Accountable Care Organizations: Proceed With Caution (Especially Nonprofit Hospitals)

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One of the lesser publicized provisions of the Affordable Care Act creates "accountable care organizations" or "ACOs" ACOs are a new healthcare delivery model for Medicare beneficiaries that attempts to address the well known problem with the current , procedure-based Medicare billing system, which encourages multiple (and sometimes redundant and unnecessary) medical tests and procedures. It also organizes the delivery of medical care around a particular diagnosis or condition, as opposed to addressing the patient's overall physical and mental well-being. Medicare has already limited reimbursements for multiple procedures but reports of unnecessary duplicate treatments – particularly with regards to imaging services – continue to surface.

Enter the ACO – a network of medical providers, hospitals and other care facilities – covering everything from obstetricians to hospice care – that agrees to provide care to at least 5,000 Medicare beneficiaries in a chosen geographic area or community for a minimum of 3 years. Under the "Medicare Shared Savings Program" ACOs would not eliminate fee-for-service Medicare billing but would provide bonuses to caregivers whose ACO meets specific savings benchmarks in four "quality domains": (1) patient/caregiver experience, (2) care coordination/patient safety, (3) preventative health and (4) "at-risk" population (frail elderly and chronic conditions). Depending upon the payment "track" that they choose, certain ACOs would initially share not just in savings but in the financial downside of failing to meet benchmarks. After completing their first 3-year period of operation, all ACOs will have to share the downside and reimburse Medicare for costs that exceed the benchmarks, which are capitated (per member/per month) figures.

"Capitation" is an HMO term, and although payments to providers under an ACO share some aspects of HMO payments, an ACO, unlike an HMO, would not impose higher charges for treatment received outside the patient's chosen ACO. An "Advance Payment" model will even allow ACOs to leverage their way into existence, by advancing anticipated savings amount to them in the initial stages of their existence, for later reimbursement. The Department of Health and Human Services has estimated that the ACO system may realize up to $940 million over conventional Medicare reimbursements in the first four years of operation.

Initial applications to take part in the Shared Savings Program are already being submitted, with the first ACO agreements anticipated in April and July, 2012. In the meantime, physicians, hospitals and other care providers are rapidly evaluating their prospects under the ACO model. As with any kind of mass migration, there are hazards for those who move too fast:

Over-Consolidation and Anti-Trust Concerns: It is almost certain that the ACO model will increase hospital mergers and other consolidation of care providers to some degree, which brings with it the potential of monopoly pricing and lack of accountability. Provider consolidation is already happening on a large scale across the country however, and in a delightful analogy, one health care analyst has likened the additional consolidation under

ACOs as calorically insignificant, compared to large consolidation trends, as the maraschino cherry on a fudge sundae. Only time will tell if that analogy is accurate.

Nonprofit Hospitals – Bonding and Other Concerns: Another potential pitfall specific to nonprofit hospitals relates to the nonprofit bonds that many such hospitals secured in order to improve and expand their facilities (particularly under California earthquake retrofitting laws). Nonprofit bonds are well outside my scope of expertise, but this piece provides a nice summary of the potential negative impact, on nonprofit bond status, of a nonprofit hospital's participation in an "exclusive" ACO. Per the article, "private business use" that exceeds 5% of a nonprofit hospital's post-bond activity may jeopardize the tax-exempt status of the bond (and presumably, larger percentages might also be inconsistent with the hospital's nonprofit charter). The solution (again – please consult the article for detailed information) appears to be that such hospitals limit themselves to *nonexclusive* ACOs (primary care physicians must form exclusive arrangements with one ACO whereas hospitals can participate in and affiliate with multiple ACOs). Again, please consult with qualified bond counsel, healthcare counsel, and nonprofit counsel, for advice on any specific factual situation.

Below are some links to more information on ACOs and the Shared Savings Program:

Final regulations on the Medicare Shared Savings Program

IRS Fact Sheet on Nonprofit Hospital Participation in Shared Savings/ACOs

Speculation that ACOs will replace insurance companies (don't hold your breath):

An Urban Institute White Paper on ACOs.

Finally, my thanks go to Arthur Rieman, principal of the Law Firm for Nonprofits, for bringing the article on hospital bonds to my attention, which led to this post. Arthur is an invaluable resource for all nonprofit legal issues.

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