

# Accountable Care Organizations: Information and Advice You Can't Afford to Miss

*New developments within the health care market landscape as well as ever changing regulations on how to provide patient care can make it challenging to determine how to remain competitive and profitable in private practice.*

As lawmakers struggle to find ways to reduce the national deficit, and with Medicare costs poised to soar over the next several years, overspending in Medicare and Medicaid has become the target of scrutiny by the department of Health and Human Services. With this scrutiny have come a myriad of changes to the models by which physicians are expected to deliver care, all of which are aimed at incentivizing hospitals and private practices to keep costs low. Although physicians are able to thrive in this new environment by meeting specific quality benchmarks, finding information on how to do so can be a challenge.

Perhaps the most complex and expensive component of healthcare reform is the emergence of Accountable Care Organizations, or ACOs. ACOs, which are networks of doctors and hospitals that share responsibility for providing care to patients, agree to manage the healthcare needs of at least 5,000 Medicare beneficiaries for at least 3 years under healthcare reform laws. This new model moves away from a fee-for-service reimbursement schema to one based on flat fees issued per Episode of Care. An Episode of Care is defined as the set of services required to manage a particular medical condition from the time of a patient's initial visit through the next 12 months. ACOs must show that the care they administer achieves the three-part goal of **1** better population health, **2** better individual care, and **3** lower cost per capita.

While this model is targeted to save Medicare up to \$960 million within these first three years, it can end up costing doctors a substantial amount of money to implement. Indeed, although ACOs who are able to save money while administering quality care would receive bonuses under the new law (as much as 60% of savings), ACOs who are not able to save money will have to foot the bill for the cost of investments made to improve care.

While ACO adoption is not yet mandated as part of the Patient Protection and Affordable Care Act (ACA), many care providers are moving early to align themselves with a potential future mandate. Medicare ACOs are currently in a three year trial phase during which they will report annually on their efficiency, savings, and patient health outcomes. But the line to form ACOs has grown and at ASE we are determined to help our members navigate these complicated waters.



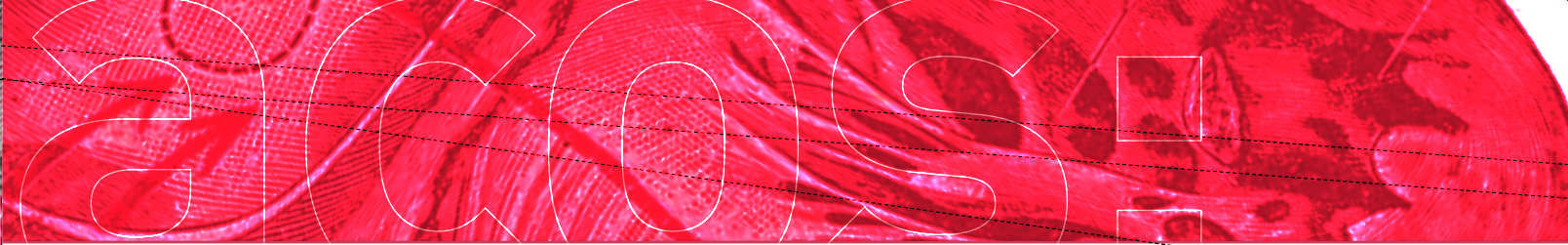
## /// ACO: NOT AN HMO

The three-letter acronym and umbrellaed nature of ACO services seem almost intentionally designed to bring to mind the dreaded Health Maintenance Organization (HMO), but this new construct is not the return of a 1990s bogeyman. It is in fact a new type of organization designed not to limit patient care and access to medical help, but instead to make physicians and hospitals more accountable to patients while bringing down the currently ballooning costs of medical coverage.

The primary difference between an ACO and an HMO lies in the fact that ACOs do not lock patients into using only providers within the ACO for their healthcare needs. While ACOs have an incentive to push beneficiaries toward using their colleagues, beneficiaries may still seek outside consultation and care without penalty. That means that a beneficiary may be assigned to an ACO for hospital visits but can still access primary care from his or her regular primary care physician, or vice versa.

While healthcare is not significantly more integrated today than it was in the era of HMOs, ACOs are designed to incentivize integration among hospitals, specialists and primary care physicians. Because they will be part of a single team in the ACO, and it is this overall entity through which cost savings will be measured, ACOs should enhance communication and efficiency in every step of the healthcare process. This process is intended to eliminate the painfully fractious communication problems of the HMO era when a hospital and primary care physician often ordered duplicate tests due to communication breakdown.





The ACO, however, does not do away completely with the fee-for-service model or change how payments from Medicare are bundled; it is designed instead to limit the amount of repeat trips to the hospital and unnecessary testing that plagued previous fee-for-service plans. The HMO era healthcare system often inadvertently encouraged hospitals and physicians to send home patients before necessary care was given due to a lack of continued reimbursement for subsequent care. The new ACO-led system forces providers to take more of a stake in the final outcome of care. A metric upon which ACOs are measured is patient readmission rates and attitudes of patients toward the care that they received. This added metric of care measurement should ensure that ACOs avoid this particular pitfall of HMOs.



**/// MSSP**

As part of the passage of the Affordable Care Act of 2010, The Centers for Medicare and Medicaid Services initiated the Medicare Shared Savings Program (MSSP) to create a financial motivation for ACOs to achieve the three goals these Organizations have been charged with» 1 Bettering population health 2 Bettering individual care 3 Lowering costs per capita.

The Shared Savings Program provides financial rewards to ACOs who are able to lower their growth in healthcare costs while maintaining a high quality of care as defined by 33 discrete measures, ranging from timely care delivery to administering influenza immunizations. Providers who are able to deliver quality care at below-benchmark costs will split those savings with CMS, which is one way ACOs stand to make money. Benchmark costs are calculated based on the per capita Part A and Part B (inpatient and outpatient) Medicare costs of beneficiaries that would have been assigned to a given ACO in the three years prior to its formation; these numbers are updated annually based on the projected absolute amount of growth in Part A and

Part B fee-for-service expenditures. A beneficiary is considered part of an ACO if he or she receives the plurality of his or her primary care from primary care physicians within the ACO, or if he or she receives a plurality of his or her primary care services from specialist physicians and certain non-physician practitioners. As a result, even specialists can help accrue the required 5,000 beneficiaries required for ACOs.

The 33 measures against which MSSP evaluates the success of ACOs are divided into 4 domains: Patient/Caregiver experience, Care Coordination/Patient Safety, Preventative Health, and At-Risk Populations. By asking ACOs to deliver quality care at below benchmark prices in these 4 areas, MSSP hopes to incentivize these Organizations to standardize patient care while decreasing the cost of its delivery. CMS rates an ACO's success against these measures using Clinician & Group Consumer Assessment of Healthcare Providers and Systems (CG CAHPS) surveys to evaluate patient experience, Group Practice Reporting Options, electronic medical records, and claims data.

**HOW IS COST SHARING CALCULATED?**

ACOs can choose one of two payment methods according to the amount of risk they wish to assume. Under the first, a one-sided model, ACOs do not assume any financial risk, and receive a portion of any savings once the minimum shared savings rate threshold of 2% is reached. Under the second, a two-sided model, ACOs take on both shared losses and shared savings. Because with greater risk comes greater reward, ACOs who adopt the two-sided model stand to gain 60% of all savings with no minimum threshold, whereas ACOs under the one-sided model can share only 50% above the 2% minimum.

**PERFORMANCE ANXIETY?**

If you are feeling overwhelmed by the thought of meeting all 33 measures right away, you are not alone. CMS recognizes

that achieving these newly defined standards for successful care will take time, so it allows new ACOs to phase in adherence over a three-year period. During the first year, a new ACO only needs to report on the 33 measures, not perform in them. During the second year, an ACO must report on all 33 measures, but perform only on 25 of them. Only in the third year will an ACO be required to perform on all 33 measures, by which time it will be comfortable delivering care in this new setting.



**/// KEYS TO SUCCESS & PITFALLS**

**APPLY FOR STARTUP CAPITAL**

Implementing the infrastructure required to coordinate care among ACO participants takes both time and money. In order to alleviate some of the financial pressure that comes with starting an ACO, CMS has established an Advanced Payment Model, which is designed to aid physician-based and rural providers who have the desire, but not the capital, to form an Accountable Care Organization. When asked about the Advanced Payment Model, President and CEO of Cardiovascular Management of Illinois Cathie Biga notes: "The announcement that 15 of the 90 [new ACOs formed last month] will be participating in the Advanced Payment Model is of particular note to the physician community since it would allow smaller physician practices some start up funding." This funding could prove invaluable to non-hospital participants who would otherwise be hard pressed to streamline and integrate the ways they deliver care. This money does not come without strings attached, however. Biga reminds physicians considering applying for this funding that Advanced Payment Model funding will later be recouped in shared savings; ACOs that do not generate enough shared savings their first year will continue to repay this loan in subsequent years. Even with these restrictions, however, the



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financial support provided by this program, which is doled out both in a lump sum and as upfront, monthly payments, can help providers gain access to the technology and staff necessary to a successful and profitable ACO. Interested readers can visit <http://innovations.cms.gov/initiatives/ACO/Advance-Payment/Application-Info.html> to find out more about their eligibility and the application process.

## REPORT THE CARE YOU PROVIDE:

As outlined above, ACOs stand to make substantial profits, but only if they have enough startup capital to be successful. In particular, ACOs need sufficient time, money, and tech-savvy to implement a data-sharing architecture that will allow them to get "credit" for the better outcomes and reduced cost care they provide. One of biggest stumbling blocks for new ACOs is figuring out how to structure the sharing of Electronic Health Records (or EHRs) for their beneficiary population. An EHR is a digital record for individual patients that can be shared across providers. Setting up a sharable database for EHRs requires significant initial investments of time and money with no guarantee of return. Without an IT structure that allows ACOs to record patient outcomes and their cost, however, they have no way of reporting their successes to CMS, so finding ways to structure EHR sharing is a necessary evil. One way to improve the likelihood that EHRs are recorded, shared, and analyzed in an effective way is to use traditional business intelligence reporting software rather than pricey products designed specifically for the healthcare market. Businesses have been sharing and mining data granularly with disparate users for years, and the software developed for these markets is more sophisticated than newer software designed specifically for the healthcare market.

Another tool newer and smaller ACOs can use to create an effective reporting system that suits their needs is called the Direct Project. This open government initiative

allows for the secure communication of health data among health care participants in a simple, secure, scalable, standards-based way over the Internet. It's less expensive than the business analytics software described above, and is customizable. More information can be found at [www.directproject.org](http://www.directproject.org).

## STUDY YOUR PATIENT BODY:

ACOs are frequently formed to administer care to a particular geographic region. Before determining which types of physicians, specialists, and facilities an ACO ought to include, providers should examine their community of patients to determine how best to administer integrated care to this group. Looking for trends within local patient populations will help ACOs be prepared to meet the medical needs of this group.

## FIGURE OUT HOW MUCH CARE ACTUALLY COSTS:

Unlike old fee-for-service models, CMS now pays ACOs bundled, negotiated reimbursements for all the services that go into one episode of care (a heart attack, for example). Under this model, CMS issues one check to an ACO to cover everything from hospital stays to specialist care to rehab post-procedure. While the individual price tags for each of these services are based on physician claims from 2010 and updated each year, they may not correspond exactly with the amount an individual provider spends providing care. One step physicians and specialists who are considering joining an ACO can take to prepare is to figure out what the actual cost is of the procedures they perform. Catherine Hanson, JD, who is Vice President of the AMA's Private Sector Advocacy and Advocacy Resource Center, considers this to be a critical procedure for physicians who hope to form an ACO. She writes that, under the new payment system, "the primary driver of the economic result to the physician practice is the extent to which the actual cost of providing care to a patient population varies from the projected budget for those

costs – physicians who come in at or under-budget prosper, while physicians who exceed the budget are penalized." [1] In other words, determining how much it costs to perform one transthoracic echo, from the electrical costs to the salaries of the sonographers, for example, will allow providers joining an ACO to craft a realistic and financially viable budget for administering care to their patient population. Once practitioners have this kind of information, they will have a better sense of how far the amount of the bundled reimbursement to which they are entitled will go, helping them cover operating costs under these new payment models. (See <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharesavingsprogram/Calculations.html> for more information.)

[1] Hanson, Catherine. "Evaluating and Negotiating Emerging Payment Options: A new physician resource published by the American Medical Association." *The American Medical Association*. 2012.

## MAKE PATIENT CARE THE PRIMARY FOCUS, NOT COST SAVINGS:

Cutting costs should not be the only goal of an ACO. Indeed, it is important to keep in mind that reducing superfluous treatments and readmissions is, at the end of the day, to the benefit of the patient. Experts remind us that the 33 quality and efficiency measures laid out by the MSSP to help ACOs become profitable should empower physicians to provide better care to their beneficiaries. While coming in under benchmark cost is important to the financial viability of ACOs, it should be undertaken as a means to improved patient outcomes through integrated care. Providing quality, streamlined care also ensures that beneficiaries do not leave the ACO (called "leakage"). As with any market driven business model, a better product means a better relationship with the customer, resulting in higher demand: in this way, better care increases an ACO's chances of success.



### **/// THE FUTURE OF PRACTICE, IN PRACTICE?**

It is not only organizations that rely on Medicare Shared Savings Program for extracting potential savings that are forming ACOs. Some insurers and care providers are banding together to form commercial ACOs that are taking the integration models and ideals set forth in the ACA to find pockets of inefficiency and waste within their organizations. They are distinguishable from Medicare ACOs because it is the commercial payer, usually an insurer, that is providing the financial incentive to lower costs. These commercial ACOs are often termed Accountable Care Initiatives, or ACIs, in order to distinguish themselves from the Medicare ACO alternative.

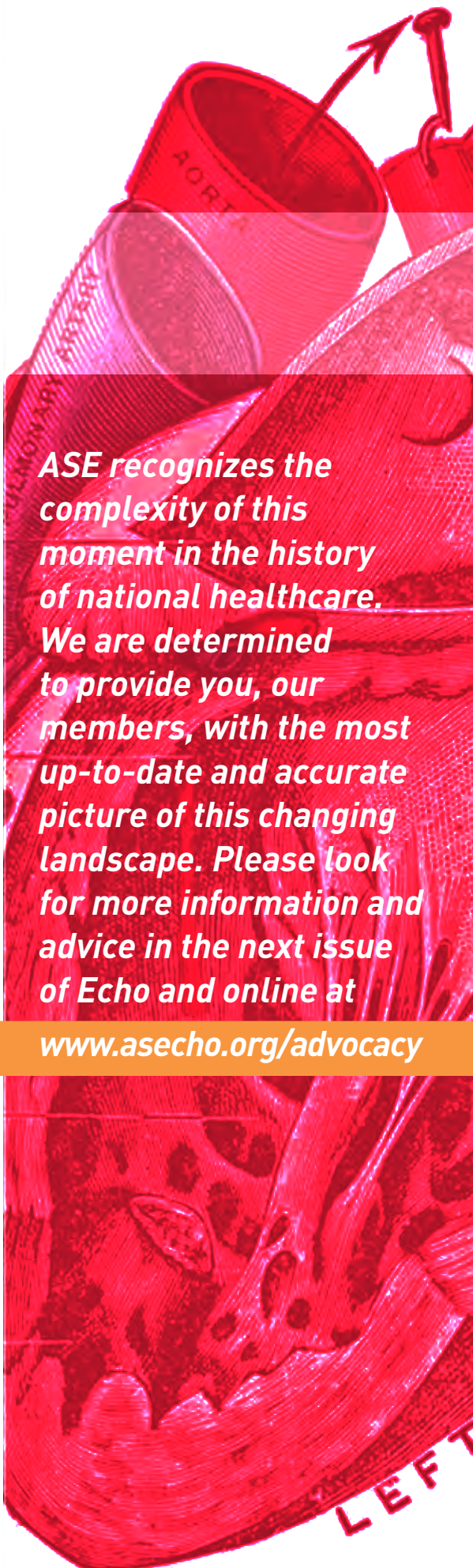
But there is wariness surrounding the use of ACIs to lower the cost of care. Using ACIs to implement cost savings strikes some as allowing commercial insurers to pay healthcare providers to lower the costs of treating beneficiaries without basing the incentives on outcomes. While one of the measures of success for a Medicare ACO is better patient health, there is no systematic way to be sure that ACIs are providing better, or even comparable, care to patients while cutting costs.

On July 1 of this year, the CMS and the Health and Human Services Secretary announced that 89 new ACOs had been added to the list of those organizations participating in the purely voluntary MSSP. These are the first true tests of the ACO model, the results of which will not be known for some time. Prior to this, the only participants in any form of shared savings programs were providers testing different models of savings payment, not those using the standard model outlined in the ACA.

The addition of these organizations brought 1.2 million new people with Medicare in 40 states and the District of Columbia into an ACO program. There is a wide variation among these organizations based on their geographical location and specialties. Almost half of the 89 new ACOs are physician-driven organizations with fewer than 10,000 beneficiaries on their rolls. The variation in size and location should provide ample evidence and practical advice for those considering starting their own ACO once they begin reporting on their progress in 2013.

On January 1, 2012, CMS began testing its Pioneer ACO Model, which took 32 regional organizations from around the country that had prior experience in coordinated, patient-centered care and placed them in an ACO-like organization. These select organizations are testing a higher risk, higher reward shared savings plan than that proposed in the ACA to see if it is more effective in controlling cost and providing better patient care. This program still provides the protection for patient care that a typical ACO would and also allows the patient to seek treatment outside of the Pioneer ACO.

Both the typical MSSP ACO and the Pioneer ACO programs are currently closed for new applicants. The Pioneer ACO program has no plans to reopen for admission, at least while the initial three year test period is still in progress. The MSSP ACO program will continue to take applications even before the 89 new ACOs have completed their initial reporting phases. The application window for 2013 ACOs closed on September 1, 2012. Please go to [www.cms.gov](http://www.cms.gov) for more information concerning future application windows and for updates on the progress of current ACOs. ♥



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