Specialties: Missing in Our Healthcare Reform Strategies?

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Given the amount of frenetic healthcare reform preparation occurring with accountable care organizations (ACOs), patient-centered medical homes (PCMHs), and bundling demonstrations, are we overlooking—or quietly ignoring—medical and surgical specialists and subspecialists in our planning? It may seem to specialists that they are off the healthcare radar screen for now.

Yes, a few medical homes and ACOs are specialty based, and some commercial health plans and for-profit entities are creating accountable care scenarios with specialists in oncology, end-stage renal disease (ESRD), and a few other medical conditions. Bundled payment demonstration projects are frequently identified with specialists, but in reality these payment models currently fit some specialties better than others. Specialists account for the majority of U.S. physicians, but the actual number of physicians involved in these initiatives is only a small percentage of the specialty workforce. Most specialists are independent and are not hospital based or hospital employed. Even if the organizations where they practice are working with ACO, PCMH, or bundling models, they are not often directly involved. Over the years, healthcare executives have been careful not to rock the boat with specialists or disturb their productivity under hospital roofs. But aren’t they a major part of healthcare reform strategies? Realize that they have a tremendous ability to change clinical costs and outcomes and to significantly affect local market dynamics.

Specialists and their practice administrators have been asking what role they play in ACOs and PCMHs. They are not seeking alternatives to fee-for-service (FFS) but, at a minimum, want to be a player at the table for the new payment models to avoid losing future referrals. The Centers for Medicare & Medicaid Services has not developed a Medicare Shared Savings Program model for specialty care (although ESRD initiatives are in the works), which is understandable, given the significant risk and complexity associated with managing smaller pools of more vulnerable patient populations. Then how do ACO and PCMH referrals differ from routine patient visits? Currently, they don’t. Unless the specialists are in a demonstration project or have an arrangement with a commercial insurer, specialty referrals generate FFS compensation, not a value-based payment.
VALUE PROPOSITION OF SPECIALISTS
Specialists need to be part of the evaluation of care delivery processes. They and their specialty associations have been involved in research regarding clinical effectiveness and efficiencies related to the medical conditions they treat regularly. It makes sense for specialties to collaborate with primary care at an early stage in the management of high-risk patient populations in terms of preventive measures, early detection, and treatment choices. Additionally, specialists have hands-on experience in service line leadership and comanagement models. In their offices, clinics, and freestanding ambulatory facilities, they often have designed efficient patient flow and care models that garner high patient and staff satisfaction. Given their higher unit cost of care, specialties have a greater opportunity than primary care does to find significant cost savings in their diagnostic and treatment protocols.

SPECIALTY TRENDS THAT COULD AFFECT HOSPITALS
Healthcare executives should make careful note of the following trends, as they could translate to either new opportunities with specialists or unanticipated consequences for both hospitals and specialties.

1. **New carve-outs.** The expansion of single-specialty groups can be seen in some areas of the country, and these entities could affect healthcare markets. For some specialties, consolidation and merger with similar practices is a viable strategy for dealing with the emerging challenges in healthcare. Similar to hospitals, practice mergers are developed with the hope of attaining economies of scale, group purchasing power, improved affordability of IT, increased market presence, and negotiating strength with payers. These carve-outs can have major market implications for providers, plans, and patients.

2. **Workforce shortage.** As with primary care physicians, there is a shortage of specialists, and this situation can create access challenges, especially with the growing number of new patients with insurance. In this supply-and-demand scenario, specialists will have the upper hand and thus more choices than hospitals. Without specialists, a hospital loses its ability to directly contract with local businesses or develop its own insurance products.

3. **Demand for specialty services and future specialty risk models.** The demand for medical, surgical, and pediatric specialties will be greater than for primary care in coming years. To improve clinical and cost outcomes to the next level, greater specialty attention will be sought in the care of high-risk and chronically ill patients as well as the growing number of elderly patients with multiple comorbidities. From the lessons learned from ACOs, PCMHs, and other demonstration programs, we will see the development of disease-specific risk models for specialties focusing on these complex patients to further reduce admissions, readmissions, and unnecessary treatment protocols.

4. **Patient choice.** Sooner rather than later, patients who sought lower insurance premium options or have high-deductible plans will realize the limitations of their
provider pool and the out-of-pocket expense to see specialists. Thus, specialty access will influence patients’ selection of plans and facilities as well as dictate their level of satisfaction. Organizations that have strong specialties will attract, and thus have a greater choice of, patients and payers.

5. **Health insurance exchanges.** With the new insurance offerings, specialty providers will need to choose which new health plans to participate in, if any. Expect that the lower reimbursement from these plans will decrease physician participation. According to the Medical Group Management Association (MGMA), 40 percent of physician practices are evaluating whether or not they will participate in health exchanges (Torrieri, 2013). Many physicians are taking a cautious approach to these new exchanges. Think of the consequences if a hospital and its specialists do not participate in the same insurance exchanges. Loyal patients could be forced to use a competitor’s facility for their total hip replacement.

6. **Service lines.** The top challenge for hospitals when developing a service line was found to be aligning specialists (Advisory Board Company, 2013). Hospitals will have to consider what service lines they will offer. This decision will primarily depend on the number of qualified specialists in the market who are willing to participate with each hospital.

7. **Clinical equity.** Specialty groups that consistently provide cost-effective and high-quality care will have significant “clinical equity” and leverage in the value-based purchasing world. Payers, hospitals, and employers will be looking for narrow market offerings from these top-performing providers.

8. **“Healthcare is local” factor.** With a greater emphasis on population and community health management, engagement and participation of community specialists will become paramount. Consider the challenges that federally qualified health centers have had finding specialists to accept their referrals. Now, managing the health and welfare of the community population is a requirement and not an option. Overall, patients consistently wish to obtain their specialty care locally and will identify health plans that provide those physicians.

9. **Specialty choices determining hospitals’ strategies.** Hospitals’ strategic decisions to develop affiliations with other tertiary or quaternary institutions (e.g., clinics, health systems, academic medical centers) will depend on the availability and loyalty of specialists in their market. Community specialists may have the opportunity to match the quality of care offered by academic medical centers at a lower price point. This factor, coupled with patients’ preference to receive care locally, will provide community hospitals with a distinct advantage.

10. **Hybrid model of physician integration.** Regardless of the fact that more specialists are being employed by hospitals and health systems, the strategy of employing physicians will be less attractive, if not financially unsustainable, for hospitals. Employed and independent medical staffs working together will become more of a reality, and hospitals will look to develop relationships with independent clinicians. New independent physician affiliations, joint ventures, or collaborations will take
precedence over hospital ownership of physician practices. These scenarios align well with many specialists’ desire to remain independent and may foster greater acceptance of partnerships with hospitals.

BEGINNING THE DIALOGUE
If you are not speaking with specialists in your region, you should begin the dialogue, especially if they have multiple referral and hospital options. This is an opportunity to discuss the Patient Protection and Affordable Care Act (ACA) with specialists who likely have not had an unbiased discussion about the pertinent details of healthcare reform. Doctors’ and surgery lounges are not the most credible places to find accurate information or real answers for the ACA. In their busy office practices, many specialists are overwhelmed by the transition to electronic health record systems (EHRs), the meaningful use requirements, and now the impending implementation of ICD-10. So let’s not assume that they have had time to understand all the implications of healthcare reform to their practice. If the conversation is frank and to the point, they will invest time to learn.

Hospitals and health systems are the best and most logical conveners of community physicians for this discussion. Start the conversation with what the ACA means to physicians in practical terms, and then identify common points of view about the opportunities as well as approaches to mitigate its challenges and unintended consequences. More specifically, consider taking the following steps:

- Clearly articulate what the ACA requires of both hospitals and physicians, and provide the opportunity for both to share their concerns and vulnerabilities.
- Appeal to physicians’ interest in achieving the best possible patient outcomes.
- Assure them that the quality of care will not be sacrificed in the efforts to reduce costs.
- Clarify that the ACA concepts and initiatives will not go away, as was the case with the managed care movement in the 1990s, because of the strong pressures of the current commercial market to keep this evolution viable.
- Discuss that the managed care aspects of the ACA will produce less adversarial and more collaborative relationships with payers and hospitals than in the past. Specialists still harbor resentment over health maintenance organizations and gatekeeper models.
- Request that physicians offer their insights and recommendations for primary care redesign to develop the most appropriate pre-specialty care—the right care at the right time and at the right place. Realize that specialists appreciate the efficiency of receiving the most relevant referrals in their offices.
- Stress the growing importance of the ambulatory diagnosis, intervention, decision making, and management for population health.
- Identify potential joint efforts to streamline care delivery both within and outside hospital walls.
- Provide physicians with educational opportunities through hospital-established programs as well as customized leadership development courses.

**ADVICE TO SPECIALISTS WHO WISH TO PREPARE FURTHER**

While specialists’ interactions with these primary care models may not differ from their routine practice, their office practices will need to mirror those of the established model’s initiatives to reduce costs and improve outcomes. They can enhance their possibilities of becoming preferred providers while simultaneously reaping the benefits of reduced operating expenses and improved care and satisfaction in their own offices. Following are important requirements for specialty practices to fulfill toward attaining referral considerations:

1. Utilize an ambulatory EHR.
2. Measure quality and safety as well as patient and employee satisfaction.
3. Provide exceptional patient referral access.
4. Understand their professional association’s best practices and evidence-based care protocols.
5. Collect and analyze data for medical conditions that have complexity and care variation.
6. Identify opportunities for improved workflow and cost-efficiency.
7. Provide prompt communication with ACOs and PCMHs.
8. Consider opportunities to manage the care of a small subset of their patient population in a low-risk model, such as value-based incentives or bonus payments.

**CONCLUSION**

Each specialty physician or group in your market will ultimately decide what makes the most business and personal sense for its practice. Nonetheless, waiting until specialty guidelines are published to engage specialists in this dialogue is a missed opportunity. The ACA provides us the best chance to create collaboratively, unlike what we have seen in recent memory. Recognize that there is a finite and often limited number of valuable players on the sidelines now who will be needed for the daunting task of population health management; do not lessen your or their options. Allow them to be a part of the solution. At a minimum, develop a relationship; learn from each other; and, if common interests align, create an affiliation that mutually works. Build strategies together now rather than separate, competing strategies later.
REFERENCES