Follow the Money

Our experts believe federal seed capital is the best way to move the ACO program forward.

There is no hotter topic in health reform today than the future of accountable care organizations (ACOs) and how healthcare providers can be given an incentive to organize and operate effectively in reducing costs and raising quality standards. At the center of any discussion over ACO potential is how they should be funded. Experts are sorting out which finance model will give these systems the best chance to improve clinical and financial outcomes.

For many networks, unable to capitalize adequately to take the material downside risk out of the equation, the initial pathway will be participation in upside risk options. Therefore, we hope CMS will provide sufficient variants for that pathway to make it attractive and financially viable. Indeed, failing to facilitate the investment in care management infrastructure could imperil ACO success.

Operational cost

In recent years, we've seen considerable success in improving quality and controlling costs by customizing care treatment plans for chronically ill individuals that factor in each patient's co-morbidities.

ACOs can implement processes to prevent conditions from escalating into unnecessary hospital or skilled-nursing stays through data analysis and by deploying teams of nurses, social workers, nutrition specialists, and community health workers

under physician clinical leadership. But the infrastructure, resources, and clinical expertise needed to optimize care does not come for free.

Depending on the populations being targeted by an ACO (Medicare, Medicaid, and commercial, for example) and their underlying disease burden and actuarial risk, a reasonable budget for care management activities would be $3 to $5 per member per month.

Effective IT tools are available for predictive modeling. The goal is to identify patients at high risk for consuming healthcare resources in the coming months and to track the chronic and readmission conditions of the relevant population.

These tools can be expensive in terms of upfront licensing fees and the ongoing resources necessary to implement the applications. The information then needs to be analyzed and acted on by clinicians and care managers at an additional cost of $1 to $3 per member per month. Combined with an effective ACO management and clinical team, these tools can play a critical role in building an integrated and effective care management program.

The assessment

Our sobering assessment is that, unless the proper components are in place, ACO applicants will have to tap their own reserves or commercial lines of credit to underwrite the necessary infrastructure. This investment would have to be made by providers that face potential reductions or redistribution in Medicare and commercial insurer payments in the coming years. More significantly, specialist and hospital participants in an ACO will experience reduced cash flow from any shared savings program that measures success through reducing volumes.

In the case of physicians in a network that seeks to become an ACO, their personal reserves may be insufficient and borrowing opportunities more limited unless they partner with an outside entity to provide these services. Private venture capital might infuse enough cash, but the repayment hurdles could hinder incentives for network formation and program participation. Moreover, many providers still carry financial and emotional scars from their experiences with physician practice management companies during the '90s.

ACOs affiliated with a hospital system might have access to reserves they can tap. However, most hospitals are already stretched. They are dealing with the demands of EHR and electronic order entry implementation, responding to "meaningful use" dictates, and integrating the many physician groups seeking alignment or employment. In addition, there are public policy reasons to facilitate a pathway for physicians to develop independent options.

A facilitative option

One option that merits study is offering an advance funding opportunity to ACOs for some portion of their population stratification and care-management activities. This might take the form of borrowing against otherwise distributable savings. To facilitate this path, the borrowing would be solely the obligation of the ACO and would not require the pledge of personal assets of the shareholders/network participants.

Requirements for demonstrating need, provider ownership, and other conditions of eligibility would need to be fleshed out. However, loans from the Medicare or Medicaid programs against the ACO's share of future savings would materially enhance the likelihood of substantial savings. Such loans would actualize the ability of these networks to fund case managers and deploy care management software with track records in other settings.

Moreover, such a loan facility would address some of the lingering issues in capitalization of a provider network. For example, does it make sense for all participating physicians to capitalize the venture equally, particularly when patient-use patterns are not fixed? If specialists bear a larger capital or loan burden than primary care in a physician-only network, will there be kickback concerns? Might the same issue not apply in a mixed-provider network context if the hospital bears most of the financing load?

Considering all of these factors, we believe it's more than reasonable to consider a loan facility from CMS to provide financial support. The Department of Health and Human Services has invested a considerable amount to encourage "meaningful use" of electronic health records. A similar investment in an ACO "superhighway" would considerably enhance the chances of successful ACOs. ✚

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