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Perspective

The role of allergists in accountable care organizations

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Accountable care organizations (ACOs) are organized legal structures that allow health care professionals to track the cost and quality of care provided to defined populations of patients. Simply stated, the ACO is responsible for the overall care provided to patients who see primary care physicians who participate in the ACO. Since the passage of the Patient Protection and Affordable Care Act in 2010, several hundred ACOs have been launched that now affect millions of Americans throughout the nation.¹ As often occurs in health care, when new ideas receive widespread national attention, the response has been an exponential growth of these organizations. The establishment of additional Medicare ACOs are expected to increase during the next several years, and with commercial insurers following suit, large numbers of Americans will likely be covered under these arrangements. It is therefore important that allergists be aware of how these organizations work and how they will affect their practices and their patients.

The structure of the ACO allows for groups of health care professionals to share infrastructure to provide medical management and care coordination, to collect and disseminate quality measures for populations of patients, and to distribute shared savings if these actions result in a reduction in the cost of care. The essential components of the ACO are the ability to track clinical and financial performance, have analytic capabilities to understand the way that care is being provided, engage patients in their care, and coordinate services across various settings of care. Specific management strategies include patient registries, health information exchanges, protocols for care management, and centers of excellence for the care of patients with the most complex conditions. The authorization of the ACOs in the Patient Protection and Affordable Care Act decreased many regulatory and legal barriers to being able to accomplish these objectives.

Most of today's ACOs operate within the context of the fee-for-service system. Allergists are paid according to their current fee schedules, with either Medicare or a participating commercial plan, yet in addition have the potential to receive additional funds for improvements achieved in cost and quality. The ACO virtually

monitors the claims for payments and calculates the total cost of care that is attributed to an individual patient. If the actual cost of a patient is less than the projected cost for that patient as projected from past years and expected cost trends, there may be savings returned to the ACO. If the actual costs are more than the expected costs, there may be downside risk for the ACO, depending on whether some level of risk was negotiated as part of the ACO contract with the payer. If savings are achieved by the ACO, then the ACO can determine how much of that savings is returned to primary care physicians and specialists. Most ACOs today favor a greater proportion of savings to primary care physicians over specialists.

ACOs are still relatively new, with the first Medicare ACOs being authorized in April 2012. Although there are some initial encouraging trends, it is still too early to determine whether ACOs are reducing costs or improving quality within their attributable populations of patients. ACOs were initially positioned as organizations that would focus on the role of the primary care physician and the patient. In fact, many ACOs have created a strategy around the deployment of the patient-centered medical home concept.² Proponents of this model of care argue that primary care physicians who coordinate care through improved communication with patients and coordination of services can reduce use of hospital services, ancillary testing, and specialist services. Such a model could potentially result in lower use of health care resources and specialty care. It is not clear, however, whether such models have an overall effect on lowering the cost of care. Little attention has been spent on understanding how ACOs will affect the role of the specialist on optimal management of chronic illness. It is also not known just how many specialists are opting to become active in patient management through ACOs. Specifically, the number of allergists participating in an ACO is not understood, and various models for primary care physician and allergist collaboration in these organizations have also not been well documented. In this article, the role of the allergist in the ACO will be explored, and recommendations will be made on how specialists may be helpful in reducing costs and improving the quality of care.

Much of the debate about the role of the allergist within ACOs centers around the issue of whether chronic illnesses are more effectively managed by primary care physicians in a patient-centered medical home model with the specialist serving as

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a consultant or whether chronic illness would be more effectively managed in a collaborative model between primary care physicians and specialists. No well-designed comparative studies have tested these models. There is, however, compelling evidence to suggest that allergists can have a significant affect in reducing costs and improving outcomes.

The role of allergists on controlling costs in asthma is well documented. With the total cost of asthma-related care in this country at approximately \$50 billion per year, treatment by a allergist has been reported to reduce inpatient hospitalizations by 95% and emergency department visits by 77%.^{3,4} Use of specific treatments, such as immunotherapy, has been found to reduce total health care costs for patients with rhinitis compared with patients treated with traditional regimens.⁵ Such therapies are more likely to be used and most likely better managed by allergists than primary care physicians. Numerous studies have found that asthma care provided by specialists has been associated with improved outcomes.⁶ Treatment outcomes that are important to overall success of the ACO include measures such as use of inpatient stays and emergency department visits, missed days from work or school, patient quality of life and functional status, mortality and morbidity, and the overall total spend of care.

Although most ACOs today assume that primary care physicians will form the foundation of the ACO physician network, it may be possible for allergists to organize their own groups to take accountability for populations of patients. Allergists could then link with other physician groups or subcontract to primary care groups to create a network of services that would meet the needs of an attributed population of patients. Allergists should also consider their role in future payment models, including bundling of services, gain-sharing models, comanagement of defined populations of patients, and risk-based contracts. Participation in clinical integrated models of care, which have contracted based on performance measures, appears to be the most likely path for meaningful specialist participation in future models of health care provision.

Another path that should be considered by allergists is to engage in the development of collaborative models of care with primary care physicians who are ACO participants. The basis for these collaborative models would be preestablished protocols for diagnostic criteria of conditions such as asthma, required workups, treatment pathways, and outcomes goals. Specific criteria for

referral to the allergists can be created as part of the collaborative model. In one study of primary care physicians, those physicians who had greater exposure to training in allergy and immunology referred patients to an allergist 30% more than those that were less well educated about allergic conditions.⁷

The future of ACOs in the transitioning health care marketplace is not certain. It is likely that the ACO may be an evolutionary vehicle to some other type of management structure or reimbursement system. Many believe that physicians are moving toward the greater assumption of financial risk and will begin to look more like insurance companies do today. Although many physicians are rightfully concerned about heading down this path, the headwinds are strong for continuing business as usual. Changes to our health care system are almost certainly going to occur at a rapid pace. Allergists have much to contribute to the solutions that are required for providing cost-effective care to defined populations of patients. Allergists should consider getting involved with the ACOs in their communities, help coordinate clinical interventions for ACO patients with allergic diseases, and collect cost and outcomes data that can be shared with primary care physicians to document improved efficiency and results. Although the path toward optimal management of care is far from clear, the riskiest option for the allergist is to sit it out on the sideline and not participate in health care's transformation.

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