

Accountable Care Organizations – Look Before You Leap

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Accountable care organization, or ACO, is a potential new model of healthcare delivery and payment system and has been a key component of the healthcare reform debate. It is currently a “hot topic” amongst healthcare providers, consultants and think tanks, and has sparked a flurry of forums and conferences on how to structure and implement an ACO. The recently passed healthcare reform act mandates the federal government to establish an ACO-based Medicare shared savings program by January 1, 2012, and multiple private organizations and state agencies throughout the country have already started developing demonstration projects of their own. In California, Anthem Blue Cross has joined two Southern California medical groups/IPAs to participate in an ACO pilot program organized by early promoters of the ACO concept – the Engelberg Center for Health Care Reform at Brookings and the Dartmouth Institute for Health Policy and Clinical Practice. In light of all the enthusiasm surrounding ACOs, hospitals and physician groups are becoming increasingly anxious to take steps to move toward an ACO model. However, despite the abundance of industry publications and articles, there is currently very little guidance provided by the federal government about ACOs or the yet-to-be-established Medicare shared savings program. Based on the current information, we believe there are multiple ways of forming an ACO (such as utilizing an existing medical foundation platform), and we caution against leaping into new arrangements or making changes to existing relationships before additional regulations become available.

What Is an ACO?

ACO generally refers to an organization of healthcare providers that agrees to be accountable for the quality, cost, and overall care of a defined pool of patients. The term was coined by Dr. Elliot Fisher of Dartmouth Medical School in 2006, and numerous subsequent papers have proposed various potential forms of the ACO model. A typical ACO model involves a group of providers in a community that provides the continuum of care for a certain number of patients, and the group is financially incentivized to provide efficient and cost effective care. A key characteristic of an ACO is the ability to coordinate patient care and implement quality and cost measures on an organizational basis. The theory is that greater coordination and cooperation among providers would result in improved quality of patient care, and, consequently, a healthier and less costly patient population. Any savings achieved would be shared with the ACO.

The ACO concept is consistent with the healthcare industry’s long-standing goal of shifting away from the current volume-driven fee-for-service payment system towards a pay-for-performance system. It is widely viewed as superior to some of the other payment models that also attempt to achieve accountability of overall cost. It is different from HMOs in that the “accountability” rests with the providers rather than an insurance company. It also differs from a primary care medical home model because that model typically excludes specialists and hospitals and therefore does not provide accountability for total per capita costs. It is also broader than the bundled payments system which only promotes efficiency and care coordination with respect to a particular medical incident. Another advantage that an ACO has over other payment models is that an

ACO would likely be built upon existing patient-physician relationships as well as an existing network of providers, so it would cause minimal disruption to how patients seek medical care.

Eligibility Criteria under the Medicare ACO Program

The recent healthcare reform act mandates the Department of Health and Human Services (the "DHHS") to establish, by January 1, 2012, a Medicare shared savings program whereby groups of providers that care for Medicare fee-for-service beneficiaries through an ACO are eligible to receive payments for shared savings. In order to participate in the program, an ACO must demonstrate the following:

- Have a sufficient number of primary care physicians to serve at least 5,000 Medicare patients, and be willing to be accountable for the quality, cost and overall care of the patients assigned to it. It is important to note that there is no explicit requirement under the statute for an ACO to include a hospital, although it is generally understood that an ACO would include at least one hospital.
- Participate in the program for at least three years and provide certain information to the DHHS, such as information regarding participating professionals, implementation of quality measures, and the determination of payments for shared savings.
- Have a formal legal structure that would allow the organization to receive and distribute payments for shared savings to the participating hospitals, primary care physicians, and other providers.
- Have defined processes to promote evidence-based medicine, report on quality and cost measures, and coordinate care through the use of health information technologies, and be able to meet certain patient-centeredness criteria.
- Have a mechanism for shared governance, and a leadership and management structure that includes clinical and administrative systems.

Additional details will be included in a Notice of Proposed Rulemaking that is expected to be published this fall. Many industry organizations (such as the American Medical Group Association) have offered recommendations for future rulemaking. Multiple private demonstration projects are being established throughout the country, and the results and experiences from these projects will presumably also be taken into consideration. The ACO model that will ultimately emerge from the Medicare program will likely serve as the standard for future government and private programs.

ACO as a Separate Legal Entity?

Based on the information currently available, we believe there are numerous ways to structure an ACO. Some have taken the position that an ACO must be established as a separate legal entity due to the requirement that the ACO must have "shared governance." For example, we understand there is an ACO model currently being discussed that is structured as a for-profit joint venture with majority ownership by physicians and minority ownership by hospitals. This structure presents multiple legal challenges, and based on the current information, formation of a separate legal entity does not appear necessary. We urge providers who are interested in creating an ACO to, at the very least, wait for additional regulations and guidance from the federal government before forming a separate legal entity for purposes of establishing an ACO.

If an ACO is not formed as a separate legal entity but rather through contractual arrangements among providers, it would need to be able to demonstrate some form of "shared governance" among the participants. One way could be to establish a separate "governance" committee with representatives from various providers groups (e.g., hospital, medical foundation and medical groups). The committee would have leadership and management responsibilities with respect to the ACO, including development and implementation of quality and cost measures, and decisions relating to the distribution of shared savings. However, it would be

important to review future regulations for additional guidance on what “shared governance” entails and how to satisfy this requirement.

Potential ACO Structure

The medical foundation model that is widely used in California could serve as a good platform for establishing an ACO. The model typically involves a medical foundation (which operates medical clinics) that is affiliated with an acute care hospital and has exclusive professional services agreements with community medical groups. The medical foundation generally would have the infrastructure for billing and collection on behalf of itself as well as for its physicians. It would also have an established legal structure through the various professional services agreements for compensating its physicians, and would be able to receive and distribute any shared savings payments among the providers. The foundation could also enter into independent contractor agreements with community physicians who wish to participate in the ACO if it wishes to increase the number of physicians participating in the ACO.

In a typical foundation model, all of the foundation’s physicians would be members of the affiliate hospital’s medical staff. Since the foundation and the affiliate hospital are related parties, the physicians, foundation and hospital generally already operate under a shared set of standards, policies and procedures with respect to patient care. Many of the foundation model delivery systems in California also have electronic health records and other technologies in place to allow for the sharing of information and reporting on quality and cost of care. As a result, the parties have already achieved a high degree of clinical integration to allow them to coordinate patient care and implement quality and cost measures, which is a key element for an ACO.

Conclusion

ACOs hold great promise as the healthcare delivery and payment system of the future. If the various demonstration projects prove the model to be successful, ACOs could be a groundbreaking change in the healthcare industry. Understandably, healthcare providers are eager to be at the forefront of this movement and proceed quickly to participate in an ACO. However, despite the overwhelming amount of industry discussion and publication on this topic, there is relatively little official guidance from the federal government, which ultimately will set the standard for ACOs going forward. Therefore, we urge providers to take caution and carefully review the current statute and future regulatory guidance before leaping into any new arrangements or making any changes to existing relationships.



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