ACO vs. PCMH: Which is Best for Your Practice?

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While both organizations focus on shared savings and greater efficiencies of care, they are not mutually exclusive.

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As healthcare reform redefines the rules by which physicians get paid, the shift to delivery models that reward for value rather than volume is well underway. Indeed, industry leaders are testing a number of new systems that seek to promote higher quality and lower-cost care. So far, two have emerged as front runners — accountable care organizations (ACOs) and Patient-Centered Medical Homes (PCMHs). Both rely on primary-care physicians to coordinate care across the healthcare continuum. And both aim to improve clinical outcomes.

But ACOs and PCMHs also involve potential risks for providers. And early adopters have reported mixed success in managing the costs associated with team-based care. As such, practices considering participation in either, or both, should first explore the cultural and financial implications that such a move would entail. "There's no one-size-fits-all model," says Todd Evenson, vice president of consulting services and data solutions for the Medical Group Management Association. "It all depends on how you want to align with the rest of your community." To make the best decision for your practice, he says, you must first be clear on how these delivery models differ.

Patient-Centered Medical Home
The Patient-Centered Medical Home seeks to transform primary-care practices to provide enhanced preventive care and better disease management. The primary-care physician in a PCMH setting is responsible for coordinating treatment with specialists, hospitals, and home health aides — all the providers involved in a patient's care — to improve patient outcomes and wring inefficiency out of the system. He also strives to engage patients as partners by fostering a trusting relationship between the care team, the patient, and, when appropriate, the patient's family.

Another goal of a PCMH is to broaden patient access through extended hours, telemedicine consults, and online patient portals — thus delivering care to patients how and when they want it. For practices that are poorly equipped, that may require an investment in their information technology infrastructure. An EHR, which enables medical homes to flag at-risk patients, is a must, says Evenson. "The IT systems have to be in place to identify those patients who are most at risk, including diabetics and heart disease patients," he says, noting some payers offer a modified payment schedule for medical homes to help offset the expense of additional technology. Many, however, still do not reimburse medical homes at a higher rate.

Medical homes that hope to achieve cost and quality goals should also employ a designated care coordinator. Her duties might include sending appointment reminders for wellness visits, ensuring needed tests are scheduled, and funneling chronically ill patients into disease-management programs to prevent hospital admissions. "There's good evidence that changing to these clinical practices improves outcomes, but there may be a fairly significant financial investment required, too, to start a PCMH," says Jordan Battani, managing director for CSC's Global Institute for Emerging Healthcare Practices in Falls Church, Va., an information technology firm that tracks industry trends. "You may have to invest in IT upgrades and there could also be higher staffing costs."

The 2013 MGMA Cost Survey for Primary Care Practices, in fact, found total general operating costs for a PCMH were $218,800 per FTE physician, compared with $187,345 for a non-PCMH. Likewise, total support staff costs per FTE physician were higher for a PCMH ($232,346) than a non-PCMH ($193,389). The survey also found that PCMHs had higher average revenue per FTE physician ($754,667) than non-PCMHs ($624,405), but Evenson notes many early adopters of the PCMH model were strong performers to begin with.

Reid Blackwelder, president of the American Academy of Family Physicians, however, contends that the costs involved in becoming a PCMH can be far less. Many practices already have an EHR in place, which may require only a minor upgrade. And, he notes, having a designated care coordinator does not necessarily add to payroll. "When you transition to electronic medical records, your staff may
have hours available every day where they no longer have to track down paper charts," he says. "Be creative. You might have to retrain a file clerk to act as your care coordinator, but that's a wonderful way to develop your staff and give them opportunities to learn new skills."

One final point where medical homes are concerned: Physicians who are evaluating whether a PCMH makes sense for their practice should reflect on how well they play with others. "There are probably still a lot of physicians who have selected this career path because they have a strong drive to act independently," says Battani. "If you want to be part of a PCMH you really have to embrace team-based care and the collaborative-patient-care model."

**Accountable care organizations**

An ACO, by contrast, is a network of healthcare providers that agrees to assume shared risk for the care of a defined patient population. ACOs are typically comprised of primary-care physicians (some of them in medical homes), specialists, and hospitals that work together to reduce duplication of services and prevent medical error. Such models utilize a shared savings structure in which groups that deliver care for less than the payer's projected cost get to share in those savings. ACOs also typically receive financial incentives for meeting quality measures. While ACOs remain a largely conceptual model for improving care delivery, Battani says the pilot programs in some regional markets, including Boston and Minneapolis, are maturing faster than others.

She also notes that smaller practices looking to participate in team-based care may find it more affordable to join a hospital-owned ACO. "You may find that from a cost perspective it's easier to join a larger existing organization," she says. "The advantages to joining an already established ACO are that the expensive investments may already be made, may be better financed, and may be available to new members at a much lower cost, with lower initial investment or even no investment."

Just be sure to review your contract with the ACO carefully and ask the right questions. Is the management agreement structured to fairly compensate the providers? How would any shared savings be distributed to the physicians? Will your practice be represented on the organization's governing body? What will the ACO require of you by way of administrative and organizational tasks, including any committees you would be required to join?

Most importantly, however, physicians should evaluate their risk exposure, says Battani. "A big question for small providers is whether they will be at risk financially if the contract fails to deliver on quality and performance benchmarks," she says. "Or, will the larger entity insulate them from that financial risk?"

**Both or neither?**

While many payers and providers favor one over the other, it bears noting that PCMHs and ACOs are not mutually exclusive. Ideally, in fact, they should work in tandem, says Blackwelder. "To be successful, an ACO must have a solid primary-care base, which is where you manage acute cases and chronic diseases," he says. Medical homes, which utilize primary-care physicians to implement effective and efficient care, can be instrumental in helping ACOs succeed. "With an ACO, it's to their advantage to have their participating providers be patient-centered homes."

Harold Miller, president and chief executive of the Center for Healthcare Quality and Payment Reform, agrees in theory, but says neither delivery model has yet solved the problem of genuine payment reform. "They should be complementary, and conceptually they are a step in the right direction, but it's the way they are being implemented in most cases that is not changing what needs to be changed," he says. Medical homes can't truly expect to be patient-centered until specialists and PCPs are equally compensated for the costs involved in providing collaborative care, he says. And ACO providers should not be held accountable for controlling total costs since they are only able to control their own expenses, Miller says. Indeed, many ACOs include community hospitals, which have significant fixed overhead expenses. "The right way to build an ACO is from the bottom up, not the top down," says Miller. "Every provider, including specialists, should be figuring out what they can do to reduce costs within the area they influence, and how they need to get paid to support that better way of delivering care."

Such challenges will be hammered out over time, Evenson predicts, as reimbursement models continue to evolve. In the meantime, ACOs and PCMHs remain the most popular delivery models to improve patient outcomes at a lower price. But they also create financial risk. "The realities around value-based reimbursement are here," says Evenson. "Practices need to address it from a business as well as the clinical side of medicine."

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