ACCOUNTABLE CARE ORGANIZATIONS:

HEALTH CENTER STRATEGIES FOR SUCCESS

NATIONAL ASSOCIATION OF
Community Health Centers

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INTRODUCTION

History of the Accountable Care Organization Model

One of the key programmatic changes created by the Patient Protection and Affordable Care Act (ACA) of 2010 was to establish a new payment methodology for the Medicare system, known as the CMS Shared Savings Program for Accountable Care Organizations. The goal of this provision of the ACA was to create an approach to paying for health care services that, over time, helps to reduce costs, improve quality, and increase the patient experience of care.

The Centers for Medicare and Medicaid Services (CMS) defines an Accountable Care Organization in the following way:

"Accountable Care Organizations (ACOs) are groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high quality care to their Medicare patients.

The goal of coordinated care is to ensure that patients, especially the chronically ill, get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors.

When an ACO succeeds in both delivering high-quality care and spending health care dollars more wisely, it will share in the savings it achieves for the Medicare program."[1]

This definition is widely accepted as it relates to the CMS Shared Savings Program for Medicare. Given that many other payers are now encouraging ACO formation, a narrower definition will be used for the purposes of this white paper:

"ACOs are groups of independent healthcare providers that collaborate on strategies to improve quality and patient experience of care, while reducing total medical expense. ACOs are eligible for financial incentives when they achieve these goals."

Dr. Elliot Fisher,[2] director at the Center for Health Policy and Research at Dartmouth Medical School, is considered the first to articulate the model and utilize the name "Accountable Care Organization." So while the ACA did not create the concept of Accountable Care Organizations, it served as a defining event in legitimizing the model as a significant attempt at redesigning the healthcare delivery system. Many similar attempts to coordinate care across independent practices and settings of care have been utilized by health insurance organizations for many years, and the Health Maintenance Organization (HMO) model of care has many similarities to the ACO model.

The ACO model fosters creativity and innovation, and there is much variation in the types of ACOs that are emerging. It is important to realize that ACOs are very new. The early data and evidence about their effectiveness is just becoming available. Therefore, it is too early in their history to determine true best practices about the real costs and benefits associated with building an effective ACO. This white paper lays out key facts about ACOs and provides a framework for evaluating whether or not they are a good model for Health Centers to continue as a part of their future strategy for serving their patients.

Since the inception of the ACO provision of the ACA in 2010, 341 organizations have entered into the Medicare Shared Savings Program for ACOs.[3] Since many Health Centers serve a small Medicare population, they have been slower to become involved in ACO models as compared to other primary care providers.

A few prominent Medicare ACOs that include Health Centers are:

- The Maine Community Accountable Care Organization (http://www.mainecommunityaco.com/)
- Community Health Accountable Care LLC (Vermont)
- Redwood Community Care Organization ACO (California, http://www.rchc.net/redwood-community-care-organization-aco)

Because of wide uptake of the model, it has had significant influence on state-run Medicaid programs and commercial health insurers, who have also seen significant growth in their own ACO-type programs. Utah, Colorado, Oregon, and Minnesota[4] were early adopters of the ACO model for their Medicaid program, while other states including Vermont, Iowa, and Illinois have each adopted their own programs. Many others are considering the model as a part of the strategy for controlling costs and enhancing quality while expanding Medicaid.

1 http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ACO/

2 http://pnhpcalifornia.org/2010/10/the-history-and-definition-of-the-%E2%80%9Caccountable-care-organization%E2%80%9D/

3 http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/News.html

4 http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8319.pdf

State implementing ACO model	Resources
Utah	• http://www.nashp.org/aco/utah • http://www.deseretnews.com/article/865600576/Utahs-Medicaid-reform-has-been-a-quiet-success.html?pg=all
Colorado	• http://www.nashp.org/aco/colorado • http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1233759745246
Oregon	• http://www.nashp.org/aco/oregon • http://www.nejm.org/doi/full/10.1056/NEJMp1214141
Minnesota	• http://www.nashp.org/aco/minnesota • http://mn.gov/health-reform/health-reform-in-Minnesota/
Vermont	• http://www.nashp.org/aco/vermont • http://gmcboard.vermont.gov/sites/gmcboard/files/Medicaid_ACO_Standards_Draft.pdf
Iowa	• http://www.nashp.org/aco/iowa • http://dhs.iowa.gov/sites/default/files/ACO%20Agreement%20470-5218%20(Final.3.14).pdf
Illinois	• http://www.nashp.org/aco/illinois • https://www2.illinois.gov/hfs/PublicInvolvement/cc/ACE/Pages/default.aspx

Because these ACO programs focus on Medicaid patients, Health Centers in these states should educate themselves about the options for participating in these programs. Health Centers may find that these programs are attractive in that they create opportunities to test new models of care, such as the Patient-Centered Medical Home, in a payment methodology that creates limited financial downside risk. Further, they will find that these programs will have an impact on the patients they currently serve. In some cases, Health Centers that wish to continue to serve these patients may be required to enter these programs.

This document is designed to help Health Centers evaluate whether participating in an ACO might make sense for their organization and patients. For a variety of reasons, which will be discussed, the ACO model may be a good opportunity for Health Centers to test their effectiveness under new payment methodologies. Recent trends in the evaluation of ACOs suggest that Health Centers may be very effective in developing care coordination models that address quality and cost.

Key Components of Accountable Care Organizations

There is a lot of complexity to how Accountable Care Organization models work as well as a lot of variation. It is best to attempt to understand key common components of these models. Because of the sheer magnitude of the CMS program, it has had a lot of influence on the design of Medicaid and Commercial models, and therefore ripe for exploration into these key concepts.

Most ACO programs have five areas in common. Health Center leaders should consider the following five areas when contemplating their participation in ACOs:

1. Attributed patient populations
2. Base compensation terms
3. Population cost baselines
4. Shared savings pools
5. Quality measures

Attributed Patient Populations

A cornerstone of the ACO model is its attribution of patients. This refers to the linking of an individual patient to an ACO, typically through the relationship that patient has established with a primary care provider participating in that ACO. Generally, this is done by analyzing historical claims data, using specific formulas to determine which primary care provider should be considered accountable for each patient. The CMS program only considers physicians in their attribution formula, and thus patients are not attributed to mid-level providers. Most Medicaid ACO programs will attribute lives to mid-levels, such as Nurse Practitioners or Physicians Assistants. This attribution is performed to establish the accountability for cost and quality outcomes. Each patient can be attributed to one, and only one, primary care provider, and each primary care provider generally can participate in one, and only one, ACO with each payer. In this way, the payer, provider, and patient are all aware of the relationship and the impact it has on the rest of the program.

Health Centers interested in the ACO model should understand the impact of specific attribution criteria on the size of the population they will ultimately serve. For example, depending on specific attribution rules, a patient receiving their primary care at a Health Center but specialty care at a hospital may be attributed to the hospital for Primary Care. This happens when the specialist bills evaluation and management codes for the patient, and either sees the patient more recently than or more often than the Health Center. Other challenges Health Centers have faced in the attribution process is proving patients are in fact receiving care at the Health Center if those patients were previously uninsured. In this case, the Medicaid agency might not have any historic claims payment data to attribute patients to the Health Center.

Health Centers have faced challenges with the population of patients attributed to their ACO because of the exclusion of mid-level providers. All programs are slightly different, but Health Centers should make sure they understand attribution rules ahead of budgeting and planning an ACO.

Base Compensation Terms

Although there are exceptions, ACO programs typically do not alter the way in which providers are paid for services. Patients can continue seeing the same providers, including primary care providers, hospitals, and specialists, and those providers continue to be paid under the same arrangements as they had been previously. This creates two important effects: first, this creates a situation where any cost savings generated by the ACO must be achieved primarily by reduced utilization of services; and second, those who wish to create or participate in ACOs do not have to negotiate new base payment terms for themselves or for other providers (i.e. specialists) they partner with to provide care to their attributed patients.

This is an advantage to health centers because they are not required to alter their current payment arrangements with CMS or others to participate. For example, and in most ACO models, a Health Center can continue to receive its Prospective Payment System (PPS) rate from either Medicaid or Medicare. ACOs are an opportunity to create additional revenue streams above and beyond PPS based upon a Health Centers ability to provide high quality care and decrease the overall health care expenditures for an identified group of attributed patients. For example, in Iowa, Health Centers seeing patients enrolled in the "Wellness Plan", which provides insurance to patients 19-64 years old with income up to 100% of the Federal Poverty Level[5], can receive care coordination payments and qualify for other financial payments based on quality scores. These Health Centers still receive their Prospective Payment System (PPS) or Alternative Payment Methodology (APM) rates in this model.

Within the CMS Medicare Shared Savings Program, Health Centers benefit by maintaining their historical payment terms from Medicare. They should be cautious, however, of State Medicaid and Health Insurance Marketplace ACO contracts that may require them to waive their historical payment options.

The Population Cost Baseline

In order to determine whether an ACO qualifies for payments based on saving money, the payer (i.e. Medicare) must calculate an anticipated or expected cost for the attributed population. This is known as the "population cost baseline". The methodologies used to determine these baselines vary across ACO program models. For example, in the case of the Medicare Shared Savings program, CMS focuses the population cost baseline by a weighted average of three-years of paid claims data history for the precise attributed population, while applying cost growth factors and an expected minimum expected savings percentage to arrive at an expected cost. In contrast, some Medicaid programs establish the baseline relative to statewide trends in Medicaid budgets, and other programs, like those being offered by health plans operating in a State Marketplace, based on a percentage of the total premium paid for the population.

5 https://dhs.iowa.gov/sites/default/files/WellnessPlanEvaluationDesignApproval.pdf

Population Cost Baselines: A Real World Example

All Medicare ACOs will receive a table similar to figure 1. This is one of the most important pieces of information an ACO will receive, because it defines how CMS reached the conclusion as to the target "population cost baselines" for each of four populations:

- ***ESRD*** – *End Stage Renal Disease*
- ***Disabled*** – *Patients who qualify for Medicare because of their disability status*
- ***Aged / Dual*** – *Patients who qualify for both Medicare and Medicaid because of their age and income.*
- ***Aged / Non-Dual*** – *Patients who qualify for Medicare, only, because of their age.*

	ACO Patients Average Annual Expenditure			
A. Assigned Beneficiary Trended Per Capita Expenditures ($)	2011	2012	2013	
A1. ESRD	72,598	71,377	73,263	
A2. Disabled	7,145	7,292	7,251	
A3. Aged/dual	8,881	9,029	9,634	
A4. Aged/non-dual	7,491	7,695	7,466	
B. Three-Year Weighted Average Annual Per Capita Expenditures ($)	2011 (10%)	2012 (30%)	2013 (60%)	Cost Baseline
B1. ESRD	7,260	21,413	43,958	$ 72,630
B2. Disabled	714	2,188	4,351	$ 7,253
B3. Aged/dual	888	2,709	5,781	$ 9,377
B4. Aged/non-dual	749	2,308	4,480	$ 7,537

Figure 1. The CMS Medicare Shared Savings Program for ACOs determines the population cost baseline of each of four population types by taking the weighted average of the previous three years cost for the population of patients served by the ACO. Note that this is sample, but representative data.

Each payer will use a different mechanism for determining a projected medical expense, or population cost baseline. CMS uses a model that is based on the historical total medical expense for the precise population of patients attributed to the ACO for the previous three years.

In figure 1, rows A1 through A4 show the annual, total medical expense for four populations of patients served by the ACO in each of the previous three years.[6] CMS assigns a weight of 10% for the first year, 30% for the second year, and 60% for the third year. This weighted average produces a Cost Baseline by population within each of the four populations presented. This can be seen in lines B1 through B4.

	Determining Cost Baseline			
C. Assigned Beneficiary Proportions and Expenditures	Percent	Number	Cost Baseline	Cost
C1. ESRD	0.006	47	$ 72,630	$ 467
C2. Disabled	0.293	2,143	$ 7,253	$ 2,129
C3. Aged/dual	0.135	987	$ 9,377	$ 1,268
C4. Aged/non-dual	0.565	4,125	$ 7,537	$ 4,258
D. Historical Benchmark (Weighted Average Per Capita Expenditures $)	-	7,302		$ 8,121
E. POPULATION COST BASELINE				$ 59,302,191

Figure 2. This chart shows how CMS uses the weighted average of the historical cost by population to determine an average total medical expense.

In figure 2, rows C1 through C4 show the percentage of the population attributed to the ACO within each of the four populations (ESRD, Disabled, Aged/dual, Aged/non-dual.) This is multiplied times the cost baseline for each population established in figure 1 to determine the amount of money, on average, that each patient should cost. This number ($8,121) times the number of attributed patients (7,302) yields the total Population Cost Baseline. In this case it would be $59,302,191. The ACOs goal would be to manage the population to a cost lower than this figure.

6 There is a very modest amount of risk adjustment/evaluation done prior to reaching these numbers but in general these are very close to the actual historical average total medical expense by population.

Health Center led ACOs will face a number of challenges in how cost baselines are established for their patients. Generally, these are the first time Health Centers are seeing the impact of historical coding and risk adjustment on the available financial resources to care for patients.

Shared Savings Pools

The difference between the population cost baseline and the actual cost of the population defines the "shared savings pool." The term "shared savings" refers to the fact that this pool is typically shared between the payer and the provider. Like with how the baseline is calculated, there seems to be a lot of variation in what percentage is eligible to be shared to the providers under ACO programs. CMS has two options, which it calls "Track 1" and "Track 2." In Track 1 the providers can receive up to 50 percent of the savings, and have no potential down-side financial risk if they exceed the population cost baseline. In Track 2, the ACO can receive up to 60 percent of the savings they generate, but they are held liable for a portion of any costs that exceed the population cost baseline.[7]

By way of example, an ACO with a cost baseline of $100M, is in Track 1, and has an actual cost for that same period of $98M could receive up to half of the $2M in savings, or $1M. The same ACO in Track 2 would be eligible to keep $1.2M (60 percent instead of 50 percent) but if their costs exceeded $100M they would actually have to pay some of the difference.

Health Centers in an ACO program will face the challenge of acquiring the skills necessary to incorporate claims data into their cost evaluations. For example, strong database programming ability will be required to access, format, and analyze very large data files and create meaningful information for clinicians. Doing this work, however, will determine how effectively the clinicians can plan new interventions and target specific patients who could be most helped by intervention. Further, ability to measure changes in cost over time, again by analyzing these claims data files, is an important predictive tool for determining whether the ACO is trending above or below its population cost baseline.

Quality Measures

The actual portion of the shared savings pool that the ACO receives is ultimately determined by performance against a series of quality measures. These measures are designed to evaluate the ACO on factors such as population health, management of at-risk and frail populations, patient experience, care coordination, and patient safety. [8] The measures adopted by CMS for the Medicare Shared Savings Program include measures that would not be appropriate for populations of patients that are not typically eligible for Medicare (such as those under age 65, the typical age for Medicare eligibility) and therefore Medicaid and commercial insurance ACO programs may likely establish different measures of quality.

In all, the quality measures are an attempt to evaluate and prevent the restriction of services in order to maximize shared savings potential. This emphasis on quality of care measures, in part, attempts to respond to widespread criticism of past attempts to manage care based on cost outcomes. HMO programs that led to "care rationing" were previously critiqued for reducing the quality of care and diminishing positive patient experience.

Some of the measures employed by the Medicare Shared Savings Program are familiar to Health Centers, as they include several measures that are identical to measures in the Table 6B of the UDS report. Several other clinical performance measures look at transitions of care, and Health Centers may not have been exposed to these measures. Other measures that CMS use include Consumer Assessment of Healthcare Providers (CAPHS) measures for patient experience of care, and measures related to utilization. There is little publicly available data to determine how Health Centers are performing against many of these measures today.

Health Centers will face challenges of developing the capability to monitor and evaluate all 33 measures throughout the program year. This is essential to ensuring a successful outcome at the end of the year, since it will allow them to change course or implement new strategies. If Health Centers in ACO models wait until the end of the program year to evaluate quality for the first time, there is little change they will be able to have a measureable impact on quality prior to submitting their data.

For more information about these measures, and how well they align with things Health Centers are already measuring, please see here: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Quality_Measures_Standards.html

In order for an ACO program to work effectively, the payers of care and the providers of care must understand each of these components and the impact they have on their reimbursement. They both must agree whom the patients are (attribution), what is paid out when those patients utilize care (base compensation terms), what the expected cost will be (cost baselines), what the unspent resources are at the end of a given time period (shared savings pool), and the impact on quality and patient experience (quality measures.)

7 http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/ACO_Methodology_Factsheet_ICN907405.pdf

8 http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/ACO-NarrativeMeasures-Specs.pdf

THE FINANCES OF ACO CONTRACTS

When entering into an ACO contract, Health Centers must understand the five principles articulated above in order to properly plan their programs. There are a few important considerations before determining whether these programs are right for a group of providers, especially Health Centers.

1. **Successful ACOs will Receive Less Total Compensation**

   Although ACO contracts do not typically change the way in which providers are paid for the services they provide to patients, creating a shared savings pool will require the reduction in *total utilization of healthcare services*. The fact that a portion of this savings remains with the payer, means for an ACO to generate an incentive payment, the total expenditure on care must decrease. Therefore, utilization revenue to the total group of providers that care for an ACOs attributed patient population will be lower than it was before entering into the ACO model.

   This effect is less pronounced for primary care providers within ACOs which are generally expected to spend *more*, not less, time with patients. Hospitals, specialists, and ancillary providers (i.e. laboratory providers, radiology providers, etc.) may see declines in their utilization and therefore revenue associated with these patients.

   While the shared savings paid to an ACO can be used to offset these losses in revenue, it is important for all participating providers to understand that, if the ACO is successful, there will ultimately still be a net decline in total utilization revenue.

2. **There are Significant Costs Associated with Starting and Running an ACO**

   The requirements for what an ACO must do in order to reduce costs and improve quality of a population of attributed patients are generally not very prescriptive. This is intentional, as it leaves the responsibility of innovation in the hands of the ACO. However, there may be regulatory or programmatic elements that will require the ACO to create enough infrastructure to meet key program requirements, such as the quality reporting requirement or governance. While not required, it is generally assumed that providers in ACO relationships have implemented Electronic Health Records (EHR) systems, and that capabilities for sharing of information between these systems may exist.

   Most ACOs have found it important to establish a common repository of patient information for the purpose of self-evaluating performance against goals and prioritizing of ACO work.

   Health Centers who enter the model should evaluate what options might already exist in their community to assist them in performing data aggregation and analysis for this program. In some cases, Statewide Health Information Exchanges (HIE) or Regional Health Information Organizations (RHIOs). Several Primary Care Associations and Health Center Controlled Networks have come together to build a shared clinical repository. For example, the Community Health Center Association of New York State (CHCANYS) has a program named the "Center for Primary Care Informatics."[9] This program allows its members to perform data analysis, benchmarking, and real-time evaluation of quality measures. Many of the measures provided are aligned with ACO quality measures. Otherwise, the cost of these systems may range from hundreds of thousands dollars to several million dollars.

3. **ACO Incentives are Generally Paid Retrospectively**

   Given that the shared savings incentives in the ACO model are based on the actual financial results of a population within a given time period (for example, 12 months), results and any payments cannot be distributed until the close of the period and an appropriate claims "run-out" period. For example, CMS uses a six-month claims run-out.

   It can take significant time to determine the actual cost incurred by a population and compare it to the expected costs to calculate if incentives are due to the ACO. Once the measurement period has begun, it is not uncommon for an ACO to wait up to eighteen months before receiving any shared savings owed to them.

   This creates a conundrum for ACOs: Should they invest heavily ahead of this curve to create programs specifically designed to minimize cost and improve quality with the potential for significant payback? If so, where will this investment come from and what impact will it have on the operating budget of the organization?

   To make an effective decision about investments that the ACO should make, they should first evaluate the potential upside of receiving shared savings and make a decision on how much to spend. The budget should

9 http://www.chcanys.org/index.php?src=gendocs&ref=Statewide%20Primary%20Care%20Informatics%20Data%20Warehouse&category=HIT

realistically allow for shared savings to be paid back by the potential shared savings incentives in the first year. Other best practices include phasing in aspects of the program over time, with a focus on clinical quality interventions that target small populations of high-risk, high-cost patients.

4. **ACOs Can Create Financial Instability in Some Markets**

In some markets, certain provider groups may face market sensitivities to the ACO model. Hospitals, in particular, may face particular financial impact on their operations if ACOs are successful in reducing total medical expense of a population. In areas where hospitals are already financially fragile, efforts to coordinate care and transition primary care conditions away from emergency departments can have significant financial impacts on financial stability of these organizations. Those who are responsible for designing an ACO will need to engage these providers to create consensus on how shared savings may be used to help shore up these organizations.

5. **Determining Models for Distributing Incentives is Challenging**

For many providers participating in an ACO, the ACO contract will signify their first foray into establishing internal policies for the sharing of incentive payments. The contract between the payer (Medicare, Medicaid, etc.) and the ACO is typically silent on the way in which savings are distributed once they are paid to the ACO. Thus, it is up to the ACO to write its own rules and policies for distributing the savings with its participating providers. ACO leaders must balance the need to utilize these incentives to incent providers to do the care coordination work necessary to generate savings, but also must consider the providers who will have sacrificed revenue to make the model work. Further, the ACO must maintain some amount of funding to support its basic operating expenses and plan for any future program enhancements.

There are now more physician-led ACOs (organized by physicians) than hospital or health-system led ACOs.[10]It is believed that part of the reason for the recent increase in the number of physician-led ACOs is that physicians, particularly primary care physicians, feel equipped to effect the cost of care with care coordination techniques. By leading the ACO, physicians can dictate how the incentives paid to the ACO are distributed. The priority will be on compensating the physician practices that are providing this care coordination.

Going forward, Health Centers will want to consider their options for joining or even forming an ACO given this dynamic. Health Centers are generally better positioned to do care coordination within their facilities than other physicians, and benefit by having a shared savings arrangement that can compensate them for the effort they apply.

6. **Different ACO programs have different financial risks**

The CMS Medicare Shared Savings Program has an option that has no "downside" risk. This means that if the ACO has a total medical expense that exceeds the target, they are not held financially liable for this risk. Known as "Track One," this is a widely chosen option. In "Track One" the ACO can receive as much as fifty (50) percent of shared savings. On the contrary, "Track Two" includes "downside" risk. In this track, the ACO has to pay back to CMS a portion of any cost overruns. In return, the ACO gains the ability to receive up to sixty (60) percent of generated savings. In models such as "Track Two", that include downside risk, participants in the ACO may have to contribute to any losses sustained by the ACO. Every ACO program is different, and it is important to understand the risk options, known as "risk corridors."

If Health Centers enter into ACO contracts or programs, it is strongly suggested that they favor options with no down-side risk in early years. This will allow them to build the capacity and expertise to better understand their risks before entering higher-risk options.

7. **Implications on Health Center reimbursement**

One of the benefits of ACO models is that they typically keep base compensation consistent with previous compensation. Thus, Health Centers that are receiving a cost-based reimbursement model prior to joining ACOs continue to receive this payment. When properly structured as incentive payments earned based on quality or cost performance, the Health Centers do not need to include distributions from an ACO when reconciling their finances. Thus, any incentives paid are truly above and beyond their cost-based reimbursement. A qualified attorney should be engaged to ensure that ACO distributions are structured properly.

On the other hand, if the Health Center is in an ACO that has "downside risk", they could be required to pay the payer back if the total cost of the population exceeds the population cost baseline. They cannot receive any reconciliation based on their PPS or APM payment methodology to compensate them for this loss. As such they could be exposing themselves to risk that could create financial challenges.

10 http://jama.jamanetwork.com/article.aspx?articleid=1861359#jvp140051r5

Generally, it is wise to consider that the total cost of implementing an ACO program and entering into ACO contracts could easily reach $1M, especially when considering the necessary capital to operate these businesses long enough to reach the first payment period.

COMMON ACO MODELS

It is a common misconception that ACOs must be led by vertical health systems and hospitals. In reality, many different models have emerged. Practically, the primary determinant of eligibility for an ACO lies in the requirement that an ACO must take accountability for 5,000 lives with an ACO payer in order to enter their contract. This varies slightly by payers, but is in fact the entry requirement for the Medicare Shared Savings Program.

There are three models that health centers should be aware of:

The Hospital or Health-System Centered ACO

In this model, a hospital, group of hospitals, or health system acts as the convener of the ACO. Currently, this model of ACO is predominant among those ACOs that have entered into the CMS Medicare Shared Savings Program. This model is popular because some hospitals or health systems have the financial resources to move effectively into these contracts, can adequately resource the infrastructure necessary to meet the program requirements, all while remaining whole financially in the event that utilization is reduced in their community. Further, hospitals and health systems may have relationships within their communities that are natural foundations for ACO activities. For example, they may run a Physician Hospital Organization (PHO), affiliate with an Independent Practice Association in their community, or directly employ primary care providers.

In this model, the hospital or health system will generally operate the ACO itself. The hospital or health system may offer participation to primary care providers and other providers in the community, but will likely require these providers to use certain information systems (including, potentially, switching EHR systems to use a common platform).

Advantages for Health Centers:

- Health systems often, but not always, cover much of the cost of forming and operating the ACO.
- Health Centers may gain improved access to needed services, such as specialists, because in this model the Health System and Health Center have mutually vested interests in the outcome.
- Health Centers can benefit from coordination approaches led by Health Systems, in terms of getting access to information to better care for their patients.

Disadvantages for Health Centers:

- Health System led-ACOs are not typically focused on the unique needs of Health Centers, and thus might not have Health Center interests as a priority. For example, Health Systems might not understand the impact of the Health Center reimbursement methodology (whether PPS or an APM). Other examples include that they may not adequately fund Health Centers to address social determinants of health, and they may prefer to work with primary care providers who are employed by their Health System.
- These types of ACOs will often have reduced options for Health Centers to participate in governance including Board participation.
- There are concerns that Health Centers may experience an increased shift in risk, receiving riskier and more complex patients, as the result of joining Health System-led ACOs. There is not enough experience yet to prove this, but it is a possibility based on a variety of factors. For example, if distributions of shared savings are made to participating organizations on a per patient basis, there may be an unintended effect of incenting a Health System to try to attract patients with less complicated diseases and social determinants.
- In markets with multiple ACOs or Health Systems, Health Centers may feel as if they have limited ability to choose between competing entities. Aligning with one ACO versus another could create a challenge working effectively with the other ACO's hospitals and specialists. This can create challenges for Health Centers that wish to remain neutral and collaborate with more than one.

The "Primary Care Only" ACO

Some ACOs include only primary care providers. There are several examples of health centers that have created "primary care only" models. In this model, the primary care organizations set up and operate a new entity to serve as the ACO, and share in savings based on the attributed population they represent.

One of the most common misconceptions about ACOs is that they must involve hospitals, specialists, and other providers. While some State programs require participation of non-primary care providers in ACOs, CMS has no such requirement. Instead, the only real requirement that determines the makeup of a Medicare Shared Savings Program ACO is that that its participants care for 5,000 or more Medicare beneficiaries. Thus, this model has gained some popularity.

The advantages of this model for Health Centers are that primary care providers can have a significant impact on cost and quality without formally involving other providers, but if they do so, they can retain a greater portion of the shared savings upside. Typical strategies for achieving success in creating shared savings and improving quality will be to identify which hospitals, specialists, and other providers in a given community offer better quality for their cost. If the ACO is successful in steering patients to these providers, they are able to realize a cost savings. Further, programs such as emergency department diversion, after hours

availability, and open-access scheduling can be implemented partially or fully without formal participation from others.

Even if there is no downside risk in the contracts themselves, there is the financial risk associated with making investments in an ACO without the guarantees of shared savings payments in the future. Primary Care ACOs must be fully funded by the participating Primary Care providers. These costs may be shared across primary care providers as lump-sum payments made into the ACO entity, or could be structured as a pro-rata payment based on percentage of attributed lives.

Another challenge that this model presents to Health Centers is that it may not be possible to fully implement desired interventions without the help of other providers. For example, it is difficult to envision an emergency department diversion program in which the hospital is not invested in the outcome. Most important, however, is that this model may be perceived as financially threatening in a given community. A successful ACO in this model, one that reduces the total cost of care, could reduce revenue to hospitals in its community, as quality improves and unnecessary care is reduced. If this comes at the expense of non-ACO providers, it can be seen as creating financial risk for the overall healthcare infrastructure in a given region.

"Primary Care Only" ACOs are worthy of consideration, particularly in the early stages of formation of a Health Center ACO, because it may be much simpler to organize initially. Health Centers generally have more understanding of their capabilities and infrastructure and those of their partner Health Centers than of hospitals and health systems. However, over time, "Primary Care Only" ACOs should consider the effect of not including other provider groups into their model. As services and interventions mature, new innovations and coordination of efforts across care settings may require partnerships among primary care in order to maximize savings and improve care coordination and quality outcomes.

Advantages for Health Centers:

- Health Centers have much greater chance of having significant influence on governance.
- Health Centers are not obligated to share savings with hospitals and other providers, in these models.
- Health Centers can build on experience working together on quality, such as disease collaborative and UDS reporting initiatives, to effectively achieve a lower total cost of care and higher level of quality. It may be easier to design the ACOs programs with a narrower group of stakeholders.

Disadvantages for Health Centers:

- These ACOs must be funded entirely by Primary Care providers, without the benefit of investment from hospitals.
- These models may be seen as disruptive to other providers, who may fear shifting of patient referral patterns and lost revenue. This could make for tense relations.
- Health Centers may have hospital or health system representatives on their Boards, further complicating these discussions.

The Primary Care Led ACO

A hybrid between the two previous models is the primary care led ACO. In this model, the primary care providers form the ACO and set its rules for participation. They then include other providers, including hospitals and specialists who may be harmed financially by reduced utilization. In this model, they look for ways to use the shared savings to incent non-primary care providers to help implement strategies to reduce utilization and share information. For example, they may require that hospitals participating in the ACO share admissions and discharge data in a timely fashion in order to be eligible for shared savings distributions. Generally, primary care providers have greater say in the governance and operations of the ACO in this model, but also may bear a much higher burden of the start up costs.

Advantages for Health Centers:

- Health Centers can lead discussions about governance and control the level of influence that other providers have, while still involving them in their ACO.
- Health Centers may be able to secure investment from others in this model.
- This model creates similar opportunities for collaboration as the "Health System-led Model."

Disadvantages for Health Centers:

- Unlike the Primary Care Only model, savings are distributed more broadly.
- Health Centers may need to provide much of the up-front investment to get the model started.
- Health Centers will face many varying opinions about how to distribute savings. These conversations can be tense and challenging, and can lead to mistrust and other issues between participants. Few proven distribution methodologies exist for developing these models at this time. If joining an ACO, the Health Center will need to know how likely the distribution methodology offered to them will cover the costs of participation. If leading the creation of an ACO, the

Health Center must be prepared to define and justify their approach to creating a distribution methodology without access to historical examples and benchmarks to compare to.

DESIGN CONSIDERATIONS FOR EFFECTIVE ACOS

An effective ACO will convene stakeholders from the healthcare provider and patient community to design and implement strategies that reduce costs, improve quality, and improve the patient experience of care. There are limitless possibilities for how to set up an effective ACO, but the following key factors will assist organizations in understanding the key operational functions:

1. Existing ACO and ACO-like networks: Not all Health Centers will have the ability to convene an ACO in their community. In some cases, ACOs will already exist and will have a significant head start on engaging participants. In other cases, networks like Independent Practice Associations and Health Systems could effectively limit the options of the ACO based on their sheer size and market penetration. This could leave Health Centers with limited options, most of which include joining with existing networks or ACOs. Existing networks and ACOs are not required to involve Health Centers at all.

   Design considerations:

   - Are ACOs already operating in a Health Centers market?
   - Are they willing to allow Health Center participation?
   - Do their opportunities for Health Centers to participate come with options to participate in the governance?
   - Will Health Centers be adequately compensated if they are effective in managing cost, quality, and patient experience?

2. Designing Effective Governing Boards and Committees: All ACOs are required to have a governing body or board. Effective ACOs are able to navigate a lot of complicated decision-making processes quickly, disseminate information and strategies to participants, and keep a close eye on ACO finances. There are many new concepts to properly educate board and committee members, and thus the time and effort commitments can be high. ACOs that have created smaller, representative boards coupled with empowered, expert committees will have an advantage in designing and governing an ACO.

   Design considerations:

   - Is the envisioned board of the ACO large and with broad enough representation from different provider types to account for differences between its participating provider organizations?
   - Yet, is the board small enough to support timely decision-making?

3. Setting Standards for Participation: Ultimately, the ACO must create consistency in care processes in order to test and evaluate its method for reducing costs and improving quality and experience. Given the limited incentives available to encourage independent providers to adopt these processes and methods, ACOs are strongly encouraged to set standards that determine whether an individual participating provider organization is eligible to receive a distribution of shared savings. For example, hospitals that agree to implement emergency department diversion programs may be eligible for shared savings distributions, whereas those who do not have these programs in place may not. Likewise, Health Centers must take a hard look at the quality indicators for other Health Centers and determine whether each would be a good fit for the ACO.

   Design considerations:

   - Does the ACO have a vision for which processes and interventions will address the unique cost, quality, and patient experience challenges associated with the population served?
   - What methods can the ACO employ to incent its participating provider organizations to implement these processes and interventions?
   - Can the ACO remove provider organizations that routinely do not assist in achieving cost, quality, and patient experience goals?

4. Recruiting Participating Provider Organizations: Often an ACO is started by a smaller set of provider organizations than is needed for it to work effectively. Therefore, almost all ACOs will find themselves at some point in their history recruiting additional participants. This can be tricky, particularly for organizations that have not had to do this type of network development previously. There will always be unanswered questions about how the ACO will be run and how successful it will be, so it is to be expected there will be a lot of uncertainty expressed by organizations who are approached to be included. The process of recruitment should be started as soon as the ACO has established some of its core standards of participation and several months before contracts require the network to be

formally defined. ACOs have found recruitment not to be a one-time activity, but something that must be revisited at each point in which a contract allows you to add or remove participants, often annually. Again, these types of conversations run contrary to typically collegial relationships most Health Centers share with one another but is nonetheless vital to ACO success.

Design considerations:

- Can the ACO identify which non-Health Center providers are most needed to help them implement the ACO processes and interventions?
- Is the ACO willing to set standards, and then hold its participants accountable to these standards? This would include denying participation to an organization not meeting its standards, and sanctioning or even removing an organization that falls below the standards.
- Is there someone working on behalf of the ACO that can engage executives within these potential partner organizations in meaningful conversations about the value of participating in an ACO?

5. Managing and Mitigating Political Challenges: Health Centers who have attempted to lead ACO development activities have found a unique set of politics in play as they undertake their work. For example, hospitals may perceive Health Centers as comparatively more expensive than other primary care providers and thus favor working with non-Health Center providers. Some states have been unclear on how shared savings payments are factored into cost reports. In some markets, Health Centers may be pressured to join local hospital-centric ACOs, which will cause them to align more closely with one hospital in their community than with another. This can create strained local relationships. Generally speaking, Health Centers should attempt to get out in front of these issues by communicating their approach broadly and by being inclusive in the ACOs design.

   Design considerations:

   - Can your Health Centers leaders effectively communicate the value of including Health Centers in ACOs?
   - Can they also effectively communicate the value of having an ACO in the community the Health Center serves?

6. Projecting the Size of the ACO: All of the financials of an ACO are driven by the number of lives attributed to that ACO. Health Centers must be aware of the factors such as their billing methods, and employment and contracted relationships with providers that could create challenges for insurers who are performing attribution of patients. Since CMS attributes patients to physicians and does not attribute them to mid-level providers, it is not uncommon for a Health Center-led ACO to see a reduction of 40 percent or more of the total number of Medicare patients as reported on their UDS report. Health Centers that wish to be involved in ACOs must be aware of this and determine how patients attributed to a mid-level provider can be linked to a Health Center physician. In newly emerging Medicaid and commercial ACO programs, Health Centers must be aware and advocate for attribution models that take the uniqueness of the Health Center model into account.

   Design considerations:

   - Does the Health Center have a large enough population of patients to consider operating under an ACO contract?
   - Can the Health Center identify which patients are likely to be attributed, based on each contacts rules for attribution?

7. Balancing Participation with Autonomy: Since ACOs will set and enforce standards, Health Centers must be aware of the impact of these standards on their autonomy in decision-making. A heavy-handed ACO program could go as far as to expect a Health Center to switch EHR platforms and to divest themselves of some existing processes to the ACO itself. Other ACOs will have much lower requirements, but may struggle to effectively move performance across the network. Whichever model is selected, Health Centers must insist on clarity early in the process before determining if an ACO is right for them.

   Design considerations:

   - Will joining an ACO require the Health Center to give up local decisions in favor of ACO decisions? (For example, will the ACO require the Health Center to convert to a new EHR?)
   - Will the ACO set other standards that are too high for the Health Center to hit?
   - Will the ACO provide a lot of central services that will be redundant with those already being provided by the Health Center (for example, care coordination?)

8. Creating Shared Savings Distribution Formulas: Discussed briefly above, ACOs must determine how to share any incentives paid to the ACO with its participants. This can be a very challenging aspect of ACO design, with little available information on which models are working most effectively. The best advice available at this time is to ensure that formulas are clear, indisputable, and create enough incentive for all participants to adhere to standards. It is also recommended that there be some flexibility in the model to address scenarios where an individual provider organization either goes above and beyond in terms of effort necessary to achieve ACO goals, or one in which an individual provider is disproportionally hurt by reduced utilization. Lastly, all ACOs should agree up front to retain some portion of shared savings to establish a reserve fund.

   Design considerations:

   - Do all participants understand how the ACO contract pays the ACO participants?
   - Can the ACO assist the Health Center in predicting the cost of implementing ACO processes?
   - Based on these costs, can the Health Center determine how to fund the necessary changes, particularly in ACO contracts that provide no up-front investment?

9. Establishing the Centralized Functions of an ACO: There is no limit on the creativity that can be applied to setting up the ACO itself. At a minimum, it is recommended that the ACO have capacity to handle the data reporting and analysis functions necessary to support the providers which includes analysis of claims data. They should have a clearly documented strategy for care management and quality improvement activities (even if these are to be handled by staff within the participating provider organizations.) They all must maintain capacity to manage compliance with ACO contracts, and should have appropriate resources to provide network development and recruiting functions. Some ACOs will stop there, while others will adopt other managed-service like functions which may include Health IT, centralized care management, telehealth capacity, or other functions.

   Design considerations:

   - Are Health Centers willing to adopt services from the ACO if they can be more efficiently delivered by the ACO?
   - Are there disadvantages to centralizing services if they are within the scope of services allowed to be performed by the Health Center?

KEYS TO SUCCESS AND GETTING STARTED

Successful ACOs achieve improvements in three key areas: reducing total medical expense of the population served, improving quality against pre-defined quality measures of care, and improving the patient's overall experience of care. More specifically, successful ACOs will create an additional revenue stream if they achieve the goals in the three areas that can be used to reinvest in primary care strategies and capacity for keeping populations healthy.

These final key factors that each Health Center leader should understand prior to entering into an ACO relationship are focused on a more basic level of success: effectively entering into ACO contracts with an eye for how these contracts will be managed to cost, quality, and patient experience outcomes.

Given the high value placed on primary care in ACO contracts, Health Centers are well positioned to create their own ACO models, or participate in hospital or health-system-led ACO models. Doing so is not a one-time activity, but instead requires an ongoing focus from Health Center executives and boards. That said, the keys to getting started effectively and creating a foundation for success are:

Understand the timelines

CMS has historically allowed entry to the Medicare Shared Savings Program once a year. Usually, an organization will have just a few short weeks to complete an application once it is released on the CMS website. Health Center leaders can check this CMS website: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Application.html to learn about whether there is an existing application available to enter the ACO program. In 2014, CMS opened an application process that required organizations wishing to enter the Medicare Shared Savings Program for ACOs to submit a letter of intent by May 30, 2014 and then complete a full application by July 31, 2014.

Medicaid ACO programs have taken longer to develop, and have typically been managed by the state in conjunction with interested providers. The time to start planning a potential ACO is not once the application is available. It is recommended Health Centers start at least six months prior to the anticipated release of an opportunity to enter an ACO contract. Realistically, many ACOs spent greater than a year getting prepared.

Understand the finances

As discussed earlier, there is no money available up front from CMS to form an ACO. While some states are offering support for ACO development, it is often not enough to do all of the things an ACO will have to do prior to receiving its first incentive payment. There are also many ACOs who have not qualified for incentive payments even well into the program. Therefore, expect for the ACO to require significant funding to reach sustainability. Each participant should expect to bear some of the cost, and the in-kind contributions of executive and provider time to design the ACO can far outstrip the actual cash outlay. Health Centers face the added challenge that their Bureau of Primary Healthcare Grants cannot fund ACO development activities, so they must be funded out of other sources.

Have a plan for diversification

Most ACOs form around the decision to enter a single ACO contract. Given all of the work necessary to make the model work, it is often advantageous to seek other potential contracts. Even if the programs do not work exactly the same, the types of capabilities an ACO will support can support multiple new payment methodologies. Since ACOs are becoming common in some states where Medicaid and commercial insurers have also introduced ACO contracts, Health Centers in these markets should evaluate how the contracts are supportive of each other in terms of building a single infrastructure for management. If any of the contracts provide up-front financial support for infrastructure development, it is strongly recommended Health Centers understand their options for using this up-front funding from one contract to build out common infrastructure for managing all patients. When done effectively, ACO contracts with up-front payments to the ACO can be used to purchase or implement programs that are capable of benefitting all patients served by the ACO.

CONCLUSION

The ACO model has gained such traction that it is estimated that as many as 40% of all Medicare beneficiaries are served by an ACO as of January 1, 2014. This represents a dramatic shift in how Medicare pays for services and it is important for all Health Centers to understand their options and consider participating in an ACO. Even if joining or forming an ACO is not right for an individual Health Center at the current time, relatively small changes in the local environment can change that decision making process dramatically. For example, in states where Medicaid has not been expanded, ACO models can emerge quickly as either an alternative to expansion or as part of an expansion strategy. Likewise Health Centers and Primary Care Associations can be driving those conversations now to assure the primary care components, and the shared savings opportunities are maximized. Health Center leaders should continually evaluate their opportunities to be a part of ACOs going forward and look to create new ones.