Washington Healthcare News®

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Details and Bedevilment: New Data Validate Concerns & Raise More Questions About ACOs

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New data available from both the Centers for Medicare and Medicaid Services (CMS)[i] and the Premier healthcare alliance[ii] offer health care providers their best opportunity yet to determine whether participating in an Accountable Care Organization (ACO) would be beneficial. While the theory of ACOs is that better care coordination and use of evidence-based practices by healthcare providers can both improve quality of and access to care for patients while generating substantial savings over current treatment and reimbursement practices, especially for high-cost patients, the new data suggest that more than the usual bedevilment is in the details of reimbursement for ACOs and that further refinement and flexibility than currently is in the models proposed by CMS will be necessary to realize this triple win and meaningfully reduce growth in the cost of care.

The initial model that CMS put forward this spring in its proposed regulations for the Medicare Shared Savings Program[iii] raised a number of questions and concerns for providers. For example, comments from the American Medical Group Association (AMGA) demonstrate that while the Shared Savings regulations resolved some issues (e.g., removing the restriction preventing physicians from participating in multiple ACO programs), many issues remain.[iv] Among the most significant of these are (1) retrospective attribution of patients; (2) increased administrative burden from reporting and care management requirements; and (3) insufficient rewards to support the investments.

Retrospective Attribution

Under the regulations, individuals will be assigned to ACO's after they have received care based on where they received the most primary care.[v] This means that primary care physicians will not know whose care they are responsible for managing until the end of the year. The Premier data suggest that organizations with high-cost patients can achieve greater savings with the prospective assignment approach under the Pioneer Program. Accordingly, the data indicate that by stipulating retrospective assignment of beneficiaries, the Shared Savings Program prevents the patient and physician from forming the care and care coordination contract necessary to effectively manage care. The absence of mutual accountability under the proposed regulations between the patient and his or her primary care physicians and among the various providers and practitioners of care undermines the potential for the Shared Savings Program to align interests

among all parties to achieve lower utilization and higher quality in the delivery of healthcare services.

Administrative Burden

Reporting obligations and technology requirements necessitate too much investment given the rewards to be realized under the Shared Savings Program. The proposed rules require ACO participants to make substantial investments in IT systems and internal processes to track data necessary to meet quality reporting requirements, implement evidence-based care and meet other administrative obligations, and also establish an unreasonably high confidence requirement for these data.[vi] Given the absence of ability to coordinate or manage care prospectively, variations among medical records associated with the assigned patients could vary substantially and potentially affect reimbursement significantly. For example, the Premier data assumes that an ACO meets all of the quality performance measurements but acknowledges doing so will be difficult for many organizations.

Insufficient Rewards

Caps on shares of savings and minimum thresholds make it unlikely that providers can realize sufficient return on investments to achieve and maintain ACO status within the Shared Savings Program. Under the Shared Savings Program, an ACO that does not elect to put itself at risk for losses in the first year of the program arrangement can only realize a 50% share of savings.[vii] An ACO that elects to take on downside risk in the first program year can achieve at most a 60% share.[viii] However, the Premier data suggest a 54% probability that the gain or loss could be higher or lower than the minimum threshold due to random fluctuations. Combined with the absence of advance assignment of patients, the existence of the proposed minimum savings requirement in proposed 42 CFR 425.7(c) creates a real possibility that ACO participants could see no share of savings at all from their care management activities. Further, by limiting their protections to the Medicare shared savings amounts, the proposed waivers from the enforcement agency are too narrow to be helpful. Commercial insureds play too large a role in the financial viability of medical providers and practitioners practices to be left out of the incentives for entering into these types of arrangements.

Following the Shared Savings Program proposed rules, the Centers for Medicare and Medicaid Innovation (CMMI) issued a request for applications for an alternative program based on ACOs (the "Pioneer Program") which provides for prospective assignment of patients and potentially increased rewards over the Shared Savings Program.[ix] Unlike the Shared Savings Program, the Pioneer Program contemplates that participating organizations will have similar arrangements with private payers and actually requires that such arrangements constitute 50% of the participating providers' reimbursement by the close of the second program year. Another difference is that the Pioneer Program offers opportunities for individual organizations to make proposals in their applications for alternative reimbursement structures focused on improving population health that may better address the context in which they deliver care. CMMI will use the proposals to create an alternative reimbursement methodology that an ACO can elect upon choosing to participate. It seems likely that CMS also will attempt to use this alternative reimbursement method to address the issues raised by geographic instability in cost-trends that the new data also demonstrate create disincentives for some providers to participate in the Shared Savings Program depending upon their location. The Premier data indicate that the Pioneer ACO methodology will work best for ACOs with more high-cost beneficiaries or those located in high-cost areas.

By establishing ACOs and providing for payers and providers to share in the savings they achieve, the CMS hopes that this concept will improve the overall health of populations, leading to a win-win-win for providers, patients and payers. The program options proposed by CMS ask much of providers in terms of administrative infrastructure, capital and data sharing but do not require patients to make any commitment. The financial data now available suggest that more refinement and flexibility in CMS's models of ACO reimbursement will be necessary to meaningfully advance healthcare quality and access while reducing growth in expenditures.

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[i]CMS has made data available for Medicare Shared Savings Program applicants to calculate shares of services in Primary Service Areas. See, https://www.cms.gov/sharedsavingsprogram/35_Calculations.asp#TopOfPage

[ii]The Premier healthcare alliance (Premier, Inc.), a performance improvement affiliation of 2,500 U.S. hospitals and 75,000 other healthcare sites, commissioned an analysis from Milliman on the risks and opportunities of five different models of ACO participation under the Shared Savings Program options and the Pioneer Program. See, Milliman, Inc. The Two Medicare ACO Programs: Medicare Shared Savings and Pioneer – Risk/Actuarial Differences (July 8, 2011). http://www.premierinc.com/about/news/11-jul/newanalysis072711.jsp.

[iii]76 Fed. Reg. 19528 (April 7, 2011)

[iv]See Letter to D. Berwick, MD from D. Fischer, Ph.D regarding Medicare Shared Savings Program: Accountable Care Organizations, CMS-1345-P (dated June 6, 2011), available at http://www.amga.org/Advocacy/ACO/ACOCommentsFINALJune6.pdf (last visited August 3, 2011).

[v]See, Proposed 42 CFR 425.6.

[vi]Under proposed 42 CFR 425.10, a discrepancy of greater than 10 percent between reported quality data and audited medical records eliminates credit for the ACO with respect to the quality measure.

[vii]See, Proposed 42 C.F.R. 425.7.

[viii]Realizing 60% of savings may not be adequate incentive for the necessary investments for several reasons, not least of which is the risk that CMS will adjust benchmarks annually without factoring in the aging of the assigned patient population along with other factors.

[ix]See Center for Medicare & Medicaid Innovation, U.S. Dept. of Health & Hum. Serv., Pioneer ACO Model, available at http://innovations.cms.gov/areas-of-focus/seamless-and-coordinated-care-models/pioneer-aco/ (last visited August 3, 2011).