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**ACCOUNTABLE CARE ORGANIZATION MUSICAL CHAIRS: WILL THERE BE A
SEAT REMAINING FOR THE SMALL GROUP OR SOLO PRACTICE?**

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ACCOUNTABLE CARE ORGANIZATION MUSICAL CHAIRS: WILL THERE BE A SEAT REMAINING FOR THE SMALL GROUP OR SOLO PRACTICE?

ABSTRACT

Accountable Care Organization (ACO) is a new and untested concept in healthcare delivery and payment, when it was introduced in the Affordable Care Act of 2010 as the new 2012 payment model for Medicare. The purpose of this study was to estimate the likelihood of engagement in ACOs by small group and solo healthcare practitioners. Evaluation of five cases studies showed that significant organizational, financial, and technological challenge had to be met in order to launch an ACO. Sufficient resources to meet those challenges were best supplied by large organizations. Small or solo practices participated only through varying levels of integration as salaried physicians or in Independent Practice Associations or Physician Hospital Organizations.

Key Words: Accountable Care Organization, Physicians, Integrated healthcare delivery, Independent Practice Associations, payment model.

INTRODUCTION

The Affordable Care Act (ACA) of 2010 addressed a wide range of healthcare issues. One significant provision called for a new paradigm in payment for healthcare services in relation to the value that they provide. This call for change was an effort to answer concerns raised by the continued escalation of United States (U.S.) healthcare spending that have reached 17.3% of U.S. gross domestic product in 2009 while underperforming other nations on quality and patient satisfaction (DeVore 2011). Wide variations in the quality and cost of care as well as lack of coordination have been additional concerns (Purington, Gauthier, Patel, & Miller 2011).

In order to address these concerns of quality, beneficiary outcomes, and cost of care, the ACA directed the Centers for Medicare and Medicaid Services (CMS) to foster delivery system reform through Accountable Care Organizations (ACOs), (U.S.DHHS 2010). An ACO is defined by CMS as an organization of healthcare providers that agrees to be accountable for the quality, cost, and overall care of Medicare beneficiaries who are enrolled in the traditional fee-for-service program who are assigned to it (U.S.DHHS, 2010). The term can also refer to private sector organizations and is defined by the Commonwealth Fund (2010) as provider-led health care systems that are accountable for patient health outcomes and coordinate health care across providers and settings. The structures of ACOs will likely differ, but all should be guided by three over arching principles: payment reform, performance measurement, and delivery system changes (Lee, Casalino, Fisher, & Wilensky 2010).

Payment reform has been called for because the prevalent fee-for-service system is viewed by healthcare policy consensus as ineffective and unsustainable (McClellan, McKethan, Lewis, Roski, & Fisher 2010). Because payments are based on volume and intensity, this system is credited with promoting more services and higher costs without yielding a better outcome.

Perverse incentives have been attributed to provision of healthcare under this current payment model (DeVore 2011). The new model has a shared savings structure that is designed to incentivize lower cost care. If an ACO can provide quality care to its assigned population at a cost below its budget benchmark, it will receive a portion of those savings (Merlis 2010).

ACOs will also have to meet quality performance measures to qualify as Medicare ACOs. These measures are expected to include clinical process measurements as well as patient care outcomes, rates of utilization, and patient experience or satisfaction measures and will be detailed in final program regulations (Berwic 2010).

Delivery system changes focus on reducing fragmentation of care, which is thought to contribute to overuse, and involve increasing coordination of care across healthcare settings. This will require increasingly integrated organizations, either in formal structure or communication, or both, because the accountability for an ACO's patients' costs of care will be shared across the spectrum of care (Purington et al 2011.)

ACOs were reportedly first discussed in a Medicare Payment Advisory Committee meeting in November of 2006. The "Accountable Care Organization" term was coined at that 2006 meeting by Elliot Fisher, a Dartmouth professor of medicine who also co-authored a landmark article in *Health Affairs* on the concept (Fisher, Stalger, Bynum, & Gottlieb 2007). Fisher and his colleagues sought to advance previous quality initiatives such as Pay-For-Performance (P4P) from focusing on the individual provider's performance to one which would assess quality across the continuum of a patient's care. Fisher et al (2007) posited that organizations which could be held responsible for a defined population's care would deliver less fragmented care of a higher quality and at a lower cost, suggesting a new organizational model

of an “extended hospital medical staff,” a virtual grouping of distinct entities, based on a patient’s most common sites of care.

In 2009, Fisher again teamed with Dartmouth colleagues as well as the Brookings Institution to further discuss the ACO concept, this time offering both ideas for incentivization and data suggesting a potential savings target (Fisher et al 2009). “Shared savings” was described as a payment reform concept of modifying fee-for-service reimbursement to allow ACOs to retain part of the benefit of reducing costs. Several structural ACO requirements were proposed, along with defining eligible organizations, determining which Medicare beneficiaries would be assigned to ACOs, setting benchmarks and cost performance targets, performance measurement, and savings distribution. Empirical analysis and simulations supported a gradual decline in Medicare spending under an ACO model (Fisher et a, 2009).

Following the legislation of the Shared Savings Program and Accountable Care Organizations in the ACA of 2010, the literature on the subject was dominated by two types of articles, case studies of building similar organizations and articles espousing either improvements or problems with the concept. A common concern was the legal ramification of healthcare businesses’ collaboration in terms of antitrust and fraud and abuse laws (Leibenluft 2011). Another issue was the method of patient attribution to the ACOs and how to engage them in the process (Sinaiko & Rosenthal 2010). Goldsmith (2011) asserted that the concept was flawed with insufficient incentives and a history of mistrust between hospitals and physicians.

Luft (2010) raised concern that the ACOs would be directly launched in January 2012 without a demonstration project and without final regulations, giving providers little time to prepare for it. Itchhaporia (2010) noted that most healthcare was delivered by independent

physicians that were not connected to large entities and questioned whether the ACO models would allow small practice participation. The National Academies of Practice (2009) noted that 75% of primary care physicians were in solo practice, and that other health professionals often worked in small practices, such as dentistry, optometry, podiatry, and psychology. Even the CMS itself seemed to recognize the difficulty of incorporating the small practice into an ACO. Dr. Donald Berwick, the administrator for CMS, called for commentary on what standards and policies should be adopted to ensure the inclusion of solo and small practice providers in the Medicare Shared Savings Program and the ACO models (Berwick 2010).

It is unclear whether small group and solo healthcare practitioners would have an opportunity to participate in a proposed new model of care, the ACO. The purpose of this study was to estimate the likelihood of engagement in ACOs by small group and solo healthcare practitioners

METHODOLOGY

The primary hypothesis in this research was: small group and solo practices would be unable to participate in the new payment model. A secondary hypothesis was: the launch of the ACO would be a further force toward formal physician hospital integrations.

The methodology for this qualitative study was a literature research and review of case studies. The electronic databases of PubMed, Academic Search Premier, and ProQuest were searched for the term 'Accountable Care Organization'. Reputable websites of the American Medical Association, the New England Journal of Medicine, CMS, and the Commonwealth Fund were also examined. Citations and abstracts identified by the search were as well assessed in order to identify relevant articles. A total of 39 articles were reviewed and 30 selected for this

research study. The literature search was conducted by AV and validated by AC for this research project.

RESULTS

As a result of this research, five case studies of organizations using payment models which were predecessors for ACOs were found. The organizations were: the Physician Group Practice (PGP) Demonstration, the Vermont ACO Pilot, Blue Cross Blue Shield (BCBS) of Massachusetts Alternative Quality Contract, Premier Healthcare Alliance, and Advocate Physician Partners/Advocate Health Care. They represented a broad variety of sponsoring organizations and structures. Each was examined to assess for a method to engage small group or solo physician practices. The results of the case analyses were summarized in Table 1.

Case One: The Physician Group Practice Demonstration

The Physician Group Practice Demonstration was a prototype for ACOs (Iglehart 2011a). This model was started in 2005 by CMS to examine whether healthcare costs savings could be generated and quality improved by reducing hospital and emergency admissions for Medicare beneficiaries. Ten large groups of physicians participated, ranging in size from 232 to 1291 physicians per group, with the incentive of sharing in potential Medicare savings. Results of the projects' fourth year indicated that all 10 groups met essentially all of the quality goals. However, only five of the groups generated savings. None of the 10 demonstration sites accommodated small or solo practice physicians.

Analysis of the PGP Demonstration data by Heywood & Kosel (2011) indicated that even large, experienced groups could not recover their original investment in less than five years.

Heywood & Kosel further suggested that the ACO payment model would result in financial challenges that made it unsuitable for most physician groups (see Table 1).

Case Two: The Vermont Accountable Care Organization Pilot

The state of Vermont expressed interest in the ACO model in 2008 and instructed the Vermont Health Reform Commission to develop pilot programs. This case was described in a research paper supported by the Commonwealth Fund (Hester, Lewis, & McKethan 2010). With legislative support, Vermont had already established a base of medical home pilot programs and viewed the ACO model as a logical expansion into the community healthcare system level. An interdisciplinary team was assembled consisting of a broad array of stakeholders, and two years of their study and design produced three healthcare provider organizations which were expected to launch ACOs in 2011. The three organizational structures consisted of a Physician Hospital Organization (PHO), a Federally Qualified Health Center (FQHC), and a community hospital with salaried physicians.

The Vermont pilot found that only large, integrated care systems had the resources to support ACOs and concluded that small practices or rural systems would require state or federal support in order to succeed (see Table 1).

Case Three: Blue Cross Blue Shield of Massachusetts Alternative Quality Contract

BCBS of Massachusetts developed a payment model in 2009 that operated with not only shared savings but also shared risk (Chernew, Mechanic, Landon, & Safran 2011). In line with the goals of the proposed ACO model, i.e. providing patient-centered care that demonstrated quality along with cost savings, this program was called the Alternative Quality Contract. Healthcare providers furnished services to BCBS beneficiaries within a global budget and

received technical support and incentive payments from BCBS for improved quality. Providers were at varying degrees of shared financial risk for care expenses exceeding budget and received shared savings on expenses less than budgeted.

All physicians who participated in the Alternative Quality Contract belonged to some structure that contracted on their behalf. These included multispecialty groups, PHOs, or Independent Practice Associations (IPA). Those physicians in solo and small group practices unaffiliated with any large organization were not eligible to participate (see Table 1).

Case Four: Premier Healthcare Alliance

In order to define best practices for implementing ACOs, Premier Healthcare Alliance formed the Accountable Care Implementation Collaborative, involving 25 healthcare systems which encompassed 80 hospitals and thousands of physicians (DeVore & Champion 2011). Criteria for participation included engaged executive leadership, private payer contracting ability, willingness to share performance data, tightly aligned physician networks, patient bases of at least 5,000 covered lives, acceptance of common cost and quality metrics, and internal data structures sufficient to collect and analyze data. Members of the collaborative organized workgroups and researched all aspects of the ACO model. They worked toward standard, workable solutions in areas such as quality measures and contracting. Their intention was to have their organizations ready to enter ACO contracts by time CMS begins the model in 2012.

In the Premier Healthcare Alliance structure, physician practices were described as tightly integrated, with employed physicians, physician joint ventures, or multi-provider networks (see Table 1).

Case Five: Advocate Physician Partners/Advocate Health Care

Advocate Physician Partners was described by Shield, Patel, Manning, and Sacks (2011). This Illinois organization consisted of 3500 physicians who formed a joint venture with Advocate Health Care, a system of 10 hospitals. Nine hundred of the physicians were directly employed by hospitals, but 2700 physicians ran independent practices.

This cooperative venture had a long, 15 year relationship. Advocate Physician Partners' focus had been to provide managed care contracting on behalf of the physicians. Concentrating on strong physician leadership and involvement, the organization had already crafted successful quality improvement and cost reduction through P4P contracts with private payers. Crucial to this task was receipt of Federal Trade Commission (FTC) approval which had allowed the independent physicians to negotiate collectively. Their P4P model with commercial payers had many similarities to the proposed ACO model. With their experience in contracting and established network of providers, the partnership of Advocate Physician Partners and Advocate Health Care signed their first ACO contract in January of 2011 with a commercial payer, BSBS of Illinois.

With their PHO model, the partnership has claimed to have found a solution to engaging small group and solo physician practitioners. However, the organization had not only cleared legal hurdles so that small practices could participate, but also provided a link to hospitals' data management and quality improvement infrastructure. Those physician practices which chose to participate remained subject to meeting ongoing quality and performance standards set by the organization (see Table 1).

DISCUSSION

The purpose of this research was to determine whether small group and solo practitioners would have an opportunity to participate in a new model of care, the ACO. The results demonstrated that none of the ACO prototype or predecessor models had included this cohort of medical practice without integration into a significantly larger organizational framework.

These findings contrasted with Fisher et al (2007) which first envisioned an ACO as a merely a “virtual” organization of providers. In fact, the organizational framework as proposed in the March 31, 2011 release of the Notice of Proposed Rulemaking (NPRM) on ACOs required corporate organization under state law with a distinct Taxpayer Identification Number (TIN), eliminating the possibility of virtual connections between providers (Hastings 2011). The ACA had already restricted ACO participant eligibility to group practices or networks of individual practices in addition to hospitals with employed physicians or joint venture arrangements between hospitals and physician groups, but had not specified a minimum practice size. The NPRM, however, reiterated that an ACO must be of a size sufficient to serve 5,000 Medicare beneficiaries (U.S. DHHS 2011). This effectively eliminated solo practices, as the average patient panel for solo family physicians numbered 2000-3000 (Borglum 2010).

All cases in the results described the need for significant resources in quality reporting and data management, and specific mention was made indicating the large organizational commitment to support the required Information Technology structures. This ability was confirmed to be essential to meet the proposed NPRM required reporting of 65 separate quality

data elements, none of which could be gained from typical claims data systems available in small practices (McClellan 2011).

Financial impediments for small group and solo participation in ACOs were mentioned in the researched cases, and those concerns were supported by the release of the NPRM. Start up and first year operating costs for an ACO were estimated at \$1.7 million, as detailed in the impact portion of the NPRM. In addition, ACOs are required to demonstrate significant capital reserves on hand. Out of reach for small physician organizations, these requirements have favored hospital based ACOs (Lieberman 2011).

While the results confirmed the primary hypothesis of this research, namely that stand alone small group and solo practices would be unable to participate in the new payment model, the secondary hypothesis suggesting ACO's promotion of physician hospital integration trends was only equivocally supported. The findings did show that small group and solo practices would have to pursue integration in order to deal with financial and regulatory challenges to the model, as each case demonstrated levels of required practice integration. However, although both Greaney (2011) and Kocher & Sahni (2011) have anticipated that the formation of ACOs would increase physicians' alignment or employment with hospitals or integrated delivery systems, this research did not confirm that physicians would choose to integrate in any larger numbers than they would have in absence of this new payment model. In addition, the NPRM estimated that only 75 – 150 ACOs would be formed in the early years of the model (Iglehart 2011b). Since participation in the payment model is voluntary and the number of expected initial ACOs relatively modest, small groups or solo practitioners might not have sufficient incentive to change their practice culture based on ACOs alone.

This study was limited due to the narrow evolving ACO regulatory environment. The sample size of case studies found was limited, and only ACO prototypes could be examined as the study took place prior to Medicare’s ACO start up.

CONCLUSION

Accountable Care Organizations will launch as a new Medicare payment model in 2012. While high hopes exist for this model to yield better healthcare at a lower cost, the structural requirements from an organizational, financial, and technological standpoint are complex. Independent small group and solo practice physicians will be unable to participate; there is no chair in the game for them.

Table 1: Case Studies in Accountable Care Organizations Formation and Participation of the Solo/Small Practice

Case	Authors	Structure	Payment model	Solo/small practices
PGP Demonstration	Inglehart (2011), Heywood & Kosel (2011).	Large group practices	Shared savings	None participated
Vermont ACO Pilot	Hester, Lewis, & McKethan (2010).	PHO, FQHC, community hospital	Shared savings, proposed	None envisioned in pilot; thought to be too expensive
BCBS of Massachusetts Alternative Quality Contract	Chernew, Mechanic, Landon, & Safran (2011).	Commercial payer	Shared risk and savings	Only if integrated into PHO or IPA
Premier Healthcare Alliance	Devore & Champion (2011).	Integrated delivery systems	Shared savings, proposed	None; physicians described as in tightly aligned network
Advocate Physician Partners/Advocate Health Care	Shields, Patel, Manning, & Sacks (2011).	Physician – Hospital joint venture	Pay for performance adapted to shared savings	Only if integrated into PHO

ACO=Accountable Care Organization. FQHC=Federally Qualified Health Center.

IPA=Independent Practice Association. PHO=Physician Hospital Organization.

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