Spring is just around the corner. Spring bulbs are poking through. March Madness will soon be here. A young person's fancy turns to, what else, but Accountable Care Organizations. This month we will answer the second question posed by physicians, following James' talk at the Sunday Times Health Care Conference. Is a de-centralized approach to care at odds with the popular, centralized care model of Accountable Care Organizations (ACOs)?

ALLEXIAN
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How will ACOs be financially viable?

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A more important question than centralized vs. decentralized, it turns out, is how can an ACO be financially viable? We provide perspective on both these questions in this month's newsletter.

This questions was in response to the following statement "...by transforming care delivery from integrated, centralized delivery points utilizing high cost interventions supported by highly skilled professionals to more disintegrated, de-centralized points leveraging lower cost interventions and supported by lower skilled professionals."

Is a de-centralized approach to care at odds with the popular, centralized care model of ACOs? In short, no. Before discussing why let's take a step back.

Few would disagree that as a nation we need to reduce the cost of health care. 91% of Medicare expense in 2007 was from patients with four or more chronic diseases. In 2017 that same number is projected to be 96%, about $800 billion. Successful chronic disease care management is therefore integral to financial viability of health care services in the US. A great deal of industry buzz has developed around ACOs. They have become the frontrunner solution to lower the cost curve.

Today an ACO is not yet clearly defined. Some say it is a PR gimmick, others that it is an integrated payer/provider. We believe ACOs are game-changers that can provide integrated and de-centralized care of chronic diseases. ACO reimbursement will most likely be a capitated fee structure rather than today's fee-

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for-service (where the incentive for clinical providers is to provide more service). This is important -- historically physicians have not been good at managing financial and population risk in a capitated model.

To provide a level of care for co-morbid chronic diseases that lowers expense, ACOs will need previously unintegrated components of clinical care and supporting infrastructure to be integrated but not centralized. Today, healthcare as we have mentioned many times before, is disaggregating into smaller more efficient business models (e.g. MedExpress, the multi-site urgent care facility).

The clinical care components could include hospital care, primary care access, medical home infrastructure, post-acute care, and new disease management programs. Supporting infrastructure could include EHRs, population risk and health analytics, health information exchanges as well as patient activation.

For a new ACO business model, the more important question is financial viability rather than whether the model is centralized or decentralized. For an ACO to be financially viable in a capitated model the most important competency after quality clinical treatment is population risk and health analytics.

Clinical providers are usually data rich but not data savvy. A data savvy organization that understands the risks of its population under management will negotiate better service level agreements and prices with other third party clinical providers and will be better equipped to provide and fine tune the best clinical services at the lowest cost. Population risk and health analytics transform a data rich organization into a data savvy organization. How does this happen?

On the one hand providers are not well equipped to do population risk and health analytics. Payers, on the other hand, are very well equipped to do this -- specifically it is a core competency for them.

At their core, payers do two things; assess population risk and arbitrage that risk. Is the only way for an ACO to operate by becoming a provider/payer -- financial viability is assured by having the liability for care as well as the insurance component in the same organization?

What today is an internal capability for payers needs to become a service offering -- that is, population risk and health analytics. While payers are pondering this, there are several solutions to population risk and health analytics from third party providers including VIPS, MedAssurant and Ingenix. Each provide population risk and health analytics solutions that could allow an ACO to function and be financially viable without becoming a payer.

New business models like ACOs will have to operate in the "white space" between traditional providers and payers. New skills, new tools, learned experience from other industries and new practices are emerging everywhere.

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