AMERICAN ACADEMY OF FAMILY PHYSICIANS

Accountable Care Organizations: A Physician's Perspective

What is an Accountable Care Organization (ACO)?

Simply stated, an ACO is a group of health care providers that agree to take on a shared responsibility for the care of a defined population of patients, while assuring active management of both the quality and cost of that care.

Why should I care about ACOs?

Whether you participate in an ACO or not, there are clear signals that the current payment environment will move away from a pure fee-for-service (FFS) model, and toward a formula that promotes value for patients and efficiency for the system overall.

Success in any aligned delivery system, including ACOs requires that you monitor and manage quality and cost. As a family physician, you should work toward implementing advanced primary care functions including risk-stratified care management, increased access and patient continuity, planned care for chronic conditions and preventive care, patient and caregiver engagement and coordination of care across the medical neighborhood.

Are there different types of ACOs or ways to structure an ACO?

The ACO framework is a widely accepted model for improving health care quality and cost through clinical and for financial integration. In implementation, the AAFP has witnessed ACOs taking different forms to meet local market conditions and levels of existing competition among providers. Many ACOs are currently participating in a Medicare ACO program including Medicare Shared Saving Program (MSSP), Advanced Payment ACO Model and Pioneer ACO model. The rest are commercial ACOs developed in partnership with third-party payers.

What is an Independent Practice Association (IPA)?

An IPA is typically a group of physician practices that have a contractual agreement to work together to provide health care for patients in a health plan network or integrated system. IPAs are important because they have existing infrastructure, management, information technology, and organizational components that can serve as the basis for a physician-sponsored ACO.

How do I get paid in an ACO?

Payment and incentives within the ACO should be structured to foster a shared sense of responsibility for both cost and quality. This provides an opportunity for a higher earning potential for physicians providing care in these ACOs. ACOs may provide any of the following compensation models for physicians:

- Productivity-based Compensation—physician income based on percentage of either billing or collections.
- Incentive-based Compensation—a portion of physician income is based on measurable performance around their ACO goals and benchmarks.
- Capitation—physician income based on a pre-established percentage of the total revenue from system payers (private and public).
- Straight Salary—Set income negotiated at time of hiring and renegotiated at set intervals. May include a bonus/ incentive program.

What is shared savings and how will the savings be distributed to providers?

The idea of shared savings is that, by working together, a group of providers can deliver care at equal—or better—quality while reducing the cost below projections. There should be some savings to be shared between the payer (the government or employer) and the providers. How that savings is calculated and distributed to the various players should be specified in the contracts between parties.

How is an ACO different from managed care and capitation models that were prevalent in the 1990s?

There are similarities, especially when it comes to the goal of cost savings. However, the ACO model is designed to achieve those savings through improvements to care quality and population health care, as per the Triple Aim, as opposed to restricting utilization of health care services. Significant changes, in terms of information technology and performance measurement, now allow for better monitoring of quality. The health care industry has been fundamentally altered by the growing prevalence of data on nearly every aspect of care delivery and purchasing.

How does the PCMH fit into an ACO?

Moving your practice to the PCMH model is a great way to assure that you can demonstrate both quality and efficiency to any ACO in your community seeking primary care services. It is best to think about the PCMH as an essential component of any ACO. Primary care provides access, disease prevention, disease management, and care coordination services that leverage overall cost savings for the system.

Other components could include specialty care, imaging, laboratory services, hospital care, and information technology support. Each component must be integrated, coordinated, and must contribute to the overall efficiency of the ACO enterprise.

I have a small independent practice; what are my options?

It is unlikely that, in a particular market, all the patients will belong to an ACO, or a single health plan. You may be able to continue in much the same way you have until now. The provisions of the current law stipulate that Medicare patients have a full choice of providers, and your long-term patients are likely to stay with you.

Leading ACO experts have come to the opinion that nonhospital affiliated and independent primary care practices stand to benefit the most from the development of the ACO model. If you want to participate in an ACO but not sell your practice, consider joining or starting an IPA affiliated with a local ACO program.

If approached to sell, what should I consider?

The right answer to this question will depend on the current status of your practice and the local market. Look for indications that the approaching entity appreciates the value of primary care and is not just looking to expand its referral base for specialty and hospital services.

Is the entity willing to support infrastructure improvements, such as electronic health records, registries, care coordination, and team care? Will your pay be based only on relative value unit production, or will there be more balanced incentives? Will there be some way for you to participate in profits from the overall efficiency of the organization?

As with any potential new position, look carefully at the total benefit package, including insurance coverage, disability coverage, retirement plan, time away from the practice for vacation, CME opportunities, work hours, and call schedules. Unfortunately, the practice itself will be valued based on accounts receivable, facilities, furniture, and equipment, all priced at discounted or depreciated levels.

Can I form an ACO with other physicians?

Sure, but it takes a lot of time and effort to get everyone on the same page, with the same goals in mind. If you are already associated with a coverage group or an IPA with some infrastructure, you will at least have a running start.

What actions should I take immediately?

Keep seeing patients to optimize your revenue in the current payment environment. Proper coding, good billing procedures, and attention to accounts receivable are still critical in a transition period.

At the same time, make the changes and installing the systems suggested that support advanced primary care functions, so you can respond quickly as the incentives change. Pay attention to what is happening in your market, and determine which players seem to value primary care as more than just a referral hub for hospitals and specialists. Read as much as you can about evolving models of payment, and be aware of incentives currently available in your market.

Where can you get help with all this change?

The AAFP has resources available to help members that includes important information about how to run a practice.

How to run a practice: www.aafp.org/practicemgt

AAFP PCMH pages: www.aafp.org/pcmh

ACO information: www.aafp.org/aco

AAFP Practice Management: www.aafp.org/practice-management