EARLY RESULTS: ACOs ARE WORKING

By: Julian D. ("Bo") Bobbitt, Jr., J.D.*

Guess what? Physician-driven accountable care organizations ("ACOs") are working. The even better news is that this trend is predictable and inevitable.

- **ACOs Are Working** – As other materials from the Toward Accountable Care Consortium detail, there are eight fairly straightforward elements required to create a successful and sustainable ACO: (1) a change in financial incentives from those which reward volume, such as fee-for-service, to ones which reward value, like shared savings, if quality benchmarks are met; (2) a primary care core; (3) physician cultural change; (4) patient engagement; (5) robust data collection; (6) clinical best practices; (7) administrative infrastructure; and (8) enough scale.

A number of ACOs that do not have these elements will fail, but fortunately, more and more are being set up properly. Recently, the consulting firm, The Boston Consulting Group, reported that ACO-like Medicare Advantage plans are reporting positive results. They are all distinguished by having "a selective network of providers, financial incentives that are aligned with clinical best practices, and active care management that emphasizes prevention in an effort to minimize expensive acute care." Not only are emergency department and ambulatory surgery procedures down 20-30%, but their analysis of data on 3-million Medicare patients showed that quality went up. These patients had lower single-year mortality rates, shorter average hospital stays, fewer readmissions, and better sustainability of health over time.[1]

- **Physician-Led ACOs Are Better** – If ACOs are good, physician-sponsored ones are better. At a recent national meeting of health insurance companies, Paul Ginsburg, Ph.D., President of the Center for Studying Health System Change, told the insurers that, "I think physician-led ACOs inherently make markets more competitive because they have an opportunity to shift patients toward high-value hospitals." Similarly, Charlie Baker, former Secretary of Health and Human Services for Massachusetts, told the group that nearly all of the Medicare Advantage risk contracts are with physician groups and not hospitals. Medicare Advantage participants are chosen by insurers, and he indicated that they know that contracting with physician ACOs is the best way to save money.[2] This truth is becoming more evident, and there are now more physician-led ACOs than any other.

- **Changing Compensation** – Primary care is the only discipline mandated to be in ACOs participating in the Medicare Shared Savings Program. This is because ACO success stems from keeping people out of the hospital, avoiding expensive procedures and reducing unnecessary tests and imaging. The "rich target fields" for ACOs to accomplish this are primarily prevention

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[1] Kaplan, J., *et al.*, *Alternative Payer Models Show Improved Health Care Value*, https://www.bcgperspectives.com/content/articles/health_care-payers-providers-alternative-payer-models-show-improved-health-care-value (May 14, 2013).

[2] Pittman, D., *Doc-Led ACOs Better Model for Saving $$$*, http://www.medpagetoday.com/washington-watch/reforms/39178.

and wellness, coordination of high-cost complex patients, reduced hospitalizations, and transition management across our fragmented system. These are all in primary care's wheelhouse. This is reflected in early ACO shared savings models. Specialist compensation will evolve as more sophisticated value-add innovations involving them drive quality and savings.

This author firmly believes that the successful and sustainable ACOs will tie shared savings distributions to relative contribution. A merit system will thus likely be primary care weighted. For example, one ACO posted this distribution: 12% to infrastructure; of the remainder, 60% to primary care, 40% to specialists, and 0% to hospitals.[3] The following small sample survey shows widely varying models, but in all cases where distribution is broken out, primary care receives as much or more than specialists and, with one exception, hospitals.

Shared Savings Distribution Examples

Fictitious MSSP ACO Name	Notes	Infra-structure	Primary Care	Specialists	Hospitals/ Inpatient Facilities	All Physicians/ Providers	Other
ACO A		15%	30%	25%	30%		
ACO B	(1)		25%	25%	50%		
ACO C	(2)	20%	56%	24%			
ACO D			48%	36%	16%		
ACO E	(3)						100%
ACO F		33.3%				66.7%	
ACO G		50%				50%	
ACO H	(4)	6%				94%	
ACO I	(5)	100%					
ACO J	(6)						100%
ACO K		30%	49%	21%			
ACO L	(7)	100%					
ACO M	(8)						100%
ACO N		33.33%			33.33%	33.33%	
		33% Median Infrastructure Allocation					

[4]

A fully evolved ACO should incentivize all providers and facilities along the entire continuum of care, but always in proportion to their value-adding contribution. While this economic reward is gratifying and validating, physicians are sometimes surprised that the biggest reward has been empowerment to do health care right and regain control of the physician/patient relationship. They say that seeing happier, healthier patients, and being able to spend more time with them, has returned the fun to the practice of medicine.

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[3] Yarapoi Accountable Care, http://yarapoiaccountablecare.com/shared%20savings.html.

[4] Anderson, G, *et al.*, *Critical Business and Design Elements of the ACO American Health Lawyers Association*, Healthcare Transactions Conference (April 2013).

County / Regional Medical Societies

Cleveland County Medical Society
Craven-Pamlico-Jones County Medical Society
Durham-Orange County Medical Society
Mecklenburg County Medical Society
Forsyth-Stokes-Davie County Medical Society
New Hanover-Pender County Medical Society
Pitt County Medical Society
Rutherford County Medical Society
Western Carolina Medical Society
Wake County Medical Society

Specialty Societies

Carolinas Chapter, American Association of Clinical Endocrinology
North Carolina Academy of Family Physicians
North Carolina Chapter of the American College of Physicians
North Carolina College of Emergency Physicians
North Carolina Council on Child and Adolescent Psychiatry
North Carolina Dermatology Association
North Carolina Neurological Society
North Carolina Obstetrical and Gynecological Society
North Carolina Orthopaedic Association
North Carolina Pediatric Society
North Carolina Psychiatric Association
North Carolina Radiologic Society
North Carolina Society of Anesthesiologists
North Carolina Soc. of Asthma, Allergy & Clinical Immunology
North Carolina Society of Eye Physicians and Surgeons
North Carolina Society of Otolaryngology – Head and Neck Surgery
North Carolina Oncology Association
North Carolina Society of Pathologists
North Carolina Society of Plastic Surgeons
North Carolina Spine Society
North Carolina Urological Association

State Society / Organizations

Community Care of North Carolina
Carolinas Center for Hospice and End of Life Care
North Carolina Academy of Physician Assistants
North Carolina Community Health Center Association
North Carolina Medical Group Managers
North Carolina Medical Society

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