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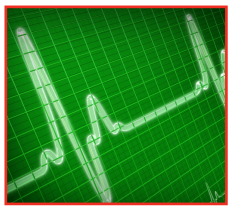


Thirteen Things Health Care Providers Should Know About Accountable Care Organizations and Health Reform

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With passage of the Patient Protection and Accountable Care Act of 2010 as amended by the Health Care and Education Affordability Reconciliation Act (collectively, the "Act"), the concept of Accountable Care Organizations (ACOs) moved from academic and policy circles to hospital board rooms. Although every consulting organization seems to be offering seminars on ACOs, much confusion persists among both physicians and hospital executives. Here are some highlights regarding ACOs and Health Reform of which you should be aware:

1 An ACO is a Concept, Not a Specific Organizational Structure. The term "ACO" is simply an umbrella concept to address the lack of accountability in today's health care delivery system for the overall cost of care, with the ultimate goal being the creation of an organization that is accountable for both the quality and the cost of health care services over a defined spectrum of care. An ACO is not, however, a specific organizational structure or form.

2 CMS is to Establish a Shared Savings Program by January 1, 2012. The Act directs the Centers for Medicare and Medicaid Services (CMS) to create a national Shared Savings Program through which CMS will share savings from budgeted costs of health care services to beneficiaries assigned to the ACO with providers and suppliers who work collaboratively to coordinate care through the ACO. CMS has indicated that regulations implementing the Shared Savings Program will be proposed in fall of 2010.

3 Not All Entities Will Be Able to Participate in the Shared Savings Program. Section 3022 of the Act identifies four types of organizational entities eligible to participate as an ACO: (1) ACO professionals, which include physicians and any non-physician practitioner paid under the Medicare Physician Fee Schedule organized as a group practice arrangement; (2) networks of individual practices of ACO professionals; (3) partnerships or joint venture arrangements between hospitals and ACO professionals; and (4) hospitals employing ACO professionals. In addition, the Secretary has the authority to determine other groups of providers of services and suppliers eligible to participate as an ACO. It is notable that a hospital is not a necessary component of a participating ACO. Nonetheless, even group practice models would need to enter into some type of downstream arrangement to furnish hospital services under the auspices of the ACO.

Additionally, the Act imposes a number of preliminary requirements on ACOs, many of which currently lack substantive detail and await the issuing of CMS regulations. Specifically, the Act requires participating ACOs to:

- possess a mechanism for shared governance with a formal legal structure that allows the organization to receive and distribute payments for shared savings to participating providers;
- assume accountability for the quality, cost and overall care of the Medicare beneficiaries assigned to it;
- have at least 5,000 Medicare beneficiaries assigned to it;
- agree to participate in the Shared Savings Program for at least a period of three years;
- include a sufficient number of primary care physicians and other practitioners to meet the needs of the Medicare beneficiaries assigned to the ACO;

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- provide the Secretary of the Department of Health and Human Services (Secretary) with information regarding participating physicians as the Secretary determines necessary;
- have in place a leadership and management structure that includes clinical and administrative systems;
- have a process to promote evidence-based medicine and patient engagement within the ACO;
- have a process to report on quality and cost measures;
- have a process to coordinate care within the ACO through the use of telehealth, remote patient monitoring and other enabling technologies;
- satisfy patient centeredness criteria as specified by the Secretary, such as the use of patient and caregiver assessments; and
- submit data regarding the quality of care furnished by the ACO as to be determined by the Secretary.

4 A Number of Requirements Must Be Met Before Any Savings Are Shared With ACOs. To share in any savings realized by the ACO under the Shared Savings Program, the ACO must meet both quality performance standards and the savings threshold established for the specific ACO by the Secretary. The savings threshold will be determined by estimating the average per capita Medicare Part A and Part B expenditures for the Medicare fee service beneficiaries assigned to the ACO, risk adjusted for beneficiary characteristics. From this estimate, CMS will establish a percentage threshold that the ACO will have to achieve in order to participate in any shared savings. For instance, if the percentage threshold is set at 0 percent, the ACO would be eligible to participate in first dollar savings. However, if the percentage threshold was set at 5 percent, the first 5 percent of savings from the budgeted estimate would go exclusively to CMS, and the ACO would only participate in any shared savings beyond that 5 percent threshold amount. It should be understood that the Act does not set any savings thresholds but that such are to be established annually for each ACO by the Secretary. In the Medicare Physician Group Practice Demonstration Project, CMS set the threshold at 2 percent. Presumably, CMS will set the threshold at an initial low level, potentially 0 percent, to encourage provider participation in the Shared Savings Program and will increase the percentage threshold over time to encourage continued savings within the ACO.

5 Many of the Details of the Shared Savings Program Are Unknown at This Time. As discussed above, CMS will establish the savings threshold on an annual basis for participating ACOs. Likewise, the percentage of the shared savings payable to the ACO has not yet been established by CMS. In the ACO concept set forth by Elliot Fisher, Mark McClellan and others, which is the model largely adopted by Congress in Section 3022 of the Act, the shared savings bonus going to the ACO was set at 80 percent of the savings below the savings threshold. That is, in such a model, any savings on actual per beneficiary expenditures under Parts A and B for those beneficiaries assigned to the ACO compared to the budgeted estimate will be shared 80 percent with the ACO and 20 percent with CMS. The Secretary has been mandated to establish limits on the total amount of shared savings that may be paid to an ACO under the program. CMS has also been given the authority to impose appropriate sanctions against the ACOs for cherry picking, i.e., avoiding at-risk patients to artificially reduce per capita beneficiary expenditures.

Likewise, the specific quality standards and measures, which will include measures of clinical processes and outcomes, utilization and patient and, where practicable, caregiver experience of care, have not yet been established. That is, ACOs currently do not know the exact quality standards or how such standards will be measured, which must ultimately be satisfied as a necessary prerequisite to realizing any shared savings. The Secretary is authorized to the extent he or she determines appropriate to incorporate the Physician Quality Reporting Initiative reporting requirements as part of the Shared Savings Program requirements.

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6 The Act Does Not Relieve Any Existing Legal Hurdles for ACOs. Although the Act gives the Secretary authority to waive the Civil Monetary Penalty Law, the Stark law, the Anti-Kickback Statute, and other Title XVIII requirements (e.g., reassignment prohibition, provider-based rules, etc.), the Act does not automatically relieve these legal obligations. Further, it is unclear whether CMS will issue a blanket waiver of these requirements to participating ACOs or whether the ACOs will have to seek such waivers on a case-by-case basis. More troubling, however, is the fact that the Act does not waive and provides no direct authority for waiving federal or state antitrust laws or other state laws that may impede the development of ACOs, such as any willing provider laws and similar anti-managed care legislation adopted by state legislatures in the 1990s.

7 Existing Structures May Serve as the Basis for An ACO. A hospital or multi-specialty group could serve as an ACO. Additionally, the various integrated delivery system models that we saw in the 1990s such as Physician-Hospital Organizations (PHOs), Independent Physician Associations (IPAs), Physician Service Organizations (PSOs) and Managed Service Organizations (MSOs) may be restructured to serve as an ACO. Although not presently anticipated in CMS' Shared Savings Program, an ACO could also be developed by a commercial insurance provider, either directly or in conjunction with a provider organization. Unlike the 1990s, the challenge for providers will be to create an effective ACO given the other physician-collaboration activities going on in their particular facilities, many of which may already include certain quality and efficiency standards (e.g., co-management arrangements, gainsharing, etc.).

8 An ACO Does Not Necessarily Have to Assume Financial Risk. Under the Shared Savings Program, health care providers and suppliers participating in the ACO will continue to receive full payment from CMS for their services under Medicare Parts A and B. The Act does authorize the Secretary to utilize other payment models to compensate ACOs, such as partial capitation arrangements whereby the ACO will be at financial risk for some but not all of the items or services covered under Medicare Parts A and B for beneficiaries assigned to the ACO. CMS is authorized to limit participation in such partial capitation models to highly integrated systems of care and to ACOs capable of bearing risk. To the extent that CMS rolls out a partial capitation payment system or any other payment system other than the shared-savings payment model, CMS is obligated to cap such payment outlays to amounts it would have expended had the model not been implemented.

9 The Role of Patients in ACOs. CMS has indicated that Medicare beneficiaries will be assigned to ACOs based upon their historic utilization of primary health care services. At this time, however, CMS has indicated that beneficiaries assigned to a particular ACO will be free to seek care outside of the ACO. Such beneficiary freedom will surely limit ACOs from participating in true risk-sharing arrangements with CMS (i.e., CMS has the authority to establish partial capitation and other risk sharing arrangements under the Shared Savings Program). Likewise, it is unclear whether CMS will share, or allow ACOs to share, any portion of the savings realized with beneficiaries. Many believe that beneficiaries will be unlikely to change how they interact with the health care delivery system without their financial incentives being aligned with the ACOs' financial incentives.

10 An ACO Can Participate in Other Payment Reform Initiatives. Interestingly, in an attempt to prevent double dipping, with the exception of the Physician Group Practice Demonstration Project, Congress prohibits a provider of services or supplier from participating in the Shared Savings Program to the extent that the provider participates in any model tested or expanded under Section 1115A of the Social Security Act that involves shared savings or any other program or demonstration project that involves shared savings or the Independence at Home Medical Practice Pilot Program.

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ACOs may, however, decide to forgo participation in the Shared Savings Program in order to participate in other payment reform initiatives. Presumably, such ACOs would already have experience assuming financial risk under commercial arrangements or, possibly, such ACOs may want to commence under the Shared Savings Program and transition to another payment reform initiative once its initial three-year commitment has concluded. The Act includes both specific payment reform initiatives such as the pilot testing of bundled payments for certain episodes of care to be initiated by January 1, 2013 (Section 3023) and less defined and possibly more creative payment reform initiatives developed under Medicare's new payment reform think tank, the Center for Medicare and Medicaid Innovation (Innovation Center) (Section 3021). Among a number of opportunities to be assessed by the Innovation Center is the establishment of a comprehensive payment to a Healthcare Innovation Zone consisting of a teaching hospital, physicians and other providers, which would cover the full spectrum of health care services to a defined community.

11 ACOs That Wish to Contract With Third Parties Must Be Integrated. Despite widespread embracement of the concept of ACOs by both the federal government and certain state governments, the Federal Trade Commission (FTC) has already expressed its concern that such arrangements may have an anti-competitive effect as ACOs move to negotiate with non-governmental payors. In fact, we anticipate that antitrust issues will be the primary legal deterrent to development of ACOs. Although the act of competitors coming together and setting the prices that they will charge purchasers is the classic antitrust cartel, the FTC and the Department of Justice (DOJ) have recognized that collective activity among health care providers may result in increased efficiencies in the delivery of health care services. In the health care industry, the DOJ and FTC have traditionally relied on the sharing of substantial financial risk among participants as a proxy for economic integration sufficient to result in a rule of reason analysis. Accordingly, ACOs that share substantial financial risk will likely be sufficiently integrated to jointly set prices among the participating providers within the ACO.

ACOs that do not share substantial financial risk will need to ensure that their participants have substantial clinical integration to justify competitors jointly setting prices, which "can be evidenced by implementing an active and ongoing program to evaluate and modify practice patterns by the network's physician participants and create a high degree of interdependence and cooperation among the physicians to control costs and ensure quality." For a long period, health care networks were hesitant to rely solely upon clinical integration as a means to justify single signature contracting because there was no meaningful guidance on what type of clinical integration program would be found sufficient by the FTC or the DOJ (or, for that matter, the courts). However, a number of recent advisory opinions from the FTC have shed some light on what factors the FTC considers when determining whether a particular clinical integration program results in "substantial clinical integration." ACOs, however, will have to determine whether to seek an advisory opinion on their particular clinical integration programs or whether to proceed at risk that such programs may be challenged in the future by the FTC, DOJ or private litigants.

12 The Role of Medical Homes in ACOs. Although the Act provides for grants for the development of patient centered medical homes, Section 3022 specifically prohibits ACOs that participate in the Shared Savings Program from participating in the patient centered medical home program. Nonetheless, ACOs may establish medical homes as a tool for assisting patients in accessing the health care delivery system at the appropriate level of care and ensuring continuity of care across the ACOs delivery network.

13 Pediatric ACOs Differ Under Health Reform From CMS' Shared Savings Program. Section 2706 of the Act directs CMS to establish a pediatric ACO demonstration project. Unlike the Shared Services Program, which is a permanent part of the Medicare program, the

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pediatric ACO is a demonstration project commencing on January 1, 2012 and continuing until December 31, 2016. Accordingly, the pediatric ACO demonstration project will most likely fall under the authority of the newly-reorganized Center for Strategic Initiatives, whereas the Shared Savings Program is under the authority of the newly-reorganized Center for Medicare at CMS. Further, unlike the Shared Savings Program, which depends on individual providers and suppliers to establish ACOs, the pediatric ACO demonstration project is a state-driven program whereby the state applies for the demonstration project and dictates the requirements for ACOs wishing to participate in an ACO to furnish services to children covered under either the Medicaid or CHIP programs.

History may show that health reform's most enduring changes may well be the restructuring of how the government pays for health care services. ACOs are likely to play a significant role in the government's payment reform initiatives. As currently envisioned, the Shared Savings Program offers providers a chance to gain experience in managing costs and quality without being put at financial risk for care to a population of beneficiaries. Providers do, however, need to recognize that in moving away from a fee-for-service mentality, ACO participants are likely to see a decrease in revenue under traditional fee-for-service payment systems before they realize an upside in the form of shared savings associated with such cost efficiencies. Further, we assume that over time the Shared Savings Program will transition towards placing more financial risk on ACOs.

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