ACOs – ECONOMIC CREDENTIALING – BUNDLING OF PAYMENTS

There are a number of medical economic issues Headache Medicine Physicians should be familiar with as we enter a new era of healthcare reform. Although the highly publicized Accountable Care Organizations (ACOs) have taken center stage, the controversial practice of physician credentialing using economic criteria is also predicted to play an important role. The Patient Protection and Affordable Care Act (PPACA) was signed into law by Congress in March 2010. By emphasizing Quality and Cost, “Value” becomes a function of Quality divided by Cost. One year after the PPACA was passed, on March 31, 2011 CMS released the proposed Rules and Guidelines (“Rules”) regarding the development and implementation of ACOs. In ACOs the governance of the entity must be composed of a leadership and management structure that includes clinical and administrative systems. Physician performance and the ability of individual providers to meet financial benchmarks will be necessary if an ACO is to be successful.

To qualify and maximize the opportunity for ACO shared savings, it is likely that physicians in a leadership position will be imposing economic criteria on their peers. The risk of individual physicians failing to meet quality standards or cost reduction goals translates into a collective burden to all the ACO members. There are still numerous concerns as well as multiple potential operational and design issues which need to be addressed before ACOs are universally implemented. Examples include whether physicians and health care organizations will be willing to incur the expense of implementing the necessary contracting and claims infrastructure necessary to handle the new payment models proposed for ACOs. Relative to Headache Medicine practices; will ACOs simulate the failed HMO capitation model where the full insurance risk was transferred to the provider? In HMOs, since physicians were held accountable for the cost of their assigned patients, there was less incentive to refer to specialists. In fact, there are critics who would argue that HMOs actually limited access of care. In ACOs, will the burden of economic criteria discourage some physicians from referring the more complex and complicated headache patients for needed specialty care to headache specialists? Will equilibrium in measuring the role that headache specialist’s play in coordinating care for acute and chronic headache disorders be influenced by cost? As the health care industry and government seeks to find an optimal balance between cost and quality, the advocates of ACOs address these types of issues by defining the current health care reform as a different model at a different time in medicine.

The “Rules” regarding the implementation of ACOs focuses on the primary care physician as the provider for the plurality of medical care to the beneficiary during the contracted year. Primary services related to a specific disease entity such as Headache Medicine are not defined in determining beneficiary assignment to the ACO. The patient assignment methodology does not address the fact that specialists such as
those providing tertiary care for complicated headache patients, and not the primary care physician, are often the “principal provider” in the medical management of often otherwise healthy patients whose primary illness might be refractory migraine or some other complex headache disorder. It would be no different than a Cardiologist serving as the principal provider for a heart failure patient or a Nephrologist serving as the principal provider for a renal failure patient. Many specialty organizations would agree that there is an important need for the physician specialist to remain actively involved in the ongoing management of patients with complex medical conditions. Unfortunately, the newly released “Rules” do not take into account the necessary ongoing services provided by specialists. If an ACO is truly focused on integration of patient care, additional consideration must be given to the role that physician specialists play in coordinating patient care. In addition, the appropriate medical management of complex patients such as those seen in most headache centers has been shown to be cost effective in achieving savings for payers; not to mention the benefits to patients. Under the newly proposed ACO guidelines, there is concern that referrals to specialists could follow the same pattern seen earlier in the HMO model.

Following the passage of the Medicare Shared Savings Program portion of the Patient Protection and Affordable Care Act, one must also consider what role credentialing by economic criteria may play as ACO providers work collectively to manage and direct the treatment of beneficiaries. As the ACO becomes accountable for the quality and cost of the overall management of patients, economic factors will likely be considered when choosing and maintaining a physician panel. Both primary care physicians as well as specialists will be required to implement performance measures as more emphasis is placed upon cost evaluation strategies. In the past, these types of measurements have been referred to as “Economic Credentialing”. Although there is no one definition of economic credentialing, the term generally connotes different policies and practices which implies measurements of a physician’s qualifications based primarily on economic factors. Thus, when economic factors become part of the credentialing equation, there is risk that the process may not focus on the quality of care, clinical competency or professional conduct of the applicant.

To better understand the potential impact of utilizing economic criteria for ACO credentialing, it is important to briefly discuss the consequences this process had when applied to different venues at different times in the development of health care guidelines. Historically the hospital staff privileging process became one of the earlier examples of utilizing economic criteria for credentialing. In the past, there are accounts of some hospitals using economic factors as a key element when granting certain medical staff appointments. This practice led to much discussion and debate among physician organizations, medical societies, other health care providers, state medical associations, the insurance industry, attorneys and eventually some state legislators.
Most of the discourse revolved around utilization of hospital resources by staff physicians who owned or were affiliated with an outside competing facility. This controversial practice led to important landmark lawsuits as well as a number of states enacting legislation prohibiting the use of economic factors in hospital credentialing decisions.

The next historical phase of economic profiling appears to have surfaced as insurance companies developed the “Tiered Provider Network”. The insurance industry has been measuring how much individual physician cost them for years. The assignment of physicians into preferred or limited panels led to a model of “rating” doctors on cost efficiency. Within this model, once physicians are rated on cost efficiency, they are then tiered in the insurance directory. Although insurance companies argue that clinical quality indicators play a role in the rating of physicians, many experts and doctors generally believe that health plans select preferred panels on the basis of cost effectiveness as opposed to evidence based standards, quality of care, or overall competency. Assuming the critics are correct and economic profiling is an accepted practice in insurance ratings, the quality of care and other traditional performance measures becomes less of a driving force as the health industry attempts to find a better balance between cost and quality. It is well accepted that the private insurance industry will participate in the ACO model. There is no template or history to define if or how the industry’s use of economic credentialing would be integrated within an ACO’s structure.

At this point it is reasonable to ask whether there are any reliable and objective studies to help define whether the use of physician economic credentialing has any credibility. The answer can be referenced in at least two excellent studies by the RAND Corporation which demonstrates that profiling of physicians by the insurance industry does have a high risk of error. RAND indicated that the current cost profiling systems used by the insurance industry is not only erroneous but produces misleading results. One study was published in the March 18, 2010 issue of The New England Journal of Medicine; the other in the May 18, 2010 issue of Annals of Internal Medicine. The conclusions of both papers stated that the insurance tiering programs are flawed and do not accurately measure a physician’s performance. In the May 18 2010 issue of Annals of Internal Medicine, RAND stated “We found that compared with the most commonly used rule, 17% to 61% of physicians would be assigned to a different category under an alternative attribution rule”. These studies additionally indicate that while a large percentage of physicians are misclassified, in some specialties physicians are misclassified two-thirds of the time. It also appears that various physicians had even been placed in three different efficiency tiers by three different insurers based upon calculations using the same data. Following these reports, the AMA in conjunction with a number of state medical societies, sent a letter to insurers nationwide questioning the
advisability of the high stakes use of cost profiling to create tiered health plan products. Although the debate of the insurance industry’s use of economic credentialing continues, based upon current information, it does appear that the data used to tier physicians is imprecise and inaccurate. Quality assessments appear to have similar issues. It is important to emphasize that some of the measurements of “quality” that are currently used also appear to be in an embryonic state. As bureaucracy and bureaucrats have made health care increasingly more complex, it can only be hoped that the physician and non-physician directors of ACOs will do due diligence when selecting and evaluating physician panels and contracting with specialists not in the organization to avoid the same historic inaccuracies that economic credentialing has produced in the past.

On April 23, 2011, almost a month following the release of the Rules and Guidance for developing ACOs, CMS announced the Bundled Payments for Care Improvement Initiative (BPCII). The BPCII is the reimbursement model which defines how the fees of multiple providers are bundled into a single payment that covers all the services in the patient’s care. Unlike fee-for-service, bundled payments focus on a single payment for a defined group of services rather than paying separately for each item or service. This type of payment process will also require that providers bear more of the financial responsibility for outcomes. While the Medicare Shared Saving ACO Rule, which outlines the statutory framework of ACOs only allows physicians and hospitals to participate, BPCII also allows participation from multiple health care agencies. CMS outlined four models for episodes of care. The first three are retrospective, the fourth prospective. They are as follows:

**Model 1**: For inpatient stay in a general acute care hospital, in which hospitals and physicians may share gains arising from better care coordination.

**Model 2**: For inpatient stay and post-hospital care, ending 30-90 days after discharge

**Model 3**: From discharge as a hospital inpatient, ending no sooner than 30 days after discharge

**Model 4**: CMS would make a bundled payment to the hospital, which would pay physicians and other practitioners involved in the episode of care instead of them making individual claims to Medicare

In Models 2 and 3, CMS will compare the aggregate payment for the providers against a target discount price of about 2%-3% less than standard Medicare reimbursement. Any reduction beyond the target price will be paid as shared savings to the participants.
As outlined in the four different models for bundled payments, the initial emphasis focuses on integrating hospitals and physician groups into a delivery system where contractual and collaborative relationships will develop between providers and facilities. Except for those headache clinics which have a hospital headache service, the majority of headache practices focus on outpatient care. In addition, BPCIi is a CMS initiative and most headache patients are non-Medicare. Thus, it would appear that BPCIi would not be applicable to most headache medicine specialists. Unfortunately that would be a naïve assumption.

While the initial experience using bundled payments will begin with small and clearly defined episodes of care in which hospitals and physicians agree to integrate into an acceptable single payment for hospital and physician services, once those programs are in effect, bundling will be expanded to include chronic care and multi-institutional episodes of care. It is anticipated that there will be a smooth transition for this type of payment system to include all providers and settings, including outpatient patient care. As physicians are encouraged to organize into integrated delivery systems such as ACOs, other organizations, including the private insurance industry, will be prepared to work collaboratively and have the mechanisms in place for implementing and transitioning all medical reimbursements into this new initiative. Again, it is important to emphasize that reform is founded upon the premise that health care will move in the direction from a perceived volume based purchasing to a value based (value = quality/cost) purchasing system. The objective is to slow the rapid growth in health care expenditures while maintaining quality. The specialty of Headache Medicine will not be immune to those initiatives.

By now, physicians should realize that the new CMS rules and regulations on ACOs and Bundled Payments are not being created to simply be a Medicare entity. Most health care changes initiated by CMS are usually assimilated into the commercial market. It is anticipated that patients of all ages will be receiving their medical care from some type of entity as an ACO. Even if ACOs were not widely adopted, there is certainty that in the future of medicine some type of organizational structure for incentivizing payments with a focus on quality and cost will be integrated as part of physician reimbursements. The effort of conceptualizing the ACO model has included much work by multiple agencies. Even if this model were to fail, the research and efforts to develop an alternative medical delivery and payment system will not be wasted.

It is coincidental that CMS introduced the regulatory templates for ACOs and BPCIi within a month of one another? Since ACOs are being considered as the appropriate entity to manage bundled payments on behalf of its providers while developing collaborative and contractual relationships with facilities such as hospitals, it would seem reasonable that the statutory framework for both services would be released in
tandem to complement one another. It is also important to again emphasize that as ACOs develop and if bundled payments are implemented as part of the reimbursement model for that organization, ongoing economic profiling of the physician panel will be necessary since the ACO will be accountable for the quality and cost of the overall care of patients. Any one “outlier” who is more expensive to the organization than other physicians providing the same or similar services could actually have a significant impact on the return of investment to the organization. This could result in a loss of income to other providers who are members of that ACO panel. In the past, doctors had very little incentive or opportunity to monitor the utilization patterns of their peers. This would have to change in the ACO environment where both primary care physicians and specialists will be required to implement performance measures which could include the use of economic credentialing as more emphasis is placed upon business evaluation strategies.

To join or not to join, that is the question! For physicians specializing in Headache Medicine, there may even be opportunity to join more than one ACO. However, whatever the options, pick your partner (or partners) well. Be intelligent and well informed. Different organizations may have different contractual arrangements. Make every effort to understand those differences and what impact joining an ACO might have on your practice before signing any agreements. One bad decision when changing an existing practice model to a new structure could be professionally catastrophic. Headache specialists would be well advised to obtain appropriate professional and legal counsel as part of the decision making process.

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