Be Successful in the New World of ACCOUNTABLE CARE ORGANIZATIONS

Contributed by

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In a few months, there will be a fundamental shift in how some Medicare providers operate with the beginning of the Medicare Shared Savings Program. In January 2012, Accountable Care Organizations (ACOs) identified by the U.S. secretary of Health and Human Resources will emerge that practice differently — placing greater emphasis on the value of each healthcare decision and action. Today the way for providers to get more money from Medicare is to increase services delivered to patients, including visits, tests, and procedures. ACOs, on the other hand, will be incentivized differently.

While the government has yet to precisely define an ACO, it can be assumed that ACOs will be networks of providers, including different combinations of physicians, hospitals, and other healthcare facilities. These networks will have incentives to provide the most efficient care that improves outcomes. If an ACO delivers superior care and achieves cost savings, it will be rewarded with a share of Medicare's overall savings.

Networks of physicians and facilities are nothing new; in fact, in the United States there are over 500 integrated networks of physicians, hospitals, and others that work together. What's different about ACOs are the strength of the relationship between the affiliated parties and their shared goals of providing excellent care while keeping costs in check. Approximately 140 networks have been identified that may become part of the first generation of ACOs; if results are positive, the industry could see more as learnings from Medicare spill over to commercial patients. Manufacturers of drugs, devices, and equipment will need to understand the structure and membership of ACOs and adapt their selling techniques to be effective in this new world.

Numbers Game

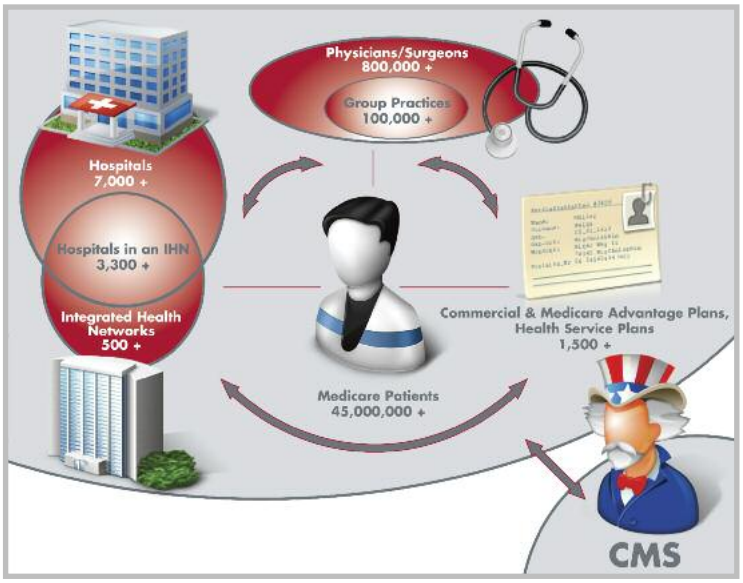
Some health networks and group practice organizations are already quite large, but there is always temptation to reach for financial benefits of scale. In an ACO world, that means gobbling up and tying together additional physician groups and treatment organizations to potentially achieve even larger financial incentives in the ACO model.

The lure of ACO financial rewards and the potential for a stable patient volume might be enough motivation for today's independent physician practices to finally succumb to the recruiting and marketing efforts of a health network. Conversely, loosely aligned community hospitals may see this as an opportune time to tighten ties with each other, as well as a few influential physician practices, in an attempt to secure a seat at the ACO table, and because the physician practices could help drive patient volume through those facilities.

If not equipped for these anticipated shifts, the next few years could become a frustrating game of "who moved the cheese." The good news is that the players (patients, hospitals, physicians, and plans) are not necessarily changing, and they may not look all that different on the surface. Thus, the key questions are still the same. Manufacturers need to know:

1. Who?
2. How much?
3. Where?
4. How are they connected/affiliated?
5. Which mix of marketing and sales tactics will maximize ROI?

Depending on your targets' ACO strategy, what may change are their leverage, influence, and financial incentives. While the act of promoting, selling, and pulling through will still require connecting with the right customer at the right location, answering "How are they connected/affiliated and collaboratively incentivized? is the new prerequisite. Solving that question will require a comprehensive understanding of affiliations and ownership structures as the ACO model unfolds. Most important, the answers to Question 4 above may precipitate rethinking the answers to the other questions.



Healthcare Organization and Healthcare Provider Relationship Changes

In the ever-evolving world of U.S. healthcare, the arrival of ACOs intensifies the need to account for the connectedness between the 7,000+ hospitals in the United States, 100,000+ group practices, and 1,000,000+ physicians/surgeons and practitioners. Marketing and selling therapies, devices, and supplies to and through those entities not only requires targeting individuals and organizations via volumetrics (prescriptions, patient counts/visits, diagnoses, and procedures), but in the quickly approach-

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ing ACO model, the relationships and affiliations are of growing importance because the desire to be rewarded financially will drive ownership changes, which will drive changes to patient path of care and type of care, which could shift the value of a sales and marketing target.

A recent example would be physicians and surgeons demonstrating a willingness to assume the risk associated with owning and operating businesses like surgery centers. Higher patient volumes, patient convenience, and streamlined reimbursement made branching out certain procedures and diagnostics from the traditional outpatient hospital setting attractive. In this example, the value of certain hospitals decreased, but the value of certain physicians (and their new organization) increased.

Like the movement toward physician-owned surgery centers, providers may be willing to swallow the risk to earn a financial bonus from Medicare. For other physicians, the ACO model and autonomously managing toward a shared financial incentive may be more risk than they are willing to accept. Either way, ACO reimbursement will be a galvanizing event in the industry, shifting the relationship/affiliation coordinates. The delivery networks and providers are crunching the numbers and submitting applications in 2011. Manufacturers will have to sort through the changes, identifying the key ACOs and touch points within, in order to maintain connectivity and continue driving share.

The primary stakeholders are highlighted in the following graphic. Physicians/group practices, hospitals/health networks, and health plans are doing the bulk of partnering to achieve quality care and contain costs. Similar to other healthcare reform efforts in recent years, quality of patient care is being emphasized in the ACO model. Therefore, continuing to understand the longitudinal continuum of patients' treatment paths and experiences will be critical for manufacturers' sales and marketing initiatives.

Who and How Much?

The players within the ACO model are not new sales targets for manufacturers, and "who" and "how much" are still vital targeting and performance indicators. Specifically, a medical/surgical device company might prioritize high-volume health networks or individual facilities for surgical glove sales contracts, and also prioritize high-volume general surgeons for pull-through. Similarly, a pharmaceutical manufacturer might prioritize influential payer/health plans regarding medication coverage, and also focus on high-volume group practices and physicians for pull-through.

On the surface, these tactics will still require an understanding of the provider and/or organizational channels and accelerators that are most critical to business objectives. But at an overarching, and perhaps less visible, level, ACOs will infuse an extra degree of complexity to strategic planning. The organizations and providers may be the same, but their financial alliances may have changed – unbeknownst to the account director or sales representative walking into that healthcare organization or practice.

In the following example, pain medication manufacturers and orthopedic device/supply manufacturers are still interested in health networks performing high volumes of orthopedic surgeries. Regardless of metrics (patient counts, medical diagnoses, office visits, retail prescriptions, hospital procedures), manufacturers will focus on moving share at networks like the four below. With integrated health networks (IHNs) already performing like ACOs in the sense that they typically already own or manage hospitals, physician group practices, and other care-delivery settings (diagnostic centers, outpatient surgery centers, urgent care centers), it would not be a stretch for many IHNs to pursue ACO status for 2012.

Top IHNs Based on Select Procedures of Interest

Integrated Health Networks (IHNs)	City	ST	Zip	Category 1 Procedure Volume	Category 2 Procedure Volume	Total Estimated Annual Volume
University of Pittsburgh Medical Center	PITTSBURGH	PA	15213	2,500	3,600	**6,100**
Baylor Health Care System	DALLAS	TX	75246	1,500	3,100	**4,600**
Mount Carmel Health System	COLUMBUS	OH	43222	1,000	2,500	**3,500**
Facility A	NEW ALBANY	OH	43054	400	1,100	**1,500**
Facility B	COLUMBUS	OH	43222	400	1,000	**1,400**
Facility C	WESTERVILLE	OH	43081	200	400	**600**
NCH Healthcare System	NAPLES	FL	34102	800	1,400	**2,200**

Figure 2

Mount Carmel – Facility B, Target Physicians

Decile	Name	Address	City	State	Zip Code	Specialty	Group Practice Identifier
10	Physician A	XXX	COLUMBUS	OH	43222	G. SURGERY	xxxxxxxc
10	Physician B	XXX	COLUMBUS	OH	43214	ORTHO. SURGERY	No Group Practice
10	Physician C	XXX	HILLIARD	OH	43026	ORTHO. SURGERY	xxxxxxxh
9	Physician D	XXX	HILLIARD	OH	43026	ORTHO. SURGERY	xxxxxxxh
9	Physician E	XXX	COLUMBUS	OH	43222	ORTHO. SURGERY	No Group Practice
9	Physician F	XXX	COLUMBUS	OH	43213	HAND SURGERY	xxxxxxxr
8	Physician G	XXX	COLUMBUS	OH	43213	HAND SURGERY	xxxxxxxr
8	Physician H	XXX	COLUMBUS	OH	43213	RECNSTRCTV. ORTH	xxxxxxxk

Figure 3

As shown in Figure 2, all three of these Mount Carmel hospitals would be of interest. Depending on your product, brand strategy, and sales and marketing resources, you might focus on driving share at the Mount Carmel Health System level and/or at one or all of the network hospitals. Your targets would include key personnel (c-suite, purchasing directors, pharmacy director) and the physicians actually delivering care at those facilities. For example, at Mount Carmel – Facility B, you would focus on the high-decile physicians there as well as other advocates for your brand, such as others within these physicians' group practices. In the ACO model, group practices and other provider-to-provider relationships around common patients become more important. You would want to pinpoint primary care physician-to-surgeon and facility-to-facility shared patient volumes.

With the onset of ACOs, and the resulting changes in ownership, organizational structure, and patient path of care, a manufacturer's valuation of some of its targets' ability to drive share might be different.

As federal guidance continues to arrive in this ramp-up period to 2012, it's difficult to quantify the exact impact this will have on business performance. But anytime healthcare providers and organizations realign their people and capital allegiances, their management best practices, treatment protocols, profitability, and financial incentives invariably change and rock the proverbial apple cart. PV