FEATURE STORY

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bumps along the ACO road

Accountable care organizations (ACOs) can expect to encounter several challenges that are not addressed in the final guidelines for participation in Medicare's ACO project.

AT A GLANCE

The success of ACOs will depend on whether they can avoid difficulties inherent in six areas:

- Measuring costs
- Computing expected costs
- Managing prevention and wellness
- Managing resources per case type
- Managing the direct cost of resource units and fixed costs
- Addressing conflicting incentives

Much has been made of the role that ACOs can play in better managing the healthcare needs and costs of the Medicare population. But making sure that an ACO will work as planned is a tricky matter. Newly emerging ACOs will encounter several bumps along the road to success.

The Department of Health and Human Services (HHS) has yet to address these obstacles. The changes between the proposed guidelines for ACOs, issued in March 2011, and the final guidelines, issued in October, deal mainly with matters of risk and risk sharing, quality measures, eligible providers, electronic health record requirements, and the assignment of patients to an ACO.[a] The Centers for Medicare & Medicaid Services (CMS) and the incipient ACOs still need to deal with the following six "bumps."

Bump No. 1. Measuring Costs

A key feature of the ACO program is shared savings. The goal is for an ACO to deliver care for its defined population at a lower cost than otherwise would have been expected. This goal raises the thorny question of exactly which costs will be measured and how. Because Medicare's traditional fee-for-service (FFS) system will remain in effect, costs likely will be measured in terms of Medicare's payments to the ACO rather than the ACO's actual costs of delivering care. But the two are quite different.

The issue is further complicated because many hospitals have failed to develop the kinds of sophisticated cost accounting systems that other

a. For a summary of the ACO final rule, see Berwick, D.M., "Making Good on ACOs' Promise—The Final Rule for the Medicare Shared Savings Program," *The New England Journal of Medicine*, Oct. 20, 2011.

industries have used for more than two decades. Instead, they compute the cost of any given test, procedure, or other activity by using a ratio of costs to charges (RCC) or a relative-value unit (RVU), both of which can be highly misleading.[b]

As to which costs will be included, the easy approach would be for CMS to sum Medicare's payments to the ACO's hospitals and physicians. But this approach leaves several questions unanswered: Will total costs also include other payments (such as for pharmaceuticals) for the ACO's patients? If not, what incentives do an ACO's physicians have to think about their prescribing or other cost-influencing decisions that are excluded from the computations?

A related question: How can an ACO juxtapose Medicare's traditional FFS system with activities that could be cost-reducing? For example, what if, instead of meeting individually with five diabetic patients to discuss blood sugar management, a physician met with them as a group? The group visit would take longer than an individual visit, but not five times longer. How should the physician bill for this? How will group visits factor into the ACO's computation of physician productivity?

Similarly, what about the cost of programs for obesity counseling or smoking cessation, which can help to reduce risk for a wide variety of conditions, but for which the ACO's physicians (and other providers) are not compensated? And on what basis should an ACO decide, say, whether to purchase (at its own expense) eyeglasses for a frail elderly patient to help him or her avoid a potential fall, which would result in a hospitalization?

To be successful, then, ACOs will need to make a variety of sophisticated and complex benefit-cost trade-offs for services that receive no (or inadequate) payment, but that may result in some substantial downstream savings. How will CMS determine if the ACO has done a good job in making these trade-offs, and how far "downstream" should CMS look? One year is too short for many of these decisions, but if the "shared savings" are to be assessed for longer than one year, the appropriate timeframe needs to be stipulated.

As with early hospital behavior under DRGs, there likely will be a few years before ACOs move from game-playing to serious cost-reducing behavior.

Bump No. 2. Computing Expected Costs

A related issue concerns an ACO's expected costs. An ACO will be responsible for a defined patient population, and CMS will forecast the expected costs of this population using per-patient expense benchmarks. What kinds of opportunities will exist for an ACO to influence the composition of its patient population in such a way that it can be reasonably assured of achieving the requisite savings?

We can speculate about how some of this will play out. In the early 1980s, when diagnosis-related groups (DRGs) were introduced, consulting firms developed sophisticated software packages to help hospitals combine primary and secondary diagnoses to classify discharged patients into allowable DRGs that were reimbursed at the highest rate. Similar game-playing behavior can be expected by an ACO that is creating its defined population. Software development probably is already under way to assist ACOs with their gerrymandering efforts. As with early hospital behavior under DRGs, there likely will be a few years before ACOs move from game-playing to serious cost-reducing behavior.

Bump No. 3. Managing Prevention and Wellness

Two important cost drivers in health care are case mix and volume. Presumably, an ACO will use

b. For a discussion of why, see Young, D.W., "The Folly of Using RCCs and RVUs for Intermediate Product Costing," *hfm*, April 2007.

screening, assessment, and counseling to help address them. To the extent that an ACO can keep its defined population healthy (or at least out of the hospital), it can keep its costs down. So immunizations, mammographies, blood pressure measurement, ventricular function assessment, and the like presumably will be emphasized.

However, it is likely that many patients will not take advantage of these wonderful opportunities to improve their health. Consider the challenges associated with a potential weight-management program, for example. In 2009, 27 percent of the U.S. population 60 and older was obese, according to the Centers for Disease Control and Prevention (www.cdc.gov/obesity/data/trends.html#State). ACOs (and, by extension, CMS) will face many challenges from patients who fail to act in their own best interests, such as nonsmoking members of the defined population who take up smoking, and patients with coronary artery disease who do not take their prescribed medications.

These challenges raise an important, and unanswered, question: How will CMS assess the performance of an ACO whose sincere efforts to offer a full range of prevention activities are thwarted by uncooperative patients?

Bump No. 4. Managing Resources per Case Type

Case mix and volume are only a part of the story. An ACO also must manage the resources it uses for particular case types. For example, it needs to know what combination of outpatient visits and pharmaceuticals are appropriate for a hypertensive patient, and how often colorectal screening should take place.

Physician choices complicate this challenge. Consider, for example, a physician who has the option to transfer a patient from an inpatient setting to some form of subacute or rehabilitation care but is deterred from writing the order by the prospect of having to round in two sites. Similarly, consider these comments by a physician: "A patient comes to my office and tells me he's been on the Internet, and has decided he needs an MRI. It will take me 20 minutes to explain to him why he does not need the procedure, and 20 seconds to write the order. What should I do?"

More generally, many physicians, especially those in academic medical centers, have resisted developing clinical pathways for their inpatients, even though the idea has been around since the early 1980s.[c] What will happen when they are asked to include pre- and post-acute care activities in the pathway? The thought is not encouraging.

These kinds of decisions, and a host of similar ones, dictate resources per case. Denying the Internet-savvy patient an MRI is only the tip of the iceberg. If early discharge from the hospital, coupled with some home visits, makes sense, how will the ACO—with its antiquated and inaccurate cost accounting system—measure the resulting cost implications? How will CMS know if the ACO has done a good job?

Bump No. 5. Managing the Direct Cost of Resource Units and Fixed Costs

Besides managing resources per case, an ACO must consider its direct cost for each resource unit a physician orders, along with its base of fixed costs. With regard to the former, suppose that part of an ACO's prevention strategy includes colorectal screening every five years (and suppose patients comply). How much should a colonoscopy cost? The amount will be quite different from the fee that Medicare pays. Among the issues the ACO must address are the length of the procedure, the appropriate combination of providers (gastroenterologists, nurses, technicians) involved, the amount of time each of those providers should spend on the procedure, and the cost of each unit of time (which results from a combination of salary and productivity). An ACO that is serious about cost control must undertake this sort of analysis for almost all of its physician-ordered resource units.

c. See, for example, Young, D.W., and Saltman, R.B., "Medical Practice, Case Mix, and Cost Containment: A New Role for the Attending Physician," *JAMA*, Feb. 12, 1982.

In terms of the ACO's fixed costs, the Accountable Care Act envisions higher utilization of expensive technology, which, theoretically, will lead to lower unit costs. Over the longer term, one logically would expect to see a reduction in a hospital's technology purchases. But will that really happen? Does CMS naively expect that medical technology equipment manufacturers will take this lying down?

A related dilemma concerns a hospital's nontechnology fixed costs, which include such items as accountants and computers in the executive suite, housekeepers and floor buffers in the housekeeping department, and dietitians and ovens in the dietary department. If, as expected, screening and prevention result in reductions in patient volume, a hospital will have less revenue available to cover these costs. In the short term, the hospital's margin will decline. Over the longer term, the hospital will need to reduce staff and delay the replacement of existing equipment. This, of course, is one way the Accountable Care Act will achieve some of its intended cost reductions. But reducing the average cost of an inpatient day will not come without some pain, especially to those individuals representing "fixed costs" who join the ranks of the unemployed.

Bump No. 6. Addressing Conflicting Incentives

Currently, there are no financial incentives to give patients "skin in the game." Indeed, because patients will be free to seek care from any Medicare provider, including those from outside the ACO's network, their incentives often will conflict directly with the ACO's cost-reduction goal. Why should patients become involved in a governing board discussion about "shared decision making" in their ACO when their time could be better spent finding a primary care provider outside the ACO's network who won't try to limit their options or nag them about their fast-food diets?

Creating appropriate incentives for patients cannot be achieved solely by instituting copayments or deductibles. Rather, an ACO (apparently without support from Medicare) will need to find ways to limit patients' freedom of choice. Patients certainly should have an appropriate channel to appeal physician decisions that they believe compromise the quality of their care, but should they be allowed to shop for more lenient physicians than those in the ACO, or to engage in behavior that is detrimental to their health?

Allowing patients who do not get the procedures or referrals they want from within the ACO to go elsewhere undermines the entire ACO concept. It also resurfaces the question of how an ACO's costs will be measured. Will the cost of treatment outside the ACO's network be part of the cost total that is compared with the expected costs, or will those costs be exempt from the comparison?

Similarly, it seems that few, if any, sanctions will exist for patients who do not follow an ACO's programs to help them manage their weight, blood sugar, hypertension, tobacco use, or any of several similar matters under their control. Should these patients be assessed some sort of noncompliance fee? Should the penalty be supplemented with a reward for engaging in health-promoting behavior, similar to what many automobile insurance companies do to encourage safe driving? Sharing in the ACO's savings, as has been suggested by some, is likely to be insufficient: The rewards will be too uncertain, too far outside of an individual patient's control, and/or too far in the future to be effective.

Ample evidence exists in the organizational theory literature to suggest that people respond to financial incentives. If patients who compromise their health were assessed some sort of fee, or if those who engage in health-promoting behavior were rewarded, the chances are good that at least some of them would alter their behavior. But as currently designed, ACOs are expected to emphasize many "quality-of-care" activities that assume, among other things, patients who will cooperate when they have no financial incentive to do so.

Moving Toward Value-Based Health Care

ACOs presumably will help in the move toward a so-called "value-based" healthcare system.[d] Because value is determined by a ratio of benefits to costs, ACOs will need to attempt to either increase benefits or reduce costs, or both, to achieve value. But will patients be prepared to accept the behavioral consequences of these efforts? It is not clear they will, but, even if they did, it is unlikely that the ACO would be able to determine value. Many benefits are difficult to measure and/or accrue over several years into the future, and computing the "full cost" of treating a patient no doubt will remain as flawed as it has been for the past 30 years.

Even without knowing per-patient costs, ACOs will need to think hard about each of the five healthcare cost drivers (case mix, volume, resources per case, direct cost per resource unit, and fixed costs). Indeed, to "bend" its total cost curve, an ACO will need to bend a lot of individual cost curves, including those of patients, equipment manufacturers, hospital employees, and physician specialists. It is not yet clear whose cost curves will be bent and by how much.

Smoothing Out the Bumps

Several of the six bumps can be addressed directly by an ACO; others will require ACOs (and the medical community as a whole) to encourage CMS to modify its thinking about what constitutes successful performance.

For example, on its own, an ACO can begin to make improvements in its cost accounting system. It can undertake activity-based costing (ABC) to gain a better understanding of the resources needed for its various "intermediate products" (such as an MRI or a lab test) associated with an episode of illness. ABC has been used in other industries for many years, and its concepts can be transferred to health care without too much difficulty.

The ACO also can gather information on the resources it uses for each case type (e.g., a DRG). Many hospitals now do this, but the effort needs to be extended to the physician practices that are part of the ACO. Properly structured, this information can identify those physicians whose ordering patterns diverge from the norm without an underlying clinical rationale. Such an effort will need to be designed and managed by physicians, not administrators.

Another step the ACO can take is to measure and manage the direct cost of providing a physician-ordered resource (such as a colonoscopy). Best practice standards can be developed and used to ensure that these resources are being provided as efficiently as possible.

ACOs also will need to work with CMS to define more clearly how "success" is measured, and to determine the timeframe that is used to measure it. Regulations (or legislation) may be needed to ensure that patients do not go outside the ACO network to seek care. Similarly, incentives will be needed to reward those patients who engage in health-promoting behavior. And it may be necessary to penalize those patients whose behavior jeopardizes their health.

Working alone, an ACO will not be able to address these broader health policy issues. Rather, ACOs will need to work cooperatively with CMS and other involved parties to craft a set of incentives that rewards them for their efforts to improve patients' health status rather than just to provide efficient care when needed. The challenges are nothing short of daunting. ●

d. For a pioneering discussion of this idea, see Young, D.W., Kenagy, J. W., and others, "Value-Based Partnering in Health Care: A Framework for Analysis," *Journal of Healthcare Management*, March/April 2001.

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