Meeting the Legal and Structural Demands of Accountable Care: Observations at the Nexus of Policy, Business and Law

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hfma maryland chapter
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The Case for Payment and Delivery Reform

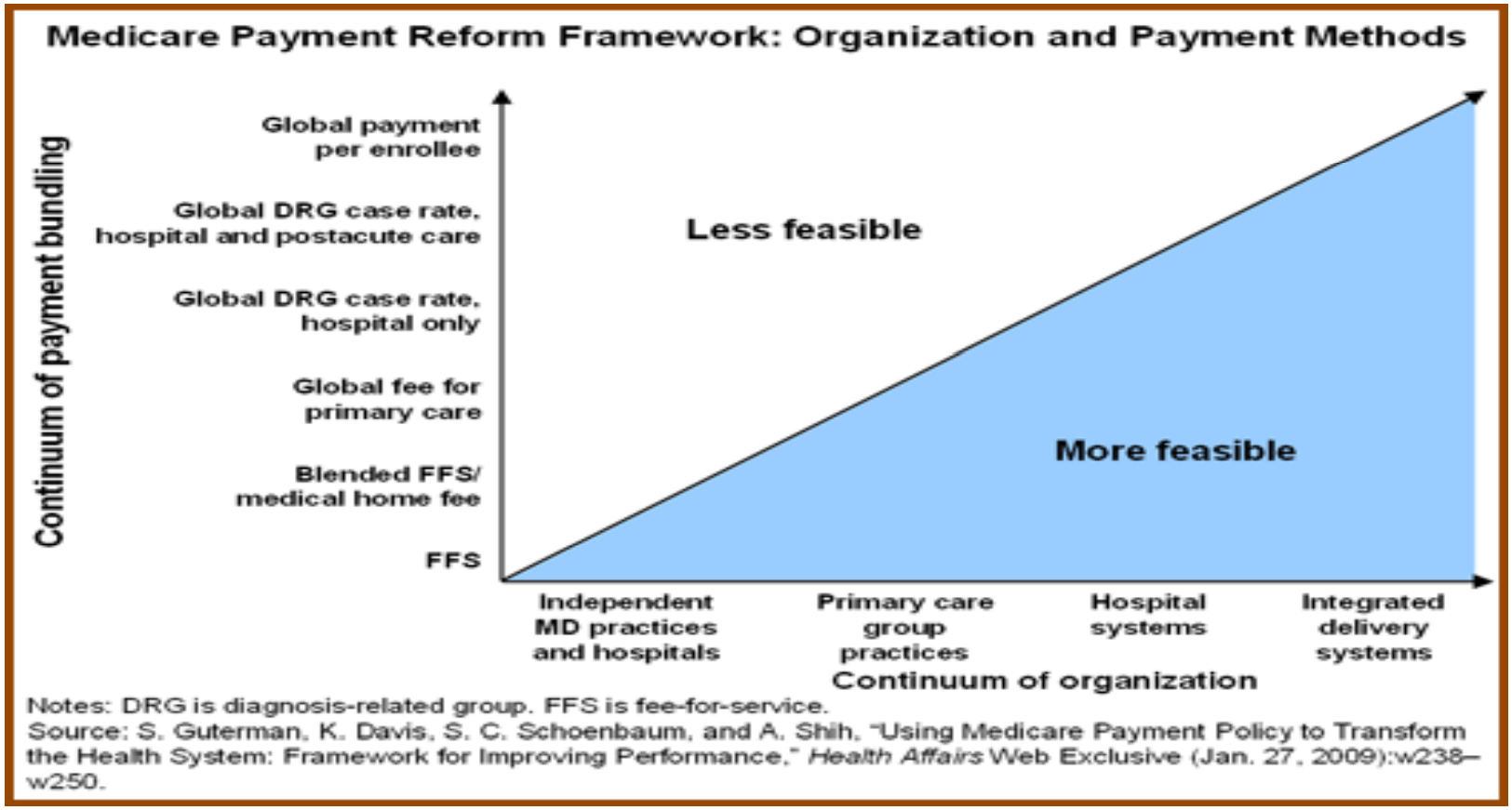
- The Problem:
  - Fragmented care
  - Uneven, unsafe practices
  - Unsustainable costs
- "Our fee-for-service system, doling out separate payments for everything and everyone involved in a patient's care, has all the wrong incentives: it rewards doing more over doing right, it increases paperwork and 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
- Quality = Care that is safe, effective, effective, patient-centered, timely and equitable

— Institute of Medicine, Crossing the Quality Chasm, 2001

The Case for Payment and Delivery Reform (cont.)

- 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
  - There is widespread agreement as to the current problems and the end goals – the challenge is the transition

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

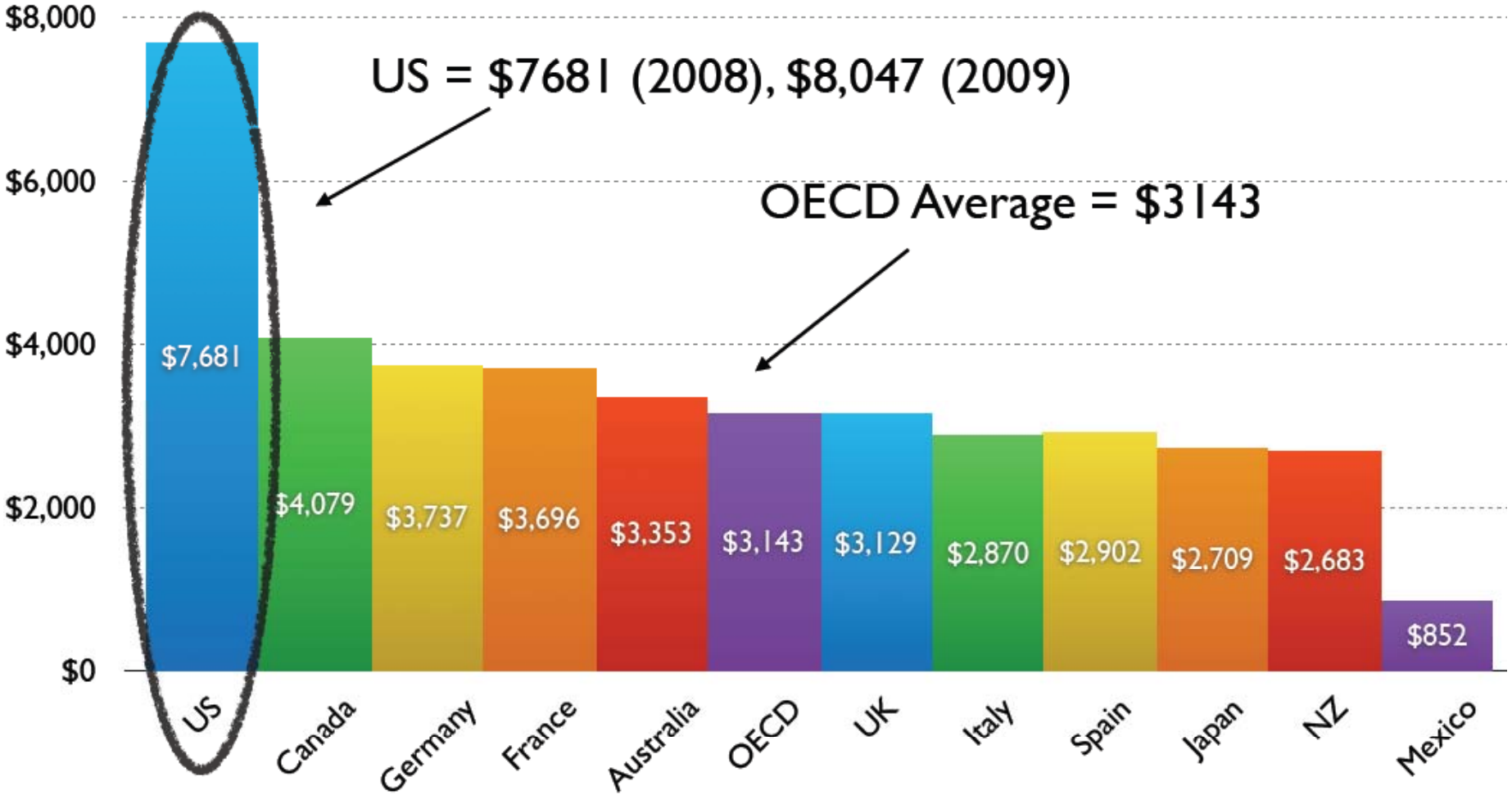
In Search of Accountable Care – Part II

- Why might accountable care 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

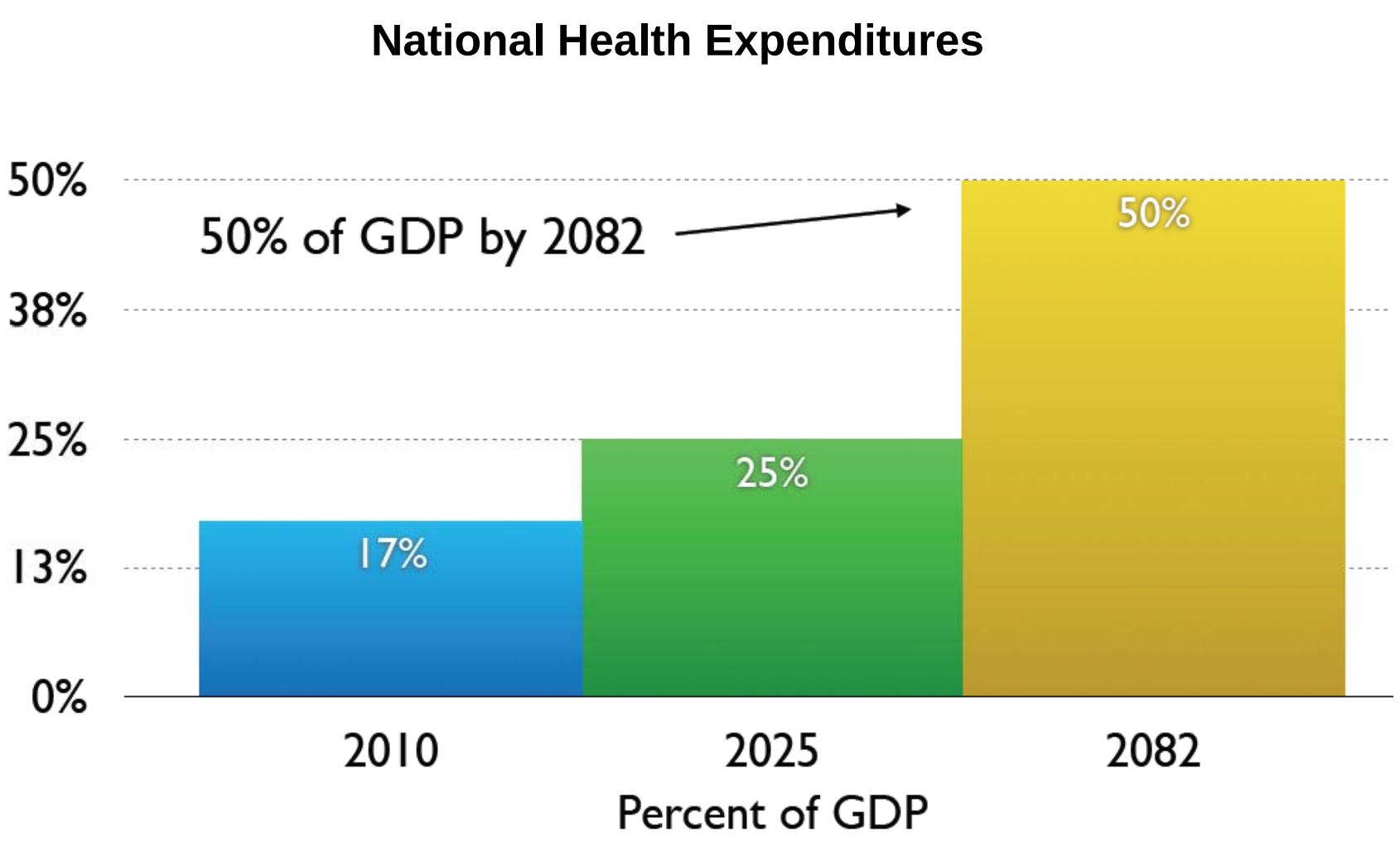
In Search of Accountable Care – Part II

- Potential Pitfalls
  - " Accountable care" and the triple aim get lost in the structural and legal debate
  - The Medicare ACO program is unsuccessful and dominates the focus
  - Patients are left out of the equation
  - Quality measures are not widely agreed upon or accepted
  - It feels too much like managed care and capitation of the 1990s
  - Cost savings are not realized fast enough

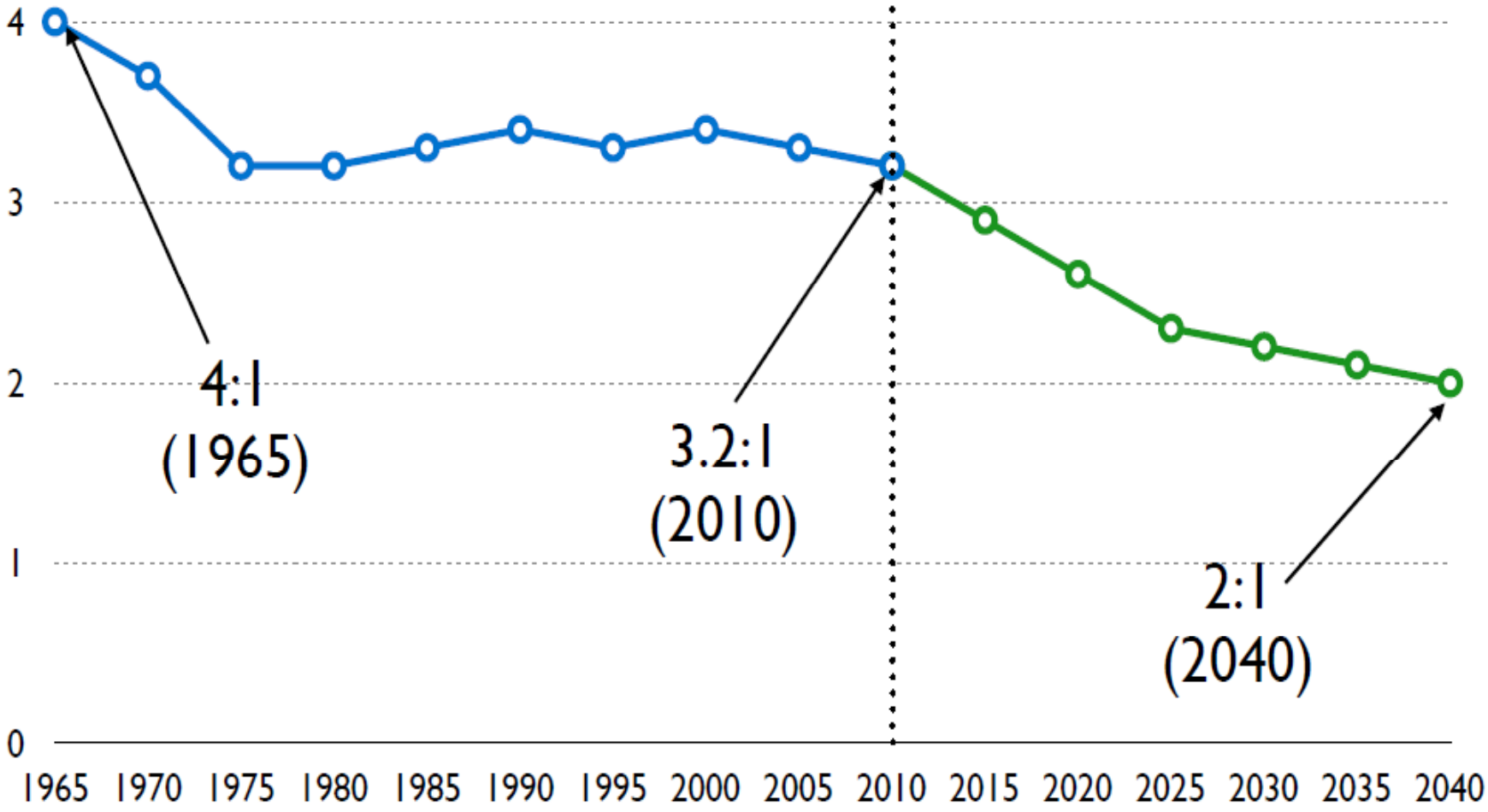
National Health Expenditures per Capita



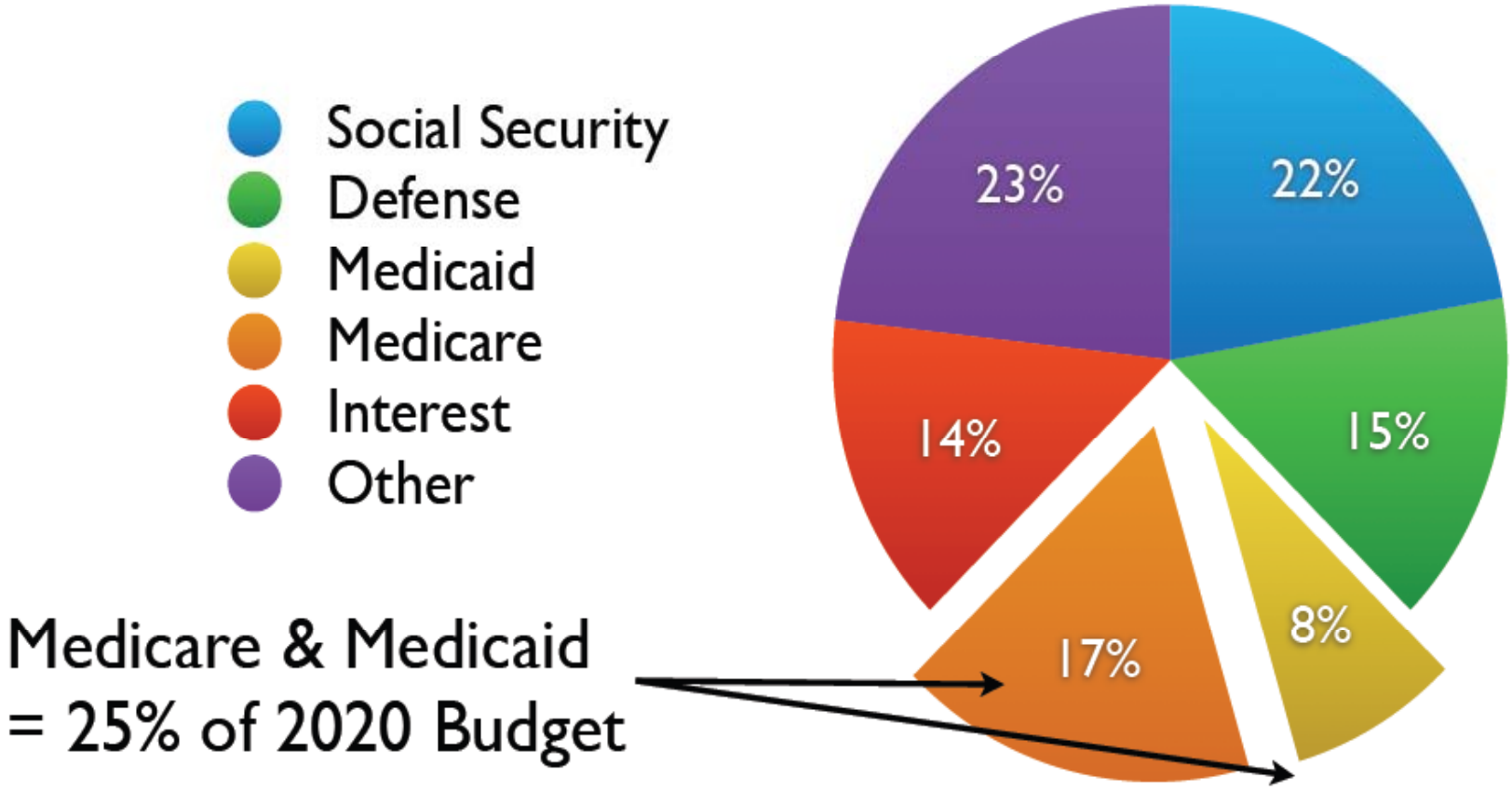
Health Care Projected Growth



Workers to Medicare Beneficiaries



Medicare & Medicaid Spending as a Share of Total Federal Outlays, FY 2020



Medicare & Medicaid
= 25% of 2020 Budget

Budget Control Act of 2011

Supercommittee Members

Democrats	Republicans
• Sen. Murray, Chairwoman	• Rep. Hensarling, Chairman
• Sen. Baucus	• Rep. Camp
• Rep. Becerra	• Sen. Kyl
• Rep. Clyburn	• Sen. Portman
• Sen. Kerry	• Sen. Toomey
• Rep. Van Hollen	• Rep. Upton

Timeline

- Debt ceiling raised until 2013
- By November 23, 2011, the Supercommittee must present a deficit reduction package of at least $1.2 trillion
- By December 23, 2011, Congress must pass the deficit reduction package without amendment (simple majorities required)
- If either deadline is not met, Medicare spending cuts are triggered, but limited to 2%
  - Medicaid and Social Security are protected from the automatic cuts

Framing Issues

- Will the target for deficit reduction be $3 trillion and not $1.2 trillion? — the President's package released September 19 calls for $3+ trillion
- What share should health care be of the package?
- Will the Supercommittee look for additional provider payment cuts?
- The SGR fix also is part of the discussion
- Big dollars potentially are available from Medicare eligibility, Part B premiums and copays/deductibles — can such changes get support from AARP and others on the theory that Exchange coverage is available?
- House Republicans preference is for Medicaid block grant reform, but unlikely to get Senate approval

Transformation Takes Time

"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

The ACA Timeline for Accountable Care

- 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
  - 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

The ACA Timeline for Accountable Care

- 2012
  - Section 3022: Medicare Shared Savings Program
  - 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

The ACA Timeline for Accountable Care

- 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

Inside the Beltway Developments

- Medicare Shared Savings Program Final Rule (or Interim Final) expected soon
- Pioneer ACOs likely to be announced any day
- CMMI Bundled Payment Initiative launched
- White House/CMS Patient Safety Initiative involving hundreds of providers
- Value Based Purchasing Program Regulations released
- Constitutional challenges to the ACA moving through the courts
- Budget/deficit debate — entitlements on the table?
- Will coordinated care become a victim of "Obamacare"?
- House Subcommittee hearings on ACOs
- Atul Gawande's latest article in *The New Yorker* again brings attention to the problems and potential solutions

Activities in the Marketplace

- Providers assessing Medicare ACO participation, both Pioneer and MSSP, and new CMMI bundled payment initiative
- Hospitals purchasing physician practices and expanding contracting networks
- Providers reassessing health plan ownership or acquiring and/or joint venturing medical management capability
- New framework for payer/provider negotiations — each looking for opportunities to experiment and to determine future role
- Payers setting up ACO, bundled payment, medical home, P4P and other value-based payment programs

Activities in the Marketplace (cont.)

- Payers purchasing providers
- Providers looking at demonstrations with their own employees and other self-funded employers
- New acute/post-acute arrangements and joint ventures being developed
- States developing their own value-based payment and ACO programs and passing new related laws
- Many large employers again becoming active in care management for their employees

Fiduciary Challenges and Opportunities in the Accountable Care Era

- Health care provider organizations and the ACOs they form or participate in face a variety of challenges and opportunities in the accountable care era; as fiduciaries, their board members will need to address the following issues, among others:
  - Fee-for-service payments are likely to decline steadily in the years ahead, challenging financial performance;
  - Additional payment changes will further reduce reimbursement to providers with poor scores on quality measures or who evidence inefficiencies such as above-average readmissions;
  - The shift to various forms of pay-for-performance, bundled payments and global or population-based payments, or other value-based reimbursement methodologies, will require infrastructure investments by providers that may or may not be reimbursed, further threatening financial solvency;

Fiduciary Challenges and Opportunities in the Accountable Care Era (cont.)

- On top of those issues, boards are faced with the fact that the increasing focus on quality measurement and reporting may trigger fraud and abuse enforcement against providers making claims to public and private payers for care that is ultimately deemed substandard;
- Greater quality data reporting and transparency will require board oversight to assure that reporting is accurate; compliance plans will need to be enhanced to address these expanded concerns;
- Provider entity boards and ACO boards will need to review their committee structures related to quality in order to ensure that the board or board committee's charter requires attention to effectiveness, efficiency and patient-centeredness in addition to patient safety;

Fiduciary Challenges and Opportunities in the Accountable Care Era (cont.)

- ACO boards and ACO sponsoring organization boards will need to ensure that appropriate and effective management and clinical personnel and protocols are in place to meet CMS, NCQA and other requirements and to achieve the ACO's quality and financial goals; and
- Health systems will need to consider which entity – one that currently exists or one to be formed – will serve as the ACO (including how many ACOs it may want to form or work with); and how to coordinate the ACO board or boards with other boards within the system.

ACO Criteria – Brookings/Dartmouth

- 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
- Three types of payment — simple shared savings, shared savings with risk corridor, partial capitation

Brookings/Dartmouth ACO Model

Steps for Initial ACO Implementation:

- Local providers and payers agree to pilot ACO reform
- ACO provides list of participating providers to payers
- Patients are “assigned” to ACOs (e.g., based on preponderance of E&M codes)
- Actuarial projections about future spending are based on last 3 years of historical data
- Determine/negotiate spending benchmark and shared savings arrangement
- ACO implements capacity, process and delivery system improvement strategies
- Progress reports on cost and quality are developed for ACO beneficiaries
- At year end, total and per capita spending are measured for all patients
- Savings under the benchmark are shared between the providers and payers

ACO Criteria – NCQA

- 2011 Draft Accountable Care Organization Criteria (released October 19, 2010)
  - Program Structure and Operations
  - Access and Availability
  - Primary Care
  - Care Management
  - Care Coordination and Transition
  - Patient Rights and Responsibilities
  - Performance Reporting

Major Regulatory Issues in Payment and Delivery Reform

- Antitrust
- Fraud and Abuse (Stark, Anti-kickback, CMP)
- State regulation of risk transfer
- Quality reporting, auditing and compliance
- Exempt organization tax law
- Privacy
- Corporate practice of medicine

Will CMS' Implementation of the Shared Savings Program Advance the Ball?

- How well do CMS' requirements for ACO structure and governance balance the need for both flexibility and real change?
- Does the way CMS handles provider risk, from both a financial and regulatory perspective, encourage ACO formation and participation in the MSSP?
- Will the nature of the ACO-beneficiary relationship established under the Proposed Rule help avoid another managed care backlash?
- Does the Proposed Rule advance the ball in measuring and promoting value in health care?
- How well has CMS balanced the need to incentivize positive collaboration among providers to form effective ACOs, while also coordinating with the OIG, DOJ, FTC and IRS in connection with their ongoing enforcement of the various laws regulating ACO participants?

Pioneer ACO Model

- The Pioneer ACO model announced by CMMI on May 17 adds a more advanced risk model; CMMI also asked for comments on an Advanced Payment Initiative.
- Key differences from the MSSP:
  - A more advanced financial risk model, including transition to a population-based payment in the third year
  - A requirement that participants have at least 50% of their total revenues derived from outcomes-based contracts by the end of the second year
  - The option of prospective patient attribution
  - Counting certain non-MD providers and specialists for attribution purposes
  - A minimum of 15,000 assigned Medicare beneficiaries (5,000 in rural areas)

Pioneer ACO Model (cont.)

- CMMI indicated that it is interested in 30 ACOs under the Pioneer ACO Model:
  - Applicants required to apply before knowing the substance of the MSSP final rule (although they are given the opportunity to withdraw their application once the final rule is out)
  - An organization cannot be in both programs
  - Interviews conducted in late September
- It will be very interesting in the Fall 2011 time period through the end of 2011 to see how many organizations apply for the Pioneer ACO model, how many are approved and how many others seek to be admitted to the MSSP.
- There is a lot riding on how this plays out — both substantively in terms of advancing the cause of accountable care and as to the perception that Medicare is or is not making a helpful contribution.

CMMI Bundled Payment Initiative

- On August 23, CMMI announced the Bundled Payments for Care Improvement Initiative
- Providers may participate in four different models wherein they receive a discounted price for a defined episode of care
  - LOIs due October 6 for model 1, November 4 for models 2,3 and 4
  - Episodes of care include inpatient stay and/or associated post-acute care
- Models cover acute and post-acute
- Payments are on a retrospective, shared saving basis for models 1,2, and 3 and a prospective basis for model 4
- If the actual payments during the episode are less than the discounted price, the participating organization may gainshare the savings with participating providers; if actual payments exceed the discounted price, the participating organization must remit the difference to CMS
- Applicants are given a fair amount of flexibility as to defining episodes and payment models
- This CMMI initiative is separate from the ACA bundled payment pilot to begin in 2013

Final Thoughts

- Medicare/Medicaid fee-for-service cuts are on the way and inevitable
- SGR ("doc fix") is still unresolved (30% cut in December)
- CMS and HHS are implementing thousands of ACA regulations
- Value-based payments, readmissions and HAC penalties add up to significant potential impact
- The payment and delivery reform train has left the station in commercial markets – in some ways leading Medicare, in some ways following

Final Thoughts (cont.)

- The legal barrier issues are not resolved
- More coordinated and efficiently delivered care, subject to quality measures and transparent reporting, will be required under any future scenario
- The exact best timing for adoption of new payment models and infrastructure development to respond, can only be answered organization by organization, but it is only a matter of time and purchasers will not be patient

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