Can Accountable Care Organizations Improve the Value of Health Care by Solving the Cost and Quality Conundrum?

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The Case for Payment and Delivery Reform

• The problems are widely recognized:
  – Fragmented care
  – Uneven, unsafe practices
  – Unsustainable costs

• *Crossing the Quality Chasm*, 2001
  – Quality = care that is safe, effective, efficient, patient-centered, timely and equitable
“Our fee-for-service system, doling out separate payments for everything and everyone involved in a patient’s care, has all the wrong incentives: it rewards doing more over doing right, it increases paperwork and the duplication of efforts, and it discourages clinicians from working together for the best possible results.”

The Case for Payment and Delivery Reform

• **Solution:**
  – Better coordinated care, more transparent to the consumer, using evidence-based measures to achieve better outcomes, greater patient satisfaction and improved cost efficiency
  – Or, in other words, “accountable care”
  – An “accountable care organization” (“ACO”) is a provider-based organization comprised of multiple providers with a level of clinical integration sufficient to deliver accountable care
  – Both the payment system and delivery system need to change together to achieve accountable care
How did we get here?

- Early alternative delivery systems development – HMOs, PPOs, EPOs, IPAs, TPAs, PSOs, DMCs
- Physician-hospital integration post-Clinton plan – PHOs, MSOs, PPMCs, IDSs
- Quality movement – PSROs, QIOs, IHI, IOM, NQF
- PACE program, current pilots and demonstrations
Why might ACOs and global payments work now when similar concepts did not in the 1990s?

- There is greater recognition of the urgency of the cost and quality problems
- The implications of evidence-based medicine are more widely understood and accepted
- There is greater understanding that good outcomes, patient satisfaction and cost-efficiency are linked
- We have learned from past experience with provider integration efforts and risk contracting
- Consensus measures and IT infrastructure have advanced significantly
- Early pilots and demonstrations show promise
“The history of American agriculture suggests that you can have transformation...without knowing all the answers up front.... Transforming health care everywhere starts with transforming it somewhere.”

Current Demonstration Projects and Pilot Programs

- Medicare Acute Care Episode (ACE) Demonstration
- Medicare Physician Group Practice Demonstration (PGPD)
- PROMETHEUS
- CMS/Premier Hospital Quality Incentive Demonstration (HQID)
- Medicare Hospital Gainsharing Demonstration
- Nursing Home Value-Based Purchasing
- Home Health Pay For Performance
- Medicare Care Management Performance Demonstration
- Care Management for High Cost Beneficiaries (CMHCB)
- End Stage Renal Disease (ESRD) Disease Management Demonstration
“To change the way health care is organized and delivered, we need to change the way it is paid for — to move from fee-for-service payments to bundled payments.”

– Gutterman, Davis, Schoenbaum and Shih, 2009
Payment Reform Continuum

- Pay for performance; value based purchasing; simple shared savings
- Inpatient bundling
- Episode of care bundling
- Per enrollee shared savings
- Partial or full global payment per enrollee (capitation)
Integration Continuum

- Contractual models – e.g., PHOs, IPAs
- Partial or virtual integration models – e.g., joint ventures, joint operating agreements, virtual governing bodies
- Fully integrated models – common ownership and employment
Recent Proposals to Divide ACOs Into Three Tiers

- **Level I** - No financial risk, but eligible to receive shared savings; minimum number of PCPs; able to report basic set of measures
- **Level II** - Greater upside on savings, but some risk for higher costs and/or bundled payments; more comprehensive performance measures; minimum cash reserves
- **Level III** - Full or partial capitation; full public reporting on comprehensive measure set; more stringent financial requirements and reserves
• **Sec. 3011. National Strategy for Improvement in Health Care.**
  – Secretary of HHS required to develop strategy to improve payment policy to emphasize quality and efficiency.
  – Strategy to focus on outcomes, cost-efficiency and patient-centeredness.
  – To address health care provided to patients with high-cost chronic conditions.
  – To enhance the use of data.
  – To disseminate best practices.
  – Due January 1, 2011.
Sec. 3021. Establishment of Center for Medicare and Medicaid Innovation within CMS.

- Creates a Center for Medicare and Medicaid Innovation (“CMI”) within CMS to test innovative payment and service delivery models to reduce program expenditures while preserving or increasing the quality of care.
- Instructs CMI to use open door forums or other mechanisms to seek input from interested parties.
- Models to be tested include medical homes; risk-based contracting; coordinated care models like ACOs; and improved post-acute care models.
- $10 billion in funding, 2011 to 2019.
- To be up and operating by January 1, 2011.
PPACA Accountable Care and Innovation Opportunities: ACOs

- **Sec. 3022. Medicare Shared Savings Program.**
  - Directs the Secretary to create a shared savings program by 2012 that will promote accountability, coordinate services between Parts A and B.
  - ACOs that feature shared governance and meet quality performance standards can receive payments for shared savings.
  - Eligible ACOs include:
    - Physicians and other professionals in group practice arrangements;
    - Networks of individual physicians;
    - Partnerships or joint ventures between hospitals and physicians;
    - Hospitals employing physicians; and
    - Other groups the Secretary deems appropriate.
  - Savings to be shared based on actual costs compared to the benchmark set by the Secretary.
  - Allows the Secretary discretion in implementing a partial capitation model for ACOs.
PPACA Criteria for ACOs

- Agree to become accountable for overall care of assigned Medicare fee-for-service beneficiaries
- Enter into 3-year agreement with HHS
- Have a formal legal structure that will allow the organization to receive and distribute payments to participating providers
- Include primary care physicians for at least 5,000 Medicare fee-for-service beneficiaries
- Have arrangements in place with sufficient specialist physicians
- Have in place a leadership and management structure including clinical and administrative systems
- Define processes to promote evidence-based medicine, report on quality and cost measures, and coordinate care
- Demonstrate patient-centeredness
Brookings/Dartmouth Key ACO Criteria (private pay)

- The ACO can provide or manage the continuum of care for patients as a real or virtually integrated delivery system.
- The ACO is of sufficient size to support comprehensive performance measurement and expenditure projections.
- The ACO is capable of internally distributing shared savings and prospectively planning budgets and resource needs.
• **Sec. 3023. National Pilot Program on Payment Bundling.**
  - Creates a voluntary pilot program implementing bundled payments surrounding hospitalizations in order to improve coordination, quality and efficiency of care.
  - To be established by January 1, 2013.
  - Can be expanded if it is found to improve quality and reduce costs.
  - Bundle to include acute, inpatient hospital services, physician services and post-acute services for episode of care beginning 3 days prior to hospitalization and 30 days post-discharge.
Other PPACA ACO-Related Provisions

- **2010**
  - Section 6301: Patient-Centered Outcomes Research
  - Section 4201: Community Transformation Grants
  - Section 3027: Extension of Gainsharing Demonstration
  - Section 2705: Medicaid Global Payment System Demonstration
- **2011**
  - Sections 3006: Plans for Value-Based Purchasing Programs for Skilled Nursing Facilities, Home Health Agencies and Ambulatory Surgical Centers
  - Section 10333: Community-Based Collaborative Care Networks
Other PPACA ACO-Related Provisions

• 2012
  – Section 3001: Hospital Value-Based Purchasing Program
  – Section 3025: Hospital Readmissions Reduction Program
  – Section 3024: Independence at Home Demonstration Program
  – Section 2706: Pediatric Accountable Care Organization Demonstration Project
  – Section 2704: Demonstration Project to Evaluate Integrated Care Around a Hospitalization
Other PPACA ACO-Related Provisions

• 2014
  – Section 3004: Quality Reporting for Long-Term Care Hospitals, Inpatient Rehabilitation Hospitals and Hospice Programs

• 2015
  – Section 3008: Payment Adjustment for Conditions Acquired in Hospitals
  – Section 3002: Improvements to the Physician Quality Reporting System
Questions for CMS

• How will Medicare beneficiaries be assigned to ACOs?
• How will the ACO benchmarks be set?
• How will savings be allocated between the ACO and Medicare?
• What quality measures will be used?
• Will CMS use partial capitation or other alternative payment methods?
• How will “formal legal structure” and “shared governance” be interpreted?
• Will there be formal rules or guidance relating to ACOs and the Stark, Antikickback, CMP and antitrust laws, among others?
Legal Issues

- Stark, anti-kickback, CMP
- Antitrust
- Corporate practice of medicine
- State regulation of risk transfer
- Quality reporting, auditing and compliance
- How to define clinical integration
- How to distinguish good collaboration from bad
Board Fiduciary Duty and Quality

- Payment changes will reduce reimbursement to hospitals with high readmissions and poor scores on quality measures.
- Increasing focus on quality reporting may result in “fraud and abuse” enforcement against providers making claims to public payers for care deemed substandard.
- Greater quality data reporting and transparency will require oversight, including assurance that reporting is accurate.
Activities in the Marketplace

- Emphasis on primary care
- Providers assessing health plan ownership
- Renewed payer/provider risk arrangement experimentation
- Acute/post-acute arrangements and joint ventures
- Medicaid state waivers
- PHOs, IPAs and clinical integration
- Physician organizations positioning to be ACOs
- Purchaser concern about "big hospital system" ACOs
A Note on the “ACOs and Market Share” Debate

• Recent volley of cross-allegations of who is at fault for price increases
• Aggregation does not equal accountability; but some size and scale is necessary for effective care coordination and quality reporting
• As long as the payment system rewards volume, unit pricing and billable transactions, this issue will be difficult to resolve
• The private sector would benefit from greater payer-provider collaboration and acceleration of the movement to accountable care
• Failure to do so will put more onus on government to regulate prices on both parties and potentially micro-manage contract provisions
• If the promise of accountable care is realized, purchasers, payers, providers and consumers all should benefit
Is Your Organization Ready to Become an ACO? - 10 Questions

• How will developing an ACO benefit the community you serve?
• Do you have the right provider components in place?
• Do you have an organizational and contracting structure that will create the necessary ownership, employment, joint venture and/or network relationships – and sufficient clinical integration – to succeed?
• Does your current board have the right mix of individuals to provide oversight in the accountable care era?
• What is your level of experience with measuring and reporting on quality, cost and outcomes?
Is Your Organization Ready to Become an ACO? - 10 Questions (cont.)

- Do you have sufficient IT infrastructure?
- Have you considered the level of capital and reserves that may be required to manage the financial risk of bundled payments?
- Have you assessed existing or planned provider-payer linkages (through ownership or contract) that might facilitate the integration of payment and delivery and the acceptance of bundled payments?
- Have you explored existing pilot programs or demonstration project opportunities with CMS, state governments or private payers?
- Do you have access to timely information about developments on the Hill, at CMS and at the state level to benefit from opportunities?