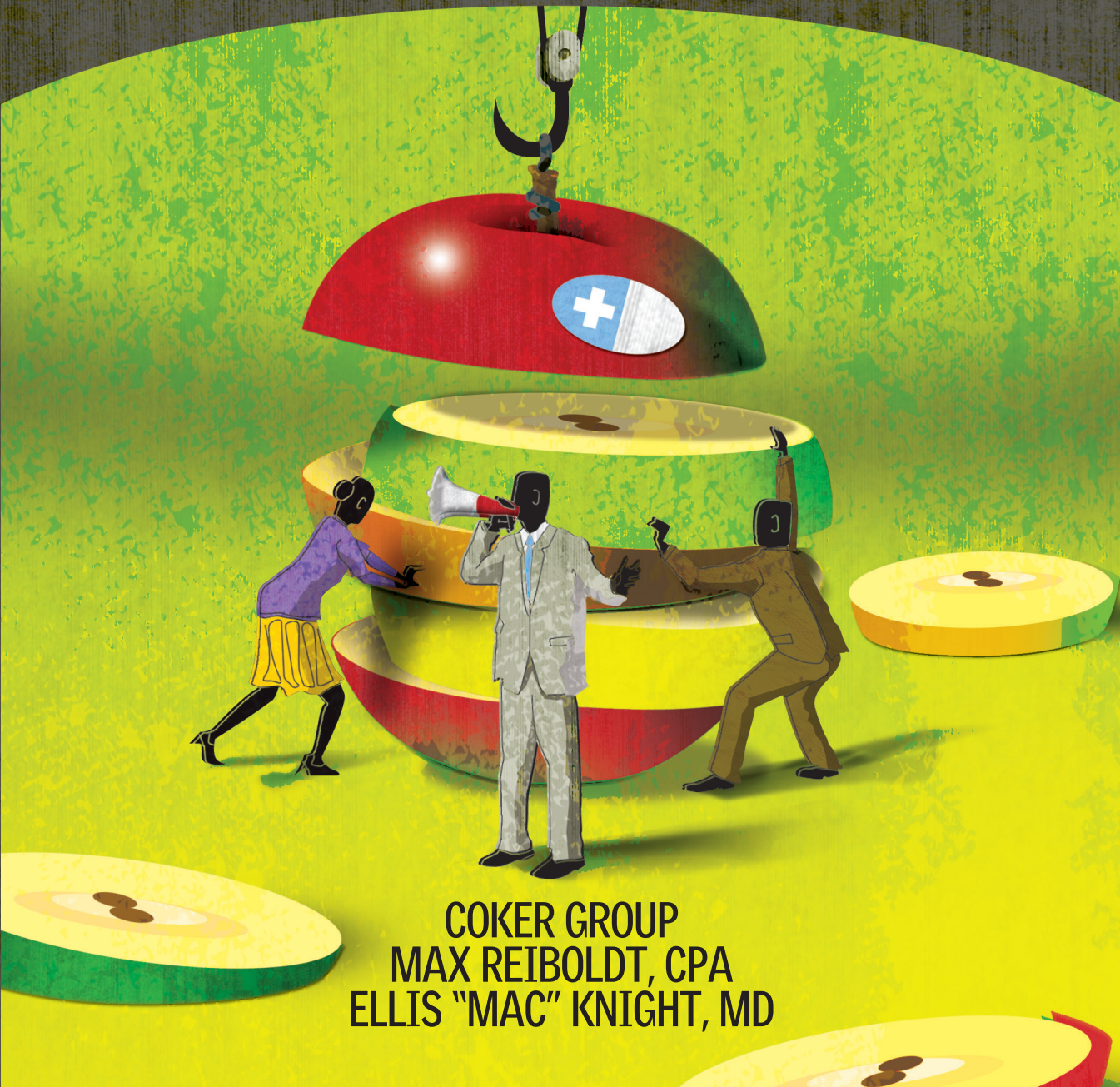
THE HEALTHCARE EXECUTIVE'S GUIDE TO ACO STRATEGY

Second Edition



COKER GROUP
MAX REIBOLDT, CPA
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The Healthcare Executive's Guide to ACO STRATEGY

Second Edition

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HealthLeaders Media

HCPro

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Kay Stanley, Editor
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Preface

When *The Healthcare Executive's Guide to ACO Strategy* published in 2012, we knew that one of the principles of the Patient Protection and Affordable Care Act (PPACA) was accountable care. More specifically, the principle, when enacted, established a provision for accountable care organizations (ACO) for Medicare beneficiaries under the fee-for-service program. At the time of writing, we examined the details of the ACO provision, which were addressed on a mere seven pages of the massive new healthcare law. Then we developed a narrative of what the ACO model would mean to providers from a regulatory standpoint, how it would function in the provision of healthcare delivery, and what it would look like in the marketplace.

Three years later, we have historical evidence to review and updates to report as to how the ACO program, as enacted, is functioning. Chapter 9 presents the outcomes of the ACO Pioneer Program as of the end of year 2014.

Undergirding the accountable care era is the concept of clinical integration. Clinical integration is the foundation for ACOs. Successively, hospitals/health systems and physicians are using the ACO model to form clinically integrated networks (CIN) or organizations (CIO) to organize their services to deliver quality and cost-effective services to patients. The CIN models are used for the purpose of working with private payers, with the intent of maximizing reimbursement for services in a new payment model.

Picking up with where the initial book ended, the second edition of *The Healthcare Executive's Guide to ACO Strategy* brings the story of clinical integration up to date. This book focuses on what we have learned about ACOs at this stage and to provide

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vital information about CINs, as well. Content includes an overview of ACOs and CINs, a history of what brought the industry to this place, what to anticipate about the changing ACO structures, and a look at the factors involved in moving from a structural construct to a functional construct. In addition, we present an update of physician-hospital integration and a review of the current and anticipated changes in compensation models. Tools for assessing your organization's readiness for entry into the ACO and CIN environment are presented, along with an update on legal considerations.

Additional chapters cover the CMS Shared Savings Program and benchmarks, quality measures, the role of information technology, patient-centered medical homes, and anticipations of the future.

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Accountable Care Organizations

The concept of accountable care organizations (ACO) has gained a great deal of attention in recent years and is reshaping American health policy. Although this term is becoming common in the healthcare delivery system vernacular, it remains an unknown concept to the vast majority of the public—including many physicians. Shared risk and reward is a foundational theory behind all aspects of accountable care. It is a goal that is essential to address during all explorations, planning, and developmental processes of these new models.

The ACO label was invented late in 2006 during a discussion at a public meeting of the Medicare Payment Advisory Commission. Included in the Patient Protection and Affordable Care Act (PPACA), this concept is now the most talked about new reimbursement and healthcare delivery system paradigm in some time. Under the 2010 Patient Protection and Affordable Care Act, Congress created provisions for voluntary ACOs. Specifically, these organizations are groups of doctors, hospitals, and other healthcare providers who voluntarily come together to give coordinated, high-quality care to their Medicare patients.

The goal of coordinated care is to ensure that patients, especially the chronically ill, get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors. As of January 2014, there were more than 600 public and private ACOs in the U.S., with more than half of the U.S. population residing in the market area of an ACO (Solheim, 2014).

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What Is an ACO?

There are multiple definitions of ACOs, but most have basic premises in common. An ACO is an integrated healthcare delivery system that contracts to provide a full continuum of services to a defined patient population, with specific reimbursement (financial) incentives for meeting both quality and expense targets. A more generic term used to describe non-Medicare/Medicaid accountable care organizations is clinically integrated networks (CINs). In general, the discussions in this book relate to both ACOs and CINs unless otherwise identified. A distinction will be made when the reference is solely to Medicare/Medicaid ACOs.

Medicare has pretty much usurped the term ACO for its own purposes, and, therefore, if you refer to a clinically integrated network as an ACO, everyone pretty much assumes that it is participating in one of the Medicare ACO programs. If, on the other hand, your network is not participating in the Medicare ACO programs, it has become commonplace to simply refer to those organizations as CINs or CIOs (clinically integrated organizations). In this chapter, we make this distinction and refer to these terms in this way throughout the book.

Is it an ACO or a CIN?

There is neither an "official" ACO nor a homegrown variety. The distinction is with which payers the organization contracts.

- If they contract with Medicare, they are generally referred to as ACOs.
- If they contract with commercial payers or large employers, they are known as CINs.

Accountable care organizations of both stripes are quickly emerging as the future care delivery and economic-reimbursement model to address the stressful challenges of increased healthcare costs and a disparate healthcare delivery system. ACO provisions are included in the PPACA, which was signed into law March 2010.

Under the title "Shared Savings Program," PPACA also established the Centers for Medicare & Medicaid Services (CMS) Center for Innovation, which will provide funding for other projects with variable financing models, including bundled payments and a form of reimbursement prevalent in the 1980s and 1990s: *capitation*.

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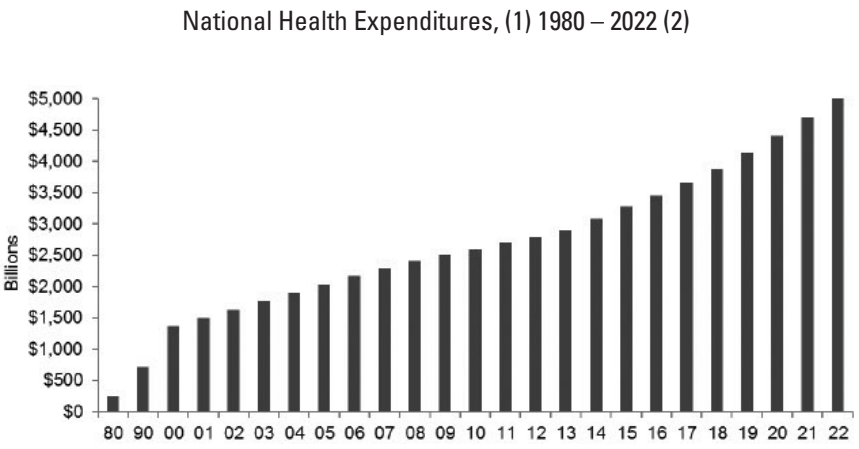
The Logic of ACOs

ACOs are a response to trends in the cost of healthcare, which has risen every year since 1989, as Figure 1.1 illustrates. Rising healthcare costs drive both government and private insurers to seek ways to address these costs through the reimbursement system. Healthcare systems can no longer tolerate such increases, so we must find a solution.

Figure 1.1 | AHA projected national health expenditures 1980–2022



Source: Centers for Medicare & Medicaid Services, Office of the Actuary. Data released 09-2013.

1. Years 2012–2022 are projections.
2. CMS completed a benchmark revision in 2009, introducing changes in methods, definitions and source data that are applied to the entire time series (back to 1960). For more information on this revision, see *www.cms.gov/nationalhealthexpenddata/downloads/benchmark2009.pdf*

American Hospital Association, *TrendWatch Chartbook 2014*, Trends in the Overall Health Care Market, Chart 1.8. Available at *www.aha.org/research/reports/tw/chartbook/2014/chart1-8.pdf*. Accessed 2-6-2015.

In addition to rising costs, there are other problems affecting the current healthcare system. For Medicare and Medicare ACOs, simply stated: Our country is aging. The mass population of baby boomers now reaching retirement means a much greater

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number will depend on government forms of reimbursement as opposed to private insurance. In addition, millions more are now insured through government-mandated and subsidized healthcare insurance offered via federal or state exchanges, which will inevitably place stress on the healthcare delivery system. This means costs must be controlled. There are simply not enough dollars to go around in the next five to 10 years and beyond.

As the U.S. healthcare industry grows in size and complexity, we see that there are significant variations in the quality of care (and to some extent how that care is delivered) and in the cost of delivering it. If you compare the Medicare spending per enrollee across the nation, you can see huge variations, even though supposedly patients receive the same level of care.

These varied costs (and some outcomes) are not only true on a total absolute dollar basis within one locale, they flow to a per capita basis also. Further, this principle applies across all levels of care and specialties. For example, the cost to deliver care, per capita, for a cardiac patient is as varied as that for an orthopedic patient. Furthermore, researchers at the Dartmouth Atlas have shown that the regional and even local variations in cost cannot be justified by improved clinical outcomes in those areas where higher costs prevail. In fact, many studies have shown no correlation between healthcare spending and quality of care (Fischer, et al, 2009).

Although ACOs are relatively new, many of the concepts and basic tenets have been around since the beginning of the HMO movement in the 1970s. There are several differences, however, between ACOs and HMOs. Accountable care combines both quality improvement efforts and cost control, whereas HMOs, particularly staff model HMOs, are concerned more with cost control. As anyone who suffered through the use of primary care gatekeepers during the managed care era of the 1980s and 1990s can attest, HMOs frequently denied care as their main method for controlling costs. Since quality outcomes were not measured or rewarded in the HMO model, the resulting poor quality of care and lack of access led to vast provider and patient dissatisfaction, and ultimately the demise of this type of delivery system.

ACOs are also frequently compared to the Medicare Advantage Program (MAP). This system currently covers roughly 30% of the Medicare enrollees and, as such, relies on private insurance companies through capitation payments to control use and costs.

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Unfortunately, even the Medicare Advantage Program, under its capitation structure, has not held down costs or exhibited significant improvements in quality and outcomes.

Although the comparison of ACOs to MAPs occurs, only some of the MAPs operate under a capitated model. Other differences that distinguish Medicare ACOs from Medicare Advantage Programs include:

1. MAP's reimbursements generally don't depend on quality performance. They use more of an old-fashioned, managed care approach, which tries to hold down costs by limiting utilization rather than improving quality.
2. MAPs contract with Medicare to manage a population of beneficiaries who have signed up for their programs. The Medicare beneficiaries in an ACO population are, instead, assigned to the ACO and do not sign up for this service. They are free to move in and out of the program as they please and to choose a physician who is or isn't participating in the ACO.

The primary goal of an ACO is to control costs while maintaining or improving the level of service and quality. We will explore this payment mechanism in detail to show how ACOs should be administered and managed.

Basic ACO Tenets

It is highly unlikely that any ACO will be successful—both initially and long term—without five foundational characteristics. Each ACO must have a solid infrastructure that adequately represents various provider disciplines and specialties (e.g., hospitals, physicians, diagnostic centers, etc.). In order to develop the infrastructure to support these five foundational characteristics, organizations need sufficient access to capital. In later chapters, we will focus on these key financial discussions, while also exploring how an ACO can best establish these cornerstones.

The five primary characteristics of accountable care are:

1. Clinical integration
2. Coordination of care
3. Engaging the patient

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4. Information technology (IT)
5. Costs and all other financial management

Eligible providers

The types of providers who are eligible to participate in an ACO entity include:

- Physicians
- Nurse practitioners
- Physician assistants
- Clinical nurse specialists
- Hospitals
- Other medical care providers/suppliers

The final CMS ACO regulations add a provision that allows specialists who deliver the greatest number of primary care services to beneficiaries to be considered a primary care provider (PCP) for assignment of Medicare beneficiaries to an ACO. In this type of situation, the specialist who is deemed to be a PCP due to the volume of primary care services rendered can only participate with one ACO during a contract period.

In addition, CMS has liberalized the section on beneficiary assignment to include nurse practitioners (NP), physician assistants (PA), and clinical nurse specialists (CNS) as designated PCPs, also limiting these providers to participation with only one CMS ACO during a given contract period. However, other specialists have the ability to participate with multiple ACOs during a contract period.

The treatment of PCPs versus specialists by an ACO boils down to the following:

- The PCP (regardless of medical specialty) is determined by Medicare to be the physician who provides the majority of services to the patient over the course of the year. Therefore, even if a cardiologist manages a Medicare beneficiary's care the majority of the time, he or she would be considered that beneficiary's primary care physician.
- The PCP (as defined above) can only participate in one ACO at a time, whereas specialty providers (non-PCPs as defined above) can participate in more than one ACO.

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Although most ACOs include one or more hospitals, they are also likely to include nursing homes, ambulatory surgery centers, diagnostic centers, home healthcare, rehabilitation, and any or all entities enrolled in Medicare.

ACO formation

ACOs encompass provider groups that have established the functionality and infrastructure for making decisions relative to care and cost but also are equipped to develop the capital and infrastructure for reimbursement distributions, including bonus payments. These may include:

- Physicians and other practitioners in private group practices.
- Networks of practices, usually involving hospitals.
- Partnerships, joint ventures, and/or other consortiums that qualify under antitrust and other regulations when involving hospitals and physicians. Foundations for these may include physician-hospital organizations (PHO), independent practice associations (IPA), and even management services organizations.
- Fully integrated organizations, usually owned by hospitals where the provider physicians are employed or directly contracted through a professional services agreement.
- Large consortiums of practitioners, which go by a variety of names (accountable care organizations, clinically integrated networks, patient-centered medical home networks, and others), and who are aligned in some manner that qualifies under antitrust restrictions; these could include physicians, non-physician providers, nurses, therapists, and others.

ACO qualifications

ACOs formed under the CMS program must meet at least the following criteria and have these features in place before they will be recognized by Medicare:

- Be accountable for the overall care of their assigned Medicare beneficiaries
- Accept at least three years of participation (or a contract period, since those signed up in 2012 were allowed slightly more than three years in the first period)
- Be structured legally to allow shared savings to be distributed to providers based on certain performance criteria, not tied to volume (and also to handle

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loss allocation to provider participants under the Track 2 model; see note that follows this list)
- Entail sufficient numbers of primary care physicians to treat no fewer than 5,000 Medicare FFS beneficiaries
- Provide CMS with data and other information concerning PCPs and specialty care physicians participating in the ACO (as required by CMS)
- Develop and have in place working relationships for covering the patient population with a core group of specialty physicians
- Have an infrastructure of management and administration to oversee clinical and administrative systems
- Promote evidence-based medicine with specific processes in place
- Be equipped to report on quality and cost measures, plus be structured to coordinate care
- Be able to demonstrate "patient-centeredness," as defined by CMS

Note › CMS defines Track 1 as Shared Savings Only for the Initial Agreement and Track 2 as Shared Savings and Shared Losses for All Years of the Agreement. These concepts are explained in detail in Chapter 10.

Financial ramifications

Here is a brief overview of bonuses and incentive payment opportunities:

- ACOs that demonstrate Medicare expenditures below established benchmarks are eligible for shared savings, provided they meet the minimum savings rate and the quality requirements during the performance year
- CMS has finalized a sliding scale minimum savings rate (MSR) for Track 1 participants based on different sizes of ACOs (size is derived by number of beneficiaries assigned to an ACO)
- Those ACO entities that choose to participate under the Track 2 model have a flat minimum savings rate of 2%
- ACOs must meet quality thresholds to earn incentive payments; these measures fall into the following categories:
  - Care coordination/patient safety
  - Patient/caregiver care experiences
  - Preventive health
  - At-risk populations

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The Key Characteristics of Accountable Care

Earlier in this chapter, we briefly considered the foundational components of accountable care. Regardless of the regulations and requirements for establishing ACOs, these five cornerstones—clinical integration, coordination of care, engaging the patient, information technology, and a financial management system—are absolutely essential.

Clinical integration

Clinical integration is not new to provider organizations in concept. It provides a conduit between various providers to exchange information in order to support and substantiate quality outcomes. Clinically integrated provider organizations (e.g., CINs) consolidate information and create improved standards of care. Ultimately, they use shared data to measure their performance against such standards. With this knowledge, compliance is the norm. Education and improving operations result in better quality overall. Thus, an ACO functions as the transforming entity within the healthcare delivery system because of clinical integration.

From a regulatory standpoint, the U.S. government (specifically the Federal Trade Commission) supports clinical integration. Per the FTC definition, clinical integration requires provider organizations to improve efficiencies through monitoring and controlling quality service and costs. Clinical integration, therefore, is the connection between providers in an ACO that supplies data for understanding overall quality and costs. Remember, an ACO contracts with providers and gives specific reimbursement (financial) incentives for meeting both quality and expense targets. This clinical integration is furthered through the selection of physician participant partners and employing evidence-based standards in the medical practice.

To build a successful infrastructure for clinical integration (through enhanced IT), you need to significantly invest in both economic and human capital. For years, PHOs and IPAs have not been qualified to be more than messenger models to and from managed care payers, but now, when they can demonstrate clinical integration, they can represent their constituent providers in joint contract negotiations with payers. Many established PHOs and IPAs morph into Medicare by following a path toward clinical integration; this clinically integrated entity is the basis for the ACO—not only structurally, but in day-to-day functionality.

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Coordination of care

Using the ACO as their vehicle, providers develop a system to coordinate care and thus exhibit a greater value in all provided care. That is, providing the care at the right time, in the right place, always. Though this is a reasonable statement, this concept represents a significant change in today's healthcare delivery model.

Care coordination is more than just case management, or simply aligning physicians into a common group, or via contracting entities such as an IPA/PHO. Care coordination encompasses a patient-centric vision and affects the way providers practice medicine. The change occurs in practice patterns plus new standards of information, management, and human resource skill sets.

Established physicians often find it difficult to change the way they practice. Although physicians do not stop the formation of an ACO, organizations may find obstacles when they require physicians to change how they think and practice. It is a major challenge, and ultimately defines the success in forming and operating an ACO, but it can be done. You will need to help physicians (through education) to understand evidence-based medicine principles and transform these principles into their day-to-day practice.

To best understand the processes and other important characteristics of day-to-day care coordination, you must work within a team. Not surprisingly, this requires the organization (and the overarching ACO) to carefully review infrastructure, approaches to care coordination programs, specific care coordination goals, and priorities in order to determine how they can be most effectively managed.

Engaging the patient

Empowering and engaging the patient is a critical component of care coordination. You must educate patients in self-care as a part of the overall care coordination plan. Patients who are engaged, well informed, educated, and motivated to help treat their problem will result in a much stronger, more viable ACO. The CMS regulations about ACOs state that communications must be easily understandable by patients, their family, and/or caregiver(s).

For strong care coordination, you need a well-defined and well-managed operational infrastructure. The organization that becomes a successful ACO and in turn provides

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good care coordination—the kind of care coordination that is required—must also have a well-defined and functional leadership and governance structure.

Information technology (IT)

Regardless of how good the clinically integrated and care-coordinated functions are, the ACO's success or failure is largely based on its ability to collect, manage, share, and interpret information through technology processes. Health IT is nothing more than a support system for the members of the ACO to accumulate and disseminate information and data. This, quite simply, cannot be done with any level of efficiency without automated healthcare technology.

An effective IT system within an ACO supports information about historical performance, future plans and budgets, and benchmarking against standards.

Financial management system

Each ACO needs a well-established and highly competent financial management system and staff. This financial system needs tools to support the financial modeling, so an ACO can establish ancillary or professional and/or hospital charges. The methodology of reimbursement requires financial and managerial expertise. To manage these new value-based payment models, an ACO needs cost accounting and data collection systems. With this financial competency in place, an ACO can work directly with the private/commercial payer community.

These five characteristics form the foundation of accountable care. Your goal is to create a functional entity, so don't take shortcuts in these areas.

Summary

In this chapter we've outlined the basic tenets of ACOs, considered the overall characteristics and requirements, explained how the reimbursement structure works, and explored proposed structure and infrastructure. In the coming chapters, we will delve into these systems in more detail, helping you to build a solid foundation for functioning in a changing healthcare environment that heavily includes ACOs.

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THE HEALTHCARE EXECUTIVE'S GUIDE TO ACO STRATEGY

Second Edition

COKER GROUP
Max Reiboldt, CPA
Ellis "Mac" Knight, MD

The Healthcare Executive's Guide to ACO Strategy, Second Edition, provides healthcare leaders with new strategies and tools to implement and manage accountable care organizations (ACO). Based on the experiences of organizations that have started down the path of ACO development, the authors discuss what has and hasn't worked and share new strategies for organizations grappling with managing an ACO.

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