

Accountable Care Organizations: Reality or Myth?

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Introduction

According to Steven Gerst, VP of Medical Affairs at MedCurrent Corporation, "The Patient Protection and Affordable Care Act (ACA), generally known as the healthcare reform law, is likely to have the greatest long-term impact on the future practice of radiology." Accountable care organizations (ACO's), also known as Medicare Shared Savings Programs, have become one of the most talked about provisions of the healthcare reform law which aims to improve the health care delivery system through financial incentives to enhance quality, improve beneficiary outcomes and increase value of care for a defined patient population. The fact of the matter is that ACO's make sense on paper, but in reality can any savings actually be achieved?

What is an Accountable Care Organization?

An ACO is a type of managed care organization in which a group of health care providers (various networks of physicians, hospitals and specialists) share responsibility for providing care to a specific group of patients. More specifically, according to the Centers for Medicare and Medicaid Services (CMS), an ACO is "an organization of health care providers that agrees to be accountable for the quality, cost, and overall care of Medicare beneficiaries who are enrolled in the traditional fee-for-service program who are assigned to it." In this way, an ACO is accountable to the patients and third-party payer for the quality, appropriateness, and efficiency of the healthcare provided, and also rids the healthcare system of the fragmented

payment system that currently exists. In another respect, there is a goal of triple aim: better care for individuals, better health for populations and lower growth in healthcare expenditures. the goal is to bring together all of a patient's care components (primary care, hospitals, specialists, etc.) and ensure that all of these components work together in a cost-effective way. The goal should not be to lower reimbursement amounts to doctors to achieve lower costs but to be more efficient and improve coordination with the services provided.

Proposed Rules

On March 31, 2011, the Centers for Medicare & Medicaid Services (CMS) proposed a new 429-page document detailing the rules for the development of ACO's. According to CMS, they have "worked closely with agencies across the Federal government to ensure a coordinated and aligned inter- and intra-agency effort to facilitate implementation of the Medicare Shared Savings Programs." Below is a brief summary of the proposed rules released by CMS. Refer to the following link for the full 429-page ruling: <http://www.modernhealthcare.com/assets/pdf/CH7349848.PDF>

To participate in the Shared Savings Program, an ACO must complete an application process with CMS which includes how the ACO plans to deliver high quality care at lower costs for the beneficiaries it serves. To be eligible to become an ACO, a group of providers must:

- Manage a minimum of 5,000 Medicare beneficiaries (retroactively assigned to an ACO based on their “plurality” of use of a primary care physician) for three years.
- Report on quality, cost and care coordination measures.
- Have a leadership and management structure that includes clinical and administrative systems.
- Form a legal structure to share and distribute savings and repay back any losses.
- Meet patient-centeredness criteria set forth by the HHS secretary.
- Become a separate legal entity with its own Tax ID number.
- Have a governing body in which 75% is made up of ACO participants have at least one Medicare beneficiary served by the ACO who has not conflict of interest.
- Beginning in the second year of the ACO's agreement with the CMS, at least 50% of the ACO's primary-care physicians must meet all meaningful-use requirements of the federal EHR incentive program under the American Recovery and Reinvestment Act of 2009.

The proposed rule would establish quality performance measures and a methodology for linking quality and financial performances. There are 65 standards by which quality will be judged. They fall into five areas: patients’ experiences in receiving care, the extent to which care is coordinated, patients’ safety, the degree of emphasis on preventive health, and the teams’ effectiveness in treating Medicare patients who

are sick and frail. Refer to the following website for a copy of the proposed measures for quality performance standards (http://healthpolicyandreform.nejm.org/wp-content/uploads/2011/03/20110331_berw_p1103602_olf.jpg). If an ACO meets the program’s quality performance standards, it would be eligible to receive a share of the savings it generates below a specific expenditure benchmark set forth by CMS.

There are also some additional requirements for established ACO’s once they are approved by CMS:

- It must notify beneficiaries that they are receiving care within an ACO and that the providers will receive Medicare payments for improving patient care.
- It must notify beneficiaries that their claims data may be shared within the ACO and give the beneficiaries an opportunity to opt-out of the sharing arrangement.

There are two different “tracks” or models of shared savings stated within the proposed rules. The first track allows an ACO to operate on shared savings only (no risk of loss) for the first two years, and then would assume risk for shared losses in the third year. Under this model, the ACO would be eligible to receive up to 50% of shared savings (additional 2.5% of savings if there is a FQHC/RHC within the ACO) above the minimum savings rate (2 to 3.9% depending on the size of the population) of the expenditure benchmark established by CMS. The percentage of shared savings is based on reporting of quality measures and the quality score achieved. The savings incentive would be capped equal to 7.5% of the expenditure benchmark in the first two years and 10% in the third year. In the third year, it would be obligated to repay shared losses that exceed 2% of the annual expenditure benchmark established.

The cap on losses would be 5% of the expenditure benchmark for the corresponding year. The second model allows an ACO to share in the savings and risk of liability for losses beginning in the first year. This model allows for a greater share of any savings it generates, up to 60% (additional 5% of savings if there is a FQHC/RHC within the ACO) above the minimum savings rate (2%) of the expenditure benchmark, as the risk of loss is present from inception. The cap for shared savings is 10% for all three years. Liability for shared losses (expenditures exceeding the benchmark by greater than 2%) would be capped at 5% during the first year, 7.5% in the second year, and 10% in the third year.

The proposed rules have also set out 16 grounds for termination between CMS and the ACO. The three most prevalent ones I have seen are avoidance of “at risk” beneficiaries, if there is a failure to meet the quality performance standards, or if the number of Medicare beneficiaries the ACO serves drops below 5,000.

It should be noted that all of the above rules are part of the proposal and CMS is requesting any feedback and comment they received during the 60-day public comment period (deadline of June 6th) on the proposal. There will then be a 30-day period to reply to comments before issuing a final rule later in the year (estimated August or September 2011 timeframe).

Timeline

In an effort to introduce payment reforms, the healthcare reform law requires that CMS create a Medicare Share Savings Programs by January 2012. With the proposed rules coming out at the end of March, and with the final rules estimating to come out in later in the year, it is unlikely that the January timeframe will be met. There are talks of delaying the start of the program but only time

will tell. That being said, there are already physician practices and private insurers across the United States announcing their plan to form ACO's. See the below section on ACO Successes for more information on already existing commercial ACO's.

Why now?

Even though ACO term has been around for many years, it has become a hot topic as of late due to the spiraling cost of healthcare. The US Treasury reports that \$514 billion was spend on Medicare in 2010 versus just \$110 billion in 1990 (equates to a 467% increase). It is also estimated the 32 million new Americans will flood the already strained healthcare system due to the passage of the healthcare reform law. There is a growing trend of elderly and disabled Americans qualifying for Medicare (aka, baby boomers). With all of this being said, lawmakers are searching for ways to reduce the deficit, with Medicare being a key target. ACO's give providers incentives to assist and save money by avoiding unnecessary procedures and tests which drive up the cost of healthcare. This is very different from the current model in which providers are rewarded for providing more and more expensive procedures and services (i.e. volume driven). Also at times, different providers who see the same patient fail to coordinate their services, leading to conflicting or duplicate treatments leading to higher healthcare costs. The hope is that with the formation of ACO's, all of this will subside.

The Proposed Benefits

An ACO will receive reimbursement/savings incentives (in addition to the participants receiving traditional fee-for-service) from the Department of Health and Human Services (HHS) based on their reduction in costs and meeting quality improvement benchmarks for any 12-month period. This includes focusing on managing

patients (i.e. avoiding unneeded procedures, educating them on their health and options, 24-hour phone programs, wellness programs, etc.) and keeping them healthy and out of the hospital. The benchmarks will be based on the most recent available three years of per-beneficiary expenditures for Parts A and B services for Medicare fee-for-service beneficiaries assigned to the ACO. As savings are produced from the ACO below the targeted trend, a portion of the savings will be paid based on the amount achieved. Specifically, savings are achieved by keeping spending growth for its population below average per capita spending growth for all Medicare beneficiaries. The incentives received will then be shared between the contracted ACO payer and provider.

The patient in return receives better quality of care under one ACO network as the network would be under pressure to provide high quality care to achieve the savings bonuses and could possibly lose their contracts if the results are not achieved. It has been noted that the patient may not even know they are part of an ACO. They will still be able to receive their care from other doctors outside of the ACO network, but will more than likely be referred to hospitals and specialists within their network by their primary care physician within the ACO.

In addition to the benefits for doctors, physicians, hospitals and patients, the Congressional Budget Office estimates that ACO's could save between \$510 and \$960 million through the first three years of the program and at least \$4.9 billion through 2019. That amount is less than 1% of Medicare spending during that same timeframe, but if ACO's could achieve initial success, the program can expect to be expanded to other patient group including Medicaid and private insurance in the future.

Proposed Challenges Facing ACO's

Many individuals within the healthcare industry believe ACO's face many challenges and road blocks in the future. One such challenge is that the success of ACO's will greatly depend on the patients' accountability for their own health. According to a study by the Agency for Healthcare Research & Quality, people who have difficulty understanding health information have poorer overall health and are more likely to use hospital ER's and inpatient care which drives up costs. To date, ACO thinking has focused on rewarding only the healthcare provider to promote wellness, prevention and cost-effective behavior, but only with the help of the patients will the ACO succeed. The accountability of a patient's own health will likely lead to reduction in the use of services and will drive down costs. The challenge will be for ACO's to properly educate patients on their accountability and assist them in managing their health when outside the healthcare system.

A second challenge is that an ACO will not know the population it is serving and the corresponding costs of the beneficiaries until after the care is already provided, as the beneficiaries are to be assigned retrospectively. This also leads to the challenge of getting Medicare patients to continue receiving their services within the network. Along those same lines, CMS has also stated that any marketing material that is used by the ACO must be first approved by CMS, which will be a challenge in itself. Right now, there is no real advantage for Medicare patients to receive care from their assigned ACO as they are free to receive care from any healthcare provider they choose.

Another such challenge is that hospitals and physicians in certain specialties benefit directly from maximizing the volume of their services and the offset of the savings incentives (or repayment for losses) within an ACO versus the revenue they

would lose from the reduction in volume would not be great enough to join. According to Jeff Goldsmith, associate professor of public health sciences at the University of Virginia in Charlottesville, “the modest rewards that the ACO model offers for cost restraint are unlikely to catalyze major change.”

This brings us to the next challenge of whether physicians will be willing to participate in ACO’s. In the current environment, there are not many physicians who favor bundled payments which does not bode well for the success of ACO’s.

Another challenge will be to determine who is going to fund the ACO and who would be in charge of running an ACO. The government estimates the first year start-up and operation costs for an average ACO will be \$1.75 million. This staggering cost is a major roadblock for smaller physician practices looking into ACO development. There has also been no definite standard set to determine if doctors, hospitals or insurers would run them. The proposed rules by CMS have left the structure open for flexibility to meet the needs of the population it would be serving.

One major opinion that has gained speed throughout the healthcare industry is that ACO’s will cause hospital mergers and provider consolidation which in turn will drive up health costs by giving them greater market share and more leverage when negotiating with insurers. Although this is a possibility, many argue that the acceleration of consolidation is already a serious issue with or without ACO’s. The major concern with consolidation is antitrust laws which attempt to limit market power that drives up prices and stifles competition. With increased market share comes increased bargaining power with private payers which in turn reduces the potential for savings. The proposed rules that were released by CMS addressed this issue. ACO’s with less than a

third of the market share (Medicare fee-for-service business) will be given leeway to the antitrust laws unless they engage in deliberately anticompetitive behavior. Those with greater than half the market share will be subject to antitrust review. Those ACO’s that fall within the middle range (30 to 50% market share) can request a review. The Department of Justice and Federal Trade Commission have issued a joint “Antitrust Policy Statement” which goes into greater detail on this issue. There is an expedited 90-day review for these larger ACO’s.

Commercial ACO Start-ups

As many as 70 highly respected insurers and delivery systems have become members of a so called “learning group” as ACO pilots are developed. Other groups such as the American Medical Group Association (AMGA) and Premier, Inc. have established sophisticated ACO learning groups. It can be expected that the concept of ACO’s will evolve over time as providers and payers learn which models work best for them under the rules CMS has yet to provide.

Even before the rules for ACO’s were published by CMS for Medicare Shared Savings Programs, there have been many that have started up with private payers. There are four sites participating in an ACO pilot led by the Brookings Institute and Dartmouth Institute for Health Policy and Clinical Practice. The five sites part of the pilot are: Norton Healthcare (Louisville, KY), Tucson Medical Center (Tucson, AZ), Carilion Clinic (Roanoke, VA) and Monarch Healthcare (Irvine, CA).

There are many more ACO formations throughout the country such as Fanciscan Alliance, Fairview Health Services, Wayne State University Physician Group & Medical One Network and Sharpe HealthCare. There is even one primary care physician-based ACO in Texas that is providing

healthcare services that improve patient care and outcomes through a network of patient-centered medical home clinics instead of a hospital. Each patient has a primary care physician who provides diagnosis, treatment, referrals to sub-specialists and coordination of all care. Patients are given a portable device that provides secure online access to their medical records, which ensures that sub-specialist physicians and hospital, nursing home or home care agency staff have the most up to date information on the patients.

How Radiologists Can Help

It will be very important for radiologists and radiology groups to assess their participation and value in an ACO in the community. According to Steven Gerst, VP of Medical Affairs at MedCurrent Corporation, “Radiology clinical and business leaders have the opportunity to establish leadership positions within these newly-forming ACO’s by defining the most appropriate way to manage these costs and appropriate patient care while the ACO structures are being defined.” Diagnostic imaging is one of the fastest growing expenses an ACO should consider controlling. According to CBS News, in a recent study in *The American Journal of Radiology*, of 459 non-urgent outpatient diagnostic imaging tests ordered by primary care physicians at a university medical center, retrospective medical record review deemed nearly 26% unnecessary which equates to projected \$35 billion. One idea on how to accomplish savings is through implementation of

decision support tools and systems. These tools can assist in enhancing a clinician’s ability to reduce duplicate services, improve productivity, minimize paperwork and improve cost efficiency. Radiologists should proactively become involved with the selection of these decision support systems and the formation of ACO’s.

Conclusion

When the final rules are established, regulators estimate that anywhere between 75 and 150 ACO’s could be formed and approved by CMS and these ACO’s would care for 1.5 to 5 million Medicare beneficiaries. The overall success of ACO’s will come down to how the rules around them are structured. According to Jordan Rau of Kaiser Health News, “Much is riding on where CMS comes down. The law gives the government broad authority in designing the program. If the rules are too lenient, ACO’s may not save Medicare the money the Obama administration is count on – and could even end up become a fiscal burden. If the rules are too strict, provider groups warn that few doctors and hospitals may take the government up on its offer to test out a new way of being paid for care.” Radiologists will have to determine how all of this will affect their practices and find a way work within the guidelines to achieve quality care while protecting their income. Only time will tell if ACO’s will succeed in the current healthcare market or whether it will help shape the future culture of the medical care system.