AMERICAN NURSES ASSOCIATION

ACOs : Follow the Money

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The proposed regulations establish a system of risks and rewards for physicians, other clinicians, and hospitals that combine to form an Accountable Care Organization (ACO) and contract with CMS for a three year period. The basic reward structure involves two factors. The first is the reduction in Medicare total approved charges. The second factor is based on quality of care. If quality measurements indicate performance at less than the top percentiles of benchmarks, then the ACO's share of any savings will be reduced. The general incentives in the ACO program are to reduce Medicare expenditures while maintaining or improving quality of care.

The risks for potential ACOs involve both startup costs and continuing costs of operation for the ACO itself. It should also be understood an ACO's health professionals will see reductions in their own Medicare revenues. Unless those reductions are offset with revenues from other patient groups some of the ACO savings logically would be netted out of the general financial returns to improved utilization. That is, if you reduce your own utilization for Medicare beneficiaries you have to plan to recoup that loss from savings elsewhere.

Based on prior ACO-like demonstration experience CMS has estimated that startup costs are likely to be on the order of $1.7 million. CMS acknowledges that ACO startup costs may be even greater if a proposed organization does not already have the infrastructure of those prior demonstration participants. In addition to startup and operational costs, ACOs will be at risk for their share of any increased expenditures experienced by beneficiaries assigned to the ACO.

There will be two types of contracts for shared savings/risks. Under option 1 an ACO will not be at risk during years one and two; only during year three. Option 1 ACOs can receive a maximum of 50% of their demonstrated savings in years one and two. Under option 2 an ACO will be at risk for all three years, however, the maximum shared savings rate will be 60%.

CMS proposed to limit the potential returns under its ACO contracts in a number of ways. Savings that may be shared with the ACO must exceed a minimum percentage, ranging from 2% for the ACOs with 60,000 or more assigned Medicare patients to 3.9% for the smallest organizations (with 5000 patients). Less than top quality scores would lower potential return percentages. CMS will also withhold 25% of any savings until the completion of the contract to help assure that the ACO can fund any potential losses. Any losses of less than two percent will not need to be repaid to CMS.

Other Considerations

There are a variety of commentators who have written of their perception of dim prospects for ACOs as proposed.[i] Nonetheless there remains a great deal of interest and advocacy expressed regarding ACOs. The CMS Actuaries project annual Medicare per capita beneficiary cost on the order of $10,143 for 2012.[ii] The smallest ACO could share in savings on a base of $50.7 million. The ACO with 60,000 beneficiaries might claim a share

of savings off a base of $608.6 million. If those per capita costs were reduced by just 2.5%, the maximum return to the larger ACO could be as much as $3 million. Thus a single year's reward could exceed the estimated startup costs. Of course, a single year's losses could have exactly the opposite effect.

There also is a chance that ACO or ACO-like programs will be started in the private market. Being involved with an actual Medicare ACO may be a useful chit to display when negotiating with potential private market funders. In fact, one potential short term advantage of being a Medicare ACO may be the somewhat reduced attention that private market negotiations with ACOs are alleged to expect from the FTC and Department of Justice. Being in the early adopter class may bring additional gains to the ACO from shared savings with private health insurers. If ACOs are the wave of the future promised by some commentators, getting in as the wave starts to build could promise a much longer ride on the board.

Cautions for RNs and APRNs

There will be opportunities for nurses that arise with the advent of ACOs. To rationalize and improve patient utilization there will be a need for care coordination. This is the essence of nursing, and one can expect increased demand for RNs with care coordination experience in hospitals, clinics, and health insurance companies. One might expect the evolution of nurse-led firms providing care coordination services on contract to ACOs.

RN employees in hospitals, clinics, and long term care facilities should see opportunities for using or adding to their care coordination skills. They should be vigilant, however, with respect to employers expecting additional work in this area without additional pay or other offsets. Those RNs may also be tasked with additional documentation duties, possibly requiring them to take time away from direct patient care. Care coordination is an important function but institutional providers may want to get it done on the cheap.

Because of drafting defects in the ACA (explained elsewhere) APRNs who are primary care providers to Medicare beneficiaries will not be counted in the specific assignment of beneficiaries to a particular ACO. In theory, however, their patient relationships with those beneficiaries can remain unchanged. They can continue to provide services to those patients on a fee-for-service basis without regard to any ACO.

For those APRNs who choose to become an ACO professional, any risks or rewards will be individual. Presumably they will continue to see existing patients. They might gain additional referrals, increasing their Medicare patient load. ACOs could achieve savings by having ACO clinicians to refer patients to APRNs rather than to MDs. As to participating in shared savings/shared losses, each APRN will have to make an individual decision. The anticipated margins between cost and potential rewards are likely to remain slim. There would be clear financial risks to signing a risk contract with an ACO.

For questions, please contact Peter.mcmenamin@ana.org

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[i] PricewaterhouseCoopers http://pwchealth.com/cgi-local/hregister.cgi?link=reg/stalking-the-aco-unicorn.pdf
Milliman http://publications.milliman.com/publications/healthreform/pdfs/at-first-look-acos.pdf
Forbes http://blogs.forbes.com/sciencebiz/2011/04/11/medicares-aco-regs-recall-mads-squamish-rulebook/
Road to Hellth http://roadtohellth.com/2011/04/are-acos-a-financial-suicide-pact/
Proposed CMS Regulation Kills ACOs Softly http://healthaffairs.org/blog/author/lieberman/
Health Care Policy and Marketplace Review http://healthpolicyandmarket.blogspot.com/2011/04/why-acos-wont-work.html
[ii] http://www.cms.gov/ReportsTrustFunds/downloads/tr2010.pdf