Accountable Care Organizations and Otolaryngology

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Abstract
Accountable care organizations represent a shift in health care delivery while providing a significant potential for improved quality and coordination of care across multiple settings. Otolaryngologists have an opportunity to become leaders in this expanding arena. However, the field of otolaryngology–head and neck surgery currently lacks many of the tools necessary to implement value-based care, including performance measurement, electronic health infrastructure, and data management. These resources will become increasingly important for surgical specialists to be active participants in population health. This article reviews the fundamental issues that otolaryngologists should consider when pursuing new roles in accountable care organizations.

Keywords
accountable care organizations, otolaryngology, alternative payment models, performance measures, health care reform

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Accountable care organizations (ACOs) were formally created with the passage of the Affordable Care Act in 2010. At that time, ACOs were widely misperceived by surgical specialties as simply a program for primary care patients with chronic disease. Since then, the number of ACOs has steadily grown (Figure 1). As of 2015, 424 Medicare ACOs exist, covering 7.8 million, or 20%, of Medicare beneficiaries.¹ As the number of patients participating in ACOs continues to rise, so will the impact on the practice of otolaryngology–head and neck surgery. ACOs represent a pivotal shift in the way that health care is delivered, but they can serve as an opportunity to gain experience in a low-risk model of payment reform. Although the specialty of otolaryngology currently lacks many of the resources necessary to transition the focus of care from volume to value, positive changes are occurring to support this.

To address quality and cost in the modern era, otolaryngologists should help to lead the effort toward creating a more effective health care system. For many otolaryngologists, this means considering whether to join an ACO or other value-based model. The purpose of this article is to address what is required of the specialty of otolaryngology–head and neck surgery so that physicians are better informed and can become active participants in ACOs.

Understanding the Foundations of ACOs
The mission of ACOs is aptly defined by the triple aim: improving the experience of care, the health of populations, and costs. This is accomplished through the delivery of coordinated, high-quality care by a designated provider group for a population of beneficiaries. If we assume that quality measure targets are met, a

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Figure 1. Growth in accountable care organizations (ACOs). Includes commercial and government ACOs. Data provided by Leavitt Partners, LLC.
Accountable Care Organizations

<table>
<thead>
<tr>
<th>Commercial</th>
<th>Government</th>
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<tr>
<td>State Medicaid ACO Programs</td>
<td>Medicare Shared Savings Program</td>
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Figure 2. Characterization of accountable care organizations (ACOs).

decrease in medical expenditures per capita may result in savings that the insurer shares with the provider. To date, more than $417 million in savings have been generated by Medicare ACOs. Notably, reducing medical expenditures for unnecessary procedures or services may reduce revenue received for a particular patient, but the goal is that improved overall efficiency will help to ensure that the right patients within a population are receiving high-quality and appropriate care, while minimizing any reduction in revenue for a provider.

There are different types of ACOs and several important distinctions that otolaryngologists should understand (Figure 2). They can be led by physicians, hospitals, insurers, or some combination thereof. While Medicare ACOs have the most publically available information, a large number of commercial ACOs have been created through private insurers (eg, Anthem, Aetna, UnitedHealthcare). This discussion focuses on Medicare ACOs, since commercial and state-run Medicaid ACOs are typically nonstandardized. There are 2 major models of Medicare ACO programs: the Medicare Shared Savings Program (MSSP) and the Pioneer ACO Model. The majority of ACOs are in the MSSP. The Pioneer ACO Model was designed for providers experienced in care coordination to facilitate a rapid transition to population-based payment. In the MSSP, ACOs can participate in either shared savings and shared risk (2-sided model) or just shared savings (1-sided). In both instances, an ACO may be eligible to receive a percentage of the cost savings, but only in a 2-sided model might an ACO be financially penalized for increasing costs. Nearly all ACOs are currently 1-sided, minimizing provider risk. The Pioneer ACO Model and the recently proposed Next Generation ACO Model have higher percentages of shared savings and risk than those of MSSP ACOs. While this increased risk sharing may prompt ACOs to adopt more rigorous interventions, it would be difficult to generalize exactly how otolaryngologists may be affected in any given ACO.

Otolaryngology-Specific Performance Metrics

Quality of care is a central component of the program, and the evaluation of ACOs include their performance on 33 quality measures, encompassing 4 broad categories: patient and caregiver experiences, care coordination and patient safety, preventive health, and disease-specific criteria in at-risk populations. While the 12 disease-specific criteria target chronic diseases not directly treated by otolaryngologists, several other metrics are strongly connected to the care of all participating providers. These include 7 patient satisfaction measures (eg, access to specialists, physician communication) and 3 care coordination measures (eg, all-cause readmission, medication reconciliation).

For otolaryngologists to meaningfully participate in a value-based system, it is imperative that specialty-specific performance metrics are created. Few such metrics currently exist, although the American Academy of Otolaryngology—Head and Neck Surgery considers performance measure development a strategic priority. The pathway to the creation of performance metrics begins with clinical guidelines. As of January 2015, 70 formal otolaryngology recommendations exist in the Agency for Health Care Research and Quality’s Guideline Clearinghouse (guideline.gov), compiled from numerous organizations and specialty societies. Thirteen Clinical Practice Guidelines have been developed by the American Academy of Otolaryngology—Head and Neck Surgery Foundation (Figure 3). These guidelines serve as the basis for the existing performance measures and performance measure groups. Where appropriate, use of performance measure groups, which use reporting on a small sample of patients instead of a majority of individuals, can reduce the documentation burden for otolaryngologists. ACOs capitalize on measure groups and existing pathways to streamline Centers for Medicare and Medicaid Services reporting. ACO quality measures are required on a sample of only 411 beneficiaries per measure annually through the Group Public Reporting Option. Providers achieving these criteria automatically qualify for the Physician Quality Reporting System’s incentive payment and avoid the system’s downward payment adjustment.

Development of and adherence to performance measures promote high-quality care through standardizing best practices. Importantly, the impact on quality improvement does not have to be limited to the otolaryngology office. Much of the otolaryngologic care in this country is delivered in a primary care setting (eg, otitis media, cerumen impaction, sleep apnea). Specialists can use performance measures to advise primary care physicians on patients with noncomplex otolaryngology issues. This requires a level of coordination of care that is arguably best incentivized and achieved through an ACO-like model.

Data Requirements for Practicing Value-Based Care

It is clear that technology is a key enabler for ACOs. The entire premise of performance metrics depends on having interpretable information that is readily available for use. However, there is currently a paucity of data available within otolaryngology. A 2011 survey by the American
Academy of Otolaryngology—Head and Neck Surgery found that only 67% of respondents reported using electronic health record technology. A robust health information technology platform and integrated electronic health record are fundamental to ensuring successful participation in a model of care where cost and quality data are essential parameters for measuring success and determining payment.

Beyond updating one’s individual electronic health record system, there are several ways that otolaryngologists can build a data network allowing for better performance under an ACO model of care. First, since otolaryngologists enter into a shared partnership when joining an ACO, utilizing the ACO’s electronic health system can aid in collaboratively managing patients. Second, insurance companies record claims data on the physicians and practices connected with their beneficiaries. These data are increasingly being used in measuring variability in quality and cost of care. Third, information on provider practices in other countries can be valuable in providing an additional objective metric for comparison although there may be some limitations. In summary, these data sources can be analyzed to help define evidence-based practices. Interoperability and transparency are inherent challenges to achieving this goal but are the bridge between ACOs’ principles of shared responsibility and shared benefit.

**Issues to Consider Before Joining an ACO**

Surgical subspecialty representation in ACOs is low. However, there are growing expectations for specialists to participate in care coordination—such that the National Committee on Quality Assurance now individually recognizes specialists with the Patient-Centered Specialty Practice Program. Otolaryngologists have an opportunity to emerge as leaders among specialists at a critical time in the transformation of the US health care system. There are costs and benefits associated with implementation of an ACO.

Some of the positive aspects may include improved quality of care, access to data, and increased referrals. Team-based support and best practice pathways can provide significant help with challenging patients. However, extensive organizational capabilities may be necessary to meet program requirements. There are numerous potential pitfalls related to the ability to manage risk, including electronic health record interconnectivity, data capture, and stakeholder cooperation. Such factors were the focus of discussion at the 2010 meeting of the American Medical Association. A list of recommendations that are most relevant to otolaryngologists has been derived (Table 1). Of note, the potential of ACOs to consolidate competition raises concerns regarding antitrust law. However, in most circumstances, ACOs obtain a type of exemption (i.e., safe harbor provision or “safety zone”) from these laws.

One of the major issues that otolaryngologists will need to address is the structure of their potential relationship with an ACO. For example, otolaryngologists functioning within a team-based model of care will depend on their interactions with care managers, the development of mutual goals, and the sharing of resources. The terms of involvement are partially defined by a participation agreement. Although the agreement can take many forms, several factors should always be included. Each ACO is allowed its own formula for allotting shared savings (and risk), so it is important to determine how that will be distributed. The majority of ACOs’ shared savings are centralized on primary care, with lower percentages typically going directly to specialists. Importantly, ACO agreements are an opportunity to define expectations for otolaryngologists and fellow providers to improve integration of care across multiple settings.

Becoming an ACO may be an independent decision or part of a larger strategy. Of note, otolaryngologists who bill under the same tax identification number as other provider groups within an ACO are automatically considered part of
that same ACO. Otolaryngologists can currently participate in only a single ACO; however, proposed MSSP rule changes could expand this number. Ultimately, each otolaryngologist or group practice will need to determine the relevance of the ACO construct as it relates to their work.

Preparing for the Future

Approximately 23,000 new providers joined an ACO at the start of 2015. However, otolaryngology as a specialty has been slow to transition to this new payment model. While other surgical specialties have been targeted by the Centers for Medicare and Medicaid Services for reform, otolaryngology has received relatively minimal pressure to reduce costs. For instance, none of the nearly 50 conditions listed on the centers’ Bundled Payments for Care Improvement initiative are typically managed by otolaryngologists. Still, it is important to invest in the present specialty to be able to focus on what is going to be valued in the future. The Secretary of Health and Human Services recently reported a target of 30% of Medicare payments through alternative payment models such as ACOs by the end of 2016 and 50% of payments by the end of 2018. Participation in ACOs ensures that otolaryngology is engaged in the future of health care delivery, helping to drive population health. The alternative is the risk of having patients and control referred elsewhere.

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Table 1. ACO Principles for Otolaryngology.

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<thead>
<tr>
<th>Issue</th>
<th>Recommendation</th>
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<tr>
<td>ACO guiding principles</td>
<td>Should be aligned with those of the physician</td>
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<td>ACO governance structure</td>
<td>Should be physician led with specialist involvement</td>
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<tr>
<td>ACO participation</td>
<td>Should be voluntary for physician and patients alike</td>
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<tr>
<td>ACO revenue and savings</td>
<td>Should be retained for primary and specialty patient care services</td>
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<tr>
<td>Potential antitrust law issues</td>
<td>Should be addressed with waivers and safe harbor provisions</td>
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<td>Securing of resources</td>
<td>Should be up-front to offset risks and start-up costs</td>
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<tr>
<td>ACO spending benchmarks</td>
<td>Should be risk, specialty and regionally adjusted</td>
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<tr>
<td>ACO quality reporting program</td>
<td>Should be nationally accepted, specialty society validated</td>
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<td>Health information technology</td>
<td>Should be interoperable between primary and specialist care</td>
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Abbreviation: ACO, accountable care organization.

