EXECUTIVE SUMMARY

Accountable care organizations (ACOs) consist of groups of health care providers who accept responsibility for the financial and quality outcomes for a defined population. As ACOs begin to actively manage populations, physicians’ roles in the caregiving process are evolving. Physician involvement is essential to achieve the goals of improving outcomes while lowering costs, as ACOs seek to coordinate care across all locations of care. As ACOs focus on chronic disease management, seek to establish standardized care protocols, encourage cost-conscious decision making, and expand access to services for patients, physicians will find new opportunities and challenges. Additionally, many new technology tools are being implemented which require physicians to learn to use and integrate these platforms into their daily workflow. ACOs are paid via new payment models which deemphasizes the volume of services provided; depending on the ACO’s performance and how physician-level payments are made, the net effect could be positive or negative for participating physicians. Participation in ACOs is not mandatory, but physicians who do not engage with ACOs may still be impacted by the emergence of ACOs in their market. While the expansion of ACOs may bring some challenges, they also offer an opportunity for physicians to take leadership roles in the redesign and improvement of health care delivery.
INTRODUCTION

In recent years, there has been a large push across the nation to change the structure of the health care system. This has prompted state and federal governments, as well as provider organizations and commercial payers, to experiment with varying methods of delivery and payment. One of the models that has emerged in the private and public sector is the accountable care organization (ACO), which is a group of providers that are financially accountable for the cost and quality outcomes of a defined population. The goal is to reduce health care costs while simultaneously improving care quality and patient satisfaction.

An ACO can be a coalition of previously independent organizations or a single organization that has independently accepted accountability for a population. Meeting the goals of accountable care requires a high degree of collaboration among the providers that serve individuals in that population. For physicians participating in ACOs, this new focus has changed the way they practice medicine and the roles they fill.

HOW HAS ACCOUNTABLE CARE CHANGED THE PRACTICE OF MEDICINE?

Care Coordination

Health care has traditionally been siloed, with each physician caring singly for a patient, often unaware of concurrent care by another physician. Accountable care is shifting this model to a team-based-care methodology, where providers coordinate regarding the care a patient receives. Coordinated care improves patient care by ensuring that patients are being correctly diagnosed, developing the right treatment plan, and receiving appropriate follow-up care to help them adhere to these plans. Many care coordination tasks are often delegated to care coordinators, which can be nurses or allied health professionals. They identify gaps in care or social determinants that are negatively affecting a patient’s health and coordinate the needed care to address them. This allows physicians to spend more time treating and diagnosing patients, while giving the patients more personalized, comprehensive care.

Care coordination also facilitates collaboration across the providers involved in a patient’s care. These providers may include primary care providers, specialists, pharmacists, mental health providers, post-acute care providers, and their associated support teams. Although only one physician will have primary responsibility for the patient’s care at a time, they are jointly responsible for developing a treatment plan and communicating often and effectively with one another. Many physicians have found great satisfaction from being part of a care team that provides comprehensive care for a patient.2

Care coordination has enormous potential to improve patient outcomes while simultaneously lowering costs, but it has its challenges.3, 4 As providers increase collaboration, each of them may have different expectations for how communication should take place, different levels of willingness to engage in coordination, and perhaps even different terminology. Overcoming barriers to effectively work with all members of a patient’s care team is no small task, and physician leadership in this effort is crucial.5

Prevention and Disease Management

ACOs are expanding their focus from addressing a patient’s immediate medical needs to improving their comprehensive health status. In particular, ACOs frequently choose to work closely with patients with chronic diseases to prevent their condition from worsening. Many ACOs are not only engaging those...
with chronic disease, but actively seeking out those
most at-risk for chronic disease, to intervene before it
becomes a problem. In many cases, this may require
physicians to employ the help of care coordinators
and outside community resources to address non-
traditional or non-medical issues that are affecting the
patient’s health.

**Care Protocols**

Many accountable care organizations are seeking
to standardize care processes and reduce variation
through the use of care protocols, which provide
evidence-based guidance on how or under what
conditions a procedure should be performed. ACOs
use care protocols to reduce unnecessary procedures
and their associated costs, as well as improve quality
by preventing gaps in care.

Care protocols provide a default course of action
that is appropriate in a majority of situations, but
physicians may also deviate from the protocol when
there is a clinically valid reason to do so. Many ACOs
use a committee composed of their top physicians
to develop care protocols, giving the physicians an
opportunity to collaboratively refine their medical
decision making and share their expertise within the
organization.

**Cost-Conscious Decision Making**

Although physician services only account for a small
portion of health care spending, physicians can
influence the majority of spending, which goes toward
hospitalizations, post-acute care, pharmaceuticals,
devices, tests, and other services. Understandably,
many physicians are wary of allowing costs to factor
into their decision making; they do not want to cut
costs to the detriment of the patient. However, there
are many treatment options physicians can provide
that are similar in effectiveness but drastically different
in cost to both the patient and ACO.

Being cost conscious can create savings for the patient
as well as the ACO. There have been some cases in
which patients have been placed under unnecessary
financial hardship because they were unknowingly
prescribed expensive medications when a lower-
cost alternative was available. By being aware of
treatment costs and communicating these costs to
their patients, not only can physicians prevent financial
hardship for the patient, but medication adherence
may also improve, as patients are more likely to take
medications they can afford.

ACOs can encourage physicians to select more cost-
effective options through the use of care protocols, but
in many cases physicians will naturally select the less
costly option when accurate information is accessible.
Unfortunately, the costs of specific treatments are
often not readily available. Efforts by payers and
EMR companies to develop technologies that better
estimate and display costs will make it easier for
physicians to make prudent decisions.

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**What Physicians Are Saying**

“Just two days ago, I got a report of cholecystectomy costs broken down by
physician, by group, by what everything costs, and we’ve said this for a long time:‘If you will
tell a physician what something really costs
and show them what impact they can make,
than they will make the decision as to whether
or not that’s important enough for them to
continue to use or not to use it.’ . . . One of the
things is that, for cholecystectomy, I have hung
on a long time to a dissection tool that is my
preference; it’s called a harmonic scalpel, but
. . . they told me . . . ‘This is how much more it
costs, and this is where you are compared to
the other physicians in the cost per case.’ . . .
I got rid of the harmonic scalpel.”

**Expanded Access**

As ACOs become accountable for a population, they
may wish to make themselves more accessible to their
patients. This can be done through extending clinical
hours, staffing mobile care units, effectively using
care coordinators, or other methods. Not only can this
accessibility provide an opportunity to strengthen
the connection between the patient and physician,
but it can also prevent non-emergent ED visits and improve customer satisfaction. Some of this expanded access can be staffed by physician extenders such as nurse practitioners, but physicians will also be required to work in different physical locations and work different hours.

Technology
The shift to accountable care has also prompted the introduction of new technologies. Some of these include analytic tools that help identify vulnerable subpopulations and identify gaps in care, care coordination tools, patient engagement tools such as patient portals and patient reminders, telemedicine tools, remote patient monitoring tools, mobile applications, and wearable devices. However, many of these tools are unproven or may not immediately deliver the expected results. Some need improvements in physician usability and system interoperability (e.g., EHRs). Despite these challenges, the potential to improve patient outcomes and reduce costs is large enough that the use of these tools is likely to persist. As physicians learn to use and integrate these technologies into their daily workflow, they may find them to be great assets. They will make data more available, inform physician decision making, and provide additional opportunities for patient interactions.

WHAT ROLES EXIST WITHIN AN ACO?

Physician Groups
There are many possible configurations of ACOs, and the role of the physician group within the ACO affects how the individual physician will be impacted. In the most-involved role, a physician group initiates and leads an ACO. The group may organize a number of other providers to jointly bear financial risk for the population, or it can choose to bear risk independently. Some physician groups will participate as a risk-bearing member of an ACO, but as a non-leading organization. In another arrangement, the physician group works closely with an ACO, but is not included as a risk-bearing member. The different roles that physician groups can play in an ACO are important because this role will impact the experience of the individual physician members.

Physicians
Within an ACO, physicians have the opportunity to take on new leadership roles in addition to their primary role of treating patients. These leadership opportunities vary in responsibility and scope, and range from managing the ACO at the administrative level to leading care teams within the practice.

Physicians interested in leading an ACO may be involved in exploring and forming a new ACO. The responsibilities these physicians take on will range from determining governance, organizational, and financial structures to determining partners and business strategies. Other physicians can become involved in an existing ACO at the administrative level through participation on various committees. Committees are formed to determine and negotiate the specifics of accountable care contracts, set priorities, determine approaches to carry out specific initiatives (e.g., a diabetes management program), develop care protocols, or select HIT vendors. Due to their knowledge and experience, physician input on these committees is integral to ACO success.

Physicians in groups with a non-leading role will likely retain duties within the practice, such as leading or participating in a care team. Care teams consist of primary care and other physicians, nurses, community health workers, behavioral health professionals, pharmacists, and other non-physician providers. The physician’s role in the team may shift over time—depending upon a patient’s health needs and circumstances—and duties may include collaborating on decisions, facilitating team meetings, delineating the roles of other team members, providing quality assurance, directing staff on patient education, jointly determining the comprehensive plan of care, or providing guidance to a care manager/coordinator.

Differing Roles of Primary Care Physicians and Specialists
By nature of the ACO model and its focus on individual care management and preventive services, primary care physicians will generally be more involved in the management of a patient’s care and care coordination efforts than a specialty physician. However, specialists
should also expect an increased amount of communication and collaboration as they work with the primary care provider and other members of the patients’ care teams. Specialists may play a larger role in the development of ACO complex care management initiatives due to their high involvement in the treatment of these populations.

**Specialty ACOs**

Although less common, some ACOs focus only on patients with specific conditions. For example, some groups have contracted with cancer or pediatric hospitals to form cancer- and pediatric-specific ACOs. Such organizations have greater challenges than traditional ACOs due to a smaller patient pool and the need to more effectively define primary and secondary physician roles with primary care providers (e.g., in a specialty ACO, the specialist could be the managing physician over a patient, rather than the primary care provider, due to the severity of the patient’s condition).

**WHAT IS THE FINANCIAL IMPACT ON PHYSICIANS?**

The impact of ACO participation on a physician’s compensation can be positive or negative and will ultimately depend on a number of factors including the physician employment arrangement, the ACO’s performance year to year, and the specific method for distributing shared savings or other bonus payments.

**ACO Payment**

Each ACO payment arrangement is unique, but most involve some form of a shared savings payment. In this arrangement the provider organizations that are participating in the ACO receive payments throughout the year for the services they provide. At the end of the year, if the total cost per patient is below the previously established target, the ACO receives a share of the savings. (Some contracts include shared losses which holds the ACO financially responsible for a share of the increased costs should they exceed the target.) This shared savings payment is divided among the organizations participating in the ACO, which then distribute the payments to their physicians. Exactly how physicians are financially impacted is determined by the specifics of the compensation arrangements between the physician, provider organization, ACO, and payer.

As with any new enterprise, there is the possibility that the endeavor will not yield positive financial results, especially in the short term. Thus far, only 24% of MSSP ACOs received shared savings in their first year of participation; 48% of Pioneer ACOs received shared savings in their second year of participation, with 13% having shared losses. With such results, the desired financial returns may take several years to materialize or may not materialize at all. Furthermore, depending on the ACO, physicians could be expected to contribute to the initial investment costs or shared losses. Before joining or investing in an ACO, physicians should make sure that they understand and are prepared for the financial risks associated with their specific situation.
Physician Payment

Because the ACO savings/loss payments are received at the administrative level, it may have little effect upon individual compensation for an employed physician. In an ACO, the physician practice or hospital still determines the physician compensation model just as it would if it were not an ACO participant, and the model may not be any different. However, many groups participating in ACOs may choose to adjust physician compensation models to incorporate measures important to the ACO, such as cost and quality performance. Depending on the individual physician and the specific adjustments, these changes could lead to either an increase or decrease in total compensation.

Physicians that have whole or partial ownership in a practice that is a risk-bearing member of an ACO will likely see a greater impact on their compensation than an employed physician. When the practice receives shared saving (or loss) distributions from the ACO, it will be distributed to the physician owners through the practice’s distribution/compensation model. Therefore, as the bottom line of the practice increases (e.g., from ACO distributions), so does the individual take-home pay of the physician owner.

Non-ACO-Participating Physicians

Participation in an ACO is voluntary. There are many physicians who will choose not to participate in an ACO, upon which there will still be an indirect financial impact. The emergence of one or more ACOs in a market can disrupt referral patterns, alter provider networks, and alter payer negotiating power. However, the degree to which these disruptions occur will be different in every market. ACO-participating physicians are incentivized to refer their patients to other participating providers. As a result, non-participating providers may see a decrease in the number of patient referrals. In addition, non-participating providers may have less negotiating power with payers. Because they have well-publicized incentives and experience in delivering coordinated care, some payers—as well as large employers—may prefer contracting with ACOs.

CHALLENGES TO SUCCESS

Even new ACOs with early success are facing challenges to long-term success and sustainability. For physicians, these challenges center on the issues of harmonization and accurate implementation of quality metrics, usability and interoperability of EHRs, enhanced data analytics, and the significant infrastructure required to establish an ACO. It will take the combined effort of all system stakeholders—physicians, hospitals, health care systems, payers, patients, and policymakers—to address these challenges to ensure sustainable success of ACOs.

CONCLUSION

The emergence of the ACO delivery model is an opportunity for physicians to refocus their work and take on new leadership roles. It will require them to learn new skills around data analytics, care coordination, management, and leadership. Though there may be challenges during practice transformation, the increased efficiency, emphasis on whole patient care, and physician collaboration has been rewarding to many physicians in this new model.

Physicians are experts in patient care and participation in a well-designed ACO gives them the opportunity to collaborate with one another to apply their knowledge throughout their practice and organization to improve patient care and lower costs. Although the success of an ACO does not depend solely on physicians, physician leadership and vision at both the administrative and practice levels are critical.
ADDITIONAL RESOURCES


The Impact of Accountable Care

Part 1: Origins and Future of Accountable Care Organizations
Part 2: Physician Participation in Accountable Care Organizations
Part 3: Hospital Involvement with Accountable Care Organizations
Part 4: Health Insurers and the Accountable Care Movement
Part 5: Employer Perspectives on Accountable Care
Part 6: How Accountable Care Impacts the Way Consumers Receive Care

All issue briefs are available at http://leavittpartners.com/impact-of-accountable-care/

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