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Accountable Care Organizations Are No Longer Unicorns, But They Are Still Zebras!

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As I continue working to establish a viable accountable care organization (ACO) for our health care system, I have learned what is required to develop a new joint venture and the importance of having physician champions to drive change. For the past 2 years, I have collaborated with physicians from 2 competing health systems in a joint venture called The Accountable Care Alliance. It is a 50/50 joint venture between 2 physician hospital organizations, which began with the goal of sharing best practices. The first goals were 1) building guidelines on common procedural Diagnostic Related Groups (DRGs) and 2) reducing 30-day readmissions.

When we began in 2009, ACOs were like a mythical creature—a unicorn. ACOs were claimed to improve the quality of health care while reducing costs. Today, I would define ACOs not as mythical, but as more of a rarely encountered animal, like a zebra. On July 9, 2012, CMS announced that only 154 ACOs exist in the United States.¹

Now that the Supreme Court has finally weighed in on the Patient Protection and Affordable Care Act (PPACA), our ACO Board must make several difficult decisions within the next few months. Are we going to build the infrastructure to participate in the Medicare Shared Savings Program? Are we going to empower and finance the drive for the changes necessary to be successful in a value-based payment environment together? Are we going to become clinically integrated and share risk? To be able to participate in the Medicare Shared Savings Program, we must consider the following questions:

- Do we have the necessary IT infrastructure and analytics?
- Can we manage patient care across the continuum?
- Do we have the culture and physician leadership necessary for collaboration?
- Can we follow physician-guided targets and metrics to improve performance and reduce waste?

These types of discussions will happen with increasing frequency. We must become educated concerning the issues of managing patients with cancer in the setting of an ACO!

Have you been recently approached or invited to join an ACO within your market? If not, I think you certainly will in the next 12 to 24 months. For this reason, an important lesson our physicians recently came to understand could be useful for you before contracting for participation in a Medicare Shared Savings ACO.

In the final ACO rules from the Federal Register in November 2011, CMS directly discusses the specialty physician exclusivity issue.² Although the exclusivity requirement clearly applies to primary care physicians (defined as physicians with a designation of internal medicine, geriatric medicine, family practice, and general practice), CMS also recognizes that instances occur when specialty physicians may also act as primary care providers.

If a Medicare beneficiary did not receive services from a primary care physician during the reporting period, CMS will identify any specialty physicians as having provided “primary care services” to the beneficiary. The rule 42 CFR 425.20 identifies the following Healthcare Common Procedure Coding System (HCPCS) codes to define primary care services: 99201-99215, 99341-99351, G0402 (Welcome to

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Medicare visit), and annual wellness visits (G0438 and G0439). The beneficiary, who receives care from a specialty physician with the primary care codes being billed, will be assigned in a “stepwise approach” to an ACO using the tax identification number (TIN) of the specialty physician group. This situation causes the specialist to be subject to the exclusivity requirement for a Medicare ACO because primary care services were provided.

Thus, the decision to participate in another ACO at a later date is not as easy as obtaining another TIN for the practice. According to our group attorney, the 2 options for participation in another Medicare ACO would be to 1) obtain another TIN with the specialty practice participating either through a different entity, or 2) have physicians individually bill through each member of the practice using their own social security number. Each group must also evaluate the business and compliance matters when considering billing and tax implications for multiple TINs. These rules are complex and in place for all physicians participating within a Medicare ACO. However, depending on the market, ACOs are also being formed for commercial insurance, and participation rules may be different and may not follow Medicare rules in these situations.

Additionally, my organization reminded our physicians of a key Medicare regulatory requirement that patients will have freedom of choice. This means that although specialty physicians may become contractually obligated to one Medicare ACO, patients remain free to receive care from any provider. This concept of patients being able to receive benefits without being required to stay with select participating physicians is very different from the strict HMO rules we all remember from the past! Patient freedom of choice is causing provider competition in more areas than just price. Other factors include great customer service, more after-hours service, and good quality outcomes. Welcome to the next evolution in managed care, where transparency puts the patient in the driver’s seat, not the powerful insurance company.

Finally, the explicit and final rules to make PPACA fully operational for state exchanges are not completely defined. Also, each state will make determinations about whether to expand their Medicaid coverage. The presidential election included health care once again as a topic for debate.

Our ACO network was recently selected to be Tier 1 providers for a commercial insurance plan in our community. A Tier 1 provider requires contracted physicians and hospitals to be paid at the highest level of benefits being offered in the new insurance plan. Physicians, hospitals, and insurance plan executives are sitting at the same table working together in this new paradigm to create plans for patients/members to be ready for the state exchange offering in 2014. One thing is certain, change is happening, and no one has the clear road map. As providers, we must take the time to become educated and be vigilant to provide the best care for our cancer patients in this next era of managed care.

References

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