An Update on the Road to Accountable Care: Observations at the Nexus of Policy, Business and Law

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The Case for Payment and Delivery Reform

- **The Problem:**
  - Fragmented care
  - Uneven, unsafe practices
  - Unsustainable costs

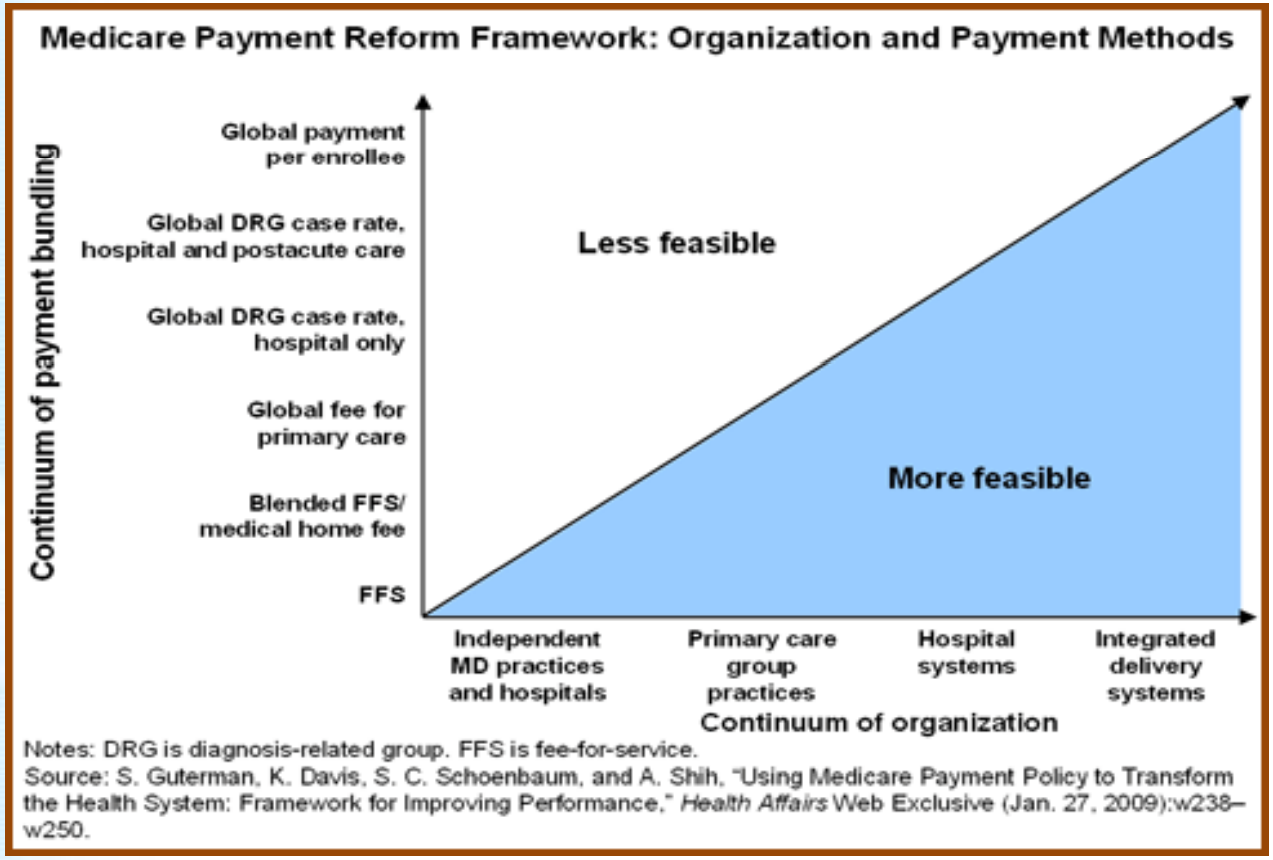
"Our fee-for-service system, doling out separate payments for everything and everyone involved in a patient's care, has all the wrong incentives: it rewards doing more over doing right, it increases paperwork and the duplication of efforts, and it discourages clinicians from working together for the 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
  - 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
  - Cost savings are not realized
  - It feels too much like managed care and capitation of the 1990s

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

Additional Inside the Beltway Developments

- Medicare Shared Savings Program Proposed Rule
- Launch of the Center for Medicare and Medicaid Innovation
- White House/CMS Patient Safety Initiative
- Value Based Purchasing Program Proposed Rule
- IOM geographic variation studies
- Constitutional challenges to the ACA
- Republican health care strategy; link to budget debate
- Will coordinated care become a victim of “Obamacare”?
- House Energy and Commerce 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 Commercial Marketplace

- Providers assessing Medicare ACO participation based on the MSSP Proposed Rule; generally negative reaction
- Emphasis on primary care/medical homes/community-based programs
- 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
- States developing their own ACO programs and passing new ACO laws
- PHOs, IPAs and clinical integration are hot topics again

Board Fiduciary Duty and Accountable Care

- 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
- Strategic assessment of risks and opportunities in the accountable care era is essential
- Increasing focus on quality reporting may result in “fraud and abuse” enforcement against providers making claims to public and private payers for care deemed substandard
- Greater quality data reporting and transparency will require oversight, including assurance that reporting is accurate

Don Berwick on ACOs – February 1, 2011

"But of course you know this issue, as we engage in this expedition toward integrated care. What will risk look like? Shared savings only? Upside/downside? Partial cap, full cap? What would work and for whom? Who can play in each of those different conditions?

The proposed rule will be a core model. It will be what anybody can play with. But we all know there are places out there that are ready to surge ahead to a completely different level of integration. They've been there already or are en route. Wouldn't it be nice if we had made a space for a vanguard, who can move ahead of the pack and teach us all the way to go? Maybe the Innovation Center can be a home for that kind of pioneering element on our behalf, on everyone's behalf. Not specialty entitled players, but our scouts.

The core to me is authenticity. As I said, I think there will be parties out there who wish to take advantage of the law and the vocabulary to re-label what they already do. To repackage the status quo. I don't think that will be enough. Not at scale. We are going to have to find a way to deliver care better. And that means change."

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

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

ACO Criteria – ACA Section 3022

- 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
- Preference may be given to ACOs participating in private payer arrangements

Overall Comments on the MSSP Proposed Rule

- Significant intergovernmental agency cooperation and coordination has gone into this effort—CMS, OIG, DOJ, FTC, IRS. We saw indicators of this at the October 5 workshop, and the draft rule bears it out.
- The preamble provides a wealth of information on CMS' thinking about the various provisions of the rule, options the agency considered and where it is interested in further comments.
- The underlying vocabulary of *Crossing the Quality Chasm,* which defines quality as care that is safe, effective, efficient patient-centered, timely and equitable, is, not surprisingly, much in evidence in the document and is cited directly at times. Indeed, there is extensive discussion of patient-centeredness criteria.

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?

Conclusion

- A key determinant of the success of the MSSP will be how many early stage provider organizations that want to become ACOs are able to meet the various minimum requirements and how many of the more advanced, integrated organizations will want to be a Medicare ACO based on their analyses of the financial implications.
- We will need to see what ACO initiatives will come out of CMS' Innovation Center under Section 3021 of the ACA.
- How many organizations will apply or be admitted to the MSSP remains unknown, but we now have a substantive proposed set of regulations to go along with a substantive statutory provision that CMS sees as a key component of implementing the Triple Aim.
- Stakeholders should engage with CMS in this effort to move forward on the road to accountable care.

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