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# Top risks and rewards of ACOs

November 25, 2017 | By Jeff Bendix

Medicare payment reform took effect this year, and one result is that doctors are showing greater interest in accountable care organizations (ACOs).

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Developed nearly a decade ago to help rein in the growth of Medicare spending and improve patient outcomes, ACOs now are gaining attention as a way for independent practices to lessen their reporting burden under Medicare's new payment system while possibly increasing their revenue.

The burgeoning interest in ACOs is evident in their growing numbers. In January, the Centers for Medicare & Medicaid Services (CMS) announced the formation of 99 new ACOs participating in the Medicare Shared Savings Program, the oldest and most popular category of ACO. (See sidebar, "Medicare ACOs: A taxonomy.") That brought the number to 480, which between them serve more than nine million Medicare beneficiaries—an increase of 1.3 million, or 19%, over the previous year.

At the same time, CMS said 28 new ACOs were joining the "Next Generation" model that CMS had created in 2016. That brought the number of Next Generation ACOs to 44.

Despite the advantages they can bring, however, membership in an ACO may not be right for every

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practice. Depending on the type of ACO, membership could carry financial risk. It may also mean practices must adopt new information technology, as well as giving up some autonomy.

Consequently, experts say, it's important for practices to perform extensive due diligence before joining an ACO—not just weighing the financial risks and benefits, but determining whether their culture and operations are likely to make it attractive to an ACO and be successful if they join.

To understand the appeal of ACOs to independent practices, it helps to remember that a major goal of the 2015 Medicare payment reform law was to move the program away from fee-for-service in favor of value-based reimbursement systems. To that end it created two reimbursement tracks, the Merit-based Incentive Payment System (MIPS) and the Alternative Payment Model (APM.) While both tracks tie reimbursement to meeting quality and cost metrics, collecting and reporting the necessary data is time-consuming and expensive for MIPS practices. But by joining an ACO, they can lessen the burden, or in some cases avoid it entirely.

"We're seeing a big ramp-up in [practice] consolidation, whether it's through an ACO or something else, because [MIPS] is a heavy financial and workflow lift, and to get the necessary support as an independent provider is pretty tough," says Steffany Whiting, MMCi, strategy and marketing officer with CHESS, a firm that provides management services to ACOs and other value-based healthcare organizations.

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(ACOs offered by commercial payers aren't included in this article since participation in them doesn't reduce a practice's Medicare reporting requirements if the practice also treats Medicare patients.)

Lessening the reporting burden was a significant motivating factor for Jeff Kagan, MD, an internist practicing in Newington, Connecticut and *Medical Economics* Editorial Advisory Board member, to join an ACO. "I'm in a two-provider practice so we can't do a lot of this stuff on our own," he says.

## Joining an ACO—and leaving

Practices joining ACOs sign contracts that spell out how any savings or cost overruns are apportioned among ACO member practices, as well as requirements in areas such as performance metrics, data reporting and use of health information technology. Contracts generally run for three years, and practices that have not met expectations or are not a good fit in other ways usually find their contracts aren't renewed.

"Not every practice is a good fit for every ACO," notes Susan Feldman, Ph.D., RN, associate professor and director of graduate programs in health informatics in the school of health professions at the University of Alabama at Birmingham. "If a practice isn't recording the right data, or not reporting it, or being defiant in some other way they can be kicked out. So it's very important for a practice to read the contract carefully before joining."

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## Commitment to the ACO concept

Physicians and administrators with experience in ACOs say the most important qualification they look for in a primary care practice is a focus on preventive care. "Traditional practices are built around the concept of reactive healthcare, whereas the future lies in getting ahead of the game and preventing problems from occurring," says Lloyd Van Winkle, MD, chief executive officer of United Physicians of San Antonio, a Medicare ACO. "So if you've embraced the concept of preventive care then you're probably going to do well in an ACO setting."

## ACO types compared

| ISSUE | Program start year | Advanced APM?* | Overview |
|---|---|---|---|
| TRACK 1 | 2012 | No | MSSP ACO Tracks 1 and 2 were included in the original Medicare Shared Savings Program (MSSP). The program stems from the Affordable Care Act and is designed to enhance care coordination and cooperation among healthcare providers with the overall goals of improved quality and patient outcomes as well as lower costs. |
| TRACK 1+ | 2018 | Yes | Track 1+ represents a new option for ACOs that will be available in 2018. This model includes elements of other tracks and represents a new two-sided risk model with less risk than Track 2, 3 or the Next Gen ACO model. Track 1+ is available for new ACOs and those in Track 1. ACOs in Track 1+ will concurrently participate in Track 1. |
| TRACK 2 | 2012 | Yes | Same as Track 1 |
| TRACK 3 | 2016 | Yes | Track 3 was added to the MSSP beginning in 2016. This model takes successful aspects of the MSSP and Pioneer model to create a new MSSP Track with higher shared savings opportunities and greater risks. |
| Next generation ACO model | 2016 | Yes | Similar to the Pioneer Model but with higher potential rewards and risk than the MSSP Tracks. Next Gen aims to transition providers from fee-for-service to capitation. Next Gen ACOs must also move to operating under outcomes-based contracts with other purchasers. |

*Under Medicare payment reform, all ACOs are considered to be alternative payment model (APMs). ACOs that include downside financial risk for their members are designated as advanced alternative payment models, in which member practices are exempt from some or all quality reporting requirements.
In addition, some practices in advanced APMs may qualify for a financial bonus equal to 5% of its Medicare Part B billings for the subsequent year.

Source: National Association of Accountable Care Organizations

Van Winkle says United Physicians vets practices looking to join it by analyzing the current procedural terminology codes its providers bill most frequently, as well as hospitalization rates involving exacerbations of existing conditions among its patients. By so doing, “you see trends over time that allow you to evaluate whether the practice is really keeping up with the medical needs of their patient population,” he explains.

He adds that a commitment to the goals of ACOs—improving care and lowering costs—requires “getting doctors to understand they can’t keep doing what they’ve always done.” Specifically, he says, United Physicians looks for providers’ willingness to use evidence-based medicine rather than relying on traditional methods of treatment. “Change is not always comfortable, but it’s absolutely essential to improving the quality of care,” he says.

## Physician engagement

Openness to change requires an ongoing sense of physician engagement, Van Winkle says, particularly when it comes to persuading patients to make the lifestyle changes that will improve their health and lower costs. He cites an example from his own practice, in which he persuaded a reluctant patient to get a pneumococcal vaccine by showing him the mortality data for adults who don’t get vaccinated—a conversation that took only a few minutes. “It has to be on your mind, the way you’re thinking about healthcare, for that to happen,” he says.

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Whiting adds that the need for strong, practice-wide commitment is especially important in the first year or so after joining an ACO, because practices often see their costs go up and revenue decrease with the increased emphasis on preventive care, she says. And while that situation generally turns around, “it needs to be part of the internal agreement that we’re in this for the long haul, we may see some financial gains but mainly we’re doing this

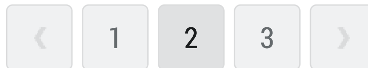
because it's the right thing for our patients," she says.

At Summit, New Jersey-based Optimus Healthcare Partners, "physician engagement" is defined as a commitment to the "Triple Aim" of improving population health, reducing costs and improving the patient experience.

"If they seem to get that message and want to work with us, they're welcome," says John Vigorita, MD, MHA, Optimus president and chief executive officer. Optimus looks for evidence of that commitment by scrutinizing a practice's Medicare claims and its hospitalization and emergency department admissions data.

Kagan notes that his ACO, which is run by the Hartford HealthCare hospital system, focuses particularly on reducing hospital readmissions. The ACO notifies him when one of his patients is discharged from a hospital or nursing home, and ACO case managers follow up to ensure the patient makes an appointment within a week of discharge. Doing so not only reduces the likelihood of readmission, he says, but enables his practice to capture additional revenue under Medicare's transitional care management codes.

Next: The role of information technology

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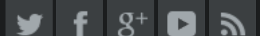

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## The role of information technology

Another attribute ACOs look for in practices is its use of health information technology, says Allison Brennan, vice president of policy for the National Association of Accountable Care Organizations. “ACOs tend to put a lot of emphasis on technology such as electronic health records [EHRs] and health analytics to understand their patient utilization patterns and where there are opportunities to improve care and care coordination,” she says.

Data gleaned from an EHR makes it easier for an ACO to evaluate practices wishing to join the ACO, Van Winkle says. In United Physicians’ case, “we like to run their [quality and cost] data against their existing payer contracts to see where they are in terms of performance,” he says. In fact, he adds, United Physicians won’t even allow a practice to join if it doesn’t use an EHR. “We just can’t afford managing a practice that’s on paper charts,” he says.

Van Winkle experienced first-hand the importance of data analytics a few years ago when his practice analyzed its claims data for patients receiving mammograms. At the time, he recalls, he’d assumed nearly all appropriate patients were getting them. But when he actually looked at the data he found that only 79% were. “Your perception of your practice may not match reality when you run the numbers,” he says.

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## Vetting an ACO

Just as ACOs look for certain qualities in practices seeking to join them, experts advise practices to look carefully at an ACO they might wish to join, starting with its quality and cost controls, says Feldman. Many costs, she says, are tied to the health and behavior of patients assigned to the ACO.

"Maybe your patients are all healthy and compliant and don't have many chronic conditions, but someone else in the ACO has a lot of patients who are non-compliant with treatment plans. Those are all part of the clinical quality measures ACOs can get dinged for. So a practice will want to ask, 'How will others in the ACO impact the quality and cost of my care?'" Feldman explains.

**Traditional practices are built around the concept of reactive healthcare, whereas the future lies in getting ahead of the game and preventing problems from occurring. So if you've embraced the concept of preventive care then you're probably going to do well in an ACO setting."**

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Similarly, it's important to know the level and type of personnel resources, including case managers, non-physician providers and psychologists, ACOs offer to help member practices meet their cost and quality benchmarks. The availability of psychologists is particularly important, Feldman notes, because patients with mental health issues often have other, chronic conditions and behaviors that

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Procedures and tests performed or ordered by specialists can also drive up costs if not carefully monitored, says Whiting, so it's a good idea to be part of an ACO that includes numerous specialties.

"The last thing an ACO wants is to have their patients go somewhere that is not operating in a value-based model, because all those costs are going to be attributed back to the primary care practice," she says. "So it's important to make sure that patients are not only getting quality care at the right time but that it's not unnecessarily expensive."

## To join or not to join?

Ultimately, of course, the decision of whether to become part of an ACO will depend on myriad factors, both financial and non-financial. "Some practices will say it's too much paperwork, too much reporting, we're already low in terms of our costs so it's just not worth it for us," says Feldman.

On the other hand, some practices value the cultural shift they experience as part of an ACO, even if they don't come out ahead financially, "What I hear a lot from docs who've made the switch is that this is why they started practicing medicine in the first place," Whiting says. "It's not about raking in the money, but aligning incentives in a way that places more value on quality and outcomes."