



***FAQs: Clinical Integration and
Accountable Care Organizations (ACOs):
For Practicing Physicians and Their Patients***

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Introduction

A key goal of federal health care reform is to transform health care delivery from the fragmented Fee-For-Service (FFS) model, which compensates physicians and hospitals on the basis of volume and intensity of services provided, to a value-based system that rewards for the improvement of population health and the lowering of costs. The mechanism for accomplishing this change will be the creation of new, clinically integrated Accountable Care Organizations (ACOs) which are now starting to be organized across the nation. The move to clinically integrated ACOs builds on the experience and investments care delivery organizations have made over the past two decades in care management and managed care contracting. The ACO concept is predicated on the belief that with the appropriate infrastructure and care management procedures in place, provider systems can positively impact patient satisfaction and clinical outcomes - while reducing costs associated with waste and inefficiency.

Much of the attention in the health care reform discussion so far has centered on Section 3022 of the Patient Protection and Affordable Care Act, the Medicare Shared Savings Program which will provide funding for Accountable Care Organizations. A second pathway for funding will come in the new Center for Medicare and Medicaid Innovation (CMMI), which will provide more flexible pathways for ACO development. However, some of the most promising efforts are coming not from the federal government, but from the private sector where clinically integrated care delivery organizations and private health insurance providers are beginning to put “value-based” contracting into place. These contracts are designed to assure patients receive safe, effective care, and that employers and employees benefit by making premium increases more predictable and in line with inflation. New payment models are emerging which combine FFS and performance-based

payment components that make providers responsible, and reasonably compensated, for the total cost of care as well health care quality.

Although Medicare ACOs may take several forms, the most anticipated form will consist of a joint venture between a set of hospitals and physicians in a clinically integrated delivery system that accepts responsibility for the quality and cost of health care for a defined population. Unlike capitation programs where patient are designated to a particular provider based on a contract enrollment, ACO patients will be assigned based on previous care patterns. Under the proposed reforms, patients will be free to choose providers as they like. Customer loyalty will be key for ACO's success since there will be no enrollment or gatekeeper function. Many of the new total cost of care contracts, in fact, contain specific provisions to guard against the inappropriate denial or withholding of care that characterized some HMO capitation experiences in the 1990s.

As health systems and physicians weigh the strategic choices offered by the road to clinical integration and Accountable Care, they need to decide whether to enjoy the status quo of FFS (assuming that remains tenable ground in the future), move to a middle ground and assure they have a clinically integrated network in place, or move decisively towards ACO leadership as many leaders are already doing. The difficulty is that the move from FFS to a designated ACO may be too large a leap for many organizations in a single stage. They will need to focus first on developing a clinically integrated delivery network to provide the foundation for Accountable Care and to establish the data systems to provide performance based outcomes measurement.

CI-NOW is a partnership between *Advocate Physician Partners (APP)* and *BDC Advisors, LLC*, to assist health care organizations in building and successfully managing integrated clinical networks. **CI-NOW** provides organizations with a set of tools and best practices, education and coaching, and the shared experience of APP and BDC physician leadership. **CI-NOW** accelerates the successful implementation of a network, and speeds the clinical efficiency results, allowing physicians to generate pay-for-performance income more rapidly and successfully.

This paper is the second in a series of Frequently Asked Question (FAQ) papers **CI-NOW** is issuing on Clinical Integration and Accountable Care. It focuses on the particular concerns of practicing physicians, who frequently face the most challenging decisions of their career in evaluating whether to join a clinically integrated network that forms the foundation of an ACO.

Dr Gary Stuck, D.O. FAAFP, is a practicing physician who is the founding President of the Advocate Christ Hospital PHO from 1995 to present, and who served as Chairman of the Board of Advocate Physicians Partners from 1998-2010. In that capacity, he played a key leadership role in the formation of the APP clinical network. APP is the largest health care provider in Illinois. It now includes some 900 employed physicians and approximately 3,000 independent practitioners, and manages nearly \$3 billion in patient care revenue

annually. His own group of seven independent primary care practitioners has been part of APP since its inception.

Dudley Morris is a Senior Advisor with BDC Advisors based in the firm's San Francisco office. Dudley Morris has over 25 years of senior consulting and management experience in healthcare and information technology companies. His practice focuses on providing strategic advice to leading national academic medical centers, integrated healthcare delivery systems, health plans, and investor owned providers.

1. What Roles do Clinical Integration and ACOs play in health reform? Are ACOs really here to stay?

Gary: The current fee for service (FFS) system is unsustainably expensive. Clinical integration (CI) and Accountable Care Organizations (ACOs) provide the most significant reforms of the delivery and financing system on the horizon. Others reforms are steps to CI and ACOs such as bundled payments, medical homes and avoidable admissions avoidance. The alternative to these changes appears to be inevitable fee reductions for both physicians and hospitals.

The common goal, therefore, is to develop systems which coordinate care and reduce costs. We think the clinically integrated system we have built in Chicago can do just that: lower costs and at the same time improve population health. Clinical integration in our market—and elsewhere—is here to stay even if there is no Medicare Shared Savings program. We don't call ourselves an ACO yet, but I think we will qualify under the CMS guidelines.

Dudley: It is true that ACOs are forming rapidly and will become a force in the market. That is already happening in most large metropolitan areas in the nation where 100 plus large, Integrated Delivery Systems serve some 40 million people. They face significant business challenges since there is no "magic bullet" that will automatically increase physician fees while waste is being driven out. A successful ACO will need to increase its number of patients or be willing to accept lower top line revenues. But since FFS will only get worse with unrelenting budget pressures, we think clinical integration and ACOs represent perhaps the last, best chance providers—particularly physicians—have to control their destiny.

2. Do I really need to get involved in Clinical Integration now?

Gary: Clinical Integration is the foundation of any ACO. You can't have one without the other. Our experience at APP is that providers will need to achieve a significant level of clinical integration before they are able to contract with health plans, or participate in any shared savings incentives program—whether it is funded by Medicare or by commercial insurance companies. After more than a decade of investment and work building our infrastructure, we have an effective, adequately funded partnership with

our hospitals, and the insurance companies who do business in our market. Clinical Integration provides an excellent opportunity to work together with the hospital as an economic unit. It is the most effective option for practicing physicians. We feel we are on a path to provide exceptional, cost-effective patient-centric care.

It was not always like this. Prior to the formation of APP in 1995, our group was involved in a failed IPA that was under-funded and had no partnership with the hospital. The hospital didn't support us and we could not afford to build the patient registry and infrastructure needed to manage care on our own. It was a disaster. We learned the hard way that you have to invest in Information technology and clinical integration and do it right. Physicians need to be prepared to invest in this—particularly their time, which can be challenging given how busy everybody is. But you have to show up at meetings, learn the rules and practice protocols, and come ready to work for clinical integration to succeed. Ideally, engaged physicians will be able to improve care to their patients and will be rewarded for their efforts.

This time our group did it right. We chose to get involved early and have been able to improve our patient quality of care while rewarding efficient providers. We have the data to demonstrate improved outcomes that our new private health insurance contracts require, and which will be a requirement to participate in the Medicare Shared Services program in 2012.

Dudley: It is important to keep in mind that Health Reform will extend coverage, but without clinical integration and ACOs, health reform does little to change the delivery of care or provider culture from FFS to a value based model. Fee-For-Service is still the dominant payment mechanism for over 70% of all physicians in the nation, and will be for some time in the future.

Gary: I had the privilege of speaking to a health system with several hundred physicians on their medical staffs in the West recently about clinical integration and Accountable Care Organizations. The physicians told me the main reason they were focusing on clinical integration was that the employers in the region could no longer sustain double digit increases in their employees' health insurance premiums. They said they were worried if the employers didn't get relief they would either close up shop or move their jobs out of state. That prospect would be devastating for the community. So the physicians felt they had to do something.

This made an enormous impression on me since most small or medium sized businesses in Chicago have the same problem. From my perspective as a practitioner the question is, "How could any physician not be interested in clinical integration and ACOs?" It's certainly preferable to rate cuts or further declines in coverage in commercial insurance programs.

3. What is the Care Delivery Model that will be used for Clinical Integration and ACOs?

Gary: At APP we have developed what we call **AdvocateCare**, which is an approach that puts the physician front and center of the continuum of care with the goal of moving from a FFS model to a Fee-For-Value model. **AdvocateCare** will become the single model of care across our entire system reflected in all of our contracts, and will eventually cover 100% of our patients. We believe that a successful ACO model will require collaboration and innovation with insurers, provide for risk-adjusted cost of care, and build in shared savings incentives.

Our value model is designed to improve access to primary care services, reduce avoidable readmissions, eliminate potentially avoidable admissions, better manage inpatient care delivery, and offer a “perfect transition” program when patients leave the hospital and go home. APP plans to use this model in all future contracting with payers whether they are commercial health insurers or Medicare or Medicaid ACOs.

APP has learned that, to be effective, ACOs will have to be flexible enough to deal with payers who have dominant payment systems of either FFS or capitation. If your organization is effective, you should be able to negotiate a common set of performance measures with all managed care organizations. A decade ago, each organization in our market had its own measure of success. It was a nightmare of complexity. By identifying and getting payers, hospitals, and physicians to agree to a single set of measures, with standard definitions and data collection mechanisms, we have been able to drive quality improvement across a broad range of measures.

Dudley: From CMS’s point of view, it appears there are really three basic alternatives for physicians in health care reform:

1. Rely on the status quo and do nothing----which may prove unsustainable over the long term given federal efforts for change and could hasten fee reductions;
2. Participate in Medicare Advantage and begin the shift to capitation or bundled payments which might be problematic for independent practices without a care management infrastructure; or
3. Join an ACO which has the resources necessary to support clinical integration.

“Fee-for-Service is dead” is one of the most popular one-liners for government health planners these days. Participation in a clinically integrated network, however, is a good middle ground since ACOs can’t succeed without them. The core of the new model is

the integration of acute care, primary care and specialty systems, and participation in a clinically integrated network may be the best option for the practicing physician regardless of what the final payments mechanism turns out to be.

4. What About Governance? Is there a preferred Organizational Structure for Clinical Integration and ACOs?

Gary: According to CMS, there are a variety of organizations which will be able to qualify as an ACO including physician groups and networks, hospitals employing physicians, and partnerships and joint ventures between hospitals and physicians. Moreover, the Secretary of HHS is given enormous discretion in deciding what kinds of ACOs will be approved for the Medicare Shared Savings Program.

But whatever the type of organization used to achieve clinical integration, physician input in governance is essential. There needs to be a cross-section of all classes of physicians in governance: employed as well as independent practitioners, primary care as well as specialists. Each one of the 10 APP affiliated hospitals has its own PHO with its own local board. We have well over 100 physicians involved in governance. Physicians are represented at the local level and on the APP Board. A super majority vote is required for decisions, but most votes are unanimous given the high level of participation and trust in the organization. We give our board members reasonable compensation to create appropriate accountability for their time so there is no excuse not is prepared to participate in business and governance affairs.

5. What Are the Membership Requirements?

Gary: Generally they are fairly standard—collecting and sharing clinical data from the practice, working on clinical improvement efforts, and a willingness to adopt common information systems, participating in Pay-For-Performance contracts, and abiding by common performance standards. Typically, there will be an Operating Committee for the Clinical Network which will finalize membership requirements as the ACO project proceeds.

Dudley: Most at risk medical groups and IPAs require primary care practitioners to be exclusive because without this control they cannot manage care and provide a successful product. But specialists such as cardiologists are generally allowed to contract with multiple providers outside the group until the patient base is large enough to sustain their practice. Some sub-specialists may never be exclusive.

6. How Will Patients Be Attributed or Assigned to a Clinically Integrated Network or ACO?

Gary: Our patients at APP are identified from our various commercial contracts or how they come in the door for Medicare. We have not seen any change in this with clinical integration nor do we expect a change when a Medicare ACO is certified. Current CMS draft plans indicate patients will be assigned by based on frequency of visits to primary

care physicians first, and then to medical specialists, and thirdly to surgical specialists. Accountability for attributed patients will lie within the ACO—in our case APP—not with an individual practitioner. It is expected physicians will refer mainly within the system, and significant communication with patients is done to encourage that.

At APP we make it clear that patients are attributed to a particular contract—not assigned. The choice of contracts is up to the patients when they make their selection at work. CMS is expected to reinforce this distinction.

7. What about my patients? Won't they just think clinical integration or an ACO is just another type of HMO?

Gary: If clinical integration and ACOs are going to be successful they will need to become a “program of attraction not a program of assignment.” The Patient Protection and Affordable Care Act makes a big point about preserving patient freedom of choice and not forcing patients to get their care from a narrow group of providers.

But freedom of choice represents a major challenge in clinically integrated networks if your program is not able to build and maintain patient loyalty. One of the main reasons for clinical integration is the recognition that to succeed we need to deliver high patient satisfaction. That is our ultimate test.

8. What are the types of financial arrangements are included in CI/ACO contracts? How will performance be rewarded?

Gary: APP has developed a Pay-For-Performance (P4P) incentive plan to reward clinical integration efforts. A crucial success factor of the funding model, of course, is to recognize physicians and their staffs for the extra work they are doing in participating in clinical integration, quality and efficiency initiatives. The incentive funds to reward physicians for this work and their accomplishments are pooled and distributed in addition to the regular FFS compensation which is paid directly to physicians by the insurance companies. Each local PHO has input into the process by which the clinical measures and incentive fund distribution rules are set by APP's Board of Directors. .

Individual incentive allocations make up 70% of the P4P fund's total; 30% is distributed for group performance as a whole (local physician hospital organization) according to criteria established by the APP board. In 2009 the P4P funds amounted to approximately 10% of each PHOs total allowable billings. All of the major players in the market contribute to the funds, and they are the basis for rewarding physicians who meet or exceed their clinical performance targets. APP's board allocates some of the funds to support our clinical infrastructure needs, with the remainder going to physician incentives.

Under the new **AdvocateCare** model, APP will in 2011 assume responsibility for the coordination and trend in the total cost of all inpatient and outpatient care for attributed BlueCross/Blue Shield patients in all PPO contracts. This new contract will

require APP to make significant investments in infrastructure to assist physicians in managing patients, but will potentially increase the amount of funds which can be shared for performance.

Dudley: In one new total cost of care contracts, efficiency savings are retained entirely by the providers. In other contracts, the saving will be split with the commercial insurer since they are already providing support for the infrastructure needed to support clinical integration. One of the advantages of the new shared saving contracts is that they tend to be longer than two years, and are designed to provide more predictable cost increases for insurers that will help them maintain sustainable premiums.

These agreements appear to be very much like the type of ACO contracts envisioned under the Medicare Shared Savings Program. In Medicare ACOs, it appears some form of bonus/withhold model will become the dominant arrangement since it would be seen as most likely to generate savings for Medicare. Payments could still be tied to current FFS arrangements. Organizations could distribute incentive funds to practitioners if they have the infrastructure in place to handle surplus distributions.

9. What Risks Are Involved?

Dudley: The federal government also appears to be taking pains not to implement new regulations which will hamper or deter organizations already providing some type of Accountable Care. Medicare ACOs which decide to continue to operate under current insurance models *will not incur any additional risks* for losses if spending exceeds targets. This is the most incremental approach with fewest barriers to entry. It is the preferred strategic option open to organizations who have not built the infrastructure necessary to support a clinically integrated network. It is unlikely, however, that CMS will provide much opportunity for shared savings under this model.

A second level of ACO funding will add more rewards but also introduce some limited risks. Finally, under a “partial capitation model”, the ACO will receive a bundled mix of FFS and capitation revenues. If the ACO was successful in meeting its performance budget there would be greater financial reward--but if they fail, they will incur more economic downside. CMS intends these three options to be the major pathways to shift from FFS to Accountable Care.

Gary: It seems unlikely CMS will sign partial capitation agreements with any clinical network that does not have substantial risk management experience. Everybody remembers the experience of organizations in California that got into the capitation business early and got burned. Many of these organizations have now folded their capitation contracts and returned to more predictable FFS--just the opposite of what CMS apparently wants to accomplish.

10. Where will the performance data come from?

Gary: All clinically integrated networks must create a robust Information Technology (IT) infrastructure—a *Clinical Integration Registry and Performance Reporting System*. This may require acquisition of new applications as well as interfacing legacy systems together. The IT infrastructure will always include a *Population/Disease Management Registry*—APP has a proprietary system it has developed—that collects clinical and operational data from a variety of sources including (i) claims data; (ii) pharmacy data; (iii) hospital and clinic data; and (iv) office ‘feeds’. This data is then mapped to patients and providers of care and provides the data for care management. Performance reports are then used to determine incentives earned. Generally, the IT infrastructure must include high speed internet access, electronic data interchanges, Computerized Physician Order Entry (CPOE) and electronic medical records, electronic ICU use, e-Prescribing, software to analyze practice patterns, and ample systems training and support for staff.

Dudley: Information technology is the largest single investment an organization will need to make in developing a clinically integrated network—so most organizations will need a thorough clinical integration readiness assessment before determining whether to pursue an ACO type of contract.

11. What do I have to do to be successful in clinical integration?

Gary: The key to successful clinical integration participation is to understand the science and reasoning behind each protocol or treatment initiative adopted by your clinical network, and then training and empowering your office staff in identifying patients needing services or interventions relating to the initiative—and then tracking and planning to progress against these goals.

The quality reporting capabilities that will be built into the clinical network will allow you to demonstrate to employers and payers that the network is providing true value for their constituents. By being able to differentiate care based on quality our practice has been able to protect and grow its patient base. We have been provided the tools to practice better medicine.

12. If clinical integration focuses on eliminating waste and unnecessary services, doesn't that mean less dollars? How will we make up for the lost volume?

Dudley: Most “low-hanging fruit” to be eliminated will come in the reduction of ER utilization, or reduction in unnecessary inpatients/admits/readmissions and patient days or a shift to less costly sites of care for services such as imaging or surgery. Initially as much as 25% of savings in some contracts are estimated to come from eliminating unnecessary inpatient days.

Patient channeling can actually increase certain volumes, and primary care physicians will be incented to refer to efficient sub-specialty and ancillary providers within their

clinical network. But it is clear that unless the ACO is providing competitive value that will draw more patients there eventually may be lower top line revenues for some providers. Fixed costs mean revenue reductions can hurt the bottom line unless costs come down equal to or greater than the lost revenues. So be careful of “the law of unintended consequences” when you put new quality initiatives into place.

Gary: Our model of care at APP will mean more work for some, such as primary care physicians, and less work for others from existing referral sources. Key success factors for our medical staff will include: (i) growing market share by expanding our participation in managed care products, and (ii) more closely aligning with our physicians to gain a greater share of their admissions.

13. Why should I want to join a clinical network? What benefits will my practice receive?

Gary: It’s a challenging time to practice medicine. There has never been a better time to consider joining a clinically integrated network to prepare for Accountable Care. The APP clinical integration program has created value for physicians, hospitals, payers, employers and our patients. For example, the current FFS model does not reimburse physicians adequately for activities such as chronic disease management, preventive counseling and care coordination. A clinical integration program can address these shortcomings through improved contracting, bundled payments and infrastructure payments.

Our health system liability costs are less than half of what they were five years ago. Electronic claims processing has provided significant administrative savings over manual processing. Electronic prescribing, which highlights opportunities for substitution of generic drugs, makes things easier for physicians. Preparation for reimbursement change to ACOs and bundled payments would have been impossible for our group to handle alone. In addition, the transparency of outcomes reporting contributes to quality even though some of our practitioners find comparisons intrusive.

Finally, our practice’s financial performance has improved significantly. This spring APP will distribute \$51 million from commercial insurance contracts to our aligned physicians for their performance in 2010, up from the \$38 million distributed in 2009. We distributed performance bonuses to physicians for hitting performance marks that averaged about 10% of their allowable billings. And this was before any share of savings from efficiencies that will be provided in new total costs of care contracts.

14. Are we ready? Where do we go from here?

Dudley: The initial step in getting started is generally for a health system and its physicians to perform an ACO readiness assessment. The methodologies developed by BDC Advisors and **CI-NOW** have identified 14 critical leadership and infrastructure requirements for successful clinical integration and ACO development. The VHA (Voluntary Hospitals of America), and the American Hospital Association have compiled a similar lists.

These requirements include an assessment of the strength of system governance, executive and clinical leadership, primary care base, organization design, of provider networks, quality and reliability of patient care, care management, information technology, financial resources, population risk management ability, physician employment and practice management capabilities, and market conditions. Much of the value assessment occurs through discussion with physician and management leadership about the capabilities needed for a successful ACO development, and whether there are particular critical deficiencies that form serious barriers to ACO development.

However you do your assessment, it will be important to have a comparable data base of how your organizations measures against other clinically integrated networks who are also going to become ACOs. CMS will be looking at a similar set of indicators, when they make their own ACO assessments---and it will be important to know how you stand before you accept any new risk.

Gary: This is clearly not a “business as usual” environment. In our market there are hospital admissions splitters who are going to need to find a system to be aligned with if they intend to participate in the new clinically integrated and accountable care networks, and qualify for shared savings incentives. I think the key choice is to decide who you are going to align with—and be prepared to do it and move forward. As we said earlier, there are going to be a lot of different options in the market. The “business as usual” option is the least sustainable choice for the practicing physician.

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