IMPLEMENTING HEALTH REFORM

Accountable Care Organizations

One new concept to come out of the health reform debate is the Accountable Care Organization (ACO). The concept builds off the idea of the patient-centered medical home and calls for primary care physicians, specialists, and hospitals to band together to provide high-quality care for patients. Under the ACO concept, payments would be linked to quality, and ACO providers would have the opportunity to share in any savings realized through better, more cost-effective care. Under the Affordable Care Act, Medicare will launch a shared savings program in 2012 to test the concept.

Dr. Lori Heim, president of the American Academy of Family Physicians, explains how these ACOs might work and what might drive their popularity.

RHEUMATOLOGY NEWS: The AAFP has spent a lot of time promoting the concept of the patient-centered medical home and the medical home neighborhood. Is an ACO the next logical step?

Dr. Heim: The ACO builds on the foundation of a medical home based in primary care. Both have the same goals for the patient: coordinated care that ensures a seamless transition from one service to another and one level of care to another.

The core of an ACO is effective primary care with a focus on prevention, early diagnosis, chronic disease management, and other services delivered through primary care practices. We believe that in order to be successful, ACOs will require a robust network of practices founded in primary care. They may involve other primary care practices, subspecialists, and in some cases hospitals. Envision the ACO as an expanding circle of health professionals with the patient and the patient's medical home in the center.

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DR. HEIM

The ACO concept requires that medical-home practices commit to performance improvement and publicly reported performance results. ACOs are a formalization of the medical home neighborhood, which is essential for a medical home to realize its full potential. Thus, an ACO may be the next logical step for physicians whose practices offer a mix of services; however, isolated rural practices will have more barriers to overcome to become members of an ACO.

RN: What are the advantages and disadvantages of an ACO?

Dr. Heim: ACOs will improve information flow and communication. They will offer payment incentives designed to produce high-quality, patient-centered, efficient care. The problem areas are in aligning the financial incentives in a way that provides the best value to the patient.

Cost savings to support an ACO will come largely from reductions in three areas: inappropriate hospital admissions and readmissions, diagnostic testing and imaging, and subspecialist expenses.

One of the greatest challenges to implementing an ACO is managing the conflicts associated with the internal distribution of funds. We are likely to see tension as health communities move away from competition and toward cooperation and collaboration.

RN: In the future, will all physicians be part of an ACO?

Dr. Heim: Because this concept is so new, it's hard to say. Decisions on organizing the delivery system will be local. We're going to see considerable experimentation with different structural models, different financing models, and different approaches to sharing payment or system savings among all providers.

The movement will likely begin in large and well-organized independent practice associations (IPAs), multispecialty groups, and integrated delivery systems. For efficiencies of scale, other physicians will first need to organize into groups that can assume performance risk (for quality and efficiency, not insurance risk) and contract with specialists, hospitals, and other providers to build out the ACO model that will be attractive to employers and insurers.

RN: What do physicians need to do now if they want to experiment with the ACO idea?

Dr. Heim: The first step is to become a high-performing practice by implementing medical procedures, protocols, and services, as well as quality improvement systems. The second step is to think about how physicians' practices fit into a larger health care community to provide comprehensive, integrated care. Physicians need to know their options for organizing into groups to create or become a part of an ACO. ■

DR. HEIM *is also a hospitalist at Scotland Memorial Hospital in Laurinburg, N.C.*

Patients Get New Rights to Appeal Insurance Decisions

BY MARY ELLEN SCHNEIDER

New federal regulations mandated by the Affordable Care Act will give patients new rights to appeal claims denials made by their health plans.

The rules, which were announced on July 22, will allow consumers in new health plans to appeal decisions both through their insurer's internal process and to an outside, independent entity. While most health plans already provide for an internal appeals process, not all offer an external review of plan decisions, according to the U.S. Department of Health and Human Services. The types of appeals processes often depend on individual state laws.

HHS officials estimate that in 2011 there will be about 31 million people in new employer plans and another 10 million people in new individual market plans who will be able to take advantage of these new appeals opportunities. By 2013, that number is expected to grow to 88 million people. The rules do not apply to grandfathered health plans.

Under the new rules, health plans that begin on or after Sept. 23, 2010, must have an internal appeals process that allows consumers to appeal whenever the plan denies a claim for a covered service or rescinds coverage. The internal appeals process must also offer consumers detailed information about the grounds for their denial and information on how to file an appeal.

The new rules aim to make internal appeals more objective by ensuring that the person considering the appeal does not have a conflict of interest. For example, the health plan is not allowed to offer financial incentives to employees based on the number of claims that are denied. Health plans will also have to provide an expedited appeals process, which would allow urgent cases to be reviewed within 24 hours.

The new federal appeals regulations also standardize rules for external appeals. ■

Medicare Reforms Are Expected To Save $8 Billion by End of 2011

BY MARY ELLEN SCHNEIDER

Provisions of the new Affordable Care Act, coupled with other payment changes, will save Medicare nearly $8 billion over 2 years and extend the solvency of the Medicare Trust Funds by 12 years, according to a new report from the Centers for Medicare and Medicaid Services.

The immediate savings come from cuts to Medicare Advantage payments, competitive bidding for durable medical equipment, changes to how Medicare pays for advanced imaging services, productivity improvements in the hospital, and efforts to reduce waste, fraud, and abuse. These changes are expected to save $7.8 billion for the Medicare program by the end of next year.

The report, issued Aug. 2, analyzes cost-cutting provisions that CMS has already implemented or will be implementing soon.

"For too long, we've paid too much for health care, gotten too little in return, and watched the situation get worse each and every year," Health and Human Services Secretary Kathleen Sebelius said at a press conference to release the report.

"The Affordable Care Act is already putting our health care system on a new course, bringing down costs while improving the quality of care and giving all Americans more value for their dollars," she said.

Ms. Sebelius noted that the new law will protect Medicare beneficiaries by maintaining current benefits and adding new ones such as free preventive care and the eventually closing the Medicare Part D prescription drug doughnut hole.

Over the long-term, CMS officials estimate that Medicare savings will exceed $418 billion by 2019. Some of those savings will come from reducing hospital readmissions and hospital-acquired infections, bundling payments for end-stage renal disease care, promoting Accountable Care Organizations, and improving quality reporting by physicians.

CMS also expects the establishment of the Independent Payment Advisory Board (IPAB), which will recommend payment changes aimed at slowing growth in Medicare spending, to contribute to those savings by cutting Medicare costs by about $23 billion by 2019.

Many physician groups have been critical of the board, saying that Congress has placed too much authority in the hands of an unelected body. Under the Affordable Care Act, the IPAB's recommendations will take effect unless Congress passes legislation that meets the same budgetary targets.

Ms. Sebelius said that she expects private insurers to follow the federal government's lead in implementing some of these payment changes as they prove effective in the Medicare program. ■