Working together: Keys for successful partnerships with specialists

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Organizationally, accountable care organizations (ACOs) are primary care physician (PCP)-centric models. Some commercial payers have adopted this structure and definition of PCPs as physicians who specialize in internal medicine, general practice, family practice, geriatric practice and primary care. Specialists who perform PCP functions for chronically ill patients can be classified as PCPs for ACO participation. In virtually all models that we have researched or encountered, PCPs are permitted to participate in only one ACO. Specialists are permitted to participate in several ACOs unless they are classified as a PCP — as in the case of illness-specific ACOs, such as cancer treatment ACOs. In rare cases, a PCP may be able to participate in more than one ACO. One example: A PCP is an employee of a hospital-based ACO and also participates in a private practice that is part of an ACO.

Once they meet benchmarks related to patient engagement, satisfaction and safety as well as cost savings and quality of care, ACO participants and contractors can share a portion of the savings or be held accountable for the lack thereof. For example, a payer could tie incentives of 5 percent to criteria such as eliminating referrals to out-of-network ambulatory surgery centers, eliminating the use of out-of-network labs, increasing the rates of e-prescribing among providers and increasing the percentage of prescriptions for generic drugs. The fee-for-service fee schedule could be calibrated at 95 percent of the approved fee rate with 5 percent paid at the end of a year if the incentives are met.

As a result, specialists, not just PCPs, need to understand the metrics, baseline data and measurement mechanisms associated with ACOs and how their behavior contributes to performance measures for each metric.

There are many integration options, including virtual organizations in which participants do not necessarily occupy the same physical office space and "super-multispecialty groups" that include PCPs. We have found that specialists are keenly positioned, as part of interdisciplinary teams, to guide clinical decisions and referral practices that help ACOs achieve benchmarks and receive the maximum shared-savings payments.

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Specialists in ACOs should carefully analyze case mix and revenue streams to negotiate optimal reimbursement. One successful tactic is to use commercial preferred provider organization (PPO) reimbursements as benchmarks because patients are rerouted from individual practices to new, integrated groups. For specialists, negotiation strategies should focus on investment in advanced medical technology, in-house ancillary services and the capacity to perform surgical procedures in office settings. As the ACO matures and more risk is delegated to participants, according to the Centers for Medicare & Medicaid Services' (CMS) structure, specialists must be aware of evolving payment methodologies, such as bundling of codes

and case rates. We have found that, if not properly managed, ACO payment mechanisms based on episodic care or population management can put specialists at risk of revenue cycle management issues. Evaluation of practice patterns will be an integral part of making ACOs effective and viable. For example, protocols for utilization of diagnostic imaging and/or testing may be reviewed to determine if and how often the procedures should be done to identify overutilization that leads to higher costs. Provider education and follow-up can help ensure compliance and gather feedback for policy review/revision, if necessary. All ACO participants and contractors will have skin in the game, which motivates teamwork to actualize the benefits.

Patient attribution — which can be retrospective or prospective by diagnosis groups or risk factors — is important to ACO participation and contracting because the way in which patients are directed to a practice affects revenue. Specialists could be paid a capitated rate per patient attributed, with or without shared savings payments, depending on the attribution model and payment mechanisms. Capitated payment for a patient population would provide a steady but smaller cash flow. Alternatively, if the fee-for-service reimbursement model is maintained, cash flow might not be initially affected, but any increases in revenue from the patient population will be tied to performance with targeted incentive benchmarks. Failure to meet the value-based incentives could require ACOs to return prospective payments or forgo shared savings payments.

Specialists who participate in ACOs will be reimbursed based on methodology and rates agreed to by all participants, whether that is done through capitation or

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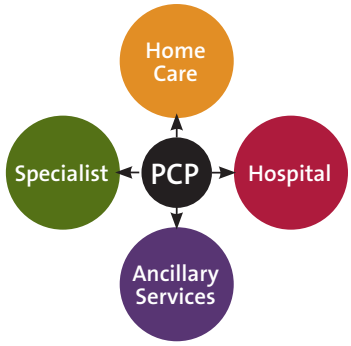

Figure 1: How a primary care provider operates with an ACO.

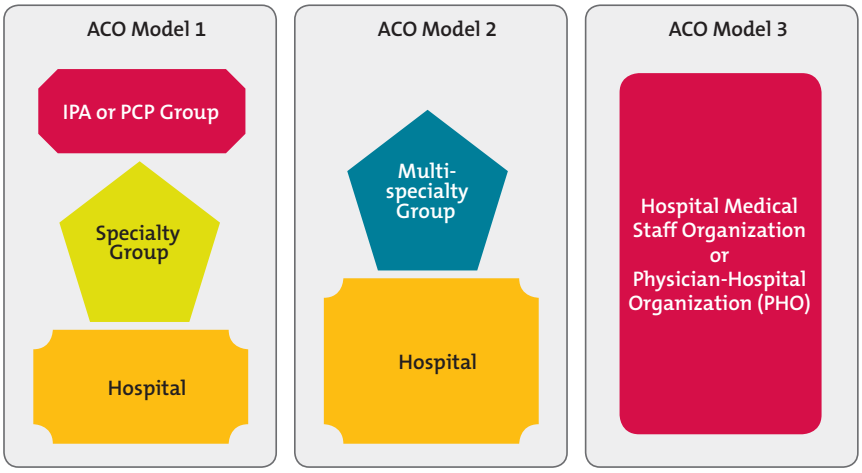

Figure 2: The ACO model is flexible, and the organizational structure can vary.

fee-for-service. CMS also included patient notification and choice protections in its shared savings ACO regulations, which compound potential impacts on revenue. The fact that attributed patients cannot be forced to stay in ACO networks to seek care creates inherent risks to patient data collection and reporting. Therefore, payer benefit plans must align with payer and ACO goals to encourage patient retention in ACO care networks and reduce negative impacts on revenue. We have been told that as payers build commercial ACO products for members and employers, many plan to provide incentives (lower premiums and reduced copays) for members to use ACO network providers and specialists.

There are several ACO programs run by the government and private groups that use different delivery and payment methodologies. Generally, the selected methodology is related to the participating providers' level of readiness to take on risk and/or population management, such as:

- Fully prepared: The provider is part of a fully integrated medical delivery system, such as Medicare's Pioneer ACOs, which have capitated/advanced payment reimbursement models.
- Prepared: These are generally fee-for-service providers who are eligible and prepared to gather and report performance data and receive shared savings payments through integration with independent provider associations (IPAs) or other network management entities.
- Need help to become prepared: These are fee-for-service providers who would like to participate in ACOs but might need operational guidance and financial assistance to acquire or expand information technology capacity to gather and report performance metrics.

Organizationally, ACOs can take many forms. They can emanate from existing IPAs; they can have virtual structures where a network of providers agrees to manage a population of patients in an integrated manner; or they can be a fully integrated physician hospital organization (PHO).

Shared risk arrangements will be reviewed for compliance under traditional anti-trust principles. Providers need to be aware of how CMS, the Department of Justice and the Federal Trade Commission define integration, coordination and collaboration. Failure to comply with those definitions and guidelines could expose ACO participants and contractors to investigation and possible prosecution. MGMA-ACMPE members are encouraged to visit mgma.com/aco for a detailed analysis on the final Medicare shared savings ACO rule.

Compliance with anti-trust regulations is only one of the challenges associated with ACO formation in the commercial market. Stakeholders who are accustomed to practicing autonomously must accept performance standards and measurement tools. In other words, a specialist accustomed to a fee-for-service PPO and health maintenance organization with direct payer in-network agreements is used to making clinical decisions without considering how his or her clinical choices impact other specialties and/or primary care decisions. For the generally healthy patient who experiences a single medical event, this might not be an issue. But it can be challenging to obtain consensus for patients who have multiple ailments and/or chronic illness, and that has the potential to create conflict between payers and providers and between ACO participants and contractors, particularly if there is no

agreement concerning who takes the lead in making clinical decisions.

For example, will the urologist be able to make an important decision about hospital readmission for a prostate cancer patient, or will he or she have to confer with a PCP member or another specialist within the ACO? Because all physician members of the ACO are potentially affected by these decisions, protocols have to be clearly defined to provide specialists with a fast path to clinical decision-making that leads to positive patient outcomes.

Practice management technology that allows for population health management through EHRs, e-prescribing and automated billing will help providers track and report population-based performance data. Some providers may be able to use state healthcare information exchanges to mitigate information technology challenges, such as providing a cloud-based portal for EHR and e-prescribing. (Read more about cloud-based technology in the February 2012 Bright Ideas column of MGMA *Connexion*.)

Although the ACO structure is somewhat flexible, we believe the most challenging aspect will be changing the entrenched fee-for-service culture among providers, which rewards volume, to collaborative contribution, which rewards positive outcomes while preserving quality of care.

Look before you leap, and make sure your specialists have the human, intellectual, financial and legal capital to develop and implement an innovative and coordinated integrated care model.

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