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The Timeline for Accountable Care: The Rollout of the Payment and Delivery Reform Provisions in the Patient Protection and Affordable Care Act and the Implications for Accountable Care Organizations

By Douglas A. Hastings

Introduction

Now that we have sweeping new health care legislation, the Patient Protection and Affordable Care Act, let's look at the rollout of the accountable care provisions—i.e., those changes to the payment and delivery system that hold the most long-term promise of improving quality and cost-efficiency. They are discussed below in the chronological order of their effective dates, referenced by the relevant title and section of the act, followed by comments as to their implications for accountable care organizations (ACOs). Keep in mind as you read these summaries the framework for health care quality provided almost a decade ago by the Institute of Medicine (IOM) in *Crossing the Quality Chasm*, which defined quality as health care that is safe, effective, efficient, patient-centered, equitable, and timely.[1]

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2010

■ *Patient-Centered Outcomes Research. Section 6301.*

Effective upon enactment of the legislation, with funding available beginning fiscal year 2010, the act establishes a nonprofit Patient-Centered Outcomes Research Institute to identify research priorities and conduct research that compares the clinical effectiveness of various medical treatments. The institute will be overseen by a board of governors drawn from the public and private sectors and will be able to call upon expert advisory panels.

ACO Implications: This institute is a strong endorsement of the promise of evidence-based medicine through scientific research. The institute will disseminate findings with respect to health outcomes, clinical effectiveness and appropriateness of medical services. To me, this provision of the act is one of the underpinnings of the new direction health care will be taking in the years ahead. The institute will set the agenda and priorities for quality research, and its findings will influence subsequent public and private sector payment and delivery policies. It also will establish a Methodology Committee to develop and improve the science of comparative effectiveness research. ACOs likely will benefit from the output of the institute, as future findings likely will support care coordination and clinical integration

[1] *Crossing the Quality Chasm,* Committee on Quality of Health Care in America, Institute of Medicine, 2001.

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where these efforts can be shown to improve outcomes and clinical effectiveness.

■ *Community Transformation Grants. Section 4201.*

Funds for this grant program supporting evidence-based and community-based prevention and wellness services are appropriated for five years beginning in fiscal year 2010. The goal is to strengthen prevention activities, to reduce chronic disease rates, and to address disparities, especially in rural and frontier areas. Grantees may be state or local government agencies, a national network of community-based organizations, state or local nonprofit organizations, or Indian tribes.

ACO Implications: These provisions link the concept of evidence-based medicine and community health and wellness. Many nonprofit ACOs should be in a position to apply for these grants. This grant program strengthens the link between ACOs, wellness and prevention and community-based care.

■ *Extension of Gainsharing Demonstration. Section 3027.*

This demonstration project, which has been ongoing for several years, is extended until 2014.

ACO Implications: Further testing of gainsharing programs, although on a somewhat limited basis through this demonstration, will continue and add to the evidence base of benefits to be gained by physician-hospital collaboration on quality and cost efficiency.

■ *Medicaid Global Payment System Demonstration. Section 2705.*

This demonstration will operate during fiscal years 2010 through 2012 in up to five states. It authorizes participating states to adjust payments to eligible safety net hospital systems or networks from a fee-for-service structure to ''a global capitated payment model.'' The demonstration will be coordinated with the CMS Innovation Center.

ACO Implications: This section of the act provides for immediate movement into a global capitation framework for Medicaid in states and for ACOs that are chosen.

2011

■ *National Strategy for Improvement in Health Care. Section 3011.*

By Jan. 1, 2011, the secretary of HHS will establish a national strategy to improve the delivery of health care services, patient health outcomes and population health. The national strategy will identify the priorities that will: (1) have the greatest potential for improving health outcomes, efficiency, and patient-centeredness: (2) have the greatest potential for rapid improvement in the quality and efficiency of patient care; (3) address gaps in quality, efficiency, and comparative effectiveness information and health outcomes; (4) improve federal payment policy to emphasize quality and efficiency; (5) enhance the use of data to improve quality, efficiency, transparency, and outcomes; (6) address the health care provided to patients with high-cost chronic conditions; and (7) improve research and disseminate best practices to improve patient safety and reduce medical errors, preventable readmissions, and health care-associated infections. Among other components, the strategy will seek to align public and private payers with regard to quality and patient safety efforts.[2]

ACO Implications: Think about the incredible potential for acceleration of change in the development and implementation of the above-described strategy. As ACOs are developed and move toward bundled and global payments, and as providers and payers position themselves for the accountable care era, the national strategy has every possibility under the right leadership to have a profound impact on the future in a relatively short period of time. The strategy is due Jan. 1, 2011—less than 10 months from now—and is to be updated not less than annually.

■ *Establishment of Center for Medicare and Medicaid Innovation within CMS. Section 3021.*

This center, CMI, is to be up and operating by Jan. 1, 2011 to test innovative payment and delivery models that reduce cost and improve quality. Among models to be tested are those that (1) promote practice and payment reform in primary care, including patient-centered medical homes; (2) feature risk-based comprehensive payments to providers; (3) promote care coordination and transition away from fee-for-service based reimbursement; (4) establish community-based health teams; (5) allow states to test and evaluate all-payer systems of payment reform; (6) improve post-acute care; (7) develop a collaboration of high-quality, low cost institutions that will disseminate best practices; and (8) establish comprehensive payments to Healthcare Innovation Zones—groups of providers including a teaching hospital that deliver comprehensive care while also incorporating innovative methods for the clinical training of future health care professionals.

ACO Implications: Again, the potential impact of CMI, and the impact of models successfully tested and reported, is readily apparent. And $10 billion is appropriated to support these innovation activities for the years 2011 to 2019. It is likely that new legislation, and certainly new regulations, will be required to implement further payment and delivery reforms resulting from CMI testing. Transactional, governance, compliance and other legal implications and consequences necessarily will follow. Innovative ACOs will benefit. To the degree that CMI and its programs are successful, and if the results are coordinated with private sector developments, the direction ACOs take in their form, structure and operations will be profoundly influenced.

■ *Plans for Value-Based Purchasing Programs for Skilled Nursing Facilities, Home Health Agencies and Ambulatory Surgical Centers. Sections 3006 and 10301.*

The secretary is required to submit a report on such plans to Congress by Oct. 1, 2011 for SNFs and HHAs and by Jan. 1, 2011 for ASCs. These plans can be expected to feature incentive-based bonus payments similar to the payments contemplated in the act for hospitals.[3]

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[2] *See, e.g.*, Sections 3013 and 3014 regarding development of associated quality measurements.

[3] In addition, similar value-based purchasing programs for inpatient rehabilitation facilities, inpatient psychiatric hospitals, long-term care hospitals, certain cancer hospitals, and hospice providers are to be tested by the secretary no later than Jan. 1, 2016. Section 10326.

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ACO Implications: This is a further incentive for ACOs to link with post-acute providers and other providers such as ASCs to manage quality and cost-efficiency across a broad spectrum of care. It is likely that, if bonus payments are deemed successful, bundled and global payments will follow.

■ *Community-Based Collaborative Care Networks. Section 10333.*

The secretary is empowered to award grants to eligible entities to support such networks. A community-based collaborative care network is defined as a consortium of health care providers with a joint governance structure (including providers within a single entity) that provides comprehensive coordinated and integrated health care services for low income populations. Networks are to include a hospital and all Federally Qualified Health Centers (FQHCs) located in the community.

ACO Implications: ACOs linking hospitals and FQHCs should be in a position to win such grants.

2012

■ *Medicare Shared Savings Program (ACOs). Section 3022.*

This is the act's most focused treatment of ACOs. To be established not later than Jan. 1, 2012, this program allows providers organized as ACOs that voluntarily meet quality thresholds to share in the cost savings they achieve for the Medicare program. To qualify as an ACO, organizations must agree to be accountable for the overall care of their Medicare beneficiaries, have adequate participation of primary care providers, must define processes to promote evidence-based medicine, must report on quality and costs and must coordinate care. The following groups of providers are identified as eligible to participate as ACOs if they have established a mechanism for shared governance: (1) physicians and other health care practitioners (defined in the act as ''ACO professionals'') in group practice arrangements; (2) networks of individual practices of ACO professionals; (3) partnerships or joint venture arrangements between hospitals and ACO professionals; (4) hospitals employing ACO professionals; and (5) others as determined by the secretary. Each ACO must: (1) be willing to become accountable for the quality, cost and overall care of the Medicare beneficiaries assigned to it; (2) enter a three-year agreement to participate; (3) have a formal legal structure to receive and distribute share savings payments; (4) have sufficient primary care ACO professionals (based on a minimum of 5,000 beneficiaries to be assigned); (5) have sufficient additional ACO professionals as determined to be necessary by the secretary; (6) have in place a leadership and management structure that includes clinical and administrative systems; (7) have defined processes to promote evidence-based medicine, report on quality and cost measures and coordinate care; and (8) demonstrate that it meets patient-centeredness criteria specified by the secretary.

ACO Implications: Huge. In less than 22 months, this defining program will be in place. While the amount of dollars flowing on day one through Medicare may only be beginning, private sector programs also will be moving forward, and the act's provisions will accelerate the process. The federal definition of an ACO likely will be adopted in the private sector. This definition clearly allows for physician networks to qualify without a participating hospital. One of the key questions will be: ''How clinically integrated does an organization, network or other collaborative group need to be to qualify as an ACO?'' The answer to this question in practice will determine the shape of the future U.S. health care delivery system. And there still is no clear language anywhere in the act spelling out how collaborating providers will be treated by the fraud and abuse and antitrust enforcement agencies as they try to put ACOs together.[4] Two years or less is not a long time to be ready for the onset of this program. Providers and payers should be working on their strategies, and developing the necessary infrastructure, now.[5] In this regard, you may be interested in an article I wrote earlier in this BNA series on 10 questions health care organizations should be asking themselves about their readiness to become ACOs.[6]

■ *Hospital Value-Based Purchasing Program. Section 3001.*

Beginning on Oct. 1, 2012, Medicare will implement a value-based purchasing (VBP) program under which value-based incentive payments will be made in connection with discharges from hospitals that meet specified performance standards related to performance on quality measures. Efficiency measures are added in 2014. Funding for these payments is generated through reducing Medicare IPPS payments to all hospitals (in an increasing amount each year), but all such reductions are returned to hospitals through incentive payments in the same year. The secretary will make the performance scores for hospitals on the measures publicly available. Also in 2012, there will be value-based purchasing demonstrations established for critical access hospitals and certain other hospitals excluded from the VBP program.

ACO Implications: It will take a host of regulations to implement the VBP program. There will be significant assessment of possible measures to be used. Hospitals, and their boards, will be challenged to assure that the financial performance of their institution does not suffer. The public reporting of results will impact public perception. All of this dovetails with the need to make progress on information technology and in hospital-physician clinical integration. Hospitals involved in effective ACOs should fare better.

■ *Hospital Readmissions Reduction Program. Section 3025.*

Beginning with discharges occurring on or after Oct. 1, 2012, Medicare will reduce payments to hospitals that are determined to have an ''excess readmissions ratio'' as defined by the secretary. This is a complex provision that includes a formula for the payment reductions that will no doubt trigger much study and

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[4] *See* 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, 6/4/09, for a discussion of a possible legal solution to this problem.

[5] *See* Douglas A. Hastings, ''Payment and Delivery System Reform: It's Only a Matter of Time,'' *BNA's Health Law Reporter*, Vol. 19 No. 7, 2/18/10.

[6] Douglas A. Hastings, ''Is Your Organization Ready to Become an Accountable Care Organization? Here are 10 Questions to Ask,'' *BNA's Health Care Policy Report*, Vol. 18 No. 1, 1/4/10; and *BNA's Health Law Reporter*, Vol. 19 No. 1, 1/7/10.

regulatory activity and there are some types of hospitals that are excepted.

ACO Implications: Hospitals involved in ACOs with effective integration, good information systems and experience with quality measures should fare better than those not so positioned.

■ *Independence at Home Demonstration Program. Section 3024.*

This program, to begin no later than Jan. 1, 2012, will provide high-need Medicare beneficiaries with primary care services in their home and allow participating teams of health professionals to share in any savings if they reduce preventable hospitalizations, prevent hospital readmissions, improve health outcomes, improve the efficiency of care, reduce the cost of health care services, and achieve patient satisfaction. The act creates a defined term, ''independence at home medical practice,'' which means a legal entity comprised of physicians and nurse practitioners that works with a team that may include physician assistants, pharmacists and others to provide home-based primary care on a 24 hour, 7 day a week basis.[7]

ACO Implications: This provision of the act, like others relating to patient-centered medical homes and community-based services, show the complementarity of ACOs and medical homes. To me, the way to understand these two concepts is that a medical home is the primary care component of an ACO, which together will promote better outcomes, greater cost efficiency and enhanced patient satisfaction in a payment system moving away from fee-for-service to more global forms of payment.

■ *Pediatric Accountable Care Organization Demonstration Project. Section 2706.*

This demonstration, effective Jan. 1, 2012 through 2016, allows pediatric medical providers organized as ACOs to receive incentive payments under Medicaid similar to general care ACOs as set forth in Section 3022 of the act.

ACO Implications: This is further evidence of the comprehensiveness of the ACO concept in the act and an important opportunity for pediatric providers.

■ *Demonstration Project to Evaluate Integrated Care Around a Hospitalization. Section 2704.*

Effective Jan. 1, 2012 through 2016, this demonstration authorizes participating states to pay bundled payments for episodes of care for Medicaid patients that include hospitalizations. Up to eight states can participate.

ACO Implications: This represents another step in transforming the payment system. Payment bundling, which falls between bonus payments in a fee-for-service setting and global capitation in the continuum of payment reform, is the subject of a Medicare pilot commencing in 2013, discussed next.

2013

■ *National Pilot Program on Payment Bundling. Section 3023.*

To be established not later than Jan. 1, 2013, and to run for five years, this important pilot program will develop and evaluate for the Medicare program bundled payments for acute, inpatient hospital services, physician services, and post-acute services for an episode of care that begins three days prior to a hospitalization and spans 30 days post-discharge. Its stated purpose is to improve the coordination, quality and efficiency of services around a hospitalization in connection with one or more of eight conditions to be selected by the secretary. If successful, the program can be extended by the secretary.

ACO Implications: By establishing this pilot to begin in 2013, the act allows evolving ACOs a couple of years to put together the provider components, the information system components and the clinical integration components to handle payments bundled this way. Organizations already well on the way down the ACO pathway today should be ready. Others may not be, but they should be able to participate in the ACO incentive bonus program beginning in 2012. All of this once again will accelerate action in the private sector.

2014

■ *Quality Reporting for Long-Term Care Hospitals, Inpatient Rehabilitation Hospitals and Hospice Programs. Section 3004.*

This section of the act sets up a process to strengthen the submission of quality data for these providers pursuant to measures endorsed by a consensus body, such as the National Quality Forum, under contract with CMS. Beginning in fiscal year 2014, payment rates will be reduced for providers failing to submit the data required. The data reported will be public.

ACO Implications: Affected providers in an ACO or otherwise organized to be in a position to meet these requirements, which presumably would mean a reasonable level of prior experience with quality data gathering and reporting, will avoid the penalty and presumably be reporting better results.

2015

■ *Payment Adjustment for Conditions Acquired in Hospitals. Section 3008.*

Beginning in fiscal year 2015, payment for discharges from hospitals whose reported data shows them to be among the quartile with the most hospital acquired conditions will be reduced by one percent. The purpose stated in the act is to provide an incentive for hospitals to reduce the incidence of such conditions. Again, the data will be made public.[8]

ACO Implications: Hospitals which coordinate care well and otherwise manage to reduce the incidence of hospital acquired conditions will not be penalized and will not suffer adverse publicity.

■ *Improvements to the Physician Quality Reporting System. Section 3002.*

Beginning in 2015, if physicians do not satisfactorily submit data on quality measures for specified procedures, the fee schedule for such services provided by

[7] *See* Sections 3026 and 3502 for other provisions relating to medical homes and community-based care.

[8] While Section 3008 is applicable to Medicare payments, Section 2702 similarly prohibits payments under Medicaid for services related to health care-acquired conditions.

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such physicians will be reduced 1.5 percent in 2015 and 2 percent in later years.[9]

Implications for ACOs: This is further incentive for physicians to aggregate or otherwise become part of an organized system or ACO that can effectively track and report quality data.

Conclusion

Altogether, I have summarized 18 provisions of the act, the most important of which commence within the next two to three years. At one level, that is not a great deal of time. But at another level, the framework is one of ongoing development, testing and the sharing of best practices. As Atul Gawande said so well in his most recent article in *The New Yorker* about the dramatic changes in U.S. agriculture in the early 1900s: ''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.''[10]

The comprehensive provisions in the act regarding payment and delivery reform reflect both the payment system continuum—from fee-for-service to bonus incentives for quality to bundled payments to partial and full global payments—as well as the delivery system continuum—from independent clinicians and hospitals to small group practices to multi-provider networks to partially or virtually integrated organizations to fully integrated systems with common ownership and employment. If implemented effectively, the act will allow today's more integrated organizations to move forward as ACOs relatively quickly but also will accommodate the formation and development of many new ACOs—thus promoting a broader reach of the goals of better outcomes, cost-efficiency and patient satisfaction while also maintaining or improving healthy competition in most markets.

Finally, a word about provider-payer collaboration. I firmly believe that payment and delivery reform, much as articulated in the act, is the pathway to improving quality, bending the cost curve and, ultimately, paying for greater access. Both the payment system and the delivery system need to change together to achieve accountable care. Notwithstanding the important federal leadership represented by the act, the private sector also needs to move forward with accountable care in private payment systems. Not only will a failure to do so put more onus on government to regulate the prices charged by both payers and providers and to micromanage the contracts between them, but it also will withhold from Americans the great benefits of achieving the IOM's six aims of quality cited at the beginning of this article. Payers and providers should make it their immediate priority to engage in their own private sector pilots and demonstrations so that the promise of ACOs can be realized in both the public and private sectors.

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[9] Additionally, Section 3007 requires the secretary to create a payment system that will adjust Medicare physician payments based on the quality and cost of the care they deliver beginning in 2015.

[10] Atul Gawande, ''Testing, Testing,'' *The New Yorker*, December 2009.