

# Accountable Care Organizations: What Are They and How Will They Impact Dermatology?

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## Practice Points

- Accountable Care Organizations (ACOs) are designed to increase the value of care by reducing costs and increasing quality.
- Accountable Care Organizations may or may not include dermatologists.
- Dermatologists may or may not benefit from affiliation with an ACO.
- Dermatologists can thrive in an environment that emphasizes value, efficiency, and patient satisfaction.

There is a strong consensus among policymakers that US health care costs are unsustainable. In 2011, total health care spending in the United States reached \$2.7 trillion, representing 17.9% of the gross domestic product and averaging \$8680 per person.<sup>1</sup> Although American health care costs are much higher than those of other nations, health care outcomes in the United States are no better and often are worse by all measures.<sup>2</sup> Overall, policymakers of all stripes have concluded that the US health care system provides poor value. Accountable Care Organizations (ACOs) are proposed to increase value by coordinating care, reducing costs, and measuring quality of care. In this article, I will describe ACOs and discuss how they may impact dermatologists and the care of patients with skin disease.

## What are ACOs?

In the simplest terms, an ACO is a group of health care providers who are held accountable for the value

of care delivered to a certain population of patients. It is important to distinguish between private ACOs and Medicare ACOs. Private ACOs may take many forms, while Medicare ACOs are well defined under the Medicare Shared Savings Program (MSSP), which was established under the Patient Protection and Affordable Care Act.<sup>3</sup>

The MSSP allows ACOs that increase the value of care to share in the monetary savings generated over a period of time for a defined population of Medicare beneficiaries. As of January 2013, there were more than 250 Medicare ACOs across the country.<sup>3</sup> A common misconception is that ACOs are simply a recapitulation of health maintenance organizations (HMOs). Both ACOs and HMOs rely on groups of health care providers to coordinate care and reduce costs, but there are substantial differences; first and foremost, most HMOs rely on capitation to control costs while traditional Medicare ACOs do not.

For the time being, health care providers within traditional Medicare ACOs are paid via a fee-for-service system; therefore, the incentive of the ACO is to reduce services, thereby reducing charges with the hope of sharing in eventual savings. Beneficiaries are retrospectively assigned to a Medicare ACO if that ACO provided most of their primary care services.<sup>4</sup> Accountable Care Organizations have an incentive to minimize specialty and procedural services and to

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refer patients within the ACO, but beneficiaries are not limited in their choice of providers.<sup>5</sup> Additionally, a Medicare ACO must reduce costs and meet 33 quality standards to obtain any shared savings.<sup>6</sup> Simply reducing costs is not sufficient.

The fine details of the MSSP are beyond the scope of this article, but in summary, Medicare ACOs cannot limit patient access to closed panels of physicians, and payments are not capitated. Medicare ACOs are tasked with reducing costs and improving quality of care for a population of patients who can choose to seek care anywhere, and ACOs will succeed or fail based on total utilization of services by their defined populations. To succeed, Medicare ACOs must satisfy patients and create systems that provide efficient, high-quality care.

Private ACOs may represent many kinds of relationships among health care providers, third-party payers, and even employers.<sup>3</sup> A private ACO may contract with a health insurer or directly with an employer, and these contracts may be capitated or may be similar to the MSSP. One prediction is that ACOs will eventually contract directly with large employers, thus ending health insurance as we know it.<sup>7</sup>

### How will ACOs impact dermatology?

Dermatologists and other specialists are uncertain of their roles within ACOs and the impact that ACOs will have on the care they offer their patients.<sup>8,9</sup> Many dermatologists who work within multispecialty groups will find themselves to be members of an ACO and wonder if and how it will change their medical practices. Dermatologists in single-specialty practices may need to decide if they are going to join an ACO. Accountable Care Organizations may or may not include certain specialties, so while a dermatologist may wonder what an ACO can offer him/her, the ACO will consider what dermatologists can offer their patients. What can dermatologists offer ACOs, and what can we expect in return?

What can we expect from ACOs? Dermatologists are unlikely to benefit directly from any shared savings. Accountable Care Organizations are primary care based, and shared savings can be expected to enhance primary care services and coordination within any ACO. On the other hand, ACOs may alter referral patterns and certain private ACOs may restrict patients to panels of physicians. Depending on the local market, a dermatologist may need ACO affiliation to maintain a steady stream of patients. More nebulous benefits include the potential to provide better care in a coordinated system with improved communication among providers.

What do dermatologists have to offer ACOs? If the ACO model fundamentally changes the financing

and delivery of health care, the provision of services for patients with skin disease may depend on the perceived importance of dermatology among other specialties, especially primary care. Dermatologists must demonstrate that we provide important, cost-effective care, and we must engage with programs to enhance health care quality. In a system that emphasizes care coordination as well as patient satisfaction, we must be team players and our patients must like us.

At first glance dermatologists seem peripheral to the goals of ACOs who are likely to focus their cost-containment efforts on expensive inpatient services, high-cost procedures, and common chronic conditions such as diabetes mellitus. Although skin cancer treatment currently represents a tiny fraction of the total Medicare budget, the number of skin cancer treatment procedures is rapidly increasing.<sup>10</sup> Once an ACO has exhausted the low-hanging fruit, skin cancer treatment may be a potential target for further cost reduction. Dermatologists may be able to improve quality of care and reduce costs for health systems in other ways. For example, a recent study showed that patients admitted to a hospital with skin findings obtained more accurate diagnoses if they were seen by a dermatologist.<sup>11</sup>

The 33 Medicare ACO quality measures do not include dermatology-specific clinical outcomes, but they do include measures of patient satisfaction and access to specialists.<sup>6</sup> A recent study of 142,377 patients demonstrated that skin disorders were diagnosed in 42% of outpatients over a 5-year period in Olmsted County, Minnesota.<sup>12</sup> Even if only a small fraction of those patients required the care of a dermatologist, there is a clear need for physicians with expertise in skin disease. Any successful ACO must plan to accommodate that need, and it is in the interest of ACOs to utilize dermatologists who meet the needs of their patients in a cost-effective manner and who have records of high patient satisfaction.

### Final Thoughts

Accountable Care Organizations may or may not prove to be successful, but one can confidently predict continued emphasis on quality of care and movement away from the traditional fee-for-service system of payment.<sup>13</sup> Dermatologists can thrive in a system that rewards efficiency and patient satisfaction, but to do so, we must demonstrate our value in the care of patients. Until data on clinical outcomes of dermatology-specific diseases become available, we must emphasize patient demand for dermatology services and our patient satisfaction rates. Equally important is the establishment of strong positive relationships with primary care and other physicians through availability for consultations, educational

sessions, and service to our hospitals and medical communities. Within our specialty, dermatologists also must develop robust quality measures; as physicians, we must be actively engaged in improving quality of care. In summary, if dermatologists work within the house of medicine to improve quality of care and control health care costs, our patients and our specialty can benefit, regardless of how our health care system evolves.

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### QUICK POLL QUESTION



#### Will you participate in an Accountable Care Organization (ACO) as a dermatologist?

- a. Yes, I already participate in an ACO
- b. Yes, I am considering it
- c. No, I won't participate in an ACO
- d. Not sure yet

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