ACO Business News

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Texas ACO That Has Improved Mortality Rates on MA Patients Will Keep Its Model

A Texas-based primary care group that's developed a unique model of taking care of Medicare Advantage (MA) patients through an ACO over the last 20 years wants to expand its patient base — but not necessarily venture into other markets beyond MA.

In particular, WellMed Medical Group in San Antonio has no plans to participate in Medicare's Shared Savings Program, mainly because it wants to preserve its MA plan format for the ACO, Gary Piefer, M.D., M.S., a family physician and chief medical officer of WellMed Medical Management Inc., the managing partner of WellMed Medical Group, tells *ABN*. While "ACO" is a relatively new buzzword on the health care reform scene, WellMed says it's been building an ACO of sorts for the past two decades that has improved outcomes for its MA population and reduced costs, using a patient-centered medical home (PCMH) approach.

The medical group is primary care-based and driven, operating 22 clinics in the San Antonio area, plus 14 clinics in other parts of Texas and Florida. Overall, it serves more than 75,000 patients, most of whom are MA patients.

WellMed's business model essentially operates as a group of physicians "that take a fixed amount of money to be accountable for the quality of outcomes and the cost," Piefer says. It isn't by any means the first to execute a model of this type, he acknowledges. "Kaiser has done it for 50 years, and there's a whole host of organizations in California that have done it."

What makes WellMed unique is its ACO takes care of just MA patients, Piefer says. "It's a completely different strategy to manage a commercial population at risk than it is to manage a Medicare population at risk. The example of success in a Medicare population is all around the management of chronic disease, where you have...three or four chronic diseases that account for 10% of patients accounting for 70% of your costs. So there's a focus of an understanding of where your costs come from."

And when you start managing these folks with chronic diseases and improving their outcomes, your total costs suddenly start decreasing by changing your delivery system, Piefer says.

Erik Johnson, senior vice president of consulting firm Avalere Health LLC, tells *ABN* that WellMed's ACO model is a good one to emulate for several reasons, one of which is its strong PCMH component. In building ACOs, medical homes are important "because the ACO construct is really just a governance [structure] and its financing is highly dependent on clinical risk management."

The thing about MA that's different from FFS is "the definition of productivity is different. [In] FFS Medicare, productivity is really determined by how many patients are seen in a day. [With] the MA model, productivity is linked to a clinical path. This is where the ACO should go to save money. The MA plans have that financial structure in place to reward that type of discipline, whereas FFS doesn't have that," Johnson says.

Under WellMed's medical home model, the primary care physician is designated as a leader of a "team of support" that allows them (with the help of health information and decision support tools) to manage patients in a non-volume-driven structure, Piefer explains. Under this model, the physician gets to worry about care management and not volume management. "And we've evolved out of a productivity model based on volume into a salary model incentivized with quality bonuses."

The medical group has its own transportation company to provide rides for patients to assure that they make their visits, he continues. Care managers are assigned to each patient and weekly care coordination meetings take place with doctors, care managers and social workers to examine these complicated patients' cases.

While the group has plans to expand the model in Texas; the Tampa, Orlando and Treasure Coast regions of Florida; and possibly other states, for now at least its ACO model will stay out of fee-for-service Medicare and other commercial markets, Piefer says.

Group Won't Do Shared Savings

CMS in its Shared Savings Program (*ABN* 5/11, p. 1) has issued proposed regulations defining an at-risk ACO. Given that WellMed plans to stay in the MA market, however, "there isn't a feasible approach to do an ACO with CMS," he says. MA plans, as a general rule, can't participate in Medicare's Shared Savings program, mainly because Medicare is the insurer under this model, limiting ACO formation to providers such as physicians and hospitals.

"In our model, we take the budget and if we save a dollar we keep a dollar. Under Shared Savings, if we save a dollar, we may get 10 or 15 cents. That's not the same savings. Under our model, we take all of the risks and get all of the benefits. Under their model, we'd take all of the risk and approximately get half of the benefit," Piefer explains.

It's possible that WellMed may look into the Pioneer pilot that CMS's Center for Medicare and Medicaid Innovation has since proposed (*ABN* 6/11, p. 1) as it "may allow organizations that are more mature like ours to move to a platform of full risk," Piefer says. Even that option, however, may not offer the savings potential that WellMed has already achieved with its MA ACO model. "We may investigate that some, but… unless we can move into a Pioneer program that's replicated that, there's no reason to add extra layers of bureaucracy and fewer layers to participate in the savings."

In some areas, at least, the model WellMed has developed appears to be improving care, according to a case study of the medical group that appeared in the January/March 2011 issue of *The Journal of Ambulatory Care Management*. In evaluating its population health outcomes in its second decade of operation, the study's authors found that WellMed's adjusted mortality rate in the WellMed ACO was half the rate in Texas for people older than 65 years of age. While preventive services improved, the study noted that WellMed did not measurably reduce its hospitalization, readmission rates and emergency department visits since 2000.

Piefer responded that the study didn't take into consideration the exponential growth of WellMed's membership "and high utilization rates that have been reduced" over time.

"We've grown about 400%, from 10,000 members in San Antonio to over 40,000 members" in the last decade, he says. "As we continued to grow, we added new patients that were poor performers or high utilizers of care, and it's [always] going to take some time to improve the health of those patients."

And that's essentially what WellMed did, he adds. What the study said was all true, but if they had examined the new patients over time, "they could have seen that the readmissions and admissions rates had decreased."

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