ACOs: The regulations are out. Now what?

CMS's ACO regulations may not push hard enough to bring about full-scale change, but they present the government's vision of the new world of value-based healthcare. Here's what they mean to you.

By Tom Main and Terry Stone

It's been three weeks since HHS issued its proposed regulations for accountable care organizations in Medicare, and frankly it seems to us that they are deeply conflicted. On the one hand, the regulations are strongly aligned with a market shift to value-based healthcare:

- Primary care drives the definition of who is "accountable" in the patient attribution model, giving primary care the patient care coordination role within the ACO
- ACOs will have money at stake through quality-based gain sharing programs; the emphasis is squarely on changing how care is delivered

On the other hand, the regulations are half-hearted in bringing about the change they envision. CMS and America's best chance for affordable healthcare is to shift to a value-based approach. And the system's best chance to make that shift a reality is for CMS to take the lead. With almost 50 percent of the nation's healthcare buying power, CMS is the only funding source with the regulatory authority and economic clout to change the game. But authority and clout are scarcely on view in the regulations.

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Here are our concerns when we look at these new ACO regulations:

- The program is too small to create critical mass. For most participating physicians, fewer than 15 percent of their patients will be affected—a share that will make it impractical for them to invest in practice-level changes.
- By CMS's own estimation, the ACO program will include only two to four million beneficiaries by the end of year three; in the early years the program will be more of a pilot than a mainstream approach to Medicare financing and delivery.
- The regulations don't go far enough on reimbursement reform. The relatively modest gain-sharing payments may not overcome the influence of the FFS reimbursement core. Faced with the investment required to make an ACO work, some providers may take a pass for now.
- The retrospective attribution model compromises one of the key design principles of effective population management—knowing who the patient is. This lack of transparency could stifle innovation and critical investment in population management.

It should come as no surprise that the regulations have evoked mixed emotions—disappointment at the missed opportunity and relief to have more time to prepare. Nonetheless, the regulations mark an important tipping point: They demonstrate CMS's long-term commitment to value-based care. CMS has fired the starter gun—giving provider organizations and ACOs the opportunity to begin the transition to value on a measured pace and with limited economic risk. While some profit maximizing organizations will be tempted to stay on the sidelines, most recognize the profound change ACOs represent and will begin the journey.

To become an ACO requires an array of changes that cut both wide and deep. The clinical model must be redesigned around populations; there needs to be a shift from a wholesale to a retail orientation; value needs to become the basis of competition; and managing population health must take its place as a core competency. Companies planning to play in the ACO world need to consider three basic truths of the new market.

1. Primary care is the core: Today, primary-care physicians focus on effective transactional medicine and play a small role in coordinating patient care. In the new ACO world, primary-care physicians will become patient-centered medical homes and redesign their practices to manage population risk. They will consider patients' total health needs and play quarterback in seeing that they are met, weaving

together elements from across the care continuum. They will invest in education and lifestyle programs to help keep healthy patients healthy and more effectively manage chronic diseases. Overall, they will play a major role in shifting the healthcare value equation and helping the ACO effectively manage clinical risk. All of this will take time, and the transition threatens to disrupt the traditional flow of patients and dollars. Primary-care development programs need to start early to give all participants time to adjust.

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As primary-care practices become strategic assets in the new ACO world, hospitals, health plans, and health enablement companies are all looking to integrate primary care practices into their developing population health management businesses. Health plans and leading health systems have already started using joint ventures, partnerships, employment, and other tools to create exclusive relationships with PCPs. In a few markets the race to control primary care is all but over. Early-stage ACOs need to develop a thoughtful primary-care integration strategy—and dedicate themselves to outmaneuvering their competition.

2. Value-based care is an information business: The logic of population risk management is simple: You understand the population's healthcare needs and risks, then design care models to effectively manage divergent population segments across the care continuum. To do this you need extensive patient information. Without it, you will find it almost impossible to understand what segments live inside the total population or how to manage them. And without an information dashboard, integration tools, and actionable insights proactively delivered at the point of care, a multidisciplinary care team will have little chance of shifting the cost/quality/value equation.

True, you will need IT infrastructure to track attribution, understand clinical expenditures against risk-based budgets, and to meet quality reporting requirements. That is simply part of the cost of entering the ACO market. But becoming an ACO means much more. It means understanding patients' health profiles, using evidence-based guidelines at point of care to reduce unwarranted practice variation, and deploying integrated planning tools to effectively manage the treatment of complex patients. It also means evaluating performance—across a panel of diabetics, for example, or across participating physicians. In short, it means becoming an information-based business.

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You already know what information-based businesses look like. Consider the retail industry. For years, the key to retail success lay in efficiency—sales per square foot, inventory turns, just-in-time distribution, logistics, operations. But the rise of Internet retailing created a new paradigm, one based on using information about consumers. Think of Amazon: The company tracks everything about its customers—their buying history, their expressed wishes, their recommendations to friends, their ratings of merchandise—and uses it at the point of sale to make recommendations, propose additional purchases, and create demand. It is this consumer information—and not the IT that enables its use—that is Amazon's lifeblood. It permeates everything the company does. And we believe a similar approach will be essential in healthcare.

If providers expect to achieve long-term success, they need to learn how to manage the new ACO business through performance-based information tools. But it takes capital and time to develop this sort of competency.

3. The profit model turns upside-down: It is pointless to try to operate as a value-based ACO under an FFS economic model. The ACO's primary tool is to refocus the use of healthcare resources and lower overall utilization. That is an economic death sentence for an FFS business; to make it work in the ACO, the economic model and the clinical model must be in sync. In traditional FFS (to oversimplify a bit), every time a doctor treats a patient, it generates revenue and profits. In a fee-for-value model, improved margins come from better-value healthcare across the population; each doctor touch needs to be an investment in a cost-effective outcome. Some population health segments, such as the poly-diseased, will require substantial increases in care coordination and management to improve the cost/value equation, while others should receive their routine care from non-physician resources. For some chronic populations or for frail elders, the ACO may invest in prevention, monitoring, wellness, and other non-reimbursable programs because they improve the cost/value equation.

Creating the new economic model is one of the more complex activities in starting an ACO. That is doubly true when only a small portion of the physician practice will be affected. The regulations allow provider organizations to slow-start risk-sharing models. Some ACOs may consider setting up a shadow full-risk agreement in order to understand how the money flows and how they would perform if the full ACO was operating under clinical risk agreements.

Developing ACOs must address the financial migration path from FFS to FFV, with the goal of coming to a full understanding of how to prosper in the new FFV world. This is a step that cannot be skipped.

Getting started

The ACO regulations are a formal announcement: The industry's long-term shift to value has commenced. The race is on, the prize is big, and the legacy business consequences are substantial. Move too fast and you could cannibalize your "today" FFS economics, putting your shareholders or mission at risk. Move too slow and you will fail to build essential competencies. There will be winners in the new value-based healthcare world—but to be among them, you need to build the primary care base, develop the information competencies required for effective population management, and learn how to make money by managing clinical risk. To get there, you need a strong development strategy.

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Kodak in the film industry, Barnes & Noble in books, and Blockbuster in video rental all thought their legacy business models would carry the day. They underestimated the disruptive innovators they faced, and even with strong brand equity, excellent market share, and financial resources they were displaced by new market players with different competencies and an improved value proposition. The message: If you don't embrace industry change, you will be left behind.

To get going, leading provider groups would do well to broaden their ACO strategy across funding sources—including commercial populations, Medicaid, and Medicare Advantage. Health plans and benefit sponsors (like Medicaid) are looking for provider groups or ACOs to manage predefined clinical populations through risk arrangements with the hope of improving the cost/quality equation. By expanding the ACO market, primary care-based ACOs will be able to leverage practice wide-investments in FFV capabilities and limit FFS cannibalization. After all, the long-term goal for providers is to attain improved economics, an expanded role in healthcare, and high growth of market share through an improved value equation. To get there ahead of the pack, you need to start your pioneering efforts now.

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