

*The goal of the ACO model is to make physicians and other providers accountable for quality and resource use.*

## The ABCs of Accountable Care Organizations

By BOB PERNA, FACMPE, Director, WSMA Practice Resource Center

**A**CCOUNTABLE CARE organizations (ACOs) are emerging as a potentially effective model of care, much as managed care did in the 1990s. As Congress continues to seek to curb expenditure growth in the Medicare program, the ACO model is gaining fresh attention.

Here in Washington state, there's a bill before the legislature to launch ACO pilot projects as early as 2011.

In June 2008, the Medicare Payment Advisory Commission (MedPAC) wrote to Congress that the goal of the ACO model is to promote accountability for quality and resource use for an extended period for a population of patients, achieved by physicians and other practitioners and health care entities working together to improve care coordination. Over time, growth in the volume of services could be controlled, as improvements in quality are realized. MedPAC suggested that some multispecialty group practices and integrated delivery systems (hospital and physician organizations) already may be functioning as ACOs, and they could volunteer to test the concept for a patient population and be rewarded on their performance.

### MEDPAC WEIGHS ACO VARIANTS

MedPAC's June 2009 report to Congress identified two primary types of ACOs: voluntary and mandatory, based on whether physicians and other entities volunteer to form an ACO or are required to participate in one.

To induce physicians and hospitals to volunteer to form an ACO, Medicare would have to provide physicians with a significant upside reward and very little (if any) downside penalty. For that reason, MedPAC

argued that the voluntary ACO model it presented at that time would be a "bonus-only" design, rather than having bonuses and penalties.

A voluntary, bonus-only model would require bonuses large enough to offset the current incentives in the fee-for-service system that increase volume. To fund bonuses of this magnitude, FFS rate increases would have to be constrained. By constraining FFS Medicare payment rates to fund larger ACO bonuses, Medicare would have

to create an environment in which physicians want to form ACOs and are rewarded when they constrain volume growth and improve the quality of care.

In contrast, MedPAC believes a mandatory ACO would have bonuses for good performance and penalties for poor performance. Savings achieved would be shared among participants.

### MEDPAC'S SUGGESTED CRITERIA

ACOs would have to be fairly large (at least 5,000 patients) to make it possible to distinguish actual improvement from random variation on a reasonably consistent basis. Each ACO would have a spending target set in advance. One approach is to set the ACO's spending target based on its past experience plus a national allowance for spending growth per capita (e.g., a fixed dollar amount of \$500 per enrollee).

MedPAC's proposal differs from some others in that the growth allowance is not affected by the ACO's past experience of spending. Over time using a single national growth allowance could compress regional variation in spending per capita. An alternative approach would set a lower allowance in high-service-use areas and a higher allowance in low-service-use areas. This alternative would place greater pressure to constrain volume in areas with historically high utilization.

Savings would result primarily from ACOs' incentive to change overall practice patterns and eventually constrain capacity. Therefore, successful ACOs would need to have a formal organization and structure that allows them to make joint decisions on capacity.

To overcome incentives to expand capacity and volume in the FFS payment system, a large share of the patients in a physician's practice would need to be in an ACO. To achieve this critical mass, private insurers might have to join Medicare in providing ACO-type incentives to constrain capacity.

In a voluntary, bonus-only ACO variant, some providers would receive bonuses for "shared savings" stemming from favorable random variation rather than from the ACO's efforts to reduce spending growth.

Currently, in the absence of ACOs, Medicare keeps all the "savings" from favorable random variation. Unless Medicare's share of true savings from ACOs' efforts to reduce spending exceeds the cost of bonuses paid due to random variation, Medicare spending will not be reduced. In part for this reason, under a voluntary, bonus-only model, FFS Medicare payment rates will likely have to be constrained.

Under a mandatory, bonus-and-penalty variant, the bonuses could be funded by the combination of true shared savings and a penalty on poor performers. Under this scheme, ACOs with high cost and low quality scores would lose their withhold payment and in effect receive lower Medicare payment rates.

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**A bill passed by this year's legislature will support the development of at least two ACO pilot projects in our state.**

## AMA AND ACOS

In its Medicare reform principles, the American Medical Association has said that new payment models such as ACOs should be strictly voluntary for physicians and should not be dominated by hospitals. The AMA also has argued that all such models should be tested thoroughly in a variety of practice settings, geographic locations, and among different specialties and payment populations.

## WASHINGTON STATE'S PROPOSED PILOTS

Washington is acknowledged nationally for achieving high quality scores and lower costs in delivering care. The Milliman Medical Index for 2009 ([www.milliman.com](http://www.milliman.com)), in studying geographic variations in health care costs across 14 major US cities, listed Seattle as the second lowest (just above Phoenix) with annual costs of \$15,564, or 92.8% of the national average of \$16,771. Miami was highest at \$20,282 or 120.9% of the average.

A bill passed by the legislature and delivered to the governor in March (she is expected to sign), Substitute Senate Bill 6522 directs the Health Care Authority (HCA) and the Department of Social and Health Services to convene a work group by January 2011 to support the development of at least two ACO pilot projects to be implemented no later than January 2012. The work group will report to the health committees of the legislature by January 2013, with recommendations and information on the progress of ACOs in the state.

The HCA is required to contract with recognized experts in the development and implementation of ACOs and related payment systems. The ACOs must abide by principles of local accountability, appropriate payment models, and performance measurement. The state's work group must research other opportunities to establish ACOs, and coordinate with current medical

home projects in this state. Currently, Washington state health agencies lead two medical home pilot projects with 33 participating primary care practitioners.

In the state ACO pilots, physicians and

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hospitals might be paid a lump sum for all services to a patient in an episode of care, such as a period of hospitalization; hospital care plus a period of post-acute care; a stretch of care for a chronic condition; or even all inpatient or outpatient care. So-called "bundled payments," where payments to physicians and the hospital are lumped together, could replace paying for a particular procedure.

An ACO offers provider organizations—e.g., a medical home or a primary care practice—the opportunity to share savings from payers through such practices as care

coordination, wellness services, chronic care management, effective referral patterns, and other approaches that achieve quality outcomes at lower expense. The concept attempts to shift the organization's emphasis from volume and intensity of services to incentives for efficiency and quality.

## ISSUES TO BE RESOLVED

Many questions remain as these concepts are developed:

- How can incentives for the individual physician, group, or combined physician and hospital ACO be coordinated to obtain best outcomes and value?

Physicians may be reluctant to be held responsible for outcomes that are not completely in their control. However, making a group rather than an individual the locus of responsibility may dilute individuals' financial incentives to improve their performance. Provider organizations vary, further complicating the coordina-

tion of measures and incentives at different levels.

- Can payment design accommodate small groups of physicians, particularly with imperfect risk adjustment and acceptance of risk?

- Will measures of quality and

Issues to be resolved: What responsibilities will patients have? Should cost sharing be designed to motivate patients to use certain physicians? To what degree should patients be locked in to seeking care from a group of physicians?

resource use have sufficient statistical significance for small groups of patients?

- What responsibilities will patients have? Should cost sharing be designed to motivate patients to use certain physicians? To what degree should patients be locked in to seeking care from a group of physicians? What information would help patients make better choices and how can it be made available?

The ACO may become a prevalent model of care delivery, or it may go the way of the 1990's managed care. In the near term, expect further interest and experimentation with the ACO model. ♣

*An accountable care organization is not a structure, or even a process, but an outcome—reducing or controlling the costs of health care.*

## Accountable care organizations: Beginning the journey

By BOB PERNA, FACMPE, Director, WSMA Practice Resource Center

**I**N THE MARCH *WSMA Reports*, I described accountable care organizations (ACOs) as an emerging model for the Medicare program, and under development in two pilot projects in Washington state. In this follow-up article I delve into ACOs in more detail.

ACOs inevitably will be among the experiments in reducing costs and improving health care outcomes in the coming months and years. This fall, the Centers for Medicare and Medicaid Services is expected to release draft rules for its ACO model, the Medicare “Shared Savings Program,” enacted in March as part of the federal health care reform law. The targeted start up is January 1, 2012.

The ACO model will need to be tested by Medicare, but it also will be cultivated by medical practices, health systems and insurers outside the Medicare program. The American Medical Association recently engaged Harold D. Miller, executive director of the Center for Healthcare Quality and Payment Reform, a group established in 2008 with funding from the Jewish Healthcare Foundation, to write a white paper on payment reform, ACOs and their role in care delivery. The complete document (for AMA members only) and an executive summary (viewable by non-members) are posted on the AMA’s website, [www.ama-assn.org/go/paymentpathways](http://www.ama-assn.org/go/paymentpathways).

### Goals and incentives

Miller writes that “the heart of the concept of an Accountable Care Organization is not a structure, or even a process, but an outcome—reducing or controlling the costs of health care for a population of individuals

while maintaining, or preferably improving, the quality of that care.” That means, he says, that a number of different types of provider or organizational structures could serve as an ACO. As long as primary

care physicians and specialists have a good working relationship, they don’t even have to be part of the same organization. The goal of the ACO, he says, “is to take responsibility for managing the costs and quality of healthcare for a population of patients, not necessarily to deliver every healthcare service itself.”

The fee-for-service model in essence rewards poor treatment outcomes.

### Comprehensive care payments

Within that framework, one way for an ACO to manage those costs, Miller says, is to pay a “comprehensive care payment” (CCP) for all care for a given condition. He argues that when designed and implemented properly, CCPs avoid the pitfalls of earlier variants on capitation. An ACO would seek to reduce expenditures for hospitalizations and readmissions, and thus would free up dollars for more appropriate primary and specialty care. The payor (insurer or government) would remit the CCP to the ACO, not directly to the component members of the ACO.

### Episode-of-care payments

As has been well-documented, the fee-for-service model, long the dominant reimbursement methodology, in essence rewards poor treatment outcomes—the longer and more intensive the intervention, the greater the revenue generated. Another proposal for modifying that unproductive result, in addition to comprehensive care payments, is to reimburse ACOs for “episodes of care” rather than for “per service” events.

The “episodes of care” model considers two or more encounters as components of the same care event, such as three office visits to treat a urinary tract infection considered one episode. This concept is not new, yet Miller argues that other payment models could co-exist with and complement it.

For example, fee-for-service payments are reasonable for simple low-intensity stand-alone services such as health screenings and minor injuries. In contrast, surgery for a hip fracture can be paid as an episode of care. A CCP alone could cover management of chronic conditions, while a combination of CCP and episode-of-care payments could cover care of a chronic illness that resulted in subsequent surgical intervention. These payment models are not bearing insurance risk—health plans continue in that role—but they do amount to performance risk, Miller notes.

Arguably, the participants of the ACO model include providers who are accountable for better outcomes, entities that partner in the ACO arrangement, and purchasers and health insurers responsible for the revenue stream.

### Making it happen

The ACO model could be a vehicle for accomplishing the oft-elusive feat of delivering cost-effective and appropriate care. To facilitate that care management, physicians will need robust data-gathering and analysis tools. They’ll need to be able to monitor patterns across physicians, across categories of patients, and across outcomes, with associated intervention strategies to improve care. Those data must be shared among the partners within the ACO, particularly primary care physicians and specialty physicians and physicians and hospitals.

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*Besides trying to provide the best care for our patients, we should be engaged with the organizations that provide the structure of professionalism.*

## Being a professional

By STEPHEN F. DUNCAN, MD, Puyallup

WE HEAR THE WORD “professional” used daily in a common way to describe an occupation: “professional wrestler” or “my profession is hair styling.” The term professional has been cheapened to mean, in the modern sense, nothing more than that one is paid to do a particular job or service.



Classically there are only three professions: divinity, medicine and law. A profession arises when a trade or occupation transforms itself through “the development of formal qualifications based upon education, apprenticeship, and examinations, the emergence of

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regulatory bodies with powers to admit and discipline members, and some degree of monopoly rights.”<sup>1</sup>

In addition to having a body of knowledge and skills, control of the teaching of the body

of knowledge and skills, and the means to certify and discipline members of the profession, a professional body is regulated by statute and forms local and national societies for the maintenance of the profession. A profession

enjoys autonomy and usually is held in high esteem by society. Members of a profession are usually paid well, and there are hidden inequities among the different members of the profession. A professional is one who engages in the service of others and is somewhat self-sacrificing.

One could argue that with the dilution of the term professional to mean nothing more than a salary for an occupation, the concept of a profession is one of a time gone by. Today with the loss of autonomy, greater regulation from without medicine, and the fragmentation of the delivery of medical care, perhaps the medical profession should just be satisfied with its position in society. Sometimes it seems that there are forces in our society that are deliberately eroding the medical profession to gain the upper hand. They might wish to see physicians disengage and accept whatever government and the regulating bodies decide. I, for one, do not accept that fate.

Besides trying to provide the best care for our patients, we should be engaged in the organizations that provide the structure of professionalism. These include: the training of new doctors; participation in the specialty-based societies; involvement in the regulatory bodies of medicine; support of local, state and national medical societies; and even engagement in the formation of laws both state and federal. It takes more than just going to the practice each day; it takes thoughtful work in all aspects of medicine.

The new members of our profession, according to surveys, are interested in how they might help in strengthening medicine. I invite you to get involved with your local county medical society, the WSMA and/or any other aspect of the medical profession. ♣

*Dr. Duncan, a family medicine physician, is president of the Pierce County Medical Society. This president's column, which appeared in the July 2010 PCMS Bulletin, is reprinted with permission.*

(1) Alan Bullock & Stephen Trombley, *The New Fontana Dictionary of Modern Thought*, London: Harper-Collins, 1999, p689.

Insurance Q & A • continued from page 6

Large clinics and integrated delivery systems will have mechanisms to share those data, at least within their respective organizations. Physicians in smaller practices can participate in an ACO, yet will be challenged by the need to aggregate and share information; independent practice associations could fill that role.

Transitional strategies—moving in an incremental fashion toward the ACO model—seem advisable to prevent large-scale disruptions in care delivery. Finding an optimal distribution formula for revenues across participants will be challenging.

### More information about state-level activity

In early June, the Washington State Health Care

Authority released a Request for Information to learn more about innovative payment and practice reforms. The recently concluded legislative session resulted in the passage of ESSB 6522, which calls for the HCA to collaborate with a “lead organization” to support two distinct ACO pilot projects, at least one integrated health care delivery system and one network of nonintegrated community health care providers. The RFI is intended to assist the HCA in implementing ESSB 6522, particularly Section 2. The lead organization must be able to support the costs of its work without recourse to state funding; however the lead organization may seek federal funds or other sources of funding.

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## Ads

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### 2010 Proposed Bylaws • continued from page 8

#### **From the bylaws committee**

The WSMA Bylaws Committee is submitting the following amendment:

#### **Article V - OFFICERS AND ELECTIONS**

**Section 1. Secretary-Treasurer – two years one year.** ♣

### Insurance Q & A • continued from page 7

The RFI and supporting materials can be found at [www.hca.wa.gov/rfp](http://www.hca.wa.gov/rfp). Select Accountable Care Organization Pilot Projects to be directed to all the documents related to the RFI.

The WSMA will continue to assist physicians and practice staff through training and other services as we embark on these lightly charted waters.

For more information contact Bob Perna at [rjp@wsma.org](mailto:rjp@wsma.org). ♣

### WSMA annual meeting • continued from page 1

health, health care economics, payer trends and negotiations, and ENT for primary care.

- A special reception for first-time attendees and young physicians to meet House speakers and the WSMA leadership.
- A special reception with physician candidates for the state legislature.
- Numerous opportunities to connect and reconnect with your colleagues from other specialties, practice settings and communities to share, debate and determine policy.
- The inauguration of Dr. Dean Martz of Spokane as incoming president of the WSMA.

All WSMA members are encouraged to attend and to engage in the reference committee hearings as well as the CME sessions. ♣