

The Family Physician's ACO Blueprint for Success

**Preparing Family Medicine for the
Approaching Accountable Care Era**



ILLINOIS ACADEMY OF
FAMILY PHYSICIANS



AAFP
STRONG MEDICINE FOR AMERICA

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INTRODUCTION

Part One contains elements for a successful ACO and implementation that transcend specialty or facility and apply equally to all ACO stakeholders.

Part Two applies the principles and processes of the Guide specifically from the perspective of the family physician.



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The ACO Guide

**How to Identify and Implement
the Essential Elements for
Accountable Care Organization Success**



I. PURPOSE OF THE ACO GUIDE

Accountable Care Organizations (“ACOs”) are emerging as a model being given serious consideration to address health care costs and fragmented care delivery. The purpose of this ACO Guide is to bring together in one source a non-technical explanation of the essential elements required for any successful ACO and practical step-by-step guidance on how to achieve each element. Because a successful ACO must be “win/win”, with every collaborative participant incentivized and empowered to achieve their optimum value-added contribution to the enterprise, these principles transcend medical specialty, employment status, payor relationship, or facility type. This Guide works for you whether you are a primary care physician, a hospital CEO, or a specialist physician. Although ACOs are still evolving, the promised federal regulations are not yet published, and definitive predictions are impossible at this time, the goal of the Guide is to give any reader a firm sense of the strengths and weaknesses of any ACO model they may encounter and confidence about whether to join one or to create one. This Guide will be updated as answers become clearer and should be considered version 1.0 as it were. There are answers to questions about who should join, who should lead, what infrastructure will work, and the phases of development to be followed.¹

II. WHAT IS AN ACO?

A. Definitions

Former Administrator of the Center for Medicare and Medicaid Services (“CMS”) Mark McClellan, M.D., Ph.D. 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 Similarly, the National Committee for Quality Assurance (“NCQA”) included the following definition in its draft ACO criteria: “Accountable Care Organizations (ACOs) are provider-based organizations that take responsibility for meeting the healthcare needs of a defined population with the goal of simultaneously improving health, improving patient experiences, and reducing per capita costs. ...[T]here is emerging consensus that ACOs must include a group of physicians with a strong primary care base and sufficient other specialties that support the care needs of a defined population of patients. A well-run ACO should align the clinical and financial incentives of its providers. ... ACOs will also need the administrative infrastructure to manage budgets, collect data, report performance, make payments related to performance, and organize providers around shared goals.”³ (Emphasis added.)

Strategic Note: The part of the definition relating to patient populations represents a major shift in practice orientation, and is very alien to a typical physician’s training and day-to-day focus.

¹ It is not the purpose of this Guide to provide legal advice. Any person or organization considering participation in an ACO should seek the advice of legal counsel.

² Mark McClellan, Director of the Engleberg Center for Health Care Reform at the Brookings Institution, *A National Strategy to Put Accountable Care Into Practice*, Health Affairs (May 2010), p. 983.

³ National Committee for Quality Assurance, *Accountable Care Organization (ACO) Draft 2011 Criteria*, p. 3. (hereinafter “NCQA”).

Without grasping this shift, an understanding of ACOs will remain elusive. It also is important to note what is not in the definition. No definitions specify any particular type of payment model or legal entity (i.e., IPA, PHO, employed). There is no mandatory organizational form for an ACO. The promised ACO regulations may provide more definition, but indications are that flexibility and local innovation are to be encouraged.

B. PPACA Requirements

ACOs eligible for the Medicaid Shared Savings Program under the Patient Protection and Affordable Care Act of 2010 (“PPACA”)⁴ must meet the following criteria:

- That groups of providers have established structures for reporting quality and cost of health care, leadership and management that includes clinical and administrative systems; receiving and distributing shared savings; and shared governance.
- Willing to become accountable for the quality, cost, and overall care of the Medicare fee-for-service beneficiaries assigned to it.
- Minimum three-year contract.
- Sufficient primary care providers to have at least 5,000 patients assigned.
- Processes to promote evidence-based medicine, patient engagement, and coordination of care.
- Ability to demonstrate patient-centeredness criteria, such as individualized care plans.

C. How Is It Different From a Medical Home?

The Patient Centered Medical Home (“Medical Home”) emphasizes strengthening and empowering primary care to coordinate care for patients across the continuum of care. It is complimentary to the ACO and can become the core of an ACO, but it is different in several respects: (1) System Focus- ACOs are more system focused than are medical homes, which retain more of a practice focus. (2) Financial Incentives - The Medical Home lacks the shared accountability feature in that it does not have financial incentives, such as shared savings, motivating providers to work together to deliver the highest quality care at the lowest cost with the greatest patient satisfaction. (3) Specialists/ Hospital Linkage - Even though there are Medical Home-only ACOs, a typical ACO is also different from a Medical Home in that it tends to have relationships with select specialists and hospitals across the full continuum of care for the targeted initiative.

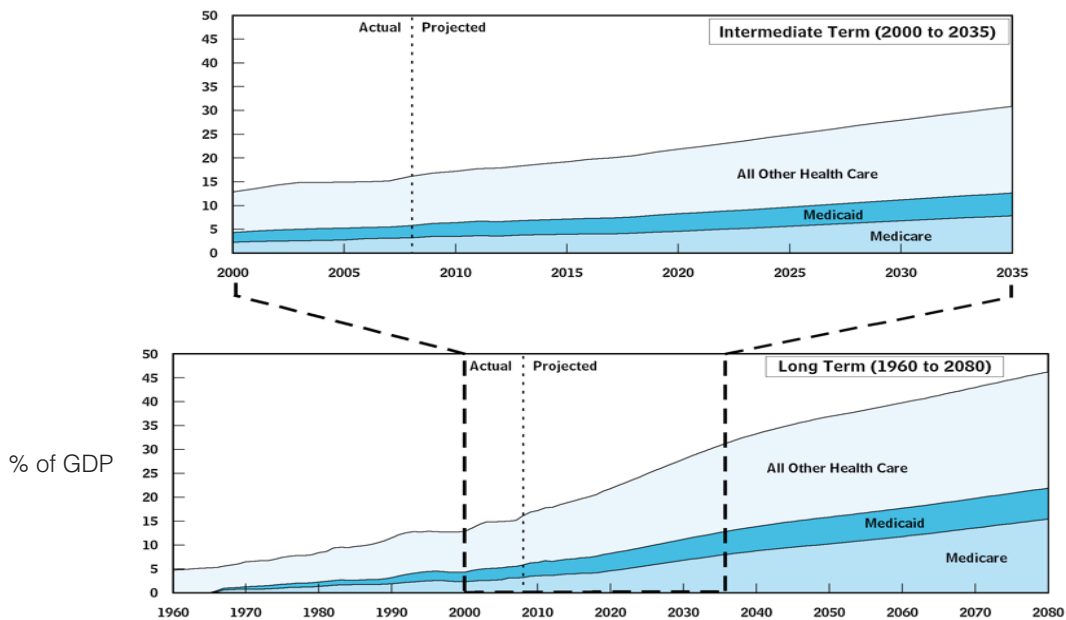
III. WHY SHOULD I CARE?

Health spending is unsustainable, even before coverage expansion of the 2010 federal health reforms. With 19% of Gross Domestic Product (“GDP”) being the rough estimate of the amount the

⁴Section 3022 of the Patient Protection and Affordable Care Act of 2010 (amends Title XVIII of the Social Security Act (42 USC 1395 *et seq.*)).

United States can collect in taxes and other revenues, by 2035, Medicare and Medicaid are predicted to consume 13% of GDP and health care costs will consume 31% of GDP. By 2080, absent drastic change, Medicaid and Medicare will consume all of our tax and other revenues, and total health spending will claim 46% of GDP. All the rest of our governmental services- education, defense, roads, can be paid for only by borrowing. President Obama is the first President facing bankruptcy of the Medicare System during a term in office.

Total Spending for Health Care Under the Congressional Budget Office's Extended Baseline Scenario



There is consensus that much of this is avoidable. The now-famous New Yorker article by Dr. Atul Gawande showing Medicare spending to be twice as high in McAllen, Texas as in El Paso, became required reading in the White House. It said: “The real puzzle of American Healthcare... is not why McAllen is different from El Paso. It’s why El Paso isn’t like McAllen. Every incentive in the system is an invitation to go the way McAllen has gone.”⁵



Article By Influential Writer Sparks Strong Debate

⁵ Atul Gawande, *The Cost Conundrum*, *The New Yorker*, (June 1, 2009).

The Congressional Budget Office Report on the ACO's predecessor, the Bonus-Eligible Organization, includes this rationale: “[P]roviders have a financial incentive to provide higher-intensity care in greater volume, which contributes to the fragmented delivery of care that currently exists.” These dysfunctions in our current system, for which the ACO is seen as a partial remedy, have been given much of the blame for our country’s health care system costing 50% more as a percentage of GDP than any other in the world but ranking only 37th in overall health and 50th in life expectancy.⁶

Because of the crisis, drastic efforts at health care cost reform seem inevitable. President Obama stated it bluntly: “So let me be clear: If we do not control these costs, we will not be able to control the deficit.”⁷ Private insurers see it, too.

The ACO's marketplace incentives offer an attractive approach to flattening the cost curve as an alternative to rationing care, imposing new taxes, or cutting provider reimbursement. Doing nothing is not an option, and all these alternatives appear unacceptable. In short, there is no “Plan B.”

IV. ARE ACOs REALLY COMING?

A. If They Repeal Health Reform, Won't This Go Away?

No. Federal health reform has three prongs: Expand Coverage (individual and employer mandates, no pre-existing condition exclusions, etc.), Fraud Control, and Cost Controls (ACOs, bundled payments, value-based purchasing, CMS Innovation Center, etc.). Many experts think that expanding coverage into our broken system has made health care even more unsustainable. However, as noted, the cost curves, even without health reform, will bankrupt our resources, and the value-based reimbursement movement was well underway before the federal legislation was passed. The public is demanding value. Increasing awareness of problems with the fee-for-service system has resulted in a growing number of initiatives that have common features of accountability at the medical community level, transparency to the public, flexibility to match local strengths to value-enhancement opportunities, and shifting to paying for value, not volume.

B. Isn't This Capitation Revisited?

You may fairly ask, “Isn't this the ‘next big thing’ to save health care, like capitation? Won't it fizzle away like that did?”

ACOs with shared savings are unlike capitation in several crucial ways. First, the payments are only bonus payments in addition to fee-for-service payments. There is no downside risk with the shared savings model. Second, vital administrative capabilities, data measurement capability, identified

⁶World Health Organization, *World Health Statistics* 2009.

⁷President Barack Obama, interview excerpt, July 23, 2009.

common metrics, severity adjustment, and electronic health information exchange sophistication were not present in the capitation era.

Strategic Note: Though many experts propose that newly-formed ACOs assume financial risk through financial penalties, or partial or whole capitation, the 15 years clinical integration experience of this author strongly suggests that ACOs be cautious about accepting downside risk until they have three consecutive years of meeting budget estimates. There are just too many new partners, roles, moving parts, untested data metrics, and variables beyond the control of the ACO. Even taking a smaller share of the savings pool to recognize the absence of downside risk is preferred to accepting the responsibility of unanticipated medical expenses without the tools to control them. Having some “skin in the game” is clearly a logical way to incentivize accountability for providing value, but thrusting that on an unready health care system could do more harm than good.

C. Can't I Wait Until Things Get Clearer?

With hospitals and physicians having lots of other things on their plates, this bearing a resemblance to other reforms that never quite panned out, and the ACO regulations having not been written, a wait-and-see attitude might at first seem reasonable. However, as the next chapter describes, successful ACO creation will require deep transformational change. The changes will have less to do with infrastructure and technology than culture. This is equally true in integrated systems with a fully-employed medical staff, as it is with other models. “Given the major cultural differences between hospitals and physicians, achieving clinical integration is one of the most difficult challenges that either party will ever undertake. ... Organizations that have not yet started down this path in earnest will need to move much more aggressively to prepare for the post fee-for-service world.”⁸ Medical home transformation is foundational to ACO development. Action is thus warranted at both the primary care practice level and the ACO level.

V. **WHAT ARE THE ESSENTIAL ELEMENTS OF A SUCCESSFUL ACO?**

There are eight essential elements of any successful ACO. All eight are required. You cannot skip a step. Because one is not concrete or measurable, it is very counterintuitive that by far the most difficult element to obtain will be creation of an interdependent culture of mutual accountability committed to higher quality and patient satisfaction at the lowest cost. “[C]linical transformation has less to do with technical capabilities and more with the ability to effect cultural change.”⁹

⁸Gary Edmiston and David Wofford, *Physician Alignment: The Right Strategy; the Right Mindset*, Healthcare Financial Management Association (December 1, 2010).

⁹*Id.*

The Eight Essential Elements of a Successful ACO



A. 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. A fully-functional ACO will catalyze the transformation of health delivery. “While strong hospital-physician alignment has always been a cornerstone of success, the necessary degree of future collaboration, partnership, and risk-sharing will dwarf what has come before it. Hospitals and physicians will have to recognize, embrace, and leverage their growing interdependence to create organizational structures and incentive models that are strategically aligned and mutually rewarding.”¹⁰

1. **Challenges for Physicians.** Physician attitudes favor autonomy and individualism over collaboration. These attitudes are inculcated in clinical training and reinforced daily in care delivery. Payment rewards an individualistic “eat what you kill” mentality. Physicians need to understand that the level of involvement needed to effect changes in quality and cost is much different than just banding together for contracting purposes. Physicians will have to be willing to change utilization, referral, and care-management patterns. In many settings, specialists will need to release primary control of patient care decision-making to the Medical Home primary care physician.

¹⁰ *Toward Accountable Care*, The Advisory Board Company (2010).

Physicians have been cynical about prior “next best things,” such as HMOs, gate-keeping, and capitation, and have little experience with, or time for, organizational-level strategic planning. “[I]f providers do not change their decision-making and behavior, ACOs will go the way of most PHOs and IPAs...to the bone yard. More importantly, the healthcare crisis will persist, and more drastic solutions will be mandated.”¹¹

2. **Challenges for Hospitals.** Will hospitals be willing to embrace a true ACO structure, which will likely drive down hospitalization? Will they be willing to distribute shared savings as intended, to incentivize and reward those who created it through high-performance care delivery and improved coordination, or will they try to take any savings dollars “off the top” to make up for the lost revenue from the reduction in avoidable hospitalizations and readmissions? Will the increased market share from joining an ACO make up for the lost revenue? Exacerbating these business risks for sharing governance with physicians and committing without reservation to an orientation of higher quality and lower costs, is a deeper cultural barrier: control. Hospitals are complex organizations, and a degree of control over operations and direction has been historically important for their viability.

“The most significant challenge of becoming accountable is not forming an organization, it is forging one.”¹²

Strategic Note: Tips on How to Create a Collaborative Culture:

- **Champions.** Vision comes first, but to sell that vision, you need physician leaders able to articulate a clear and compelling vision of change. They need to be champions of the transformational changes needed. As few as one, and rarely more than five, are needed. If a hospital is involved, the CEO needs to show commitment to the shared vision.
- **Governance Structure.** The structure must have meaningful input from the various parties to have status and credibility. It must exhibit shared control. Management teams can be pairings of physicians with hospital administrators.
- **Incentives Drive Alignment.** “[I]f incentives are correctly aligned, organic innovations to solve other problems can and will engage.... Anticipated early versions of ACO payment incentives are likely to be directionally correct but unlikely to be sufficient to create the needed burning platform.”¹³ Compensation plans for hospital-employed physicians must not be limited to individual productivity, but also have incentives for accountability for success of the ACO team.

¹¹ Phillip L. Roning, *Becoming Accountable*, HFMA Compendium—Contemplating the ACO Opportunity, Appendix (November 2010), p. 40.

¹² *Id.*

¹³ Ann Robinow, *Accountable Care News*, The Top 3 Obstacles to ACO Implementation, (December 2010).

- “Spiral of Success.” The following strategy could help meld team culture: An early pilot project for your ACO should be consistent with the new vision, led by champions and cut across specialty and department lines. A multi-disciplinary team decides how to collect and share data in new ways to facilitate this care initiative. The data, in paper or electronic format, is available at the point of care. Quality goes up and there is a savings pool. New team habits begin to emerge. Small scale is OK, but it must succeed, so the “spiral of success” can start. Trust goes up and buy-in for the next collaboration will occur more quickly.
- Employment Not a Panacea. In states allowing it, isn't the most obvious path to integration through hospital employment? This is a feasible approach if not prohibited by corporate practice laws in your state and the parties have worked together in the past and there is a pre-existing level of trust and respect. This will not work if there are not shared goals and the control and financial incentive issues are not resolved. “Current trends in physician employment represent neither a necessary nor sufficient condition for true integration; value-added integration does not necessarily require large-scale physician employment and simply signing contracts does not ensure progress toward more effective care coordination.”¹⁴

B. Essential Element No. 2: Primary Care Physicians



1. What Is the Role of Primary Care In ACOs? As discussed in detail in Section V.G. below, the highest-impact targets identified for ACOs lie in the following areas: (a) prevention and wellness; (b) chronic disease management; (c) reduced hospitalizations; (d) improved care transitions across the current fragmented system; and (e) multi-specialty co-management of complex patients. Primary care physicians can be drivers in all of these categories.

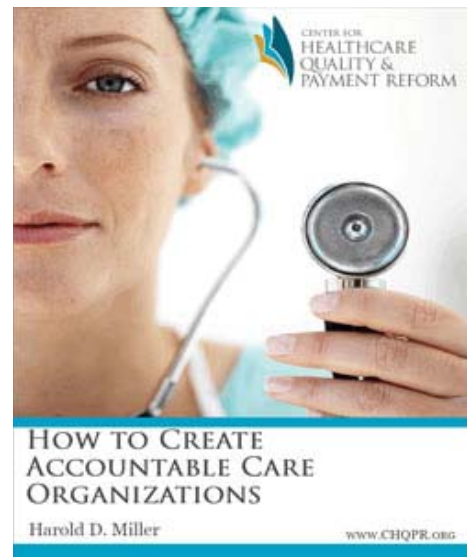
Harold Miller of the Center for Healthcare Quality and Payment Reform concluded, “it seems clear that, in order to be accountable for the health and healthcare of a broad population of patients, an Accountable Care Organization must have one or more primary care practices playing a central role.”¹⁵ He envisions different levels of ACOs, with the core Level One consisting primarily of primary care practices. Level Two would include select specialists and potentially hospitals. As the diverse patient populations are included, Level Three expands to more specialists and facilities, and Level Four includes public health and community social services. As noted, **primary care is the only provider or health care facility mandated for inclusion to qualify for PPACA’s ACO Shared Savings Program.**

¹⁴ *Toward Accountable Care*, The Advisory Board Company (2010).

¹⁵ Harold D. Miller, *How to Create Accountable Care Organizations*, Center for Healthcare Quality and Payment Reform, p. 8, (September 2009).

2. What Are the Roles of Specialists In ACOs? It is becoming clear that specialists are going to serve important roles in ACOs. Given the opportunities for ACOs listed in Section V.B.1. above, specialists should see roles in assisting Medical Homes in diagnosis and treatment, transitions across settings, reducing avoidable hospitalizations, and in multi-specialty complex patient management. Inpatient specialists can tackle hospital through-put, minimizing avoidable adverse events and readmissions, and quality improvements. Specialists intent on preserving volume at the expense of best practices have no role in an ACO.

3. What Are the Roles of Hospitals In ACOs? Hospitals are logical ACO partners for several reasons: Patients will need hospitalization, hospitals have extensive administrative and HIT infrastructure, ACOs are consistent with their missions, and hospitals are often a medical community's natural organizational hub. But the typical ACOs tend to reduce hospitalizations. As Mr. Miller observes, "the interests of primary care physicians and hospitals in many communities will not only be unaligned, but will be in opposition to one another."¹⁶ A litmus test for hospital membership (or whether to join an ACO that includes a hospital) is whether it is committed to overall increased savings, improved quality, and improved patient satisfaction for patient populations, even if hospitalization rates are reduced. It is also unacceptable if a hospital permanently seeks to capture most of the shared savings "off the top" to make up for lost revenue. A hospital at over-capacity should not have this conflict. Moreover, many hospitals see full institutional commitment to accountable care as the best way to prepare for the future, maximize their fair amount of the shared savings dollar, and grow market share. Once the tipping point of the shift from payment for volume to payment for value has been reached, these conflicts should dissolve.



In summary, because primary care will drive so many of an ACO's most high-yielding initiatives, it is an essential element of a lasting and successful ACO. "Accountable care absolutely must be about improving and maintaining the health of a population of patients and not just controlling costs. It must be about proactive and preventive care and not reactive care. It must be about outcomes and not volume or processes. It must be about leveraging the value of primary care and the elements of the Patient-Centered Medical Home."¹⁷

¹⁶ *Id.*, p. 15.

¹⁷ Terry McGeeney, M.D., *The Patient-Centered Medical Home and the Accountable Care Organization*,

<http://transformed.com/CEOReports/PCMH-and-ACO.cfm>, (2010).

C. Essential Element No. 3: Adequate Administrative Capabilities



What Kind of Organization Can Be an ACO? 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 NCQA’s ACO criteria look to core competencies and infrastructure to implement them, but are “agnostic to organizational structure (i.e., whether or not it is led by a multi-specialty group, hospital, or independent practice association).”¹⁸ Similarly, a wide array of organizations may become eligible for CMS Shared Savings Program under PPACA: group practice arrangements, networks of practices, joint ventures between providers and hospitals, hospitals employing providers, and other approved structures. There are three essential infrastructure functional capabilities: (1) performance measurement, (2) financial administration, and (3) clinical direction. A legal entity of some sort is necessary, and a number of choices are available. The form ultimately chosen should be driven by what most readily facilitates achievement of the functional needs of the ACO initiatives in your community. **The ultimate goals of accountable care are to improve patient outcomes and patient satisfaction while also achieving greater cost efficiencies.** The key to achieving this goal is enhanced coordination of care among diverse providers through the application of evidence-based clinical protocols and transparent measurement and reporting. **“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.”**¹⁹

What Are Key Legal Issues Affecting ACOs? ACOs require collaboration, referrals, reductions in unnecessary care, and sharing of revenues among sometime competitors. All of these characteristics, and more, in furtherance of health policy, also happen to raise a number of challenging legal-compliance issues for a body of state and federal health care law largely premised upon the fee-for-service model. Adaptations of the most problematic laws and regulations are underway. A properly configured ACO should be successful in navigating this legal minefield. The principle bodies of law affecting ACOs are:

- Antitrust
- Anti-kickback
- Stark
- Civil Monetary Penalties Law
- Tax
- HIPAA
- Malpractice

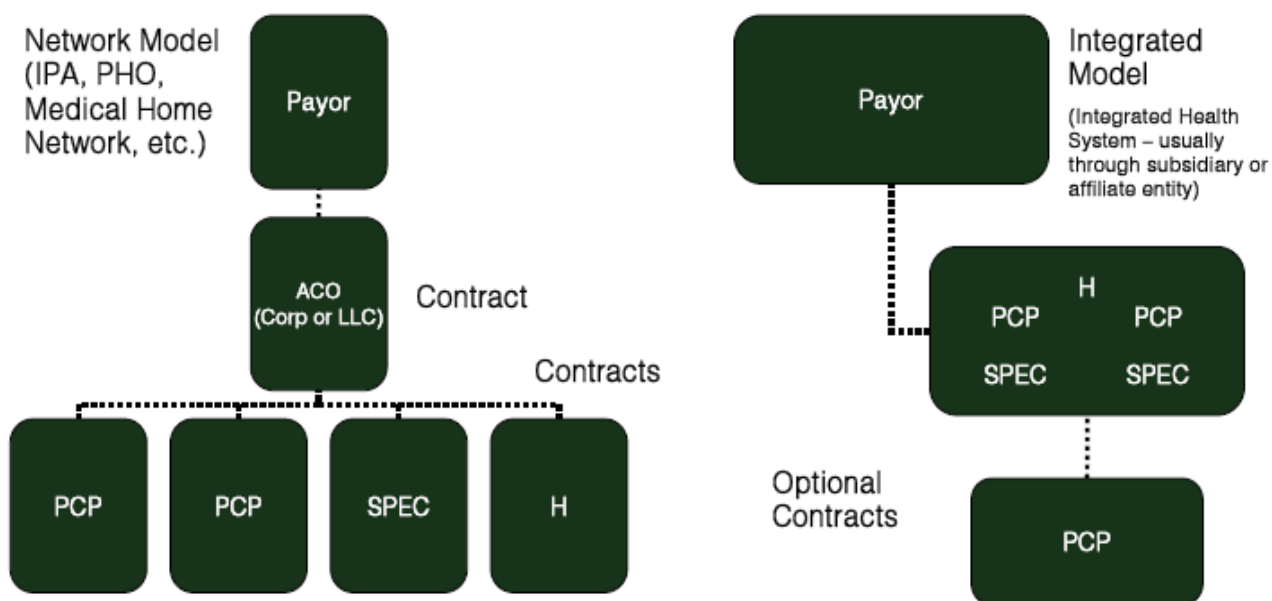
¹⁸NCQA, pp. 7-8.

¹⁹ Doug Hastings, Accountable Care News (December 2010), p. 6.

- Corporate Practice of Medicine
- Insurance
- Intellectual Property
- State Self-Referral Laws
- Business Law

For a complimentary, detailed analysis, please contact Julian (“Bo”) Bobbitt at bbobbitt@smithlaw.com, and ask for a copy of “ACOs: Navigating the Legal Minefield.”

Possible Organizational Forms



1. Network Model

a. Independent Practice Associations (“IPAs”) – An IPA is basically an umbrella legal entity, usually an LLC, for-profit corporation or nonprofit organization, with physician participation contracts with hospital-employed and independent physician practices. Payors contract with the IPA. These structures became familiar in the fee-for-service and capitation eras, and the form is still suitable for the accountable care era. However, the IPA now needs to have ACO-level infrastructure as described in this Guide. It is particularly dependent on robust health information exchange, as the continuum of care is more “virtual” because the providers are independent. The participation agreements are different, too. The provider agrees to undertake the responsibilities agreed upon by the ACO and accept some type of performance-based incentive, like shared savings, in

addition to fee-for-service. It can have any combination of specialists, primary care, hospital, and tertiary care participation contract. An IPA is owned by physicians. Legal issues of note in IPAs involve antitrust, self-referral, insurance regulation, HIPAA, malpractice, and the Stark law (see Legal Issues in Appendix).

b. Physician/Hospital Organization (“PHO”) – The PHO is very similar to an IPA, but the main difference is that it is co-owned and governed by physicians and a hospital or health system and includes a hospital participation contract. The same requirements and caveats apply.

c. Medical Home-Centric Model – Under this variation, an umbrella entity is owned by Medical Home practice members or networks. It contracts with payors, initially for the medical-home-related primary care services, but includes accountable care financial arrangements and performance measurement capabilities. It broadens the scope of initiatives and patient populations by adding select specialists and hospitals through contractual arrangements. These may be sub-ACO arrangements whereby the contract is with a PHO or hospital ACO. The same requirements and caveats of the other Network Model forms apply. Community Care of North Carolina is an example of a confederation of 14 Medical Home-Centric Networks.

2. **Integrated ACO Structure** – With this variation, the hospital, health system, foundation, or multi-specialty clinic employs, rather than contracts with, the physician. It may own, capitalize, and control the ACO, with physicians on advisory committees. The HIT and other infrastructure is the controlling entity. It may have contracts with independent providers and facilities if necessary to round out the breadth, depth, and reach of services needed to accomplish its initiatives.

D. Essential Element No. 4: Adequate Financial Incentives



1. Isn't This the Same As Insurance? No. An insurance company assumes the financial risk of whether a person gets ill or has an accident requiring medical care. Accountable care risk is accountability for higher performance wellness, prevention and treatment of a designated patient population. This gets fuzzy when one remembers that the ACO may assume more risk, as in full capitation. However, this distinction is why the ACO performance expectations need to be severity-adjusted.

2. What Are the Types of Financial Incentive Models for ACOs? There are three tiers: upside-bonus-only shared savings; a hybrid of limited-upside and limited-downside shared savings and penalty; and full-upside and full-downside capitation.

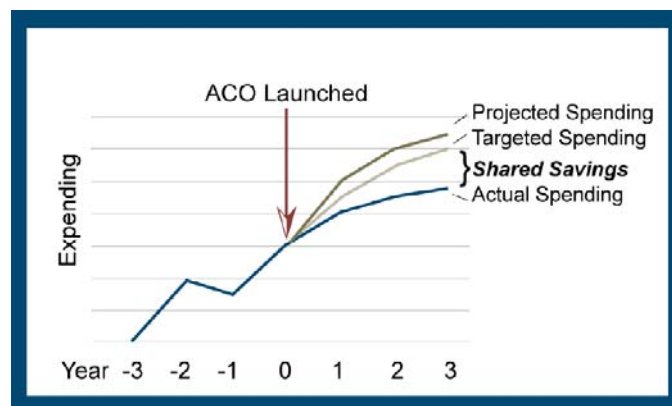


a. **Shared Savings** – If quality and patient satisfaction are enhanced or maintained and there are savings relative to the predicted costs for the assigned patient population, then a portion (commonly 50% according to some surveys and publically available CMS Demonstration Project information) of those savings is shared with the ACO. This is stacked on top of the provider’s fee-for-service payments. The savings pool is divided in proportion to the level of contribution of each ACO participant. This aligns incentives of all ACO participants to keep patients as well as possible, and if ill, to receive optimum care in a team environment across the care continuum. If primary care has especially high medical home management responsibility, this may be accompanied by the addition of a flat per member/per month payment.

Some of the savings pool distributions should be used to maintain the ACO infrastructure, but as much as possible should go to reward providers and facilities for the extra time and attention devoted to patient management and technology investments. As mentioned, it should not go to pay affected physicians or hospitals for reduced revenues under fee-for-service for reductions in volume.

A strength of this model is that it is easy to understand and transition to, since it builds upon the familiar fee-for-service system. That is also its weakness, since fee-for-service still rewards volume, not value. This shared savings model has been criticized as being “asymmetric” or “one-sided,” with no consequence if there are higher costs or no care improvement. Another problem is that there is by necessity a lag time to measure the “delta,” or the difference between the actual costs and the expected costs, so the ACO is uncertain whether there will be savings. The delay saps the incentivization to adhere to the ACO’s best practices and coordination. Also, won’t the most inefficient ACOs reap the greatest reward because they have the most potential savings? Not necessarily, since as the immediately following Strategic Note details, an ACO’s savings would be measured “against the field,” not itself year-to-year.

The Shared Savings Model



*Courtesy of the Brookings Institute

Strategic Note 1: How to Calculate Shared Savings. Although the concept is simple – the ACO gets 50% of the difference between what the costs for the population turned out to be versus what the costs would have been if the ACO were not in place – DO NOT try to do this by comparing your population costs year-to-year. It might work the first year, but will be inappropriate after that. Having to beat your performance from the prior year, every year, is like calling an Olympic medalist a failure if she does not break her world record the next time out, each time. In some CMS demonstration projects, relatively unmanaged counties in other parts of the country were picked as the control populations. Another way that works is to use an actuary that can predict the medical costs for your region or comparable community and use that actuarially valid projected amount as your unmanaged “comparable.”

Strategic Note 2: Be Patient Before Taking on Risk. Do not repeat the disaster of the '90s, when providers took on risk without proper technology, infrastructure, best practices, or experience. We recommend that you come within 5% ± of your predicted costs for three consecutive years before leaving the shared-savings bonus model. You may have unexpected costs over which you have no control. You will likely want to work with your colleagues and health system to improve the exchange of clinical data, from practice to practice, and practice to hospital. Include relevant data elements, and see which of your ACO providers “get it.” In our experience, fears that lack of downside risk will deter performance improvement are overblown. On the contrary, a meaningful bonus payment is very motivating, as much as a recognition of and respect for the clinical leadership of the physicians as it is the benefit of dollars involved. Individual distributions that differ based on performance determined by peers is also a “grade” that high-achieving individuals work hard to earn.

b. Savings Bonus Plus Penalty – 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 for exceeding pre-set goals. Fee-for-service is retained.

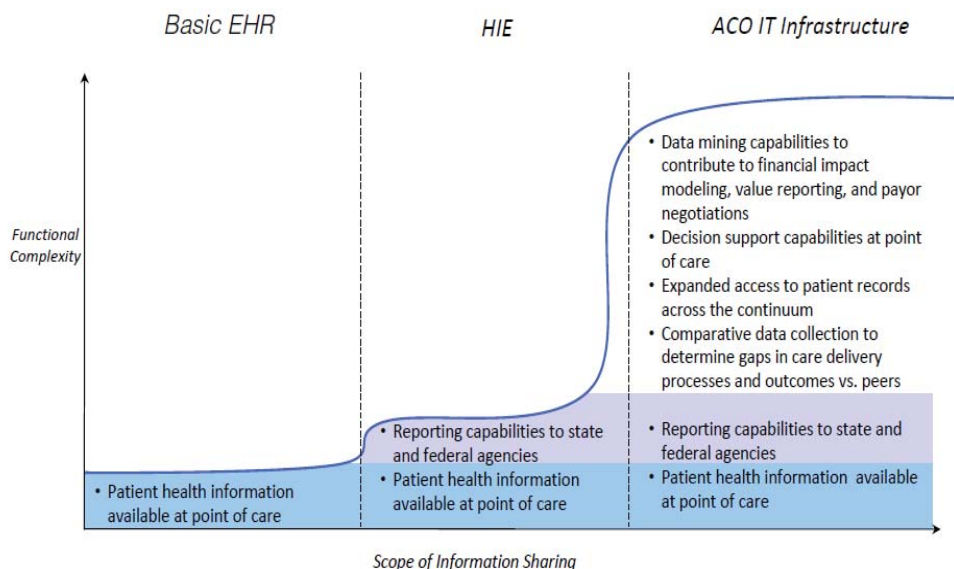
c. Capitation – A range of partial capitation and full capitation models are possible. Fee-for-service payment is modified by flat payments plus potential bonuses and penalties. Only seasoned and truly clinically integrated ACOs should attempt this level of risk. Yes, the upside is higher, but the disasters of the '90s should not be forgotten.

3. Is This the Same as Bundled Payment or Episode of Care Payment? ACO incentives can be aligned with these and other payment experiments under consideration. An “episode of care” is a single amount to cover all the services provided to a patient during a single episode of care. When that episode payment covers providers who would have been paid separately under fee-for-service, that is a “bundled payment.” Such a payment mechanism that excludes payment for treatment of avoidable readmission or hospital-acquired infections motivates better care. These approaches do not incentivize prevention and medical-home coordination.

4. “Meaningful Use” Regulations Incentives. We include the “Meaningful Use” payments as an ACO financial incentive because the basic Health Information Exchange within your ACO will likely qualify the ACO’s providers for the Phase Two and Phase Three “Meaningful Use” incentives.²⁰ If your ACO can go ahead and establish its data flow needs relatively soon as outlined in this ACO Guide, you stand a good chance that the federal government will help finance the ACO’s HIT needs. See Section V.E. below for more detail.

²⁰ 75 C.F.R. 44314 (July 28, 2010).

E. Essential Element No. 5: Health Information Technology and Data



1. **What Data?** ACO data is usually a combination of quality, efficiency, and patient-satisfaction measures. It will usually have outcomes and process measures. It aggregates clinical, operational and financial data from multiple sources and clinical information can be systems-wide claims based, EHR based or a blend. Nationally-accepted benchmarks are emerging. There are three categories of data needs for an ACO:

a. **Baseline Data** – This is often overlooked. To compare anything, there needs to be a beginning reference point. Can you collect costs and quality data? Who owns it now? Who collects it? Do you trust the current owners to be accurate and objective?

b. **Performance Data** – In the value-based reimbursement era, it will not be enough to provide exceptional cost-effective care, you must prove it. A practical way to determine your ACO's needed performance data is to start by selecting the ACO's targeted initiatives. Then select from emerging nationally recognized quality and efficiency metrics, if they apply. Even if they do apply, convene a multi-specialty committee of clinicians to vet their clinical validity. This committee will recommend performance benchmarks from scratch if national standards are not yet available for all of the care pathway of your initiative. They should address quality, patient satisfaction, and efficiency. They need to be severity-adjusted. Obviously, if and when a third-party payor, including CMS, sets the performance benchmarks, they should be part of the performance array. Many payors want to allow local flexibility and clinical leadership in metric-setting.

Who collects the data? Are there variables outside of your control affecting your performance scores (i.e., patient non-compliance)? What financial incentives/penalties are tied to each?

c. **Data As a Clinical Tool** – Once the ACO targeted care initiatives are selected, the best practices across the care continuum will be determined. The appropriate ACO committee will then usually “blow up” each pathway into each component and assign clinical leadership, decision support, data prompts, and relevant clinical data to each step at the point-of-care. ACOs are discussing virtual workstations and data dashboards. Coordination with downstream providers will be optimized with the real-time sharing of upstream care results and scheduling.

Strategic Notes: (1) The ACO should periodically internally grade itself against the performance benchmarks to create a constant quality/efficiency/satisfaction improvement loop. This not only will hone the contributions of the ACO initiatives, but also will prepare it to increase its financial rewards once the performance results drive a savings pool on bundled payments. Gaps in care should be flagged and addressed before your compensation depends on it. Clearly, clinically valid, accurately collected, severity-adjusted, and properly benchmarked data are essential for any compensation model based on performance. (2) Data that reflects a track record of high performance serves as a bargaining tool when reimbursement is being negotiated, even in fee-for-service. (3) Use data first to **target** the “low-hanging fruit,” high-impact, value-add initiatives in your area best suited to your specialty or facility. Next, use data to **collect evidence** of your performance. There will be specific baseline, performance, and clinical data elements needed for each participant to meet objectives, maximize their measured contribution, and thus reap a meaningful reward from the savings pool.

d. **Data Summary** – An essential element of an ACO is for health data management to be the platform for collaborative patient care, aggregated performance measurement, and payment calculation. “Health reform legislation leaves the final decision of measure selection for ACOs to federal officials, and the literature does not provide guidance on how to choose appropriate measures. As the CMS program and other provider initiatives are established, it is important to ensure that the quality benchmarks established and how they are interpreted and reported are standardized nationwide. ... Finally, the benchmarks will need to be a combination of process, outcomes, and patient experience measures.”²¹

e. **HIE Capability** – Your ACO will need Health Information Exchange (“HIE”) capabilities sufficient to move this data across the continuum in a meaningful way. This HIE is aligned with the Meaningful Use regulations. It will need to be able to aggregate data from multiple sources into user-friendly formats with decision support and relevant data that follows the patient to maximize chances of success in the ACO’s targeted initiatives. It needs to minimize the data collection burden on workflows. Done right, these are multi-million dollar initiatives. To reduce capital costs, tying into existing regional or statewide HIE frameworks is obviously something to explore.

²¹ American Hospital Association, *Accountable Care Organizations – AHA Research Synthesis Report*, pp. 10-11, (June 2010).

F. 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. An ACO may start out with a single patient population (i.e., morbidly obese patients) or disease-state (i.e., diabetes).

The five identified high-impact target areas for ACO initiatives are:

- Prevention and wellness;
- Chronic disease (75% of all U.S. health care 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.”²²

As discussed earlier in Section V.B., the richest “target fields” from this array will vary by specialty and type of facility. Looking at these suggested initiatives, it is no wonder why primary care is emphasized as key for ACOs, since they could play a significant role in every area. The ACO should match its strengths against the gaps in care in the ACO’s market to find the proverbial “low-hanging fruit.”

G. Essential Element No. 7: Patient Engagement



Patient engagement is another essential element. Without it, an ACO will not fully meet its potential. Unfortunately, many of today’s health care consumers erroneously believe that more is better, especially when they are not “paying” for it, insurance is. Patient noncompliance is a problem, especially regarding chronic diseases and lifestyle management. 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 your control, patient adherence. Currently, asking a patient to be a steward of his or her own care puts an ACO at a competitive disadvantage. But patient engagement is part of patient-centeredness, which is required by PPACA for an ACO to qualify for CMS’ Shared Savings Program.²³

²² *Toward Accountable Care*, The Advisory Board Company (2010).

²³ Section 3022 of the Patient Protection and Affordable Care Act of 2010 (42 U.S.C. §§ 1395, et seq.).

What Can an ACO Do to Engage Patients?

Better information at a societal level and also at the medical home point of care.

- The Patient Compact – Some ACOs, such as the Geisinger Clinic, engage the patient through a compact, or agreement. It may involve a written commitment by the patient to be responsible for his or her own wellness or chronic care management, coupled with rewards for so doing, education, tools, self-care modules, and shared decision-making empowerment. The providers will need to embrace the importance of patient involvement and hold up their end of the engagement bargain.
- Benefit Differentials for Lifestyle Choices – The financial impact of many volitional patient lifestyle choices is actuarially measurable. A logical consequence of the patient choice could be a benefit or financial differential reflecting at least partially these avoidable health care costs, such as increasing premiums for smokers.

H. Essential Element No. 8: Scale-Sufficient Patient Population



It is OK, even desirable, to start small; to “walk before you run,” so to speak. However, it is often overlooked that there needs to be a minimal critical mass of patients to justify the time and infrastructure investment for the ACO. PPACA’s Shared Savings Program requires that the ACO have a minimum of 5,000 beneficiaries assigned to it.

Strategic Note: Some ACOs commence activities through a single pilot, or demonstration project, without a sustainable patient population scale. It can de-bug the initiative and test-run the ACO early enough to fix problems before ramping up. This must succeed, however. If it does, it will be much easier for the ACO champions to gain buy-in from others.





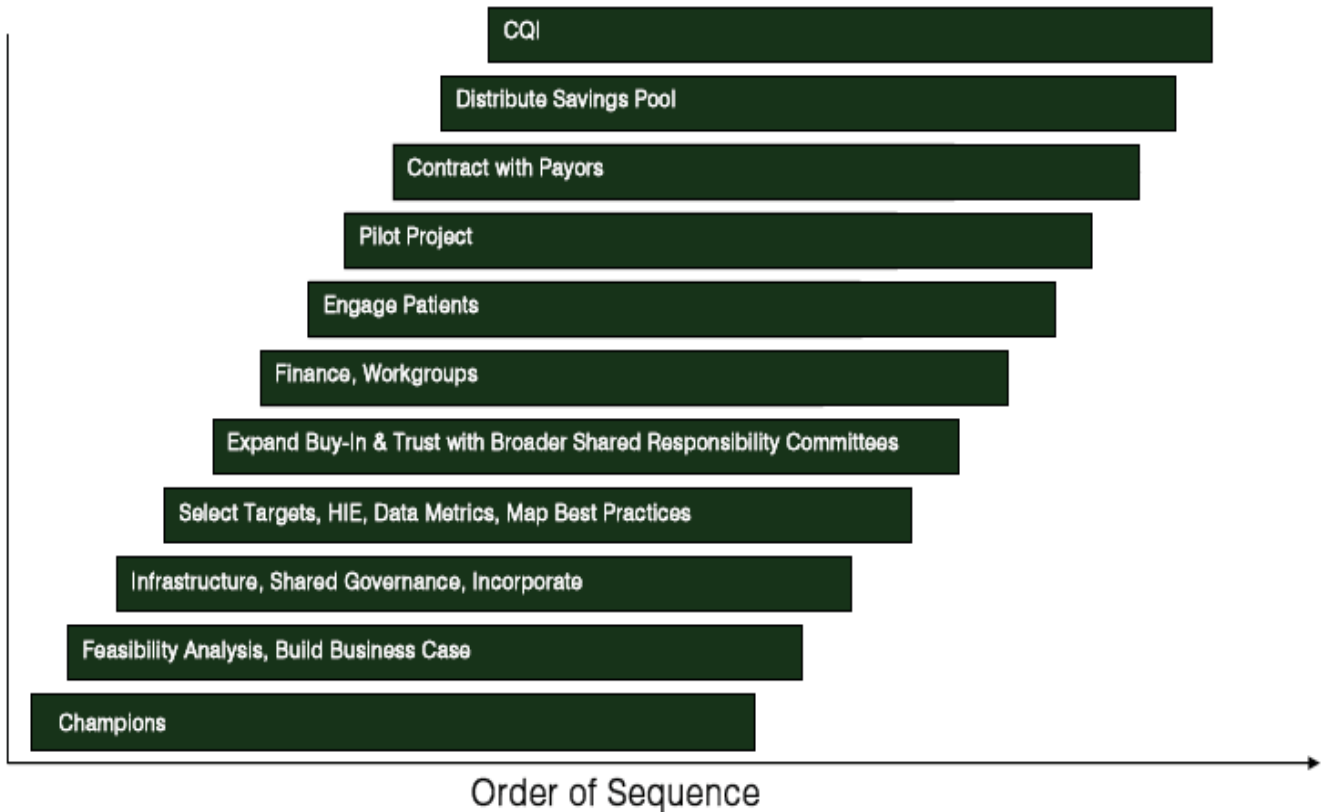
The elements do come together and mesh. Culture dominates. Each one can be built. These are not mysterious. They are doable. It will be hard. Once the ACO organizers embrace the opportunity in this change, achieving all of the elements for sustainable success is quite feasible. Conversely, if you are evaluating a previously organized ACO, there are clear indicators regarding these essential elements that will predict reliably its likelihood of success.

VI. SUCCESSFUL IMPLEMENTATION – A STEP-BY-STEP GUIDE

A. Where Do I Start?

OK, you now may be saying: “I know what an ACO is, why it is important, and how to identify ones that will succeed. However, how do I build one? Where do I start? I know where to go now, but how do I get there?” The creation of an ACO follows basic business planning and start-up principles. Expert advice on ACO implementation is uniform. The following is a step-by-step guide to building an ACO.

B. Step-By-Step Guide



1. **Informed Champions** – Perhaps even ahead of this first step may be that there needs to be some ACO information available to plant the seed of awareness with a few local champions. These champions, whether hospital CEO, family physician, or neurosurgeon, will need to invest their “sweat equity” to get up to speed (the main purpose of this ACO Guide). The champions need to reach beyond silos and see whether cultural compatibility is possible.

2. **Strategy Formulation/Gap Analysis** – Next, a small core group should honestly assess where they are and where they need to go. What is the target market (i.e., chronic disease, Medicaid, the elderly)? Does an ACO make sense? What do we target? How do we make sure this is fair and successful so that we get buy-in? Some experts recommend a phased approach starting with primary care, then adding select specialists and hospitals around targeted high-impact initiatives, then a comprehensive panel, and then, finally, including public health and social services. Other experts recommend matching the natural strengths of the ACO with the greatest gaps in care for the local area. Then they would have the ACO model a strategic business case, to create a roadmap to development. How will it achieve all of the 8 Essential Elements? Building the infrastructure from scratch will be quite expensive, perhaps costing in the millions of dollars. Can you tie into an existing medical home, hospital or regional HIE infrastructure to reduce those costs? Keep the team very small at this stage.

3. **Clear Vision** – The organizing group needs to have credibility and will need to unite around a clear and compelling shared vision.

4. **Clinical Integration** – Through shared decision-making and champion leadership, build capabilities of a clinically integrated organization. Review plan for presence of the 8 Essential Elements listed in Section V.

- a. Start with your initial targeted initiatives.
- b. From them, establish best practices for the continuum of care for all providers involved with that type of patient.
- c. “Blow up” the best practices into component parts and assign clinical leadership responsibility for each.
- d. Identify which clinical data sets and decision support tools are needed at each step.
- e. Assign performance metrics and financial accountability for same.
- f. Determine HIT technical requirements.
- g. Determine best financial tools to incentivize desired behavior by all involved (i.e., share savings with predetermined performance benchmarks and distribution methodology).

5. **Structural Foundation** – Choose the legal entity approach and formal governance structure most appropriate to your culture and business plan. It must be driven by the form most likely for the success of the ACO, not control by or success for any particular stakeholder. Establish membership criteria and a shared decision-making structure. Design and undertake training. Develop payor strategy and contract terms. Do “ROI” predictive modeling to estimate savings and quality benefits. Create credible value talking points for all stakeholders.

6. **Expand Buy-In** – Broaden structured involvement. Create a multi-disciplinary integration committee with HIT, best practices, patient engagement, and finance subcommittees.

7. **Accountability Function** – Develop data metrics, measurement capability, and sophisticated financial administration capabilities to manage financial shared savings distribution. Set performance targets. Normalize data. Make sure your performance-based incentives target your ACO objectives.

8. **Start Small** – Start with a demonstration or pilot project.

9. **Contract with Payors** – Once ready, contract to provide integrated accountable care services on a shared savings basis, at least initially, for your target patient population. The patient population scale must be adequate to achieve economies of scale. Consider a Medicare ACO starting in 2012 as part of a broader strategy.

10. **Assess and Improve** – Assess results of the process. Make adaptations to create a constant quality improvement (“CQI”) loop. Collect and distribute the savings pool roughly in proportion to contributions to it.

VII. CONCLUSION

The Accountable Care Organization holds great promise to address many of the ills of America's health care system. However, it will require new skill-sets, collaboration partners, technology, and systems. It will require a radically different approach to shared accountability. It is the goal of this ACO Guide to demystify ACOs for all stakeholders and to provide some tools and confidence to allow health care leaders to take prudent risks for greater success than they otherwise would have.

Part Two: ACO Strategies for the Family Physician



I. INTRODUCTION

Part One of the ACO Blueprint describes what it takes to create a successful ACO and the steps to get there. Since it is fundamental that an ACO be a win/win for all involved, it applies whether one is a primary care physician, specialist physician, or hospital executive. Part Two, on the other hand, spells out specific strategies for the family physician, whether in a small independent practice, part of a large multi-specialty group, or employed by a health system. The overarching message is that family physicians may well control both their own fate and the fate of the ACO movement. Passivity risks defaulting American health care to Draconian alternatives.

II. COULD AN ACO BE A GOOD THING FOR FAMILY PHYSICIANS?

In Part One of the ACO Guide, we learned what an ACO is, that it will not be going away even if part of health reform is repealed, and that most experts think it will be centered on a strong primary-care base, preferably a medical home model with financial accountability infrastructure and shared savings contracts. But what, specifically, will this mean for the family physician?

A. Pros

Many family physicians find the biggest positives of the primary care centered ACO movement to be respect and validation of the reasons they went to medical school and chose family medicine. There also is a sense of empowerment from being asked to guide health care delivery and being given the tools to do so. There is a sense of fulfillment from leading change that will save lives and improve patient access to care. There also is, of course, the potential for financial gain. Unlike other specialties, family medicine has many opportunities in accountable care: prevention, chronic disease management, complex patient management, transitions in care, and reduced hospitalizations, to name just a few.

B. Cons

Most family physicians are overworked, burned out, and do not have the time, resources, or remaining intellectual bandwidth to get involved. They have seen this before, and it didn't work out as advertised. They fear "they" will do it to you again. They have little capital and no business or legal consultants on retainer, like other health care stakeholders. There is a family physician workforce shortage and the ACO model is asking that you take on more responsibilities. It is hard to give up independence and rely on specialists and hospitals. A hospital-employed physician may feel powerless. As a result, the profession risks not recognizing in time the magnitude of its role, so that the opportunity for ACO success passes by and is replaced by dismal alternatives.



Strategic Note: Case Study Example – Starting with several simple Medicaid initiatives, North Carolina primary care physicians have created a statewide confederation of 14 Medical Home ACO networks. Though the work involved is plentiful, so have been the rewards. They are finding more empowerment and options in health care through contacts with payors, specialists, patients, or facilities. Several were interviewed for this paper, and the consensus is that though much is uncertain, they feel much more prepared to face the changes in health care having created first the medical home networks, then medical home-centric ACOs.

C. Suppose I’m Employed By the Hospital (or Foundation or Clinic)?²⁴

The pathway may be different, but the same pros and cons apply generally. By being on the “inside,” and having read this ACO Blueprint, they may actually have more influence to shape a successful ACO that fairly values the prime role of primary care. However, they may have more difficulty freely associating with an ACO outside of the hospital’s ACO. Specific hospital-employed family physician strategies are set forth below in Section III.E.

III. ACO STRATEGIES FOR THE FAMILY PHYSICIAN

A. Awareness/Leadership/Urgency

Family medicine needs to know what an ACO is, how to recognize one with a likelihood of success, and the professional opportunities and risks involved. A number of leaders need to get up to speed and be catalysts for this transformative change. These champions need to act with confidence, but also a sense of urgency. This is mentioned as a strategy in and of itself because almost every properly created ACO will empower an informed family physician, but if too many primary care leaders do not recognize this, the entire ACO movement may fail. Also, as mentioned in Section VI of Part One of the Guide, every successful ACO starts with a few champions. Why not have one be a family physician? As they say, “If you don’t have a seat at the table, you are on the menu.”

Suppose I’m Employed by the Hospital? Though the old hospital “top-down” control habits will remain in many settings until the “tipping point” in the transition to value-based reimbursement, one of the best things that can happen to a hospital administrator these days is having a well-informed, employed,

²⁴ Although the formal legal entity that employs a physician, is a foundation or large multi-specialty clinic, that operates differently because of corporate practice of medicine laws or other reasons, the leadership opportunities, negotiation leverage and constraints are roughly the same as those faced by the hospital-employed physician. This similarity will not be further noted when hospital employment is mentioned but generally applies throughout.

primary-care physician willing to champion an ACO. Stay patient, stay persistent, and freely share credible third-party authoritative sources that confirm this. The employed physician may have an advantage to raise awareness and develop relationships from the “inside.”

B. Readiness Assessment of Your Practice

Evaluate the practice's readiness for accountable care. As noted, preparing to be, or participating in, a medical home is entirely consistent with this readiness effort. Remember that of the 8 Essential Elements of an ACO discussed in Part One, culture change is the hardest. Cultivate relationships, get outside of the “silo,” have “what if” creative conversations with open-minded specialists, other primary care physicians, allied providers, and hospital administrators. Assess your HIT, data capture, care capabilities, patient education, and self-support tools and how you can increase value. Information on how to become a medical home may be found at: <http://www.aafp.org/online/en/home/membership/initiatives/pcmh.html> and <https://www.transformed.com/>.

Suppose I'm Employed by the Hospital? Try to participate on all relevant ACO feasibility and implementation committees. One reason physicians want to work for a hospital probably was to gain access to sophisticated and sometimes expensive resources. Show the hospital the high “return on investment” or “ROI” of such investments in the practice. Help integrate the practice into the ACO.

C. Create or Join a Medical Home Network

As noted in Part One, the Medical Home is a precursor to the recommended primary-care-centered ACO. As also noted, many high-impact, high-reward opportunities accrue to family physicians through a medical home component of an ACO. Recent successes of medical homes should stimulate this movement even more.²⁵

As physician-owned Medical Home networks become more common, a wise strategy may be simply to join an existing one if it has, or will have, the 8 Essential Elements for ACO success identified in Part One of the ACO Guide. This is a rare opportunity, not available to specialist physicians, to not only have such a rich “target field” of high-impact ACO initiatives to choose from, but also to have friendly pre-existing vehicles becoming available. The statewide confederation of 14 Medical Home Networks under a nonprofit umbrella organization, North Carolina Community Care Networks, Inc., is a case in point.

If a medical home network does not exist, creating one should be a basic strategy.

Suppose I'm Employed by the Hospital? Some hospital executives are actively trying to create medical home networks or “neighborhoods” to complete their ACO network. Others will be awakening to this reality as the “go live” date of 2012 for the CMS ACO initiative looms.²⁶ Being an informed champion will facilitate this evolution.

²⁵ Kevin Grumbach, M.D., *Outcomes of Implementing Patient-Centered Medical Home Intervention*, (November 16, 2010).

²⁶ See http://www.aconline.org/advocacy/where_we_stand/policy/pcmh_neighbors.pdf

D. Evolve to Medical Home-Centered ACO

The differences between an ACO and a medical home are the former's ability to incentivize accountability for value delivery through administration of shared savings or similar financial arrangements and reach out to include specialists and hospitals. In some areas, the medical home attracts payors interested in efficiencies and quality improvement and it becomes the contracting vehicle. Select specialists and hospitals contract with the medical home, sometimes through a sub-ACO. In other areas, a hospital or health system jointly controls the ACO and contracts with the medical homes to complete its network. If the 8 Essential Elements for ACO success are present, either option or variations thereof will all work well. If these options are not available, your strategy should be to work to make sure your ACO has the core primary care components and high-yield primary care initiatives outlined in the ACO Guide. A number of current practical publications provide more detail than possible in this executive briefing.²⁷

Should I join more than one? At the very least, you should consider participation in any ACO which may contain the 8 essential elements of success, and evaluate whether to become a champion to improve chances for success. Several in your region may have different attributes such as payor relationships, patient populations, or progressive initiatives, which would merit joining several ACOs. The informed family physician will have choices not available to some other specialties.

E. Hospital-Employed Physician Strategies

1. **Engage** – Thoughtful leadership to help the hospital create a successful ACO is the best strategy. Get informed, get involved. Make sure the ACO's goals are aligned with all stakeholders and are clearly articulated. Will the ACO have the 8 Essential Elements outlined in the ACO Guide? Is there a culture of partnership? Seek involvement in anything regarding best practices, incentive payments, compensation design, bundled payments, etc. Seek compensation for this administrative time. Become a champion if there is a chance for success.

2. **Compensation Design** – The employment agreement should have financial incentives to reward accountability for the success of ACO initiatives over which the physician has control. Negotiate so that the shared savings distribution will be in addition to, and not limited by, any salary cap. Some contracts tie a percentage of compensation to the success of the entire organization. This can be rather attenuated, since one may not be able to influence this overall metric meaningfully, but it is better than having all compensation based on personal productivity.

²⁷ Bruce Flareau, MD, FAACP, FACPE, CPE, [Accountable Care Organizations: A Roadmap for Success: Guidance on First Steps](#) (2011) (Dr. Flareau is President of the Florida Academy of Family Physicians.); The Brookings Institution, [The Accountable Care Organization Toolkit](#) (2011); and Harold D. Miller, [How to Create Accountable Care Organizations](#), Center for Healthcare Policy and Payment Reform (2009)

3. Suppose The Hospital's ACO is Fatally and Irrevocably Flawed? Attitudes are changing rapidly regarding ACOs, so “never say never,” but if the ACO will never pass muster, this raises the question of the legality of economic credentialing and non-compete covenants that may bar the employed physician from participating in other ACOs. As of the date of this writing, these are untested legal concepts. Traditionally, freedom of contract prevails unless the restriction will limit access to needed care or offend some other public policy. Since primary care is in such short supply, if the prohibition on participating in an ACO will limit access by patients contracting through it, it might not be enforceable as against public policy. The AAFP has recommended legislation prohibiting a single ACO “lock in” for employed physicians.

Since the hospital employs, it also stands to profit from the shared savings distribution to its employee in any ACO. It may view this similarly to an owned practice signing up with a desirable managed care company. However, the hospital might not accept a family physician employee helping to make a competitive threat more successful.

IV. WHAT SPECIFIC ACO INITIATIVES SHOULD FAMILY PHYSICIANS TARGET?

Other specialties around the country are scrambling to determine which ACO initiative, if any, allows them to demonstrate value, and thus gain reward. Thanks to the track record of the Medical Home, the family physician does not have this problem. As noted in the ACO Guide, a nascent ACO should involve physicians to design a deliberate targeting process. Looking first at the recommended target zones...

- prevention
- chronic disease management
- reduced hospitalizations
- complex patient management
- effective transitioning

...where the ACO matches its strengths against the community's largest care deficiencies. One looks also to the targets with the highest impact and those most quickly accomplished the most easily. With the success of Medical Homes around the country, family physicians have a “menu” of targets to choose from. See what is working elsewhere but do not be afraid to innovate.

V. WHAT ARE THE IMPORTANT DATA METRICS FOR FAMILY PHYSICIANS IN ACOs?

The medical home demonstration projects are generating data metrics for quality, efficiency, and patient satisfaction. They should be the starting point but should be vetted by a local physician committee. Benchmarks chosen for payment should be aligned to measure accomplishment of the ACO's particular targeted goals (i.e., morbid obesity management).

VI. NEXT STEPS?

You now know what an ACO is, why it is important, how to build or identify one that might succeed, and which initiatives for family medicine are most ripe for success within an ACO. It is ironic that the potentially career-changing opportunities for family medicine may never be realized because not enough family physicians become engaged in time. We recommend concerted strategic briefing efforts at the national and state academy levels, and increased local leadership by focused family physician champions. This window will not stay open very long. The CMS Shared Savings Program starts in 2012 on a voluntary basis. With primary care the only required specialty, it would seem logical to get involved early to help create a standard of having a strong primary care role in ACOs.

VII. ACO RESOURCES FOR FAMILY PHYSICIANS

In addition to this ACO tool kit, the AAFP has gathered additional information that can be located at <http://www.aafp.org/online/en/home/practicemgt/specialtopics/designs.html>. The AAFP will be working with the Chapters on offering additional resources. Be sure to check on the AAFP website and your Chapter's website for updates.