*Volume 2, Number 2* *February 2011*

# ACO Business News

**Timely News and Business Strategies on Accountable Care Organizations**

## Physicians, Health Systems Should Weigh Other Delivery Reforms in Building ACOs

Developers of accountable care organizations should factor in other pieces of health delivery reform, such as assessing how they will organize or "bundle" payments to providers, or integrate a medical home-type concept into the model, to optimize their ability to lower costs and improve care, health industry observers are advising.

A number of changes under the new health reform law promise to deliver on a more efficient health care system, with similar objectives on cost reduction and quality improvements. Whereas the Center for Medicare and Medicaid Innovation promises to deliver on new ways of testing care delivery, including medical home concepts, a proposed rule CMS issued on Jan. 7 establishes a hospital program to link financial incentives to improve the quality of care. Yet another provision taking effect on Jan. 1, 2015, will tie physician payments to the quality of care they provide. The law also establishes a national pilot program by 2013 to encourage providers to "bundle" their payments for an episode of care to align incentives of those delivering the care.

All of these reforms are going to have to work in conjunction with one another, as each one has the overarching goal of improving quality, lowering costs and increasing patient satisfaction outcomes, and "they all seem to be coalescing under the ACO," Sheila Schweitzer, a senior vice president with Ingenix, tells *ABN*.

The desired outcome for bundled payments, for example, is collaboration, coordination and definition of care, using evidence-based medicine and protocols, Schweitzer tells *ABN*. Keeping in mind that the ACO's charge is to deliver on high quality, lower costs and better customer satisfaction, it's likely that ACOs will use bundled payments for an episode of care, something that's already happening in the commercial sector, she says.

Bundled payment capabilities, as authorized in the reform law's pilot program, could certainly be used to augment the ACO structure, "or alternately, provide health care systems and networks the ability to experiment with risk before they go into a full-fledged ACO operational mode," Erik Johnson, senior vice president with Avalere Health, tells *ABN*. What all of these payment reforms have in common is the shift of either clinical or financial risk from Medicare to the providers, Johnson continues. The bundled payment demo does that with respect to financial risk, "and I think that can be incorporated into the ACO."

In assessing future relationships between ACOs and medical homes, it's important to distinguish between the two, Schweitzer says. While their objectives may be similar, "think of the ACO as a risk-bearing entity, the organization that's supplying the opportunity for care. An ACO can't just be a single discipline of medicine. An ACO is a collaboration of constituents necessary to deliver episodes of care. So a risk-bearing entity might be a group of oncologists, but it also has to have a lab, a hospital." The medical home, in turn, is a tool that these providers can use to deliver that care, she explains.

Medical homes are a natural investment for an ACO to make, "and I think it's a highly recommended one," Johnson says. "It just provides an easier vehicle by which to align quality and cost pressures. Because otherwise, you end up dealing with a population health management strategy that's a little bit unfocused. The great thing about the medical home is if it's done right, it provides some focus to a non-trivial portion of the population that you're supposed to manage. And given capital constraints, what an ACO is going to want to do is focus on predictable, chronic care populations that lend themselves well to the medical home model."

Mark Hedberg, a Richmond, Va., partner with the health care group of law firm Hunton & Williams LLP, expects that many ACOs will adopt some incarnation of a medical home into their respective models. "I don't know that they will all call it [a medical home], but at the end of the day, I think the ones that are going to be successful will be using strategies that look awfully similar" to what medical homes are doing. It may just be on a slightly different scale, he tells *ABN*.

Because the culture of each practice will be different, ACOs in all likelihood will leave the specific details

to the practices, and use those experiences as ways to develop best practices down the line, he explains.

Value-based purchasing programs will also be an U.S. integral part of the ACO, according to health care industry observers. "The value based purchasing program essentially takes whatever DRG [i.e., diagnosis-related group] payments hospitals would receive and shaves them by a bit to create a pool of money to pay to those hospitals that provide high quality care to Medicare beneficiaries. It's a fee-for-service driven payment.…And that kind of fee-for-service mentality at least initially will be present in the ACO Shared Savings model" developed under the CMS regulations, Hedberg says.

Any major health system looking to create an ACO should start evaluating or investing in these other aspects of health delivery reform right now, Johnson says. At a minimum, they should be asking themselves, "how do we manage the bundle, how do we unbundle it? Do we have the financial systems in place to parcel that bundle out to the various providers we contract with? What type of medical homes do we need? What type of populations can we manage from a quality standpoint, whether it's diabetics, mental health, heart failure or high blood pressure? These are all serious conditions, but if they're managed well through the medical home, the costs can be made very predictable. And then I'd be looking at the value-based purchasing proposed rule to see how I perform against those metrics, not just from a financial standpoint, but how this dovetails with my medical home strategy. Is this where I'm choosing to focus my attention in the near term?" Johnson advises.

Ultimately, the health systems developing these ACOs are going to have to make tradeoffs, he says. "Systems are going to have to choose what they're going to focus on, and what they're going to choose to ignore for now."

Contact Schweitzer at sschweitzer@caremedic.com, Hedberg at mhedberg@hunton.com and Johnson at ejohnson@avalerehealth.net. ✧