COACH'S CORNER
From the president/CEO

Is there an ACO in your future?

If your e-mail inbox is anything like mine, it fills up with advertisements for seminars, webinars and publications about accountable care organizations (ACOs) with increasing speed. Even though the rules implementing the Medicare ACO provisions of the Patient Protection and Affordable Care Act have not been published in proposed form — much less as final regulations — the structure is a hot topic in healthcare. Everyone sees one in their future.

But what exactly is an ACO?

A lot of large multispecialty groups and integrated delivery systems believe they are well-positioned to function as ACOs, but I've also met people from a variety of other organizations — small and large — who see their groups becoming ACOs. They include a 36-bed rural hospital with a medical staff of 22, and a five-physician rheumatology practice that plans — you guessed it — to contract as an ACO with payers.

The term was first coined by Dartmouth researcher Elliott Fisher in a *Health Affairs* article in 2007.[1] Although he did not offer a precise definition for ACOs, the concept centers around a hospital and its physicians coming together to offer coordinated care to a defined patient population, and accepting a degree of shared financial risks and rewards for the cost-effectiveness, safety and quality of that care.

Much of the ACO frenzy is fueled by the rapid pace of practice sales to hospitals and integrated systems. That trend is no doubt accelerated by the deteriorating economics of smaller practices, the increasing desire of younger physicians to be employees rather than owners and ongoing payment uncertainty due to Medicare's sustainable growth rate debacle.

The ACO garners increasing attention, I believe, because of the realization that physicians (and hospitals) working together offer our best hope for slowing the spiraling cost of healthcare.

Is there an ACO in your future?

Probably. But that doesn't necessarily mean you must give up managing an independent practice and sell to a hospital. ACOs are likely to come in many organizational forms. Some (many, perhaps) will operate with hospitals and integrated systems at the center, but multispecialty groups and clinically integrated independent practice associations with common EHRs, aggressive quality and utilization management and performance transparency are equally viable models.

The economics of running a successful ACO will certainly be different. In the past, the name of the game was productivity and increasing the number of RVUs performed by increasing patient volume, increasing practice throughput and boosting the number of billable services per patient. The ability to manage a practice to meet that expectation has been the definition of a successful practice leader.

But the financial ground rules will shift with ACOs.

Certainly, some element of fee-for-service will endure, but it will be joined by new payment methods that require greater integration and increased risks assumed by providers. At the lower end of the scale there will be performance bonuses (gain sharing) for achieving specific quality, safety and efficiency goals. These bonuses will be layered on top of a reduced fee schedule. A bit higher on the risk scale will be bundled payments for procedures and episodes of care. And at the top of the scale

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you will see capitated payments, which place the full financial risk for population health in the provider's court. It's likely that ACOs will see a mix of all these payment schemes at any point in time, which poses a significant management challenge for practice executives.

While scenarios may differ, the key word that stretches across all shapes and sizes of these organizations is accountability. Practice executives of the future must be skilled in measuring quality, safety, cost-effectiveness and satisfaction. They must also be capable of using those measurements to help physicians continually improve performance. Payers and employers (and probably some patients) will demand access to that measurement data. And practices will succeed or fail financially based on their performance.

Business as usual is not an option. But leading a practice that is accountable into the future, regardless of the type of organization with which it is affiliated, is certainly an exciting prospect.

join the discussion: Give us your perspective on ACOs at mgma.com/connexioncommunity or connexion@mgma.com.

Notes:

1. Elliott S. Fisher, Douglas O. Staiger, Julie P.W. Bynum and Daniel J. Gottlieb, Creating Accountable Care Organizations: The Extended Hospital Medical Staff, *Health Affairs*, 26, no. 1 (2007): w44-w57 (Published online) doi: 10.1377/hlthaff.26.1.w44.