Accountable Care Organizations and Cardiology Practice—A Wave of the Future?

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There has been much discussion recently about how to control rising health care costs. The commonly held belief is that striving for quality care will also decrease unnecessary costs, and certainly much has been debated about how to achieve quality health care. In this quest, a new tool has been introduced—the accountable care organizations (ACOs).

Kelly Devers and Robert Berenson, of the Urban Institute (Washington, DC), describe an ACO as a local heath care organization that includes a group of primary care and specialty physicians and a hospital that would be held accountable for the cost and quality of care delivered to a defined population. The ACO would have quality and cost goals which, if met, would result in financial rewards and, if not met, would be subject to a financial penalty.[1]

ACOs and HMOs differ in 3 main ways. In an ACO, the accountability would rest on the providers and the organizations rather than the insurance companies. There would be direct contracting with provider organizations without having an insurance company intermediary. Lastly, ACOs would provide some degree of flexibility that allows local markets to dictate which ACO organizational model (independent practice association or physician–hospital organization) and payment structure would match their needs.

There are many broad proposals of the ACO concept, but the specifics are still being debated. According to Devers and Berenson,[1] there are still 5 issues that need to be discussed: 1) how the ACO will be designed; 2) whether provider participation will be voluntary or mandatory; 3) how patients will enter an ACO; 4) what the payment structure will be; and 5) what the quality measures will be.

With regard to the last question, there are 2 proposed types of payment for Medicare: a shared savings program (SSP) based on a fee-for-service model and a partial capitation program based on a population-based payment. Recently passed health care legislation calls for pilot testing for both.

There are also implementation challenges that involve the impact on and participation of private payers and new roles and responsibilities for health care providers and government agencies. From a private payer's perspective, will the collaboration between physicians and hospitals actually increase the provider's market power so as to drive the cost up?

There is much skepticism about ACOs. Historically, when provider organizations have taken on the risk of managing care, they have done so by restricting a patient's choice and thus have failed. The administrative problems of executing these care plans along with limiting patient's choices caused the demise of such organizations. Patients may see ACOs as health maintenance organizations (HMOs) in disguise. In a recent *Healthcare Economist* article, it is noted that "if beneficiaries believe that the ACOs are essentially tightly managed 'HMOs in

drag' that are going to restrict their choices, undermine the doctor-patient relationship, and result in cheaper but lower-quality care, the concept will be met with skepticism, if not overt opposition."[2] Again, according to Devers and Berenson,[1] ". . . the ACO model that is receiving the most attention now—the shared saving payment approach that does not restrict patient choice or require any provider to take financial risks" also is inherently flawed. They note that in many medical communities, physicians have gotten away from the hospital and function more independently. "The weak financial incentives in the SSP payment model. . .would not bring together these increasingly independent professionals."

Because most health care is delivered in the ambulatory setting, it remains to be determined whether the ACOs are best developed in parallel among physician practices and hospitals or as partnerships between hospitals and physicians. Many are concerned that hospital-led ACOs will force physician employment by hospitals with possible unintended negative consequences for physicians, hospitals, and patients. Patients, physicians, other providers, and payors are in a better position to guide the redesign of the health care delivery system than government agencies, policy organizations, or elected officials, no matter how well intended they may be. The ACC has proclaimed that change in health care delivery must be accomplished with patients and physicians at the table.

In the August 2009 issue of the *Journal of the American College of Cardiology*, past American College of Cardiology (ACC) Presidents James T. Dove, MD, and W. Douglas Weaver, MD, and current Chief Executive Officer Jack Lewin, MD, wrote an article titled "Health Care Delivery System Reform: Accountable Care Organizations"[3] in which they discussed ACOs. They noted one problem, that "[o]utside the integrated systems, government regulations have made it difficult or even illegal for practices and hospitals to coordinate care and quality. Because most of the care is delivered by small groups of physicians that are not connected, the challenge is to allow trials of ACOs that are not legal large partnerships or entities." This is complicated, and the ACC believes clinicians, patients, and payors should have input about the design and function of this new structure. The ACC, for example, believes an ACO should reward providers for reducing unnecessary and discretionary services without denying necessary care. ACO members also should not be at risk for costs they can't control.

They point out that long-term incentives for participation is an area that needs to be fleshed out. Also, it was mentioned that because most health care is delivered in the ambulatory setting, it remains to be determined if the ACOs are best developed in parallel among physician practices and hospitals, or as partnerships between hospitals and physicians. There also are concerns that hospital-led ACOs will force physician employment by hospitals with possible unintended negative consequences for physicians, hospitals and patients.

They wrote that the ACC strongly believes "that change in health care delivery must be accomplished with patients and physicians at the table. Past policies and the status quo have failed. Bold new solutions are necessary." They also state that "[e]xperimentation should be encouraged"; and "[a]lthough there are risks before us, we have greater opportunities than perhaps ever before to rejuvenate the profession in the challenges ahead."[3]

At the present time, there is much discussion about practices integrating with hospitals. Accurate data about the number of practices across the country that have merged with hospitals are lacking. The best estimates indicate that from 30% to 60% of practices have merged (the ACC is in the process of gathering these data). The main reason appears to be the declining viability of practices in the setting of rising costs and declining reimbursement.

There are many conferences currently being offered about integration models, including one held June 3-4, 2010, in Las Vegas, NV, which was sponsored by the ACC. If ACOs become a reality, it will behoove each of us to become better educated about the concept and the options. ■

References

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President's Note

In recent issues we have discussed board certification and recertification for American cardiologists. Our British colleagues have also been grappling with the issue of knowledge assessment. As we refine our processes, we thought it would be informative to hear about it from someone who is starting the process.

Knowledge Assessment for UK Cardiology Trainees

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As part of the process of updating the UK Specialist Training Curriculum for Cardiology there was a need for the curriculum and its assessment system to meet new government standards laid out by the training regulator, the General Medical Council (GMC). This required us to develop a method for assessing the acquisition of core cardiology knowledge by our trainees (specialist registrars).

The assessment is known as the Cardiology Knowledge-Based Assessment (KBA) and is administered by the British Cardiovascular Society (BCS) in conjunction with the Joint Royal Colleges of Physicians Training Board. The KBA only demonstrates adequate knowledge of the cardiology curriculum and is just 1 of several forms of assessment that trainees will have to undergo. The objective is to complement the workplace-based assessments that are the mainstay of assessing trainees' progress in developing the necessary competences that are needed to practice satisfactorily as a cardiologist.

Trainees in their third year of a 5-year training program will take the KBA. Following a successful UK pilot examination last year, the first batch of trainees sat the examination in earnest in June, 2010. The KBA consists of 120 best-of-5 multiple choice questions. The examination is computer based, allowing for the use of still and video images, as well as text, in the stem of the questions. It is held at a single site, under invigilated conditions, during the Annual Conference & Exhibition of the BCS in Manchester, UK.

The BCS has collaborated in the question-writing process with the European Board for the Specialty of Cardiology, a body under the joint aegis of the Cardiology Section of the Union of European Medical Specialties and the European Society of Cardiology (ESC). The ultimate objective is to develop a European-wide KBA, for which the UK is the pilot.

Question writers were recruited by the BCS and the ESC from among its members and trained at a 1-day workshop on the drafting of multiple choice questions, run by experienced Membership of the Royal Colleges of Physicians of the UK (MRCP[UK]) question writers. Question writers prepare draft questions in advance of meeting to subject all the material to peer-group review and editing. The question topics are selected to cover all aspects of the cardiology syllabus. The group meets twice yearly to review the performance of questions, and to process new draft questions for addition to the question bank. To ensure content validity, all questions are drafted by active clinical cardiologists, who are briefed to ensure that question material is relevant to trainees approaching the end of their core specialty training and representative of the level of knowledge required by a newly appointed consultant. To provide face validity, question writers are required to set each question as far as possible within a relevant clinical context, representative of a candidate's everyday activity.

The development of the KBA has been an important project for the BCS that has required close cooperation with the ESC. Crucial to its success has been the involvement of many of its members who have freely given their time to produce the required multiple choice questions. ■