Physician Involvement in ACOs – The Time is Now

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"The most significant challenge of becoming accountable is not forming an organization, it is forging one." ~ Phillip I. Roning[1]

I. Introduction

Due to the unsustainable costs of health care, the movement toward accountable care with value based reimbursement is inevitable. There is a window of opportunity for the physician community to control its own destiny by developing fair, sustainable, and successful collaborative systems, frequently referred to as accountable care organizations (ACOs). Not being prepared and defaulting to the status quo through passivity, however, is also a choice that promises less access, lower quality, more work, and less compensation for physicians. The choice is clear. This article will provide a non-technical overview of ACOs and discuss the eight essential elements of a successful, sustainable ACO.

II. What Are ACOs and Do They Really Work?

Former Administrator of the Centers 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]

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.* "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.*"[3]

Savings Are Achievable

One pediatric ACO-type project, which achieved improved measured quality, may provide some direction on whether savings are really achievable. Beginning at the medical home level, through Community Care of North Carolina (CCNC), care coordination for child and adolescent Medicaid beneficiaries has yielded well-documented results. On December 15, 2011, the actuary Milliman Inc. issued a public report on CCNC savings. For children age 20 and under (excluding Aged, Blind, and Disabled), risk adjusted costs were about 15% less in FY 2010 ($218.09 Per Member Per Month vs. $185.15) for patients in CCNC. The dollar savings to

the Medicaid program were significant: 2007, $177-million; 2008, $202-million; 2009, $261-million; 2010, $238-million.

Building on this pediatric medical home ACO base, and recognizing that: (1) the 5% of children who are chronically ill consume 53% of Medicaid child care costs, (2) referral patterns for these complex patients are not local but statewide (often to different academic medical centers for different needs), and (3) patient engagement is not just with the child but also parents, teachers, and others, CCNC is now sponsoring the Child Health Accountable Care Collaborative of North Carolina (CHACC). It will transform often isolated medical homes. The state's academic medical centers are involved. CHACC will include high-risk pediatric patients with a heterogeneous mix of complex chronic conditions or technology assistance and yield net projected savings of $24,089,682 over three years, in addition to the previously-noted medical home savings levels.

Extending pediatric care along the entire continuum in this manner, while monitoring quality, access, and savings, positions these coupled programs to leverage significant savings in the future.

A Specialist-Led ACO Initiative: The Complex Obese Patient Project ("COPP")

COPP focuses on the obese patient population with at least one chronic condition, 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. It creates: (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.

Anesthesiologists became aware of a new value-adding role in accountable care: that being the agent for patients transitioning from the medical home to the hospital, navigating the perioperative process while in surgery, and returning to the medical home. They realized that their highest opportunity lay with complex patients frequently in and out of the hospital, where fragmentation of care and lack of patient follow-up is particularly bad under fee-for-service. Surgeons, anesthesiologists, and other specialists not normally associated with ACOs found a particularly successful model through which to contribute to better health and lower costs.

III. The Eight Essential Elements of an ACO

"[C]linical transformation has less to do with technical capabilities and more with the ability to effect cultural change." ~ Gary Edmiston and David Wofford[4]

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

The most important element, yet the one most difficult for physicians to attain, is a team-oriented culture with a deeply-held shared commitment to reorganize care to achieve higher

quality at lower cost. Physician attitudes favor autonomy and individualism over collaboration. These attitudes are inculcated in clinical training and reinforced daily in care delivery. 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. Furthermore, physicians tend to be 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.

B. Essential Element No. 2: Primary Care Physicians

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."[5] This need is logical when you examine the highest impact targets identified for ACOs: (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.

C. Essential Element No. 3: Adequate Administrative Capabilities

There are three essential infrastructure functional capabilities: (a) performance measurement; (b) financial administration; and (c) clinical direction. For example, ACOs qualifying under the Medicare Shared Savings Program must have a leadership and management structure that includes clinical and administrative systems that align with the aims of the Shared Savings Program. The ACO must have an infrastructure capable of promoting evidence-based medicine and beneficiary engagement, reporting on quality and cost metrics, and coordinating care.[6]

D. Essential Element No. 4: Adequate Financial Incentives

Three tiers of financial income models are available to ACOs: upside-bonus-only shared savings; a hybrid of limited-upside and limited-downside shared savings and penalty; and full-upside and full-downside capitation.

1. **<u>Shared Savings</u>**. 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%) of those savings is shared with the ACO. To maximize incentivization, the savings pool should be divided in proportion to the level of contribution of each ACO participant. If primary care has especially high medical home management responsibility, this responsibility may be accompanied by the addition of a flat per member/per month payment.

2. **<u>Savings Bonus Plus Penalty</u>**. 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.

3. **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.

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

ACO data are usually a combination of quality, efficiency, and patient-satisfaction measures. The data will usually have outcomes and process measures. Nationally-accepted benchmarks are emerging. Three categories of data needs exist for an ACO: baseline data, performance measurement data, and data as a clinical tool. The ACO will need the capability to move data across the continuum of care in a meaningful way, often termed "health information exchange" capability.

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. "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."[7]

G. Essential Element No. 7: Patient Engagement

Patient engagement is another essential element. Unfortunately, many of today's healthcare consumers erroneously believe that more is better, especially when they are not "paying" for it, insurance is. It is difficult to accept a compensation model based on improved patient population health when that is dramatically affected by a variable outside of your control, patient adherence.

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

It is okay, even desirable, to start small or "walk before you run." However, potential ACOs often overlook the requirement that there needs to be a minimal critical mass of patients to justify the time and infrastructure investment for the ACO. The Medicare Shared Savings Program, for example, requires that an ACO have a minimum of 5,000 beneficiaries assigned to the ACO.

IV. The Time is Now

The North Carolina Medical Society, along with 26 other NC medical societies and organizations, and in collaboration with key physician leaders and experts in accountable care, is implementing an initiative known as "Toward Accountable Care." The Toward Accountable Care (or "TAC") Initiative will provide specific and practical tools for physicians and other health care providers to successfully navigate, and thrive in, this new collaborative care

environment. Drawing on years of research and experience, the TAC Initiative will develop a comprehensive ACO guide, with the goals of empowering physicians to develop successful ACOs through the provision of specific guidance and resources, and providing specific strategies and step-by-step guidance for ACO development and participation by each medical specialty. Building on the core ACO product, the Initiative will undertake a multi-media educational campaign to assist the health care provider community in developing successful, sustainable ACOs. The Initiative will also provide guidance on receiving funding through the Medicare Shared Savings Program and CMS Advanced Payment Program.

For more information, interested parties should contact Melanie Phelps of the North Carolina Medical Society at (919) 833-3836 or mphelps@ncmedsoc.org. The time is now, and the choice is clear. The current system is unsustainable. America is betting big on the ACO alternative.

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[1] Phillip I. Roning, *Becoming Accountable*, HFMA Compendium—Contemplating the ACO Opportunity (November 2010); p. 40.
[2] Mark McClellan, M.D., Ph.D., *A National Strategy to Put Accountable Care Into Practice*, Health Affairs, May 2010, at 983.
[3] Doug Hastings, Accountable Care News, December 2010, at 6 (emphasis added).
[4] Gary Edmiston and David Wofford, *Physician Alignment: The Right Strategy, the Right Mindset*, HFM, Dec. 2010, http://www.hfmq.org/Templates/print.aspx?id=23980.
[5] Harold D. Miller, *How to Create Accountable Care Organizations*, Center for Healthcare Quality and Payment Reform, September 2009, at 8.
[6] 76 Fed. Reg. 67,976 (Nov. 2, 2011).
[7] The Advisory Board Company, *Toward Accountable Care*, (2010).