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Sara J. Rosenbaum
George Washington University

Peter Shin
George Washington University

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RCHN Community Health Foundation Research Collaborative**

Policy Research Brief # 23

**Medicare's Accountable Care Organization Regulations:
How Will Medicare Beneficiaries who Reside in
Medically Underserved Communities Fare?**

**Sara Rosenbaum, JD
Peter Shin, PhD, MPH**

The George Washington University
School of Public Health and Health Services
Department of Health Policy

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About the Geiger Gibson / RCHN Community Health Foundation Research Collaborative

The Geiger Gibson Program in Community Health Policy, established in 2003 and named after human rights and health center pioneers Drs. H. Jack Geiger and Count Gibson, is part of the School of Public Health and Health Services at The George Washington University. It focuses on the history and contributions of health centers and the major policy issues that affect health centers, their communities, and the patients that they serve.

The RCHN Community Health Foundation, founded in October 2005, is a not-for-profit foundation whose mission is to support community health centers through strategic investment, outreach, education, and cutting-edge health policy research. The only foundation in the country dedicated to community health centers, the Foundation builds on health centers' 40-year commitment to the provision of accessible, high quality, community-based healthcare services for underserved and medically vulnerable populations. The Foundation's gift to the Geiger Gibson program supports health center research and scholarship.

Additional information about the Research Collaborative can be found online at www.gwumc.edu/sphhs/departments/healthpolicy/ggprogram or at rchnfoundation.org.

Executive Summary

On March 31, 2011, the Centers for Medicare and Medicaid Services (CMS) released proposed regulations implementing the Medicare Shared Savings Program (MSSP). The thrust of the MSSP is to promote savings to Medicare as well as the greater clinical integration of health care through incentive payments to accountable care organizations (ACOs) that meet Medicare standards for structure, performance, and health care outcomes. The effort to spur greater clinical integration through the MSSP was part of a broader set of reforms contained in the Affordable Care Act (ACA) whose aim was to improve health care quality and efficiency. Among these reforms is an \$11 billion investment in community health centers, known as federally qualified health centers (FQHCs) under the Medicare program. In 2009, health centers served nearly 19 million low-income patients, including 1.4 million Medicare beneficiaries. By law, health centers must provide comprehensive primary health care while also serving as gateways to a full range of necessary care, including inpatient and specialty care. Federal data on health center services show that primary care represents 98.2 percent of all health care furnished by FQHCs.

Despite the broad aims of the ACA, CMS' proposed rule bars participation by health center-formed ACOs. Furthermore, while the rule permits health centers to be ACO participants, it also prohibits the assignment of Medicare patients to ACOs for shared savings purposes. Despite the absence of any legal barriers to FQHC participation in the statute, CMS bases this exclusionary policy on the fact that the FQHC payment method, which consists of a bundled payment for all primary health care services furnished by FQHC staff, does not allow the agency to identify which procedures are furnished by physicians, whose presence in care provision is a requirement of the ACO statute. In medically underserved communities, however, health care teams are essential because of the severe shortage of physicians; furthermore, FQHCs use health care teams to ensure comprehensive care.

CMS policy has the potential to produce a series of downstream consequences, most notably, the systemic exclusion of the poorest and most underserved patients from the benefits of ACOs and the disincentivization of meaningful FQHC affiliation agreements with hospitals and specialty groups participating in ACOs. The exclusion of Medicare FQHC patients comes at a time when health centers have experienced explosive growth in the number of Medicare patients served -- a doubling of patients over the past decade, even as the number of low-income Medicare beneficiaries grew by less than 10% nationwide.

The ACO statute provides the Secretary with the discretion to interpret the statute's assignment rule to recognize physicians as providers of health care regardless of whether they furnish health care directly or as part of health care teams. Although technical issues will arise in designing a shared savings methodology for health care team arrangements that rely on bundled payments, this challenge ultimately pales alongside the implications of excluding FQHC Medicare patients from the potential benefits of ACO practice.

Introduction

The Patient Protection and Affordable Care Act (ACA) establishes a “Medicare Shared Savings Program”¹ (MSSP). The purpose of the program is to improve health care by rewarding certain types of provider collaborations -- known under the law as Accountable Care Organizations (ACOs) -- that are expected to control costs while improving quality.² Experts have identified ACOs as an important step forward in achieving greater efficiency and quality in health care.³ Over time, ACO formation is expected to become a major feature of the U.S. health care landscape, not only for Medicare but for other sources of coverage such as Medicaid, CHIP, employer-sponsored health plans, and ultimately, qualified health plans (QHPs) sold in state health insurance Exchanges. For this reason, the formation of ACOs is a matter of great importance to the future of health care financing and access generally. Indeed, ACO formation is a focus of the federal agencies that regulate competition within the health care system as a whole.⁴

According to the Centers for Medicare and Medicaid Services (CMS), the agency that oversees the MSSP, the program’s aims are to foster “(1) better health care for individuals; (2) better health for populations; and (3) lower growth in expenditures.”⁵ By promoting clinical integration through ACO formation and compensation, the ACA reflects longstanding recognition of integration as central to improving the quality and cost-effectiveness of health care.⁶ Congress’ decision to spur the formation of such entities through creation of the MSSP comes at a critical time in U.S. health care, as health care costs continue to rise far faster than the general rate of inflation and quality measures continue to lag well behind those of other nations.

The use of Medicare payment incentives to spur ACO formation was part of a broader set of health care quality and efficiency reforms contained in the ACA. Chief among these other reforms was an \$11 billion investment over the FY 2011-2015 time period in the expansion of community health centers (known under Medicare and Medicaid as federally qualified health centers, or FQHCs) in order to reach a far greater number of rural and urban medically underserved communities, in preparation for the coverage expansions due to take place in 2014. By law, health centers must affiliate with other health care providers in order to promote health care quality and continuity

¹ SSA §1899 (A) as added by PPACA §3022

² §1899(a)(1)(A)

³ MedPAC, 2009 Report to Congress, Ch. 2 http://www.medpac.gov/chapters/jun09_CH02.pdf (Accessed April 9, 2011)

⁴ See, e.g., FTC/DOJ Proposed Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program (Notice with Comment Period) <http://www.ftc.gov/os/fedreg/2011/03/110331acofrn.pdf> (Accessed April 9, 2011)

⁵ 76 Fed. Reg. 19528, 19531 (April 7, 2011)

⁶ Clinical integration as a key aspect of health care quality improvement was recognized as early as the 1933 Report of the Committee on the Cost of Medical Care <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC402728/pdf/canmedaj00128-0076.pdf> (Accessed April 9, 2011)

and access to medically necessary inpatient and specialty care.⁷ Thus, viewed through the wider lens of the ACA as a whole, it is evident that Congress sought to maximize clinical integration across the health care system, in medically underserved communities and elsewhere, through a combination of incentives and investments. In the case of health centers, Congress' vision was not simply to make primary health care more accessible but also to assure that new primary care access points would serve as gateways to comprehensive, high quality health care for medically underserved populations. Because the purpose of the MSSP is to spur the types of integration that in turn generate patient and population health improvements, health center patients in particular stand to gain from this policy advance.

Among the nearly 19 million medically underserved patients served by health centers in 2009 were nearly 1.4 million Medicare beneficiaries. Data from the Uniform Data System (UDS), which collects information on all federally-funded health centers, indicates that health center patients are overwhelmingly low income; more than 71% have family incomes below 100% of the federal poverty level. While there exist no data on the specific income characteristics of Medicare beneficiaries served by health centers (the UDS provides information about patient income information separately from information about insurance coverage), it is safe to assume that as residents of medically underserved communities, Medicare patients resemble other patients in their depressed economic circumstances.

How the CMS Proposed Rule Addresses Medicare Patients Served by Health Centers

Despite the ACA's overall emphasis on clinical quality improvement, the Congressional investment in health centers, and, as CMS notes, FQHCs' "critical role in the health care system,"⁸ the proposed rule effectively places the potential benefits of ACOs out of reach of medically underserved patients. The rule does so by not only barring participation in the MSSP by health center-formed ACOs,⁹ but also by disincentivizing ACOs from including health centers because of its prohibition of the assignment of FQHC Medicare patients to ACOs for shared savings purposes.

Barring health center-formed ACOs from participation in the MSSP: Nothing in the statute directly addresses the question of which ACO entities can participate in the MSSP. Indeed, the statute states simply that "groups of providers of services and suppliers meeting criteria specified by the Secretary may work together to manage and coordinate care for Medicare-fee-for-service beneficiaries through an accountable care organization."¹⁰ Thus, the issue is left to the discretion of the Secretary. But the proposed rule forbids participation by FQHC-formed ACOs,¹¹ allowing access by

⁷ Sara Rosenbaum et. al., *Assessing and Addressing Legal Barriers to Clinical Integration Among Community Health Centers*, (Commonwealth Fund, 2011) [forthcoming]

⁸ 76 Fed. Reg. 19528, 19538.

⁹ Id.

¹⁰ SSA §§1899(A)(1)(A) as added by PPACA §3022.

¹¹ 76 Fed. Reg. 19538.

FQHCs (as well as rural health clinics, or RHCs) only if they participate in ACOs that are permitted under the rule to be part of the MSSP.¹²

Barring inclusion of FQHC Medicare patients in ACOs for shared savings purposes: Furthermore, inclusion of health centers in ACOs is disincentivized because the proposed rule bars registered FQHC Medicare patients from being assigned to the ACO in which a health center participates.

Both policies – barring participation by FQHC-formed ACOs and barring the inclusion of Medicare FQHC patients – are the result of CMS’ position that for purposes of shared savings, only those patients who receive care from physicians may be counted. Reflecting the severe shortage of physicians in the communities in which they operate, health centers use primary care teams; moreover, in furtherance of the Medicare statute’s FQHC provisions, health centers are paid on an all-inclusive encounter rate basis. Paradoxically, these two key factors, the shortage of physicians and Medicare’s use of a bundled payment approach to pay FQHCs – the very payment approach encouraged under the ACA, – mean, according to CMS, that it is not possible to determine whether a Medicare FQHC patient has received any particular covered treatment or procedure from a physician.

CMS’ conclusions are based on its interpretation of SSA §1899(c), the provision of the ACO statute that addresses patient assignment. In CMS’ view, the statute (§§1899(c) and (h)(1)(A)) specifies that the only patients who can be assigned to an ACO for shared savings purposes are those whose care is furnished by a participating health professional who is a physician. Because the primary care services furnished by health centers are paid on a bundled basis, CMS concludes that CHC patients cannot be assigned to an ACO because the physician’s precise role in care cannot be ascertained.¹³ Thus, the exclusion of FQHC Medicare beneficiaries ultimately rests on the absence of procedure codes under the FQHC payment system.

In order to counter the potential for total exclusion of FQHCs and their patients, CMS proposes to create FQHC-related financial incentives. The first incentive exempts “one-sided” ACOs from an otherwise applicable adjustment to their net savings thresholds under the shared savings program if 50 percent or more of assigned beneficiaries have at least one encounter with a participating FQHC.¹⁴ But since registered Medicare FQHC patients cannot, under the terms of the CMS rule, count as assigned ACO patients, this incentive appears to be linked to use of FQHCs by assigned patients (that is, other patients seen by those ACO participating professionals whose patients *do* count). Since assigned patients presumably are already under the care of a participating physician, it is unlikely that 50 percent will visit an FQHC as well.

¹² Id. CMS notes that “[i]t is, however, possible for [FQHCs] to join as an ACO participant in an ACO” that has been formed by organizations recognized by CMS as authorized to form an ACO.

¹³ 76 Fed. Reg. 19538, 19562

¹⁴ 42 C.F.R. §425.7(c)(4)(iv)

The second incentive comes in the form of an increase of up to 2.5 percentage points in the final shared savings rate for a one-sided ACO (and up to 5 percentage points in the case of a two-sided ACO) if the ACO includes “a” FQHC.¹⁵ However, as with the net savings threshold bonus, in order to qualify for this shared savings bonus, the ACO’s *assigned* patients must use the FQHC. As with the first incentive, use of the FQHC by the FQHC’s patients does not count, because Medicare FQHC patients are not considered assigned. Again, it is doubtful that patients under the care of participating ACO physicians would also receive care from an FQHC.

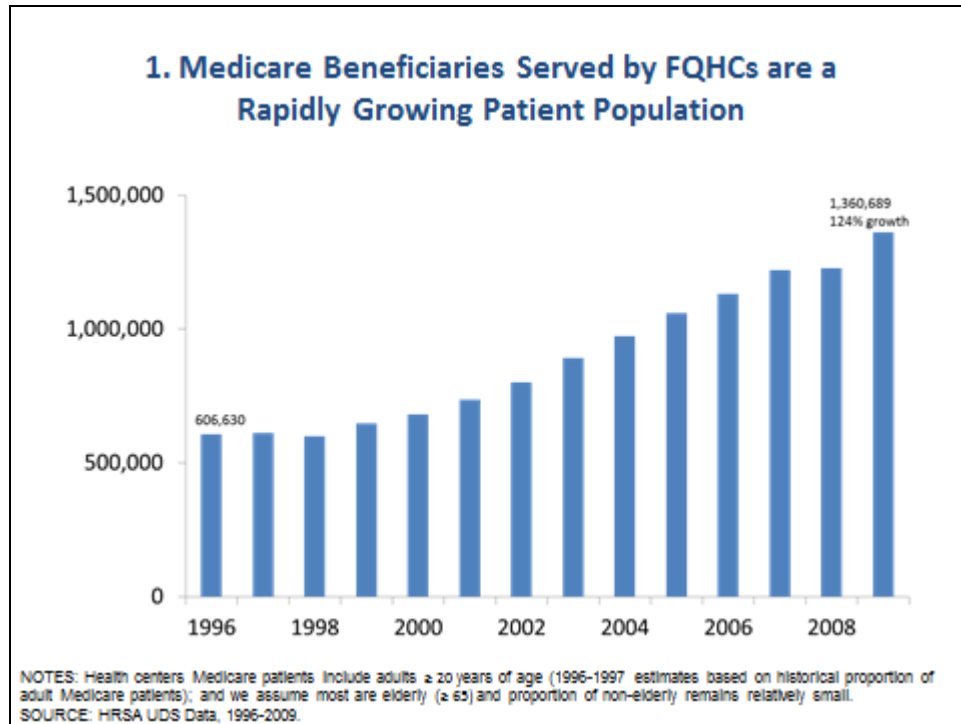
In sum, while the ACO statute expressly recognizes the eligibility of many clinical professionals other than physicians to participate in ACOs, CMS has interpreted the provisions of the assignment statute to preclude assignment of patients to ACOs other than those for whom care is provided by a physician. Because medically underserved communities heavily depend on the use of health care teams that include a full range of health care professionals (a practice encouraged under the broader provisions of the ACA), the proposed rule effectively excludes patients whose communities lack primary care physicians and that depend on health care teams to bridge this shortage.

Despite CMS’ express acknowledgment of the quality of health center services and their “critical” role in health care, the rule thus achieves a result that effectively excludes all patients served by one of Medicare’s most important sources of primary health care for medically underserved populations. Patients of both FQHCs and RHCs are adversely affected by this result, as are those under the care of nurse-managed clinics and other practice arrangements that rely on primary health care professionals other than physicians. Although CMS attempts to fashion an incentive to overcome the impact of its interpretation, the incentive operates only in relation to assigned patients; by definition, this incentive therefore excludes all FQHC Medicare patients.

Who Are the Medicare Patients Served by Health Centers?

Health centers play a considerable – and growing – role in caring for the most at-risk Medicare patients. **Figure 1** shows that Medicare beneficiaries served by FQHCs are a rapidly growing part of the FQHC patient population. Data from the UDS covering the period 1996 - 2009 shows that over this time, the FQHC Medicare patient population grew by 124%, with growth concentrated in the 1998 - 2009 time period.

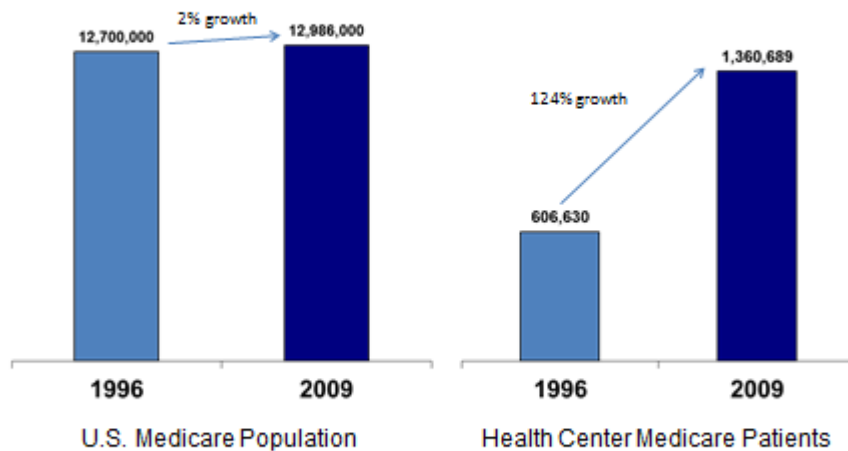
¹⁵ 42 C.F.R. §425.7(c)(7)



Several underlying factors may account for this explosive growth. One possible explanation is an increase in the number of health centers in operation and in the total number of patients served; health centers grew from 686 to 1,131, while the total number of patient served grew from 8.1 million to 18.8 million. But the Medicare patient increase outstrips the overall patient increase. Another explanation may be a slight rise in the number of low-income Medicare beneficiaries generally (**Figure 2**). Still another explanation might be a decline in other sources of primary health care in medically underserved communities.¹⁶ Yet another explanation might be a change in Medicare and Medicaid payment policy under the Balanced Budget Act of 1997 (BBA). The BBA authorized state Medicaid programs to cease paying Medicare rates for dually eligible beneficiaries. In the wake of the BBA, virtually all states took advantage of this flexibility and eliminated Medicare-level payments for dually eligible beneficiaries. Given the fact that FQHC Medicare patients are likely to be dually enrolled, a possible cause of the growth is that as states ceased Medicare payment practices for dually eligible persons, the number of private, dually participating physicians in these communities also declined.

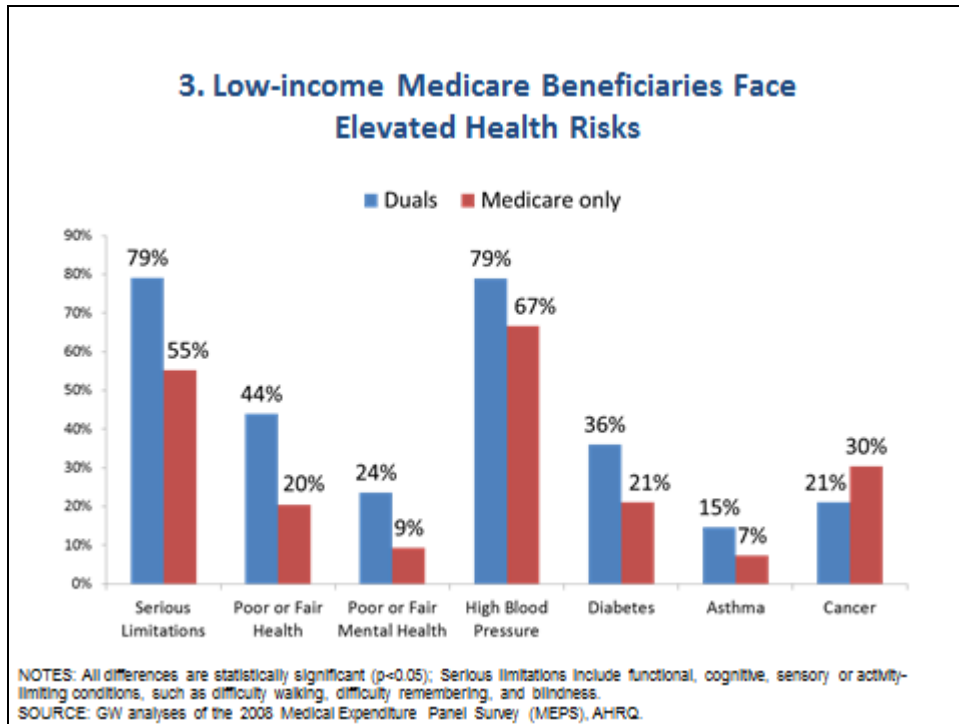
¹⁶ National Association of Community Health Centers, George Washington University, and the Robert Graham Center, *Access Transformed: Building a Primary Care Workforce for the 21st Century*. 2008. <http://www.nachc.com/client/documents/ACCESS%20Transformed%20full%20report.PDF>.

2. The FQHC Medicare Patient Population is Growing Far Faster than the Low-income Medicare Population Generally



NOTES: 1996 U.S. Medicare estimates based on 1995 Medicare-poverty estimates and 1996 Medicare elderly population; 1996 health center patient estimates based on historical proportion of adult (≥ 65) Medicare users. SOURCE: GW analysis of U.S. Census Bureau Data, 1996 and 2009 and HRSA UDS Data, 1996 and 2009.

Evidence drawn from the Medicare Expenditure Panel Survey (MEPS) underscores the elevated health risks experienced by low-income individuals dually enrolled in Medicare and Medicaid. As shown in **Figure 3**, dual enrollees are over 1.5 times more likely to experience serious health limitations, more than twice as likely to experience fair to poor health, nearly 3 times as likely to experience fair to poor mental health, nearly twice as likely to experience diabetes, and over twice as likely to experience asthma. Thus, dual enrollees are significantly more likely to experience not only worse health, but also worse health arising from conditions whose outcomes can be significantly improved through ambulatory care. They are precisely the patients whose health outcomes might most improve through health care furnished in clinically integrated systems.



The Potential Downstream Effects of the Proposed Rule

By excluding health center-formed ACOs from participation, and by excluding FQHC Medicare patients from the shared savings program, the proposed rule has the potential to trigger a series of serious downstream effects.

1. The rule excludes the poorest beneficiaries with the highest health risks

Paradoxically, the proposed rule specifies that CMS will monitor ACOs to assure that they do not attempt to avoid “at risk” beneficiaries,¹⁷ defined as “a beneficiary who (1) has a high risk score on the CMS-HCC risk adjustment model; (2) is considered high cost due to having two or more hospitalizations each year; (3) is dually eligible for Medicare and Medicaid; (4) has a high utilization pattern; or (5) has had a recent diagnosis that is expected to result in increased cost. Dual eligibility is sufficient to trigger monitoring for avoidance, and yet by excluding the very primary care providers that disproportionately treat dual enrollees, CMS essentially has excluded nearly 1.5 million FQHC Medicare beneficiaries from the program, as well as many more who receive their care through clinical settings that rely on health care teams, such as RHCs. As health centers expand, the number of poor beneficiaries excluded from this important access and quality initiative will grow.

¹⁷ 42 C.F.R. §425.12(b)

2. The rule penalizes medically underserved communities that lack primary care physicians, whose residents rely on health care teams and non-physician primary care providers

Provision of care through health care teams has been identified as an important measure of quality and efficiency; indeed, CMS itself discusses the importance of teams in the Preamble to the rule. In medically underserved rural and urban communities the use of health care teams and non-physician providers is essential, but the rule penalizes their use as a result of the agency's interpretation of the statute as limiting assignment to patients cared for by physicians. This approach to the statute effectively forecloses the growth of ACOs in communities that depend on health care teams.

3. The rule disincentivizes health center efforts to affiliate with hospitals and specialty practices

In recent years, health centers have enjoyed major growth in affiliation activities, and health center networks have grown as a means of improving quality and efficiency. Of particular importance has been the growth in hospital/health center affiliation, both to promote a more cost effective form of care for patients who otherwise depend on emergency departments, and to improve the quality and continuity of care. For example, Denver Health, which is nationally renowned for the quality of its care,¹⁸ provides much of its care through affiliated, independent FQHCs. To the extent that the rule means that Denver Health's affiliated Medicare FQHC patients cannot be assigned to an ACO, the system's ability to move forward would be adversely affected.

By disincentivizing health center participation in ACOs, either through health center-formed ACOs or on an individual basis, the rule threatens to reverse this movement toward greater affiliation. The structure of the rule's FQHC incentive may mean that no ACO will be able to claim credit for including an FQHC, since the incentive is available only if assigned patients use the FQHC, and FQHC's patients cannot be assigned patients. Ironically, the CMS ACO interpretation coincides with a highly important CMS initiative aimed at developing FQHCs into medical homes for Medicare beneficiaries. To fully succeed as medical homes, of course, health centers participating in the demonstration will need to be able to overcome clinical integration barriers on behalf of patients who require specialty and inpatient care. The ACO rule, with its shared savings incentive, might have helped health centers build such a continuum of care; instead, the rule has the potential to undermine health centers' ability to find partners in care.

4. The rule has implications for the ability of health center patients to be counted in other payers' shared savings programs

It is widely expected that other payers such as Medicaid, CHIP, and private health insurers and employer-sponsored plans will also begin to contract with ACOs on

¹⁸ See e.g., Patricia Gabow and Philip Mehler, A Broad And Structured Approach To Improving Patient Safety And Quality: Lessons From Denver Health, *Health Affairs* 30:612-618 (April, 2011)

a shared savings basis. Because of Medicare's enormous influence on the health care system, it is likely that these payers will utilize the Medicare ACO rules. Thus, it is possible that health center-formed ACOs will be excluded from participation in state Medicaid programs and furthermore, that health center patients will be excluded in other payers' shared savings programs. Such a result would be particularly unfortunate in the case of Medicaid, because of the importance of quality and efficiency improvements in that program. While the terms of the MSSP statute apply only to the Medicare program, the reach of the statute's methodology may ultimately extend much further.

An Alternative Approach to the Proposed Rule

Ultimately CMS' interpretation of the statute's assignment provision drives the exclusion of health center patients from the MSSP. Section 1899(c) provides that "[t]he Secretary shall determine the appropriate method to assign Medicare fee-for-service beneficiaries to an ACO based on their utilization of primary care services *provided* under this title by [a physician]." This section does not require that services be provided *directly* by physicians, but only that physicians "provide" care. There are many ways to provide care, and this flexibility is captured by §1899(b)(1)(E) of the statute, which gives the Secretary the discretion to designate a broad range of ACOs and ACO participants.

Moreover, although FQHCs have begun to utilize procedure codes as part of their Medicare billings, the simple fact is that, according to the publicly-available UDS health center reports, 98.2 percent of all medical services provided by health centers in 2009 were furnished by primary care providers. To conclude that the absence of procedure codes effectively negates the ability of FQHC Medicare patients to gain the benefits of ACO formation and operation simply makes no sense. This position also overlooks the provisions of the Medicare FQHC statute, which specifies physician services as a core element of FQHC coverage and payment, along with the services of other members of a health center's health care team. Regardless of whether care at health centers is provided *directly* by a physician in all cases, physicians are deeply involved in the provision of primary care to all patients.

Furthermore, CMS' *de facto* insertion of the word "directly" after "provided" under its interpretation is at odds with the range of physician practice that is recognized under state law. State law recognizes physicians as providers of health care – and accountable for the quality of that care – whether they furnish the care directly or provide such care by supervising (either directly or indirectly) the activities of other health professionals.

To be sure, technical issues arise in fashioning a shared savings methodology for use in health care settings in which primary care is furnished by teams and payment is bundled. But this task is hardly insurmountable, and CMS has long been a leader in payment innovation. Ultimately, developing such a payment incentive pales alongside the long-term consequences of a policy that effectively excludes medically underserved patients from participation in a major practice and quality advance.