



Evolution of Care Delivery- Accountable Care Organizations and Preparing for Implementation

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Physician practices, hospitals, and payor organizations have worked together to advance a new healthcare service model to improve quality, efficiency and cost of care. This article describes some of the currently known requirements for establishing this new model called the accountable care organization (ACO) under the forthcoming Center for Medicare and Medicaid Services (CMS) ACO program. Potential benefits from implementation, along with challenges, are discussed that include: management of the ACO, technology infrastructure (electronic health records (EHR) and health information exchange (HIE)), equitable distribution of savings, maintaining patient volumes, and financing of care.

Introduction

In 2001 the Institute of Medicine (IOM) noted six redesign challenges for reforming the United States (US) healthcare system¹. Today, physicians, hospitals and payor organizations are confronting these challenges along with lessons learned from managed care programs as part of the impetus for change through the 2010 Patient Protection and Affordable Care Act (PPACA).

In the following sections we address the emergence of the ACO model, keys to its implementation, potential benefits to be derived, and challenges to be overcome as demonstration projects accelerate and ACOs are becoming a new element of healthcare service delivery across the United States.

ACO Emergence

The emergence of ACOs as a new care delivery model has happened over the last 10 years. This is a model that has the potential to improve quality, efficiency and cost of care for services covered by Medicare Parts A and B, Medicaid and private payors for a defined population with shared financial rewards going to ACO participants (i.e. physician practice organizations, hospitals, academic medical centers, etc.) for achieving

quality of care goals. Public sector demonstration models have been tested but challenges still lie ahead. The Center for Medicare and Medicaid Service (CMS) initiated the Medicare Physician Group Practice (PGP) Demonstration Program in 2000ⁱⁱ. This was a 5-year program involving 10 different physician groups/health systems across the country that documented improvement in quality outcomes for a defined Medicare beneficiary population with chronic illnesses or co-morbidities. This group included the Dartmouth-Hitchcock Clinic, Geisinger Health System, Marshfield Clinic, and the University of Michigan Faculty Group Practice. As a result of the improved outcomes, the physician groups received over \$16M in incentive payments for improving quality of care based on 32 quality measures. A summary of the improvement in quality scores on the conditions measured over the first two years cumulatively for the participant practices is noted as follows:

<u>Improvement</u>	<u>Chronic Condition Measured</u>
11%	Congestive heart failure
5%	Coronary artery disease
9%	Diabetes mellitus

It was reported that these improvements were achieved due to the following actions being takenⁱⁱⁱ:

- ◆ Having clinical champions (doctor or nurse) responsible for quality reporting at each practice
- ◆ Redesign of clinical care processes
- ◆ Investment in health information technology. EHR and patient registry improvements allow practices to better identify gaps in care, alert physicians to these gaps during patient visits, and provide interim feedback on performance.

The results from this program supported CMS's movement toward value-based purchasing (VBP) and laid the foundation for CMS's ACO model. In 2009 the Medicare Payment Advisory Commission (MEDPAC) defined an ACO in their 2009 report to Congress^{iv} as follows:

“The defining characteristic of ACOs is that a set of physicians and hospitals accept joint responsibility for the quality of care and the cost of care received by the ACO's panel of patients. The goal is to create an incentive for providers in the ACO to constrain volume growth while improving the quality of care.”

These programs, congressional reports, and related initiatives led to the ACO model being included in the 2010 PPACA under Section 3022 as the “Medicare Shared Savings Program” that CMS is preparing to launch January 1, 2012. Additionally, Section 2706 of the PPACA establishes the “Pediatric Accountable Care

Organization Demonstration Project” also scheduled to launch January 1, 2012. This program follows the same rules established under Section 3022 but serves as a separate program for pediatric medical care providers and State Medicaid agencies. In the private sector, a number of organizations have led efforts to prepare for ACO projects. The Premier Accountable Care Organization Collaboratives^v and the Accountable Care Organization Learning Network^{vi}, a joint initiative between the Brookings Institute and the Dartmouth Institute for Health Policy and Clinical Practice, are two of the leading programs in the industry. A number of physician practices and health systems from across the country are participating in these programs to prepare for implementing ACOs. An example of one recently launched private sector ACO is between CIGNA and Piedmont Physician Group in Atlanta, GA. This program started July 1, 2010 and covers approximately 10,000 individuals. The ACO’s payment structure was described in the following statement:

“CIGNA will pay the primary care physicians of the Piedmont Physicians Group as usual for the medical services they provide, plus an additional fee for care coordination and other medical home services. The physicians also will be rewarded through a “pay for performance” structure if they meet targets for improving quality and lowering medical costs.”^{vii}

An important feature of the ACO model is its flexibility in allowing for the configuration of different types of organizations to be part of an ACO^{viii}. In light of the mixture of public and private sector health service providers in each community, this feature affords great advantages for ensuring that the ACO is set up to meet the local needs of the community. Types of organizations that can become part of an ACO^{ix} include but may not be limited to:

- ◆ Integrated delivery systems
- ◆ Multispecialty groups
- ◆ Independent practice associations (IPA)
- ◆ Virtual physician organizations
- ◆ Physician-hospital organizations
- ◆ Hospitals (private, public, and academic)
- ◆ Home health agencies
- ◆ Nursing homes

Key for the physician practices, the patient-centered medical home (PCMH) model is seen as a foundational element for ACOs as they “provide a way for ACOs to fix internal accountability for performance at the unit of analysis closest to where care is provided and where quality and cost data are generated.”^x The ongoing industry efforts for adoption of PCMH models in primary care settings serves as a clear advantage and positive step forward for ACO implementations.

Keys to Implementation

There are several keys to implementation in an ACO model. In addition, Section 3022 of the PPACA identified a number of requirements for each ACO. Exhibit 2 provides a table that illustrates these requirements.

Exhibit 2: General Requirements for an ACO Per PPACA Section 3022^{xi}

Topic	Description
Management	Formal legal structure: <ul style="list-style-type: none"> ◆ ACO professionals^{xii} in group practice arrangements, ◆ Networks of individual practices of ACO professionals, ◆ Partnerships or joint venture arrangements between hospitals and ACO professionals, ◆ Hospitals employing ACO professionals, ◆ Other groups of providers of services and suppliers deemed appropriate by the Secretary of the Department of Health and Human Services (DHHS), Each ACO will have “shared governance” and leadership that makes joint decisions in operations and provide administrative and clinical systems.
Time Commitment to Venture	Each ACO must have an agreement with DHHS to participate in the ACO program for no less than a 3-years.
Number of Medicare Beneficiaries	Minimum of 5,000.
Structure	ACO shall both receive and administer payment of shared savings to participant organizations.
Patient-centeredness Criteria	Use patient and caregiver assessments or individualized care plans.
Health Information Technology	Coordinate care through the use of telehealth, remote patient monitoring, and other enabling technologies.
Defined Processes	Promotion of evidence-based medicine and patient engagement.
Performance Reporting	Specific quality measures will be identified by DHHS but will include care transitions across care settings. Reporting shall also incorporate requirements of the physician quality reporting initiatives (PQRI).
Benchmarking	DHHS will establish a benchmark for each ACO’s 3-year period with the most recent 3 years of “per-beneficiary expenditures” assigned to the ACO.
Shared Savings	When an ACO beats established benchmarks, a percent of the difference may be paid to the ACO and the program shall retain the remainder. The benchmarks shall be set by DHHS “using the most recent available 3 years of per-beneficiary expenditures for parts A and B services for Medicare fee-for-service beneficiaries assigned to the ACO.” ^{xiii} DHHS will also establish limits on shared savings that can be paid out.

A final rule on ACOs will be issued by CMS to provide more clarity regarding several issues on ACO formation, operation, performance measurement, and gain sharing in 2011 leading up to the program launch on January 1, 2012. In addition to these issues that will be expanded upon, how about the use of

electronic health records (EHR) in ACOs? PCMH models require the implementation of EHRs and will be in place to provide the benefits to the ACO for managing and tracking patient care activities, improved quality reporting capabilities, health information exchange (HIE), and improved care coordination. Additionally, meeting CMS's Meaningful Use of EHRs timeline through Phases 1-3 will coincide with the growth and expansion of ACOs across the country. Therefore, having a robust EHR in place to meet both health information technology (HIT) requirements and quality reporting requirements is supported by the American College of Physicians in their April 2010 ACO position statement that "*ACOs should promote the principles of the PCMH*" and that certified EHR technology should be used in all ACO affiliated physician practices.^{xiv}

As with any major organizational transformation initiative, one key issue for an ACO implementation is managing the cultural transition and the human-side of the organizational changes that occur over time. Having leaders that can motivate, secure trust across disparate stakeholder groups, communicate a strong vision, and guide the organization on a path to the future state are just a few of the issues to be dealt with by clinical, technical, and administrative leaders involved in the establishment of an ACO. Resistance to change and the impact on adoption of the new operating model is a natural concern, but the incentives (i.e. opportunities for shared savings) available through the PPACA and private payor ACO programs helps mitigate this issue. Recognizing the importance of the human-side of the organizational transformation, preparing for it, and helping managers and team members cope with it can not only accelerate adoption of new processes but in these cases result in even stronger improvement of patient care and maximize the potential for shared savings for the ACO.

Challenges to Mitigate

Even with the ACO successes that have been demonstrated across the industry, there are a number of challenges organizations should prepare for in the journey to establishing an ACO. Some of these challenges (and our thoughts on mitigating their impact) include the following^{xv}:

- a. Lack of understanding across the healthcare industry regarding the definition of an ACO.
 - a. **Mitigating Impact Point:** The emergence of the ACO in the PPACA legislation is resulting in organizations seeking out advisory support for the implementation of these initiatives. A number of private/public sector resources are helping organizations prepare for and make the transition to this new model of care.

- b. Lack of knowledge and experience with both providers and payors for establishing the ACO's legal structure, performance measurement systems, and payment systems.
 - a. **Mitigating Impact Point 1:** In regards to performance measurement, many concerns have been expressed on these topics and it is possible that solutions will emerge in phases as seen in CMS's Meaningful Use of EHRs program.
 - b. **Mitigating Impact Point 2:** As ACOs are relatively new organizational structures there will be new measures developed and tested by the National Quality Forum (NQF) and other healthcare quality organizations that will help evaluate the effectiveness of the ACO programs as they mature.
 - c. **Mitigating Impact Point 3:** Alignment of clinical quality measures mandated under the CMS Meaningful Use criteria (Stage 1 and future Stages 2-3) should also be considered in measure selection.
- c. Uncertainty about the legal and regulatory issues surrounding the establishment of ACOs. This includes anti-trust implications for participants in the ACO.
 - a. **Mitigating Impact Point:** Based on a 2010 survey of health care leaders regarding ACOs^{xvi}, 74% noted a key concern with *"providers acquiring excessive market power and dominance."* Given differences in each community's local markets for healthcare services, this is an important issue to address. A March 2010 analysis of anti-trust issues related to ACOs by the Robert Wood Johnson Foundation examined a number of historical Federal Trade Commission (FTC) rulings relevant to ACOs and their findings were summarized as, *"A comparison of ACO characteristics and those used by the FTC to determine whether the goal of clinical integration has been met to a degree sufficient to justify collective financial negotiation shows a high degree of concordance. This degree of concordance would be even more so in ACO models that employ both clinical integration and financing arrangements that rely on population- based capitation and use of a salary-plus-performance-bonus payment system."*^{xvii}

Other challenges with ACO implementations include: a) managing the complexity of partial capitation and fee-for-service, b) equitable distribution of savings to ACO participants, c) maintaining patient volumes, and d) establishing interoperable EHRs with bilateral health information exchange (HIE) for all participants.

Conclusion

We believe the ACO models (public and private sector) show great promise for the next stage of healthcare service delivery transformation across the industry. Recognizing that there are unique challenges to address in each ACO, we stand ready to support industry leaders in the planning, design and implementation of this model throughout its life cycle in each organization.

As a starter we offer the “***DIVURGENT ACO Prep List***” as a general set of questions to address regardless of the stage of planning for the participants:

<i>DIVURGENT ACO Prep List</i>	
Area	Question
Management	Who are your partners and the ACO leadership team?
Infrastructure	Is your infrastructure ready?
	<ul style="list-style-type: none"> ◆ Have you discussed interoperability with the other providers in your community in the context of an ACO?
	<ul style="list-style-type: none"> ◆ Does your HIE strategy include sharing the data types needed for successful ACO execution?
	<ul style="list-style-type: none"> ◆ Does your clinical and financial data repositories/ warehouses accept data from outside of your institution?
Performance Measurement	Do you have a strong performance measurement system?
	<ul style="list-style-type: none"> ◆ Do your quality measurement tools support longitudinal data collection and measurement?
Reward Sharing	What is the plan for distribution of savings?

Improving the quality and cost of care is crucial to advancing care delivery in the US. Implementation of ACOs drives toward meeting the redesign challenges set forth by the IOM in 2001. A key change is made in placing the locus of control with the physicians and care provider organizations at the local level transitioning away from the managed care locus of control with the insurer^{xviii}. A benefit from the expansion of ACO models may be the increased opportunities to bring public health, mental health and wellness related organizations in communities under an ACO model^{xix}. Collectively these entities can then collaborate more effectively to positively impact population health and function as part of the ACO in driving toward higher levels in quality of care. Benefits for the patient populations can include improved coordination of care, reduced cost of care, improved quality of care, and a more meaningful relationship with their care providers. Initiatives such as this may require new ways of measuring effectiveness of the

ACO along with payments for services but this is not a challenge that cannot be overcome. With the passage of the PPACA in 2010 and the HITECH Act in 2009 significant positive changes are taking shape across our US health system and the continued growth of ACO models will be an important part of the successful industry transformation.

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References

- ⁱ Committee on Quality of HealthCare in America, Institute of Medicine. Crossing the Quality Chasm: A New Health System for the 21st Century. Washington D.C.: National Academies Press; 2001. Chapter 5: Building Organizational Support for Change, pages 117-18.
- ⁱⁱ “Roadmap for Implementing Value Driven Healthcare in the Traditional Medicare Fee-for-Service Program.” CMS Report. April 2, 2101. Page 13- Physician: PGP Demonstration. Accessed online at http://www.cms.gov/QualityInitiativesGenInfo/downloads/VBPRoadmap_OEA_1-16_508.pdf
- ⁱⁱⁱ “Roadmap for Implementing Value Driven Healthcare in the Traditional Medicare Fee-for-Service Program.” CMS Report. April 2, 2101. Page 14- Physician: PGP Demonstration. Accessed online at http://www.cms.gov/QualityInitiativesGenInfo/downloads/VBPRoadmap_OEA_1-16_508.pdf
- ^{iv} “Report to the Congress: Improving Incentives in the Medicare Program.” Medicare Payment Advisory Commission (MEDPAC). June 2009. Chapter 2: Accountable Care Organizations, pages 39. Accessed online at: http://medpac.gov/documents/Jun09_EntireReport.pdf
- ^v Premier Accountable Care Organization Collaboratives. Accessed online at: <http://www.premierinc.com/quality-safety/tools-services/ACO/index.jsp>
- ^{vi} Accountable Care Organization Learning Network established by the Brookings-Dartmouth Collaborative. Accessed online at <https://xteam.brookings.edu/bdacoln/Pages/home.aspx>
- ^{vii} “CIGNA and Piedmont Physicians Group Launch Accountable Care Organization Pilot Program in Atlanta for Better Care Coordination.” Business Wire press release September 7, 2010. Accessed online at: http://www.smartbrief.com/news/EHEALTH/industryBW-detail.jsp?id=96EBB2F9-BF21-4895-BEF6-9FD99A545770&sb_code=RSS&i=Health%20Care%20Plans
- ^{viii} Kelly Devers, Robert Berenson, “Can Accountable Care Organizations Improve the Value of Health Care by Solving the Cost and Quality Quandaries?” Robert Wood Johnson Policy Analysis Paper, October 2009, page 3. Accessed online at: <http://www.rwjf.org/files/research/acobrieffinal.pdf>
- ^{ix} Stephen Shortell, Lawrence Casalino, Elliott Fisher. “How the Center for Medicare and Medicaid Innovation Should Test Accountable Care Organizations.” Health Affairs, 29:7, July 2010, page 1294.
- ^x Stephen Shortell, “Bending the Cost Curve: A Critical Component of Health Care Reform”, JAMA, 302:11, September 16, 2009, page 1224
- ^{xi} H. R. 3590: “Patient Protection and Affordable Care Act” Section 3022(b)
- ^{xii} “ACO Professional” is defined as a physician (see H.R. 3590 Section 3022(1)(h)(1)(A)), or physician assistant, nurse practitioner, or clinical nurse specialist (see H.R. 3590 Section 3022(1)(h)(1)(B) and Social Security Act 1842(b)(18)(C)(i) accessed online at: http://www.ssa.gov/OP_Home/ssact/title18/1842.htm).
- ^{xiii} H. R. 3590: “Patient Protection and Affordable Care Act” Section 3022(d)(1)(ii)
- ^{xiv} “Policy Statement Pertaining to the Development of the Accountable Care Organization Model.” American College of Physicians, April 2010. Accessed online at: http://www.acponline.org/advocacy/where_we_stand/policy/aco.pdf
- ^{xv} Mark McClellan, Aaron McKethan, Julie Lewis, Joachim Roski, Elliott Fisher, “A National Strategy to Put Accountable Care Into Practice.” Health Affairs, 29:5, May 2010. Page 987
- ^{xvi} “Experts Believe Lack of Incentives and Financial Interests Are Barriers to Integrated and Accountable Care.” The Commonwealth Fund. July 26, 2010 press release. Accessed online at: <http://www.commonwealthfund.org/Content/News/News-Releases/2010/Jul/Experts-Believe-Lack-of-Incentives-and-Financial-Interests-Are-Barriers.aspx>
- ^{xvii} Taylor Burk, Sara Rosenbaum “Accountable Care Organizations: Implications for Antitrust Policy.” Robert Wood Johnson Foundation Analysis Paper. March 2010. Accessed online at: <http://www.rwjf.org/files/research/57509.pdf>

^{xviii} Kelly Devers, Robert Berenson, “*Can Accountable Care Organizations Improve the Value of Health Care by Solving the Cost and Quality Quandaries?*” Robert Wood Johnson Policy Analysis Paper, October 2009, page 3. Accessed online at: <http://www.rwjf.org/files/research/acobrieffinal.pdf>

^{xix} Mark McClellan, “*Accountable Care Organizations in the Era of Healthcare Reform.*” *American Health & Drug Benefits*. July/August 2010. 3:4, page 242-44. Accessed online at: <http://www.ahdonline.com/feature/accountable-care-organizations-era-healthcare-reform>