

***** DRAFT *****

ACO Service Models

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ACOs will need to handle a variety of management, analytic and financial services. In some ways, an ACO will look somewhat like a health insurer but will have several key differences – it will likely be paid using Fee For Service (FFS) methods and only be “at risk” for bonuses based on shared savings. The underlying “insurance risk” will remain as the responsibility of the payer, whether Medicare, Medicaid or a private payer. But, managing the “provider risk” is an important reason for ACOs to have access to key services – especially since the shared savings are derived by comparing per capita spending on all services to the per capita budget targets.

Some of these services can be provided internally by competent staff of the ACO. For example, financial reporting is a standard requirement for most health care providers today and will not be substantially different for an ACO. Other services, however, may be harder to staff with internal resources, especially those related to insurance-like functions, e.g., claims adjudication or utilization management, or distributing bonus payments associated with shared savings.

Services Needed

ACOs will have differing levels of capabilities. Some of the services they will need to provide or obtain will include:

1. Timely claims adjudication

Claims for services from both ACO and non-ACO providers will need to be adjudicated for payment by an organization with claims payment skills. Depending on the payment mechanism used (See Chapter XX), claims payment may be straightforward using common rules or could involve using new payment mechanisms, like bundling. For example, Medicare claims could either be processed by a Medicare Administrative Contractor (MAC), by the ACO itself, or perhaps a “batch” summarized copy could be provided to the ACO.

2. Network contract prices

To the extent that an ACO chooses not to make use of either FFS Medicare pricing for its Medicare patients or private payer contracts for non-Medicare patients and establishes its own payment terms for ACO member providers, it may need to obtain access to necessary discounts on its own. This can be done through common PPO arrangements for a fee (PPO network rentals) but may not be advisable in the short run. Rental network PPOs generally do not have as favorable unit price deals as either Medicare or dominant private payers. As an alternative, the ACO could negotiate its own standard contracts with its member providers and other participating providers (e.g., 100% of Medicare for Medicare beneficiaries and 115% for commercial members).

3. Bonus settlement adjudication (after claims are paid)

Another type of financial transaction may be retained by the ACO: payout of any accrued bonuses. Some of these payout transactions may be simple – following contractual requirements. Others might require either a “second paying” of bonuses tied to historic payments or to more complex data analysis of ACO performance (e.g., greater payments to those providers that saved more against budget). The more complicated the rules governing distribution of bonuses, the more involved the process for allocating bonus payments.

4. Physician organization management services

Depending on the structure of the ACO, there may be a need for help in managing newly emerging physician practices or other integrated delivery systems. While hospitals typically have well-developed management structures (e.g., including finance, IT, contracting and quality improvement), many small physician practices may not have those capabilities. In some cases, they may want to “invent” that capability; however, if organizations are available to provide many of these services on a fee basis, that might be preferred. For example, many physicians out-source billing and collection today. In addition, ACOs may encourage physicians to change their typical referral patterns, based on ACO participation, efficiency and appropriateness of care, and/or quality metrics.

5. Care Coordination and Utilization Management services

Care coordination will become a very important role inside ACOs. The greater the effectiveness of care coordination, the more likely an ACO is to meet or exceed its budget savings targets. “On the ground” care coordination will likely be accomplished in the physician office, but may need assistance with registries, post-discharge coordination, disease management reminder calls and other similar activities. Hospital partners may be able to supply assistance and new HIT software may provide further help. But, some practices may want to combine

efforts with stand-alone vendors. ACOs may want to invest in acquiring care coordination and utilization management services, which can either be “owned” by the ACO or subcontracted to other vendors. One option might be specialty benefit management companies that provide criteria and utilization management services for high cost services, such as advanced imaging.

6. Quality and Efficiency Metrics Analysis

A key to a successful ACO will be measurement and attainment of quality and efficiency metrics. While some measurement may be done by outside agents (e.g., CMS or a private insurer), it is very likely that ACO management will want to obtain timely reports on successes or possible issues. For a large ACO, it probably makes sense to have that capability “in-house.” For smaller ACOs, obtaining qualified assistance may require contracting with experienced vendors.

Possible Sources of Services

CMS

Because CMS uses its huge bargaining power to purchase certain services at marginal cost rates, it may make sense to use as many of those services as possible. In particular, CMS contracts with MACs at very low rates to adjudicate claims using Medicare PPS payment rules. If an ACO is going to pay all or some of the claims for Medicare beneficiaries at FFS Medicare rates, there is no way to get better payment rates than through these existing arrangements. This assumes that any Medicare-ACO demonstration would provide access to these services. One option would be for MACs to normally adjudicate the Medicare claims of ACO members (i.e., as if they remained normal FFS beneficiaries) but provide detailed but timely (e.g., bi-weekly or monthly) electronic reports on utilization of services by ACO members.

At the same time, the ACO should be alert to the need for vigilance in the areas of fraud and abuse and in terms of utilization management. Medicare pays its MACs for quick payment according to PPS rules, not for attention to utilization management. While CMS and its MACs attempt to control fraud and abuse, there are many instances where problems have been found.

CMS may also be able to provide basic data services to the ACOs, although CMS staff is already burdened with many activities. Beyond having to determine the amount of shared savings, it remains to be seen how much assistance CMS staff or its contractors (e.g., MACs) will be able to actually provide that goes beyond their normal processing and review of claims.

Private Payer Services

Private payers will be able to provide a variety of services. If the ACO is in a synergistic contract with a dominant private payer at its site, it is likely to want to make use of many of the following common ACO services:

- Access to payer data to identify and attribute beneficiaries
- Possible use of payer contract rates inside the ACO
- Use of contracted payment rates with providers “outside” the ACO
- Claims adjudication by the payer
- Data analysis services by the payers actuarial or finance staff
- Use of some of the utilization management services available (e.g., a nurse help-line or contracts with Radiology Benefit Managers)
- Calculation of bonus amounts according to agreed-upon formulas

For some activities (e.g., utilization management and care coordination), the ACO and its management team may prefer to handle those at the individual or team provider level. But for other activities, “renting” a nurse hotline at marginal cost rates with all infrastructure provided (e.g., telephone triage) may prove to be the most efficient way to include these services.

Services from Large Multi-Specialty Provider Groups or Similar Organizations

Certain areas of the nation have had a long and successful history of integrated delivery systems (e.g., Intermountain) or big multi-specialty groups (e.g., Geisinger or Hill Physicians in California) that have “solved” their own service needs over the last 20 years. It is possible that negotiating for services with these kindred organizations of providers might provide services that are already closely tailored to the needs of ACOs. For example, some of these groups already pay claims and calculate bonuses that are shared among provider partners. Many have experience in quality measurement metrics (e.g., California provider groups which benefit from IHA P4P payments).

Another possible service may be management consulting support – help with the set-up and ongoing management of complex provider organizations. Rather than “re-invent the wheel,” ACOs may be able to draw on the lessons learned by these successful groups.

Third-Party Vendors

In several areas, there are third party vendors (independent organizations that are not related to private payers) that provide certain services. In particular, various kinds of utilization management services are readily available for hospital management (e.g., renting hospitalists), renting nurse hotlines, using radiology benefit managers (RBMs) and similar therapy-specific managers, etc.

In addition to clinical management services and claims adjudication, there are many actuarial/financial consulting firms and a small number of data analysis firms. In the last

category, some West Coast firms have provided analytic services to large multi-specialty groups and PHOs for over a decade. While ACOs represent a new version of capitated provider groups, the similarities should allow rapid transition for the services required.

The “Make” or “Buy” Decision

Some ACOs are likely to want to be on a rapid learning curve about many or all of these activities. Although there may be a bias towards a “buy” of support services, they may want to hire and train staff to carry out several of these necessary functions. Consultants from various areas are likely to emerge to serve ACO clients. A word of caution is obvious: choose consultants with appropriate hands-on experience rather than those that “talk a good game.”

The availability and advantages/disadvantages of “make” vs. “buy” are quickly apparent. They include:

- Control/priority of staff and project time
- Skill levels of internal staff vs. dedicated and experienced staff at vendors and consultants
- Learning necessary skills vs. an ongoing need to retain consultants and vendors
- Start-up time needed to bring internal staff up to speed

In a likely environment of close scrutiny and demand for “immediate” results, ACO managers will need a candid assessment of their organization’s staffing and talent. “Early adopter” purchasing of these services might be made at favorable rates as vendor organizations and consultants gain ACO skills and testimonials. Last, the physical location of the “back office” for services is less important than ever today; excellent operational experience is the key element.