Accountable Care Organizations

BY JANE SHERWIN

Accountability is good, most people would say. Will the same hold true regarding accountable care organizations (ACOs)? Or—if, as the saying goes, a camel is a horse designed by a committee—will ACOs resemble bureaucratically designed networks with elements of health maintenance organizations (HMOs), medical homes, physician group practice (PGP) demos, provider-sponsored organizations (PSOs), and others patched together?

Time will tell.

Just what are ACOs? They are networks of health care providers that will be rewarded financially if they slow the growth in their patients’ health care spending while maintaining or improving the quality of the care they deliver. Roshunda Drummond-Dye, JD, regulatory and payment counsel in APTA’s Government and Payment Advocacy Unit, explains, “The goal of the ACO is to provide seamless, high-quality care instead of fragmented care in the current Medicare fee-for-service model.”

The Affordable Care Act (ACA) authorized the creation of ACOs and allowed Medicare to contract with them. [See “What Are ACOs?”] The Centers for Medicare and Medicaid Services (CMS) issued final regulations on October 20. In January, it began accepting applications from providers interested in forming ACOs.

Certain types of health care providers are eligible to form or “sponsor” ACOs. These include physicians, hospitals, networks of individual practices, partnerships and joint ventures between physicians and hospitals, and critical access hospitals. Physical therapists (PTs) can’t create ACOs, but all Medicare providers—including PTs—can participate in them.

ACO providers will be paid with a combination of the familiar Medicare fee-for-service reimbursements and bonuses based on cost savings. CMS is offering providers 2 models: (1) a 1-sided shared savings model, in which providers only share in savings; and (2) a 2-sided shared savings and losses...
model, in which providers also share losses if the ACO’s costs go up. ACOs may share up to 50% of the savings under the 1-sided model. But with more risk comes more reward. ACOs selecting the 2-sided model may share in up to 60% of the savings, depending on their quality performance.

CMS has targeted 4 areas in which to measure quality:

- Patient experience
- Care coordination and patient safety
- Preventive health
- Caring for at-risk populations

The higher the quality of care delivered by providers and the greater the cost-effectiveness of their care coordination, the more savings they may keep. CMS estimates that federal savings could be as great as $940 million over 4 years.

**What Do ACOs Mean For PTs?**

As noted above, PTs can’t form ACOs, but they can participate in them, sharing both the benefits and the potential risks.

APTA President Scott Ward, PT, PhD, commenting on proposed regulations last June, wrote, “APTA is pleased that physical therapists will have the opportunity to participate in ACOs and will continue to actively encourage its membership to improve health care to their patients through innovative health care delivery models including ACOs . . . As stated in the proposed rule, the goal of the ACO is to carry out the 3-part aim of health reform, which is to provide better health care to individuals, better health for populations, and to lower growth in expenditures. These are goals that APTA is very committed to achieving.”

The PTs interviewed for this article agree that PTs should be well-positioned

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**What Is an Accountable Care Organization?**

Section 3022 of the 2010 Affordable Healthcare Act called for “a shared savings program to facilitate coordination and cooperation among providers to improve the quality of care for Medicare fee-for-service beneficiaries and reduce unnecessary costs.” Accountable Care Organizations (ACOs) are CMS’ response. The final CMS regulations were issued October 20 and published in the November 2 Federal Register.

Simply put, an ACO is a shared savings program for Medicare providers. ACOs are intended to help solve the problem of fragmented, wasteful, and poor quality care. ACOs also are meant to address the lack of financial incentives for good health outcomes among Medicare beneficiaries, and the huge growth in Medicare costs. (Between fiscal years 1975 and 2008, federal spending for Medicare rose from 0.8% of GDP to 2.7%.)

CMS says it hopes that ACOs will improve Medicare patient health and increase the value of care by:

- promoting accountability for the care of Medicare fee-for-service beneficiaries,
- requiring coordinated care for all services provided under Medicare fee-for-service, and
- encouraging investment in infrastructure and redesigned care processes.

Some critics have argued that an ACO is just an HMO in another form. In fact, though, the differences are significant. For one thing, patients are not restricted to treatment by ACO providers. While physicians are required to tell patients they are part of an ACO, patients may see any provider they wish. As one analysis put it, “beneficiary choice is protected.” Second, ACO reimbursements are based on quality performance, not on return of funds withheld during the year. What HMOs and ACOs do have in common is an attempt to coordinate care and improve health through preventive means.

ACOs also have been compared to medical homes. Again, though, the differences are major. Although a medical home is a team-based approach to patient care, it is not Medicare-specific. In a medical home, a provider team offers coordinated care, with teamwork and attention to critical points such as transition from hospital to home, ongoing treatment of chronic conditions, and social services. A strong ACO may well incorporate a number of medical homes into its structure to achieve high-quality, efficient, and coordinated care.

**What Will ACOs Look Like?**

An ACO will be a legal entity capable of distributing shared savings to its various providers. It will be quite large, with a minimum of 15,000 patients, 5,000 of them Medicare beneficiaries. Providers may include hospitals, physicians and physician networks, and partnerships between physicians and hospitals. Physical therapists may participate in ACOs, but are not permitted to form them.

One reason ACOs are required to have a large number of patients is the statistical technique for attributing patients to a particular ACO. CMS’s stated goal is to encourage providers to extend high-quality, coordinated care to all their patients, whether Medicare beneficiaries

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to function within ACOs, should they choose to do so.

Michael Weinper, PT, DPT, MPH, predicts that the use of measurements, especially for outcomes, is the wave of the future. He says that physical therapists would do well to develop their capacity for both measuring and marketing their outcomes for patient interventions. Weinper is president and CEO of PTPN Inc, a network of independent rehabilitation providers that operates in 23 states representing over 1,000 clinics in private practice.

Weinper concedes, “Most physical therapists have avoided examining their patient outcomes, being fearful that they weren’t as good as they would like to be. But the reality is that life is a bell-shaped curve. No one is perfect. Over 5 years ago, we required our PTPN providers to measure clinical outcomes.”

Weinper recommends the use of a “provider report card” in demonstrating performance—an approach that will fit well into the outcomes measurements required of ACOs. “We need to be able to demonstrate that PTs are doing what we are supposed to. Then, once we have a good report in place, how should we publicize it?”

Weinper says that PTs increasingly are recognizing the need to demonstrate their strengths. Physicians already are involved in “pay for performance” arrangements, and physical therapists can expect the same in the near future, he predicts.

Weinper also points to the CMS Physician Quality Reporting System.3 Launched in 2006, it was designed to encourage providers—including PTs—to provide quality care by offering bonuses for measures such as balance and fall risk, pain assessment, and screening for osteoporosis. “The idea,” says Weinper, “is that if you can demonstrate applying these measures to a

or not. In ACOs, patients are free to move from one provider to another without penalty.

An ACO must have significant administrative—and therefore financial—strengths;10

• The capacity to administer the collection and distribution of shared savings among facilities and staff
• A strong electronic health records system, essential to tracking performance and providing complete and accurate patient data for clinicians
• A willingness to track and be measured on some 33 different quality measures

How Will ACO Providers Be Paid?

ACO providers will be paid with a combination of the familiar Medicare fee-for-service reimbursements. In addition, providers will be eligible to receive bonuses. They also may be liable for penalties.

CMS is implementing 2 ACO models: (1) a 1-sided shared savings model, in which providers only share in savings; and (2) a 2-sided shared savings and losses model, in which providers also share in losses if costs rise. ACOs may share up to 50% of the savings under the 1-sided model and up to 60% of the savings under the 2-sided model, depending on their quality performance.

An ACO’s quality performance will be judged on 4 factors:

• Quality standards on patient experience
• Care coordination and patient safety
• Preventative health
• At-risk populations

CMS says, “These standards will be measured in a way that accounts for providers who treat patients with more complex conditions.”

ACO regulations are highly specific as to the steps providers must take both to maintain and improve the quality of the care they offer, and to document that quality. A physician-directed committee is required to oversee a quality assurance program, hold ACO providers accountable, and identify and correct compliance issues.

One recent analysis noted: “The final regulations call for ACOs to be notified in advance about the patients for whose cost and quality of care they are likely to be held accountable, with quarterly updates of both the list of patients and information about them. Knowing the patients for whom they are being held responsible in advance should give ACOs a better opportunity to focus on improving their care and assessing their progress.”11

What Criteria Will Measure ACO Performance?

To share in savings, ACOs in the first year must fully and accurately report across all 4 domains of quality. Providers will begin to share in savings based on how they perform in some of 33 quality measures in the second and third performance years.

The details of these standards are extensive. For example, the ACO must use annual surveys of patients to evaluate patient/caregiver care experiences. In terms of care coordination, a 30-day post-discharge physician visit is required.6
large enough population of Medicare patients, you will be rewarded.”

By 2015, Weinper observes, the bonuses, including those for physical therapy, will be replaced with a penalty for failing to apply such measures. “In other words, the outcomes measurement approach is here to stay.”

Janice Kuperstein, PT, PhD, associate professor and chair of rehabilitation sciences at the University of Kentucky College of Health Sciences, says, “One of the key advantages of ACOs is that they are motivated to provide coordinated interprofessional care by staff who include not only physicians and nurses but also a variety of other health care professionals. ACOs have a strong financial incentive to provide high quality care across the continuum. This means having all the right people on board. In many cases, physical therapists are important members of this team.”

This applies not only to PTs in private practice, but also to PTs in hospitals and other institutions. “Physical therapists who are hospital employees need to understand, and make a case for, the value of their work in patient care,” Kuperstein says. “To give the best quality care, physical therapists should be integrally involved in a hospital’s administration. This is part of what hospitals should be looking at: the mutual education of physical therapists and other organizational leaders.”

Kuperstein agrees with Weinper that it’s essential for physical therapists to make a documented case for the strength of their own services, whether or not they join an ACO. “Individual and group practices are starting to market themselves in terms of outcomes, sharing their own results, and providing comparisons with other practitioners. More physical therapists need to start doing that.”

**Not All PTs Will Opt for ACOs**

Selena Horner, PT, MS, GCS, ATC, owner of Red Cedar Physical Therapy in Williamston, Michigan, reports that she has been compiling outcome measures for at least a decade. Since opening her solo practice in 2005, she has been using hard copy tools for measurement such as the Lower Extremity Functional Scale, the Patient-Specific Functional Scale, and the Oswestry Disability Index, tracking patients and using software programs such as Access and Excel to analyze outcomes, review treatment with physicians, and determine strengths and weaknesses in her practice.

“I use the data for queries about my treatment of various diagnoses. I can get average scores, medians, standard deviations, and give potential clients a sense of how much improvement they likely will experience and how long it will take.” Despite this, however, Horner is uncertain about the value of ACO participation to her practice. Nevertheless, she recently has begun exploring electronic systems for tracking her outcomes.

Mark Acierno, PT, DPT, OCS, SCS, whose Frederick Sport and Spine Clinics in Frederick, Maryland, has 5 physical therapists and 1 physical therapist assistant, is very much aware of the movement toward ACOs, but is not sure whether participation would be a good idea for his practice.

One of his concerns is the difficulty and expense of implementing electronic health records (EHRs). Acierno uses a variety of paper-based scales and

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indices to monitor treatment outcomes. “The [electronic] system we implemented 6 years ago was technologically obsolete almost immediately. We don’t have the time or money to find and implement a new one,” he says.

Acierno appreciated APTA’s recommendation that CMS provide “the appropriate financial resources and support that will enable ACO participants such as physical therapists to adopt EHRs.” Unfortunately, the final rules were silent on this point.

However, some ACOs participating in CMS’ Medicare Shared Savings Program (MSSP)—including small physician practices and rural community hospitals—will be allowed to take out loans from CMS to pay for infrastructure investments such as purchasing EHR systems. These loans would be deducted from any future shared savings payments for which the ACO might qualify from CMS.

Should You Join an ACO?

Drummond-Dye says, “Overall APTA is supportive of physical therapists working in integrated ACO-type systems with nurses and physicians. We don’t feel we can comprehensively tell our members that ACOs are good or bad. Our role is to empower members with as much information as possible, giving them the tools to decide whether participation in an ACO is good for their individual practice.”

If you do decide that you want to become involved in an ACO, Drummond-Dye advises: “If you have a private practice and an ACO is forming in your area, how can you reach out and build relationships and make your own practice attractive to the ACO? You will want to show how your patients already have benefited from your care. You’ll want to show how in your practice costs are lower and quality is improved.”

In short, PTs will have to demonstrate their value to ACOs—not just in their ability to help patients...
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However, even with the final rules issued in October, Weinper and Kuperstein agree that the ACO concept as it now stands is unsettled and not entirely clear.

“There’s been pushback by many providers who say the ACO concept is too complex, rigorous, and confusing,” said Weinper. “Very few have actually formed. Medical associations are pushing back, and providers don’t know where to start. The next few years are going to be very confusing for the average provider—physical therapists as well as physicians.”

Drummond-Dye says that APTA will continue to provide its members with ACO information through its Web site and educational venues including online documents and podcasts.

“We want members to be able to hear from colleagues about successful, innovative models of care and even physical therapists’ work in nontraditional settings such as the intensive care unit.

“APTA will provide information about good practices regarding ACO membership, such as how to market your services, how to begin to gather information about patient outcomes, whether to incorporate information technology in your practice, and how to pick an IT vendor.”

References