

2011 FALL IDN SUMMIT

PEER-TO-PEER LEARNING EXCHANGE RESEARCH REPORT

**Will Accountable Care
Organizations Fulfill Their Promise?**

SPONSORED BY

ARJOHUNTLEIGH



TECSYS®



Introduction

A pillar of the 2010 healthcare reform law, accountable care organizations (ACOs) have been viewed by many policymakers as a kind of panacea for the U.S. healthcare system: the means to lower-cost and higher-quality care delivered by tightly linked, physician-led provider networks. All of the reform ideals – clinical integration, meaningful use of information technology, evidence-based medicine and cost-efficiency – are part and parcel of the ACO concept.

For all that promise, a proposed rule put forth by the Centers for Medicare and Medicaid Services (CMS) to implement ACOs through a new Medicare Shared Savings Program has left some cracks in the pillar. Providers of all stripes are up in arms about almost every aspect of the plan, from the number of proposed quality measures (65) to the startup costs for forming an ACO to the amount of money that is at risk for failing to achieve cost savings to how Medicare beneficiaries are assigned to an ACO.

Public comments suggest CMS seems to be willing to overhaul its plan in a final rule this fall, but will likely stick to its guns in terms of using the program to encourage a new approach to coordinated care across the continuum and ensure that providers collect data and report on many more quality of care measures. The main program was set to roll out late in 2011, but now seems likely to get under way no sooner than spring of 2012.

The controversy over the proposed rule has overshadowed the fact that the payment system is heading in the same direction as ACOs are pointing, whether or not ACOs wind up being the vehicle of choice. Many integrated healthcare systems have already embarked on the road toward more coordinated and accountable care delivery. And surveys continue to show that hospitals, physicians and even insurers are busy planning new alliances to follow suit.

“I think the storm of criticism (over the ACO rule) is an indication of how much it matters” to providers and other organizations, said Mark McClellan, the former Centers for Medicare and Medicaid Services administrator. “The fundamental need for ACO reforms is not going away.”

Paul B. Ginsburg, president of the Center for Studying Health System Change, sees a willingness on the part of CMS to consider changes based on voluminous stakeholder comments, but warns that the agency shouldn’t be too willing to lower the bar. “Noting the substantial investments required for ACOs to improve care delivery, some have concluded that the prospects for earning an acceptable return on investment are small and that CMS may have been too ambitious in trying to generate large savings in what is, in essence, a voluntary demonstration. But providers should consider ACOs as more than a short-term business opportunity.”

Instead, providers should see in the demonstration the chance to remake their organizations to prepare for future changes to the reimbursement system, Ginsburg wrote in an essay in the *New England Journal of Medicine*. “It may be better to spend now in order to save later and avoid the consequences of the inevitable ratcheting down of fee-for-service rates.”

In the meantime, CMS Administrator Donald Berwick, MD, and his team have come up with a new form of ACO designed to lure organizations that are already highly integrated to be flagships for the Shared Savings Program.

So-called Pioneer ACOs would be fast-tracked, with integrated delivery systems -- already providing coordinated care and managing risk --able to apply immediately. CMS is hoping to have them up and running under shared savings before the end of 2011. About 30 applicants will be selected.

The Pioneer model was developed after industry leaders such as Cleveland Clinic and Mayo Clinic announced that they would likely sit out the ACO process. (Mayo, at least, is not mollified by this proposal and doesn’t see any advantage to placing part of its reimbursement at risk when it is already a top performer, according to Douglas Wood, its chairman of health care policy and research.)

The Pioneer plan has a number of sweeteners in it, including higher shared savings than the conventional ACO plan, an option for prospective assignment of beneficiaries (meaning providers will know which of their patients is actually in the ACO), severity adjustment of patients with multiple co-morbidities, and the ability for a group to work in coordination with private payers with which they may already have structured, ACO-style relationships.

As one barometer of potential interest, a CMS conference call to provide more information about the Pioneer ACO model attracted more than 850 participants.

ACOs: The Basics

Amid the hyperbole surrounding the proposed rule, it might be worth a short refresher course on what CMS actually said in the 429-page document.

Under the plan, ACOs would be organizations whose primary care providers are accountable for coordinating care for at least 5,000 Medicare beneficiaries and would have mechanisms for shared governance and shared savings.

The ACO must be a separate legal entity, with at least 75% of the provider members serving Medicare patients. Eligible Medicare providers include:

- Group practices
- Networks of individual medical practices
- Partnerships or joint ventures between hospitals and physicians
- Hospitals employing physicians

An ACO would not be required to have a hospital member, but the administrative and information technology requirements imposed on ACOs makes the involvement of a hospital almost inevitable. At the very least a large, multi-specialty group practice/clinic would have to take part.

The core of the ACO, however, would be the primary care physician, whose job it is to control utilization and therefore costs, so the ACO can achieve, and share, in savings generated for the Medicare program.

Specialists participate as employees of the ACO, joint venture partners, or providers under contract with the ACO, but compared with typical practice, specialists would see fewer referrals and perform fewer tests. Since beneficiaries would be retrospectively assigned to the ACO (in the first year, a full 12 months after the ACO starts up) to prevent gaming of the system, more cost-effective care will have to be provided to every patients of a referring ACO member organization or provider.

All ACOs must demonstrate what the proposed rule calls “patient-centeredness.” That is defined as:

- Better care for individuals – as described by all six dimensions of quality in the Institute of Medicine’s Crossing the Quality Chasm report: safety, effectiveness, patient-centeredness, timeliness, efficiency and equity.
- Better health for populations with respect to educating beneficiaries about the upstream causes of ill health – such as poor nutrition, physical inactivity, substance abuse, economic disparities – as well as the importance of preventive services such as annual physicals and flu shots.
- Lower growth in expenditures by eliminating waste and inefficiencies while not withholding any needed care that helps beneficiaries.

Patient-centered care, CMS says, should be individualized based on a person’s unique needs, preferences, values and priorities. Patients should have access to their own medical records, as well as the clinical information they need to make informed choices and be partners in the care they receive. Transitions in care should be highly coordinated to prevent repeated tests and ensure quality.

Required quality metrics and processes

CMS would require ACOs to report metrics on their clinical processes and outcomes, patient experience, utilization and costs – all of which will be calculated to create a per-member cost for treatment in a given time frame. This figure would be compared to benchmarks the government would establish based on rolling averages of per-beneficiary costs for the ACO, plus an adjustment to account for national expenditure growth.

The proposed performance measures are grouped into five domains – Patient Experience of Care, Coordination of Care, Patient Safety, Preventive Health and Care for At-Risk Populations. Other than patient safety, which includes hospital-acquired conditions, the measures appear to be designed to demonstrate the effectiveness of the ambulatory care environment.

The domains mean that ACOs must have:

- A patient satisfaction survey in place that measures the experience of care during transitions from one provider to another.
- A process for evaluating health needs of the population.
- A process for delivering individualized care plans targeting high risk populations.
- Coordination of care mechanisms.
- Electronic exchange of care information consistent with meaningful use under the electronic health records incentive program.
- Communication of clinical knowledge/evidence-based medicine to patients in an understandable way.
- Measurement of clinical and service performance by physicians across the practices (such as clinical integration programs).

For each quality measure, a performance benchmark and a minimum attainment level would be set. CMS would calculate a percentage score and average these to determine a final score, with all domains weighted equally. Benchmarks would be established using the most currently available data source and most recent available year of data prior to the start of the Shared Savings Program in 2012.

The Group Practice Reporting Option (GPRO) is the method by which CMS proposes to calculate results for the first year of the program. The GPRO is similar to the current Physician Quality Reporting System. CMS says the GPRO tool is a mechanism by which beneficiaries’ lab results and other clinical information can be reported to CMS for determining shared savings. Measures reported under the GPRO must consist of at least 411 assigned beneficiaries per measure set/domain, and if the pool of eligible beneficiaries is less than 411 for any measure set or domain, then the ACO would have to report on 100% of all assigned beneficiaries.

A shared savings bonus is payable if an ACO meets quality standards and savings against a “target” expenditure. A minimum rate of savings must be attained before the sharing of savings tally begins. That was established in the proposed rule as 2% for large providers and 3.9% for small providers.

How the money will be distributed among the participants of the ACO is based on the patient's utilization of services within the ACO. Currently, the proposed regulations do not specify how much the incentives for providers will be.

The proposed rule would allow ACOs to apply for one of two risk models in order to benefit from shared savings over the three-year program. In the first model, providers would share savings of 50% in all three years, but would be at risk in year three for any losses that exceed 2% of the benchmark established by CMS. In the second model, ACOs could receive a higher percentage of shared savings, up to 60%, but would be at risk of absorbing losses in each of the three years if their expenditures exceeded the CMS benchmark.

Beneficiaries would be retrospectively assigned to the ACO to reduce the possibility that providers may avoid patients with multiple diagnoses. But this requirement concerns many healthcare organizations, which say they won't know which patients they should focus on.

Evidence of Success

The public clamor over the ACO rule overshadowed the announcement in August of positive results from the five-year CMS demonstration project on an earlier ACO model. The Medicare Physician Group Practice demonstration included 10 large multispecialty groups with diverse organizational structures, including freestanding physician groups, academic faculty practices, integrated delivery systems and a network of small physician practices. Like ACOs, the test had the participants coordinating care for a population of Medicare beneficiaries and sharing in any savings produced, as well as meeting a wide range of performance measures.

In the fifth year of the demonstration, seven of the 10 groups achieved benchmark performance on all 32 performance measures; three groups achieved benchmark performance on at least 30 of the 32 reported measures.

Four of the groups received incentive payments of \$29.4 million (out of total savings to Medicare of \$36.2 million) in the fifth year. Over the five years, Medicare paid \$110 million in incentives to seven of the participants for achieving savings, quality improvements and higher patient satisfaction. The majority of the savings at all sites occurred in outpatient, not inpatient, services, and there was some evidence that having a hospital as part of the model was a disadvantage.

Perhaps an even more successful test of the ACO concept was reported about the same time as the CMS results. An ACO-like collaboration among Blue Shield of California, Catholic Healthcare West and Hill Physicians Medical Group saved more than \$20 million in costs in just its first year, while reducing hospital length of stay and readmissions.

The partners overhauled procedures for medical treatment and hospital care. They started by sharing closely guarded financial and medical information. Among the discoveries was that a handful of elective procedures, including weight-control measures, were among the biggest cost drivers. They took action to cut these costs. Overweight patients, for instance, were given an opportunity to enroll in a Hill Physicians weight-loss program in which a psychotherapist and dietitian teach how to manage food cravings and make healthier eating choices.

The efforts helped reduce the surgeries by 13% last year, Catholic Healthcare West said.

Now, Blue Shield of California has inked a deal to work with another provider, St. Joseph Health System in Orange County, Calif., to collaborate on an ACO to serve approximately 30,000 Blue Shield HMO members. Blue Shield and St. Joseph will share clinical and case management information and to coordinate comprehensive healthcare services.

Conflicting Scenarios

CMS initially predicted that 75 to 150 groups would be selected from many more applicants as initially satisfying the ACO program requirements. Based on that estimate, administration officials anticipated savings for Medicare from the program of \$510 million to \$960 million in the first three years, with total bonus payments to ACOs of \$800 million and total penalties paid to CMS of about \$40 million.

In a letter to Berwick, American Medical Group Association (AMGA) President and CEO Donald W. Fisher warned that a survey of its members found that 93% would not enroll as an ACO under the proposed regulations. The AMGA believes the CMS plan is fatally flawed, an opinion shared by other trade groups.

A major issue is the likely costs for forming an ACO. CMS estimated startup investment and first-year operating expenditures of \$1.75 million per ACO. The American Hospital Association, which conducted a study of the issue, estimates startup costs at \$11.6 million to \$26.1 million. The study identified a total of 23 different capabilities that must be developed across four categories to achieve the desired transformation in care delivery, including network development and management, care coordination, quality improvement, utilization management, clinical information systems and data analytics.

The American Medical Association's immediate past president, James J. Rohack, MD, said that the AMA believes the benefits of ACOs "cannot be fully realized unless physicians in all practice sizes can be involved." According to the AMA, 78% of office-based physicians in the U.S. work in practices with nine physicians or less. The AMA has asked CMS to provide assistance for physicians in small practices, including startup capital and small business loans, to meet the large initial expenses that will come with participation in ACOs.

However, a number of observers believe that the negative outlook presented by trade associations is belied by the reality on the ground.

From 60 to 80 healthcare organizations use private accountable care models now, and that number will rise by at least 100 next year as the Medicare pilot program begins, according to Elliott Fisher, director of Dartmouth's Center for Health Policy Research. That number will exceed 200 in 2013 and grow to 500 to 1,000 such organizations within three years, he predicted. Dartmouth and the Brookings Institution are running a pilot project with five private sector ACOs.

Underscoring Fisher's estimates, a *USA Today* and Fidelity Investments survey in late July of executives at 1,852 hospitals found that a third of respondents' organizations were "extremely likely" to become part of an ACO. A survey in June by staffing agency AMN Healthcare of 882 healthcare administrators and physicians had similar findings, with 58% of respondents' organizations in the process of forming an ACO or considering doing so.

Conclusion

Regardless of how the CMS ACO final rule shakes out, it seems quite likely that a large-scale test of some form of this provider integration model will take place across the U.S. in the coming years. There is simply too much momentum in both the public and private spheres for closer alliances of physicians, hospitals and insurers for a Washington policy dispute to derail progress.

Most providers have read the handwriting on the wall. The time for highly accountable care has arrived. Now we just have to wait to find out exactly what the winning model will look like and whether it can deliver on the great promise of a reformed healthcare delivery system.

Questions for Discussion

1. Do you see ACOs playing a major role in solving the healthcare system's issues of quality and efficiency?
2. What are the biggest barriers to forming an ACO?
 - Lack of physician alignment
 - High costs
 - Need to invest in IT
 - Lack of established evidence-based treatment protocol
 - Legal hurdles/antitrust concerns
3. If CMS is to successfully rewrite the proposed rule to encourage applicants for the Shared Savings Program, what are the most significant changes it should make?
 - Assign beneficiaries prospectively
 - Reduce the number of quality metrics
 - Increase provider share of savings
 - Reduce providers' shared risk
 - Simplify the governance rules
 - Lower the bar on information technology use
4. Is shared risk and savings the way of the future in healthcare, regardless of the specific rules CMS establishes for the ACO program?
5. What role do you foresee for private payers to join ACOs, either under the federal program or in private organizations with providers?

Further Reading

"Assessing an ACO Prototype — Medicare's Physician Group Practice Demonstration," *New England Journal of Medicine*, January 2011

"Spending to Save — ACOs and the Medicare Shared Savings Program," *New England Journal of Medicine*, May 2011

"Leaders Respond to CMS' Proposed ACO Regulations," *HealthLeaders*, April 2011

Accountable Care Organization Proposed Regulations: Resources, Kaiser Family Foundation

Upcoming Webinar Opportunity:

Will Accountable Care Organizations Fulfill Their Promise?

Moderated by Greg Shufelt, Senior Manager, The Camden Group

Wednesday, Nov. 16, 2011 2:00 PM EST

For more information, contact Lisa Ponssa, IDN Summit Director of Content

lisa@idnsummit.com or Ph: 859.309.6725