ACO v Group Practice P4P: How Medicare Costs and Quality Calculations Affect Your Bottom Line

written by Dave Halpert | April 1, 2015

Now that Value-Based Health Care defines the landscape, reporting for revenue is on its way out. Value-based quality is in.

Medicare's transition to Pay for Performance gives providers just three options—and no out—for participating in reimbursement models that reward for higher quality and lower cost:

> Build or participate in an Accountable Care Organization;
> Report PQRS and submit to the risk of the practice-based Value-Based Payment Modifier;
> Receive automatic financial penalties.

Given that the last option is not really viable, which way should providers participate in Medicare's Value-Based Health Care?

An Accountable Care Organization (ACO) is a network-based model for managing the risk of providing care to Medicare Part B recipients. The ACO can be comprised of multiple entities, a conglomeration of private practices and hospitals, or even a national retail chain. An ACO is formed by an application that includes the various entities and is approved by CMS. But

patients don't actually "join" the ACO and still have free choice of provider. They are assigned by prior claims experience with providers, and Medicare lumps these groups together for the purpose of assessing ACO value. All of the calculations for savings are done behind the scenes.

The Value-Based Payment Modifier (VBPM) is a different Medicare calculation of cost and quality, but it is calculated at the practice level, if the practice is not part of an ACO. CMS determines the VBPM quality component based on the measures reported for PQRS.

For groups weighing the advantages and disadvantages of ACO participation, here's what you need to know about how Medicare calculates costs and quality, how that will affect your bottom line—and how a Registry can help you to achieve your goals, whether for the ACO or for a practice at risk under the VBPM.

What's the Same? Both ACO and VBPM Measure and Compare Quality of Care and Associated Costs

On the surface, a Medicare ACO and the VBPM are very different models of health care delivery. An ACO is usually a multi-practice model; under PQRS with VBPM, the practice itself assumes its own risk. Operating as a network, the ACO usually has resources to assume responsibility for patients and the potential to expand into health plan contracting, while practices subject to the VBPM work in a Fee-for-Service world with Medicare.

But CMS regulations have imposed similar goals for both programs to measure and compare quality of care along with the associated costs. In an ACO, participants are entitled to share in any savings based on historical spending, and the provider agreement with the ACO will determine how money flows back to participating practices. In a practice group, a positive VBPM will return incentives (or penalties) directly to the practice. The modifier itself is a multiple of the regular fee schedule (a 4 percent VBPM means that your Medicare reimbursement for the target year will be Standard MPFS x 1.04).

Patient attribution is a key component of the ACO and VBPM. Since patients don't actually choose a permanent place for care under either an ACO or regular delivery system, Medicare calculates which patients belong to a practice or the ACO network, which includes mid-level providers. After attribution of patients, both calculations look at costs on a Medicare Spending Per Beneficiary (MSPB) basis, meaning that costs aren't limited to the costs of care that you provide, but the total cost of care for that patient as he or she moves across the continuum of care. In effect, the patient's costs are your costs—for an orthopedic surgeon, for example, if a patient is attributed to you, you're "on the hook" for that patient's COPD admission.

In each program, Medicare attributes patients using a two-step process:

If the patient has seen a primary care provider (internal medicine, family medicine, geriatrics), patients are assigned to that provider (and then linked either to the group or ACO).
If the patient has not seen a primary care provider, that patient will be assigned to the provider who has provided "the plurality of primary care services," including office visits. That is how the patient with COPD gets attributed to an orthopedic surgeon and, subsequently, the group.

CMS scores quality for ACOs and the VBPM based on a set of measures, and calculates re-admissions and admissions related to Ambulatory Care Sensitive Conditions (ASCSs) for patients attributed to the group or organization. Medicare believes that these admissions could have been prevented had the required care been provided in the ambulatory setting. Of course, CMS recognizes that this is not always the case, which is why your scores are weighted and compared to the CMS weighted average.

Differences Between ACO and VBPM: Administrative, Financial and Strategic

Although each program has similar goals and scoring methodologies, there are three critical distinctions.

First, the method of determining quality performance is very different. While ACOs report on a pre-defined set of metrics, groups who choose the VBPM route have more freedom. For the VBPM, CMS calculates a score based on the measures that a group reports for PQRS, against the Medicare average and then aggregated into a National Quality Strategy (NQS) Domain score. NQS Domain scores are then rolled up into a total score.

Actual VBPM quality performance results can be advantageous because the VBPM is based only on reported PQRS measures; therefore, careful selection can optimize quality tiering. ACOs, however, must report on an unbroken set of 411 patients per measure, which can be a challenge, and the sample may not represent the true performance of the organization.

Second, the ACO's measurement of cost is compared to a weighted history of costs for its prior years for attributed patients. With VBPM, measurement of cost is compared to other groups by CMS. This makes cost control a potential advantage for the ACO, because the entity is also likely to have more resources to dedicate to cost control efforts.

Finally, the success of the ACO in achieving those lower costs rests on factors that are not in control of individual practices. While ACOs have the opportunity to use CMS claims in their reporting (provided patients agree to share), giving the organization a more global view of the patients as well as the costs incurred, that does not necessarily translate into a clear path to

savings. This creates a risk for practices that may be able achieve success on their own through careful optimization of the VBPM, but depends on the success of the group for savings in the ACO. It is worth noting that most ACOs did not achieve savings last year.

A practice will make a decision to bind its future in the short and long term with an ACO, or to go it alone. It's important to be able to measure the potential results at least by evaluating the CMS report on the practice quality and cost, the Quality Resource and Utilization Data, to determine the practice risk by going solo. It may also request similar data on the largest group(s) forming the ACO.

To succeed in either program, both ACOs and practices need to be able to measure and prove better performance. That also means the ability to act throughout the year—once the reporting deadline looms, your chances to actually improve outcomes are gone. There is not time to assess the effects of a nutrition plan or tobacco cessation plan, no time to measure the effects of a new medication, and certainly no chance to identify an underlying issue contributing to admissions.

How Registry Reporting with Population Health Can Improve Either Choice

All organizations, regardless of type, need to adopt a system for performance measurement in order to see where they stand against Medicare and health plan norms, and to provide a baseline for improvement. A registry provides the mechanism for organizations to view their data against targets, whether that means a practice view or an ACO. Since CMS is rewarding or penalizing based on either historical or comparative performance—or both—knowing where each provider stands and how to reach the goal is now essential for maintaining revenues.

Performance measurement and improvement efforts go hand in hand. The right Registry partner will also have Population Health tools that are meaningful, helping you track what actions have been taken, and informing you if they've worked. Effectiveness research must be a part of population health programs to avoid spending resources on efforts that produce no results.

Examining hospitalization experience will be essential for each program, and a Registry can sort patient admissions into groupings for review. Collecting feedback from your providers and staff throughout the year can also be revealing. For patients who have been re-admitted, is there an underlying issue? Engaging providers to assist in determining the "why" an event occurred is a more positive approach than penalizing them for the fact that it happened, and may be a more effective way to prevent that same event from happening again.

To succeed in a Pay for Performance initiative, preparation and long-term planning is

paramount. The all-out reporting blitz will only take you so far, and you will stop short of achieving any lasting change in quality or cost. The good news is that the methods can succeed in either program. The “pay” portion of Pay for Performance will follow, but only for those who take action.

Download your free copy of the ICLOPS *Insider’s Guide to PQRS 2015 Reporting: How to Succeed in the Value-Based Health Care Environment*.

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