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SUMMER 2018 NEWSLETTER

Within the past two weeks, we've received multiple calls from clients regarding participation in Accountable Care Organizations (ACOs). In an effort to respond to the many questions asked, we're looking both backward and forward in time.

Margie Satinsky

ACOs IN NORTH CAROLINA: WHERE ARE WE NOW?

Looking Back and Moving Forward

The shortcomings of fee-for-service medicine were apparent to policy makers, public and private insurers, providers and the general public well before the 2010 passage of the Affordable Care Act (ACA), known as Obamacare. Value-based purchasing for a defined population was already on everybody's radar screen by the time the Act offered an approach directed toward the Medicare population.

The ACA formalized the creation of Accountable Care Organizations (ACOs), provider-based organizations that assume the responsibility for meeting the healthcare needs of a defined population. ACOs coordinate the treatment of patients across the continuum of care, including physician practices, hospitals, skilled nursing facilities, long-term care facilities and other providers and suppliers of Medicare-covered services.

ACOs have three goals: (1) promote accountability for a patient population comprised of Medicare fee-for-service beneficiaries; (2) coordinate covered items and services in Medicare Parts A and B; and (3) encourage investment in the infrastructure and redesigned care processes that lead to high quality and efficient service delivery.

Although ACOs initially focused on the Medicare population, the notion of population-based care supported by strong infrastructure and efficient processes has expanded. ACO participants now have opportunities to work collaboratively with private as well as public insurers to manage other defined populations. Let's look at current developments and opportunities in North Carolina.

1. **How many ACOs are there in North Carolina?** Currently there are 30 ACOs in the state. The number includes those that participate in the Medicare Shared Savings Program (MSSP) and three that are Next Generation (NextGen) model ACOs. The NextGen models, currently in the test stage, are directed toward ACOs that are experienced in coordinating care for specific populations and that are willing and able to assume higher levels of risk than are available under the MSSP. At the time of writing, at least two new ACOs had announced future plans.

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2. **Are there ACOs in every county in North Carolina?** No. There are 6 counties that have no ACOs, 57 have 1 or 2 ACOs, 33 have 3-5 ACOs and 4 counties have between 6 and 9 ACOs.

3. **Do all ACOs in North Carolina accept all interested physicians or do some have membership restrictions?** Philosophically, the larger the population base, the easier it is to spread risk. But ACOs don't necessarily accept all interested physicians. Some require participants to have already reached a certain certification level in the Patient Centered Medical Home (PCMH) program. Some have other quality achievement targets. Some have criteria for continued membership and procedures for terminating physicians and practices that don't meet ACO standards. Most ACOs limit participation to practices that are located in particular counties. It's imperative for practices with multiple locations in different counties and/or plans for geographical expansion to understand the implications for ACO membership.

4. **Are all ACOs in North Carolina the same or are there significant differences between them?** There are many differences. Here's a partial list of important distinctions.
    - **Membership:** ACO membership is non-exclusive for specialists and hospitals. Primary care physicians must be exclusive to one ACO for a specific patient population. It is therefore possible for a PCP to be in one ACO for MSSP and another ACO for a commercial contract. As explained in #3 above, ACOs may limit addition of new members and/or geographical coverage.
    - **Structure:** Although primary care is the backbone of ACOs, comprehensive care management naturally involves care that is provided by other healthcare providers. Some ACOs are formally structured as partnerships between physicians, hospitals, healthcare systems and professional support vendors that gather and share data with members. Many ACOs develop special contractual arrangements with groups of specialty physicians. Primary care physicians are expected to refer to these "preferred providers", and the ACO may have a special tool for managing referrals.
    - **Size of covered population:** There's great variation among ACOs. For example, Mission Health Partners in western North Carolina is one of the largest ACOs in the country. It includes hospitals, physicians and other healthcare providers and covers 47,000 Medicare beneficiaries, 18,000 lives through the Mission Health employee benefits plan and 8,200 patients through Medicare Advantage plans. Most North Carolina ACOs are much smaller. Size of the covered population is directly related to risk; the larger the population, the easier it is to spread risk.
    - **Geography:** With the exception of a new ACO expected to become operational in January 2019, ACOs in North Carolina are regional.
    - **Track record:** ACOs vary in their ability to meet the specific requirements of each value-based program in which they participate as well as in the surplus/loss that each has generated. Several North Carolina ACOs have already received national recognition. For example, in 2016, Coastal Carolina Quality Care in New Bern ranked first in the nation for quality performance as a Medicare Shared Savings Program (MSSP)

ACO. That same year Physicians Healthcare collaborative, the ACO associated with Wilmington Health, ranked 15th in the nation.

- **Behind-the-scenes support for population-based care:** Well-managed ACOs partner with a vendor experienced in population-based care. The vendor has its own software system that brings together payer-specific requirements and data on practice and individual physician performance. That information can be combined with data from individual practice EHRs to create a composite picture of each practice. ACOs vary in their ability to generate meaningful data about individual physicians within a practice.

5. **Do the different North Carolina's ACOs work together to share best practices and other experiences?** More than four years ago, a group of far-sighted individuals launched the Toward Accountable Care Consortium and Initiative (TAC). The Consortium now includes more than 40 healthcare association and organization members, each of which joined in order to prepare for the transition to value-based care.

6. **What resources on ACOs are available to North Carolina physicians?** With generous financial support from The Physicians Foundation, TAC has developed toolkits that cover the range of specialties and topics related to legal and financial issues. The toolkits are free and can be downloaded from the TAC website, **http://www.tac-consortium.org**.

7. **How are commercial third-party payers (i.e. health plans) working with ACOs on value-based care for defined populations?** Many of the major health plans have at least one value-based contract in North Carolina. Here are some examples.

   - **Aetna** has several value-based programs. For example, through Aetna Whole Health, it has established partnerships with Duke Health, WakeMed Key Community Care (WKCC) and Triad Physicians Network. WKCC is an ACO that brings together Key Physicians and WakeMed Health and Hospitals. The ACO includes 350 primary care providers and 750 specialists. Aetna Whole Health-Duke Health, WakeMed Key Community Care and Triad Physicians Network are available to employers and individuals in eighteen North Carolina counties. Aetna also has bundled payment programs for specific specialist physicians (e.g. cardiology, gastroenterology and orthopedic surgery) who agree to take risk, operate on a budget and meet specific thresholds.
   - **Blue Cross Blue Shield of NC** has launched numerous value-based programs with innovative payment mechanisms, administrative structures, and care delivery models that seek to improve health outcomes and patient satisfaction while lowering medical costs. Initiatives include but are not limited to incentive programs for primary care physicians (e.g. Blue Cross Quality Physicians Program (BQPP)) and the new ObGyn Care Collaborative launched in 2018. Blue Cross also collaborates with a number of ACOs throughout the state as well as with health systems.
   - **CIGNA** has accountable care relationships with multiple health systems in North Carolina.

- **UnitedHealthcare** has initiated several value-based programs with North Carolina providers. These include: Medicare and Commercial ACOs; Medicare Incentive Programs for PCPs and Performance-based Contracting for Commercial Plans.

8. **Are there any new ACOs on the horizon?** Yes. Here are details on two new ACOs.
   - In June 2018, Aledade, Inc., an organization that partners with primary care physicians throughout the country to build and lead ACOs, has joined with North Carolina-based Emtiro Health, LLC to work together to support independent physician practices in a new physician-led ACO. The projected launch date is January 2019 and the ACO will be statewide.
   - Emergent ACO, an affiliate of Quest Diagnostics, is in the process of planning a multi-state ACO. One of the unique features of this ACO will be its ability to financially support case management services within each practice setting. Many ACOs offer case management support as an external service instead of as a service that patients are able to receive directly from practice staff.

9. **From a private practice perspective, what are some of the challenges in participating in ACOs?** Our clients' experiences have provided good insights.
   - Value-based care is a two-way street involving both changes in payment and operational transformation. Many practices are unprepared to assume financial risk and lack the internal ability to make necessary changes without significant technical assistance from an experienced external professional.
   - Determining a system for distributing surplus/deficits among various providers can be challenging. Some practices use an equal distribution system, some use a volume- and procedure-based system and others have developed other methods.
   - Success in value-based payment requires commitment by both practices and individual physicians to learn best practices and make ongoing improvements.

10. **If a practice does not currently belong to one or more ACOs, what questions should it ask?** We recommend starting with the indicators of ACO success that are laid out in *The Physician's Accountable Care Guide* and additional items. Here's the list.
    - **Interpersonal relationships:** As always, the ability to succeed in new forms of organization that require new tools and skills are heavily dependent on good working relationships, inside and outside the practice setting. If you're not a team player, an ACO is not for you.
    - **Strong leadership:** Strong leadership by primary care, specialist physicians and hospitals is critical. Leaders need vision and the ability to make things happen.
    - **Administrative skill:** Complement strong provider leadership with experienced and competent administration. New ACO members, especially small practices, need considerable assistance in understanding and meeting expectations.

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- **Provider willingness to take ownership of a defined population:** There's a big difference between treating patients sporadically when they make appointments and managing the care of patients for whom you are responsible.
- **Shared governance:** Successful ACOs share the governance among different parties, rather than concentrating it in the hands of the strongest partner.
- **Recognition of the importance of primary care:** Primary care physicians are the key to making ACOs work.
- **Data:** IT must support the ACO goals and priorities. There's a big difference between churning out reports that nobody reads and developing useful information that can be used to bring about real change.
- **Best practices across the continuum of care:** ACOs must use evidence-based medicine to deliver high quality care.
- **Engagement of the patients for which the ACO is responsible:** ACOs depend on provider-patient collaboration.

Additional Resources About ACOs

- **Toward Accountable Care Consortium and Initiative (TAC):** Melanie Phelps, North Carolina Medical Society Senior VP for Health System Innovation and Deputy General Counsel, mphelps@ncmedsoc.org.
- **Aledade, Inc./Emtiro Health, LLC partnership** to develop a new ACO for primary care physicians practicing throughout North Carolina: Angela Diaz, adiaz@aledade.com.

For Assistance with Medical Practice Start-up and Management

For assistance with the following, please contact us at **919.383.5998** or **margie@satinskyconsulting.com**.

- Medical Practice Start-up and Expansion of Services and/or Locations
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- Disaster Planning
- Information Technology Planning and Implementation
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Satinsky Consulting, LLC
201 Cedar Ridge Way
Durham, NC 27705-1981
919.383.5998
Fax 919.309.0109
www.satinskyconsulting.com