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Medicare ACOs: Not the Best Way to Start

By Nathan Kaufman *August 29, 2012*

Begin the transition to an ACO with employees rather than Medicare patients.

Editor's note: *This is the fourth installment in "From the Trenches," a new monthly series that continues through October.*

If we're going to reduce the cost of health care, someone has to get paid less. In 2011, according to former CMS administrator Donald Berwick, M.D., the cost of overtreatment, failure to coordinate care, and excessive pricing was estimated to be between $267 billion and $449 billion. While these costs rightfully are characterized as waste by Berwick, they are currently revenue for physicians and hospitals.

Clearly, the federal government's primary strategy to reduce the cost of care must be to eliminate waste. The Medicare ACO programs provide an economic incentive for physicians and hospitals to share in the savings from eliminating waste and improving quality. But there are better approaches than Medicare ACOs that will enable health systems to deliver accountable care.

Meager Potential

The ACO concept has been pilot tested under the Physician Group Practice Demonstration Project. According to a CMS fact sheet, 10 of the nation's most integrated medical groups participated in the PGP demonstration, which provided each group the "opportunity to earn performance payments derived from savings for improving quality and efficiency of delivering health care services through better coordination of care and investment in care."

After five years, these 10 leading groups received a shared savings payment only 40 percent of the time. In fact, during the first year, only two groups received a shared savings payment. By the fifth year only six groups received any payout. Ultimately, over the five years, only 20 shared savings payments were distributed out of a possible 50. An objective observer of the demonstration results can only conclude that:

- it is extremely difficult for even the most integrated medical groups (as opposed to the most loosely integrated networks now being formed) to generate significant savings from Medicare fee for service patients;
- if one accepts the American Hospital Association's assumptions about the infrastructure cost of developing and operating a Medicare ACO, then even when most demonstration groups received shared savings payments, the magnitude of those payments was not sufficient, in most cases, to cover the cost.

The National Institute for Health Care Reform research brief No. 2 published in January 2011, "Lessons from the Field Making Accountable Care Organizations Real," noted that "the economic and market rewards [for ACOs] may not materialize for a long time, if ever & ." It also stated, "None of the organizations [in the demonstration] indicated positive return on investments related to improvement activities."

Many individuals within the federal government question the impact of ACOs. In his Feb. 28, 2012, testimony before the House Budget Committee, Centers for Medicare & Medicaid Services Chief Actuary Richard Foster expressed skepticism about the ability

of ACOs to tame the growth of health care costs.

In its report on Medicare demonstration projects, published in January 2012, the Congressional Budget Office reported that in the second year of the demonstration, on average, Medicare saved about $7 per beneficiary. Moreover, the office contends that these estimates of savings "probably overstate the amount of savings attributable to the demonstration because some of the physician groups appear to have changed diagnos-tic coding practices in a way that increased the risk scores of their patients relative to those of a comparison group." It is no wonder that the office questioned whether there would be any significant cost savings from the Medicare ACO program.

In a November 2011 speech, J. Thomas Rosch, commissioner of the Federal Trade Commission, also expressed skepticism about ACOs. Rosch noted that savings from the PGP demonstration "were nothing to crow about" and, therefore, reflect meager potential for ACOs to produce meaningful savings. He said that "even in the most optimistic scenario, the savings to Medicare from the ACO program are no more than a rounding error."

Second Thoughts

In addition, there is little hard data documenting the primary source(s) of the cost savings that generated the shared savings payments in the demonstration. In my discussions with PGP participants and a CMS official, they reported anecdotally that whatever savings were achieved came from reductions in both admissions and high-cost procedures such as imaging.

I have not found objective data identifying the overall impact of the demonstration on the participants' organizations when shared savings payments, reductions in utilization and infrastructure costs are all taken into account. With the exception of the Marshfield Clinic and possibly the University of Michigan, it appears that the return on investment for 80 percent of demonstration participants may have been negative even before accounting for the loss of admissions and procedural revenue.

From a financial perspective, most of the participants would have been much better off not participating in this ACO-like demonstration. Clearly this is the belief of the Everett (Wash.) Clinic, a high-performing medical group with extensive experience serving Medicare Advantage patients. The Everett Clinic participated in the PGP demonstration and has elected not to participate in the Medicare ACO program. The clinic reports that it spent about $1 million on infrastructure for its ACO, but earned only about $125,000 in shared savings payments.

The research organization RTI International and others have identified several key challenges (below) to generating savings. Unfortunately, many of these challenges were not addressed or mitigated in the final ACO regulations.

- To share savings, an ACO has to save Medicare more than 2 percent of its expected payments. This is a big number, especially for those in lower-cost Medicare regions. Geisinger, Billings Clinic, Park Nicollet and the Everett Clinic were unable to achieve this magnitude of savings in the demonstration.
- The magnitude of fee-for-service incentives overwhelms potential shared savings incentives, especially for specialists.
- Few organizations have the sophisticated infrastructure necessary to achieve significant savings.
- The patients have no skin in the game. Medicare ACOs have no power to encourage the patient to stay within the ACO network and comply with recommended medical protocols.

An Accountable Care Organization for Employees

As I stated in my previous column on strategy, organizations fail when they attempt to implement a strategy while lacking the essential competencies to execute those strategies successfully. Given that most health systems and their physicians do not yet possess the Kaiser Permanente-like competencies to achieve higher quality and shared savings, it would seem far more reasonable to build the competencies by targeting the organization's own employees rather than the Medicare population. The reasons for this are many:

- As a self-funded provider of health benefits, the health system can incentivize the employees to stay within the network and comply with medical protocols.
- Reducing employee utilization would lower the cost of health benefits, thereby improving the health system's financial performance.
- The accountable care organization would not have to contend with an external bureaucracy; the health system can make the rules.
- The target population is well-defined and relatively healthy.

Focusing on the health system's employee population and its beneficiaries, the physicians and hospital can develop the critical competencies that are needed to deliver accountable care successfully. These competencies include:

- digital connectivity of electronic health records with point-of-care protocols;
- portal for submitting all encounter data as a transitional step until the health system fully implements an integrated EHR network;
- ability to capture all claims data for every "covered life" so that cost and quality can be monitored in near real time;
- primary care capacity (medical homes using mid-level providers);
- engaged physician champions leading the accountable care organization;
- evidence-based inpatient and outpatient care plans;
- proactive programmatic approaches to chronic diseases;
- dedicated infrastructure and post-acute capabilities;
- performance-based rewards and consequences for providers.

One significant benefit of establishing these competencies is that the accountable care organization would be considered "clinically integrated" and thus could negotiate managed care contracts as a single entity.

If the health system insists on targeting the Medicare population, then it should explore co-branding or joint venturing with an established Medicare Advantage plan. Most Medicare Advantage plans possess the competencies and systems to manage a population of Medicare beneficiaries efficiently. Medicare Advantage plans profit by capturing the savings from reducing both the use of and payments for hospital services. By joint venturing or co-branding with a plan, the health system can benefit from these competencies and share in the savings.

The Place to Start

No one denies that to benefit from the intense focus to eliminate waste, physicians and hospitals have to become high-functioning, clinically integrated networks that are accountable for the cost and quality of care they provide. The empirical evidence suggests that a Medicare ACO is *not* the place to start developing these necessary competencies. Instead, the health system should create an ACOE, an accountable care organization for its own employees. The system should build its competencies in an environment where there is limited external bureaucracy, where it can incentivize patients to remain in network through plan design, and where it can reap the financial benefits of every dollar saved.

Nathan Kaufman *is the managing director of Kaufman Strategic Advisors LLC in San Diego. He is also a member of Speakers Express.*

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