Special double issue
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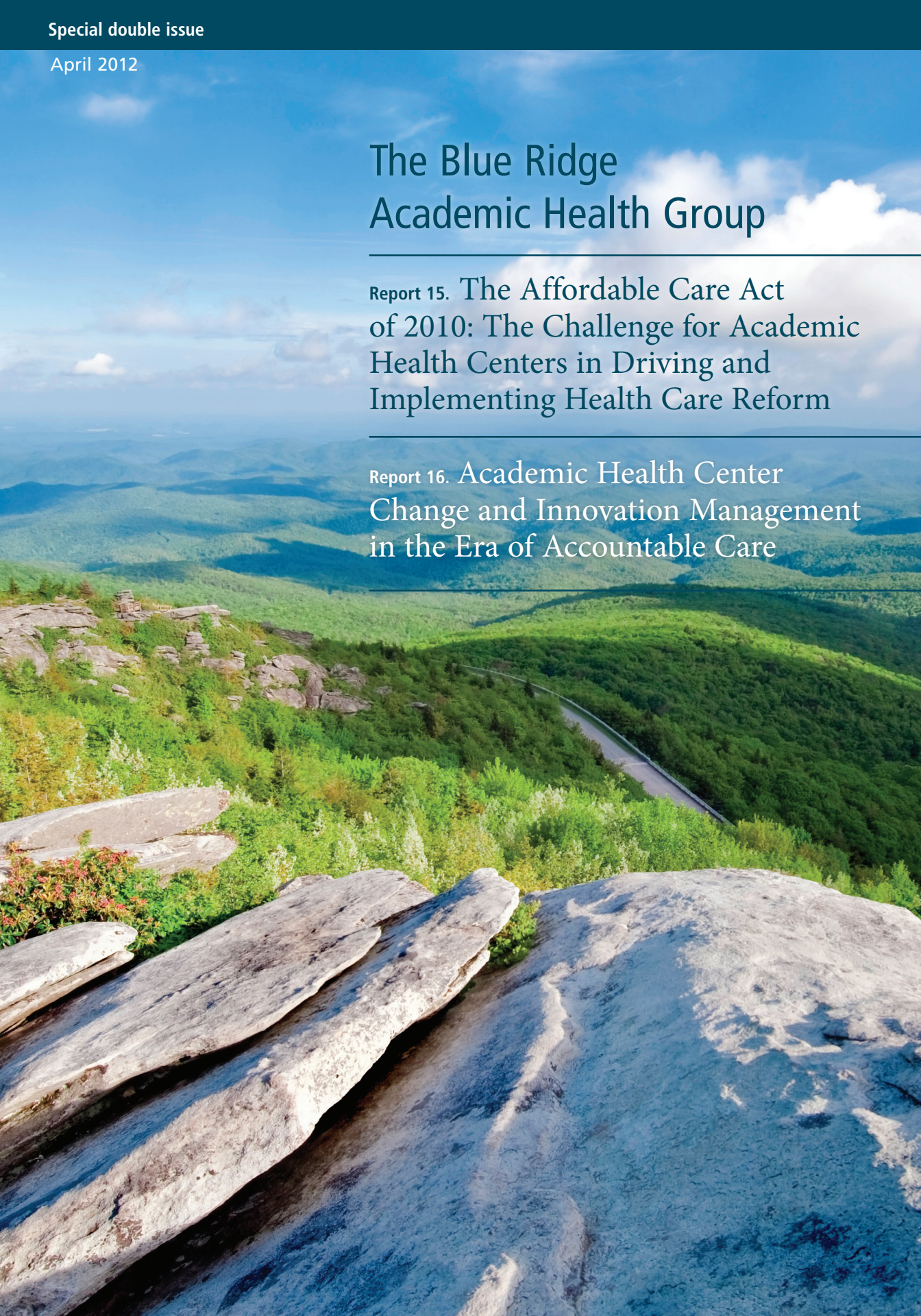
The Blue Ridge Academic Health Group

Report 15. The Affordable Care Act of 2010: The Challenge for Academic Health Centers in Driving and Implementing Health Care Reform

Report 16. Academic Health Center Change and Innovation Management in the Era of Accountable Care



Mission: The Blue Ridge Academic Health Group seeks to take a societal view of health and health care needs and to identify recommendations for academic health centers (AHCs) to help create greater value for society. The Blue Ridge Group also recommends public policies to enable AHCs to accomplish these ends.

Special double issue

The Affordable Care Act of 2010: The Challenge for Academic Health Centers in Driving and Implementing Health Care Reform is the 15th in a series of reports produced by the Blue Ridge Academic Health Group. The recommendations and opinions expressed in this report represent those of the Blue Ridge Academic Health Group and are not official positions of Emory University. This report is not intended to be relied on as a substitute for specific legal and business advice. Copyright 2012 by Emory University.

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Prelude

The Blue Ridge Academic Health Group (Blue Ridge Group) studies and reports on issues of fundamental importance to improving the health of the nation and our health care system and enhancing the ability of the academic health center (AHC) to sustain progress in health and health care through research—both basic and applied—and health professional education. In 14 previous reports, the Blue Ridge Group has sought to provide guidance to AHCs on a number of critical issues. Among them are ways to foster a value-driven, learning health care system for our nation; enhance leadership and knowledge-management capabilities; aid in the transformation from a paper-based to a computer-based world; and address cultural and organizational barriers to professional, staff, and institutional success while improving the education of physicians and other health professionals.

Reports also focused on updating the context of medical professionalism to address issues of conflict of interest, particularly in the relationship between academic health professionals and institutions and their private sector partners and sponsors; quality and safety; and improved care processes and innovation through the use of informatics. One key report explored the social determinants of health and how academic health centers could reshape themselves to address this critical dimension of improving health. The group also issued a policy proposal that envisioned a new national infrastructure to assure ongoing health care reform, calling for a United States Health Board. (For a complete list of titles of previous reports, see page 41.)

In this special double issue, including Reports 15 & 16, we examine the new health insurance and care delivery landscape as created by the enactment of health care reform legislation in March of 2010. In Report 15, we locate both the compelling near-term opportunities and the most critical challenges for AHCs and their partners as the new law is implemented and challenged in the coming months and years. In Report 16, we examine ways in which AHCs can leverage their unique characteristics and capabilities through the Accountable Care Act (ACA) to improve health care, research, and training systems. We also explore and recommend several initiatives that could help AHC leadership further these essential missions in achieving value-driven health in the era of the ACA and accountable care. The recommendations for action from both reports are combined and contained at the end of Report 16, page 37.

For more information and to download free copies of our reports, please visit **www.whsc.emory.edu/blueridge**. Note: The Blue Ridge Group meetings for Reports 15 and 16 were held in June 2010 and 2011, respectively.

Report 15 The Affordable Care Act of 2010: The Challenge for Academic Health Centers in Driving and Implementing Health Care Reform

Introduction

"In countless meetings on health reform over the past three years, I never met a single politician who spoke about adding more money to the health care system."

—William Petasnick
Immediate Past Chairman
American Hospital Association, June 2010

A historic watershed event occurred in U.S. health policy in the early months of 2010. The Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act, became law (hereinafter referred to as the "Accountable Care Act" or "ACA"). The ACA represents a culmination of decades of incremental reforms, experimentation, and learning in the context of repeated attempts at a major health system overhaul. Typical of the legislative process, the new law represents not an ideal but something cobbled together from a variety of proposals and programs traceable to a wide range of public policy initiatives and studies by scholars, policy-makers, and organizations. In addition, the ACA was born into a very uncertain environment that includes partisan political polarization and a global economic recession. Indeed, as was the case with the passage of the Social Security Act of 1965, which created Medicare and Medicaid, the ACA is very much a partisan act, passed in part due to the presidency and legislative branch enjoying a rare one-party Democratic majority. But unlike in the Johnson era, the extreme partisanship of the moment and the economic crisis both act as significant constraints on development of the regulatory structure of the ACA and its implementation. Both also mean that political capital and financial resources needed to implement many provisions of the ACA will be under consistent and long-term pressure.

The Blue Ridge Group was encouraged by the passage of the ACA but has serious reservations about the viability and/or advisability of many elements of the new law in their current forms. The Blue Ridge Group has long advocated for major reform that could lead to the establishment of a value-driven and evidence-based health care system, one that, ". . . promotes the health of individuals and the population by providing incentives to health care providers, payers, communities, and states to improve population health status and reward cost-effective health management."[1]

And there is no question that significant health care reform was and remains necessary, based on well-documented problems, including lack of universal access to health care, affordability, serious problems with health care quality and safety, and always-climbing costs. Global financial challenges, a huge national debt burden, significant unemployment, and an economy struggling to recover from a deep recession also argue for successful health reform implementation. Indeed, the pressure to "bend the cost curve" has only increased since passage of the legislation, while the coming retirement of the Baby Boom Generation will put huge demands on the entire health care sector. By 2030, the part of the population over 65 years of age will increase from 37 to 70 million; one in five Americans will be over 65 years of age. It is likely that the nation will be awash in chronic illnesses needing attention. And without reforms, Medicare could soon be bankrupt.[2]

The *2004 Blue Ridge Group Report 8,*[3] made what turns out to have been the relatively prescient argument that, after so many decades of debate, there was a convergence in health policy around the broad outlines of principles for health

care reform. We reported on our review of the work of a broad array of leading experts, organizations, state-based initiatives, and government agencies that had stepped up their focus on the six aims of the Institute of Medicine (IOM).[4] Our analysis found significant convergence on health reform goals and principles: ". . . the goals of universal coverage and a health care system that is safe, effective, patient-centered, timely, efficient, and equitable reflect societal aspirations for our nation's health care system around which it is now possible to discern a convergence of consensus. This convergence should enable the creation a road map to national health security."[3,5] It turned out that there was also significant convergence within the general public on these health goals and principles, shown by a variety of studies of public opinion as late as 2008—before Barack Obama was elected President.[6] It is therefore not completely surprising that health care reform was President Obama's top agenda item. We, as a nation, have been seeking reforms for decades.

While the ACA can lead to achievement of important reforms, there is also much that falls short of what we would have wanted and that presents daunting or dubious new elements and approaches. In addition, many political leaders and citizens question the approach that has been taken. In December 2011, 41% had a favorable view of the law, while 43% had an unfavorable view. These numbers have scarcely changed since passage of the law.[7] One Blue Ridge Group contributor, Jeff Goldsmith, has analogized this to the situation of someone having acquired some heavily promoted or coveted product, having ignored the innocent enough warning: "Directions and Batteries not Included."

Indeed, we are now faced with the daunting task of actually putting the pieces together and building a better American health care system in the midst of major legal challenges to the law as well as the need for continued reform and improvement of some of its provisions. We therefore see our 2004 call to action as now more urgent and relevant than ever:

"AHCs must take the lead in modeling and developing STEEEP* approaches to—and systems of—care that can demonstrate proof of concept in the widest possible array of populations, disease states, and settings. . . . Through our own innovations and demonstrations and in partnership with the public and private sectors, we must demonstrate and advocate for the vast improvements in health services and population status that are possible in a system that is STEEEP and accessible to all."[3]

Herein, we offer guidance and suggestions for such constructive engagement.

The Accountable Care Act of 2010

The ACA builds upon America's uniquely market-based model of health care delivery and financing, supplemented by public programs for our most vulnerable populations and for populations not easily served through market mechanisms. There is much within the ACA that maps directly to the goal of a value-driven, evidence-based health care system. The goals of the ACA have been characterized in the simplest possible terms by Don Berwick, former administrator of the Centers for Medicare and Medicaid Services (CMS), as the "triple aim" of lower costs, improved care, and better health.[8] Major ingredients of the ACA were drawn from prior health reform proposals and approaches from across the political and policy spectrum. The 2001 IOM report, *Crossing the Quality Chasm,* is perhaps the most well-known antecedent, but there are many, many others.[4]

As we see it, the ACA involves five very ambitious and potentially disruptive goals:

1. coverage expansion,
2. insurance market reform,
3. payment and delivery reform,
4. quality and safety improvement, and
5. cost control.

Also important focus areas are

1. workforce issues,
2. health information technology, and
3. patients and families.

*an acronym for IOM's six aims re-ordered as safe, timely, effective, efficient, equitable, and patient-dentered

Each goal and focus area involves a complex array of programs and regulations. Most are tied to staged rollout schedules that span the coming decade.[9]

An inventory of key elements

The National Quality Strategy

The ACA is based upon a National Strategy for Quality Improvement in Health Care (the National Quality Strategy or NQS) developed by the Secretary of the Department of Health and Human Services (HHS). The NQS sets priorities to guide implementation of the ACA. In the interest of capturing the broadest possible input, the Secretary developed an initial NQS through a process that included more than 300 groups, organizations, and individuals representing all sectors of the health care industry and the general public. In addition, the NQS incorporates input gathered through 50 organizations as part of the National Priorities Partnership committed to health system reform. The NQS sets out principles for its implementation. First among these is that the ACA is to be based in incentives and rewards designed to achieve desired health care policy outcomes among all stakeholders:

> Payment arrangements should offer incentives that foster better health; promote quality improvement and greater value while creating an environment that fosters innovation. Health care systems should be rewarded for working collaboratively to improve efficiency and adopt evidence-based practices across the spectrum of inpatient and outpatient services. Medicare, State Medicaid programs, and many private sector health plans and purchasers are moving rapidly to change payment systems to reward coordination and better outcomes. New payment incentives and delivery models that will be launched under the auspices of the Medicare, Medicaid, and private sector partnerships will provide the opportunity to evaluate and bring successful models to scale.[10]

To define, drive, and achieve health policy goals, the ACA employs familiar forms of individual and market incentives and rewards directed to all parties in the health care system. Clearly, incentivization of desired processes and practices is considered fundamental to achieving those goals. Development of the NQS will be ongoing and is intended to lead to actionable and measurable improvements in systems, outcomes of care, and overall health of the American people.[11]

Goal 1: Coverage expansion

The ACA aims to achieve coverage expansion to as many as 32 million currently uninsured Americans. To do so, the ACA provides two major mechanisms: the establishment of state-based insurance exchanges and the expansion of the Medicaid program. To facilitate establishment of exchanges, states are incentivized through substantial grants and other measures to create insurance exchanges designed for easy and transparent access to health care information and provider quality metrics, a robust choice of coverage options, and health care "homes." Community health centers are being subsidized to expand their capabilities for both individual and population health management. The law then provides for the subsidization of insurance plan costs for individuals up to 400% of poverty in order to help make insurance coverage affordable for up to 16 million Americans who currently cannot afford such coverage.

The ACA's second major mechanism to expand insurance coverage is by expanding Medicaid eligibility in order to bring insurance coverage to another 16 million Americans of very low income (up to 133% of poverty). The ACA guarantees states full payment for newly eligible Medicaid enrollees through the year 2018 and then 90% of the payment thereafter. States also are being subsidized to create high-risk pools to deal with the most-difficult-to-insure patients. Additionally, the ACA incentivizes small businesses through tax credits to provide insurance to their employees. There are also incentives (both positive and negative) for large employers to retain and enhance health coverage among their employees. And in 2017, states have the option of allowing large employers to secure employee coverage through insurance exchanges.

One early example of coverage expansion that

has been well received by the public has been the provision that allows young adults up to age 26 to continue health insurance coverage through the policies of their parents. More than 2.3 million young adults have obtained coverage on their parents' plan as a result of the ACA.[12]

The ACA also works to improve Medicare coverage with the addition of payments to fill the gap in the Medicare "donut hole," as well as with provisions requiring Medicare policies to cover "selected" preventive care visits and services. The ACA originally provided for the creation of a new long-term care financing program to support community living for the elderly and disabled, but implementation of this provision has been suspended.[13]

As these and more coverage expansion provisions are implemented through 2018 and potentially beyond, a broad array of additional incentives and rewards is scheduled to be introduced, designed to engage all parties in achieving the broadest possible enrollment of Americans in health insurance and to achieve near universal coverage.

Of course each of these programs comes with its own set of problems and potential unintended consequences. For example,

- For states, the financial incentive to enroll those newly eligible for Medicaid also entails disincentives to dis-enroll current enrollees (at a time of recession and tight budget when states are desperate to reduce Medicaid budgets) and the likelihood of increased fiscal burdens for the costs of this expanded population in the years ahead.
- For businesses, the intention is that they will continue to pay the lion's share of benefit premiums and manage or contract for aspects of employee health. Yet there is some legitimate concern that more employers than expected may drop employee coverage, which would cause serious erosion in employer-based insurance, a key feature of American health care since World War II.
- For individuals, while many will get access to affordable insurance coverage, those who purchase insurance through exchanges will have to learn to budget for this health care expense.

These and many other consequences must be weighed and understood by all stakeholders.

Goal 2: Insurance market reforms

To achieve insurance market reforms, the ACA also imposes a new set of market regulations that are designed to restructure the business practices of insurers so that they can become more in line with desired societal outcomes for more coverage, better quality, and less cost. New insurance market rules will greatly limit risk-based underwriting, including insurers' capacity to restrict or rescind coverage or to vary premiums based on individual health or demographic factors. Insurers also are subject to new requirements to reduce administrative costs and to stay within certain medical loss ratios (MLRs). Within such a restructured marketplace, the ACA is designed to tap the knowledge and competitive capacities of the insurance industry and direct these toward new metrics that promote societal goals for better health and improved health systems. These would include such metrics as price; provider network breadth; care quality, safety, and outcomes; service; and patient satisfaction. The best case would be for new standards to be developed that push health care quality and outcomes far beyond standards that currently exist.

A major incentive for insurers is the promise of millions of new paying (and government subsidized) subscribers. But since risk-based underwriting is extensively restricted, the ACA also con-

[+]A good example of the broad pedigree of the ACA is the provision establishing an individual insurance mandate, which has become a particularly contentious issue. The individual mandate, the proposal to establish near-universal access with premium assistance, and the notion of a mandate on businesses to provide health insurance, among other provisions of the ACA, have long been considered mainstream and viable approaches in public policy debates. All of these provisions, for example, were contained in the Health Equity and Access Reform Today Act of 1993 (known then as the HEART bill), sponsored by 20 Republican senators, including Senators Hatch, Dole, Chaffee, Bond, Warner, and Lugar, which was filed as an alternative to President Clinton's proposed health care reform overhaul in 1993.[14]

tains an individual insurance mandate. Without such a mandate, or a similar provision, individuals would have no incentive to buy health insurance except when they were already sick. This would undermine the private insurance industry under the new market rules.[+]

Goals 3, 4, and 5: Payment and delivery reform, quality and safety improvement, and cost control

To achieve payment and delivery reform, quality and safety improvement, and cost control, the ACA provides a long menu of programs and incentives. Perhaps the most significant ACA initiative is the provision establishing within CMS a Medicare Shared Savings Program (MSSP) and the regulatory framework for the Accountable Care Organization (ACO) program within it. The ACO program, perhaps more than any other, appears designed to catalyze the formation of health services organizations that can take leadership in delivery reform, quality advancement, and cost control. CMS's initial proposed ACO regulations were roundly criticized by almost all stakeholders as unworkable. The regulations were too burdensome, the costs of entry too high, the risks too great, and the rewards too low. As a stopgap, CMS quickly created two new programs to jump-start ACO development. One is the "Pioneer Program" designed "to move more rapidly from a shared savings payment model to a population-based payment model on a track consistent with, but separate from, the Medicare Shared Savings Program."[15] Another is the "Advanced Payments Initiative" (API),[16] designed to provide financial assistance for the start-up costs of establishing an ACO.[17] There has been some significant uptake on these initiatives.

The ACA is designed to tap the knowledge and competitive capacities of the insurance industry and direct these toward new metrics that promote societal goals for better health and improved health systems.

Then in October 2011, CMS issued its final ACO rule.[18] The revised regulations were met with much better acceptance by the broad range of stakeholders. The final regulations provide for far less burdensome governance and start-up requirements:

- "Meaningful use" of electronic health records is now a performance measure, rather than a precondition for ACO implementation.
- The number of performance measures has been reduced from the 65 to 33.
- The approach to assigning beneficiaries to an ACO has been significantly revised so that ACOs will not held responsible for those beneficiaries who shift their care to other providers during the reporting year.
- The costs of entry have been substantially reduced.

Perhaps the greatest concern with the initial rule was the requirement that all ACOs must assume financial risk by year 3. Under the final rule, CMS offers a three-year shared-savings-only version. Also, the formula for shared savings has been revised so that ACOs that reach savings targets receive a share of the "first dollar" savings (which varies according to risk-track and quality performance). The final rule also adds additional support in the form of subsidies and incentives for physician-led ACOs and for providers serving low-income and rural patients.

These and other actions by CMS indicate that CMS is committed to the ACO program and is working to ensure that it becomes a centerpiece of efforts to achieve a more value-driven health care system.

Another major aspect of the ACA, this one devoted to promoting evidence-based care, is the Patient-Centered Outcomes Research Institute (PCORI). PCORI is an independent organization designed to conduct research to provide information about the best available evidence to help pa-

tients and their health care providers make more informed decisions. PCORI's research is intended to give patients a better understanding of the prevention, treatment, and care options available and the science that supports those options. Evidence will be generated from studies that compare drugs, medical devices, tests, surgeries, or ways to deliver health care.[19] PCORI represents the type of commitment to evidence-based medicine that the Blue Ridge Group has advocated for years to achieve a value-driven health care system.

The ACA also created the Independent Payment Advisory Board (IPAB)[20] to find ways to eliminate waste and achieve cost savings within Medicare. The IPAB is highly controversial among physicians and some other health industry stakeholders because of its makeup and mandate. Its members are to be nominated by the President and confirmed by the Senate and must serve full-time. The board is to have 15 full-time members, but only a minority of them can be health care providers involved in delivering Medicare services. The President must get input from leaders of both parties in Congress in nominating 12 of the 15 appointees. Members are to represent a mix of experts in health policy, representing geographic diversity as well as consumers and the elderly. The board must include individuals who are expert in specific areas, including pharmacoeconomics or prescription drug benefit programs, health services, and health economics research, outcomes and effectiveness research, and technology assessment.[20]

IPAB's mandate, beginning in 2015, is to develop proposals to bring the net growth in Medicare spending back to target levels if the Medicare actuary determines that net spending is forecast to exceed target levels. The IPAB was significantly restricted by law and cannot recommend rationing health care, raising revenues or Medicare beneficiary premiums, increasing Medicare beneficiary cost sharing (including deductibles, coinsurance, and co-payments), or otherwise restricting benefits or modifying eligibility criteria.[21]

Because of its controversial status, the future of the IPAB is uncertain. In any case, the IPAB is unlikely to affect Medicare spending over the next decade. In March 2011, the Congressional Budget Office estimated that the Medicare baseline level of spending would not exceed targets from 2015 to 2021.[22]

For providers, in 2011, the new Center for Medicare and Medicaid Innovation (CMMI), began sponsoring the testing of delivery and payment reforms that reward providers for quality and value and incentivize the creation of health care homes and innovations in providing primary and preventive care. The ACA provides $10 billion in funding for CMMI to evaluate and test a number of care delivery models. Among these is the provision to develop Healthcare Innovation Zones (HIZs). HIZs should be of particular interest to AHCs. They were proposed by the Association of American Medical Colleges (AAMC) to provide resources to support building AHC leadership capacity in clinical innovation involving community partners. According to the ACA, Section 3021, HIZs are: "groups of providers that include a teaching hospital, physicians, and other clinical entities, that, through their structure, operations, and joint activity, deliver a full spectrum of integrated and comprehensive health care services to applicable individuals while also incorporating innovative methods for the clinical training of future health care professionals."[23]

For AHCs, HIZs can potentially provide a useful ACA mechanism through which to evolve clinical services and training programs into more integrated clinical delivery systems while strengthening community partnerships. The larger ACO program can be daunting for AHCs that have yet to effectively integrate traditional academic and clinical units in ways that can compete with community health systems and providers that do not carry the academic mission. And university academic health systems have only so much capacity to accept clinical risk before serious questions arise about fiduciary responsibility to the rest of the university and its educational missions. The HIZ program could provide significant funding to incentivize innovative models for clinical integration in the AHC and partner environment. As with many of the initiatives being sponsored by the CMMI, the HIZ program should

be one with which AHCs engage closely as CMMI refines the HIZ programmatic focus.

Another important CMS initiative is the Medicare Value-Based Purchasing program (VBP).[24] VBP looks at performance in measurable clinical process, outcome, and utilization (70%) and patient experience (30%) within a specific pool of dollars by disease entity. The VBP penalizes poor performers and rewards good performance. The ability to adopt such a program is based on advances made in the use of standardized process, outcome, and experience metrics that are benchmarked across large populations. In addition to process and outcome metrics, patient experience metrics have now been standardized through the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS).[25] HCAHPs is a joint initiative of CMS and the Agency for Healthcare Research and Quality (AHRQ). The HCAHPS initiative provides a standardized survey instrument and data-collection methodology for measuring patients' perspectives on hospital care. There is a real opportunity here for AHCs to become expert in quality and safety improvement and to pioneer the highest standards with and through the VBP and HCAHPS.[26]

Workforce

The ACA contains numerous provisions related to developing elements of the health care workforce. But the Blue Ridge Group is also concerned about the aspects of workforce that are not addressed.

The ACA creates a National Health Care Workforce Commission (NHCWC) to advise policy-makers on ways to improve the health care workforce; to improve coordination at the federal, state, and local levels; and to encourage innovations that address population needs, changing technology, and other environmental factors.[27] Also created is the National Center for Health Workforce Analysis (NCHWA) within HHS. The ACA also authorizes such state and regional centers. These centers will collect, analyze, and report data and develop comprehensive information describing and analyzing the health workforce and workforce-related issues as well as performance measures and benchmarks.[28] There are also programs for Medicare incentive payments to primary care providers (PCPs), increased Medicaid payments to PCPs, increased funding for the National Health Service Corps, and Health Workforce Development Grants administered by the Health Resources and Services Administration in consultation with the NHCWC). A Primary Care Extension Program is providing grants through AHRQ to establish state hubs and local extension agencies and grant support for local primary care physicians with the implementation of medical homes, evidence-based medicine, and improved community health. Also included are grants to develop/expand PCPs, the geriatric workforce, rural physician training, graduate medical education technical fixes, and a wide range of programs and initiatives to support other essential personnel like nursing, allied health, rural health, local direct care providers, patient navigators, and many others.[29]

All of these provisions are intended to improve access for millions of newly insured Americans by the following means:

- increasing the supply of needed health workers, particularly PCPs,
- increasing efficiency and effectiveness by encouraging systems redesign,
- addressing problems of mal-distribution, and
- improving quality of care through improved education and training.

The ACA also creates an infrastructure to collect and disseminate better data and information to inform public and private decision making around the supply, education and training, and use of health workers.[29]

Yet while there is a great deal of important investment in workforce contained within the ACA, some critical areas of workforce development are not addressed. There is much evidence suggesting that shortages already exist in primary care and gerontology as well as in particular medical and surgical specialties, including psychiatry and general surgery, with projections of shortages developing in fields like orthopedic surgery.[30,31] Considering the large number of Americans to be insured through the ACA as well as the expected future increased demand from a Baby Boom Gen-

eration that is just beginning to reach retirement age, there is cause for concern that the measures to address workforce are insufficient. Clearly, any national workforce plan must take into account the full array of disciplines and specialties and design incentives and programs needed to support this full array of identified needs.[32] This is a critical area in which AHC and other medical professional leadership must work together to bring these specialty physician workforce needs more clearly before HHS, along with appropriate programmatic proposals with which HHS can address these needs.

Health information technology

Health information technology (HIT) and the adoption of electronic health records (EHRs) and interoperable health information systems are critical factors for the success of the ACA and health system reform. The migration of health care information and record keeping from paper-based systems to electronic systems is vital to creating a more effective, safer, and higher-quality health care system.

The ACA is not the sole source for key tools needed and deployed for all stakeholders in the reform effort. The American Recovery and Reinvestment Act (ARRA) of February 2009 included the Health Information Technology Economic and Clinical Health (HITECH) Act, which established the goal of nationwide adoption of the meaningful use (MU) of electronic health records. HITECH authorized up to $27 billion in incentive payments to eligible professionals, hospitals, and critical access hospitals (CAHs) to adopt and demonstrate meaningful use of certified EHR technology. Another $2 billion was authorized to build a national EHR support infrastructure. As in other aspects of the health reform process, CMS is providing payments to eligible providers to incentivize the adoption of HIT and EHRs.

According to CMS, "meaningful use" (MU) means "[P]roviders need to show they're using certified EHR technology in ways that can be measured significantly in quality and in quantity."[33] MU has three main components:

1. The use of a certified EHR in a meaningful manner, such as e-prescribing, and electronic management of a patient's medications, problem list, and active diagnoses.

2. The use of certified EHR technology for electronic exchange of health information to improve quality of health care.

3. The use of certified EHR technology to submit measures of clinical quality and other metrics. [33]

CMS has separate Medicare and Medicaid EHR incentive programs. The Medicare EHR Incentive Program provides payments to eligible professionals up to $44,000 over five years, with additional incentives for eligible professionals who provide services in a health professional shortage area. The Medicaid EHR Incentive Program will provide incentive payments to eligible professionals, eligible hospitals, and CAHs as they adopt, implement, upgrade, or demonstrate meaningful use of certified EHR technology in their first year of participation and demonstrate meaningful use for up to five remaining participation years. As a measure of how seriously CMS takes the need to move providers to meaningful use of HIT, the program provides for penalties for those providers who do not demonstrate meaningful use by 2015. Given the economic downturn, there is ongoing debate about whether the proposed rewards are sufficient for certain providers, especially those in rural and small practices.

The separate Medicaid EHR Incentive Program is voluntarily offered by individual states and territories. Eligible professionals can receive up to $63,750 over the six years that they choose to participate in the program. MU is being phased in through a staged sequence, with stage 1 now under way. Stage 2 is scheduled to be implemented in 2013, with stage 3 in play by 2015.[34]

The exact metrics for meeting MU criteria and qualifying for incentive payments, like many other aspects of the ACA implementation, are being negotiated on an ongoing basis. But it is clear that incentives will remain through the duration of the program and that meaningful goals and milestones will need to be met in order to qualify for the incentive payments.

Also being implemented is a national in-

frastructure supporting MU, also authorized by HITECH. The Office of the National Coordinator for Health Information Technology (ONC) within HHS is implementing a system of 62 regional extension centers (RECs) across the nation providing local support for providers, especially for smaller primary care practices and for small and rural hospitals. The goal is to support 100,000 primary care physicians in achieving MU.[35] ONC is also providing financial support for six-month HIT workforce training curricula at 84 community colleges around the country, most of them offering distance as well as on-campus enrollment.

The goal is to enroll 10,000 people per year. An initial group of 3,400 completed the curriculum in the spring of 2011.[36] One limitation of these programs is that many of the educational sites have had little to no experience with EHRs, and there is a tendency to focus upon EHRs simply as being an IT undertaking rather than a challenge requiring changing one's entire mode of practice. The transition to ICD-10 from ICD-9 is further complicating the environment since it was delayed in the United States for many years through effective lobbying by the hospital sector. And now the transition is being opposed by the American Medical Association, which has stated that the ACA is requiring such significant changes from physicians that the ICD-10 transition should be indefinitely postponed.[37]

The ONC is also supporting the establishment of state Health Information Exchange (HIE) programs. These enable each state to undertake customized statewide HIT coordination consistent with broader interoperability standards. So far, 35 states have HIE plans approved for implementation, though progress varies greatly by state.

Ideally, EHR adoption and MU could enable deployment of unprecedented capacities for health care decision support and great advances in both personal and public health. MU is a cornerstone of a value-driven health care system. However, it is unclear how well the current rollout of MU capabilities will succeed.

Meaningful use goes beyond mere acquisition or installation of HIT. Meaningful use of IT requires training throughout professional education and deployment throughout medical practice: the continuum of care. Successful implementation will need to aggregate the people, talents, and facilities to be able to provide coordinated services across this continuum. In complex cases this means coordinating care outside of hospital and traditional outpatient settings, including home and assisted-living care as well as hospice and end-stage care These challenges of implementing HIT must be recognized in health professional educational curricula and supported by appropriate funding and research, both in the technologies themselves and in the cognitive dimensions of technological adaptation and implementation as well as user interfaces and related issues.

While EHRs have been around for 30 years, the initial criteria for approval set too low a bar, and both doctors and ONC could pay a price for that lapse of discipline for some years to come as the market eventually consolidates into fewer providers capable of really delivering a useful, robust product. The goal needs to be to increase quality and safety metrics into the care "recording" process so that system improvements occur and physicians and other clinicians are rewarded for using computer-compatible, evidence-based care guidelines.

The Health Information Technology Extension Program could be helpful in this. The program has created HIT RECs throughout the country as well as a national Health Information Technology Research Center (HITRC). The concept of an HITRC is sound. It is designed to gather information on EHR adoption, MU, and provider support that can be implemented through training programs at the RECs. One limitation of the RECs and this program, however, is that RECs are designed to provide mostly primary care clinicians with the training and support services to become proficient users of HIT, especially EHRs. However, it is clear that all health professionals should have access to such training and support programs. Broadening the scope of research and training support for all providers is an area that AHC leadership should work together to address.

Further, the American Board of Medical Specialties approved a new sub-certificate for a

specialty in clinical informatics. This is needed across all clinical disciplines. Too little investment has been made in research. And money to support the National Library of Medicine training programs in informatics was basically overlooked. This could prove to be a fatal oversight to the longer-term HITECH aspirations. EHRs being sold by vendors today are still very user-unfriendly, and there is little incentive today for vendors to invest in the substantial research and development needed to produce the needed user-friendly products. AHC leadership has a big role to play in refining the focus on HIT training and support.

Patients and families

Patients and families also factor strongly into the ACA. The promise of the ACA is better systems of health care designed around the patient and incentivized to constantly improve service, safety, and outcomes. Providers know that ill-informed and under-informed patients and families can be less than ideal partners in treatment decisions and compliance. Through CMMI and other existing agencies and programs, HHS and CMS are designing and sponsoring programs to improve patient capabilities, knowledge, and compliance in all aspects of their health and care. The goal of initiatives for these "end-users" is the same as it is with all other stakeholders: accountability and mutual, reciprocal responsibility for improving health and the systems of care. The CMMI ". . . fosters health care transformation by finding new ways to pay for and deliver care that can lower costs and improve care."[38] The support for innovation and the many incentives for providers to be accountable for the care they provide are clearly meant to further spur physicians to work with patients to ensure that they understand and can participate as partners in their care.

Additionally, many incentives to the states are designed to make health care exchanges and Medicaid programs easy to access, transparent, and patient/user-friendly. Employers are encouraged to adopt wellness programs and to align co-pays and other costs and benefits to incentivize preventive care and healthy behaviors.

A focus on patients is also to be found within the area of HIT. The secure patient portals identified in the MU criteria for the later years could prove to be a highly important application for bringing patients with chronic illness into their own care in an "up close" and engaged manner. Literacy and languages remain a challenge and are likely to be so for some time to come.

While continuously adopting accountable and increasingly risk-bearing approaches to integrated, patient-centered care, AHCs must ensure that policy-makers recognize their critical missions.

Costs

While many commentators suggest that "bending the cost curve" was not addressed comprehensively by the ACA, the ACA does contains numerous provisions related to cost containment. Many of the provisions for cost containment have been piloted over the past several decades, including bundled payments, global budgets, pay for performance, and a variety of other "managed" care and incentive-based approaches. The MSSP is a prime example. The program is fostering the development of large-scale and some smaller-scale ACOs. These ACOs are expected to move forward from what has been learned about restructuring health care delivery, payment, and practices. Risk-based accountable care provider payment methodologies will be implemented to try to achieve greater efficiencies, quality improvements, and cost savings across systems of care. These experiments could inform ways in which the health care system is organized such that many factors contributing to overutilization and inefficient delivery of care can be eliminated.

The law also does the following:

- imposes new fees on health insurers, drug makers, and some medical devices and indoor tanning services as a way of inducing changes

and reductions in consumption and utilization. Other cost-control provisions are aimed at drug and medical device price inflation;
- requires states to review premium rate requests by insurers to identify excessive or unreasonable premium increases;
- limits insurers to stay within particular medical loss ratios (of course these limits are being negotiated in some instances);
- offers standardized plans through the exchange programs to facilitate comparison shopping as well as spur competition and decrease premiums;
- creates the CMMI, designed to test new delivery system models designed to provide higher quality care more efficiently;
- charges the IPAB with finding pathways to limit overall growth in Medicare spending; and
- beginning in 2018, creates a new tax on high-cost "Cadillac" health plans designed to tamp down unnecessary health spending.

These and many other provisions show that cost control is a significant focus of the ACA, with the cost curve bending out over many years into the future.

Much assembly required

This synopsis of key provisions is meant to highlight ways in which the ACA endeavors to provide a framework to promote and incentivize access, quality, and better value across the health care system. All stakeholders are affected and are expected to find pathways through which to engage and pursue reforms, improvements, and innovations.

The complexity and scope of the ACA and the environment that surrounds it contains dangers for AHCs: One is that they will become passive and "wait until the dust has cleared" to really engage the challenges of the ACA. Another danger is that the sheer volume of new initiatives, both required and optional, will cause AHCs to approach the ACA in ways that are fractured, unfocused, and uncoordinated.

AHCs can ill afford to be unfocused, slow, or unclear about seizing the opportunities and meeting the responsibilities provided within the ACA to adopt accountable care and management practices, to pursue cutting-edge research, to pilot new forms of integrated care, and to engage in ACA-related programmatic initiatives that can facilitate and accelerate an array of reforms and improvements in educational, research, and care programs and processes.

In this context, AHCs have a challenging mission ahead of them as they engage in this process: While continuously adopting accountable and increasingly risk-bearing approaches to integrated, patient-centered care, AHCs must ensure that policy-makers recognize and support AHC critical missions in health professions education, in basic and clinical research, and in providing clinical services that span everything from comprehensive primary and preventive care to care at the cutting edge and into the realm of discovery research.

The Blue Ridge Group believes that there are major risks and opportunities ahead for AHCs (and other provider organizations). Federal and state budgets are shrinking and middle class income is stagnant. There is tremendous pressure to reduce spending in health care throughout the economy. AHCs must marshal the leadership and discipline to approach the multiple aspects and opportunities in the ACA so as to catalyze system-wide innovation, integration, and accountability. Can AHCs accomplish this in such a resource-constrained environment? We believe the answer is a guarded yes, if only because the emerging environment will require it.

Driving value through accountability

It seems hardly possible to overstate the centrality and importance of accountability, not just to the ACO program but to the ACA and to the possibility of real health care reform and coverage expansion. The ability to reform our health care delivery and financing system through a market-based approach such as the ACA is built around depends upon the widespread adoption of accountability as the underlying value, the basic glue, of a value-driven health care system. Put into historical context, the goal is to move beyond health maintenance organizations to ACOs: orga-

nizations capable of assuming responsibility for actually delivering not just services, but "health," to defined populations.

Additionally and equally as important is provider willingness and ability to accept and manage risk that can drive the types of integration and innovation needed to create a value-driven health care system. Incentives/rewards and disincentive/penalties are the fundamental mechanisms available to spur accountability in a market-based system. Risk tolerance and management are fundamental aspects of all businesses and business relationships in a competitive marketplace. The ACA clearly envisions these marketplace fundamentals—accountability and risk-assumption—as animating features. We have seen that these fundamentals are built into virtually every important goal and metric within the ACA.

The ability to reform our health care delivery and financing system through a market-based approach depends on the widespread adoption of the concept of accountability as the basic glue to enable the assembly of a value-driven health care system.

There is some uncertainty at the moment about the extent to which AHCs will be able or willing to engage in risk management. A fundamental issue for AHCs is lack of appropriate and necessary risk-adjustment methodologies for the life circumstances of the populations disproportionately cared for by AHCs: the poor, the less educated, the disabled, the morbidly obese, smokers, and substance abusers. AHCs can get into real financial stress if they take on the financial risks of serving those who live in poverty. AHC and other health professional leadership will have to work hard with HHS to ensure that the proper risk-adjustment safeguards are in place so that AHCs can accept risk for populations they serve. For providers, managers, administrators, and executives of AHCs (and all other provider organizations), it is clear that this requirement to assume and manage risk goes to the very heart of the ACA and of their organization's capabilities and aspirations within the new national health reform framework.

Many health industry leaders understand the importance of accountability as not just a goal but a value. They see adopting accountability as a value as a way to achieve success in their missions and in their bottom lines. They also understand that being accountable entails assuming real risk, even though it will be mediated and negotiated through Medicare. As in any vibrant marketplace, accountability and risk management are there to frame and to motivate the types of behaviors and outcomes that competitive markets are capable of, including efficiency, lower cost, innovation, and re-investment. These competitive fundamentals are the very mechanisms that the Blue Ridge Group has advocated as necessary to reform that, ". . . promotes the health of individuals and the population *by providing incentives* to health care providers, payers, communities, and states to improve population health status and reward cost-effective health management [emphasis added]."[3]

The trillion dollar question

Will AHCs assume and manage the risks of accountable care?

The Blue Ridge Group believes that the way forward for highly organized health systems, including AHCs and many other types of provider organizations, is the commitment to accountability and assumption and management of risk. However, there are real questions about whether the vast majority of AHCs will be capable of making these commitments to accountability and risk management, at least in the near term. In many ways perhaps the most complex and defining challenge facing many AHCs is the issue of how

to participate in the new ACO programs. A recent survey of AHC leaders found widespread doubts about whether their AHCs will be able to do so. But this was not because the ACO standards are so high. The survey was done before the proposed regulations were issued. Instead, the vast majority of AHC leaders reported that their AHCs are still far from having the basic systems, processes, and cultures in place that would enable accountable care and risk assumption.[39]

This is a troubling finding. But the truth is that accountability of providers and provider organizations requires a significant degree of clinical, informational, and managerial integration that is still rare in AHCs. Most AHCs have succeeded in organizing certain clinical services into quasi-integrated services—what has been described as "lateral integration."[40] This is the type of integration found among similarly situated clinical specialists that enables the sharing of facilities and certain resources. Often spine centers and sleep labs are organized in this way, where a number of different specialty departments and providers collaborate and consult together. But almost all such lateral integration into "centers" is based in provider-centric rather than patient-centric models. They rely on and maintain traditional clinical structures rather than integrating them into more efficient patient-centered models of care. They often fail to integrate and share accounting, finances, financial risk, or even basic functions like consolidated billing and scheduling.

There are real questions about whether the vast majority of AHCs will be capable of making commitments to accountability and risk management, at least in the near term.

Similarly, few AHCs have consolidated their management such that the traditional autonomy of schools, departments, centers, divisions, and even individual faculty is mediated by accountability beyond the immediate unit and to a senior team of officials responsible for overall system performance.

None of this is a secret or surprising. There is abundant evidence of the results of this slowness to integrate across the full spectrum of AHCs' missions, from the relatively slow progress in the provider community in realizing even modest improvements in quality and safety metrics over the past decade,[41] to the reluctance of many medical and surgical specialties to adopt broadly vetted revised guidelines for resident training and safety.[42] The fact is that, despite decades of lofty and aspirational rhetoric and initiatives directed at leading change and defining the future (including our own Blue Ridge reports), many AHCs continue to look and operate very much the way they did 30 years ago. Arguably, the most important missing ingredient in the capacity to systematically align and integrate our AHCs over these many years has been a lack of system-wide commitment to accountability for the STEEEP aims articulated by the IOM and for accountability as contemplated in the ACA—especially as it is being made manifest within the regulations governing ACOs.

AHCs have special missions in education, research, and care. But many AHC leaders do not disagree that these have often been developed and protected by winning "favored nation" status in Congress or with federal funding agencies with special carve-outs for direct and indirect medical education and disproportionate share payments and new government-sponsored research programs, like comprehensive cancer center designations and the newer clinical and translational science award grants. It's not that such support for the special missions of the AHC is not warranted. It is that it has largely been structured and provided in the form of add-ons to payment and funding systems that have not been designed within an overall accountability framework. (And though it is certainly the case that AHCs are not alone in having not been held accountable in the ways we are now seeing proposed within the ACA, our focus here is primarily on AHCs). This is largely because we drifted along in America for

decades without coming to grips with the need to more firmly define the place of health care in our national life—and therefore without an agreed national approach and commitment to improving health care and systems.

But now through the ACA, however controversial some of its provisions remain, our nation has adopted a framework designed to achieve near-universal coverage and move toward a value-driven health system. AHCs, as the font of leadership in academic medicine, must resolve to become accountable and to lead in championing the future of a value-driven, accountable health care system. This will be a daunting task. AHCs will have to commit to transitioning from being centers of very special interests and exceptional individuals and individual programs to becoming ever more integrated systems, as well as full community and national partners in creating our value-driven health care system.

The good news is that every AHC has some experience with reforming, adapting, and integrating clinical, research, educational, and managerial structures and functions. All have success stories and war stories that have, in forms great and small, helped prepare faculty, students, administrators, trustees, and patients for the levels of accountability that are now contemplated. Some of these have been based on taking initiative and a leadership role in exploring and innovating along the continuums of care delivery, research, training, and health systems management. Some have been the result of that mother of invention, necessity. Regardless, all AHCs have this relevant experience, and now the task becomes to take this experience and grow it, replicate it, and share it until the cumulative impact is that we are all working together, even if sometimes only in parallel, to assemble the value-driven health care system we want.

This is the toughest challenge we've faced over the past 30 to 40 years. With the credit crisis and the nationwide recession we have experienced, we now face a perfect storm of national economic distress, anti-tax sentiment, state budget crises, and falling reimbursements—all at the same time that the ACA is pushing at the entire industry, from every direction, to reduce costs (revenues) and improve services. The federal and state governments have serious financial problems. The federal budget deficit stood at 10.6% of GDP in 2010, which is well above the target of less than 3%. The federal debt stood at 94.3% of GDP in 2010, about 50% larger than the target level.[43] There is just about complete consensus that debt and deficits at this level are both unsustainable and very dangerous for the economy and for the prospects for our future prosperity. And states are in many ways in even more serious trouble because they must balance their budgets every year. All states have had to cut back on outlays to all sorts of essential services, from Medicaid to schools and teachers and public safety personnel.

So for the foreseeable future, the work of reforming and restructuring in health care to achieve accountability will occur within overarching constraints on federal and state spending and the pressures to increase public revenue collection (taxes). And of course, these critical fiscal policy challenges will continue to be framed by a highly partisan political environment, including a near-term presidential election cycle. As a result, this will continue to be a highly fluid environment.

All AHCs, whatever their level of experience with clinical integration, system-wide accountability, and/or ability to assume and manage risk, must now look to ask the very hardest questions and to assess their capabilities thoroughly. They must take an honest inventory of their strengths and weaknesses relative to the accountability and risk-management metrics that are being written into the federal code. They must be full partners with their communities and regions in order to bring some coherence and economy to health care.

The passage of the ACA represents only the beginning of a long journey ahead in refining and implementing measures that will create a value-driven, evidence-based health system. It is imperative that AHCs participate thoroughly in creating such a health system. There are many incentives and programs within the ACA through which AHCs can make progress along each of their missions, as well as contribute to the overall

health policy goals for the health system. There are also many areas in which AHC leadership will be needed to rectify shortcomings in the new law or redirect elements of rule-setting and its implementation.

Conclusion

Health reform and restructuring in the United States is at a crucial crossroad. We have embarked on a new national project in health care reform in the midst of a perfect storm of economic and political problems. On top of this are ongoing major workforce issues, impending population shifts, global financial instability, and other key forces shaping a future about which we know scarcely only two things for certain: It will be different, and it will be difficult. While the nation's AHCs have been through many periods of change over the past few decades, the Blue Ridge Group understands that the current environment is unlike anything we have experienced in decades. Ours is a unique period of both great challenge and great opportunity. AHCs, by virtue of being multispecialty practices, are well positioned to provide essential leadership in developing accountable health care. But AHCs have much to do to better position themselves for an accountable care world in which success is to be based on achieving targeted financial efficiencies and measurable care outcomes. It is imperative that AHCs are proactive and take leadership roles in achieving the value-driven health care system that we want.

Recommendations from the Blue Ridge Group for where to go from here are consolidated for Reports 15 and 16 on page 37.

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The Blue Ridge Academic Health Group

Report 16. Academic Health Center Change and Innovation Management in the Era of Accountable Care

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Prelude

In this special double issue, Report 15 reviewed the main provisions of the Patient Protection and Affordable Care Act, hereinafter referred to as the "Accountable Care Act" or "ACA", and took stock of the opportunities for academic health center (AHC) leadership in achieving a value-driven health care system. In this, our 16th report, we examine ways in which AHCs can leverage their unique characteristics and capabilities through the ACA to improve health care, research, and training systems. We also explore and recommend several initiatives that could help AHC leadership further these essential missions in achieving value-driven health in the era of the ACA and accountable care. Note: The Blue Ridge Group meeting for Report 16 was held in June 2011.

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Academic medicine is "the perfect storm of organizing difficulties which renders leadership weak and vulnerable to the demands of multiple professional identities seeking to assert control over their own professional practice."

—Tom Gilmore, University HealthSystem Board of Directors

You never change things by fighting the existing reality. To change something, build a new model that makes the existing model obsolete.

—R. Buckminster Fuller, 20th century inventor and futurist

The past isn't dead. It isn't even past. —William Faulkner

AHC Change and Innovation Management in the Era of Accountable Care is 16th in a series of reports produced by the Blue Ridge Academic Health Group. The recommendations and opinions expressed in this report represent those of the Blue Ridge Academic Health Group and are not official positions of Emory University. This report is not intended to be relied on as a substitute for specific legal and business advice.

Report 16 Academic Health Center Change and Innovation Management in the Era of Accountable Care

Introduction

The Blue Ridge Academic Health Group for years has advocated for reforms that will improve the health and productivity of American citizens through assured access to evidence-based care and services within a value-driven health care system. The health reform law or Accountable Care Act (ACA) passed by Congress and signed by President Obama in March 2010 contains important provisions that should help in achieving these goals. As detailed in Report 15 of this special double issue, the ACA includes plans for a significant expansion of health care coverage to as many as 32 million Americans, primarily through new state-based health insurance exchanges and expanded Medicaid eligibility. It also presents a vast, highly complex menu of opportunities and responsibilities for academic health centers (AHCs) and all other providers. While the ACA is being challenged in many ways, from the constitutionality of its "individual mandate" to its congressional funding, this report assumes that the ACA more likely than not will continue to be rolled out over the next nine years. AHC success in this era of national health care transition and beyond will require both the willingness and ability to become accountable for the triple aim of lower costs, improved care, and better health.[1]

Because AHCs come in many varieties and exist in many different kinds of local and regional environments, it is difficult to generalize about them and their prospects. But an important reality for most AHCs is that they are parts of larger universities. As such, AHCs consist of not just academic and clinical departments, but also of business and operating units that must be managed within the overall missions, budgets, and priorities of the university. Each university must view its AHC from the perspective of its contribution to the overall university mission. Each also must view its AHC as a very large health care "business" that must be managed within the framework of its brand and financial position in the marketplace. The performance of AHCs has serious implications for the overall financial viability of parent universities, including their credit ratings and therefore the costs of borrowing and the capacity to raise funds in the bond marketplace.

AHCs have had to adapt to increasingly competitive markets for health care services while also covering their added costs as the main centers of bioscience and clinical research and of health professions education. A major historical strength for AHCs has come from their pricing power and from their capacity to expand their clinical services. By doing more and charging more, AHCs have been able to generate more revenues. AHCs are by no means unique in this regard. Evidence indicates that much of the steady increase in health care spending in recent years derives from steadily increasing costs per case across the health care system. These are among the types of costs being targeted for reduction by the ACA.[2]

A legacy of AHCs' historic market power has been that AHCs have generally been neither incentivized nor known especially for their service efficiency. Now, AHCs' traditional market growth strategies may not be enough to sustain market share:

- There is increasing downward pressure on health care reimbursement rates.
- The evolving health reform environment could accelerate both a patient and a payer mix shift that could put significant new pressure on AHC revenues.
- There has been pressure to reign in tuition increases and for providing enhanced financial aid. Net tuition per student is falling.
- Reimbursement of research costs from sponsors has been under increasing scrutiny.
- To the degree that government-sourced funding

increases are in question, pricing independence could be eroded, further reducing pricing power.

- Resources are being squeezed by mission elements that are not fully funded by revenues or by overhead support from services rendered. These include educational costs, some health services that do not fund themselves, and many biosciences initiatives. These require growing subsidization at a time when resources are fewer.
- Internally generated reinvestment capital is insufficient for capital renewal, growth, and service/program enhancements.

The new market realities are complex and challenging in themselves for the AHCs. For their parent universities, these issues can create challenges that go to the heart of the university mission. The operating budgets of many universities are intimately tied to their AHC revenues. For many, the AHC represents by far the largest part of their budget and the majority of their payroll and workforce. If revenues are squeezed such that AHCs no longer pay for themselves, not to mention provide cash to the rest of the university budget, this will implicate fundamental issues within the university about how to balance university-wide missions with health system priorities.

Given trends in the health care marketplace, the pressures to add clinical capacity are great. Many AHCs are making significant investments in community-based clinical capabilities and partnerships. At the scale that some AHCs are pursuing such assets, there is a danger that a threshold or tipping point could be reached where the clinical mission overshadows the academic missions and poses risk to the entire enterprise if capital access to deal with cash-flow pressures becomes too costly. With health reform solutions and a new health law calling for providers to work within budgets and with incentives and to assume financial risk for patient populations, AHCs face even larger pressures to scale up clinical business and accept risk in patient management. University boards and leadership will likely be increasingly vigilant and active in monitoring this dynamic within their AHCs. This, in turn, will likely implicate health system business practices, autonomy, and control and bring heightened scrutiny of the AHC's commitment and capacity to meet indispensable missions in education and research.

There are many approaches that AHCs and universities have begun to use to grapple with the realities of this stark economic and policy environment. These include the following:

- Efforts to rationalize budgeting across traditional departmental and unit "silos." This includes important efforts to institute financial and budgeting transparency as well as clarity on cross-subsidization. This has led to more capacity for institutional prioritizing and to more conscious pooling of resources toward highest priorities.
- Redesign of administrative and functional support models in AHC schools and other units to reduce variance and redundancy and to improve cost-effectiveness.
- Integration and optimization of support functions where benefits of scale can be realized. This includes consolidation in areas such as legal, human resources, and audit services; information technology; debt; and investments.
- Philanthropy: Renewing capital and subsidization funds for new facilities, hospital/clinic reinvestment and redevelopment, research, endowment, and program and financial aid.

All of these approaches are required to enable the continued viability of the AHC as a mission-driven unit within the university.

But in this new environment, even more will be required. Many AHCs will have less market power to command higher prices, and they will have less capacity to grow services. Absent the development of new market approaches, some AHCs could face challenges in being able to provide sufficient cash from operations to simultaneously meet current operating needs, invest in and renew physical plants, and grow and enhance clinical, educational, and research programs.

We believe that the vast majority of AHCs can and will find productive and successful paths into the era of accountable care but not without unprecedented attention to their roles in their local and regional marketplace and to their roles within their university environments.

The Challenge: Bigger and better solutions

AHCs traditionally have been organized to implement discrete and relatively small-scale changes in areas such as a clinical business line or the negotiation of a particular insurance contract. The success of such localized solutions has protected and enhanced many an AHC bottom line. But with the social forces now in play, including the ACA's focus on organizing large provider organizations into ACOs, many AHCs, like other health care provider organizations, will need to be organized for implementing larger, system-wide solutions. This will not be easy. There are cultural forces throughout the AHC rooted in long-standing professional values, academic customs, and service practices that are resistant to change. Historical approaches to clinical success and expansion have in many ways served to further reinforce these.

But the health care system is moving inexorably, if clumsily, toward evidence-based and value-driven medicine, whether or not ACA is repealed either in whole or in part. Legacy cultural issues and systems that get in the way of integrated care delivery must be addressed. For AHCs that can address these, there are opportunities for major improvements in quality and cost-effectiveness, within the value proposition embedded in the academic enterprise.

Dynamics of the current provider market

The health care delivery system is evolving from fragmented and volume-driven care to care that is integrated, accountable, and value-driven. These market pressures are catalyzing consolidation and various degrees of delivery system integration.

- Physicians in independent solo or small practices are being pushed to combine with larger provider organizations. They face pressures from electronic health record (EHR) investment requirements, increasing reimbursement complexity, increasing regulatory restrictions on ancillaries, and limited access to capital.
- Hospitals have an increasing need for operating scale and broader geographic reach required for enhanced care management. They face physicians transitioning from traditional relationships and seeking alignment solutions and competitors locking up physicians. They see revenues moving from inpatient to outpatient settings.
- AHCs face the need to have a served population large enough to draw sufficient volume of "quaternary" care, such as transplant, cancer, and other highly complex care to maintain the special skills of faculty and to fulfill their research and educational missions.
- The health system overall is facing slowing payment growth, increasing costs, an enhanced emphasis on care management, and an expanded need to coordinate along the continuum of care and services.

The ACA codified into law significant structural and payment mechanisms and incentives designed to increase these market pressures and achieve rationalization in delivery and payment systems. Major programmatic initiatives (outlined in detail in Report 15) include the following:

- coordinated networks of providers (ACOs) with shared responsibility and accountability for delivering better care at a lower cost,
- Medicare shared-savings programs designed to enable providers to share in the savings that result if they are able to take steps that drive and achieve value,
- bundled payments, and
- Medicaid demonstrations.

However, unlike previous episodes of change in the health care environment and marketplace, the ACA provides a comprehensive road map that details what to expect and when, assuming that the law rolls out within a reasonable approximation of its original scope and time lines. So while the marketplace changes being engineered by the ACA are large, AHCs and other health system stakeholders are not flying blind as in previous times when no national policy guided reform or the changing marketplace. The changes being proposed and rolled out are in public view, as are the many implementation mechanisms. And rather than being a major departure from past experience or marketplace trends, as managed care was when it transformed the health care marketplace

two decades ago, the new health care law reinforces and builds upon payer and practice reforms that have been developing and operating in the health care marketplace for decades.

With such large marketplace changes having been codified into national policy and the scope and time line for these changes having been formally laid out, the case for undertaking larger than normal solutions becomes both more obvious and more compelling. Having such a national framework, for the first time ever, makes it possible to better understand and project the potential risks and impacts for stakeholders in undertaking the bigger solutions that are being incentivized. It also makes it possible to play a role in informing and revising the law, including the regulations that are written and the rollout of specific provisions. And while this "public" aspect of our public policy does bring with it an element of uncertainty, there seems very little doubt that the larger trends toward consolidation, integration, efficiency, risk-assumption, and improved cost and outcomes will continue to shape the health care marketplace in big ways, regardless of the inevitable interim policy skirmishes and detours.

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What we have then is a health care marketplace that will increasingly move away from fee-for-service payments and toward bundled and incentivized payments. The marketplace is being designed to reward the assumption and management of risk to achieve new levels of value: quality, safety, and efficiency in the context of a growing insured population with commensurately better access to health care services. It is a relatively fast-evolving marketplace that requires all stakeholders, including AHCs, to find significant new efficiencies, to work to higher-quality metrics in their health care delivery systems, and to find new market approaches.

What we know of the paths forward

For AHCs, the pathways to integration and efficiency have never been easy to find or navigate. The legacy systems and values and multiple mission focuses that impede such efforts have been documented exhaustively in previous Blue Ridge reports (see page 41), even as many organizations have undertaken significant and often difficult initiatives to integrate and improve both clinical and business processes. Unfortunately, whether in the AHC or other provider organizations, most of the clinical consolidation and integration achieved so far, including of large organized networks of physicians, has stopped well short of transformative redesign and alignment of clinical, governance, and business systems. Inevitably, these limited efforts exhaust capacity to achieve significant improvements in value and to face renewed market pressures. In the new health care marketplace, many provider organizations will scale up and will assume risk and manage care to find cost savings and drive quality improvements. To succeed in a market that is incentivizing the formation of such large provider organizations and the transition from fee-for-service to assumption and sharing of risk, AHCs must be able to move beyond facile models of clinical integration.

There is reason to wonder about the ways in which AHCs will function in the new marketplace. AHCs in general have the advantage of being almost "innately" integrated in the sense that their faculties include broad and deep rosters of specialists and specialized services, along with the capacity for providing comprehensive primary care. There are many possible scenarios for the future. Many AHCs may not be able or willing to achieve the scale required to assume risk and manage the care of large populations. And because of their additional missions in education,

research, and community service, many will seek to maintain essential but costly services, like burn units. Many also will continue to see a patient mix that skews toward sicker and poorer patients. But the market for AHC services is uncertain, and it is likely that special mechanisms must be continued (e.g., disproportionate share payments, graduate medical education funding, etc.) or new ones found that can appropriately compensate AHCs for these services. But regardless of these dedicated mechanisms, AHCs must position themselves in new ways for the new marketplace:

- Some AHCs might take the approach of negotiating with payers and partners to serve as a regional center of excellence for certain specialized services or patient populations or subgroups.
- AHCs might consider coming together to create organizations than can contract regionally or nationally for bundled or specialized services.
- Many AHCs will choose to operate and compete within their existing marketplaces by joining or creating new partnerships with community and industry partners and/or by entering into new types of contracts with payers. The Healthcare Innovation Zone (HIZ) Program within the Center for Medicare and Medicaid Innovation (CMMI)[3] is potentially an important vehicle for such strategies and approaches.
- Some AHCs can collaborate to consolidate high-end services, such as cancer care and transplantation.
- Some AHCs could decide to change their missions or narrow them to align more closely with local and regional needs or with changed university priorities.

Regardless of how any particular AHC moves to position itself in this new marketplace, in order to remain financially viable over the coming decade, AHCs will have to organize themselves to be able to play new roles with public, community, and industry partners. In order to remain viable clinical care systems and to be compelling partners, they must at the least look to genuinely align clinical, governance, and business systems to create heretofore unprecedented and unified AHC clinical systems or businesses.

Who can make the big changes?

For an AHC to remain competitive and compelling as either an independent entity or a partner in the new marketplace, the large magnitude of cost savings likely to be required suggests a need to look very carefully at the basic operating model and organization of AHCs. AHCs that are more integrated have the potential to eliminate significant costs by combining the physician and hospital "businesses." There are great efficiencies to be gained from this and attendant changes, such as

- consolidating practice plan and hospital administration,
- consolidating department administrators,
- consolidating departments,
- creating integrated, multi-disciplinary programs with faculty from two or more departments,
- redesigning care processes to reduce costs and improve outcomes,
- monitoring adherence to practice guidelines and addressing gaps in performance,
- producing the data needed for decision-making and informed contracting, and
- creating a culture of accountability throughout the enterprise.

Each of these represents a big, ambitious goal. As we argued earlier, the new marketplace for health care requires that AHCs venture into unfamiliar territory and prepare to tackle larger system challenges. The project of integrating physicians and hospital services can seem overwhelming. But looking forward, such integration appears to be not just unavoidable, but indispensable. After all, the bulk of AHC patients have always been and should continue to be not the most complex cases, but the volume cases upon which a large group practice must rely. Few volume providers will survive in this new marketplace if they are unable to manage populations.

The capacity to reach such goals depends on a host of variables, the most important of which is effective leadership. But great leadership is not enough without critically important organizational, operational, cultural, and even some intangible assets.

Models and types of delivery system integration and alignment

The following typology, elaborated and tested by the Chartis Group, helps in understanding the importance of the overall corporate organization of AHCs. In almost every case, AHC organization takes one of five distinct forms (see Figure 1):

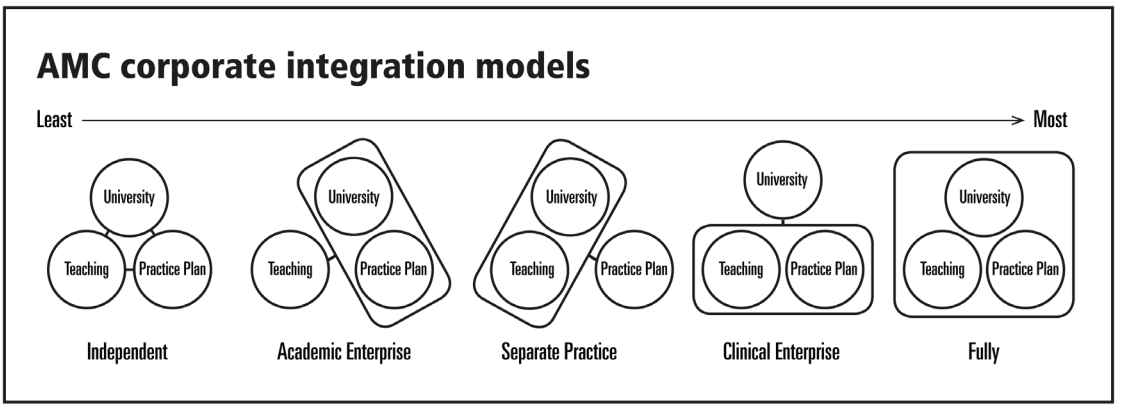
- The independent model: AHCs in which the primary teaching hospital, school of medicine, and faculty practice plan are not formally related by shared or overlapping governance.
- The academic enterprise model: AHCs in which the school of medicine and the faculty practice plan are under common ownership, but the teaching hospital is legally separate from the school/practice plan.
- The separated practice plan model: AHCs in which the school of medicine and the university hospital are under common ownership, but the faculty practice plan is legally separate from the school/university hospital.
- The clinical enterprise model: AHCs in which the faculty practice plan and the teaching hospital are under common ownership, but the school of medicine is legally separate from the clinical enterprise.
- The integrated model: AHCs in which all three entities are formally related through a unified or overlapping governance structure.[4]

The majority of AHCs have at least one key component of their organization legally separated from the other components and so are not of the fully integrated model. While full integration is more common among the top 25 AHCs (as ranked by NIH awards or *US News & World Report*), it is much less common among the remaining AHCs. In the 1980s and 1990s, many universities acted to separate their university hospitals from the university to provide greater operational and financial flexibility. In the ACA era, this separation appears to make achieving needed operational and management alignment more challenging.

What is meant by "alignment?" Alignment is found where ". . . medical school, practice plan, and university hospital leaders act in concert to achieve a common vision and goals."[4] The Chartis Group has found that this requires alignment in four key areas (see Figure 2):

- Strategic alignment. This reflects agreement on a vision, measurable goals, specific strategies, and the commitment of resources required for implementation. The vision and strategy should reflect the unique value proposition that leverages capabilities and resources from across all missions to differentiate the AHC from non-academic competitors.
- Governance alignment. This reflects governance approaches that bring together senior leadership across the AHC, whether school, practice plan, or hospital-based, and provide effective mechanisms for oversight and coor-

Figure 1



Source: Levin S, et al.[4] (Organizational structures and diagram originally described by Levine JK. Considering alternative organizational structures for academic medical centers. *AAMC Academic Clinical Practice.* Summer 2002; 14:2.)

dination among units. The availability and use of timely performance information and the willingness of leaders to bring difficult issues to the governance group are key factors in success.

- Economic alignment. This reflects the organization of funds flow to enable and create incentives for individuals and units to support and meet personal and organizational goals. Small changes to funds flow methodologies can have a large impact on behavior and performance. Experience also shows that the development of appropriate mechanisms to share financial information across units and missions can be a critical success factor.
- Management alignment. This reflects the organization of senior team roles, responsibilities, processes, and information required to effectively coordinate programs across multiple units and missions. The involvement of faculty leaders in management of programs across and between units, supported by strong managers who are able to work collaboratively, helps to build support for AHC-wide goals. Other critical success factors include unified or interoperable management systems, timely sharing and transparency of information, and individual performance incentives that align planning and behaviors around predetermined objectives and missions.

Research has shown that the AHCs that are fully integrated at a corporate level report higher levels of alignment in all four of these dimensions.[4] The clinical enterprise model also shows capacity for strong overall alignment. The evidence also shows that such alignment is key to being able to engage system-wide on the big problems with commensurately big solutions.

But even in AHCs that are structurally integrated at the corporate level and whose alignment is described as strong in each dimension, it is often found that alignment is not so strong at the operational level. Operational alignment, which must occur at the level of implementation, can be elusive without keen attention to the details and to the dispersed leadership needed to translate strategic objectives into successful action. Details that can easily slip include a lack of resources to support strategy implementation and a lack of clear accountability mechanisms and actionable metrics. Trust is an essential intangible, as is an organizational culture that encourages, supports, and rewards accountability.

At least one study suggests that, at least for AHCs, functional alignment is more strongly associated with improved fiscal and mission performance than structural integration.[5] But there is also good evidence that functional integration can be greatly facilitated by structural integration, and a number of AHCs have reorganized themselves to achieve structural integration for strategic reasons.[4] It is likely that AHCs structured on the independent, academic enterprise, and separated practice plan models generally will find it more difficult to prepare for and to implement big solutions to forthcoming marketplace changes. Generally, AHCs structured in these ways are slower to move beyond very localized market adaptations and lack the experience of tackling larger or system-wide integration of clinical and administrative systems. And even once the AHC is motivated in this direction, clinical integration and alignment are not efforts that can be accomplished quickly.

Stages of alignment and integration

There is a set of stages through which people and systems tend to progress in attempting to strengthen their degree of integration and move toward alignment. They can be characterized as follows:

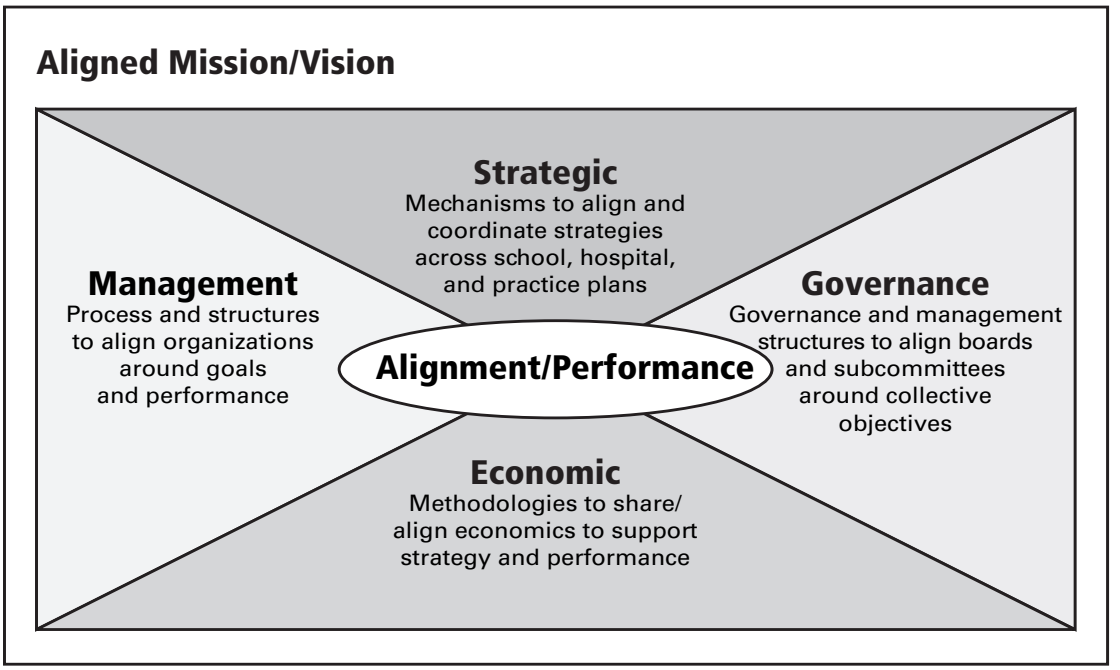
Aggregation stage—

- Health systems and large groups acquire physicians to gain market share and defend referrals.
- The physician organization is fragmented, lacking unified clinical or business processes or market presence as a group practice.

Integration stage—

- Employed physicians evolve toward group practice with standard clinical and business processes and a governance model within the health system.
- Physician and hospital businesses are managed separately.
- Ancillary income locus drives economics.
- Financial incentives are used to align behaviors.

Figure 2



Alignment stage—

- Physician and hospital economics are integrated.
- Physicians serve in key health system leadership roles.
- Fully integrated service lines are created.
- The focus is on optimizing overall performance rather than simply on business unit performance.

Of course every AHC can be seen to be an amalgam of these, and most are characterized especially by the first two stages. The stage of full alignment is not easily achieved and remains difficult to sustain in the fee-for-service environment. But as we move forward, this type of alignment will become increasingly adaptive and advantageous.

Moving from the aggregation stage to the integration stage in even one or two dimensions in one or two units or divisions has often taken years. It requires the transition from traditional autonomous practice patterns to group practice and shared accountabilities. Both the systems and behaviors required for this transition must be developed through experience and the investment of significant resources.

Some AHC leaders believe that change at this level and of this magnitude requires a "burning platform" or will inevitably be jump-started in this way. And it may be the case that the fiscal, organizational, and management issues within some AHCs are simply too daunting to allow for an orderly and staged transition to highly integrated or aligned visions, goals, and systems. But with ACA now in place and the marketplace for health care services such as it is, one can hope that the AHC community increasingly will understand that integration, alignment, and accountability are baseline elements of future success. To wait for a burning platform to motivate change is paramount to abdicating leadership and responsibility for the critical missions that AHCs perform for society.

Despite the daunting nature of the changes that must be undertaken and the daunting environment within which such changes must be accomplished, the motivated change agent can find many resources to help catalyze needed change.

The experience of many AHCs and other provider organizations can show the way through the process of adapting to big changes and developing leading solutions.

In fact, 11 AAMC member institutions are among the sites designated under the Pioneer Accountable Care Organization (ACO) Program in December 2011. This federal initiative is designed to encourage institutions to provide better and more coordinated care for their Medicare patients and control health care costs. Allina Hospitals & Clinics, Banner Health Network, Beth Israel Deaconess Physician Organization, Bronx Accountable Healthcare Network, Dartmouth-Hitchcock ACO, Fairview Health Systems, Partners HealthCare System, Mount Auburn Cambridge Independent Practice Association, OSF Healthcare System, TriHealth, Inc., and University of Michigan were the AAMC members included with 21 other organizations in an announcement by HHS Secretary Kathleen Sebelius. As AAMC President and CEO Darrell G. Kirch, MD, said at the time, "The health care systems chosen for this initiative have passed a rigorous selection process and have demonstrated creative and effective approaches to health care delivery and cost containment. We are pleased that a number of our members will be part of this exciting, important effort."[6]

A word of fiscal caution

Many AHCs have become financially overleveraged. AHCs, especially some of those that are most research-intensive, have invested heavily in fixed assets and capital building projects. As a result, they are cash-poor, have high debt-to-cash ratios, and/or high ratios of illiquid to liquid assets. Such financial positions give an AHC and its parent university very little margin for error or for maneuvering in the case of significant market changes. This is a great liability for some AHCs and should provide further motivation to accelerate integration and alignment, especially of clinical assets. At the precipice of the new era of accountable care, all AHCs should be shoring up their financial positions and building liquidity that can provide a greater degree of institutional agility in case of need. System-wide integration and alignment have the potential to provide a needed measure of system-wide cost savings as well as the ability to negotiate and pursue other market advantages with payers and partners and to identify and support innovation on the part of internal change agents.

Examples of adaptive approaches by academic health centers and systems

There are some very adaptive approaches that some AHCs have already pioneered to effect cost-control, delivery reform, and educational and research innovation. The capacity to effect big changes and solutions follows in the experience of successfully undertaking increasingly more systemic integration and consolidation initiatives. There is much fertile ground for such initiatives throughout the tripartite AHC missions.

The following examples are meant to illustrate particular AHC approaches to innovation and leadership in the new era of accountable care. As AHCs come in many shapes and sizes, these examples may not be directly transferable to the circumstances or environment of other AHCs. Nevertheless, at a minimum, we believe that the following examples do illustrate the types of strategic and integrative thinking and action that can position AHCs for success in the era of accountable care.

University of California Health System

The University of California Health System (UC Health) has succeeded in both system-wide and more localized but also systemic innovation in the direction of value-driven care as well as in the integration and alignment of educational and research components with the care delivery system.

UC Health is a virtual organization that includes 16 UC health professional schools and 10 UC medical centers on 8 of UC's 10 campuses.

UC Health has a history of leveraging resources through partnerships. In the past decade leading up to and into our current ACA era, there has been strong work both in-house and with partners in critical areas that include the following:

- payment optimization;
- purchasing and supply chain initiatives;
- programs related to clinical quality, safety, effectiveness, and coordination; and
- performance based incentives.

To catalyze and share innovations systemwide, UC Health established the UC Center for Health Quality and Innovation in October 2010. This center is designed to "promote, support, and nurture innovations at UC medical center campuses and hospitals to improve quality, access, and value in the delivery of health care."[7] The center operates as a best practices clearinghouse, helping to identify innovations already under way across UC that contribute to advances in health care delivery. The center provides grants for promising projects and also helps determine their appropriateness and replication throughout the UC system. So as to leverage the widest and deepest experience and expertise possible in innovative health services and best practices, the center fosters collaborative relationships with the full range of constituencies served by UC, including policy-makers, employers, health plans, regulators, other health care institutions, and patient advocacy organizations.

UC Health has also been very successful in leveraging resources through partnerships.

UC Davis

Internal—At UC Davis there has been much innovative work done in integrating and aligning educational resources organized around an innovative learning model. The school of medicine, Betty Irene Moore School of Nursing, health informatics, and public health programs are all collectively integrated as the UC Davis Schools of Health. Together, they have developed integrated programming to prepare health professionals for team care, team science, and team learning. They have leveraged and aligned programs so that there are substantive inter-professional education opportunities, with shared infrastructure and collaboration among faculty. UC Davis has also been able to eliminate and consolidate redundant services to achieve efficiencies and cost savings. Such alignment among faculty and students builds both the organizational and cultural experience necessary to meet the demands of an accountable health care system.

Community: San Joaquin Valley Program in Medical Education—Looking outward to their community, UC Davis has teamed with UC Merced and UCSF Fresno to extend its integrative framework outward into the community while creating an innovative approach to recruiting and training future physicians. The program is anchored in community-based research and educational experiences. What is most innovative about this program is that it trains medical students to provide care in one of the state's most medically underserved areas. It recruits medical student applicants from the valley who are likely to stay in the valley to practice. "The diversity of the San Joaquin Valley, including health systems, diverse patient populations, and broad community partnerships, is a core component of the effort to improve the health and health care of the region."[8] The program utilizes tele-education and faculties at both UC Merced and UCSF Fresno. The program could become the precursor to establishing a UC medical school branch in this underserved area but also serves as a laboratory for new approaches to rural and distance learning with a diverse student and patient population.

Industry—UC Davis is also collaborating with industry partners to leverage resources that would otherwise not be available to their faculty and students, while bringing new sources of funding support into the system. An innovative research model is their PETNET collaboration. A molecular imaging technology agreement creates a hub for research and commercial production. The partners include Siemens' PETNET Solutions, Northern California PET Imaging Center, and UC Davis. In this collaboration, PETNET rents UC Davis space for radioisotope production and for a distribution center for their national radiopharmacy network. UC Davis researchers can do cutting-edge research to develop specialized imaging agents. The partnership is a win-win for all stakeholders and is likely a model for public/private collaboration and leveraging resources.

Global partnerships—Another innovative

research partnership is that between UC Davis and BGI, the world's largest genome sequencing institute, which is based in China. This is a model global academic-industry partnership to build and leverage research infrastructure. This global partnership enables UC Davis to work on large-scale genome sequencing and functional genomics as well as programs in food, human and animal health, and the environment. The connectivity among all of these diverse areas creates a uniquely rich environment for exploring and developing new approaches to health care.

Social determinants—Another innovative research model at UC Davis is the Institute for Population Health Improvement (IPHI). The social determinants of health are seldom factored into health professions education and practice. UC Davis has recognized the centrality of these factors and has established the IPHI in order to create a model that can fill this gap. The mission of the IPHI is "to create, apply, and disseminate knowledge about the many determinates of health in order to improve health and health security and to support activities which improve health equity and the elimination of health disparities."[9] IPHI is pioneering in the area of increasing health care provider competence in recognizing and addressing psychosocial and environmental causes of health conditions.

UC Irvine

UC Irvine is another campus of the UC Health system that is innovating, in this case with an online learning project designed to explore and pioneer the possibilities for online and distributed interactive learning. It is a project that produces previously unavailable assessment and evaluation data about online instruction, while spurring investment in institutional capacity and system-wide efficiencies through a common learning environment.

The potential benefits include the ability to increase capacity for enrollment to meet access and workforce demands, while extending the UC reach to rural areas. There are also revenue and cost implications that include the potential for

- greater tuition revenue,
- reduced instruction costs,
- reduced costs for students through faster time to degree,
- improved management of the teaching workload (particularly in skill-based, foundational, and developmental courses),
- additional time for research,
- additional time for clinical care, and
- continuous feedback on student comprehension.

These and other programs all represent great examples of approaches to integration, alignment of vision, and partnerships that go well beyond traditional boundaries. AHCs characterized by such efforts and initiatives are organizations that are positioning themselves well for the demands of the dawning era of accountable care.

University of Pennsylvania (Penn Medicine)

Another good example comes from the University of Pennsylvania Perelman School of Medicine and the University of Pennsylvania Health System (UPHS). The senior leadership recognized more than two decades ago that institutional success in the future would require integration of individual components into a meaningful whole. Leadership worked diligently over the past decade to implement and refine a distributed leadership structure that facilitates alignment of purpose and activities around strategic priorities. The new model required cultural change. Faculty, chairs, and administrative leadership (school of medicine, practice plan, health system) had to adopt a holistic view of Penn Medicine.

It was incumbent upon senior leadership to instill a collaborative approach toward achievement of institutional goals. This required not just a clear plan for management and governance but also the building of trust. Success would depend on the willingness of individuals and whole units to forego some level of autonomy in favor of shared responsibility for collective priorities. This philosophy had to be implemented in a transparent and practical manner with tangible benefits, both to individuals and to the institution. As anyone associated with an AHC could well attest, achieving such a culture is a tall challenge.

The effort was comprehensive but also focused on some fundamental elements needed for such large-scale change. Among these were funds flow and incentives. These were targeted to

- align with the Penn Medicine strategic plan,
- be fair and transparent,
- match revenues and expenses,
- provide appropriate incentives (for leadership, individual accomplishment was recognized in the context of collective vision and rewarded by means of an incentive plan (50% individual and 50% team),
- develop methodologies to support funds flow for all three missions, and
- measure and monitor over time.

Creating integrated decision-making was key. Penn Medicine established senior leadership coordination meetings, joint meetings of basic science and clinical chairs, a standing committee of department chairs and center and institute directors and the faculty practice plan (Clinical Practices of the University of Pennsylvania [CPUP]), and subcommittees.

Key initiatives—These included the development of a financial partnership to enhance academic investment and development built around incremental investment by UPHS and CPUP. Developing institution-wide buy-in and transparency on funds flow and utilization throughout the academic missions was critical.

Comprehensive assessments and initiatives were also undertaken in the three mission areas of education, research, and clinical care. The results in each mission area have been exemplary. Among other things, Penn Medicine has emerged as a leader in medical education, especially in educational programs designed for a new model of physician who can share accountability, work in collaborative clinical and research teams, and coordinate care. Penn also adjusted its curriculum to help better prepare students for the societal complexities of modern medicine. It is now routine for Penn Medicine students to earn not just an MD but also another joint or advanced degree or program certification. For instance, 52% of 2010 Penn graduates completed either an MD plus Degree Program or a Combined Degree Program. Nationally, 92% of medical school graduates graduate with an MD degree only.

In research, the leadership initiative resulted in Penn Medicine moving aggressively toward innovation in cross-cutting research programs and also to streamline and enhance research administration and support. Again, the results have made Penn more competitive for sponsored research and in measures of faculty research productivity and results.

In the clinical mission, a highlight has been the Leadership Alignment for Clinical Success Initiative, which has instituted innovative approaches to improving clinical quality and outcomes throughout the health system. For instance, in all hospital units, a three-way partnership has been established in which a physician leader and a nurse leader are paired at the unit level with a project manager for quality who brings real-time data and project-management skills to the clinical environment. This innovation has enabled Penn Medicine to target and achieve large gains in quality across a wide spectrum of quality metrics.

Conclusion and lessons learned

The experiences of the UC Health System and campuses and of the University of Pennsylvania provide good examples of AHCs and health systems that have taken the necessary bold and innovative steps to prepare themselves for the big challenges of the era of accountable care and our emerging value-driven marketplace. They present models of what can and must be accomplished through courageous leadership with vision. These are AHCs and systems that are animated by the goals of integrating and aligning systems to improve care, education, and research. These are organizations that have grown cultures of teamwork and collaboration. From the work they are doing, it will not be so much of a stretch for faculty, staff, students, and partners to take further steps into the era of accountability, building on the experience and trust that has so far been translated into adaptive change.

A major lesson from these examples is the importance of courageous and visionary leader-

ship. Such leadership will be required in order to move AHCs beyond the familiar price and brand strategies to the challenges of integrating clinical services and aligning the entire AHC enterprise for success in a value-driven health system.

Key takeaways

- Despite some of the uncertainties about the future of the ACA, both public and private health policy is now very much aligned around the transition to near-universal access to affordable, integrated, and accountable health care.
- Provider organizations that can align physician and hospital services into unified clinical businesses will have distinct advantages in most markets.
- Academic health centers are in a unique position and are particularly suited to align services and lead change in health care. AHCs already integrate comprehensive health professional workforces and clinical services with education and training, infused with the commitment to progress and knowledge creation. In other words, AHCs have many of the elements that are most difficult to acquire in order to provide integrated, comprehensive care. Their common project is to engineer and to pioneer in developing model centers of accountable care.
- Certain approaches can be catalysts for integration and adaptation to the new accountable care environment. AHCs are strongly encouraged to pursue the following in a staged and structured way:
  - system and services integration, as shown in the University of California example (see pages 33-36),
  - risk contracting,
  - bundling, and
  - accountability for group performance and outcomes.
- There is a structural solution for every organization and environment. AHCs and other health services organizations must ensure that they are working always to integrate and align systems and services.
- But structural changes are only part of the solution. Meaningful and lasting change is possible only where organizations and their cultures share the goals and values of accountability and have in place a structured plan to achieve improved care outcomes and value.
- Key principles in the building of such organizations and cultures include
  - trust,
  - transparency,
  - operational excellence,
  - accountability, and
  - organizational nimbleness.
- Courageous leadership and goal-setting are absolutely critical for success in all AHCs.

Report 15 & 16: Combined recommendations

On the basis of Reports 15 and 16 and ongoing study of the evolving accountable care environment, the Blue Ridge Group offers the following recommendations:

Overall, AHCs should participate meaningfully in helping to achieve the goal of a value-driven, evidence-based health care system through the ACA's "triple aim" of lower costs, improved care, and better health.

- AHCs should take every opportunity to incentivize and develop integrated approaches to health care, education, and research and their related administrative services. The experience of working toward and achieving integration and alignment is critical to the capacity of all AHC faculty and staff to become engaged change agents for the era of accountable care.
  - The ACA presents a menu of programs, grants, and research initiatives for which AHCs are well suited to compete. We recommend strong engagement in these programs:
    - initiatives in health care delivery and payment reform being sponsored by the CMMI and in particular, the Healthcare Innovation Zones (HIZ) Program;
    - numerous quality initiatives being defined by the National Quality Strategy;
    - extensive work on comparative effectiveness and the evidence base for medicine

and health that will be sponsored by the Patient-Centered Outcomes Research Institute; and
- the build-out and standardization of health information technology (HIT), record keeping and sharing, and meaningful use (MU) through the Office of the National Coordinator (ONC) for HIT.
- workforce development grants, programs, and revised payments being rolled out in various workforce development programs.

There are many other discrete programs through which AHCs can leverage and build their strengths across their missions.

- AAHCs and their universities must think strategically about the role and place of the AHC clinical system in the overall university mission. The age of accountable care suggests the likelihood of an extended period of focus on the integration, consolidation, and expansion of health care delivery systems. AHCs must find pathways through this intense, clinically focused era of transition that also integrate and strengthen their other essential university missions in education and research.
- Much evidence suggests that AHCs that organize their clinical systems on the integrated "clinical enterprise" or "fully integrated" models are likely to be more successful in an accountable care environment than AHCs organized around the academic enterprise or otherwise. Understanding that all alignment begins in the particularities of institutional history and circumstances, AHCs are strongly encouraged to integrate and align their organizations and governance wherever possible around a clinical enterprise or fully integrated model, with functional integration as the goal.
- AHCs are encouraged to consider jump-starting their accountable care capacity-building by working with partners and payers to engage, at a minimum, in limited risk-contracting, bundling, and other contractual methods of creating accountabilities for group performance. Adopting such accountable approaches for even limited service lines can provide indispensable foundations for transitioning toward accountable care delivery models more broadly. AHCs regionally and nationally should investigate opportunities through the ACA's ACO provisions, through the Healthcare Innovation Zone Program, and otherwise, to create collaborative accountable care relationships that can leverage AHC capacities as regional and national centers of excellence. AHCs will need to develop the relationships and coordinating functions for the continuum of care if they are to avoid being relegated to a niche of care players. A development that might be seriously investigated would be where two or more AHCs create a corporate structure through which to pool and leverage the special characteristics of AHCs in regional or national accountable care marketplaces.

It will be important for HHS to adopt the Institute of Medicine (IOM) definition of primary care to ensure that AHCs and other highly complex providers are enabled to participate fully in the ACO program. The IOM defines primary care as follows:

"Primary care is the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community."[10]

- AHC leadership is needed in order to address significant problems and uncertainties, both within the ACA and in the political and economic environment in which it is being implemented. Therefore, the Blue Ridge Group also recommends constructive engagement by AHC leadership in improving or correcting the ACA where it falls short. Areas needing strong engagement include the following:
  - Workforce: With such a large increase in demand for services as a result of enabling up to 32 million more American to acquire health insurance, too little attention was given to workforce enhancements. While there is a dramatic increase in the National Health Service Corps and a Health Workforce Commission as well as incentives to train and retain more primary care providers, evidence is strong that the current shortage

of specialists in many areas will only increase. It is uncertain how the increased number of patients will gain access to needed services without significant new workforce development programs. AHC and other medical professional leadership must work together to draw attention to the need for HHS to address specialty physician workforce shortages.

- Medicare payments, sustainable growth rate (SGR) fix: There was no "fix" to the SGR for physician payment. SGR reform is essential because it remains a sword of Damocles hanging over the provider community. One idea that AHC leadership might pursue is a value-based SGR that puts physicians and other clinicians at some risk but with an opportunity to "claw back" and earn a reward for overall system improvement. This would be in line with the incentive-based ACA structure and would help ensure that the system becomes sustainable and sufficiently reformed. Of course, such a value-based SGR would require a pooling of Medicare A and B, with both devils and angels in the details. But working through the details of such a solution seems like a risk worth taking in order to bring about the needed reforms.
- Independent Payment Advisory Board (IPAB): There is reason for concern about the mandate and makeup of the IPAB. The IPAB is to be a governmental body separated from Congress, composed of 15 experts in health policy and related fields. The members will be appointed by the President and confirmed by the Senate. All members of the IPAB must serve full-time, which makes it impossible for currently active physicians or other health care providers to serve. The IPAB is to make recommendations to reduce Medicare spending in any year that it exceeds prescribed targets. These recommendations must be adopted by the Department of Health and Human Services unless Congress enacts an alternative that achieves the same targeted outcome. Because of this novel approach, the IPAB is restricted by law and cannot, through 2019, recommend rationing health care, raising revenues or Medicare beneficiary premiums, increasing Medicare beneficiary cost sharing (including deductibles, coinsurance, and co-payments), or otherwise restricting benefits or modifying eligibility criteria. These and other restrictions mean that payments for inpatient and outpatient hospital services, inpatient rehabilitation and psychiatric facilities, long-term care hospitals, and hospices are exempt from IPAB-proposed reductions in payment rates during that time. During this initial time frame, the IPAB can only address Medicare Advantage, the Part D prescription drug program, skilled nursing facilities, home health, dialysis, ambulance and ambulatory surgical center services, and durable medical equipment.

  The IPAB is a focus of great concern for many reasons, though primarily because it has such independent power to change Medicare, with little oversight to prevent outsized cuts to providers or to ensure quality and patient choice. With no active physician representation on the board, the IPAB could quickly lose touch with the realities of providing care within Medicare. AHC leadership must play a strong role in addressing these concerns about the IPAB, whether through amending its charter or working to abolish it altogether.
- Health information technology (HIT) and meaningful use (MU): The initial criteria for approval of HIT vendors has set too low a bar and has enabled some HIT vendors to be approved for products with insufficient functionality to meet clinical and MU needs. There are still too few vendors capable of delivering a robust product. The goal needs to be to increase quality and safety metrics in the care-recording process so that system improvements occur and so that physicians and other clinicians are rewarded for using computer-compatible, evidence-based care guidelines.

  The aim is to separate clinical notes from administrative tasks so that clinical notes are focused on useful information for patient care and progress and not for audit and payment.

Those latter functions need to be relegated to the background but tracked by audit trails. Documentation tasks have been "dumped on" clinicians over the years, with insufficient investment in separating business data needs from the complex clinical data that caregivers need to achieve safe, high-quality care and desired outcomes as their primary focus. AHCs are gaining substantial experience with EHRs and could be very helpful in these critical innovations. The goal is to use EHRs to work smarter, not harder.

Furthermore, training programs for physicians to become proficient users of HIT, especially EHRs, are too limited in scope. And support for National Library of Medicine training programs in informatics was basically overlooked. All health professionals should have access to robust training and support programs. The American Board of Medical Specialties approved a new sub-certificate for a specialty in clinical informatics. This is needed across all clinical disciplines. Broadening the scope of research and training support for all providers is an area that AHC leadership should work together to address.

Finally, too little investment has been made in research. EHRs being sold by vendors today are still very user-unfriendly, and there is little incentive today for vendors to invest in the substantial research and development needed to produce user-friendly products. AHC leadership has a big role to play in refining the focus on HIT standards, training, and support.

- Provider empowerment: More and more physicians are working under contracts rather than as independent practitioners. It remains to be seen the degree to which they become part of the leadership team or revert to organized labor strategies, despite the propensity of elected leaders to demonstrate willingness to stand up to organized labor groups. Today, the key individual decision-maker, the individual physician, can feel less and less empowered to be a potent force for evolving a newer, leaner, higher-quality system with better safety and greater economy. AHC leadership must work to ensure that physicians do not become merely line workers in an over-bureaucratized universal health care system. Professional associations also must work to further enhance professionalism in medicine with all of the ethical and social responsibilities this entails for each and every physician.

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