Is There a Role for the Orthopaedic Surgeon in ACOs?

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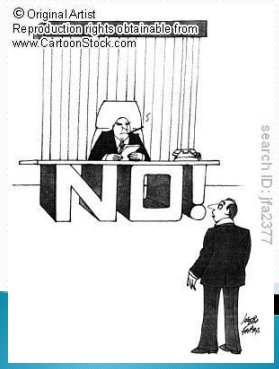
SCA
Surgical Care Affiliates



The question of ACO's for the Orthopaedic Surgeon is a challenging one.

What does the A stand for anyway?

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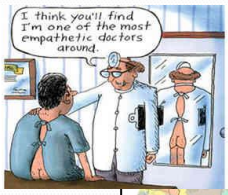
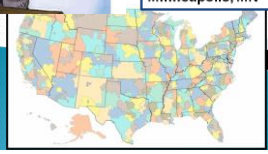
ACOs do *not* materially change the structure of payments
and they do *not* create "closed networks"
Providers are still paid Medicare fee-for-service rates
Patients in ACOs can still choose any provider

So why should Orthopaedic surgeons join?

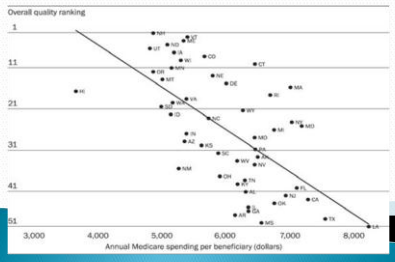
The numbers are certainly compelling



Medicare Spending Per Capita 2003	
Miami, FL	$11,352
Los Angeles, CA	$9,752
Worcester, MA	$8,203
Boston, MA	$7,901
Springfield, MA	$7,103
San Francisco, CA	$6,408
Lebanon, NH	$5,254
Minneapolis, MN	$5,213



Medicare spending per beneficiary not correlated with widely accepted quality outcomes measures



Who can form an ACO?

- Physicians and other professionals in group practices
- Physicians and other professionals in networks of practices
- Partnerships or joint venture arrangements between hospitals and physicians/professionals
- Hospitals employing physicians/professionals

Requirements for ACO:

- Have a sufficient number of *primary care professionals* for the number of assigned beneficiaries (to be 5,000 at a minimum)
- Agree to participate in the program for not less than a 3-year period
- Have defined processes to (a) promote evidenced-based medicine, (b) report the necessary data to evaluate quality and cost measures, and (c) coordinate care

What Does Not Change With ACOs

From National ACO Summit, presentation by Steve Lieberman, visiting scholar at The Brookings Institution, presented 6/7/2010

- ACOs are not gatekeepers
- ACOs do not require changes to benefit structures
- ACOs do not require patient enrollment
- PCPs must be exclusive to one ACO (to minimize concerns about selection & dumping); specialists can be part of multiple ACOs
- Providers affiliated with only one ACO can refer patients to non-ACO providers

ACOs Do *Not* Create "Closed Networks"

- Medicare ACO description document:

  "Q: Will beneficiaries that receive services from a health care professional or provider that is a part of an ACO be required to receive all his/her services from the ACO?

  A: No. Medicare beneficiaries will continue to be able to choose their health care professionals and other providers."

- Document at: http://cms.gov/officeoflegislation/downloads/accountablecareorganization.pdf

Provider Structure Is Not Exclusive

ACO patients can access any providers – no gatekeeper or closed network

- **Community Providers** not part of ACO but may provide care to ACO patient. Some community providers may contract with ACO or routinely receive referrals, while others may have no relationship (or be out of area).
- **ACO Providers**: Members govern ACO and, if exclusive, have patients assigned to them. Other providers may join multiple ACOs.
- **Bonus-Eligible Providers:** ACOs have discretion to pay bonuses to a subset or all ACO members, varying treatment and amounts (e.g., all PCPs could receive bonuses, while only some specialists might).

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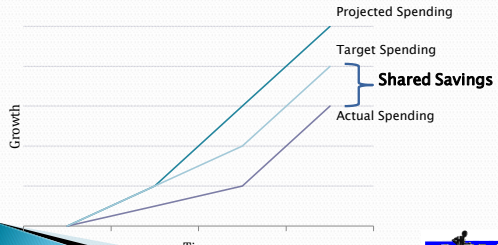
Savings Payment Structure

Providers and Payer rewarded with portion of savings compared to target (normally projected spending less some margin)



Is Share Savings enough of a carrot to belong to a specific ACO?

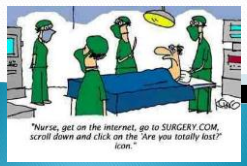
More questions than answers:

1) Who decides who gets a portion of the shared savings?
2) Is there resentment regarding income levels between primary care physicians and orthopaedic surgeons?
3) If the group demonstrates shared savings for the initial 3 years what happens to the benchmark moving forward?
4) Does it become an impossible target to reach without rationing care?

Is Share Savings enough of a carrot to belong to a specific ACO?

More questions than answers:

5) Remains to be seen whether hospital can co-exist with ACO
   Incentive for hospital is to fill beds / drive utilization
   ACO driven to reduce utilization
   Will "bonus" be big enough to change behavior?



What we do Know

ACOs unlikely to materially change practice patterns

ACOs do not create closed networks

ACOs do not change basic FFS payments

What we do Know

ACO regulations appear to view specialists and surgery centers as necessary evils
(Scott Becker, JD 5/1/2010)

Regulations would seem to aimed at reducing the use of specialists

Primary care physicians may only participate in one ACO, however a surgical provider may participate in more than one

What we do Know

The ACO is responsible for distributing savings to participating entities

No savings are shared unless the savings are at least 2 per cent below the benchmark

ACOs must meet certain quality standards and promote evidence based medicine

What Should we do Now?

1) **Practice** the highest quality, most cost efficient orthopaedic surgery we can.
2) **Align** ourselves with ASC's that provide lower costs and the highest quality of care.
3) **Document** outcomes so that quality is easily demonstrated
4) **Do not** be the first kid on the block that has to try the new toy
5) **Maintain** our **free agent status** so that we may provide the best care for the greatest number of patients.
6) **Prudent to assess** affiliating with dominant market player if it becomes imperative take sides

Even what initially seems like a bad trip can have a happy ending!