Accountable Care Organizations—New Opportunities, New Risks

On October 20, 2011, the Centers for Medicare & Medicaid Services (CMS) released its “Final Rule Provisions for Accountable Care Organizations” under the Medicare Shared Savings Program (MSSP).

The MSSP promotes the formation and operation of accountable care organizations (ACOs) to serve Medicare fee-for-service beneficiaries. According to CMS, this program is intended to encourage providers of services and suppliers (e.g., physicians, hospitals, and others involved in patient care) to join together and create a new type of healthcare entity, an ACO. The ACO must agree to be held accountable for improving the health and experience of care for individuals and improving the health of populations, while reducing the rate of growth in healthcare spending.

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Hospitals employing ACO professionals
Other Medicare providers and suppliers, as determined by the Secretary of Health and Human Services.

In addition, certain critical-access hospitals, federally qualified health centers, and rural health clinics may be eligible to participate independently in the MSSP. These providers may become ACOs and be used for purposes of assigning patients to the ACO. In recognition of the fact that these facilities may not have access to the capital needed to fund an ACO infrastructure, Medicare established the Advance Payment Model. The model is open to two types of organizations only: ACOs that do not include any inpatient facilities and have less than $50 million in total annual revenue; and ACOs in which the only inpatient facilities are critical-access hospitals and/or Medicare low-volume rural hospitals and have less than $80 million in total annual revenue.

Organizations such as skilled nursing centers, home health agencies, and hospices may participate in an ACO, but they may not be used for purposes of assigning patients to the ACO.

An ACO must agree to accept responsibility for at least 5,000 Medicare fee-for-service beneficiaries to be eligible to participate in the MSSP. The ACO must complete an application providing the information requested by CMS, including a full description of how the ACO plans to deliver high-quality care and, at the same time, dampen the increases in expenditures for the beneficiaries it serves. If the application is approved, the ACO must sign an agreement with CMS to participate in the MSSP, for a period of at least three years.

In addition to the MSSP, Medicare offered the opportunity to participate in the Pioneer ACO Model, designed for healthcare organizations and providers that are already experienced in coordinating care for patients across multiple care settings. It will allow these provider groups to move more rapidly from a shared-savings payment model to a population-based payment model, e.g., capitation. On December 19, 2011 CMS published its list of the 32 organizations selected to participate in the Pioneer ACO Model.

Through the CMS regulations, ACOs have an opportunity to provide high-quality, evidence-based healthcare to Medicare enrollees, while eliminating waste and reducing excessive costs. To the extent that an ACO is successful in capitalizing on this opportunity, its members will share in the savings achieved.

As is often the case, however, opportunity is accompanied by challenge: the challenge to “get it right” in order to achieve maximum savings, to change care delivery and improve patient safety, and to avoid running afoul of regulations that were designed to protect the healthcare consumer. An organization will be challenged to correctly structure or modify its insurance and risk-financing programs in response to the risks presented. This article focuses on several areas of risk considered key to formation and implementation of the ACO model.

Structure and governance
An ACO must be a legal entity that is capable of receiving and distributing shared savings, repaying shared losses, and reporting quality performance data. It must have its own governing body, separate from those of its participants. This means that the ACO’s board members cannot be “absorbed” into an existing directors and officers liability policy.

If an ACO consists of more than one large organization, e.g., a health plan and a health system or a hospital and large multispecialty physician group, there may be conflicts with respect to which organization will control the purchase of insurance. If both organizations retain significant liability risk through a self-insurance trust or captive insurer, will the ACO be able to retain similar risk?

As a legal entity, the ACO may own or lease property or office space in its own name and employ workers under a separate Federal Employer Identification Number, all of which will require a separate purchase of insurance. Liability insurance will be required in order to address the indemnification assumed in lease agreements and professional services contracts.

Several government agencies, including the Internal Revenue Service, Federal Trade Commission, and U.S. Department of Justice’s Antitrust Division, have provided guidance for ACOs formed under the MSSP. While this guidance will be helpful in the formation of Medicare ACOs, it may not be as applicable to commercial ACOs, leaving them with more uncertainty regarding regulatory risk.

Many hospitals and health systems have ramped up their acquisition of physician practices in preparation for providing the full continuum of care to ACO beneficiaries. These acquisitions may result in more intense government scrutiny with respect to market share. Hospitals frequently find themselves assuming responsibility for physicians’ prior liability exposures, purchasing an extended reporting endorsement from the physician’s insurer, or absorbing the risk into the hospital’s own risk-financing program. As the hospital’s number of ratable exposure units increases, its medical professional liability (MPL) premium and/or self-insurance funding may increase substantially.

Electronic health records
ACOs must meet 33 quality measures established by CMS in order to receive productivity bonuses under the MSSP. Implementation of electronic health records (EHRs) will be a fundamental component of any ACO, enabling the organization...
and its participants to share clinical data and provide results, quickly and accurately.

Underwriters generally agree that EHRs will improve quality and patient safety over time. Some liability insurers, however, believe that claims will rise during the adjustment period, as providers work out the kinks in these new systems. Providers may be open to more errors and system breakdowns in the early stages of EHR implementation. In addition, it may be easier than ever for plaintiff attorneys to obtain the records they need for building their case against a provider.

A New York Times article, December 15, 2011, revealed a new phenomenon, a consequence of the explosion of technology in the healthcare setting: the distracted professional. According to the article, physicians and hospital staff are increasingly using hospital computers and their own smart phones for personal business—instead of tending to the patient. The article cites an MPL settlement involving a neurosurgeon who allegedly made at least ten personal phone calls while performing surgery.

Privacy protection and cyber-liability
The number of healthcare data breaches continues to outpace those reported in other vertically integrated business—including banking and government. The Second Annual Benchmark Study on Patient Privacy and Data Security conducted by the Ponemon Institute and sponsored by ID Experts found that, despite generally greater compliance with HIPAA and the Health Information Technology for Economic and Clinical Health Act, healthcare data breaches are on the rise—eroding patient privacy, contributing to medical identity theft, and costing billions annually.

Healthcare organizations seem particularly prone to internal problems, including malicious theft and unintentional loss of storage devices containing treasure troves of database information.

Earlier this year, the Department of Health and Human Services (HHS) imposed its first-ever civil monetary penalty on a covered entity for violating the privacy rule of the HIPAA. HHS ordered Cignet Health of Prince George’s County, Maryland, to pay $4.3 million for violating the rights of 41 patients in denying them access to their medical records when requested.

It will be critical for the ACO and its participants to have robust data security and compliance programs, along with properly structured privacy protection and cyber-liability insurance.

Changing delivery models
The CMS final rule requires that the ACO have procedures and processes that will promote evidence-based medicine, engagement of beneficiaries in their care, and coordination of care. CMS expects that ACOs will invest continually in the workforce and in team-based care. To assure program transparency, the final rule requires that ACOs issue public reports on certain aspects of their performance and operations, and that CMS publish public reports on certain quality-related data.

ACOs may find themselves taking on more financial risk as the concept matures, not unlike the capitation models so prevalent in the 1990s. Smaller ACOs may entrust all of their business operations to an outside consulting or management firm. Managed care errors and omissions and stop-loss insurance may be needed to address the financial, credentialing, network management, and utilization review exposures presented by such arrangements.

ACOs are required to have systems for identifying and developing care plans for high-risk individuals. They must promote evidence-based medicine and “medical homes,” i.e., coordination of care across all providers. Demonstrating evidence-based medicine will require meticulous documentation, as well as more sophisticated processes and procedures. In time, it may become more difficult to defend lawsuits alleging deviation from the standard of care.

The medical home concept will require more collaboration between members of the care team, such as case managers and home health providers. And medical homes will need to include systems for ensuring the timely and accurate sharing of information among all participants.

Patient-centered care is encouraged, putting the beneficiary and family at the center of every aspect of care. Informed consent may give way to “informed choice”; providers will need to document the fact that the patient and his family refused available alternatives of the treatment chosen.

It’s too soon to predict how these changes in care delivery will impact medical liability litigation. The frequency of lawsuits could increase as plaintiff attorneys test new theories in litigation against ACO organizations and professionals.

Conclusion
There was a well-worn phrase during the infancy of managed care: “When you’ve seen one HMO, you’ve seen one HMO.” The same phrase could apply to ACOs. Recognizing that each ACO will be unique in its structure, governance, relationships, and delivery model is essential when evaluating its risk-financing needs. ACOs will be well served by involving their insurers and brokers early on in the planning stages, thereby ensuring a risk-financing program that is tailored to their unique risks.