Affordable Care Act: ACOs Are Slow, But Radiology Must Prepare

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Accountable care organizations are beginning to emerge, but radiology has been slow to join. Here’s how imaging fits in and how the industry must prepare. (Part 2 of 4)

This is the second in a four-part series on the Affordable Care Act’s impact on radiology. The first part examined emerging radiology payment models.

The nationwide launch of the accountable care organization (ACO) model is less than six months away, and several facilities across the country are already experimenting with the concept. For the most part, though, this proposed care-and-payment healthcare structure has not yet come to radiology.

Designed to control healthcare expenditures by requiring providers to collaborate on patient care — while asking them to split a lump-sum reimbursement payment — ACOs are one of the most well-known provisions of the Affordable Care Act. The CMS-designed Medicare Shared Savings Program (MSSP) is set to begin in January 2014, but the agency also created the Pioneer ACO program in 2012 for facilities with previous coordinated-care experience. Thirty-two organizations opted to get a head start as Pioneers.

In virtually all these facilities, radiology services touch the vast majority of patients. But, to-date, ACO cost-containing and service-coordinating measures have been focused elsewhere.

Bibb Allen, MD, FACR “One of the main complaints I hear is that ACOs are, to some degree, ignoring radiology,” said Bibb Allen, MD, FACR, vice chair of the American College of Radiology Board of Chancellors. “The reason for that, in my opinion, is that the low-hanging fruit to get savings are in the management of chronic disease — heart disease, diabetes, obesity.”

Radiology is a part of chronic disease management, but the industry’s main concern, he said, is more on acute care episodes and cancer management. Consequently, the slow ACO development within healthcare groups simply hasn’t progressed enough to significantly reach radiology practices.

ACOs and Imaging

Under the MSSP, eligible providers and suppliers form ACOs and are rewarded for making cost reductions and slowing the growth of expenditures while simultaneously meeting quality metrics. For the most part, these control efforts have focused on primary care services. But the time to hone in on radiology and imaging utilization is coming, said Ed Gaines, JD, chief compliance officer for Atlanta-based Medical Management Professional Inc.

The overall impact will likely vary by region or even hospital-by-hospital, he said. What works in San Antonio, Texas, might be ineffectual in Atlanta. Additionally, facilities have no control over whether patients step outside the ACO for treatment, leaving the hospital on the financial hook, he said. Such actions could create cost fluctuations or, conversely, result in greater collaboration between neighboring clinical environments.

Any specific effect on imaging utilization, however, is still fuzzy.

“Is imaging a target of CMS for decreasing its usage? Yes. It is a target for commercial health plans? Yes. Is it potentially a target for bundled payment or ACOs? Yes,” Gaines said. “From the 40,000-foot view, we don’t know yet what will happen, but we do know that radiologists are left with the question of how they can succeed in this environment.”

It’s no secret that radiology has felt its belt tighten in recent years. Outside mandates to reduce...
imaging utilization and cut reimbursement rates have left many specialty leaders feeling the healthcare industry has painted radiology with a bright target, said David Rosman, MD, medical director for Massachusetts General Imaging in Worcester and chair of the ACR’s Radiology Integrated Care (RIC) Network, a group charged with monitoring radiology-ACO activity. Getting involved early is the best thing providers can do, he said.

David Rosman, MD  “Radiologists need to be participating in the governance structure and in the negotiations on how decisions are made within the ACO context,” he said. “If you’re trying to figure out how to improve care while minimizing cost or eliminating waste, it’s very important that radiologists participate in those discussions. Without our perspective and participation, these decisions could be bad for radiology, and they have the potential to be bad for patient care.”

RIC members have talked with a number of radiologists whose organizations are involved with accountable care contracting or are participating in Pioneer ACOs. Unfortunately, he said, it’s clear that too few radiologists are currently involved in their groups’ high-level ACO discussions. There are, however, some common characteristics among those organizations that are already dipping their toes in the ACO pool, said Allen, who is also a private-practice radiologist in Birmingham, Ala. Facilities are overwhelmingly located in urban, mostly East Coast areas. They tend to appear in locations that most readily accept changes in the industry, such as Massachusetts where health maintenance organizations (HMOs) were adopted early. These groups also tend to focus solely on the financial aspects, he said, and they’re having early success. They’re engrossed in improving their efficiency and proving they spent less than the previous year — all while likely continuing to pay their providers through the fee-for-service model. Early positive results could become problematic, however, if CMS and the Department of Health and Human Services opt to require continued, increasing annual efficiencies and impose penalties for poor performance.

Navigating ACOs

The lingering question about ACOs, Gaines said, is how participating facilities will best be able to control their costs and manage their image utilization. Failing to do so puts these groups at great compliance and financial risk. So far, though, no one appears to have discovered the best solution. “I don’t know that anyone has any real clear answers to this question,” he said. “A lot of people are working on it but I don’t know if anyone has figured it out yet.”

Some facilities, however, are already trying to find strategies that will sustain their current operations, said Lawrence Muroff, MD, CEO and president of Imaging Consultants, Inc. and radiology professor at the University of Florida and University of South Florida Colleges of Medicine.

Lawrence Muroff, MD  “We’re seeing hospitals considering, more diligently than they have in the past, the possibility of employing radiologists,” he said. “If you employ all physicians in your ACO, then it’s far easier to divvy up the bundled payment.” There is resistance within radiology to this idea, however, said Muroff, who is also part of the ACR’s Radiology Leadership Institute. And, the ACR’s Harvey L. Neiman Health Policy Institute is currently creating an evidence-based method that will help radiologists determine their share of a bundled
payment, giving them the data needed to stave off hospital employment. “Hospitals don’t need to be in the radiology business, worrying about recruitment, management, and productivity metrics when the radiology groups can continue doing it for free,” he said. “Using ACR parameters, radiologists can calculate — and provide supporting documentation — that they’re entitled to a certain percentage of the bundled payment.” If radiology can make its case, it will likely be the only specialty at the table with that type of information, Muroff said. If not, the pressure to become employees will be immense.

Simply starting a dialogue with hospital partners can also work in radiology’s favor, Gaines said. He recommended practice leaders talk with administrators and identify how their PACS, RIS, and electronic health records can integrate with and support the hospital’s existing systems.

Rosman agreed, adding that the key is to be proactive. Radiology leaders must make sure their voices are part of any decisions affecting the specialty. “Hospital governance, from the physician’s perspective, is often a shunned responsibility, but success in the ACO environment will partly depend on asking for a seat at the table,” Rosman said. “Radiology needs to ask for a seat within the governance structure of the contracting group and the ACO governance.”

Securing those spots before radiology becomes a true target means radiology leaders can offer cost-saving solutions that avoid deep cuts to imaging utilization, he said.

What If the ACO Fails?

Just as there’s no one-size-fits-all approach to ACO design, there isn’t likely to be a solitary definition for an ACO failure. In fact, as many as nine of the 32 Pioneer ACOs have alerted CMS that they are abandoning their fast-track ACO experiments in favor of the slower-implementation Medicare Shared Savings Program, citing long-term unsustainability and unpalatable risk levels.

The ACO model overall runs the risk of falling victim to the same problem that doomed HMOs, Rosman said. After a few years, HMOs maxed out on achievable cost savings, and facilities aborted the model. Finding the right balance with ACOs could also be difficult. “If people anticipate that ACOs will continue to get the same amount of savings past the first three years, they will be disappointed, and could try to ratchet too hard toward over-restricting patient care and hospital services. This ultimately stifles innovation,” he said. “But if people are willing to accept that they’ll have more efficiency and better coordination with modest savings after a few years, then the situation might be different.”

Ultimate ACO success, he said, will depend on managing expectations and goals. And, making cost-cutting the sole determining factor would be a mistake. To avoid that pitfall, radiologists must advocate that the ACO's focus be on decreased waste, improved outcomes, and enhanced care coordination.

No matter the situation, Allen said, radiology must do its best at every juncture to take the lead in finding ways to ensure value accompanies the volume of imaging produced. By using their expertise to make appropriate recommendations about imaging, providers will have the opportunity to move the value curve in a positive direction — even if the fate and face of ACOs is still undetermined. “The next 10 years are apt to be the biggest change in healthcare that we’ve seen since Medicare came on the scene in the 60s,” Allen said. “Right now, we don’t exactly know where that’s going to go, but the ACR has its hands in the pies for every potential thing that’s out there so we can be prepared and prepare our members for the things that stick.”

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