange of information so that everyone’s ideas are on the table.

“Everybody understands that an ACO is a combination of quality and cost-effectiveness coming together to drive value,” Johnson says. “We’re going to have to take a risk for a total population. But there is no cookie cutter model for an ACO. If you’ve seen one, you’ve seen one. This is an incredible opportunity for those who are willing to be creative and to get out in front and lead as opposed to waiting for someone to tell them how to do it.”
Nugent. “I would argue that on a Friday afternoon and on weekends in many major cities 60 percent of the operating rooms are empty. Much of this waste stems from a healthcare system that revolves around acute care at the expense of prevention and chronic disease management. To solve long-term healthcare spending issues, we need a balance of acute and chronic capacity. This is primary care’s time to shine.”

**Add New Pricing Tactics**

Patient incentives also need to be aligned around health and value within the new model. “Jacking up patient co-pays, deductibles and coinsurance does not drive quality and efficiency,” Nugent says.

Instead, payors and providers should consider ways to incentivize patients to use clinically equivalent, lower-cost options. This includes lower out-of-pockets to use low-cost sites of care. Providers should also explore pricing opportunities in which savings from consolidating services during periods of peak demand are passed on to patients in the form of reduced fees, he says.

“Imagine you have the choice of paying a higher price to get your elective scan done now instead of paying less by going during a time of off-peak demand like a Thursday evening,” says Nugent. “Most would

**Provider Perspective: Farther Down the Road**

**Advocate Health Care, Oak Brook, Ill.**

Advocate Health Care has been on its ACO journey for more than three years. It recently signed a landmark deal with Blue Cross Blue Shield of Illinois and is launching a benchmark care delivery system that will continue to drive enhanced collaboration among physicians, hospitals, payors and employers.

Lee B. Sacks, MD, FACHE, executive vice president and chief medical officer of Advocate Health Care, says organizations should get on the ACO road now.

“Get started,” he says. “But it will take time to build the culture based on trust between physicians and the health system necessary for accountable care. This is where an investment in physician leadership development will pay dividends.”

Sacks is also president of Advocate Physician Partners, a joint venture between more than 3,600 physicians and eight hospitals in the Advocate Health Care system. The nonprofit organization operates as a clinically integrated network serving nearly 1 million people in the Chicago area.

From a financial perspective, Sacks urges organizations to focus on good reporting on actionable items such as financial reports that show performance by appropriate groups of physicians, whether it’s a medical group, a physician-hospital organization or a practice group, so that this performance can be tracked and managed over time.

“It also takes time to refine this reporting in order to satisfy all of the skeptics that the reporting reflects accurately on their performance,” he says.
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choose the less expensive option (Thursday evening), which means that a city wouldn’t need as many scanners. Who wins? The patient.” Providers should be thinking now of ways to incorporate these new tactics into their service line, managed care and pricing strategies, Nugent adds.

Huge additional savings can be achieved when financial incentives are in sync, and when there are more dollars to share, more people can win, he says. Shared savings arrangements allow providers to share some of those savings with patients in the form of rebates, for example, for receiving a specific brand of hip implant or other device from a vendor with whom a provider has contracted.

According to Nugent, providers need to start with quality and affordability for the patient and re-engineer from there. For example, what is the 40-step protocol to deliver great cardiac surgical services, and how much do those services really cost? These providers will be able to guarantee outcomes through proven care products in which patients do not pay for readmissions. “Imagine the competitive power of a proven care guarantee that does not charge for an avoidable readmission,” he says. “The organizations that are thinking in terms of accountable care and alignment of financial incentives are going to compete on cost and quality in a way that the non-ACO can’t.”

Simplify Administrative Standards and Payment Infrastructure

Nugent advises providers to develop administrative standards that include a simplified payment infrastructure aimed at reducing overhead from an average of 30 percent to 5 to 10 percent. By demonstrating these efficiencies to payors, they can earn exemption from much of healthcare’s ubiquitous paperwork burden.

The documentation, extra coding and other administrative hoops that providers have traditionally jumped through to get paid—at an average annual administrative cost of $85,000 to $95,000 per physician—have created an expensive “cat and mouse game” between providers and payors in which neither party wins, Nugent says. “We need some rules of the road to transition from transactions-based payor relationships to ones that optimize purchaser and patient value,” he says.

The ACO model is “a call to hospital CEOs and CFOs to stand up and commit to reconfiguring the system to be more cost-effective,” Nugent says. The administrative overhead of processing payments in other industries is a fraction of that in healthcare. “How much money do we want to spend on the administration of healthcare versus the delivery of healthcare?” he asks.

With reform, the key question for providers is how to reduce costs and improve quality to compete in a world where the payor isn’t going to reimburse nearly as much as in the past, Nugent says. “The dynamic is still a matter of margin strength,” he adds. “We’re connecting the dots between ACOs and margin optimization. The issue is how I maintain and steer my margins. In this new world, the fundamental premise is that the rate of rate increase will never be what it once was. It’s competition, but from a quality and cost perspective.”

Adds The Camden Group’s Smith, “We are telling our clients not to wait but to begin to rethink the way care is provided today and to start to change. Focus on the areas with the most opportunities. Recruit the right people, give them the right resources and tools, and invest in IT and connectivity. The road is long. Begin the journey.”

Susan Birk is a freelance writer based in Wheaton, Ill.

Editor’s note: Michael Nugent is co-author of a forthcoming Health Administration Press book on accountable care organizations, scheduled for release in Spring 2011. For more information, visit ache.org/HAP and reference the “Coming Soon” area. A resource currently available via webinar CD is “ACOs: The Benefits and Challenges.” Visit ache.org/WebinarCD for more information.
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