Published in final edited form as:

Otolaryngol Head Neck Surg. 2015 August ; 153(2): 170–174. doi:10.1177/0194599815587509.

Accountable Care Organizations and Otolaryngology

Kevin J. Contrera, BS¹, Lisa E. Ishii, MD², Gavin Setzen, MD³, and Scott A. Berkowitz, MD MBA⁴

¹Johns Hopkins University School of Medicine, Baltimore, Maryland, USA

²Department of Otolaryngology-Head & Neck Surgery, Johns Hopkins University, Baltimore, Maryland, USA

³Albany ENT & Allergy Services PC, Albany, New York, USA, Albany Medical College, Albany, New York, USA

⁴Department of Medicine, Johns Hopkins University, Baltimore, Maryland, USA, Accountable Care, Office of Johns Hopkins Physicians, Baltimore, Maryland, USA

Abstract

Accountable Care Organizations represent a shift in health care delivery, while providing a significant potential for improved quality and coordination of care across multiple settings. Otolaryngologists have an opportunity to become leaders in this expanding arena. However, the field of otolaryngology-head and neck surgery currently lacks many of the tools necessary to implement value-based care, including performance-measurement, electronic health infrastructure and data management. These resources will become increasingly important for surgical specialists to be active participants in population health. This article reviews the fundamental issues that otolaryngologists should consider when pursuing new roles in Accountable Care Organizations.

Key Word List

Accountable Care Organizations; Otolaryngology; Alternative Payment Models; Performance Measures; Health Care Reform

Accountable Care Organizations (ACO) were formally created with the passage of the Affordable Care Act in 2010. At that time, ACOs were widely misperceived by surgical specialties as simply a program for primary care patients with chronic disease. Since then, the number of ACOs has steadily grown (Figure 1). As of 2015, 424 Medicare ACOs exist, covering 7.8 million or 20% of Medicare beneficiaries.¹ As the number of patients participating in ACOs continues to rise, so will the impact on the practice of otolaryngology-head and neck surgery. ACOs represent a pivotal shift in the way health care is delivered but can serve as an opportunity to gain experience in a low-risk model of payment reform. Though the specialty of otolaryngology currently lacks many of the resources necessary to

Address correspondence, reprint requests, and proofs to: Kevin Contrera, 2024 E. Monument St, Suite 2-700, Baltimore, MD 21205, Telephone: (410) 955-0491, Fax: (443) 614-9625, kcontre2@jhmi.edu.

Disclosures:

Presentations: none

transition the focus of care from volume to value, positive changes are occurring to support this.

In order to address quality and cost in the modern era, otolaryngologists should help to lead the effort toward creating a more effective health care system. For many otolaryngologists, this means considering whether to join an ACO or other value-based model. The purpose of this article is to address what is required of the specialty of otolaryngology-head and neck surgery so that physicians are better informed and can become active participants in Accountable Care Organizations.

Understanding the Foundations of ACOs

The mission of Accountable Care Organizations is aptly defined by the triple aim: improving the experience of care, the health of populations, and costs. This is accomplished through the delivery of coordinated, high quality care by a designated provider group for a population of beneficiaries. Assuming quality measure targets are met, a decrease in medical expenditures per capita may result in savings that the insurer shares with the provider. To date, over \$417 million in savings have been generated by Medicare ACOs.¹ Notably, reducing medical expenditures for unnecessary procedures or services may reduce revenue received for a particular patient but the goal is that improved overall efficiency will help to ensure the right patients within a population are receiving high quality and appropriate care while minimizing any reduction in revenue for a provider.

There are different types of ACOs, and several important distinctions that otolaryngologists should understand (Figure 2). They can be led by physicians, hospitals, insurers or some combination of the three. While Medicare ACOs have the most publically available information, a large number of commercial ACOs have been created through private insurers (e.g., Anthem, Aetna, United Healthcare). This discussion focuses on Medicare ACOs, since commercial and state-run Medicaid ACOs are typically nonstandardized. There are two major models of Medicare ACO programs: the Medicare Shared Savings Program (MSSP) and the Pioneer ACO Model. The vast majority of ACOs are in the MSSP. The Pioneer Model was designed for providers experienced in care-coordination to facilitate a rapid transition to population-based payment. In the MSSP, ACOs can participate in either shared saving and shared risk (two-sided model) or just shared savings (one-sided). In both instances, an ACO may be eligible to receive a percentage of the cost savings, but only in a two-sided model might an ACO be financially penalized for increasing costs. Nearly all ACOs are currently one-sided, minimizing provider risk. The Pioneer and the recently proposed Next Generation ACO Model have higher percentages of shared savings and risk than MSSP ACOs. While this increased risk sharing may prompt ACOs to adopt more rigorous interventions, it would be difficult to generalize exactly how otolaryngologists may be impacted in any given ACO.

Otolaryngology-Specific Performance Metrics

Quality of care is a central component of the program, and the evaluation of ACOs include their performance on 33 quality measures, encompassing 4 broad categories: 1) patient/caregiver experiences, 2) care coordination/patient safety, 3) preventive health, and 4)

disease-specific criteria in at-risk populations. While the 12 disease-specific criteria target chronic diseases not directly treated by otolaryngologists, several other metrics are strongly connected to the care of all participating providers. These include 7 patient satisfaction measures (e.g., access to specialists, physician communication) and 3 care coordination measures (e.g., all-cause readmission, medication reconciliation).

For otolaryngologists to meaningfully participate in a value-based system, it is imperative that specialty-specific performance metrics are created. Few such metrics currently exist, though the American Academy of Otolaryngology-Head & Neck Surgery Foundation (AAO-HNS/F) considers performance measure development a strategic priority. The pathway to the creation of performance metrics begins with clinical guidelines. As of January 2015, 70 formal otolaryngology recommendations exist in the Agency for Health Care Research and Quality's Guideline Clearinghouse (guideline.gov), compiled from numerous organizations and specialty societies. 13 Clinical Practice Guidelines have been developed by the AAO-HNS/F (Figure 3).² These guidelines serve as the basis for the existing performance measures and performance measure groups. Where appropriate, use of performance measure groups, which use reporting on a small sample of patients instead of a majority of individuals, reduce the documentation burden for otolaryngologists. ACOs capitalize on measure groups and existing pathways to streamline Centers for Medicare and Medicaid Services (CMS) reporting. ACO quality measures are only required on a sample of 411 beneficiaries per measure annually through the Group Public Reporting Option. Providers achieving these criteria automatically qualify for the Physician Quality Reporting System (PQRS) incentive payment and avoid the PQRS downward payment adjustment.

Development of and adherence to performance measures promote high quality care through standardizing best practices. Importantly, the impact on quality improvement does not have to be limited to the otolaryngology office. Much of the otolaryngological care in this country is delivered in a primary care setting (e.g., otitis media, cerumen impaction, sleep apnea). Specialists can use performance measures to advise primary care physicians on patients with non-complex otolaryngology issues. This requires a level of coordination of care that is arguably best incentivized and achieved through an ACO-like model.

Data Requirements for Practicing Value-Based Care

It is clear that technology is a key enabler for ACOs. The entire premise of performance metrics depends on having interpretable information that is readily available for use. However, there is currently a paucity of data available within otolaryngology. A 2011 survey by the AAO-HNS found that only 67% of respondents reported using electronic health record (EHR) technology.³ A robust health information technology platform and integrated electronic health record are fundamental to ensuring successful participation in a model of care where cost and quality data are essential parameters for measuring success and determining payment.

Beyond updating one's individual EHR system, there are several ways that otolaryngologists can build a data network allowing for better performance under an ACO model of care. First, since otolaryngologists enter into a shared partnership when joining an ACO, utilizing

the ACO's electronic health system can aid in collaboratively managing patients. Second, insurance companies record claims data on the physicians and practices connected with their beneficiaries. This data is increasingly being used in measuring variability in quality and cost of care. Third, information on provider practices in other countries can be valuable in providing an additional objective metric for comparison although there may be some limitations. In summary, these data sources can be analyzed to help define evidence-based practices. Interoperability and transparency are inherent challenges to achieving this goal but are the bridge between ACOs' principles of shared responsibility and shared benefit.

Issues to Consider Before Joining an ACO

Surgical subspecialty representation in ACOs is low.⁴ However, there are growing expectations for specialists to participate in care-coordination—such that the National Committee on Quality Assurance (NCQA) now individually recognizes specialists with the Patient-Centered Specialty Practice Program.⁵ Otolaryngologists have an opportunity to emerge as leaders among specialists at a critical time in the transformation of the US health care system. There are costs and benefits associated with implementation of an ACO. Some of the positive aspects may include improved quality of care, access to data, and increased referrals. Team-based support and best practice pathways can provide significant help with challenging patients. However, extensive organizational capabilities may be necessary to meet program requirements. There are numerous potential pitfalls related to the ability to manage risk, including electronic health record interconnectivity, data capture, and stakeholder cooperation. Such factors were the focus of discussion at the 2010 Meeting of the American Medical Association.⁶ A list of recommendations that are most relevant to otolaryngologists has been derived (Table 1). Of note, the potential of ACOs to consolidate competition raises concerns regarding anti-trust law. However, in most circumstances, ACOs obtain a type of exemption (i.e., safe harbor provision or “safety zone”) from these laws.⁷

One of the major issues otolaryngologists will need to address is the structure of their potential relationship with an ACO. For example, otolaryngologists function within a team-based model of care will depend on their interactions with care managers, the development of mutual goals, and the sharing of resources. The terms of involvement are partially defined by a participation agreement. Although the agreement can take many different forms, there are several factors that should always be included. Each ACO is allowed its own formula for allotting shared savings (and risk), so it is important to determine how that will be distributed. The majority of ACOs' shared savings are centralized on primary care, with lower percentages typically going directly to specialists. Importantly, ACO agreements are an opportunity to define expectations for otolaryngologists and fellow providers in order to improve integration of care across multiple settings.

Becoming an ACO may be an independent decision or part of a larger strategy. Of note, otolaryngologists who bill under the same tax identification number as other provider groups within an ACO are automatically considered part of that same ACO. Otolaryngologists can currently only participate in a single ACO; however, proposed MSSP rule changes could

expand this number.⁸ Ultimately, each otolaryngologist or group practice will need to determine the relevance of the ACO construct as it relates to their work.

Preparing for the Future

Approximately 23,000 new providers joined an ACO at the start of 2015.¹ However, otolaryngology as a specialty has been slow to transition to this new payment model. While other surgical specialties have been targeted by CMS for reform, otolaryngology has received relatively minimal pressure to reduce costs. For instance, none of the nearly 50 conditions listed on CMS's Bundled Payment Initiative are typically managed by otolaryngologists.⁹ Still, it is important to invest the present specialty to be able to focus on what is going to be valued in the future. The Secretary of Health and Human Services recently reported a target of 30% of Medicare payments through alternative payment models such as ACOs by the end of 2016 and 50% of payments by the end of 2018.¹⁰ Participation in ACOs ensures that otolaryngology is engaged in the future of health care delivery, helping to drive population health. The alternative is the risk of having patients and control referred elsewhere.

Acknowledgments

Funding:

This publication was made possible in part by the Johns Hopkins Institute for Clinical and Translational Research which funded Kevin Contrera by Grant Number TL1 TR001078 from the National Center for Advancing Translational Sciences a component of the National Institutes of Health, and NIH Roadmap for Medical Research. Its contents are solely the responsibility of the authors and do not necessarily represent the official view of the Johns Hopkins ICTR, NCATS or NIH.

Dr. Setzen: TEVA & MERCK Pharmaceuticals, Speakers bureau; Advance Health Solutions, Medical Advisory Board; SALVAT Pharmaceuticals, Clinical Trials Investigator; Advance Health Solutions, Medical Advising Board

We would like to thank Dr. David Nielsen, M.D., and Dr. Jane Dillon, M.D., M.B.A., for their insights and advising on this project.

References

1. Cavanaugh S. ACOs Moving Ahead. The CMS Blog. 2014; 2015 <http://blog.cms.gov/>; Centers for Medicare and Medicaid Services.
2. Gurgel RK. Updating Clinical Practice Guidelines: How Do We Stay Current? Otolaryngol Head Neck Surg. Prepublished March 9, 2015.
3. Sun GH, Eisenberg LD, Ermini EB, et al. 2012 update on meaningful use of electronic health records: recommendations from the AAO-HNS Medical Informatics Committee. Otolaryngol Head Neck Surg. 2012; 146(4):544–546. [PubMed: 22241788]
4. Dupree JM, Patel K, Singer SJ, et al. Attention to surgeons and surgical care is largely missing from early medicare accountable care organizations. Health Aff (Millwood). 2014; 33(6):972–979. [PubMed: 24889946]
5. National Committee for Quality Assurance. Patient-Centered Specialty Practice Recognition. <http://www.ncqa.org/Programs/Recognition/Practices/PatientCenteredSpecialtyPracticePCSP.aspx>.
6. American Medical Association. Accountable Care Organization Principles: H-160.915. <https://ssl3.ama-assn.org/apps/ecom/PolicyFinderForm.pl?site=www.ama-assn.org&uri=%2fresources%2fhtml%2fPolicyFinder%2fpolicyfiles%2fHnE%2fH-160.915.HTM>. Published November 9, 2010.

7. Federal Trade Commission, Department of Justice. Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program. 70(114):67026–67032. <http://www.gpo.gov/fdsys/pkg/FR-2011-10-28/pdf/2011-27944.pdf>. Published October 27, 2011.
8. Centers for Medicare & Medicaid Services. Medicare Shared Savings Program: Accountable Care Organizations Proposed Rule Changes. 79(114):72760–72872. <http://www.gpo.gov/fdsys/pkg/FR-2014-12-08/pdf/2014-28388.pdf>. Published December 8, 2014.
9. Centers for Medicare & Medicaid Services. [Accessed January 12, 2015] Bundled Payments for Care Improvement (BPCI) Initiative. <http://innovation.cms.gov/initiatives/bundled-payments>
10. Burwell SM. Setting Value-Based Payment Goals - HHS Efforts to Improve U.S. Health Care. N Engl J Med. 2015

Figure 1.
Growth in Accountable Care Organizations (ACOs). Includes commercial and government ACOs. Data provided by Leavitt Partners, LLC.

Figure 2.
Characterization of Accountable Care Organizations.

Figure 3.
Clinical practice guidelines in otolaryngology.

Table 1 Accountable Care Organization (ACO) Principles for Otolaryngology.^a

Issue	Recommendation
ACO Guiding Principles	Should be aligned with those of the physician
ACO Governance Structure	Should be physician led with specialist involvement
ACO Participation	Should be voluntary for physician and patients alike
ACO Revenue & Savings	Should be retained for primary and specialty patient care serves
Potential Antitrust Law Issues	Should be addressed with waivers and safe harbor provisions
Securing of Resources	Should be up-front to offset risks and start-up costs
ACO Spending Benchmarks	Should be risk, specialty and regionally adjusted
ACO Quality Reporting Program	Should be nationally accepted, specialty society validated
Health Information Technology	Should be interoperable between primary and specialist care

^aDerived from American Medical Association Policy H-160.915 ACO Principles, 2010