By now, everyone has heard of Accountable Care Organizations, but there is a dearth of information on how they might involve postacute and long-term care physicians and facilities. In fact, it is unclear how, exactly, ACOs will involve any posthospital care outside physicians’ offices.

ACOs can be viewed as an attempt to improve a model of health maintenance by aligning incentives for high-quality, efficient patient care across all providers. Previous payment models, such as fee for service or the health maintenance organization, are viewed as encouraging over- or underutilization of care. Theoretically, by improving not just cost, but also outcomes and patient satisfaction, and allowing savings to be shared by providers, ACOs align incentives for providers to improve patient outcomes, save money for payers, and still provide good incomes for professionals.

So far, it is unclear how successful early ACOs have been. Medicare’s Physician Group Practice Demonstration project involved 10 sophisticated practices, with only half achieving savings of 2% or more at the end of the 5-year project. It is unclear whether newer versions of ACOs will be able to provide cost savings over traditional fee-for-service Medicare.

The Problems of ACOs and PA/LTC
Simply put, the current ACO models have favored large, vertically integrated systems, which represent only a minority of providers, and have been designed with little thought to integrating postacute and long-term care (PA/LTC) providers. There are newer models of ACOs that encourage smaller groups to join by requiring less up-front investment and mitigating against early fiscal risk, but it is unclear how well they will penetrate into smaller groups and whether they will be more successful than the original pilot projects. The larger problem for the PA/LTC practitioner is that most ACOs are designed for hospitals, outpatient diagnostic-and-treatment centers, and exclusively office-based physicians, not PA/LTC-focused physicians.

The coming of ACOs has been a major impetus for vertical integration of hospital systems, which find it is more straightforward to compete in the developing health care market by owning all aspects of care: physician practices, hospitals, and outpatient diagnostic-and-treatment centers. Because the health-reform law laid out ACO rewards and penalties in hospital and outpatient settings, health care systems were compelled to integrate these areas quickly. Additionally, the potential for higher fee-for-service reimbursements outside the ACO model has encouraged physician groups and outpatient facilities to offer themselves for sale.

There is no clear driver to integrate PA/LTC facilities and physicians into such vertical systems. In fact, the forces against that integration are powerful, including factors such as PA/LTC’s general lack of adequate information technology, low margins, and historical involvement in multiple health care systems.

It is far more rewarding for a health care system to purchase an office-based physician’s practice or a diagnostic-and-treatment facility than a nursing facility or the practice of a physician already serving multiple health care systems. Nursing home operators are still not fully informed of what ACOs involve, let alone how and whether they should participate, and whether ACOs will endure.
ACO Assignment and Exclusivity

The assignment of a Medicare beneficiary to an ACO is somewhat complex, but basically involves delegating the patient to the doctor who gives the majority of services. Once an assignment is determined, that person’s primary care physician (or specialist supplying primary care services) and his or her group are likely to be forced to join that ACO, and become exclusive only to that ACO, or lose the patient.

Medicare currently includes skilled nursing and custodial nursing home care as primary care services. This can pose serious problems, especially for physicians seeing patients in multiple PA/LTC facilities. Nursing home lengths of stay and associated practitioner visits may exceed those made by the patient’s usual ACO-affiliated doctors. These patients would then become assigned to the nursing home physician, causing that physician and his or her group to become exclusive to that ACO.

This situation poses obvious problems for the physicians in a facility with patients assigned to multiple ACOs, and for the groups that might be affiliated with those physicians. Various solutions have been proposed, including having physicians create multiple corporations to service each individual ACO or to divide patients among different groups based on their current or projected ACO assignments.

But what seems to be happening is a shift to multiple ACOs in the United States, which is evolutionarily vital. It is a very challenging situation, though, to ensure the best patient care.

The Potential for PA/LTC in ACOs

Noting these previously mentioned concerns, there are possible ways for PA/LTC physicians and facilities to be successful in the ACO model. First, physicians should help their facilities determine their readiness to work with ACOs. What information technology will be needed for the facility and the physician to meet the analytic needs of the ACO model? An area that AMDA is actively working on: What quality measures are appropriate to have Medicare exclude SNFs from ACO-assignment and ACO-exclusivity conditions as currently defined.

The medical director and concerned attending physicians should be active in this process.

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