



HEALTH CARE POLICY



VOL. 19, NO. 28

REPORT

JULY 11, 2011

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CMS Struggles to Find an Accountable Care Organization Model That Works



BY BARBARA EYMAN AND PETER HOLMAN

Barbara Eyman, a partner with Ropes & Gray LLP, Washington, works with hospitals, academic medical centers, and other providers on challenges posed by federal and state health care programs, including Medicaid, Medicare, the Children's Health Insurance Program, and new programs being established under the Patient Protection and Affordable Care Act. With a long health policy background and reimbursement expertise, Eyman assists clients in understanding the impact that rapidly changing federal laws and regulations will have on their organizations, developing strategies to succeed under health care reform, and mitigating the impact of shrinking public health care program budgets. Peter Holman is an associate with Ropes & Gray, Washington, in the corporate department, with an emphasis on health care.

To say that the release in March of the proposed rule on Medicare Shared Savings Program Accountable Care Organizations (ACOs) by the Centers for Medicare & Medicaid Services (CMS) was disappointing would be an understatement. The ACO regulations have arguably been the most-anticipated aspect of health reform to date, expected to forge new ground in improving patient care while curbing rising health care costs. The ACO concept seemed to strike the right balance: higher quality for patients, incentivized payments for providers, and lowered costs for the system as a whole. Yet the March 31 release of the proposed rule has discouraged those who were previously intent on forming ACOs, and has tarnished the ACO concept as a mechanism for true delivery system reform. It remains to be seen whether CMS' upcoming revisions to the ACO rule will make it a viable option for providers. In the meantime, CMS has taken steps to look beyond the Shared Savings Program to develop alternative ACO models through the considerable demonstration authority granted to it in the Affordable Care Act (ACA).

Reception to the ACO proposed rule has, from the outset, been overwhelmingly negative. Large integrated health care systems, such as the Cleveland Clinic, Mayo Clinic, Intermountain Healthcare and Geisinger Health System, which were anticipated to embrace ACO participation, have all indicated that they will not participate in the program as proposed.¹ All ten participants in CMS's Physician Group Practice (PGP) Demonstration program—which served as the model upon which ACOs were developed—have written CMS to highlight their

¹ Rebecca Adams, *Model ACO Health Centers Skeptical of Proposed Rule*, THE COMMONWEALTH FUND HEALTH POLICY WEEK IN REVIEW, May 6, 2011, <http://www.commonwealthfund.org/Content/Newsletters/Washington-Health-Policy-in-Review/2011/May/May-9-2011/Model-ACO-Health-Centers-Skeptical.aspx>.

reservations with the proposed program.² Their sentiment, which is echoed by, among others, the American Hospital Association's recent comments on the proposed rule,³ is that the economics of the program and the complexity of the regulations provide little incentive for providers to participate.

Stakeholders have pointed to a number of shortcomings in the proposed rule. For example, the 65 quality metrics that are required to participate are seen as overly burdensome, requiring the investment of vast new resources to measure and track these metrics on top of those they are already tracking for other purposes. The proposed retroactive assignment of patients is seen as disadvantageous because it will limit an ACO's ability to understand the health needs of the population it serves and to respond accordingly. In addition, the performance benchmarks that CMS proposes would fail to take into account the risk profile of the population actually assigned to an ACO, meaning that benchmarks may not be achieved in the event that the population is older or sicker than anticipated. Further, many providers believe that CMS has failed to do enough to guarantee that sufficient safe harbor and other protections will be in place to remove the many legal barriers to entry, including those posed by anti-trust and fraud and abuse regulations.

Likely the biggest pitfall of the ACO rules, however, is the complexity of the proposed shared savings model, coupled with the significant costs associated with ACO formation. Potential participants have pointed out that the start-up and ongoing first-year costs of ACOs are likely to be very high—one estimate prices it out as upward of \$11.6 million to \$26.1 million just for a "medium" ACO⁴—and that it will require time for ACOs just to recoup their expenditures for infrastructure.

As a consequence, it is unlikely that many participants will be enticed by the Track 2, "two-sided" risk model, which would expose ACOs to risk of loss in all three years of the ACO program. Still, CMS's proposed Track 1 model is not much more appealing. Under the Track 1 model, ACOs would not be exposed to risk in the first two years, but in the third year the ACOs would be required to shift to a two-sided model.

To exacerbate the problem, providers are not convinced that there is sufficient upside benefit to participation in an ACO. Their reasons are many:

- The threshold amount that must be saved (the "minimum savings rate") to receive shared savings is, in the opinion of many stakeholders, too high, and too complex, as it varies not only based on which track an ACO chooses to use, but also on the size of the ACO.
- Once the minimum savings rate has been achieved, those entities that are not exposed to any downside

risk are only entitled to share in savings above the threshold amount (generally 2 percent to 3.9 percent) rather than first dollar savings, further cutting into their return on investment.

- Many would-be participants are convinced that the proposed 50 percent shared savings for ACOs not at risk for losses and 60 percent shared savings for at-risk ACOs are nearly unachievable because they would require the ACO to get a perfect score—i.e. meet the CMS-set performance benchmark—on all 65 quality measures. Any less than that and the savings rate is reduced accordingly. In reality, therefore, the 50 percent and 60 percent savings that CMS proposes would be a goal, not a guarantee, for many ACOs, and the benefit that they actually get back from CMS could be well below that rate.
- CMS will withhold 25 percent of all shared savings until completion of the three-year program, making it even more difficult for ACOs to quickly recoup much-needed funds to cover their startup costs.

In sum, the shared savings model is complicated, exposes ACOs to too much risk, and provides insufficient benefit to garner the interest of many providers.

Given the unenthusiastic response of providers, CMS will need to make significant modifications to the proposed rule if the program is to achieve its intended purpose. Comments for the proposed rule were due June 6, but even before then, CMS was well aware that stakeholders were unimpressed with what the agency had put forward. And agency officials have already hinted that changes would be in store. For example, at a recent briefing on ACOs, Richard Gilfillan, acting director of the Center for Medicare and Medicaid Innovation (CMMI), said, "We know this is a proposed rule, and that the goal is to take our best shot and then work with the industry, work with interested parties to figure out what the best approach is."⁵

At tension in the rewrite, however, is the question of how attractive CMS can make the program to potential participants while still achieving scorable savings for Medicare. The Administration badly wants evidence that the ACA is reining in health care spending, and ACOs are the highest-profile delivery system reform initiative in the bill. Yet many of the changes sought by providers will reduce the savings to Medicare. Cognizant of this pressure, some providers have begun weighing in directly with the Office of Management and Budget (OMB), urging it not to book too high a savings level for the Shared Savings Program as it resets the budget baseline in its upcoming mid-year budget review.⁶ Doing so would tie CMS' hand in structuring the final rule, forcing it to implement a program that theoretically achieves savings at the OMB level but in practice changes nothing, since few if any providers would participate.

CMS is unlikely to turn around a final rule until late this year at best, calling into question the feasibility of meeting the statutory implementation date of Jan. 1,

² Letter from Physician Group Practices to Donald M. Berwick, Administrator of CMS (May 12, 2011), available at <http://thehill.com/images/stories/blogs/healthwatch/unhappyacos.pdf>.

³ Letter from Rick Pollack, executive vice president of the American Hospital Association to CMS Administrator Donald M. Berwick (June 1, 2011), available at <http://www.aha.org/aha/letter/2011/110601-cl-acoprprule.pdf>.

⁴ McMANIS CONSULTING AND THE AMERICAN HOSPITAL ASSOCIATION, THE WORK AHEAD: ACTIVITIES AND COSTS TO DEVELOP AN ACCOUNTABLE CARE ORGANIZATION (April 2011), available at <http://www.aha.org/aha/content/2011/pdf/aco-white-paper-cost-dev-aco.pdf>.

⁵ Richard Gilfillan, Acting Director of the Center for Medicare & Medicaid Innovation, Accountable Care Organizations: A New Paradigm for Health Care Delivery? (May 13, 2011), available at <http://www.allhealth.org/briefingmaterials/Transcript-2030.pdf>.

⁶ Sam Baker, *Providers Say ACO Savings Estimates Are Too High*, HEALTHWATCH, June 9, 2011, <http://thehill.com/blogs/healthwatch/health-reform-implementation/165607-providers-say-aco-savings-estimates-are-too-high>.

2012. Yet CMS would be well-served to spend the time necessary to seriously consider and creatively address the many concerns raised by its target audience of Medicare providers. Doing so could reenergize potential participants and recapture the promise of reform that ACOs embodied just a few short months ago.

The Promise of the Center for Medicare and Medicaid Innovation

If the Medicare Shared Savings Program itself fails to gain traction, the establishment of the CMMI could help salvage the ACO concept for government programs. CMS Administrator Donald Berwick has called the CMMI the “crown jewel” of the ACA, recognizing its value in setting policies that will shape payment and delivery system reform. The CMMI is charged with identifying, testing, and reproducing effective payment and service delivery models, and has been appropriated \$10 billion over the next 10 years to do so. Although the ACA suggests several types of demonstration projects that the CMMI could test, it is not bound to test those models and may develop its own initiatives with an unprecedented degree of legal flexibility and financial resources. Moreover, if a project tested by the CMMI proves successful in improving quality and reducing costs, the CMMI has the authority to expand the scope of the model, including instituting it program-wide.

The CMMI has already signaled its recognition of the significant challenges that may serve as a barrier to entry in the ACO market. In late May, for example, CMMI sought feedback on a proposed Advance Payment Initiative to pre-pay ACOs participating in the Shared Savings Program a portion of their shared savings. The prepayments could be used by ACOs as much-needed upfront capital to invest in infrastructure and staff necessary to begin operations. The prepayments would then be recouped from the shared savings payment that would otherwise be due to the ACO. Based on the feedback received, the CMMI will decide whether and how to run this demonstration in conjunction with the Shared Savings Program.

Another early initiative the CMMI is touting, the Pioneer ACO model, attempts to develop an alternative ACO model that will address some of the perceived shortcomings of the Shared Savings Program proposal. Announced in late May, this demonstration is intended for up to 30 organizations that already have experience in providing coordinated patient care. Although built upon the same structure as the Medicare Shared Savings Program, the Pioneer ACO model differs in several significant respects:

- The Pioneer ACO demonstration will permit participating organizations to elect prospective beneficiary assignment instead of retrospective assignment as required under the proposed ACO rule.
- Primary care services provided by nurse practitioners (NPs), physician assistants (PAs) and certain specialists will be factored into the ACO assignments. In contrast, the Shared Savings Program pro-

posal would look only to primary care physician services for this purpose, excluding a wide swath of settings in which beneficiaries actually receive primary care. This expansion is particularly important for underserved areas which often rely on NPs and PAs for patient care.

- The Pioneer model would give ACOs the option to receive a higher percentage of shared savings, though such option would also include assumption of risk for a greater percentage of losses.
- The payment arrangement begins to incorporate a partial capitation concept once the ACO has a demonstrated track record of achieving savings, though the capitation payments eventually get reconciled to fee-for-service expenditures with shared savings.
- CMS will offer a yet-to-be-announced alternative payment arrangement, based on ideas submitted by applicants.
- Pioneer ACOs would be required to contract with private payers on an accountable basis, which many believe is a critical component to incentivize expansion of the ACO model.

To be sure, the Pioneer model does not address all of the concerns raised about the proposed Shared Savings rule. But in announcing the demonstration even before the Shared Savings rule comment period ended, CMS took quick steps to emphasize that the Shared Savings Program is not the only possible approach to establishing ACOs for government programs. Presumably, more models will be in the offing targeting specific needs, particular providers, special populations and identified policy goals.

The failure of the proposed ACO rule to garner any enthusiasm from providers underscores the need for CMS to have the kind of flexibility provided by the CMMI. CMS lays the blame for some aspects of the ACO rule on the terms of the statute, claiming, for example, that the law does not permit the agency to include primary care providers other than physicians in its assignment algorithm. Used properly, the authority provided by the CMMI should allow for CMS to use the feedback provided by stakeholders on the Shared Savings Program to design a variety of models that are attractive to participants, good for beneficiaries and successful in achieving better care at an affordable cost.

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With a near-unanimous consensus among stakeholders that the proposed ACO rule has fallen short, CMS will presumably revamp the final rule in major ways, responding to the concerns that startup costs are high and the potential return on investment is limited. Hopefully, the changes to the proposed rule will rekindle the excitement about ACOs shared by many providers earlier this year. But even if the ultimate vehicle for launching the spread of ACOs is not the Medicare Shared Savings Program, CMS still has the ability, through the extraordinary resource that is the CMMI, to move providers towards the goal of working together to improve care, reduce costs and help keep communities healthy.