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# Accountable Care Organizations and Bundled Payments in Health Reform: Observations and Implications

By Douglas A. Hastings

As we reach the next phase of the health care reform debate, it is reasonable to expect that if a bill is passed, it will include provisions related to accountable care organizations (ACOs) and bundled payments. The Senate Finance Committee bill (S. 1796), as amended,[1] contains the following provisions in this regard:

**Accountable Care Organizations**

- ACOs eligible for bonuses beginning in 2012 are defined as group practices, networks of practices, joint ventures between hospitals and practitioners, hospitals employing practitioners, among others the secretary determines appropriate.
- Interested organizations may voluntarily seek to meet the criteria, obtain recognition as an ACO, and qualify for an incentive bonus.
- The criteria set forth in the chairman's mark require that potential ACOs:
  - — Agree to become accountable for the overall care for their Medicare fee-for-service beneficiaries.
  - — Agree to a minimum three-year participation.
  - — Have a formal legal structure that would allow the organization to receive and distribute bonuses 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.
  - — Demonstrate to the secretary of HHS that it meets patient-centeredness criteria determined by the secretary, such as use of patient and caregiver assessments or the use of individualized care plans.
- A formula related to total per beneficiary spending (for those Medicare beneficiaries assigned to an ACO) would be the basis for possible shared savings payments to the ACO, which would then distribute such savings among its contributing providers.

**Bundled Payments**

- The secretary of HHS would be required to develop, test and evaluate alternative payment methodologies through a national, voluntary pilot program that is designed to provide incentives for providers to coordinate patient care

[1] *America's Healthy Future Act of 2009*, September 2009. For more details on the full set of delivery system reform provisions on the Senate Finance Committee bill, see D.A. Hastings, "Health Care Delivery System Reform Provisions in the Baucus Bill: A Substantive Set of Provisions," *BNA's Health Law Reporter*, Vol. 18, No. 37 (18 HLR 1270, 9/24/09).

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across the continuum and to be jointly accountable for the entire episode of care for designated conditions starting in 2013.

- The secretary would be required to determine which Medicare statutory provisions and related regulations would be appropriate to waive in order to conduct the pilot program (including waiving the anti-kickback and civil monetary penalty statute after consultation with the inspector general).
- The secretary is instructed to select eight conditions to be included in the pilot.
- The bundled payment for each of the eight selected conditions would be based on the average hospital, physician, and post-acute care payments made over the hospitalization period per patient.
- Payments could be made to a single provider or multiple providers, but an acute care hospital must be included.
- If the secretary finds that the pilot program results in significant improvements in quality and outcomes and reductions in cost, then the secretary would be required to submit an implementation plan to Congress in FY 2016 with recommendations regarding making the pilot a permanent part of the Medicare program in FY 2018.

The House tri-committee bill has similar provisions for both bundled payments and ACOs. In addition, on the House side, there is specific reference to partial capitation payments to ACOs. The House bill also gives the secretary of HHS the ability to waive other provisions of the Social Security Act in order to facilitate the development of ACOs for Medicare. While these provisions are variously in the form of pilot programs, studies or requirements that become effective in future years, they constitute a clear and fairly comprehensive approach to payment and delivery system reform with significant implications for health care providers and, to an extent, private sector payers as well.

## How We Got Here

A multi-year set of developments related to health care quality and integrated delivery systems has brought us to this point. Certainly, the national debate over the Clinton health plan and the integrated delivery developments of the 1990s, many of which failed but many of which did not, was a key stage in the process. Then, the seminal publications by the Institute of Medicine of *To Err is Human*[2] in 1999 and *Crossing the Quality Chasm*[3] in 2001 brought evidence-based medicine out of academia and into the mainstream and helped prompt a ''quality'' movement that is reaching a critical mass crescendo as a major health care insurance overhaul is being debated. Further important work and encouragement by the IOM, the Commonwealth Fund, the National Quality Forum, the Dartmouth Institute for Health Policy, the Brookings Institution, the Institute for Health Care Improvement, the Medicare Payment Advisory Commission and many others has contributed to this movement in the eight years since the publication of the *Chasm* report.

Meanwhile, some private payers have begun to work with providers to develop the next generation of bundled payment/capitation arrangements with ACO-like provider organizations of various sizes and structures. Many more are in the works. If a reform bill passes, it will accelerate these developments.

The scientific and policy basis for these increasingly rapid changes is the recognition that evidence-based measures can define proper use by identifying overuse, underuse and misuse, and thereby, through measurement and reporting, promote the six aims of quality as defined by the IOM: safety, effectiveness, efficiency, patient-centeredness, equity, and timeliness. In other words, quality and cost efficiency go hand-in-hand through better preventive care and care coordination. There is a general consensus in the health policy community that both payment reform and delivery system reform are needed to make real progress in this direction.

## Implications of ACO and Bundled Payment Legislation for Providers and Payers

### ■ There will be organizational structuring, restructuring and new transactions related to forming qualifying ACOs.

The key question here is how much integration will be required of ACOs. Will it be necessary to be close to the Mayo Clinic, Cleveland Clinic, Geisinger end of the spectrum or will a new generation of groups without walls, networks, and virtual organizations come into being and operate as ACOs? What will be the role of hospitals? Clearly, academic medical centers where the hospital and faculty are well integrated should be in a strong position to qualify as ACOs, as are hospital systems that employ large number of physicians. But what about the many hospitals, physicians, nursing homes, home health agencies and other providers not currently integrated across provider types or diverse episodes of care?

Many proponents of the ACO model believe that some allowance for virtual ACOs should be made.[4] Questions will arise as to whether a particular ACO will truly be able to coordinate care and invest in the infrastructure necessary to do so.

### ■ New or revised forms of contracts will need to be developed.

Presumably all of the contracts linking the providers in an ACO will have to be created, or existing contractual provisions revised, to accommodate the performance of the ACO's obligations. Even in large organizations where physicians currently are employed, internal protocols will need to be reviewed and possibly revised, and new contractual arrangements with non-employed physicians or other types of institutional providers will need to be made.

[2] Linda T. Kohn, Janet M. Corrigan, and Molla S. Donaldson, Editors; *To Err is Human: Building a Safer Health System*, Committee on Quality of Health Care in America, Institute of Medicine.

[3] *Crossing the Quality Chasm,* Committee on Quality of Health Care in America, Institute of Medicine.

[4] E.S. Fisher, D.O. Staiger, J.P.W. Bynum et al., ''Creating Accountable Care Organizations: The Extended Hospital Medical Staff,'' *Health Affairs* Web Exclusive, Dec. 5, 2006.

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■ **Compliance with existing regulatory laws and enforcement priorities will remain a challenge.**

I have written elsewhere in this BNA series[5] about the regulatory conundrum related to efforts at clinical integration and posed a suggested resolution to the impact of the antitrust, anti-kickback, Stark, and Civil Money Penalty laws, among others, on the ability of ACOs to actually qualify for bonus incentives received from the government and share such bonuses with its participating providers. Suffice it to say here that virtually every health lawyer in America would agree that these laws will create obstacles to the level of payment and delivery system reform contemplated in the proposed legislation. Further legislation, clarifying regulations and, probably, some litigation will be required to sort the issues out over time.

■ **There will be new compliance responsibilities in connection with ACO requirements.**

The proposed 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 debate over which measures should be used and how the reporting should work. 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.

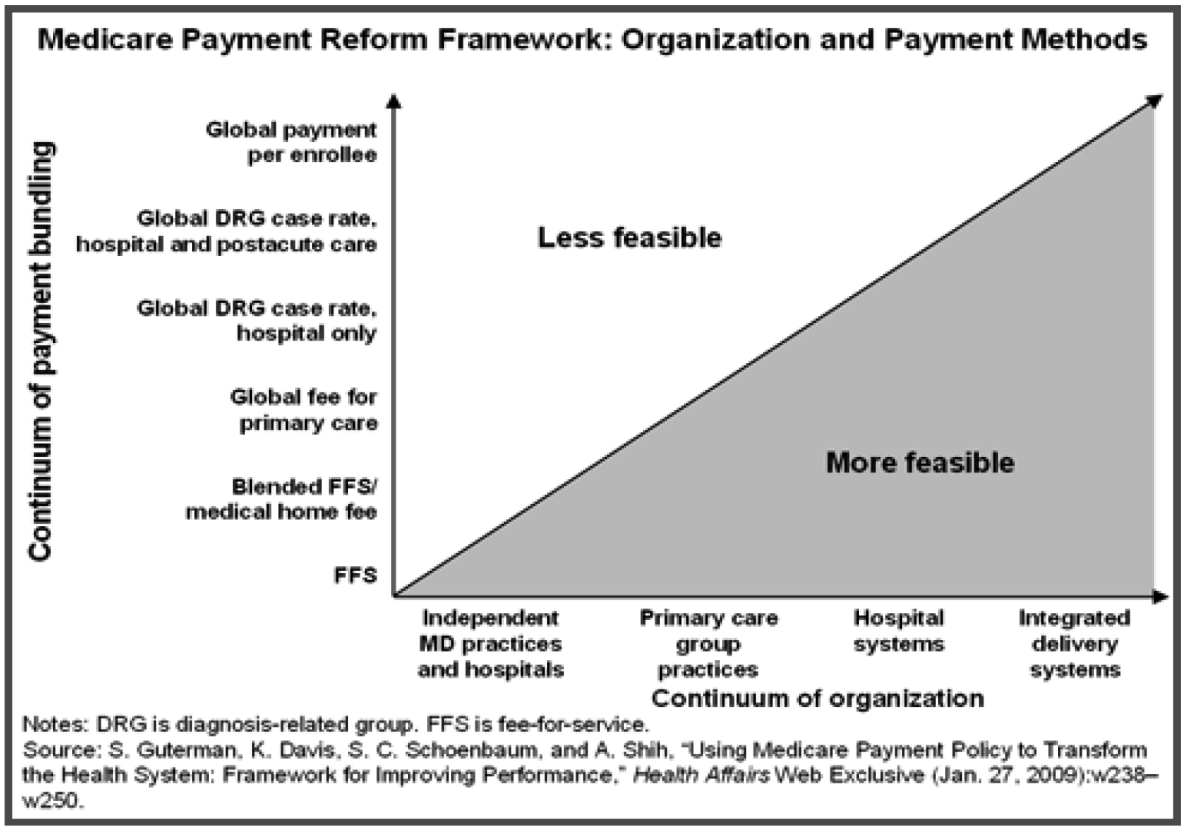
■ **New board and management responsibilities will arise.**

Existing integrated delivery systems that are well-positioned today to qualify as ACOs may have most of the leadership infrastructure in place to move forward under ACO legislation. But many organizations seeking to make changes in order to qualify will have to enhance and refocus their leadership activities to meet the legal obligations as well as market requirements to function effectively as ACOs. We may see both new qualifications sought at the board level and new jobs created at the management level.

■ **A new generation of bundled or capitated payments will test the ability of ACOs to take risk.**

Just as there is a continuum of degrees of clinical integration among providers, there is a continuum of degrees and types of bundled payments. The following chart, from the Commonwealth Fund, illustrates both of these continuums.

Under the Senate bill, if the Medicare program determines that its bundled payment pilot is successful, the program may be made a permanent part of Medicare. The House bill contemplates partial capitation payments to ACOs. Thus, while the legislation currently contemplates ACO payments as a bonus in the current fee-for-service payment system, it also contemplates




[5] D.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 (18 HLR 740, 6/4/09),

moving to bundled payments in the future. The strong policy belief is that such further payment reform will be required to truly achieve higher quality and cost effectiveness.

The potential 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. Will that be where the current effort again leads or can we develop an approach that affords ACOs a more flexible approach that still protects beneficiaries? Are we further along the continuum with data capabilities and internal protocols so that ACOs over the next decade can better manage global case rates and global payments per enrolled beneficiary than PHOs, MSOs and other provider networks were in the 1990s?

■ **New private market arrangements between payers and providers involving bundled payments to ACO-like organization will be developed.**

Such new arrangements already are being implemented, although still on a relatively small scale. A recent national Hospital Payment Reform Summit features presentations on such developments by CMS, the state of Minnesota, and Geisinger Health System, among others. Presumably, a major federal push in this direction would accelerate similar changes in the private sector. Such a trend would have the potential to usher in a new era of payer-provider cooperation, rather than the confrontation and dispute-oriented approach of the past decade. New, complex contractual arrangements and joint ventures might arise. Even as both industry sectors continue to consolidate, both might benefit from greater cooperation, financially and in the public's eye. And patients would benefit through better health outcomes.

## *Conclusion*

There are many exciting new policy and legal developments to contemplate in the payment and delivery system reform elements of the larger health care reform process currently taking place. As I have said elsewhere, there is a relatively high level of consensus around the provisions discussed in this analysis around Capitol Hill and in policy circles. If a health bill passes, I believe that ACOs and bundled payments will receive a major boost. Even if no bill passes, these approaches will move forward in the private sector. Many health care providers and payers, and their counsel, are knee-deep in these issues already and many more will be in the months and years ahead. It is a good development with real promise to improve health care in America.

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