

MEDICARE ACOs NOT A GOOD SEASON FOR LEMMINGS

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A growing chorus of commentators is critical of ACO development for Medicare subscribers under the regulations as currently drafted.^{1 2 3} This article suggests special circumstances that might make Medicare ACO development a sound business decision. Also identified are situations where watchful waiting may be a better option.

Following the passage of the Affordable Care Act, healthcare providers were moving in lemming-like lock step: attending conferences to learn about accountable care organizations, defining potential models and preparing to be “an ACO” while eagerly awaiting the release of draft ACO regulations. Then, the tides shifted. First, the results of a five year CMS Physician Group Practice (PGP) Demonstration pilot were published indicating none of the ten leading medical groups had been able to generate a return on the infrastructure investment required to generate healthcare cost savings.^{4 5} Next, on March 31, long delayed draft regulations were issued for comment. The complexity of the regulations reflected the government’s mixed, and often conflicting, agendas. For example, fragmented providers should organize delivery networks and also maintain competitive markets.

Pundits launched. A few supportive commentators assumed many providers would participate and enthusiastically declared the end of “fee for service medicine.”⁶ However, the majority of opinions fell on the critical side of the ledger decrying the reach and complexity of the regulations. Most notably, in a joint letter, leaders from the ten physician groups in the PGP demonstration project enumerated their collective concerns including the risk and cost of participation. Unanimously, the group executives indicated that their groups would not participate as ACOs under the regulations as drafted.⁷ The groups are willing to extend the demonstration for an additional two years.⁸ There is no downside risk in the demo.

It is BDC Advisors’ view that the fundamental drivers of health reform – cost, quality, and access - remain imperatives regardless of the following outcomes:

- industry’s response to Medicare ACO development
- fate of healthcare reform in the courts
- election results in 2012

Healthcare’s basic products are too frequently defective and often poorly delivered. The cost is unsustainable. The level of uninsured and its consequences are indefensible. In an era of value based purchasing⁹ and growing transparency, BDC Advisors continues to guide clients on steps they can take to address these fundamental deficiencies. In

many cases, the structural changes involved in ACO development have the added benefit of enhancing outcomes for commercial payers and their subscribers under current reimbursement models. As a result, they represent a strategic opportunity to better serve, and thereby retain or grow share of, this profitable payer segment. On the other hand, ACO development targeting the Medicare program needs to be carefully assessed to ensure the effort does not increase subsidies required from commercial payers.

Both a provider's network capabilities and market conditions need to be assessed when considering Medicare ACO development. A few of the more difficult challenges presented by the regulations as currently drafted include:

- CMS benchmarking and retroactive attribution make care management and risk management actuarially difficult and, therefore, high risk.
- Timetables are very ambitious. Most providers will be hard pressed to both complete the required application and implement the infrastructure required to be successful on the timetables published.
- Cost of compliance is high and unfunded. The PGP group's estimated new data requirements alone would cost each medical group \$2.0 million.¹⁰ This is on top of the \$1.7 million average spent by each of the ten groups in the first five years of the demonstration.
- Uncertainty clouds CMS' long-term intent. There is a constituency in CMS and Congress that seeks to preserve Medicare FFS.

Circumstances for Avoiding Medicare ACO Development

Medicare ACO development should be avoided when the following conditions prevail (not all need apply):

1. **Sole Provider Communities**: It's hard to imagine how a hospital or medical group that is the only provider in a community could benefit from participating in the program. In announcing the regulations, CMS estimated savings of \$960 million over three years due to the ACO regulations.¹¹ How will solo providers replace this lost revenue?
2. **ACO Already Developed for Commercial Market**: Providers already developing clinically integrated networks (CINs) with the strategic intent to better serve commercial clients can proceed without the additional burden of the application and regulatory process involved in becoming a Medicare ACO.
3. **Existing Medicare Advantage**: Providers with Medicare Advantage (MA) plans may be best served by continuing to serve Medicare subscribers through the existing program. The ACO regulations incorporate burdensome features similar to the MA requirements. For example, both programs require prior approval of marketing materials; however, Medicare Advantage plans do not face the challenge of retrospective attribution of members and the resulting complexity of estimating and managing risk inherent to the ACO regulations. Finally, it is hard to imagine a situation in which operating two Medicare risk-sharing programs with distinctly different regulations would be advisable or operationally workable.

4. Low Use Rates: Providers in low use rate markets (typically west of the Mississippi and outside of Texas) are less likely to be able to generate performance below the CMS calculated “benchmark” and, therefore, may opt to maintain efforts to enhance performance without the burdens, risks, and costs of becoming a Medicare ACO.
5. First Experience in Practice Pattern Change: Even in high use rate markets where “low hanging fruit” is assumed to exist, providers with limited experience in reducing admission rates should proceed with extreme caution. The ACO program’s comparatively short duration may not allow sufficient time to generate savings by influencing physician practice patterns. Fundamental changes usually require multiple cycles with sufficient, reliable data to permit credible profiling and learning that typically precedes fundamental practice changes.
6. Market Leaders: Providers with greater than 30% market share in at least one service will face even greater compliance and regulatory hurdles.
7. Limited Market Risk: CMS expects only 75 to 150 systems¹² to qualify to participate in the initial round of the program. Participants will not include some larger systems (e.g. Kaiser).¹³ Consequently, most communities and most systems face a low probability of market share changes from ACO development, at least in its initial rounds. Furthermore, the current application timetable will restrain the number of credible applicants. Thus, the objective odds of market share impacts (gains or losses) will be minimal in most communities.

Finally, an organization which passes on the current Medicare ACO opportunity, and is successful in producing cost savings, will likely become a more attractive future option for serving Medicare subscribers. On the other hand, if Medicare ACOs fail, non-applicants will have avoided the associated headaches. Finally, fee for service Medicare and Medicare Advantage remain in place and demonstration projects are becoming available through the Innovation Center. Some of these may prove to be less onerous.¹⁴

Special Circumstances (not all need apply):

On the other hand, provider systems in the circumstances outlined below should more thoroughly assess their opportunities to better serve their communities and may conclude they should apply and become a Medicare ACO.

1. Market Opportunity to Replace Lost Revenue. Providers may want to consider using the Medicare ACO route if they have a low Medicare market share linked with a well-defined strategic opportunity to gain Medicare share and supported by a strong tactical plan to shift business (test: any advocate should be willing to invest their own money in the plan). This is typically a smaller system in the 3rd to 5th competitive position and where Medicare has been identified as the best segment to target in order to gain share. Similarly, a provider might submit an ACO application if they perceive an opportunity to enter a new market and they are well positioned to relate to and organize a primary care network as an entry tactic. In short, incremental market opportunities may represent a special circumstance that might make an ACO application favorable since such opportunities do not involve lost revenue associated with lowering use rates for customers already being served by the system.

Key questions: could the opportunities referenced above be pursued without taking on the burdens and risk of Medicare ACO development? What unique advantage(s) is gained through Medicare ACO participation?

2. Medicare ACO is the Best Opportunity to Organize Physicians: The creation of a primary care led physician network could only be accomplished by following the mandated Medicare template. The client's goal and end result would be a positive rebalancing and strengthening of physician relationships.
3. High Use Rates Subject to Precipitous Decline: The market is noted for high use rates, and it is judged better to initiate an orderly reduction process rather than leave the change process to be directed by other less friendly actors.
4. ACO Infrastructure, Risk Capital and Track Record in Place: Providers may be more inclined to submit ACO applications if they have substantial investments in infrastructure in place, especially IT and medical leadership, with a track record of accomplishment in care management and use rate reduction. Such providers should also have a strong capital position sufficient to fund additional regulatory related startup investments and potential risk management losses.
5. Advantages Associated with Regulatory Protection: In select circumstances, a provider system that already meets the majority of the ACO requirements might see advantages to obtaining the FTC letter approval. Also, providers with excellent access to key individuals in the Federal agencies may be able to favorably influence regulation and its application to their advantage. Finally, some providers may feel "required" to participate by perceived prestige or other leadership related needs.
6. Timing Considerations: Nimble decision-making and project management talent will be essential for meeting the ACO proposed timetables. Few providers will be able to apply and successfully build at the same time. Providers already in operational or build stages of ACO development may have a time advantage.

Smaller, well-disciplined systems may have the best shot.
7. Alternative to Complex Mergers or Acquisitions: In larger markets with fragmented hospital and medical group ownership, Medicare ACO development may present an opportunity to act cooperatively with a blessing from anti-trust authorities and without the complexities associated with ownership change required by merger or acquisition. For example, Catholic hospitals in St. Louis share a common religious heritage. However, separate sponsorships may have represented a hurdle to development of a network capable of challenging market leader BJC. Medicare ACO development may represent a potentially attractive opportunity for these sponsors. In other markets with structures similar to St. Louis, ACO development for Medicare may prove to be a less complex path to strengthen market competition, enhance the sustainability of Catholic healthcare while avoiding the complexities of sponsorship change typically associated with merger or acquisition.

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¹ Health Affairs Blog “Proposed CMS Regulation Kills ACOs Softly,” Posted By [Steven Lieberman](#), April 6, 2011 @ 11:38 am

² “ACOs Generate High Interest, but Is Bar Set Too High?” Philip Betbeze, for HealthLeaders Media, April 22, 2011

³ “Overweight and Out Of Shape: ACO Regs Need a Major Makeover,” Posted By Ron Klar, April 7, 2011 @ 5:07 pm

⁴ NEW ENGLAND JOURNAL of MEDICINE “The ACO Model — A Three-Year Financial Loss?” Trent T. Haywood, M.D., J.D., and Keith C. Kosel, Ph.D., M.B.A., M.H.S.A.

⁵ Medical group participants included several with extensive experience in managing healthcare cost risk.

Physician Groups	Location
Geisinger	Pennsylvania
Park Nicollet	Minnesota
Novant	North Carolina
The Everett Clinic	Washington
Marshfield Clinic	Wisconsin
Mercy St Johns	Missouri
Middlesex Hospital	Connecticut
Billings Clinic	Montana
Dartmouth Hitchcock	New Hampshire
University of Michigan	Michigan

⁶ Modern Healthcare “We Can Have It All,” Don Berwick, MD and CMS Administrator, May 17, 2011

⁷ Comment letter submitted by the 10 PGP participant Medical Groups, May 12, 2011

⁸ Modern Healthcare “Testing ACOs-Medicare Seeks Trial Run with Physician Group,” Melanie Evans, April 11, 2011.

⁹ Modern Healthcare “Paying for Performance Insurers expected to Follow WellPoint’s Lead,” May 23, 2011

¹⁰ Comment letter submitted by the 10 PGP participant Medical Groups, May 12, 2011

¹¹ CMS press release letter accompanying publication of draft regulations, “Accountable Care Organizations: Improving Care Coordination for People with Medicare,” 3/31/2011

¹² Modern Healthcare “Accountability Arrives” By Rich Daly and Jessica Zigmond, Posted: April 4, 2011 - 12:01 am ET

¹³ Kaiser CEO George Halvorson quoted by Michael F. Cannon, 6/3/2011, Cato@Liberty, the new law’s ACO program “is not as good as Medicare Advantage when it comes to promoting accountable care.”

¹⁴ Modern Healthcare “CMS announces three ACO initiatives,” by Jessica Zigmond and Melanie Evans, Posted: May 17, 2011 - 11:45 am ET