Physician Specialists and ACOs - Keys for Successful Participation

By: Susan Charkin, President, Healthcents, Inc.; Steve Selbst, CEO, Healthcents, Inc.; Regina Vasquez, Sr. VP of Accounts, Healthcents, Inc.; Neil Baum, M.D.

DEFINITIONS:

ACO – Accountable Care Organization

ACO Contractor – A provider or group of providers who have an agreement with an ACO to provide medical services to ACO Participant patients.

ACO Participant – A provider or group of providers authorized to act as an ACO and has a direct agreement with the insurance payer.

Beneficiary – An individual receiving or having privately purchases or having provided through their employer public or commercial insurance benefits.

CMS – Centers for Medicare and Medicaid Services

DHHS – Department of Health & Human Services

DOJ – Department of Justice

EMR – Electronic Medical Records

FTC – Federal Trade Commission

OIG – Office of the Inspector General
Why ACOs?

Succinctly: better care at lower cost. That is the goal. ACO delivery and payment models are designed to lower healthcare costs and ensure that patients receive the right care at the right time. Many believe the U.S. healthcare system is broken. The current administration has staked its political reputation and the preservation of Medicare for future beneficiaries on innovative cost-saving measures, the leading model of which is the ACO. The ACO model will have far reaching impact on patients, doctors, hospitals, and payers. This article focuses on how physician specialists can successfully integrate into the ACO model. Those who read this article will understand how specialists can achieve success working with ACOs by providing readers with real life examples and industry quotes.

SPECIALISTS’ ROLE IN ACOs

Physician specialists play a key role in developing clinical pathways and care plans that promote patient compliance and increase efficiency in delivery of health care. Participation in an ACO, whether as a direct participant or a contractor, requires an operational, behavioral and attitudinal paradigm shift from a volume based practice to an outcome based practice. Organizationally, CMS ACOs are PCP-centric. Generally, commercial payers have adopted the CMS ACO
structure and definition of PCPs as physicians of internal medicine, general practice, family practice, geriatric practice and primary care providers. However, specialists who perform substantial PCP function as the provider of care for chronically ill patients, can also be classified as PCPs for the purposes of ACO participation. This is important because PCPs are only permitted to participate in one ACO, while specialists can participate in several ACO’s.

In return for meeting benchmarks related to patient engagement and satisfaction, patient safety, quality of care and cost savings, ACO participants and contractors will have an opportunity, to either share a portion of the savings, or be held accountable for lack of savings. So, it is important that physician specialists understand the metrics, baselines and measurement mechanisms. It is equally important that physician specialists understand how their individual behavior contributes to the performance measure for each metric. Evaluation of practice patterns will be an integral part of making the ACO effective and viable. All ACO participants and contractors will have “skin in the game” and will have to work as a team to actualize the benefits.

Understanding how patients are attributed to an ACO is important to the decision to participate or contract with an ACO. Patients can be attributed retrospectively or prospectively, by diagnosis groups or by risk factors. Knowing how and which patients will be directed to your practice is essential to understanding the potential revenue impact of ACO participation. In response to early criticism that ACOs were re-vamped managed care organizations, patient notification and choice protections were included in the CMS ACO regulations. Attributed patients cannot be forced to stay in the ACO network to seek care, which could compromise data
collection and reporting for ACO participants. Therefore, payer benefit plans must align with payer and ACO goals to encourage patients to remain in the ACO care network.

The CMS ACO model is flexible and allows different delivery and payment methodologies. CMS ACOs generally fall into three categories: Pioneer ACOs, Shared Savings ACOs, and Fee for Service Providers. Pioneer ACOs are integrated delivery systems that are capable of moving to a population based payment model. Shared Savings ACOs are eligible to share in the savings when performance benchmarks are met, but do not bear risk if benchmarks are not achieved. Another category are groups that would like to form ACOs but need operational guidance and financial assistance to acquire or expand IT capacity in order to be able to gather and report performance metric data.
For ACOs that are established in conjunction with commercial payers, shared risk arrangements will be reviewed under traditional anti-trust principles, and any provider in an ACO needs to be fully aware of how CMS, DOJ and FTC define integration, coordination and collaboration. Failure to comply with those definitions and guidelines could expose the ACO participants and contractors to risk of investigation and possible prosecution under anti-trust laws and regulations.

Compliance with anti-trust regulations is only one of the challenges to ACO formation in the commercial market. Performance standards and measuring tools will need to be accepted by stakeholders who are accustomed to practicing autonomously. Obtaining consensus will be a challenge and has potential to create conflict, not only between payers and providers, but also between ACO participants and contractors.

The cost of IT may be prohibitive for small groups and solo providers. Without robust practice management technology that allows for population health management, many providers will lack the ability to track and report population-based performance data. Several statewide exchanges have been established that may assist some providers in meeting IT challenges.

**The Future of ACOs**

Until June 2012, when the US Supreme Court is due to issue its judgment, durability of the individual mandate and the healthcare law itself are uncertain. Even if the Court strikes down the healthcare law in part or entirely, it is anticipated that fee-for-service reimbursement rates will increase very slowly from year to year, though insurance premiums will continue to
Physician Specialists and ACOs - Keys for Successful Participation

Page 6 of 8

escalate rapidly. If ACOs are successful in lowering cost, the hope is that the savings will be passed along to consumers.

The focus of many ACOs has been chronic disease management. For example, Boeing and Blue Shield of Washington developed an intensive outpatient care model for treating 750 employees with multiple health conditions. Providers received a combination of fee-for-service and monthly payments. Boeing reported a twenty percent decrease in cost from fewer hospitalizations and emergency room visits.

**Are ACOs Right for Your Practice?**

Do the homework. There are many options available for integration, including virtual organizations or creation of super-multispecialty groups that include PCPs. As part of an interdisciplinary team, physician specialists are keenly positioned to provide input to guide clinical decisions and referral practices to help ACOs achieve benchmarks in order to receive maximum shared savings payments.

Physician specialists should carefully analyze their case mix and revenue streams so they can negotiate for optimal reimbursement in ACO payment models. When negotiating with an ACO, specialists should negotiate rates using commercial PPO reimbursements as a benchmark and guide, since patients are being re-routed from an individual practice to a new, integrated group. For the physician specialist, negotiation strategies should focus on investment in advanced medical technology, in-house ancillary services, and the capacity to perform surgical procedures in an office setting. As the ACO matures, and more risk is delegated to the participants, specialists must be cognizant of evolving payment methodologies, such as bundling
of codes and case rates. ACO payment mechanisms can put physician specialists at risk for revenue cycle management issues as reimbursement moves from fee-for-service to episodic or population-based models.

**Conclusion**

While the ACO structure is flexible, the most challenging aspect of ACOs will be changing the entrenched culture of fee-for-service delivery, which rewards volume, to collaborative contribution, which rewards outcome, while preserving quality of care. Look before you leap! Make sure your physician specialist organization has the human, intellectual, financial and legal capital to develop and implement an innovative, coordinated, integrated care model.

References:


Physician Specialists and ACOs - Keys for Successful Participation


Dr. Bart Azner Monarch Healthcare, Susan Charkin onsite interview, orange county CA, September 14, 2010.

Ernie Schweffler and Dr. Mark Bellham – Blue Cross of California, Susan Charkin interview via conference call, September 16, 2010.

Dr. Elliott Fisher – Dartmouth University, interview via conference call, September 17, 2010.


