Health Providers Examine Promise of ACOs

BY MARY ELLEN SCHNEIDER

The medical model of "the more you do, the more you make" is out, according to Dr. William Chin, and so is the idea that the physician needs to do everything personally. If a service can be provided more efficiently by a nurse or social worker, that may be the way to go under the next big thing in health care – the accountable care organization.

Dr. Chin, executive medical director for HealthCare Partners, an independent physician association (IPA) based in Torrance, Calif., said his group plans to participate in the new Medicare shared savings program for ACOs, which will launch in January. The group has been preparing for the transition for a while: They are currently also working with Anthem Blue Cross in California to test how an ACO would work in the commercial market as well as testing ACO accreditation standards being developed by the National Committee for Quality Assurance (NCQA).

HealthCare Partners' physicians in California have been working in the global capitation market for many years and Dr. Chin said this experience will help them transition to being an ACO.

"We have had the experience of improving outcomes and reducing costs, improving patient satisfaction, improving the patient experience in our model," Dr. Chin said. "Some of the common goals of the ACO are things that we are doing today."

This year is likely to be a "learning year" for their practices, Dr. Chin said, as they prepare to meet the various standards being developed for ACOs. One advantage they will have is that their practices have already adopted electronic health records. Without that investment in technology, it's nearly impossible to become efficient and improve quality because paper charts are intractable to analysis, according to Dr. Chin.

But even with EHRs in place, all practices seeking to become ACOs will have to deal with significant culture changes and shifts in the delivery model, he said.

ACOs have been a hot topic in health care circles since they were written into the Affordable Care Act. The law includes the shared savings program through Medicare, which will allow ACOs to earn additional payments if they can both save the government money and meet quality benchmarks. As the program goes forward, physicians also would assume some financial risk if they are unable to provide cost-effective care.

Officials at the Centers for Medicare and Medicaid Services released a proposed regulation on Mar. 31 outlining how the Medicare ACO program will work. Under the new voluntary program, ACOs could include physicians in group practices, networks of individual practices, hospitals that employ physicians, and partnerships between these entities, as well as other providers.

An ACO will be a partnership among both primary care and specialist physicians; however, only primary care providers will be able to form an ACO, according to the proposed regulation.

Providers working in an ACO would continue to receive regular payments under Medicare fee for service, but could qualify for additional payments if they save money for the program. The proposed regulation requires that ACOs meet quality standards and demonstrate that they have reduced costs in order to be eligible to share in savings.

The proposal outlines 65 quality measures in five domains: patient experience, care coordination, patient safety, preventive health, and metrics for the care of at-risk and frail elderly populations.

The proposed regulation also creates two models for how an ACO can share in the potential Medicare savings, depending on its level of maturity. Under a one-sided risk model, a less-developed ACO can share in the savings they produce during the first 2 years and then assume financial risk in year 3, sharing in any potential financial losses.

More mature organizations can pursue the two-sided risk model and share in the potential savings and losses immediately. As an incentive to assume risk earlier, ACOs that pursue the two-sided risk model will be eligible for a shared savings percentage of 60%, as compared with 50% for those in the one-sided risk model.

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Physicians may need to invest in health information technology, said Jonathan Blum, director of the Center for Medicare Management.

Physicians' groups see pluses and minuses in the government's vision for ACOs.

The proposed regulation has some good points, said Dr. Roland A. Goertz, president of the American Academy of Family Physicians, but doesn't provide much incentive for small- and medium-size practices to participate. For example, the program focuses on too many quality measures in the first year and the number of covered beneficiaries that must be in an ACO might be too high for many smaller practices to reach. Also, the design for one-sided and two-sided risk is likely too complex to attract practices without experience operating as an ACO, he said.

Dr. Goertz said the AAFP will file public comments on the proposed regulation urging changes to make it more attractive to smaller practices. In the meantime, he advised family physicians not to rush into any ACO deals. Family physicians are in a good bargaining position and should try to avoid making commitments to other organizations before they have a clear sense of the final regulation from the CMS.

When it comes time to make those agreements, physicians must be clear on the details of risk sharing and payments to individual physicians. "Don't undervalue yourself in terms of the potential of the ACO," he advised.

Officials at the American Medical Association also have voiced some concerns about the investments that physicians, especially those in small practices, would need to make in order to become part of an ACO. Potential investment might include an electronic health record, hiring nurse care managers to assist in patient education and self-support, or adding currently unreimbursed services such as e-mail communication with patients and other physicians.

The AMA has recommended that the CMS create loan- and technical-assistance programs to help small physician practices in becoming ACOs. Since commercial lenders might be reluctant to grant lines of credit, given the uncertainty and confusion that surround health care payments, the AMA suggested that the CMS educate lenders on the new revenue streams associated with ACOs. CMS also could create a loan guarantee program to make it easier for small physician practices and IPAs to get financing from commercial lenders. Or, the AMA suggested, the CMS could make grants to nonprofit commercial organizations that could provide grants, loans, and technical assistance.

One area in which physicians may need to make investments is in health information technology. Jonathan Blum, director of the Center for Medicare Management, said the ACO proposal is closely aligned with the Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009 and the electronic health record incentive programs. Coordinating the ACO quality measures with those in the EHR incentive programs reduces the burden on physicians and hospitals that are submitting data through the various programs, Mr. Blum said. It also offers the potential for physicians to offset some of their technology costs through the bonus payments they can earn by achieving meaningful use of their EHRs.

The move to ACOs will be a major shift, said Dr. Paul Grundy, director of health care transformation for IBM and president of the Patient-Centered Primary Care Collaborative. "You've got a $2.7 trillion stream going in the wrong direction," he said. "That's a huge river to overcome."

But despite the financial and cultural barriers that have prevented these types of shifts from occurring in the past, Dr. Grundy said the medical community is ready to make a change toward the patient-centered medical home concept and ACOs.

Many purchasers of health care, including Fortune 100 companies and the federal government, are already supporting the concept of the medical home and physicians who have made the switch love it, he said. "I think it's really clear that this is where we're going and where we have to go."

The trend is being driven by more than just the provisions in the Affordable Care Act, he said. The escalating cost of health care is pushing businesses and other health care purchasers to look for alternatives to keep costs down. At the same time, there are finally data to show how patients are being managed and what types of care are cost effective. Additionally, younger consumers want to access health care the same way they do their banking and shopping. "For them to be told by a practice that they can't access their laboratory data online, they'll just keep looking until they find someone who can," Dr. Grundy said.

Another player in the ACO field is the NCQA. The not-for-profit organization offers recognition programs for physicians, hospitals, and health plans in a number of areas. Starting this summer, the organization plans to unveil its standards for ACO accreditation. The first ACOs to go through the program could receive accreditation in 2012, according to Raena Grant Akin-Deko, assistant vice president for development at the NCQA.

The standards could be a "road map" for organizations to begin to build the capabilities to become an ACO, she said. "What we've done through these standards can help people understand what the important capabilities are and give them some direction about what are the things that they should be thinking about."

The NCQA recently concluded testing of its standards with 10 organizations that represent IPAs, multispecialty practice groups, and integrated delivery systems. One issue that came up during the testing is the importance of leadership within the ACO.

"We can define structural features that are important for [ACOs], but I think you cannot underestimate the importance of leadership and the cultural change toward patient-centered care in forming these organizations," she said. ■

Alicia Ault and Naseem Miller contributed to this report.

To view a video interview with Mr. Blum, scan this QR code.