

HealthCare Reform 2012: Accountable Care Organizations (ACOs) and the Allergist

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Healthcare reform is inevitable, and the overall growth in health care expenditures is expected to grow considerably over the next decade. This growth is largely the result of an aging American population and an increasing number of Medicare eligible and disabled beneficiaries. To address the ever-increasing Medicare costs, President Obama signed into law the Patient Protection and Affordable Care Act on March 23, 2010. Some of the goals of the Patient Protection and Affordable Care Act are to provide an opportunity to improve access to care and manage cost of the overall health care delivery, while at the same time providing improved quality and compassionate care. Many of the provisions of the Affordable Care Act are already in place or are evolving, such as the extension of health care benefits to family members, differential management of pre-existing medical conditions, and implementation of electronic health records. However, it is the latest governmental acronym – ACO (Accountable Care Organizations) - that has created the greatest conversation. It is hoped that ACOs will provide a vehicle to bridge the cost - care gap. At the same time, it is ACOs that provide the greatest unknowns and anticipated challenges facing health care providers and hospitals alike. What exactly are ACOs and how will they affect the practicing allergist?

Health care and the delivery of that care in the United States will surely evolve over the next few years. How this evolutionary process will transpire is not absolutely clear, but agility will be required at all levels on the part of the practicing allergists. ACOs are merely one of the latest models for the delivery of health care services and offer health care providers and hospitals incentives to provide high quality care while at the same time managing the overall costs of health care delivery. Although initially a federally driven program directly addressing the ever-increasing cost of Medicare, its appeal has incentivized private carriers and states to set up their own versions of ACOs.

At its heart, an ACO is a network of doctors and hospitals that share the responsibility to care for patients, agreeing to attend to the health care needs of at least 5,000 Medicare eligible beneficiaries. The ACO would bring together the many and varied components of the health care system such as hospitals, primary care, specialty care, home health, and laboratory and radiology services. The intended effect of this cooperative effort, if achieved, would result in overall cost savings and also achieve the stated goal of improved quality of care.

According to the Affordable Care Act (section 3022) ACOs may begin to contract with Medicare in January 2012. The rules make ACOs responsible, and hold all providers jointly accountable, for the care of their patients while at the same time providing financial incentives to implement coordinated care. The cost savings goals would be realized through avoiding unnecessary tests and procedures as well as improved care coordination

though shared information systems. Additional savings would be found in paying special attention to patients with chronic conditions. Simply keeping patients healthy and out of the hospital would result in cost reduction. For ACOs that are not able to save money, that cost burden would be assumed by all members of the ACO. It is this shared risk that has created much of the anxiety regarding ACO implementation. How an ACO is implemented throughout the country is also quite varied. Depending on where one resides or practices, such as California or many large east coast cities, the infrastructure is already in place in the form of large multi-specialty organizations. In other regions, large insurers, hospitals or other regional systems are purchasing practices as they prepare to form their own ACOs.

In March 2011, The Center for Medicare & Medicaid Services (CMS) released the proposed rules for the Medicare Shared Savings program (a prototype for an ACO). The public comment period closed in June 2011 and the Final Rules were published in October 2011. The initial proposal had features that were particularly unattractive such as risk-sharing provisions, strict baseline data management, and cumbersome reporting requirements. There are a number of pilot ACO programs across the country. Many of these pilot programs failed to achieve the cost saving objectives, although the physician managed pilots did comparatively well when compared to non-physician managed programs. In the October 2011 Final Rule a number of significant improvements were included.

The October 2011 changes include many critical provisions. The important changes include allowing providers to participate with minimal financial risks, giving practices more time to prepare by creating a rolling application process, and removing some of the requirements that targeted primary care providers, including reducing the number of quality care measures as well as loosening the electronic medical health requirements. Other adjustments included funding for rural and small practice communities as well as anti-trust considerations incorporated into the changes. . In addition the Federal Trade Commission and Justice Departments have eliminated the mandatory antitrust review for startup ACOs. Finally, the Final Rules, through CMS, provide for \$170 million in up front costs for small physician groups and rural hospitals

The American health care system is in transition, and a response in both care and cost improvements to that system is inevitable. As such it is important to understand that health care reform is a dynamic process. As Fisher and colleagues point out, "These observations [on ACOs] suggest that ACO formation should be understood not through the lens of a specific settled contract, but rather as an emerging payment model that can be implemented alongside the fee-for-service payment system while supporting a transition to the goal of fully coordinated and accountable care."¹ The most successful model for managing health care cost has not emerged, but for the moment it would appear that ACOs will be at least a part of that transition. It is essential for practicing allergists now to strategically position themselves to thrive in this emerging ACO payment model. How they accomplish that and how outpatient specialist positions himself or herself in an ACO structure will be the subject of future articles.

1. Fisher ES, McClellan MB, Safran DG, Building the Path to Accountable Care. N Engl J Med 2011; 365: 2445-7