

Accountable Care Organizations and the Allergist: Challenges and Opportunities

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For decades, health care policy experts have wrestled with ways to solve problems of access, cost, and quality in US health care. The current consensus is that the solution to all three lies in changing financial incentives for providers and delivering care through integrated systems. The currently favored vehicle for this, both in the public and private sectors, is through Accountable Care Organizations (ACOs). Medicare has several models and has fostered rapid growth in the number of operative ACOs. At least an equal number of private ACOs are in operation. Whether or not these organizations will fulfill their promise is unknown but there is reason for cautious optimism. Allergists can and should be part of the process of this transformation in our health care system. They can be integral to helping these organizations save money by reducing hospitalizations and improving the quality of allergy and asthma care in the populations served. In order to accomplish this, allergists must become more involved in their medical communities and hospitals. © 2014 American Academy of Allergy, Asthma & Immunology (J Allergy Clin Immunol Pract 2014;2:34-9)

Key words: Access, cost, and quality; Accountable care organization; Attribute; Bundled payment; Fee-for-service; Independent practice association; Information technology; Medicare; Medicaid; Patient-centered medical home; Patient Protection and Affordable Care Act; Payment model; Pioneer; Shared risks and savings; Tax identification number

The American health care system has been the subject of concern by policy makers for nearly a century because it is imperfect in 3 major realms: access, cost, and quality. Calls for reform date back to the presidency of Theodore Roosevelt (through that of his cousin Franklin), and Franklin D.

Roosevelt's successor Harry Truman, who advocated for a national health system. Medicare and Medicaid under President Lyndon Johnson set about helping seniors and low-income people get care that had eluded them and President Richard Nixon led the efforts to rein in spending for health care by establishing health maintenance organizations and managed care. President and Mrs Clinton attempted and failed to get comprehensive reform in the 1990s, and the factors that motivated all these leaders to achieve some measure of change only continued to become more acute over the next decade. It was only with the passage of the Patient Protection and Affordable Care Act in 2010 and the upholding of its central provision, the individual mandate, by the Supreme Court in 2012, that real change became possible.

The realities that health policy makers confronted in 2008 when President Obama was elected included millions of Americans who lacked insurance coverage for medical expenses. As of 2010, nearly 50 million Americans lacked health insurance. Many Americans were being deprived of essential health care, often with disastrous results for them or their families.¹ This is the problem of access.

Comparison of the costs of medical care between the United States and the rest of the developed world showed that the United States was spending nearly twice as much on medical care as the next highest-cost country, Switzerland.² This is the problem of cost. Unfortunately, there is no evidence that spending more was getting Americans better outcomes. In fact, by many measures, Americans live shorter and unhealthier lives than most Western Europeans. Outcomes are not commensurate with cost. We pay a lot for care that may not be cost effective and for new methods of diagnosis and treatment that are expensive without demonstrable improvement in results.

Finally, too many errors are made in our system. This problem was highlighted by the landmark Institute of Medicine report of 1999, which estimated there are 100,000 unnecessary deaths a year in US hospitals because of errors, many of which are avoidable.³ These usually are systems errors, not mistakes made by individuals, which implies that the systems need repair, not that health care providers need remediation. These are the problems of quality.

The outcry for change comes, not just from policy makers and analyst but also from employers, for whom medical insurance is one of their major costs and for whom suboptimal employee health is a significant cause of lost productivity. Thus, calls for reform and initiatives for change come from both public and private sectors, and both of which are key to explosive growth in interest in forming accountable care organizations (ACO). It is postulated (and hoped) that costs can be reduced by improving quality through better coordination of care in integrated health care organizational structures in which payment incentives encourage efficient and quality-driven care, or, as is popular to

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Abbreviations used

ACO- Accountable care organizations
CMS- Centers for Medicare and Medicaid Services
FFS- Fee-for-service
IT- Information technology
PCMH- Patient-centered medical home
PCP- Primary care physician
TIN- Tax identification number

say among health policy gurus, the system becomes value, not quantity, driven.

So, what is an ACO? ACO refers to a legal entity composed of a group of providers that assume responsibility (are accountable) to manage and coordinate care for a defined group of patients in an effective (high quality) and efficient (low cost) manner. Any of the following entities can form ACOs:

- Group practices
- Integrated delivery systems (eg, Geisinger Health System)
- Networks of individual practices (eg, independent practice associations)
- Partnerships or joint venture arrangements between hospitals and other providers (eg, Physician Hospital Organization)
- Hospitals employing other providers
- Regional collaborations of health providers (North Carolina Community Connections 646 Project) (S. Erickson, personal communication, August 2012)

ACOs have 2 major sets of functions, clinical and administrative. Clinical functions include coordination of clinical efforts among all participating providers (eg, primary care, specialists, and inpatient facilities), facilitating the delivery of more effective and efficient care through increased care access, population management, care management and care self-management education, and facilitating the ability to translate patient clinical and service use data to promote more effective care and establish clinical guidelines to more effectively care for these patients.

Administrative functions consist of establishing infrastructure for administration and governance, providing information technology, developing budgets, contracting with providers and establishing provider payment procedures, contracting with payers, and managing risk when necessary. The composition of ACOs includes primary care physicians, specialists, and, often but not necessarily, hospitals. Primary care physicians (PCPs) are considered to be the essential foundations of ACOs. There is considerable data that PCPs improve care access, provide preventative care, coordinate care, and can limit unnecessary emergency department and in-patient care.⁴ Specialists may or may not be included in ACOs, either as participants or as contracted providers. Specialists could also form their own ACOs but not under Medicare. Hospitals often form their own ACOs because they have the access to capital and the infrastructure required to operate such systems. Their formation of ACOs accounts for their purchasing physician practices to “capture” them for the organization. Other organizational arrangements also exist in which entrepreneurs are founding ACOs in the private market. Even insurance companies are involved as partners with hospital systems or, in some instances, purchasing hospital systems to develop their own ACOs.

Various payment models have been used to pay ACOs and, within ACOs, to pay physicians. The shared savings model

payment is based on the savings in health care costs achieved in a defined population over a specific time (usually 1 year) compared with previous risk-adjusted benchmark for the population with quality measures included. The savings are split between providers and payers. In this model, providers are typically paid on a fee-for-service (FFS) basis. That payment may include a monthly bundled severity-adjusted care coordination fee and a performance-related bonus based on meeting quality measures. Another model is a partially capitated, bundled payment. This model is often linked to care for specific disease states, such as diabetes or congestive heart failure or to episodes of care, for example, pneumonia. A third popular model, in private but not federally funded ACOs, is full capitation in which there is a per patient per month payment. These payments are typically risk adjusted and include a quality component. This is used for ACOs set up by large health care organizations that have considerable experience in managing complex health care systems and are sufficiently capitalized to take on risk.

In theory, it is believed that ACOs hold considerable promise in improving the quality of care by putting PCPs at the center of a patient's care. The patient-centered medical home (PCMH) is seen as the cornerstone of a successful ACO and encourages a team approach, with close coordination of efforts among members of the patient's health care team, the patients, their families, and, if appropriate, the community. It is believed that changing incentives through movement away from FFS and inclusion of quality measures in reimbursement will change the behavior of providers.

The current status of ACOs is that, as of February 2013, there were 429 ACOs in 49 states,⁵ of which 250 were Medicare sponsored. Currently, there are as many physician-led groups as hospital-based ACOs, and physician-led groups are the faster-growing segment.⁶ More are being formed all the time. Medicare expects to approve new ACOs annually. The Affordable Care Act mandated the formation of ACOs under Medicare in an effort to encourage this major transformation of how health care is delivered in this country. There are 2 major models of Medicare health maintenance organizations, the Shared Savings and Pioneer models.

There are more than 250 Medicare Shared Savings model ACOs currently operating or approved. The ACO and Medicare share any savings above 2% (lower savings might be due to statistical noise variations). One variation on this method is a 2-sided sharing in which the ACO also shares in losses, but they can then get a higher percentage of any savings. The savings are determined retrospectively by comparing the costs of care in that year with a comparable group of Medicare patients not participating in the ACO.

Another variant on this model is the Advance Payment model in which Medicare will subsidize the ACO formation and Medicare will recoup those costs through the savings generated. This is for smaller, typically rural, groups of providers that do not have the resources needed to set up an ACO. Finally, there currently are 32 Pioneer model ACOs operating under Medicare. But, in July 2013, 9 announced that they were dropping out of the Pioneer program. Seven wanted to go to the Shared Savings plan because the quality measure achievements for the next year were too burdensome. Two groups are dropping out entirely.⁷ Those organizations staying with the Pioneer model will have to accept global payments, within 3 years, from Medicare, and 50% of their private contracts will have to be risk based by then. They will take on risk for the total care of the patient. This is only for larger, experienced integrated delivery systems such as Partners Healthcare in Boston.

One can well ask if the existing ACOs are successful in meeting expectations of improving quality of care while reducing costs. There are, in fact, very little data to support any firm conclusion. The July 2013 Centers for Medicare and Medicaid Services (CMS) report⁸ of the first year's data on Pioneer model ACOs showed that all had improvement in quality measures. Thirteen participants noted reduced costs by a total of \$86 million; 2 increased costs. Overall, they increased Medicare costs by 0.3%, whereas general Medicare spending increased 0.8%.

A CMS sponsored Physician Group Practice Demonstration study^{8,9} compared the results of 10 group practices that used the Shared Savings model with those of Medicare patients, in the same region, receiving care from non-Physician Group Practice Demonstration physicians. The primary outcome was annual spending per FFS beneficiary. The secondary outcome was changes in quality metrics by using 32 quality measures. Further comparisons were made for single Medicare and dual-eligible Medicare-Medicaid patients.

Overall, the annual savings were modest, \$114/beneficiary, but the savings were much greater in dual-eligible patients (\$532) than in single-eligible patients (\$59). Four sites had savings across all patients, whereas 3 had no change and 3 had increased costs. All showed reduced hospitalizations and reduced emergency department visits in those sites with reduced costs for dual-eligible patients. It would appear that the greatest savings were for the more complex and medically needy patients, the dual-eligible ones. One valid criticism of the study is that 3 years, which was the duration of the study, was far too short to implement the kinds of changes needed to maximize quality and savings. Also, most of the savings were realized in only one of the 10 groups. Nevertheless, there are considerable data that PCMHs can improve outcomes and save money by incentivizing coordinated quality care, so it is hoped that the same principles could apply to larger integrated health care structures.

So, what does this mean for allergists? Should allergists participate? What are the pros and cons to be considered in participating? The decision to participate is already made for those allergists who are in large, multispecialty groups that are forming ACOs. This applies to those in academic medical centers or in integrated delivery systems, for example. Allergists in solo or single specialty groups have a harder decision to make. The new fault line in American medicine is the size of one's medical practice. The stated goal of the Affordable Care Act is to phase out FFS medicine by 2014 and replace it with "bundled payments," and to pay physicians as collective groups. Is the decline of the solo and small group allergy practice a condemnation of the traditional FFS payment model? For the time being, the answer is a definite maybe. Some small allergy practices (those with 9 or fewer clinicians)^{10,11} may lack the infrastructure and resources necessary to survive in today's health care market. Within the changing health care landscape, one wonders if the allergist's star is still ascending, despite the nationwide allergy and asthma epidemic. A more pressing concern is whether small allergy practices will be able to survive in today's marketplace. The ACO health care model is not inherently friendly to small allergy practices. The new health care environment threatens small allergy practices that may find it particularly difficult to become vertically integrated into health care organizations such as ACOs. Some health care experts believe that small allergy practices are an endangered species, threatened with extinction.

These solo and small group allergy practices must position themselves to prepare for the future during this time of change in the

medical marketplace by taking small incremental steps to document the quality of their rendered services. They must prepare for the new quality-based rather than a volume-based health care delivery system. The small allergy practices that will do well in the future are likely to be the ones that are able to demonstrate that they can provide "value" for the money being spent, that is, superior outcomes at lower cost.⁸ Because the health care system places a greater emphasis on keeping patients out of the hospital, there is an opportunity for allergists, who have already demonstrated unique skills in this regard; the management of asthma serves as a stellar example.^{12,13}

Health care reform is a dynamic process, and the American health care system is in transition. Fisher et al^{3,14} remind us that "These observations [on ACOs] suggest that ACO formation should be understood not through the lens of a specific settled contract, but rather as an emerging payment model that can be implemented alongside the FFS payment system while supporting a transition to the goal of fully coordinated and accountable care." Most ACOs today are still mixed models, with some patients being served through ACO-style or capitated contracts and some through traditional FFS contracts. It will take years to shift an entire population from one model to another. The presently unanswered question is how efficiently will ACOs be able to change the widespread FFS delivery that rewards volume, to the collaborative contribution, which rewards outcome, while still preserving quality of care?

There is increasing pressure on allergy practices' viability, independent of their size, due to declining reimbursement, increasing expenses related to data acquisition and reporting, new practice regulations, increasing insurance costs, costly information technology infrastructure, and increasing demands on physician's time for management and administrative duties. Indeed, some allergists are struggling to maintain their incomes in the face of increased overhead costs, including staff salaries. Allergists are still trying to figure out their role in ACOs and are certainly not taking the lead in the formation of ACOs. Most allergists are still focused on a particular episode of care, which is not what ACOs are all about. Can allergists afford to sit on the sideline and ignore the opportunity to become intricately involved in ACOs? Is forming an ACO or joining one immediately urgent for the allergist?

If an allergy practice decides to get involved with an ACO, should the allergist(s) seek to be employed by an integrated health care system or by an ACO; should the allergist(s) become an "at-risk" participant in an ACO; or should the allergist(s) contract allergy services with negotiated reimbursement arrangements? There is no single answer that is right for all allergists. Some ACOs may not consider contracted allergists and other cognitive subspecialists to be true partners in the organization but rather as cost centers. A challenge for nonparticipating allergists is that primary care physicians involved in an ACO might direct most or all patients with allergies to allergists who are participating in the ACO, thereby disrupting historic referral patterns. These selected allergists would be likely to manage patients with allergies according to an ACO set of parameters and provide data required for reporting. It is anticipated that such disruption of current practice models might accelerate the current trend toward involvement in integrated health care systems and toward physician employment.

Another issue of great concern for allergists (and any other specialist) is that Medicare rules require a tax identification number (TIN) be exclusive to one ACO if the TIN bills for primary care services, such as codes 99201 through 99205. An individual provider can belong to multiple ACOs if they have multiple TINs. This applies to the Medicare Shared Savings ACOs, maybe in some

TABLE I. The pros, cons, and tips for ACO payment models

Type	Pros	Cons	Tips
Pay for performance	Least financially risky for physicians compared with all other models; in common use	Payers typically set the standards; definition of success necessary for payments can vary	Insist that insurers share all measures used to evaluate quality profile and performance; insist that measures used are nationally recognized
Capitation	Monthly payments to physician for case management in PCMHs can be in addition to FFS and pay for performance payments; you can do well with a panel of healthy patients	Of all models listed, this one requires practices to be extremely efficient with their resources	Steer clear of this model if you do not have great experience in managing risk
Bundled payments	Good for huge group practices that are highly integrated with a big infrastructure	Avoid unless the practice is highly integrated, with a big infrastructure; big risk for small practices	Find out how care or episodes are defined, duration of bundle and how basic bundle payment is calculated
Shared savings	Standard for ACOs; in some cases, share in savings but not risks if costs exceed budget	In some cases, share risk and savings; efficient practices may reach the point of diminishing returns with a decrease in shared savings	Find out how the payer calculates quality and cost benchmarks by which performance is judged; how will Shared Savings and risks be apportioned; how will the payer set costs year by year?
Withholds and/or risk pools	If all providers do well, then you move out of the risk pool	Model failed in 1990s: many practices saw no money returned	Read contract carefully with attorney; negotiate well

Pioneer systems but not in private ACOs. It arises because Medicare applies costs retrospectively at the end of the year and uses provider TINs to attribute patient care costs to a specific ACO. If providers belonged to more than one ACO and only had one TIN, then Medicare would not know which ACO should be charged with the cost of that care. This creates obvious problems for multispecialty groups or for groups in places with more than one ACO or for single specialty groups that have locations in different places with different ACOs. If a group gets multiple TINs, then it risks running afoul of laws that define group practice. Groups could elect to be an “other entity,” under contract to ACOs without being members but they lose certain benefits of membership, such as qualifying for Physician Quality Reporting System payments, having a say in ACO governance, and possibly not qualifying for shared savings. This matter, as of this writing, is being addressed by the American Medical Association and the American College of Physicians who are working with CMS to find a solution to the problem.

Performance standards and measuring tools will need to be accepted by allergists who are accustomed to practicing autonomously. Many allergists will lack the ability to track and report population-based performance data without robust practice management technology. The cost of information technology may be prohibitive for solo allergists and small allergy groups. The good news is that several statewide exchanges have been established that may assist some allergists in meeting these information technology challenges. For those allergy practices that are sufficiently large, (eg, large group practices or independent practice associations, which elect to contract allergy services with negotiated reimbursement arrangements), it is important to understand the metrics, baselines, and measurement mechanisms of the ACO with which they contract. Allergists should carefully analyze their case mix and revenue streams to negotiate for optimal reimbursement in ACO payment models. When negotiating with an ACO, allergists should negotiate rates by using

commercial preferred provider organization reimbursement as a benchmark and guide because patients are being rerouted from an individual practice to a new integrated group. Knowing how and which patients will be directed to one's allergy practice is essential to understanding the potential revenue impact of ACO participation because patients can be attributed to a practice either retrospectively or prospectively and by diagnosis groups or by risk factors. It also is important to understand that attributed patients are not required to stay within an ACO care network. As the ACO matures and more risk is delegated to the participants, allergists must be cognizant of the great likelihood of evolving payment methodologies such as bundling of codes and cost rates, and the yet undetermined impact of International Classification of Diseases, Tenth Revision (ICD-10) implementation beginning in 2014. These considerations are of major importance because ACO payment mechanisms can put allergists at risk for revenue cycle management issues as reimbursement moves from FFS to episodic or population-based models. Allergists also should be mindful of the fact that the time spent communicating and coordinating care with PCPs may not be compensated except within the context of any shared savings. It remains to be seen how such savings will materialize and how they will be shared.

Many allergists have become passively inactive in hospital activities or have completely opted out of participation in hospital medical staff activities. Allergists who anticipate becoming a part of an ACO should begin to cultivate relationships with hospitals, insurance companies, and managed care organizations because many ACOs are run by these entities. Cultivating these relationships looms large for allergists who plan to remain in practice for the next several years.

Before joining an ACO, allergists should ask the following questions:

- What are the ACO's bylaws?

TABLE II. Differences and similarities between PCMHs and ACOs

Differences	Similarities
Numbers: A PCMH refers to a single primary care practice; ACOs are umbrella organizations that typically incorporate multiple primary care practices, specialists, and at least 1 hospital.	More than just FFS: The intent of each model is to reduce financial incentives for providers to earn more by treating more; each model incorporates FFS but also uses another revenue stream.
Shared risks and savings: ACOs are designed to better align incentives with behavior by requiring participants to share bonus payments for savings generated beyond established benchmarks, or penalties for cost overruns; PCMHs have no such sharing mechanism.	Better care through coordination: Improved integration and coordination of care among disparate providers is a key driver behind the better health outcomes that each model is expected to produce.
Autonomy: Physicians who join ACOs can expect to enter into contractual arrangements with the ACO around referral and care management protocols; PCMH physicians retain a greater degree of independence.	Information technology (IT): Each model heavily leverages IT to improve quality of care and produce better patient outcomes.

- What representation will I have on the ACO's governing board? (Do cognitive subspecialists have a prominent role on the governing board?)
- What are the administrative and organizational requirements to participate, (eg, data submission, committee participation).
- What practice transformation changes will be required to participate, (eg, use of an Electronic Health Record system, 24 hours a day, 7 days a week access or triage, provision of case management and ongoing care coordination)?
- What financial and "in kind" assistance can one expect from the ACO to implement and maintain any required practice transformation?
- What are responsible estimates of shared savings or extra payments that the ACO can earn?
- How will any earned shared savings or extra payments be distributed?
- Is there any potential for accrued losses and participation in a "pay back" to the payer? (The allergist must be keenly aware of the potential for the absence of profit or even loss in a given care delivery payment model.)
- Is there a mechanism for rewarding strong performances?
- Is the ACO adequately protected from relevant federal and state penalties (related to antitrust and anti-kickback statutes)?
- What are the advantages and disadvantages of ACO participation versus establishing an independent service contract with an ACO?
- Can allergists who perform substantial primary care physician functions for those with chronic illnesses be classified as primary care physicians for the purposes of ACO participation?
- Can the practice get out of the ACO easily?

In addition to the CMS payment models discussed earlier, commercial ACOs may offer payment models that can be equally complex. A number of issues to consider in these models are itemized in Table I.

After joining an ACO, consider participating in the ACO governance structure. Consider participating in comanagement programs for cost containment and quality improvement, and consider participating in the development of critical pathways. To excel in this new arrangement, the allergy practice must prepare for process development of quality, outcome, and patient satisfaction measures to be obtained from the practice and provided to the ACO for reporting. The practice must be prepared for the additional timed requirements for provider-to-provider communications and care coordination.

Some allergists will have already begun to participate in PCMHs as a neighbor before signing on with an ACO. Such a move may be an important first step in moving in the direction of contracting

with an ACO because PCMHs are the core of an ACO, even though the 2 entities are not the same. Both models include FFS payments, but each also includes other means of payment to participating physicians. PCMHs typically include a per-patient care management fee, and ACOs typically include a pay-for-performance financial component. Some of the differences and similarities between PCMHs and ACOs are highlighted in Table II.

There is a great deal of anxiety in the entire physician community about the changes that are sweeping our health care system, with the looming implementation of the Affordable Care Act and the changes in the organization of and payment for medical services. Change is always difficult and uncertain, but we believe that these changes will take place gradually over the next decade. This gives all physicians time to accommodate to the new medicine. We have accommodated to the introduction of federal involvement in the system with Medicare and the change from straight FFS UCR (usual, customary, and reasonable) reimbursement to managed care. We can certainly learn to adapt to the new ways of delivering care. It also is important to remember that there will be continued evolution and modification of our health care system as we find out what works and what does not. It is crucial that physicians take the lead in effecting and shaping these changes so that policy makers and politicians who may not understand the dynamics of proper patient care do not harm the interests of our patients. "*Primum no nocere*" remains our central creed.

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