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.

FAMILY PRACTICE 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 and 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.

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.

FPN: 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.

The ACO movement will likely begin in large and well-organized independent practice associations, multispecialty groups, and integrated delivery systems.

One of the greatest challenges to implementing an ACO is managing the conflicts associated with the internal distribution of funds. So, while we're likely to see improved referral patterns and communication that will provide seamless, high-quality health care, we also are likely to see tension as health communities move away from competition and toward cooperation and collaboration.

FPN: 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 medical home is important because its performance can be quantified and compensated relative to the value it brings to the entire system.

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.

FPN: 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. They need to understand their options for, and the implications of, contracting with or being employed by hospitals.

Hospitals are strategically buying primary care and subspecialty practices in markets where ACOs are mostly likely to form in order to maintain a flexible posture for the future. It is important for us to examine future contracts in light of potential shared savings for ACO and other payment models, whether we remain in private practice and negotiate contracts, or consider becoming salaried physicians. ■

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

Millions of Women Could Benefit From Health Reform Law

BY NASEEM S. MILLER

As many as 30 million women could benefit from the health reform law over the next decade, according to an analysis of the Affordable Care Act by the Commonwealth Fund. This includes up to 15 million women without health insurance who could get subsidized coverage; 14.5 million insured women who will benefit from improved coverage or reduced premiums; and an estimated 100,000 uninsured women who could gain coverage under the Pre-Existing Condition Insurance Plan.

Women's health care needs leave them more vulnerable than men to high health care costs, and they are more likely to lose their health insurance.

The study authors said that although women are as likely as men to be uninsured, their health care needs leave them more vulnerable to high health care costs and they are more likely to lose their health insurance. Insurance carriers consider women, especially those of childbearing age, to be at a higher risk than men, according to the study. In addition, most policies sold on the individual market won't cover the cost of pregnancy, according to the study. Women also are more likely to delay their care and be more central in coordinating health care for their families.

Although this is good news for women across the nation, the question remains whether there will be enough physicians to provide care for them.

Physician shortage in the United States is documented through dozens of studies by organizations such as the Association of American Medical Colleges, in addition to several states.

But Karen Davis, Ph.D., Commonwealth Fund's president, said that there are provisions in the Affordable Care Act that could help alleviate the current physician shortage and encourage more physicians to accept Medicaid and Medicare patients.

For instance, there will be an increase in primary care fees that are paid by Medicare, and Medicaid reimbursement rates for physicians will come up to Medicare level in the next several years, she explained.

But, "the big improvement comes from increased funding for community health centers," Davis said. She said that the Act's provisions will double the capacity of community health centers, which mostly provide care to low-income patients.

Some of the ACA provisions that benefit women will start as early as September of this year. Others, such as expansion of Medicaid eligibility and new state insurance exchange with premium and cost-sharing subsidies of up to 400% of federal poverty level, will go into effect after 2014.

The report, titled "Realizing Health Reform's Potential: Women and the Affordable Care Act of 2010" is the first in a series of analyses by the Commonwealth Fund, focusing on how health reform will affect various groups and populations. ■