



Internal Medicine

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# What Hospitalists Need to Know About Accountable Care Organizations

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[Disclosures](#) | October 25, 2016

Accountable care organizations (ACOs) represent a large and growing part of far-reaching transformations for the US healthcare system, says Bradley Flansbaum, DO, MPH, MHM, a hospitalist at Lenox Hill Hospital in New York City.

But ask him how the hospitalist's working life is different today under an ACO, and he replies, "It's not. There is no difference in the way they get paid in an ACO," he says. "I don't know of any hospitalist group that has changed its financial incentives for members in response to ACOs."

Dr. Flansbaum, a member of the Society of Hospital Medicine's (SHM's) Public Policy Committee, blogs at [The Hospital Leader](#) about these transformations, which are sometimes lumped together under the rubric of healthcare reform, payment reform, bundled payment, population health, or value-based care.

## So, What Exactly Is an ACO?

ACOs are groups of doctors, hospitals, and other healthcare providers that come together voluntarily to provide coordinated, high-quality care to covered populations of patients. The Centers for Medicare and Medicaid Innovation has been testing three models of Medicare ACOs, whereas commercial plans are embracing ACOs defined more casually to include loosely knit networks of providers, Dr. Flansbaum says. ACOs now number 838 nationally.<sup>[1]</sup>

ACOs are often associated with other alternative payment methodologies that are starting to replace fee-for-service reimbursement for healthcare. The goal is to get providers to share in the financial risk for providing healthcare to defined populations by offering rewards for care that meets the so-called "triple aim" articulated by the Institute for Healthcare Improvement: "better care for individuals, better health for populations, and lower per capita costs."<sup>[2]</sup>

## No Effect on Day to Day, for Now

"But we're not there yet," Dr. Flansbaum says. "The ACO represents a mindset that the healthcare system is embracing. But we still live in the fee-for-service world. Depending on the local market's evolution and models of ACOs, they are still far removed from the mainstream of hospitalist practice."

For individual hospitalists, their parent health system's participation in ACO contracts has not yet percolated down to their daily work life, he says. The hospitalist might not even know whether a given patient is part of an ACO at the time of admission.

But there will be increasing expectations for quality and value. This will include, for example, effective patient transfers, prevention of readmissions, communication with primary and post-acute care providers, patient satisfaction scores, and other quality metrics. The percentage of beneficiaries who are in Medicare Advantage plans is growing, and more than 30% of Medicare payments are now made to health systems that reward quality and cost-effectiveness over volume of services provided.<sup>[3]</sup>

"In 10 years, we'll all be in the population health business," says Ron Greeno, MD, MHM, senior advisor for medical affairs at Team Health, North Hollywood, California, and SHM's president-elect. "Hospitalists today are most involved with bundled payment models. But in all models, they'll see higher percentages of their revenue tied to performance metrics. Every healthcare organization in America is getting ready for this change," says Dr. Greeno, who in October gave a keynote address, "Hospitalists in the World of Population Health," at the 14th Annual Rocky Mountain Hospital Medicine Symposium in Denver.

The good news for hospitalists, Dr. Greeno says, is that they are an absolute necessity for success under the new payment schemes.

"I can't think of a single health organization in the country with managed care and population health experience that is successful without having a strong hospitalist program. From the start, we were not paid for billing productivity alone, but for what we contribute to our hospital or health system," he says.

Dr. Greeno says hospitalists will need to do what they always do, but better.

"We'll need to be more efficient, with more focus on financial risk, and we'll be more heavily scrutinized by our health systems. As your hospital gets knee-deep into ACOs, you'll need to make good decisions about individual patients—providing the right care right now," Dr. Greeno says.

There are still misaligned incentives in the system, but if a patient is in an ACO, that patient should come into the hospital only if they absolutely need to, he says.

"Eventually, it will be all about the lowest per capita cost for delivering high-quality care, and the hospitalist will be asked to support that goal," Dr. Greeno says. "If you undertreat or discharge the patient too soon, it will come back to haunt you. If you get a call from the emergency department for an ACO patient, you'll want to hot-foot it down to that department and make sure the patient really needs to be admitted."

## Being Part of the Conversation

Hospitalist Ami Parekh, MD, JD, acknowledged a widely used metaphor for healthcare today: "Yes, we are in two payment systems right now. But we've got to put them together and make a catamaran. If we don't, we could fall in the water," she says.

Dr. Parekh is executive director of population health and accountable care for the University of California, San Francisco (UCSF) health system, although she still sees patients in the hospital and outpatient clinic. UCSF Health participates in five commercial ACOs, she explains. Her biggest challenge, she says, is to educate staff about healthcare reform.

She explains it this way: "Someone from the health system is going to come up to you in the not-too-distant future and say something like this: There's this subset of ACO patients for whom I would like you to check in 3 days after discharge. You need to do a clear, doctor-to-doctor handoff and, if they get readmitted to the hospital, we want the same doctor to see them. And we want you to communicate more with other doctors in our system, and with post-acute care providers. We will also be looking at patient-reported outcomes for your patients at 90 days."

John Nelson, MD, MHM, a hospitalist at Overlake Hospital Medical Center in Bellevue, Washington, as well as a consultant and SHM cofounder, says that he too is trying to stay abreast of these new payment models.

"Recently, I've been thinking a lot about how much full-time clinicians should be expected to know this stuff. They can focus on the broad outlines, but leave it to others to keep up with the details," he says.

Perhaps someone in the hospitalist group can volunteer to be the expert on accountable care, just as many groups have a designated leader in health information technology.

"I can't think that frontline doctors should feel obligated. It's just too much to keep up with all the details," Dr. Nelson says. "Eventually, a health system administrator will come to your group with new performance metrics. But I'm sure there will be room for give and take. They can't just start measuring you without your participation in that conversation."