Accountable Care Organizations: What Do They Mean for Emergency Medicine?

an Information Paper

Developed by Members of the Emergency Medicine Practice Committee

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Background

With the passage of the Patient Protection and Affordable Care Act (PPACA) in 2010, the concept of Accountable Care Organizations (ACOs) became a model for the future of American health care. According to the Centers for Medicare and Medicaid Services (CMS), ACOs are “groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high quality care to their Medicare patients.”

The goal of an ACO is to create seamless, coordinated care that is intended to result in improvements in quality and cost efficiency by creating incentives for health care providers to work together to treat an individual patient across care settings, from doctor’s offices to hospitals to long term care settings. By participating in ACOs, providers of health care services will be better positioned to accept shared savings granted through gainsharing arrangements.

The outlined plan calls for a group of health care suppliers and providers to formally apply to CMS for inclusion in the program as an ACO. There are certain features of potential ACOs that must be present in order to be considered for participation. The minimum number of patients covered by the ACO is currently set at 5000 Medicare beneficiaries. ACOs must have “invisible enrollment.” This means that patients do not have to choose to take part in the ACO and are not formally enrolled. It is the care providers who must meet the guidelines of the ACO, not the patients. Measurement of performance will be a key aspect of ACOs. ACOs will need to meet specific quality, efficiency and patient satisfaction measures established by CMS. Organizations that fail to meet these standards will be disqualified from the third key aspect of ACOs, “shared savings.” The ACO, if successful in controlling health care costs in comparison to historical controls, will be entitled to share the savings with Medicare (ie, gainsharing). How these financial reimbursements are distributed to health care providers is to be determined by the ACO.

ACOs differ significantly from managed care organizations (MCOs) of the past. The responsibility for controlling health care delivery costs in MCOs lay primarily with the insurers themselves. These capitation systems allocated a fixed dollar amount per covered life to cover health care associated costs. Insurers who were able to limit costs by lowering beneficiary utilization were financially rewarded. In addition, in the MCO model, beneficiaries elected to participate in the MCO and abided by the rules set forth by the MCO. ACOs do not require patients to actively enroll in the program, and there is no requirement for patients to stay within the ACO for their care. While ACOs are designed to apply to Medicare patients, almost all payers are now requiring health care providers and suppliers to comply with set quality standards in order to qualify for payment.

The Current State of ACOs

Prior to the passage of the PPACA legislation, a handful of large integrated health care systems (eg, the Cleveland Clinic, Mayo Clinic, Intermountain Healthcare and Geisinger Health Systems) participated in
bundled payment pilot projects for selected disease or elective surgical conditions.\textsuperscript{4} Presumably the success of these pilots was the reason for inclusion in the ACA legislation. However, none of these health care systems have chosen to participate in the Pioneer ACO Model, citing concerns about the regulatory burden and requirements that did not impact patient outcomes.\textsuperscript{5}

In January 2012, 32 ACOs were selected as part of the Pioneer ACO Model by CMS to begin reporting data and quality measures. They include:

- Allina Hospitals & Clinics
- Atrius Health Services
- Banner Health Network
- Bellin-Thedacare Healthcare Partners
- Beth Israel Deaconess Physician Organization
- Bronx Accountable Healthcare Network
- Brown & Toland Physicians
- Dartmouth-Hitchcock ACO
- Eastern Maine Healthcare System
- Fairview Health Systems
- Franciscan Health System
- Genesys PHO
- Healthcare Partners Medical Group
- Healthcare Partners of Nevada
- Heritage California ACO
- JSA Medical Group, a division of HealthCare Partners
- Michigan Pioneer ACO
- Monarch Healthcare
- Mount Auburn Cambridge Independent Practice Association
- North Texas Specialty Physicians
- OSF Healthcare System
- Park Nicollet Health Services
- Partners Healthcare
- Physician Health Partners
- Presbyterian Healthcare Services–Central New Mexico Pioneer ACO
- Primecare Medical Network
- Renaissance Medical Management Company
- Seton Health Alliance
- Sharp Healthcare System
- Steward Health Care System
- TriHealth, Inc.
- University of Michigan

To be eligible, organizations must provide services based via one of the following models:\textsuperscript{3} providers in group practice arrangements, networks of individual practices of providers, partnerships or joint venture arrangements between hospitals and provider groups, hospitals employing providers, or Federally Qualified Health Centers (FQHC).
Additional requirements include:

- Participants must have a minimum number of 15,000 beneficiaries who must be enrolled in traditional Medicare (not Medicare Advantage plans); rural programs require only 5,000.

- Participating organizations must obtain 50% or more of their revenue from other payers, such as commercial insurers, employers or Medicaid. By the end of the second year of the program, the Pioneer ACOs will have to demonstrate similar cost savings with these payers. Participating ACOs that demonstrate cost savings in the first two years can then proceed to a bundled payment model. This is a per-beneficiary per-month payment intended to replace the fee-for-service (FFS) model.6

- By the end of year 2012, 50% or more of primary care providers in the ACO will have to attest that they have met requirements for meaningful use of electronic health records in order to receive further payment.7

From a quality perspective, the participating ACO will be monitored under the same quality measures as the Medicare Shared Savings Program. The Shared Savings Program is designed to improve beneficiary outcomes and increase value of care by:

- Promoting accountability for the care of Medicare FFS beneficiaries
- Requiring coordinated care for all services provided under Medicare FFS
- Encouraging investment in infrastructure and redesigned care processes

So how are they doing so far? Some ACOs have pointed out the importance of open communication with employees in their system about how health care delivery is changing, the eventual evolution of payment models, and the role of ACOs.9 Other ACOs report that so far most of the advances have been operational, including programs for the elderly and developing nursing programs within the community. The most optimistic feel it will be many months before they are ready to see the results of their work.9

In the first four months of 2012, the initial participating ACOs combined with Medicare Shared Savings Programs have achieved a 3% Medicare market share, representing more than 1.1 million Medicare beneficiaries.10 In a recent article in the New England Journal of Medicine, authors surmise that because of geographic variations in spending growth, Medicare's use of national growth factors to set spending targets could cause ACOs in a particular hospital referral region to gain or lose financially without changing anything in the way they deliver care. Using data estimates from Dartmouth Atlas for each hospital referral region of the 32 Pioneer ACOs, they found that ACOs in low growth, low spending areas had the greatest advantage and those in high growth high spending area the least. The amount that could be gained or lost from the two groups varied by as much as 14% in their model.11

As ACOs mature, many questions remain. Will there be enough cost savings to the organization to make the upfront expenses of starting an ACO viable? Which ACO model works best, ie, physician practice model, hospital based model, or an insurance carrier model? Will monitoring and reporting of stated quality indicators be onerous and restrictive to the way physicians wish to practice? Will patient care be improved? Will necessary testing be limited? Will patients like the concept or will it be so seamless that they are wholly unaware that they are even participating? And finally, where does emergency medicine fit into the model?
Potential Impact on Emergency Medicine

By virtue of its prominence at the beginning of the cycle of care, it is difficult to imagine emergency medicine not playing a central role in the success of ACOs. However, the exact details of how the emergency department (ED) will operate within an ACO or in partnership with an ACO is speculative at this point. Emergency medicine has thus far received scant attention in both the initial guidelines for ACOs set forth in the PPACA as well as the final regulations released by the Department of Health and Human Services in October 2011.4

The effect ACOs could have on emergency care has yet to be determined. There are several broad areas to consider: utilization of emergency services, coordination of care, implementation and adherence to quality metrics and provision of mandated services, and the financial impact on emergency medicine.

Emergency Care Utilization

One important question to be addressed is whether the ascendancy of the ACO model will challenge the “prudent layperson” standard in which the patient determines what a medical emergency is. ACOs are often heralded as a mechanism through which unnecessary or inappropriate ED visits could be minimized. The implication is that within an ACOs bundled payment structure, financial incentives are such that patients may be directed towards alternative sites of care if the condition is deemed to be non-emergent. However, it remains unclear who will make this determination and what barriers patients who seek emergency care will face either directly or indirectly. A further question is whether this will conflict with the federal mandate to provide care under EMTALA.

Care Coordination

Coordination of care with primary providers will be an important component of working with or within an ACO. On the front end, triage systems will take on greater importance. Call centers or other services such as telemedicine are opportunities for growth and a potential role for emergency medicine. Likely, there will continue to be growth in alternative sites of care such as urgent care, fast-track units, free-standing EDs, retail minute clinics, etc. However, the challenge will not only be to provide timely and consistent care (particularly during weekends and evenings), but also to ensure that these services are well-integrated with each other and within the ACO. Of particular importance will be investment in information technology infrastructure in order to improve care coordination. Unfortunately, this may raise the upfront cost of establishing or participating in an ACO.

Ultimately, in order to improve care coordination, emergency medicine may need to diversify the options available for management of patients evaluated in the ED who are not admitted as inpatients. Observation units are a promising area for growth, as are ED-run follow-up clinics and follow-up call centers staffed by physician assistants, nurse practitioners, or nurses. Home health services represent another opportunity for emergency medicine to improve transitions of care. EDs will most likely have to devote more resources to case management to coordinate referrals to rehab and skilled nursing facilities (SNFs), visiting nurse services, and other outpatient management tools and services such as Holter monitors or peripherally inserted central catheter (PICC) lines. Emergency medicine and ACO administrators will
need to coordinate efforts to identify additional opportunities for improving the value of care provided. For example, consideration should be given to lobbying CMS to exempt ACOs from the long-held requirement that Medicare beneficiaries be admitted to the hospital for a minimum of three days before they can be admitted to a SNF.

There is reason for optimism that emergency medicine can rise to the challenge of integrating itself successfully within a broader system. Elliot Fisher has cited the success of emergency medicine in helping establish networks of regional trauma centers as well as working in close partnership with state and local EMS providers. Another area in which EDs have begun to show dramatic ability to improve care management and control effective resource utilization is in the creation of community care plans. Many EDs have a small group of patients who constitute a disproportionate percentage of their ED visits and who could, through proper medical management in partnership with local community providers, be better managed with lower resource utilization. ED groups across the country have begun developing care plan programs, often with noticeable success when measured by decreased ED utilization and decreased medical costs.

Another potential area for ED involvement is in creation of accepted community standards of care. Patients with certain medical conditions (eg, COPD, CHF, cellulitis) tend to have recurrent exacerbations of their conditions that lead to frequent ED utilization. By working with ACOs to determine goals of ED care, including alternatives to admission such as observation admissions or next day community follow-up plans, EDs may be able to provide just as good, if not potentially better care at a much lower cost.

Quality Indicators

Improving health care delivery is a driver of ACO development. As quality indicators for care delivery are being developed, the measures used to evaluate care delivered within an ACO (including within the ED) have yet to be determined. For example, the role of emergency care in the acute management of a chronic disease episode has not been clearly defined. The exacerbation of chronic disease is often seen by payment policymakers as a “potentially avoidable complication,” and the care delivered to these patients in the ED has yet to be valued appropriately.

In addition, as payment policies increase pressures to decrease hospital re-admissions, there will likely be strong incentives to avoid or delay hospital admissions. How will this affect ED operations, as emergency physicians are often the decision makers regarding hospital admission? Furthermore, there may be different perceptions of risk among the physician groups that have a stake in the patient’s cycle of care. Will the financial risk of failing to meet targets be spread evenly across groups within the ACO? What about the medico-legal liability of inappropriate or adverse disposition decisions -- will this also be shared across the ACO? What role will patients themselves and their families have in these disposition decisions? These are critical questions that must be addressed going forward.

Another important consideration is the concept of ED “mission-creep” and the potential expectation that EDs provide a panoply of mandated screening, counseling and education to ED patients. Many such targets (such as depression screening, aspirin use and tobacco counseling) are perhaps best suited to the
primary care setting, as inclusion in the ED visit may undermine the ability of the ED to effectively carry out its core mission. Measured discussion regarding any such proposed ED requirements is essential.

Financial Impact on Emergency Medicine

There has long been a consensus that value-based and bundled purchases of medical care hold much promise in controlling costs and delivering better quality care. However, important questions remain about how shared savings (and losses) will be distributed across the ACO, specifically with regards to the ED.

The main body of experience with population-based, bundled payment emergency care comes from the pre-paid health care models of the late 1980s and 1990s. Unfortunately, much of this experience is unlikely to be directly applicable to ACO design since pre-paid care was based on a narrowly defined, risk-adjusted patient population while an ACOs patient population isn’t known until after the measurement period. Pre-paid care also restricted the patient to a narrow choice of providers while ACOs must allow the patient to see any provider he or she wishes. Nevertheless, the pre-paid capitation model is the closest example available to assist in defining the value of emergency care in a bundled payment model, and should be examined when considering how emergency medicine might fare in an ACO model.

A typical cost breakdown of a pre-paid managed care model for physician services included 23% of premium allocated to primary care, 56% to specialists (including EM), 14% to ancillary services and 7% to administration. Individual per-member per-month capitation rates were calculated according to the following formula: (Per Member Utilization Rate x Fee for Service Rate)/12.

The pre-paid capitation model valued all emergency care services, both facility and professional components, at something less than 4% of premium cost. Emergency physician per-member per-month payments ranged between $0.44 and $1.50 with facility payments making up the balance of the 4% at an assumed utilization rate of 0.37 visits per member per year. To calculate the appropriate capitation amounts today one would need to adjust for inflation, the current utilization rate and the increase in average emergency physician compensation. In an ACO model, age, risk and out-of-network adjustments would have to be made after the fact because it is only then that the measurement population is known. Given the potential variation and numerous unknown factors, accurately forecasting the financial impact on emergency medicine is difficult at best.

Beyond calculating the value of emergency medicine within an ACO model, consideration must also be given to the impact of ACOs on ED utilization and revenue generation. Emergency medicine is a flow-based business and if decreasing ED utilization is a consequence of the ACO model, there are likely to be important financial repercussions for emergency medicine. Will reduced volume necessarily lead to a decrease in revenues? Will shared savings from participation within an ACO make up some of this difference? An interesting possibility is that the acuity mix may shift towards sicker patients and perhaps result in higher average margins for the ED that may partially offset the reduced volume. Finally, the concomitant introduction of expanded insurance coverage through provisions of the ACA may actually lead to an increase in national ED volume. The overall financial impact on emergency medicine is therefore uncertain at this point.
Another challenge to consider will be how emergency groups will exist within the ownership and management structure of an ACO. Large hospital groups and integrated health systems are better organized and capitalized and therefore have a substantial advantage in forming and financing the transition to ACO. However, many emergency physicians are not hospital employees, but work for smaller independent practice groups that contract with hospitals. They may have limited leverage, both financially and with regards to governance, to become full partners within an ACO. Preserving the autonomy of these smaller practices as they attempt to integrate with larger hospital-owned practices will be a major challenge going forward.

**Recommendations**

We believe that emergency medicine groups must be at the table with their hospital and health care system during the design and implementation of an ACO strategy. Failure to actively participate as these programs are organized could have dire consequences for emergency medicine, as ED care is almost reflexively viewed as a high-cost service that should be limited. In addition, ACOs are uncharted territory, so there is ample opportunity for the emergency physicians to mold the program to better suit the needs of their patients and their groups.

When considering participation in an ACO, emergency medicine groups should pay particular attention to the following:

- Patient diagnoses and clinical metrics that indicate the need for care.
- A complete picture of the patient’s total health care experience, including clinical records, claims data, and information gathered from and shared with other area providers
- Comprehensive health plan and provider performance data.
- Payer analysis across various patient populations
- Accounting and allocation of all revenue as directed by the ACO reimbursement model.

On a broader scale, as emergency medicine navigates through the development and implementation of ACOs, leaders must remain mindful of the myriad potential effects on the specialty, including alteration in the utilization of emergency services, creation of new opportunities for care coordination, introduction of new measures of quality, and the emergence of additional threats to revenue generation.

Whether ACOs will achieve their shared savings objectives or become the dominant medical services delivery model of the future remains to be seen. The impact ACOs will have on emergency medicine is similarly difficult to predict. However, active participation in development projects helps to ensure that emergency care will be maximally valued within these new care delivery systems.

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References