Expanding Your ACO: The Best Recruiting Strategy for Bigger ACO Savings

written by Dave Halpert | December 16, 2015

Whether your ACO is in its infancy or is established and growing, you've probably had to make some difficult choices about which groups to include—and exclude.

Your ACO's success is almost entirely driven by your ACO network's participating providers (and their patients). They provide the care and generate beneficiary costs, and help to ensure better patient outcomes. Developing that network intelligently is key to achieving shared savings. We're here to help.

Know this: one "free market" concept behind Alternate Payment Models is flawed—the assumption that providers who can demonstrate better results in quality and costs will be in higher demand. On its face, the idea seems logical; ACOs acting in their own best interests (shared savings) will create better care for the population at large, starting by recruiting or retraining providers to generate the best patient results and cost savings.

Realistically, however, under existing relationships and program rules, the "free market" for providers is a stretch. Full participation in an ACO is tied to the group Tax Identification Number, meaning that an ACO cannot pick and choose providers within the same practice; they are either all in or all out. For some ACOs, a majority of the provider base will be defined from the start. For example, in a hospital-based ACO, the employed group is a given.

In addition, provider-based results are not widely available, making it all the more challenging

for ACOs to make wise provider recruitment decisions. With public reporting for providers in its infancy, only limited results are available to reveal either quality or costs associated with providers. So how can your ACO avoid making decisions based entirely on politics and include providers that will best help you to succeed?

The QRUR: Four Keys for Provider Recruitment and Performance Improvement

Many ACOs focus on improving performance retrospectively, but forget to examine performance prospectively for providers that will become part of the ACO. Start with the tools that Medicare has in place. As in any good business partnership, it makes sense for there to be due diligence between ACOs and providers, and the group's annual Quality and Resource Use Report (QRUR) is an important baseline for ACOs and for the practice itself. The QRUR compiles group cost and quality scores based on CMS claims information and can also incorporate quality data and survey results.

QRURs have been provided nationwide to all providers, whether solo or group, as of September 9, 2015. There are several indicators that can help you to determine whether or not a potential member is likely to strengthen your ACO, as well as what support the provider group will need to be an asset. Here's how you might use some of the QRUR indicators:

1) Evaluate Patient Attribution to Specialty and Primary Care.

As we saw from the most recent set of ACO results, the most successful ACOs had a strong primary care foundation. ACOs with a larger percentage of specialty care are more likely to miss savings.

When evaluating a specialty or multi-specialty group, look closely at the number of patients that Medicare has attributed to specialists. If the attribution methodology has linked a high percentage of patients to a specialist, those patients may not have a primary care provider. Your ACO will be held responsible for all costs of those patients that are not being managed by a primary provider. The QRUR, in this case, will reveal that you need to implement a strategy to identify and manage those patients within the ACO or to ensure that they visit their external primary care physician so that you are not responsible for their full costs.

2) Examine Providers' Ambulatory Care Sensitive Condition (ACSC) Admissions.

Each group is scored on a pair of ACSC admission measures: a chronic conditions composite and an acute conditions composite. Medicare assumes that admissions for chronic disease could have been prevented by better provider management. The composite scores are doubly

important, as the risk-adjusted scores are used to calculate a group's quality composite and also carry heavy costs.

ACSC composite scores that reflect admission rates lower than the CMS benchmark are good; they suggest the possibility of high quality ambulatory care and preventive services. If a candidate provider group has a high number of admissions, the ACO will need to determine why and what strategy will address the issue.

3) Measure the Group's PQRS Performance.

PQRS measure reporting is used in the calculation of a group's quality composite, and results are incorporated into the QRUR. Completion of PQRS reporting is a key indicator of a practice's willingness to participate in quality effort. More importantly, you can evaluate a group's performance on these measures by making an easy comparison to the CMS Mean, which is provided in the QRUR, and the ACO average, particularly for existing ACOs. Whether their performance on these measures is higher or lower, both comparisons are important to review.

Even if a group reported a different set of metrics, previous PQRS measures can shed light on whether a group is a good fit for your ACO. The measures reported by the group compared to typical specialty mix, the inclusion of unexpected measures and the percentage of patients reported—all may reflect a reporting strategy that could indicate performance issues that the group has been trying to correct.

4) Compare Costs by Category.

CMS has broken down the types of care received by a group's patients, on a per-capita basis. This is very similar to how health plans historically shared comparative statistics with providers. The risk-adjusted costs are benchmarked and compare how resources are allocated across the population at large.

The Medicare Spending Per Beneficiary (MSPB) measure also addresses costs by category. Surrounding a hospitalization, this shows episodic costs, revealing whether emergency department services or re-admissions are problematic.

High costs aren't always bad—a group with high per-capita costs for ambulatory care in-network could mean that patients *stay* in-network. Patient choice is the wild card in the ACO mix, so costs must be examined along with in- and out-of-network costs, patient attribution and other situations, to understand what is driving the costs.

Start with Data, but Ask Questions

Using Medicare data to evaluate potential provider groups—in the same way that Medicare will be evaluating the ACO—shouldn't be your only tactic to evaluate your ACO network. Numbers are a guide to asking the right questions, but they do not always give a comprehensive picture. For example, has the group taken any steps to address performance? These will not be apparent in a retrospective QRUR, but if you discover that the group is already taking proactive steps, you have a signal that this group is engaged and may be an asset.

Conversely, if a group is doing well but has no plans to continually improve, it may be a performance risk. Since ACO benchmarks are based on prior years' performance, those who are unable to improve continually are at risk of falling below targets.

Other factors that can help guide your ACO's evaluation of providers:

Practice growth or attrition;
Administrative turnover;
Participation in other quality programs (e.g. Patient-Centered Medical Home);
Referral patterns.

Participation of specialty groups in an ACO is tricky for both the ACO and the practice. While the group may be key to continuing care for your patients, it does not necessarily warrant full-fledged participation. Incorporating that group through the "Other Entity" designation will enable you to bring them into the fold, but preserve the group's ability to practice in a wider geographic area.

Creating a system that ensures that patients receive care from one end of the spectrum to another is an inspiring goal, but requires a strategic and detailed implementation plan. The reality is that participation in an ACO will soon become essential because of the passage of MACRA and the push toward several Alternate Payment Models. Done correctly, an ACO can provide good care for patients and generate savings. Strategically developing your provider network to make that happen will assure your ACO's success.

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