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GET THE GOVERNMENT TO FUND YOUR ACO START-UP COSTS

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Julian D. "Bo" Bobbitt, Jr.

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There seems to be a cruel irony at work: It is generally recognized that a primary care physician-based accountable care organization stands the greatest chance of successfully squeezing the waste out of our health care system – yet that same system has historically deprived primary care of the means to finance an ACO.

Worse, most of the payments that are necessary to fund and sustain ACOs are deferred for more than a year, because they come from savings created during the prior year. It is the proverbial "you can't get there from here" problem.

How do we avoid this "Catch-22," in which the primary care-driven ACO model is best suited to meet the goals of ACOs but often is least able to afford the costs of creating ACOs?

The answer may be the federal government. There are several viable options available to have the government effectively fund 100% of your ACO start-up costs.

Consider the following:

- **Meaningful use incentives.** Why not have the government pay for your ACO technology platform? If you think ahead, the health information exchange you will want for your ACO will likely qualify you for stage 2 and stage 3 meaningful use incentives. You can earn up to \$44,000 over 5 years from Medicare, or up to \$63,750 over 6 years from Medicaid. Instead of data being a burden under fee for service, access to and exchange capability of data will be a huge asset.

You will need to make these investments anyway. If you have your ACO game plan in place, much of what you and your colleagues do to meet the meaningful use criteria can be used to fund your ACO.

- **Advance payment model program.** The Centers for Medicare and Medicaid Services apparently recognized the "you can't get there from here" dilemma by creating the advance payment model program. Physician-run ACOs in rural areas have been singled out to receive enough up-front funding to completely pay for the development and implementation of the Medicare Shared Savings Program (**MSSP**) ACO until shared savings payments kick in.

In addition to the MSSP application, ACOs that wish to receive advance funding from the CMS **Innovation Center** must also complete the advance payment model application. The advance payment model is open to only two types of ACOs: ACOs that do not include any inpatient facilities and have less than \$50 million in total

annual revenue; and ACOs in which the only inpatient facilities are critical access hospitals and/or Medicare low-volume rural hospitals, and that have less than \$80 million in total annual revenue. ACOs that are co-owned with a health plan will be ineligible, regardless of whether they also fall into one of the above categories.

The advance payment model application consists of two primary sections: the ACO's financial characteristics; and the ACO's investment plan.

With respect to the financial characteristics, the ACO will need to list the total annual revenue and total Medicaid revenue for each ACO participant during the preceding 3 years. The information submitted by the ACO will need to be based on either federal tax returns or audited financial statements.

The second key section of the advance payment model application is the ACO investment plan. The ACO must explain how it intends to use the advance payment funds awarded from CMS.

Specifically, the investment plan must include:

- A description of the types of staffing and infrastructure that the ACO will acquire and/or expand using the funding available through the advance payment model.
- The timing of such acquisitions or expansions, and the estimated unit costs.
- A description of how such investments build on staff and infrastructure the ACO already has or plans to acquire through its own upcoming investments.
- An explanation of how each investment will support the ACO in achieving the three-part aim of better health, better health care, and lower per capita costs for Medicare beneficiaries.

The advance payment model money may not be renewed once the initial \$1 billion budgeted amount is exhausted. But if the results and return on investment are as powerful as predicted for the targeted ACOs, this could be viewed as a sound investment by CMS.

At current levels, an ACO will receive an up-front fixed amount of \$250,000, a variable \$36/member, and then \$8/member per month. This will be repaid if there are ACO shared savings later on.

Beyond the dollars and cents impact, the APM program is vivid evidence for primary care physicians of just how promising CMS believes physician-directed ACOs are.

Primary care physicians are starting to understand the professional and financial rewards behind ACOs. They should not be dismayed by lack of funding. The payers know that funding these ACOs is a smart "investment" in reforming our inefficient and wasteful current system.

*This article appears courtesy of **Internal Medicine News**. Bo Bobbitt is the author of Internal Medicine News "ACO Insider" column.*

*Bo has many 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, please contact **Bo Bobbitt**.*

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