

10 Healthcare Leaders Share Thoughts on Final ACO Rule

Written by Bob Herman | October 21, 2011

Tags: [ACO final rule](#) | [ACOs](#) | [AMA](#) | [American Medical Association](#) | [AMGA](#) | [Avalere Health](#) | [Blair Childs](#) | [CHIME](#) | [Compliance Law Group](#) | [Dan Mendelson](#) | [Daniel Marino](#) | [Dr. Ken Anderson](#) | [Dr. Peter Carmel](#) | [George Roman](#) | [Health Directions](#) | [HHS](#) | [hospital physician](#) | [Ken Perez](#) | [MedeAnalytics](#) | [Michael Regier](#) | [MSSP](#) | [NorthShore Health](#) | [Premier](#) | [Sharon Canner](#) | [VHA](#) | [Wayne Miller](#)

The healthcare industry has been abuzz since the Department of Health and Human Services released its final rule for the [Medicare Shared Savings Program](#) yesterday. Several changes have been made from the proposed rule. Quality measurements were reduced from 65 to 33, and other proposed requirements were relaxed. Here are 10 healthcare leaders' thoughts on the ACO final rule and what it could mean for the future of ACO adoption.

Ken Anderson, DO, chief medical quality officer for NorthShore University HealthSystem in Evanston, Ill.: I was most excited about the changes to the quality performance standards. They now number 33, which is down from 65 as originally proposed, and [this] was really designed to help engage more healthcare-provider teams to focus on addressing the practical and doable areas of quality performance that will improve care across the United States. These measures are certainly important and relevant for healthcare-provider teams, and this will allow many more groups to be interested in participating.

Also, here at NorthShore, where we have a long history of EHR use, I do believe CMS' option to waive the initial requirements of 50 percent of all primary care physicians to be meaningful users of EHRs will probably help spur greater interest in physician practices that currently aren't on EHR platforms or are in process of transitioning to EHR platforms.

Finally, I applaud them for really having a sound way of listening to the 1,320 comments as a way of listening to frontline healthcare-provider teams and address levels of concern that provider groups had. I give tremendous credit to CMS for listening to healthcare providers and professional society organizations to make those changes. This takes a first step forward to focus on value and clinical outcomes and spur innovation in healthcare system design.

Sharon Canner, director of advocacy for the College of Healthcare Information Management Executives: Generally, CHIME is pleased with the changes made by CMS to make ACOs a more viable, more attractive way for hospitals and providers to achieve better health, better healthcare and lower costs. We have continued concerns about data sharing but are encouraged by the changes made to proposed quality measures, meaningful use requirements and prospective beneficiary assignments.

CHIME voiced concern about the practical necessity of having robust information exchange be part of any ACO. In the final rule, CMS states that having staggered start dates of April 1 and July 1 of each calendar year "will provide ACOs an 'on ramp' to get the appropriate health information exchanges in place before they enter the program." We believe the additional start dates will be beneficial for those providers who have evolving HIEs and HIOs, but we remained concerned that some of the most difficult aspects of exchanges, like patient matching, do not have widely-adopted solutions. With ACO success largely contingent upon robust exchange, it remains an area of concern for us.

In our comments filed last May, CHIME acknowledged that CMS was trying to encourage electronic health record meaningful use, and we fully support efforts to incentivize health IT adoption and use. But we said it was unnecessary to require 50 percent of an ACO's primary care physicians to meet all MU standards by the beginning of the second year of the ACO's agreement — and CMS listened. Under the final rules, EHR use is a quality measure that is weighted higher than other measures for quality-scoring purposes, but using certified EHRs is no longer a condition of participation.

Peter Carmel, MD, president of the American Medical Association: We are pleased that the final rule on Medicare ACOs includes many of the important changes recommended by the AMA to allow all interested physicians to lead and participate in these new models of care. After preliminary review, the AMA believes this final rule includes a number of positive changes. The AMA recommended that the risk and payment structure for potential ACOs should encourage participation by physicians in all practice sizes, and we are very pleased that this rule allows ACOs to share in every dollar of cost savings and includes an option that limits financial risk, which is important for many physician practices.

Other changes should also allow for greater physician participation in ACOs, including a rolling application process that allows more time for practices to prepare and removing the requirement that 50 percent of primary care physicians in an ACO must be 'meaningful users' of EHRs. The final rule [also] reduces the number of required [quality] measures by half, including removal of the hospital-acquired condition measures, but the AMA would have preferred even greater flexibility on which measures practices are required to report.

Blair Childs, senior vice president of public affairs for Premier: The Premier healthcare alliance supports CMS in its efforts to develop people-centered, sensible regulations for ACOs. This new model of care delivery represents one of our best hopes for overcoming fragmentation in care delivery. In forming ACOs, we believe we will achieve greater clinical integration and collaboration among doctors, hospitals and other care providers, and foster alignment of accountable care principles across public and private payors. The end result will be better, safer and more convenient care delivered at a lower cost for the benefit of healthcare consumers nationwide.

Daniel Marino, president and CEO of Health Directions: There are three significant areas that will positively affect organizations: care coordination, requirements around meaningful use and reliance on electronic health technology.

The most significant changes in the final ACO regulations are around the measures for establishing quality performance-scoring. The measures that were retained support care coordination around chronic disease management and prevention. More specifically, the final regulations remove the complicated care coordination measures relating to complications of chronic disease. These changes will allow organizations that are just beginning to build clinical integration a better opportunity to succeed under the shared savings model.

The second area of opportunity comes in the way of requirements around MU. The final regulations speak to MU compliance and providing a benefit, through a higher allocated score, to organizations who have more of their primary care providers MU-compliant. There is no longer a minimum percentage of providers that must be meaningful users. Instead, ACOs that have high percentages of meaningful users have an opportunity to achieve higher quality scores via a new, weighted scoring method.

The third area of opportunity is around the relaxed reliance on integrated health technology to support the ACO. The final regulations limit the requirement around advanced care coordination across the patient's care continuum. Initially, this was a major concern of many organizations since creating an advanced integrated technical infrastructure was very expensive, and in some cases cost prohibitive to organizations. This less prescriptive approach will allow ACOs more flexibility and room for innovation.

The final regulations appear to create a nice balance between driving care coordination around patient quality outcomes to reduce costs and not overburdening organizations with significant new infrastructure investments and cumbersome reporting requirements.

Dan Mendelson, CEO of Avalere Health: The new rule is an easier pill to swallow but still difficult for most systems to fully digest. ACOs will get to keep more of the upside profits from effective cost control — including savings from reduced re-hospitalizations — and there are fewer quality metrics, and many of the industry's legal concerns appear to have been addressed. But fundamentally, most health systems continue to struggle with the fact that their present operations are oriented toward billing per service and not taking on risk and responsibility for quality.

Wayne Miller, JD, Compliance Law Group: With respect to a number of changes, CMS appears to be making

participation in the ACO program easier for provider organizations that are small or newly forming. The relevant changes address the financing of participation, how participation is determined and easier hurdles to reach a bonus level. Providers who felt the original rules favored established accountable care groups may find the program more desirable under the new rule.

Two changes in the calculation of savings would appear to lessen barriers to receiving bonuses under the program. First, ACOs can participate under an option where they assume no downside risk for the initial three-year term at the expense of a lower share of savings. Further, unlike the earlier rule, there are no "withheld" bonuses. As soon as the ACO reaches its expenditure target, it begins sharing savings immediately. These and other changes make participation more likely to "pencil out."

Ken Perez, senior vice president of marketing and director of healthcare policy for MedeAnalytics: The final rule clearly shows that CMS listened to and took into consideration the some 1,320 public comments on the proposed rule. Like many dialogues in Washington, D.C., today, the discussion on the terms and conditions of the Medicare ACO program — as presented in the proposed rule — often resembled a protracted negotiation, while during the same time commercial ACOs — led largely by innovative health plans — continued to develop and flourish. Though the final rule is unquestionably more generous, flexible and supportive to providers, it remains to be seen whether this voluntary program will regain the momentum and sense of optimism held by providers that was seriously diminished by the proposed rule.

Michael Regier, senior vice president of legal and corporate affairs for VHA: Overall, I'm actually kind of surprised to see as many changes as were made. To me, it seems clear CMS really paid attention, received a lot of feedback — probably more than they expected to get — and made an effort to respond to the significant amount of comments they got.

There are a number of things in the final rules that address what the providers raised. One of the key components is ACOs have to be willing to accept responsibility for at least 5,000 Medicare beneficiaries and have the primary care physician capacity to do so. The proposed rule was going to assign Medicare beneficiaries using a retrospective methodology. The final rule changes that and uses a prospective assignment methodology. Essentially, it means they are going to assign Medicare beneficiaries to an ACO on a going-forward basis, and there will be reconciliation at end of each performance year to make sure they are correctly attributing patients to the right group of providers and ACO.

Another concern for providers was the number of quality measurements required. The initial set of regulations said there would be 65 quality measures required. In this final rule, CMS says they are going to move it to 33 different measures, and they will use a longer ramp-up period moving from paying for reporting initially to paying for reporting and performance by the [ACO's] third year. That's another big change that helps make it a bit more attractive to participate in the program.

However, from where I sit, I still don't see that there will be a rush to the ACO door. In part, it's because even with the changes, the three-year performance period and limited opportunity to recoup the capital investment that is inherent in the model is going to make it difficult for providers to feel it would be in their best collective financial interest.

George Roman, senior director of health policy for the American Medical Group Association: Much to my very pleasant surprise, I found that CMS had listened to what we and many others had to say and changed several things in the rule. CMS has demonstrated a level of responsiveness that isn't typical in the evolution of proposed rules to final rules. In the proposal, quality was an integral aspect of the accountable care framework, and 65 quality data metrics were proposed. We, and many others, thought that was excessive and administratively burdensome. More is not only burdensome, but it is also costly. CMS listened and scaled it back to 33. The reduced number of quality measures is an indicator the burden has been lowered, a very good, constructive step in the right direction.

In the original proposal, CMS also put forward participation in upside, sharing in the savings, and in downside risk, sharing in any loss risk. This model would've been a great impediment, as many providers are not willing to engage in downside risk. After all, this is a voluntary program.

CMS has also changed the minimum savings rate. This is a statistical device and measure instituted by CMS designed to assure efficiencies are the result of clinical interventions and quality care and not from random statistical fluctuation, a function of the size of the number of patients. CMS has kept the minimum savings rate but has modified its approach so that if the rate is attained, all savings are used as the basis to compute the payout split, a favorable turn of events.

The composite of all these various elements is what will be evaluated by the interested participants. I think of this as a jigsaw puzzle: Each piece has worth, but the composites combine to form a bigger picture. CMS does not have purview over other areas such as antitrust and fraud that come largely under other agencies. However, several guidance documents [from the Department of Justice, the HHS Office of Inspector General and the Internal Revenue Service] were also issued. So the full picture for evaluation purposes can only be formed on how the guidance documents dovetail with the framework CMS has put forward. It's complex and difficult but important. Overall, from what I've read, our impression is cautiously optimistic. Our view of the proposal was not good, as it was not attractive to garner any meaningful, voluntary interest, but it has changed in some noteworthy ways. Based on my limited reading to date, I am more optimistic about the framework than I was, but the devil is in the details and I must read more to form a comprehensive opinion.

Related Articles on ACOs:

[Dr. Don Berwick: ACO Final Rule is "More Feasible"](#)

[8 Things to Know About the ACO Final Rule](#)

[Advance Payment Model for ACOs Designed to Ease Start-Up Costs](#)

To receive the latest hospital and health system business and legal news and analysis from *Becker's Hospital Review*, sign-up for the free *Becker's Hospital Review E-weekly* by [clicking here](#).