The Next Shiny Object: Understanding Accountable Care Organizations in the PCMH and Meaningful Use Context

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The Patient Protection and Affordable Care Act (PPACA) requires, under Section 3022, that the Secretary of Health and Human Services (HHS) "establish a shared savings program that promotes accountability for a patient population and coordinates items and services under Medicare parts A and B, and encourages investment in infrastructure and redesigned care processes for high quality and efficient service delivery." The Medicare Shared Savings Program (MSSP), which is intended to improve quality of care while containing costs, will begin by January 1, 2012. Groups of providers, healthcare organizations and other entities deemed appropriate by the Secretary of HHS may form Accountable Care Organizations (ACOs) in order to qualify for payments or shared savings by managing and coordinating care for Medicare fee-for-service beneficiaries.

The Centers for Medicare and Medicaid Services (CMS) released a Proposed Rule governing the implementation of the MSSP on March 31, 2011 (Section 3022, Patient Protection and Affordable Care Act and Section 1899, Title XVIII Social Security Act, 42 U.S.C. 1395 et seq.)[1], and the rule is presently in a 60-day comment period.

The proposed rule describes an Accountable Care Organization as a health care entity responsible for the provision of care and "accountable for improving the health and experience of care for individuals and improving the health of populations while reducing the rate of growth in health care spending." [2] ACOs must:

- Have a legal structure that allows for the distribution of shared savings among the participants and have a management structure that includes both clinical and administrative systems;
- Include a number of primary care providers sufficient to serve a minimum of 5,000 Medicare fee-for-service beneficiaries; and
- Define processes for evidence-based medical practice and patient engagement as well as report on quality and cost measures and care coordination through use of technologies such as telehealth and remote patient monitoring.

The Secretary of HHS is required by the statute to publish guidelines for the measurement of both quality improvement and cost reduction as well as to set a level of cost reduction for an ACO to qualify for shared savings payments.

A good part of the proposed Rule deals with how healthcare organizations could organize, apply for and qualify to be considered an ACO. Shared savings for eligible ACOs will be determined on the basis of one of two risk models. The" one-sided risk" model permits sharing of savings only for the first two years and sharing of both savings and losses in the third year, while the "two-sided" risk model entails sharing of both savings and losses for all three year, allowing the ACO to opt for either model. [3] Eligible ACOs will be able to opt for either model, allowing organizations with less experience in risk-based models a gateway in to the program.

As promulgated, however, the proposed Rule limits direct participation by Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs). As reported in a recent policy brief by Sara Rosenbaum and Peter Shin, "Medicare's Accountable Care Organization Regulations: How will Medicare

[1] 42 CFR Part 425 Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations [CMS-1345-P]
[2] CMS MEDICARE FACT SHEET, March 31, 2011
[3] 42 CFR Part 425 [CMS-1345-P], p. 27

Beneficiaries who Reside in Medically Underserved Communities Fare?"[4] FQHCs are excluded because of CMS' interpretation of the statute, as requiring that only patients who are cared for directly by a physician can qualify for shared savings. [5] Essentially, because FQHCs often provide team-based care, and FQHC data is not procedure-code specific, lacking the HCPCS codes and data linking service to a specific provider, FQHC- formed ACOs are eliminated. FQHCs may, however apply, in collaboration with non-FQHC organizations, though this may prove challenging.[6] Further, incentives are provided for ACOs that include FQHCs (and RHCs) in the form of higher percentages of shared savings rates based on the percent of visits made by their eligible populations to an FQHC (up to 2.5% higher for 41%-50% of beneficiary population with 1 or more visits per year). Again, however, there are limitations to the incentive that effectively exclude FQHCs.

CMS has stated "As the Shared Savings Program develops, we will continue to assess the possibilities for collecting the requisite data from FQHCs (and RHCs), and in light of any such developments we will consider whether it is possible at some future date for Medicare beneficiaries to be assigned to an ACO on the basis of services furnished by an FQHC (or RHC), thereby allowing these entities to have their Medicare beneficiaries included in the AACO's assigned population."[7]

While health centers are not initially able to qualify for shared savings, it is critical that CHCs and RHCs understand the ACO performance requirements since these will, in part, drive CMS focus on technology-enabled clinical reporting, financial reporting and outcomes measurement. First, once qualified, ACOs must stay in the program for at least three years, and are required to provide the data to calculate a per-beneficiary baseline for Medicare fee-for-service costs based on the beneficiary population and a Minimum Savings Rate (MSR) primarily driven by the size of its beneficiary population and some risk-adjustment for population health and circumstances.[8] In addition, the ACO must report on 65 unique performance measures in five categories:

- Better Care for Individuals:
    - Patient/Caregiver Experience
    - Care Coordination/Information Systems
    - Patient Safety
- Better Health for Populations:
    - Preventive Health
    - At-Risk Population/Frail Elderly Health

While grappling with ACOs, health centers must also address the meaningful use requirements for both Stage 1 (2011) and Stage 2 (2013) as well as Patient-Centered Medical Home (PCMH) certification. These will require substantial clinical and administrative process and information technology change. Are these changes complementary to, neutral toward, or - at worst - in conflict with the changes required by ACO participation? Let's try and see…

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[4] Sara Rosenbaum and Peter Shin," Medicare's Accountable Care Organization Regulations: How Will Medicare beneficiaries who Reside in Medically Underserved Communities Fare" Geiger Gibson RCHN Community Health Foundation Research Collaborative, April 20, 2011.

[5] Rosenbaum, p.6

[6] 42 CFR Part 425, pp 44-46

[7] 42 CFR Part 425, p. 46

[8] CMS MEDICARE FACT SHEET, March 31, 2011 & CFR 42 Part 425 pp.234-237.

The chart below summarizes some of the similarities and differences across these three initiatives. It is not meant to be an all-inclusive or authoritative comparison, but to compare and contrast the major elements. Sources for these comparisons are footnoted here.[9]

Category	Meaningful Use-Stage 1	Patient-Centered Medical Home	CMS ACO Guidelines	Remarks
Financial Analysis & Measurement	N/A	N/A	• Calculation of per capita fee-for-service Medicare baseline cost based on ACO beneficiary population • Calculation of Minimum Savings Rate (MSR) for ACO	No alignment
Patient/Caregiver Experience	N/A	1A, 1B – Access to Care: • Providing timely appointments • Providing timely advice (telephonically, electronically)	Patient/Care Giver Experience: • Timely care, Appointments, Information (NQF #5[10]) • Provider communication • Shared decision making	PCMH & ACO relatively well aligned, both will require electronic communication (patient-provider, provider-provider)

Care Coordination	• Receiving Provider must perform medication reconciliation of 50% of clinical transitions between levels of care
	• (Stage 2 criteria address some team-based practice)
		1D, 1E, 1F, 1G – Continuity, Medical Home Responsibilities, Culturally Appropriate Services, Practice Team
		• Select a personal clinician
		• % of visits with personal clinician
		• Coordination of care across multiple settings
		• Provision of patient access to evidence-based care and self-management support
		• Provide bilingual services & translated material in appropriate language
		• Defining roles for clinical & nonclinical staff, training & carrying out team-based practice
			Care Coordination:
			• 30-day risk standardized readmission rate (CMS)
			• Medication reconciliation (NQF #554)
			• Ambulatory sensitive admissions (NQF #s272-281, 668)
			  ○ Diabetes
			  ○ Congestive heart failure
			  ○ Others
				Limited alignment ACO guidelines, primarily hospital focused

Information Systems	Electronic Access: • e-copy of health records for patient (50%) • eAccess of health record for patients (10%) • eSummaries of encounters (50% within 3 business days)	1C - Electronic Access: • eCopy of health records for patient (50%) • eAccess of health record for patients (10%) • eSummaries of encounters (50% within 3 business days) • 2-way eCommunication	Information Systems: • 100% EPs meet Stage 1 Meaningful Use • % eRX use • Patient registry use	Well-aligned except for 2-way eCommunication requirement which are not in Stage 1 Meaningful Use

[9] 42 CFR Part 425 pp. 174-194 and NCQA Patient Centered Medical Home (PCMH) 2011 – Appendix 2 – PCMH and Stage 1 Meaningful Use Requirements, March 28, 2011 and ONC *Request for Comment regarding the Stage 2 Definition of Meaningful Use*, dated January 6, 2011

[10] National Quality Forum: http://www.qualityforum.org/Measures_List.aspx

	Patient & Clinical Data • patient problem & medication lists • lab results • patient reminders in Stage 1, 2	(patient-provider) 2A,2B, 2D – Patient Data, Clinical Data, Population Management • Patient demographic data • Patient clinical data • Proactive reminders		
Educational & Community Resources	Use of certified EHR to identify and provide patient identified educational resources	4A, 4B – Provide Self-care Support & Community Resources	Integration of Community Resources into treatment plans	Limited alignment on community resources
Care Coordination	Electronic exchange of clinical data and summary records for care transitions,	5A, 5B, 5C – Track & Coordinate Care	Care coordination required across multiple organizations and for chronic conditions (NQF #224)	relatively good alignment
Clinical Reporting/ Patient Safety	• Submission of PQRI measures to CMS • Electronic submission of data to disease registries • Electronic submission of syndromic surveillance data to public health agencies CMS to announce rules to integrate PQRI & meaningful use incentives on January 1, 2012	6A…6F – Measure & Improve Performance • Submission of PQRI measures to CMS • Submission of clinical quality measures to other external agencies • Electronic submission of data to disease registries • Electronic submission of syndromic surveillance data to public health agencies	Patient Safety/Preventive Health • Acquired Conditions Composite (AHRQ PQRI, NQF #531) • Specific measures including: (Various PQRI & NQF measures) ○ Mammography screening ○ Colorectal cancer screening ○ Adult weight management ○ Others	PCMH & EHR incentives somewhat aligned, but limited alignment with ACO guidelines
At-Risk Populations	See above	See above 6A…6F	At Risk Populations: • Various clinical procedures regarding (Various CMS, PQRI & NQF measures): • Diabetes • Heart failure • Coronary artery disease • Hypertension • COPD[11] • Frail/Elderly	Limited alignment

In a sense, the specifics notwithstanding, we could say that these three initiatives are in fact "well aligned" since the ACO guidelines also require 100% of Eligible Providers in the ACO to meet Stage 1 meaningful use criteria as well as the PCMH and meaningful use requirements. All three initiatives require some level of:

- ePrescribing;
- Medication reconciliation;
- Use of patient registries;
- Reporting of selected PRI measures;

[11] Chronic Obstructive Pulmonary Disease

- Use of information exchange (of various types) for care coordination;
- Provider to provider & provider to patient communication of various types.

In actuality, while there are some easily- identified similarities, the requirements of each initiative have many differences.

Furthermore, demonstrating performance in these areas will require an information technology infrastructure and application suite that may be more extensive than that in place today in most CHCs. This may include:

- A high speed network at least at T1 speeds (1.5MB/second) or higher for health information exchange (HIE);
- Network monitoring and management tools to ensure reliability and availability of service;
- Redundant, modern application server hardware (reliable commercial hardware running a Microsoft or Linux server operating system with at least 4 GB of random access memory & 150 GB of user accessible memory per node);
- Redundant database server hardware (as above) managing at least 1 TB of data storage;
- Application suite consisting of a practice management system integrated with a certified EHR that provides a portal for consumer access to health records (or a separate collaboration portal that provides external provider access as well as consumer access. Both types of access could be provided by secure email (NwHIN Direct), but consumers would need direct access by Stage 2 meaningful use).
    - EHR or separate software must also provide connections to disease registries, public health agencies & HIE capability;
- Finally, ACO participation will require financial analytic software and possibly the ability to provide data extracts from clinical and administrative data.

There are two factors that make requirements for all of this complex IT and HIT infrastructure less daunting. The first is that the infrastructure may serve to support qualification for all three initiatives. Second is that all of this capability could be provided through a health center controlled network (HCCN), a state or regional primary care association (SR/PCA), or through a commercial hosting arrangement. That's the good news. The complexity is that qualifying for any of these initiatives will require changes in how a health center operates both its clinical and business functions. , While all of these changes are positive over time, considerable effort will be required on the part of CHCs to make them a reality.

So what are the implications of all this for health centers? Is there a strategy here that makes sense? In the end the implementation of an information technology infrastructure and application suite that will support and enable qualification for meaningful use and PCMH is essential. The close alignment of PCMH and meaningful use allows a single IT infrastructure to support both. Associated with building or contracting for this infrastructure is the training and change management required to meet the performance and utilization measures for both meaningful use and PCMH. This infrastructure also provides the foundation for building out the financial analysis and reporting capabilities that are required for ACO qualification and eventual participation in an ACO or other risk model. The clinical performance and reporting requirements for ACO participation can, for the most part, be met by the meaningful use/PCMH infrastructure.

Understanding the requirements for all three initiatives is the crucial first step. Health centers have been working on meaningful use and PCMH for some time, but now need to quickly begin understanding the proposed ACO model. A next step is making sure that the center's HIT infrastructure and application suite will support each initiative, either in a standalone effort or through a PCA, HCCN or hosting partner. The final step is planning and implementing the capability for risk- based financial measurement. . This

need not be done immediately, but doing so will put a health center in a much better position to determine if ACO or other risk-based participation is right for them. Given the alignment across certain performance measures, and the shared emphasis on clinical coordination, evidence-based care and decision support, qualifying for meaningful use and/or PCMH certification should position health centers well for eventual ACO participation. Planning for the eventual calculation of per-patient (Medicare/Medicaid) costs will prove to be an operational advantage for, and those that have implemented sophisticated risk-model financial capability will be better positioned to participate in new payer models.