Leadership in Creating Accountable Care Organizations

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General internists need to take an active leadership position in the creation of accountable care organizations (ACOs). The basic idea behind ACOs is relatively simple. Physicians, hospitals, and other health care providers will continue to be paid fee-for-service by the Medicare program, but if they can work together to better manage people with chronic conditions, reduce avoidable complications, reduce unnecessary specialty referrals, and improve transfer of beneficiaries as they transition from one care provider to another; then there is the possibility of shared savings with the Medicare program. ACOs are likely to alter existing referral patterns among general internists and specialty physicians and engender debates over how to allocate any financial savings. They are scheduled to begin operation on January 2012. As ACOs are established, general internists should review the operation of the care management and disease management programs. They should understand the financial arrangements and quality indicators that the ACOs establish. They should be involved in identifying the patients that would benefit from better care management. They should identify changes in care processes and payment reforms that would improve the care for these patients. ACOs represent an opportunity for general internists to change the way medical care is delivered.

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General internists should take leadership positions in the creation of accountable care organizations (ACOs). By all indications, insurance companies and the hospitals are currently taking leadership positions and doing most of the planning. Medical specialists are becoming involved. Within academic medical centers and large integrated delivery systems, general internists should be playing more of a central role. Quite simply, ACOs cannot operate without the active participation of general internists, and if ACOs are going to be effective over the long run, general internists must take an active role in their design and implementation. ACOs offer general internists the opportunity to change the way medical care is delivered.

One of the provisions of the Patient Protection and Accountable Care Act that received bipartisan agreement was the establishment of ACOs. ACOs give the people and organizations that actually deliver medical care the opportunity to design a more effective delivery system. CMS has recently issued draft regulations detailing the rules that will govern the creation of and payment to ACOs, and has solicited comment before they issue the final rules¹. Comments on the proposed regulations are due to CMS by June 6, 2011. The 429-page proposed regulation states that an ACO must be able to provide the full continuum of Medicare benefits to at least 5,000 Medicare beneficiaries, and it is responsible for the costs and quality of their care. ACOs are likely to alter existing referral patterns and engender debates over how to allocate any financial savings among primary care and specialty physicians. They are scheduled to begin operation on January 2012². Physician participation in the ACO program is voluntary.

Physicians will still be paid fee-for-service by the Medicare program within ACOs, but ACOs have the opportunity for additional revenues if certain cost and quality targets are met. If an ACO meets the cost and quality standards, then the ACO will earn a bonus. There are two options with differing risks and rewards. Under one option there are no penalties if the cost and quality standards are not achieved in the first 2 years. Under a second option, there are financial penalties if the goals are not achieved, but the possibility of greater rewards if the goals are achieved. ACOs can choose either option.

All over the country, insurers, hospitals, and physicians are rushing to establish ACOs³. CMS estimates that between 75 and 150 ACOs will become operational in the first year. Many academic medical centers are considering applying. While each ACO may be unique in some aspects, most of them will be some form of an integrated delivery system, a medical group aligned with hospitals and other institutional providers, an academic medical center, a hospital consortium, or individual practice organization. A key aspect for many internists will be seeing who is managing the operation, since the management will control the resources, potentially retain the surplus, operate the entity, and establish the quality standards. General internists need to play an active role in the design and management.

If ACOs are smart, their focus will be on the most expensive beneficiaries because the potential for cost savings, and quality improvement is greatest in this population⁴. Beneficiaries with five or more chronic conditions are responsible for 66% of Medicare spending, and these same beneficiaries are 99 times more likely to have a preventable hospitalization than a beneficiary with no chronic conditions⁵. These beneficiaries see an average of 13 different physicians during the year—9 in ambulatory settings and 4 in the hospital. They also fill over 50 prescriptions a year. The challenge for ACOs will be to prospectively identify those Medicare beneficiaries where

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improvements in care processes can lead to cost savings and improved outcomes. Not all beneficiaries with multiple chronic conditions are candidates for quality improvements and lower spending. General internists are perhaps the physicians most able to identify these individuals and design better care practices.

Unfortunately, most of the demonstrations to date have shown little impact on cost savings⁶. In 2005, CMS allowed ten large group practices to participate in a "gain sharing" program. Under this program, physicians continued to receive their usual fee-for-service payments, but if they achieved certain cost and quality targets, then they could receive 80% of the cost savings. This is similar to the ACO arrangements. The results from the evaluation suggest that the groups were able to exceed most of the quality standards, but only half of the plans were able to generate cost savings as well. Looking more deeply at the successful plans could provide ideas for successful ACOs. One of the common complaints among all ten plans was that CMS did not provide timely information on utilization patterns. The ACOs may need to invest in this type of information technology in order to be successful.

Another problem with the prior demonstrations is that many plans allowed people with a wide range of illnesses and comorbidities to enroll. For beneficiaries with zero, one, or two chronic conditions, the potential for ACOs to generate substantial savings or a quality improvement is reduced. Better targeting of beneficiaries is critical to the success of ACOs, and general internists may be able to assist in the targeting.

The basic idea behind ACOs is relatively simple. Physicians, hospitals, and other health care providers will continue to be paid fee-for-service by the Medicare program, but if they can work together to better manage people with chronic conditions, reduce avoidable complications, reduce unnecessary specialty referrals, improve transfer of beneficiaries as they transition for one care provider to another, and thereby find ways to reduce health care costs, then there is the possibility of shared savings with the Medicare program. The participation of general internists in the process would allow them to better align their clinical responsibilities with financial rewards. By taking the lead in the design and implementation, general internists can make sure that better care is provided while obtaining some of the benefits associated with cost savings. The objective of the ACO program is to allow the ACOs to design processes that remove some of the existing barriers that routinely prevent physicians from providing the most cost-effective medical care. General internists may be the most knowledgeable about which processes are stifling cost-effective care.

The financial arrangements at the fundamental level are relatively simple. As usual, the devil is in the details, and internists will need to pay attention to the details. Assume, for example, the expected annual cost to the Medicare program of insuring a group of 10,000 Medicare beneficiaries enrolled in an ACO is \$100 million dollars or \$10,000 per beneficiary. Now assume through effective care management and other cost-saving interventions the ACO can provide the service to these same beneficiaries for \$90 million. In this case, the Medicare program would share the \$10 million in savings with the ACO assuming that quality standards and other objectives are met.

The question becomes where will the majority of the savings be generated? Most likely, the savings will come from fewer hospitalizations, fewer specialty consults, and less testing.

Unlike general internists, hospitals and specialty physicians may have a conflict of interest in managing ACOs. This conflict of interest could reduce their ability to control costs and reduce the possibility of substantial cost savings. This is because ACOs are likely to use fewer of their services. Fewer services will mean fewer dollars for them, and even if they get some of the money back from the bonus Medicare payments, they are unlikely to be fully compensated for their reduced utilization. As a result, they might not want to play or will try to redirect the dollars in a way that still keeps their utilization rates high. In any case, they have reduced financial incentive to manage patients more effectively since much of the savings will come from reduced utilization of their services. General internists, on the other hand, may see little change in their utilization or even increased payments if their responsibilities increase. Also the ACO may be able to pay for things like e-mail communication or care coordination conferences that the current Medicare payment system does not cover. Internists will need to consider what additional services will both improve outcomes and lower costs.

ACOs are a way for the Medicare program to save money. General internists may have the most to gain financially if ACOs are able to lower utilization rates and therefore the most to gain if they take leadership positions in forming ACOs. Unlike insurers, hospitals, and specialty physicians, general internists are already the primary care giver for many of the most complicated Medicare beneficiaries. They have the experience in managing complex patients with multiple comorbidities. They also have the nursing staff with experience in coordinating care for these patients.

Insurance companies would like to operate ACOs and participate in any savings. Although the law says they cannot operate ACOs, they are positioning to play an important role. Internists will need to determine what services the insurance companies can provide most effectively. Insurers have experience in managing care for Medicare beneficiaries under Medicare Advantage and Special Needs Plans. Many of them have sophisticated information systems and practice management algorithms. They are familiar with financial risk and monitoring spending. While insurers have much to offer, unlike many of the existing programs such as Medicare Advantage or Special Needs Plans, the ACO program has providers (not insurers) taking the lead. Providers need to take advantage of this opportunity. Within ACOs, the insurer's role is secondary, and insurers should focus on the services they can provide the best. Partnering with an insurer might be a good idea if the services the insurer will provide are tightly prescribed.

As ACOs are established, general internists should review the operation of the care management and disease management programs. They should understand the financial arrangements and quality indicators. They should be involved in targeting the patients to focus primarily on the programs that treat beneficiaries with multiple chronic conditions. Many organizations use the chronic care model developed by Ed Wagner at Group Health of Puget Sound as a starting place, while others have participated in guided care, transitional care, PACE, special needs plans, Ever-care, and medical home. Evaluations of many of these programs have found that many of them have been unable to generate quality improvements and/or cost savings⁷. The evaluations have also shown that successful programs share a number of attributes in common including: careful targeting of who they enroll, how they involve people with multiple chronic diseases and

where the care coordinator is physically located. Internists establishing ACOs will need to learn from prior mistakes and benefit from successful programs.

In summary, general internists are well suited to take a leadership role in ACOs. The alternative is for someone else to manage the care of the complex patients and for general internists to become employees. January 2012 is coming very soon, and the choice is now.

Conflicts of Interest: None disclosed.

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REFERENCES

1. **Iglehart J.** The ACO regulations—some answers, more questions. *N Engl J Med* 2011; April 13, 2011.
2. **Lieberman S, Bertko J.** Building regulatory and operational flexibility into accountable care organizations and 'shared savings.' *Health Affairs* January 2011; vol. 30 no.1 23–31.
3. **Kocher R, Sahni N.** Physicians versus hospitals as leaders of accountable care organizations. *N Engl J Med.* 2010;363:2579–82.
4. **Anderson G.** Medicare and chronic conditions. *N Engl J Med.* 2005;353:305–9.
5. **Anderson G.** Making the case for chronic care published by the Robert Wood Johnson Foundation available at <http://www.rwjf.org/pr/product.jsp?id=56788>.
6. **Iglehart J.** Assessing an ACO prototype—Medicare's physician group practice demonstration. *N Engl J Med.* 2011;364:198–200.
7. **Bott D, Kapp M, Johnson L, and Magno L.** Disease management for chronically ill beneficiaries in traditional Medicare. *Health Affairs* January 2009 28:186–98.