

ACO Regulatory Review

Identifying Concerns, Moving Forward



AMGA

American Medical Group Association

Meetings

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In April, the Centers for Medicare and Medicaid Services (CMS) released their eagerly anticipated proposed rules for Accountable Care Organizations (ACOs). In this no-holds-barred meeting of the ACO Collaboratives and other interested members of the American Medical Group Association (AMGA), participants asked questions, voiced their concerns, and identified obstacles to making the ACO model work. AMGA was collecting feedback before submitting official comments to CMS at the beginning of June as part of the public comment period.

“Don’t hold anything back. Today is the day we want to hear everything you have to say about these regulations and how they will affect you.”

— Julie Sanderson-Austin, R.N. Consultant, Quality Management and Research, AMGA

Uncertain Evaluation of a Daunting Application

According to George Roman, AMGA Senior Director, Health Policy, applicant ACOs will have to submit “the electronic equivalent of the *Encyclopedia Britannica*” covering governance, coordination of care mechanisms, individualized care plans, processes for evaluating population health needs and much more. What will the reviewers be looking for, participants asked? Will back-and-forth discussion be entertained after an application is submitted? In the words of Marci Sindell of Harvard Vanguard Medical Associates, “Will CMS accept 100 percent of us who are brave enough to apply?”

Problematic Participation Limits

Once ACOs make the three-year commitment, proposed rules prohibit them from entering into arrangements that involve new tax ID numbers, possibly because such arrangements might spur Federal Trade Commission inquiries. Many participants identified this prohibition as a deal-breaker.

“What if, midway, you find a group you want to affiliate with?” said Smokey Stover of MultiCare Health System. “You can’t have new primary care doctors in your ACO unless you employ them,” observed Mark Shields of Advocate Physician Partners. “Seventy-five percent of our doctors are in private practice.”

Participants suggested alternatives to the proposed three-year commitment:

- ▶ A five-year option for participants who need more time to set up infrastructure
- ▶ A three-year commitment with an option to renew for two more years
- ▶ A five-year commitment with other variables adjusted

Attribution Rules vs. Realities

The number of patients attributed to an ACO determines expenditure targets, cost information, and other vital metrics. CMS proposes a combined approach: retrospective assignment to determine shared savings eligibility and prospective lists (with names, dates of birth, gender, and Medicare numbers) to identify the assigned population at the start of each performance year. Patients will be assigned to the system where they receive plurality of primary care, as determined from claims data allowed charges of certain narrow bands of HCPCS codes, primarily E/M services.

For participants, the gaps between proposed rules and on-the-ground realities expose them to risk. “Attribution is based on physician visits,” Sindell observed. “What if you’re trying to bring costs down by having other care providers see patients? And hospitals have to let primary care physicians know when patients are in the hospital.” According to Shields, “We could live with this attribution if we get the claims data promptly”—say, on a monthly basis.

Investment and Risk vs. Upside Potential

Under the proposed rule, an ACO is paid a shared savings bonus if it meets quality performance metrics and savings against a targeted expenditure, called a “benchmark” in the proposed rule. The quality performance score is applied to results to yield shared savings. A minimum savings rate (MSR) of 2% to 3.9% must be attained before shared savings begins. Losses (excess over the targeted expenditure) are capped at 5%, 7.5%, and 10%, respectively, over the three-year term. Losses over the cap are absorbed by the Medicare program and smaller losses must be repaid by the ACO.

Infrastructure expenditures: For many participants, the potential risks of this structure far outweigh the potential savings. “CMS does not comprehend the cost of the infrastructure, the care management staff,” said Shields. Bob Matthews of PriMed Physicians proposed a higher savings rate in year one to reflect infrastructure investments and to encourage people to “get in and experiment.” He said, “it would feel like we’re taking our doctors to the roulette table” to spend millions for such uncertain returns. Sindell suggested that quality should be an incentive payout on top of—as opposed to being a component of—the savings rate.

Withholding fund requirements: For the largest ACOs, these are expected cost of doing business, covered by a few million dollars already in the bank. For mid-size and smaller ACOs, however, setting aside 25% of shared savings to cover possible losses represents a significant expense. Dollars not necessary for repaying losses are to be returned at the end of the participation period, the three-year ACO enrollment term.

Accommodations for statistical variation: The MSR requirement is intended to assure that savings can be attributed to ACO practices and not to random factors or statistical variation. Exceptions will be given to rural systems and systems with fewer than 10,000 attributed patients meeting one of a number of other criteria.

CAHPS Concerns

Sanderson-Austin discussed potential issues with CMS using the Consumer Assessment of Health Providers and Systems (CAHPS) survey instrument to measure patient satisfaction. CAHPS addresses neither patients receiving care from a care team or care delivered across a care setting. AMGA is working with Press Ganey to develop an alternative tool addressing these weaknesses.

This concerned participants for many reasons:

- ▶ **The MSR doesn't account for all risk:** "Statistical variation goes in both directions. These rules only acknowledge it in one," observed Stover. In addition to the MSR being applied to positive results only, Matthews added that the MSR didn't take into account other variables in the area of population risk, such as performance or the introduction of new technologies.
- ▶ **The 10,000-patient minimum to qualify for an MSR exception is too low:** The minimum statutory number for an ACO is 5,000 and with that few beneficiaries, it wouldn't have the scope to function, said Roman.
- ▶ **There are better ways to accommodate for statistical outliers:** Sanderson-Austin suggested trying techniques used in actuarial research.

Quality Reporting Overload

In demonstration projects of the ACO concept, 32 quality reporting measures were phased in over time—and participants struggled to accommodate them. The proposed ACO rules outline 65 quality reporting metrics—more than twice as many—that must be in place from day one. Some of these will be passive (at least in year one), acquired from claims data, said Roman. CMS also is in the process of harmonizing measures from existing metrics.

Participants, however, shared several other quality reporting concerns, including:

- ▶ **Unreasonable ramp-up:** "I don't mind 65 measures, but [meeting these must] be spread out, and there has to be an assurance that you can't get all this set up and [lose for failing] on one measure," said Matthews. "There's no way anyone who hasn't done a good part of this already could get this started in one year."

- ▶ **Stringency without flexibility:** Even though quality measures will evolve over time, CMS will hold ACOs accountable for meeting every requirement completely and accurately, at the risk of losing out on shared savings. “ACO quality rules have gone too far,” said Matthews. “You have to prove you’re an absolute saint.”
- ▶ **Incomplete benchmarks:** “This is the section we think has the biggest risk,” said Sindell. “Because there are many measures for which there is no data being collected today, half of the ACOs would be below 50% [since only ACOs would be in the comparison pool].” CMS will need to come up with a national benchmark, said Roman.

Participants also cited specific quality metrics as troubling—for example, metrics asking ACOs to track flu shots, even though patients could receive these outside of the ACO system at a health fair or pharmacy. “Statutorily, we can’t control patient choice, so we can’t take that upside risk,” said Stover.

Insufficient Risk Adjustment

For the risk-adjusted benchmark called for in the ACO statute, CMS has opted to apply the Hierarchical Condition Category (HCC) to determine health status of the ACO patient population and is “keeping time static,” in Roman’s words, to discourage increased coding that “games” the system, behavior seen in Medicare Advantage and mentioned in the rule.

For some participants, not being able to adjust for risk as an ACO program moves forward will be cause to bow out. “There needs to be the opportunity to constantly update the population in question for the accurate calculation of spending targets,” said Matthews. According to Shields, “If the financial model was generous enough, you’d be able to take on the risk without adjustments.”

Participants also observed that this method of risk adjustment does not account for the introduction of new technologies—even as simple as a new shingles vaccine for 10,000 people—and discourages new programs—such as a new teaching hospital or transplant program.

Unclear Legal Interpretation and Enforcement

Participants expressed concern with the uncertainties of contracting with CMS—is CMS open to discussion or negotiations?—and the lack of an appeals process beyond CMS or an independent review board.

Roman said he personally would like something more firm than the proposed rules’ “safety zones” and “don’t break the law and we won’t prosecute you.” He cautioned, “I wouldn’t proceed without a review. Otherwise you’re taking a big chance.”

How Insurers and Hospitals Are Responding

Spurred by many of the same factors driving the federal ACO model, such as the wish to reduce the rate by which healthcare spending is growing, insurance companies are showing considerable interest in an ACO-like payment system that can be quickly brought up to scale, said Roman. Some insurance providers are open to sharing actionable patient data with ACOs, coordinating care management processes and supporting solutions for small providers. Others are testing the possibility of commercial ACOs. For example, Anthem is undertaking project with Sharp-Rees Stealy Medical Group with several advantages over the proposed federal ACO model, such as:

- ▶ Patient incentives for participation (recruiting is forbidden in the Federal model)
- ▶ No minimum savings rate
- ▶ Prospective patient attribution, with a commitment to obtaining as close to real-time data as possible

Hospitals also want to be ready. The American Hospital Association recently hired a director-level staffer for physician matters. On one hand, hospitals want to lock up referrals and reap potential in-patient services savings. On the other hand, they're in an inherently defensive position. "A lot of the savings will come out of their hide," said Roman.

Cumbersome Communications

The marketing communications challenges and pitfalls health systems experienced under Medicare Advantage might be a coming attraction of what lies ahead for ACOs, Roman warned. Specific concerns included:

- ▶ **Pre-approval of materials:** Roman predicts that this will play out in practice with CMS providing ACOs with communications templates, rather than getting every letter and brochure approved.
- ▶ **Informing beneficiaries:** "It frightens me to death to try to explain this to people," said Matthews. "I can't even explain this to my father in an hour over Easter dinner." Sanderson-Austin suggested that the notification process likely would be similar to that used in demonstration projects: A letter goes from CMS to beneficiaries; then provider groups follow up with their own communications.
- ▶ **Approval lag times:** In a worst-case scenario, a health system might be approved as an ACO but its materials might not be. Sindell related a story that happened to her group under Medicare Advantage. In 2006, they had to inform all patients that one plan had been cancelled, but they weren't allowed to talk about substitutes.

Next Steps: Compiling Comments, Hoping for Changes

For participants daunted by the proposed rules Roman mentioned that CMS Deputy Administrator and Director Jonathan Blum, at a recent AMGA Board meeting, offered two alternatives for groups on Medicare's path to value-based purchasing: Medicare Advantage and future opportunities within the Center for Medicare and Medicaid Innovation (CMMI). Not all participants were excited about CMMI, however. "Don't make poor policy and then go on a fishing expedition for ideas," said David Zielke of the Iowa Clinic.

Despite the many questions and concerns, not all enthusiasm for the ACO model had diminished. When asked at the end of the day if they would like to be able to participate, several participants raised their hands. "A lot of AMGA members have been doing ACO-type care delivery all along," said Roman. "We'd like to be able to make this work."

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