Considerations for Joining an Accountable Care Organization

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Learning Objectives

- Understand what to consider before joining an Accountable Care Organization (APM participation)
- Analyze the costs and benefits of APM participation
- Assess profit and loss potentiality
- Review the experiences of your colleagues

Assumptions for the Session

1. The audience is largely comprised of people who have a stake in an independently owned clinic – clinicians or otherwise
2. The decisions to take part in a Medicare Alternative Payment Model (APM) though an "accountable organization (AO)"* has been, at least in part, researched
3. The results of the said research has not yielded an obvious choice

*To include convening organizers, accountable care organizations, direct contracting entities, etc.

Poll –
Are These Assumptions Correct?

Yes – At least for the most part

No – Not even close

What I've Experienced: How Can I Be Sure I'm Making the Right Choice?

"Uncertainty is present in the decision-making process, not so much because there is a future as that there is, and will be a past… We are prisoners of the future because we will be ensnarled by our past."

--Robert Dixon, Australian Economist

Image - "Christ In The Storm On The Sea Of Galilee." 1633 - Rembrandt

What to Consider before Joining an Accountable Care Organization

Determine the Scope: What Proportion of Your Patient Population Is Involved?

In the case of evaluating Medicare Shared Savings Program (MSSP) participation:

Quantify:

1. How many unique patients (all payers) does your clinic serve?
   a) A two-year look-back period yields a reasonable estimate.
2. Of the population mentioned, how many are traditional Medicare patients?
   a) Quality Payment Program (QPP) or Quality and Resource Use Reports (QRUR) data?
3. How has the relative proportion of the Medicare population changed over the past few years?
   a) Are there internal reasons for this change?
   b) Are there external reasons for this change?
4. Where do you see these proportions going in the next five years based on number 3 above?

What Are Your Corporate Goals?

Common answers:

- Acquisition and expansion
- Increase revenue/ encounters
- Relative market growth
- Maintain a stable business – and provide great care

The key strategy questions:

1. Where are you looking to compete?
2. How are you going to win?

Is There Strategic Alignment?

Things to think about with respect to strategy:

- Be able to describe a strategic win
- Recognize that saying yes to a strategic decision (such as joining an ACO) often means saying no to other, often really good ideas

"Strategy therefore requires making explicit choices – to do some things and not do others – and building a business around those choices."

– Roger Martin

Lafley, A. G., & Martin, R. L. (2013). *Playing to win: how strategy really works*. Boston, Mass.: Harvard Business Review Press.

Assess Stakeholders

How do you and your colleagues, and those most affected by joining an ACO, generally feel about the core aspect of *accountable care* type work?

- Increasing time spent on preventive care visits
- Implementing principals of team-based care
- Providing mentoring and coaching – helping your staff work at the top of their licensure

Have you participated in similar projects in the past?

What did you learn from those experiences?

Tools to aid in asking the right questions

There are several things to consider – see the included checklists:

1. Primary Care Physician APM General Readiness – Questions for Primary Care
2. APM Specialist Readiness – Questions for Specialists
3. Accountable Organization Review Checklist – Questions for the AO

Analyze the Costs and Benefits of APM Participation

Costs – List Fixed Costs

Fixed Costs (example):

1. Professional time to sign up – Someone will have to vet option and complete an application/agreement.
2. Do you have to buy into a key piece of technology or update any systems?
3. AO start-up costs – what do we have to pay to become part of the ACO in question?
4. Pre-implementation training – Are there training needs before you begin?
5. Ongoing time obligations – Are there recurring meeting or administrative responsibilities as part of the ACO involvement (e.g., board meetings, clinical calls, additional quality reporting)

Costs – List Variable Costs

Variable Costs (example)

1. Per Member Per Month (PMPM) fees – these are typical for many ACOs, they are often based on attribution, which may change substantially
2. Staffing Needs:
   a) Care managers
   b) Increased task load on office staff (e.g., contacting patients for prospective care, annual wellness visits, transitional care management, referral management)

For staffing-related strategies and estimated costs – consider contacting a similar-sized partner who is already doing the work. The ACO will be able to point you to these partners.

Benefits – List the Benefits Associated with Full Engagement

Start with the tangible – what can you monetize?

1. Revenue from ACO related services – Annual Wellness Visit (AWV), Chronic Care Management (CCM), and Transitional Care Management (TCM)
2. Task distribution – can you turn staff time into billable time? (e.g., nurses can bill for AWVs, medical assistants can bill for CCM)
3. Time efficiency – can you offload patient visit time from the clinician to other staff members, thus freeing up the clinician?
4. Bonuses – what potential revenue is generated from shared savings and other quality-related incentives?

Benefits – List the Benefits Associated with Full Engagement

Turning to the intangible – items for which it is harder to assign a dollar value, yet are relevant to the organization

1. Resources and data – the clinic is tapping into a larger network
2. Work satisfaction – ACO work can be very rewarding from many perspectives, including the opportunity to work as a team on important issues
3. Networking – building better relationships with referral partners
4. Quality measurement and improvement – ACOs should provide data and expertise
5. Patient satisfaction – Patients should respond positively to an increase in services
6. Promote success with future efforts – Your work will often have positive effects on efforts with other payers (e.g., better Hierarchical Condition Category [HCC] coding)

Putting the Data Together

1) Gather the figures outlined previously
2) Build a spreadsheet detailing your assumptions
3) Consider modeling out the first two years of work

*Note: There are many software solutions that can help: Smartsheet, Tableau, Excel, etc.
- You can run more sophisticated statistics including rate of return, net present value, etc., which is helpful in comparing potential projects

We will share a tool developed by Comagine Health for profit-and-loss analysis related to common ACO work

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Putting the DataTtogether

Generic Medical Clinic

YOUR PRACTICE'S FEE-FOR-SERVICE MEDICARE DATA (CY 2016):

Quality Improvement Organizations — Sharing Knowledge. Improving Health Care. CENTERS FOR MEDICARE & MEDICAID SERVICES | HealthInsight

Medicare FFS (Part B) Patients Attributed to Practice[1]	1,200

Annual Wellness Visits				Chronic Care Management			Transitional Care Management		
Visit Type	Number	%	% of Total	Chronic Care Management Service	Number	Unique Pts	Transitional Care Management Service	Number	Unique Pts
Any Type of Wellness Visit	199	17%		20 Minutes (99490)	12	10	Moderate Complexity w/in 14 Days of Discharge (99495)	22	20
Welcome to Medicare (G0402)	17	1%	9%	Complex - 60 Min. (99487)	8	7			
Initial AWV (G0438)	23	2%	12%	Complex - Addl. 30 Min. (99489)	1	1	High Complexity w/in 7 Days of Discharge (99496)	9	8
Subsequent AWV (G0439)	159	13%	80%						
TOTAL MEDICARE PAYMENT			**$24,120**			**$1,284**			**$4,351**
							TOTAL MEDICARE PAYMENT FOR ALL SERVICES (AWVs, CCM and TCM) COMBINED		**$29,755**

		Distribution of Service Types	Participation Count	Annual Total	2017 National Fee[4]	Annual Revenues	Provider Time *(minutes/unit)*	Clinical Staff Time *(minutes/unit)*	Annual Provider Time *(hours)*	Annual Clinical Staff Time *(hours)*	Total Annual Clinical Staff and Provider Cost	Net Revenue
Medicare FFS Population	1,200											
Clinical Staff[2] Cost - Fully Loaded /Hour	$55.00											
Provider[3] Cost - Fully Loaded /Hour	$165.00											
ANNUAL WELLNESS VISITS												
Wellness Care - Overall Participation		70.0%	840									
Welcome to Medicare (G0402)		10.0%	84	84	$168.68	$14,169	60	30	84.0	42.0	$16,170	
Initial AWV (G0438)		10.0%	84	84	$173.70	$14,591	30	60	42.0	84.0	$11,550	
Subsequent AWV (G0439)		80.0%	672	672	$117.71	$79,101	20	45	224.0	504.0	$64,680	
TOTAL						**$107,861**					**$92,400**	**$15,461**
CHRONIC CARE MANAGEMENT												
Patients Eligible for Chronic Care Management		30.0%	360									
Patients Eligible for CCM Who Participate		50.0%	180									
Monthly: Eligible Pts Receiving CCM (any type)		25.0%	45									
CCM - 20 Minutes (99490)		70.0%	32	384	$42.71	$16,401	0	25	0.0	160.0	$8,800	
CCM - Complex; 60 minutes (99487)		30.0%	14	168	$93.67	$15,737	0	70	0.0	196.0	$10,780	
CCM - Complex; Addl. 30 Minutes(99489)		5.0%	2	24	$47.01	$1,128	0	35	0.0	14.0	$770	
TOTAL						**$33,265**					**$20,350**	**$12,915**

You may find this helpful – though you may find a Word document with your findings is sufficient.

Quality Payment Program of Illinois

Great Lakes PTN

Assess Profit and Loss Potentiality; Review the Experiences of Your Colleagues

Where Are You Entering "Pathways to Success"? Note the One-Sided Options.

	BASIC Track's Glide Path				ENHANCED Track (risk/reward)
	Level A & Level B (one-sided model)	Level C (risk/reward)	Level D (risk/reward)	Level E (risk/reward)	
Shared Savings (once MSR met or exceeded)	1st dollar savings at a rate up to 40% based on quality performance; not to exceed 10% of updated benchmark	1st dollar savings at a rate of up to 50% based on quality performance, not to exceed 10% of updated benchmark	1st dollar savings at a rate of up to 50% based on quality performance, not to exceed 10% of updated benchmark	1st dollar savings at a rate of up to 50% based on quality performance, not to exceed 10% of updated benchmark	No change. 1st dollar savings at a rate of up to 75% based on quality performance, not to exceed 20% of updated benchmark
Shared Losses (once MLR met or exceeded)	N/A	1st dollar losses at a rate of 30%, not to exceed 2% of ACO participant revenue capped at 1% of updated benchmark	1st dollar losses at a rate of 30%, not to exceed 4% of ACO participant revenue capped at 2% of updated benchmark	1st dollar losses at a rate of 30%, not to exceed the percentage of revenue specified in the revenue-based nominal amount standard under the Quality Payment Program capped at 1 percentage point higher than the benchmark nominal risk amount (e.g., 8% of ACO participant revenue in 2019 – 2020, capped at 4% of updated benchmark)	No change. 1st dollar losses at a rate of 1 minus final sharing rate, with minimum shared loss rate of 40% and maximum of 75%, not to exceed 15% of updated benchmark

Taking on Risk – What Would I Have to Pay Back Should Things Deteriorate?

This is a very good question, and one that any risk-bearing ACO can answer.

Genal options for risk:

1. Avoid – eliminate the risk (preferable, but not always possible)
2. Mitigate – decrease the probability or impact (i.e., accept the risk)
3. Transfer – shift the impact to a 3rd party

Risk Options from CMS for ACOs

An ACO that will participate in a two-sided model must establish one or more of the following **repayment mechanisms** in a specific amount and by the deadline specified by CMS:

1. Funds placed in escrow established with an insured institution;
2. A line of credit established at an insured institution, as evidenced by a letter of credit, Medicare could draw upon; or
3. A surety bond issued by a company included on the U.S. Department of Treasury's list of certified (surety bond) companies.

*Note: Many ACOs use a collection of these mechanisms to manage downside risk

Take away message – talk to the ACO about how it manages risk and read all contracts carefully before signing.

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/Repayment-Mechanism-Guidance.pdf

The Hidden Costs – Opportunity Costs

Once you have compiled the cost benefit analysis – think about alternatives.

What other things would you do with the time and capital you are investing in an ACO?

On Alternatives and Timing

What should I do if there aren't good ACO options or the timing isn't right?

- Alternative payment models are evolving, and new options will be created
- The Merit-based Incentive Payment System (MIPS) is a good alternative to ACO participation and is a stepping stone into accountable care
- If you are in primary care – think about your population's baseline spend
  - If you are planning to ramp up service lines that will initially present a cost to Medicare, starting earlier will help build costs into future baseline calculations
- For specialists – forming partnerships without actual ACO participation may be beneficial (e.g., you may get higher-quality referrals)

Resource for primary care efforts:

https://healthinsight.org/outpatient-clinicians/strengthening-primary-care

Questions?

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Comagine Health
Formerly HealthInsight

Strengthening Primary Care – tools for many ACO-type activities including spreadsheets for business calculations:

https://healthinsight.org/outpatient-clinicians/strengthening-primary-care

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