From Medical Practice to Medical Home to Accountable Care Organization: *Opportunity or Threat?*

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INTRODUCTION

A growing amount of literature is available on comprehensive care models that are designed to "own" patients and assure that their care is coordinated. Primary care practices can evolve into Medical Homes and integrated healthcare organizations can become Accountable Care organizations (ACOs). Without doubt the concepts are good ones but, as with many good ideas, thinking is not the same as doing.

At present both of these models are more concept than reality. While some demonstration projects are starting overall reimbursement has not moved from the piecemeal payment approach to a comprehensive care program. At the most complex end of the spectrum ACOs are global capitation on steroids.

These models are based on a seemingly simple concept that was first introduced in the 1970s, capitation. A fixed payment per covered individual that was designed to provide whatever care was needed. Providers were encouraged to be innovative in the methods used to deliver that care and there were clear incentives for keeping people well. As providers became used to the model, and actually realized that they could do well financially, payers moved back to discounted fee for service in response to concerns about care denied and the fact that they could spend less under the discount model.

If we have been down this road before or at least a similar road, why do it again? Simple, Medicare is unsustainable under its current model and the government is unwilling to publically mention what is needed to stabilize it, rationing. Or at least serious utilization control. The simple answer is to offload the problem on providers under the guise of comprehensive, coordinated, quality care.

THE MODEL

Both Medical Homes and ACOs are based on fixed global payments for designated packages of care. The theory is that who better to decide what care is needed than physicians and the payment strategy rewards them for controlling utilization and keeping folks healthy. Curiously, the Civil Money Penalties Act provides for stiff fines for any incentives that might be provided to deny or limit services the Medicare beneficiaries. That minor problem will be left to congress to address.

MEDICAL HOME

The Medical Home suggests that the providers at the "Home" practice will coordinate care, be the primary repository of all medical data related to the patient, and will only utilize those providers that have demonstrated both care quality and cost effectiveness. The Medical Home can also take advantage of non-traditional encounter models such as email, group sessions and video visits.

The downside is that coordinating staff takes people and people cost money. If the Home cannot develop a cost effective quality network, revenue will be lost to fee for service care and the cost of

coordinating that care will produce a bottom line smaller than in the traditional reimbursement marketplace. Add to that the difficulty of measuring quality and coordinating care in settings not controlled by the physician, such as hospitals.

Early data does not indicate a marked improvement in the health status of individuals enrolled in medical home environments. This may be true to the immaturity of the model or mean that the fee for service world isn't that bad after all.

This said, the Medical Home may be an attractive marketing opportunity in a hospital-affiliated network. If financial losses are acceptable the competitive advantage that the Home would provide could be valuable in contested turf.

ACCOUNTABLE CARE ORGANIZATIONS

This is a popular concept but, except for highly visible organizations such as Mayo, Kaiser, Cleveland Clinic, Geisinger, and a few others, is untried.

The cornerstone of the model is integration. Clinical, as well as business. ACOs will essentially become the insurance company for a fixed population.

Any organization that wants to evolve into an ACO (according to CMS) will need to:

- be willing to be accountable for the quality, cost and overall care of the population
- have a formal legal structure that would allow the organization to receive and distribute revenue
- have the resources to remain engaged for at least three years
- have sufficient primary care physicians to care for at least 5,000 beneficiaries
- engage in evidenced-based medicine
- have the administrative capacity to manage the program (the cost tracking and utilization tracking data requirements will be daunting)

Add to this the fact that the organization will need to exist in both the fee-for-service as well as ACO environments for an extended period.

THE CHALLENGE

It is highly likely that Medicare will need to encourage the development of risk-sharing delivery systems and private payers will quickly understand the advantages of doing the same as their premium structures come under federal scrutiny. The greatest challenge will be for organizations that have little, if any,

experience operating in a coordinated manner to successfully move into a care delivery environment that can quickly bankrupt the inexperienced. The traditional hospital/independent medical staff model has no chance.

Given that huge downside would it not be smart to simply allow others to take the risk? Not in the least. Organizations that "get it" will quickly control large populations of patients and those that are slower to wade into the waters will be left as either contractors or, worse, without patients.

The selling of this concept to the public will also be a challenge. While the concept of an all-caring clinical environment will attract many they will quickly learn that controls on who gets to go where and get what will be mandatory. Medicare recipients have enjoyed nearly 40 years of control-free fee for service care. Setting boundaries will not be easy but the future of the Medicare system requires them.

WHAT SHOULD WE DO?

It may well be time to test the collaborative waters. Waiting will only delay learning whether hospitals and physicians can create a philosophical common ground. To do so will require the breaking of the fee for service mentality and force hospitals to truly bring physicians into operational and policy roles.

It is likely that ACOs will be a few years away but starting now to explore gain sharing opportunities, the development of robust data systems that can collect and report the financial and clinical data that will be the foundation of the ACO, and the identification of which physicians and which hospital leaders are going to succeed in the power-sharing environment will be the key to survival.

Open the dialogue and you will either see a clear opportunity or realize how far you will need to travel.

For more information on exploring the physician-hospital alignment for your organization's future, and specific initiatives discussed in this report, contact Coker Group's Greg Mertz, at (757) 689-2225, **gmertz@cokergroup.com**.