Accountable Care Organizations: The Practical Reality

BNA Webinar

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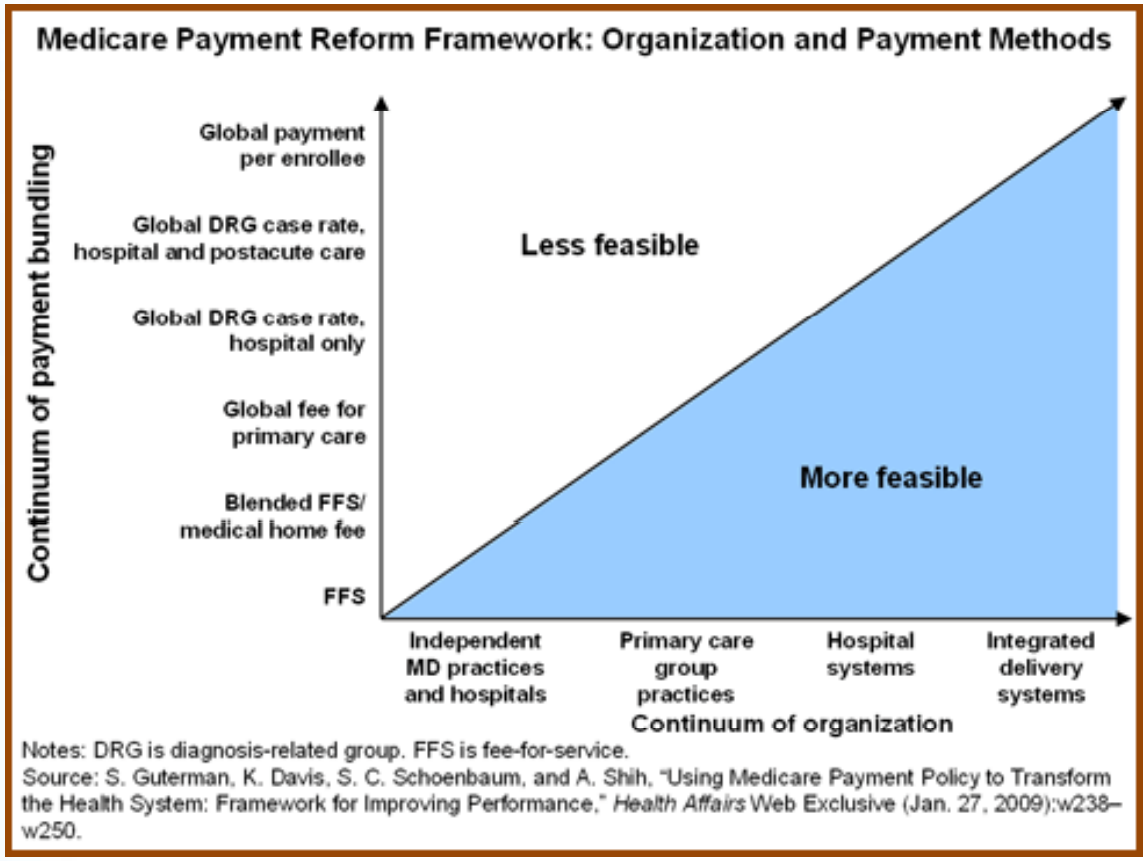
The Case for Payment and Delivery Reform

- 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

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”
  - “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

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

PPACA Accountable Care Organization Provision

- **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 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.
  - Allows the Secretary discretion in implementing a partial capitation model for ACOs.
  - Prohibits any additional program expenditures; incentive payments to an ACO under this provision must be funded from savings generated by the ACO.

PPACA 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

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
  - Section 3011: National Strategy for Improvement in Health Care
  - Section 3021: Establishment of Center for Medicare and Medicaid Innovation within CMS
  - 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

- 2013
  - Section 3023: National Pilot Program on Payment Bundling
- 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 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


CARILION CLINIC
Briggs W. Andrews, Esq.
Senior Vice President & General Counsel

Carilion Clinic Profile

- Eight hospitals – from critical access to tertiary care (Level One Trauma Center)
- 525 FTE physicians (140 primary care) and 125 mid-level practitioners
- 1 million people in the service area with 600,000 in the primary service area
- Converting from a hospital system with employed physicians to a physician led clinic with hospitals
- Epic EMR being implemented across the system
- Recently opened a large multi-specialty group clinic building
- ACO pilot project with Brookings and Dartmouth and the development of medical homes

Carilion Clinic Vision

- Care integration with excellent outcomes
- Coordinated and planned care
- Efficient access to care
- Lower cost of care
- Population management
- Chronic disease management
- Physician leadership with accountability

Golden Living

David C. Beck, Esq.

Senior Vice President & Chief Legal Officer

Golden Living

- Golden Living is one of the largest providers of healthcare services in the United States.
- Golden Living companies operate skilled nursing and assisted living facilities, provide rehabilitation therapy, hospice care, home health services and healthcare staffing services.
- The Golden Living family of companies include Golden Living Centers, Aegis Therapies, AseraCare Hospice and Home Health, and 360 Healthcare Staffing.
- There are more than 300 Golden Living Centers in 21 states. Golden Living also offers assisted living services at more than 40 locations.
- Golden Innovations companies partner with more than 1,000 nursing homes, hospitals and other health care organizations in 37 states and the District of Columbia.
- Collectively, the Golden Living family of companies has more than 40,000 employees who provide quality healthcare to more than 60,000 patients every day.

Connecticut Children's Medical Center

Ann G. Taylor, Esq.

Senior Vice President & General Counsel

Connecticut Children's Medical Center

Connecticut Children's Medical Center in Hartford, CT is Western New England's Only Free-Standing Academic Medical Center Dedicated Exclusively to Children

- ✶ Opened in 1996 and now employs more than 2,000 people
  - ✶ Operates 147 inpatient beds including 32 bassinets

- The Connecticut Children's Specialty Group is a wholly owned subsidiary of the medical center and operates the full spectrum of outpatient subspecialty services.
- In 2009, Connecticut Children's cared for more than 270,000 children including 35,000 primary care visits, 51,000 emergency department visits, and 9,800 surgeries.
- In addition to our main campus in Hartford, Connecticut Children's offers services in 20 other cities and towns across the state including our ten partner hospitals.

Connecticut Children's Medical Center: Provides Critical Access for Vulnerable Children

- Our primary care clinic is a Federally Qualified Health Center that is owned by Charter Oak Health Center, but operates within our walls.
- Connecticut Children's is the Pediatric Department for the University of Connecticut School of Medicine.
- Children's hospitals have a unique relationship with public payers.
  - More than 50% of our inpatient care, 65% of our emergency department care, and 90% of our primary care is devoted to children who rely on Connecticut's HUSKY Program (Medicaid + the Children's Health Insurance Program).
  - We are projected to lose $21 million in 2010 caring for HUSKY-covered children.
  - We receive virtually no Medicare funding.

Questions for the Panel

Question #1

Do you own/employ all of the provider components you believe that you will need to function successfully as an ACO? If not, how will you acquire/contract for the additional components?

Question #2

Do you see legal barriers to ACO development that you believe should be addressed in regulations or further legislation?

Question #3

Is your organization/ACO prepared to take on risk arrangements? How will these differ from the efforts of the 1990's?

Question #4

Has the evolution of “accountable care” affected the role of your Board or the way they oversee organizational accountability?

Question #5

Any comments on private payer activities related to ACOs and the future relationship between public sector and private sector payment practices?