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Accountable Care Organization Regulations -

The ACO is a Camel, Not a Unicorn

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listen now

The final Accountable Care Organization regulations are out, the initial flurry of commentary is out (including my own ACO webinar with simultaneous #ACOchat tweetchat - available for replay; slides here now: "ACOs, Bundled Payments and the Future of Health Care"), and we can now all catch our collective breath and contemplate the draft vs. final ACO regulation comparisons, the meaning of this new, final set of regulations, guidances and statements from CMS, FTC, DOJ, OIG, and IRS on ACOs and Medicare Shared Savings Programs, and all of the attendant antitrust, antikickback, Stark, and other fraud and abuse matters, and of course tax issues.

So, now that these final regulations are out, and the mythical characteristics of the ACO will soon be dispelled (see under: unicorn), I propose a new animal kingdom metaphor for discussion of Accountable Care Organizations:

The Camel's Nose is in the Tent.

The definition of a camel, as those of you who tuned into my ACO webinar already know, is a horse designed by a committee. And, given the nature of the legislative and rulemaking processes, that's exactly what we have before us - a camel.

The clincher, though, is the way in which the final regulations have been engineered.

CMS would have ACOs, by virtue of participating in the MSSP, diffuse all the ACO goodness of care management, quality and cost control, etc., into the broader Medicare population. This conclusion is inescapable. CMS is focused on the question of how to do more with less, and the ACO conceptual framework, if not the details, will permeate many arenas across the health care landscape.

ACO assignment is still retrospective (even if there is a nod to prospective assignment, that nod is provisional, and reconciliation must be done after the close of

the contract year). Since an ACO never knows for sure which patients' experience will form the basis of its gainsharing or risk-sharing, it must behave as if each Medicare beneficiary who receives care form its providers will ultimately be attributed to the ACO.

In addition, the slimmed-down set of 33 ACO quality measures focus in part on "better care for individuals" (through CAHPS scores for patient/caregiver experience, also care coordination/patient safety measures, too), and in part on "better health for populations" (vaccinations, screenings, diabetes management).

These are just two examples of the ways in which CMS is leveraging its MSSP authority to engineer provider focus on improving population health.

Another "proof text," if you will, is the fact that at most, CMS anticipates that no more than two million Medicare beneficiaries will be seen by no more than 270 ACOs in the initial three to four years of the program. (Compare those figures to the roughly 47 million Medicare beneficiaries and 6000 hospitals, and you will quickly get the sense that the MSSP / ACO is a test probe, not a wholesale shift.) Even if the maximum anticipated ACOs are established and beneficiaries are served, projected savings to Medicare will top out at less than $1 billion over four years. In a $2.5 trillion a year health care economy, this is *bupkes* (a technical term).

So, the idea of the ACOs under the MSSP is the camel's nose in the tent -- the forerunner, the disruptive innovation that is intended to set the rest of the system off-kilter until it reaches a new status quo on the other side of the Triple Aim.

Given the emphasis on a wholesale departure from fee-for-service payment (even if it's done through workarounds thanks to the inertial forces of the "assets in place" of existing law and the systems built up around it), which will reverberate throughout Medicare and the rest of the health care system, it is critically important for health care providers to begin now -- if they have not already begun -- to take a broader view of the patient encounter, to get a firm grasp of their own costs and the costs of their partners, and to start thinking about the power of collaboration. Physicians, hospitals and all other sorts of health care providers need to think about episodes of care, bundled payments, care management, cost control and the path forward to a win-win-win for patients, providers and payors in a blown-up-and-put-back-together high-performing health care system.

Oh -- camels spit, so be prepared!

David Harlow
The Harlow Group LLC
Health Care Law and Consulting