Introduction

Recently, the U.S. healthcare system has been in an unprecedented state of flux, and a new era of accountable care has emerged as the downfalls of a volume-based payment system have come to light. The stakeholders of the national healthcare system have realized that the cost of healthcare will continue to experience exponential and unsustainable growth if the healthcare system does not shift from one rewarding the quantity of care to one that rewards the quality of care. In the current healthcare system, healthcare practitioners and patients are generally insulated from the third-party payor, thereby having little to no financial stake in the cost of care provided. The result has been unbridled spending through the prevalent fee-for-service payment system and growing interest in more accountable models of value-based care, particularly among payors.

As the single largest payor in the U.S. healthcare system, the federal government is understandably concerned with the inherent disadvantages of the prevailing volume-based payment system. Consequently, the Medicare Shared Savings Program (Shared Savings Program) was established through the Patient Protection and Affordable Care Act of 2010 (PPACA) in an effort to encourage the formation of Medicare Accountable Care Organizations (ACOs).\(^1\) A Medicare ACO is a group of Medicare providers who coordinate their efforts with an aim toward providing high-quality and efficient care for a

\(^1\) 42 C.F.R § 425 (2011).
designated group of Medicare Fee-for-Service (FFS) beneficiaries. The Shared Savings Program incentivizes a Medicare ACO to provide the highest quality care while concurrently eliminating unnecessary costs through the possibility of sharing in any Medicare savings that result from the successful efforts of the Medicare ACO. The final regulations implementing ACOs within the Shared Savings Program were published on November 2, 2011, and may be found at 42 C.F.R. Part 425. With this landscape in mind, this Executive Summary outlines the various opportunities and challenges payors may encounter when contracting with Medicare ACOs established through the Shared Savings Program.

Because the Shared Savings Program is specific to Medicare FFS beneficiaries, a Medicare Advantage Organization and other payors are not eligible to form a Medicare ACO. However, Medicare ACOs and their participants (e.g. providers and hospitals) may seek to partner with payors to align accountable care payment programs and share in the expertise and economies of scale many payors have gained through previously implementing care management initiatives.

Newly formed Medicare ACOs likely will lack the care management capabilities necessitated by the Shared Savings Program, and managed care payors such as Medicare Advantage Organizations will be able to supply the infrastructure and experience the Medicare ACO lacks. Whether implementing an aligned accountable care model or acting as a strategic operational partner to providers participating in the Shared Savings Program, payors can leverage their experience and expertise in managed care to take advantage of a vast array of opportunity areas.

Financial and Information Transparency

The Centers for Medicare & Medicaid Services (CMS) evaluates a Medicare ACO based on the ACO's ability to effectively manage the quality and efficiency of care for a

\^Id.
designated population of Medicare FFS beneficiaries, which contrasts with the traditional model in which providers focused on managing individual episodes of care, resulting in higher volumes of care for each individual beneficiary. Without a complete picture of a patient’s claims history and the financial data related to such claims, a Medicare ACO provider does not have the essential tools critical to value-based clinical decisions and avoidance of duplicative or ineffective care. In hindsight, the failure of capitation arrangements in the 1990s has been largely attributed to a lack of data transparency and performance measurement capabilities necessary for providers to effectively manage their patient’s health. However, current technology far exceeds that which existed during the 1990s, and the success of many managed care organizations utilizing risk-based provider contracting has shown that the technology infrastructures necessary for successful shared risk arrangements now exist.

Based on these principles, the Shared Savings Program requires a Medicare ACO to develop an infrastructure for internal quality and cost reporting, and the success of an ACO is heavily based on free-flowing, actionable information, e.g. claims, financial information, and clinical decision-making support. Payors traditionally have experience with the infrastructure and reporting systems needed to facilitate such information sharing, while individual providers and provider groups traditionally do not. By contracting with or strategically partnering with payors, a Medicare ACO can implement data sharing initiatives that otherwise might be impossible for an ACO lacking the size and information technology (IT) infrastructure of a health plan.

Once a Medicare ACO has identified and collected the information necessary to support participating providers and allow compliance with CMS reporting mandates, accurate reporting capabilities become the next necessary achievement. A Medicare ACO is required to define processes to report on quality and cost measurements, and for the first performance year of an ACO contract with CMS the quality performance standard is

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3 Id. § 425.112(b)(3).
set as the complete and accurate reporting of all quality measures.\(^4\) This means that a Medicare ACO can meet its first-year quality standards and share in savings solely through submitting 100% complete and accurate reports to CMS. This further emphasizes the importance of accurate data collection and reporting in the Shared Savings Program, and the enormous value payor collaboration can bring to an affiliated Medicare ACO.

**Risk-based Contracting**

A Medicare ACO that achieves savings under the Shared Savings Program has broad discretion for distributing its portion of the shared savings among its participants. The Medicare ACO must develop the distribution methodology early on in its formation, however, as the methodology must be approved by CMS via the ACO application process.\(^5\) A Medicare ACO will need to choose the appropriate structure for provider agreements, incorporating various goals, incentives, or penalties that will facilitate the ACO’s desired level of accountable healthcare delivery. The structure of the Medicare ACO provider agreements will be critical to the ACO’s success, and will require an informed analysis of each provider’s current capabilities and growth areas.

Although a payor would not directly assist with ACO participant contracting, by looking to a payor’s experience with the different factors that need to be considered when creating risk or value-based payment agreements, a Medicare ACO can implement the value-based contracting methods that have proven themselves most effective. Medicare ACOs will benefit by taking a page from the payor’s handbook when considering the individual characteristics of contracting providers and carefully drafting agreements that customize various goals such as electronic medical record implementation, care integration, and centralization of data. Many of the goals payors strive for in risk-based contracting mirror those of a Medicare ACO under the Shared Savings Program, and

\(^4\) Id. at § 425.502(a)(1).
\(^5\) Id. at 425.204(d).
taking advantage of the path already paved by payors with risk-sharing provider arrangements would be advisable to aspiring Medicare ACOs.

Even after establishing an appropriate incentive structure for participating providers, challenges can arise if a Medicare ACO expands its contracting to multiple payors or has only partial participation in a contracting payor’s network. Different payors may not choose quality metrics identical to those imposed under the Shared Savings Program or by other payors, and this discrepancy in standards can create a heavy administrative burden for the Medicare ACO. Consequently, it may be advantageous to both Medicare ACOs and contracting payors to engage in health plan contracting that is aligned with the Medicare ACO provider agreements or based on common measures such as the Healthcare Effectiveness Data and Information Set (HEDIS), so that providers have streamlined standards to adhere to and aligned goals to achieve.

In addition, if a payor contracts with a Medicare ACO that includes non-participating providers or facilities, referral patterns of the Medicare ACO may not support the payor’s desire for optimized utilization of participating providers. This concern may lead a payor to decide there is a need to include all of the Medicare ACO participants in their preferred network, thereby adding another layer of complication to the contract negotiation process.

**Antitrust and Fraud and Abuse Issues**

Although arrangements between a Medicare ACO and payors can be mutually advantageous, the parties must understand the antitrust implications of various contracting activities. For example, a Medicare ACO cannot tie its services to those
provided outside of the Shared Savings Program. In addition, the Medicare ACO cannot prevent a payor from incentivizing patients to choose certain providers.\(^6\)

There are also fraud and abuse issues that should be considered. In general, a Medicare ACO’s distributions of shared savings to ACO participants are exempt from application of the Stark Law or Anti-Kickback Statute.\(^7\) However, any distributions of savings to an entity outside of the ACO (whether payors or providers) are excluded from protection of the fraud and abuse waivers offered by CMS and the U.S. Department of Health and Human Services, Office of Inspector General.\(^8\) A payor and a Medicare ACO must proceed with caution when contemplating a performance-based payment arrangement, and must ensure that any distributions fall under a Stark exception\(^9\) or Anti-Kickback safe harbor\(^10\) if applicable.

**Managed Care**

A Medicare ACO is accountable for the quality, cost, and overall care of the population of beneficiaries assigned to it.\(^11\) Therefore, Medicare ACOs must find a way to reduce unnecessary healthcare expenses while maintaining or improving the quality of care a beneficiary receives. The primary means to this goal are to implement managed care programs that mimic those that many managed care payors already utilize, such as encouraging preventive care, disease management, overall wellness programs, and conducting internal quality improvement programs. A Medicare ACO implementing these programs independently will probably incur substantial capital expenditures. Consequently, it may be crucial for a Medicare ACO to contract with a payor that already has the infrastructure, economies of scale, and experience needed to distribute


\(^7\) 42 C.F.R. Ch. V (2011).

\(^8\) Id.

\(^9\) Many risk-sharing arrangements can comply with the Physician Self Referral Law exception for risk-sharing found at 42 C.F.R. § 411.357(n).

\(^10\) See the Anti-Kickback Statute safe harbor for managed care arrangements at 45 C.F.R. Ch. V.

\(^11\) 42 C.F.R. § 425.100(a).
effective educational materials and tools that will help a provider target high-risk patients and practice proactive healthcare.

Traditionally, providers have not operated under a population management mindset, and have practiced episodic care that focused on individual short-term results. Consequently, the skills related to underwriting and stratification of risk are probably not familiar to most Medicare ACO participants. On the other hand, payors have extensive experience in understanding the health status and risks of a defined population of patients and identifying high-risk patients who require more care and proactive intervention than others. Risk management is yet another arena in which contracting with an experienced payor can assist those Medicare ACO participants who have little to no experience with aggregate population responsibility.

Quality Controls

Medicare ACOs will be held to thirty-three strict quality control metrics, and will not be eligible to receive distributions of shared savings if these quality measures are not sufficiently met. The quality measures cover areas such as patient experience, care coordination, patient safety, preventive health, and at-risk population management. Adhering to these standards will require a level of diligence and audit responsiveness that may be unfamiliar to most providers. On the other hand, a payor’s experience with internal quality guidelines, CMS audits and reporting requirements for Medicare Advantage Organizations, state regulatory requirements, credentialing activities, and provider performance reporting can greatly assist a Medicare ACO in ensuring quality measures are met.

As discussed above, there is a mutual benefit when private and commercial payors seek to align their quality standards with those established by CMS through the Shared

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12 Id. at § 425.500.
13 Id. at § 425.502(d).
Savings Program. The implementation of PPACA has placed financial pressure on payors to reduce healthcare costs, and imposing standards or reporting requirements that differ from those set forth in the Shared Savings Program on a Medicare ACO will decrease the efficiency of a data-sharing/reporting infrastructure and could even create conflicting incentives for Medicare ACO providers. This is not a result that would be beneficial to either the affiliated payor or the Medicare ACO, so the alignment of incentives and standards will become a crucial component of Medicare ACO relationships with non-federal payors.

Health IT Tools

Most of the aforementioned areas necessitate IT tools to compile claims and payment data of participating providers, aggregate patient medical data, identify patient or group risk/opportunity areas, and provide clinical decision-making support. These tools are not widely available to individual practice groups or providers due to the prohibitive cost, while payors have historically had the size and financial resources to access and utilize these IT tools. A Medicare ACO can assuage its onerous startup investment requirements by contracting with a payor that can share their experience with and access to the infrastructure and functionality of enterprise-wide health IT systems.

Compliance with Regulatory Initiatives

Recent regulations, such as the minimum Medical Loss Ratio (MLR) requirement enacted through PPACA, mandate that health plans reduce administrative costs and spend as much as 85% of premium revenue on clinical costs and quality-improving activities.\textsuperscript{14} Under the federal MLR regulation, cost-containment measures such as retrospective or concurrent utilization review are treated as administrative expenses and not included in quality-improving costs for the purposes of meeting the minimum MLR.\textsuperscript{15} Payors who contract with a Medicare ACO in a risk-sharing arrangement are able to delegate some of these activities and oversight and reduce the related internal

\textsuperscript{14} 45 C.F.R. § 158.101(2010).
\textsuperscript{15} Id. at 158.150 (2010).
administrative costs. By contracting with a Medicare ACO, a payor is ensured that the participating providers are taking an active role in care management and value-based utilization, administrative roles that were traditionally held by a payor.

In addition, certain payors are subject to scoring based on HEDIS or Medicare Advantage Star Ratings systems. By utilizing value-based contracting, these payors can incorporate the quality metrics they adhere to into a relationship with a Medicare ACO to improve or sustain their ratings and performance reviews.

**Conclusion**

The behavior of both the payors and providers of healthcare is undergoing a discernible shift toward the accountable and value-driven delivery of care. This shift will present both opportunities and challenges that will not only change the way providers care for their patients, but also give non-payor healthcare participants a reason to pay attention to how healthcare dollars are being spent. This paradigm shift from quantity to quality, and away from a system where providers and patients are insulated from third-party payors, indicates that providers will be looking to private and public payors to provide the collaborative guidance, know-how, and experience that those organizations have been accumulating for years.