

# ACCOUNTABLE CARE ORGANIZATIONS

*Implementing Efficient, Value-Based Health Care Programs*

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## Implementing Efficient, Value-Based Health Care Programs

### ABSTRACT

By 2019, health reform will expand health insurance to over 33 million Americans (95%), not only providing unprecedented opportunities for coverage, but also placing considerable pressure on the economic viability of the nation's health care system.<sup>1</sup> Additionally, a growing number of people with chronic illness and the soon retiring baby-boomer generation will add challenge to payment and delivery reform. The Patient Protection and Affordability Care Act (PPACA), signed on March 23, 2010 by President Barack Obama, changes Medicare payments to providers in order to slow the growth in costs and facilitate better coordinated care and improved health outcomes. In this new environment, Accountable Care Organizations are poised to play a vital role in containing the exponential rise in health care costs and improving quality of care for Medicare, Medicaid and private coverage.

## Overview

### Background

Growth in spending among Medicare beneficiaries is largely due to the increase of spending on chronic conditions; mainly diabetes and hypertension.<sup>2</sup> People with chronic illnesses often have multiple conditions and see as many as seven or eight medical providers, many of them in different locations. The multiple physicians and visits tend to result in uncoordinated care, leading to increased preventable hospital admissions and readmission, poor adherence to medication regimens, and inadequate follow-up care.<sup>3</sup>

The traditional fee-for-service (FFS) payment models under Medicare, Medicaid and private insurance programs do not facilitate cost effective care. FFS payments encourage overutilization of services and even promote waste. If Medicare covers a service, a healthcare provider can deliver that service to a Medicare beneficiary and receive reimbursement, even if a less costly service would have achieved a similar or even better outcome.<sup>5</sup> Providers thereby have a fiscal incentive to do more procedures. Instead of focusing on overall health outcomes, FFS systems provide

payment for disjointed procedures. In such a system, providers and hospitals are more focused on individual treatments and less invested in improving overall patient health.

The PPACA contains provisions that attempt to reduce costs and improve quality, encouraging FFS providers to move towards more efficient, value-added health care delivery. The consensus among health policy experts is that a system of Accountable Care Organizations (ACOs), when implemented correctly, will help to significantly contain costs, deliver the appropriate level of needed care and improve quality. The following report attempts to define how an ACO functions, describes the nature of ACOs under the guidelines of federal reform, discusses the many challenges to developing and operating an ACO, and offers recommendations for successful implementation.

## Introduction

PPACA will provide an opportunity to develop major, innovative improvements to the nation's health care delivery, including the voluntary option for health care providers to form ACOs. ACOs are teams of providers that manage and coordinate care for patients across different care settings to improve outcomes and share cost savings. The ACO concept creates

an organization that is rewarded for improving quality of care, where providers are paid in a way that influences them to work together to improve health care outcomes. The goal of an ACO is to contain costs through better integration among health care providers, where delivering high quality of care is encouraged through financial rewards based

ACOs are defined under the new legislation as groups of providers that have the legal structure to receive and distribute payments to participating providers, to provide care coordination, to invest in infrastructure and redesign care processes, and to reward high quality and efficient services.<sup>6</sup>

upon performance measurement. If the ACO meets its performance and savings guidelines, the members receive a portion of these savings as an incentive for successful collaboration. By utilizing different payment mechanisms, such as partial capitation based on patient populations, or modified FFS payments, ACOs create more appropriate financial incentives for providers to share responsibility in the continuum of patient care. Through this team-based approach, primary care practices may become better equipped to provide higher quality care to more patients, addressing the nation's physician shortage.

## Provisions

The PPACA introduces new patient care models that consider changes in payment mechanisms in order to contain health care costs and enhance quality of care. As subcomponents of ACOs likely to be mandated, these models include a National Pilot Program on Payment Bundling (PPACA § 3023) and a five-year Pediatric Accountable Care Organization Demonstration Project. Within the Centers for Medicare and Medicaid Services (CMS), the new Center for Medicare and Medicaid Innovation (CMI) will test payment and service delivery models that lower costs, yet preserve or improve quality (PPACA § 3021). The law also expands the scope and purpose of the Medicare Rural Flexibility Program to permit ACO incentive payments.

The Social Security Act's Medicare Shared Savings Program offers potential ACOs an opportunity to be formed. To participate, entities must be created before January 1, 2012 and apply for certification from the Secretary of the U.S. Department of Health and Human Services (HHS). ACO programs may link physicians into group practices with hospitals in order to create ACOs that serve at least 5,000 patients, share governance and legal structure, and can distribute shared savings. These ACOs will be accountable for their populations for at least three years, using evidence-based medicine to deliver high-quality, efficient, patient-centered care to Medicare beneficiaries. Provided that they do not purposefully avoid high-needs beneficiaries, ACOs that perform well will get a portion of the system savings.<sup>7</sup>

In an effort to simplify the administration process within an ACO, there will be incentives to promote the use of e-prescriptions, electronic health records (EHRs) and similar health information technology (HIT). Performance data will be publicly available and ACOs must adhere to annual quality targets set forth by the Secretary of HHS. The Secretary also has the ability to issue regulations to permanently establish patient care models that prove their success.

On the federal level, key players involved with the formation of ACO guidelines and enforcement include CMS deputies, former Virginia Health Secretary Marilyn Tavenner and Jonathan Blum, former staffer to Senate Finance Committee chair Max Baucus.<sup>8</sup> In California, it is essential that state policy makers, academics, providers, and other professionals are included in developing and implementing ACO related health reform policies.

## Development and Capacity

### Design Principles

In defining what kinds of organizations can serve as ACOs and what kinds of support they will need to succeed (such as payment changes or degree of technical assistance) it is helpful to examine existing programs that have achieved successful implementation of an ACO. The California Association of Physician Groups (CAPG) has provided some of the highest quality, most efficient, and most affordable health care in the nation; about two-thirds of the practicing CAPG physicians in the state are part of an ACO. Also successful with ACO formation are California's large multi-specialty group practices based in the Los Angeles and Bay Area metropolitan regions.<sup>7</sup> California may wish to expand upon these existing models and promote the use of ACOs in its Medi-Cal, Healthy Families and other publicly financed programs.

The development and operation of efficient ACOs will largely depend on the dynamics established between health care providers and their capacity to adapt to new payment methods and guidelines. An essential part of proper ACO function is the correct alignment of incentives to provider groups to promote higher quality care and ensure that the performance measures chosen are valid, risk-adjusted indicators of higher quality care. Different combinations of providers may create varying types and magnitudes of cost reductions and savings.

Although ACO operations vary in their configuration, health experts agree that all ACOs should be designed upon three main principles:

- 1) Accountability for the entire continuum of care for a defined population of patients;
- 2) Payment reforms that reward quality improvements and slow spending increases while avoiding excessive financial risk; and
- 3) Reliable performance measurements to support improvement and provide public confidence that ACOs will achieve lower costs and better, more efficient care.<sup>6</sup>

### Potential ACOs

Medical practices vary across states and most seriously ill people receive their care from multiple providers. Five different kinds of health care organizations have the potential to qualify as an ACO. These five models, outlined in the table below, include the integrated delivery system (IDS), the multi-specialty group practice

(MSGP), the physician-hospital organization (PHO), the independent practice association (IPA), and loosely organized small physician practices.

<b>Health System</b>	<b>Arrangement</b>	<b>Examples</b>	<b>Capacity</b>
Integrated Delivery Systems	*Common ownership of hospital *Physician practices or insurance plan	Kaiser Permanente, Group Health Cooperative of Puget Sound, and Geisinger Health System	Easier transition to ACO due to aligned financial incentives, electronic health records, team based care, resources
Multispecialty Group Practices	*Own or have a strong affiliation with a hospital *Usually do not own a health plan; have contracts with multiple health plans in their areas	Mayo Clinic, Cleveland Clinic	Most have a long history of physician leadership and highly developed mechanisms for providing coordinated clinical care
Physician-Hospital Organizations	Subset of the hospital's medical staff	Hill Physicians Group, (Northern California)	Need strong financial incentives and technical assistance
Loosely Organized Small Independent Physician Practices	Led by individual physicians in rural areas or by a local medical foundation, state Medicaid agency, or similar organization	Community Care of North Carolina	*Need assistance with leadership, infrastructure, and resources  *Assistance to develop disease registries; implement electronic health records; share information; and provide better-coordinated, cost-effective care

Table contents<sup>2</sup>

Health care organizations will vary in their ability to become an ACO depending upon their legal structure and capacity to redesign care processes. Most IDSs and large MSGPs have a greater infrastructure and more resources and therefore will move more quickly to an ACO model. Other types may require assistance as they develop their arrangement. Instilling flexible guidelines will be important in allowing for all kinds of providers to transition to and advance within an ACO system.

## Implementing ACOs

### Current Pilots

Earlier this year, Blue Shield of California launched an ACO project with Hill Physicians Medical Group and the Catholic Healthcare West hospital chain. In addition, the Hospital Association of Southern California proposed a plan to create a single foundation of multiple facilities to contract with physicians.

In May 2010, Anthem Blue Cross and HealthCare Partners physician group announced a pilot program designed to replace traditional FFS payments with a lump sum paid to physicians for the overall management of patient care. The pilot program focuses primarily on Anthem's Southern California members enrolled in PPO plans. In addition to HealthCare Partners, Orange County physician group, Monarch HealthCare, is also expected to participate in the program.<sup>10</sup>

### Qualifications

Most academics agree that there are three levels of development when creating and defining ACOs.<sup>11</sup> Each tier is based on the degree of financial risk assumed by the ACO and the degree of rewards that could be achieved by meeting performance goals, which would increase from Level I to Level III.

<b>ACO Levels</b>	<b>Description of risk-reward relationship</b>
Level I	Receive smaller proportions of shared savings/bonus payments for cost reduction and quality improvement, but assume the least risk
Level II	Eligible for greater payment rewards and incentives but would also assume greater risks
Level III	Eligible for the greatest rewards but also share the greatest risk

Under this paradigm, payment approaches are adjusted to each qualification level. A majority of Level I ACOs will operate with FFS payment and shared saving are achieved upon delivering quality care at a cost lower than a mutual, predetermined target. For certain conditions, Level I ACOs might adopt some episode-of-care or bundled payment methods. Level II ACOs would use far more of the bundled

payments and episode-of-care based payments. Level III ACOs, having the highest degree of risk, would use more partial and global capitation payments.

This system of qualification allows medical practices at a lower level the chance to develop the capabilities to provide cost-effective, coordinated care and advance to higher level ACOs over time.

## Challenges

While the potential for ACOs is immense, there will need to be changes in the healthcare system in order to encourage and support the operation of ACOs. Legislation has yet to be detailed and much remains uncertain. Main issues to consider include specific legal barriers, degree of technical assistance, payment mechanisms, and accountability measurements.

### Legal Barriers

Potential ACO participants will need to navigate existing laws and certain regulations may need to be adjusted in order to allow for proper implementation and growth of ACOs. Some of these potential legal obstacles include:

- A federal antitrust law that prohibits anti-competitive might prevent some providers and organizations from forming an ACOs;
- State corporate practice of medicine statutes that prohibit some corporations from employing physicians or practicing medicine;
- A federal anti-kickback statute that prohibits the offer or receipt of remuneration in return for referrals for services reimbursable under Medicare or Medicaid;
- The Federal Stark law that governs physician self-referrals; and
- A federal civil monetary penalties law.

### Technical Assistance

Electronic Health Record (EHR) projects are core to ACO formation and Health Information Technology (HIT) must precede the final rule making.

While existing MSGP and IDS likely have in place sufficient technical infrastructure, most providers lack the ability to implement the HIT that ACOs require. Assistance for smaller practices, IPAs and PHOs, will be necessary for beginning level ACO qualification.

### Accountability and Patient Attainment

For California, in particular, it will be important to allay consumer skepticism, largely brought about during the late 1990's from the capitation payment method of HMO systems. The greatest concern among those opposed to an ACO comes from the fear that providers may be encouraged to do less than stellar care in order to maximize their payment. Differentiating between ACOs and HMOs will help consumers separate their opinions and dispel their views that ACOs are mini HMOs. ACOs differ from HMOs, in that there are far stronger financial incentives for providers to improve quality of care and outcomes. ACOs direct contracts with provider organizations to improve patient outcomes and performance.

Building patient confidence is integral to the spread of its ACO concept; thus patient enrollment should be voluntary and performance measurements made public. Medicare, Medicaid and private insurance plans should provide patients with at least one option to choose an ACO, especially marketing the ACO concept to populations with chronic conditions.

## **Payment Mechanisms and Incentives**

Specific payment models and approaches could be linked to different levels of ACO qualification criteria, as mentioned earlier. CMS and private insurers should provide incentives for physicians who wish to develop and join high performing ACOs by providing grants and loans targeted to more loosely organized IPAs and small physician practices who are ready and interested in becoming a well-managed ACO. Establishing loan forgiveness programs for providers could encourage those who wish to join high performing qualified ACOs.

A medical school loan forgiveness program could be implemented for younger physicians who join an ACO that has demonstrated superior performance. This provides an incentive for younger physicians to join high performing ACOs and also provides incentives for developing or established ACOs to have access to the best young physicians available.

## **Discussion**

While planning begins for ACO development, there will be several key elements to define. Five major questions are listed below:

1. How will beneficiaries be assigned?
2. How will savings be calculated based from historic Medicare costs?  
-What percentage of savings will be shared with an ACO?

3. How will benchmarks be determined?
4. What type of patient-centeredness?
5. What quality standards will the ACO have to satisfy?

In order to overcome the challenges and create meaningful reform, it is important for all stakeholders/providers and payers participate in defining ACO qualifications, legal matters, and quality benchmarks.

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