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ACO Final Rule: The Opportunity Cost

Law360, New York (November 02, 2011, 1:31 PM ET) -- There was much immediate rejoicing regarding the decision by the Centers for Medicare and Medicaid Services not to require Track 1 participants in the Medicare Shared Savings Program (MSSP) to bear “downside” risk in the third year of their contracts. However, the reaction misses the nature of the risk that participating providers will continue to take in choosing either track of the MSSP over other strategic choices.

The risk that providers will be assuming under MSSP is the risk that they will not realize an appropriate return on their investment of scarce capital, management time and clinical resources, in comparison to other investment options. In other words, even after the improvements in the final rule, providers have a continuing need to assess the opportunity cost of MSSP participation.

That opportunity cost issue is a real one for hospitals and other providers. They face declining Medicare and Medicaid reimbursements, with cuts from the congressional "Super Committee" or sequestration looming on the horizon. They face capital challenges regarding the electronic health record investment that the federal government is pushing them to make.

The cost of purchasing and managing primary care physicians is not insignificant. Meanwhile, hospitals that purchased specialists must assess the future costs of carrying unhappy physicians who face declining reimbursement on their books.

Beginning in 2012, hospitals will be confronted with new financial risk to their Medicare reimbursement in the form of value-based payment penalties and readmission penalties calculated on data already being collected. Moreover, hospitals and other providers face the potential of millions moving from private insurance to Medicaid and exchanges by 2014.

Revenue risk remains under each of those payment changes. As a result, there is opportunity cost in pursuing MSSP, relative to strategies addressing these other payment challenges. Likewise, hospitals face capital investment needs in consideration of merger opportunities and in physician practice acquisition — the failure to have the money or management time to pursue these successfully may have strategic cost.

Finally, opportunities exist to pursue value-based purchasing on a more targeted basis, through the various models of bundled payments and by offering equivalent options to commercial payers and self-funded employers. Executives and boards need to carefully consider the opportunity cost of MSSP participation even under the sweeter terms now offered.

In the end, CMS, Congress and ultimately the taxpayer have the most at stake in the design of MSSP and other value-based purchasing programs. Neither Congress nor CMS has any other politically palatable tricks up its sleeves in addressing the cost curve. CMS must bring to the table programs with sufficient potential return on investment to convince providers to change their volume-based business models.

With that perspective, it would be sensible for Congress to seriously subsidize provider systems' development of population health management capabilities in the same way it has invested in "meaningful use" of health information technology.

Let's remember that MSSP still requires providers to invest in care management capabilities in return for a 50-percent share of savings — and that 50-percent share is still subject to a cap. (In a joint venture in any other context, the counterparty would share all the benefit its joint venture partner created.)

MSSP still requires providers to trust CMS to pay in timely fashion, and be reasonable in finding that the savings exceed a basket and that quality metrics — although fewer in number than originally proposed — have been satisfied. From a provider perspective, it is they who must still make the significant investment on behalf of the Medicare program in care management, and they must do so with a counterparty that retains all the cards concerning whether they get paid, how they get paid, how much and when.

It's worth noting that this MSSP investment must still be made in a program where the beneficiary is not incentivized to do his or her part to take responsibility for his or her own health, or to stay in network. And, while the need begins to be addressed in the rule, the mechanics of access to the data essential to timely case/disease management are yet to be determined.

Therefore, it could be argued that removing overt downside risk in Track 1 is the least CMS can do under the circumstances. It will be interesting to see how many systems assume the risk of the opportunity cost associated with Track 1 and embark on the investment in care management under the MSSP program, relative to other CMMI options and additional types of investment.

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