

AAFP Accountable Care Organization Task Force Report October 2009

Table of Contents

Background.....	2
Accountable Care Organization Description	3
Delivery Systems to Support Accountable Care Organizations	3
Payment Models to Support Accountable Care Organizations	5
Differences between the Patient-Centered Medical Home and Accountable Care Organization models	6
Possible Impact of Accountable Care Organizations on Family Medicine Practices	6
Essential Features for Primary Care Practices to become Accountable Care Organizations.	7
Principles of an Accountable Care Organization	8
Conclusion	9
How to Create Accountable Care Organizations (Executive Summary).....	10
Comparison of Payment Reform Models	13
SWOT analysis: ACO impact on small and medium-sized family practices	14
Sources.....	15

Background

The AAFP Board of Directors established an AAFP Accountable Care Organization Task Force to study the Accountable Care Organization topic and provide a report to the Board for consideration at its October 2009 meeting. The Task Force charges were to:

1. Present information on the current state of Accountable Care Organization development and the potential impact of Accountable Care Organizations on family physicians in various practices settings especially those in small and medium-sized practices.
2. Develop a set of guiding principles for an Accountable Care Organization to bring to patients a foundation of primary care (comprehensive, longitudinal, coordinated) supplemented by other services including sub-specialist consultations, inpatient services, community resources, etc. The principles should also address a payment model to incentivize appropriate care, quality and efficiency in addition to how payment would be distributed in an Accountable Care Organization.
3. Describe what the AAFP should do as next steps to inform and assist family physicians' participation in Accountable Care Organizations especially those in small- and medium-sized practices. *(This report's version does not include recommendations to the AAFP)*

The goal is for AAFP to prepare its membership for a future that may include a comprehensive, population-based accountable health care delivery system with a redesigned payment system.

Special thanks to those who volunteered their time to this activity.

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Statements and recommendations in this report are not intended to represent a consensus opinion by the members of the Task Force, and individual members may disagree with specific statements or recommendations in the report.

Acknowledged resources utilized in developing the report are listed in Attachment 4.

Accountable Care Organization Description

Currently, there is a multitude of private-sector and public-sector efforts underway to control health care costs while improving quality and outcomes. The Task Force determined that a recently-published paper “How to Create Accountable Care Organizations” authored by Harold Miller for the Center for Healthcare Quality and Payment Reform, best defines the Accountable Care Organization concept.

The literature describes an Accountable Care Organization as a means by which providers of care are accountable for the cost and quality of the care for a specified patient population. The Task Force supplemented this definition by including a reference to primary care: “an Accountable Care Organization is a primary care-based collaboration of health care professionals and health care facilities that accept joint responsibility and accountability for the quality and cost of care provided to a defined patient population.” This differs from an HMO in that an ACO does not accept insurance risk.

An Accountable Care Organization is an extension of a strong primary-care based health care delivery system that provides better, more affordable care. Miller emphasizes that, “*The core of an Accountable Care Organization is effective primary care. Although the majority of healthcare expenditures and increases in expenditures are associated with specialty and hospital care, some of the most important mechanisms for reducing and slowing the growth in specialty and hospital expenditures are prevention, early diagnosis, chronic disease management, and other tools which are delivered through primary care practices.*”

Delivery Systems to Support Accountable Care Organizations

The Task Force concurred with Miller’s statement that “*an organization’s ability to serve as an Accountable Care Organization should be determined by its success in improving outcomes – controlling costs, improving quality, and providing a good experience for patients – not on its organizational structure or even the specific care processes it uses. In the short run, since outcomes can only be determined after the fact, some structural and process criteria are needed to define which organizations have the greatest probability of success.*” The Task Force further agreed with Miller and others’ assertions that a true, clinically integrated delivery system could serve as the ideal model for the Accountable Care Organization. Miller categorizes different delivery systems into four ACO levels. The Task Force recommends that they be called “types” to prevent an assumption that levels represent any order or relative value.

- Type 1 ACO: Primary care practices functioning together through an Independent Practice Association (IPA) or other organizational mechanism and focusing on prevention and improvement of care for ambulatory care-sensitive conditions.
- Type 2 ACO: Primary care practices and frequently-used specialties, working together through an IPA or multi-specialty group practice, and focusing on prevention and improvement of care for ambulatory care-sensitive conditions and common specialty procedures.
- Type 3 ACO: Primary care practices, specialists, and hospitals, working together through an integrated delivery system or other organizational mechanism, and focusing on all or most opportunities for cost reduction and quality improvement.

Type 4 ACO: Healthcare providers, public health agencies, and social service organizations working jointly to improve outcomes for a very broad patient population, including homeless individuals and the uninsured.

There will be examples of Accountable Care Organizations along a continuum to becoming fully accountable for a defined patient population. One type is not necessarily better than another, but the maturity of an integrated delivery system may aid the progress towards a “fully accountable” care organization. Miller describes several roles that payers may play in an organization. They may supply patient clinical and costs of care data. Additional important functions for health plans include: (a) administration of traditional health benefits; assumption of insurance risk; (b) creation of payment mechanisms and alternatives to support improved efficient, quality care; and (c) offering care management services as an extension of the organization.

Dr. Elliott Fisher supports two virtual Accountable Care Organization concepts: one that places all physicians in a particular geographic area as an Accountable Care Organization, and the other that payers identify and designate all physicians who admit patients to a particular hospital as an Accountable Care Organization. The logic being is that the typical medical staff structure is “essentially a hospital-associated multi-specialty group practice that is empirically defined by physicians’ direct or indirect referral patterns to a hospital.” The Task Force examined this virtual Accountable Care Organization concept and determined that this delivery system is not well-tested or integrated. Further, Dr. Fisher outlines three key elements of an Accountable Care Organization: *local accountability* for quality and per capita cost for their patient population, *standardized performance measurement*, and *payment reforms* that transition payments from rewarding volume/intensity to increasing value for patients. Dr. Fisher believes that an Accountable Care Organization should have a population of at least 5,000 Medicare beneficiaries or 15,000 beneficiaries with private insurance. He contends that primary care practices should participate in no more than one ACO while specialists would be able to participate in multiple ACOs. He reasons that fewer specialists will be needed. Conversely, demand for primary care practices is likely to increase.

The House bill, H.R. 3200, includes language calling for pilot testing of the Accountable Care Organization model. Specifically, it states that the Accountable Care Organization should be “organized in part for the purpose of providing physicians services,” and there is nothing to prevent a “qualifying” ACO from including a hospital or any other provider of services.” To qualify as an ACO, “the group must have a legal structure that outlines how incentive payments will be made and must have a sufficient number of primary care physicians for the applicable beneficiaries for whose care the group is accountable.” Further, the bill states that the [ACO] group utilizes patient-centered processes of care, including those that emphasize patient and caregiver involvement in planning and monitoring ongoing care management.” Lastly, the legislation allows for the Accountable Care Organization to negotiate a similar contract (as will be the case in the planned government pilot) with private payers.

MedPAC recommends the idea of testing an Accountable Care Organization in its April 9, 2009 report. MedPAC analysts define an ACO as an integrated health care delivery system that relies on a network of primary care physicians, one or more hospitals, and sub-specialists to provide care to a defined patient population. Under the model, hospital and physician networks would be responsible for the quality of care delivered to patients and would receive bonuses for providing high-quality, low-cost care. Medicare may apply payment penalties for an Accountable Care Organizations for delivering low-quality, high-cost care. MedPAC outlined both voluntary and mandatory approaches for physicians while the Centers for Medicare and Medicaid Services (CMS) would assign patients to physicians and their affiliated hospitals. Patients would have the freedom to select their providers within the Accountable Care Organization.

Fisher holds that a hospital must be included while Miller states that the inclusion of a hospital is not an absolute. Fisher appears to be the only proponent that suggests limiting primary care physicians to a single Accountable Care Organization. Miller clearly asserts that the key to a successful Accountable Care Organization is to build it on a primary care foundation. This sentiment is supported in HR 3200 as it recognizes the importance of a primary care-based delivery system, and states that an Accountable Care Organization must have a sufficient number of primary care physicians.

Payment Models to Support Accountable Care Organizations

Fee-for-service (FFS), capitation, salary, and Pay-for-Performance (P4P) all have a place in physician incentive structures. Miller described some additional payment models for physicians and other health care providers: episodic, global, care management, blended payments, and shared savings.

(Attachment 2)

- Episode/bundled payment rates would be based on the resources needed to provide care that is consistent with established clinical guidelines and would include payments to all providers involved in the care of the patient for the specific episode.
- Global payment.
- Care management fee would include services otherwise not recognized as part of the payment for patient care, e.g. non-face-to-face care, telephone services, etc.
- Blended payments would include a combination of the above payment models, e.g. FFS, PFP, partial capitation, bundled, and care management payment.
- “Shared savings” would be a percentage of the difference between the actual and projected costs for the defined patient population served by the Accountable Care Organization.

Episode payments have the potential for reducing utilization, while enhancing quality and provider integration. Global payment has the greatest potential for controlling utilization and encouraging provider integration, but like episode payments, it requires a strong performance monitoring framework and financial incentives to ensure quality. Global payment is also the most challenging to implement on a large scale. Internal physician compensation systems must parallel incentives for value. “Shared savings” alone, states Miller, are insufficient to enable Accountable Care Organizations to truly transform the way they deliver care. Regardless of the details of the payment models and financial incentives built into the models, most Accountable Care Organization experts agree that newer payment mechanisms should be implemented over a period of time and focus on supporting primary care.

One successful example of how shared savings payment mechanism can lead to better care and lower expected costs is the five-year Medicare Physician Group Practice (PGP) Demonstration method. The 10 PGPs include freestanding group practices, components of integrated delivery systems, faculty group practices, and a physician network organization comprising small and individual physician practices. The practices participating in the demonstration are geographically diverse and have a minimum of 200 physicians, and together number more than 5,000. Medicare holds multi-specialty groups/organized systems of care responsible for quality of care improvements and cost savings. Together, they provide the largest portion of primary care services for more than 220,000 Medicare FFS beneficiaries. In the first two years of the pilot, there were impressive quality improvements and Medicare program savings of \$9.5 million and \$17.4 million, respectively. Physician groups earn incentive payments based on the quality of care provided and the estimated Medicare savings generated for their patient population. In performance year 3, CMS reports that 5 physician groups will receive performance payments totalling \$25.3 million, which is their share of \$32.3 million in generated Medicare savings. For each year, the groups increased their quality scores.

Differences between the Patient-Centered Medical Home and Accountable Care Organization models

The Accountable Care Organization model mainly differs from the Joint Principles of the PCMH in that the PCMH focuses on physician practice structure and processes improvements (e.g. electronic health records, patient registries, same-day appointments, etc.) and not on accountability for cost and quality for a defined patient population. Presently, the PCMH model presumes that if a practice meets the NCQA PPC-PCMH recognition requirements, the practice will deliver better, more cost-effective care. Miller contends that there is not strong evidence to support this notion. He adds that the primary care practice needs to commit to performance improvement and publicly report performance results. Such transparency of health care quality and costs is essential to promote “value-based health care.” While the PCMH Joint Principles document does not include mandatory quality performance measurement and reporting, it does highlight the importance of performance improvement: “Physicians in the practice accept accountability for continuous quality improvement through voluntary engagement in performance measurement and improvement.”

Both the PCMH and Accountable Care Organizations seek to improve outcomes and fit well with each other. In fact, a group of experts in health care delivery systems released the “Complementary Models of Delivery System Reform,” document in July 2009 that supports both models. It states, that in order to succeed:

ACOs must be built on a strong foundation of primary care and promote high performance in all domains of care, including access, patient engagement, meaningful use of health information technology, care coordination, and chronic disease management -- all of which are critical elements of the PCMH model.

PCMHs should operate within the context of a supportive and coordinated “medical neighborhood” involving non-primary care sectors that are focused on the same goals of improving quality and affordability. ACOs could provide an important structure for achieving these objectives.

Possible Impact of Accountable Care Organizations on Family Medicine Practices

The Task Force developed a basic SWOT analysis to define some strengths, weaknesses, opportunities, and threats of an Accountable Care Organization on small and medium-sized practices (Attachment 3). The greatest strengths are that Accountable Care Organizations require physician leadership and strong primary care. Unfortunately, this is not always the case in IPAs, which apparently has caused frustration for family physicians, according to the Task Force. A significant weakness is that it will be challenging to form true collaboration across diverse (geographically, demographically, low-tech vs. high-tech, varying structure and processes of care, etc.) physician practices. With respect to some of the opportunities, if done right, Accountable Care Organizations can serve as learning collaborative and motivation to smaller family practices to redesign to become stronger primary care practices that are more financially viable and provide better care. Further, by implementing alternative payment models to support Accountable Care Organizations, the overall health care cost growth in the country should fall. The greatest threat is that some family practices, especially the small- and medium-sized, will be left behind and not able to form or participate in an Accountable Care Organization. This is precisely why AAFP wants recommendations on how it can best assist its membership on being successful in an Accountable Care Organization, which are identified below.

If payment to support the Accountable Care Organization model implementation grows, hospitals may look to purchase or affiliate with select smaller family practices to provide the necessary primary care foundation. Alternatively, some family practices will not be selected and consequently, excluded from the hospital created Accountable Care Organization. Then, the hospital negotiates contracts with the payers in its market place leaving unaffiliated physician practices excluded from the Accountable Care Organization. Similarly, physician-owned Accountable Care Organizations may be more selective in which practices compose its entity because poor performance will affect their ability to negotiate and their bottom line. Such a movement would have the ripple effect as unaffiliated practices' insured patients may be obligated or financially incentivized to seek care within the Accountable Care Organization leaving some practices with fewer patients.

Many private payers already operate high-performance/select physician networks. They often exist as a concentric network inside a larger network and the payers "steer" beneficiaries through health benefits differentials (lower financial outlays) for seeking care within the smaller network. In an Accountable Care Organization environment, payers will likely place downward pressure on fee-for-service payment rates, resulting in less revenue for unaffiliated practices. Further, as the pressure increases for physician practices to make available cost, quality and patient experience information, patients may be more selective in choosing their physicians based on perceived "value".

These health care industry pressures further highlight the imperative for family physicians to transform their practices to become medical homes. More of the same is not acceptable. Also, while most small- and medium-sized PCMH-designated family practices will not be able to simply flip a switch to automatically become an Accountable Care Organization, they will be more attractive to others looking to include family medicine practices in their Accountable Care Organizations.

Essential Features for Primary Care Practices to become Accountable Care Organizations

With the preceding description of the model medicine interested start to The Task Force endorses Miller's eight essentials for primary care practices to become an Accountable Care Organization.

1. Complete and timely information about patients and the services they are receiving;
2. Technology and skills for population management and coordination of care;
3. Adequate resources for patient education and self-management support;
4. A culture of teamwork among the staff of the practice;
5. Coordinated relationships with specialists and other providers;
6. The ability to measure and report on the quality of care;
7. Infrastructure and skills for management of financial risk;
8. A commitment by the organization's leadership to improving value as a top priority, and a system of operational accountability to drive improved performance.

Physicians from many small- and medium-sized family medicine practices may look at the Accountable Care Organization model and initially conclude that there is no way for them to become one. While challenging, this conclusion is false. Miller asserts, and the Task Force supported, that in order to be successful, primary care practices must strive to:

- manage and coordinate patient care across all areas of care;
- manage financial risk associated with the costs of patient care; and
- measure cost and quality in a statistically valid way.

While some small practices may be unable individually to meet the above essential functions, Miller holds that they could collaborate with other small practices to form an organizational structure such as an IPA or a Physician Organization to enable them to efficiently provide the services needed to serve as an Accountable Care Organization. These economies of scale in sharing services allow smaller practices, which otherwise would not be able to provide them on their own, to meet the demands of serving as an Accountable Care Organization.

Miller emphasizes that even though it may logically seem that an Integrated Delivery System can easily serve as an Accountable Care System, the true test should not be based on its structure alone; rather, it should be whether the delivery system has the appropriate processes in place, and, ultimately, on the outcomes it achieves. This is precisely where effective primary care brings “value” to the Accountable Care Organization.

An important element of effective primary care is engaging patients in their own health and wellness, which is a key feature of the PCMH. Family physicians have a responsibility to motivate patients to take better care of themselves through self-care management and wellness activities.

Principles of an Accountable Care Organization

The Task Force emphasized that for an Accountable Care Organization to be successful it must include strong physician leadership and support clinical integration that enables the exchange of patients’ quality data across care settings and services. This will assist with the provision of comprehensive care in the PCMH by primary care physicians (family physicians) with continuing longitudinal data collection which allows assessment of outcomes. A fully-functioning, compatible and interoperable electronic health records will ultimately streamline this process. An effective Accountable Care Organization will show measurable quality improvement over time while reducing direct and indirect costs of health care.

Accountable Care Organization Principles

Structure

1. The core of an Accountable Care Organization is to provide accessible, effective, team-based primary care for the defined population it serves, which includes efforts to deliver care in a culturally competent and responsive manner.
2. Should include strong physician leadership, be clinically integrated and operated in a true partnership among physicians and all other participants.
3. Physician and patient participation in an Accountable Care Organization should be voluntary. However, if patients are assigned to an Accountable Care Organization they should be encouraged to select a primary care physician.
4. Nationally-accepted, validated clinical measures focused on ambulatory and in-patient care should be used to measure performance and augment efficiency and patient experience measures.
5. Clinically integrated information systems should provide relevant information at the point of care and assist in care coordination among multiple clinicians and across transitions of care.
6. Accountable Care Organization participants will support continuous innovation to identify best practices that provide value to patients.
7. Organizational relationships, spending and quality benchmarks, and payment distribution mechanisms need to be clearly defined and agreed to by participants.

8. Accountable Care Organization structure and payment systems should be implemented in an incremental manner and monitored to prevent "unintended consequences," such as poor access to physicians or denial of needed care.
9. A sufficient number of patients in an Accountable Care Organization is necessary to statistically determine if the care provided and not mere chance resulted in the reported outcomes.
10. Primary care physicians and sub-specialists should have the option to participate in multiple Accountable Care Organizations.
11. Accountable Care Organizations should purposefully involve and provide incentives for patient engagement in their health and wellness.
12. Changes to antitrust regulations and to Stark self-referral regulations need to be explored to allow physicians to fully participate in ACOs especially for physicians in small- and medium-sized practices.

Payment

13. Payment models and incentives must align mutual accountability at all levels, fostered by transparency and focus on disease prevention, care management, and coordination.
14. Recognition as an Accountable Care Organization and rewards for its performance should be based on a combination of absolute standards, relative performance, and improvement.
15. Payment changes should evolve over time in ways that support the transitional changes in care processes and information systems.
16. Primary care practices designated as PCMH and participating in an Accountable Care Organization should be eligible for payments in both models of care (i.e. fee-for-service, episode/bundled payment, global payment, care management fee, bonuses, shared savings, blended payment, etc.)

Conclusion

The Task Force recommends that the AAFP monitor and learn more about Accountable Care Organization activities and determine where this falls on the list of Academy priorities. The concept and early implementation of the Accountable Care Organization model is on an accelerated trajectory. This is evidenced by the inclusion of legislative language regarding testing Accountable Care Organizations in the health care reform bills in Congress as well as reports that some health plans are moving forward with performance-based contracts built on the Accountable Care Organization model. Although the magnitude of the Accountable Care Organization model will take time to manifest itself fully in the market place, it is clear that the *value* of this model is that its foundation is effective primary care – an extension of the PCMH model of care.

How to Create Accountable Care Organizations (Executive Summary)

By Harold D. Miller

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The goal of Accountable Care Organizations should be to reduce, or at least control the growth of, healthcare costs while maintaining or improving the quality of care patients receive (in terms of both clinical quality and patient experience and satisfaction). There are many opportunities that exist for improving quality and reducing healthcare costs without the need to ration care. These include improved prevention and early diagnosis, reductions in unnecessary testing and referrals, reductions in preventable emergency room visits and hospitalizations, reductions in infections and adverse events in hospitals, reductions in preventable readmissions, and use of lower-cost treatments, settings, and providers. (See pages 3-5 for more detail.)

Although Accountable Care Organizations should accept greater accountability for reducing costs, they should not be expected to take on insurance risk, i.e., the risk associated with whether the patients who come to them are sick or well (unless they choose to do so). Insurance plans should continue to manage insurance risk, and Accountable Care Organizations should manage performance risk, i.e., the ability to successfully treat an illness in a cost-effective way. (See page 5 for more detail.)

Accountable Care Organizations should not be expected to take responsibility immediately for all possible opportunities for cost reduction. They can be accountable for total costs and make significant impacts on those costs just by pursuing a subset of the many opportunities for cost reduction. (See page 6 for more detail.)

To the maximum extent possible, an organization's ability to serve as an Accountable Care Organization should be determined by its success in improving outcomes – controlling costs, improving quality, and providing a good experience for patients – not on its organizational structure or even the specific care processes it uses. In the short run, since outcomes can only be known after the fact, some structural and process criteria are needed to define which organizations have the greatest probability of success. (See page 7 for more detail.)

The core of an Accountable Care Organization is effective primary care. Although the majority of healthcare expenditures and increases in expenditures are associated with specialty and hospital care, some of the most important mechanisms for reducing and slowing the growth in specialty and hospital expenditures are prevention, early diagnosis, chronic disease management, and other tools which are delivered through primary care practices. (See pages 7-8 for more detail.)

In order for primary care practices to become an Accountable Care Organization, they will need to have at least eight things:

- 1) Complete and timely information about patients and the services they are receiving;
- 2) Technology and skills for population management and coordination of care;
- 3) Adequate resources for patient education and self-management support;
- 4) A culture of teamwork among the staff of the practice;
- 5) Coordinated relationships with specialists and other providers;
- 6) The ability to measure and report on the quality of care;
- 7) Infrastructure and skills for management of financial risk;
- 8) A commitment by the organization's leadership to improving value as a top priority, and a system of operational accountability to drive improved performance.

(See pages 8-10 for more detail.)

Efforts to help primary care practices become more effective, such as the tools of Patient-Centered Medical Homes, the Chronic Care Model, etc., are helpful, but not sufficient. In order to create a successful Accountable Care

Organization, primary care practices must add the capability to manage both cost and quality outcomes. Moreover, not all of the standards in current Medical Home accreditation programs may be necessary to success as an Accountable Care Organization. (See page 10 for more detail.)

Small primary care practices that work together through organizational mechanisms such as an Independent Practice Association (IPA) have a better ability to form an Accountable Care Organization if the number of participating physicians and their organizational structure gives them:

- 1) The ability to manage and coordinate patient care;
- 2) The ability to manage financial risk associated with the costs of patient care; and
- 3) The ability to measure cost and quality in a statistically valid way.

(See pages 10-12 for more detail.)

It is undesirable to require or encourage all physicians in a geographic area to form a single Accountable Care Organization. Participation should be voluntary – based on a commitment to success. There are advantages to having multiple Accountable Care Organizations in a region, but also some additional challenges, and the best approach will vary from region to region. (See pages 12 and 17 for more detail.)

Specialists will continue to play an important role in patient care, but their roles relative to primary care will need to be rationalized and better coordinated, and the volume of referrals to specialists will need to decrease in most regions. Although an Accountable Care Organization will need to have effective working relationships with specialists, specialists do not necessarily need to be part of the Accountable Care Organization itself. (See pages 13-14 for more detail.)

It can be very advantageous to have a hospital included in an Accountable Care Organization if the hospital is committed to the goals of reducing total costs and improving quality. However, Accountable Care Organizations should not be *required* to include a hospital, since the interests of hospitals and physicians may be in conflict in the early stages of development of Accountable Care Organizations. (See pages 14-16 for more detail.)

Integrated Delivery Systems could serve as an ideal model for Accountable Care Organizations if they have true clinical integration and a commitment by their leadership to fulfill the vision of an Accountable Care Organization. (See page 16 for more detail.)

Since providers in different parts of the country differ dramatically in terms of size, clinical and corporate integration, and skills in managing costs, there is no single definition of “Accountable Care Organization” that will work everywhere. Four different levels of Accountable Care Organizations (ACOs) should be considered:

Level 1 ACO: Primary care practices functioning together through an IPA or other organizational mechanism and focusing on prevention and improvement of care for ambulatory care-sensitive conditions.

Level 2 ACO: Primary care practices and frequently-used specialties, working together through an IPA or multi-specialty group practice, and focusing on prevention and improvement of care for ambulatory care-sensitive conditions and common specialty procedures.

Level 3 ACO: Primary care practices, specialists, and hospitals, working together through an integrated delivery system or other organizational mechanism, and focusing on all or most opportunities for cost reduction and quality improvement.

Level 4 ACO: Healthcare providers, public health agencies, and social service organizations working jointly to improve outcomes for a very broad patient population, including homeless individuals and the uninsured.

(See pages 18-19 for more detail.)

Payment systems need to be changed significantly to support Accountable Care Organizations (ACOs).

Payment re-forms should achieve five goals:

- 1) Provide the ACO with the flexibility to deliver the right services to patients in the right way at the right time;
- 2) Enable the ACO to remain profitable if it keeps people healthier or reduces unnecessary services;
- 3) Pay the ACO more for high-quality care than for low-quality care, and encourage patients to use higher-quality ACOs;
- 4) Pay the ACO adequately, but not excessively, to cover the costs of the services it provides for all of its patients; and
- 5) Avoid penalizing the ACO for caring for sicker patients (unless the sickness was caused by the ACO itself).

(See pages 20-21 for more detail.)

Offering arbitrarily defined “shared savings” to an ACO is not sufficient to encourage the formation of ACOs and to enable ACOs to truly transform the way they deliver care. To be effective, shared savings would need to be based on net savings (including unreimbursed costs of changes in care delivery) and combined with other payment changes. (See pages 22-23 for more detail.)

A properly-structured Comprehensive Care Payment (or global payment) system can achieve all of the goals of payment reform, as long as it is structured so as to avoid the problems of traditional capitation payment systems. (See pages 24-25 for more detail.)

Episode-of-Care Payment can serve as both a transitional payment reform and as an important long-run component of an overall payment system. (See pages 26-27 for more detail.)

Hybrid payment models (e.g., partial comprehensive care payments with bonuses and penalties based on savings and quality) can also be used as a transitional payment reform. (See page 27 for more detail.)

In addition to implementing new payment *methods*, effective mechanisms for setting appropriate payment *levels* will also be needed. The appropriate mechanisms will vary from region to region and provider to provider, depending on the structure of local healthcare markets. (See page 28 for more detail.)

Comparable changes in payment systems should be made by all payers, but as a minimum, changes need to be made by the payers that provide health insurance coverage for a majority of an Accountable Care Organization's patients so that the ACO has the resources and ability to change the way it cares for all patients. Medicare needs to have the flexibility to change its payment systems to match the changes local payers make. (See pages 29-30 for more detail.)

The outcomes and measures of success for Accountable Care Organizations should be defined by the community they serve, rather than by individual payers. States, Regional Health Improvement Collaboratives, large payers, and consortiums of payers can play a key role in building consensus among payers and providers on what the standards for success should be and on the appropriate transitional paths. (See pages 30-31 for more detail.)

It is critical to build support among consumers and patients for changes in care delivery and payment, and to have consumers actively engaged in achieving the desired outcomes, rather than trying to hold Accountable Care Organizations solely accountable for improving quality and reducing costs without adequate patient support and involvement. (See pages 31-32 for more detail.)

Other changes in laws and policy would be helpful in encouraging and supporting Accountable Care Organizations, such as malpractice reform, changes in accreditation processes, and modifications to anti-trust laws and gain-sharing laws. (See pages 32-33 for more detail.)

It is unreasonable to expect healthcare providers in most parts of the country to successfully accept full accountability for costs and quality quickly or in a single step. Transitional approaches will be needed. (See page 34 for more detail.)

Support should be made available to willing providers to help them get started, including coaching and technical assistance, information on their current costs and quality, shared services for improved care management, financial resources to support changes in care, and financial modeling to help in taking on financial risk. (See pages 34-35 for more detail.)

A multi-year process for transitioning to full accountability should be used, such as focusing initially on subgroups of patients and subsets of costs. Measures of success should be based on absolute standards of performance, relative performance compared to other providers, and improvement relative to a provider's own baseline. (See pages 35-36 for more detail.)

Special attention should be given to underserved communities and consumers to ensure they participate in and benefit from improved care delivery. (See page 37 for more detail.)

Payment changes should also transition over time in ways that support the transitional changes in care processes. Since initial payments will be based on the fee-for-service system, reforms to the current fee-for-service system, particularly its support for primary care, should be a high priority. (See pages 38-40 for more detail.)

Medicare should encourage and participate in regionally defined Accountable Care Organization initiatives by waiving Medicare requirements and changing payment rules to match what other major payers in the region, including commercial payers and Medicaid, are doing. (See pages 38-39 for more detail.)

Comparison of Payment Reform Models

	Accountable Care Organization (Shared Savings)	Primary Care Medical Home	Bundled Payments	Partial Capitation	Full Capitation
General strengths and weaknesses	Makes providers accountable for total per-capita costs and does not require patient “lock-in.” Reinforced by other reforms that promote coordinated, lower-cost care	Supports new efforts by primary-care physicians to coordinate care, but does not provide accountability for total per-capita costs	Promotes efficiency and care coordination within an episode, but does not provide accountability for total per-capita costs	Provides “upfront” payments that can be used to improve infrastructure and process, but provides accountability only for services/providers that fall under partial capitation, and may be viewed as too risky by many providers/patients	Provides “upfront” payments for infrastructure and process improvement and makes providers accountable for per-capita costs, but requires patient “lock-in” and may be viewed as too risky by many providers/ patients
Strengthens primary care directly or indirectly	Yes – Provides incentive to focus on disease management within primary care. Can be strengthened by medical home or partial capitation to primary-care physicians	Yes – Changes care delivery model for primary-care physicians allowing for better care coordination and disease management	Yes/No – Only for bundled payments that result in greater support for primary-care physicians	Yes – Assuming that primary care services are included in the partial capitation model allows for infrastructure, process improvement, and a new model for care delivery	Yes – Gives providers “upfront” payments and changes the care delivery model for primary-care physicians
Fosters coordination among all participating providers	Yes – Significant incentive to coordinate among participating providers	No – Specialists, hospitals and other providers are not incentivized to participate in care coordination	Yes (for those within the bundle) – Depending on how the payment is structured, can improve care coordination	Yes– Strong incentive to coordinate and take other steps to reduce overall costs	Yes– Strong incentive to coordinate and take other steps to reduce overall costs
Removes payment incentives to increase volume	Yes – Adds an incentive based on value, not volume	No – There is no incentive in the medical home to decrease volume	No, outside the bundle – There are strong incentives to increase the number of bundles and to shift costs outside	Yes/No – Strong efficiency incentive for services that fall within the partial capitation model	Yes – Very strong efficiency incentive
Fosters accountability for total per-capita costs	Yes – In the form of shared savings based on total per-capita costs	No – Incentives are not aligned across provider, no global accountability	No, outside the bundle, no accountability for total per-capita cost	Yes/No – Strong efficiency incentive for services that fall within partial capitation	Yes – Very strong accountability for per-capita cost
Requires providers to bear risk for excess costs	No – While there might be risk-sharing in some models, the model does not have to include provider risk	No – No risk for providers continuing to increase volume and intensity	Yes, within episode – Providers are given a fixed payment per episode and bear the risk of costs within the episode being higher than the payment	Yes – Only for services inside the partial capitation model	Yes – Providers are responsible for costs that are greater than the payment
Requires “lock-in” of patients to specific providers	No – Patients can be assigned based on previous care patterns, but includes incentives to provide services within participating providers	Yes – To give providers a PMPM payment, patients must be assigned	No – Bundled payments are for a specific duration or procedure and do not require patient “lock-in” outside of the episode	Yes (for some) – Depending on the model, patients might need to be assigned to a primary-care physician	Yes – To calculate appropriate payments, patients must be assigned

Source: Reforming Provider Payment, Issue Brief, Engelberg Center for Health Care Reform at Brookings and Dartmouth Institute for Health Policy and Clinical Practice, March 2009.

SWOT analysis: ACO impact on small and medium-sized family practices

<p>Strengths</p> <ul style="list-style-type: none"> • Requires strong primary care and physician leadership • Potential larger/institutional support for quality changes • Principles of ACO are ones that all health care providers should strive for (lower cost, potential improved outcomes) • Alternate payment model that may lead to lower health care costs for the US • Payment incentives/bonuses that may increase monies paid to primary care • May help improve collaboration between specialists and primary care if all are working toward the same goal; perhaps increased communication and collaboration 	<p>Weaknesses</p> <ul style="list-style-type: none"> • Difficult to pull together geographically diverse physicians/practices to achieve true collaboration • ACO appears to lose the “patient centered” part that family medicine does so well (regardless of group size) unless PCMH is in the picture • Challenging to find large enough patient base among smaller providers to achieve statistically significant results (5000 Medicare, 15000 <65yo) • Mechanisms do not exist for measuring quality data in many smaller practices (still paper based), and may be difficult across multiple systems even in practices w/ EHR's • No good way for providers “outside” an ACO to get “inside” if the people on the inside don't have motivation to share savings; might need more savings as more involvement is demonstrated
<p>Opportunities</p> <ul style="list-style-type: none"> • Assistance for smaller practices to become PCMH's by using learning collaborative and resources of the larger group thus leading to PCMH benefits/payments • Increased EHR/HIE opportunities when this becomes a part of why/how we get paid • Ultimately, all ACO's may merge to form one HUGE ACO across the entire US...this would provide us the “systems of care assume responsibility for patients across providers and settings over time” that Brookings lists as their final stop in the quality improvement continuum • Peace, nirvana, and joy for all patients, providers and insurers • Hospital system wanting to increase its primary care capacity may purchase family practices. • With improved patient information, patient safety and overall quality of care should improve. • Promise of better payment under an ACO may motivate family physicians to invest in EHRs 	<p>Threats</p> <ul style="list-style-type: none"> • Some practices may be left out in the cold (last one picked on the playground analogy) • Hospitals would likely have the administrative power and money to start an ACO and may “drive” without regard to primary care, especially among small practices (no cash) • Specialists may see PCMH's as part of the problem (getting money from insurance companies to improve care but taking it out of the general pot of shared savings) leading to conflict • Potential conflicting priorities between physicians and critical access hospitals – docs want to improve care which may decrease hospitalizations, hospitals need the volume to survive, patients need hospitals in their communities, but improved care may decrease need and closing hospitals, which in turn may worsen outcomes because of increased distance to care (vicious circle) • Primary care could lose its identity inside a huge ACO • Family practices not wanting to adopt meaningful health information technology (eventually EHRs) may lose insured patients due to costing them more out-of-pocket or may be out-of-network.

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