ACOs: Will There be Savings to be Shared?

By Stephen Rose
Health Care Attorney and Owner
Garvey Schubert Barer

Overview

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

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

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

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

Providers Begin to Express Concerns

More recently, health care providers and provider organizations have started the process of

Please see> ACOs, P4
Dear Reader,

The volume of online job postings can indicate the strength of the economy. However, it can also be misleading.

I review The Conference Board’s Help Wanted Online (HWOL)™ report each month to see how postings are trending. The number of postings on Healthcare News web sites are at all-time highs so it didn’t surprise when HWOL reported online postings rose 148,800 during May 2011 when compared to April 2011. The hottest categories have fewer unemployed persons than online ads. Computer and math science (.23) and healthcare practitioners and technical (.37) categories have the highest demand when comparing unemployed persons to online ads.

However, while healthcare and computer/math science jobs go begging, postings in other industries are scarce. This probably explains why the U.S. Department of Labor has been reporting initial claims for unemployment insurance above 400,000 for the past few months.

For the foreseeable future, there will be high demand in some industries while others languish. Expect healthcare workers to continue to be in short supply so make sure your recruiting budgets are adequately funded.

David Peel, Publisher and Editor

Letter from the Publisher and Editor

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

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

For example, the Cleveland Clinic expressed its disappointment with the proposed rules, stating that:

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

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

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

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

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

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

Conclusion

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

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

Stephen Rose has more than 25 years representing healthcare providers in matters relating to Medicare/Medicaid reimbursements, government audits, and corporate compliance plans. He can be reached at srose@gsblaw.com or 206.816.1375.

2Id. at 19531.
3Id. at 19530.
5Id.
8Id.
9Id.

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Providence Regional Medical Center Everett Opens $460 Million State-of-the-Art Tower

By David Brooks
Chief Executive Officer
Providence Regional Medical Center Everett

Providence Regional Medical Center in Everett will take its award-winning healthcare to the next level June 14 when it opens a new $460 million, state-of-the-art medical tower, the largest and most comprehensive building project in our hospital’s 150-year history.

The 12-story Marshall and Katherine Cymbaluk Medical Tower, one of the largest private investment projects ever in Snohomish County, is the centerpiece of a comprehensive plan to ensure Providence Regional remains well equipped to provide first-class health care in our growing community.

The new tower was designed around Providence’s patient-and family-centered care philosophy, with comfort, privacy and convenience in mind. By combining cutting-edge technology with patient-centric care, Providence aims
to set a new standard for the way patients and their families experience hospital care in America.

The facility, which houses many Providence services, features $60 million in the latest medical equipment and is designed to adapt to technology as it evolves in the future. It dedicates an entire floor - larger than an NFL football field - to emergency services, which includes 79 private treatment rooms including four trauma rooms. CT and X-ray services are also located within the department to provide quick access to imaging capabilities.

More than $20 million in diagnostic imaging equipment, including two MRI scanning machines and four CT scanners, are housed on the diagnostic imaging floor. The department has a unique design that will accommodate both inpatient and outpatient imaging needs. Electronic medical records allow doctors and staff from multiple organizations to share information in real time, which speeds diagnosis and treatment.

Two floors of the tower are dedicated to both surgical and interventional procedures and two floors will house 48 patient rooms dedicated to intensive care, which include six dialysis stations. Each of the top three floors has 56 patient rooms for medical or post-surgical patients.

We worked closely with our Patient and Family Advisory Council when designing the tower and, as a result, incorporated several elements not typically found at a hospital. For example, most rooms have a special ‘family zone’ area, complete with a sleeper sofa and storage area for patients’ family members to stay with them.

Of equal importance, the tower is designed to be a calming, healing environment for patients, family members and visitors alike. The building brings nature and the outdoors inside, with features that include a two-story atrium lobby, patient rooms with sweeping views on all sides of the building and a rooftop viewing garden with native plants, grasses and trees. It also features family lounges with internet access, and the surgery waiting areas provide a kitchen, playroom and resource center for all.

The doctors, nurses and other caregivers at our new tower will provide the industry-leading care Providence is known for – but we expect our warm, welcoming approach to serving patients and their families is what will truly set us apart.

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Accountable Care Organizations: The Future of Quality Healthcare?

By Loy Maslen
RN, BSN, NNP-BC, CPUM Associate Quality Improvement and Education Consultant
Derry Nolan & Associates, LLC

Healthcare reform is about accountability for care. As a nurse, should someone ask me if I provide quality care, I would answer, “Absolutely.” But if they ask me, “What is your data to support that claim of quality care?” Then I may need to say, “I’ll be right back with you on that.”

That’s where the ACO comes in. ACOs are a type of payment and delivery reform model that begins to tie provider reimbursements to quality metrics (measures of quality indicators) and reductions in the total cost of care (performance and process improvement) for an assigned population of people; i.e. Medicare patients.

The Center for Medicare and Medicaid Services (CMS) is asking healthcare providers to be accountable to the care provided. That includes administration, governance, and implementation either within the scope of our roles or in our employment positions. It also encompasses the obligation to report, explain and be answerable for any resulting consequences.

Initiated by the goals of the Affordable Care Act to improve care while lowering its cost, ACOs will help make quality a habit in healthcare. Those ACOs that meet required quality performance standards have the potential to receive payments from the Medicare Shared Savings Program, which “promotes accountability for a patient population, coordinates items and services under Parts A and B, and encourages investment in infrastructure and redesigned care processes for high quality and efficient service delivery.”

From an operational perspective, as well as from a clinical one, the ACO model makes sense. Today’s healthcare organizations are often fraught with inefficient workflows and faulty communication habits, causing quality and outcomes to suffer. To combat these issues, a recognized ACO will need to meet indicators and data derived from five key areas:

1. Patient and providers’ experience of care (patient and staff satisfaction scores)
2. Care coordination (information sharing across the continuum of care)
3. Patient safety (reporting, analysis and error prevention)
4. Preventive health (treatments to minimize illness and hospital admissions)
5. At risk population, frail and elderly health (using proven care standards to assist with care provision)

The overall quality performance score will be calculated on 65 quality metrics within those five defined key areas, equally weighted. CMS will define the quality performance benchmarks based on Medicare Fee-For-Service (FFS), Medicare Advantage or ACO performance data over time.

Note that the ACO is eligible for monetary compensation only if it demonstrates to CMS that it has
fulfilled the required quality performance elements and achieves the other regulatory performance criteria. Mature organizations exist that already meet the measures required. Those organizations not only meet the clinical measures, but are also likely made up of high performance teams.

Creating High Performance Teams

Healthcare is complex, so approaching issues as a cohesive group working together to achieve a goal allows for creativity, sharing expertise, developing new skills, increasing personal autonomy and influencing decisions. Such teams can only come together through eliminating barriers encountered in everyday communications. Communication excellence is the key to unlocking team performance and quality outcomes.

Communication should be a simple concept, particularly in healthcare. Patients talk to doctors, nurses and other staff members. Healthcare providers talk to each other. Unfortunately, the barriers that frequently block understandable exchanges create gaps. Those gaps in quality communication limit quality service to patients and staff alike. The natural progression? Patient and staff dissatisfaction and frustration.

Failure to address these communication issues in healthcare leads to inefficiency, ineffective and potentially unsafe care, rework, a diminished capacity for team performance and unintended outcomes. Simply improving and standardizing parts of our communication strategies can eliminate these types of costly wastes.

Consider this: the products of healthcare systems are services. Therefore, measuring healthcare quality must extend beyond clinical measures. Organizations must also measure patient perceptions and experiences. So, although service quality is usually measured by five dimensions:

1. Tangibles
2. Reliability
3. Responsiveness
4. Assurance
5. Empathy

We will add two more:

6. Accessibility

Please see > Quality, P14
Legal Challenges to Medicaid Rate Reductions Frustrated by Proposed Federal Rules

By Renee M. Howard
Shareholder
Bennett Bigelow & Leedom, P.S.

Providers who participate in Medicaid should familiarize themselves with proposed federal regulations published on May 6, 2011 that, if adopted, would substantially impede their ability to challenge Medicaid rate reductions in court. Interested parties may submit comments to the proposed rules, which must be received by the Centers for Medicare and Medicaid Services (“CMS”) no later than 5 pm EST on July 5, 2011.1

The proposed rules interpret a federal Medicaid law that limits how state Medicaid programs can set payment rates. That law, known as “Section 30(A)” of the Medicaid Act, requires state Medicaid Plans to utilize “methods and procedures” that “assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the same extent that such care and service are available to the general population in the geographic area.”2 These payment-related requirements are known as the “quality” and “access” standards.

In recent years, various types of providers have brought successful legal challenges to Medicaid rate cuts that do not comply with Section 30(A) quality and access requirements. While providers cannot get money damages in these lawsuits, they have been able to block state Medicaid programs from implementing rate cuts that violate Section 30(A).

Since 1997, federal courts in Washington and elsewhere in the Ninth Circuit have required states, in order to comply with Section 30(A), to conduct “responsible cost studies” to ensure Medicaid rates will be “reasonably related” to provider costs, and to conduct such cost studies prior to setting the new rates. Orthopedic Hosp. v. Belshe, 103 F.3d 1491, 1497 (9th Cir. 1997).3 Based on this requirement, many health care providers have successfully challenged budget-driven Medicaid rate reductions on the basis that the state did not conduct a responsible cost study prior to developing a new rate (or that the study itself was inadequate), and that the providers would be financially harmed if such rate went into effect.

The proposed rules would substantially alter this legal standard. Rather than require cost studies, the rules would allow states to conduct a more flexible access analysis that examines three factors: (1) enrollee needs; (2) availability of care and providers; and (3) utilization of services. Clarifying that the relationship of rates to provider costs is no longer the primary focus of an “access” analysis, CMS noted: “Depending on State circumstances, cost-based studies may not always be informative or necessary. In addition, because many State payment rates are not specifically calculated based on provider cost considerations, it can be burdensome and not particularly productive to rely solely on that one factor as a measure of access.”4 Going a step further, CMS suggests that a Medicaid rate can satisfy Section 30(A) requirements
irrespective of the payment level: “If beneficiaries are able to gain access to care . . . then clearly the standards of the Act have been met regardless of other factors, including payment levels.”

The singular focus on “access” to Medicaid services is problematic for providers such as hospitals, which must provide some measure of treatment to all who come to the emergency department regardless of insurance status or payment rates. Indeed, the framework in the proposed rules was developed based on a study that focused on primary and specialty care providers and services, and did not specifically address hospital, ancillary, and long-term care services.

The rules also do not address Section 30(A)’s second requirement that states must ensure “that payments are consistent with efficiency, economy, and quality of care,” in addition to ensuring access to services.

Finally, the proposed rules would make it difficult for providers to establish that a state failed to satisfy Section 30(A) access requirements, as the rules give CMS discretion to deny a State Plan Amendment only where a state fails to conduct an access analysis altogether and not where the access review is methodologically unsound or reveals deficiencies. For example, if a state’s access review identifies access issues, instead of denying the State Plan Amendment, the proposed rules permit the state to submit a corrective action plan, and take up to twelve months to remediate the deficiency.

Given these issues, Medicaid providers should critically examine the proposed rules and consider submitting comments to ensure that the final rules provide meaningful protections against budget-driven rate cuts.

Renee is experienced in representing a wide range of health care providers and suppliers, including hospitals and health systems, academic medical centers, physicians, imaging centers, and medical suppliers and distributors. She has represented health care clients in litigation and government investigations implicating the federal False Claims Act, the federal Anti-Kickback Statute and physician self-referral (“Stark”) laws, state Medicaid issues, and health care licensing matters. Renee also assists clients with internal investigations of allegations of fraud or other noncompliance with state or federal health care laws, and re-

Please see> Medicaid, P14
sponding to Medicare, Medicaid and third party payor audits. Renee regularly advises clients on Medicare and Medicaid reimbursement and payment issues, structuring financial relationships under fraud and abuse and self-referral laws, and other health care compliance matters. She can be reached at rhoward@bbllaw.com.

3Holding reaffirmed in Indep. Living Ctr. v. Maxwell-Jolly, 572 F.3d 644 (9th Cir. 2009).
5Id. at 26350.
7Proposed 42 C.F.R. § 447.204(b).

7. Communication
The high performance teams that grow from achieving these measures experience bonus benefits: job satisfaction and communication improves, mutual respect grows. If your healthcare organization can build such high performance teams, you will naturally evolve to improved quality and outcomes. Your healthcare organization can meet ACO performance criteria. But first, we must begin to truly communicate, laying the foundation for the high performance teams that will make quality a habit.

Loy Maslen, RN, BSN, NNP-BC, CPUM Associate, is a quality improvement and education consultant with Derry, Nolan & Associates, bringing over 30 years of diverse healthcare experience to inpatient and outpatient organizations. A TeamSTEPPS™ Master Trainer and VitalSmarts™ Crucial Conversations Master Trainer, Maslen helps clients learn effective evidence-based communica-

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