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Physician Involvement in ACOs: An Overview and Real-World Examples

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

Introduction

The unsustainability of the current fee-for-service healthcare delivery model makes inevitable movement toward creation of accountable care organizations (ACOs). Physicians and their organizations stand to thrive in this new era but will need to understand the deep transformational changes required. As counsel to physicians and physician organizations, you can greatly benefit your clients by also understanding the sweeping changes in culture, infrastructure, reporting, and financing, and assist them in navigating the new legal minefield. The purpose of this article is to provide a non-technical overview of ACOs and several concrete examples of early ACOs.

Former Administrator of the Center for Medicare & Medicaid Services (CMS) Mark McClellan, MD, PhD, 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]

ACO Structure

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 National Committee for Quality Assurance's (NCQA's) ACO criteria look to core competencies and infrastructure for implementation but are "agnostic to organizational structure (i.e., whether or not it is led by a multi-specialty group, hospital, or independent practice association)."[3] *"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."*[4]

Key Legal Issues Affecting ACOs

ACOs require collaboration, referrals, reductions in unnecessary care, and sharing of revenues among sometime competitors. Many of these characteristics also happen to raise a number of challenging legal compliance issues for a body of state and federal healthcare law largely premised upon the fee-for-service model. A properly configured ACO should be successful in navigating this legal minefield. For overview purposes, the principal bodies of law affecting ACOs are: antitrust; Anti-Kickback Statute; Stark Law; Civil Monetary Penalties Law; tax; federal and state privacy laws; malpractice; corporate practice of medicine; insurance; intellectual property; state self-referral laws; and state business law.

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[5]

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. 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 simply banding together for contracting purposes. Furthermore, physicians tend to be cynical about prior "next best things," such as health maintenance organizations, gate-keeping, and capitation, and have little experience with, or time for, organizational-level strategic planning.

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."[6] This need is logical when you examine the highest impact targets identified for ACOs: (1) prevention and wellness; (2) chronic disease management; (3) reduced hospitalizations; (4) improved care transitions across the current fragmented system; and (5) multi-specialty co-management of complex patients.

Essential Element No. 3: Adequate Administrative Capabilities

Three essential infrastructure functional capabilities are required for ACOs: (1) performance measurement; (2) financial administration; and (3) clinical direction. For example, qualifying ACOs under the Medicare Shared Savings Program (MSSP) must have a leadership and management structure that includes clinical and administrative systems that align with the aims of MSSP. The ACO must have an infrastructure capable of promoting evidence-based medicine and beneficiary engagement, reporting on quality and cost metrics, and coordinating care.[7]

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.

Shared Savings

If quality and patient satisfaction are enhanced or maintained and the ACO realizes savings relative to the predicted costs for the assigned patient population, then a portion (commonly 50%) of those savings is shared by the government with the ACO. To maximize incentives, 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.

Savings Bonus Plus Penalty

In this model, 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 or exceeding pre-set goals. Fee for service is retained.

Capitation

A range of partial capitation and full capitation models are possible in an ACO. In this model, fee-for-service payments are replaced by flat payments plus potential bonuses and penalties.

Essential Element No. 5: Health Information Technology and Data

ACO data is usually a combination of quality, efficiency, and patient-satisfaction measures. It usually will include 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 in a meaningful way, often termed "health information exchange" capability.

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 five identified high-impact target areas for ACO initiatives are: prevention and wellness; chronic disease (75% of all U.S. healthcare 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.[8]

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 input on improved patient population health when that is dramatically affected by a variable outside of physician's control-patient adherence.

Essential Element No. 8: Scale-Sufficient Patient Population

It is okay, even desirable, to start small; to "walk before you run," so to speak. However, potential ACOs often overlook the requirement that an ACO needs to have a minimal critical mass of patients to justify its time and infrastructure investment. The Patient Protection and Affordable Care Act of 2010's (PPACA's) Shared Savings Program requires that the ACO have a minimum of 5,000 beneficiaries assigned to the ACO.

Real-World Examples

So we understand the concept, but what next? How does one decide what to tackle? Will ACOs really work? This article next profiles two examples of ACOs. The first illustrates how specialists, who were not normally associated with ACOs, selected a promising ACO initiative. The second example illustrates the significant potential savings possible for an ACO and its participants. These examples were also chosen to illustrate how neither could exist in a fee-for-service system.

Both examples utilized all eight essential elements. For their location and configuration of specialties, each ACO next selected their targets based on the following criteria:

a. Greatest and quickest impact by patient population or resource consumption;

b. Greatest unjustified variation;

c. Existing best practices, documented success, and outcomes metrics;

d. Greatest gap between actual and expected/achievable performance;

e. Greatest interest from clinical champions; and

f. Readiness of medical community for degree of integration required.

Example No. 1: A Specialist-Led ACO Initiative: The Complex Obese Patient Project (COPP)

The 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.

Through COPP, its participating anesthesiologists became aware of new value-adding roles for their specialty in an accountable care model: being the agent for patients transitioning from the medical home to the hospital, navigating the perioperative process while in surgery, and assisting patients returning to the medical home. They realized that their highest opportunity lies with complex patients, who are frequently in and out of the hospital, where fragmentation of care and lack of patient follow-up is particularly poor under a fee-for-service model. In COPP, 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—setting a valuable precedent for other similarly situated, more typically hospital-based specialists.

Example No. 2: Significant Documented Savings—The Pediatric ACO

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. This model sets up a best practice protocol to direct pediatric patients with complications to the correct specialists, typically at academic medical centers—a radically different referral pattern. CCNC also effectively utilizes care navigators to provide support to patients and enables children to live at home with their families rather than being sent to out-of-state facilities. On December 15, 2011, Milliman Inc., the actuary company, issued a public report on CCNC savings. For children age twenty 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), a network of medical home pediatricians and academic medical centers. It will transform often-isolated medical homes. The state's academic medical centers are involved. CHACC will include more than one million children and yield net projected savings of $105,600,645 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 programs to leverage significant savings.

Conclusion

Through this simplified overview, one can see past the jargon and confusion often associated with these models that ACOs may be a logical reconfiguration of the way healthcare would be delivered under a true value-based reimbursement model. Understanding the "why" behind ACOs should assist legal counsel in guiding clients successfully. The current system is unsustainable. America is betting big on the ACO alternative and the role of the physician is critical.

1 Phillip I. Roning, *Becoming Accountable*, HFMA Compendium—Contemplating the ACO Opportunity (November 2010); p. 40.
2 Mark McClellan, MD, PhD, *A National Strategy to Put Accountable Care Into Practice, Health Affairs*, May 2010, at 983.
3 National Committee for Quality Assurance, *Accountable Care Organization* (ACO) Draft 2011 Criteria, at 7-8.
4 Doug Hastings, Accountable Care News, December 2010, at 6.
5 Gary Edmiston and David Wofford, Physician Alignment: *The Right Strategy, the Right Mindset*, HFM, Dec. 2010, *available at* www.hfma.org/Templates/print.aspx?id=23980.
6 Harold D. Miller, How to Create Accountable Care Organizations, Center for Healthcare Quality and Payment Reform, September 2009, at 8.
7 76 Fed. Reg. 67976 (Nov. 2, 2011).
8 The Advisory Board Company, *Toward Accountable Care*, (2010).