Testimony of Charles Chodrof
HITPC Accountable Care Work Group Hearing
12/5/13

Thank you for the opportunity to share my organization's experience with accountable care arrangements and how you might help us better use IT technology to help us meet our objectives. I serve as the Senior Vice President of Population Health for WellSpan Health, an integrated delivery system that includes 700 physicians, a home care agency, a managed care plan and four hospitals serving a population of three-quarters of a million people in south central Pennsylvania.

WellSpan has determined that we will migrate our business model from fee-for-service payments to accountable care relationships. As such, we entered into an accountable care relationship with Aetna this fall and anticipate additional ACO relationships with other payers over the next five years with the expectation that most of our revenue will come from these types of payment arrangements.

We hope that future requirements from ONC will provide incentives that help us succeed under accountable care payment arrangements. Many of the requirements of the HITECH act have up until this point focused on by providers. My comments will focus on efforts that might be undertaken to enhance coordination and build expectations with the other two stakeholder groups, payers and consumers.

I would suggest three broad initiatives that could create leverage for mutual success by these three stakeholder groups. These initiative involve better identification of specific individuals in the managed population who are at highest risk, improved ability to proactively identify patients in populations covered by accountable care arrangements, and additional actions that will help patients and community support groups engage with us electronically to collaboratively manage high-risk individuals in the community.

The current meaningful use requirements do not segment the served population according to their healthcare risk. The requirements for communication, coordination, and automated interventions are the same regardless of the severity of illness, absence or presence of social or community supports, or anticipated resources needed by the patient. Yet, the success of most accountable care arrangements depends upon payers and providers assuring that those at most risk of unnecessary costs are quickly identified and managed.

We suggest that ONC require providers and payers to adopt a standard methodology that assigns a risk score to help categorize patients. Several methodologies are publically available based on research supported by AHRQ that calculate an estimated risk of health deterioration. A standard set of data fields and set of data definitions would enable both providers and payers to immediately focus on those who need case management services. Patients and their family members would recognize that they have been identified as being at risk for a complication, such as a fall in the home or inability to properly self-manage without assistance, and might be more willing to accept care management services that otherwise might be wrongly dismissed as unnecessary or extravagant. These requirements, combined with case management tracking functionalities, could be part of voluntary certification of HIT applications designed to help ACOs manage their populations.

The second initiative would enable providers and payers to prospectively identify patients who are included in accountable populations. It is difficult to reliably monitor populations of patients when providers are unsure of who is in the mutually accountable population. Payers, particularly CMS under the Medicare Shared Savings Program, provide information on the population after services have been rendered and opportunities to intervene on the accountable population may have passed by. Providers

can intervene on those patients for whom they directly provide services, but what happens if the assigned individual decides to seek care from another, unaccountable, provider? The services might proceed uncoordinated from the providers in the assigned ACO who continues to bear the risk. Proactive identification of those in the assigned population using a universal patient identifier would help coordinate patients. We propose that even though the benefit plans do not require selection of a network, that the ONC work with payers and providers to facilitate the identification of individuals in the accountable care population prior to the beginning of a risk period.

The third initiative we propose is a set of actions designed to better engage patients, families, and community support groups in the coordination of patients, particularly palliative care plans and end-of-life interventions designed to support for the individual in their home and engage support for community agencies. Public information programs were highly successful in educating the public on the hazards of high blood pressure and high cholesterol. Could HHS do a better job of explaining to the public how they can expect to act with providers who are committed to e-engagement?

The focus needs to begin to shift from incentives to providers to education of the public, helping to create the "pull" from the patients for services offered virtually rather than as part of face-to-face visits. Part of this effort would involve enhancing future meaningful use requirements such that providers have the requirement to collaborate in the management of a common, patient-developed Shared Care Plan, managed by the patient electronically, that could then be linked to faith-based organizations, community support agencies, and other members of the public who are part of the individual's social support system. This common document, promoted through public education, would serve as the backbone for a broader communication program designed to engage the patient in an e-community of providers.

We believe these changes – focusing on the identification of vulnerable populations, prospective identification of individuals in ACO arrangements, and enhanced patient engagement strategies will help advance our ACO ambitions and support WellSpan's mission to our community.