

Legal Mechanisms Supporting Accountable Care Principles

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Abstract

Public health and private providers and facilities may shape the future of the US health system by engaging in new ways to deliver care to patients. “Accountable care” contracts allow private health care and public health providers and facilities to collaboratively serve defined populations. Accountable care frameworks emphasize health care quality and cost savings, among other goals. In this article, I explore the legal context for accountable care, including the mechanisms by which providers, facilities, and public health coordinate activities, avoid inefficiencies, and improve health outcomes. I highlight ongoing evaluations of the impact of accountable care on public health outcomes. (Am J Public Health 2014; 104:2048-2051. doi:10.2105/AJPH.2014.302161)

Introduction

As the US health system undergoes transformation, public health departments are engaging in new ways to deliver health care with private entities. One such method is “accountable care,” the coordinated provision of patient services by health care and public health providers and facilities with the goals of improving outcomes and avoiding inefficiencies.¹ The core tenets of accountable care are prevention, health care quality, patient satisfaction for the population served, and cost savings to the health care system.² Accountable care frameworks are based on risk and reward, with providers and facilities agreeing to collectively share the financial risk for a population in return for the opportunity to access rewards for attaining pre-established health care goals.

Entities that seek to engage in accountable care are formed according to legal principles governing businesses and contracts, but federal and state laws³ specifically incentivize the formation and success of

¹ Elliott S. Fisher et al., *A Framework for Evaluating the Formation, Implementation, and Performance of Accountable Care Organizations*, 31 Health Aff. 2368, 2368–78 (2012).

² *Id.*

³ Information on the formation of legal entities under state law is available elsewhere. See, e.g., Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program, 76 Fed. Reg. 209, 67026 (October 28, 2011); B.M. Fried et al., *Accountable Care Organizations: Navigating the Legal Landscape of Shared Savings and Coordinated Care*, 4 J. of Health and Life Scis. Law 88

these entities by establishing antitrust waivers, fraud and abuse protections, and mandates to coordinate care. Although much has been written on the legal basis for establishing accountable care entities, with this article, I seek to inform public health practitioners of the relationship between the laws that recognize accountable care principles and the public health goals of improving patient care, impacting quality and outcomes, and measuring population health.

In this article, I discuss 3 mechanisms by which providers, facilities, and public health may contract together to maintain legal entities that implement accountable care principles. First, health care providers and payers have pursued private contracts to provide accountable care to improve outcomes in their patient populations.⁴ Second, the Centers for Medicare and Medicaid Services authorizes Medicare reimbursements for legal entities certified as accountable care organizations (ACOs) through traditional fee-for service and other payments upon meeting benchmark cost and quality standards.⁵ Third, state laws incorporate accountable care mechanisms into Medicaid provisions, permitting state programs to reimburse accountable care entities that serve vulnerable populations.⁶ Finally, I offer suggestions for evaluating the impacts of accountable care on public health outcomes.

Private Accountable Care Entities

Private payers and providers have led the shift toward accountable care frameworks for more than a decade, developing health care quality metrics that public health departments use to track population health today. Providers embraced the concepts of “care coordination” and “integrated networks of care,”

(2010); J. Williams, *The Shared Accountability Approach to Physician Payment: Four Options for Developing Accountable Care Organizations*, 7 *Indiana Health Law Review* 185 (2010).

⁴ See, e.g., Paul DeMuro, *Accountable Care*, 24 *The Health Lawyer* 6, 5–8 (Aug. 2012) (discussing early accountable care developments at the Mayo Clinic, Kaiser Permanente, and Group Health Cooperative of Puget Sound, among other provider arrangements).

⁵ Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) (establishing the Medicare Shared Savings Program). The Affordable Care Act also established the Center for Medicare and Medicaid Innovation, which launched the Pioneer Accountable Care Organization Model, a shared savings program “designed specifically for organizations with experience offering coordinated, patient-centered care, and operating in ACO-like arrangements,” *Pioneer Accountable Care Organization Model: General Fact Sheet*, Centers for Medicare and Medicaid Services (Sept. 12, 2012), <http://innovation.cms.gov/initiatives/Pioneer-ACO-Model>.

⁶ M. Gold et al., *Emerging Medicaid Accountable Care Organizations: the Role of Managed Care* (May 2012), <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8319.pdf>.

championing patient-centered medical homes for primary care and participating in the 2005 Medicare Health Care Quality and Physician Group Practice demonstrations.⁷ Acceptance of these concepts allowed some providers and facilities to incorporate holistic patient care principles into existing contracts and employment relationships.⁸

Other health care entities developed new contracts and legal relationships to experiment with accountable care concepts: large multispecialty medical group practices contracted with health plans, and physicians jointly owned integrated delivery systems, sometimes with insurers.⁹ Advancements in defining health care quality metrics and improving health information technology, and cultural shifts toward accountability and transparency, aided these innovations.¹⁰ Although the new practices supported goals of patient outcomes and satisfaction, the emphasis remained on lowering health care costs for their populations served.¹¹

A 2006 Massachusetts law promoting health system transformation through lowering health care costs further incentivized private sector innovations that espoused accountable care principles.¹² For example, the insurer Blue Cross and Blue Shield of Massachusetts provided up-front funding, known as “global budgets,” to 8 private medical groups, based on historical per-member per-year spending, through its Alternative Quality Contract Program, and additional financial incentives to improve the quality and cost of services for its members.¹³ Although the funded providers contracted with existing health management organizations instead of creating new co-owned networks, the initial outcomes of the program showed

⁷ See, e.g., Leighton Ku et al., *Promoting the Integration and Coordination of Safety-Net Health Care Providers Under Health Reform: Key Issues*, The Commonwealth Fund (Oct. 2011), http://www.commonwealthfund.org/~media/files/publications/issue-brief/2011/oct/1552_ku_promoting_integration_safetynet_providers_under_reform_ib_v2.pdf.

⁸ *Id.*

⁹ See *supra*, note 3.

¹⁰ See *supra*, note 3.

¹¹ Susan DeVore & R. Wesley Champion, *Driving Population Health Through Accountable Care Organizations*, 30 *Health Aff.* 1, 41–50 (2011).

¹² See Mass. Session Laws 2006, ch. 58 (April 12, 2006).

¹³ Robert Mechanic et al., *Medical Group Responses to Global Payment: Early Lessons from the “Alternative Quality Contract” in Massachusetts*, 30 *Health Aff.* 1734, 1734–42 (2011).

lowered cost and improved quality for eligible populations through providing holistic patient care.¹⁴

Although they are not based strictly on population health measures, these successes nevertheless set the stage for developing an accountable care framework with quality and cost metrics at the federal level.

Anticipating federal incentives for ACOs, the private Premier Health Care Alliance launched the Accountable Care Implementation Collaborative in May 2010 to “develop the key capabilities needed to operate an ACO based on a common model and consistent measures of success.”¹⁵ Although this demonstration relied on member hospitals’, health systems’, and physician practices’ up-front contributions of \$150 000, the capabilities still included patient-centered medical homes, population health data management, and patient satisfaction.¹⁶ Unlike ACOs authorized by federal law, discussed in the next section, the Collaborative does not function as a single, co-owned legal entity, but its members are still accountable for cost and quality measures according to their contracts.¹⁷ Without further data, it remains to be seen whether the measures Premier developed will help private or public health entities to evaluate the effectiveness and impact of accountable care on population health.

Medicare Accountable Care Organizations

In contrast to the variability of the private entities described previously, federal law provides a uniform set of standards for ACOs that will serve Medicare populations and potentially incorporate public health entities and measures. Section 3022 of the Patient Protection and Affordable Care Act of 2010 established the Medicare Shared Savings Program (MSSP), which authorizes reimbursements to ACOs certified under the Medicare program.¹⁸ Under the resulting final rule, ACOs are defined as new legal entities recognized and incorporated under applicable state, federal, or tribal law and authorized to conduct business in every state of operation. In addition, an ACO must be formed by 1 or more service providers

¹⁴ Zirui Song et al., *The “Alternative Quality Contract,” Based on a Global Budget, Lowered Medical Spending and Improved Quality*, 31 Health Aff. 1885, 1885–94 (2012); Mechanic, *supra* note 13 (comparing the state program targeted to health maintenance organizations to federal authorizations for new accountable care organizations).

¹⁵ Devore and Champion, *supra* note 11, at 42.

¹⁶ *Id.*

¹⁷ *Id.*

¹⁸ Medicare Shared Savings Program, 76 Fed. Reg. 67, 802 (November 2, 2011).

and suppliers, potentially including rural health clinics and federally qualified health centers, that work together to manage and coordinate care for Medicare fee-for-service beneficiaries.¹⁹ No restrictions are placed on the distribution of rewards and penalties among the participants, which may present opportunities and challenges for the successful formation and management of the ACO. A fully functioning ACO under the MSSP is capable of receiving and distributing shared savings, repaying losses, and establishing, reporting, and ensuring providers' compliance with quality standards.²⁰

To receive federal reimbursements for providing care under Medicare, ACOs must meet stringent requirements. The ACOs must enter into a 3-year agreement to participate in the MSSP with the Secretary of Health and Human Services, have a formal legal structure supporting shared payments according to the terms of provider and supplier contracts with the ACO, and have a leadership and management structure that includes clinical and administrative systems.²¹ Accountable care organizations are approved by the MSSP if they become accountable for the quality, cost, and overall care of the assigned population, include enough primary care ACO professionals to serve a minimum of 5000 beneficiaries, provide information on participating professionals, define processes for and report on care, and demonstrate that they meet patient centeredness criteria.²² The ACOs must enter into a data use agreement with the MSSP and comply with limitations on use and disclosure of identifiable health information required by the Health Insurance Portability and Accountability Act of 1996 and other statutory, regulatory, and contractual requirements.²³

¹⁹ 42 C.F.R. §§ 425.100, 425.102 (2012) (designating the following groups as eligible participants: accountable care organization professionals in group practices, including physicians, physician assistants, nurse practitioners, and clinical nurse specialists; networks of individual accountable care organization professionals; partnerships or joint ventures between hospitals and accountable care organization professionals; hospitals employing accountable care organization professionals; critical access hospitals; rural health clinics; and federally qualified health centers). Other providers, such as long-term care hospitals, home health agencies, and skilled nursing facilities, may participate in the program through collaborations with accountable care organizations formed by eligible entities.

²⁰ 42 C.F.R. § 425.104 (2012) (specifying that accountable care organizations will be identified by a Taxpayer Identification Number).

²¹ 42 C.F.R. § 425.20 (2012).

²² *Id.*

²³ 42 C.F.R. §§ 425.708, 425.710 (2012).

To encourage providers to participate in the MSSP, 2 “tracks” of ACOs were authorized for reimbursement with different levels of risk and savings. The first track allows the ACO to share up to 50% of its savings with Medicare once it spends less than a defined benchmark, set at the level of the population’s use of primary care services at the end of each previous year.²⁴ The second track requires the ACO to assume risk, allowing it to share in a greater portion of any savings, but also to share in any losses incurred if it fails to meet its benchmark.²⁵ A third payment model provides ACOs that serve primarily rural or Medicaid populations, characterized by low annual revenues and with limited inpatient facilities, access to capital up-front like a global budget, but requires repayment of costs that are not recouped.²⁶ The specific amount of shared savings that these ACOs will receive depends on whether providers meet quality performance standards, creating an incentive for the ACO to improve the quality of care for the population covered.²⁷ At the time of this writing, Centers for Medicare and Medicaid Services has not posted evaluation results that describe initial effects on population health outcomes or cost by MSSP accountable care organizations.

A separate category of ACOs authorized by federal law are pediatric ACOs, which are largely demonstration projects authorized under section 2706 of the Affordable Care Act. Pediatric ACOs are distinct from the MSSP accountable care organizations and operate under Medicaid or the Children’s Health Insurance Program.²⁸ Because reaching these populations requires state action, pediatric ACOs are discussed in the Medicaid and Accountable Care section.

²⁴ 42 C.F.R. § 425.604 (2012).

²⁵ *Id.*

²⁶ *Advance Payment Accountable Care Organization (ACO) Model*, Centers for Medicare & Medicaid Services (Nov. 2012), http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/ACO_Advance_Payment_Factsheet_ICN907403.pdf (detailing the obligations of the accountable care organization to repay costs that are not recouped in contract provisions).

²⁷ *Summary of Final Rule Provisions for Accountable Care Organizations Under the Medicare Shared Savings Program*, Centers for Medicare and Medicaid Services (2012), http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/ACO_Summary_Factsheet_ICN907404.pdf.

²⁸ Affordable Care Act, *supra* note 5.

Medicaid and Accountable Care

Since 2010, state laws have applied accountable care principles to Medicaid programs in an effort to align incentives and improve costs in parallel with the Medicare reforms detailed in federal law. Although the dominant model for payment continues to be managed care through either risk-based managed care organizations or fee-for-service primary care case management programs, states are incorporating accountable care strategies and patient centered medical homes into Medicaid programs to improve quality, effectiveness, cost containment, and health outcomes.²⁹ For example, capitated managed care plans can encourage efficiency to keep savings and reduce risk through disease management and care coordination, and primary care case management can incentivize decreased utilization among providers paid through fee-for-service payments and per-member-per-month fees through addressing mental health or chronic obstructive pulmonary disease.³⁰ Many of the new strategies are demonstration projects that must be approved or “waived” by Centers for Medicare and Medicaid Services under section 1115A of the Social Security Act, which establishes the Center for Medicare and Medicaid Innovation to test methodologies for service delivery and payment for Medicare, Medicaid, and the Children’s Health Insurance Program.³¹

There are tremendous variations in state accountable care strategies, likely reflecting “individual states’ history and experience with managed care, other existing delivery arrangements within Medicaid, and the challenges inherent in serving low-income and chronically ill populations.”³² For example, Medicaid accountable care entities may be regulated as insurers alongside managed care organizations, such as in Mississippi and New Hampshire.³³ They could exist within capitated managed care plans as a single health care provider, as “enhanced medical homes” in a collaborative demonstration project in Colorado,

²⁹ Gold et. al, *supra* note 6.

³⁰ Ku, *supra* note 7.

³¹ Section 1115A of the Social Security Act, as added by section 3021(a) of the ACA, Pub. L. No. 111-148, 124 Stat. 119; *see also Five Key Questions and Answers About Section 1115 Medicaid Demonstration Waivers*, Kaiser Commission on Medicaid and the Uninsured (June 2011),

<http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8196.pdf>.

³² *Id.*

³³ Ku, *supra* note 7.

and as recognized providers in Montana, New York, Texas, and Utah.³⁴ Blending these strategies, Medicaid programs also recognize accountable care entities as subcontractors that participate in shared savings with other healthcare entities, as in Washington’s pilot program for providers and networks with patient-centered medical homes.³⁵ Finally, pediatric ACOs may be approved under Medicaid or the Children’s Health Insurance Program as 5-year demonstration projects, although states have great discretion to determine their scope and specific measures for success.³⁶

The focus on improving population health through accountable care also differs between state laws. Some states require public health agencies or practitioners to participate in Medicaid accountable care entities to emphasize population health measures, including mental health and substance abuse services in Illinois; behavioral health, dental, pharmacy, and other services in New Jersey; and chronic conditions, mental illness or chemical dependency; and preventive, remedial, and supportive care and services in Oregon.³⁷ Other states do not mention health outcomes, and instead focus entirely on cost outcomes and quality measurements, such as patient experience data in Washington.³⁸ Most commonly, state laws specify types of health conditions or problems that accountable care entities must help address, but do not dictate the public health partners who must be involved or the manner in which those issues must be tackled.³⁹ Even where target health outcomes are identified, accountable care entities must still develop and meet standards and metrics for the improvement of population health that are attainable and sustainable over time.

³⁴ Ku, *supra* note 7, at 7 (raising a potential problem where mandatory managed care could assign patients on a prospective basis, locking them in to a Medicaid accountable care organization and thereby restricting their choice of providers); *but see* 10 Colo. Code Regs. § 2505-10:8.205, as amended by 2012 Colo. Reg. Text 278321 (2012); *see also* Mont. Code Ann. §§ 33-31-102, 33-31-201 (2011); N.Y. Pub. Health Law §§ 2816, 2999-p, 2999-q (McKinney 2011); Tex. Admin. Code tit. 1, § 371.1607 (2012); Utah Code Ann. 1953 § 26-18-408 (2013).

³⁵ Ku, *supra* note 7; N.J. Stat. Ann. § 30:4D-8.3 (West 2011) (establishing a demonstration project that allows nonprofit corporations to become certified as Medicaid accountable care organizations and include the state health department, managed care organizations, and other facilities and providers as participants); Oregon House Bill 3650 (2012), <http://www.oregon.gov/oha/OHPR/PSDM/HB3650.pdf> (incorporating demonstration projects of “coordinated” care organizations into the state Medicaid program); Wash Code Ann § 70.54.420 (West 2010).

³⁶ ACA, Pub. L. No. 111-148, 124 Stat. 119; *see also* N.H. REV. Stat. Ann. § 126-A:3 (2011).

³⁷ *See, e.g.*, 20 Ill. Comp. Stat. Ann. 1340/25 (West 2011); N.J. Stat. Ann. § 30:4D-8.3 (West 2011); and Or. Rev. Stat. Ann. § 414.625 (West 2012).

³⁸ *See, e.g.*, Wash. Rev. Code Ann. § 70.54.420 (West 2010).

³⁹ *See, e.g.*, Colo. Rev. Stat. Ann. § 25.5-4-418 (West 2011).

Developing the Evidence Base for Accountable Care

Although opportunities to experiment with new health care delivery frameworks appear to be expanding under federal and state laws, to date there are little data to suggest that the accountable care mechanisms discussed previously will improve population health.⁴⁰ Because these laws require accountable care entities to both measure and meet designated benchmarks, the evidence collected on implementation may outpace the evidence collected on health outcomes for some time.⁴¹ In place of public health impact data, experts support the evaluation of process measures, including provider and payer readiness to adopt an accountable care framework and contract structures, implementation activities undertaken, and the intermediate outcomes achieved.⁴² For example, the Alternative Quality Contract performance measures in Massachusetts included primary care—oriented measures under the direct control of providers, including aggregate and individual measures in chronic care management, adult preventive care, and pediatric care.⁴³

At the same time, experts have proposed new types of organizations that could benefit from qualifying as accountable care entities under existing laws. In addition to existing large group practices and integrated delivery systems in the private accountable care framework, physician---hospital organizations that function within a hospital’s medical staff, independent practice associations that have become organized networks of physician practices, and “virtual” physician organizations comprised of small, independent physician practices may all develop contracts to serve as accountable care entities.²⁶ To evaluate these new types of mechanisms, providers and facilities will have to collect data not only on cost, quality, and the population served, but also on electronic health record use, quality improvement and care management processes, and training programs.⁴⁴

⁴⁰ Fisher, *supra* note 1.

⁴¹ *Id.*

⁴² *Id.*

⁴³ Song, et al., *supra* note 14.

⁴⁴ Stephen M. Shortell et al., *How the Center for Medicare and Medicaid Innovation Should Test Accountable Care Organizations*, 29 Health Aff. 1293, 1293–98 (2010).

In addition to research on process measures, there are other opportunities to evaluate the long-term impacts of this framework, including health, cost, and behavioral outcomes. As with previous health system transformation research, evaluations may be designed to study health impacts on distinct populations: those covered under an accountable care contract, those cared for by the providers outside the contract, and the community as a whole.⁴⁵ Evaluations may also measure performance against quality and cost benchmarks for vulnerable populations, particularly those with complex medical problems or social disadvantages, to determine if Medicaid accountable care entities can serve their unique needs.⁴⁶ Once decision-makers determine the metrics that will be used to measure population health measures for the accountable care framework, further research may show which accountable care mechanisms, if any, will be useful in improving public health.

Conclusions

Accountable care frameworks have emerged as one way for health care and public health providers and facilities to address health outcomes while maintaining cost and quality goals for the services provided. Private provider networks, including new types of practices and organizations, have established quality metrics from the innovations made over the course of the past decade that can track public health outcomes. Medicare ACOs could serve to support holistic patient care if providers and facilities are able to meet the cost and quality benchmarks designated. State accountable care strategies translate these principles to the care of the most vulnerable populations through Medicaid. Future research efforts designed to show effects on population health through these and other health care delivery systems that expand accountable care into public and private networks will require benchmarks that measure prevention, health care quality, and patient satisfaction. Ultimately, the evidence may support law-based interventions that achieve effective, sustainable health care delivery systems and improve public health through accountable care.

⁴⁵ *Id.*

⁴⁶ Valerie A. Lewis et al., *The Promise and Peril of Accountable Care for Vulnerable Populations: A Framework for Overcoming Obstacles*, 31 Health Aff. 1777, 1778–85 (2012).

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Note. This article should not be construed as providing legal guidance or advice. Please seek the advice of an attorney or other qualified professional with questions regarding the application of law to a specific circumstance.

Human Participant Protection

Human participant protection was not required because the research did not involve human participants.

Endnotes

Endnotes in the original publication have been changed to footnotes for the purposes of this online copy.