As hospitals and large multi-specialty group practices gear up for accountable care organizations, procedure-oriented specialists are still trying to figure out their role in them.

"Specialists are not taking the lead in the formation of ACOs," says Aric Sharp, CEO of the Quincy (Ill.) Medical Group, a 130-provider multi-specialty group. "The physicians who are interested are in multi-specialty groups or integrated models with hospitals."

This makes sense. Most specialists are focused on a particular episode of care, which is not what the ACO is all about. These new models of care emphasize the whole spectrum of healthcare, not just one episode.

**ACOs need specialists**

Everybody agrees, however, that ACOs will need to reach out to specialists and include them in their networks. Furthermore, even hospitals with many employed specialists may have to add independent specialists to fill out their networks, says Laura P. Jacobs, executive vice president of the Camden Group in Los Angeles. "Primary care physicians in ACOs will need specialists to link up with them," she says. "They will want them to collaborate."

But as ACOs begin to reach out to specialists, will specialists respond in kind?

Some observers believe some specialists will be swept up in the general enthusiasm for accountable care and find their place in ACOs. Paul Keckley, director of the Deloitte Center for Health Solutions, says specialists will join ACOs because "it's better to be in the room. The natural inclination of most specialists would be it's better to be a player than to be left out."

**The financial incentives**

But what specific incentives does a specialist have to join an ACO? Mr. Keckley and other ACO experts readily admit it could take years for many ACOs to make enough shared savings to pay out significant sums of money. Indeed, these sums would have to be hefty enough to be an incentive for the wary specialist to join up.

One impediment to initially paying out shared savings might be the need to pay off high start-up costs for ACOs. In the Medicare Physician Practice Demonstration Project, the model for ACOs, start-up costs were pegged at $1.75 million for each organization, and the costs of ACOs are expected to be higher.

Moreover, ACOs face the possibility of losing money by at least the third year, as part of the new "two-sided" risk model in the proposed regulations. But Mark Lutes, a healthcare attorney with Epstein Becker & Green in Washington, D.C., thinks that it would be up to the original investors in the ACO, and not specialists, to cover expenses like start-up costs and downside risk. "Losses would be covered by the original investors," he says.

The prospect of losses leads to another problem, the possibility that many ACOs could fail. "Clearly, we know
that a substantial number of them won't be successful," says Keith Kosel, PhD, senior director of the Social Sciences Practice at VHA Inc. "If you see 70 percent standing after three years, you might be able to call that a success. If only half survive, I'd call that a failure."

If an ACO has high chances of failure, why would a specialist want to join?

**Prospect of losing referrals**

One oft-cited reason for specialists to join an ACO is the potential of losing referrals. True, many specialists have very busy practices right now, and the prospect of adding more patients at lower-paying Medicare rates may not be appealing. But if a specialist does not join an ACO, "the primary care physicians in the ACO could shift the specialist's referrals to someone else," says J. Peter Rich, an attorney at McDermott Will & Emery in Los Angeles.

It might not be that easy for primary care physicians to direct patients to another specialist, considering that Medicare beneficiaries in an ACO cannot be stopped from going to any provider they wish to, even a specialist who has no connection to the ACO. But Mr. Lutes believes beneficiaries will listen. "When your primary care physician refers you somewhere," he asks, "how many times have you refused to go?"

Even so, Mr. Kosel at the VHA thinks it could take time for primary care physicians to change referral patterns. "Changes in referral patterns may be not that significant in the short term but they may be a big issue as time goes by," he says.

**Other responsibilities**

However, specialists weighing the possible loss of patients if they don't join an ACO may have to weigh that against extra responsibilities if they do join. For example, experts agree that physicians in an ACO will have to lend a hand in reporting 65 quality measures that CMS plans to require.

It is also widely assumed that specialists in an ACO would need to adopt some form of information technology system, which most specialists don't have yet. The proposed ACO rules say that half of primary care physicians in an ACO would have to be in compliance with meaningful-use provisions on electronic medical records by the second year of participation. Mr. Kosel thinks specialists would also need to have some type of EMR. "You're going to need some degree of EMR," he says. "I don't know how complex or pervasive it has to be, but something has to be there."

"Perhaps the specialist isn’t ready to connect electronically, so he'll say, "I can't do it," Ms. Jacobs at the Camden Group says. Even so, she believes ACOs will place other demands on specialists, such as agreeing to be available to see patients. For example, they may have to agree to see patients within a week or two weeks, she says. She also thinks ACOs might ask specialists to participate in meetings, such as a quality committee or an orthopedic implant committee.

**Clinical guidelines**

One mantra of ACOs is to closely monitor the cost of care. An ACO's payments to specialists could be "tied to reducing cost trends associated with volume/intensity of specialist referrals," wrote family physician L. Allen Dobson Jr., MD, in a presentation on specialists in ACOs to the North Carolina Medical Society last year.

There is the possibility that specialists who join ACOs might be expected to help create and then adhere to clinical guidelines. Would an orthopedic surgeon, for example, be required to use certain implants? "That depends on the internal workings of the ACO," Ms. Jacobs says. "Over time, they might make such
requirements. But they probably won't be that prescriptive. They wouldn't be saying use this particular implant and go to this particular hospital."

Even if specialists aren't held to clinical guidelines, widespread use of guidelines in the ACO could result in fewer referrals to specialists for procedures. For example, some clinicians argue that less invasive techniques are preferable to back surgeries.

For this reason, Mr. Keckley at Deloitte argues that specialists would want to have a hand in developing clinical guidelines. "They would want to be there to help formulate the clinical pathways of care, including such things as the risk factors and the comorbidities," he says. "The specialists need to give primary care physicians the diagnostic queries for the patient."

Would there be a contract?
The specialist's obligations as well as the manner in which payments would be distributed could be spelled out in a contract between the specialist and the ACO, says Mr. Rich, the healthcare attorney.

Mr. Rich readily agrees, however, that not all specialists in a Medicare ACO would have contracts. Medicare beneficiaries in an ACO would be able to see anyone they want, with or without a contract. But an ACO formed with private payors could require contracts, he says.

Since a contract is not necessary in a Medicare ACO, Mr. Lutes envisions a "dialog" between the specialist and the ACO. The specialist would be asked to help hospitals and primary care physicians that run the ACO to set up a "care path" for the integrated care of the patient, the healthcare attorney says.

Other models of care may be better fit
Some experts think ACOs may ultimately not be the best fit for specialists. Instead, Mr. Lutes says bundled payments might be a better fit because they are linked to a particular procedure, which specialists can understand. Under a bundled payment, the hospital and specialists work together to bring down the cost of a certain procedure, such as knee implants. "The specialist might have more of an incentive to improve care with a bundled payment than under shared savings payments in an ACO," Mr. Lutes says.

The Medicare Acute Care Episode demonstration project has had success with bundled payment pilots for heart, total joint and hospital-acquired infections. More providers may be added to existing bundled payment demonstrations in 2013, and HHS has been authorized to roll out five more areas of focus in 2015.

Mr. Sharp at Quincy Medical Group is skeptical of bundled payments. "From the broad policy standpoint we've got to keep in mind the key factor is coordination of care," he says. "We need to be careful not to piecemeal things out."

But Mr. Keckley at Deloitte thinks bundled payments show promise. "The concept of bundled payments has been generally well received," he says. He adds that the new Center for Medicare and Medicaid Innovation is expected to develop more models that might be even better for specialists.