BNA's
HEALTH CARE POLICY
BNA Employee-Owned Since 1947
VOL. 0, NO. 0 REPORT JANUARY 4, 2010

Health Care Quality

Is Your Organization Ready to Become an Accountable Care Organization? Here Are 10 Questions to Ask

By Douglas A. Hastings

With the Senate bill now passed,[1] and dramatic health care reform—40 years in the making—increasingly imminent, health care providers should be assessing their interest in and capability of participating in what I think can now be called the ''accountable care era.'' As I have previously written,[2] this era follows and builds on the ''quality movement'' of the last decade as well as the physician-hospital integration and ''integrated delivery system'' activities of the last two decades. Now, as a new era dawns, providers have a new, exciting, challenging, and potentially transformational set of opportunities to position themselves to provide care in a more coordinated, efficient and patient-centered way—and get paid for it!

Both the Senate and House versions of health care reform contain significant, and very similar, provisions regarding health care quality, cost efficiency, pay-for-performance, accountable care organizations (ACOs), bundled payments, and related provisions. Among the key provisions are the following:

- 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;
- Revisions to expand and extend quality reporting for physicians and other nonhospital providers;
- A charge to the secretary of health and human services to establish a national quality improvement strategy, which would, among other things, address im-

Hastings is partner and chair, Epstein Becker & Green PC; member, Board on Health Care Services, Institute of Medicine; past president, American Health Lawyers Association; member, BNA's Health Law Reporter Advisory Board. He can be reached at dhastings@ebglaw.com or (202) 861-1807. *The author gratefully acknowledges the assistance of Shawn Gilman, Esq. in the preparation of this article.*

[1] Patient Protection and Affordable Care Act, H.R. 3590, 111th Cong. (2009).

[2] Douglas A. Hastings, ''Health Care Delivery System Reform Provisions in the Baucus Bill: A Substantive Set of Provisions,'' *BNA's Health Care Policy Report*, Vol. 17, No. 38, Sept. 28, 2009; ''Accountable Care Organizations and Bundled Payments in Health Reform: Observations and Implications,'' *BNA's Health Care Policy Report*, Vol. 17, No. 42, Oct. 26, 2009; ''In Search of Cooperation—Part II,'' *Modern Healthcare* (Dec. 3, 2009); ''Freshmen Democrats' Amendment Package Strengthens Payment and Delivery Reforms in Senate Reform Bill,'' *BNA's Health Law Reporter*, Vol. 18, No. 47, Dec. 10, 2009.

 ISSN 1068-1213

provements in patient safety, health outcomes, disparities, effectiveness, efficiency, and patient-centeredness;

- Recognition of 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;
- 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; and
- Extension of the current gainsharing demonstration.

While we will need to see the outcome of the House-Senate reconciliation for final language, there is unlikely to be material changes made to these key quality-related provisions. Thus, it is not too soon to be planning accordingly now.

All kinds of providers are in a position to participate—hospitals and health systems, physicians and physician groups, ambulatory surgical centers and other outpatient centers, post-acute care providers, federally qualified health centers (FQHCs) and others. While the new legislation will relate to the federal payment programs, private payers are developing similar new payment systems, and federal reforms will further accelerate private sector efforts. Asking the following questions now, and taking the appropriate actions, is a prudent step for all interested providers.

1. How will developing an accountable care organization benefit the community you serve?

ACOs are part of a larger response to the need to develop safer, more effective, efficient, timely, equitable, and patient-centered care through better coordination among providers across episodes of care and patient populations. This goes to the heart of the core mission of health care delivery. Each ACO, and each of its provider participants, will need to have a clear vision of how the ACO's structure, provider components, information technology (IT) platform, and other elements will, indeed, produce better health care for the community and patients served. Such a clear vision, with a workable plan to achieve it, will result in more likely participation in federal pilots, new private payer programs and success in the marketplace, along with the principal goal of providing ever better care.

2. Do you have the right provider components in place?

We will need to wait for the outcome of the reconciliation of the Senate and House bills to know the full extent of the specific federal programs to be developed and what specific requirements there may be as to necessary provider components. But at the very least, it appears clear that, to effectively coordinate care across the provider continuum, a hospital component will be required, along with the appropriate mix of primary and specialist physicians to provide the services required. The Senate bill requires that an ACO seeking to participate in the Medicare Shared Savings Program must, among other requirements, become accountable for the quality, cost, and overall care of the Medicare fee-for-service beneficiaries assigned to it; commit to a minimum of three years of participation as an ACO; include sufficient primary care physicians to coordinate the care of the (at minimum) 5,000 Medicare beneficiaries assigned to it; and have a legal structure that would allow the ACO to receive and distribute shared savings payments it may receive.[3]

Other delivery system reform provisions in the bills, in addition to ACO formation, have accountable care elements. For instance, the Senate bill requires participants in two new patient care projects, the Demonstration Project to Evaluate Integrated Care around a Hospitalization[4] and the Pilot Program on Payment Bundling,[5] to include post-acute care providers. Also, the House bill includes a Post-Acute Care Services Payment Reform Plan and Bundling Pilot Program with the goal of improving the outcome for Medicare beneficiaries by reducing the need for readmissions to hospitals from post-acute care providers.[6] And, in the Senate bill, FQHCs receive a significant increase in funding,[7] a prospective payment system,[8] and annual market basket updates.[9]

3. 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?

While large integrated delivery systems, clinics and academic medical centers may be in a strong position to qualify and succeed as an ACO, not every physician, hospital, and other provider is in a large integrated delivery system today. The whole point of coordinated care is to bring smaller, independent providers as well as large single-entity providers together to offer more effective and efficient evidence-based care. One of the leading proponents of ACOs has asserted this from the beginning.[10] The accountable care era offers the opportunity for diverse providers to come together and succeed in the pilots envisioned by this legislation if they can develop the level of structural and clinical integration necessary.[11] Even large integrated delivery systems will need to connect with others they do not own—e.g.,

---

[3] Patient Protection and Affordable Care Act at § 3022(b)(2).

[4] *Id.* at § 2704.

[5] *Id.* at § 3023.

[6] Affordable Health Care for America Act, H.R. 3962, 111th Cong. § 1152 (2009).

[7] Patient Protection and Affordable Care Act at § 5601.

[8] *Id.* at § 5502(b).

[9] *Id.* at § 5104.

[10] Elliott S. Fisher, Douglas O. Staiger, Julie P.W. Bynum, and Daniel J. Gottlieb, ''Creating Accountable Care Organizations: The Extended Hospital Medical Staff,'' 26 *Health Affairs* 1 (2007).

[11] Douglas A. Hastings, ''Accountable Care Organizations and Bundled Payments in Health Reform: Observations and Implications,'' *BNA's Health Care Policy Report*, Vol. 17, No. 42, Oct. 26, 2009.

   ISSN 1068-1213

independent physicians, community hospitals, post-acute care providers and FQHCs—to fully reach the potential envisioned in the bundled payment provisions of the legislation.[12] Depending upon what, if any, legal protection is provided by regulation as these reforms are implemented,[13] providers will need to be sufficiently integrated with each other from a financial and operational standpoint to withstand potential legal scrutiny under the antitrust, anti-kickback, and Stark laws, among others.[14] Clinical integration should be under way now.

4. Does your current board have the right mix of individuals to provide oversight in the accountable care era?

Effective board leadership and oversight of health care companies is critically important and in many ways daunting. Much has been written on this topic in recent years.[15] While accountable care offers much opportunity for providers to transform existing methods of health care delivery, it also challenges leadership in new ways. Quality oversight will increase in importance and complexity as providers seek to qualify as ACOs and comply with ACO requirements. The legislation is full of references to the public reporting of data related to provider performance on applicable measures as well as to overall patient health. There will be legal implications related to the process to apply and qualify as an ACO as well as the formula by which ACOs will be paid. All of this will expand the compliance obligations of ACOs and their participating providers and, presumably, failure to properly follow the ACO program rules, including the reporting requirements, will have legal consequences. Behavior determined to have had the intent to avoid reporting or to misreport presumably will have very serious consequences.

Thus, these new opportunities presented for enhanced revenues under Medicare will come with increased compliance responsibility and also will dovetail with the increased regulatory focus in recent years, at both the federal and state level, related to quality of care. These new responsibilities of ACOs will require additional skills and areas of focus at the board level. To the extent some ACOs are virtual, the board leadership issues, as well as those of management, are likely to be even more complex and require careful attention. Accordingly, health care organizations interested in becoming or participating in federal ACOs, or similar private sector initiatives, will need to review and possibly restructure their governing bodies to provide appropriate leadership and oversight.

5. What is your level of experience with measuring and reporting on quality, cost, and outcomes?

The best answer is: the more the better. There will be time to see what specific measures the new legislation will require ACOs to use. But no doubt the initial measures will include many of those already in use, such as the measures promulgated by the National Quality Forum. The legislation also calls for the development of many new measures and is replete with increased reporting and transparency requirements.[16] Providers interested in ACO participation will need to be carefully following the regulatory adoption of measures, developing systems that can do the measurement and expanding, or at least beginning to implement, quality programs.

6. Do you have sufficient IT infrastructure?

It is difficult to know what is really sufficient, but IT is a critical element of success, yet an elusive goal. The ability to develop and manage clinical integration and quality data will be necessary, in addition of course to sufficient and compatible electronic health records. Getting to an appropriate level involves a certain amount of trial and error. In addition, ACOs will have to face the challenge of legacy systems and incompatible and overlapping systems among multiple providers. There is tremendous focus on this need at the federal level.[17] There remains development time in light of the phased implementation schedule laid out in the legislation,[18] but ACOs will need to commit significant time and resources to this aspect of their operations.

7. Have you considered the level of capital and reserves that may be required to manage the financial risk of bundled payments?

This question, and the answer, will influence the scope of bundling that any particular ACO should seek to obtain. Indeed, absent the appropriate capability in this regard, any particular ACO should focus on the bonus payment opportunities in a fee-for-service setting

---

[12] Patient Protection and Affordable Care Act at § 3023.

[13] There has been much discussion in policy circles and on Capitol Hill of creating new safe harbors or directly removing regulatory barriers, but no such legislative language has been forthcoming. A proposed study by the Government Accountability Office of these barriers originally was included in amendments proposed by several freshman Democratic senators, but that proposal was removed.

[14] *See, e.g.*, Douglas A. Hastings, ''Addressing the Legal Issues in Achieving Quality and Cost Efficiency: The Need for a Rebuttable Presumption,'' *BNA's Health Law Reporter*, Vol. 18, No. 22, June 4, 2009; (a specific assessment of these legal issues, the benefits of clinical integration and a proposed legislative solution).

[15] *See, e.g.*, Douglas A. Hastings, Lewis Morris, and Michael W. Peregrine, *The Health Care Director's Compliance Duties: A Continued Focus of Attention and Enforcement*, The Governance Institute (2009). In particular, please note the third article, ''Corporate Responsibility and Health Care Quality: A Resource for Health Care Boards of Directors.''

[16] *See, e.g.*, Patient Protection and Affordable Care Act at § 3305 (quality reporting by cancer hospitals); *Id.* at § 3023 (quality reporting under National Pilot Program on Payment Bundling); Affordable Health Care for America Act at § 1461 (reporting by hospitals and ASCs on health care associated infections).

[17] *See, e.g.*, American Recovery and Reinvestment Act of 2009, H.R. 1, Title XIII: Health Information Technology for Economic and Clinical Health Act (HITECH Act).

[18] *See, e.g.*, Patient Protection and Affordable Care Act at § 3022 (Medicare ACO Program starting no later than Jan. 1, 2012); *Id.* at § 3023 (National Pilot Program on Payment Bundling starting no later than January 1, 2013); and Affordable Health Care for America Act at § 1152 (Post Acute Care Bundling Pilot Program starting no later than Jan. 1, 2011).

as outlined in both the House and Senate bills.[19] Just as there is a continuum of degrees of clinical integration among providers, there is a continuum of degrees and types of bundled payments, ranging from hospital-physician bundling for inpatient care, to pre-acute and post-acute care bundling for a particular episode, to a global capitation payment for all care given to a patient population. The movement to bundled payments raises the question, visited at various times over the last 40 years, of what it takes for a provider organization to accept insurance-type risk. Presumably, another extensive round of legislation and regulation will be required over the next decade to clarify this issue once again. In the past, the regulatory tendency has been to follow the state insurance regulatory model and require providers taking capitation to look very much like HMOs, especially with regard to capital and reserves. In any event, ACOs and their provider components will need to be considering their financial wherewithal to take this kind of risk and the information they will need to manage it, regardless of the regulatory requirements that evolve.

8. 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?

The Senate bill contains provisions added by a group of freshman Democratic senators[20] that promote Medicare adoption of private-sector innovations that are working well. The private sector already has begun a new round of bundling programs in certain markets. To play in this new (or shall we say, ''trying again with new measures and resources'') world of bundled payments, ACOs may need payer partners. Getting those relationships in place should be under consideration now. This need relates directly to Question 7 above. Some providers are corporately linked with payer organizations today, such as Intermountain Health Care, Kaiser and Geisinger. Most are not. Smooth data sharing and collaboration between the financing function and delivery function will be essential to ACOs involved in bundling.

9. Have you explored existing pilot programs or demonstration project opportunities with CMS, state governments or private payers, even as you await final passage of the federal health reform bill?

A great deal of activity in the accountable care era already is taking place.[21] There are new pilot programs and demonstration projects currently available and others awaiting creative and innovative ACOs to seek in a proactive way. The new legislation provides lead time to implementation of the potentially transformational payment and delivery system reforms contemplated.[22] But two or three years—even five—will go by quickly given the complexity of the issues and the implementation challenges.

10. Do you have access to timely information about developments on the Hill, in the Administration, at CMS, and at the state level to benefit from opportunities as reform implementation rolls out?

The passage of a final bill by Congress is the beginning, not the end. There will be many subsequent amendments and presumably a massive amount of regulation rolling out over the upcoming months and years. Monitoring these developments, and even influencing them in a focused way as they may affect particular providers, the ACOs they participate in, and payers they may work with, is worth considering and acting on. It is certainly possible through direct regulatory contacts, including at CMS and the relevant state agencies, to come to a better understanding, at a minimum, or possibly a better regulatory outcome, by engaging actively in the process, while also preparing to comply with the laws and regulations ultimately promulgated.

Conclusion

The real promise of the new legislation, which is the significant long-term opportunity to improve health care quality and ''bend the cost curve'' through the ACO, bundled payment and related provisions, remains under-reported in the press and not well understood by the general public. Yet these provisions have been part of both the House and the Senate bills from the start and have undergone little change through the process, other than some strengthening. In my view, the effectiveness of the implementation of these payment and delivery system reforms, which will take strong dedication, innovation, and cooperation among private sector health care organizations—and collaboration between the public and private sectors—will be a significant determinant of not only the shape of our future health care system, its quality, and its cost, but also the shape of the U.S. economy. How health care providers answer the above questions and approach this accountable care era is that important.

[19] Patient Protection and Affordable Care Act at § 3022(d)(2); Affordable Health Care for America Act at § 1301(c).

[20] *See, e.g.,* Patient Protection and Affordable Care Act Manager's Amendment at §§ 3006, 3014, 3021, 3022, 3023, and 3401(f); Douglas A. Hastings, ''Freshmen Democrats' Amendment Package Strengthens Payment and Delivery Reforms in Senate Reform Bill,'' *BNA's Health Law Reporter*, Vol. 18, No. 47, Dec. 10, 2009.

[21] *See, e.g.,* Brookings-Dartmouth ACO Pilot Project; Robert Wood Johnson Foundation Prometheus Payment Model; CMS/Premier Hospital Quality Incentive Demonstration; CMS Acute Care Episode Demonstration; and CMS Physician Group Practice Demonstration.

[22] *See, e.g.,* note 18.

   ISSN 1068-1213