Building an accountable care information system

Rich Moyer
Paul Leonardo

Whatever the outcome of healthcare legislation currently before Congress, it is clear to most observers that the U.S. healthcare system will have to change significantly at some point. There is general agreement that projected cost increases are unsustainable. Reducing the cost of healthcare is no easy matter. Many changes to the system have been proposed and tried. Some of them, such as certain elements of managed care, have been widely adopted. But it is apparent from the cost trends that more fundamental and widespread changes must be implemented.

A NEW HEALTHCARE PAYMENT MODEL?

One of the changes that many observers foresee is a shift away from the fee-for-service model, which currently drives much of the U.S. healthcare system, and toward a system of accountable care.[1] Many experts[2] feel that fee-for-service payments take at least some of the blame for the rapid pace of medical cost increases as well as significant disparities in care from place to place. By paying providers for performing procedures rather than improving health, such systems are thought to create perverse incentives that lead to more care, not necessarily better care. The alternative is to change the system so that it rewards performance, making providers increasingly accountable for the outcome of the care they provide. Providers who accept such a system will necessarily be taking on performance responsibility for some elements of the financial risk currently borne by patients and payors.

These models are being evaluated and even implemented today. The state of Massachusetts, for example, now facing the cost consequences of providing universal health insurance, has been forced to evaluate strategies for aggressively reducing healthcare costs and is beginning to implement aspects of accountable care. Its Special Commission on the Health Care Payment system has recommended payment systems (based on either global payments or episodes of care) in which physicians are accountable for their performance.

Implementing outcomes-oriented healthcare could solve some of the problems ostensibly created by the fee-for-service system we have now. But an outcomes-oriented healthcare system requires a different approach than is common today. There must be broad agreement and standardization around which outcomes and what forms of provider performance are acceptable and at what cost, and these factors must be measurable. Physicians face the prospect of managing fixed payments, requiring them to make care more efficient and effective. The tools to achieve these goals exist today, but are most frequently used by payors rather than providers.

AN ENGINE FOR ACCOUNTABLE CARE

Milliman's data warehousing and analysis application, MedInsight®, is one such tool. It is widely used by insurers to understand the interaction between care quality, utilization, and cost. One of the key advantages of MedInsight is that it is backed by an organization with more than 50 years of healthcare consulting experience. This experience will be crucial in adapting the toolset to the new scenarios created by any movement toward accountable care. In that setting, providers and policymakers will find themselves dealing with issues that were once the concerns mainly of payors.

For example, one of the first and most obvious questions in accountable care is: How, exactly, do you measure performance and outcomes—especially in a field as complex and open-ended as human health? One of the reasons that the fee-for-service system continues to exist is that it is easy to understand. The doctor performs a procedure or a patient stays a certain number of days in a particular wing of the hospital. The payment is based on the services rendered.

Accountable care is completely different. It compensates providers based on how care is provided and what happens to the patient. Yet every patient and every course of disease is different. For accountable care to work, we must have transparent standards around best practices and expected outcomes—and a system that is flexible enough to account for appropriate regional health variations as well as a certain degree of randomness.

It must also be a system that helps us see where improvements can and should be made.

Measuring provider performance and patient outcomes is something that forward-thinking payors already do. They look at which hospitals and doctors are following evidence-based measures (EBMs). Payors examine which providers cost more than the average and why. In an accountable care setting, these tasks will become essential to the system as a whole.

1 Parke, R. & Fitch, K. (Oct. 13, 2009). "Accountable care organizations: The new provider model?" Milliman on Healthcare. Retrieved Jan. 7, 2010, from http://www.milliman.com/perspective/healthreform/accountable-care-organizations-new.php.

2 Shreve, J. (May 26, 2009). "Changing expectations in healthcare." Milliman on Healthcare. Retrieved Jan. 7, 2009, from http://www.milliman.com/perspective/healthreform/changing-expectations-in-healthcare-RR05-26-09.php.

Users need to create benchmarks based on a variety of public and proprietary data, including tools such as the Milliman Health Cost Guidelines™, the healthcare industry standard reference on expected costs for a comprehensive spectrum of conditions and treatments.

MedInsight can be used to create accountable care benchmarks specific to geographic regions and populations. In essence, it can be used to develop answers to the essential questions for accountable care: What kinds of utilization are providers seeing, and what levels of variation are acceptable?

Creating fair and objective standards for payment is critical not only for the functioning of the system itself, but also in persuading providers to embrace it. Those providers would be paid based on the benchmarks. If the benchmarks are seen as opaque, arbitrary, unfair, or poorly designed, providers will understandably try to opt out of the system. Additionally, accountable care systems typically base some part of payment on the use of EBMs. Providers who fail to use EBMs can expect to be penalized, while those who use them would be rewarded. This occurs because EBMs are typically those measures proven to improve outcomes or reduce cost. MedInsight enables stakeholders to measure and understand the effectiveness of using EBMs on a case-by-case basis. If such a system is to make headway, providers must have evidence that doing so is demonstrably better than what they are doing now.

MEASUREMENT LEADS TO QUALITY AND EFFICIENCY

By providing the right incentives, accountable care systems are expected to help us get better, more cost-efficient healthcare. We've discussed how this might work from the perspective of setting up the system. The other side of the coin is how providers can thrive in an accountable care setting.

First, they become responsible through their professional performance for some of what is the financial risk currently borne by payors. In order to make the incentives work in their favor, providers must become good stewards of the financial resources allotted to them. They need to understand the factors that affect utilization and how to optimize them so that patients are not consuming too much or too little care. They need to compare their costs and utilization rates to benchmarks and identify where there is room for improvement.

In effect, they need to adopt some of the tools that payors use. This is actually a good feature of accountable care systems. Today, because they are largely responsible for managing costs, payors take responsibility for managing aspects of care that providers should be able to do better. For example, insurance companies are frequently the ones implementing disease management programs to help reduce medical losses when those programs might make more sense in the hands of providers, implementing them to improve health outcomes.

A CULTURAL HURDLE

But the responsibility for managing factors such as utilization and disease management from the perspective of minimizing costs will be new to many, if not most, providers. Again, a tool such as MedInsight can be invaluable in that situation. By giving provider organizations an intuitive way to discover and manage aspects of care and operational practices so as to achieve a convergence of quality and cost effectiveness,[3] MedInsight can help them thrive financially in an accountable care setting while reducing waste and providing better care. It would give providers a window into how they are performing versus both broad and specific benchmarks. These are all tasks for which payors use MedInsight today, and MedInsight could easily be adapted to the needs of accountable care organizations (ACOs).

In our country's ongoing efforts to achieve a more effective and less costly healthcare system, proven tools for using data to make the right decisions will become increasingly important. MedInsight offers a broad spectrum of data warehousing, benchmarking, analysis, and reporting tools that will be of use to a variety of participants in an accountable care setting. It can help with the design of accountable care systems that are fair and transparent; and it can help providers thrive by helping them better understand and manage the relationship between cost and quality. Combined with Milliman's expertise, MedInsight can make a real contribution anywhere that an accountable care model is under consideration or already being implemented.

[3] Blumen, H, Nemicollo, L. "The Convergence of healthcare quality and efficiency," June 25, 2009. http://www.milliman.com/perspective/healthreform/convergence-quality-efficiency-role-RR06-01-09.php

Rich Moyer is the MedInsight product manager. Paul Leonardo is a healthcare management consultant with the Seattle office of Milliman. For more information, contact them at 206.624.7940 or at rich.moyer@milliman.com and paul.leonardo@milliman.com.

1301 Fifth Avenue, Suite 3800
Seattle, WA 98101-2605
+1 206 624-7940
www.milliman.com