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ACOs: The Train is Leaving the Station—Are You Onboard?

A recent study by the national consulting firm Oliver Wyman examines the current state of the ACO (Accountable Care Organization) movement. This article summarizes the findings of their study.

According to the study by Oliver Wyman, a common belief in the U.S. healthcare system is that ACO programs have not had a significant impact on the delivery and finance of healthcare services. Their new study seeks to paint a different story. They argue that accountable care offers a massive opportunity to redesign the healthcare delivery system and achieve cost savings while improving the quality and coordination of healthcare services. The fact that millions of dollars have already been invested in this move by providers, government and commercial payers, and other healthcare organizations cannot be ignored. The ACO movement has earned the confidence of sophisticated players and corporations across the healthcare system who see it as more than a government mandate or a buzz word and are already viewing it as a means to improve their organizational performance and their bottom lines. According to the authors, these organizations understand that value-based care is the future and, they argue, in some of the most progressive regional markets across the country is already becoming the standard. Healthcare players who intend to prosper in the changing market must move quickly in order to have any opportunity at success.

ACOs are intended to shift the focus away from the traditional fee-for-service model toward a focus on delivery that encourages provider organizations to compete on quality and price. The theory is that this sort of competition, if it spreads throughout the U.S. healthcare system, will accelerate a movement toward healthcare that is priced and paid for in terms of value, not volume of services rendered. Skeptics have argued that not only will ACOs fail to achieve significant savings but that they would be unable to achieve critical mass throughout the non-Medicare environment, so that any impact they might have would be limited to the Medicare population and the pilot programs undertaken by the Centers for Medicare and Medicaid Services (CMS). Indeed, last July, after the first two rounds of enrollment, CMS reported that 116 ACOs were participating in its shared-savings program, in addition to 32 Pioneer ACOs. At that point, these organizations represented about 2.4 million Medicare patients, only about 5% of total Medicare beneficiaries. Those numbers were increased in January 2013 with the addition of 106 new ACOs, bringing the total beneficiaries covered by these entities to 4 million. Applications for the fourth round of participants are due this summer and those organizations selected will join the program in January 2014.

What Is the Real Number?

The Oliver Wyman study argues that focusing on these seemingly small numbers is misleading and misses the broad impact ACOs are already having on the healthcare system. In their survey of provider organizations across the country, they found that a much larger number of organizations and a much more significant patient population can arguably be attributed to the ACO model. This study defined ACOs as provider organizations participating in population-oriented, value-

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based care delivery and reimbursement models and did not include providers that had only progressed to piloting bundled payment programs, nor those that only receive pay-for-performance or care-coordination payments. Only organizations working under value-based shared savings or risk arrangements on the total cost of care for one or more sets of attributed patients were included in their examination of ACOs.

Using their methodology, in addition to the already identified 2.4 million Medicare patients, they would include 15 million non-Medicare patients cared for by Medicare-affiliated ACOs. They base this on the argument that a provider organization that is committed to delivering services under an ACO model for its Medicare patients cannot easily sustain a separate delivery model for its commercial patients. Providers that move to value-based contracts with a payer as significant as Medicare will eventually move all of their patients to value-based contracts. Typically, this will happen over time as arrangements are negotiated with multiple payers who may be at different points in their ability to participate in value-based contracting, but it is in the interest of an ACO to apply the same clinical model to all of its patients, and this is what appears to be happening already with many provider organizations.

Commercial ACOs Count Too!

The spotlight over the past 18 months has clearly been on Medicare ACO development, but there are roughly the same number of ACOs contracting with private payers as exist in the Medicare program. National and regional commercial payers have begun to pilot ACO partnerships with provider groups selected in individual markets, and in some cases the providers have been the initiators testing the concept with a willing commercial partner or even their own employee base. Some commercial payers have been collaboratively engaged in testing new clinical models, often with some amount of advanced payment or enablement support for provider organizations that may want to test the waters before adopting CMS' model. One of the largest ACOs, Advocate Health Partners in Chicago, has been in an arrangement with Blue Cross/Blue Shield of Illinois since 2011 and brought its 2237 physicians into a Medicare ACO in July of 2012. According to Oliver Wyman's study, somewhere between 8 and 14 million non-Medicare patients are being cared for in these commercial ACO systems. Combining the 2.4 million Medicare beneficiaries officially counted as part of CMS ACO pilots with these additional commercial populations brings the total of U.S. patients receiving their healthcare through ACOs to 25-31 million, roughly 10% of the population. The study argues that this rate of growth for a new and extremely complex form of payment and care delivery is amazing and represents only the beginning of the potential impact these organizations will have. They note that the Medicare ACO programs were designed to create a multi-payer care delivery model that can compete in the market with fee-for-service. Using Dartmouth Atlas primary care service areas (PCSAs), 45% of the U.S. population live in a PCSA served by at least one ACO, and 17% live in a PCSA served by 2 or more ACO organizations.

Given this level of penetration, if existing ACOs can produce substantial improvements in quality and cost, they are positioned to rapidly drive change across the entire healthcare marketplace. Arguably, many of these existing ACOs have not achieved "real" ACO status. Even within the CMS programs, only a small number of participating provider organizations are taking on both upside and downside risk. Many of them may not be able to make the transformative changes needed in clinical processes, incentive models, data tools and infrastructure in order to achieve the full rewards of accountable care.

Average vs. Exceptional

Despite the incomplete transformation of many existing ACOs, the study argues that some of the first commercial payer ACO arrangements have already proven their ability to significantly impact medical cost trends. The Blue Cross/Blue Shield of Massachusetts Alternative Quality Contract, which many have read about, has achieved a 1.9% savings in its first year, and one developed by Blue Shield of California, Dignity Health and Hill Physicians,

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The Denver Medical Society

Cordially Invites Physicians and/or Practice Managers

"Show Me the Money!"

Presented by

Devin Detwiler, Program Manager/Quality Improvement Specialist
Colorado Foundation for Medical Care (CFMC)

- $ **Are you able to report PQRS data this year (2013)? Did you know you could qualify for incentive payments in 2013 and 2014 if you do?**
- $ **Did you know that this year's PQRS data (2013) will be used to determine possible penalties implemented in 2015?**
- $ **Did you know that providers NOT reporting PQRS Data in 2013 will have their Medicare Part B reimbursements cut by 1.5% in 2015?**
- $ **Want to know what is required and how to comply? Plan on attending!**

All eligible professionals who satisfactorily report quality-measures data for services furnished during a PQRS reporting period are eligible to earn an incentive payment in 2013 and 2014; however, non-participating providers are subject to a penalty beginning in 2015.

The Colorado Foundation for Medical Care (CFMC) will be able to follow up with both Primary Care and Specialty individual practices to help comply with this reporting - free of charge. Want to know more? Attend this free event!

Tuesday, June 25th 2013

Mile High Room – COPIC building, 7351 E. Lowry Blvd., Denver, CO

7:00 AM - Continental Breakfast —- 7:30-9:00 AM - Program

RSVP with attendee names by Friday, June 21st to info@denvermedsociety.org.

‘Be Prepared’ When Testifying in a Malpractice Lawsuit

If you’re faced with a malpractice lawsuit, you may feel that the entire litigation process—from discovery to trial—is beyond your control. But there is one very important element that you can control: your own testimony. Because the courtroom differs from the exam room or the surgical suite, and because opposing counsel’s job is to attempt to discredit you, being prepared is a must. Physicians can start the preparation process by reviewing these basic tips before testifying:

1. Limit Your Answers - Whether you’re on the witness stand or in a deposition room, your only obligation is to answer the question you were asked. You may be tempted to provide additional information that you think is relevant, but you could inadvertently harm your case. Stay within the scope of the question. Your attorney—not you—has responsibility for making sure that all relevant information is introduced.
2. Provide a Careful, Precise Answer - When you answer precisely, you remove ambiguity from your testimony. But be sure not to box yourself in. If you are asked for a complete list of your actions, answer carefully. Unless you are absolutely sure you’ve provided every element, leave the list open. For example, if you are asked to detail the steps you took before arriving at a diagnosis, it is acceptable to say, “At this time, these are the steps I remember taking.”
3. Stay Calm - Keep your cool. You lose credibility when you become sarcastic, raise your voice, or get defensive. Opposing counsel may try to provoke you. Don’t take the bait. If you can feel your blood pressure rising, pause for a moment to collect yourself before answering the question.
4. Be Straightforward - The facts will come out in your deposition or at trial, so there is no point in trying to avoid an admission, even if you think that making it will hurt your case. When opposing counsel asks a question, don’t obfuscate. Quickly provide a clear answer. Dancing around the issue will only give it more prominence.

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The Denver Medical Society
cordially invites our Young Physicians

Who Do You Want Controlling Your Future?

Speaker

Jay Want, MD

Principal, Want Healthcare, LLC

Innovation Advisor to
Centers for Medicare and Medicaid Services

CMO, Center for Improving Value in Healthcare

Nationally Recognized Leader in Healthcare Transitions

U.S. Healthcare is facing a paradigm shift that will impact every physician's future. Dr. Want will help you understand:

- What's Really Happening in the Market
- When Payment Reform Will Impact Your Practice
- Why Transparency Matters to You
- Why You Must Know Your Own Data and Demonstrate Value
- Why Referring and Receiving Referrals Will Be a New Game

Cool River Café
8000 E. Belleview Ave., Greenwood Village

Thursday evening, June 20, 2013
6:00 Beer, wine and hors d'oeuvres
7:00 Dinner and Program

You are welcome to bring a guest.

To **RSVP** call 303-377-1850 or email info@denvermedsociety.org.

This program generously sponsored by THE DOCTORS COMPANY

ACOs: The Train Is Leaving

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delivered a 0% premium increase to CalPERS members in its first year. The study's authors argue that these early success stories, as opposed to the average performance across ACOs, are where attention should be focused. They contend that it is the gap that separates these successes from other ACOs and fee-for-service providers that will catalyze and accelerate change across all provider groups.

"Successful ACOs won't just siphon patients away from traditional providers and attract the attention of payers, employers, and partner organizations. They will change the rules of the game in the regions where they operate, leading purchasers to expect lower cost, higher quality, and greater patient satisfaction," according to the authors. Providers that fail to adopt these best models will find themselves unable to compete.

They go on to suggest that first movers, as they describe those provider groups that are now actively engaging in the ACO transformation, will have a substantial advantage in partnering with forward-looking payers and shaping an arrangement that suits their organization. Early success will further position them to attract physicians and other critical provider partners and allow them to offer higher value care to an increasing patient base.

The Train Is Leaving

In order to achieve this first mover advantage the authors claim it is essential to be a "real" ACO that is able to successfully blunt the cost trend by changing the way in which care is delivered. This will require investing more time and resource in the sickest patients, heading off exacerbations of chronic diseases through a proactive care management approach, and partnering with patients to help them stay well. Organizations able to make this type of transformational change will redefine the basis of competition. Those that fail to act at all, choosing a wait-and-see approach or becoming an ACO in name only, will play catch up and will need to meet benchmarks set by their competitors.

Achieving this level of transformation in a complex system like healthcare delivery is likely to occur in stages. The authors suggest that the ACO might begin by focusing on the sickest of the sick within their senior population and develop capabilities to effectively manage patients with multiple chronic conditions and complex psycho-social needs. This will lead to the development of meaningful components of the toolkit needed to manage dual eligibles and complex commercial patients. Once they expand this capability to other expensive conditions such as oncology, heart disease, and renal disease, they will achieve control of 45% of all healthcare dollars spent in the U.S. Prioritizing early efforts around high opportunity areas that require focused care coordination should result in success that can fund needed investments in prevention, wellness, and consumer engagement to bend the longterm healthcare cost curve.

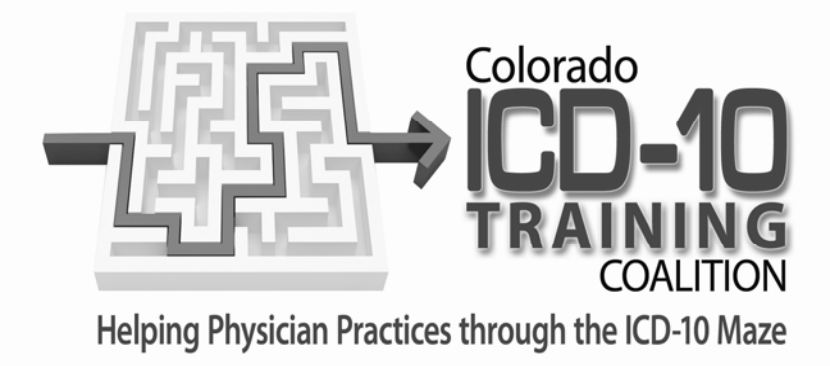
The study concludes that the outlines of tomorrow's healthcare market are already clear and that those who do not move quickly will shortly find themselves at the back of the pack as the U.S. healthcare marketplace undergoes a fundamental and irreversible paradigm shift.

WHAT DOES REAL TRANSFORMATION LOOK LIKE?

What is the difference between an ACO in name only and an ACO that is truly poised to improve the quality of care, make patients healthier, and reduce costs? We think these four factors are a good indication:

1. **You treat clinical transformation as *the* organizational priority.** It is visibly on the CEO's agenda and not just another strategic initiative. You're investing substantially in infrastructure. And you're working to move to risk-based contracts across Medicare, Medicaid, and commercial payers to align incentives across your entire patient population.
2. **You focus more on the *AC* than on the *O*.** You're promoting true accountability across the organization. You're identifying over– and under-utilization and eliminating both, while also shifting care to lower acuity settings regardless of parochial interests.
3. **You've put patients at the center.** You're ceasing to practice "body-part medicine" and instead focusing on patients' overall health needs. You're working to understand the clinical and social needs of the populations and sub-populations you serve.
4. **You're engaging physicians and other clinicians in a new way.** You're getting physicians to commit to a model of care that is more patient-centric than physician-centric. You have a plan to dramatically change the way physicians are compensated in order to align incentives.

"The ACO Surprise", Oliver Wyman 2012



CMS Coalition Creates tools to Assist Physicians and Staff Address More Than 55,000 Code Changes

The Colorado Medical Society's ICD-10 Training Coalition has launched a website at www.cms.org/icd-10 to provide physicians with resources to navigate new requirements of the International Classification of Diseases, 10th Revision (ICD-10) code sets and tailor an implementation plan to fit their practices' needs in time for the Oct. 1, 2014, implementation deadline.

These resources and training materials include live seminars and a free monthly webinar series. Archived recordings and slide presentations from the first three webinars are available on the website.

CMS coordinated the formation of this statewide training coalition comprised of educators, consultants, physician practices, the Denver Regional Office of the Centers for Medicare and Medicaid Services and others, uniting all partners under the goal of ensuring physicians and their staff are prepared for ICD-10.

The switch to the new code set adds more than 55,000 codes to the previous version and will require changes to how health care information is collected, documented and used in physician practices, both internally and externally. Physicians and their staff must begin preparing now.

The ICD-10 pathway involves seven stages:

- Build awareness and engage with physicians and staff
- Assess the impact
- Create your timeline
- Develop your project plan
- Begin your preparations
- Train staff and physicians
- Test ICD-10 readiness
- Implement your transition plan
- Follow up post-transition

Be sure to explore and share the website with your colleagues and staff as new information is added. Stay up-to-date on training coalition events and resources by signing up for the CMS mailing list at www.cms.org/news/livewire.

Save the date for the
2013 Colorado Medical Society Annual Meeting

September 20-22, 2013

Vail Marriott Mountain Resort, 715 West Lionshead Circle, Vail, CO 81657

Meeting registration will be open soon at www.cms.org