Accountable Care Organizations:  
A Primer for Orthopaedic Surgeons

2010-2011 AAOS Health Care Systems Committee:
Kevin J. Bozic, MD, MBA, Chair
Thomas C. Barber, MD
William R. Beach, MD
Timothy Bhattacharyya, MD
Craig A. Butler, MD
David L. Cannon, MD
John M. Cherf, MD, MPH, MBA
Maureen A. Finnegan, MD
Mark I. Golod, MD
Alexandra E. Page, MD
Ranjan Sachdev, MD, MBA

February, 2011
© 2011 American Academy of Orthopaedic Surgeons
Disclaimer

This Accountable Care Organization Primer is intended to provide general, authoritative information, available at the time of publication, in regard to the subject matter covered. It is offered with the understanding that the publisher and the contributors are not rendering formal legal, accounting, or information systems consulting advice. Nothing contained herein is intended to serve as a substitute for obtaining such advice.

The American Association of Orthopaedic Surgeons does not endorse, support or accept the applicability of this data to any reader’s particular practice setting. Each practice has its own particular needs, patient populations, revenues, volume and mix of services, and professional goals and objectives.

Disclosures

Richard Afable, MD (Newport Beach, CA): (n). Submitted on 10/13/2010 and last confirmed as accurate on 10/15/2010.

Thomas C. Barber, MD (Oakland, CA): 9 (American Total Joint Registry Board; FDA: Co-leader on international registry project; FDA Orthopaedic Device Panel; RAND/AMA PCPI Committee on Meaningful Use). Submitted on 10/27/2010.

William R. Beach, MD (Richmond, VA): 5 (Arthrex, Inc; Smith & Nephew; Bon Secours Health Systems; Synthes); 9 (American Board of Orthopaedic Surgery, Inc.; Arthroscopy Association of North America; American Orthopaedic Society for Sports Medicine). Submitted on 03/31/2010 and last confirmed as accurate on 09/25/2010.

Timothy Bhattacharyya, MD (Bethesda, MD): 3B (Best Doctors, AllMed). Submitted on 10/22/2010 and last confirmed as accurate on 10/22/2010.

Kevin John Bozic, MD, MBA (San Francisco, CA): 9 (AAOS; Agency for Healthcare Research and Quality [AHRQ]; American Association of Hip and Knee Surgeons; American Joint Replacement Registry; American Orthopaedic Association; California Joint Replacement Registry Project; California Orthopaedic Association; Orthopaedic Research and Education Foundation). Submitted on 01/04/2011 and last confirmed as accurate on 01/04/2011.

Craig Alan Butler, MD (Tallahassee, FL): 9 (Florida Orthopaedic Society Risk Purchasing Group). Submitted on 07/15/2010 and last confirmed as accurate on 01/03/2011.

James T. Caillouette, MD (Newport Beach, CA): 1 (DePuy, A Johnson & Johnson Company); 3B (DePuy, A Johnson & Johnson Company); 9 (California Orthopaedic Association). Submitted on 10/06/2010.


John Cherf, MD, MPH, MBA (Chicago, IL): 1 (Innomed); 2 (Breg); 3B (Breg); 4 (DePuy, A Johnson & Johnson Company); 9 (AAOS). Submitted on 10/15/2010.

Maureen A. Finnegan, MD (Dallas, TX): 8 (Clinical Orthopaedics and Related Research); 9 (AAOS; Texas Orthopaedic Association). Submitted on 01/04/2011.

Marilyn L. Fox, PhD (Rosemont, IL): (n). Submitted on 11/12/2010.

Mark Ira Golod, MD (San Jose, CA): 9 (AAOS Health Care Systems Committee; Santa Clara County [CA] Individual Practice Association). Submitted on 01/18/2011.

David Jevsevar, MD (Saint George, UT): 2 (Medacta USA; Omni Life Sciences); 3B (Medacta USA; Omni Life Sciences); 4 (Omni Life Sciences); 5 (Medacta USA). Submitted on 09/07/2010.


Ranjan Sachdev, MD, MBA (Great Bend, KS): 4 (Stockholder in retirement fund; Bristol-Myers Squibb; Eli Lilly; General Electric; Johnson & Johnson; Pfizer; Procter & Gamble; Sanofi-Aventis; Stryker; Zimmer; Founder and shareholder of Exscribe Inc, an EMR company). Submitted on 01/10/2011.


Toya M. Sled, MPH, MBA (Rosemont, IL): (n). Submitted on 10/26/2010 and last confirmed as accurate on 01/13/2011.

Wade Russell Smith, MD (Danville, PA): 2 (Synthes); 3B (Osteotech; Synthes); 5 (Synthes); 7 (McGraw Hill); 8 (Journal of Trauma). Submitted on 09/29/2010 and last confirmed as accurate on 11/17/2010.


Mark Wieting, MA (Rosemont, IL): (n). Submitted on 10/19/2010 and last confirmed as accurate on 11/15/2010.

Disclosure Items: (n) = Respondent answered ‘No’ to all items indicating no conflicts. 1 = Royalties from a company or supplier; 2 = Speakers bureau/paid presentations for a company or supplier; 3A = Paid employee for a company or supplier; 3B = Paid consultant for a company or supplier; 3C = Unpaid consultant for a company or supplier; 4 = Stock or stock options in a company or supplier; 5 = Research support from a company or supplier as a PI; 6 = Other financial or material support from a company or supplier; 7 = Royalties, financial, or material support from publishers; 8 = Medical/orthopaedic publications editorial/governing board; 9 = Board member/committee appointments for a society.
AAOS Board of Directors
John J. Callaghan, MD
President
Daniel J. Berry, MD
First Vice President
John R. Tongue, MD
Second Vice President
Frederick M. Azar, MD
Treasurer
Jeffrey O. Anglen, MD
Richard J. Barry, MD
Kevin P. Black, MD
M. Bradford Henley, MD, MBA
Gregory A. Mencio, MD
Michael L. Parks, MD
Fred C. Redfern, MD
David D. Teuscher, MD
Paul Tornetta III, MD
Daniel W. White, MD
George Z. Wilhoit, MS, MBA
Joseph D. Zuckerman, MD
Karen L. Hackett, FACHE, CAE
(Ex Officio)

American Academy of Orthopaedic Surgeons Staff
Mark Wieting
Chief Education Officer
Marilyn L. Fox, PhD
Director, Publications
Matt Twetten
Senior Policy Analyst
Toya M. Sledd
Clinical Quality Improvement Coordinator
Suzanne O’Reilly
Graphic Designer, Publications

February, 2011

© 2011 American Academy of Orthopaedic Surgeons
February, 2011

Dear Colleague:

The AAOS Health Care Systems Committee (HCSC) has developed this Primer to help educate AAOS members on issues related to Accountable Care Organizations (ACOs). The HCSC reports to the Council on Advocacy, and has been tasked with addressing issues related to hospital-physician alignment.

The goal of this Primer is to help orthopaedic surgeons understand and prepare for the changes that lie ahead as our healthcare system undergoes fundamental reform related to the financing and delivery of care. We’ve gathered national experts on the subject to provide the best available information on the following topics:

- Vertical integration and ACOs
- Lessons learned from integrated health systems
- Hospital perspective on ACOs
- Alternative models for vertical integration
- Early experiences in bundled payments
- Legal considerations in establishing an ACO
- Opportunities for specialist participation in ACOs

AAOS members can download a PDF copy of this Primer from the online Practice Management Center (www.aaos.org/pracman) or the online Government Relations page (http://www.aaos.org/Govern/Govern.asp).

A cautionary note: A primer is “a book or booklet that covers the basic elements of a subject.” This Primer is not designed to make you an expert on ACOs, but it will give you important tools to improve your knowledge of vertically integrated care delivery models and ACOs.

Members of the 2010-2011 HCSC, whose names are listed on the inside front cover, helped develop this Primer. Specifically, input was provided by HCSC members Kevin Bozic, MD, MBA; Timothy Bhattacharyya, MD; Craig Butler, MD; John Cherf, MD, MBA, MPH; Alexandra Page, MD; and Ranjan Sachdev, MD, MBA. The HCSC wishes to acknowledge the contributions of legal expert Anthony Schiff, Esq; Richard Afable, MD, MBA; James Caillouette, MD; Susan Charkin, MPH; David Jevsevar, MD, MBA; Wade Smith, MD; and Richard White, Jr., MD.

AAOS HCSC staff liaisons Toya Sledd and Matthew Twetten made additional contributions. This Primer could not have been written without them.

Kevin J. Bozic, MD, MBA
Chair, AAOS Health Care Systems Committee
Table of Contents

Introduction ................................................................. 8
Vertical Integration and ACOs: Impact on Healthcare Delivery Through Medicare ................. 12
Lessons Learned From Integrated Health Systems ......................................................... 13
Hospital Perspective .......................................................... 17
Alternative Models for Vertical Integration ................................................................. 18
Episode of Care (‘Bundled’) Payments ................................................................. 18
Legal Considerations in Establishing an ACO .......................................................... 20
Ongoing Challenges to the ACO Model ................................................................. 23
Opportunities for Specialist Participation in ACOs .................................................. 24
Summary ............................................................................. 26
Introduction

In the national effort to curb healthcare costs and broaden benefits, stakeholders such as the Centers for Medicare and Medicaid Services (CMS), government policy makers, hospitals, payers, and physician groups agree that the current system is unsustainable. These stakeholders are looking for ways to shift payment models from fee-for-service toward episode-based payment models that provide shared accountability and shared savings for all of the providers involved in managing a patient’s care. Accountable Care Organizations (ACOs) are entities being created and piloted as the primary approach to reduce health care costs and improve outcomes and the overall quality of care.

Although joining or forming an ACO is not immediately urgent, orthopaedic surgeons cannot afford to ignore the opportunity to be on the leading edge of this new care delivery model. The ACO delivery model, although centered around the primary care provider (PCP), creates important opportunities right now that orthopaedic specialists should understand so they can develop strategies and tactics that work for them. An ACO, in short, is a fully integrated, continuum healthcare delivery model that provides for complete and coordinated patient care, including hospitalization and specialty services, with the goal of improving quality and health outcomes at a lower cost.

ACO Overview

ACOs are mandated by the Patient Protection and Affordable Care Act (ACA) of 2010 under Title XVIII of the Social Security Act (42 USC §1395 et seq.) This law states that not later than January 1, 2012, the Secretary of the Department of Health and Human Services (HHS) shall establish a shared savings program that promotes accountability for a defined patient population, coordinates items and services under Medicare Parts A and B, and encourages investments in infrastructure and redesigned care processes for high quality and efficient service delivery. The primary purpose of an ACO is to decrease Medicare costs so that Medicare will be in place for the next generation and beyond. Even a small decrease in healthcare cost, as little as 1-2%, could make the difference.

Also, it is very likely that ACOs will foster lower cost commercial insurance products, which, combined with significant pressure from employer groups and individuals who purchase health insurance, will put downward pressure on traditional insurance payment methodologies. This, in turn, puts pressure on clinical providers, such as physicians and hospitals, to reduce their costs and improve the efficiency and quality of care. To meet the goal of providing a continuum of care for a pre-designated population of patients, ACOs will include PCPs, specialists, hospitals, and ancillary care providers who are jointly held accountable for achieving measured quality improvements and reductions in the rate of spending growth.

If you are thinking that ACOs sound familiar, they are. One pilot participant described an ACO as “a health maintenance organization (HMO) on steroids.” The following are key differences between HMOs and ACOs:

1. The ACO model is the first to attempt to link quality and patient experience to financial rewards when providers meet quality and cost containment benchmarks. The ACO is accountable for meeting quality and cost containment targets. As such, providers have a strong incentive to keep their patients happy and healthy.

2. ACOs are owned and operated by physicians and hospitals, not health plans. ACOs are provider-centric, recognizing and rewarding efficiency in the delivery of quality care. Innovative providers can be rewarded for reducing the cost of delivering care in episode treatment groups (ETGs) and/or uncomplicated treatment through referral patterns, data flow, and coordinated care team structures.

The ACO model is flexible enough to include many existing delivery systems. Entities such as physician-hospital organizations (PHOs), independent physician associations (IPAs), and virtual organizations of providers could all qualify to organize as new ACO structures. All ACOs incorporate legal, administrative, and clinical structures and systems that will enable both the development of evidence-based, coordinated clinical practice and the development and implementation of quality and cost measures. Additionally, ACOs require technology platforms and systems that will enable data gathering, data integration, and public reporting of quality and cost outcomes. Many providers do not have this level of sophistication built into their current systems. Strategic relationships could help fill these technology gaps. Eventually, with input from Medicare, individual state departments of insurance and managed care will likely require licensure for ACOs as they grow to take on more of the risk burden.

Fee-for-service payments have been targeted as a major factor contributing to rising healthcare costs. A system that pays providers piecemeal for services provided creates an inherent incentive to provide more services. Healthcare providers and hospitals have no financial incentive to minimize the number of duplicate tests or consultations. PCPs and care managers receive no reimbursement for time spent coordinating care. For both PCPs and specialists, it is easier and more lucrative to transfer care to the specialist rather than have the specialist communicate with the PCP and attempt to manage the patient’s problem within the primary care practice.

Furthermore, the profound geographic differences in practice patterns and healthcare spending have highlighted
the possibility that care is often given without regard to efficiency or evidence-based practices. Marked regional deviations between specialty referral and surgery rates have been noted, and improved care integration has been proposed as a way to address these discrepancies.\(^1\)

Recently, attempts have been made to minimize costs associated with what are perceived as preventable poor outcomes. Because the federal government bears the costs of treating complications in Medicare patients, this expense is essentially invisible to hospitals, physicians, and patients. Attempts to address this problem by linking reimbursement to demonstrable quality outcomes or to reductions in complications, such as pay-for-performance programs and value-based purchasing, have been proposed. However, these programs still do not shift liability for the cost of complications to hospitals and physicians. Thus, there has been a concerted effort to increase the financial incentive for avoiding complications. As quality of care improves and fewer complications arise, Medicare and healthcare providers could benefit financially.

The ACO’s primary goal is to align all healthcare providers to provide coordinated care in the most effective and cost-efficient manner. From a financial standpoint, the model incentivizes hospitals, physicians, and other care providers to work together to improve quality and contain costs. As integrated payment models mature, a focus on improving quality and patient outcomes will be increasingly important both internally (to control costs) and externally (to modify reimbursements).

**What Does All This Mean?**

It is highly unlikely that Medicare and Medicaid fee-for-service physician reimbursement rates will significantly increase in the coming years. Insurance premiums, on the other hand, will likely continue to rise. More than one of the stakeholders interviewed for this Primer stressed that neither ACOs nor the ACA will likely bring down the cost of insurance premiums. The hope, according to payers, ACO program designers, and demonstration project participants, is that ACOs will slow the rate of increase of overall healthcare costs. Although this legislation was widely touted as providing cost-containment benefits to consumers, the ACA does not put a cap on commercial insurance premiums. Although under the ACA, medical loss ratios (the percentage of healthcare premium dollars spent on delivering care) are required to increase to 85%, payers can mitigate this financial risk by passing on this cost in the form of higher premiums. In theory, the healthcare legislation mandate will bring more healthy people into the insurance market who will pay premiums without utilizing benefits. In practice, however, the ACA’s following provisions have triggered cost increases: no lifetime caps on benefits, coverage for children up to the age 26, no-cost preventive screenings, and a requirement that no more than 15% of healthcare premiums be diverted to administration and overhead cost. Insurance carriers, in anticipation of increased costs to their plans, have already raised premiums to group plan consumers. In turn, the groups have raised their employees’ contributions. This behavior has drawn sharp criticism from the HHS Secretary, but insurance carriers and employer groups continue to adjust their business models to deal with the higher cost of coverage in advance of the mandates’ effective dates.

In addition, insurance carriers are reacting to market forces that limit how much they can raise premiums by enacting regional fee schedules, wherein they implement a standard fee schedule for all providers for all services. This business practice virtually eliminates a medical practice’s ability to negotiate for increased reimbursements, even as physicians face premium increases for themselves and their employees. On one hand, payers are refusing to enter into negotiations with doctors, claiming pressure from employer groups to keep costs down. On the other hand, insurance companies are raising premium prices to those same physician groups when they renew their policies.

The ACO model is a risk-sharing-and-reward model that may provide relief on both sides of that equation. If the pilot programs prove promising and this new program structure advances, the ACO model could help control costs and improve patient care. However, logistic complexities, even in small geographic areas, and shifting market conditions make a “one-size-fits-all” version of an ACO impossible to develop. For actual cost savings to be achieved, The Vermont Accountable Care Organization Pilot: A Community Health System to Control Total Medical Costs and Improve Population Health report indicates that 70 percent of the managed care population (including participation of all Medicare and Medicaid recipients) would have to “opt-in” to an ACO healthcare delivery system, which makes voluntary participation questionable. At these levels, mandatory patient participation will be more likely.

**Precursors to the ACO Model**

The ACA includes provisions for the formation of “shared savings programs” by January 1, 2012, for items and services under Medicare Parts A and B. However, CMS has been exploring options for improved healthcare coordination for many years. In compliance with the Medicare, Medicaid, and State Child Health Insurance Program (SCHIP) Benefits Improvement and Protection Act of 2000, the physician group practice (PGP) demonstration was established to improve care coordination and cost efficiency. In 2003, the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) required the HHS Secretary to “establish a pay-
for-performance demonstration program with physicians to meet the needs of eligible beneficiaries through the adoption and use of health information technology and evidence-based outcome measures.” Out of this mandate came various demonstration models including the Medicare Care Management Performance (MCMP), Medical Home, and various care coordination demonstrations. Outcomes from the demonstrations have been encouraging, but with reservations. For example, the PGP demonstration showed steady improvements in quality indices, but even in the third year of the demonstration, only 50 percent of the participating groups were able to achieve payment under the performance payment methodology. The MCMP demonstration is in progress. Early reports indicate that involved practices have found that tracking data on patient care has enabled them to improve awareness of care gaps, but the high level of effort and costs associated with reporting has threatened the long-term viability of the program. Although the Medical Home demonstration rewards PCPs for their vital role in care coordination, this plan lacks motivation for cost containment.

More recently, ACO models have been further refined through the Brookings/Dartmouth Accountable Care Collaborative, which includes five systems across the country representing diverse structures and markets. These are devised as part of a “learning network,” enabling the sharing of best practice information. Thus, the current model of the ACO has evolved from various demonstrations exploring ways to optimize healthcare delivery. The regulations for enactment have not yet been written, so specifics remain subject to change.

**Definition of an ACO**
The ACA states that “…an ACO shall ... be willing to become accountable for the quality, cost, and overall care of the Medicare fee-for-service beneficiaries assigned to it.” Accordingly, an ACO model must have the following fundamental components:

1. The ability to provide care across a continuum of settings, including at minimum ambulatory and inpatient settings for a minimum of 5,000 Medicare beneficiaries
2. The capability for planning budgets and resources and participation in shared savings
3. Sufficient size to monitor and report on quality measurements
   1. Provide continuum of care An ACO must be able to meet all patient needs in one formal legal structure for a minimum of three years. A PCP would be the care coordinator, but an ACO must provide access to all specialties. Participation of a hospital is necessary to meet the requirement for inpatient services. Although the model requires access to all specialties, all specialists do not need to be a part of the ACO. Contracting with outside providers is permitted. However, lack of coordination between PCPs and specialists can result in duplication of effort (laboratory tests, imaging studies) and poor support for preventing complications. These increased costs would detract from the shared savings of the ACO. Thus, a successful ACO could promote PCP-specialist coordination regardless of whether the specialist is part of an ACO or an outside, contracted provider of services.
   2. Budget and resource planning An ACO is expected to have a leadership and management structure to manage finances. Such a structure would appropriately accept and distribute the shared savings component of income. The shared savings represent funds returned to the ACO from CMS if the cost of care provided is below the established benchmark, which is based on historic healthcare spending for the population being managed. The savings between projected cost and actual cost would be shared between CMS and the ACO. The potential for additional income from the shared savings provides the financial motivation for providing coordinated, cost-effective care for the patients in the ACO.

Many of the savings forecasted by CMS and lawmakers rely on improving efficiency through better use of technology. Because the costs of implementing technologies such as electronic medical record (EMR) systems and telemedicine are high, an ACO must have sufficient financial resources available to cover such costs.

Additionally, the structure of an ACO supports effective use of existing capital resources. For example, rather than adding hospital beds to increase volume, incentives could be provided to hospitals and physicians to reduce admissions through preventive care and to shorten length of stay.

3. Sufficient size and quality monitoring ACOs must be sufficiently large to be able to monitor and report on quality measures. The Medicare Payment Advisory Commission (MedPAC) estimates “sufficient size” as 5,000 patients. The definition and measurement of quality are more elusive. For an ACO, quality monitoring must be considered in two discrete components. First is the quality of care provided to the patient. Increasingly, quality of patient outcomes will be defined by subjective, patient-centered criteria (eg, overall hospital experience and ability to return to work or sports). This is markedly different than most of the current orthopaedic metrics utilized by hospitals or payers, which are more objective, physician-defined definitions (fracture alignment, joint range of motion, blood loss). The second aspect of quality for which an ACO will be responsible involves the system itself. Reporting on metrics involving the system’s efficiency and effectiveness, including care transitions and readmissions, can be expected. Reimbursement will likely be tied to both of these quality components.
Critical Differences Compared to Other Models

Looking at the parameters, it is easy to confuse an ACO with the failed HMO model from the 1990s. The critical difference hinges on the distinction between accountability for the cost of providing care for a patient (the HMO model) versus accountability for the quality of the care delivered (the ACO model). Although it also was an attempt to streamline care and eliminate duplicated services, the HMO model sought to use a PCP as a gatekeeper to restrict rather than to coordinate care. Capitation transferred financial responsibility for the patient to the physician or organization, creating a conflict with a financial incentive to withhold care. In contrast, an ACO maintains accountability for the overall quality of the outcome of care. The financial responsibility is disengaged from the provision of care, as providers assume financial risk for the cost associated with acute services and preventable complications, but not the insurance risk (that is, the risk that a patient will acquire that condition, as is the case under capitation). As an example, in an HMO model, a financial disincentive existed for a PCP to order an MRI or provide an orthopaedic referral for a patient with a suspicious mass. In an ACO, the driving force should be to avoid a poor outcome (eg, delay in diagnosis of a sarcoma that could ultimately require more care for metastases and a poor outcome). The financial pressure would be to ensure communication between the surgeon and the PCP (eg, order the MRI with contrast to avoid the need to repeat the study).

Further, the Congressional definition of the ACO permits great latitude in design, permitting flexibility in types of organizations that can qualify as ACOs. This flexibility allows many existing practices to collaborate to meet the requirements, including:

- Fully integrated healthcare systems
- Multispecialty group practices
- Physician-hospital organizations
- Independent physician associations

Ideally, there should be no requirement for changes in benefit structure. Patients do not need to formally enroll in an ACO; in fact, in many cases, assignment to an ACO may be invisible to a patient.

The goals of healthcare delivery for an ACO and a Medical Home are similar. Both share a desired outcome of patient-centered care with a PCP acting in a central role to coordinate effective and efficient care. In both models, technology, registries, and patient education are seen as tools to enhance performance. There is a critical difference, however. The Medical Home concept has no provision for measuring or financially incentivizing either quality outcomes or cost of care. Although the Medical Home concept allows for higher payments to primary care practices, it is not clear that this model will actually result in improved outcomes for patients or lower costs for payers. Evaluation of the Medical Home model by the Congressional Budget Office estimated that use of this model for chronically ill patients would increase spending by $5.6 billion.1

References:

Chapter 1
Vertical Integration and ACOs: Impact on Healthcare Delivery Through Medicare

Perennial increases in the cost of health care continue to have a significant impact on the US economy and present an economic challenge for federal and state governments, which have the responsibility of providing care for Medicare and Medicaid beneficiaries. The recent Patient Protection and Affordable Care Act (ACA) will put additional pressure on the healthcare system by adding 30 million uninsured people to the system in 2014. In addition to costs, the healthcare system also struggles with nonstandardized practice patterns, a lack of sound evidence-based provider behavior, a lack of coordinated care, irrational pricing of technology, and overall results that are inferior to those of most other industrialized nations.

Musculoskeletal care is an important component of our healthcare system. Nearly one in seven healthcare dollars is spent on conditions that affect the musculoskeletal system. Approximately 13 percent of hospital admissions are related to orthopaedics, and the forecast for future demand on both inpatient and outpatient services suggests that orthopaedic care will have larger demand and growth than any other service line. Although musculoskeletal care is well-positioned for future demand and growth, initiatives are targeted at controlling escalating orthopaedic costs.

Current payment for healthcare providers is based on a fee-for-service model. Many analysts believe this payment system promotes fragmented care and overutilization. The cost and lack of coordinated care is particularly problematic for Medicare patients with chronic diseases. Patients with five chronic conditions see on average 14 physicians a year. Medicare is particularly interested in better management of the patient cohorts that consume significant resources.

As CMS shifts from being a passive payer of health care to an active purchaser of value, it will foster an era of value-based purchasing. This pursuit of value involves searching for quality care at an optimal cost. Several recent examples of Medicare’s focus on value include pay-for-performance programs; the mandate for adoption of electronic medical records; pilot payment programs for acute care episodes (e.g., bundled payments); and interest in shared savings programs such as ACOs, as suggested in the ACA.

The ACO model is unique because it is designed to promote (1) coordination of care across a continuum, (2) risk sharing by providers who will be required to control costs while maintaining or improving performance, and (3) incentives to share savings as providers eliminate waste, overutilization, and excessive cost of care. ACOs are not gatekeepers, do not require changes to benefit structures, and do not require patients to enroll. Medicare beneficiaries may not even know they are being treated by an ACO, because their choice of provider will not be limited. Physicians will play a central role in the management of ACOs. Alignment and demonstrated performance are the key attributes of an ACO. Specialists, particularly orthopaedic surgeons, also would be considered important members of any ACO.

Until more details about these new shared savings initiatives are available, the true impact and longevity of this latest government strategy to control healthcare costs is under question. Several government and commercial initiatives over the years have had little or no success at bending the cost curve of health care. There will be many challenges in adopting the ACO model. These challenges include obtaining a critical mass of provider participation, adequate financing for an ACO start-up, information technology (IT) demands, creating and monitoring the proper performance metrics, changing provider culture and patient behavior, avoiding the undesirable exercise of market power, and the costs for developing and maintaining the ACO. Are the potential savings and additional revenue to providers sufficient to change practice behavior? Will this generate more confusion with only one payer participating? Are there easier ways to better manage large sources of waste such as hospital-acquired conditions and readmissions? Is the ACO a realistic model to address the value of the health care that is provided to Medicare beneficiaries? The answers to these questions remain to be seen.

One of the most significant consequences of more coordinated care with clinical and financial integration is the development of greater “supplier power.” In a fragmented provider landscape, providers lack negotiating power. As the industrialization of medicine continues, stakeholders in the medical economy will have more influence and ability to optimize payment and profits. Today, most physicians and hospitals are poorly aligned. The desire for better alignment and shared savings under programs such as ACOs will likely increase their ability to negotiate with a very concentrated commercial payer market. When negotiating together, hospital and physicians will enhance their bargaining power. The savings for CMS may come at a cost to commercial payers who are left negotiating with a more powerful provider base that can leverage scale. If this occurs, it may result in reactionary legislation such as price caps and all-payer rate setting.

Another potential adverse consequence of shared savings programs is the exclusion of solo practitioners, small groups, and small hospitals that do not have the critical mass to justify participation in an ACO-type initiative.
This is a particular concern, because today more than 20 percent of orthopaedic surgeons are in solo private practice. Further consolidation of orthopaedic surgeon providers and an acceleration of hospital employment of physicians may result.

Another potential risk of provider alignment and integration is that it may reduce or eliminate an important check-and-balance in the current system. Physicians often challenge hospitals and hospitals often question physicians about patient care initiatives, leading to a healthy debate and problem solving. This dynamic may decrease in fully integrated and hospital employment models.

The impact on healthcare providers of a change in payment strategies by CMS will likely be significant, regardless of whether the ACO model is fully rolled out in the healthcare system. Many providers are embracing the idea of change today and are focused on being prepared for the future. The interest in ACOs has become a hot topic amongst providers and will likely change behavior and foster more attention on cost of care and appropriate utilization independent of participation in an ACO program. It is entirely possible that the indirect effect of the ACO model will have a greater impact than the direct effect. For this reason, we will likely see significant change in healthcare provider behavior long before these programs are scheduled to take effect in 2013.

Chapter 2
Lessons Learned From Integrated Health Systems

From a practical standpoint, ACOs will be similar in many aspects to vertically integrated healthcare systems. Currently, integrated health systems flourish with several different models. These systems share the common vision that the providers, hospitals, and in some cases insurers, have aligned incentives to act in the best interest of the patient and the healthcare system. The physician may contract with the integrated system, or may be employed by the system or group. Regardless of the model of integrated health system, there are advantages for the provider, the hospital, and most importantly, the patient.

All of the integrated health system delivery models employ a common theme. They offer the distinct advantage of shared accountability for the quality and value of care delivery. The benefit of all parties participating as a team is the potential for marked improvement at all levels of patient care and care delivery. Examples of integrated health systems include Intermountain Health Care, Geisinger Health System, and Kaiser Permanente.

A hallmark of integrated healthcare delivery is innovation in the theory and practice of patient and disease management. Most integrated health systems focus their efforts on improving disease management through the analysis of data to improve local or system process, performance, or outcome measures. The innovations seen in these programs may significantly improve quality of patient management. These integrated systems impact healthcare delivery from beginning to end of disease management because they involve most aspects of that delivery. Improvements in disease management almost uniformly decrease costs by decreasing variations in care.

Quality of Care Oversight and Management

Most integrated organizations approach quality of care from a systems approach. First, they gather the data necessary to measure performance and potential improvement. Then they carefully plan and execute a change — most often with physician leadership. After implementation, careful measurement of results is critical as is the further refinement of the processes over time.

One example of a systems approach is Kaiser Permanente’s implementation of secure messaging. Kaiser carefully measures patient satisfaction with visits and with electronic communications. In addition, the system tracks patient visits, visits per doctor, and patient visits in a physician’s panel. Kaiser implemented secure messaging between doctors and patients in a few clinics. The organization found that when 25% of a provider’s panel was enrolled in messaging, there was a major reduction in clinic visits, marked improvement in patient satisfaction, and improved work life for the physician. If less than 25% of a patient panel was enrolled, the work was actually greater than without the program, and physicians were miserable. Kaiser used these findings in a program-wide implementation of secure messaging. In orthopaedic surgery, some total joint providers have been able to provide their postoperative total joint care after 3 months via secure messaging — improving follow-up and patient satisfaction, and reducing patient office visits. This works in an integrated healthcare model because Kaiser physicians are salaried and not dependent on fee-for-service revenue.

Another area of frequent focus is length of stay. This is a complex area where coordination of multiple services is essential. The factors involved can include surgeon preferences, amount and quality of physical therapy available in-house, availability of home nursing services, quality and timeliness of discharge planning, pain protocols, nursing protocols, and even time of discharge. To manage this complex problem, all parties – physical therapists, surgeons, anesthesiologists, nurses, home health workers, and discharge planners – need to work together in face-to-face and virtual meetings and agree upon a single common pathway that has the potential to decrease length of stay without negatively affecting quality of care. This is
not a simple process, and may require a project manager to coordinate the work and bring everyone together. The ability of an integrated care organization to bring a single common perspective makes this work possible. Without the common focus, perspective, and incentives provided by integration, these types of coordinated care process overhauls are virtually impossible to implement. The availability of near real time data is critical to allow longitudinal assessment of length of stay, complications, and readmissions within 30 days for key procedures such as primary hip and knee arthroplasties.

Another example in total joint replacement is the Proven Care Model designed at the Geisinger Clinic. The Proven Care methodology is a process whereby care providers use evidence and consensus-based information to establish a detailed best practice care map for a specific intervention such as cardic bypass surgery, primary joint replacement, or neonatal ICU care. The care map is based on core measures agreed upon through a group effort led by a physician–leader who has clinical expertise in that field. Each pathway requires integration of order sets into the computerized physician order entry system (CPOE); real time alerts on all pathway violations; follow-up and loop closure for violations; and physician-specific compliance data. These essential steps require a financial investment, and each pathway must be coordinated with hospital administration. At Geisinger, the intense information technology (IT) requirements for each start-up Proven Care pathway limit the number of projects that can be initiated at a given time. Thus, there is some internal competition to “get in line.” This leads to improved business plans, more thoughtful justification, and a sense of urgency once one’s own plan is approved. A final level of institutional responsibility. This is passed onto the provider by incentivizing them financially to reach 100% compliance with all core measures.

In orthopaedic surgery, Proven Care models for primary hip and knee replacement have shown significant initial successes related to length of stay, infection, DVT, patient satisfaction, and cost savings. The margin for joint replacement has increased over the 2 years of implementation. A similar process for hip fractures has begun, which includes moving hip fractures into the medical home model of the Geisinger Health Plan in an effort to decrease readmissions and secondary complications. Because of the vertical integration of the Geisinger Health System and the physician employee model, a common pathway beginning within minutes of admission to the emergency department and extending through the first postoperative year is now the standard of care for all hip fracture patients. The 33 critical core measures primarily deal with medical evaluation, surgical timing, perioperative management, and outpatient monitoring. Interestingly, the orthopaedic surgeons and residents involved in the surgical care of the patients are often unaware of the pathway because the steps occur automatically once instituted. The surgeons’ input on timing, implant use, and DVT prophylaxis were initially queried but after consensus was reached by the group, the automated nature of CPOE permits the system to run without the need of busy surgeons to “remember” to write appropriate orders.

Resource Management

Inclusion of appropriate stakeholders in the process of managing scarce resources offers significant advantages. A good example is managing prosthetic costs for the operating room. The surgeons choose the implants, but the hospital bears the cost. With a good coordinated effort at choosing the best quality implants at the best price, significant cost savings can be obtained. Within Kaiser Permanente, a panel of 10 orthopaedic surgeons are charged with selecting orthopaedic implants. These physicians initially review offerings from all implant companies, and select those companies that they feel can deliver high quality implants to all of the 34 Kaiser hospitals around the country. These companies get a request for proposal (RFP) that might be quite innovative — for instance, asking each vendor to provide a global price for tibial prosthetics in total knee replacement (rather than a fee for the entire knee replacement construct). With a well-designed contract, surgeon choice can be maximized, while reducing cost significantly. The success of the contract effort is dictated by the success in implementation. The discounted cost rate is possible because Kaiser can deliver 98% compliance with restrictive contracts.

Similarly, Intermountain Healthcare developed a committee of regional orthopaedic surgeon representatives to address implant pricing. The committee consisted of eight orthopaedic surgeons, only two of whom were employed by Intermountain. The organization sought to have the thought leaders for that region sit on the committee. It also did not shy away from surgeons who had consulting relationships with orthopaedic implant companies. When provided with comparative national data, the committee sought to establish a “price-point” structure by component similar to Kaiser. Intermountain has achieved yearly savings of over $5,000,000 with this program. The data provided to the committee helped to offset the public relations campaigns instituted by the implant companies. Organizations without vertical integration have a more difficult task of delivering a similar level of compliance.
Intermountain Healthcare also utilizes a clinical program approach to evaluate, implement, and monitor the data available from 22 hospitals within its system. Blood utilization is a costly issue for most hospitals and healthcare systems. Dixie Regional Medical Center in southwestern Utah was especially vulnerable because of its remote location, high volume, and lack of blood banking services. Dixie initiated analysis of its data and embarked on a pilot study to improve blood utilization. An exhaustive data analysis revealed that orthopaedic cases used the greatest number of blood products. A program was then developed to provide orthopaedists with their transfusion rate data, as well as an evidence-based algorithm for blood utilization. This presentation reviewed the fallacies of traditional transfusion triggers, and the risks and costs of transfusion. Small gains in blood utilization were obtained, but much less than anticipated.

Further data analysis revealed that attributions of blood transfusion orders were incorrect, and a large percentage of the blood transfusion orders came from other consulting providers. Subsequently, a system-wide training program on blood utilization for all physicians was started. Significant gains in blood transfusion rates were seen, especially in patients undergoing joint arthroplasty. Attribution of blood transfusion orders was also improved, allowing targeting for those physicians or groups of physicians who still showed significant variation. Because all parties had a shared vision of evidence-based optimization of transfusions, substantial clinical improvements could be achieved.

Physician Incentives

Many ACOs are likely to go down the path of using salaries to compensate physicians. The present fee-for-service model has been criticized by many because of the difficulty in aligning incentives among providers, patients, and hospitals. A salaried compensation agreement for surgeons might be problematic because some surgeons will elect to reduce their productivity under a salaried system. One solution to this problem is to establish a ratio where as much as 20% of salary is dependent on variable factors such as productivity, quality measurements, group contribution, etc. Financial incentives for production can exist but must be limited in scope in order to keep an incentivized focus on quality metrics. Bonuses can also be used for this purpose — to reward those who have performed well by whatever standards the organization judges to be important. Appropriate high-impact, measurable quality incentives can produce significant behavioral or practice changes. Physician bonuses can then be almost entirely qualitative instead of quantitative. The ideal financial incentive structure for ACOs, physicians, and the public is a set of quality incentives that are so well-aligned with optimal performance that the organization profits from providing value.

Liability Concerns

As physicians move into ACOs, the cost of the professional liability coverage will often become the responsibility of the larger organization rather than the individual. Clearly the emotional issues around being sued will always be personal, but the transfer of financial liability leads to a different paradigm. There tends to be a higher focus on prevention of lawsuits in these organizations. For instance, at the Oakland Medical Center, Kaiser has two professional lawyers serving as mediators in all cases of unanticipated adverse outcomes. They meet with patients and their families, often involving the surgeon in these conversations. These attorneys have the ability to make small gestures like waiving hospital deductibles, providing medical supplies to the patient, and most importantly giving the patient a forum to express his/her concerns. These advocates have reduced medical liability expenses dramatically.

A physician director of medico-legal issues who can deal with attorneys and physicians who have been sued was also installed. These directors can coordinate professional medical opinions, and assist clinicians with the distress associated with being sued. In some cases, as in Kaiser Permanente, patients are required to agree to binding arbitration for all medical malpractice claims. This may be financially beneficial overall, but is not a panacea because of the variable quality of the arbitrators.

Regulatory Oversight

The larger the organization, the greater the need for concern for regulatory issues. A robust compliance staff must pay great attention to performance that is reported to regulators. This might include Medicare’s nonpayment for so-called “never events” such as hospital-acquired pressure ulcers or noncompliance with Health Insurance Portability and Accountability Act (HIPAA) standards. Physicians will often be asked to assist in the compliance task. A common pitfall for physicians in these large organizations is the ease with which they can access the EMRs of family members. Of course this a violation of privacy rules, and larger organizations track the electronic access to charts by physicians. This can lead to physicians and other staff being disciplined or fired for inappropriate chart access, as has happened on many occasions at Kaiser — especially when accessing charts of celebrities or other public individuals. Kaiser now has a “break the glass” function on their EMR that makes the physician go through an extra step to access charts of certain patients to remind providers they should have a good reason to access that chart. At Intermountain, employee termination is mandatory for violating this policy.
Electronic Systems

One key advantage to integrated organizations is the availability of an integrated electronic medical record. A surgeon can access key medical information on a patient quickly and efficiently. Documentation and radiographs are available at home, on the road, or at a restaurant. These systems also can lead to frustration, as some of them are oriented toward specialties other than orthopaedic surgeons. Integration with hospital systems is a real benefit and allows signature on inpatient medical records from virtually anywhere via the Internet.

The key lessons here are that integration with a hospital EMR is critical, and that the system used should be appropriate for orthopaedic surgery. Physician involvement in the selection of the EMR system, picture archiving and communication system (PACS), and auxiliary systems (such as electronic consultation requests, or durable medical equipment ordering) is essential. Setting up these systems to integrate with a total joint registry is a great bonus.

The Gathering and Use of Data

The volume and quality of data collected in an integrated health system offer another significant advantage. Integrated health systems possess IT capabilities that the small group or single providers are unable to match. The data can be used to improve physician and hospital performance and patient care quality. Generally, integrated health systems also offer data analysts and clinical statisticians who enhance the understanding and utilization of the data. These pooled data enable observation of trends, variations, and outcomes that are not available to the single practitioner. Several practical applications of data have been presented.

A prerequisite for data analysis is that the data must be both valid and correctly interpreted. Providing physicians with incorrect or misapplied data will quickly lead to provider indifference to health system data. Intermountain Healthcare adopted the Crimson Physician Management Software for timely performance data monitoring. These data were based on hospital discharge codes. Initial evaluation of many orthopaedic physicians revealed a significantly higher than average “complication of care” and “complication rate.” These rates did not correlate with hospital-measured complication rates. Because Crimson was adopted to allow individual physician usage, this irregularity was investigated. In-depth evaluation of the discharge coding revealed that the software included all International Classification of Diseases (ICD-9) codes in the 900s as complications, even though these patients were largely admitted for these complications. For example, a patient admitted for revision joint arthroplasty was frequently mis-coded as having a complication. This finding was shared with all physicians so that the veracity of the data would not be questioned.

Leadership Structure

Regardless of the integrated health system model, the key to the development of physician culture, program development, and care process models is strong physician leadership. Significant process improvement is unlikely to occur without a strong physician leader who is respected, fair, and consistent, because it is the physician leader who will ensure the focus remains on patient care. The leadership activities and duties are often cumbersome and require a significant time commitment. The health system or hospital must recognize the importance and time commitment of this leadership, understanding that the physician leader works at a macro-healthcare level to improve system or hospital patient care delivery and must be willing to provide appropriate and fair administrative compensation to offset the loss of income related to patient care. This compensation cannot be rendered at a one-size-fits-all reimbursement level. Many physician compensation scales, such as the Medical Group Management Association (MGMA) scale, are based on physician specialty data, and provide examples of hourly physician pay rates. Health systems and hospitals must recognize the importance of differential specialty pay scales to attract the best and brightest physician leaders. Advanced administrative, business, or public health education training is helpful, but not mandatory for excellent physician leadership.

Leadership is required at all levels of the organization, and often a matrix-type organization is able to achieve the best results. A physician partner for administrators in the hospital — in the operating room, for the hospital floors, for risk and compliance, etc. — is critical to ensure that all aspects of problems and solutions are dealt with. Kaiser has a physician-in-chief of each medical center as well as assistant physicians-in-chief in charge of IT, risk, hospital, quality, operating room and surgical services, wellness, outside services, emergency room, graduate medical education, and human resources. The structure facilitates regional and national collaboration from colleagues in the same areas, and allows smooth implementation of new programs.

Organizational Financial Incentives

Just as important as the physician incentives are the incentives built into the financial allocation model. The allocations between hospitals and physicians, and to different facilities, are critical to maintaining appropriate behavior in a large organization. An example would be bonuses given to facilities for achieving access to care measures at Kaiser. When greater than 75% of patients
referred to a specialty are seen within 10 days, there is a monthly $3,000 bonus to the facility for each specialty that hits the mark. So with $36,000 at risk for each specialty per year, and over $500,000 annually at risk throughout the hospital, a fair amount of attention is spent making sure that patients can be seen within 10 days in every department. Every organization will have unique challenges based on geography, specialties provided, and size. The financial incentives must be carefully thought out and have the patient’s best interest at heart.

**What Are the Opportunities for Orthopaedists?**

As has been discussed, vertically integrated ACOs make financial and clinical sense in an increasingly complex healthcare universe in which the cost effectiveness of care will be part of the payment formula for physicians. However, many orthopaedic surgeons and orthopaedic group practices have traditionally provided high levels of clinical care while generating high incomes without association with such models. Why should orthopaedic surgeons consider joining or forming vertically integrated ACOs? Are ACOs an opportunity for administrators to take away surgical autonomy and substitute a corporate mentality that benefits the bottom line by forcing orthopaedic surgeons into an assembly line model of health care? These are clear concerns and frequent questions asked by the AAOS membership.

The honest answer is that depending upon the situation and circumstances, vertically integrated ACOs could lead to decreased incomes and practice restrictions or offer tremendous opportunities for growth, expansion and long-term security. The difference depends to some degree on logistics and geography, but primarily on physician leadership. A characteristic of successful vertically integrated systems with highly satisfied physician groups is that senior leadership includes and involves physician leaders. Those systems without active physician leadership tend to be less successful because they lack a shared vision, goals, and incentives. Therefore, a best practice recommendation is to seek vertically integrated systems with a tradition of physician leadership and for AAOS fellows to seek out opportunities to lead. Successful ACOs permit a blend of clinical practice, research, administration, and teaching within an orthopaedic department. The increased efficiencies, flexibility of job descriptions, and successful margins of ACOs generally provide for orthopaedic positions with interesting variety, competitive and consistent salaries, and reasonable lifestyles. These advantages are coupled with a sense of participation in organizations that are focused on quality work. Overall, for the ACO to be successful long term, physicians must enjoy their work and feel that there are significant long-term advantages to participation.

---

**Chapter 3**

**Hospital Perspective**

The current climate for hospitals in the United States can be described as pressured. In many markets, outpatient surgeries are moving away from hospital outpatient surgery departments to ambulatory surgery centers. Costs of medications and medical devices are rising. Regulatory burdens are increasing. Recovery Audit Contractors (RAC) can deny payments from years past. Hospitals are operating on margins as low as three percent.

In their study of Medicare billing patterns to support the creation of Medical Homes, Fisher et al [1] noted that 30 percent of physicians never visit a hospital. Office-based practices with integrated laboratory facilities and treatment centers are fast becoming the norm. In this environment, a switch to ACOs, which allow better physician and hospital alignment, represents an opportunity to bring physicians and their patients back to the hospital.

In serving as the centerpiece of an ACO, hospitals bring a number of potential value propositions to the table. First, hospitals (in particular, large academic institutions) traditionally have represented the highest level of care and technology in the system. Thus, their brands and standing in the community offer a head start as the logical first choice to be the headquarters for any ACO. Second, their history of negotiating with insurance companies and managing large contracts brings critical experience to the table. Third, most hospitals have strong support from their communities and local governments. Because they are a strong source of jobs and revenue for a community, their success is considered a priority. Finally, many hospitals have already made investments in health IT that could serve as a hub for a shared EMR.

Despite their obvious central role in the healthcare system, many hospitals are missing a critical ingredient — aligned physicians. In the United States, patients tend to have long-standing relationships with primary care and specialty physicians. Doctors are chosen first, and the patients are directed to appropriate hospitals and facilities. Orthopaedic surgeons know this firsthand, and are well aware of their ability to move surgical cases to different facilities in pursuit of quality care.

Hospitals face marked headwinds in their transition to ACOs. Bringing the specialist groups, who were previous competitors, on board and to the same table will be a significant challenge. Developing pathways that involve PCPs who never set foot in the hospital creates still another set of challenges.

This stormy environment represents a major opportunity for specialist physicians to take a lead in developing the next generation of healthcare delivery models. With their ability to understand patients’ and hospitals’ needs and
Chapter 4
Alternate Models for Vertical Integration: Physician Management of Orthopaedic Service Lines within a Health System

A different but rather unique model of vertical integration has been developed by some orthopaedic surgeons working proactively with their local hospitals. This model leverages physician expertise to develop and manage an orthopaedic service line within an integrated delivery system.

Success of this model is based on the premise that both parties are willing to compromise and work diligently to establish a good working relationship with a strong sense of trust as the foundation. Both physician and hospital leaders have to think long term and work proactively to establish value for consumers and stakeholders. This model was developed based on the following simple but profoundly effective concepts: Payers value good outcomes with efficiently delivered health services. Patients value good results and transparency.

Hospital and physician leaders need to understand that the greatest opportunity for all stakeholders is a frictionless combination that harnesses the deep knowledge of both entities. The following table outlines the expertise each party can bring to these collaborations.

<table>
<thead>
<tr>
<th>Area of Need/Expertise</th>
<th>Physician expertise</th>
<th>Hospital expertise</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subject expertise</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Evaluating new products</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Managing supplies</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Designing protocols</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>HR management</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Facilities management</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Marketing resources</td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>

Establishing trust is the key to success in sustainable hospital-physician relationships. To achieve this, both sides must deliver on promises in a timely fashion and both sides should benefit from the joint venture. Since VALUE = OUTCOMES/COST, the value of any hospital-physician joint venture or partnership requires careful measurement of outcomes as well as cost.

After success has been demonstrated, physician leaders are more likely to get support from hospital management for more innovative delivery methods and more encompassing joint ventures such as managing a service line within a hospital or an integrated healthcare system. This could entail contracting directly with the payers and managing negotiations with vendors and suppliers. The greatest challenges that physician leaders may need to overcome may originate from within the system, such as the perception of creating silos in the health system, disagreements with colleagues over selection of implants, and dealing with envy and power struggles among physicians and administrators.

There are many advantages to this type of integration. Physician leadership and management can solve many of the issues that hospitals face in controlling costs. Most of the delivery costs are directly related to orders that originate and are signed by physicians. By engaging physicians in the development of evidence-based care pathways, both the costs and quality of care can be effectively measured and managed. Likewise, implant and new equipment costs can be a significant drain on finances and often no definite benefit can be demonstrated by using a specific implant. Setting up systems that require demonstration of or agreement on the clinical benefits of a new technology can result in substantial cost savings, e.g., before purchasing new equipment or higher cost implants. Finally, such a system preserves pride of ownership and physician autonomy and entrepreneurship, which have been elements of private practice success in the past.

Chapter 5
Episode of Care (‘Bundled’) Payments
Definition and Purpose in Payment Reform: What is a bundled payment?
Episode of care or ‘bundled’ payments are defined as single payments for all services (physician, other providers, and technical/facility fees) related to a specific episode of care or condition. This single payment may be for services spanning multiple providers in multiple settings. In agreeing to bundled payments, the provider accepts financial risk for the cost of services and overall quality of care for a particular episode of treatment or a given condition to include costs associated with preventable complications. Bundled payments are also frequently referred to as episode-based payments, acute-care episode payments, or case-rate payments. They are less frequently referred to as global payments or comprehensive care payments, but one must be very careful in assuming these terms refer to bundled payments in all situations.
The bundled payment was conceived to incentivize greater coordination of care among hospitals, physicians, and other providers in both the acute and post-acute care settings, and thus hold multiple providers in multiple settings jointly accountable for the total cost and quality of care delivered for a given treatment or condition. Postacute care spending accelerated significantly after the introduction of diagnosis-related group (DRG) payments for hospital acute care services. By linking the total episode costs of both acute and post-acute care with a single payment, bundled payments were aimed at encouraging more cost-effective uses of healthcare resources and at reducing post-discharge costs. By sharing financial risk, providers have incentive to eliminate unnecessary services and to reduce the cost of care.

It is important to understand that bundled payments, conceptually, need not center on a hospital episode of care. The focus on bundling payments around a hospitalization episode evolved as a starting point based upon the recommendations of MedPAC to Congress in 2008. [1] Theoretically, a bundled payment could include only targeted physician services or possibly all costs related to an episode regardless of whether or not they constitute a provider service (e.g., drug costs).

Structure and Function: How do bundled payments work?
The initial amount of a bundled payment for an episode of care will likely be based on historic costs. There may be planned future adjustments or reductions in payments related to changes in efficiency and in the level of complications. There will also likely be risk adjustments to these payments made for the severity of illness or disease commensurate with provider financial risk. In establishing the starting point for bundled payments, the providers must consider the following basic equation:

\[ \text{Bundled Payment Amount} \leq \text{COST Acute Care} + \text{COST Postacute Care} \]

The goal is to make the amount of the bundled payment less than or equal to the total combined historic cost of both acute and post-acute care. Given this key calculation, transparent and accurate cost accounting information must be provided and shared amongst bundled providers. In a prototypical bundled payment agreement, if the cost of an episode of care is less than the bundled payment amount, the bundled providers keep the savings. If the cost of an episode of care exceeds the amount of the bundled payment, the bundled providers absorb the loss. The cost of treating avoidable complications and readmissions (i.e., a warranty) will be included in calculating the episode costs.

Historic and Current Trials: Has This Been Tried Before?
One of the earliest bundled payment experiments involved orthopaedic procedures. In 1987, Lanny Johnson, MD, and the Ingham Medical Center in Lansing, Mich., offered a fixed price for arthroscopic surgical procedures involving the knee and shoulder. Accountability was monitored by reporting surgical indications, and the fee covered a two-year warranty. This innovation reduced the surgical incidence by 42% over expected rates while hospitals and physicians earned more than expected under the preexisting payment model.[2]

Medicare has also had several completed demonstration projects including the Heart Bypass Center Demonstration (1991-1996) and the Cataract Surgery Alternate Payment Demonstration (1993-1996). The most recent demonstration includes orthopaedic procedures and is known as the Acute Care Episode (ACE) Demonstration.

The ACE Demonstration Project
Medicare’s ACE demonstration project provides global or bundled payments for 28 select orthopaedic and cardiovascular inpatient procedures. [3] Three of the five centers presently involved participate in the bundling of orthopaedic procedures. Total knee and total hip replacement are the major orthopaedic procedures included in the demonstration project. The bundled payment covers all Part A and Part B Medicare services to include physician services pertaining to the inpatient stay for Medicare fee-for-service beneficiaries. Post-acute care services are not included in this particular demonstration project.

The stated goals of this bundled payment experiment are to improve patient outcomes and to align physician and facility incentives in reducing the cost of these episodes of care. Both physicians and facilities share in any savings generated. Beneficiaries also share 50 percent of the savings, up to a maximum level equal to the annual Part B premium. [4]

Early results in the facilities participating in the orthopaedic portion of the demonstration are encouraging. The Hillcrest Medical Center in Tulsa, Okla., has reported cost reductions in personnel (6%), supplies (18%), implants (7%), and other direct costs (2%) for a total of 10% overall for the chosen high-cost, high-volume procedures. All participating physicians received the maximum incentive payments (25% over the Medicare physician fee schedule), and hospital net revenue per case increased 7%. [5]

Current Private Bundled Payment Initiatives
Private payers and providers are also continuing to expand the use of bundled payments. The Geisinger Health System’s ProvenCareTM, the PROMETHEUS Payment
model, Fairview Health Services in Minnesota, and Blue Cross Blue Shield of Massachusetts (BCBSMA) are examples of ongoing programs in the private sector. The Alternative Quality Contract (ACQ) offered to providers by BCBSMA is the most comprehensive model to date and it covers all conditions a member may present with across the continuum of care. An estimated 20 percent of the provider network has signed on to the ACQ. [6]

Pertinent Issues for the Orthopaedic Surgeon: What should I know?

For the surgeon anticipating future participation in a bundled payment model there are numerous questions, issues, and concerns. These will vary from general issues to specifics that depend on the particular market and the services being bundled.

Questions that need to be considered include:
• What data are needed to support the bundled payment?
• What capabilities are needed for your organization to administer a bundled payment?
• Which providers and services should be included in the bundled payment?
• To which procedures or conditions should bundled payments be applied?
• How can provider cost accountability be determined?
• How should the bundled payment amount be calculated?
• What should be the timeframe included in the bundled payment?
• How should the bundled payment be risk-adjusted?
• Will bundled payments work in your specific market?
• Will bundled payments affect your ability to provide high quality care for your patient population?
• What are potential unintended consequences of bundled payments for your patients?

Given the nascent stage of the market movement toward bundled payments, there are clearly more questions than answers. Orthopaedic providers are encouraged to actively survey their local healthcare markets and seek to engage their major payers in this particular effort to control costs if this effort materializes.

The Bundled Payment in an ACO Framework

At this stage in their deployment, the role of bundled payments in the ACO payment model is unclear. As emphasized above, in a typical bundled payment model the savings (and the losses) generated accrue to the providers. The ACO model is based upon the concept of shared savings between the provider and the payer. It is unclear how this potential conceptual conflict will be addressed, but given the flexibility of the ACO models one would expect to see some bundling. It is also expected that fee-for-service, versions of capitation, and bundled payments will all be part of transitional or perhaps permanent ACO payment methodology. The ultimate goal in the ACO, however, would be a single comprehensive payment for the management of a defined population divided between all providers.

References

4. Ibid.
6. Ibid

Chapter 6
Legal Considerations in Establishing an ACO

When designing an ACO under the ACA, organizers must successfully navigate critical legal and regulatory landmines. This brief survey focuses in particular on the following five key issues.

A. Organizational Dynamics Fundamentally, an ACO must agree to be responsible for the quality, cost, and overall care of a defined population of Medicare fee-for-service beneficiaries for a period of at least three years. To qualify under ACA, an ACO must be organized as a formal legal entity so that it can receive and distribute payments for shared cost savings. To manage the risk associated with its clinical and administrative responsibilities, an ACO must have a proper governance infrastructure, including well-defined management and administrative systems. Congress enumerated five different ACO models in the ACA, an explicit acknowledgement that one size does not fit all insofar as healthcare markets are concerned. These alternative models are:
1. ACO professionals in group practice arrangements
2. Networks of individual practices of ACO professionals
3. Partnerships or joint venture arrangements between hospitals and ACO professionals
4. Hospitals employing ACO professionals
5. Such other groups of providers of services and suppliers as the HHS Secretary determines appropriate

In general, the first three models above will most likely provide physicians with the ability to assume leadership positions in ACO development and operations. The first model, more commonly referred to as the group practice model, contemplates the organization of a large, multispecialty medical group through the consolidation of multiple primary care and single specialty practices. The physicians — ACO professionals — would own and govern the group practice while performing professional services as employees. The group practice model will likely achieve the highest degree of clinical and economic integration of the alternate models. The group practice model will likely also require ACO professionals to make substantial capital investments.

The second model, the so-called network model, involves the formation of a large multi-specialty physician network (i.e., an independent practice association) through the affiliation of multiple primary care and specialty medical practices. The network model can achieve clinical and economic integration, but not to the same extent as the group practice model. On the other hand, the network model will not require the same level of capital investment by ACO professionals as the group practice model. And, the network model permits ACO professionals to maintain their existing practice paradigms and, correspondingly, to retain the lion’s share of their professional autonomy.

The third model, or joint venture model, contemplates the formation of a joint venture between the group practice and/or network organization, on the one hand, and a hospital or health system, on the other hand. By its very name, the joint venture model is a partnership between ACO professionals and an institutional provider(s), with operating control shared between or among the “partners.” The joint venture model may provide the vehicle for ACO professionals to tap the resources of the institutional providers to finance the delivery of healthcare products that ACO professionals could not otherwise fund on their own. The joint venture model would achieve the level of clinical and economic integration commensurate with its healthcare products. In the latter regard, the joint venture model would provide ACO professionals and institutional providers with the most flexibility to develop new and/or expand existing bundled service programs.

As the above makes clear, capitalization is a critical issue. ACO promoters will need to raise funds to finance both start-up and ongoing clinical operations, most likely through capital contributions by participating ACO professionals. Depending on the size of their investment, ACO professionals/equity stakeholders may require reasonable assurances regarding the recovery of their investments upon dissociation, and the financial means by which an ACO would fund its redemption obligation. The ACO “buy-sell” issues are typically addressed by contract, along with the provisions relating to dissociation generally. Importantly, financial integrity and related solvency standards may restrict the ability of an ACO to redeem the ownership interests of dissociating providers. In short, issues concerning ACO ingress and egress are complicated and, if not properly considered, could be traps for the unwary.

Additionally, nonprofit, tax-exempt hospitals are subject to certain additional requirements and restrictions. Most notably, tax-exempt hospitals which participate in ACO joint ventures must be certain that the integrated delivery systems serve community purposes and do not generate impermissible “private benefits” to others.

The statutory definition of an ACO is necessarily general. Congress has ordered HHS to provide guidance on the formation and operation of an ACO. HHS has not yet issued ACO-related regulations, leaving a vacuum in the healthcare market about key organizational dynamics. For example, what types of healthcare providers can form an ACO? What governance requirements must an ACO adopt and implement? What capitalization and other specific financial standards will demonstrate the ability of an ACO to manage patient outcomes and medical costs efficiently and effectively? [1]

B. State Law Preemption Many states prohibit hospitals and health insurance companies, among other lay entities, from entering into arrangements or series of arrangements with physicians or groups of physicians through which those lay entities improperly influence or affect the professional judgment of such physicians. Hospitals are unable to employ physicians in states with the “corporate practice of medicine” prohibition. Many states have also adopted sophisticated statutory frameworks to regulate payment for and delivery of healthcare services by or through networks of risk-bearing and/or risk-sharing arrangements. Consumer protection is at the heart of these statutory paradigms.

Will HHS promulgate regulations that interpret the statutory models of ACO organization as preempting conflicting state laws? Specifically, will state medical boards retain the authority to regulate their licensiates generally and ACO-related activities specifically? Will state insurance commissioners and/or managed care directors retain the authority to regulate ACO risk-bearing and/or risk-sharing activities in order that traditional Medicare beneficiaries have the same or substantially similar consumer safeguards and protections as the enrollees of Medicare Advantage organizations?

For physicians in most states, hospital affiliation, including medical staff membership and the ability to
exercise clinical privileges, constitutes a fundamental economic right that cannot be abrogated without cause and, typically, where there is no nexus to patient care or safety. Furthermore, even where good cause may exist, the hospital cannot take final adverse action without providing the affected physician with written notice of the charges and a forum to challenge the allegations that meets the standards of procedural due process.

In some states, these same legal principles that protect physicians vis-à-vis their hospital affiliations have been extended to protect physicians and their memberships on provider panels of payers, including preferred provider organizations and independent practice associations, that control substantial volumes of patients in the communities. If so, then must an ACO accept all qualified physicians on its provider panel? Can an ACO limit membership on its provider panel, even if that decision results in certain otherwise qualified physicians being denied access to patients and, correspondingly, the ability to exercise their vested and fundamental economic rights? Will applicable state law or, if necessary, HHS regulations exempt ACO from such legal scrutiny?

C. Antitrust Issues The ACA is shepherding in a revolution in the delivery of inpatient and outpatient medical care. The 1980s, too, saw significant changes in healthcare delivery systems, particularly by physician organizations, along with a flood of antitrust enforcement activity by the Federal Trade Commission (FTC) and Department of Justice (DOJ). Price fixing, group boycott, and product tying became watchwords as healthcare providers attempted to consolidate in order to level the playing field when negotiating with powerful payers. [2]

ACO promoters and their advisors should be aware that federal and state antitrust laws may apply to their arrangements. In the mid 1990s, the FTC issued guidance to providers seeking to consolidate, in the form of safe harbors. Although healthcare reform legislation encourages providers to align more closely in the delivery of patient care, an ACO may be unable to achieve the levels of economic and/or clinical integration necessary to withstand antitrust scrutiny. ACO development yields increases in negotiating leverage of the affiliated professionals, the extent of which will depend on the size of the relevant geographic market. Many experts predict that an ACO will need to service Medicare and commercial patients in order to achieve economic viability. In the absence of a clear safe harbor, an ACO that flexes its newfound negotiating muscle should expect the commercial payers to seek redress to recover the resulting losses and, in so doing, expose the ACO to legal scrutiny under applicable antitrust laws.

The FTC is soliciting public comments as it works to develop policies on ACO competition and reimbursement. Providers can expect updated regulations and guidance as the federal government works out how to address these important issues.

D. Anti-kickback and Stark Laws Federal laws prohibit the acceptance of cash or any item of value in return for the referral of health services that are later billed, in whole or in part, to federal healthcare programs. The cardinal sin that anti-kickback statutes intend to prohibit is the creation of relationships between providers that have as their primary business objective the funding of payments in exchange of patient referrals. [3] The ACO model contemplates the integration of providers in order to create in-network financial incentives regarding the referral of Medicare beneficiaries. The cost savings are shared among ACO providers. Undeniably, the ACO model also has many of the hallmarks of gainsharing arrangements, under which hospitals proposed to share cost savings with referring physicians in order to create financial incentives for them to help re-engineer the delivery system and utilize inpatient services more efficiently.

HHS has struggled with the issue of gainsharing for over a decade, ultimately deciding not to issue any safe harbor for such programs under the federal anti-kickback statute. HHS may change its position on gainsharing when issuing regulatory guidance on ACO development, and additional anti-kickback safe harbors are expected. In all events, ACO promoters and their advisors should consider adopting a conservative approach when structuring and implementing payment and cost-sharing methodologies.

The federal self-referral law, commonly referred to as the Stark law, prohibits a provider from referring federal healthcare program beneficiaries for certain designated health services (eg, inpatient/outpatient hospital services) to entities in which such a provider has, directly or indirectly, a financial interest. The Stark law provides many exceptions to the referral prohibition. In an ACO, each participating provider has the requisite financial interest (ie, the right to receive payment for services furnished to patients and to receive a portion of any shared savings). Accordingly, an ACO provider would be prohibited from referring Medicare beneficiaries to another participating provider for designated health services, unless that financial interest qualifies for an exception to the Stark law. [4] Currently, the Stark law does not provide an exception for gainsharing arrangements. However, it is often possible to structure ACO relationships to meet other Stark law exceptions, such as the personal services arrangement and/or fair market value exceptions.

E. Civil Monetary Penalties Law The Civil Monetary Penalties Law (CMP) gives HHS the power to levy substantial monetary penalties for various forms of improper conduct. Among other matters, CMP prohibits the payment or offer of any other form of inducement to reduce or limit the items or services provided to fee-
for-service federal healthcare program beneficiaries. ACO payment models are intended to improve efficiency and, as a result, generate cost savings in which the participating providers share. ACO providers can certainly achieve operational efficiency, ie, cost savings, by reducing the volume or the scope of services, especially when such reduction deviates from the historic clinical practices of such providers. To withstand CMP scrutiny, ACO providers should be prepared to demonstrate that limitations or reductions in items or services yielded no adverse affect on the quality of care or patient outcomes. Importantly, participating providers can mitigate potential CMP liability by meeting an ACO core value — namely, the implementation of patient-centered protocols, consistent with evidence-based medicine, along with incentives for improving patient outcomes.

In short, CMP presents another regulatory concern. In recognition of the consequences of CMP liability, ACO promoters and their advisors should be mindful to avoid the adoption of clinical protocols that are intended to control cost and improve efficiency, without implementing safeguards to improve patient outcomes, particularly when the treatment protocols deviate from historic practices of the participating providers.

There remains a paucity of regulatory guidance available on these critical issues, although federal agencies are charged with addressing them in the near future. If and/or when approached by promoters to participate in ACO’s, physicians and other healthcare providers should consult their healthcare counsel about the legal and regulatory issues that arise from the proposed ACO model. Indeed, the devil is in the detail.

References
1. 42 USC §1320a-7(a)
3. 42 USC §1395nn.
4. 42 USC §1320a-7(a).

Chapter 7
On-going Challenges to the ACO Model

There are multiple challenges to the ACO coordinated care model. The deep fragmentation of our current delivery system has created mistrust issues among stakeholders. There is also the question of how any potential shared savings will be divided among providers. The ACO model requires a paradigm shift in referral and follow-up discipline, which may create antitrust issues. The CMS and the FTC, in a recent open workshop to discuss FTC regulatory approval and oversight as it pertains to the development and implementation of ACOs, acknowledged that ACO formation is challenged and inhibited by existing antitrust safe harbor laws. The maximum percentages of market share dictated in current antitrust laws are an impediment to the development of ACOs, because it is to the benefit of the ACO and patients if providers agree to exclusively provide services to only a single ACO. In fact, the stakeholder interviews supported this concern. PCPs will need to be exclusively tied to a single ACO as they represent the core of the business model.

Another issue is the extent to which the Secretary of HHS is granted liberal use of power to waive the application of the Stark law, anti-kickback statutes, and civil monetary penalty laws. The Stark law prohibits self-referrals. In other words, physicians are not permitted to refer to a designated health service or provider if the referring physician or any member of their immediate family has a financial stake in the referred provider’s entity. The CMS, FTC, and Administration are currently working on language for an exemption to the Stark law for the ACO model as it pertains to incentives and savings sharing. This should not discourage a practice from investigating opportunities around forming an ACO.

Lawmakers and regulatory agencies are finalizing the rules for formation and operation of ACOs. It will be important for orthopaedic specialists to get proper legal counsel to navigate the legal framework and protect themselves from civil or criminal liabilities.

Information technology infrastructure is another challenging area. Many providers, including hospitals, lack the ability to track services, costs, and care protocols. The federal government is driving adoption of health IT, and promoting and supporting the growth of health information exchange efforts. ACOs will require a level of patient health management that pushes the capability envelope of most current Electronic Health Record (EHR) systems. Supplemental technologies, such as systems for tracking, monitoring, and creating actionable reports on care gaps will be required to integrate existing EHR systems. Supplemental information technologies will include, but may not be limited to, electronic registries, multiple outreach and communications methods, software or systems capable of grouping patients by health conditions or status coupled with assessment programs that will then be able to automatically deliver educational materials and health notices directly to patients. HHS is funding several grant programs for the development and implementation of statewide exchanges that may assist some providers in meeting IT challenges. There are working examples of these types of state-wide exchanges, such as the Indiana Health Information Exchange (www.ihie.com).
Chapter 8
Opportunities for Specialist Participation in ACOs

The ACA provides the framework for building ACOs. This framework, along with the momentum supplied by CMS, the largest payer for medical services in our country, will likely result in the eventual deployment of the ACO model in at least some markets. Given this inevitability, orthopaedic surgeons in markets where there is significant movement should seize the opportunity to take leadership roles in formulating the musculoskeletal care component of their local ACOs.

To capitalize on the opportunities available, the specialist must understand where they potentially fit into the ACO structure. Additionally, specialists must identify the high-value priorities of other stakeholders that deserve our focused attention. The specialist’s ultimate priority, however, must be to both deliver and increase value in the patient-centered services that constitute our specialty.

Where is the Specialist in the ACO?
Although the ACO may seem similar to a patient-centered medical home (PCMH) with the primary care physician as the most important player, an ACO will be required to provide care from specialists including orthopaedic surgeons, and there are variations in how this can be achieved. The ACO itself is not mandated to include all specialists, but must manage the cost and quality of providing specialty care.

For integrated delivery systems interested in forming an ACO, there will be fewer changes. If healthcare providers organize into a Level 2 model (a multispecialty group plus a hospital), the specialist may need to join the group to continue providing service to the patients attributed to that ACO. For many specialists, the transition of their patients into an ACO may be invisible. Referral patterns, however, may be markedly affected. Although a specialist could have a relationship with several ACOs, the motivations to minimize cost and maximize quality may lead an ACO to identify “preferred” specialists. Preference could be expected for specialists who provide cost-effective and coordinated care through communication with their referring doctors.

Regardless of the level of integration of an ACO, coordination of care between the specialist, the PCP, and other care providers will be expected. This coordination is expected at multiple levels, from avoiding unnecessary duplication of labs or imaging to insuring appropriate specialist referrals. Further, communication between specialists and the referring PCPs will increase in importance, both to avoid duplication and to guide the PCPs in conservative treatment of the patient. At each step, there will be an expectation to provide appropriate care in a cost-effective manner. Successful implementation will require significant cultural changes from the motivations inherent in a fee-for-service model. Spontaneous implementation of change could be difficult, but reimbursement will likely be the driving force to bring coordinated care to fruition.

Participating in Payment Reform
ACO models evolved as a response to increasing medical costs without commensurate improvements in health outcomes of our population. In the past decade much of this cost increase has occurred in specialty care. Consequently, to achieve the goal of decreasing costs while maintaining quality, cost-intensive specialties such as orthopaedics must be actively engaged. As addressed in previous sections, this will require a culture change for orthopaedic surgeons habituated to a fee-for-service environment. ACOs seek to avoid the HMO model of the 1990s with the primary PCP as a gatekeeper by having all providers jointly at risk in containing the cost of care. More directly, the shared savings component of compensation will incentivize cost containment. Because these funds are anticipated to be returned to the ACO as an organization, a specialist will need to have in place agreements for his/her portion of the shared savings. If a surgeon is contracted as an independent provider of specialty services rather than a formal member of the ACO, the surgeon may not be eligible for shared savings reimbursements.

Another way to align all providers toward efficient delivery of care for well-defined illnesses or conditions is through bundling of episodes. Chapter 5 details the payment model, which is essentially a contracted payment amount for all costs associated with providing acute and post-acute care for the condition. Similarly, financial incentives for cost containment come from the portion of savings which CMS will return to those ACOs providing care below the projected cost.

For both bundled payments and shared savings, the surgeon should anticipate negotiating in advance with the ACO to determine apportionment. Local community
Defining Quality Measures for Orthopaedic Specialists
Under ACA, payment will be linked to various performance and quality metrics. Therefore, these metrics will become increasingly important. Measuring and tracking quality are requirements for approval as an ACO by Medicare and will predictably be required by commercial insurance carriers. These metrics will likely reflect the overall patient satisfaction with their care and outcome, as well as technical quality and value of the outcomes. All providers in an organization contribute to patient satisfaction. Value will ideally be addressed through a payment system that encourages efficiency over unnecessary care. However, early and active participation by the specialist is necessary as the system evolves. The more involved orthopaedic surgeons are in creation of the metrics for evaluating outcomes of orthopaedic procedures and surgeries, the more accurate and clinically relevant these metrics will be.

Orthopaedics, in general, lacks adequate objective data to define quality outcomes from a patient perspective. Subjective patient outcomes such as ability to return to work or recreation should complement objective, surgeon-defined measurements such as joint range-of-motion or radiographic measurements. However, tracking and evaluating patient outcomes is difficult and expensive. Using the EMR and establishing clinical registries will be valuable methods for tracking outcomes. Total joint arthroplasty registries have emerged as important tools for tracking complications such as device failure or infection rates that fall outside an expected norm. With electronic records, concerns can be identified early, minimizing hazards to future patients. Currently, the registry concept is expanding in orthopaedics, including all surgical procedures from ACL reconstructions to subtalar fusions. These registries will provide more data to guide development of patient-centric outcomes. Implementation of registries for most, if not all, common orthopaedic procedures is an anticipated response to the ACO’s mandate to monitor and report on quality measurements.

Improving the Effectiveness and Value of Orthopaedic Care
The specialist can fill a dual role in the ACO. An orthopaedic surgeon obviously would provide specialty skills for the patients who need them, but could also help to educate the PCPs and other referring providers in the management of musculoskeletal disease. As it moves toward more cost-effective care, the ACO might be expected to promote conservative treatment of musculoskeletal ailments by PCPs and physician extenders (physician assistants or nurse practitioners). To support these providers, orthopaedic surgeons should develop appropriate use criteria, review appropriate conservative treatment for routine diagnoses (e.g., managing ankle sprains, early arthritis), and perhaps even offer instruction for simple procedures such as joint injections.

Despite the emphasis on cost-effective care, improving the overall quality of the care should be even more important. Ideally, treatment adhering to evidence-based practices should decrease the overall cost of care. Quality in this sense should minimize the risk of complications such as postoperative infection or other adverse outcomes. Coordinating care with other care providers through improved communication can also minimize readmissions.

Contracting Issues for Orthopaedic Surgeons
When orthopaedic surgeons decide to participate in an ACO, they should negotiate rates commensurate with their current PPO and HMO reimbursement rates from the payer organization involved, because this is essentially a re-routing of patients from the same payer to a different program/product.

Currently, revenue is derived through frequency of a service performed multiplied by the rate paid for that service. This is today’s fee for service model. Initially this may not change, even in an ACO. However, as the pilot program progresses and more risk is delegated from the PPO and IPA to the ACO, surgeons should be cognizant of the changing payment methodologies, bundling, and reductions for repeated tests and/or procedures. Specialists may want to specify exclusions for services or procedures where this type of payment mechanism puts their practice at greater risk for loss.

Ideally, as the pilot program progresses, the risk pools are ultimately designed to contribute upside revenue to the surgeon’s practice which can be measured by his or her organization. Specialists should ensure that they are adequately compensated for the performance risk they assume if in fact they are able to improve quality and reduce the cost of musculoskeletal care. With the shift to
ACOs in some parts of the country, there is a change in reimbursement methodology for private payers toward fee-for-service reimbursements as a percentage of the local Medicare fee schedule versus proprietary fee schedules with the ability to carve out additional reimbursement for certain procedures. Orthopaedists should carefully analyze their revenue stream and case mix to make sure that they are positioned to get the highest reimbursement if they add PCPs and corresponding risk pools to their business model. Surgeons should also take note of specific payer trends moving toward state-wide, all-provider fee schedules. Negotiation strategies with the ACO, or with any commercial insurance payer, should focus on investment in advanced medical technology, efficiencies achieved through coordinated care (lab, pathology, radiology, CT, rehab, etc), and doing minor surgical procedures in the office, if possible, as much as possible. It would be better to work toward multiyear contracts with built-in cost-of-living adjustments to hedge against today’s economic risks.

Orthopaedists should do their homework before entering into an ACO arrangement. They may want to discuss the formation of an ACO organization with PCPs, other specialty groups, and/or hospitals in their local community. Another option is to combine multiple specialties into a “super-multispecialty” group capable of working with multiple PCP groups or hospitals to support their ACO pilot programs. Orthopaedic surgeons shouldn’t jump to replace all of their PPO plans with an ACO model.

The ACO model is an exploratory change and evolution of the fee-for-service payment model to provide incentives for achieving higher quality, more coordinated and cost-effective care. No one knows if this will work to achieve the goal of improved quality at lower cost. No one — including the payers, program developers, and IPAs piloting ACOs — knows if this new shared risk approach will achieve its goals. However, as part of an interdisciplinary, coordinated care team, specialists are keenly positioned to provide valuable input to ACOs. They can guide clinical decisions and improve triage, referral practices, discharge planning, and referrals to rehabilitation services and follow-up to help the team achieve benchmarks and to increase profits through shared savings bonuses.

Involvement in an ACO organization offers both challenges and opportunities for orthopaedic surgeons. It is important to remember that much of this new ACO model is yet to be defined. Tread cautiously and deliberately.

Summary
The ACO model requires involvement of specialists. Although specialists do not need to be formal members of such an organization, there may be referral or reimbursement pressures that make it desirable in some communities. Regardless of the legal relationship between the specialist and the PCP, specialists will be expected to coordinate care with other physicians. Beyond avoiding duplication of services, specialists may be expected to help guide appropriate conservative treatment through the development of appropriate use criteria for referrals to specialists and diagnostic and therapeutic interventions.

The ACO has developed as a way to address unsustainable healthcare costs and to deliver cost-effective health care. The actual payment mechanisms will move farther from fee for service and will likely involve bundled payments for some common orthopaedic procedures.

Ideally, the overall quality of care will be the primary driver for the ACO. By avoiding expensive complications, including reoperations and readmissions, ACOs can anticipate cost savings. However, the metrics of quality of care, particularly for orthopaedics, are poorly defined. Orthopaedic surgeons will need to play an active role in defining the metrics for measuring quality and in developing appropriate criteria for diagnostic and therapeutic interventions for managing musculoskeletal health.

Further Reading

Summary
Accountable care organizations represent a new model where physicians, hospitals, and other care providers work together to develop a more reliable, efficient, patient-centric delivery system. Unlike a managed care organization, ACOs exist in a fee-for-service system but with a shared-risk model.

What role should the orthopaedic surgeon play in the transition to ACOs? First, surgeons must understand the terminology and recognize that the current system is unsustainable. Because orthopaedic surgery in most cases is elective and is associated with high costs, it is likely to be a prime focus of early attention from ACOs.

Second, physicians should meet with their local hospital administrators early in the process of ACO development.
It is likely the ACO story will play out very differently in different regions and different markets. Thus, it is important to understand what direction your hospitals are taking, and make sure they know to come to you with questions about managing musculoskeletal care.

Third, orthopaedic surgeons should play a leadership role in choosing and defining the performance metrics that will be used to evaluate the care they deliver.

Fourth, orthopaedic surgeons should understand that it is often better to work with other physicians (including other orthopaedic groups), hospitals, and payers rather than against them. Leadership and collaboration from orthopaedic surgeons is sorely needed to ensure high quality, cost-efficient musculoskeletal care delivery under the ACO model.

The future of accountable care organizations is not yet written. But unless specialists play an active role, they are likely to be left behind.