

# ACOs and the Specialist

Insights and Impacts

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# The Question: Unicorn Sighting or Cattle Stampede?



- “An ACO is like a unicorn. No one has ever seen one” (George Ma, M.D., President LACMA).
- “Although joining or forming an ACO is not immediately urgent, orthopaedic surgeons cannot afford to ignore the opportunity to be on the leading edge of this new care delivery model” (The ACO Primer, AAOS)

Practical Aspects of ACO Participation for Specialists:

# The Good, The Bad, and The Apocalyptic



# THE “GOOD”

- Cost containment and quality reporting are coming. An integrated model such as the ACO provides a framework to become involved in these initiatives.
- If effective, such a program should be able to improve integration of care among providers, and decrease unnecessary treatment and diagnostic testing.
- The possibility would exist for remuneration above historical Medicare rates.
- As designed, there is a possibility for improvement in quality and outcomes if useful policies, procedures, and data can be developed and utilized.

# The “Bad”

- Need for involvement in complicated entity which involves management of financial, administrative, and medical aspects of a the entire spectrum of care
- Significant physician time requirement for participation in management, data collection, and quality assessments.
- Possible significant capital requirement for start-up and ongoing expenses
- Need for sophisticated EMR system

# The “Apocalyptic”

- Possible significant shift in patient demographics if Medicare or 3<sup>rd</sup> party payers mandate ACO involvement
- Possible continuing decline in reimbursement as new quality and cost benchmarks are introduced by CMS
- Increasing pressure on private practice viability due to declining reimbursement, increasing expenses related to data acquisition and reporting, and costly IT infrastructure.
- Increasing demands on physician time for management and administrative duties related to ACO functions.

# The “Apocalyptic” (Cont.)

- Increasing pressure on ancillary services viability if clinical pathways are developed that limit access to those services.
- Potential for diminution in collegiality among providers as decisions for remuneration are placed into the hands of the ACO governing board.
- Effective loss of physician control depending on relationship with hospital partner and/or financial backers.

# The Problem-What ACOs Require:

- “All ACOs incorporate legal, administrative, and clinical structures and systems that will enable both the development of evidence-based, coordinated clinical practice and the development and implementation of quality and cost measures. Additionally, ACOs require technology platforms and systems that will enable data gathering, data integration, and public reporting of quality and cost outcomes.” (ACO Primer)

# Potential Roles for the Specialist

- Employed by integrated health system or ACO entity.
- “At risk” legal participant in the ACO
- Contracted provider with negotiated reimbursement

# Potential Issues: The Time Commitment

- “For both PCPs and specialists, it is easier and more lucrative to transfer care to the specialist rather than have the specialist communicate with the PCP and attempt to manage the patient’s problem within the primary care practice.” (ACO Primer)
- Coordination of care is purported to improve quality and outcomes, resulting in cost savings. However, time spent communicating and coordinating care with PCPs will not be compensated, except in the context of any shared savings. Whether such savings materialize, and how they would be shared remain a question.

# The Time Commitment (Cont.)

- Recent demonstration projects have a history of difficulty managing the requirements for quality assessment and reporting. Significant time, personnel, and infrastructure requirements may play a role in this regard.
- “The MCMP (Medicare Care Management Performance) demonstration is in progress. Early reports indicate that involved practices have found that tracking data on patient care has enabled them to improve awareness of care gaps, but the high level of effort and costs associated with reporting has threatened the long-term viability of the program.” - ACO Primer

# Potential Additional Time Requirements:

- Possible participation in ACO governance structure
- Participation in hospital co-management programs for cost containment and quality improvement
- Quality, outcome, and patient satisfaction data to be obtained from your practice and provided to the ACO for reporting
- Participation in the development of clinical pathways
- Additional time requirements for provider-provider communication and care management

# Potential Issues: Financial Considerations

- Capital investment for ACO start-up - (Start up and first year costs in the range of \$1,755,000)
- Investment in EMR system and additional IT resources required for reporting and integration ( \$45-90,000/physician FTE)
- Potential for additional personnel required for data acquisition and reporting

# Employed Physician Impact

- Overall impact may be reduced depending on current level of system integration
- However, historical relationships with respect to organizational and financial structure may need to be re-assessed.
- Will require a strong primary care base, or this will need to be developed or acquired
- May require significant increase in time commitments for process development with respect to quality, outcome, and patient satisfaction measures.

# Private Practice Physician Impact

- Financial impact will be dependent on penetration of the ACO in the market and the physicians' relationship with the ACO
- Part of the potential cost savings for the ACO would be realized through decreased utilization of specialty services. Decreased FFS revenue would need to be offset by a proportionate share of any savings. The ACO would also need to be vigilant in controlling expenses as its overall FFS revenue decreases.

# Private Practice Physician Impact

- Participation in shared savings will require time commitment for development of clinical pathways, hospital co-management of orthopedic service line, participation in ACO governance, etc.
- Data collection and reporting will need to become a standard part of practice protocols.
- Inter-operability of EMR systems will most likely be required.

# What is the Potential Impact on the Medicare Patient Base?

- Current law does not mandate participation by Medicare beneficiaries. However, the goal is cost savings.
- “For actual cost savings to be achieved, The Vermont Accountable Care Organization Pilot: A Community Health System to Control Total Medical Costs and Improve Population Health report indicates that 70 percent of the managed care population (including participation of all Medicare and Medicaid recipients) would have to “opt-in” to an ACO healthcare delivery system, which makes voluntary participation questionable. At these levels, mandatory patient participation will be more likely.” (ACO Primer)

# Specialist Access to Medicare Beneficiaries:

- Current regulations does not restrict Medicare beneficiaries from seeking care outside the ACO
- Beneficiaries will only be assigned to the ACO retroactively, and it will therefore not have specific information concerning them until after care is delivered.
- One of the reasons given by CMS for this rule is to “encourage the ACO to redesign its care processes for all Medicare FFS beneficiaries” .

# Specialist Access (cont.)

- It would therefore follow that PCPs involved in an ACO might seek to direct most or all Medicare patients to those specialists directly involved in the ACO. Those specialists would be most likely to manage patients according to the ACO parameters, and provide the data required for reporting.
- This has the potential to significantly disrupt historical referral patterns.

# Summary

- The impact of this new practice model is virtually unknown. Recent demonstration projects utilizing already highly integrated delivery systems show uneven results.
- Although there is significant interest among hospitals and other stakeholders in developing such programs, there will be significant challenges limiting entry.
- Patient acceptance of such a program is unknown, and current regulations don't restrict patient access to providers outside the system.

# Summary

- Exact physician impacts remain unknown due to the above factors.
- Financial and time requirements have the potential to be significant
- Disruption in current practice models may accelerate a trend towards physician employment and involvement in more highly integrated systems

# Action Plan for Employed Physicians:

- Become informed and educated about what your institution is planning with respect to the development of an ACO
- Consider involvement in the physician governance side of the management of such an entity. As in most aspects of the politics of medicine, the declaration that “If you are not at the table, you may find yourself on the menu”, may prove prophetic in this case as well.
- Begin to address potential revenue stream and compensation issues early. The financial aspects of any business venture are often a source of contention, and also a critical component of success. The sooner those issues are addressed, the easier it may be to obtain a consensus.

# Action Plan for Private Practice Physicians:

- Evaluate the potential for further vertical integration of your practice within your community. The ability to participate in a more integrated delivery model, and provide a broad spectrum of services, will be attractive to organizations looking to achieve the goals as outlined by HHS.
- If you have not yet instituted an EMR system, do it now. A practice without a robust IT infrastructure will not be able to provide the information required in the new model.
- Begin a data collection and quality monitoring program. If you are not already doing so, institute a patient satisfaction survey. Your ability to provide this information will be a sign that you understand what will be required of the ACO. It will also allow you to evaluate your EMR system, and personnel infrastructure, for its abilities to provide the needed information.

# Action Plan (cont.)

- Consider developing an orthopedic co-management program with your hospital. The programs and processes developed will become part of an ACO quality program and familiarize you with the necessary steps and time commitment required.
- Assess your ancillary service lines with respect to quality and efficiency parameters. In order to survive, they will need to prove superior when subjected to the same scrutiny as the providers of similar services outside your practice.
- If your practice does not routinely engage in strategic planning, make time to do so. The only way any business survives in a competitive environment is by knowing where it is, deciding where it wants to be, and devising a plan to get there.

# A Final Thought

- “A government big enough to give you everything you want, is strong enough to take away everything you have.” (Thomas Jefferson)

