

**The New Healthcare Delivery System: What Are Medical
Homes and Accountable Care Organizations?**

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Healthcare reform legislation includes a number of proposals to support the development of alternatives in the delivery system, including both medical homes and accountable care organizations (ACOs). Both the Senate and House proposals encouraged the development of alternative payment arrangements including medical homes and ACOs, and would fund demonstration projects regarding these innovative delivery systems and related payment systems that focus on quality and management of care rather than volume.

With the focus on these systems, some basic questions arise: What are these organizations? What does it take to establish a qualifying medical home or ACO? What distinguishes these organizations in a manner that is seen as likely to bring about both quality improvement and cost control?

Accountable Care Organizations

In essence, an ACO is a group of providers who are responsible for the quality and cost of care delivered to a defined group of beneficiaries. An ACO might take various forms, include different types of providers, and have mandatory or voluntary provider participation. Responsibility for quality and cost is ultimately enforced through direct payment impact: If the ACO meets cost and quality targets, it receives a bonus; if it falls short, ACO providers would receive less reimbursement. An ACO is generally considered to consist of primary care physicians, specialists, and at least one hospital.

In its June 2009 report to Congress,¹ the Medicare Payment Advisory Commission (MedPac) addressed the ACO model. Starting with the premise that the current trajectory of Medicare fee-for-service spending is unsustainable, MedPac approached ACOs as a way to create incentives to tie provider payments to quality and resource use rather than volume. The ACO would consist of a group of physicians teamed with a hospital that are jointly charged with responsibility for the quality and cost of care provided to a large Medicare population (at least 5,000 individuals, in MedPac's estimation, to achieve statistically meaningful results). Incentives could be structured so as to encourage cooperation among physicians and hospitals to improve quality, and reduce regional variation in care delivery by reducing unnecessary services in high use areas.

MedPac considered an ACO to include primary care and specialist (e.g., surgeons) physicians, as well as a hospital. Structurally, ACOs could operate through integrated delivery systems, physician-hospital organizations, or a hospital teamed with independent, multi-specialty physician groups.

MedPac addressed both voluntary and mandatory ACOs:

- In the voluntary model, physicians and a hospital could choose to organize themselves and be considered as an ACO by Medicare; patients would be assigned to the ACO based on the primary care physician providing the plurality of office visits. The ACO would be paid regular Medicare rates, with the potential to earn a bonus based on spending and quality targets. Spending targets would be structured to take into account differences in regional costs but also encourage efficiencies in high-use areas, while providing areas that are already relatively low use areas an incentive as well. Quality metrics would include mortality, avoidable hospital admissions, readmissions, patient satisfaction, clinical outcomes, and improvements in

¹ MEDICARE PAYMENT ADVISORY COMM'N, REPORT TO THE CONGRESS: IMPROVING INCENTIVES IN THE MEDICARE PROGRAM (June 2009). MedPac refers to and draws in part upon studies published by Elliott S. Fisher and others associated with Dartmouth. See, e.g., Elliott S. Fisher, Mark B. McClellan, John Bertko, Steven M. Lieberman, Julie J. Lee, Julie L. Lewis, and Jonathan S. Skinner, *Fostering Accountable Health Care: Moving Forward in Medicare*, HEALTH AFFAIRS 28, No. 2 (2009): w219-w231 (published online Jan. 27, 2009; 10.1377/hlthaff.28.2w219). Accountable care organizations have been the topic of many other studies and writings. See, e.g., Harold D. Miller, Center for Healthcare Quality and Payment Reform, *How to Create Accountable Care Organizations*, First Edition, Sept. 7, 2009, available at www.CHQPR.org.

functionality. Both quality and spending targets would need to be met to qualify for a bonus.²

- In the mandatory ACO model, patients would be assigned to the primary care physician responsible for the plurality of their office visits; physicians would be assigned to the hospital in which they did most work, or which was used by the plurality of their patients (if the physician did no inpatient work). The group of hospitals and physicians would earn bonuses and be subject to penalties based on their joint performance—even if they had no other connection or cooperative entity through which they directly coordinated. ACO providers would be subject to a withhold on their fee-for-service payments, but if quality and resource use targets were met on the basis of ACO performance measures, then the providers assigned to the ACO would receive their withhold as well as a bonus. Withholds would not be returned if the ACO failed to meet quality targets over a three-year period. The payment implications would tend to encourage the development of organizational structures (physician-hospital organizations) to coordinate in an attempt to reach bonus targets as a group.³

To avoid random variations, MedPac considered that ACOs would need to be relatively large, including at least fifty physicians and 5,000 or more patients.⁴ This in and of itself has some interesting implications for structuring ACOs. MedPac recognized that in low population density areas, ACOs could encompass large geographic areas, including areas that were not proximate to each other. In such large groups, the ability to affect individual physicians based on financial incentives alone is somewhat muted because both bonuses and penalties are spread across the entire group.

MedPac considered that the ACO program would most likely generate net savings for the Medicare program if the model fostered behavioral changes that would constrain capacity and if the bonus payments were funded through a reduction in fee-for-service payments. Such savings were unlikely to be achieved through the strictly voluntary model with bonus incentives. At the same time, mandatory ACOs were unlikely to achieve the types of structural changes most likely to constrain spending unless they

² MEDICARE PAYMENT ADVISORY COMM'N, REPORT TO THE CONGRESS, *supra* note 1, at 43-45.

³ *Id.* at 45-47.

⁴ *Id.* at 48-50.

developed a formal organizational structure allowing for joint decision making on such matters as care protocols, purchase of equipment, recruitment strategies, and bonuses to individual physicians.⁵

Legislation has been introduced⁶ to amend the Social Security Act to establish an ACO pilot program in order to reduce the growth of expenditures and to improve health outcomes under the Medicare program. Under that proposal, a qualifying ACO would refer to a group of physicians, all of whom participate in the ACO, and who are: (1) organized through a legal structure allowing for the group to receive and distribute incentive payments; (2) include sufficient primary care physicians; (3) report data to monitor and evaluate the pilot program; (4) contribute to a best-practices network or website; and (5) utilize patient-centered processes of care, including those that emphasize patient and caregiver involvement in care management. Under this proposal, qualifying physicians could affiliate with other providers, such as a hospital. The ACO could be paid under various models, including receipt of an incentive payment in the event target spending levels were met, or under a partial capitation model for those ACOs capable of bearing financial risk.

Medical Homes

MedPac considered that the development of ACOs was consistent with another initiative in which it was interested—the development of medical homes.

The medical home concept dates back to the sixties, when the American Academy of Pediatrics (AAP) used the term to refer to a central location for archiving a child's medical record. The AAP later expanded medical homes to encompass the concepts of accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective care. The characteristics of a medical home were described in *Joint Principles of the Patient-Centered Medical Home*, issued in March 2007 by the American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, and the American Osteopathic Association, to include the following:

⁵ *Id.* at 52.

⁶ H.R. 2959, introduced June 18, 2009 (sponsored by Rep. Peter Welch (D-VT)).

- Each patient has an ongoing relationship with a personal physician to provide the first contact and continuous care;
- The personal physician leads a team of practitioners who collectively take responsibility for the ongoing care of patients;
- The personal physician is responsible for providing (or arranging for) healthcare needs at all stages of life, including acute care, chronic care, preventive services, and end-of-life care;
- Care is coordinated across all elements of the healthcare system (hospitals, home health agencies, nursing homes, and subspecialty care) and the patient's community (including family and community-based services);
- Care is facilitated by information technology, registries, and health information exchange;
- Quality and safety are hallmarks implemented through the following measures:
 - Patient advocates;
 - Use of evidence-based medicine tools;
 - Physicians accept accountability for continuous quality improvement through voluntary participation in performance measurement and improvement;
 - Patients actively participate in decision making;
 - Patients and families participate in quality improvement; and
 - Practices demonstrate their ability to provide patient-centered services through a voluntary recognition process with a non-governmental entity;
- Access to care is enhanced through open scheduling, expanded hours, and new options for communication among physicians, practice staff, and patients; and
- Payment is structured to recognize the value added by the medical home, including the value of the following:
 - The value of care management work outside of patient visits;

- Care coordination, within a given practice and among consultants, ancillary providers, and community organizations;
- The adoption of health information technology and enhanced communication access such as secure email and telephone consultation;
- Recognition of case mix differences in the patient population being treated by the practice;
- Allowing physicians to share in savings from reduced hospitalizations; and
- Allowing for additional payments for achieving measurable and continuous quality improvements.

As noted by MedPac, a number of medical homes could be included in an ACO.

Issues in Formation of ACOs and Medical Homes

Existing hospital systems and other healthcare providers considering an approach to formation of an ACO or medical home would face a number of implementation challenges:

- These models are centered on primary care providers. The current and projected shortage of these practitioners, particularly in certain areas, will require thoughtful planning and implementation of recruitment agreements to assure sufficient professionals are available to serve as the core of these systems. While physician groups and hospital systems that include a substantial primary care component will be in good form to embark on organization of an ACO or medical home, the number of physician employees or contractors alone is only one element. Competition is likely to emerge for those practitioners perceived as the most qualified providers—and those likely to contribute to positive results for the ACO (and maximize quality and care management performance and, consequently, bonus payments). Education of all providers regarding these organizations and development of the skills needed to function in an environment that will value certain performance measurements rather than procedure volume will be essential.

- As the ACO model is considered for reimbursement purposes, various types of providers have begun to advocate the need to include their services in ACOs to qualify for bonuses and the like (e.g., hospitals, post-acute service providers). The credentialing and contracting methods used by providers to organize themselves into ACOs—whether encouraging exclusive participation in one organization or refusing to admit providers perceived to lack the skills needed to optimize performance of the organization—will require rethinking traditional hospital and managed care credentialing systems, and may well spawn litigation unless or until legal consensus emerges on the appropriate standards.
- These models are premised on close communication involving a fairly wide circle of providers and other support systems, including electronic health records. The expense and coordination issues involved in implementing a common records system will be exacerbated if, as noted in the MedPac report, some ACOs may need to span very large geographic territories that are not proximate communities in order to serve a sufficiently large patient population. Providers—whether hospital systems or physician groups—that are able to take the lead in this arena may have a large impact on the ACO organizational process.
- Unless referral laws, antitrust laws, and gainsharing principles are relaxed in the context of these organizations, attempts to affiliate numerous providers across the care management spectrum to coordinate and be accountable for the care of large patient populations will be hampered by rules that are intended to regulate heavily financial transactions among providers who refer to each other, sharing of pricing and other sensitive competitive information, and making payments to reward cost savings in the delivery of patient care. As MedPac’s discussion of the “involuntary” ACO model demonstrates, these types of organizations are likely to be most effective for the government’s purposes if there is an organized effort among providers committed to cooperate in both care delivery and distribution of incentive compensation.
- The ability of ACOs and medical homes to produce significant reductions in healthcare spending—which is the ultimate goal of government healthcare

programs—has yet to be determined. As noted by MedPac, bonus payments offered to these organizations on top of fee-for-service rates may simply generate additional expenditures if the care management conducted by these organizations does not generate a sufficient volume of actual savings. Providers participating in and managing the professionals in these organizations will need to find ways—through employment/contractor bonuses, withholds, internal quality incentive payments, or non-monetary recognition valuable to those participating—to keep professionals incentivized even if the success of their efforts results in lower volume of care and, thus, lower fee-for-service payments. Investments needed to recruit and train professionals, implement electronic health records, and plan and execute on contracts to affiliate necessary providers across an ACO territory will put providers at financial risk if the results of their care do not earn sufficient reimbursement through the payment system that emerges in the post-reform landscape.

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