Pioneer ACOs: Quantifying risks and identifying opportunities

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In May of 2011, the Centers for Medicare and Medicaid Services (CMS) unveiled a program to spur growth of accountable care organizations (ACOs) prior to the full implementation of the Medicare Shared Savings program. Named *Pioneer ACOs*, these organizations are intended to be hospitals or large medical practices with a demonstrated history of care coordination and quality improvement. They are *pioneers* in the sense that they have already embarked on organized care practices and have some of the needed infrastructure in place and are therefore leading the way for others. As such, it is expected that Pioneer ACOs will be able to demonstrate methods for achieving both cost savings and care improvement in the Medicare fee-for-service (FFS) population.

Participants in this program will have the potential to be financially rewarded for per-patient savings, but they are also at risk for a loss should patients cost more than expected in aggregate. In this white paper we discuss the elements of risk associated with Pioneer ACOs as well as potential strategies for controlling costs and identifying opportunities for savings.

ACO REIMBURSEMENT

The Pioneer ACO reimbursement arrangements contain strong incentives to reduce patient costs in the form of relatively high shared savings. ACO performance will be measured financially by comparing actual per-member costs against a target per-capita benchmark developed by CMS. This benchmark will be determined by analyzing the three-year actual retrospective costs, their growth, and the medical risk of the actual underlying population that will be *attributed* to the Pioneer ACO. The core payment arrangement with CMS takes the form of increasing risk-bearing for the Pioneer ACO according to the following schedule.

Year 1: The Pioneer ACO will enter into a shared savings arrangement with CMS in which the Pioneer ACO will either receive payment from CMS (for savings) or make a payment (for average per-person costs exceeding the benchmark) subject to a 1% savings/loss threshold compared to the benchmark to account for random variation. The Pioneer ACO will bear 60% of the savings/losses subject to a maximum of 10% of total projected Medicare Part A and B expenditures for aligned patients.

Year 2: Payment arrangements will be similar to Year 1, with the modifications that the Pioneer ACO will retain 70% of shared savings/losses subject to a cap of 15% of aggregate (Part A and B) expected costs.

Year 3: Pioneer ACOs that have achieved minimum average annual savings (between 1% and 5% depending on the state of operation) in Years 1 and 2 will be eligible to move to a *population-based* model in Year 3. In this arrangement, the Pioneer ACO will receive fee-for-service payments of 50% of the standard rate schedule, as well as capitated monthly payments that equal the projected remainder of fee-for-service per-member costs. Costs will be reconciled, and under the core arrangement 70% of savings/losses will be borne by the Pioneer ACO, subject to the 15% cap. This arrangement is intended to foster methods of care delivery that may be uncompensated in the current fee-for-service arrangement.

Years 4 and 5: CMS may offer two additional performance periods (subject to the same payment arrangements as Year 3) if the ACO continues to demonstrate savings and/or meet performance standards. In Years 4 and 5, baseline expenditures would be reset to reflect average Medicare spending for aligned members during 2011-2013 (this includes Years 1 and 2 where costs have, in theory, been managed down from the initial baseline).

Above we describe the *core* reimbursement arrangement; however, CMS has also outlined Options A and B, which are variations on the core arrangement and represent lower risk and

higher risk, respectively. Additionally, CMS has been open to alternative arrangements and at least two such alternatives have already been announced.

MANAGING FINANCIAL RISK AND UNDERSTANDING COST DRIVERS

Given the possibility of downside risk (which is not required in the first three years of the Medicare Shared Savings Program (MSSP) ACO arrangement with CMS), Pioneer ACOs must actively take steps to manage financial risk. Some of the possible risks include the following:

- Variability of typical patient costs
- High-cost illness and end-of-life care
- Variability of physician practice patterns
- Variability of patient physician choices

Pioneer ACOs must understand that they are not HMOs; benefits may not be restricted and patients may not be limited to using physicians within the Pioneer ACO. As a result, the Pioneer ACO must seek other avenues of reducing per-member expenditures while maintaining quality and patient choice.

Per-person medical costs can vary significantly from year to year for a variety of factors. To dampen the effects of unexplained variation, CMS requires that Pioneer ACOs have a member base of at least 15,000 (5,000 for rural entities).

The exhibits below demonstrate how a lower variation in costs significantly reduces the probability of actual costs exceeding the benchmark as a result of random fluctuation.

In the exhibits, the blue curve represents expected claim costs before the implementation of the ACO, while the red curve represents the expected claim costs after the implementation of ACO cost and utilization control measures. The expected claim cost in each curve is the peak of the curve; note that the expected cost after starting the program is lower than the expected cost before implementation as shown by the red curve moving to the left of the starting blue curve. The tan area represents the probability that, even after ACO cost control measures are implemented, actual claim costs are higher than the benchmark.

In Figure 1, high variability of expected costs (illustrated by the fatter curves) shows that there is a significant possibility the ACO will exceed the CMS benchmark despite reduced costs (sizeable tan area). In Figure 2, which has half the standard deviation (illustrated by the skinnier curves), we see there is a significantly diminished probability of loss (relatively small tan area).

The exhibits illustrate the importance of understanding the variability in claims that contribute to the benchmarks. The savvy ACO will want to understand the variability in underlying claims in order to best understand the change in claim costs needed to maximize the probability of achieving shared savings.

Even the ACO that implements successful programs may see shared savings diminished or wiped out by a large random fluctuation in patient costs. To hedge against these effects, it would be prudent for the ACO to address the following questions.

- Year over year what services are associated with the highest variability in cost?

FIGURE 1: HIGH FLUCTUATIONS IN YEARLY COSTS

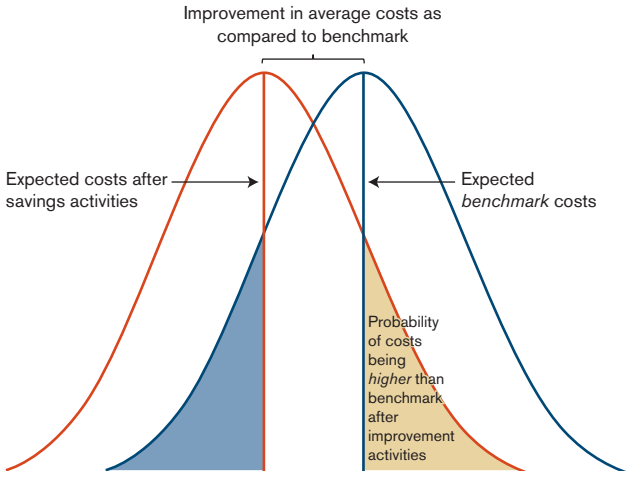
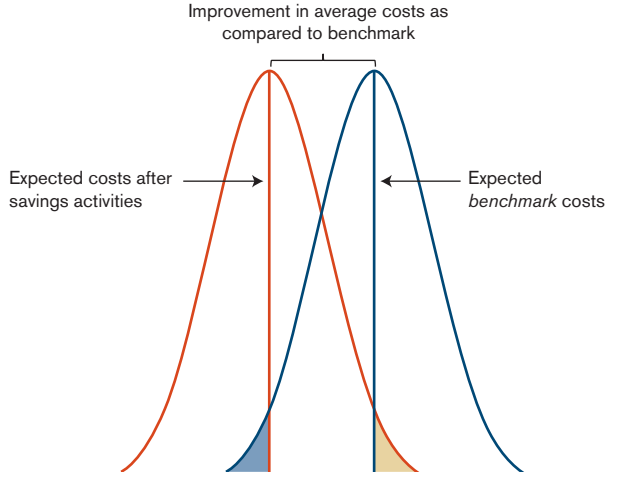


FIGURE 2: REDUCED FLUCTUATIONS IN YEARLY COSTS



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- What patients have experienced high cost volatility? What are their characteristics, and how might such patients be identified in the future?
- How do physician-driven decisions on treatment for high-cost conditions result in varying overall claims costs?
- How will an increased patient population size reduce the risk of random fluctuations in cost? What are the probabilities of loss as the ACO expands?
- Are there standards of care that can be implemented that would reduce volatility?

The financial teams behind Pioneer ACOs should carefully consider the magnitude of potential financial loss and take steps to hedge against this risk much as an insurance company would. This may take the form of setting aside financial assets to cover losses (reserves) or purchasing insurance (reinsurance). A detailed understanding of the downside risks will help the Pioneer ACO determine its needs in these areas.

Understanding cost drivers

Although there will always be some degree of unexplained variation in medical costs, there will be a substantial number of opportunities for the Pioneer ACO to manage patient care, resulting in improved outcomes and reduced costs. In the Pioneer ACO's efforts to reduce costs, it will be essential to understand what is driving patient costs and in doing so assess what is and isn't working. It will be beneficial for the Pioneer ACO to investigate the following.

- How do patient costs and utilization compare to national or regional benchmarks? What are the sources of deviation?
- Who are the most expensive patients? What are their characteristics? Are there patients with similar characteristics (e.g., age, gender, medical conditions) that have lower costs? What is driving the difference?
- What procedures or services have the highest costs or highest utilization rates? What are the outcomes of patients who use these procedures or services? Is there an opportunity to use lower-cost procedures that are equally effective?

Pioneer ACOs will have the opportunity to work with CMS to obtain medical claim data for their aligned members. These data can be carefully analyzed to help identify and correct issues, such as those mentioned above.

IDENTIFYING OPPORTUNITIES

The Pioneer ACO program structure gives participants the unique opportunity to reevaluate the cost-to-benefit impact of services. Carefully planned programs have the opportunity to both benefit patients and improve cash-flow for the organization.

Identifying interventions

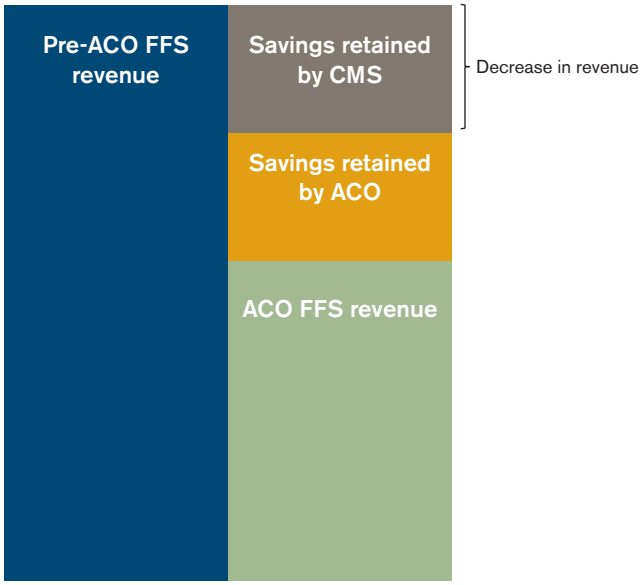
Physician Donald Berwick, the former chief of CMS, characterized health spending in the United States as fraught with *an extremely high level of waste*. Often, patients receive care that is both expensive and unnecessary, leaving both the payor and the patient dissatisfied. Careful analysis can identify patients who may benefit from intervention.

- Are there any patients who exhibit unexpected jumps in costs or utilization? Can these patients be assigned a case manager to help manage their conditions? Although these interventions rarely produce short-term savings, they have been shown to improve clinical outcomes and may reduce costs in the long term.
- Are there any patients who have inappropriately high levels of utilization, especially ER use? This can be a sign of underlying problems, including poor home care or depression. Such patients should be identified and appropriate care provided.
- Through what channels are individuals being attributed to the ACO? What are the variations in cost and utilization based on attribution (provider) source? Are there opportunities to provide more appropriate care?

Maintaining or expanding margin

In aggregate, successfully achieving shared savings will necessarily reduce aggregate revenue. Figure 3 illustrates how even a Pioneer ACO that achieves savings will, in aggregate, have less revenue.

FIGURE 3: COMPARISON OF AGGREGATE REVENUE BEFORE AND AFTER THE IMPLEMENTATION OF A SUCCESSFUL ACO (YEARS 1 & 2)



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Of course, a decrease in net revenue does not necessarily mean a decrease in profit margin. Shared savings payments will increase Pioneer ACO profit margin. Additionally, a Pioneer ACO may wish to understand which services have both a low margin and a low relative utility and seek to drive down utilization of such services.

Working with CMS

Pioneer ACOs, to a greater degree than Medicare Shared Savings ACOs, are in a good position to work with CMS using payment arrangements that are mutually beneficial. Because the Pioneer ACO is taking on substantial risk, it will be essential that it understands and agrees that baseline benchmarks are fair and well-grounded, and that shared savings payments are accurate and based on fully completed data.

A successful ACO will have a deep understanding of its own data, understanding drivers behind patient costs as well as unavoidable sources of increasing costs (such as an aging patient base). Detailed records will allow the Pioneer ACO to work successfully with CMS. This is particularly true in Years 3, 4, and 5 when partial capitation and rebasing of expected member costs will expose the Pioneer ACO to additional risk.

A careful and ongoing understanding of patient expenses will place a Pioneer ACO in a position to manage arrangements that are mutually beneficial.

WHAT DOES THIS MEAN?

Pioneer ACOs need to be aware of the numerous sources of financial risk associated with variation in patient utilization patterns, patient choice, physician practices, and aggregate revenue streams. It is important to properly prepare for and manage the potential for loss as well as to develop strategies for maximizing the potential for shared savings. Ultimately, Pioneer ACOs must move away from the fee-for-service mentality to develop programs that drive down patient costs through care coordination and patient support. Pioneer ACOs should use their unique positions to enter into payment mechanisms that support development while mitigating the potential for serious loss for the Pioneer ACO.

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