# Don't Let Wishful Thinking and Healthy Patients Harm Your ACO

written by Dave Halpert | December 2, 2015

Can healthy patients actually hinder your ACO's ability to generate shared savings? Without a multi-layered strategy to improve continually over the course of the ACO agreement, the answer is yes. With the majority of ACOs failing to generate shared savings, a growing number of groups are beginning to realize that serving either the healthy or seriously ill end of the population health spectrum creates its own set of challenges.

Compared to the Value-Based Payment Modifier program, ACOs are finding it nearly impossible to distinguish themselves through performance on quality measures. For ACOs to prove that they are more effectively coordinating care and improving outcomes, it is increasingly clear that success is measured in cost. Reporting the ACO measures is nearly universal, and performance on those measures is approaching peak levels across the board. So how can ACOs differentiate themselves from the pack? By spending fewer healthcare dollars than CMS estimates a group will cost.

This is already a challenging prospect—the rise of Alternate Payment Models and push for Pay for Performance is forcing groups into an awkward position. They must give up guaranteed fees for services rendered for a chance to share a portion of savings that may come from eliminating that payment method. Regardless of the industry, that's a tricky proposition. To compound your challenge, in a three-year ACO agreement, you must continually improve in order to succeed. It's equivalent to making it through the first round of the limbo game—how low can you go?

## As Outcomes Improve, ACO Cost Benchmarks Will Decrease

## *Round 1: Attribution*

The issue is rooted in how your ACO's yearly spending benchmarks are calculated. Since CMS can't predict who will receive care, they set their benchmarks by examining the patients who would have been attributed to your ACO within the last three years. CMS will assign patients to the ACO using their attribution methodology and the list of providers in the ACO.

First, they will use their claims to identify whether a primary care practitioner provided the "plurality of primary care services" to the Medicare enrollee. If that primary care provider is in the ACO, that enrollee becomes your ACO's patient. Should there be no primary care provider, CMS will analyze claims to see if specialists provided any primary care services. Patients may only be assigned to one ACO. In other words, if a specialist in your ACO has seen a patient in the office and that patient has not seen a primary care doctor, then that patient is assigned to your ACO, with no one coordinating that patient's care.

## *Round 2: Timing*

Of course, patients' visit patterns change, and CMS accounts for this by weighting each of the last three years differently. The previous year is worth 60 percent, the year before is worth 30 percent, and the third year accounts for the remaining 10 percent. The more recently an enrolled ACO provider (particularly a primary care provider) has seen a patient, the more that patient will play into the ACO's cost benchmarks.

## *Round 3: Benchmarks*

Once those patients have been identified, CMS uses that population to define benchmarks. First, they will risk-adjust the hypothetical population based on Hierarchical Condition Category (HCC) Score, geography, socioeconomic status and other factors. Once adjusted, CMS will calculate what would have been spent for this specific group of patients.

Past benchmarks are trended forward, using Medicare Part A and Part B growth rates—in essence, Medicare is calculating their own healthcare cost "inflation rate." The end result is a CMS estimate of how much would have been spent on an ACO's patients in previous years, in terms of today's fee schedule. Each ACO has its own cost benchmarks—an amount that may generate shared savings in one ACO could mean shared losses in another.

## *The Result:*

As outcomes improve, cost benchmarks will decrease. Not only will the majority of your target be calculated from the previous year's success, but also your risk-adjustment will be less generous. After all, healthier patients (based on HCC Score) shouldn't incur the same costs,

right? It's no wonder that some have lamented they have "bottomed out" and may have sabotaged their ability to generate shared savings in future years.

## How to Save Your ACO from the Stagnant Costs Trap

1. Phase in performance improvements during the three-year window in your plan. Don't spend the first year trying to implement as much as you can. Adopt an iterative process, focusing on key, high impact items that are apparent by looking at your major groups' Quality and Resource Use Reports (QRUR): readmissions, Ambulatory Care Sensitive Conditions, and core chronic conditions. You can evaluate the effectiveness of your efforts before investing in resources to tackle the next challenge. This will also allow you to pace the purchase and implementation of technology and analytics you need in a more rational way.

2. Get bigger. One of the sustainable strategies to cost reduction will be to get new patients and to help them improve. In fact, because of the weights associated with prior year costs, it's one of the few options open. Making this a positive gain, however, is the hard part, since growth will come primarily from adding new providers. This leads directly into the next issue: how to select your best providers who can reduce costs for patients within a relatively short time frame.

3. Carefully select ACO participating providers. You can request QRURs, or use a consultant to assess them, for each provider entering the network. This allows you to determine potential downstream costs, evaluate the HCCs of patients coming into the ACO, and establish a provider-focused plan for keeping costs under control. Also, configuring your network to include important specialists as "other entity" providers is a plus for controlling your costs, without capturing the providers in your ACO completely.

4. Strengthen the primary care connections. Ensuring that patients have access to a primary care provider is the best way to reduce out-of-network care and encourage preventive care and screening services. If you are not using Medicare Wellness Visits to cement this connection with your patients and to strengthen your attribution of patients by Medicare, consider this: If your patients are more committed, you will have a better chance of keeping them healthy and in network for services.

5. Measure your performance across all Medicare patients. Too many ACOs leave performance measurement to the reporting period and don't have enough information about ongoing issues across all patients. You need to look at ongoing results and tweak the process going forward. By assuming things are going according to plan, you're putting yourself doubly at risk—for the clinical costs that aren't coming down and for the administrative costs that aren't producing results.

6. Let data lead you to refining clinical processes. Redesigning care is one of the most difficult but necessary tasks to undertake in an ACO. But unless you know what is driving the specific trouble spots of costs and quality, you are operating in the dark. Deploy not only analytics, but also external help to identify and change processes based on associations and analyses of the data. Care redesign that precedes an understanding of the root causes that are identified by data won't help the ACO—but existing staff often favor this approach because it is based on experience and intuitive thinking. Remember that studying a problem by the same individuals who have been involved in the process is a favorite tactic to delay or control change.

7. Use a Clinical Data Registry to facilitate the measurement of your effectiveness. Tracking outcomes over time requires the ability to integrate multiple data points to create a comprehensive patient record and longitudinal view. It is not a simple process—different data standards and variation in documentation from group to group illustrate that, while EMR use has advanced, it's not been perfected. A CDR will soon be able to collect and analyze Medicare claims data, and because of the Meaningful Use Public Health Reporting Objective, will also be a major source of data benchmarking and data analysis.

An all-specialty CDR has the technology to create and maintain a mechanism for your evaluation of efforts to improve performance. The goal is not only to improve outcomes and reduce costs, but also to determine whether your efforts are really working and if your resources are used wisely.

ACOs may need to zig and zag through a series of complex actions to achieve savings. The reality is that it will take more than achieving better clinical outcomes. Like any business that must operate at a "profit," an ACO will also need to refine care delivery processes, continually examine the morbidity and risk of its patients, plan for expansions (through choice of additional providers) and ensure that its provider network is on board with ACO objectives. Make no mistake—there will be winners and losers. Which is why there is another important step to take:

8. Don't count on a single solution, a silver bullet that will "solve" your ACO. Whether this is big technology, a huge provider network, a major initiative or a special partnership—don't count on the promise that a single approach will be enough to achieve the hundreds of small improvements that will result in real savings.

ACOs have tens of thousands of patients, and some are well into the six figures. Achieving shared savings will take hard work. This is why you need to test your approach on a focused group to help you perfect a program before mass release. This approach isn't a failure—discovering what doesn't work in order to learn what actually does is essential for

success.

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