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ACO Special Report: The right medicine for our ailing health system?

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Several concerns remain about whether model can improve care quality, save costs

The proposed accountable care organization (ACO) regulations arrived on March 31 and have caused much strife and speculation in the medical and legal communities in recent months.



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The ripples of these imminent regulations extend into many areas, from patient-physician interaction to electronic health record (EHR) systems installation to management structuring. The entire arrangement can be pared down to two goals, however. One goal is improved quality of patient care, but the major goal is cost savings. The bottom line is, this system has been created to benefit the Centers for Medicare and Medicaid Services (CMS) by promising physicians and hospitals a portion of health cost savings, but the savings may not be nearly as much as what the government spends to run the bureaucracy that CMS is necessitating by the complexity and far-reaching scope of these regulations.

The overall concept is that Medicare will calculate a "benchmark" based on how much it normally would cost to pay for Part A and Part B services for Medicare fee-for-service patients assigned to the ACO over the previous 3 years, and if Medicare actually pays less overall for the patients assigned to the ACO during each agreement period, then the ACO will generally receive 50% to 60% of the savings. If Medicare pays more than the benchmark for the patients assigned to the ACO, then the ACO may be responsible for a portion of the losses.



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Because the entire ACO system is built on this premise, it becomes crucially important to examine how effective these proposed measures may be in accomplishing these savings.

Improved quality of care is a fantastic goal to work toward. Cohesive EHR systems, and physicians who work together toward patient welfare, would be ideal for all parties involved. Unfortunately, these improvements will only happen because everyone is seeking to increase their bottom lines. In this article, we'll examine the requirements of ACOs and the potential to generate the profits CMS is seeking.

According to the preamble preceding the proposed ACO regulations, CMS will save \$510 million during the first 3 years of operation. Other sources have indicated projected savings up to \$960 million. The estimates for the subsequent bonuses to ACOs range from \$560 million to \$1.13 billion in that same time period.

How accurate are these projections? Many experts believe that the numbers are inflated and inaccurate and that many potential factors have not been considered. The ACOs essentially will be new businesses, and a very real danger exists that many of them simply will fail. They may not be able to pull together the internal management and information technology (IT) systems required. They may not be able to successfully meet the 65 quality-of-care markers imposed on them. Or they may just not be able to generate the savings required to

turn a profit.

The only external group with a stake in these ACOs will be the government, which is working "without a net." If an ACO fails, the government will suffer some of that loss. Taxpayers will not want the government to "bail out" ACOs that are failing, but pressure from patients, physicians, and investors may prove too strong. This scenario has played out before: In the 1990s, millions of dollars in losses occurred when practice management companies boomed, and then dramatically busted, at the great expense of thousands of physicians.

Remember, before any of the promised savings are realized, a multitude of requirements must be met:

5,000 PATIENTS, AND ONLY PRIMARY CARE PATIENTS COUNT

Each ACO will be required to have 5,000 or more primary care Medicare patients, and only primary care patients count. Patients of a specialist who are not "signed on" with one of the ACO's primary care physicians (PCPs) will not be included as ACO patients for the 5,000 patient requirement or for financial reward purposes. If at the end of a year the ACO does not have enough patients, it has a 1-year grace period to correct this issue. If at the end of the grace period year the ACO's population has not reached at least 5,000, then the arrangement will be terminated and the ACO will not be eligible to share in savings for that year.

Although 5,000 patients generally is the minimum required to be in the program, ACOs will want to have more patients, because the minimum savings rate that an ACO must achieve to receive payments under the program is lower if an ACO has more patients.

65 QUALITY MEASURES

Before being eligible to receive any bonus payments, an ACO must meet a minimum standard with respect to 65 quality measures.

These measures are described in the preamble preceding the proposed ACO regulations and are subdivided into five categories: patient/caregiver experience, care coordination, patient safety, preventive health, and at-risk population/frail elderly health.

THE MINIMUM SAVINGS RATE

An ACO must achieve a minimum savings rate if it is to receive any bonus payments.

Number of patients	Minimum savings rate
5,000 to 5,999	3.9% to 3.6%
6,000 to 6,999	3.6% to 3.4%
7,000 to 7,999	3.4% to 3.2%
8,000 to 8,999	3.2% to 3.1%
9,000 to 9,999	3.1% to 3.0%
10,000 to 14,999	3.0% to 2.7%
15,000 to 19,999	2.7% to 2.5%
20,000 to 49,999	2.5% to 2.2%
50,000 to 99,999	2.2% to 2.0%
60,000 +	2.0%

The minimum savings rate for a "two-sided model" ACO is 2%. The minimum savings rate for a "one-sided model" ACO varies from 2% to 3.9% depending on the number of patients. In the two-sided model, savings and losses are shared all 3 years, and in the one-sided model, savings are shared for the first 2 years and losses are shares all 3 years.

The accompanying chart illustrates how the minimum savings rates for one-sided model ACOs will vary based on the number of patients.

For example, a one-sided model ACO with 9,000 patients will have a minimum savings rate of 3.1%, and a one-sided model ACO with 9,999 patients will have a minimum savings rate of 3.0%.

ENTITY OWNERSHIP REQUIREMENTS

The regulations indicate that the ACO shall be a separately formed legal entity, which can be a limited liability company, a professional corporation, or another entity.

The ACO will have a separate taxpayer identification number that will be linked on Medicare records with the identification numbers of all ACO participants. The organization will have to have bylaws or equivalent documentation to show appropriate ownership and governance.

The following ACO participants are eligible, separately or in combination, to form ACOs:

- ACO professionals, including physicians and nurse practitioners, in group practice arrangements;
- networks of individual practices of ACO professionals;
- partnerships or joint venture arrangements between hospitals and ACO professionals;
- hospitals employing ACO professionals;
- providers or suppliers; and
- critical access hospitals.

CONTROL REQUIREMENTS

At least 75% of control of an ACO's governing body must be held by ACO participants. ACO participants are described in the six categories above.

At least one Medicare ACO system patient must sit on the governing board. Ownership limitations are not discussed, which would indicate that any combination of ownership will be satisfactory if appropriately registered and legal in the state of operation.

For example, hospitals and specialist groups may fund ACOs in exchange for rights of participation and percentages of profits. PCPs may be given ownership and rights to a percentage of profit in exchange for being willing and able to participate in the ACO and to bring significant portions of their patient bases in for participation. Profits may be allocated among PCPs and specialists in recognition of how their ACO patient expenses compare with those of others in the ACO.

TRACK 1 AND TRACK 2

The proposed ACO regulations establish two alternative programs into which an ACO may elect to participate: "Track 1" and "Track 2." Each track will be subject to the same measurement regarding whether the ACO has financially provided Medicare with an annual savings or loss by comparing the benchmark with the actual ACO costs.

A Track 1 ACO will bear no risk and have only an upside for 2 years, but its profit potential will be less than a Track 2 ACO. If for any year net Medicare savings exceed the minimum savings rate, then a Track 1 ACO generally will receive 50% of the additional net Medicare cost savings in excess of such rate. The 50% shared savings rate may be increased up to 52.5% based on the number of proactive patient visits to a federally qualified health center or rural health center. The Track 1 ACO will operate under the one-sided model for the first 2 years and, therefore, will not be liable for any losses that occur in the first 2 years. For the third year, however, the ACO under Track 1 converts to the two-sided model and will be subject to the risk of loss. For an ACO in Track 1 that has entered its third year, the amount of shared losses for which the ACO would be liable is limited to 5% of the benchmark.

A Track 2 ACO operates under the two-sided model for all 3 years of the agreement. For any year in which net Medicare savings exceed 2%, the Track 2 ACO generally will receive 60% of all the net Medicare cost savings, including the initial 2% savings. The 60% shared savings rate may be increased up to 65% based on the number of proactive patient visits to a federally qualified health center or rural health center. The Track 2 ACO, however, also would be responsible for the same percentage (60% to 65% as modified based on the number of proactive patient visits to a federally qualified health center or rural health center) of any loss incurred for any of such 3 years. The amount of shared losses for which the ACO would be liable is capped at 5% of the benchmark in the first year, 7.5% in the second year, and 10% in the third year. The proposed ACO regulations are not clear on what happens to the cap if a Track 2 ACO signs on for another 3-year contract. Does the cap reset to 5%? Does the cap stay at 10% and never increase? Does the cap start at 10% for the fourth year and keep increasing? We hope these questions will be answered by the U.S. Department of Health and Human Services soon.

After the initial 3-year agreement, an ACO may only operate under the two-sided model, sharing in savings or

losses with the Medicare program.

ADJUSTMENTS FOR THE 1% MOST EXPENSIVE PATIENTS

ACOs may not avoid at-risk beneficiaries in an effort to keep their costs down. An "at-risk beneficiary" is defined as a patient who has a high-risk score on CMS' hierarchical condition categories risk adjustment model, is considered high-cost due to having two or more hospitalizations each year, is dually eligible for Medicare and Medicaid, has a high utilization pattern, or has had a recent diagnosis that is expected to result in increased cost. The highest-cost 1% of patients will not be counted in the calculations, however.

MANDATORY 25% WITHHOLDING

Under both a one-sided model and a two-sided model, the ACO is required to withhold 25% of any bonuses it receives, as escrow to cover potential future losses. The problem with this withholding provision is that it does not take into account ACOs not receiving any bonus money, which are the biggest liability. If an ACO does not meet the minimum savings rate, it receives no bonus money whatsoever. No additional source of funding is proposed for an ACO that is failing. Even a 25% withholding may be nowhere near the amount necessary to cover substantial losses for a large ACO, and no projected "buy-in" for ACO participants exists that might provide additional funds that could be set aside. The bottom line looks great on the surface, but the math may not be adding up.

IS IT WORTH IT?

The potential flaws in the bonus system itself need to be examined.

The bonus for an ACO is derived from the savings it generates for CMS. The number of patients determines the minimum savings rate the ACO must reach before it can receive any bonus profits at all; this number is roughly between 2% and 4% (the amount of profits is further determined by whether the ACO is Track 1, meaning it assumes no liability in its first 2 years, or Track 2, meaning it assumes liability from the onset).

The bonuses are evaluated on a yearly basis, and the implication and fear is that an ACO that does an excellent job of saving in its first year would have its benchmark reset to that savings level as "normal" and then would have an increasingly difficult time generating savings and profits in subsequent years. In essence, this situation could punish an organization that made large strides in a single year and might create a yo-yo pattern, wherein an ACO saw large bonuses one year and tiny bonuses the next. To avoid this problem and maintain incentives that seem to be reachable goals for ACOs, CMS will have to exercise caution in determining the general patient expenditures and be sure to base the information on the patient costs of "middle-of-the-road" organizations rather than exceptionally successful ones.

Further, CMS does not appear to have accounted for how its own infrastructure may have to change. To manage and deal with the ACOs, CMS will have to acquire new personnel and will have much higher costs, which will make it more difficult to see true savings, although savings will be passed on from the ACOs. This is a further source of government liability that has yet to be addressed.

Who is most likely to walk away from this venture with a fattened wallet? Ironically, the managed care organizations (MCOs) that the proposed ACO regulations are seeking to work around may end up thriving in this environment.

We recommend that ACOs keep their initial patient numbers small, particularly if they have to make large investments in personnel, infrastructure, and IT and EHR systems. Trying to grow too large too quickly may lead to failure. This is where the MCOs come in. In most situations, only MCOs have the computer systems, physicians, facilities, and other structures in place to handle a large number of patients within a cohesive structure. They have "deep pockets" and are able to put forth any upfront costs to make sure their systems comply with the regulations without breaking the bank.

The fear is that once they have become entrenched in the ACO systems and have achieved the maximum bonuses from their savings on large numbers of patients, they will decide that they no longer need to operate under the ACO umbrella. They may attempt to switch their ACO patients back into their MCOs, further expanding their patient base and retaining 100% of the profits, rather than 50% to 60% under the ACO regulations.

What about people looking to increase their own personal bottom line? We are concerned that the ACO regulations might promote corruption, even as the regulations themselves are striving to improve quality of care, transparency, and compliance. Corruption could arise when lobbyists pressure those government officials who have influence overseeing the ACOs: they might be able to assign groups of patients to a particular ACO or do favors for special interest groups so that they get to retain more profits. Both the ACOs and the government, as organizations, want to save money, but that does not mean that individuals will not act in their own best interests.

What the proposed regulations have done right is make several valiant and well-thought-out attempts to protect the patient. The 65 quality measures are intended to not only improve quality of care but also to ensure that patient care does not suffer in an attempt to generate more savings and bonus profits. In an ideal situation, all of a patient's physicians would work together, with full access to organized and thorough medical records. Relationships, physician-patient and hospital-physician, would improve. It is important to remember, however, that without that bottom line in place and increasing, much less incentive will exist to effectuate these changes.

CMS is now working to finalize the regulations. No doubt, speculation will continue for the coming months, and possibly years, as to how successful these organizations truly will be. We have addressed the concerns we see at this point in time, and we hope the finalized regulations will address them as well. It is vital, however, that if you are considering affiliating with an ACO, you become as educated and aware as possible and use good, honest advisers who are unbiased as to whether you should pursue an ACO.

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THE PROS AND CONS OF ACCOUNTABLE CARE ORGANIZATIONS

DISADVANTAGES OF ACOS:

- Tremendous learning curve for the uninitiated physician and practice.
- Extremely high costs of setting up the infrastructure.
- Complexity of payment.
- Unclear regulations.
- Delayed payments.
- Government involvement extremely high.
- Extremely data-driven; thus, physician groups and practices will need to hire specialists in IT, database

management, utilization, quality control, customer service, compliance, finance administration, and physician networking.

- Close work with hospitals is essential; solo or silo practices will be increasingly vulnerable, and corporatization of medicine will happen. In fact, it already has begun.
- Physicians will need to follow rules, often set by nonmedical personnel.
- Patient care will become more time-consuming with the increased need for documentation, coordination of care, communication with other specialists and patients, and review of data.
- Physician performance will be under the scanner of customers, vendors, peers, and the government.
- Physicians will have less ability to be independent and will be held accountable.

ADVANTAGES OF ACOS:

- Objectivity is brought to the care of patients.
- Goals and objectives are defined and made mandatory.
- Patient and peer communication will improve.
- Teamwork among physicians and administrators will improve.
- The patient experience will improve, along with patient care, due to continuity of care.
- The horizontal and vertical integration of medicine is happening, driven by data, finances, and organizational interrelationships.
- Compliance is critical and is better for patients and physicians.
- Reduction of costs is possible if healthcare can be integrated.
- Goals and business strategies are shared among hospitals, physician practices, and management service organizations.
- A paradigm shift will occur in healthcare if appropriately drafted and implemented, and this shift this will reduce mortality and morbidity.

STEPS TO PREPARE FOR ACCOUNTABLE CARE ORGANIZATIONS

- If you don't have one already, obtain a meaningful use-certified electronic health records system, and start using it meaningfully.
- Learn to start measuring your own performance against the indicators advised by the government. Start tracking your performance on Healthcare Effectiveness Data and Information Set scores, customer satisfaction, etc.
- Be strong with compliance. Take it very seriously. Retain consultants who will give you unvarnished opinion about your practice, then follow it. Use your attorney to sign up your compliance consultant.
- Study the data of your practice and your utilization. You can obtain such data can from the American Health Care Association, federal government data sites, managed care organizations, independent practice associations, hospitals you use, and other sources.
- Work with managed care specialists and experts in compliance and Medicare regulations. Learn from them.
- Create synergies of operation with people who know more than you—consultants, experts, etc.
- Work with specialists in your area to create a team approach to patient care.
- Become accountable to yourself, your patients, and employees and fellow professionals.
- Keep the focus on quality.
- Remember, customer service is paramount. Treat your patients as your most valuable assets in addition to your medical license and your ability to practice.
- Think long-term, and do not act out of fear or greed.
- Know your strengths and weaknesses as a healthcare provider, businessperson, practice administrator, investor, and manager.
- Learn, learn, learn. Study the market, and study the providers who are more successful than you. Consider this learning a new residency of sorts, during which you learn a new paradigm of practicing medicine.


Prize integrity above all else.

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9,000 to 9,999	3.1% to 3.0%
10,000 to 14,999	3.0% to 2.7%
15,000 to 19,999	2.7% to 2.5%
20,000 to 49,999	2.5% to 2.2%
50,000 to 59,999	2.2% to 2.0%
60,000 +	2.0%

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