

Opportunities and Risks in Health Care Reform

ACOs, CINs, insurance exchanges, and other future possibilities.

BY PAUL STERNBERG, MD

Currently, there are political, social, and economic forces—many of them beyond our control—that are influencing the environment in which we practice and the environment in which we are going to practice. Over the past few decades, the growth in the annual cost of health care has increased dramatically. In 1960, it was \$150 per capita; by 1975, it was \$600 per capita; and now it is greater than \$8000 per capita and continuing to rise. Clearly, we cannot sustain these costs, and the government and commercial payers are trying to determine ways to address this unsustainable growth. There are several problems that must be fixed, including variability and inequality of costs, poor care coordination, failure to reliably apply what is known, and failure to engage patients and their families in the care process.

Several solutions have been proposed in response to these problems. An accountable care organization (ACO), originally described by Elliott Fisher, MD, at Dartmouth Medical School, is a model in which providers are jointly held accountable for the cost and quality of care of a defined patient population. There is another model being discussed called a clinically integrated network (CIN). ACOs and CINs are very similar, but there are some slight yet important differences. With ACOs, the incentives are typically part of a capitated risk-based model, whereas in CINs, the shared savings do not require bundling or capitated payments. Instead of applying strict quality and outcome measures across a broad range as occurs with ACOs, in CINs, the focus is on integration of both acute and post-acute specialty and quality care. CINs can also set their own quality metrics, and you have the opportunity to reduce costs. Both ACOs and CINs require engagement of the physician, as well as some degree of infrastructure and technology, to be successful. CINs may be an effective way for a practice to learn how to function in a capitated model before participation becomes required. An organization can be in a CIN without participating in an ACO.

ADVANTAGES

There are several upsides to participating in a CIN. First, the physician can prepare for risk models while still enjoying some degree of fee-for-service reimbursement. You can also increase your focus on quality, defining your own metrics (rather than having the government define them for you), and you may gain access to patient volumes through referral networks within the CIN. You can define shared incentives and participate in regional health exchanges.

In a CIN, you promote increased capture of an employer's employee base within the network. The employer contracts with your network, and then hopefully refers employees and their dependents to providers who participate in the network. The shared savings relate to your being incentivized to bend the cost curve by more efficient utilization of health care dollars; that reduction in claims will be shared partially by the employers and partially by the providers. You have a certain defined area of claims cost, but if you are able to reduce that, it will come back to you.

DISADVANTAGES

There are several downsides to CINs as well. There will be increased attention on your ability to achieve those costs savings as well as quality and outcomes. There is a possibility that if you do not meet the metrics, you will be excluded from that network, which might decrease your ability to participate in mandated programs down the road. There may be some loss of autonomy, either real or perceived, and there is some downside risk to revenue. There may be withheld payment depending on CIN overall performance, placing you somewhat at risk.

To prepare, you first must focus on your being able to demonstrate good outcomes. You also need to focus on reducing variability in your care. You need to get your patients engaged, ensuring that you are getting good patient satisfaction and that your utilization of resources is appropriate. It is important to understand what behaviors within your practice could have unexpected

consequences in driving up costs—such as your use of ancillaries or high-cost drugs—and you must pay attention to your referral patterns: How much are you able to do within your practice and how much do you send out?

EFFECT ON RETINA

How will retina fit into either of these models? It is likely that ophthalmology, and retina in particular, will be a peripheral component of ACOs. We certainly have the potential of being carved out, which will be to our benefit for a short period of time, but then we may be mandated to be included. If a CIN is being developed in your area, you should look to see if this is something in which you want to participate; if not, maybe even think about initiating one on your own.

An employer or payer will want to contract for eye care or retinal care mainly if you can demonstrate value. There is an intersection of cost to the consumer and outcome and benefit received. I think all of us know intrinsically that what we do truly provides great outcomes and benefits per cost, but that doesn't mean that there aren't opportunities for us to be better, and it also doesn't free us from the obligation to demonstrate this.

INSURANCE EXCHANGES

Another component of the Affordable Care Act is insurance exchanges, which are designed to provide ways for the population of uninsured or underinsured patients to get at least some degree of insurance coverage. These insurance exchanges will create a population of additional paying patients, as there are a large number of previously uninsured or underinsured individuals who will now have access to lower-cost insurance products. This is good for the overall patient population and may provide an opportunity for you and your practice. It does, however, provide challenges around utilization, as uninsured patients are sometimes the greatest utilizers of services. It will require patient education, and bringing those patients into your practice may adversely affect your outcomes, as they may be some of the sickest patients you take care of.

THE VALUE PROPOSITION

At the end of the day, value and quality will be critical, whether we are talking about ACOs, CINs, or insurance exchanges. Administrators are going to look at clinical outcomes and at the health of the population being served. How are we providing our services? How easy is it for patients to get an appointment with us? Then finally, they will look at innovation. What are we doing that is special and unique? Are we reliably translating and applying evidence and discovery in our clinical practices? In retina, we should be looking at clinical outcomes and at the

health of our populations. We should be working side by side with internists and endocrinologists to help improve the quality of care and the health of our patients.

You have an opportunity to improve your quality and to keep your costs low: This is value. There will be a premium on your quality and your costs. High cost relates both to the rates you charge and to your utilization. Low-quality, high-cost providers will not work in these networks. The payers have much more data than you think they do about what resources you use, how often you use them, what you charge for them, etc. There will be competition for lower-cost options to take to market. Quality and cost will be critical to be competitive in any model, whether ACO, CIN, or exchange. In particular, insurers will be pushing for lower market rates because they are not getting paid very much for these exchanges. So the providers they are going to want for the exchanges are those that remain competitive in their pricing structure.

There are a number of examples in innovation that we can apply. The American Academy of Ophthalmology wants us to take an active role. Perhaps you could offer flat fees for retinal detachment management, meaning you get paid a certain amount regardless of how many operations are required. Another possibility is that there will be a flat fee for care of neovascular age-related macular degeneration, and you will get paid a certain amount for a year of care per patient, regardless of how many optical coherence tomography images, angiograms, and injections you perform or which drug you use. You will assume the risk, thereby saying, "I can take care of this patient for this many dollars." Then you have to manage that patient. Remember, your outcomes will be watched. You cannot just provide care that is inexpensive; it must still be quality care with good outcomes.

At Vanderbilt, we are piloting a concept called *diagnostic management teams*, which are designed to help doctors diagnose conditions more quickly and accurately, thereby avoiding unnecessary tests and increasing the potential success of treatments. We have been exploring this concept with regard to conditions such as bleeding disorders, but it may also have potential in the treatment of patients with uveitis. Diagnostic management teams help ensure that a patient's workup is focused and that the right tests are performed for the right symptoms, as opposed to sending the patient for an extensive battery of test and imaging studies, regardless of the specificity of the symptom complex.

Advanced medical home care is a model that is often brought up in the discussion of conditions such as diabetes, congestive heart failure, and hypertension. This concept has been proposed to better manage and control disease indicators with fewer office visits, using care coor-

dinators. There is currently a study being conducted in patients with glaucoma in which investigators are looking very carefully at compliance with glaucoma medications in an attempt to reduce the number of visits the patient needs to make.

POTENTIAL RISKS

What are the risks for retina moving forward? First, we will have less control over our clinical decision-making. Theoretically, our drug costs can be very high. I think you will see more of these programs that will either be controlling what drugs we use or at least steering us in certain directions. Our imaging utilization has been growing exponentially; this already is coming under great scrutiny. As subspecialists become increasingly tethered to large primary care groups, this creates the potential for reduced control of reimbursement.

Other than those of us who participated in capitated plans in the 1990s, we do not have a lot of experience to carry with us. That door was open for a short time, but then it closed both because patients demanded access to a wider range of providers and because the economy improved dramatically, reducing the impetus for stricter control of costs.

CONCLUSION

The growth in the cost of health care is not sustainable, and the government recognizes this. We all recognize this. The Affordable Care Act is only part of what is going to happen: If it were to be repealed, many of the market forces that it set in motion would continue even without the government mandates. However, there are several initiatives that accompany health care reform that are aimed at improving value and reducing costs. A lot of this reads like what we experienced in the 1990s with capitated care and sharing risk.

There is uncertainty about whether all of these formal initiatives will be implemented, but the environment is changing. Retina practices will be protected to a certain extent because much of what we do is peripheral to the larger drivers of cost. However, there are opportunities for us to demonstrate value. The take-home message is that I encourage you to take advantage of these opportunities; we have to do it before they do it to us. We must stay ahead of government-mandated changes. ■

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