Unveiling the Unicorn: A Leader’s Guide to ACO Preparation

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EXECUTIVE SUMMARY

The great uncertainty surrounding healthcare reform provides little incentive for action. However, as healthcare leaders wait for final rules and clarity about accountable care organizations (ACOs), inaction is the inappropriate response. Several central themes emerge from research about beginning the ACO process. Leaders should be able to understand and articulate ACO concepts. They should champion embracing cultural change while partnering with physicians. Inventory of skills and capabilities should take place to understand any deficiencies required to implement an ACO. Finally, a plan should be formed by asking strategic questions on each platform needed to ensure performance and strategic goals are at the forefront of decisions regarding structure and function of an ACO. It takes a visionary leader to accept these challenges.

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One of the most discussed and transformational elements of healthcare reform included in the Affordable Care Act (ACA) of 2010 is the accountable care organization (ACO) model. At a recent meeting of the North Texas chapter of the American College of Healthcare Executives, Doug Hawthorne (2010), FACHE, CEO of Arlington-based Texas Health Resources, said of ACOs, “They are like unicorns. They are mythical creatures no one has ever seen.”

Neil Godbey (2010), president of The Godbey Group, characterized ACOs by saying, “Everyone wants one, but no one knows what one is.”

These sentiments are due to two circumstances. First, an ACO can take many forms, which makes it difficult to know how to define one. Second, as of this writing, the US Department of Health and Human Services has not yet released final rules and regulations for ACOs. This lack of information has paralyzed many leaders.

Because of the vast uncertainty at hand, the challenges for healthcare leaders have never been greater. For the nimble healthcare leader, however, opportunities have never been more abundant. As rules for ACOs are still being finalized, executives should be making certain timely steps now to prepare their organizations. Many suggestions and models have emerged from the recent literature that can help leaders plan for, prepare for, and implement this new care model. Although the suggestions vary, similar themes arise that are valuable to any organization preparing for ACO implementation.

**STEP 1: TALK THE WALK—UNDERSTAND AND ARTICULATE THE CONCEPT**

Although all the rules have not been decided, some defined criteria for what constitutes an ACO do exist. Healthcare leaders should be able to articulately define an ACO. Elliott Fisher, MD, director for the Dartmouth Institute Center for Health Policy Research and one of two people credited with developing the original concept, defines an ACO as “a local network of providers that can manage the full continuum of care for all patients within their provider network” (Ronning 2010). A less vague phrasing is, “a type of reform model in which financial incentives are provided to reward lower costs and higher quality through collaboration and integration of care and providers.”

CMS (Centers for Medicare & Medicaid Services) has been working through demonstration groups to test payment reform with integrated delivery models. One program that lays some foundation for ACOs is the Medicare physician group practice demonstration. In this demonstration, physician groups were incented to reduce costs per Medicare beneficiary by sharing a bonus payment for meeting certain performance goals. This demonstration program helped CMS create some of the ACO rules. Although an ACO can have different rules for commercial payers than for providers, CMS has established a program based on Medicare, the Medicare Shared Savings Program (SSP). This voluntary program will be open to ACOs beginning January 1, 2012. The SSP model calls for a separate legal entity to be created that represents all providers.
in the ACO. The entity will distribute savings to the ACO, which then distributes it to the providers. Organizations that qualify as ACOs under SSP will sign three-year contracts that may commit them to supplying data to CMS about quality and claims (Ronning 2010). Savings will be calculated based on the difference between a projected cost and a target cost to treat each patient. If the ACO hits the target, CMS will share savings with the ACO. The savings split has not been determined. It could range anywhere from 80/20 in providers’ favor to 50/50. Currently, no penalty is in place for exceeding spending targets. Each group must meet criteria to participate in the SSP (Ronning 2010):

1. The group must be “accountable for care, quality, and cost of population of Medicare beneficiaries.”
2. It must participate for a minimum of three years.
3. The group must be part of a legal structure capable of receiving and distributing shared savings payments.
4. It must include primary care physicians.
5. The organization should demonstrate that it includes enough primary care physicians so that the combined Medicare patient population totals at least 5,000.
6. The group must have in place leadership, management, and administrative systems.
7. It must “promote evidence-based medicine, report quality and cost measures, and coordinate care, including the use of technological systems.”
8. The organization must demonstrate that it is patient centered.

Another form of ACOs expected to become common is the clinically integrated network (CIN), which is made up of private practice physicians, organized by a health system, and includes the health system’s integrated or employed physician practices (Moore and Coddington 2010).

ACOs do not exist in concept only; several pilot programs are already in practice. The Carilion Clinic in Roanoke, Virginia, for example, is an ACO pilot site for Medicare (Moore and Coddington 2010). Beyond pilots, the Engelberg Center for Health Care Reform at Brookings and the Dartmouth Institute for Health Policy and Clinical Practice have partnered to form the ACO Learning Network, which aims to provide information about ACOs and help organizations who have begun implementation. The current functions of particular health systems may inherently create accountability and drive results to achieve the goals of an ACO. An integrated delivery system that includes a health plan, for example, such as Scott & White in Temple, Texas, may already have been functioning as an ACO for some time (Moore and Coddington 2010). No matter the form, healthcare executives should know enough to talk the walk, and they should take comfort that others are already charting the way.

**Step 2: Direct the Culture—Champion Your Cause**

Anyone interested in leading an ACO implementation should understand
the magnitude of the change about to take place. To fully understand may require answering the question, “Why do it in the first place?” A healthcare leader should be ready with answers for other executives, the board, physicians, and patients.

Among the reasons to become an ACO are financial incentives. From 2001 to 2008, total Medicare inpatient margin percentages for short-term acute care hospitals decreased every year (Schumann 2009). Reimbursements have decreased and bad debt has increased, all while healthcare costs continued to rise. Such financial trends indicate that our current model of healthcare financing is unsustainable. During the same period, some hospitals were able to better control their costs, which led to positive margins (Schumann 2009). These results should serve as incentive for hospitals to embrace cost control as a cultural norm.

Care delivery methods need to change, and the ACO model works to promote quality of care. In certain geographic regions, healthcare facilities spend three times more per Medicare beneficiary than do facilities in other regions. However, this increased cost of care does not correlate to an increase in quality (Dartmouth and Brookings 2009). Current Medicare payment systems might not promote innovation or prevent avoidable complications or services, and the systems tend to promote high volume and high intensity of care regardless of quality (Dartmouth and Brookings 2009). Because of findings like these, the Medicare Payment Advisory Commission plans to mandate ACOs if voluntary ACOs are unsuccessful (Ronning 2010).

Another impetus to change is accountability to community health. In discussing his organization’s reason for implementing the ACO model, Joel Allison, CEO of Baylor Health Care System (BHCS) in Dallas, said, “This is all about . . . focusing on wellness, on prevention” (Arnst 2010). Gary Brock, COO of BHCS, said, “We’re not creating an accountable care organization, we are becoming an accountable care organization.” (Roberson 2010). Not all leaders are so willing to adopt change. In fact, some may be against anything outside the status quo. Some organizations currently enjoy strong financial positions, well-respected brands, and high quality of care and have no incentive to change. As the tide of reform begins to roll, even these healthcare systems will succumb to the need to change and adapt—partially because payers will demand it. As payers nationwide begin to reap the financial benefits of reform, they will be more inclined to suggest similar agreements with other providers. Patients will also demand change. As transparency becomes increasingly prevalent, patients will take notice if they are paying more for care than they would in other parts of the country or with other health systems. This patient dissatisfaction will open the door to competitors willing to accept lower payments using a collaborated accountable care model. Leaders of such systems are tasked with recognizing the need to change now, even in the midst of success.

**STEP 3: PARTNERING FOR SUCCESS—ENGAGE YOUR PHYSICIANS**

One significant determinant of success is hospitals’ and physicians’ ability to
cooperate while working toward lower cost and higher quality of care.

Groups that represent physicians have been fighting for power throughout the healthcare reform process. They do not want final regulations for ACO formation to be primarily hospital based. However, in many cases hospitals are natural choices to lead ACO development because of their access to capital investment and management expertise. The community orientation and ties of most hospitals, and their good reputation, can give ACOs strength (Moore and Coddington 2010).

The preliminary rules require that ACOs include primary care physicians, giving little other guidance about the organizations’ makeup (Moore and Coddington 2010). This requirement has grown from the medical home concept, which is based on the idea that care is geographically concentrated and primary care physicians are best qualified to coordinate patient care.

Hospitals and physicians are well positioned to make a difference in cost of care. If they are unable to work together, costs increase. Competition between hospitals and physicians results in underutilization of capital and misappropriation of resources. This can result in duplication of facilities and equipment and in higher costs for patients (Carlson and Greeley 2010).

Steps should be taken to partner with physicians. Although a hospital may be a natural choice to lead an ACO, it will need more than healing hands to meet the goals for an ACO. Part of the challenge is that the ACO model asks for voluntary concessions. Because better coordination of care and preventive measure should yield less utilization, becoming an ACO should have a direct financial impact on physicians and hospitals. If this model is implemented correctly, there will be a downward pressure on doctors’ and hospitals’ revenue streams (Roberson 2010). For some hospitals, leading this change means giving in less to physician demands. The strong leadership ACOs require will necessitate sweeping changes in some hospitals’ culture (Moore and Coddington 2010). Perhaps the best way to ensure collaboration is for hospitals to employ physicians—a situation that an increasing number of physicians want. Competition between hospitals and physicians, reductions in physician reimbursement, changing demographics, and physicians’ desire for a more predictable lifestyle have all led to this trend (Carlson and Greeley 2010). In one study, more than 40 percent of employed physicians responded that the relationship with their hospital was “going well,” while only 16 percent of private practice physicians gave that answer (Carlson and Greeley 2010).

Regulatory factors prohibit many hospitals from entering into employment agreements with physicians. One strategy to facilitate physician alignment is to include physicians in hospital leadership roles. Especially in hospitals currently without physician leaders, this strategy delivers a strong message that hospital leadership is willing to listen to and work with physicians. Adding physician leadership can make physicians more effective partners (Carlson and Greeley 2010).

A second, and perhaps more substantial, strategy is to revise the organization’s mission, vision, and values to reflect physician alignment (Carlson...
If this strategy is pursued, physicians should be equal partners in making the revisions. In a properly integrated hospital, physicians completely assume or share responsibility for “physician leadership, governance, physician recruitment, clinical quality, professional and appropriate behavior in the practice of medicine, a values-based culture, and a physician compensation model that supports the goals and philosophy of the healthcare system” (Carlson and Greeley 2010). This may be a big step toward alignment, but to succeed in the future, hospitals will need to work better with physicians then they have in the past.

**STEP 4: INVENTORY YOUR RESOURCES—WHAT DO YOU NEED?**

Two primary requirements for provider groups that want to become ACOs are primary care physicians willing to participate and a Medicare patient population of 5,000 or more. Leaders should inventory their organization’s skills and capabilities and identify gaps. One area to heavily scrutinize is IT. Many organizations plan to take advantage of federal funds available under meaningful use guidelines to purchase or upgrade IT equipment. ACO requirements should be considered in IT system purchasing. Coordination, documentation, and reporting features must be available to meet ACO guidelines, and information flow must be in place (Coddington and Moore 2010). Some organizations fear the IT reporting and administrative costs involved with ACOs. If the Medicare physician group practice (PGP) demonstration is any indication, these worries could be justified. The average organization in the PDP demonstration spent $489,354 to initiate and $1,265,897 to operate the project in the first year (Ronning 2010). These costs, however, are higher for a demonstration project than for a pilot because of higher administrative and reporting costs (Ronning 2010). Much of the required quality data reporting capability is already in place for these participants, so the additional costs might be minimal (Ronning 2010). Whatever the costs, efficient data reporting and collaborative IT capabilities are an essential piece of ACO success.

The people tasked with leading implementation need additional skills and capabilities. Interpreting the collected data to gain valuable information will require skilled, knowledgeable employees. ACO champions need certain skill sets to lead change. Leaders may find it difficult to communicate the need to move from “what works well” to “what works better” or “what will be necessary in the future.” To convince the board, physicians, and other executives of the need to change, leaders must use vision, charisma, and interpersonal skills. If a leader finds herself deficient in these qualities, other executives or particularly influential physicians who possess these skills should be selected to lead the ACO charge.

Process improvement skills are crucial to reach the cost control and quality goals of ACOs. Employees trained in Lean Six Sigma or other quality methodologies will prove valuable to an organization that is focused on efficiency. These core skills and capabilities will
serve as a strong base to any healthcare organization implementing an ACO.

**STEP 5: PLAN YOUR WORK, WORK YOUR PLAN**

Because healthcare is not homogeneous, the question of how to begin ACO implementation does not have a one-size-fits-all answer. In fact, the best answer begins by asking questions. Healthcare leaders should speak with various stakeholders to determine the most appropriate way to begin the process, and throughout implementation should keep in mind the original reasons to take the ACO journey. Moore and Coddington (2010) suggest a seven-step process:

1. Choose a target market. Will you choose Medicare alone or include other patient groups?
2. Choose a service area. How large an area do you want your ACO to cover?
3. Choose a reimbursement methodology. Will you use the SSP model or choose one that is more risk-based, such as capitation?
4. Identify the provider structure. Which provider groups will be included?
5. Design, develop, enhance, and modify core support elements. Examine your IT reporting capabilities and process improvement personnel.
6. Identify patient-related strategies for improvement. These may include, for example, enhanced service experience, quicker patient throughput, or reduction of errors.
7. Identify organizational strategies for improvement. For example, consider improvement committees, quality initiatives, Lean Six Sigma, or ACO-specific department.

The organization should answer the following questions (Moore and Coddington 2010):

Who should the ACO include, and what organizational form should it have? How should it be developed? How should it be governed? How should the IT be integrated and the necessary information flows developed? How should it be financed? What should its strategy be? How should the transition be managed? How should the organization develop the culture and day-to-day decision-making required to be successful? How can risks be minimized?

Nugent (2010) provides a model that lists questions in five key areas that health systems should consider:

1. **Patients**
   - Which populations should be covered?
   - Which conditions should be covered?
   - What should the benefits and incentives be?
2. **Physicians**
   - What provider panel and incentives should be implemented?
   - What services should be treated out of network?
   - What is the contract duration?
3. **Targets and goals**
   - What are the utilization reduction targets?
   - What are the unit reimbursement and cost reduction targets?
   - Where should future growth in profit margins be targeted?
4. Financial incentives
   - How can managed care reimbursement principles align with internal funds flow and incentives?
   - What surplus/loss distribution rules should be put in place?
   - What stop-loss or other risk management provisions should be implemented?
   - What are the implications for managed care contracting strategy and negotiation?

5. Clinical delivery model
   - What productivity, supply, and health information improvements are needed to achieve the goals?
   - What changes to ambulatory and physician practices are needed?

Once these questions have been answered, the simplest next step may be to form an organization and start a pilot in order to limit exposure of a large portion of revenue to new performance measures (Moore and Coddington 2010). While analyzing the decision to fully implement an ACO model, leaders should consider three questions (Nugent 2010):

Where are our best opportunities to maintain our margins over the next several years as rate increases are reduced and pockets of high cost and utilization are exposed? How will we optimize existing productivity and scale, and even exit certain lines of service, so we can make more with less? How could an ACO help us do all this over the next five years?

It is important to ask big questions, see the overall picture instead of merely the mechanics, and keep in mind the results that ACOs must achieve over time (Nugent 2010).

CONCLUSION
After CMS releases the final rules about ACOs, healthcare leaders will redefine the concept. However, leaders who have taken the five steps suggested here will be more ready than their peers and competitors to take action. The leaders who are able to articulate the concept, champion change, partner with physicians, inventory skills and capabilities, and strategize a plan are the leaders needed for today’s and tomorrow’s healthcare organizations. If ACOs are like unicorns, it takes leaders with vision to see them and make them real.

REFERENCES
Godbey, N. 2010. Personal communication at HFMA Lone Star Summer Institute, August 19.
Hawthorne, D. 2010. Personal communication with author at ACHE North Texas Chapter General Meeting, November 4.

