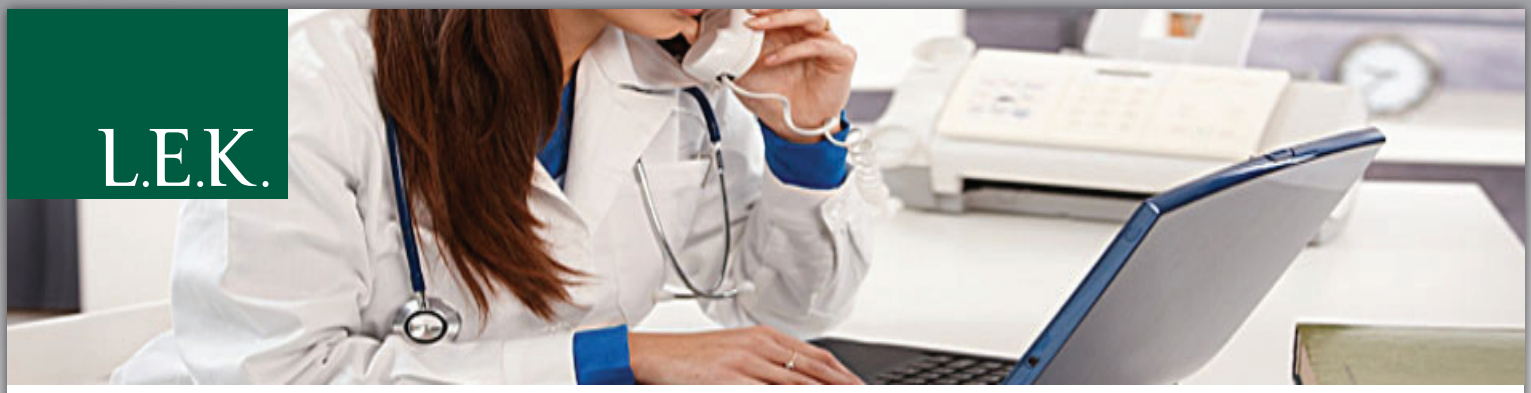

L.E.K.

EXECUTIVE INSIGHTS

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Healthcare Transformation: Who Should Drive the ACO Train?

One growing crack in the foundation of our healthcare system is caused by the misguided incentives that reimburse care providers for individual patient visits and treatments rather than the overall improvement of patient care and wellness. These rules of engagement can make the providers across the continuum of care territorial rather than collaborative, and create ongoing friction between care providers and payers.

To address this challenge, a central element of The Patient Protection and Affordable Care Act (PPACA) is the creation of Accountable Care Organizations (ACOs), which are designed to unify a broad spectrum of care providers and establish incentives for them to work collaboratively to address patients' overall health. Although ACOs are initially chartered for patients with Original Medicare coverage, L.E.K. Consulting believes that the ACO model may eventually be expanded to serve additional federally funded programs and private health plans, and modified to address individual market requirements.

By linking payment rewards to patient outcomes, federal officials project that ACOs will help Medicare save up to $960 million over three years. ACO partners that meet care quality standards in five areas would be eligible to share savings: patient safety, preventative health, care coordination, the patient care experience and at-risk population/frail elderly health.

Healthcare Transformation: Who Should Drive the ACO Train? was written by **Bill Frack,** Vice President and Head of L.E.K.'s North American Healthcare Services Practice; and **Joan Kim**, Vice President of L.E.K. Consulting. Please contact L.E.K. at healthcare@lek.com for additional information.

While there is overwhelming support for these lofty goals, there are significant challenges to creating a working model because there is no clear directive regarding ACO management and administration. This begs the question: who will assume the leadership role in aligning and managing ACO partners moving forward?

Seven Hurdles to Successful ACO Adoption

L.E.K. research shows that large hospital-led integrated delivery networks (IDNs) have taken the most action to form ACOs, but a lack of consensus by care providers on a number of issues has prevented many ACOs from formally launching. Participating in an ACO requires a shift in how partners work together: how they coordinate care, adopt standard care metrics and share revenues. This requires ACO partners to rethink their relationships with each other – and in some cases, make individual concessions to ensure that the ACO is well-positioned for sustainable success.

L.E.K. has outlined seven key challenges that ACO partners face when transitioning this model from concept to practice. These issues will need to be resolved in each and every successful ACO implementation:

1. Care Coordination: Hospitals and physicians have very different perspectives regarding care coordination. Many hospitals believe they are in charge and physicians need to follow their direction regarding patient care while also being sensitive to the hospital's economic interests. As an example, hospitals do not normally view the reduction of bed days associated with superior coordination of care as being in their

economic interest. On the other hand, most physicians view themselves as the initiators of virtually all patient care. And yet, many physicians fail to see their patients immediately after being discharged from the hospital. Physicians and hospitals are each concerned about their respective piece of the healthcare pie, often, at the expense of the other party. Hospitals and physicians need to agree on a number of pivotal issues that include:

- determining how to coordinate patient care;
- establishing the most appropriate and cost-effective care settings;
- developing guidelines for determining care that is in a patient's best interest; and
- sharing in the patient care risk/reward dynamic.

2. Medical Quality Metrics: Physicians and hospitals are not aligned regarding the adoption of ACO medical quality metrics because virtually all hospitals and physicians see themselves as high-quality providers. Therefore, ascribing grades to each provider's relative performance will be unpopular and difficult to agree upon. There should be joint collaboration and agreement by all concerned parties including: patients, physicians, hospitals and payers regarding meaningful and measurable standards. Facilitation of this process, along with the measurement of results (grading), will likely require retention of an impartial but knowledgeable outside party/agency.

3. Incentives: Clinical alignment and associated incentives have not been determined. If there is debate about which quality measures to adopt, it will be very difficult to fully align incentives in a meaningful way and assure that they help to improve patient outcomes. Collaboration among all ACO participants is required to establish the right incentives that are aligned with care quality benchmarks and improved outcomes. The amount that all parties are eligible to receive is dependent on mutual cooperation and adherence to agreed standards and metrics. Ironically, the increase in the number of physicians employed by hospitals has muted alignment because employed physicians tend to have limited or no performance-based incentives.

4. ACO Governance: ACO leadership and governance per the ACO rules are not in sync with the current reality on the ground. Physicians and patients need to be actively involved and assume proactive leadership roles for ACO development from the very outset, rather than being asked to rubber stamp a hospital-driven process.

5. Provider Connectivity: Data connectivity between hospitals, physicians and other providers is critical but fragmented. Physicians tend to adopt less expensive and smaller electronic health records (EHR) systems to meet their discreet patient care needs. Hospitals, on the other hand, deploy enterprise systems that are economically beyond the reach of medical practices. By example, one L.E.K. client built a new free-standing clinic that was fully digital (i.e., paperless), but the onsite doctors could not access lab results electronically from their affiliated hospital because the clinic and hospital IT systems were not compatible.

Although data connectivity is a necessary step in ACO formation, many health officials mistakenly assume that EHR adoption alone will enable care coordination. In truth, clinical integration, clear guiding principles, governance structure and incentive alignment are what enable care coordination. EHR is merely a tool to facilitate collaborative care activities, and should include all care that has been delivered, additional care that is required and where the patient care should be provided. This will help to eliminate duplicate procedures, incomplete patient data and provide patients with efficacious care.

6. The Role of Payers: Many payers are still evaluating if and how they will participate in ACOs, as concerns abound regarding their role in ACO collaboration. Payers, by virtue of their longstanding ability to assess and manage risk, could advise (for a fee) and also backstop/provide (sell) stop-loss coverage. Payers have the benefit of historical claims data and analysis, which enables them to have a fact-based understanding of utilization patterns and associated medical costs that their contracted provider organizations currently lack.

Perhaps the most fundamental implication of the payers' role in an ACO is the impact of payer participation on provider viability. After the heavy investment required for development and implementation, ACO's will need to seek payers' help in driving volume through their ACO. However, each ACO may have to partner with one participating payer at the risk of alienating other plans. Transitioning from the current model whereby a healthcare system's revenues are split across multiple health plans, partnering with one health plan in order to consolidate member volume could be problematic. The health plans not

Healthcare Groups Pioneering the ACO Model

In December 2011, the Centers for Medicare & Medicaid Services (CMS) selected 32 organizations to test a new phase of the ACO payment model. The participants fall into three categories: integrated delivery networks (IDNs), hospital system physician group partnerships and physician groups.

Of note, nearly two-thirds of ACOs listed below are anchored by a participating hospital. This underscores the central role that L.E.K. expects hospitals to play in creating and maintaining a viable ACO model.

Figure 1

Pioneer ACOs by Type

Integrated Delivery Networks (IDNs) (13 Participants Total)	
Name	**Service Area**
Allina Hospitals & Clinics	MN, WI
Banner Health Network	AZ
Bellin-Thedacare Healthcare Partners	WI
Dartmouth-Hitchcock ACO	NH, VT
Eastern Maine Healthcare Systems	ME
Franciscan Alliance ACO	IN
OSF Healthcare System	IL
Park Nicollet Health Services	MN
Partners Healthcare	MA
Presbyterian Healthcare Services – Central New Mexico Pioneer ACO	NM
Sharp Healthcare ACO	CA
Steward Health Care System	MA
TriHealth, Inc.	IA

Hospital System and Physician Group Partnerships (7 Participants Total)	
Name	**Service Area**
Bronx Accountable Healthcare Network (BAHN)	NY
Fairview Health Services	MN
Genesys Physician Hospital Organization	MI
Michigan Pioneer ACO	MI
North Texas ACO	TX
Seton Health Alliance	TX
University of Michigan Health System	MI

Physician Groups (12 Participants Total)	
Name	**Service Area**
Atrius Health	MA
Beth Israel Deaconess Physician Organization	MA
Brown & Toland Physicians	CA
Healthcare Partners Medical Group	CA
Healthcare Partners of Nevada	NV
Heritage California ACO	CA
JSA Medical Group	FL
Monarch Healthcare	CA
Mount Auburn Cambridge Independent Practice Association (MACIPA)	MA
Physician Health Partners	CO
Primecare Medical Network ACO	CA
Renaissance Medical Management Company	PA

63% of Pioneer ACOs have a participating hospital

Source: The Centers for Medicare & Medicaid Services, L.E.K. analysis

selected as a partner could steer their membership elsewhere to competing health systems, which could financially cripple the ACO.

7. Payer and Provider Information Sharing: L.E.K. research shows that payers and providers typically do not share data that is utilized in the annual negotiations between the associated parties – including patient encounter, financial and care information. However, sharing this data will be pivotal for ACO success, as virtually every ACO will require payer collaboration with hospitals and physicians. Unfortunately, the parties do not always trust each other. For an ACO to be successful, all parties will have to establish a new form of collaboration that features agreed upon care metrics – as well as shared financial gains and exposure to risk (financial losses).

Key Takeaways: Scripting Next Steps

Despite the challenges facing ACOs, hospitals are showing their commitment to this healthcare model. L.E.K.'s Strategic Hospital Priorities Study found that more than 15% of hospitals surveyed are already participating in the formation of an ACO and an additional 61% of hospital executives believe that there is some likelihood that their organizations will join an ACO within the next three years. Although hospitals are the most common "lead" in ACO formation and coordination, all ACO member constituents will need to have an active voice in how ACO guidelines are established for care coordination and quality metrics, incentives and information sharing.

In fact, many physicians are hesitant to commit to ACOs because they do not feel that they have had an appropriate say in the development process. To help build consensus on critical governance issues, ACOs may consider enlisting outside parties to provide independent recommendations for these key issues, and use this counsel to accelerate consensus by all members.

Ultimately, there must be ACO leadership that all of the partners universally accept and follow. In many cases, hospitals will provide the overarching coordination and administration while payers draw from their strengths to manage risk. And within these agreed upon guidelines, physicians and other care professionals will be empowered (and incented) to take a more active role in improving overall patient health.

L.E.K. Consulting is a global management consulting firm that uses deep industry expertise and analytical rigor to help clients solve their most critical business problems. Founded nearly 30 years ago, L.E.K. employs more than 900 professionals in 20 offices across Europe, the Americas and Asia-Pacific. L.E.K. advises and supports global companies that are leaders in their industries – including the largest private and public sector organizations, private equity firms and emerging entrepreneurial businesses. L.E.K. helps business leaders consistently make better decisions, deliver improved business performance and create greater shareholder returns.

For further information contact:

Boston
75 State Street
19th Floor
Boston, MA 02109
Telephone: 617.951.9500
Facsimile: 617.951.9392

Chicago
One North Wacker Drive
39th Floor
Chicago, IL 60606
Telephone: 312.913.6400
Facsimile: 312.782.4583

Los Angeles
1100 Glendon Avenue
21st Floor
Los Angeles, CA 90024
Telephone: 310.209.9800
Facsimile: 310.209.9125

New York
1133 Sixth Avenue
29th Floor
New York, NY 10036
Telephone: 646.652.1900
Facsimile: 212.582.8505

San Francisco
100 Pine Street
Suite 2000
San Francisco, CA 94111
Telephone: 415.676.5500
Facsimile: 415.627.9071

International Offices:
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