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Medicare Shared Savings: A PRACTICAL Path to Accountable Care

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Ambulatory practices are concerned.

They know that healthcare cost increases are unsustainable and reimbursement is changing. Evidence is building that their long-term viability may depend in part on their ability to improve outcomes and keep healthcare costs in check. Literally and figuratively, practices need to deliver.

Many practice leaders plan to implement process improvements and empowering technology to provide comprehensive, coordinated care to patients. They anticipate that the collective responsibility among caregivers, closer partnerships between physicians and their patients, and smarter use of information will enhance outcomes and reduce system-wide costs — in other words, improve the value of care delivered.

These progressive practices also have an opportunity to strengthen a culture of care collaboration and quality improvements while sharing in the financial benefits of their cost-saving efforts by joining or forming Accountable Care Organizations (ACOs). But should they? And if so, how?

This document delves into the "what" and "why" of ACOs. It outlines the drivers behind the model, highlights the Medicare Shared Savings Program option, recognizes potential pitfalls and presents key considerations for ambulatory practices facing these difficult questions.

ACCOUNTABLE CARE: ACOS AND THE DRIVERS BEHIND THE MODEL

Critics of the conventional method of paying healthcare providers — fee for each service — say that this payment approach causes wasteful spending and does not encourage care coordination. They argue that it rewards providers simply for doing more procedures, rather than for maximizing efficiency and quality of care.

As patients move across health settings and among providers, including ambulatory practices, communication breakdowns and incomplete transitions of care can occur. Different organizational forms, payment methods and quality assessment systems work to reinforce a system known for being disjointed and poorly coordinated.[1]

BACKGROUND

In an effort to overhaul healthcare delivery to enhance value to patients, employers, and taxpayers, various combinations of public and private payers and organized groups or networks of providers have been operating for decades. In 2000, Congress passed a law directing the Centers for Medicare & Medicaid Services (CMS) to test a model whereby participating physician groups (PGPs) were eligible to keep a portion of the savings they generated for Medicare, relative to a projected spending target, and could increase their share of savings depending on how well they improved performance on a set of quality measures.[2]

The "PGP pilot," as it was known, was one of several precursors to the ACO model, all of which subscribed to the notion that effective coordination and delivery of patient care (and thus cost savings) is difficult to achieve without integration among providers delivering the care.

Dartmouth researcher Elliott Fisher stimulated broad policy interest in the ACO approach by introducing the concept of an "extended hospital medical staff" at a 2006 meeting of the Medicare Payment Advisory Commission (MedPAC).[3] The passage of the Patient Protection and Affordable Care Act of 2010 refined the ACO concept, and CMS issued its final regulations for the program on October 20, 2011.[4]

ACOS: WHAT THEY ARE, WHY THEY MATTER

An ACO is a healthcare organization characterized by a payment and care delivery model that seeks to tie provider payments to quality metrics and reductions in the growth of the total cost of care for an assigned population of patients. A group of coordinated healthcare providers (which can include primary care doctors, specialists, hospitals, labs and other healthcare service providers) forms an ACO, and the group provides coordinated healthcare under one umbrella. It is jointly accountable to patients and the third-party payer for the quality, appropriateness and efficiency of the healthcare provided.

In addition to comparisons to spending benchmarks, doctors and hospitals have to meet specific quality benchmarks, focusing on prevention and carefully managing patients with chronic diseases.

The first letter of the ACO acronym has significant meaning — the entity is accountable for outcomes, costs and risk. Accountability encourages all involved to organize and align healthcare services to deliver seamless, coordinated care whether the ACO is contained within a single corporate structure or is an organized network of independent but associated healthcare professionals.

In exchange for investing in this reformed structure, ACO members can share in savings that result from their cooperation and coordination.

Although ACOs are designed to be flexible, they incorporate three core principles[5]:

» They are provider-led organizations with a strong base of primary care that are collectively accountable for quality and total per-capita costs across the full continuum of care for a population of patients.

» Their payments are linked to patient satisfaction and quality improvements that also reduce or control overall costs.

» Reliable and progressively more sophisticated performance measurement supports improvement and provides confidence that savings are achieved.

ACOs are not just for hospitals. As of May 2012, 221 ACOs existed in 45 states, according to a study by Leavitt Partners.[6] Of these, 118 were primarily sponsored by hospital systems, 70 by physician organizations,

29 by insurance companies, and four by community-based organizations. In fact, within the Medicare Shared Savings Program, about half of the organizations had no named hospital partner.

MAIN EXTERNAL DRIVERS SUPPORTING ACO ADOPTION

Participation in ACO programs is growing rapidly. In January 2013, Medicare announced the formation of 106 new Shared Savings Program ACOs.[7] Several factors are driving public and private sector payer support for the ACO model:

» **The need to increase the appropriateness and efficiency of care.** By increasing care coordination, ACOs can help reduce unnecessary medical care and improve health outcomes, leading to a decrease in utilization of acute care services. Medicare ACOs place a degree of financial responsibility on providers in hopes of improving care management and limiting unnecessary expenditures while continuing to provide patients freedom to select their medical service.[8] Recent estimates from CMS indicate that Medicare Shared Savings ACO implementation will save the federal government up to $940 million over four years.[7]

» **The importance of integrated systems offering coordinated, connected care.** Failure to coordinate care can often lead to patients not getting the care they need, receiving duplicative care, and being at an increased risk of suffering medical errors. Improving coordination and communication among physicians and other providers and suppliers through ACOs can help improve the care beneficiaries receive. Also, patient engagement in decision-making and feedback is central to effective integrated systems.

» **The desire to align payment incentives with outcomes.** The underlying goal of ACO efforts is to improve the quality and lower the cost of care. Doing so effectively requires aligning goals with incentives by fostering greater accountability on the part of providers for their performance. For example, if an ACO reduces hospital admissions and emergency room visits, its members, not just payers, are rewarded.

EXPECTED BENEFITS TO MEDICAL PRACTICES

Although the benefits to the healthcare system are clear, many ambulatory care leaders wonder if ACO participation would be advantageous for their organization. Practices can consider these potential benefits from such participation:

» **Improved outcomes and healthier patients.** The quality focus of many ACOs can foster coordinated, data-driven care and continuous improvement. An emphasis on shared decision-making could encourage patients to be more engaged in issues that affect their health, to more often communicate important information to their physician, and to better adhere to care plans. Together, these shifts can lead to a more efficient and effective delivery system that may improve outcomes and enhance the reputation of the practice.

CMS ACO Payment Models

CMS runs these ACO programs:

SHARED SAVINGS PROGRAM

The Shared Savings Program facilitates coordination and cooperation among providers to improve the quality of care for Medicare fee-for-service beneficiaries and reduce unnecessary costs. Savings/loss determinations are based upon the difference between FFS expenditures (Parts A and B) for the defined population for the year and a risk-adjusted benchmark that is an estimate of the Part A and B Medicare expenditures that would have occurred in the defined population in the absence of the ACO. The expenditure benchmark is based on the previous three-year expenditures history (Medicare Parts A and B) of prospectively assigned beneficiaries to the ACO.
ACOs can choose one of two shared savings risk models (tracks):

ONE-SIDED RISK: The ACO would operate under a shared savings only model (no loss potential) for the three years of the initial contract provided that a minimum shared savings rate threshold of 2% is reached. This would be more suitable for smaller ACO's and those with minimal experience with this type of accountable care activity. These groups would be limited to a maximum of 50% of obtained savings each year. This one-sided risk option is only available during the first three-year contract.

TWO-SIDED RISK: Participants would be at risk of a portion of loses for each year of the 3-year period. These groups could earn up to a maximum of 60% of obtained savings. Losses must be over 2% of benchmark to be considered. Once above this minimum, these ACO's would be responsible for paying losses on a "first dollar" basis calculated by multiplying the loss amount (excess above benchmark) by 1 minus their final sharing rate (maximum shared rate (60%) adjusted by quality score). Maximum loss sharing limits are 5%, 7.5% and 10% of the benchmark over the first three years of the contract. ACOs under this track must provide a loss repayment mechanism in

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» **Patient retention, loyalty and growth.** ACOs that measure patient experience provide a common scorecard that practice leaders can share with providers, patients, and payers. Medical practices and ambulatory care centers can win patient loyalty and become a provider of choice. As people engage in provider-shopping, provider scorecard initiatives are proliferating to assist purchasers in their buying decisions. Recently, 28 large U.S. employers adopted the "Care Focused Purchasing" approach that takes into account not only claims data but outcomes, patient satisfaction, and efficiency in an effort to let employers and employees make more informed healthcare choices. Providing a quality patient experience is a powerful growth strategy.

» **Revenue gains.** Under some programs, ACO members can offset payment reduction trends and enhance revenue through "gain sharing" (sharing of savings resulting from collaborative efforts to provide care cost-effectively) with ACO-involved payers if the overall costs of care for the beneficiaries attributed to it are lower than predicted and quality and other performance thresholds are met. In the longer term, ACO models that involve greater financial risks for the providers, such as through capitation, also provide greater opportunities to capture the savings associated with more effective care, again offsetting negative payment trends.

MEDICARE SHARED SAVINGS PROGRAM: LOW-RISK ENTRY

Some ambulatory practices stand to gain significantly from becoming an ACO, but the endeavor is not without risk. Indeed, the most successful practices in the world of accountable care will become adept at managing risk. For those contemplating adopting the ACO model for the first time, it is important to note that not all programs are identical, and practices should explore their questions about which type to pursue and the potential drawbacks.

Private health insurers have entered into ACO contracts with provider groups, and those private contracts give patients added incentives to seek care within their plan's provider network, such as by offering reduced premiums for individuals who receive care from providers taking part in such arrangements.[9]

This document focuses on CMS' ACO programs, and one in particular — its Shared Savings Program — that makes providers eligible for bonuses, but does not put them at as much financial risk if they exceed spending targets.[10]

LIMITED DOWNSIDE RISK WITH MEDICARE SHARED SAVINGS PROGRAM

CMS offers organizations three ACO platforms — the Pioneer Model, the Medicare Shared Savings Program, and the Advance Payment Model. (See "ACO Payment Models" on this page.) The Pioneer Model is tailored to practices with substantial experience in coordinated care and risk management.

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its application that ensures repayment of potential losses to at least 1% of assigned beneficiaries Part A and B expenditures.[11]

ADVANCED PAYMENT MODEL

Some providers have expressed a concern about their lack of ready access to the capital needed to invest in infrastructure and staff for care coordination. The Advance Payment Model is designed for providers who have come together voluntarily to give coordinated high quality care to the Medicare patients they serve. Selected participants receive upfront and monthly payments, which they can use to make investments in their care coordination infrastructure.[12]

The Advance Payment ACO Model targets two types of organizations participating in the Shared Savings Program: (1) ACOs that do not include any inpatient facilities and have less than $50 million in total annual revenue, and (2) ACOs in which the only inpatient facilities are critical access hospitals and/or Medicare low-volume rural hospitals and have less than $80 million in total annual revenue. The application scoring criteria favor ACOs with the least access to capital, ACOs that serve rural populations, and ACOs that serve a significant number of Medicaid beneficiaries.

PIONEER MODEL

A more advanced ACO, the Pioneer Model is designed for healthcare organizations and providers that are already experienced in coordinating care for patients across care settings. It enables ACOs to earn higher shared savings bonus payments than under the Shared Savings Program, but also puts them at risk of paying back higher amounts to CMS if they increase spending above projections.[13]

Most ambulatory practices venturing into the world of value-based payments for the first time would likely be most comfortable in an ACO that adopts what's called the "one-sided" payment model of the Medicare Shared Savings Program. Under the model, providers are still compensated on a fee-for-service basis. However, members also have the opportunity to share in the reward of cost savings and are not required to assume financial risk of cost-of–care increases throughout a three-year contract period. Like a runway, the program lowers the risk of experimentation so organizations can more quickly learn how to operate within the world of value-based payments. For subsequent contract periods, participants must elect the two-sided risk model. In both versions of program, the bonus structure offsets fee-for-service incentives to increase volume, and rewards organizations for preventive care and disease management.

CMS' Advanced Payment Model is a variant of the Shared Savings model, suited for smaller ambulatory practices. Selected participants receive upfront and monthly payments, which they can use to make investments in their care coordination infrastructure. Organizations selected to participate in this ACO program receive three types of upfront payments designed to help them cover fixed and variable startup costs.

HOW TO SUCCEED: THE POWER OF DATA AND PATIENT-CENTERED CARE

For those who choose to pursue the Medicare Shared Savings Program, the basic recipe for success is clear: Keep quality high, save money by improving (rather than by restricting) care, and remain attractive to beneficiaries, who can go anywhere for care, especially under the Medicare models.

Quality measurement is key. The Medicare Shared Savings ACO rules link the amount of shared savings an ACO in the Shared Savings Program may receive to its performance on 33 quality measures in five key areas that affect patient care: (1) patient/caregiver experience of care, (2) care coordination, (3) patient safety, (4) preventive health and (5) at-risk population/frail elderly health. ACOs that do not perform at the 30th percentile on at least 70% of the measures aren't eligible to share in any savings they generate and have one year to improve performance before being terminated from the program. ACO members are eligible for higher shares of savings if they perform at higher percentiles on these measures.

To be successful, therefore, ACOs should adopt processes that leverage data to elevate the standard of care within their practice and reduce the cost of care so they continue to deliver more value to beneficiaries. To that end, practices need to embrace electronic medical records (EMRs) and expand the role of quality measurement and other forms of analytics. In healthcare, information is power, and ACOs underscore the value of investing in IT infrastructure.

At the same time, it is important for a practice to put the patient at the center of care and embrace a culture of continuous improvement. A prime example of a model that optimizes care and reduces health expenses is a well-run Patient Centered Medical Home (PCMH). In a

Share of Savings Linked to Quality Metrics

PATIENT & CAREGIVER EXPERIENCE

Timely access to care, effective clinical communication, and shared decision-making are important elements of success. Systems and processes that make it more convenient for patients to communicate with their providers, increase patient access to care, and promote patient engagement in their own health will support the ACO's objectives.

CARE COORDINATION / PATIENT SAFETY

Minimizing hospital readmission, the incidence of in-patient treatments for conditions suitable for the ambulatory setting, and frequency of other patient safety matters are among the metrics tracked for the Medicare Shared Savings Program. Successful ACOs employ technology and processes to execute seamless transitions of care and minimize medical errors.

PREVENTIVE CARE & SCREENING

From immunizations to vaccinations to cancer screenings, the Medicare Shared Savings program emphasizes the importance of preventing health problems. Successful ACOs will have the processes and technology in place to accurately track which patients need preventive services and encourage patient action.

AT-RISK POPULATIONS

For patient populations with certain known risk factors, the Medicare Shared Savings program expects practices to track intermediate physiological and biochemical measures associated with negative outcomes and encourage the patient to make appropriate lifestyle changes.

PCMH model, providers coordinate care throughout the health system to ensure optimal benefit for patients, providers and payers. Mounting evidence suggests that PCMH models offer great hope for primary care physicians and patients. Under the model, physicians and other caregivers — collectively members of a healthcare team — are financially rewarded for improving outcomes and reducing costs through well-orchestrated care coordination.

The PCMH approach is likely to be at the core of a successful ACO, especially one that is primarily organized around physician practices. Early adopters of the PCMH approach have demonstrated improved quality and lower costs by promoting prevention, coordinating physician services, and reducing unnecessary hospitalizations.

Operational excellence supported by robust and effective health information systems can help an organization perform well against the Medicare Shared Savings Program measures and ultimately succeed as an ACO.

It should be noted, though, that even in the one-sided risk track of the Shared Savings Program, an organization could fail to earn a return on its investment or go several years before breaking even. Success requires a significant investment in process changes and health information technology.

PRACTICAL PATH TO GET STARTED: 4 KEY CONSIDERATIONS

Ambulatory practices and larger physician groups preparing for the changing landscape are asking, "What does the shift toward accountable care mean for our practice?" They wonder how to translate these concepts into actionable steps. Many of these organizations simply need a starting point — practical insight that can serve as a beacon and help them navigate a clearer direction for moving forward.

Here are four considerations all progressive ambulatory practices should take into account, especially if they pursue participation in the Medicare Shared Savings Program or another ACO:

1. The Platform: Sophisticated HIT with an Integrated EMR/PM System at the Core

Electronic health records (EHRs) and practice management (PM) tools are both integral to success as an ACO. Ideally, they should also be integrated — combined in a single system that enhances productivity and improves clinical quality.

Ambulatory practices should seek meaningful use-certified technology that includes powerful clinical data reporting capabilities, collaboration tools, flexible workflows and interoperability. From the same technology, those practices should also receive a financial toolkit that empowers them to realize the "why" behind the "what."

Practices without EHRs or with outdated EHR or PM technology should pay attention to the functionality needed to support ACO practices now, select products that are certified for meaningful use, and also have components that will prepare them for healthcare reform. Key features to compete in the healthcare reform environment include flexible functionality that can be configured to support practice workflows, highly usable clinical documentation

tools that preserve productivity, strong decision support capabilities, patient engagement tools, interoperability and health information exchange capabilities, and clinical and financial analytics.

Ambulatory practices should select technology that provides these benefits:

» Ability to measure quality and continuously improve

» Ability to deliver proactive, team-based care

» Ability to increase patient/family access and engagement

» Ability to identify ways to improve financial performance

» Streamlined access to information

» Ability to connect with other providers and organizations in an ACO, a community and beyond, using standards-based approaches to health information exchange and interoperability.

2. The Provider: Meaningful User of Technology

Before clinicians and their organizations form or join an ACO, they must identify and develop the skills needed for success in an accountable care environment. One key step is attesting to meaningful use of certified EHR technology, which focuses on both the acquisition and effective use of the core technologies needed to manage individual patients and populations in an accountable manner. For example, one central goal of the first stage of the federal meaningful use program is entering information as structured data that can be searched and reported and used for such tools as clinical decision support, quality measurement, and health information exchange.

However, attesting to meaningful use for the sake of attestation alone is insufficient. It's not enough for today's ambulatory care practice to simply collect data. Those practices must connect with the data — to harness it, and turn information into action. Without analysis, numbers are just integers instead of ideas.

Although many organizations have mastered measurement of some core operational processes such as revenue management and productivity, most haven't evolved their systems of measurement to include a closer scrutiny of experience and health outcomes, access to care and cost across the "continuum of care."

As ambulatory practices strive to establish successful accountable care initiatives, they'll need to develop more transparent procedures and practices as they analyze business and clinical data. Data analytics will be a foundation upon which successful ACOs will depend.

3. The Practice: Operational Excellence in Data-Driven, Coordinated Care

In accountable care, there's no such thing as a meaningless decision. Even seemingly minor choices should matter to an ACO responsible for maximizing quality while limiting expenses. Practices should use technology to understand what the next care invention should be, and understand the organization's performance across the components of health, experience and cost.

Practices should be able to collaborate and exchange clinical information in real time within and across specific care settings, and their EHR and other HIT products and services should also enable them to

manage and coordinate care for populations of their patients, such as those with specific chronic illnesses.

Success often requires transformation — a shift in mindset and organizational strategy that embraces continuous improvement. New delivery models such as the National Committee for Quality Assurance's (NCQA) Patient-Centered Medical Home[14] describe concrete steps that organizations can employ to help them elevate the standard of care. Making wise use of technology enables practices to achieve the level of operational excellence required by ACOs.

Achieving operational excellence in data-driven care involves the following hallmarks:

- Management of episodes of care, not just single events
- A team approach to care management
- Effective use of health information exchange and interoperability standards, tools, technologies, and services
- Management of cost, performance and outcomes across multiple care settings
- Coordination of care across those same settings
- Population-based preventive and acute care
- Strong patient involvement in disease and wellness management
- Continuous improvement to elevate the standard of care and performance relative to specific quality measures

4. The Partnership: Communication and Trust

As health networks have expanded, so have the challenges associated with managing a diverse collection of physicians and other clinicians and provider organizations, each with differing loyalties, referral patterns and behaviors.

When navigating the twists and turns of ACOs, selecting the right team and partners will play an important role. ACOs composed of separately recognized legal entities must establish a new legal entity that is composed of the combined participants. It's wise to align with other healthcare leaders who can exchange ideas and communicate openly about governance, goals, commitments, roles and problems. Such collaboration is the only way to establish clear rules on sharing savings across providers with different performance levels.

Successful ACO partnerships require a shared strategic vision that identifies longer-term goals of the ACO within the context of community health needs, provider capabilities, and state and federal health policy.

In addition, the right technology partner — one that understands the complexities of the changing healthcare landscape and that is responsive, flexible and takes time to understand needs before suggesting solutions — will prove to be a valuable asset.

LOOKING AHEAD

Many healthcare providers, policymakers, and analysts have criticized the incentives inherent in the current fee-for-service payment approach, which rewards providers financially for

prescribing additional services that drive up healthcare costs for patients. For many, the goal of new health policy-making has been to find a model that aligns healthcare providers' and patients' interests.

As healthcare delivery models change, ambulatory practices should constantly analyze ways to focus their approaches to care delivery around the needs of their patients, and evaluate and implement ways to deliver more effective patient care. Practices, often operating in partnership with other healthcare organizations, that can deliver high-quality and efficient care are well-positioned to become involved in the accountable care movement.

Because much remains uncertain — from interpretation of ACO regulations, to the response of employers and consumers to new health plan options, to the growth of ACOs in specific markets — the options can seem daunting. Ambulatory practices should analyze their present situation to determine whether it makes sense for them to make a change. Organizations with access to capital will have an easier time financing the initial investment in processes, technology, and people required to succeed as an ACO. If they conclude that moving to an integrated delivery system makes sense, they should carefully evaluate the likelihood of a particular system to be successful.

Regardless of the specific "ACO or not" choice, it is likely that all ambulatory practices will need to push for more HIT-enabled communication, care coordination and quality measurement reporting, drawing on the concepts of accountability and the patient-centered medical home, as they aim for improved quality and lower costs.

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