Five Strategies for Specialists: How to Safely Navigate ACO Arrangements

written by Theresa Hush | September 27, 2018

Amidst the furor over health care access and affordability, most consumers believe that the exceptional quality of America's health care is due to specialty medicine. But Value-Based Health Care may well dramatically change specialty practice by putting specialists under financial risk arrangements. That's because the most prestigious and flourishing providers in health care are also the most expensive for ACOs and health plans. That makes them a target for cost control.

We have spoken about the need for ACOs to evaluate specialists carefully and ensure that specialists have input into ACO assessments of their cost and quality. Here we address specialists and specialty practices: *What should you do* to strengthen your position with ACOs and health plans under VBHC, and *how do you develop an understanding* of your market performance profile—and your options?

Specialists Unprepared for Move from Fee-for-Service to Per-Case Fees

ACOs, Medicare Advantage Plans and other health plans have an objective: eliminate reimbursements that reward volume of services and replace them with fixed fees per-case or per-patient. Bundled payments are likely to be the future norm for specialists, based on procedures or diagnoses that cover all services or only professional fees, depending on the organization. Medicare has already moved some procedures, such as total hip and knee replacements, into a mandatory bundled payment reimbursement. Other procedures and some diagnosis-based episodes will soon follow.

Here's the problem: few specialists have data and processes in place to examine episodes of care for their specialty or to understand cost variations by patient. They know their own procedural fees, of course; but how those calculate into a cost-per-case is more complicated. One of the difficulties is that some data for services is outside their scope of care, like those of other specialists or facilities. Accurate measurement of episodes is also challenging, along with the variation caused by different patients, risk levels and incidental services.

The biggest shortfall of all: most specialty practices haven't begun the process of creating episodes or pulling together their cost performance information. And some have only captured quality or outcome data through MIPS or other reporting methods.

Specialists, who have depended on a flow of patient referrals from primary care physicians—in addition to patient self-referrals—are already scrambling to figure out how they should be participating in organized provider arrangements. Some are worried that competitors have already taken the best partners; to overcompensate, these specialists are acting precipitously to enter arrangements that could harm their patient flow, revenues or scope of services.

Specialty Practice Spectrum Requires Strategies Tailored to Each Group

Specialty practices can range from small, independent, single-specialty groups to large, consolidated, multi-specialty practices operating in academic medical centers. The market reach differs, as well. Each type of group has distinct challenges and benefits for ACO or other risk arrangements, so the ACO negotiation strategies must be tailored not only to specialty type, but also related to their market strength and size, practice scope, structure and their tolerance of risk.

Single-specialty groups will have an easier time organizing services, because they are

more easily packaged. If they have significant volume, they are well-positioned to participate in ACOs for specialty referrals, because bundled payment reimbursement can be focused in discrete areas and on fewer procedures.

Multi-specialty groups (except for the rare handful of nationally recognized names) are more diffuse and have a harder time establishing the brand and identity they need to compete. The ACO may have a desire to pick and choose specialists, which may be both financially and logistically difficult for the group. Because the group will compare costs by procedure and/or diagnosis and by specialty, multi-specialty groups should be prepared to be flexible with multiple types of risk-based reimbursement, including capitation payments.

Hospital-owned multi-specialty practices have the advantage of closer facility connections to address the total cost of care versus limited professional fees, as well as resources that are usually greater than those of independent groups. These groups may find the benefit of negotiating bundled payment episodes, including multi-specialists plus facility fees, most lucrative—even if the distribution of funds is extremely difficult.

Academic groups have credentials, but can suffer when converted to full-time equivalent clinician staff, so many providers generate lower volume services. This makes it difficult to entertain episodic risk. Even when they do have good cost performance—and some do, because they can be large Medicaid providers—their attractiveness to ACOs and other risk-based plans is diminished by the diffuse goals of the academic center. That challenge can be made worse by the small procedural volumes that make it difficult to accurately price. Like other large groups, they may find the easiest scheme to be capitated payments that are then actuarially distributed to specialties and specialty groups.

Five Pre-emptive ACO Readiness Actions for All Specialty Groups

Specialists must recognize the shifting social-to-business transition that is occurring quickly because of financial risk. The personal and collegial relationship, once the foundation for primary-to-specialist referrals, will be severely limited by the addition of financial risk. The metrics of cost, quality and patient experience (outcomes and satisfaction) will determine whether specialists will have patient flow. Even hospital-owned ACOs in the future will be leaning more heavily on their own specialists to cut episodic costs, because revenues will depend on achieving expenditure targets.

Given the tendency for ACOs, hospitals and health plans to want to “score” physicians, just as they have done with quality incentives, these metrics have the potential to discourage and anger physicians. Therefore, physician groups and hospital-physician groups should engage in pre-emptive strategies to control their data, facilitate sensible episode and bundled payment

developments, and be involved in processes to support physicians in investigatory—not punitive—processes of understanding cost variations in total and by patient.

Regardless of size and structure, here are five steps that all specialty physician groups should follow:

Take control of the story and the numbers. If you are up to speed on how ACOs and health plans are using data to calculate specialty provider costs, you will realize that you can't be passive and accept external numbers. You will need to compile your costs, your volume, your claims data (to extent available) and to evaluate existing comparative data from prior Medicare QRUR supplemental reports, to examine costs by diagnosis as well as cost outliers for the specialty group.

Collaborate with an ACO or another partner in examining your cost structure and your specific per-case costs. Groups that have resisted cost sharing in the past should recognize that there are provider-identified sources of claims data that health plans and others are purchasing for comparing providers. It's a new day, and if you can collaborate and share the costs of data and analytics, you are that much farther ahead.

Create both procedural and diagnosis episodes for use in tracking costs over time by patient and provider. Why? Because you need a common standard to compare variations of care across patients and providers, as well as to capture patient risk and other factors along with the episodic transactional data. These episodes—mostly procedures—will reveal both cost and data issues to explore. Diagnosis episodes, in general, are not well adapted to bundled payments, except for per patient/year payments for major chronic diseases; the data embeds diagnosis-coding disparities between providers, which makes cost calculations difficult.

Establish key core quality and outcome measures—including complications, redo's, readmissions, mortality and patient-reported outcomes that are evaluated in each episode along with cost metrics. It is not enough to use MIPS process measures because the objective is to identify quality of the episode along with costs. That's the story that must be sold for every specialty practice.

Distinguish your practice by what you do better and differently with more data, especially gathered from patients. Like any business outside health care, you must create a reason for people to choose you. Important components of this choice have to do with functional outcomes that can and should be reported by your patients, along with patients' stories and your practice improvement programs. Specialty practices can't rest on past accolades when data is being used for specialty selection.

The most important strategy for specialty providers to undertake now: get started, and work collaboratively with risk-bearing entities. Specialists are in a unique position to contribute to the

understanding of costs and, in particular, to analyze variation in costs per patient. Active participation in developing the practice metrics will create a learning environment within the practice, if pursued carefully and without punitive goals. Physicians must lead this effort if they want to avoid inaccurate conclusions by non-clinicians regarding efficiency and effectiveness of specialty care.

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