ACO Under MACRA? Five Essential Takeaways

written by Theresa Hush | August 24, 2016

While Accountable Care Organizations (ACOs) get a little boost under proposed MACRA Rules, this comes at a price. MACRA provides a 5 percent bonus and a MIPS reporting exemption for providers who participate in an Advanced Alternative Payment Models, the most common being a Stage 2 or 3 ACO—*if and only if* they assume a minimum requirement for risk.

The deal is this: CMS wants providers to move toward Alternative Payment Plans with greater financial risk by living under the equivalent of a budget for their patients' health care. That concept, which imposes downstream risk to physicians if the budget is exceeded by more than a small amount, requires navigation around the hazards inherent in the CMS Advanced Alternative Payment Plan/ACO model. This is no easy task, and you will need a good map.

ACO Failure Can Lead to Penalties Under MIPS

If you have an ACO but have decided not to meet the risk requirements for an Advanced APM, you can still have an ACO—but your providers do not get the incentive and are not exempt from MIPS. You may only have been able to get agreement to participate if providers can ride in your boat without the risk of failure to meet the target budget. But you and they still have consequences if your boat does not float.

That's because even under a Stage 1 ACO MSSP, Medicare dollars remain constant and yours will fluctuate depending on the aggregate cost of services. If they are below budget, your organization wins. If they are over, your organization will get less, and the loss may be not be attached to individual participants. But those providers may still experience losses tied to ACO quality reporting and costs under MIPS. ACO values are used to calculate providers' MIPS

scores, and the provider could be pushed into penalties under MIPS for an ACO failure.

Here are five important points of knowledge and tactics to help your ACO succeed under MACRA.

1. There's Risk to every ACO entity for not achieving the budget, and there are always consequences for your participating providers.

That's why many ACOs that have been putting an emphasis on growth—without understanding what potential risks are being brought to the ACO by individual providers—are not following a sound strategy. Even one or two high cost providers could push your ACO costs over budget, and everyone could get penalties under MIPS.

Whether or not your ACO does not impose a risk on providers, you must ensure that they will not have penalties for poor quality or cost performance. Otherwise you will risk an exodus of providers or lose their cooperation. Regardless of your ACO model, this means that your tactics toward savings have to be a comprehensive, all-hands-on-deck approach. This requires attention to the next points.

2. Meeting savings targets requires performance improvement.

Let's review that concept. Since your ACO budget for patient care is built on historical claims, the only way to cost less is to improve your cost and quality performance. Realistically, this means multiple performance improvement activities, each of which is a detailed initiative involving a population of patients, interventions, measurement of results and measures of how effective each intervention is (cost-benefit) of achieving effectiveness.

This requires a targeted project management approach, with detailed plans and technology that will support your projects. For example, you will need to have rapid ability to build populations and store them in a technology, test results of various approaches and interventions that you have used to impact results (along with outcomes), and an ability to compare your results across multiple projects before rolling them out. That's complicated, and it requires specialized technology in performance measurement. This is what a Qualified Clinical Data Registry (QCDR) with performance improvement functionality is built to do.

3. Think of your Medicare ACO as a pilot; coming under MACRA are ACOs with both Medicare and Health Plan patients.

That means your quality reporting, cost evaluation and performance improvement need to be focused on much more than Medicare patients—rather, on everyone. For example, reporting quality for your Medicare ACO using the web interface may look easier, but it doesn't give you two things: (1) any idea of what is happening in your entire population and (2) any mechanism

to see and correct performance outside of the reporting period.

To succeed, you must have a Quality Measurement process applied across all patient groups, with the ability to group different coverage plans. That means you will need to use a Registry or QCDR to help you establish a broad-based program to identify gaps and performance issues among your providers, and see if these are isolated by providers or other factors in the populations.

4. Seriously evaluate the cost partners in your ACO.

Evaluate your provider network and determine where your patients are coming from. Larger is not always better, and adding specialists could cost both you and the specialists, as noted above; and, it could potentially hurt the marketability of the specialty group to be fully participating in the ACO. The tools to assess costs and quality performance come from Medicare's QRUR reports of each practice, and they are indispensable views into the quality and efficiency of the providers.

As part of an ACO that has mutually shared risk, providers should be willing to share their data and reports in a transparent process—as long as the ACO takes a constructive rather than punitive approach. The QRUR should be the baseline in defining the ACO's tactics to help providers. How do you do this? This is where you should look for a data aggregator that can integrate source data and Medicare's patient data, evaluating the specifics of cost and quality trends. A comprehensive QCDR supporting all-specialty quality measurement as well as cost analysis is an excellent resource.

5. Analyze patient attribution and outflow from your ACO.

In a Medicare ACO, patients are free to go wherever they want for care, and they will do so depending on the strength and scope of your services as well as other factors—your organization's cohesiveness, your brand's strength and patient-orientation, the quality of your communication with patients from every level—the ACO entity down to the nurse or receptionist in the physicians' office. If patients don't like the way you communicate with them, or if you think "patient engagement" means "patient compliance," you'll see how that hurts your ACO by looking at the outflow of patients to other non-ACO providers.

Whatever technology you are using in your ACO, functionality needs to be dedicated to evaluating every indicator of your ACO patients' ambulatory, emergency room, diagnostic, and other outpatient and inpatient use of services. And these indicators must also be aligned with costs and outcomes data. Taking responsibility for the patient experience is essential to the next step, connecting them with appropriate primary care providers and specialists in your ACO. Your attribution of patients in your ACO is the magic ingredient to both identifying the

failures of your system as well as generating a plan that will meet their needs within the budget.

MACRA Will Reimagine the ACO Concept

As MACRA goes live next year, it will reimagine the ACO concept by redefining its goals as well as internal requirements. Taken as a whole, MACRA is putting providers to the test of developing more serious efforts to deliver care in better and more efficient ways. Providers can't do this without the supportive structure that CMS has also reinforced under MACRA: better data available through Medicare, new requirements for EMRs and their connectivity and use, and calling out the QCDR to measure performance, benchmark, risk adjust and improve performance.

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