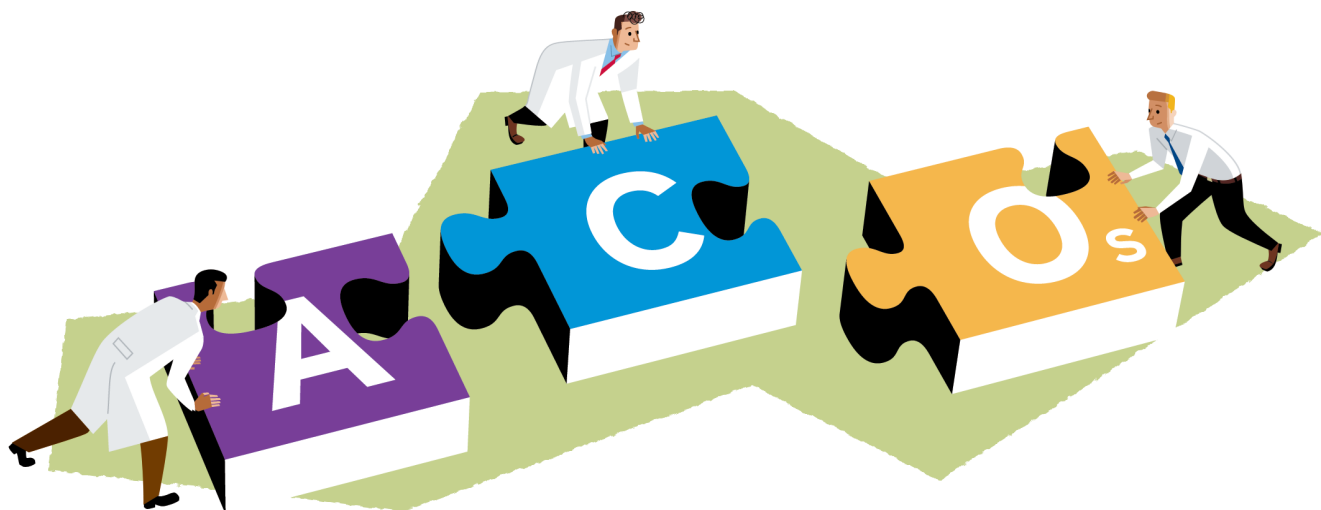


# WHAT FAMILY PHYSICIANS NEED TO KNOW ABOUT



**Accountable care organizations could be the next big thing in health care delivery. Here's what you need to know – and what you need to do – now.**

Julian D. Bobbitt, JD

**A**ccountable care organizations (ACOs) are one of the most anticipated and, perhaps, most confusing developments in health care today. The Patient Protection and Affordable Care Act called for the creation of ACOs as a way to encourage physicians, hospitals and other health care providers to work across settings to coordinate and improve care for a defined population of patients and take part in any cost savings they achieve.

The health care reform law mandated that the Medicare ACO program (called the Medicare Shared Savings Program) be operational by January 2012 – an ambitious deadline given that the final rule governing Medicare ACOs has not yet been issued. The proposed rule, published March 31, 2011, was widely criticized by physician groups, including the AAFP and the AMA, as being too burdensome and forcing physicians to bear too much risk. Even the American Medical Group Association, which represents major multispecialty groups such as the Mayo Clinic and the Cleveland Clinic, those in prime

position to form ACOs, warned that 93 percent of its members would not participate in the Medicare Shared Savings Program unless the rules changed substantially. In response, the Centers for Medicare & Medicaid Services (CMS) launched the Pioneer ACO program to offer already-integrated systems a streamlined method for participation. The final rule is expected this fall.

Although the final rule is important, it only governs ACOs that contract with Medicare. ACOs that want to contract with private payers are free to proceed without the government's rules – and they are doing just that. For example, Advocate Physician Partners in Illinois has signed its first ACO contract with Blue Cross Blue Shield of Illinois; Norton Healthcare in Kentucky has partnered with Humana to develop an ACO; Sharp Community Medical Group and Sharp Rees-Stealy Medical Centers have partnered with Anthem Blue Cross on an ACO pilot in San Diego; and Carilion Clinic in Roanoke, Va., has collaborated with Aetna to form an ACO, to name just a few. It is said that “necessity is the mother of inven-

## ALTHOUGH MULTIPLE TYPES OF PROVIDERS CAN PARTICIPATE IN AN ACO, HIGH-PERFORMING PRIMARY CARE PHYSICIANS ARE ESSENTIAL.

tion.” With the fiscal crisis so bad in many states, we are seeing ACO innovation at the state Medicaid level, as well.

“Whatever form ACOs eventually take, one thing is certain,” according to Don Berwick, MD, CMS Administrator. “The era of fragmented care delivery should draw to a close.”<sup>1</sup>

### What is an ACO?

At the most basic level, an ACO is an entity made up of health care providers who take responsibility for the health care needs of a defined population of patients, with the goals of improving care coordination, quality and the patient experience and reducing per capita costs. ACOs that achieve specific benchmarks related to these goals distribute any shared savings to the providers.

The name “accountable care organization” suggests that an ACO is a particular type of organization; however, that is not the case. The NCQA’s ACO criteria, for example, are “agnostic to organizational structure.”<sup>2</sup> An ACO could be created by any of the following entities: independent physician practices (connected via an independent practice association or a virtual physician organization), a multispecialty group practice, a hospital (either with employed physicians or affiliated practices), an integrated delivery system or some combination of the above. Of course,

more integrated entities, such as multispecialty group practices and integrated delivery systems, would likely have less work to do to develop the capabilities of an ACO and could assume greater risk at the outset than less integrated entities.

Although multiple types of providers can participate in an ACO, primary care physicians – particularly high-performing primary care physicians – are essential.<sup>3</sup> In fact, they are the only providers mandated for inclusion in the Medicare Shared Savings Program. Harold Miller of the Center for Healthcare Quality and Payment Reform envisions four levels of ACOs, with the core, level one, consisting primarily of primary care practices. Level two would include other specialists and potentially hospitals. As diverse patient populations are included, level three would expand to more specialists and facilities, and level four would include public health and community social services.<sup>4</sup>

The ACO itself must be a separate legal entity with its own tax identification number so that it can receive payments from a third-party payer (e.g., Medicare or a private health plan) and then distribute shared savings payments to providers. It must have processes in place to measure and report quality performance (see more on that below). It must also have a minimal critical mass of patients to justify the time and costs involved in developing the infrastructure and to generate sufficient savings. For the Medicare Shared Savings Program, that minimum is 5,000 beneficiaries.

ACOs are sometimes confused with patient-centered medical homes. It may help to think of the patient-centered medical home as the core of an ACO. However, ACOs tend to offer two components that medical homes do not:

**1. Financial incentives.** ACOs promote shared accountability by offering financial incentives, such as shared savings or even penalties in some models, motivating provid-

■ ACOs encourage providers to work across settings to coordinate and improve care for a defined population of patients.

■ If an ACO meets defined performance goals, its providers receive a portion of any cost savings achieved.

■ An ACO could be created by independent practices, a multispecialty group, a hospital, an integrated delivery system or some combination.

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ers to work together to deliver the highest quality care at the lowest cost with the greatest patient satisfaction.

**2. Specialist/hospital linkages.** ACOs tend to have relationships not only with a strong base of primary care physicians but also with other specialists and hospitals across the full continuum of care.

In these respects, ACOs also differ from many of the integrated models thrust upon physicians in the 1990s.

## What are the key functions of an ACO?

ACOs are more about function than form. Regardless of the specific organizational structure chosen for an ACO, it must be able to carry out the following key tasks:

### 1. Creating a culture of teamwork, shared

**commitment and clinical integration.** The most important, and perhaps most difficult, task for an ACO is to create a team-oriented culture with a deeply held, shared commitment to reorganize care to achieve higher quality at lower cost. “While strong hospital-physician alignment has always been a cornerstone of success, the necessary degree of future collaboration, partnership and risk-sharing will dwarf what has come before it,” according to an analysis from the Advisory Board Company. “Hospitals and physicians will have to recognize, embrace and leverage their growing interdependence to create organizational structures and incentive models that are strategically aligned and mutually rewarding.”<sup>5</sup>

It’s important to note that employment does not ensure this type of teamwork and integration. “Current trends in physician

■ An ACO must be a separate legal entity with its own tax identification number.

■ The Medicare Shared Savings Program requires ACOs to have a minimum of 5,000 beneficiaries.

■ One of the most important tasks for an ACO will be creating a clinically integrated team of providers who are committed to shared goals.

## SAMPLE PERFORMANCE MEASURES

ACOs will be required to measure and report provider performance. The proposed rule for the Medicare Shared Savings Program recommended 65 measures, a sampling of which are provided below.

### Patient/caregiver experience

- Timely care, appointments and information
- Helpful, courteous and respectful office staff
- Patients’ ratings of doctor
- Shared decision making

### Care coordination

- 30-day post-discharge physician visit
- Medication reconciliation
- Admissions for uncontrolled diabetes
- Percentage of all physicians meeting stage-1 HITECH meaningful use requirements

### Patient safety

- Blood incompatibility
- Pressure ulcer, stages III and IV
- Falls and trauma
- Catheter-associated UTI

### Preventive health

- Influenza immunization
- Colorectal cancer screening
- Cholesterol management for patients with cardiovascular conditions
- Tobacco use assessment and tobacco cessation intervention

### At-risk population/frail elderly

- At-risk population – Diabetes mellitus: hemoglobin A1C control (<8%)
- At-risk population – Coronary artery disease: oral antiplatelet therapy prescribed
- At-risk population – Chronic obstructive pulmonary disease: spirometry evaluation
- At-risk population – Frail elderly: falls: screening for fall risk

employment represent neither a necessary nor sufficient condition for true integration; value-added integration does not necessarily require large-scale physician employment, and simply signing contracts does not ensure progress toward more effective care coordination.<sup>25</sup>

Physicians in ACOs need to understand that they are not simply banding together for contracting purposes. They must be willing to change their utilization, referral and care-management patterns. In many settings, specialists may need to release primary control of patient care decision-making to primary care physicians.

Hospitals and other large entities involved in the ACO also need to be willing to relinquish control and become more collaborative partners. The ACO structure must have meaningful input from the various parties to have status, credibility and long-term success.

**2. Establishing adequate financial incentives.** Current ACOs are characterized by three tiers of financial incentive models:

- **Shared savings:** In this model, if an ACO is able to enhance quality and patient satisfaction and achieve savings relative to the predicted costs for the assigned patient population, then the payer shares a portion of those savings (usually 50 percent) with the ACO. In other words, the ACO gets 50 percent of the difference between what the costs for the population turned out to be and what the costs would have been if the ACO had not been in place. This is on top of the providers' fee-for-service payments. The shared savings are divided according to the level of performance of each ACO participant, as determined by benchmarks set by either the ACO or the payer, depending on the agreement in place. (See the next section on performance measurement.) If the ACO's primary care physicians have especially substantial medical home management responsibilities, the ACO may also elect to give them a flat per-member-per-month payment, or care management fee. For example, a primary care physician's compensation might be made up of 50 percent fee-for-service payments, 20 percent care-management fees and 30 percent performance incentives. If fee-for-service payments comprise too high a percentage of physician compensation, there will likely be no substantial change in physician behavior.

Note that an ACO's cost savings should not be determined by simply comparing its population's costs year to year. That might work the

first year, but it will be difficult to beat performance levels from the prior year every year. In some CMS demonstration projects, cost savings comparisons were made using relatively unmanaged counties as the control populations. A better approach might be to engage an actuary to predict the medical costs for an ACO's region or comparable community to use as a comparison. The agreement between the ACO and payer should specify how this task will be handled and by whom. ACOs should come within 5 percent, plus or minus, of their predicted costs for three consecutive years before leaving the shared-savings bonus model and taking on risk.<sup>6</sup>

- **Savings bonus plus penalty:** As with the shared savings model, under this model, providers receive shared savings for managing costs and meeting quality and satisfaction benchmarks. The difference is that they are also liable for expenses that exceed spending targets. This model is called "symmetric" or "two-sided." Providers still receive fee-for-service payments, but to a lesser degree. The bonus potential increases along with the risk.

Under the Medicare Shared Savings Program, ACOs can choose between two versions of this model: one includes risk from year one but offers a larger bonus potential, and the other delays risk until year three and offers a smaller bonus potential.

- **Capitation:** In a partial or full capitation model, fee-for-service payments would be replaced by a global payment for services, plus potential bonuses and penalties. Only seasoned and truly clinically integrated ACOs should consider taking on this level of risk.

In all of these models, risk adjustment must be in place to ensure that the ACO is not penalized for having sicker patients. Risk adjustment can be as simple as offering different payment levels based on patient age and gender.

**3. Measuring performance.** In the value-based reimbursement era, it will not be enough to simply provide exceptional, cost-effective care. ACOs will also have to prove it by establishing measures, gathering data (including baseline data) and then reporting performance. The proposed rule for the Medicare Shared Savings Program included 65 measures for ACOs (see "Sample performance measures" on page 19). For ACOs in the private marketplace, performance benchmarks may be set by third-party payers, or the ACO

■ An ACO must offer adequate financial incentives to encourage physicians to change their behavior.

■ Some ACOs use bonuses only, while others use both bonuses and penalties.

■ ACOs will need to gather and report data to prove that they provide high-quality, cost-effective care.

## “VALUE-ADDED INTEGRATION DOES NOT NECESSARILY REQUIRE LARGE-SCALE PHYSICIAN EMPLOYMENT, AND SIMPLY SIGNING CONTRACTS DOES NOT ENSURE PROGRESS TOWARD MORE EFFECTIVE CARE COORDINATION.”

may be able to select its own, drawing from nationally recognized quality, efficiency and patient satisfaction metrics, where they exist, that match the ACO's targeted initiatives (e.g., improving diabetes care). To gain buy-in on the measures, ACOs may choose to convene a multispecialty committee of clinicians to vet their clinical validity. This committee could also recommend additional performance benchmarks or develop them from scratch if national standards are not yet available for a particular targeted initiative.

**4. Implementing best practices across the care continuum.** The ultimate goals of accountable care are to improve patient outcomes and patient satisfaction while also achieving greater cost efficiencies. One key to achieving these goals is enhanced coordination of care among diverse providers through the application of evidence-based clinical protocols. The ACO must take the lead in translating evidence-based guidelines into actionable best practices across the continuum of care for selected targeted initiatives. An ACO may start out with a single patient population (i.e., morbidly obese patients) or a single disease state (i.e., diabetes). The best targets for improvement will be clinical areas fraught with waste and inefficiency, unnecessary spending (often related to poor clinical coordination) and unwanted variation in clinical outcomes due to lack of adherence to best clinical practices.<sup>5</sup>

**5. Engaging patients.** Without patient engagement, an ACO will not fully meet its potential. Many of today's health care consumers erroneously believe that more is better – more tests, more pills, more services – especially when they are not “paying” for it and insurance is. Patient noncompliance is also a real problem, especially regarding chronic diseases and lifestyle management. Understandably, many physicians have difficulty accepting a compensation model based in part on improved health of a patient population

when a key variable (patient adherence) is outside the physician's control.

Geisinger Clinic engages patients through use of a patient compact. This is a written commitment by the patient to be responsible for his or her own health, including communicating with the health care team, involving family in the care process, taking medications as prescribed and undertaking appropriate follow-up and preventive care. Patient education, self-care tools and shared decision-making techniques are also key. Additionally, ACOs could partner with insurers to offer benefit differentials based on patients' lifestyle choices, such as smoking or being overweight.

### What steps should I take now?

Now that you know the basics of ACOs and how they function, you may be wondering what you need to do to be prepared for this new model. Here are three strategies:

**Take the lead.** Family physicians who understand ACOs, their key functions, and the potential risks and rewards will be in prime position to provide leadership within their organizations or communities. Every successful ACO starts with a few champions. Family physicians should be among those champions. You can help make sure the ACO has a strong primary care foundation and clear goals that all stakeholders share.

*For doctors employed by a hospital:* You can still be a leader in this effort. Though your hospital's “top-down” control habits will likely remain until we reach a tipping point in the transition to value-based reimbursement, one of the best things that can happen to a hospital administrator these days is having a well-informed, employed, primary care physician willing to champion an ACO. Try to participate on all relevant ACO feasibility and implementation committees. You may actually have an advantage in raising awareness and developing relationships from the “inside.” ➤

Starting with a single patient population or disease state, ACOs must translate evidence-based guidelines into best practices across the continuum of care.

For an ACO to be successful, its patients must be invited into the care process.

By being informed and involved, family physicians can help shape ACO efforts in their communities.

# AS A PRIMARY CARE PHYSICIAN, YOU MUST RESIST THE TEMPTATION TO WITHDRAW FROM THESE CHANGES OR TO BLINDLY RUSH INTO NEW ARRANGEMENTS.

**Assess your practice's readiness for accountable care.** Primary care practices that embody the principles of the patient-centered medical home will be best positioned for accountable care. This means having systems in place to optimize patients' access to care, ensure safe prescribing, proactively manage chronic conditions, etc. It also means being prepared for culture change. Family physicians must be willing to cultivate relationships, get outside of their silos and have "what if" creative conversations with open-minded specialists, other primary care physicians, allied health professionals and hospital administrators. Physicians should also assess their health IT systems, their ability to capture data, their patient care capabilities, their patient education and self-support tools, and how they can increase value.

**Form strategic partnerships.** Individual physicians will have to partner with other physicians, medical groups, hospitals or health systems to participate in the ACO model. These relationships can be loose, such as an IPA, or they can involve full-on employment. There are reports of hospitals scrambling to purchase independent practices in preparation for ACOs, so practices should be prepared for this possibility and proceed with caution. (For additional advice on this topic, AAFP members can download the AAFP white paper *The Family Physician Practice Affiliation Guide* from <http://bit.ly/ACOinfo>.) As noted previously, employment does not ensure proper teamwork and integration. It will depend on the characteristics of the organization.

One of the most promising arrangements is a medical home network. Physician-owned medical home networks are simply a loose association of primary care practices operating under the patient-centered medical home model. As these networks become more common, a wise strategy may be simply to join an existing one if it has, or soon will have, the capabilities of becoming an ACO. For example, North Carolina has a statewide confederation of 14 medical home networks that operate under a nonprofit umbrella orga-

nization, North Carolina Community Care Networks. If a medical home network does not exist in your area, creating one could be an effective strategy. The medical home network can attract a payer interested in efficiencies and quality improvement to become the contracting vehicle. Specialists and hospitals would then contract with the medical home network to help provide the full services of an ACO. Alternatively, a hospital or health system could establish the ACO and then contract with the medical homes to complete its network.

If these options are not available, your strategy should be to evaluate potential ACO partners carefully before aligning with them, and then work to make sure your ACO has a strong primary care base and can carry out the key functions outlined above.

## The bad news, and the good news

This is a time of great change in health care, which produces significant stress and uncertainty. As a primary care physician, you must resist the temptation to withdraw from these changes or to blindly rush into new arrangements. Instead, stay informed and involved, and remember that you are key to a high-quality, cost-effective health care system. **FPM**

Send comments to [fpm@aaafp.org](mailto:fpm@aaafp.org).

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■ To be ready for accountable care, physicians may need to update the systems in their practices.

■ Physicians may also want to begin forming strategic partnerships, such as medical home networks.

■ Before aligning with potential ACO partners, physicians should evaluate them carefully.