

Understanding the Future of Shared Accountability

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SHARED ACCOUNTABILITY

The shared accountability (ACO, et al) market is in its infancy. Only about 40% of U.S. healthcare providers are participating in some type of shared accountability arrangement (ACO or commercial). That means that the majority is on the sideline in a “wait and see” mode. And, of those who ventured in early, some are indicating they do not intend to continue. This kind of churn will characterize the market for some time.

My prediction is that this phenomenon is here to stay because of the fiscal crisis in which U.S. healthcare finds itself, but that the growth of shared accountability will mature less rapidly than many are predicting and will move forward in fits and starts as purchasers and providers understand that they have oversimplified and undervalued what the other participants in the equation contribute.

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VERTICAL INTEGRATION

Vertical integration will play a major role in the maturation of the shared accountability market. It will occur in three major phases, which will blend one into the next.

Initial Phase

The initial phase (in which we now find ourselves) will be characterized by disparate sponsors (medical groups, hospital and other facility-centric healthcare organizations, and purchasers); arms-length, often adversarial contractual relationships between stakeholders based on a transfer-price mentality; and exploitation of downstream contracted entities.

Intermediate Phase

As the market matures, the stakeholders will begin to recognize the distinctive roles of administrative services providers (e.g., ASOs, insurers), medical groups, hospitals and post-acute care organizations and that the roles “foreign” to the sponsoring stakeholder were “not as easy as they looked.” This maturation will lead to the intermediate phase, characterized by market consolidation.

In this phase, hospital-based systems will likely expand their contractual relationships with affiliated, non-employed physicians; expand ownership and/or formal contractual relationships with post-acute care providers (SNF, IRF, home health, hospice); develop or expand a relationship with an administrative services provider; and develop greater sophistication in evaluating and responding to RFIs and RFPs for purchaser contracts.

The natural vertical integration pathway for physician-based accountable care sponsors will begin with horizontal integration with other physicians to expand geographical coverage. As they gain critical mass, the next logical step will be to expand vertically into ambulatory facilities such as surgery centers and imaging centers. They will also use their power to direct patients as leverage as they engage in volume-based purchasing with preferred hospitals. Like their hospital-sponsored counterparts, they will look to develop or expand their relationship with an administrative services provider and will develop greater sophistication in evaluating and responding to RFIs and RFPs for purchaser contracts.

In this middle phase, purchaser-based systems will begin to recognize the potentially superior value and effectiveness of physician-driven utilization management in comparison to the traditional insurance model with its remote nurse-based utilization management. This will lead to initiatives to expand and deepen relationships with physician groups and their affiliated ambulatory facilities. They will also attempt to expand relationships with far-sighted hospitals who have invested in physician relationships. Purchasers will find a niche in providing administrative services to physician- and hospital-sponsored organizations and in providing stop-loss and reinsurance coverage.

Mature Phase—“Steady State”

As the market matures toward the steady state, the final phase will be characterized by market consolidation resulting in fewer, larger provider systems, fewer larger purchasers and competition between a small number of vertical systems, some of which will be fully economically integrated and others whose predominant integration will be virtual.

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In this phase, the “low-hanging” fruit and the “win-lose” risk arbitrage opportunities will have pretty much played themselves out. The vertically integrated systems who prevail in the steady state will be the ones who focus first and foremost on improving their cost structure, on bending the cost curve. That is why effective [Population Health Management](#) is so critical to Shared Accountability/ACO success. It is the key to cost structure improvement.

DESIGNING THE SHARED ACCOUNTABILITY SYSTEM

Far-sighted sponsors of Shared Accountability systems will need to focus on at least three critical elements in designing their system for success in the steady state, including:

- Constructing the vertically integrated healthcare delivery system;
- Stratifying and allocating the risk; and
- Managing the financial risk.

Constructing the Optimal Vertically Integrated Healthcare Delivery System

The first series of questions to be addressed revolve around which elements of the continuum of care should be included in the vertically integrated healthcare delivery system. Theoretically, fully economically integrated systems enjoy greater legal and other flexibility than those bound together by independent contractor relationships. However, merger-acquisition discussions can sometimes drag on for years.

Sometimes in the past, anti-trust laws and the enforcement agencies have failed to keep pace with the nature of market competition; e.g., have failed to realize that allowing vertical systems to form up and compete with each other may be more pro-competitive than applying old principles, which prevent hospitals and physicians from aggregating to provide viable coverage across relevant geographies.

Ultimately the integrated organization needs to decide which venues of the continuum need to be owned by the system and how they can be managed to optimize their cost structure contribution to the overall system. For example, as systems get better at triaging patients to the most appropriate venue of care, inpatient capacity will become available. Far-sighted organizations that can think outside the box will see in these changes opportunities to organize Post-acute Care step-down facilities (e.g., SNF, IRF) within the walls of the hospital. They will appreciate that property, plant, and equipment costs are often only 10+% of total costs and that conversion of part of the plant to a continuum component with a lower cost structure can help reduce the cost structure of the overall system.

Risk Stratification and Risk Allocation

Once the delivery system asset is defined and its cost structure is understood, the next step is to market the asset to purchasers. As noted in the Vertical Integration section above, the initial phase of market maturation will be characterized by naivete regarding assumption of insurance financial risk. Assuming too much financial risk, especially for random (stochastic) events can erode confidence in the system, especially among physicians. For example, physicians may become disillusioned and

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disengage, if they work diligently to implement improvement projects, which generate savings only to see those savings eroded by one or two random, high-cost outliers over which they feel they had very little control.

Risk stratification and risk allocation is one of the core competencies, which delivery system participants in Shared Accountability arrangements will need to develop or acquire. As a general rule, delivery systems will be more successful if they are able to define and quantify risk for inlier cases (e.g., establish reasonable financial outlier trim points) and use their efforts to “tighten the curve” for the inliers and shift it in the desired direction. Especially in the early phases of market maturation, delivery systems will do well to err in a conservative direction rather than becoming greedy and getting burned by stochastic outliers.

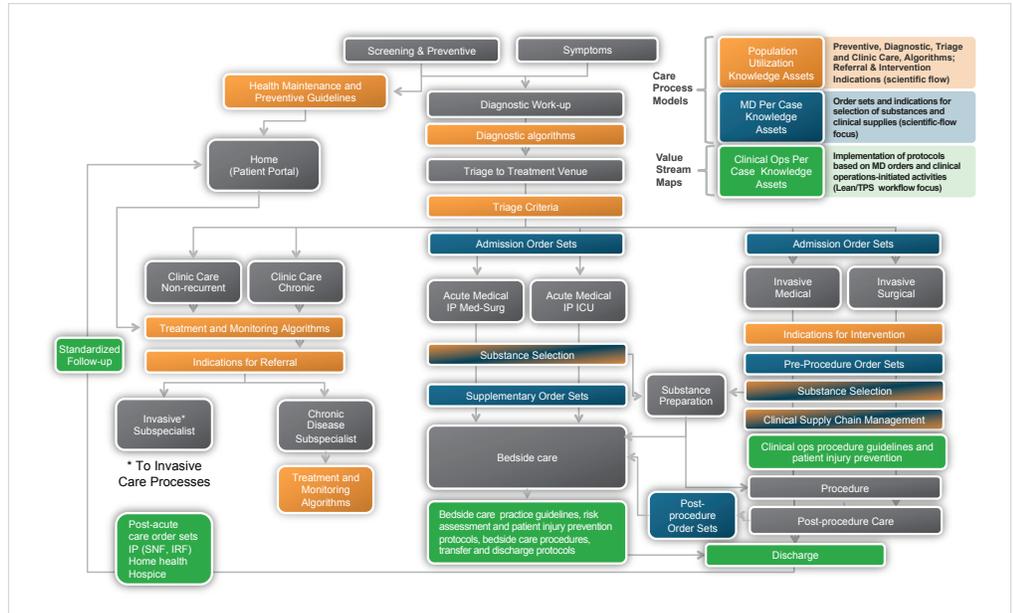


Figure 1 - Anatomy of Healthcare

Reducing variation in the “blue-box” processes in The Anatomy of Healthcare Delivery is more familiar territory for physicians and hospitals than managing the “orange-box” processes. Data regarding the blue boxes are more available to hospitals and physicians than data regarding the orange boxes, because neither hospitals nor physicians typically have access to data sets with a denominator (e.g., all members enrolled in a managed care health benefit program). Thus, it may behoove provider-based systems to cut their teeth on bundled per case (e.g., for physician and hospital payment for acute care processes) rather than starting out with per capita payments for a chronic disease population (e.g., diabetics) or for an entire population.

Health Catalyst has developed risk stratification tools (e.g., Comorbidity Analyzer), into which the elements of published comorbidity models (e.g., Charlson Deyo, Elixhauser) can be loaded or which can be used to develop customized models (e.g., Texas Children’s Hospital’s pediatric comorbidity model). Such models can be helpful in stratifying risk and informing decision making in negotiations with purchasers, stop-loss carriers and reinsurers.

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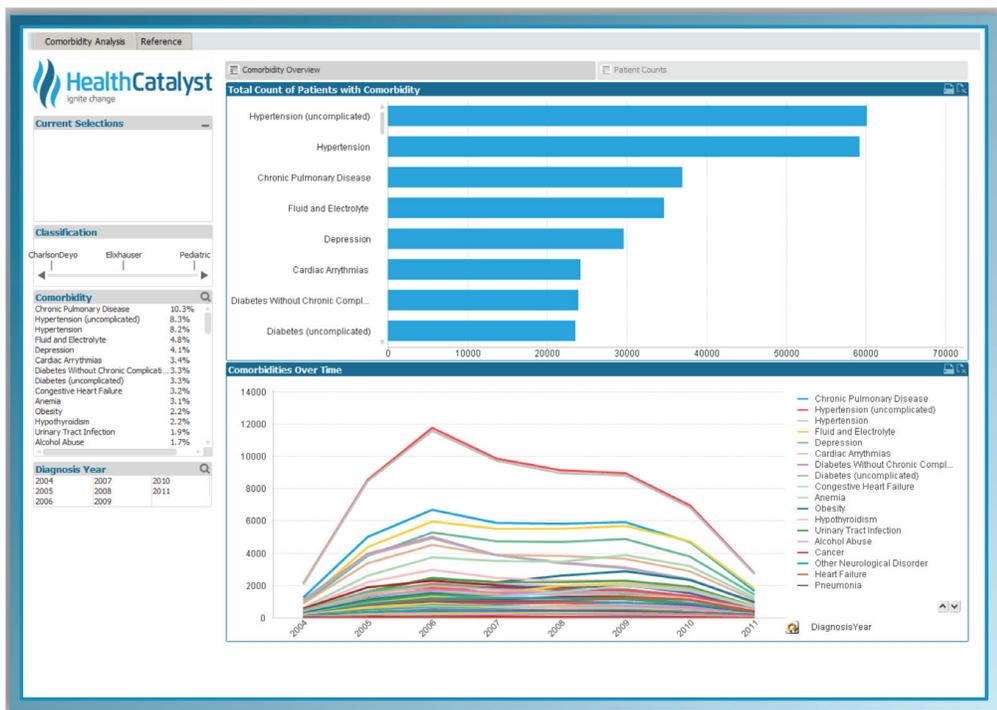


Figure 2 - Comorbidity Analyzer

Managing the Financial Risk

Once the delivery system and the purchaser have come to agreement regarding the risk inherent in the proposed population to be managed and the allocation of the risk for inliers and outliers, the financial risk must be managed.

In the early phases of market maturation, providers will tend to underestimate the skills and systems needed to manage the administrative operations and financial risk traditionally provided by an insurance company or an administrative services only (ASO) provider. For example, the organization will need to be able to pay participants for claims submitted and distribute surplus. It will need to define what reserves need to be set aside to cover the cost of care that has been incurred but not yet reported (IBNR) by members included in the population for which the organization has assumed financial risk within the premium dollars. Also, the organization which assumes prospective premium-based risk will need to comply with required State Insurance Department filings of financial results and proposed health benefit program design.

In short, provider organizations who decide they will turn a profit by “eliminating the middle man” by forming their own insurance company are likely to learn some expensive lessons in the school of hard knocks. They may well discover that the cost of building internally the administrative functions necessary to assume health care financing risk are more expensive at cost than a partnership would have been even with a reasonable profit for the insurance or ASO partner.

CONCLUSION

Success in the new Shared Accountability environment will require skills and competencies in two broad arenas:

1. Population Health Management to improve the cost structure of the healthcare delivery system by improving the cost structure of the individual component parts of the system across the continuum of care; and
2. Shared Accountability management to develop the requisite skills or partner with enlightened healthcare financial managers such as insurance companies and/or administrative services only (ASO) providers

This will be a high-stakes game, but well worth the cost of the candle. The transformation of U.S. healthcare hangs in the balance. 🕯️

ABOUT THE AUTHOR:

Dr. David A. Burton is executive chairman of Health Catalyst, which provides hospitals and health systems with Late-Binding™ data warehousing and healthcare analytics to transform clinical, financial and patient safety outcomes. A former Senior Vice President of Intermountain Healthcare where he served in a variety of executive positions for 23 years, Dr. Burton spent the last 13 years of his career co-developing Intermountain's Clinical Integration Strategy to which the EDW was critical. Dr. Burton is the former founding CEO of Intermountain's managed care plans (now known as SelectHealth), which currently provide insurance coverage to approximately 530,000 members.



About Health Catalyst

Based in Salt Lake City, Health Catalyst delivers a proven, Late-Binding™ Data Warehouse platform and analytic applications that actually work in today's transforming healthcare environment. Health Catalyst data warehouse platforms aggregate and harness more than 3 trillion data points utilized in population health and ACO projects in support of over 22 million unique patients. Health Catalyst platform clients operate 96 hospitals and 1,095 clinics that account for over \$77 billion in care delivered annually. Health Catalyst maintains a current KLAS customer satisfaction score of 90/100, received the highest vendor rating in Chilmark's 2013 Clinical Analytics Market Trends Report, and was selected as a 2013 Gartner Cool Vendor. Health Catalyst was also recognized in 2013 as one of the best places to work by both Modern Healthcare magazine and Utah Business magazine.

Health Catalyst's platform and applications are being utilized at leading health systems including Allina Health, Indiana University Health, Memorial Hospital at Gulfport, MultiCare Health System, North Memorial Health Care, Providence Health & Services, Stanford Hospital & Clinics, and Texas Children's Hospital. Health Catalyst investors include CHV Capital (an Indiana University Health Company), HB Ventures, Kaiser Permanente Ventures, Norwest Venture Partners, Partners HealthCare, Sequoia Capital, and Sorenson Capital.

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