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REPORT

Accountable Care Organizations: Promise of Better Outcomes at Restrained Costs; Can They Meet Their Challenges?

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Introduction

There has been much talk of Accountable Care Organizations (ACOs) in the discussions surrounding comprehensive health reform legislation. ACOs have been viewed by their proponents as critical to addressing two of the principal drivers leading to the call for comprehensive health reform—the restraint of health care cost increases and the enhancement of quality care.

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Proponents argue that ACOs will address the cost and quality issues by transforming how health care is delivered. Providers (primarily physicians), the ones who best understand what care is appropriate and what care is unnecessary, will be held accountable for the cost and quality of care provided. Unlike the current system, which rewards increased utilization, the goal of ACOs is to incentivize clinical integration, and the provision of better and more efficient care, not just more care. These incentives will occur by a transfer of risk of the health care delivered to ACOs and their participating providers.

What Is An ACO And What Will An ACO Look Like?

An ACO is a flexible concept intended to further the goal of increasing quality and reducing health care

 ISSN 2154-8986

costs. An ACO may be an integrated provider, or group of providers organized in any fashion that permits the ACO to seek the goals of improving quality while controlling costs. They are designed to make physicians and providers (not insurance companies or administrators) accountable for the quality and utilization (efficiency and cost) of health care through integration and coordination of care.

Entities that could be ACOs include:

- Integrated Delivery Systems Including Hospitals, Physicians and Ancillary Providers
- Muti-Specialty Group Practices
- Primary Care Clinics
- Provider Networks Linked by Contractual Agreements
- Joint Ventures or other Organizations that Combine Providers (PHO, MSO).

The structure selected will depend upon the unique circumstances of particular entities desiring to establish an ACO, infrastructure needs, the payment model in which the ACO will operate, and the feasibility of functioning effectively with coordinated care.

How Are ACOs Treated in the Health Reform Law?

Comprehensive health reform that passed in March (the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010[1] (which, as amended, we refer to as ''PPACA'')), embraced ACOs, but did so in a tepid manner. Section 3022[2] of PPACA requires the Secretary of HHS to establish a shared savings program (a ''SSP'') no later than January 1, 2012, that ''promotes accountability for a patient population and coordinates items and services under Parts A and B [of Medicare], and encourages investment in infrastructure and redesigned care processes for high quality and efficient service delivery.''

Section 3022 goes on to provide that ACOs, meeting certain criteria, will be eligible to receive payments under the SSP. Under PPACA, eligible ACOs must have a mechanism for shared governance, must be a recognized legal structure or one approved by the Secretary, and must meet the following requirements:

- willing to be accountable for the quality, cost and care of Medicare fee-for-service beneficiaries
- enter an agreement with the Secretary to participate in the SSP for at least a 3-year period
- have a formal legal structure that allows for receipt and distribution of shared savings payments to participating providers
- include primary care professionals that are sufficient to treat a minimum of 5,000 Medicare beneficiaries assigned to the ACO
- have a leadership and management structure that includes clinical and administrative systems
- define processes to promote evidence-based management and patient engagement, report on quality and cost measures, and coordinate care
- meet patient-centeredness criteria.

Under the SSP, participating ACO providers will continue to be paid under the original fee-for-service programs of Parts A and B of the Medicare program, but will be eligible to receive additional payments of recognized shared savings. The amount of shared savings paid to the ACO will be, as determined by the Secretary, a percentage of the difference between (i) the estimated annual average per capita Medicare expenditures for patients assigned to the ACO for a year, adjusted for beneficiary characteristics; and (ii) a benchmark set for the ACO. To receive such percentage of the savings, the ACO must meet established quality performance standards, must have per-capita fee-for-service costs at least a percent set by the Secretary below the benchmark, and must not have taken steps to avoid patients at risk.

Section 3022 of PPACA also gives the Secretary discretion to consider substituting a partial capitation or other payment method for the shared savings.

Aside from the SSP payment model, PPACA does not require implementation of ACOs. Rather, PPACA requires and/or authorizes the Secretary to establish numerous pilot or demonstration projects to test accountable care concepts. One such pilot is a national pilot program for payment bundling (PPACA § 3023). In this program, a bundled payment would be paid to an organization for acute care, physician services, outpatient services and post-acute care around a given hospitalization.

Additional pilot and demonstration programs in PPACA include:

- An independent at home medical practice demonstration project (PPACA § 3024)
- An extension of an existing gainsharing demonstration project (PPACA § 3029)
- A medical global payment system demonstration project (PPACA § 2705)
- A demonstration project to evaluate integrated care around a hospitalization (PPACA § 2704)
- A pediatric ACO demonstration project (PPACA § 2706).

The demonstration and pilot programs are intended to test ACOs and the many challenges and questions associated with making them effective. This article will describe the most likely ACO payment methods and the many challenges and questions ACOs face to be effective.

What Payment Changes Will Be Involved With ACOs?

Those of us who have been engaged in the health care industry for years know that, if you want to drive certain behavioral changes, you should establish a payment system that incentivizes the desired behavior. As such, if ACOs are to meet their promise, they will need to be accompanied by changes in how health care services are rendered, which furnish incentives for heightened quality and reduced costs.

Today, physician and other services are largely paid on a fee-for-service basis without any coordination or management of the Medicare services provided. In a fee-for-service system, increased volume is rewarded, even if it may involve some unnecessary care.

As indicated in the discussions above, with ACOs, the payment system would change to:

- Shared Savings Programs

[1] Patient Protection and Affordable Care Act, Pub. L. No. 111-148 (2010).

[2] Section 3022 of PPACA adds Social Security Act Sec. 1899.

  HIR ISSN 2154-8986

- Bundled Payments for Episodes of Care
- Global or Partially Globally Payment Systems
- Combinations of the Foregoing.

A. Shared Savings Program

Shared Savings Programs are a logical first transition step away from fee-for-service payment. As discussed above, in SSPs, providers are paid on a fee-for-service basis but may earn additional payments based upon the savings against cost and quality benchmarks. In SSPs, providers have an upside reward for delivering quality and efficient care, but there is no downside risk.

A key question of whether such payments are successful in realizing cost and quality benefit is whether the ''carrot'' of additional bonus payments is sufficient to change the behavior of ACO participants. The likely answer will depend upon the relative size of the bonus payments to the various participants as compared to the fee-for-service amounts.

B. Bundled Payment System

In a bundled payment system, the ACO would receive a single payment for all or a significant portion of the care provided with respect to an episode of care. The bundled payment is like a budget for the particular care to be provided. There is an opportunity for an upside reward if the cost of care is below the bundled payment, but the ACO is at risk if the costs of care exceed the bundled payment.

Bundled payments promote integrated care and collaboration. They disincentivize unnecessary procedures. However, there is no incentive for an ACO to avoid a new episode of care in the first instance.

C. Global Payments or Partial Caps

With global payments or partial caps, a payment is made to the ACO to furnish all or a portion (such as all physician services) of the care for a given population of patients over a given time frame. There is no volume based payment. Rather, the ACO takes the risk to provide the health care needs of the population covered. Often, the payments may be risk adjusted for such things as the age, health status, etc. of the population to avoid having the ACO take the ''insurance risk.''

Participating ACOs will likely consider stop-loss insurance to protect against the risk inherent in such a payment system. These payment methodologies place significant risk on providers, including risks they do not control merely by providing high quality and efficient care.

What Financial and Practical Issues and Challenges Do ACOs Face?

Implementation of any of the payment methodologies described above will involve a number of issues and challenges that will need to be addressed.

There are also some overriding issues. Among the issues are:

- *Most payors must participate*. If ACOs are to be successful in transforming how health care is delivered, most payors (the government, insurance companies, self-funded) will need to utilize the same payment mechanisms. For example, if only a few payors pay on a bundled basis, but many others still pay on a fee-for-service basis, it is unlikely providers will consciously change how they provide services.

- *How individual providers are paid will matter*. It is not just how the ACO is paid that will matter, but the ACO and the individual physicians or other professionals will need to be paid on a similar basis. If individual professionals continue to be paid on a fee-for-service basis (such as based on work RVUs), there will be little change in practice patterns. The payment mechanism will have to carry through to the individual professionals, as well.

- *ACOs will require significant capital*. Successful ACOs will require significant capital to attract management talent, information systems and other infrastructure to coordinate the care provided. Many will recall issues and financial challenges IPAs faced when they were used with some similar payment methods. ACOs will need access to significant capital to be successful.

- *The compensation for providers must be adequate*. If the payment method does not fairly compensate providers, there will be problems. Physicians and other providers who are not fairly compensated will become disgruntled, will not be committed, and will not participate in ACOs. ACOs also may well face financial issues.

- *Unique Situations*. Any payment methodology will need to address varying circumstances of unique providers, such as children's hospitals, academic medical centers, sole community hospitals, mental health hospitals and long-term acute hospitals. There also will be a need to develop payment systems to pay for capital, innovation, medical education, charity care and geographic variation. Without addressing these issues and their effect on cost, important aspects of our health care system will not be funded or addressed.

- *Cost Shift*. If one payor continues to pay less than other payors, the cost-shift issues that remain will push ACOs into situations in which they try to avoid care for certain payors. Such cost shifts will affect the success of ACOs.

- *Protection Against Stinting on Care*. The payment methods will create concerns that, to help to maximize their compensation, providers will avoid the provision of needed care to patients. Regulations to protect against this patient stinting will be important.

- *Services Provided By Those Not Participating in the ACO*. There must be a mechanism in place to address care provided by providers who do not participate in the ACO. For example, if a physician group does not participate in an ACO and the ACO is paid on a bundled basis but its patients use the non-participating group's services, how will the group's services be paid and will the proper incentives apply? What if a resident from a northern climate spends the winter months in Florida and seeks services in Florida from providers who are not part of a bundled or capitation payment?

- *Coordinating Care*. A very large issue will be how the ACO ensures participants appropriately coordinate care. Even if an ACO controls all participants (through employment for example), will the ACO be able to deliver on care coordination? Having significant clinical care protocols that are enforced will be important. Control without coordination and care management will not realize the goals of ACOs.

■ *Systems to Monitor Care*. The ACO will also need to monitor the care and the quality of care provided of all participants. This will require an electronic medical record and information systems that allow the ACO to have information at the claims level (and reduce ''incurred but not reported'' issues) on all participants in the ACO. Will ACOs be able to justify the significant investments needed for such systems?

Legal Issues

The changes envisioned in our health delivery and payment systems also will present issues and challenges for the legal framework that has developed to regulate fraud and other improper behavior in our current health care system.

In our current fee-for-service system with prospective payment, DRG reimbursement for hospitals, the regulatory framework is largely intended to:

■ control overutilization

■ remove financial considerations from medical decision-making

■ regulate the failure to provide medically necessary care under the DRG system

■ help ensure a level, competitive playing field.

The arsenal of laws regulators have at their disposal today include: the Anti-Kickback Statute (42 U.S.C. § 1320a-7b), the Stark law (42 U.S.C. § 1395nn) and the Civil Monetary Penalty law (CMP) (§ 1320a-7a) (which prohibits hospital payments to reduce or limit hospital services).

These laws focus on financial and payment relationships affecting providers and contain requirements that must be satisfied to avoid liability in such relationships.

ACOs and the payment reforms discussed above will change payments and relationships between various providers. Generally, the goal will be to structure payments to reward the provision of minimally necessary care while ensuring good outcomes. The payment methods will move away from fee-for-service payment.

In the reformed payment system, laws will need to focus on ensuring that medical decisions are based upon clinical analysis and improving care for patients. As before, the regulatory environment will need to limit the effect of financial decisions in medical decision-making. A key change will be the new, stronger regulations designed to protect against providers avoiding the provision of necessary care.

The various payment models intended for ACOs include the following potential issues:

■ overutilization (for participants who continue to be paid on a fee-for-service basis in shared savings programs and for those who do not participate in ACOs)

■ underutilization (for ACOs in any of the three payment methods)

■ cherry-picking healthy patients (and avoiding care for very sick patients)

■ providing data that improperly affects the benchmarks that are set or that misreport on outcomes achieved.

The Stark exceptions, the Anti-Kickback safe harbors and the CMPs may all need to be modified or waived (PPACA authorizes the Secretary of HHS to waive provisions of all three laws as needed) to permit ACOs and their new payment models to function effectively.

Other laws also are affected by ACOs and will present challenges to ACOs. These include:

■ Antitrust laws

■ Corporate Practice of Medicine applicable in certain states

■ State insurance laws

■ Tax exemption issues.

Antitrust Laws

The antitrust laws are an area of concern for ACOs. ACOs, except in rare circumstances/instances with fully integrated systems where only controlled providers participate in the ACO, will require independent providers, who often will be competitors, to collaborate. This sets off a red flag under the antitrust laws.

When an ACO tries to determine which providers will participate in the ACO and which providers are not invited to participate, potential antitrust issues are presented. The excluded provider is a potential antitrust plaintiff. For example, if exclusive contracts are entered into for one group in a particular specialty and another group in the same specialty is not allowed to participate in the ACO, the excluded specialists may contemplate an antitrust challenge.

These issues are more acute to the extent that the ACO holds market power, as in smaller markets, or where the ACO ties up most of the providers of a particular type in a given market.

The antitrust laws also may create challenges for ACOs that enter exclusive arrangements with certain payors.

There is also a potential argument, if the ACO is not properly created, for the ACO to be the subject of allegations of price fixing, improper exclusive dealing or other improper collusive activity.

In addition, when independent providers join together to negotiate fees with payors, the antitrust laws are potentially implicated. Such joint negotiation is likely to be present for ACOs that have independent providers. The issue will be whether there is sufficient financial or clinical integration across the full array of services the ACO provides such that joint negotiation is permissible. The rules of such integration can be challenging to meet.

Further, in sharing information in the creation or operation of an ACO, the gathering and maintenance of pricing information and price-like information may create potential antitrust issues.

Corporate Practice of Medicine

A key consideration for ACOs is their ability to manage and coordinate the providers and the care they provide. In bundled payment and global payment/partial capitation arrangements, all participants in an ACO need to be coordinated and managed to provide quality, coordinated care, or there is a risk of significant losses.

Employment of physicians provides the best opportunity to control the behavior of, and the care provided by, professionals. Yet many states, through limitations on the corporate practice of medicine, preclude employment or control over the care provided by physicians and other providers.

In states with corporate practice of medicine laws, ACOs will need to develop other methods and/or structures to establish, control and manage the care furnished by its providers.

  HIR ISSN 2154-8986

State Laws

Payment methods, such as capitation, can be viewed as shifting insurance risk which implicate state insurance laws. This limitation may be an issue if a self-funded payor desires to provide such a global payment arrangement to an ACO. State fee-splitting statutes may also pose regulatory challenges. Moreover, certain states have other laws concerning which entities may accept capitation or certain other payments. All such issues need to be reviewed.

Tax Exemption Issues

Whether the ACO may qualify for a tax exemption itself poses further issues. In addition, ACOs may well involve a mix of tax-exempt providers and for-profit, taxable entities. In such situations, the payment and other relationships between and among such entities will need to be carefully reviewed to ensure that the benefits available to tax-exempt entities do not constitute private benefits inuring improperly to the benefit of for-profit participants.

Finally, an ACO structure may implicate the rules on utilization of the proceeds from tax exempt financings.

Summary

ACOs hold promise to control cost increases and improve quality of care. They present many financial, practical and legal issues and challenges, however. Perhaps for this reason, PPACA did not embrace fully the potential for ACOs. Rather, we can expect and PPACA indicates that ACOs and accountable care concepts will be tested over the next several years presenting opportunities to work through the numerous issues, questions and challenges.