Ready or Not, Providers Will Face Risk Under ACOs or Medicare Advantage

written by Theresa Hush | September 6, 2018



In any other industry, companies work hard to interpret

purchasing and regulatory trends, and adapt quickly in times of change. Swift action is a hallmark of competitive business; those that linger risk failure. Examples of business adaptation are everywhere: a move to digital applications that help consumers and other purchasers connect and build loyalty; acquisition or spin-off of business services to enhance growth; immediate response to negative press.

But in health care, the pace of change at the industry's core—healthcare organizations and health systems—is slow and barely responsive to the market. Case in point: while government and private health plans are moving to risk-based reimbursement, and health care costs continue to escalate beyond affordability, healthcare organizations are re-inventing revenue cycle strategies and initiatives to optimize Fee-for-Service revenues and investing in consolidation plans that push costs higher. They often still lack an understanding of patients as their customers and offer few conveniences to them or individualized plans of care to accommodate finances or barriers.

Late to the Party, Can Providers Still Be Ready for Financial Risk?

To many health care organizations, financial risk may be a future possibility rather than present reality. They haven't prepared for this reality by measuring cost performance. In fact, a good number of Medicare Shared Savings Plan (MSSP) ACOs—a plan intended to move into risk-based reimbursement—now say they will quit rather than accept losses that will require payback to Medicare.

That vision of reality is myopic. It is hard to see a future

where participation in Medicare is truly optional for many providers, with an aging population and Medicare enrollment headed toward 80 million beneficiaries. With the release of the Proposed Rule on ACOs last week, CMS also removed any doubt that they intend to push providers into financial risk.

Providers not reading signs of change in the market will be caught short when the switch flips to financial risk. Private sector-Medicare ACO partnerships are poised to rise, following a penetration of private health plan ACO enrollees that already outpaces Medicare. Along with the shift in costs for health care consumers, the trend promises to push consumers into plans that cap their costs and provide more benefits. These are, of course, risk-based plans.

There is no longer any doubt that a provider stand-off on risk acceptance—including spending targets, capitation and paybacks in payer contracts—has little chance of success. In fact, the percentage of payment at risk is likely to increase over time, along with the power of risk-based entities and payers.

Given that reality, the key question is whether providers still have the time to create ACOs and make them work or, for that matter, create a successful venture under any risk-based reimbursement.

Tougher Future for ACOs Under Proposed Rule, but Some New Advantages

The new Proposed Rule requires that ACOs move to financial risk faster, and a longer contract term ensures that they are serious about making it work. “Practice time” for achieving savings will be minimal if they don’t get it right from the

beginning; however, there's no break from Medicare—providers can't avoid losses by reorganizing an ACO, and even if they break up, payback of losses to CMS is still required.

ACOs will be able to offer some financial incentives to patients to maintain health services and can inform beneficiaries of their ACO enrollment. How the ACO handles this outreach and other customer services will determine whether patients see this feature as positive or negative.

Many hold-out organizations will still find ACOs too risky an endeavor. But don't worry, because if providers are unsuccessful or don't participate, CMS already has a back-up plan—Medicare Advantage (MA). Indeed, CMS is signaling its support for higher Medicare enrollment in MA.

Providers will have to decide which path is better for them in the future: an ACO, where they have the potential to keep and distribute savings earned through their own innovations and initiatives, or Medicare Advantage, where they are participants in a plan with dictated rules and their future is still based on cost and quality.

Medicare Advantage Plans Are Getting New Rewards from CMS

Medicare Advantage is really the natural fit for an administration that would like to cap costs and minimize regulations. MA is the "privatize Medicare" solution, but the difference is that it's already happening. A little known fact about Medicare Advantage: MA plans have experienced such rapid growth over the last several years that they now account for a third of all Medicare beneficiaries.

In fact, some project that MA will overtake traditional Medicare within a decade. However, the state-by-state coverage differs dramatically, with top states like Florida at 65 percent market penetration, and others in the Midwest at 11 percent. While a payer market strategy is partially at work, there is another interesting metric that may be having an impact—areas with high ACO activity have lower MA enrollees.

CMS is pointing to MA plans as successful experiments in controlling costs. Even in the opening sections of the recent Proposed Rule on Shared Savings Plan ACOs, there is favorable language regarding MA: "If these changes are finalized, we will continue to monitor the program's ability to reduce healthcare spending and improve care quality to inform future program developments, including whether the program provides beneficiaries with the value and choice demonstrated by other Medicare options such as Medicare Advantage (MA)."

Providers should see this as a warning that ACOs will be measured against the benchmark set by Medicare Advantage plans. MedPac, the advisory body on Medicare reimbursement, is also watching MA as a comparison to ACOs and suggests that ACOs' transition into Medicare Advantage plans is likely, since it will ensure the enrollment (and better control) of patients and their services and costs.

MA plans were also recently awarded additional advantages for their participation in Medicare, to further motivate enrollment. They will be able to offer additional benefits to Medicare beneficiaries beyond traditional Medicare such as home modifications and help to allow seniors to stay in their homes.

Finally, under Proposed Rules for MIPS, CMS is granting providers a free pass on MIPS reporting if they participate in a MA risk-based plan.

Paths Open to Providers to Participate in Medicare—with Revenues at Risk

With decision time fast approaching for providers to determine how to participate in Medicare Value-Based Health Care, what options are promising? There are essentially five paths that organizations can take if CMS adopts the Proposed Rule as currently structured, described below.

But here's the catch—playtime is no longer available. Organizations that still want to have ACOs should heed three pieces of advice:

First, build on existing network and market strengths. There is no time, for example, to turn around a big specialty ship to become a primary-care centric ACO model. Instead, a specialty-rich organization should build on its strengths to participate in other ACOs and risk-based reimbursements through specialty-appropriate risk models, such as episode-of-care fees.

Second, ACOs must be ruthless about choosing their member physicians and practices in the network. The days are gone when specialists can be automatically included because they are salaried members of a hospital-based group. In fact, hospitals should already be separating out multi-specialty groups with single Tax Identification Numbers (TINs) to improve chances of ACO savings. This doesn't mean specialists are out—they can participate as the referral network, but patients attributed to them under ACO

attribution rules will not improve ACO finances.
Third, hospital-based ACOs have particular challenges and by-and-large have poor cost results. Consolidated networks must embark on a different strategy, inventing ACOs that can act like a physician-led enterprise. We have outlined how this innovation might work in a recent article on developing ACOs.

The following five paths for participating in risk focus on physician strategy, because this is the key to how ACOs work. Patients are attributed to primary care physicians based on an algorithm of their historical services. Costs of care are assigned to the ACO based on a formula. But with time running out to make such a simple proposition save money, providers must develop a strategy that has the best chance for success, immediately.

Note that for specialists, membership in an ACO under the first two paths is not beneficial. Specialty risk will only make sense under a plan of episodic payments for procedures. In addition, there is not yet enough data or experience to establish reimbursement for complex medical management of chronically ill patients or those with multiple risks performed by medical specialists.

With those caveats and context, consider these pathways:

1. Develop an ACO or other APM to incrementally move the organization safely into financial risk.

This assumes that the health care organization has a

substantial enough primary care network and the infrastructure to manage ACO initiatives or, alternatively, a Primary Care Medical Home (PCMH). Because CMS removed the option to continue a shared savings plan with no revenues at risk under the Proposed Rule, the entity must be positioned for savings from Day One. This means having tight coordination of patient services as well as data and infrastructure at inception, and the attention of specialists and facilities for referral arrangements that will be critical to cost performance.

2. Participate in another ACO or APM with acceptance of its financial risk.

The Proposed Rule makes this an important distinction from the first path because, once created, an ACO cannot reorganize itself to dodge repayment of cost excesses to Medicare. Organizations that fear the long term impact of an ACO may choose to participate in another as long as there is the possibility of exit, but that flexibility will be unlikely if the organization is a dominant player in the market or the ACO.

Again, this pathway should only be considered by primary care physicians—full membership in an ACO by specialists should be carefully considered by both the ACO for cost reasons, and by the specialty group for reasons of regional market referrals. And it goes without saying that no primary care group should join an ACO without first vetting the ACO's potential for success and having validated information about their partner groups in the enterprise. Success and failure of an ACO occurs as a network and is dependent on the participants.

3. Participate in Medicare Advantage Plans.

Both primaries and specialties can participate in MA plans, negotiating arrangements like any managed care agreement. MA participation does not negate the possibility of developing an ACO, but it will impact your network and patient group. Apart from potentially lower fees, this option allows providers to participate with the least disruption to their organizations. Do not be fooled, however—MA plans will increasingly depend on financial risk to cap expenditures, just like ACO plans, returning to capitation for primary care and episodic payments for specialists. Many MA plans already reimburse in these ways.

So, if your objective is to create your own ACO in the future but you aren't ready yet, MA has both pros and cons. In particular, if the MA plan contracts with a multispecialty group and pays capitation, a big downside requirement is a claims shop to pay specialists. Another disadvantage is that participation in MA could syphon off the patient population that would otherwise be attributed to your ACO, because the benefits and capped costs are a strong MA enrollment incentive.

4. Develop a Medicare Advantage Plan.

ACOs can eventually develop their own MA plan. There is discussion around this concept in policy circles, and the potential for greater cost control and enrollment will appeal to some ACOs. However, being a MA plan cannot make up for a poor network, lack of cost performance monitoring tools and initiatives, and provider engagement. A MA plan should be considered after success is already achieved as an ACO. As a MA plan, both primaries and specialists could participate in the network, but specialists may be contracted separately and

referrals, controlled.

5. Create Specialty Episodes and Fees.

Specialty/multi-specialty organizations and academic centers have the most difficult and uncertain future under Value-Based Health Care. Most lack a large enough primary care network to live from inside referrals; they are regional players with a wider geographic draw of patients. The best path for most specialty organizations is to create episodic payments coupled with a contracting strategy that will achieve targeted savings. But to get there is difficult, demanding that initiatives be established in each specialty to create procedural or medical management episodes. Nevertheless, future payments using this structure are inevitable, and specialists should at least be monitoring episodes with data and technology, if not actually selling those packages to health plans such as MA plans.

It’s not too late for providers to organize and establish ACOs or other APMs, if they pursue it with a business perspective. That involves mitigating the risks of failure by creating a network with proven history of cost-effectiveness, and a customer services strategy developed with patients to keep them happy. The window is closing quickly, however, for providers to create their own solutions. The market is moving on, and financial risk is inevitable for all providers. Only those health systems and groups prepared to act like competitive businesses and respond to the changes now will be able to offer attractive solutions to consumers and patients.

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their value and succeed in Risk. Roji Health Intelligence is a CMS Qualified Clinical Data Registry.

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