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Clinical Integration and Accountable Care Organizations: Getting Started Down the Road to Accountable Care

The Patient Protection and Affordability Act (ACA) sets a national agenda for improved access to care, improved healthcare quality and lower costs. The ACA, as implemented by the Department of Health and Human Services (HHS) focuses particular attention on Accountable Care Organizations (ACOs) as a key reform strategy that will transform the business model of healthcare from one based on fee for service and units of service to one where payments will be bundled for a group of providers and will be tied to the quality and value of the care provided. This article identifies some of the key steps that health system executives and board members should be taking and answers some basic questions about ACOs.

The provision of healthcare in the United States has been described as fragmented, with patients accessing care through multiple, often unrelated providers. Section 3022 of the ACA directs the Secretary of HHS to implement an integrated care delivery model in Medicare, the Medicare Shared Savings Program, using ACOs. HHS is expected to issue regulations for the Shared Savings Program in early 2011, but providers should already begin preparing for the transition to accountable care. An understanding of ACOs and their role in the healthcare delivery system starts with an understanding of some basic concepts about accountable care as compared to the traditional delivery of healthcare:

1. **What is an ACO?** An ACO is a collection of providers in a local delivery system who accept joint responsibility for the quality and cost of healthcare for a defined population. The ACO contracts with payers to be accountable for the entire continuum of care provided to a defined population.

If the cost of care provided is less than targeted amounts agreed to by the payer and the ACO, and certain quality measures are achieved, the ACO and the payer will share the savings generated. While ACOs can be designed with varying features, most ACOs put primary care physicians at the core and emphasize reducing the cost of providing care and improving the quality of the care provided. Successful clinical integration is the cornerstone of accountable care. ACOs must have the organization and information system capability to support and measure quality in order to appropriately award efficient providers.

2. **Why do health systems need ACOs?** Health systems need to start migrating toward an ACO structure now. They must begin the transformation to new payment methodologies such as medical homes, gain sharing and pay for performance. Regardless of the direction of the Medicare Shared Savings Program, private payers have already started pushing providers toward accountable care payment models. Moreover, many systems are pursuing ACO-type contracts with payers to try and develop the means to steer patients from one system to another.

3. **Where do we start in developing an ACO?** One prerequisite for an ACO is a clinically integrated network that includes the types of providers required to deliver the clinical services to a particular population. The network can take many forms, such as hospital-employed physicians, a physician-hospital organization or other organizational forms. The network participants must work together to achieve clinical integration by collecting and analyzing performance data, developing clinical protocols and contracting with health plans for pay for performance contracts. Significant investment in information technology may be required. Fundamental to ACO success is the use of performance data to drive decision-making. ACOs must have the infrastructure in place, including electronic medical records and disease registries, to extract data, run analytics, and use that information to improve prognosis and outcomes and reduce costs for the population assigned to the ACO.

4. **What roles do physicians play in an ACO?** The vast majority of individual decision-making for patients is made by physicians, particularly primary care physicians. In order to qualify for the Medicare Shared Savings Program, organizations will need a population of at least 5,000 Medicare beneficiaries. The ACO model explicitly couples quality and savings and requires providers to achieve savings while maintaining or improving quality. Accordingly, physicians will play a key role in setting and monitoring quality measures. However, incentive payments to physicians and joint contracting by providers raise issues under the Stark Law, the Anti-Kickback Law and the antitrust laws, which will need to be addressed in the upcoming

regulations by the Federal Trade Commission (FTC), the Centers for Medicare and Medicaid Services (CMS) and the Office of Inspector General (OIG) of HHS. For an extensive analysis of the key role physicians play in ACOs and the regulatory issues involved, see the article ACOs: Physician Participation Required, authored by Husch Blackwell attorneys Howard Hahn and Torri Criger, that was published by the American Health Lawyers Association in January 2011.

Stay Tuned

Additional information will be forthcoming from Husch Blackwell concerning ACOs. Husch Blackwell will keep its clients and friends apprised of these developments, including the regulations and guidance expected to be issued in early 2011 by the FTC, CMS and OIG. Once these regulations and guidance are released, look for announcements concerning special programs that will be presented by Husch Blackwell attorneys to analyze their impact on the Medicare Shared Savings Program in particular and ACOs in general.

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