Navigating the ACO Labyrinth to Success: How to Find Your Way to Quality and Shared Savings

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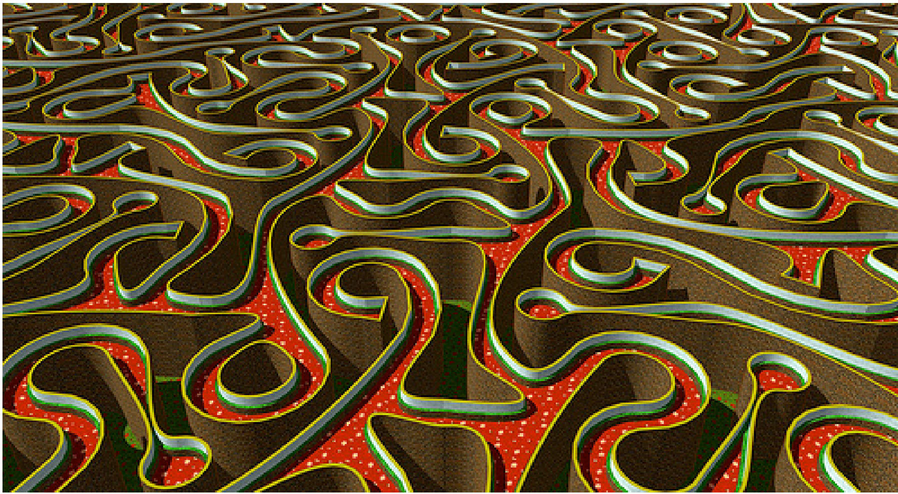

Last year, less than one quarter of Medicare MSSP ACOs achieved success in generating shared savings. Not a good report card, given that Accountable Care Organizations form for the explicit purpose of delivering high quality, coordinated care, with shared savings as in incentive to avoid duplication of services.

But ACOs are complex endeavors, both administratively and clinically. Better coordination of patient care does not guarantee success. Your efforts must be complemented by a solid understanding of Medicare's basic rules for quality reporting and methods of attributing patients to the ACO, so that you can keep your patients within the network.

In fact, much of your ACO success will depend on how well you manage under Medicare's rules for evaluating quality and cost. Will your ACO be one of the ACOs that achieve shared savings this year? And what impact will the success or failure of the ACO have on your practice, if you don't meet both the CMS quality or cost requirements?

Two Tests for ACO Success

When grading ACOs, Medicare has two important tests. First, ACOs must successfully report quality in the first year and meet performance in the second. The third year is based entirely on performance. But reporting is not as easy as it looks, because Medicare requires sequential reporting of 411 patients from a sample of 616 per module, and all quality measures must be completed.

Even if your ACO has integrated data collection to include EMR data and CMS claims, there will be gaps in measures for individual patients that require you to check the patient record in order to complete the measure. Failure to do so will result either in reporting holes, which could break the sequence of patient reporting in the sample, or failure to meet CMS's benchmark reporting rate. There can also be a measure performance failure in those same patients that will cause the ACO to flunk the quality test. That failure will negate any savings distribution to the ACO. It will also cause penalties for providers participating in the ACO, explained below.

Second, CMS calculates the amount of savings an ACO achieved as compared to its historical costs. ACOs hope to achieve these savings from a variety of proactive processes: coordinated treatment to prevent an admission, early identification of disease and early treatment, and avoiding repeat tests through shared access to medical records and test results. These are likely to produce short-term savings and are difficult to achieve. But in the long run, providers will need to improve outcomes for patients in order to continue achieving savings and providing quality care. Population health technology and processes are essential for identifying patients by group to make it easier to implement processes that will provide better coordinated care, and for testing interventions to improve outcomes.

Since the patient is free to choose care from outside your ACO network of providers, your organization needs to gain the loyalty and exclusivity of your patients to achieve the care coordination you require to realize savings. Key to that result: understand how Medicare assigned those patients to your ACO in the first place. Especially if your ACO includes specialists in addition to primary care physicians, you need to increase the likelihood that patients will choose your network for all their services through patient and clinical outreach efforts.

Challenges for ACO-Participating Practices

Success factors for your practice are more complicated. Reporting itself carries a risk for penalties, and participating in an ACO carries a greater risk for providers now than in previous years. This is partly due to the quality reporting hierarchy that CMS has defined. If a provider (designated by a combination of Tax Identification Number and individual National Provider Index Number) is an ACO participant, that provider may not participate separately in PQRS.

However, some practices—especially specialists—participate both in an ACO for some providers (for services billed under an ACO Participant Tax Identification Number) as well as in their private practice (for services by other providers in the practice under their practice TIN, not assigned to the ACO). These practices and providers will be on the hook for PQRS penalties even if the ACO successfully reports. Your ACO's structure determines this. Failing to recognize this distinction can have big consequences: penalties for PQRS and for the Value-Based

Payment Modifier (VBPM).

Even providers who are full ACO participants are at risk. In previous years, joining an ACO was a safe stand-in for PQRS. That is no longer true. Should the ACO fail to report successfully in 2015, all providers within the ACO will incur both the 2 percent non-reporting penalty for PQRS and the 4 percent VBPM penalty in 2017—a 6 percent total penalty.

To make matters more complicated, even if your ACO reports successfully, your providers are still individually at risk, under the VBPM. The quality composites for their own Value-Based Payment Modifiers will be taken from the ACO's quality reporting. So, your ACO may meet the reporting milestone, but Medicare is applying that information outside of the ACO for VBPM, just as they are for a provider's PQRS measures.

How to Create Success for Both the ACO and Its ACO Providers

If you're already in an ACO, you may be wondering how to navigate your practice to success. As a practice, you should ensure that you have the information you need to manage patients that are attributed to you, as well as an easy way of meeting the quality reporting requirements. That means working with your ACO to make positive results. Here are some basic actions you and your ACO can take:

- Understand your ACO's participation agreements with physicians, and how your practice is participating. This will help you determine your level of risk and how to work with the ACO to make your reporting work beneficially for the ACO and for your practice.
- Get access to ACO Population Health technology to manage your patient population and to view patients with ACO measure gaps or performance problems. If you can't review your patient outcomes or receive only benchmarking reports through analytic reports, it will be very hard to improve outcomes. You need to be able to evaluate what is happening with your patients and participate in a process of change. If your ACO doesn't have this technology, push for it.
- Download and review your VBPM quality tiering reports from CMS. You need to be aware of your standing against other practices in quality and cost tiering, so that you can see where your efforts will be most effective.
- Establish your method of reporting PQRS so that you will not face a total PQRS and VBPM penalty of 6 percent, unless your practice is exempted from reporting PQRS entirely because you are not billing Medicare under your practice TIN.
- Ensure that your ACO has the right infrastructure and tools for making it a success, because your practice revenues depend on it. This normally means having a good ACO technology partner to manage the reporting and population health needs.

Getting the Right ACO Infrastructure

The underlying factor within every aspect of the ACO reporting process is a steady flow of information to and from your practice, your ACO, and to CMS. Whether the task is administrative (e.g. contacting patients to obtain data sharing permission) or clinical (recording lab values for a patient in the ACO), you will need the technical infrastructure to support this exchange, or a partner who does. Because this is highly specialized work, most ACOs go the partner route.

The right ACO infrastructure partner can help you meet your goals through technology and services to handle ACO reporting, administration, analytics and population health. You may decide to pick more than one partner because these services are not always well integrated in the current market; what works at a general ACO administrative or analytics level often fails to engage providers in change. Population health products require more clinical and research sophistication.

Here are some critical features your infrastructure should have:

- Delineate patients and sub-populations in the ACO and how they are attributed to each provider;
- Track required patient outreach and patient feedback regarding willingness to share their CMS data with your ACO;
- Enable providers to access the technology, to interact with their patients' data and to add new clinical or outcome data;
- Track ACO Measures to highlight areas where required clinical data is missing for reporting, or where performance does not meet the CMS standard;
- Aggregate analytics on patient costs and quality by core conditions and procedures, as well as analytics based on CMS claims for participants that show services being used (and by whom);
- Trend patient results over time to view how patient outcomes are improving or flat-lining;
- Include functionality to test interventions that improve outcomes for sub-populations.

Improving outcomes is a marathon, not a sprint. Without the ability to actively manage your population and demonstrate effective care, your ACO and your practice are at risk for both quality and cost.

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