Journal of the National Comprehensive Cancer Network

Commentary

Accountable Care Organizations Versus Accountable Care: Is There a Difference?

"An accountable health care organization is one which has explicitly focused on its clinical culture as supportive of appropriate quality for which such organization is willing to be evaluated, compared and held responsible."

Alice Gosfield[1]

Alice G. Gosfield, Esq.

Alice G. Gosfield, Esq., is an attorney in Philadelphia. She has been named one of the top 25 health lawyers in the country. She is the Chairman of the Board of the Health Care Incentives Improvement Institute, Inc, past Chairman of the Board of NCQA, and Past President of the National Health Lawyers Association. She also serves as outside counsel to NCCN. She can be reached at agosfield@gosfield.com.

The notion of accountable health care is not new, although the measures of accountability have changed in the 13 years since I wrote the definition above. In addition to measuring quality, virtually all current notions of accountability incorporate cost components as well. Today, the real value of the care delivered is based on quality measured against an evidence base and that also incorporates patient safety and accounts for the patient experience of care, with contained costs.

The Health Reform legislation is replete with references to value, quality, transparency, patient experience of care, efficiency, and effectiveness. Many of the mandatory Medicare initiatives for hospitals and physicians—as well as the many demonstrations and pilot programs that the law has spawned—were intended to address these new performance demands. In particular, hospitals are facing a new value-based purchasing mandate that will reduce Medicare payments overall but will reward specific hospitals that score well. Hospitals will be denied payment for hospital-acquired conditions and avoidable re-admissions. Physicians will also be subject to a value-based purchasing program applied to the Medicare Physician Fee Schedule. These are mandatory programs.[2]

Against that background, it is fairly astonishing that what began as the concept of measuring hospital quality performance by aggregating data from the "extended medical staff"[3] morphed into the Medicare shared savings program available to accountable care organizations (ACOs) in the legislation. Even more astonishing has been the fervor with which the consultancy community has pushed the idea on health systems and physicians that they must become ACOs to survive.

The relatively brief legislative provision, which has very little by way of detail, is not even a pilot or demonstration program. It is merely a voluntary opportunity. Further, now that the proposed regulations have been published, many of the organizations that spent large amounts of time and money preparing to become ACOs are questioning the viability of the proposition.

Whether there will be any savings shared will be measured by the expenditures for beneficiaries assigned to the ACOs, which must accept and distribute payments from Parts A and B. This approach has no precedent, but the closest analogue is the Medicare Group Practice Demonstration. In that demonstration, after a similar 3-year obligation, only half the participants saw any bonus at all.[4]

That very few of the more than 5700 hospitals and 780,000 physicians in America will be able to function as Medicare ACOs in the Health Reform legislation is becoming clear. The Centers for Medicare & Medicaid Services (CMS) projects that only 75 to 150 organizations in the country will be able to be ACOs. The capital requirements are high and the information technology necessary to manage financial risk is often lacking. The organizational infrastructures to govern such organizations do not exist in most quarters; and, above all, the change in clinical process design necessary to be able to eventually benefit financially from the Medicare model requires far greater sophistication than most health care systems currently demonstrate. Even the American Medical Group Association, whose

The ideas and viewpoints expressed in this commentary are those of the author and do not necessarily represent any policy, position, or program of the NCCN.

members seem the best positioned to become ACOs, has expressed skepticism about what the proposed regulations offer.

Commercial payors who purport to be entering into ACO-like arrangements are all over the ballpark in terms of what their programs look like and what their payment models incorporate. Although some may well piggyback onto the Medicare model for organizations that seek to be Medicare-approved ACOs (under the proposed regulations they must apply and be accepted), many commercial payors are still struggling with how to manage pay-for-performance and what new payment models should look like.

So, in what direction should the vast majority of hospitals and physicians in this country be headed? Regardless of the architecture within which changed clinical behavior is deployed, all providers will—unquestionably—be held increasingly accountable for the care they deliver. The Health Reform legislation includes more measuring and reporting than at any time in the last 30 years of health care. There are programs to develop new measures for virtually every kind of care financed by the public programs, and everything measured will be transparent and posted on Internet sites. Employers, who still foot the bill for most health care in the United States, will also demand a better value proposition, because current volume-driven approaches are not sustainable.

To be accountable is to understand that care will be measured and reported and that quality must improve, all while costs are controlled, or at least monitored. One of the most compelling pathways to changing behavior is in the clinical integration of physicians with each other and with the broader teams of providers with whom they work. Virtually every provider-based program in the Health Reform legislation will require some degree of clinical integration, with a very heavy emphasis on physician engagement.

Although clinical integration has, since 1996, been discussed primarily in antitrust terms, the concept has more vitality in the current moment of health care change than ever before. Whether within a single health care delivery system, an organized medical staff, an academic medical center, a multispecialty group practice, a multidisciplinary cancer center with independent practitioners, or a 3-physician hematology oncology practice, delivery of a far broader concept of clinical integration will be essential to providers who will be held accountable for their care. This includes those who seek to be Medicare ACOs. This broader view entails "physicians working together systematically, with or without other organizations or professionals, to improve their collective ability to deliver high-quality, safe, and valued care to their patients and communities."[5] How hospitals support their legions of newly employed physicians must also confront clinical integration if these transactions are to have any shelf life at all.

It is the systematic and collective nature of the broad and deep clinical collaborations that will be the foundation for delivering measured value. At least 17 attributes might need accounting for in a fully clinically integrated delivery model, which does not require a single organization.[6] From the foundational issue of whether the structure and purpose of the group—a combination of providers, organized medical staff, coalescing organization, or single medical practice—is directed at clinical integration and value, to the direction and orientation of its governance and leadership, clinical integration entails vertical and horizontal considerations. How leaders interact with those they are leading, with transparency and based on what core values, is also significant. That shifting from volume-driven payment models to episode rates, bundled payments and budgets, and other shared incentives for cost and quality will enhance the ability to clinically integrate is not in question. How physicians are compensated and the incentives within individual compensation

also matter. Cross-disciplinary collaborations within a hospital and how financial relationships between physician groups with hospitals function are part of what can support and bolster a clinically integrated setting.

Standardization of as much as can be standardized is the essence of clinical integration. From practicing in accordance with clinical practice guidelines and protocols, to standardizing to whom and when referrals are made and how care is coordinated with those outside the group, to including those from whom referrals are taken and how communication occurs among referral sources, are part of the coordination and collaboration of real clinical integration. Standardization of electronic health information and forms and styles of documentation are relevant as well. Internal measurement and transparency regarding performance and its improvement is fundamental. The extent to which teamwork is incorporated in processes of care and is standardized among clinicians, along with how non-physician clinicians are used, can facilitate and propel clinical integration. Patient-centeredness is a hallmark of the paradigmatic high-performing health care organizations cited in the health reform debates. It is a basic attribute of a clinically integrated program. Finally, the extent to which the value of care is a core, explicit value of the organization is an essential feature of clinical integration.

Without intentional broad and deep clinical integration, succeeding in an accountable, measured health care delivery environment will be difficult. For most of the American health care delivery system, the Medicare shared saving program of ACOs will prove elusive and potentially distracting. By contrast, a committed focus on what it takes to be accountable for care delivery will be the touchstone of provider systems—whether integrated into single organizational structures or independent—that will succeed. Clinical integration is the key to moving forward toward truly accountable care.

References

1. Gosfield AG. Quality and clinical culture: The critical role of physicians in accountable healthcare organizations. 1998. Available at http://www.ama-assn.org/ama1/pub/upload/mm/21/quality_culture.pdf.
2. Gosfield AG. The new value on provider 'value.' In Health Law Handbook, 2011 ed. New York: WestGroup, a Thomson Company. Available at http://gosfield.com/PDF/The%20New%20Value%20on%20Value.pdf.
3. Fisher ES, Staiger DO, Bynum JPW, Gottlieb DJ. Creating Accountable Care Organizations: The Extended Hospital Medical Staff. Health Affairs 2007:26:w44–w57. Available at http://content.healthaffairs.org/content/26/1/w44.full.html.
4. Iglehart JK. Assessing an ACO prototype: Medicare's physician group practice demonstration. N Engl J Med 2011;364:198–200.
5. Gosfield AG, Reinertsen JL. Achieving clinical integration with highly engaged physicians. 2010. Available at http://gosfield.com/PDF/ACI-fnl-11-29.pdf.
6. Gosfield AG, Reinertsen JL. Clinical integration self-assessment tool. 2011. Available at http://www.uft-a.com/CISAT.pdf.

Join the Debate

What do you think? We welcome your comments about this article, any of the materials in *JNCCN*, or any topic relating to cancer prevention, detection, treatment, supportive care, or survivorship. Please e-mail correspondence (include contact information if you would like your comments considered for possible publication) to JNCCN@nccn.org or mail to *JNCCN*, 275 Commerce Drive, Suite 300, Fort Washington, PA 19034.