

Proposed Guidelines for Accountable Care Organizations - Perspectives on Potential Market Impact for 2011

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Summary of Proposed Guidelines

On March 31, 2011, the Centers for Medicare & Medicaid Services (CMS), part of the Department of Health and Human Services (HHS), issued its long-awaited proposed rules for the formation of Accountable Care Organizations (ACO), required by Section 3022 of the Patient Protection and Affordable Care Act (PPACA) (*U.S. Department of Health and Human Services Press Release, March 31, 2011*). The purpose of the ACO plan, officially referred to as the Medicare Shared Savings Program, is to “establish a shared savings program to facilitate coordination and cooperation among providers to improve the quality of care for Medicare fee-for-service beneficiaries and reduce unnecessary costs.” PPACA directs HHS to establish the shared savings program no later than January 1, 2012. Contracts with CMS must be signed for a three-year period, during which time HHS estimates that ACOs will save Medicare between \$510 million and \$960 million. Officials expect 75 to 150 ACOs to launch during this period, caring for 1.5 million to 4 million Medicare beneficiaries. (N.B. The CMS ACO plan only targets traditional Medicare fee-for-service beneficiaries and not Medicare Advantage beneficiaries.) ACOs work by creating financial incentives or bonus payments, subject to meeting certain performance standards based on quality and outcomes, for providers working together to deliver cost-efficient care for a specific patient population across a variety of care settings, e.g., ambulatory medical practices, hospitals, nursing homes, home care, and other facilities. The rules include financial penalties if the ACO exceeds spending. ACOs may include various types of providers and suppliers of Medicare-covered services including physicians and hospitals in group practice arrangements, networks of individual practices (independent practice associations), partnerships or joint venture arrangements between hospitals and physicians, or hospitals employing physicians. While participation by both providers and patients is entirely voluntary, if a patient’s primary care provider joins an ACO and the patient does not want to participate, the patient must change providers.

Groups of providers can qualify as ACOs if they are able to provide primary care for at least 5,000 patients. They also must meet 65 quality standards, encompassing five categories - patient/caregiver experience; care coordination; patient safety; preventive health; and at-risk populations/frail elderly. The ACO will be responsible for monitoring and reporting on the care it delivers, including analyzing claims, reporting on numerous financial and quality data, producing

quarterly and annual aggregated reports, performing site visits, and conducting beneficiary surveys. ACOs must also establish a governing body, or board, representing ACO providers, suppliers, and Medicare beneficiaries. The board will have administrative, fiduciary, and clinical operations responsibilities for the ACO.

The 429-page proposed rule for ACOs is part of a broader effort by the Obama Administration to improve the quality of healthcare services in the U.S. Donald M. Berwick, M.D., CMS Administrator, says that “ACOs are not just a new way to pay for care but a new model for the organization and delivery of care.” The official ACO Notice of Public Rule Making (NPRM) was published in the *Federal Register* on April 7, 2011. The deadline for comments on the proposed ACO rule is June 6, 2011. The final rule is not likely to be issued before September 1, 2011. The proposed rule and joint CMS/OIG notice are posted at: www.oig.gov/inspection.aspx. For more information, go to www.HealthCare.gov/news/factsheets/accountablecare03312011a.html.

Frost & Sullivan’s Perspective on Potential Market Impact for 2011

Anyone following the highly complex and dynamic U.S. healthcare marketplace has undoubtedly heard a lot of buzz about ACOs over the last year. The subject was certainly a very hot topic at the recent HIMSS11 conference and exhibition held in February; almost every health IT vendor was touting some product or service geared towards meeting what they hope will be significant demand created by this new payment and care delivery model. If early feedback is any indication, it is highly doubtful that the proposed rules, as written, will make it over the finish line intact by September 2011. However, it is very valuable to take a hard look at what the government is proposing at this stage as it provides a good idea of the current thinking at HHS around issues of payment reform and care coordination. The proposed rules will likely yield many comments from a broad array of constituents over the next few weeks, and indeed CMS is strongly encouraging opinion and debate.

A summary of our take on the potential impact on various stakeholders is provided below -

Information Technology Companies - The proposed rule mentions the need for electronic health records and other health IT tools, stating that ACOs “will draw upon the best, most advanced models of care, using modern technologies, including telehealth and electronic health records, and other tools to continually reinvent care in the modern age”. The complexity of care coordination both at the individual and population level, monitoring and reporting on quality and outcomes, and managing finances required by the ACO rule will require a robust (and expensive) suite of technology tools including -

- patient registry programs

- scheduling systems
- care management software
- financial management systems
- tools to communicate with and educate patients, like PHRs or patient portals
- clinical decision support
- electronic prescribing
- evidence-based guidelines
- bidirectional health information exchange
- business intelligence and clinical analytics tools
- privacy and security infrastructure

ACOs will require considerable investments in IT infrastructure as well as staffing to ensure appropriate data capture and analysis. ACO IT requirements go significantly beyond that required for Stage One Meaningful Use (MU). Most significantly, CMS notes that at least half of primary care physicians in an ACO must have achieved MU of EHRs by the beginning of year two of the ACO. This is a tall order for many physicians, particularly those in small and/or rural practices. Information technology vendors have been extremely bullish on ACOs but it is important to look beyond what these companies are saying to evaluate the full potential for this new care model.

Providers - The ACO model is designed to benefit patients by ensuring a better quality of care, payers by enabling a more cost-efficient care delivery system, and providers by delivering bonus payments for improved quality and efficiency. But there's a lot of risk for providers, especially if they fall short of quality and cost measures. It is important to keep in mind two key terms that are at the heart of ACOs - accountability and coordination. ACOs require significant process re-engineering. Beyond IT investments, workflows need to be adjusted and attitudes need to change, including that of physicians' willingness to work collaboratively with each other and non-physician clinicians. Meeting these goals requires a high degree of trust among members as well as lean and cost-efficient business and clinical management. As for physicians, there is a lot of speculation about whether they are ready to change their attitudes to embrace collaboration and share risk. It's a legitimate concern. For some physicians, the loss of independence is a big deal both from a financial and clinical perspective. If doctors strongly reject the ACO model, this could spell trouble.

Providers have an enormous amount on their plate at present. Many still struggle with access to capital and staffing resources so desperately needed for IT initiatives related to MU as well as system upgrades for HIPAA 5010 and ICD-10. Providers are not likely to rush into forming ACOs; the model as proposed appears to be quite administratively complex, requiring

significant overhead for appropriate management, thus significantly cutting into potential savings.

Commercial Payers - ACO programs are not just limited to Medicare beneficiaries. Private commercial payers are also planning to form ACOs and are particularly motivated by potential cost-savings, especially in light of coming challenges to their revenue as a result of changes enacted by PPACA. For example, Cigna claims that its ACO has saved an average of \$336 per patient per year. Still, commercial payers are treading carefully like so many others and seem concerned about how large groups of coordinated providers might impact their business. America's Health Insurance Plans President/CEO Karen Ignagni recently stated that "we remain concerned that ACOs could accelerate the trend of provider consolidation that drives up medical prices and result in additional cost-shifting to families and employers with private coverage."

Manufacturers - If ACOs take off in a significant way, this could be a game-changer for how pharmaceutical companies market and sell their products in three key ways - 1) the cost-containment focus of ACOs will drive the use of generics and other low cost therapies; 2) the emphasis on evidence-based guidelines will mean that cost-benefit must be clearly demonstrated, thus driving the need for more pharmacoeconomic studies; and 3) formularies and other mechanisms of organizational control could further limit individual physician decision-making around the use of specific drugs. Some of these issues are certainly not new. Pharmaceutical and device manufacturers have been strategizing about how to navigate changes brought on by healthcare reform, cost containment efforts, and the move towards group purchasing as a result of provider consolidation for some time. Still, ACOs might just accelerate these trends, particularly in the ambulatory market, and manufacturers should be prepared for coming changes.

Patients -The patient perspective is critically important to gauge, given that ACOs are mainly targeting the Medicare population, a group well-known for their political activism and strong voice in influencing policy. Of potential concern is that even if a patient decides to participate with an ACO provider, they can still refuse (or opt-out) of the requirement to share data with CMS. If this takes place on a significant scale, it could undermine the evidence-based care model that ACO's depend on. How the prospect of ACOs plays out in the media over the next few months will be interesting to watch. If ACOs get branded as "the new HMOs" (*not* a positive connection in consumers' minds) or the perception takes hold that cost-savings will be at the expense of limiting care for seniors, expect major grumbling from the public.

Conclusion

While it's a bit early to predict the full impact of the proposed ACO rules, we can say at this point that the rules are so complex and the IT requirements so steep that only large, sophisticated healthcare organizations with a strong network of primary care providers can reasonably be expected to form an ACO, at least in the short-term. The government estimates that the average ACO will spend \$1.75 million in the first year, but this significantly underestimates the real costs, according to some industry observers. While all range of providers are looking carefully at ACOs and many are putting together initial plans, planning and implementing are two different things. Providers will need to carefully weigh all the financial risks and rewards. While we definitely note a strong level of interest in the ACO model, we are somewhat pessimistic that providers - and consumers, for that matter - will be as enthusiastic as the government and some health IT vendors have predicted. That said, we do believe that investments in health IT systems will continue to move ahead at a steady clip. The proposed ACO rules will likely provide a slight stimulus in sales for those providers thinking about getting their systems in place *just in case* they decide to move forward with an ACO model. However, the proposed rules are not expected to be a significant driver of health IT purchasing in 2011.

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