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ACO INSIDER

CMS makes economics of primary care ACOs more appealing

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As you may have read, accountable care organizations have met uneven success over the last several years. But, when they are broken down into categories, physician-sponsored ACOs have done better, particularly those with a strong primary care core.

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This is true for several reasons.

In this transition period from a fee-for-service payment system that rewards volume and expensive inpatient care to a pay-for-value system, some ACOs set up by health systems or specialists envisioned the savings coming through lower utilization of their services. They had an inherent impediment to fully committing to keeping people well and avoiding acute care. In contrast, primary care providers are free to be all in with population health value-based programs.

Second, the high-impact initiatives that lead to ACO success are all in primary care's wheelhouse: prevention, wellness, patient-centered medical home (PCMH) care coordination of complex patients, and reduced hospitalizations. It is no fluke that primary care is the only subspecialty mandated to be in the Medicare Shared Savings Program (MSSP).

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However, because the fee-for-service system has historically left primary care physicians at the bottom of the compensation food chain, we have a "can't get there from here" dilemma. It is a cruel irony that the group best suited to stretch America's health care dollar and benefit both professionally and financially usually does not have the capital to create and operate an ACO for the roughly 18 months before shared savings are distributed.

The Centers for Medicare & Medicaid Services has tried to mitigate this by offering financial support for small, non–health system ACOs, particularly those in rural areas. Some of those enrolled ACOs are primary care driven and have been among the most successful in the MSSP.

Nonetheless, the upfront costs, paired with the long delay for the sole economic return on the investment – shared savings – have combined to be deal killers for many promising would-be primary care ACOs.

New upfront payments are game changers

A successful ACO will be assigned one or more patient populations and be given a minimum of 50% of the savings for the overall costs for those populations, if the quality of their health is maintained or improved.

To excise avoidable waste, the ACO looks at gaps in care for those populations – frequent emergency department use for nonemergencies, avoidably high levels of diabetes and obesity, too-high readmission rates, unnecessarily high postacute care costs, etc. They then use evidence-based best team care practices – from patient self care and prevention, to multispecialty coordination and PCMH care management.

Why? Because these proved to give the highest impact on quality and reducing costs. To achieve significant shared savings, the costs are usually measured for a calendar year, then it takes about 6 months for the claims to be reported and paid. Thus, the shared savings check to the ACO will arrive about 18 months after all this is started.

The CMS has also figured out that primary care physician care coordination and management drive quality and savings. The agency knows that incentivizing this type of care, the very type calculated to create ACO success, will net significant savings to the Medicare program.

For example, the pilot project for preventing diabetes will be expanded, because Medicare hopes to save several thousand dollars a year per beneficiary in health care costs.

In a blog entry the day the expanded population health management codes were announced, the CMS acting administrator wrote that, "Over time, if the clinicians qualified to provide these services were to fully provide these services to all eligible beneficiaries, the increase would be as much as $4 billion or more in additional support for care coordination and patient-centered care."

CMS revenue streams to support ACO success-driving activities include:

• Value-based screening and counseling codes to decrease downstream costs.

• Upward adjustment of evaluation and management reimbursement for assessment of care and care plan development for mobility-impaired patients.

• Annual wellness visits.

• Prolonged E&M services that accrue outside of a patient visit.

• Collaboration with mental health specialists.

• Comprehensive assessment and care planning for patients with cognitive impairment.

• Expansion of the diabetes prevention pilot program; diabetes prevention and diabetes education are two separate services.

• Transitional care management for high-risk patients post discharge.

• Structured obesity management.

The 2017 Medicare fee schedule smoothed some of the bumps in administering and being paid for chronic care management (CCM) services, and it added codes with increased reimbursement aligned with increased complexity of comorbidities/illness.

Perhaps the biggest new payment boost for primary care to engage in ACO high-value activities is actually the Merit-Based Incentive Payment System (MIPS) under MACRA, the Medicare Access and CHIP Reauthorization Act of 2015.

Under MACRA, all Medicare compensation for physicians will be determined by relative delivery of quality and efficient care. Experts are recommending that primary care physicians participate in non–risk-taking ACOs to optimize MIPS value scoring, while also

reducing administrative burdens of compliance. Use an ACO's analytics to support collaborative care and provide the reports required under MIPS.

Let's be smart about it

According to Gordon Wilhoit, MD, a practicing physician and chief medical officer of an all–primary-care-physician ACO in South Carolina, "This is a no brainer. Start first with your MSSP ACO high-value game plan, then align the complementary care coordination codes, CCM, MIPS, and other revenue stream and reporting activities with it. Now, primary care physicians can finance their ACO and MIPS care coordination efforts with a stream of ongoing payments from these care management codes.

"One of my colleagues saw a 27% increase in revenues in 6 months just from providing and billing for this type of care," Dr. Wilhoit explained. "And, not counting shared savings or MIPS incentive payments, our office's reimbursement from these care management codes now exceeds our fee-for-service income, which has not decreased."

Even with these payments, the CMS will reduce overall net expenditures. Your impact on health care will be more powerful as a manager of the team addressing patients' overall health than reacting to patient sickness one at a time. The patients you impact the most may be ones you don't actually see. Your empowerment to practice medicine the right way will continue to grow.

Now, finally, you may start getting compensation that takes away the last big hurdle to creating the infrastructure you need to succeed.

Mr. Bobbitt is a head of the health law group at the Smith Anderson law firm in Raleigh, N.C. He is president of, and Dr. Wilhoit is a consultant with, Value Health Partners, LLC, a health care strategic consulting company. He has years of experience assisting physicians form integrated delivery systems. He has spoken and written nationally to primary care physicians on the strategies and practicalities of forming or joining ACOs. This article is meant to be educational and does not constitute legal advice. For additional information, readers may contact the author at either bo@vhp.care or 919-906-4054.

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