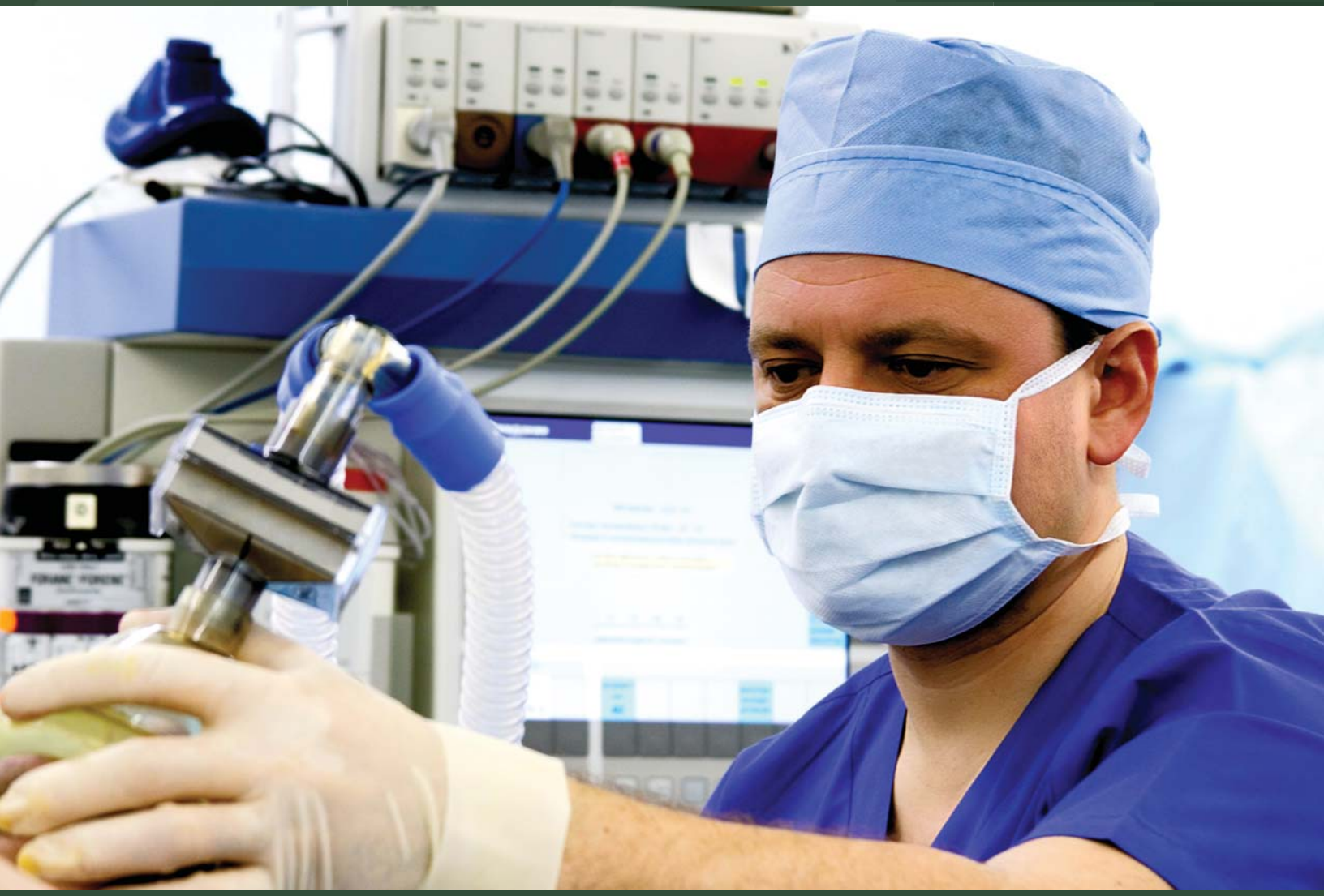
The Anesthesiologist's ACO Toolkit©

Preparing Anesthesiology for the Approaching Accountable Care Era



NC society of ANESTHESIOLOGISTS
THE BEACON OF PATIENT SAFETY

SMITH ANDERSON

ACKNOWLEDGMENT

This strategic guide for anesthesiologists involved input through interviews with and participation by many members. NCSA staff was engaged to collect relevant resources and facilitate involvement by thought leaders. We are grateful to Julian D. ("Bo") Bobbitt, Jr. of the Smith Anderson law firm, who has many years' experience providing our members strategic counsel regarding integrated care, for compiling the information in this non-technical "blueprint" format. The purpose of this paper is to arm you with knowledge and confidence as you consider joining or forming an accountable care organization.

INTRODUCTION

Part One contains elements for a successful ACO and implementation that transcend specialty or facility and apply equally to all ACO stakeholders.

Part Two applies the principles and processes of the Guide specifically from the perspective of the anesthesiologist.

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The ACO Guide

How to Identify and Implement the Essential Elements for Accountable Care Organization Success

SMITH ANDERSON

I. PURPOSE OF THE ACO GUIDE

Accountable Care Organizations ("ACOs") are emerging as a leading model to address health care costs and fragmented care delivery. The purpose of this ACO Guide is to bring together in one source a non-technical explanation of the essential elements required for any successful ACO and practical step-by-step guidance on how to achieve each element. Because a successful ACO must be "win/win", with every collaborative participant incented and empowered to achieve their optimum value-added contribution to the enterprise, these principles transcend medical specialty, employment status, payor relationship, or facility type. This Guide works for you whether you are a primary care physician, a hospital CEO, or a specialist physician. Although ACOs are still evolving and definitive predictions are impossible at this time, the goal of the Guide is to give any reader a firm sense of the strengths and weaknesses of any ACO model they may encounter and confidence about whether to join one or to create one. There are answers to questions about who should join, who should lead, what infrastructure will work, and the phases of development to be followed.[1]

II. WHAT IS AN ACO?

A. Definitions

Former Administrator of the Center for Medicare and Medicaid Services ("CMS") Mark McClellan, M.D., Ph.D. described an ACO as follows: "ACOs consist of providers who are jointly held accountable for achieving measured quality improvements and reductions in the rate of spending growth. Our definition emphasizes that these cost and quality improvements must achieve overall, per capita improvements in quality and cost, and that ACOs should have at least limited accountability for achieving these improvements while caring for a defined population of patients."[2] Similarly, the National Committee for Quality Assurance ("NCQA") included the following definition in its draft ACO criteria: "Accountable Care Organizations (ACOs) are provider-based organizations that take responsibility for meeting the healthcare needs of a defined population with the goal of simultaneously improving health, improving patient experiences, and reducing per capita costs. …[T]here is emerging consensus that ACOs must include a group of physicians with a strong primary care base and sufficient other specialties that support the care needs of a defined population of patients. A well-run ACO should align the clinical and financial incentives of its providers. … ACOs will also need the administrative infrastructure to manage budgets, collect data, report performance, make payments related to performance, and organize providers around shared goals."[3] (Emphasis added.)

Strategic Note: The part of the definition relating to patient populations represents a major shift in practice orientation, and is very alien to a typical physician's training and day-to-day focus.

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[1] It is not the purpose of this Guide to provide legal advice. Any person or organization considering participation in an ACO should seek the advice of legal counsel.
[2] Mark McClellan, Director of the Engleberg Center for Health Care Reform at the Brookings Institution, *A National Strategy to Put Accountable Care Into Practice*, Health Affairs (May 2010), p. 983.
[3] National Committee for Quality Assurance, *Accountable Care Organization* (ACO) Draft 2011 Criteria, p. 3. (hereinafter "NCQA").

Without grasping this shift, an understanding of ACOs will remain elusive. It also is important to note what is not in the definition. No definitions specify any particular type of legal entity (i.e., IPA, PHO, employed). There is no mandatory organizational form for an ACO.

The proposed Medicare Shared Savings Program regulations (Proposed ACO Regulations")[4] released by CMS on March 31, 2011 contain an interesting definition emphasizing structure in contrast to the ones above focusing on function: "Accountable Care Organization (ACO) means a legal entity that is recognized and auhorized under applicable State law, as identified by a Taxpayer IdentificationNumber (TIN), and comprised of an eligible group (as defined at § 425.5(b)) of ACO participants that work together to manage and coordinate care for Medicare fee-for-service beneficiaries and have established a mechanism for shared governance that provides all ACO participants with an appropriate proportionate control over the ACO's decision-making process."[5]

B. PPACA Requirements

ACOs eligible for the Medicaid Shared Savings Program under the Patient Protection and Affordable Care Act of 2010[6] must meet the following criteria:

- That groups of providers have established structures for reporting quality and cost of health care, leadership and management that includes clinical and administrative systems; receiving and distributing shared savings; and shared governance.
- Willing to become accountable for the quality, cost, and overall care of the Medicare fee-for-service beneficiaries assigned to it.
- Minimum three-year contract.
- Sufficient primary care providers to have at least 5,000 patients assigned.
- Processes to promote evidence-based medicine, patient engagement, and coordination of care.
- Ability to demonstrate patient-centeredness criteria, such as individualized care plans.

The Proposed ACO Regulations and three other related documents involving five federal agencies amplify these PPACA criteria. References to this guidance will be made throughout where relevant.

[4] 76 Fed. Reg. 19527-19654 (April 7, 2011)
[5] 76 Fed. Reg. 19641
[6] Section 3022 of the Patient Protection and Affordable Care Act of 2010 (amends Title XVIII of the Social Security Act (42 USC 1395 *et seq.*)).

C. How Is It Different From a Medical Home?

The Patient-Centered Medical Home ("Medical Home") emphasizes strengthening and empowering primary care to coordinate care for patients across the continuum of care. It is complimentary to the ACO and can become the core of an ACO, but it is different in two main respects: (1) Financial Incentives - The Medical Home lacks the shared accountability feature in that it does not have financial incentives, such as shared savings, motivating providers to work together to deliver the highest quality care at the lowest cost with the greatest patient satisfaction. (2) Specialists/ Hospital Linkage - Even though there are Medical Home-only ACOs, a typical ACO is also different from a Medical Home in that it tends to have relationships with select specialists and hospitals across the full continuum of care for the targeted initiative. For example, the Proposed ACO Regulations would require quality reporting across 65 metrics, which span from the Medical Home to the inpatient setting.[7]

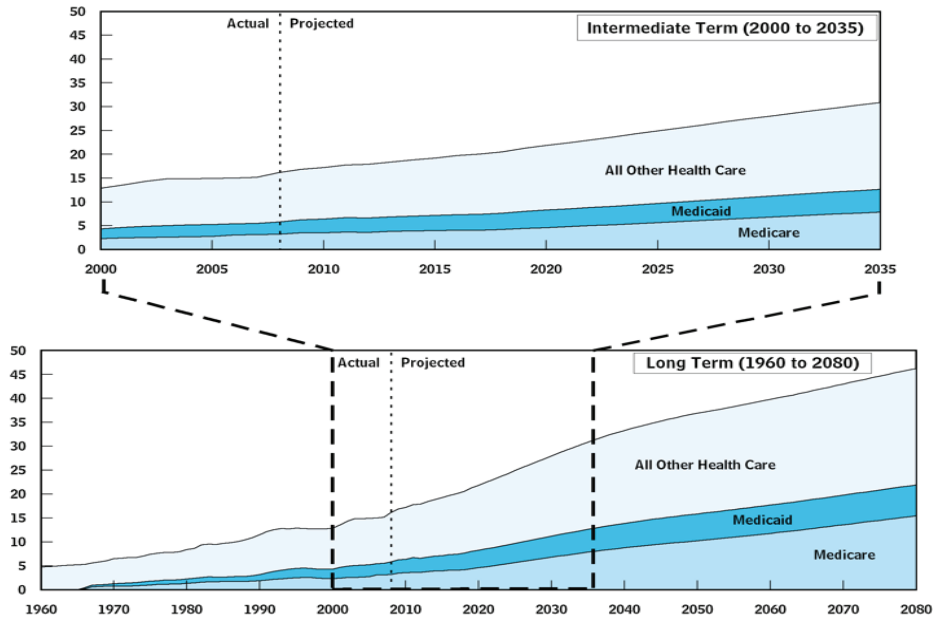
III. WHY SHOULD I CARE?

Health spending is unsustainable, even before coverage expansion of the 2010 federal health reforms. With 19% of Gross Domestic Product ("GDP") being the rough estimate of the amount the United States can collect in taxes and other revenues, by 2035, Medicare and Medicaid are predicted to consume 13% of GDP and health care costs will consume 31% of GDP. In other words,

health care alone will cost well over all we collect. The rest, defense, education, roads, etc. we can only pay for by borrowing. By 2080, absent drastic change, Medicaid and Medicare will consume all of our tax and other revenues, and total health spending will claim 46% of GDP. President Obama is the first President facing bankruptcy of the Medicare System during a term in office.

[7] 76 Fed. Reg. 19658, et seq.

Total Spending for Health Care Under the Congressional Budget Office's Extended Baseline Scenario



There is consensus that much of this is avoidable. The now-famous New Yorker article by Dr. Atul Gawande showing Medicare spending to be twice as high in McAllen, Texas as in El Paso, became required reading in the White House. It said: "The real puzzle of American Healthcare…is not why McAllen is different from El Paso. It's why El Paso isn't like McAllen. Every incentive in the system is an invitation to go the way McAllen has gone." [8]

The Congressional Budget Office Report on the ACO's predecessor, the Bonus-Eligible Organization, includes this rationale: "[P]roviders have a financial incentive to provide higher-intensity care in greater

[8] Atul Gawande, *The Cost Conundrum*, The New Yorker (June 1, 2009).

volume, which contributes to the fragmented delivery of care that currently exists." These dysfunctions in our current system, for which the ACO is seen as a partial remedy, have been given much of the blame for our country's health care system costing 50% more as a percentage of GDP than any other in the world but ranking only 37th in overall health and 50th in life expectancy.[9]

Because of the crisis, drastic efforts at health care cost reform seem inevitable. President Obama stated it bluntly: "So let me be clear: If we do not control these costs, we will not be able to control the deficit."[10] Private insurers see it, too. The President of Blue Cross and Blue Shield of North Carolina recently stated: "Even if federal health overhaul is rejected by the Supreme Court or revamped by Congress, the market must continue to change. The system that brought us to this place is unsustainable. Employers who foot the bill for workers' health coverage are demanding that BlueCross identify the providers with the highest quality outcomes and lowest costs."[11]

Flattening the cost curve is possible through the ACO's marketplace incentives without rationing care, imposing new taxes, or cutting provider reimbursement. Doing nothing is not an option, and all these alternatives appear unacceptable. In short, there is no "Plan B."

IV. ARE ACOs REALLY COMING?

A. If They Repeal Health Reform, Won't This Go Away?

No. Federal health reform has three prongs: Expand Coverage (individual and employer mandates, no pre-existing condition exclusions, etc.), Fraud Control, and Cost Controls (ACOs, bundled payments, value-based purchasing, CMS Innovation Center, etc.). Many experts think that expanding coverage into our broken system has made health care even more unsustainable. However, as noted, the cost curves, even without health reform, will bankrupt our resources, and the value-based reimbursement movement was well underway before the federal legislation was passed. Increasing awareness of problems with the fee-for-service system has resulted in a growing number of initiatives that have common features of accountability at the medical community level, transparency to the public, flexibility to match local strengths to value-enhancement opportunities, and shifting to paying for value, not volume.

B. Isn't This Capitation Revisited?

You may fairly ask, "Isn't this the 'next big thing' to save health care, like capitation? Won't it fizzle away like that did?"

ACOs with shared savings are unlike capitation in several crucial ways. First, the payments are only bonus payments in addition to fee for service payments. There is no downside risk. Second, vital

[9] World Health Organization, *World Health Statistics* 2009.
[10] President Barack Obama, interview excerpt, July 23, 2009.
[11] Brad Wilson, President of BlueCross BlueShield of North Carolina, *The News & Observer* (January 29, 2011).

administrative capabilities, data measurement capability, identified common metrics, severity adjustment, and electronic health information exchange sophistication were not present in the capitation era.

Strategic Note: Though many experts propose that newly-formed ACOs assume financial risk through financial penalties, or partial or whole capitation, the 15 years clinical integration experience of this author strongly suggests that ACOs NOT ACCEPT DOWNSIDE RISK UNTIL THEY HAVE THREE CONSECUTIVE YEARS OF MEETING BUDGET ESTIMATES.[12] There are just too many new partners, roles, moving parts, untested data metrics, and variables beyond the control of the ACO. Even taking a smaller share of the savings pool to recognize the absence of downside risk is preferred to accepting the responsibility of unanticipated medical expenses without the tools to control them. Having some "skin in the game" is clearly a logical way to incentivize accountability for providing value, but thrusting that on an unready health care system could do more harm than good.

C. Can't I Wait Until Things Get Clearer?

With hospitals and physicians having lots of other things on their plates, this bearing a resemblance to other reforms that never quite panned out, and the ACO regulations have not been written, a wait-and-see attitude might at first seem reasonable. However, as the next chapter describes, successful ACO creation will require deep transformational change. The changes will have less to do with infrastructure and technology than culture. This is equally true in integrated systems with a fully-employed medical staff, as it is with other models. "Given the major cultural differences between hospitals and physicians, achieving clinical integration is one of the most difficult challenges that either party will ever undertake. … Organizations that have not yet started down this path in earnest will need to move much more aggressively to prepare for the post fee-for-service world."[13]

V. WHAT ARE THE ESSENTIAL ELEMENTS OF A SUCCESSFUL ACO?

There are eight essential elements of any successful ACO. All eight are required. You cannot skip a step. Because one is not concrete or measurable, it is very counterintuitive that by far the most difficult element to obtain will be creation of an interdependent culture of mutual accountability committed to higher quality and patient satisfaction at the lowest cost. "[C]linical transformation has less to do with technical capabilities and more with the ability to effect cultural change."[14]

[12] The Proposed ACO Regulations allow two years without accepting risk, but would mandate acceptance of risk for the third year of the three-year contract. 76 Fed. Reg. 19643.
[13] Gary Edmiston and David Wofford, *Physician Alignment: The Right Strategy; the Right Mindset*, Healthcare Financial Management Association (December 1, 2010).
[14] *Id.*

The Eight Essential Elements of a Successful ACO

A. Essential Element No. 1: Culture of Teamwork – Integration

The most important element, yet the one most difficult to attain, is a team-oriented culture with a deeply-held shared commitment to reorganize care to achieve higher quality at lower cost. A fully-functional ACO will catalyze the transformation of health delivery. "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. 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."[15]

1. **Challenges for Physicians**. Physician attitudes favor autonomy and individualism over collaboration. These attitudes are inculcated in clinical training and reinforced daily in care delivery. Reimbursement rewards an individualistic "eat what you kill" mentality. Physicians need to understand that the level of involvement needed to effect changes in quality and cost is much different than just banding together for contracting purposes. Physicians will have to be willing to change utilization, referral, and care-management patterns. **In many settings, specialists will need to release primary control of patient care decision-making to the Medical Home primary care physician.**

[15] *Toward Accountable Care*, The Advisory Board Company (2010).

Physicians are cynical about prior "next best things," such as HMOs, gate-keeping, and capitation, and have little experience with, or time for, organizational-level strategic planning. "[I]f providers do not change their decision-making and behavior, ACOs will go the way of most PHOs and IPAs… to the bone yard. More importantly, the healthcare crisis will persist, and more drastic solutions will be mandated."[16]

2. **Challenges for Hospitals.** Will hospitals be willing to embrace a true ACO structure, which will likely drive down hospitalization? Will they be willing to distribute shared savings as intended, to incentivize and reward those who created it through high-performance care delivery and improved coordination, or will they try to take any savings dollars "off the top" to make up for the lost revenue from the reduction in avoidable hospitalizations and readmissions? Will the increased market share from joining an ACO make up for the lost revenue? Exacerbating these business risks for sharing governance with physicians and committing without reservation to an orientation of higher quality and lower costs, is a deeper cultural barrier: control. Hospitals are complex organizations, and a degree of control over operations and direction has been historically important for their viability.

"The most significant challenge of becoming accountable is not forming an organization, it is forging one."[17]

Strategic Note: Tips on How to Create a Collaborative Culture:

- Champions. Vision comes first, but to sell that vision, you need physician leaders able to articulate a clear and compelling vision of change. They need to be champions of the transformational changes needed. As few as one, and rarely more than five, are needed. If a hospital is involved, the CEO needs to show commitment to the shared vision.

- Governance Structure. The structure must have meaningful input from the various parties to have status and credibility. It must exhibit shared control. Management teams can be pairings of physicians with hospital administrators. As noted, it is such a point of emphasis that the Proposed ACO Regulations would require shared governance[18] that the phrase is included in the definition of "Accountable Care Organization."

- Incentives Drive Alignment. "[I]f incentives are correctly aligned, organic innovations to solve other problems can and will engage…. Anticipated early versions of ACO payment incentives are likely to be directionally correct but unlikely to be sufficient to create the needed burning platform."[19] Compensation plans for hospital-employed physicians must not be limited to individual productivity, but also have incentives for accountability for success of the ACO team.

[16] Phillip L. Roning, *Becoming Accountable*, HFMA Compendium—Contemplating the ACO Opportunity, Appendix (November 2010), p. 40.
[17] *Id.*
[18] 76 Fed. Reg. 19641, 19643.
[19] Ann Robinow, Accountable Care News, The Top 3 Obstacles to ACO Implementation, (December 2010).

- "Spiral of Success." The following strategy could help meld team culture: An early pilot project for your ACO should be consistent with the new vision, led by champions and cut across specialty and department lines. A multi-disciplinary team decides how to collect and share data in new ways to facilitate this care initiative. The data, in paper or electronic format, is available at the point of care. Quality goes up and there is a savings pool. New team habits begin to emerge. Small scale is OK, but it must succeed, so the "spiral of success" can start. Trust goes up and buy-in for the next collaboration will occur more quickly.

- Employment Not a Panacea. Isn't the most obvious path to integration through hospital employment? This is a feasible approach if the parties have worked together in the past and there is a pre-existing level of trust and respect. This will not work if there are not shared goals and the control and financial incentive issues are not resolved. "Current trends in physician 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."[20]

B. Essential Element No. 2: Primary Care Physicians

1. **What Is the Role of Primary Care In ACOs?** As discussed in detail in Section V.G. below, the highest-impact targets identified for ACOs lie in the following areas: (a) prevention and wellness; (b) chronic disease management; (c) reduced hospitalizations; (d) improved care transitions across the current fragmented system; and (e) multi-specialty co-management of complex patients. Primary care can be drivers in all of these categories.

Harold Miller of the Center for Healthcare Quality and Payment Reform concluded, "it seems clear that, in order to be accountable for the health and healthcare of a broad population of patients, an Accountable Care Organization must have one or more primary care practices playing a central role."[21] He envisions different levels of ACOs, with the core Level One consisting primarily of primary care practices. Level Two would include select specialists and potentially hospitals. As the diverse patient populations are included, Level Three expands to more specialists and facilities, and Level Four includes public health and community social services. As noted, primary care is the only provider or health care facility mandated for inclusion to qualify for PPACA's ACO Shared Savings Program. In the Proposed ACO Regulations, CMS proposed "to assign beneficiaries to an ACO on the basis of primary care services rendered by physicians in general practice, internal medicine, family practice, and geriatric medicine."[22]

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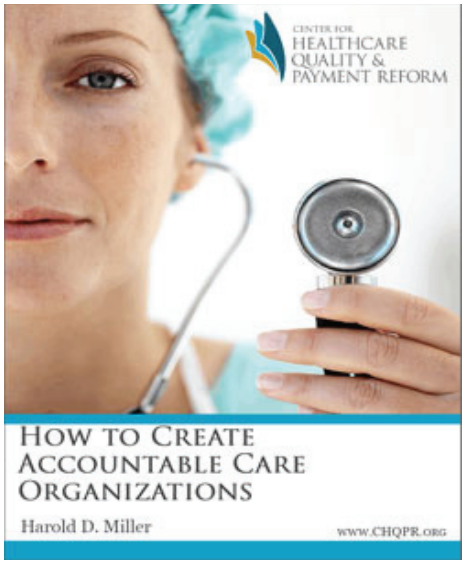
[20] *Toward Accountable Care*, The Advisory Board Company (2010).
[21] Harold D. Miller, *How to Create Accountable Care Organizations*, Center for Healthcare Quality and Payment Reform, p. 8, (September 2009).
[22] 76 Fed. Reg. 19545.

2. **What Are the Roles of Specialists In ACOs?** It is becoming clear that specialists are going to serve important roles in ACOs. Given the opportunities for ACOs listed in Section V.B.1. above, specialists should see roles in Medical Home coordination on diagnosis and treatment, transitions across settings, reducing avoidable hospitalizations, and in multi-specialty complex patient management. Inpatient specialists can tackle hospital through-put, minimizing avoidable adverse events and readmissions, and quality improvements. Specialists intent on preserving volume at the expense of best practices have no role in an ACO.

3. **What Are the Roles of Hospitals In ACOs?** Hospitals are logical ACO partners for several reasons: Patients will need hospitalization, hospitals have extensive administrative and HIT infrastructure, ACOs are consistent with their missions, and hospitals are often a medical community's natural organizational hub. But the typical ACOs tend to reduce hospitalizations. As Mr. Miller observes, "the interests of primary care physicians and hospitals in many communities will not only be unaligned, but will be in opposition to one another."[23] A litmus test for hospital membership (or whether to join an ACO that includes a hospital) is whether it is committed to overall increased savings, improved quality, and improved patient satisfaction for patient populations, even if hospitalization rates are reduced. It is also unacceptable if a hospital permanently seeks to capture most of the shared savings "off the top" to make up for lost revenue. A hospital at over-capacity should not have this conflict. Moreover, many hospitals see full institutional commitment to accountable care as the best way to prepare for the future, maximize their fair share of the shared savings dollar, and grow market share. Once the tipping point of the shift from payment for volume to payment for value has been reached, these conflicts should dissolve.



In summary, because primary care will drive so many of an ACO's most high-yielding initiatives, it is an essential element of a lasting and successful ACO. "Accountable care absolutely must be about improving and maintaining the health of a population of patients and not just controlling costs. It must be about proactive and preventive care and not reactive care. It must be about outcomes and not volume or processes. It must be about leveraging the value of primary care and the elements of the Patient-Centered Medical Home." [24]

[23] *Id.*, p. 15.
[24] Terry McGeeney, M.D., *The Patient-Centered Medical Home and the Accountable Care Organization*, http://transformed.com/CEOReports/PCMH-and-ACO.cfm, (2010).

C. Essential Element No. 3: Adequate Administrative Capabilities 

What Kind of Organization Can Be an ACO? The very label "accountable care organization" tends to convey an impression that an ACO must meet a particular type of organization. In retrospect, it probably should have been called "Accountable Care System." **It is about function, not form.** The NCQA's ACO criteria look to core competencies and infrastructure to implement them, but are "agnostic to organizational structure (i.e., whether or not it is led by a multi-specialty group, hospital, or independent practice association)."[25] Similarly, a wide array of organizations may become eligible for CMS Shared Savings Program under PPACA and the Proposed ACO Regulations:[26] group practice arrangements, networks of practices, joint ventures between providers and hospitals, hospitals employing providers, and other approved structures. There are three essential infrastructure functional capabilities: (1) performance measurement, (2) financial administration, and (3) clinical direction. A legal entity of some sort is necessary, and a number of choices are available. The form ultimately chosen should be driven by what most readily facilitates achievement of the functional needs of the ACO initiatives in your community. The ultimate goals of accountable care are to improve patient outcomes and patient satisfaction while also achieving greater cost efficiencies. The key to achieving this goal is enhanced coordination of care among diverse providers through the application of evidence-based clinical protocols and transparent measurement and reporting. **"While ACO formation and ongoing structural, operational, and legal issues related to ACOs are important, it is this transformation in clinical care that must remain the overriding focus of ACO development."**[27]

What Are Key Legal Issues Affecting ACOs? ACOs require collaboration, referrals, reductions in unnecessary care, and sharing of revenues among sometime competitors. All of these characteristics, and more, in furtherance of health policy, also happen to raise a number of challenging legal-compliance issues for a body of state and federal health care law largely premised upon the fee-for-service model. Adaptations of the most problematic laws and regulations are underway. On March 31, 2011, organizations contemplating participating in Medicare's Shared Savings Program were given guidance by the respective federal agency having jurisdiction over each program, on the application of the antitrust, anti-kickback, Stark, Civil Monetary Penalties, and tax laws to these activities. A properly configured ACO should be successful in navigating this legal minefield. The principle bodies of law affecting ACOs are:

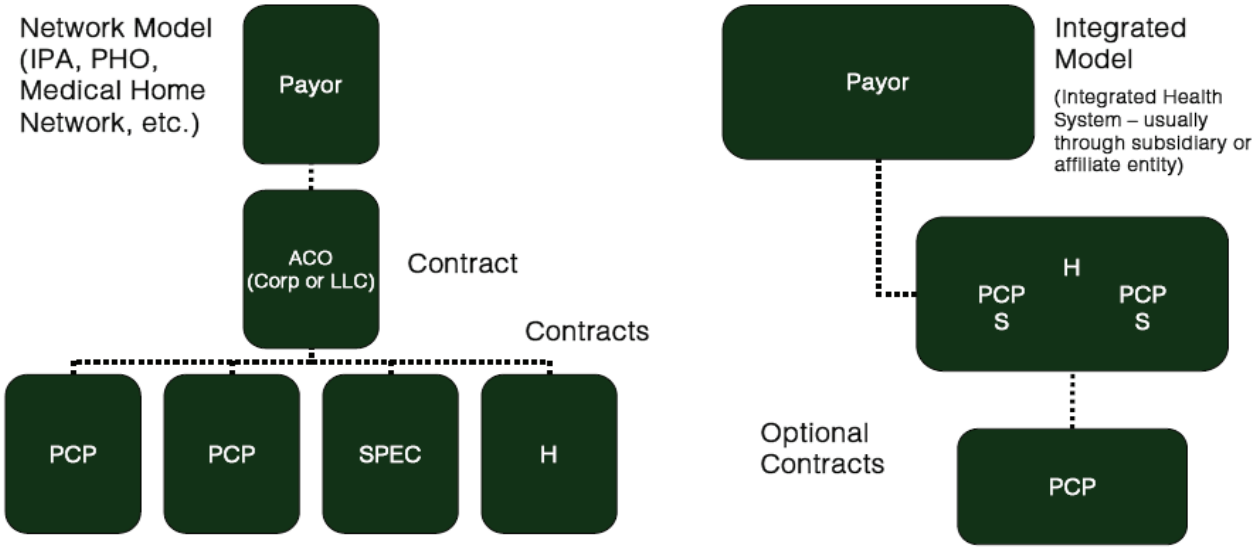
- Antitrust
- Anti-kickback
- Stark
- Civil Monetary Penalties Law

[25] NCQA, pp. 7-8.
[26] 76 Fed. Reg. 19537, 19642.
[27] Doug Hastings, Accountable Care News (December 2010), p. 6.

- Tax
- HIPAA
- Malpractice
- Corporate Practice of Medicine
- Insurance
- Intellectual Property
- State Self-Referral Laws
- Business Law

For a complimentary, detailed analysis, please contact Julian ("Bo") Bobbitt at bbobbitt@smithlaw.com, and ask for a copy of "ACOs: Navigating the Legal Minefield."

Possible Organizational Forms



1. Network Model

a. Independent Practice Associations ("IPAs") – An IPA is basically an umbrella legal entity, usually an LLC, for-profit corporation or nonprofit organization, with physician participation contracts with hospital-employed and independent physician practices. Payors contract with the IPA. These structures became familiar in the fee-for-service and capitation eras, and the form is still suitable for the accountable care era. However, the IPA now needs to have ACO-level infrastructure as described in this Guide. It is particularly dependent on robust health information exchange, as the continuum of care is more "virtual" because the providers are independent.

The participation agreements are different, too. The provider agrees to undertake the responsibilities agreed upon by the ACO and accept some type of performance-based incentive, like shared savings, in addition to fee-for-service. It can have any combination of specialists, primary care, hospital, and tertiary care participation contract. An IPA is owned by physicians. Legal issues of note in IPAs involve antitrust, self-referral, insurance regulation, HIPAA, malpractice, and the Stark law (see Legal Issues in Appendix).

b. Physician/Hospital Organization ("PHO") – The PHO is very similar to an IPA, but the main difference is that it is co-owned and governed by physicians and a hospital or health system and includes a hospital participation contract. The same requirements and caveats apply.

c. Medical Home-Centric Model – Under this variation, an umbrella entity is owned by Medical Home practice members or networks. It contracts with payors, initially for the medical-home-related primary care services, but includes accountable care financial arrangements and performance measurement capabilities. It broadens the scope of initiatives and patient populations by adding select specialists and hospitals through contractual arrangements. These may be sub-ACO arrangements whereby the contract is with a PHO or hospital ACO. The same requirements and caveats of the other Network Model forms apply. Community Care of North Carolina is an example of a confederation of 14 Medical Home-Centric Networks.

2. Integrated ACO Structure – With this variation, the hospital, health system, foundation, or multi-specialty clinic employs, rather than contracts with, the physician. It may own, capitalize, and control the ACO, with physicians on advisory committees. The HIT and other infrastructure is the controlling entity. It may have contracts with independent providers and facilities if necessary to round out the breadth, depth, and reach of services needed to accomplish its initiatives.

D. Essential Element No. 4: Adequate Financial Incentives 

1. **Isn't This the Same As Insurance?** No. An insurance company assumes the financial risk of whether a person gets ill or has an accident requiring medical care. Accountable care risk is accountability for higher performance treatment of patients once they become ill. This gets fuzzy when one remembers that the ACO will be responsible for an entire patient population, especially as it assumes more risk, as in full capitation. However, this distinction is why the ACO performance expectations need to be severity-adjusted.

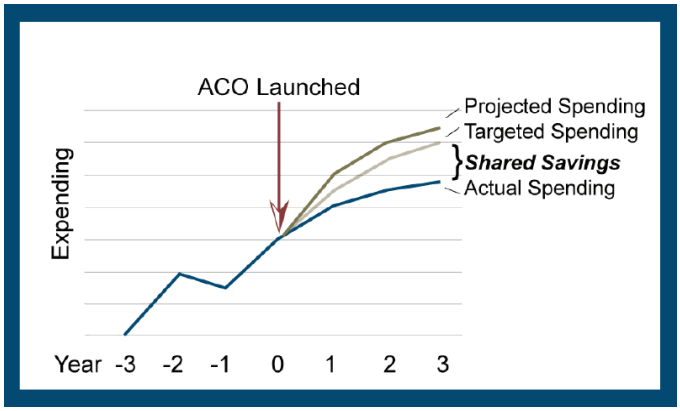
2. **What Are the Types of Financial Incentive Models for ACOs?** There are three tiers: upside-bonus-only shared savings; a hybrid of limited-upside and limited-downside shared savings and penalty; and full-upside and full-downside capitation.

a. Shared Savings – If quality and patient satisfaction are enhanced or maintained and there are savings relative to the predicted costs for the assigned patient population, then a portion (commonly 50% according to some surveys and the Proposed ACO Regulations) of those savings is shared with the ACO. This is stacked on top of the provider's fee-for-service payments. To maximize incentivization, the savings pool should be divided in proportion to the level of contribution of each ACO participant. This aligns incentives of all ACO participants to keep patients as well as possible, and if ill, to receive optimum care in a team environment across the care continuum. If primary care has especially high medical home management responsibility, this may be accompanied by the addition of a flat per member/per month payment.

Some of the savings pool distributions should be used to maintain the ACO infrastructure, but as much as possible should go to reward providers and facilities for the extra time and attention devoted to patient management and technology investments. As mentioned, it should not go to pay affected physicians or hospitals for reduced revenues under fee-for-service for reductions in volume.

A strength of this model is that it is easy to understand and transition to, since it builds upon the familiar fee-for-service system. That is also its weakness, since fee-for-service still rewards volume, not value. This shared savings model has been criticized as being "asymmetric" or "one-sided," with no consequence if there are higher costs or no care improvement. Another problem is that there is by necessity a lag time to measure the "delta," or the difference between the actual costs and the expected costs, so the ACO is uncertain whether there will be revenues. The delay saps the incentivization to adhere to the ACO's best practices and coordination.

The Shared Savings Model



*Courtesy of the Brookings Institute

Strategic Note 1: How to Calculate Shared Savings. Although the concept is simple – the ACO gets 50% of the difference between what the costs for the population turned out to be versus what the costs would have been if the ACO were not in place – DO NOT try to do this by comparing your population costs year-to-year. It might work the first year, but will be inappropriate after that. Having to beat your performance from the prior year, every year, is like calling an Olympic medalist a failure if she does not break her world record the next time out, each time. In some CMS demonstration projects, relatively unmanaged counties in other parts of the country were picked as the control populations. Another way that works is to use an actuary that can predict the medical costs for your region or comparable community and use that actuarially valid projected amount as your unmanaged "comparable." A variation of this latter approach has been chosen by CMS for calculation of the Medicare Shared Savings Program savings.[28]

Strategic Note 2: Be Patient Before Taking on Risk. Do not repeat the disaster of the '90s, when providers took on risk without proper technology, infrastructure, best practices, or experience. We recommend that you come within 5% ± of your predicted costs for three consecutive years before leaving the shared-savings bonus model. You may have unexpected costs over which you have no control. You will likely want to improve your Health Information Exchange, include relevant data elements, and see which of your ACO providers "get it." In our experience, fears that lack of downside risk will deter performance improvement are overblown. On the contrary, a meaningful bonus payment is very motivating, as much as a recognition of and respect for the clinical leadership of the physicians as it is the benefit of dollars involved. Individual distributions that differ based on performance determined by peers is also a "grade" that high-achieving individuals work hard to earn.

[28] Fed. Reg. 19654-19647.

b. Savings Bonus Plus Penalty – As with the shared savings model, providers receive shared savings for managing costs and hitting quality and satisfaction benchmarks, but also will be liable for expenses that exceed spending targets. This model is called "symmetric" or "two-sided" and the bonus potential is increased to balance the accountability for exceeding pre-set goals. Fee-for-service is retained. This resembles the "two-sided" model mentioned in the Proposed ACO Regulations.[29]

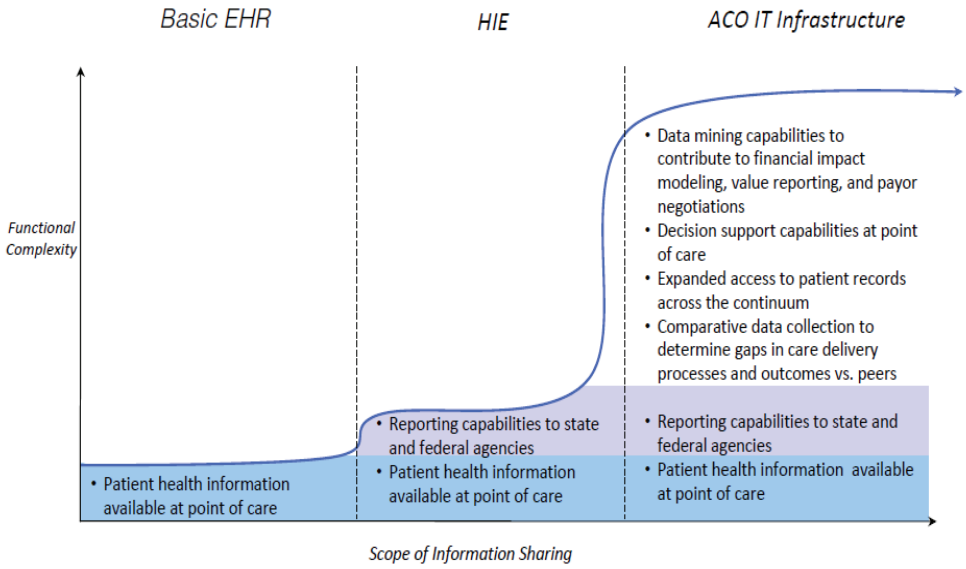
c. Capitation – A range of partial capitation and full capitation models are possible. Fee-for-service payments are replaced by flat payments plus potential bonuses and penalties. Only seasoned and truly clinically integrated ACOs should attempt this level of risk. Yes, the upside is higher, but the disasters of the '90s should not be forgotten.

3. **Is This the Same as Bundled Payment or Episode of Care Payment?** ACO incentives can be aligned with these and other payment experiments under consideration. An "episode of care" is a single amount to cover all the services provided to a patient during a single episode of care. When that episode payment covers providers who would have been paid separately under fee-for-service, that is a "bundled payment." Such a payment mechanism that excludes payment for treatment of avoidable readmission or hospital-acquired infections motivates better care. These approaches do not incentivize prevention and medical-home coordination.

4. **"Meaningful Use" Regulations Incentives.** We include the "Meaningful Use" payments as an ACO financial incentive because the basic Health Information Exchange within your ACO will likely qualify the ACO's providers for the Phase Two and Phase Three "Meaningful Use" incentives.[30] If your ACO can go ahead and establish its data flow needs relatively soon as outlined in this ACO Guide, you stand a good chance that the federal government will help finance the ACO's HIT needs. See Section V.E. below for more detail.

[29] 76 Fed. Reg. 19647.
[30] 75 C.F.R. 44314 (July 28, 2010).

E. Essential Element No. 5: Health Information Technology and Data



1. <u>What Data?</u> ACO data is usually a combination of quality, efficiency, and patient-satisfaction measures. It will usually have outcomes and process measures. Nationally-accepted benchmarks are emerging. There are three categories of data needs for an ACO:

a. <u>Baseline Data</u> – This is often overlooked. To compare anything, there needs to be a beginning reference point. Can you collect costs and quality data? Who owns it now? Who collects it? Do you trust them to be accurate and objective?

b. <u>Performance Data</u> – In the value-based reimbursement era, it will not be enough to provide exceptional cost-effective care, you must prove it. A practical way to determine your ACO's needed performance data is to start by selecting the ACO's targeted initiatives. Then select from emerging nationally recognized quality and efficiency metrics, if they apply. Even if they do apply, convene a multi-specialty committee of clinicians to vet their clinical validity. This committee will recommend performance benchmarks from scratch if national standards are not yet available for all of the care pathway of your initiative. They should address quality, patient satisfaction, and efficiency. They need to be severity-adjusted. Obviously, if and when a third-party payor, including CMS, sets the performance benchmarks, they should be part of the performance array. Many payors want to allow local flexibility and clinical leadership in metric-setting.

Who collects the data? Are there variables outside of your control affecting your performance scores (i.e., patient non-compliance)? What financial incentives/penalties are tied to each?

c. Data As a Clinical Tool – Once the ACO targeted care initiatives are selected, the best practices across the care continuum will be determined. The appropriate ACO committee will then usually "blow up" each pathway into each component and assign clinical leadership, decision support, data prompts, and relevant clinical data to each step at the point-of-care. ACOs are discussing virtual workstations and data dashboards. Coordination with downstream providers will be optimized with the real-time sharing of upstream care results and scheduling.

Strategic Notes: (1) The ACO should periodically internally grade itself against the performance benchmarks to create a constant quality/efficiency/satisfaction improvement loop. This not only will hone the contributions of the ACO initiatives, but also will prepare it to increase its financial rewards once the performance results drive a savings pool on bundled payments. Gaps in care should be flagged and addressed before your compensation depends on it. Clearly, clinically valid, accurately collected, severity-adjusted, and properly benchmarked data are essential for any compensation model based on performance. (2) Data that reflects a track record of high performance serves as a bargaining tool when reimbursement is being negotiated, even in fee-for-service. (3) Use data first to target the "low-hanging fruit," high-impact, value-add initiatives in your area best suited to your specialty or facility. Next, use data to collect evidence of your performance. There will be specific baseline, performance, and clinical data elements needed for each participant to meet objectives, maximize their measured contribution, and thus reap a meaningful reward from the savings pool.

d. The Proposed ACO Regulations Provide Details – The Proposed ACO Regulations would require mandatory reporting on 65 quality measures within the following five (5) domains: patient/caregiver experience; care coordination; patient safety; preventative health; and at-risk population/frail elderly health. The goals of measure setting includes seeking "a mix of standards processes, outcomes, and patient experience measures, including measures of care transitions and changes in patient functional status," severity adjusted and, to the extent practicable, nationally endorsed by a stakeholder organization.[31]

e. HIE Capability – Your ACO will need Health Information Exchange ("HIE") capabilities sufficient to move this data across the continuum in a meaningful way. This HIE is aligned with the Meaningful Use regulations. It will need to be able to aggregate data from multiple sources into user-friendly formats with decision support and relevant data that follows the patient to maximize chances of success in the ACO's targeted initiatives. It needs to minimize the data collection burden on workflows.

[31] 76 Fed. Reg. 19530, 19531, 19648.

F. Essential Element No. 6: Best Practices Across the Continuum of Care

Another essential element of a successful ACO is the ability to translate evidence-based medical principles into actionable best practices across the continuum of care for the selected targeted initiative or initiatives. An ACO may start out with a single patient population (i.e., morbidly obese patients) or disease-state (i.e., diabetes).

The five identified high-impact target areas for ACO initiatives are:

- Prevention and wellness;
- Chronic disease (75% of all U.S. health care spending, much of it preventable);
- Reduced hospitalizations;
- Care transitions (across our fragmented system); and
- Multi-specialty care coordination of complex patients.

"The best bet for achieving returns from integration is to prioritize initiatives specifically targeting waste and inefficiency caused by fragmentation in today's delivery system, unnecessary spending relating to substandard clinical coordination, aggravated with the complexity of navigating episodes of care, and unwanted variations in clinical outcomes driven by lack of adherence to best clinical practice." [32]

CMS writes in the Proposed ACO Regulations, "In practice, such an approach should involve the establishment and implementation of evidence-based guidelines based on the best available evidence concerning the effectiveness of medical treatments at the organizational level.[33]

As discussed earlier in Section V.B., the richest "target fields" from this array will vary by specialty and type of facility. Looking at these suggested initiatives, **it is no wonder why primary care is emphasized as key for ACOs, since they could play a significant role in every area.** The ACO should match its strengths against the gaps in care in the ACO's market to find the proverbial "low-hanging fruit."

G. Essential Element No. 7: Patient Engagement

Patient engagement is another essential element. Without it, an ACO will not fully meet its potential. Unfortunately, many of today's health care consumers erroneously believe that more is better, especially when they are not "paying" for it, insurance is. Patient noncompliance is a problem, especially regarding chronic diseases and lifestyle management. It is difficult to accept a

[32] *Toward Accountable Care*, The Advisory Board Company (2010).
[33] 76 Fed. Reg. 19547.

compensation model based on input on improved patient population health when that is dramatically affected by a variable outside of your control, patient adherence. Currently, asking a patient to be a steward of his or her own care puts an ACO at a competitive disadvantage. But patient engagement is part of patient-centeredness, which is required by PPACA for an ACO to qualify for CMS' Shared Savings Program.[34]

What Can an ACO Do to Engage Patients?

Better information at a societal level and also at the medical home point of care.

- The Patient Compact – Some ACOs, such as the Geisinger Clinic, engage the patient through a compact, or agreement. It may involve a written commitment by the patient to be responsible for his or her own wellness or chronic care management, coupled with rewards for so doing, education, tools, self-care modules, and shared decision-making empowerment. The providers will need to embrace the importance of patient involvement and hold up their end of the engagement bargain.

- Benefit Differentials for Lifestyle Choices – The financial impact of many volitional patient lifestyle choices is actuarially measurable. A logical consequence of the patient choice could be a benefit or financial differential reflecting at least partially these avoidable health care costs.

H. Essential Element No. 8: Scale-Sufficient Patient Population 

It is OK, even desirable, to start small; to "walk before you run," so to speak. However, it is often overlooked that there needs to be a minimal critical mass of patients to justify the time and infrastructure investment for the ACO. PPACA's Shared Savings Program requires that the ACO have a minimum of 5,000 beneficiaries assigned to it.

[34] Section 3022 of the Patient Protection and Affordable Care Act of 2010 (42 U.S.C. §§ 1395, et seq.). see also 76 Fed. Reg. 19547-19550.

Strategic Note: Some ACOs commence activities through a single pilot, or demonstration project, without a sustainable patient population scale. It can de-bug the initiative and test-run the ACO early enough to fix problems before ramping up. This must succeed, however. If it does, it will be much easier for the ACO champions to gain buy-in from others.

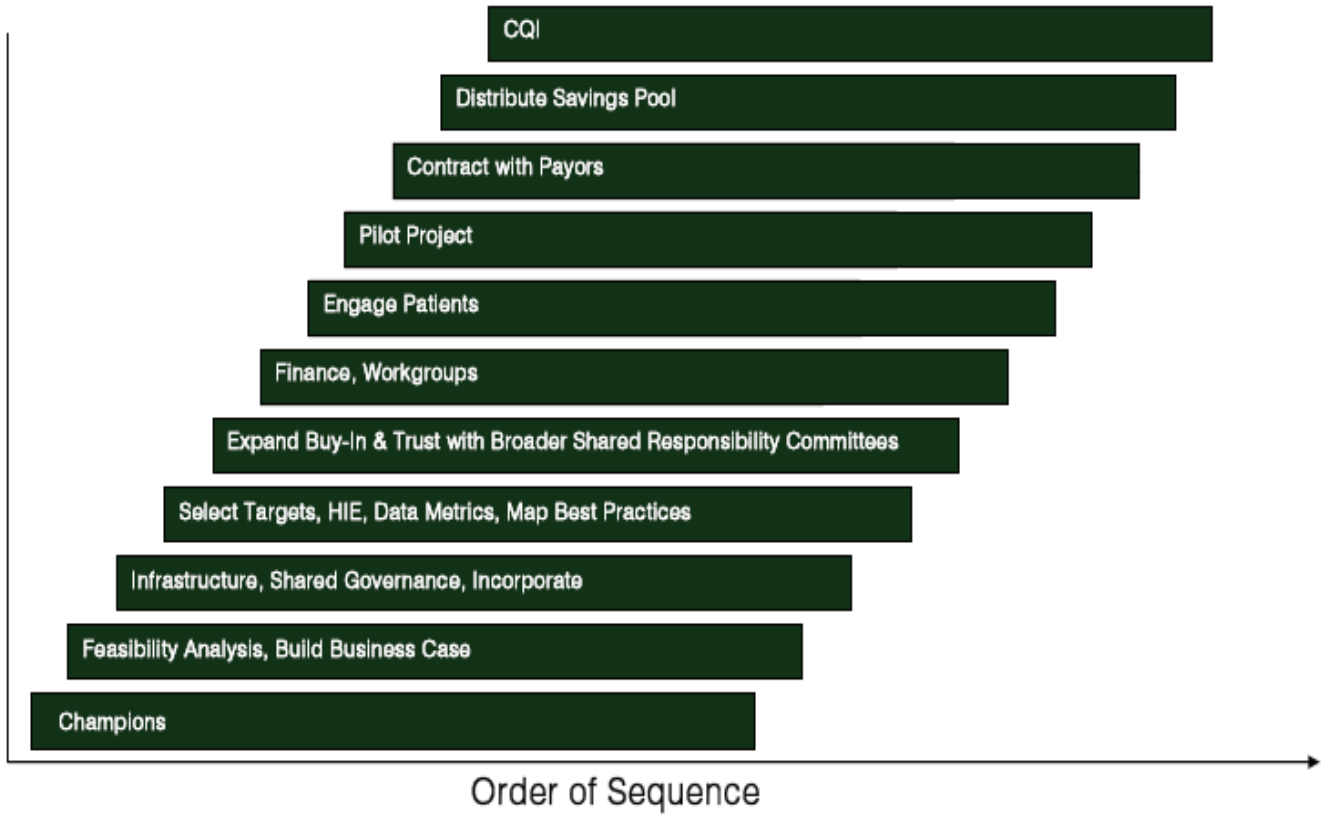
The elements do come together and mesh. Culture dominates. Each one can be built. These are not mysterious. They are doable. It will be hard. Once the ACO organizers embrace the opportunity in this change, achieving all of the elements for sustainable success is quite feasible. Conversely, if you are evaluating a previously organized ACO, there are clear indicators regarding these essential elements that will predict reliably its likelihood of success.

VI. SUCCESSFUL IMPLEMENTATION – A STEP-BY-STEP GUIDE

A. Where Do I Start?

OK, you now may be saying: "I know what an ACO is, why it is important, and how to identify ones that will succeed. However, how do I build one? Where do I start? I know where to go now, but how do I get there?" The creation of an ACO follows basic business planning and start-up principles. Expert advice on ACO implementation is uniform. The following is a step-by-step guide to building an ACO.

B. Step-By-Step Guide



1. **Informed Champions** – Perhaps even ahead of this first step may be that there needs to be some ACO information available to plant the seed of awareness with a few local champions. These champions, whether hospital CEO, family physician, or neurosurgeon, will need to invest their "sweat equity" to get up to speed (the main purpose of this ACO Guide). The champions need to reach beyond silos and see whether cultural compatibility is possible.

2. **Strategy Formulation/Gap Analysis** – Next, a small core group should honestly assess where they are and where they need to go. What is the target market (i.e., chronic disease, Medicaid, the elderly)? Does an ACO make sense? What do we target? How do we make sure this is fair and successful so that we get buy-in? Some experts recommend a phased approach starting with primary care, then adding select specialists and hospitals around targeted high-impact initiatives, then a comprehensive panel, and then, finally, including public health and social services. Other experts recommend matching the natural strengths of the ACO with the greatest gaps in care for the local area. Then they would have the ACO model a strategic business case, to create a roadmap to development. How will it achieve all of the 8 Essential Elements? Keep the team very small at this stage.

3. **Clear Vision** – The organizing group needs to have credibility and will need to unite around a clear and compelling shared vision.

4. **Clinical Integration** – Through shared decision-making and champion leadership, build capabilities of a clinically integrated organization. Review plan for presence of the 8 Essential Elements listed in Chapter V.

a. Start with your initial targeted initiatives.
b. From them, establish best practices for the continuum of care for all providers involved with that type of patient.
c. "Blow up" the best practices into component parts and assign clinical leadership responsibility for each.
d. Identify which clinical data sets and decision support tools are needed at each step.
e. Assign performance metrics and financial accountability for same.
f. Determine HIT technical requirements.
g. Determine best financial tools to incentivize desired behavior by all involved (i.e., share savings with predetermined performance benchmarks and distribution methodology).

5. **Structural Foundation** – Choose the legal entity approach and formal governance structure most appropriate to your culture and business plan. It must be driven by the form most likely for the success of the ACO, not control by or success for any particular stakeholder. Establish membership criteria and a shared decision-making structure. Design and undertake training. Develop payor strategy and contract terms. Do "ROI" predictive modeling to estimate savings and quality benefits. Create credible value talking points for all stakeholders.

6. **Expand Buy-In** – Broaden structured involvement. Create a multi-disciplinary integration committee with HIT, best practices, patient engagement, and finance subcommittees.

7 **Accountability Function** – Develop data metrics, measurement capability, and sophisticated financial administration capabilities to manage financial shared savings distribution. Set performance targets. Normalize data. Make sure your performance-based incentives target your ACO objectives.

8. **Start Small** – Start with a demonstration or pilot project.

9. **Contract with Payors** – Once ready, contract to provide integrated accountable care services on a shared savings basis, at least initially, for your target patient population. The patient population scale must be adequate to achieve economies of scale. Consider a Medicare ACO starting in 2012 as part of a broader strategy.

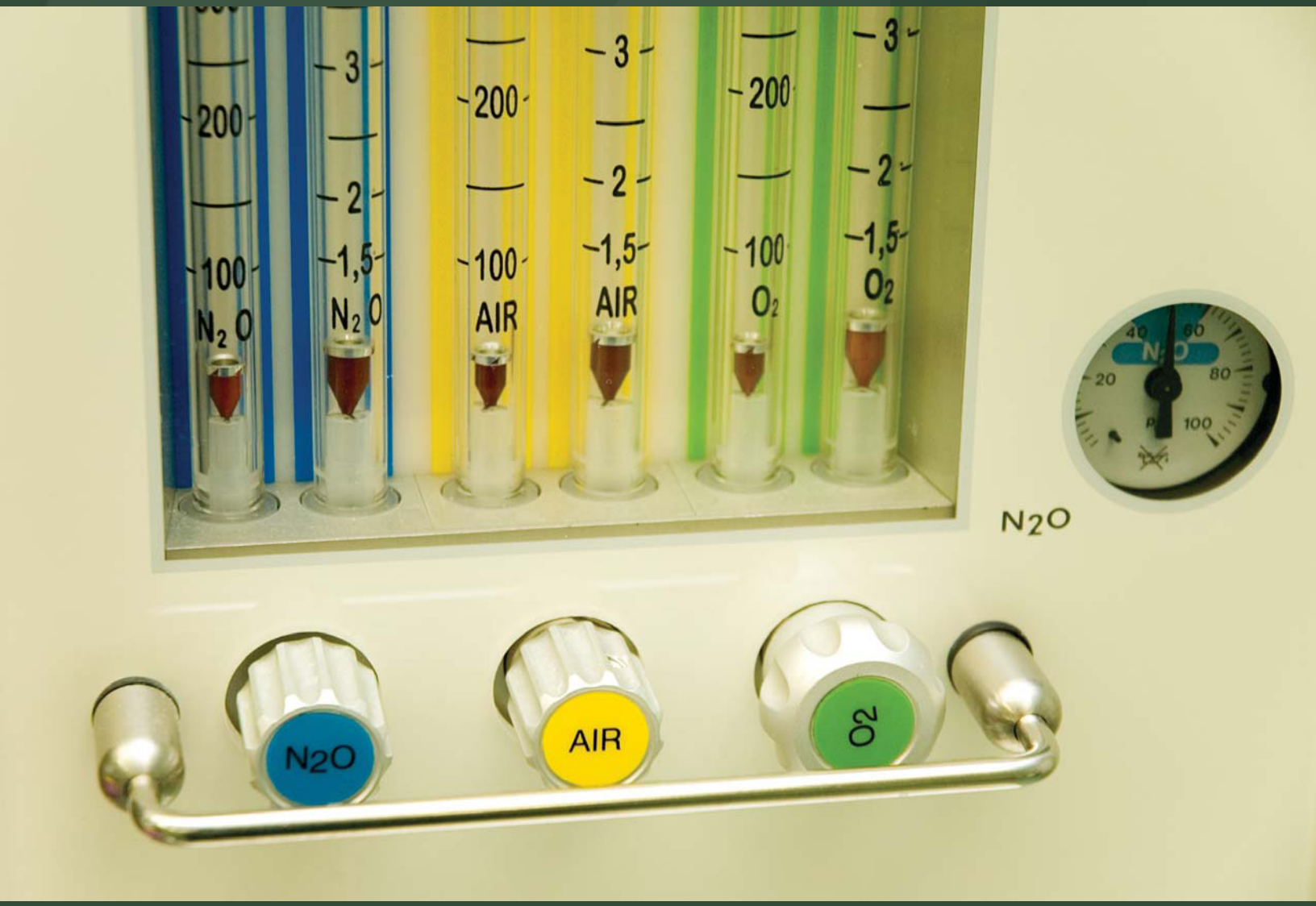
10. **Assess and Improve** – Assess results of the process. Make adaptations to create a constant quality improvement ("CQI") loop. Collect and distribute the savings pool roughly in proportion to contributions to it.

VII. CONCLUSION

The Accountable Care Organization holds great promise to address many of the ills of America's health care system. However, it will require new skill-sets, collaboration partners, technology, and systems. It will require a radically different approach to shared accountability. It is the goal of this ACO Guide to demystify ACOs for all stakeholders and to provide some tools and confidence to allow health care leaders to take prudent risks for greater success than they otherwise would have.

For more information on any aspect of this ACO Guide, please contact Julian ("Bo") Bobbitt at either 919-821-6612 or bbobbitt@smithlaw.com. (www.smithlaw.com)

Part Two: ACO Strategies for Anesthesiologists



NC society of ANESTHESIOLOGISTS
THE BEACON OF PATIENT SAFETY

SMITH ANDERSON

I. INTRODUCTION

Part One describes what it takes to create a successful ACO and the steps to get there. Since it is fundamental that an ACO be a win/win for all involved, it applies whether one is a primary care physician, specialist physician, or hospital executive. Part Two, on the other hand, spells out specific strategies for the anesthesiologist, whether in a small independent practice, large multi-state independent practice, or employed by a health system.

II. COULD AN ACO BE A GOOD THING FOR ANESTHESIOLOGISTS?

In the ACO Guide, Part One of this Anesthesiologist's ACO Toolkit©, we learned what an ACO is, that it will not be going away even if health reform is repealed, and how to know if one stands to be successful. But what, specifically, will this mean for the anesthesiologist?

A. Pros

Many anesthesiologists find that the greatest positives of a well-organized ACO are the return of control of the physician/patient relationship to the physician and patient, and how system-wide care improvement vastly leverages their power to heal. Anesthesiologists are culturally and experientially comfortable with dealing among diverse specialties, technologies, and sophisticated perioperative systems. These skills are proving to be leadership assets in forming collaborative cultures adhering to the eight essential elements for successful ACOs identified in Part One. As with all physicians who have heroically been battling a deeply fragmented system to provide cost-effective care, anesthesiologists find that a model designed to truly gauge and value their contributions to health care shows respect for what they have been attempting to do and a validation of why they went to medical school and chose anesthesiology. Once health care moves well into the value-based reimbursement transition, anesthesiologists view involvement in a successful ACO as important to provide professional economic reward. The stakes are too high; the risks of doing nothing are much higher.

B. Cons

Anesthesiologists are working very hard and have run out of spare intellectual bandwidth. You have seen this "next big thing" before and it didn't work out as advertised. You have little experience and less spare capital to undertake something this complex. Yet, you are hospital-based and the health systems where you must work are usually the default organizers in your medical community and have access to resources on an incomparable scale. ACOs will reduce (avoidable or unnecessary) surgeries, thus bringing down fee-for-service income, which might not be made up. Some ACO models do not include anesthesia and ignore your role in transition and perioperative process improvement. "I just want to see

patients." It is hard to give up independence and be interdependent with other physicians and hospitals. Another risk is that anesthesiologists and other physicians will not step up to have a seat at the table, ACOs will not be properly constructed, the model will fail, and only dismal alternatives will remain.

North Carolina Society of Anesthesiologists
The BEACON of Patient Safety in North Carolina

Strategic Note: Starting with several simple Medicaid initiatives, a cadre of primary care physicians created a statewide confederation of 14 Medical Home ACO networks—Community Care of North Carolina ("CCNC"). Documented savings of over $500-million, with simultaneous improvements in quality, have drawn attention from the largest private, public, and self-funded payors. CCNC is reaching out to specialists and health systems and has found that anesthesiologists are a natural inpatient link to the medical home for surgical patients. These initiatives have meshed nicely with similar efforts of the North Carolina Society of Anesthesiologists ("NCSA") and they have resulted in a Complex Obese Patient Project ("COPP") pilot project (described in more detail at Section C.4).

Though the work involved is plentiful, all the physicians involved have found the rewards to be as well. New dynamics of influence are emerging, spearheaded by payors' clear demand for ACO initiatives that will work to save money and improve quality. The consensus of the involved anesthesiologists who were interviewed for this paper is that though much is uncertain, the opportunities of ACO leadership outweigh the risks of passivity.

III. ACO STRATEGIES FOR THE ANESTHESIOLOGIST

A. Awareness/Leadership/Urgency: Anesthesiology's Role in Guiding Change

Anesthesiology needs to know what an ACO is, how to recognize one with a likelihood of success, and the professional opportunities and risks involved (the purposes of this ACO Toolkit). A number of leaders need to get up to speed and be catalysts for this transformative change. These champions need to act with confidence but also a sense of urgency. This is mentioned as a strategy in and of itself because the biggest risk of failure of the ACO movement and either collapse of Medicare and Medicaid or default to Draconian alternatives, is lack of informed physician leadership. If you do not become involved, there is a good chance that the perioperative process improvement and other roles of anesthesiology will be missed and, like some early ACOs, you will not be involved at all in the shared savings pool distribution. For example, reflecting a major misunderstanding of your role as transition and perioperative process care coordinators, the ACO Toolkit of the Brookings Institution virtually dismisses the role of anesthesiologists in ACOs because they "do not have an ongoing relationship with patients" and are likely to be "less

involved in the coordination of care." The Toolkit goes further and recommends that therefore, anesthesiologists receive no shared savings.[1] As stressed in Part One, the ACO Guide, every successful ACO starts with a few champions. Why not have one be an anesthesiologist? As anesthesiologist Bert Coffer, M.D. said: "If you don't have a seat at the table, you are on the menu."

B. Negotiation Strategies for Joining or Forming an ACO

1. How Many? – Will there be multiple ACOs in a region? Should anesthesiologists join more than one? Will payors opt to go exclusively with just one? Which one will be the eventual winner? Am I locked in through loyalties, exclusive contract, or otherwise to my hospital ACO?

As noted in the ACO Guide, experts contend that at least in the present predominantly fee-for-service environment, there is inherent antagonism in the interests of ACOs started by primary care and by health systems. However, any ACO that commits to the eight essential elements outlined in Part One has a high likelihood of success. Since one of the elements is due and fair regard for the contributions of all providers, including anesthesiologists, it is in your strategic best interest to consider participation in any and all ACOs in your region that has this potential for success. If the elements are present, it makes no difference whether it is hospital, primary care, or specialist-sponsored. Further, being informed, you should actively help the potentially viable ACOs achieve success.

Strategic Note: The New Leverage? In the fee-for-service environment, the revenue and influence centers have also been the cost centers—for example, highly reimbursed high-volume surgical procedures.

[1] *Accountable Care Organization Toolkit,* The Brookings Institution, pp. 19, 20 (January 2011).

As health care moves to value-based reimbursement for large patient populations, it is logical to assume that there will be a shift in negotiating leverage to the value centers—preventive care, transitions, and process improvement. Anesthesiologists are particularly well-suited to drive the latter category in the inpatient setting. Though ahead of the transition now, this will be your "seat at the table" if and when health care moves to accountable care. As noted, there is still a presumption by many ACO consultants that all you do is provide anesthesia to whomever is in front of you.

Strategic Note: Why Champions? As noted in the ACO Guide, change and uncertainty lead to stress. Stress triggers the survival instincts of fight, flight, or freeze. This is great if you are being chased by a saber-toothed tiger, but not good if you need to exploit opportunity that resides in change and uncertainty. Anesthesiologists have more comfort in and experience with adapting to change and share an innate curiosity of best practices and technology that might improve patient care. Anesthesiologists simply seem less daunted by the challenges of ACOs. Fortunately, the confidence of a well-informed champion is quite infectious and is the reason champions are so important to ACO development. In North Carolina, anecdotal experience indicates that anesthesiologist champions have been welcomed both by primary care medical home ACOs, surgeons, other specialists, and health systems, as linkages between outpatient and inpatient care and facilitators in seamless collaborative care pathways across settings.

C. Anesthesiologist ACO Targeting

1. What is Working Elsewhere? – Unlike experiences accumulating from the largely medical home demonstration projects, there is not yet a proven track record of successful anesthesiologist ACO initiatives. It would be ideal if active state chapters and the ASA could establish a mechanism to collect what is going on in the ACO world affecting anesthesiologists. It would be particularly useful to glean anesthesiologist value-add targets or initiatives that show promise as ACOs evolve. Perioperative process improvement, coined "The Surgical Home" by some, is starting to emerge as a consensus recommended area of focus.

2. Applying ACO Target Categories to Anesthesiologists – Note that references throughout are to anesthesiologists, not anesthesiology. This is because, as one anesthesiologist interviewed for this paper stated: "ACOs will best accomplish their goal of improved patient care simultaneous with efficiency through interaction prior to the OR and in focusing on system issues. We need to broaden our view from just doing anesthesia well." As discussed in Part One, the high yield targets for ACOs generally have been identified as:

- Wellness/Prevention;
- Chronic Care Management;
- Reduced Hospitalizations
- Care Transitions (across fragmented system); and
- Multi-Specialty Coordination of Complex Patients.

Applying these categories to anesthesiologists, the following targets may be worth considering for your ACO:

a. Perioperative Process Improvement – A clear opportunity for anesthesiologists is to lead perioperative process improvement. This includes primary care coordination to have the patient's diagnosis and preparation optimized, and all relevant data from the medical home presented preoperatively. The anesthesiologist can be part of the perioperative team to schedule the surgery and the transition of the patient from the outpatient to the inpatient setting.

Once in the perioperative setting, the anesthesiologist can lead development of pre-, intra-, and post-operative protocols. Members of the ACO Work Group of the North Carolina Society of Anesthesiologists, who were consulted in the preparation of this paper, suggested a number of possible evidence-based best practice protocol steps to improve the perioperative process:

- Develop preoperative screening criteria for specific procedures and/or complex patients (i.e., morbidly obese; ESRD or HD).
- Monitor and minimize anesthesiologist-related delays.
- Monitor and minimize surgeon-controlled delays.
- Enable and incentivize anesthesiologist frontline leadership in through-put.
- Ensure SCIP initiatives met.
- Postoperative pain control protocols and best practices.
- Optimal referrals without unnecessary costs or delays.
- HIT—includes real-time critical information, decision support for best practices, which follows patient across care settings, "hardwires" ACO initiatives, and support.
- Coordination to avoid duplication of tests, delays, insufficient referrals, or compromised actions.
- Identify and correct delays in surgery because of equipment malfunction.
- Localized systems analysis to implement meaningful start time and through-put improvement.

b. Inpatient Link for Medical Home – Primary care/medical home initiatives have been the first ACO activities implemented in many areas. As the reach of these initiatives extends to the inpatient setting, anesthesiologists can assume leadership, particularly for patients who will be having surgery. This is based upon skill sets more than on the science of anesthesiology. You are comfortable with systems, technology, protocols, clinical management, and working with diverse health care providers. Your role in the preoperative evaluation and handoff from the Medical Home present opportunities to become involved, if not lead. Is there a recurring frustrating type of surgical or pain procedure? Are there patterns causing frequent delays, errors, bad results, and/or gaps in care?

Strategic Note: The value of anesthesiologists will be amplified if they help create the outpatient/inpatient bridge. We are not aware of any other specialty as well-positioned.

c. High-Impact Avoidable Adverse Events – In 1999, the Institute of Medicine published its landmark study entitled To Err is Human, reporting that as many as 98,000 people die each year in hospitals as a result of medical errors that could have been prevented.[2] As follow-up, the Office of Inspector General ("OIG") of the Department of Health and Human Services undertook a study entitled Adverse Events in Hospitals, issued in November of 2010.[3] This analysis surveyed the adverse events of Medicare patients, those that were avoidable, and ranked them according to the greatest harm. In the Winter of 2010/2011, the NCSA ACO Work Group reviewed these results and prioritized the avoidable adverse events over which anesthesiologists might exert the greatest reduction. These are apt for ACO targeting for the obvious health policy reasons, but also because the OIG recommended that "CMS look for opportunities to hold hospitals accountable for adoption of evidence-based practice guidelines," and CMS commented that it will "aggressively pursue" lowering the incidence of these adverse events.

Avoidable Hospital Adverse Events that Anesthesiologists Should Target:

- Hypoglycemic coma and permanent brain injury secondary to insulin management in patient with anoxic encephalopathy following cardiac arrest.
- Recurrent hypoglycemia secondary to diabetes medication (glipizide).
- Cascade event in which narcotic analgesic (hydromorphone) led to respiratory failure and recurrent somnolence.
- Respiratory failure secondary to sedative (benzodiazepine).
- Hypoxic respiratory failure secondary to IV volume overload.
- Pulmonary edema and respiratory distress secondary to IV volume overload.
- Respiratory failure secondary to IV volume overload.
- Cascade event in which failure to diagnose hypotension and septic shock led to severe hypotension.
- Hypoxia resulting from failure to stabilize tracheostomy and provide oxygen during transfer.
- Hematoma following knee athroplasty.

[2] *To Err Is Human: Building a Better Health System*, Institute of Medicine (Nov. 1999).
[3] *Adverse Events in Hospitals: National Incidence Among Medicare Beneficiaries*, Department of Health and Human Services, Office of Inspector General (Nov. 2010. (27% of patients suffered adverse events or temporary harm; 44% of those were clearly or likely preventable; $4.4-billion in added costs per annum.)

- Delay in surgery because of equipment malfunction.
- Cascade event in which vascular catheter led to (a) sepsis, deep vein thrombosis, and pulmonary embolism, or (b) septicemia and deep vein thrombosis.

If every specialty took the OIG's list and designated the ones it can impact like these anesthesiologists, it would be a giant first step in a meaningful reduction in adverse events. These "targets" could then be woven into ACO initiatives or become initiatives in and of themselves. Many of these were caused by system dysfunctions for which ACOs are well-suited—less than perfect interactions of personnel, lack of adherence to evidence-based best practices, failure of data protocols, or inadequate processes.

Strategic Note: Organized anesthesiology may wish to drill down further into methods to attack these adverse events and become a national leader. It is more desirable to shape the agenda through proactive initiative than to react to mandates from CMS or others.

3. I've Got the "Menu" of Possibilities Now, But How Do I Know the Right Initiatives for My ACO? – The following are criteria for use by ACOs in choosing an initiative for their local situation:

- Greatest and quickest impact by patient population or resource consumption
- Greatest unjustified variation.
- Existing best practices, documented success, and outcomes metrics.
- Greatest gap between actual and expected/achievable performance.
- Greatest interest from clinical champions.
- Readiness of medical community for degree of integration required.

Following the implementation steps in Part One, an anesthesiologist should become informed about ACO initiatives most likely for success generally for the ACO, the ones outlined in this Part Two as most likely to optimize the anesthesiologists' contributions, and these criteria for picking the "low-hanging fruit" for your particular local circumstances. You should try to be involved in ACO planning and help design initiatives that meet the greatest gaps in care locally and that overlap with opportunities for anesthesiologist involvement. Ideally, your committee will have access to predictive modeling, information technology, and actuarial expertise. Next, develop the expected financial gains, best practice steps, and outcomes metrics for the initiative. Design teams work through work-flows, development of financial incentives, regulatory reviews, and "hardwire" medical data and decision support into the HIT. Post-care performance is monitored and the initiative is re-engineered through Constant Quality Improvement.

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4. Complex Obese Patient Pilot ("COPP") Case Study – Initiated by anesthesiologists, the COPP has generated significant interest from the statewide medical home ACO confederation in North Carolina, Community Care of North Carolina, other specialists, and payors. This is a good project for case study in that: (a) it meets most of the categories recommended for ACO targeting in Section C.2; (b) it scores high using on the local project selection criteria in Section C.3, and (c) when reviewing this against the recommended anesthesiologist ACO initiatives above, it is clear that anesthesiologists can contribute in multiple ways.

What is the Complex Obese Patient Project ("COPP")?

COPP is a replicable shared savings pilot project focusing on the complex obese patient population using best practices across the continuum from diagnosis to discharge, created by a multi-disciplinary team with the goal of increasing quality, patient satisfaction, and savings for this patient population. Initial thinking has identified potential opportunities for: (1) better information at the primary care diagnosis and treatment design phase, (2) better information flow along the entire continuum of care, (3) improved transition from the outpatient to the inpatient setting, (4) improved perioperative processes and outcomes, and (5) improved post-op follow up. The COPP would access the existing Medical Home network, Informatics Center, and payor relationships of Community Care of North Carolina ("CCNC"). To align incentives to create the highest quality at the lowest overall cost, an important feature of COPP would be a shared savings payment component, which would be in addition to fee-for-service payments.

Why COPP Now?

- It targets some clear disconnects in our current fragmented system. Significant savings are anticipated in high-yield areas of: prevention, chronic disease management, care transitioning, and process improvement.
- Champions from different specialties and hospital administration have been identified.
- Tackling the obesity epidemic and the cost impact of the "super-utilizers" are in the national health policy forefront.
- A small pilot with champions and likely high-impact initiatives may be appropriate to spark a "spiral of success" in working together in the future to achieve greater value in health care. The prospects are reasonably high for there to be a meaningful shared savings pool. If this happens, it will be much easier to generate buy-in for additional successful projects.
- CCNC brings existing systems, IT, payor relationships, and a primary care physician Medical Home panel to the table.
- There are good prospects for payor funding and reasonable prospects for grant funding.

[4] "Two-thirds of adults and nearly one in three children are overweight or obese. … The sobering impact of these numbers is reflected in the nation's concurrent epidemics of diabetes, heart disease, and other chronic diseases. … This future is unacceptable." (Message from the Surgeon General, *The Surgeon General's Vision for a Healthy and Fit Nation*, 2010, U.S. Dept. of Health and Human Services.) See, "The Hot Spotters – Can We Lower Medical Costs By Giving the Neediest Patients Better Care?" (Atual Gwande, The New Yorker, January 24, 2011.) "Spending per capita for obese adults exceeded spending for adults of normal weight by about 8% in 1987, and by about 38% in 2007." (The Congressional Budget Office, *How Does Obesity in Adults Affect Spending on Health Care?*, September 8, 2010.)

EXECUTIVE SUMMARY

• Diagnosis and Treatment Planning. The primary care physician, preferably in the medical home model, will have better access to relevant data and evidence-based best practices. A complex obese patient comprehensive data template will facilitate intake and later hand-offs. The CCNC Informatics Center will supplement data access, including real-time medication reconciliation and history and data to identify high-risk patients. This will build upon existing hospital and CCNC diabetes and other initiatives. A multi-disciplinary Complex Obese Patient Support ("COPS") team (nutritionist, mental health professional, orthopedic pain management specialist, clinical pharmacist, case navigator, etc.) will provide real or virtual access to specialized expertise for optimum diagnosis and treatment planning.[5]

• Wellness/Lifestyle Management. Continued access to the COPS team to manage and identify co-morbidities and weight-loss techniques. Tools for patient education and engagement. Relevant decision support and clinical data follows patient through virtual-provider workstation.

• Surgery.

a. Non-weight loss surgery. These are often very difficult surgical candidates with many medications, co-morbidities, sleep apnea, and other high-risk issues. However, they often require surgeries due to poor health status. The multi-specialist team will have best practices for pre-surgical evaluation, data transfer, anesthesia-specific pre-op, cardiac evaluation, OSA screening, HTN screening, upper GI if appropriate, patient education, airway assessment and possible need for tracheotomy, etc. There will be enhanced transition coordination with the Medical Home. The surgery would follow optimum perioperative process best practices and utilize the virtual-data workstation. Post-op and post-discharge, the patient is transitioned back to the Medical Home. The physicians have met several times to map out preliminary pathways from the initial visit to three years post-surgery follow-up.

b. Weight Loss Surgery. Same as other surgeries, but would be recommended only if the patient is unsuccessful losing weight by all other measures after a six-month + period, the patient is otherwise a proper candidate (i.e. BMI and health status) and the surgery otherwise comports with evidence-based best practices. A special post-weight-loss-surgery patient follow-up protocol will be managed by the Medical Home physician with ongoing support from the COPS team. Currently, the surgeon usually provides medical and lifestyle management for these patients for up to three years.

• Reporting/Shared Savings. Appropriate quality, patient satisfaction, and cost-effectiveness performance metrics will be established using nationally recognized benchmarks. If the quality and satisfaction standards are met, and there are savings for this patient population enrolled with a particular payor, 50% of those savings would be

[5] "There is little or no coordination between primary care physicians and specialists, or between multiple specialists seeing the same patient … In many cases, more coordinated care could be provided by having the specialist consult with the primary care physician … rather than having the specialist separately manage a portion of the care." Harold Miller, "How to Create Accountable Care Organizations," Center for Healthcare Quality and Payment Reform.

distributed to care providers roughly in proportion to their relative estimated contributions to the savings pool. Financial predictive modeling is anticipated.

Preliminary "SWOT" Analysis

- Strengths – Chances for success high—targets four of the top five recommended areas for collaborative care. (Prevention/wellness, chronic disease management, transitions across fragmented parts of system, and multi-specialty complex patient management. Would not likely impact the fifth area: reduced hospitalizations.) Natural collaboration and transition opportunities. Tied to existing CCNC framework and payor relationships. Particular local expertise in complex obese patient management and treatment.

- Weaknesses – Physicians lose some independence. Hospital loses some control. Hasn't been done before. Participants already are too busy. Do I trust my partners enough? Do we have an interested payor? Will this cost money? Will I lose volume?

- Opportunities – Low-risk pilot. Good way to begin building culture and skills. Existing champions. (Primary care, anesthesia, surgical, other.) Could build market share. Great potential ROI documentation for bariatric surgery. Politically consistent with health policy objectives, image, and community benefit.

- Threats – I might not get fair credit. The data and/or the money will be manipulated. Still in the fee-for-service environment. This is too early to create a precedent that might reduce hospitalization and surgical volumes even though this one won't. I have other priorities. I'm wary of shared-savings methods.

On the other hand, what is the threat of not doing this? Do we risk being unprepared when the transition hits the tipping point of value-based reimbursement?

IV. WHAT ARE THE RELEVANT DATA METRICS FOR ANESTHESIOLOGIST ACO INITIATIVES?

A. What Are the ACO Initiatives?

You will need baseline data, of course, to create the comparison point on quality, efficiency, and patient satisfaction "before" the ACO took over so you can compare it to what happened "after." Hopefully, some of this data will also be useful to determine local gaps in care to help you pinpoint initiatives to pursue.

B. Performance Metrics

These need to match your initiatives that were selected. There is no "one-size-fits-all" set of metrics. They will need to cover quality, efficiency, and patient satisfaction. There will be some that are conclusory in nature (i.e., OR through-put) and some over which you have minimal control (i.e., the hospital's

of the data will depend on the sophistication of your ACO.

Are there performance metrics already worked out and validated for this type of initiative? Who is collecting it? Is it severity adjusted? Do you trust it to be accurate? Is it timely? Is it actionable? Is it directly or indirectly related to something an anesthesiologist can control?

C. Quality and Patient Satisfaction Metrics

There are a number of nationally recognized metrics for quality in the delivery of anesthesia care. There are recognized methodologies for evaluating patient satisfaction regarding care, including anesthesia, surgery, and the inpatient experience. Examples include: cancellations due to difficult intubations, respiratory arrests in OR or PACU, reversal agent given in PACU, deaths and cardiopulmonary arrest within 48 hours, neurological injury from anesthetic, hypothermia on arrival in the PACU, pneumothorax associated with central line placement, dental injuries, prophylactic beta blockade administration, spinal or epidural requiring ventilator support, protocol for timely antibiotic administration, protocol for perioperative normothermia, protocol for comprehensive pain management planning, choice of perioperative antibiotics, sharing of AIMS data, perioperative prophylaxis for venous thromboembolism, elevation of head in bed, patients mechanically ventilated post-operatively, protocols to address targeted adverse events identified in OIG Report. More broadly, the SCIP initiatives and other quality metrics may be available as your perioperative role expands. These transcend specific ACO initiatives.

D. Efficiency

However, the metrics and benchmarks for efficiency-related initiatives being chosen by anesthesiologists are not yet as clear. The ACO Work Group of the NCSA evaluated recommendations from ACOs, anesthesiologist pay-for-performance contracts, the ASA, operating room efficiency recommendations, the OIG study on adverse events, and local practice metrics. The ACO Work Group made the following findings in this emerging area in hopes that it will be useful to anesthesiologists confronted with the question of which efficiency metrics to use in conjunction with the ACO initiatives in which they are participating.

1. Initiative – Perioperative Process Improvement

- General
  - Measure overall improvements in operating room through-put (i.e., "wheels in, wheels out").
  - Measure reduction in anesthesiologist delays.
  - Measure shorter recovery time trend.
  - Measure improved primary care and specialist coordination to avoid duplication of tests, delays, inefficient referrals, or compromised outcomes.o Preoperative screening criteria by diagnosis.

- Specific Protocol Compliance Measurement.
  - Preoperative readiness process.
  - Preoperative screening criteria by diagnosis.
  - On-time starts.
  - Reduced surgeon controlled delay; targeted cases with greatest time variability by surgeon.
  - Measure anesthesiologist frontline leadership.
  - Postoperative pain control process.
  - Intake process for efficient referrals—active communications with primary care physician.

2. Inpatient Link to Medical Home – Performance metrics would address success in facilitating specialist input to assist medical home physician in diagnosis; better admission and discharge communications and coordination; protocols to smooth transitions; and collecting and delivering relevant clinical data to the caregiver at the point of care across the continuum.

3. Adverse Events in Hospital – These "efficiencies" or savings, if you will, largely stem from better quality and cost savings through avoided errors. Efficiency performance metrics will, at best, be incidental to the quality protocols and metrics.

V. HOW DO I ASSURE THAT THE SAVINGS POOL DISTRIBUTION IS FAIR?

As mentioned in Part One, some of the savings pool distributions should be used to maintain the ACO infrastructure, to "prime the pump" as it were. As much as possible should go to incentivize providers and facilities for the extra management time, practice pattern changes, and effort to create those savings. To create maximum motivation and trust, presumably the proportion of distributions should be in proportion to the relative contributions to the pool. The more incentive, the greater the odds of increasing the size of the savings pool going forward.

Strategic Note: Some ACOs may choose to use a portion of their shared savings to partially compensate hospitals and specialists who are seeing revenue reductions due to changes in practice patterns (which is not offset by increase in market share and overhead reductions). Some ACOs will distribute savings to capital investors. We caution that such tactics will slow the transformational changes needed, sap motivation, and ultimately challenge the competitive viability of the ACO altogether.

VI. CONCLUSION

America's health care system will soon become unaffordable absent major change. The ACO movement holds promise to address runaway costs and must thus be taken quite seriously. There are opportunities for professional and financial reward for the informed anesthesiologist. Put another way, the risks of passivity are just too great. All the alternatives to a physician-led system of providing the highest

quality at the lowsest cost are unacceptable. Anesthesiologists have skills and experience that position them to lead in the creation of ACOs, but this is not widely recognized yet within the medical community. To make sure a fair and sustainable ACO model becomes reality, it is important for anesthesiologists to step up with like-minded physicians to lead in this potentially career-changing transformation.

VII. ACO RESOURCES FOR ANESTHESIOLOGISTS

The NCSA realize(s) both the magnitude and difficulty of the change to accountable care. We are committing significant resources to be at your disposal. In addition to this Anesthesiologist's ACO Toolkit©, there will be frequent communications and programs. For a list of ACO resources, please go to www.ncsoa.com or contact NCSA Executive Director, Maeve Goff, at 919-838-2027 or at mgoff@smithlaw.com. If there is sufficient member interest, we will be sponsoring an Anesthesiologist ACO Boot Camp for champions who want a higher level of readiness, and **as a special member service, we have made available up to one hour per practice of consultation services without charge with our legal counsel, the Smith Anderson law firm.**