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Panel 1: Physician-Led Accountable Care Arrangements
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Thank you for the opportunity to testify on behalf of physician-led accountable care groups. I am the Executive Director of MedChi Network Services (MNS), a company started by the Maryland State Medical Society in order to support the private practice of medicine. To further that mission, we created three physician-led Medicare Shared Savings Program Accountable Care Organizations (ACOs). Each was awarded an Advanced Payment by CMS. The governing boards for each ACO selected MNS as its management company and appointed me as Executive Director.

The three ACOs created and managed by MNS are the Maryland ACO of the Eastern Shore, the Maryland ACO of Western Maryland, and the Lower Shore ACO. The Eastern Shore and Western Maryland ACOs received designation in the second round, July 2012, and the Lower Shore ACO received designation in January 2013. The participants for each are solely primary care, independent physicians. Practice sizes range from solo doctors to groups of five doctors. There is no large institution, health system, or insurance company supporting any aspect of these ACOs; they are truly physician led.

The ACOs consist of approximately 80 providers in 30 practices supporting 22,000 assigned Medicare beneficiaries. The ACOs are located in rural parts of Maryland and have residents as well as participants in neighboring states. MNS worked with the boards of managers and medical directors to formulate appropriate short- and long-term strategies for improving quality throughout each community. The practices are becoming clinically integrated and using a care management infrastructure consisting of local coordination, central nurse management, and a robust IT infrastructure for analytics and risk stratification.

The MNS care management program is based on industry best practices. The primary purpose is to enhance quality across a variety of outcome measures, thereby increasing patient satisfaction and lowering health care costs. The care guidelines and infrastructure were developed with the knowledge that the ACO management programs and strategies are likely to change as the ACOs evolve. MNS, the medical directors, the boards, and all participants maintain an open dialog and encourage regular reviews so methods and resources are adjusted to improve outcomes.

Physician leadership within the ACOs and the MNS team determined the key priority in the infrastructure to be flexibility. The systems must be flexible to interface and work with multiple vendors – many of which are likely to change. The delivery mechanisms must be flexible to adapt to different physician preferences, practice sizes, and specialties. The patient engagement methods must be flexible to encourage the greatest outcomes from a diverse community.

The clinical strategies for quality and cost targets are purposefully simple: supporting transitions of care to avoid preventable readmissions, working with patients and providers to decrease

emergency department utilization, and encouraging consistent preventive health services for the entire population. MNS is providing resources to practices to address these strategies. None of the ACOs is dictating how guidelines and metrics are addressed; rather, the Medical Directors are making the goals and processes known and leaving it up to each group to develop strategies to comply. The MNS team is available to support the practices in the areas they identify (with operations consulting and encouragement).

The ACOs require an IT infrastructure that is capable of aggregating data from multiple sources, matching data with unique patients, applying rules to ensure accuracy and integrity, and analyzing information to drive action. This infrastructure must be completely secure, auditable, and compliant with federal, state, and local regulations. MNS and its partner Health Prime International are using internally developed products and external companies to meet these qualifications. The ACO enterprise platform's data warehouse is set up through Amazon Web Services and risk stratification is done by Covisint, while the practice web portal for data entry as well as the point of care notification (physician portal) were developed internally.

MNS is also working closely with Maryland's state-designated health information exchange (HIE), the Chesapeake Regional Information System for our Patients (CRISP) to facilitate timely patient interventions by primary care physicians. CRISP currently offers encounter notification and query portal services, essential pieces of transitional care management. ACOs are a natural compliment to HIEs because they generate additional incentives for connectivity and supply practices with additional resources required to implement new workflows.

The largest IT challenge faced by MNS and the ACOs is data sharing. Creating two-way interfaces between certified EHRs and the MNS data warehouse has been costly and time-consuming. Many vendors offer solutions for data sharing, but they require all users to be on the same platform or expensive fees (or both). There are over ten different EHR systems in use across the ACOs, and it is impractical to require small, primary care practices to absorb the high cost of switching to one uniform technology. Meaningful Use Stage 2 offers some hope through DIRECT exchange, although physicians are required to purchase and implement system upgrades which may not happen for some time.

In addition to the technical challenges, all ACOs are facing significant workflow issues. Community physicians must have access to extensive patient data at the point of care to be successful in an ACO model, and clinical data must flow back to the ACO. EHR interface restrictions mean that some other method must be utilized to relay data at the point of care. MNS created a simple web portal to allow office staff to enter quality data prior to a patient's visit. Because the web portal automatically displays known data from the data warehouse, any missing values are also an indication of overdue patient services. Ideally this would be managed directly through EHR systems, but it is not practical at this point.

Community practices are overwhelmed by the myriad of changes in health care reimbursement and policy. Health IT, especially in independent practices, has been lagging behind most other industries. Meaningful Use Stage 2 is the next big challenge, but Stage 1, the Physician Quality Reporting System, and ePrescribing are all new developments. Our goal – and a significant obstacle – is to help physicians get through this transition and be in a better position to demonstrate quality as payment systems shift away from fee-for-service.

The physicians MNS is working with through the ACO program are precisely the people who can support institutional change. They are in rural communities with defined populations. They are low cost providers whose largest expense is running a small business. And they are eager for support as more and more changes affect their industry. While each of the groups we work with is technically a competitor, they embraced collaboration through the ACO model because they knew it would enhance their patients' lives. For these reasons, we strongly support the Advanced Payment and other similar initiatives. Our physicians would not be working together in an ACO if it were not for this program; they likely would have eventually been forced into a bundled payment program led by an insurance company or large health system.

MNS supports efforts to standardize data sharing and to increase data liquidity. Significant resources are being devoted to gathering data from multiple sources and making it accessible at the point of care. EHR systems do not have the population health capabilities to perform analytics required at the ACO level, but they are the only system physicians consistently use. It is impractical to expect a physician to log into multiple portals from multiple databases (hospitals, commercial insurers, and others) prior to interacting with each patient. We would like to see physicians have access to their patients' data in a universal format, and in a straightforward manner, so that it may be tailored for practice workflows in initiatives that support quality and patient satisfaction.

I appreciate the chance to share our experience and feedback regarding physician-led accountable care initiatives. We are excited by the progress we see in our practices every day and in similar models across the country. As the health care industry use IT to shift to performance-based services, we strongly believe that collaborative physician-led programs will demonstrate the best quality and financial results.