ACOs: Applying 20th Century Laws to 21st Century Ideas

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With the number of pronouncements from the federal government in recent weeks with respect to accountable care organizations (ACOs), it is certainly time to reflect on the amount of attention this idea has been given. ACOs arise out of the Patient Protection and Affordable Care Act (PPACA) and in particular with those sections of the PPACA devoted to the Medicare Shared Savings Program. The Centers for Medicare and Medicaid Services (CMS) has recently published a Request for Information relating to ACOs and the Shared Savings Program in the Federal Register.

Many of the basic characteristics of ACOs were set forth in our April 15 Health Care Law Alert, “Are Accountable Care Organizations in Your Vocabulary?” But since that time there has been robust discussion among providers and their legal advisors about how to establish an ACO or integrated clinical structure and how those structures meet the requirements of various state and federal laws. Those laws were largely developed to rein in alleged abusive practices by providers in the fee-for-service environment. ACOs and companion bundled payments from the Medicare program are considered to be the antidote for the incentives of increased utilization and patient volumes inherent in a fee-for-service system that could allow the provider to benefit.

From a patient perspective, ACOs might have challenges ahead, as the industry learned in the era of managed care. Patients like to choose their own providers. They are not sensitive to how, in a fee-for-service system, their choices without guidance from a focused medical team drive up costs and may not result in increased quality of care. These realities are well documented.

As reported in Modern Healthcare, the chairman of the American Hospital Association recently advised a gathering of industry leaders to focus their efforts on “accountable care” and not “accountable care organizations.” Why would a leader of America’s hospitals make such a remark? What could be the implications of putting more focus on care and not on the structures for delivering care? Federal regulators, including CMS Administrator Dr. Donald M. Berwick and his counterparts at the Federal Trade Commission (FTC) and other federal agencies, are attempting to promote the idea of physician/facility collaboration but are not yet willing to admit that the laws and rules so exhaustingly pressed by regulators and Congress in the past will actually work on these new ideas developed for a system focused on the population’s health. While ACO discussions and “open mikes” at government-sponsored events clearly are encouraging providers to move forward with clinical and structural integration, these same government representatives represent agencies that are still focused on fighting fraud, suspicious of consolidation by providers in competitive markets and concerned that providers do not become insurers by taking on risk. Clearly they are reluctant to call for a wholesale change in the game.

Can government regulators reverse decades of antitrust policy, court cases and FTC guidance to permit these new delivery models to flourish? Will the Office of Inspector General (OIG)
and the folks at the Department of Health and Human Services (HHS) sweep away the many restrictive provisions of the Stark law, various fraud and abuse pronouncements and safe harbors, which in the past narrowly restricted the ability of physicians and hospitals to share profits and collaborate on patient care integration? These issues make many experienced advisors caution their clients when they are assessing the investment of becoming an ACO. In this uncertain environment, providers should not look at an ACO for a hospital as an opportunity to increase its market share. If increasing market share becomes the motivating factor, all ACO pronouncements aside, such an intent could come to haunt any project, so strategists would be wise to cast their rhetoric appropriately even in the planning stages and internal presentations.

The recent white paper “Accountable Care Organizations in California: Lessons for the National Debate on Delivery System Reform” published by the Integrated Healthcare Association (IHA), a nonprofit organization based in California and that represents various stakeholders in integrated delivery in that state, describes the California experience in providing integrated healthcare delivery to its residents. The white paper claims that California has 285 organizations that demonstrate the characteristics being established by CMS for ACOs. While the white paper celebrates the large number of individuals served by these ACO-like organizations in that state, the authors offer their guidance on issues they see as potential challenges for the nationwide development of these innovative approaches to care delivery:

- **Organizational Structure:** Should the base of the ACO be physicians, independent practice organizations (IPAs) or physician-hospital organizations (PHOs)? Should the structure be something newly created to allow for maximum flexibility and size in terms of the number of patients in the ACO? How does the related health care institution fit within the model of care, with more care being delivered by physicians in outpatient settings as an example?

- **Payment Methods:** How does the ACO migrate from a fee-for-service environment to capitation and finally to a bundled payment? What is the ideal methodology for rewarding successful care on the basis of cutting expenses and providing quality care to patients?

- **Relations with Health Insurance Plans:** While the impetus for most ACO development now is a result of CMS initiatives, how will these integrated care organizations work with other third-party payors? With CMS under pressure to cut its Medicare payments to providers to help pay for PPACA initiatives to be more inclusive and cover the uninsured, will private payors decide to support these new structures and care models? If private payors do support ACO development, how will efficiencies and delivery of quality care be consistent with what CMS decides with respect to Medicare payments to the ACOs, physicians and hospitals?

- **Maintenance of Consumer Choice:** How does the integration of clinical services going to affect currently unfettered patient choice? Will patients and consumers accept the panels to be established by the provider networks, and, if they are still permitted to choose out-of-network services, how will that right be tracked to ensure appropriate reporting of quality and savings measures?

- **Public Policy and Regulation:** Since the ACO concept in the PPACA is titled “Shared Savings Program,” how will the CMS portion of the savings be administered? Will the amount of the savings being kept by CMS result in a destabilization of private efforts? How will owners of ACOs react in cases in which there could be concern about the future viability of the ACO created? As ACOs grow in size and strength, will competition be reduced, resulting in price increases? The IHA acknowledges that as ACO-like structures have developed in California, prices of physician and hospital services have continued to rise. While such increases cannot be traced to ACO-like developments in California, it might be one of the causes.

No one has all the answers to how ACOs will actually develop and become an accepted vehicle to deliver quality integrated care to Medicare patients. It is clear that providers contemplating proceeding with the exploration of an ACO in their community need to continue to monitor the thinking of various regulators — CMS, HHS and the FTC, among others — with a role in overseeing the development of these types of organizations.

A good example of the many groups and regulators who are observing the development of ACOs was set forth in a recent comment letter sent to CMS in response to the CMS Request for Information from the Medicare Payment Advisory Commission (Medpac). In a letter dated November 22, 2010, Medpac made it clear that they were encouraging the use of ACOs to “correct some of the undesirable incentives inherent in fee-for-
In Medpac’s comments they asked CMS to change the incentive model from one based totally on bonus payments to ACOs that meet both quality targets and keep spending on the population served by the ACO at below target levels. Medpac criticizes such a system, arguing that the bonus system puts total risk on the Medicare program in the event that no savings are achieved. In that case, Medicare will still pay the ACO its fee-for-service revenue. Similarly, Medpac points out that the failure of an ACO to meet quality targets would simply mean that the ACO would not receive its bonus but would still receive a fee-for-service payment. Medpac proposes a “two-sided risk model, which incorporates a share of first-dollar savings and some form of risk corridors.” Medpac believes only with this approach will ACOs succeed and program objectives be realized.

In Medpac’s November 22, 2010 letter they also provided their views on whether beneficiaries who are assigned to ACOs should be advised of their status. Observing that knowledge of the beneficiary’s status with their provider is vital to an understanding by the beneficiary of the goals of the program: to provide higher quality care at reduced cost. Trust, according to Medpac, could be a major factor of success. Medpac comments that this approach will hopefully avoid the “backlash” of the 1990s, when patients felt they were being forced into managed care plans by their employers. As a result, Medpac urges CMS to provide beneficiaries with prospective notice, as opposed to retrospective notice of their classification in the ACO.

Finally, Medpac’s submission to CMS suggests some population-based outcome measures that CMS should consider implementing:

- emergency room use
- potentially preventable admission rates
- in-hospital mortality rates
- readmission rates.

**Conclusion**

There is certainly plenty of information and speculation available about ACOs, one of the most talked-about ideas in years. Questions remain about the extent of the financial and legal parameters that will emerge. It would not be the first time that a great idea was handicapped by overly restrictive oversight. In the meantime, legal experts question whether, as plans move forward on proposed ACOs across the country, government leaders will be consistent in their approach to success across agency jurisdictions. Who actually has the power to speak for them all? More importantly, are regulators prepared to rein in decades-old concepts to find a way to avoid the financial perils ahead for Medicare and other government programs? We will continue to monitor developments and provide our guidance on these important issues.