ACO Primer: Reviewing the Proposed Rule on Accountable Care Organizations

Save to myBoK

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In April the Centers for Medicare and Medicaid Services (CMS) published a notice of proposed rulemaking for the Medicare Shared Savings Program. The program was mandated by the Affordable Care Act to encourage the development of accountable care organizations (ACOs) in Medicare.

The program intends to:

- Promote accountability for a patient population
- Coordinate items and services under Medicare parts A and B
- Encourage investment in infrastructure and redesigned processes for high-quality and efficient care

This Medicare delivery system reform initiative proposes a new approach to the delivery of healthcare aimed at achieving three goals: better care for individuals, better health for populations, and lower growth in expenditures.[1]

This article provides an overview of the program's proposed requirements, payment models, and incentives and outlines the considerations for those organizations planning to participate in the program.

ACO Requirements

Participation in the program requires eligible groups of service providers and suppliers meet certain requirements. Proposed participation requirements include:

- **Accountability**. An ACO must be willing to become accountable for the quality, cost, and overall care of the Medicare fee-for-service (FFS) beneficiaries assigned to it.
- **Agreement**. ACOs must enter into an agreement with the HHS secretary to participate in the program for no less than three years.
- **Legal structure**. ACOs must have a formal legal structure that would allow organizations to receive and distribute payments for shared savings to participating service providers and suppliers.
- **Primary care engagement**. An ACO must include a sufficient number of primary care ACO professionals for the number of Medicare FFS beneficiaries assigned to it. At a minimum, the ACO is required to have at least 5,000 beneficiaries assigned to it. CMS is proposing at least 50 percent of primary care physicians are "meaningful EHR users" by the start of the second year in order to continue participating in the program.
- **Reporting**. ACOs must provide the HHS secretary with such information regarding professionals participating in the ACO as the secretary determines necessary to support the assignment of Medicare FFS beneficiaries to an ACO, the implementation of quality and other reporting requirements, and the determination of payments for shared savings.
- **Structure**. An ACO must have a leadership and management structure that includes clinical and administrative systems.
- **Process development**. ACOs must have defined processes that promote evidence-based medicine and patient engagement, report on quality and cost measures, and coordinate care through the use of telehealth, remote patient monitoring, and similar enabling technologies.
- **Patient centeredness**. An ACO must demonstrate that it meets patient-centeredness criteria specified by the HHS secretary, such as the use of patient and caregiver assessments or the use of individualized care plans.

ACO Payment Models and Incentives

In the proposed rule, CMS describes two methods for distributing potential shared savings to ACOs. The first model includes one-sided risk sharing. In this scenario, the ACO would share in any cost savings but would not be required to pay a penalty for any increased cost of care.

CMS proposed this option to encourage participation from ACOs that are beginning to implement risk models and may be unwilling to commit to loss sharing immediately. However, loss sharing becomes mandatory in the third year of the program.

The second model implements two-sided risk sharing. In the two-sided model, the ACO would share in both the savings and the burden of any increased cost of care for their population. The two-sided model offers a higher share in the savings than the one-sided model.

ACOs that have experience in risk contracting either in a physician hospital organization or through managing capitated contracts may opt to be paid via the two-sided model for the entire three-year period.

To achieve additional payment, ACOs must attain quality and performance benchmarks in addition to demonstrating per-beneficiary savings. The maximum sharing percentage is 60 percent in the two-sided model and 50 percent in the one-sided model. The proposed cap on the shared loss is 5 percent of the benchmark cost in the first year, 7.5 percent in the second year, and 10 percent in the third year.

CMS does not state a preferred method for distributing shared savings to the providers participating in an ACO. It is likely that the ACO will be responsible for distributing any incentive payments throughout the organization. Many physician hospital organizations already have incentive arrangements in place. It is likely that those would be expanded to include the distribution of any Medicare incentive payments.

Emphasis on Quality and Efficiency

One of the primary features of the ACO program is the emphasis on the quality and efficiency of the care provided. This is in contrast to the current healthcare model, where payment is often based on quantity of services and not on the delivery of the right care at the right time.

Leveraging principles developed by the Institute of Medicine's report "Crossing the Quality Chasm: A New Health System for the 21st Century" and the National Partnership for Women and Families, CMS is focused on integrating patient-centered care in the development of ACOs. As such, ACOs must meet the following patient-centered criteria:

- Surveys of beneficiary experience in place and a description in the ACO application of how the ACO will use the results to improve care over time
- Patient involvement in ACO governance by having a Medicare beneficiary on the governing board
- A process for evaluating the health needs of the ACO's assigned population, including consideration of diversity in their patient populations, and a plan to address the needs of their population
- Systems in place to identify high-risk individuals and processes to develop individualized care plans for targeted patient populations
- A mechanism in place for the coordination of care (e.g., use of enabling technologies or care coordinators)
- An established process for communicating clinical knowledge or evidence-based medicine to beneficiaries in a way that is understandable to them
- Written standards in place for beneficiary access and communication and a process in place for beneficiaries to access their medical record
- Exisiting internal processes that measure clinical or service performance by physicians across the practices and use these results to improve care and service over time.[2]

Quality and efficiency are relatively difficult to measure with the current limitations in organizations' IT structures. The measurement of outcome and process depends on collecting more than payment method-driven billing data.

The meaningful use requirements released by CMS are designed to support the capture and analysis of more robust clinical data elements that ideally will support quality and efficiency measurement.

ACO Participation Considerations

The program and the development of ACOs will have a direct effect on the healthcare industry and the HIM domain. Healthcare organizations will consider the following issues when deciding whether to participate in the program.

Coding, Revenue Cycle, and Payment

In traditional FFS payment plans, capturing the appropriate diagnosis and procedure codes affects an organization's reimbursement. As the payment methods migrate away from FFS, the focus of coding shifts to diagnosis and procedural indices in order to accurately identify patient populations.

Coded data facilitate identification of the patient population and allow for the creation of registries. ACOs that understand their patient populations are better prepared to manage the resources and derive patient-centered services.

Even though the payment method is different in an ACO model, revenue cycle management remains a vital function. Monitoring reimbursements in the program creates challenges as payment methods become more complex in calculation and distribution across providers. Understanding the ACO payment method is an important first step.

Risk Mitigation

One risk in the proposed models for distributing shared savings is an ACO's ability to estimate and control the cost of care it delivers to its subscribers. Patient registries are one effective strategy for tracking patient risk factors and problem lists. Registries will be so critical to the success of an ACO that organizations should consider implementing them even if they have yet to implement a full EHR system.[3]

Aggressive case management is a proven method of reducing the cost of care for patients with chronic diseases.[4] Disease management programs cannot be effective unless patients with chronic diseases such as asthma, diabetes, or hypertension can be identified and tracked for follow-up and intervention.

CMS proposes providing physicians with patient-level service and demographic information to help them avoid duplicate diagnostic testing and adverse drug interactions. Physicians may use these data to identify patients that are good candidates for patient management programs, and the information may serve as the basis for problem lists.

It is not clear if physicians will be provided with the necessary tools to synthesize and analyze the data. HIM staff with strong analytic skills can be critical in ensuring the accuracy of registry information and translating the service history data into information that allows an ACO to manage the care of its patient populations.

An additional risk for ACOs is the fact that beneficiaries are not required to enroll in a particular ACO. They may seek treatment from any ACO, and any reductions in the cost of their care may be distributed among all ACOs involved in their care. This is one of the key differences between an ACO and an HMO or Medicare Advantage plan.

In an HMO, beneficiaries choose a plan and become a member. They must seek care within that HMO's network or be subject to additional co-payments. Since beneficiaries may seek care from a number of ACOs, the cost savings from one ACO may be offset by a cost increase by another. This puts the ACOs projected shared savings at risk.

Quality Measurement and Reporting

As noted, ACOs will be required to report quality measures, which they will do in a form and manner defined by the HHS secretary. CMS has proposed 65 measures for use in establishing quality performance standards for the first performance period. Measures for the remaining two years will be discussed in future rule making. CMS expects to expand the measures to include other highly prevalent conditions and care settings, such as hospital, home health, and nursing home.

CMS plans to calculate performance results for the first program year via survey instruments, claims data, and the Group Practice Reporting Option (a CMS data collection tool). In subsequent years, CMS proposes to expand measures reporting to include EHR-based mechanisms. For example, by the second performance year, CMS proposes to develop the capability of the Group Practice Reporting Option so that it interfaces with EHR technology and allows EHR data to populate the reporting tool.

ACOs must assess data capture, reporting, and performance requirements associated with each performance year and ensure the appropriate technology and workforce are in place.

Clinical Documentation and Health Record Management

All organizations and providers need accurate and timely information to efficiently and effectively treat their patients and enable high-quality, patient-centered care. CMS recognizes the importance of technology and information exchange as part of the ACO care coordinating and patient-centered criteria.

CMS has proposed that ACOs will be required to have processes in place to enable the electronic exchange of information, evaluate the health needs of assigned populations, develop individualized care plans for targeted populations, allow beneficiary engagement and shared decision making and allow beneficiaries access to their health record.

Detailed clinical documentation and health record management practices will be critical to the success of an ACO.

Information Sharing and Patient Privacy

ACOs and their suppliers are covered entities under the HIPAA privacy rule and are thus subject to its requirements. An ACO may be a HIPAA covered entity if it conducts electronic transactions for claims, eligibility, or enrollment.

In addition to the HIPAA guidelines, CMS is proposing to require an ACO to enter into a data use agreement in order to participate in the program. Under the agreement, the ACO would be barred from sharing Medicare claims data provided through the program with anyone outside of the ACO.

This will be considered a compliance requirement as a condition of an ACO's participation in the program. If the ACO does not comply with this requirement it will no longer be eligible to receive data, and its participation will be terminated.

Notes

1. Centers for Medicare and Medicaid Services, Office of Inspector General. "Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations and Medicare Program: Waiver Designs in Connection with the Medicare Shared Savings Program and the Innovation Center." *Federal Register* 76, no. 67 (April 7, 2011). http://edocket.access.gpo.gov/2011/pdf/2011-7880.pdf.
2. Ibid.
3. Sacks, Lee. "Clinical Integration: The Foundation for Accountable Care." 2011 HIMSS Convention Proceedings, February 2011.
4. Fireman, Bruce, Joan Bartlett, and Joe Selby. "Can Disease Management Reduce Health Care Costs By Improving Quality?" *Health Affairs* 23, no. 6 (2004): 63–75. http://content.healthaffairs.org/content/23/6/63.full.

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