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# SUMMER 2011 NEWSLETTER

**Accountable Care Organizations (ACOs) are a hot topic right now. This summer's newsletter explains the concept and answers questions that physicians frequently ask. Our comments relate to the Proposed Rule issued by CMS on March 31, 2011. We'll address the Final Rule in a future newsletter.**

**Margie Satinsky**

**If you're short on time and want to know where we stand without reading the details, here's the bottom line for medical practices. Less important than the nitty-gritty of ACOs is the continuing shift to value based purchasing by both public and private payers. If payers require collection and reporting of data that demonstrates compliance with specified requirements, can providers produce and report what is needed in the specified format? Even more important, can providers use their own data to better manage patient care? While CMS is working on the Final Rule on ACOs, ponder those two questions!**

## IS AN ACCOUNTABLE CARE ORGANIZATION (ACO) IN YOUR FUTURE?

**The topical links below can help you navigate quickly to the ACO-related Q&As of greatest interest to you.**



### *Definition, Goals & Timing*

#### 1. What is an Accountable Care Organization (ACO)?

The concept of an Accountable Care Organization (ACO) had its roots in the Affordable Care Act of 2010, landmark legislation that established the Medicare ACO Shared Savings Program. ACOs are provider-based organizations that assume the responsibility for meeting the healthcare needs of a defined population. ACOs will coordinate the treatment of patients across the continuum of care, including physician practices, hospitals, skilled nursing facilities, long term care facilities, and other providers and suppliers of Medicare-covered services.

#### 2. What are the goals of an ACO?

ACOs have three main goals: (1) promote accountability for a patient population comprised of Medicare fee-for-service beneficiaries (i.e., not members of Medicare Advantage plans); (2) coordinate covered items and services in Medicare Parts A and B; and (3) encourage investment in the infrastructure and redesigned care processes that lead to high quality and efficient service delivery. The underlying assumption is that with financial incentives, providers will collaborate to ensure that the patients for whom they are accountable receive the right medical care at the right time and in the right setting, thus resulting in better outcomes and lower costs.

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### 3. What's the timetable for ACOs?

The target start date for ACOs is January 2012. The Proposed Rule was released on March 31 and published in the Federal Register on April 7. Public comments were due by June 6, 2011, and with OMB approval, CMS will issue a Final Rule in late summer or early fall 2011. Participating ACOs must commit to a three-year agreement. Each performance measurement period is for one year.

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## *Differences from Other Concepts*

### 4. Is there a relationship between the concepts in the ACO program and those in the Patient Centered Medical Home (PCMH)?

PCMH is the foundation for ACOs, but there are important differences. The PCMH concept focuses on primary care physicians as the coordinators of care for patients across the continuum of care. But PCMH lacks a financial incentive that encourages providers to work together. Another difference is the breadth of relationships with non-primary care providers. Most ACOs involve relationships among primary care physicians, specialists, hospitals, and other healthcare providers across the continuum of care.

### 5. Are ACOs the same as capitation?

No. As explained by Smith Anderson in its 2011 ACO Guide, there are at least two important differences. Under capitation, providers receive a set payment based on the cost per member per month. With shared savings, providers receive both fee-for-service payments plus bonus payments if they meet specific criteria. There's no downside risk if an ACO doesn't meet the criteria; it still receives compensation for the services that providers rendered to beneficiaries. A second important distinction is the current availability of tools for capturing, reporting, and using patient information. When capitation was in vogue, it was far more difficult to document performance and use information in a positive way to manage patient care and costs.

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## *ACO Formation*

### 6. Can integrated delivery systems that are already engaged in coordinating care and that currently participate in outcome-based contracts with private payers accelerate their participation in ACOs?

Yes – in two ways. CMS has already created a Pioneer ACO Model that will allow up to 30 ACOs to escalate their assumption of shared savings and risk. CMS is also considering an Advanced Payment Initiative (AP) to determine whether or not providing ACOs with an advance on expected shared savings could increase participation in the Medicare Shared Savings Program.

### 7. Who can take the initiative in forming an ACO?

The Proposed ACO Regulations issued by CMS do not mandate a particular organizational form for an ACO. ACOs can be formed in different ways, provided that they are legal entities recognized and authorized under State law, as identified by a Taxpayer Identification Number (TIN). Entities that are eligible to apply to CMS to qualify as an ACO include professionals in group practice arrangements, individual practices of ACO professionals that form a network, partnerships or joint ventures between hospitals and ACO professionals, hospitals that employ ACO professionals, or certain critical access hospitals.

### 8. What requirements must ACOs meet?

a. **Governance:** Establish a governing body representing ACO providers, suppliers, and Medicare beneficiaries. That entity must be able to receive and distribute shared savings, repay shared losses, and ensure and report compliance with program requirement and perform other ACO functions.

b. **Meaningful commitment:** Make a meaningful financial or time/resource investment in the ongoing operations of the ACO.

c. **Patient-centeredness:** Patients come first not only with respect to clinical care, but with respect to all aspects of work flow. ACOs must:

   i. Implement a beneficiary experience of care survey (e.g., patient satisfaction survey) and a plan to use the results to improve care.

   ii. Adopt a process for evaluating the health needs of the assigned population and develop and implement a plan to address those needs.

   iii. Implement systems to identify and update high-risk individuals and a process to develop individualized care plans for these people.

   iv. Establish a process for beneficiary engagement and shared decision-making that takes into account beneficiaries' needs, preferences, values, and priorities.

d. **Documentation:** Document plans to promote evidence-based medicine and patient engagement.

e. **Quality of care:** Coordinate care, and implement quality and cost measures.

### 9. Is there a minimum number of Medicare beneficiaries for which an ACO must be responsible?

Yes – each ACO must assume responsibility for a minimum of 5,000 original Medicare beneficiaries (i.e., not Medicare Advantage). Small practices that don't meet the minimum requirements can either (a) link up with other practices to form a larger network or (b) become part of a hospital collaborative ACO. ACOs that wish to be Pioneer ACOs must have 15,000 beneficiaries.

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## *Provider Impacts & Concerns*

### 10. When the dust settles around ACOs, will independent physicians who are not part of larger organizations lose their ability to remain in private practice as they now know it?

ACOs don't force independent physicians to become part of larger organizations. But the increasing importance of ACOs and other value-based purchasing methods means that physicians that choose to remain independent must learn to deal with the same types of incentives as their colleagues in more organized settings.

### 11. Is there a limit to the number of ACOs to which providers can belong?

Yes, primary care providers (e.g., internal medicine, general practice, family practice, geriatric medicine) can participate in only one ACO. Hospitals and non-primary care medical and surgical specialists can participate in more than one ACO.

### 12. How are providers paid for the care they render to Medicare beneficiaries?

a. Providers in an ACO are eligible to receive both the traditional Medicare fee-for-service payments under Medicare Parts A and B plus additional payments if the ACO meets both quality and savings requirements.

b. Payments are made directly to the ACO. The ACO then distributes the money to participating providers.

**c.** The Interim Rule offers ACOs two risk models. The one-sided model shares only the savings for the first two years, and shares savings and losses in the third year. The two-sided model shares savings and risks in all three years.

### 13. What concerns about the Proposed Rule have been raised by the provider community?

a. **Cost:** Setting up an ACO that meets the certifying requirements requires a significant capital investment by both the ACO and at the individual practice level. Staffing and information technology will be two high cost items.

b. **Workflow issues:** Providers must make major changes in order to meet patient-centered care criteria.

c. **Patient management:** Because the Proposed Rule protects and preserves beneficiaries' rights to seek care from non-ACO providers, management of patients and information outside of an ACO network is challenging.

d. **Extent of commitment:** Although the ACO bonus/penalty structure is likely to lead to tighter referral networks, specialists can belong to multiple ACOs – requiring commitments of both time and money.

e. **Scope of public reporting:** ACOs must report at least name, location, contact, participating providers, participants in joint ventures between ACO professionals and hospitals, identification of representatives on governing body, associated committees and leadership, quality performance standard scores, shared savings information, total proportion of savings distributed to participants, and total used to support quality performance.

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## *The ACO/CMS Relationship*

### 14. How do ACOs share savings with CMS?

If the per capita costs for the population for which an ACO is responsible are reduced and the ACO meets quality performance standards, the savings are shared between CMS and the ACO.

### 15. Against what benchmark will CMS measure ACO savings?

Using data available for the most recent three year period, CMS will develop cost and quality benchmarks for each ACO. In order to receive its portion of shared savings, an ACO must show savings of more than 5% of its benchmark.

### 16. Do Medicare beneficiaries enroll in an ACO?

Beneficiaries do not enroll. They can become members of an ACO in one of two ways. First, a primary care physician can notify a beneficiary about that physician's own membership in an ACO. The beneficiary has a choice of continuing to receive care from the physician or of selecting a different physician who is not part of the ACO. Second, a beneficiary can become an ACO member if, at the end of a period, the individual receives the majority of his/her care from a physician member of an ACO. In this case, the beneficiary can retrospectively be assigned to an ACO. The key word is **can.** In either case, beneficiaries retain their ability to select their providers, and they continue to receive the full Medicare Part A and Part B benefits.

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## *Implementation & IT Challenges*

### 17. What challenges to implementation of ACOs exist at the federal level?

Making ACOs work at the federal level requires coordination among many agencies, including CMS and the Office of the Inspector General, the Internal Revenue Service, the Federal Trade Commission, and the Department of Justice.

### 18. What information technology (IT) challenges are associated with ACOs?

a. The Information Technology (IT) community has expressed concern about the required level of sophistication of systems needed to make the ACO concept work. Specific issues are the adequacy of metrics, interoperability, process automation, and wellness management.

b. Compliance with the Meaningful Use of Certified EHR Technology: By the ACO's second performance year, a minimum of 50% of each ACO's primary care physicians must comply.

c. Meeting specified health IT performance thresholds, such as the percentage of primary care physicians using clinical decision support.

d. Accessing data for three purposes: (1) analysis and reporting on trends in clinical and claims data; (2) supporting traditional clinical care and administrative recording processes; and (3) managing shared information across multiple providers.

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## *Quality Standards & Success*

### 19. How will ACOs demonstrate quality?

ACOs are expected to report on 65 measures in five categories: patient experience (7); care coordination and IT (16); patient safety (2); preventive health (9); and at-risk/frail elderly health (31). For most of these measures, ACOs are required to use the CMS specified data collection tool called the Group Practice Reporting Option (GPRO Tool).

### 20. Once an ACO receives certification from CMS, can it be terminated from the program?

Yes, termination is possible for ACOs that fail to deliver the minimum quality standards and/or that avoid at-risk beneficiaries.

### 21. What factors are most likely to contribute to the success of an ACO?

a. **Interpersonal relationships:** As always, the ability to succeed in new forms of organization that require new tools and skills are heavily dependent on good working relationships, inside and outside the practice setting. If you're not a team player, an ACO is not for you.

b. **Strong leadership:** Strong leadership by primary care, specialist physicians, and hospitals will be critical. Leaders need vision and the ability to make things happen.

c. **Administrative skill:** Complement strong provider leadership with experienced and competent administration.

d. **Provider willingness to take ownership of a defined population:** There's a big difference between treating patients sporadically when they make appointments and managing the care of patients for whom you are responsible.

e. **Shared governance:** Successful ACOs will share the governance among different parties, rather than concentrating it in the hands of the strongest partner.

f. **Recognition of the importance of primary care:** Primary care physicians are the key to making ACOs work. Existing organizations in North Carolina such as Cornerstone Health Care and Community Care of North Carolina are already well-positioned.

g. **Data:** IT must support the ACO goals and priorities.

h. **Best practices across the continuum of care**: ACOs must use evidence-based medicine to deliver high quality care.

i. **Engagement of the patients for which the ACO is responsible**: ACOs depend on provider-patient collaboration.

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## *Maintaining Awareness*

### 22. Given that the ACO Final Rule is likely to change many of the provisions of the Proposed Rule, what should we be doing in our own settings in anticipation of future changes and clarity?

a. **Large practices:** Determine how much integration with hospitals is suitable and how internal IT systems can become interoperable with a multitude of external platforms.

b. **Small practices:** If you don't provide care to 5,000 beneficiaries, investigate options for joining a network of small practices to meet the minimum beneficiary requirement. Develop creative and affordable ways to create a care team and supportive IT structures that support patient management.

c. **Hospitals and health systems:** Address penalties for readmission that may result in a 3% penalty on Medicare DRG payments. Focus on IT infrastructure that will allow information to flow securely and efficiently from hospitals to physicians.

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### 23. If I'd like to know more about ACOs, where can I get additional information?

a. **North Carolina Medical Society**: Access the handouts from the July 16, 2011 program on ACOs (**http://www.ncmedsoc.org/pages/advocacy_govt_affairs/accountable_care.html**)

b. **The Carolinas Center for Medical Excellence:** (**http://www.thecarolinascenter.org**)

c. **EHR vendors**: Many but not all of the vendors have prepared comprehensive information for their clients. See what your vendor offers.

d. **Medical Group Management Association** (MGMA): (**http://www.mgma.com**)

e. **Healthcare IT News**: The first in a three-part series called "The HIT of ACOs" by John Loonsk, MD is available online: (**http://www.healthcareitnews.com/news/hit-acos-need-part-i-analytic-data**)

f. **Smith Anderson**: The ACO Guide, 2011.

g. **Stay tuned to this newsletter for additional information once CMS issues the Final ACO Rule.**

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## How Satinsky Consulting, LLC Can Help Your Medical Practice

As you determine where your organization fits into the world of value based payment, let us help you with the following important tasks:

- **Practice Assessment:** Request an outside view of your organization and management structure; financial management (including managed care and revenue cycle management); planning and marketing; human resources; operations; and compliance.
- **Compliance with HIPAA Privacy and Security Rules:** Make sure you comply with HIPAA Privacy and Security Rules and with the 2009 updates. Our customized materials guide you through the requirements, provide policies and procedures, and help you train your staff. Penalties are stiffer, and they are enforced, so don't delay. (See our **Winter 2011 newsletter**.)
- **Revenue Cycle Management:** As methods of payment change, make sure you understand all the steps involved in maximizing revenue. We help with managed care contracting, work flow analysis, and efficiency in billing and collections.
- **Revenue Enhancement through Participation in Incentive Programs:** We can help you meet the requirements for Meaningful Use and understand the implications of ACOs for your practice. Get more details on the Meaningful Use incentive in three of our previous newsletters – **Summer 2010**, **Fall 2010**, and **Spring 2011**.
- **Software Companies:** More and more software companies are finding themselves needing to address HIPAA requirements. We now provide consulting services to help software companies understand the ins and outs of HIPAA Compliance.

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