EPSTEIN BECKER & GREEN P.C.

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

AHIP 2010 National Policy Forum

March 9, 2010

Douglas A. Hastings
Chair and Partner, Epstein Becker & Green, P.C.
dhastings@ebglaw.com

Yes, but not alone

The Current State the U.S. Health Care System

- 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

The Current State the U.S. Health Care System

"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."

— Atul Gawande, "Testing, Testing," The New Yorker, 12/14/09

The Current State the U.S. Health Care System

- 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”
  - “Accountable care organization” (ACO) means a provider-based organization comprised of multiple providers with a sufficient level of clinical integration to deliver accountable care
  - Both the payment system and delivery system need to change together to achieve accountable care

Payment and Delivery Reform: It's Only a Matter of Time

- There is great consensus in the policy community, in both parties and in both houses of Congress, as to the current problems and the endpoint goals — the challenge is the transition, but it has begun
- Under current proposed federal legislation, both payment and delivery reforms are phased in over time
- Even without comprehensive reform, these changes can be attached to regular budget and Medicare legislation and CMS actions
- States are actively implementing new programs based on accountable care principles
- Private sector accountable care innovations between payers and providers are taking place in a number of locations throughout the country

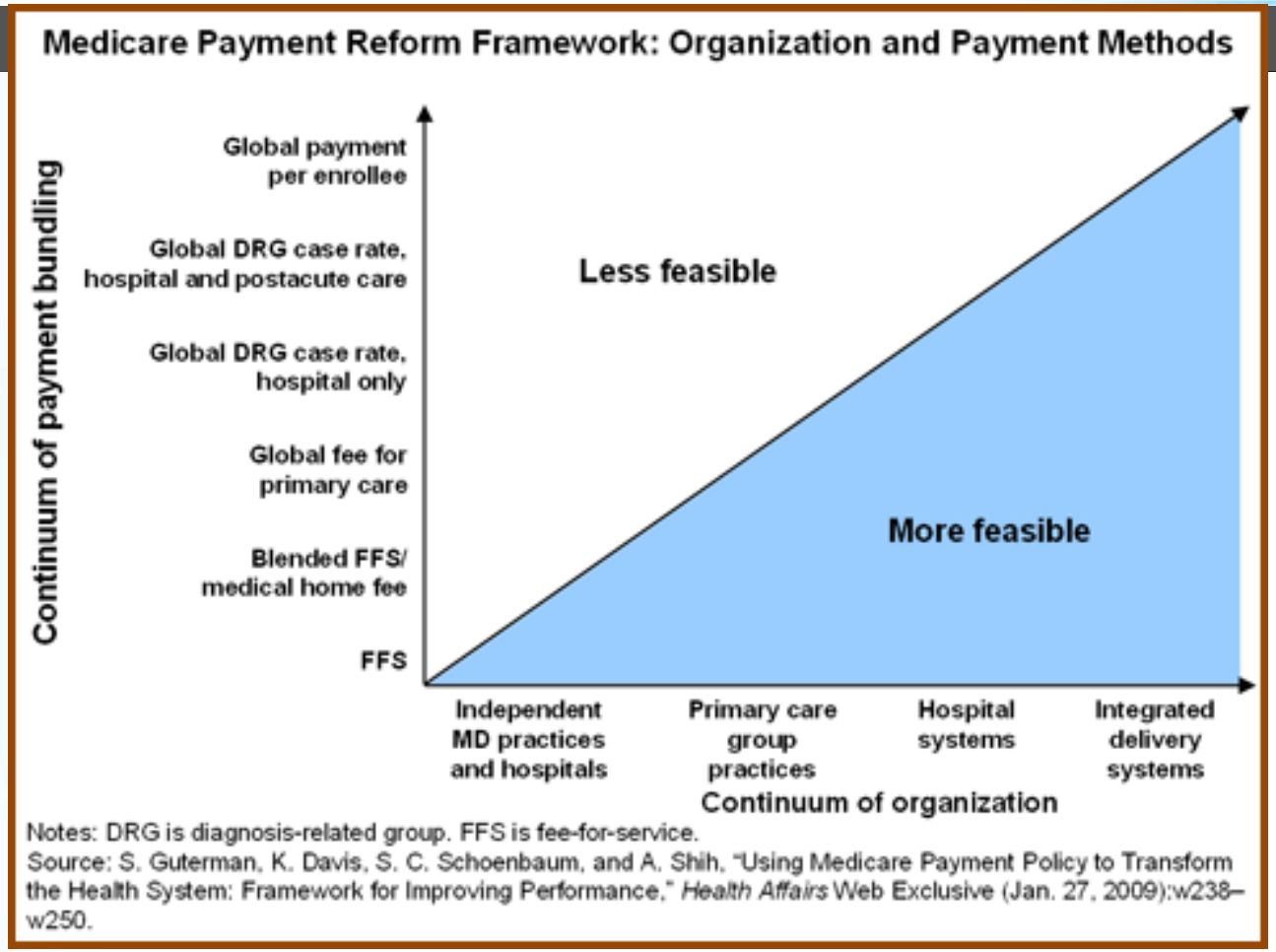
Key Accountable Care Provisions in the Senate Bill

- A hospital value-based purchasing program in Medicare that moves beyond pay-for-reporting on quality measures to paying for hospitals actual performance on those measures
- Recognition of accountable care organizations (ACOs), which would be allowed to qualify for incentive bonus payments; among other requirements, an ACO would have to have a formal legal structure to allow it to receive bonuses and distribute them to participating providers
- Formation at the Centers for Medicare & Medicaid Services of an Innovation Center that would be required to test and evaluate patient-centered delivery and payment models

Key Accountable Care Provisions in the Senate Bill (cont.)

- The establishment of a bundled payment pilot program involving multiple providers to cover costs across the continuum of care and entire episodes of care; if the pilot is successful, it would be made a permanent part of the Medicare program
- Reductions in Medicare payments to hospitals with preventable readmissions above a threshold based on appropriate evidence-based measures

The Accountable Care Framework



"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 – Volume to Value

- Pay for performance
- Inpatient bundling
- Episode of care bundling
- Per enrollee shared savings
- Partial or full global payment per enrollee

ACO Structure Options

- Contractual models
- Partial or virtual integration models
- Fully integrated models

Senate Bill Criteria for ACOs

- Agree to become accountable for overall care for their Medicare fee-for-service beneficiaries
- Have a formal legal structure that would 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 a core group of specialist physicians
- Have in place a leadership and management structure, including with regard to clinical and administrative systems
- Define processes to promote evidence-based medicine, report on quality and cost measures, and coordinate care

Brookings/Dartmouth Key ACO Criteria

- Can provide or manage the continuum of care for patients as a real or virtually integrated delivery system
- Are of sufficient size to support comprehensive performance measurement and expenditure projections
- Are capable of internally distributing shared savings and prospectively planning budgets and resource needs

Legal Issues

- Stark, antikickback, CMP
- Antitrust
- HIPAA, corporate practice, other
- State regulation of risk transfer
- How to define clinical integration
- How to distinguish good collaboration from bad

A Note on the Antitrust Debate

- Recent volley of cross-allegations of who is at fault for price increases
- Aggregation does not equal accountability
- 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

In Search of Accountable Care – Part II

- 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 Benefit of Pilots and Demonstrations

"The history of American agriculture suggests that you can have transformation without a master plan, without knowing all the answers up front…Transforming health care everywhere starts with transforming it somewhere."

— Atul Gawande, "Testing, Testing," The New Yorker, 12/14/09

Conclusion

- Payment and delivery reform is the pathway to improving quality, bending the cost curve and, ultimately, paying for greater access
- Federal leadership would be extremely helpful, but the private sector needs to move forward regardless
- Payers and providers need to work together more than ever, and they ignore this imperative at their peril
- Suggestion: AHIP-sponsored laboratory for accountable care
  - Support a series of pilots/demonstrations/implemented arrangements that highlight collaborative payer-provider efforts that achieve accountable care goals and facilitate the necessary transition