Constructing Accountable Care Organizations: Observations at the Nexus of Policy, Business and Law

Health Insights

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The Case for Payment and Delivery Reform

- **The Problem:**
  - Fragmented Care
  - Uneven, Unsafe Practices
  - Unsustainable Costs

"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

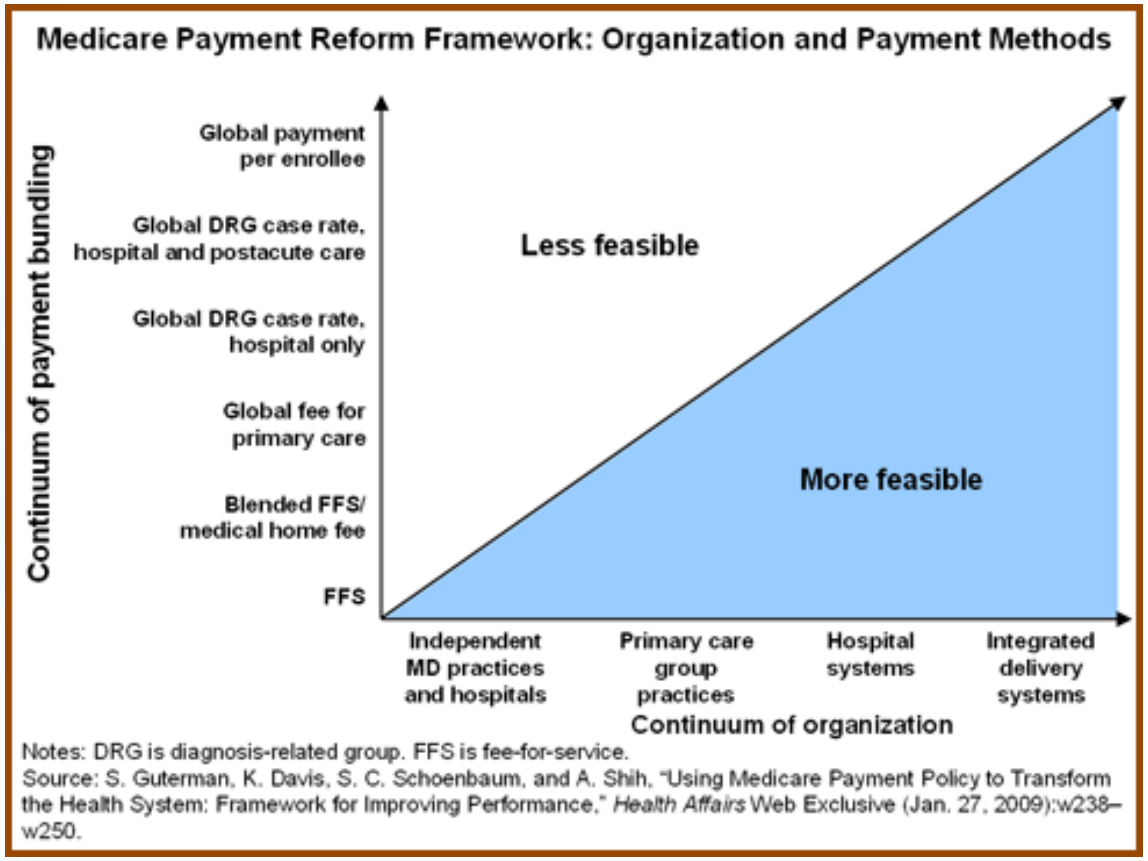
The Case for Payment and Delivery Reform

- **The 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 (in both the public and private sectors) need to change together to achieve accountable care

In Search of Accountable Care – Part II

- Why might ACOs work now when similar concepts did not in the 1990s?
  - There is greater recognition of the urgency of the cost and quality problems
  - The applicability of evidence-based medicine is 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 have shown promise

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

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 on 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

The Benefits of Pilots and Demonstrations

"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."

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

ACA Accountable Care: Innovation Opportunities

- **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

ACA Accountable Care: Innovation Opportunities

- **Sec. 3022. Medicare Shared Savings Program.**
  - Directs the Secretary to create a shared savings program by January 1, 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

Section 3022 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 sufficient 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

ACA Accountable Care: Innovation Opportunities

- **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

Questions for CMS Related to the ACO Program

- How will “formal legal structure” and “shared governance” be interpreted?
- How will Medicare beneficiaries be assigned to ACOs?
- How transparent will the ACO-patient relationship be?
- 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 this program relate to the value-base purchasing program?
- Will there be guidance to states regarding the potential regulation of provider risk sharing?

ACO Legal Issues

- Stark, anti-kickback, CMP
- Antitrust
- Exempt organization tax law
- Corporate practice of medicine
- State regulation of risk transfer
- Medical liability
- Quality reporting, auditing and compliance

Key Fraud and Abuse and Antitrust Questions

- Do we need a new definition of fraud and abuse?
- Will the Secretary use the waiver authority conferred in the ACA?
- Will federal qualification as an ACO serve as formal legal recognition that the ACO provider components are clinically integrated?
- How will market power issues be resolved?
- October 5 CMS, FTC, OIG, workshop on ACOs

Board Fiduciary Duty and Quality

- Medicare fee-for-service payments are declining
- Payment changes will further reduce reimbursement to hospitals with high readmissions and poor scores on quality measures
- Shift to bundled or global payments will require infrastructure investments
- 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/medical homes/team-oriented care
- Providers reassessing health plan ownership
- Renewed payer/provider discussions – each looking for opportunities to experiment and to determine future role
- Providers looking at demonstrations with their own employees and other self-funded employers
- Acute/post-acute arrangements and joint ventures
- Medicaid state waivers
- PHOs, IPAs and clinical integration are hot topics again
- Physician organizations positioning to be ACOs
- Purchaser concern about ACO market power

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 clinical pathway development, care coordination and 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?
- How do you plan to navigate the transition away from fee-for-service payment and have you considered the level of capital and reserves that may be required to manage the financial risk of bundled and/or global payments?
- Are you assessing provider-payer linkages (through ownership or contract) that would provide experience in new accountable care payment methodologies?
- Are you exploring pilot programs or demonstration project opportunities with CMS, state governments and private payers?
- Do you have access to timely information about developments at CMS, on the Hill and at the state level to benefit from opportunities?