

Preparing for the Arrival of Accountable Care Organizations

Executive Summary:

- Proposed rules for ACO's were issued at the end of March and are undergoing comments presently
- ACO organizations will likely be widespread and have a large impact on healthcare
- Primary care physicians and specialists will be affected by ACO organizations, whether the group is an ACO member or not
- PCP and specialists should move to adopt the quality measures of ACO organizations due to the widespread impact of ACO's
- ACO's are legally formed provider organizations which focus on coordination of care, quality measures and share in saved savings with CMS

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As healthcare providers wait for the final rules for forming Accountable Care Organizations now is a good time for healthcare providers to begin adopting the processes, tools, measures and guidance laid out in the initial rules document. It is likely that CMS will begin signing agreements with ACO organizations sometime in 2012.

Some wonder whether Congress will find a way to stop the development of CMS's ACO program? Based upon my knowledge of what is occurring in Michigan and in other areas of the country, I find that many organizations believe that CMS will find a way to fund oversight of ACO's. The three major hospital-physician groups in Grand Rapids are already preparing to apply for ACO status. The University of Michigan is engaging independent physicians across the state to form an ACO. U of M is providing leadership in the development of ACO's; Dr. Caroline Blaum, Associate Chief of University of Michigan Faculty Group Practice will be one of the featured faculty at the second annual National Accountable Care Organization Summit being held in Washington June 26-28 (find out more at [www.acosummit.com](http://www.acosummit.com)).

Given the fact that many organizations are forming ACO structures now, I believe that it is important that physician practices and other healthcare organizations start planning for their arrival, both those groups planning to become a part of an ACO and those who are not planning on becoming a part of an ACO. Whether you are becoming a part of an ACO or not, your organization will be affected in some way. For those becoming a part of an ACO, the governance structure in the ACO rules and the quality and reporting requirements of the rules will have a high impact on you. Primary care physicians who do not plan on becoming a part of an ACO and who have a substantial number of Medicare beneficiaries in their practice will be impacted by the CMS Value Based Purchasing Program soon, if not already. By pursuing the measurements of quality in the proposed ACO rules, such a group will ready itself for the advent of such payment programs; fee-for-service will certainly be curtailed and replaced or modified by pay based upon value of services delivered. For specialists, such as a pulmonologist, whether

becoming a part of an ACO or not, it will be necessary to support the efforts of primary care physicians who are part of an ACO. The specialist should view the PCP's as their suppliers and act to support the PCP organization in achieving the goals of its ACO.

Since the ACO structure will have a broad impact, let me lay out a few of its salient features, especially those that are related to quality and measuring quality. First, with what kind of organizations will CMS sign an agreement as an ACO? The proposed rule lists four types:

- ACO professionals in group practice arrangements
- Networks of individual practices of ACO professionals
- Hospitals employing ACO professionals
- Such other groups of providers of services and suppliers as the Secretary of HHS deems necessary.

ACO professionals are defined as physicians, nurse practitioners, physician assistants and clinical nurse specialists. From further reading, I am almost certain that CMS will not contract with an organization that does not supply primary care services to its patients. CMS will certainly want primary care support for its beneficiaries who are in ACO organizations.

Next, what is the intent of CMS in signing agreements with an ACO organization? It is as quoted from the proposed rules "to promote accountability for a population of Medicare beneficiaries, improve the coordination of FFS items and services, encourage investment of infrastructure and redesigned care processes for high quality and efficient care delivery, and incent higher value care." The provider must be patient-centered. The rules draw upon the goals listed in the Institute of Medicine's *Crossing the Quality*.

Namely, providers should supply care that is

- Safe
- Timely
- Patient-centered
- Effective
- Efficient
- Equitable

Based upon these goals, CMS has listed 65 indicators with accompanying descriptions of how they will measure the indicators. CMS will grade providers on these outcomes based upon benchmarks from providers who are not in ACO organizations. If the ACO exceeds these benchmarks significantly it will be rewarded financially for the savings that it provides CMS. The 65 indicators will be adjusted for regional outcomes and on other factors which can impact the ACO. Success in achieving the measures will be based upon the population level outcomes for patients of the ACO who are Medicare beneficiaries.

Some of the measures are:

- Controlling cholesterol levels of the patients with coronary artery disease
- Controlling blood pressure of patients with hypertension

- Achieving patient satisfaction on a number of factors as measured by Clinical/Group CAHPS
- Achieving A1c levels below 7% for diabetics

Providers will need to take a thorough examination of processes and population level outcomes to achieve these goals and make changes in their processes in order to reach the goals. Advantage Health of Grand Rapids in conjunction with Saint Mary's Health Services is becoming certified as patient-centered medical homes by NCQM in order to achieve the level of outcomes specified by CMS. Dr. David Blair of Advantage Health and Roberta Jelinek of Saint Mary's recently outlined this approach at the Michigan Medical Group Managers Association's spring conference. Another successful approach is to use a Lean Healthcare approach which is based upon the Toyota Production System and is becoming more widespread in healthcare as more individuals are being trained and certified in this area.

Let me end with a personal example of good coordination of healthcare services. Usually after my annual physical I ask my physician to have his staff arrange an appointment with a dermatologist if he and I agree that there are some moles on me that are suspicious. I seek the help of a dermatologist as my twin sister died from melanoma some years ago. We both grew up in Texas and were both exposed to the sun a great deal in our youth. Once my dermatologist is done with the exam, he verifies who my primary care physician is so that a summary of findings can be sent to him. Also, my dermatologist call me within two days with the results of any biopsy. At my next annual exam, my physician reviews the dermatologist's findings with me again. I find it very encouraging that the dermatologist makes an extra effort to be sure my physician is up to date with the findings. Under the rules of an ACO, such coordination will become commonplace. Can your site achieve such outcomes? I believe it will be necessary to do so soon.

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If you need a speaker to present at a meeting or conference, please contact me and I will consider doing so.

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