The CMS Next Generation ACO Model – Will It Increase Medical Malpractice Risk?

By Susan Huntington

The Patient Protection and Affordable Care Act of 2010 (“ACA”) provides for the formation of accountable care organizations (“ACOs”) to encourage physicians, hospitals, and other health care providers to come together and deliver better coordinated, high-quality care to Medicare patients and the chronically ill.

The ACA also instituted the Medicare Shared Savings Program (“MSSSP”) under which ACOs are eligible to receive shared savings from Medicare from the calculated reduction in Medicare spending. After the ACA was enacted, many physicians and other providers moved quickly to form ACOs that would allow them to take advantage of the MSSP payment model.

Since its original enactment, the Centers for Medicare and Medicaid (“CMS”) has made numerous revisions to the MSSP model. Most recently, the CMS Center for Innovation announced the application process for its newest MSSP option called the “Next Generation ACO” which goes into effect January 1, 2016. This Next Generation ACO allows ACOs to assume a higher level of financial risk and reward than is currently available in Medicare ACO initiatives, including full capitation. Other new features of the model include provisions to increase the Medicare beneficiary’s engagement and alignment with the ACO.

While such improvements may increase the attractiveness of participating in an MSSP ACO for health care providers, will these enhancements create additional medical malpractice exposure for such ACOs, similar to the risks encountered by capitated HMOs in the 1990s?

Challenges with Measuring Savings in Shared Savings Arrangements

By Jill Herbold, FSA, MAAA and Anders Larson, FSA, MAAA

Although both providers and payers agree on the general concepts and objectives of shared savings arrangements, the practical task of measuring reductions in healthcare expenditures that are due to actions by providers is another matter. Changes in risk profile, selection bias, outlier claims, and underlying medical trends can all influence how expenditure levels change for a population over time. For these arrangements to work for both parties, the measurements must be as accurate, fair, and transparent as possible.

The key is to estimate what the expenditures would have been in the absence of the intervention. Without a random control trial, which is not practical in a shared savings arrangement, measuring savings is inherently tricky. There are a variety of ways of attempting to do this, and these options can often produce vastly different results, none of them necessarily “correct.”

For instance, the trend that is applied to the historical benchmark can be based on an agreed-upon market trend, such as the Milliman Medical Index™, or it can be based on the changes in expenditures for a reference population that is comparable to the accountable care organization (ACO) population. Adjustments for changes in the risk profile of the assigned population can be based upon prospective or concurrent risk score algorithms, which may be proprietary or publicly available.

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Editor’s Corner

Raymond Carter, Senior Editor, Accountable Care News

We continue with our op-eds and brief reports from the field this month with a commentary from Dave Ehrenberger, MD on PCMH-Powered Family Physicians.

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The New Center of Gravity in Healthcare: PCMH-Powered Family Physicians

“Where’s the beef?”

That is the central question behind the Patient Protection and Affordable Care Act (now known generally as the ACA) and the ACO movement. Patients, purchasers, employers, CMS…all are asking what they get for their money in healthcare, where’s the value. It is of great importance to family medicine that the answer is NOT found in more MRI’s, more subspecialist procedures or more (avoidable) acute hospital admissions. The answer is found in a dramatic and profound innovation in healthcare: the patient centered medical home. For family physicians, this is the clarion call for our revitalization and for us to grab the golden ring of opportunity as the ACO future emerges. Let’s examine why.

The ACO construct may be the roadmap for healthcare reform, but the medical home is the vehicle to get us there. Consider how the architects of the ACO model, Dr. Mark McClellan, Dr. Elliott Fisher, and others, defined its three core principles:

1. Provider-led organizations with a strong base of primary care that are collectively accountable for quality and total per capita costs across the full continuum of care for a population of patients;
2. Payments linked to quality improvements that also reduce overall costs; and,
3. Reliable and progressively more sophisticated performance measurement, to support improvement and provide confidence that savings are achieved through improvements in care.1

For students of PCMH, these principles will resonate: after all, NCQA’s medical home standards are enhanced access and continuity, management of patient populations, evidence based planned care, patient engagement, care coordination, and performance improvement.

Or consider the Department of Health and Human Services guidelines in the ACA to promote evidence-based medicine and patient engagement, monitor and evaluate quality and cost measures, meet patient-centeredness criteria, and coordinate care across the care continuum. These guidelines are used to define the essential elements of ACO’s, but they could just as well be used to define the medical home.2 Here’s the recipe: just add regional provider collaboration plus accountability for value to a foundation of PCMH’s and, voila, you’ve got an ACO.

OK, so PCMH is the darling of the ACO movement, the heart and soul of the ACA. But if transforming traditional family medicine practice into “advanced primary care” -- PCMH -- is hard work, then transforming the village into teamwork accountable for lower cost and higher quality is even harder. Where will we get the high-octane fuel to power this kind of earth-shaking change? This is the easy part: from healthcare waste -- there’s lots of it and a rich opportunity for us in family medicine.

Thanks to a recent think-tank article out of the Institute of Medicine, we now know the value of waste in our healthcare system: about $750 billion annually, with the top three offenders being unnecessary services, inefficient care delivery, and excess administrative costs.3 That’s more than the yearly budget of the Defense Department And the Center for Medicare and Medicaid Services’ “waste reduction” pilot with 58 ACOs—the Medicare Shared Savings Program—saved $705 million during its first year of ACO implementation while improving on 30 of 33 quality measures.3

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Effective Population Health Management Delivers Sustained Medicare Star Improvement

By Saeed Aminzadeh

Over the past several years, the concept of population health management has somehow become an ill-defined concept that is relegated exclusively to epidemiologists and clinicians. At its core, however, population management is simple. Plainly, population health management is a group of activities designed to improve health outcomes by impacting the clinical, socio-economic, and behavioral determinants of those outcomes. In other words population health management is about improving health and minimizing the need for expensive interventions.

If we look at the Medicare Star measures in the context of the above definition, we will quickly see that the Star measures, by design, try to address all of the determinants of improved health outcomes: from improving process outcomes, to boosting clinical outcomes, to increasing satisfaction, to minimizing mental and physical decline. The key to consistently delivering sustained improvements in your Medicare Star ratings is to construct a population health management program that is focused on the member (not the measure), and is targeted to improving the member/patient’s engagement with the entire healthcare ecosystem in the context of the member’s greatest barriers to engagement.

Addressing and Enhancing Patient Engagement

If we define patient engagement as an individual’s emotional involvement with their health and the healthcare system, enhancing patient engagement is at the core of improved outcomes, loyalty, and satisfaction – in other words, improved Medicare Star.

To date, most health plan strategies around population health, quality improvement, and member engagement have typically been reactive, designed to target compliance with evidence-based guidelines. Though this approach provides incremental improvement, it is inefficient and does not produce a sustained and long-lasting impact on quality, loyalty, and utilization because it lacks many of the key components necessary for success, including:

**Identification of behavioral and engagement risk** -- today, most population health management programs have analytical underpinnings designed only to identify clinical risk and severity. Empirical evidence suggests, however, that member behavior and engagement are two of the most significant contributors to undesirable clinical behavior and outcomes. To address these factors, plans must employ strategies to identify and address the behavioral and engagement risk associated with undesirable outcomes.

Member prioritization -- with a limited budget and resources, plans simply cannot reach out to every member for every issue with the same intensity. Recognizing that members vary in terms of their predicted behavior relative to quality, loyalty, and utilization, plans must deploy their limited resources in a way that maximizes the impact to their members’ outcomes and plan performance.

Relevance of outreach to members -- to change behavior and improve quality effectively, loyalty and utilization, member outreach and communications must be personalized in a way that addresses the member’s specific barriers to engagement and compliance.

Intensity and channel mix -- the intensity and channel selection should be based more on a data-driven understanding of channel preference and likelihood of success, and less on the proximity to the end of the measurement year and the number of open gaps.

Focus on more than just gaps in care (HEDIS) -- improving performance and sustaining excellence is more than maximizing HEDIS metrics -- a smart, data-driven approach to improve engagement is critical to long-lasting quality improvement and loyalty, and it will impact more Star measures (such as the Health Outcomes Survey measures, readmissions, and ER Utilization).

Mastering the Population Health Management Challenge

One of the most complex challenges facing healthcare organizations is delivering positive outcomes across key, disparate health and clinical domains. The question becomes, how can you deliver positive outcomes across multiple domain outcomes, while communicating with members efficiently and personally, and with the least amount of member abrasion? In other words, how can you improve outcomes across multiple domains and across the same population without communicating with each member about each topic with the same (or similar) intensity?

The most effective way to deploy a population-level strategy is to identify behavioral risk proactively for each member and then measure and prioritize members and measures based on their potential impact, and deliver personalized communications that address a member’s specific barriers to engagement.

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Effective Population Health Management Delivers …continued from page 3

For example, a member may be at high risk for non-compliance with their preventive screening and chronic care measures because of health literacy issues, but very low risk for disenrollment, dissatisfaction, and re-admissions. In this simple example, a directed communication focused on educating the member on self-care and prevention is the best and most efficient communication because it addresses the area of greatest risk in manner that has the highest probability of generating sustained behavior change.

Most members, however, do not fall neatly into a single segment. Members may be at high risk for all measures, or they may be at high risk for several measures and lower risk for others, or they may be at low or moderate risk for all measures. How can multiple risk levels across multiple measures be prioritized in a way to address what is truly important for each member, while also improving performance across all measures?

The key lies in two critically important concepts:

- **Prioritizing your domains of focus.** For example, for a diabetic member who is at high risk to leave the plan, and at high risk to adhere to their medication regimen and their screening schedule because of health literacy issues, their medication adherence and screening risk is prioritized. The goal would be to communicate with the member personally, addressing their health literacy barrier, and ultimately impact their health literacy, their adherence and compliance with evidence-based guidelines, and also their ultimate loyalty to the plan.

- **Understanding your resource constraints.** The fact is, you simply cannot afford to visit every single member in their homes, or even have a nurse or clinician call every single member. The question is how many members can you contact given your resources and budget, and how can you stretch your budget by using alternative, less expensive resources and channels that acknowledge a member’s channel preference and their risk level. In the example above, a diabetic member that is at high risk to adhere to their medications and screenings because of health literacy issues is a good candidate for clinical, live call contact (a letter listing their gaps in care will likely not make them health literate), while a diabetic member that is at moderate risk to adhere to their medications and screenings because of health system engagement issues is a good candidate for less intensive outreach.

Creating a Continuous Learning Model

Part of implementing any population health management model is to be ready for some sort of failure. We need to think of failures, not as failures, but rather as opportunities to understand what worked and what did not work. The fact is, very few things are complete failures, and it is important to analyze the impact of your programs in the context of where they succeeded, and the potential reasons for where they failed so that you can modify the programs to create sustained success. An initiative to improve diabetic medication adherence, may have failed to improve adherence in the aggregate, however, it’s important to analyze the member segments and sub-segments for which adherence was improved and not improved, and continually retain or discard certain portions of the program to optimally improve performance.

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The performance period expenditures are often adjusted in some way in these arrangements. One common adjustment is to remove or truncate large claim costs for individual patients in order to reduce statistical variation of expenditures in the estimation of savings.

Setting the threshold for this adjustment should be done carefully because managing high-cost, complex chronic conditions is a key way for providers to reduce overall expenditure levels. For instance, the Medicare Shared Savings Program sets this threshold as the 99th percentile of annual expenditures for all ACO-eligible beneficiaries nationwide within each Medicare entitlement category.

**Bias in Using Cohort Approach.** A key component of any shared savings arrangement is the methodology for assigning patients to the ACO in current and historical time periods. The cohort approach uses the same set of patients in the performance period and the baseline period.

The Medicare Pioneer ACO Program used a cohort approach for its first three years, 2012 through 2014. The use of the cohort approach necessitated additional complexities, such as a decedent adjustment to account for the fact that the baseline period would not include anyone who died during that time period.

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The cohort approach also introduced a bias into the savings calculations that was problematic for many ACOs. The bias is due to differences in the composition of an ACO population compared with the national Medicare reference population. An ACO population, in any given year, contains two types of patients: those who were assigned to the ACO in the prior year and those who are newly assigned this year.

However, the reference population also includes a third type: patients who were assigned to an ACO in the prior year but are not assigned in the current year. This is because the reference population includes all ACO-eligible beneficiaries, regardless of which (if any) ACO they are assigned to.

Figure 1: Composition of ACO Population vs. Reference Population

We have found that newly assigned patients tend to have above-average trends from the baseline period to the performance period, whereas patients who lose assignment tend to have below-average trends between these periods. The chart in Figure 2, which is based on data from a Pioneer ACO in its third performance year, shows the expenditures over time for the newly assigned patients.

Note the spike in expenditures toward the end of the assignment period, indicated by the blue vertical lines. Expenditures do not fall back to earlier levels after this spike, leading to a 94% trend from the baseline to the performance year.

The reason for these excessively high trends is that patients are often assigned to the ACO because of an acute medical event that caused them to visit ACO physicians. However, these patients were generally healthier in earlier time periods, which is precisely why they were not visiting ACO physicians at that time.

Figure 2: Progression of Costs for Beneficiaries Assigned for First Time in Performance Year 3 (PY3)
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With the cohort approach, the ACO is now responsible for all historical expenditures for these patients, inflating the ACO trend. The reference population also includes these type of patients, but the high-trend patients are offset by the low-trend patients who recently lost assignment.

This situation may be exacerbated if the ACO includes providers such as cardiologists or skilled nursing facility (SNF) physicians who deal with patients during high-cost episodes. Trends also might not be as extreme as the example above in shared savings arrangements where the baseline period is the same as the assignment period.

A cross-sectional approach for measuring savings uses the same algorithm to assign patients separately in the performance period and the baseline period. It eliminates much of the bias of the cohort approach because when patients are newly assigned to an ACO their historical expenditures are ignored. Conversely, when patients lose assignment, their historical expenditures are still used in calculating baseline expenditures.

The expenditures in historical periods do not change over time, assuming the ACO does not change its list of participating providers. For one ACO, we estimated that using the cross-sectional approach would have improved the gross savings percentage by approximately 6% and allowed the ACO to share in substantial savings.

The Pioneer ACO Program moved to a cross-sectional approach in 2015, consistent with the approach used by MSSP since its inception in 2013.

Unintended Consequences that are Due to Assignment Methodology. Even if the cross-sectional approach is used, there are other aspects of the shared savings arrangement that can adversely affect the measurement of savings. One of these aspects is the assignment methodology. Because these arrangements rely on passive assignment, the arrangement must specify a way to identify which patients should be assigned to the ACO.

Some arrangements look back as far as 36 months to determine whether a patient should be assigned to an ACO. Others rely on a much simpler algorithm, such as assigning patients to an ACO for the prior calendar year based solely on their last evaluation and management (E&M) visit during that year. In this case, a patient visiting an ACO physician on December 31, despite having 10 E&M visits to non-ACO physicians earlier in the year, would be assigned to the ACO for the entire year. For obvious reasons, the "recent E&M assignment" methodology can cause patients to move in and out of the ACO often.

The goal of the assignment methodology should be to assign members to the ACO physicians that are providing the majority of the member’s primary care services. Relying on an overly simplistic approach can lead to problems. For instance, consider an ACO looking to reduce its SNF expenditures by steering patients to facilities with ACO physicians. Even if these physicians are successful in reducing expenditures for these patients, the steerage may increase the number of less healthy patients that are assigned to the ACO, because those few recent visits by ACO physicians in the SNF may be enough to assign the patient to the ACO.

The chart in Figure 3 illustrates this issue. This illustrative situation assumes a 1% trend for all beneficiaries in the absence of any initiative. The initiative reduces expenditures for beneficiaries in the SNF by 10%, but it also causes more of these beneficiaries to be assigned to the ACO.

Figure 3: Trends With and Without SNF Initiative

<table>
<thead>
<tr>
<th>Time Period</th>
<th>Non-SNF PMPM</th>
<th>SNF PMPM</th>
<th>Portion of Assigned Lives in SNF</th>
<th>Total PMPM</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline</td>
<td>$800</td>
<td>$2,000</td>
<td>2%</td>
<td>$824</td>
<td>n/a</td>
</tr>
<tr>
<td>Performance (without initiative)</td>
<td>$808</td>
<td>$2,020</td>
<td>2%</td>
<td>$832</td>
<td>1.0%</td>
</tr>
<tr>
<td>Performance (with initiative)</td>
<td>$808</td>
<td>$1,800</td>
<td>3%</td>
<td>$838</td>
<td>1.7%</td>
</tr>
</tbody>
</table>

In many shared savings arrangements, there would be a risk adjustment that would increase the ACO's benchmark in this situation, which is due to the fact that the ACO now has a less healthy population. However, it is unlikely that a risk adjustment based on health status would fully account for the known increased prevalence of expenditures for SNF services, unless the risk adjustment model explicitly incorporated variables beyond diagnoses and drug information.

Concurrent or Prospective Assignment? The choice of whether to use concurrent or prospective assignment is not clear-cut, and the preferable option may vary based on the circumstances of the particular arrangement.

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Prospective assignment is appealing to ACOs because it allows them to begin managing a particular set of patients at the start of the performance year without the risk of those patients being de-assigned during the year. Additionally, the ACO will not have any patients assigned that it was not aware of during the performance year. With concurrent assignment, the ACO might receive quarterly or monthly lists of patients that are likely to be assigned, but the true list of patients is not final until the year is over.

The trouble with prospective assignment is that the ACO inevitably will be responsible for ACO-assigned patients who see non-ACO physicians for the majority of their primary care during the performance year. Patients may see ACO physicians regularly during a historical period, but because of a change in circumstances (perhaps the onset of a new condition), they see non-ACO physicians for their care during the performance year. Under prospective assignment, the ACO is still responsible for the expenditures for these patients, yet the ACO has little opportunity to manage their care. In the Medicare ACOs, it is not uncommon to see year-to-year turnover rates above 20%, meaning that a sizable portion of patients are not seeing the ACO physicians they are assigned to for care during the performance year.

Ultimately this decision is a matter of preference. Concurrent assignment may produce a more meaningful estimate of the ACO’s impact, but prospective assignment removes uncertainty about which patients the ACO is responsible for.

Conclusion and Other Considerations. There are certainly other considerations in designing a shared savings arrangement. For instance, there should be sufficient incentives to entice both efficient and inefficient providers to participate. Under the current Medicare Shared Savings Program regulations, it may be challenging for provider organizations that are already operating efficiently to succeed financially, because the savings are based on expenditure trends rather than the overall level of expenditures. One possible solution would be to adjust the benchmark trend that ACOs must beat based on the overall level of expenditures for the ACO. In this case, the benchmark trend would be decreased (making it more challenging) for providers that start the program with expenditures above a certain risk-adjusted level, while the benchmark trend would be increased (making it less challenging) for providers that start the program with expenditures below a certain risk-adjusted level.

With time, we have been able to observe many challenges with the measurement of savings in the shared savings arrangements in use today. We know that any method for attempting to measure savings will be imperfect in some way, but at the same time we cannot let “perfect be the enemy of good.” As changes are proposed to the current arrangements and as new arrangements are established, it is critical to perform simulation and modeling in advance to help avoid unintended consequences. This process provides the best chance for shared savings arrangements to have the intended effects of reducing expenditure levels while maintaining a high quality of care, thereby increasing the long-term viability of this payment model.

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Financial Incentive Concerns

In theory, ACOs may decrease medical malpractice exposure for several reasons. First, the goal of clinical integration required by ACOs is to lower overall health care costs by increasing quality and creating an integrated set of resources to manage care through the current fragmented health care system. Second, the clinical integration of providers in an ACO requires the use of evidence-based treatment options which should lead to better outcomes. Third, the implementation of sophisticated information technology required in ACOs should increase communication between providers and the availability of information necessary for effective patient care management.

However, whenever cost-saving efforts play a role in the delivery of health care services, there is the inevitable risk of a claim that financial considerations adversely impacted the patient’s care. Under prior MSSP models, ACOs could choose between an upside-risk-only payment contract (sharing in savings; no risk for losses) or an upside/downside-risk contract (sharing in savings while being at risk for losses associated with medical costs).

The Next Generation Model includes more options for payment mechanisms, including full capitation, but requires both upside/downside risk. This requirement for the ACO to be responsible for financial losses as well as savings from the care provided to patients will create more incentive for providers to control costs and avoid procedures that are considered non-critical. This can include decisions related to diagnostic tests, such as costly MRIs, which may lead to higher exposure for failure to diagnosis allegations. This requirement for the ACO to be responsible for financial losses as well as savings from the care provided to patients will create more incentive for providers to control costs and avoid procedures that are considered non-critical. This can include decisions related to diagnostic tests, such as costly MRIs, which may lead to higher exposure for failure to diagnosis allegations. Similarly, financial considerations or contractual requirements related to risk assumption between the ACO MSSP participating providers may impact referrals for specialty care or hospitalization creating patient concerns about denied care.

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Beneficiary Alignment and Expectation Concerns

In the Next Generation ACO model, Medicare beneficiaries are still allowed to go to the provider of their choice which creates challenges for the ACO managing their care. To help improve beneficiary engagement with the ACO, the Next Generation ACO Model includes specific benefit enhancement tools, including (i) the opportunity for beneficiaries to receive reward payments for receiving the majority of their care from ACO providers, and (ii) a process for beneficiaries to confirm their care relationship with ACO providers. Thus, more than ever before, beneficiaries will be better informed and aware that the ACO is responsible for coordinating and providing their care. They will also know that the goal of an ACO is to improve efficiency and the quality of care using national standards and reporting on defined quality metrics. This transparency can lead to higher expectations from the patient regarding the standard of care they are supposed to receive from their ACO providers.

Risk Management Considerations

Many of the HMO liability cases in the 1990s were decided under federal ERISA pre-emption law which limited the HMO’s liability. However, ERISA does not apply to the Medicare Shared Savings Programs so its pre-emption protection will not help MSSP ACOs. In addition, the ACA does not contain any pre-emption protection for ACOs. In fact, provisions within the ACA state that ACOs will adopt rules for the provision of patient centered medical care. Therefore it will be harder for ACOs to assert – like HMOs did in the past - that they only provide administrative or management services and don’t provide patient care.

Some ACOs employ health care providers and have vicarious liability for the medical malpractice of such employees in its capacity as the employer. The majority of ACOs contract with health care providers through participation agreements which generally contain the usual language on independent contractor relationship and the responsibility of the provider to determine the course of care for the patient. However, the ACA contains language stating that an ACO is “accountable” for the “quality, cost and overall care” of the Medicare beneficiaries and such language may create direct liability for the ACO, even if there is express language to the contrary in the provider participation agreement.

While CMS’s new financial risk methodology and beneficiary alignment provisions may increase risk for ACOs that sign up for the Next Generation model, every ACO should consider the following to mitigate their legal and regulatory risks:

- A consequence of outcome-based payment and the quality reporting required of MSSP ACOs is that publicly reported quality and outcomes data is now readily available. It is yet to be fully determined how this data will be used to support malpractice allegations against an ACO or a provider. Thus, it is important for each ACO to do internal utilization and quality reviews of providers, especially physicians, and document any actions taken by the ACO to remediate the situation.
- Since the ACO will be seen as “accountable” for the “quality, cost and overall care” of patients, it is important for the ACO to secure traditional medical malpractice coverage either in addition to or as part of its managed care professional liability coverage.
- The ACO must require adequate malpractice coverage (and obtain documentation of such coverage) for all participating providers (physicians, hospitals, laboratories, skilled nursing facilities, etc.) to avoid having the ACO becoming the “deep pocket” in the event of a claim.
- Any ACO guidelines will likely be discoverable in a law suit. Consequently, it is prudent to use nationally recognized standard clinical guidelines for the delivery of clinical services, rather than adopt customized guidelines to avoid unintentionally creating a different or higher standard of care.
- Create and actively maintain a process for any beneficiary (or their family member or friend) to report complaints about any perceived denied or delayed care.
- Avoid tying provider payments solely or directly to their demonstrated ability to decrease medical costs.
- Ensure that the ACO has received appropriate state regulatory approvals and/or licenses that govern the assumption of insurance risk by providers including, in some cases, the need to demonstrate the availability of adequate reserves to cover potential losses, and/or a licensure as a third party administrator, utilization management reviewer or insurance company.
- In the event of a malpractice claim, hire defense counsel who not only understands medical malpractice but also the applicable ACO regulations and how ACOs operate.

ACOs have the potential to address many of the problems in the current fragmented U.S. health care system effectively. However, it is important for ACO managers to remember the liability experience of past cost-containment experiments, such as capitated HMOs, and to avoid or mitigate potential unintended consequences of increased liability risk.

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Each month, we ask a panel of industry experts to discuss a topic of interest to the accountable care community.

Q. “Section 512 of the legislation repealing the SGR calls on the Secretary of HHS in consultation with the Inspector General to review and make recommendations to Congress in 12 months on options to amend the gainsharing rules. Could this be a big deal for ACOs? How might it affect CMS revenue paid to ACOs? How would you amend the rules?”

“The context of Section 512 of H.R. 2 has to do with fraud and abuse, primarily about organizations in gainsharing arrangements, such as ACOs. HHS and the Inspector General want to ‘limit inducements to stint on care, discharge patients prematurely, or otherwise reduce or limit medically necessary care,’ which an extremely shortsighted organization in a gainsharing arrangement could be tempted to do in order to reduce utilization in an attempt to garner more shared savings. Two factors should mitigate that risk, however.

First, most Medicare ACO programs, such as the most popular Medicare Shared Savings Program, in some sense are a quality improvement and utilization reduction ‘overlay’ on top of the fee-for-service system, so even as an ACO, the healthcare provider is motivated to provide (and get reimbursed for) medically necessary care. (Some would argue that that motivation is deeply ingrained.)

Second, ACOs that are in the program for the long haul -- and the usual minimum requirement is three years -- have a vested interest in not stinting on appropriate care or discharging patients prematurely because doing so would eventually result in some preventable ED visits, admissions and readmissions -- which painfully penalize the ACO.”

Ken Perez
Vice President of Healthcare Policy
Omnicell, Inc.
Mountain View, CA

“Section 502 of the recently passed SGR bill (the Medicare Access and CHIP Reauthorization Act or MACRA) requires the DHHS Secretary to submit to the Congress next spring a report that identifies options to amend existing fraud and abuse laws and regulations related to waivers MSSP ACOs have been granted in order to permit care coordination and gainsharing or shared savings arrangements. Section 502 states further the Secretary’s report should consider whether these waived provisions should apply to ownership interests and compensation arrangements and how these provisions address accountability, transparency, and care quality.

As Medicare Shared Savings Program providers will recall, CMS last October extended these waivers (self-referral, anti-kickback, gainsharing, and beneficiary inducement) for another year, or until November 2, 2015. In extending the interim final rule for another year, DHHS asked stakeholders for additional input regarding the efficacy of these waivers generally. The inclusion of Section 502 along with just an extension of the Interim Final Rule certainly suggests both the DHHS Secretary and the Congress are interested in pursuing further how best to balance the benefits derived by improving patient care coordination against the potential harm associated with self-referral and financial incentives.

Concerns about accountability, transparency, and care quality are altogether appropriate. However, since the MSSP has been tightly regulated to date, we hope this exercise does not ultimately further constrain ACO providers from improving patient care and outcomes. It is just one of many areas where the government needs to adapt the old fee-for-service rules to a new world of population health.”

Clif Gaus
President and Chief Executive Officer
National Association of ACOs (NAACOS)
Washington, DC
“Section 512 is additional evidence that the message is getting across to Congress that fraud and abuse laws now on the books need to be further reconciled with the move to value-based payments. Section 512 (a) is immediately helpful by amending the Civil Money Penalty Statute to lessen the absurd possibility that a hospital would be penalized for gainsharing with physicians to reduce medically unnecessary services. Section 512(b) calls for the report to Congress regarding options for further amendments to permit gainsharing “that improve care while reducing waste and increasing efficiency. Such further amendments, depending on their scope, could be particularly useful to ACOs in the commercial market that do not benefit from the current waivers to certain of the fraud and abuse rules that are applicable to Medicare ACOs only. As with all such regulatory guidance, however, I would expect any further exceptions or safe harbors to the fraud and abuse rules to be quite narrow, leaving continued challenges in interpretation and uncertainty as to compliance in real world applications. Nevertheless, continued attention by the regulators to these challenges and their attempts to update their enforcement protocols to address changing circumstances is a good thing.”

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Chair Emeritus
Epstein Becker & Green, PC
Washington, DC

“Section 512 brings the Gainsharing CMP (Civil Monetary Penalties) into closer step with the provisions of the ACA that allows providers to enter into certain shared-savings arrangements with ACO’s and their clinically integrated networks of physicians. Because of the new protections available under the ACA, the Office of Inspector General had already determined in October that pending further notice, gainsharing arrangements were no longer going to be an enforce-ment priority -- unless there was evidence that beneficiaries were being deprived of ‘medically necessary services’ -- a distant possibility given the quality safeguards built into all shared savings contracts. Of course, we will need to see how CMS will interpret the phrase ‘medically necessary’. But for now at least it appears that gainsharing rules are off the table as a big ACO concern since the OIG has clearly signaled it is giving enforce-ment a low priority. In terms of suggesting future gainsharing rules, we think the main focus should be improving the viability of the ACOs business model. We agree with the NAACO that the current balance between risk and rewards for the current ACOs is not a sustainable long term business model. The new gainsharing recommendations should address the need for streamlined quality metrics that reflect a ‘better, smarter, simpler’ way of managing care.”

David Fairchild, MD, MPH
Director and Senior ACO Advisor
BDC Advisors
Miami, FL

“Ongoing review of new and emerging health care delivery models is always important. Accountable care organizations are an emerging vehicle for meeting the dual goals of improving care and addressing costs. As they’re implemented, we’ll be able to see challenges that must be resolved and successes that should be replicated, and a review of those is important to ensuring their ongoing success. We look forward to seeing the report when it’s completed and submitted to Congress.”

Robert Wergin, MD
President
American Academy of Family Physicians
Leawood, KS

The New Center of Gravity in Healthcare…continued from page 2

So who better to dissect and eliminate this waste -- billions of dollars of it -- than family physicians, the experts in coordinating effective, efficient and patient-centric teamwork, providing enhanced primary care access and continuity, management of high risk populations, and closing the gap in evidence based care? We’re not talking magic here, but rather science and economics: across the developed world, PCP-led teams practicing advanced primary care deliver “better care at lower cost.”5 Here in the United States, medical home studies have shown a return on investment of 1.7:1 and a PMPM (per member per month) savings between $17 and $89.6 We are the motive force of ACO transformation and the reason that payment reform -- compensating primary care physicians well as the “new CEO’s” of the healthcare team -- will lead system reform. The center of gravity in healthcare is shifting. (continued on page 11)
The New Center of Gravity in Healthcare…continued from page 10

The philosopher and sometimes musician, Jerry Garcia, put it well: “Somebody has got to do something and it’s just incredibly pathetic that is has to be us.” He is spot-on but for one thing: it is incredibly fortunate that is has to be us, family physicians at the PCMH helm, who will be the heart and soul -- the center -- of the ACO revolution.

Dr. David Ehrenberger is Chief Medical Officer for Avista Adventist Hospital and Integrated Physician Network in Louisville, CO. He may be reached at DavidEhrenberger@centura.org.

References
2. PPACA, Patient Protection and Affordable Care Act, March 31, 2011, Section 3022
5. How is a Shortage of Primary Care Physicians affecting the Quality and Cost of Medical Care? ACP, White Paper, 2008.

Industry News

The **Health Affairs** Blog Features New ACO Posts

Two recent ACO-related **Health Affairs** Blog posts include the following:

- Suzanne Delbanco, PhD offers a retrospective yardstick measuring how Medicare has been paying for health care so far.
- Stuart Pollack, MD argues that systems seeking to transform and achieve the Triple Aim must build their front-line day-to-day processes loosely but the processes that determine their culture very tight.

**Researchers Report First Year Pioneer Results**

Researchers from Harvard Medical School, Brigham and Women’s Hospital, and Beth Israel Deaconess Medical Center reported aggregate first year results from the Pioneer program in the April 15 issue of the **New England Journal of Medicine**. The researchers estimated that overall spending was reduced by 1.2 percent, or $118 million in estimated savings. Quality performance vs. a control group was small or no different.

**CMS Touts Two-Year Pioneer ACO Savings**

Writing in the online **Journal of the American Medical Association**, CMS and CMMI executives reported that the Pioneer ACOs achieved an estimated $385 million in savings during the first two years of the program. Savings came primarily from reductions in inpatient costs, but were augmented by reductions in emergency room visits, post-acute care, and physician services. Editorials from Lawrence Casalino, MD and Mark McClellan, MD accompanied the article.

**2015 Pioneer ACO Face-to-Face Learning Session**

CMMI convened its 2015 Face-to Face meeting with 70 leaders from the 19 Pioneer ACOs on May 7-8 in DC. Briefings from ACOs, CMMI, and contractor staff were combined with interactive discussions and an executive session with ACO leadership, led by CMMI staff. **Accountable Care News** sponsored a networking reception at the event but, by agreement, cannot disclose the content.

Catching Up With …continued from page 12

**Accountable Care News**: The safety net clinics and Federally Qualified Health Centers (FQHCs) that have successfully transformed into patient-centered medical homes or health homes seem to be doing a much better job than traditional primary care practices in integrating primary care with behavioral health and even oral health. This must be a great boon to any Medicaid ACOs that get created, no?

**Tricia McGinnis**: Yes, there are a few promising examples of FQHCs participating in Medicaid ACO programs, and hopefully more will emerge in the future. In Minnesota, the FQHC Urban Health Network was an early adopter, bringing together 10 FQHCs to form an ACO network. All Medicaid ACOs realize that providing integrated physical and behavioral health services is critical to this model’s success, and clearly partnering with an FQHC or community mental health clinic may be one path toward achieving that integration.

**Accountable Care News**: Finally, tell us something about yourself that few people would know.

**Tricia McGinnis**: I’m dying to see a horse win the Triple Crown. I’ve been going to the Belmont Stakes for the past 14 years in hopes of seeing one, including the past year when I was over eight-months pregnant.
Accountable Care News: Before we get to ACOs let’s talk a little straight Medicaid. As you look around the country, are you excited about the new enrollees in Medicaid that have been made possible by the ACA or frustrated at what might have been had not so many States rejected the expansion because of politics?

Tricia McGinnis: The large coverage gains made by the initial 25 expansion states and the four additional states that expanded Medicaid under a waiver are headline worthy. In these 29 states, rates of uninsurance decreased from roughly 18 percent to under 11 percent. While uninsurance rates also dropped in non-expansion states, the decreases are not as dramatic. Hopefully this success in increasing access to coverage, along with the possibility of tailoring the expansion through a waiver, will encourage more states to expand.

Accountable Care News: Early on, there were fears that rapid expansion of health insurance coverage in the commercial sector and Medicaid in particular would overwhelm the primary care system with pent-up demand, hitting the community health center community especially hard, and also bringing lots of new high-risk patients into play. Have you seen evidence of this?

Tricia McGinnis: Demand for primary care services has certainly increased among certain populations, but we have not seen evidence that community health centers or primary care providers have been overwhelmed by this demand. Since passage of the ACA, health centers treated nearly 5 million more patients a year, but they concurrently added more than 43,000 new full-time positions and received $11 billion in new funding to build capacity and infrastructure. A recent survey of newly insured adults with Medicaid or private coverage found that of those who tried to find a primary care physician, three-quarters found it easy to do, and two-thirds got an appointment within two weeks.

Accountable Care News: States seem to have taken up the ACO banner. What are some encouraging signs you see around the country?

Tricia McGinnis: We’re seeing promising early results. Colorado’s statewide Medicaid ACO, the statewide Accountable Care Collaborative, reported roughly $29 to $33 million in net savings over three years. In Oregon, emergency department visits decreased by 21 percent since 2011 under the state’s Coordinated Care Organizations. Overall inpatient and outpatient costs also declined, even while primary care and pharmacy expenditures increased, suggesting that patient care is shifting away from high-cost settings. In its first year, Minnesota’s ACO program reported savings of $10.5 million. Looking ahead, as providers become accountable for the total cost of care, they are pursuing models of behavioral health integration and developing partnerships to help address the social determinants of care. In tandem with this shift, states are re-examining how these services are paid for to better align with and support providers.

Accountable Care News: With State budgets often tight, how are States providing financial incentives to their Medicaid ACOs to deliver quality care, lower cost, and good patient experiences?

Tricia McGinnis: Most Medicaid agencies are using shared savings incentives that allow providers meeting pre-determined quality criteria to share in some of the cost savings that they achieve through better care management. Medicaid providers realize that value-based payment reform is the wave of the future and, if they hop on now, they will have a better chance of successfully transitioning their clinical and business models to this new world. So while shared savings may not be sufficient to recoup ACO investments, it does create a “glide path” to assuming greater financial responsibility. Other states like Colorado provide their ACOs with a per member per month management fee, while states like Oregon and Utah provide their payer-led ACOs with an upfront global budget to deliver higher quality care.

(continued on page 11)