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ACOs: Will There be Savings to be Shared?

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Overview

After months of anticipation and speculation the Centers for Medicare and Medicaid Services issued proposed rules relating to a voluntary Shared Savings Program for Medicare providers and suppliers participating in Accountable Care Organizations (ACOs).[1] Under the Shared Savings Program, providers and suppliers will continue to receive traditional Medicare fee-for-service payments under Parts A and B, and be eligible for additional payments if specified quality and savings requirements are met.

As with other healthcare initiatives in the past, the premise of ACOs is that they will improve the health of the population; enhance the patient experience of care (including quality, access, and reliability); and reduce, or at least control, the per capita cost of care.[2] The "savings" created by ACOs participating in the Medicare Shared Savings Program will then be "shared" between the federal government and the ACO. The Shared Savings Program is only one of several programs envisioned by the Affordable Care Act ("PPACA"):

> The Affordable Care Act includes a number of provisions designed to improve the quality of Medicare services, support innovation and the establishment of new payment models in the program, better align Medicare payments with provider costs, strengthen program integrity within Medicare, and put Medicare on a firmer financial footing.[3]

Immediately after the publication of the proposed regulations various commentators warned that those who wanted to participate and meet the ACO implementation date of January 2012 had better join the mad scramble to comprehend the requirements and prepare to meet the quality and savings requirements or be faced with the very real possibility of not having a seat in this regulatory game of musical chairs.

Providers Begin to Express Concerns

More recently, health care providers and provider organizations have started the process of drilling down through the regulations. Questions are being raised regarding whether it is possible to increase quality of care to a larger population of recipients while simultaneously lowering costs or at least lowering the growth in overall expenditures. Thus far there is not one "cookie-cutter" model for an ACO. The nuts and bolts of what an ACO could look like have been well chronicled by others and will not be reiterated here. Without endorsing or criticizing the positions taken, this article focuses on some of the concerns raised by providers and provider organizations.

As a general statement, it appears that most health care providers support the concept and goals of ACOs but believe that the proposed regulations impose significant impediments to successfully participating in a Shared Savings Program.

For example, the Cleveland Clinic

expressed its disappointment with the proposed rules, stating that:

> Rather than providing a broad framework that focuses on results as the key criteria of success, the Proposed Rule is replete with (1) prescriptive requirements that have little or nothing to do with outcomes, and (2) many detailed governance and reporting requirements that create significant administrative burdens. Further, we have concluded that the shared savings component (Shared Savings) is structured in such a way that creates real uncertainty about whether applicants will be able to achieve success.[4]

The letter from the Cleveland Clinic then goes on to list seven more pages of, what the Clinic terms,"recommendation[s] to improve the proposed rule."[5]

The Medical Group Management Association ("MGMA") recently commented that the Shared Savings Program detailed in the proposed regulations ". . . may not be viable as a national strategy unless significant program policies are modified when final rules are promulgated.[6] As an overall observation MGMA notes that the ACO model is a hybrid business model somewhere between the traditional fee for service model and a capitation or similar "all-risk" model. MGMA comments that ACOs purport to provide the best of both ends of the spectrum: cost control and cost certainty from the government's perspective as a payer and patient and provider freedom of choice. MGMA wonders out loud whether Medicare (and each of its stakeholders) can "have its cake and eat it too" using the ACO model.

Four specific areas of concern raised by MGMA are: (1) The complexity of the ACO program creates a bias against participation; (2) The cost of ACO development and ongoing operations are too high relative to the potential financial benefits; (3) The potential financial benefits are too small and too uncertain; and (4) The regulatory risks under the related joint notices concerning ACOs issued by CMS, the Office of Inspector General, the Federal Trade Commission, and the Department of Justice are substantial and add another disincentive to participation.

Other provider organizations have commented that the proposed regulations do not allow a gradual transition that would allow providers new to care coordination ample time to build the infrastructure needed to function successfully as an ACO or within an ACO. Rather, they state that the proposed regulations demand that all ACO "participants quickly move to taking on downside risk."[7] CMS acknowledges that requiring all ACOs to take this risk ". . . would likely inhibit the participation of some interested entities."[8] However, CMS believes that requiring participating ACOs to take on downside risk quickly is best for the program because ". . . payment models where ACOs bear a degree of financial risk have the potential to induce more meaningful systematic change in providers' and suppliers' behavior."[9] The debate here is not whether ACOs should take on downside risk but how soon in their lifecycle that risk should be borne. Many providers believe that if ACOs take on too much risk too soon the ACO may be forced out of business.

Complaints have been registered regarding how CMS will calculate the expenditure benchmark for ACOs. The benchmark will be unique to each ACO. CMS will base the benchmark on estimated Part A and B expenditures for ACO beneficiaries. Some provider groups have argued that a better approach would use blended regional and national expenditures to create a benchmark.

Conclusion

As with any potential decision, health care providers must assess the pros and cons associated with joining or creating an ACO or refusing to do so. ACOs have been heavily promoted as a panacea for control of health care spending while increasing health outcomes; a world view that is yet to be proven. However, some of the criticism may be equally flawed.

A decision whether to participate in the Shared Savings Program and the provider's selection of an ACO to join, are weighty decisions that require a careful consideration with a full appreciation of both the costs and the benefits evaluated in the context of your specific situation.

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[1]76 Fed. Reg. 19528-19654 (April 7, 2011).

[2]Id. at 19531.

[3]Id. at 19530.

[4]Letter from Delos M. Cosgrove, President and CEO, Cleveland Clinic to Donald Berwick, M.D., Administrator, CMS (May 26, 2011) (http://www.medcitynews.com/wordpress/wp-content/uploads/Cleveland-Clinic-ACO-letter.pdf).

[5]Id.

[6]Letter from William F. Jessee, M.D. for MGMA to Donald Berwick, M.D., Administrator, CMS (June 1, 2011) (http://www.mgma.com/WorkArea/DownloadAsset.aspx?id=1366447).

[7]76 Fed. Reg. at p. 19618 (April 7, 2011).

[8]Id.

[9]Id.