Controlling Healthcare Costs through Accountable Care Organizations

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Anne P. Sharamitaro, Esq.
Senior Vice President, Health Capital Consultants
About the Presenter

Anne P. Sharamitaro, Esq., is a Senior Vice President of HEALTH CAPITAL CONSULTANTS (HCC), where she focuses on the areas of Certificate of Need (CON); regulatory compliance, managed care, and antitrust consulting. Ms. Sharamitaro is a member of the Missouri Bar and holds a J.D. and Health Law Certificate from Saint Louis University School of Law, where she served as an editor for the Journal of Health Law, published by the American Health Lawyers Association, and has been admitted to the Missouri Bar. She has presented healthcare industry related research papers before Physician Hospitals of America (f/k/a American Surgical Hospital Association) and the National Association of Certified Valuation Analysts and co-authored chapters in Healthcare Organizations: Financial Management Strategies, published in 2008.
INTRODUCTION TO ACOs
What is an Accountable Care Organization?

Healthcare organization with a coordinated set of providers...
- Provider mix dependent on type of structure: federal or commercial ACO structure

Who share responsibility and accountability for the continuum of care...
- Clinical accountability – Quality of care
- Financial responsibility – Cost of Care

By providing the highest possible value of care...
- Increase quality
- Decrease costs

For financial incentives or “shared savings”...
- Value-based payments
- Reimbursement for achieving cost and quality goals

From participating payors.
- Public Payors (e.g., Medicare, Medicaid)
- Commercial Payors (e.g., BCBS of MA)

Key Principles and Elements of ACOs

Local Accountability

- Able to provide and manage across the continuum of care
- Responsible and accountable for quality and cost of care
- Incentivize providers for quality – not quantity

Shared Savings

- Legal entity and governance structure that allows receiving/distributing shared savings payments
- Invest shared savings in delivery system improvements
- Capable of financial and resource planning

Performance Measurement

- Ongoing metrics to obtain evidence of meaningful outcome improvements and cost impacts
- Measurements must be transparent and accessible
- Essential cost savings are the result of meaningful improvements

Why Accountable Care?

National Health Expenditures per Capita, 1960-2010

**Why Accountable Care?**

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Care</td>
<td>30.5%</td>
</tr>
<tr>
<td>Physician/Clinical Services</td>
<td>20.3%</td>
</tr>
<tr>
<td>Other Health Spending</td>
<td>15.9%</td>
</tr>
<tr>
<td>Other Personal Health Care</td>
<td>14.9%</td>
</tr>
<tr>
<td>Rx Drugs</td>
<td>10.1%</td>
</tr>
<tr>
<td>Home Health</td>
<td>8.2%</td>
</tr>
</tbody>
</table>

*Note: Other Personal Health Care includes, for example, dental and other professional health services, durable medical equipment, etc. Other Health Spending includes, for example, administration and net cost of private health insurance, public health activity, research, and structures and equipment, etc.*

Why Accountable Care?

1. Includes Research (2%) and Structures and Equipment (4%)
2. Includes expenditures for residential care facilities, ambulance providers, medical care delivered in non-traditional settings (such as community centers, senior citizens centers, schools, and military field stations, and expenditures for Home and Community programs under Medicaid
3. Includes Durable (1%) and Non-durable (2%) goods

Note: Sum of pieces may not equal 100% due to rounding.
Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group.
THE PATH TO ACCOUNTABLE CARE
The Path to Accountable Care

“The only thing new in the world is the history you don’t know.”

- Harry S. Truman

The Path to Accountable Care

**Managed Care**

- *Managed care* plans integrate the financing and provision of health services
  - Administered by one *managed care organization (MCO)* in an effort to contain costs
- Hold providers accountable for providing care to a population through:
  - Clinical practice standardization
  - Selective contracting
  - Low-cost settings
  - Reduced discretionary hospital admissions
  - Effective staff use

# The Path to Accountable Care

## The Four Phases of Managed Competition

<table>
<thead>
<tr>
<th>1st Generation</th>
<th>2nd Generation</th>
<th>3rd Generation</th>
<th>4th Generation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Managed Access</strong></td>
<td><strong>Managed Benefits</strong></td>
<td><strong>Managed Care</strong></td>
<td><strong>Managed Outcomes</strong></td>
</tr>
<tr>
<td>- Emphasis on managing/restricting patient access</td>
<td>- Emphasis on managing benefits</td>
<td>- Greater emphasis on treatment planning and quality management</td>
<td>- Operational, clinical, and financial integration</td>
</tr>
<tr>
<td>- Administrative burdens (e.g., pre-certification, significant co-pays)</td>
<td>- Pre-certification primary and treatment planning secondary</td>
<td>- Focus on most appropriate care in most appropriate setting</td>
<td>- Locally responsive delivery systems and services based on national standards and capabilities</td>
</tr>
<tr>
<td>- Reliance primarily on non-clinical reviewers</td>
<td>- Cost containment emphasized over clinical management</td>
<td>- Patients managed through continuum of care</td>
<td>- Mutually beneficial partnerships with physician community</td>
</tr>
<tr>
<td>- Physician totally outside system</td>
<td>- Traditional treatment models employed</td>
<td>- Clinical management of network; provider-care manager collegiality</td>
<td>- Effective use of technology to measure, report, and enhance quality and outcomes</td>
</tr>
<tr>
<td></td>
<td>- Physicians “included”, but their care delivery “inspected”</td>
<td>- Shift toward improving access and benefits to reduce costs</td>
<td>- Proof of value for patients</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Full accountability for costs and quality</td>
</tr>
</tbody>
</table>
The Path to Accountable Care

Accountable Care is Not a New Concept

- Accountable care was linked to better healthcare in 1932 when the Committee on the Costs of Medical Care suggested, among other things, that the focus of medical care should be on coordination of care to help lower costs.

"The Final Report of the Committee on the Costs of Medical Care" California and Western Medicine, 1932, p.397
The Path to Accountable Care

**Main Predecessor – Managed Care**

- Health Maintenance Act of 1973
  - Designed HMOs to contain healthcare costs and integrate health systems
- Significant consumer backlash during the 1990’s

The Path to Accountable Care

An Evolved Form of Managed Competition

- Dominant theory of 1990’s healthcare reform
- Formalized by Alain Enthoven of Stanford University in 1993
- Blends competitive and regulatory strategies
- Aims to achieve maximum value for both consumers and providers

**Enthoven’s Definition of Managed Competition**

Competing healthcare entities, mainly payors, are monitored by a supervisory structure that establishes: equitable rules; creates price-elastic demand; and, avoids uncompensated risk selection

The Path to Accountable Care

The Birth of a Term

• Medicare Physician Group Practice (PGP) Demonstration
  o Examined incentive-based payment methods
  o Initiated in 2005
  o Took place over a 5 year period
  o Main Foundation for Medicare Shared Savings Program (MSSP), a/k/a, Federal ACOS

• Term ACO was coined in 2006
  o Elliott Fisher, a physician and professor of medicine at Dartmouth Medical School
  o Glenn Hackbarth, the chairman of the Medicare Payment Advisory Commission (MedPAC)
The Path to Accountable Care

Enter Healthcare Reform

• March 23, 2010

• The Patient Protection and Affordable Care Act (ACA) was signed into law

• A mere four pages introduced the next big movement in healthcare... ACOs
The Path to Accountable Care

The 2010 Affordable Care Act and ACOs

“Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations and Medicare Program: Waiver Designs in Connection With the Medicare Shared Savings Program and the Innovation Center; Proposed Rule and Notice” Federal Register, Vol. 76, No. 67 (April 7, 2011), pg. 19531;
“Patient Protection and Affordable Care Act” Public Law 111-148, Section 3022, 124 STAT 395 (March 23, 2010).
Related ACA Provisions

**Value Based Purchasing (VBP)**

- VBP refers to any concept that links payments to quality of care
  - Rewards providers for providing high quality, efficient clinical care
- The ACA establishes several VBP demonstration programs
  - Hospitals (§3001)
  - Home health agencies (§ 3006)
  - Ambulatory surgery centers (§ 10301)
- The MSSP is one form of value-based purchasing linking provider payments to efficient coordinated care of Medicare beneficiaries that meets standards set within CMS’s proposed rules

Related ACA Provisions

Other Payment Reforms

• **Medical Home Model**
  - Promotes team-based approach to care of a patient through a spectrum of disease states and across the various stages of life

• **Bundling Demonstration Projects**
  - A voluntary national pilot program on bundling payments to healthcare providers
  - Aims to provide incentives for providers to coordinate patient care across the continuum and to be jointly accountable for an entire episode of care

Related ACA Provisions

Other Payment Reforms

• Community Health Teams
  o ACA Section 3502 directs the Secretary to establish a program to provide grants to enter into contracts with eligible entities
  o Establish community based interdisciplinary, interprofessional teams (referred to in the statute as “health teams”) to support primary care practices (including OB-GYN practices, within the hospital service areas served by the eligible entities)
CMS Final Rule For ACOs

MEDICARE SHARED SAVINGS PROGRAM
Medicare Shared Savings Program

Overview and Intent

Encourage ACO development for Medicare populations through a program that:

“[P]romotes accountability for a patient population and coordinates items and services under parts A and B, and encourages investment in infrastructure and redesigned care processes for high quality and efficient service delivery.”

# Medicare Shared Savings Program

## ACO Requirements

<table>
<thead>
<tr>
<th>Category</th>
<th>Requirements</th>
</tr>
</thead>
</table>
| **Legal Entity**    | • Formal legal structure established  
                     • To receive and distribute any shared savings  
                     • Proposed rule modified to allow participation of entities organized under Federal or Tribal law |
| **Sufficient Size** | • Sufficient number of primary care physicians to provide care for at least 5,000 beneficiaries |
| **3-Year Commitment** | • Must commit to participate in the program for at least three years  
                            • Must provide CMS with 60 days advance notice if terminating agreement  
                            • Participating ACO will not share in any savings in the performance year for which it notifies CMS of termination |

Medicare Shared Savings Program

**ACO Requirements**

**Leadership & Governance**
- Must have a mechanism for shared governance and responsibility
- Management structure must include both clinical and administrative systems
- ACO participants must hold at least 75% control of the ACO’s governing body
- Where ACO comprises multiple, otherwise independent entities not under common control, governing body must be separate and unique to the ACO
- Must provide for beneficiary representation on governing body
- If governing body does not meet requirements, ACO must describe why it seeks to differ from requirements and how it will involve ACO participants in governance in innovative ways and/or provide for meaningful governance participation by Medicare beneficiaries
- ACO’s operations must be managed by an executive, officer, manager, or general partner, whose appointment and removal are under the control of the governing body
- Clinical management and oversight must be managed by a senior-level medical director who: is one of the ACO’s physicians; is physically present in an established ACO location on a regular basis; and, is board-certified and licensed in one of the states in which the ACO operates

**Performance Measurement**
- Must define, establish, implement, and periodically update processes to promote evidence-based medicine
- Guidelines must cover those diagnoses with significant potential for achieving quality improvements, while taking into account individual beneficiaries’ circumstances
- Must define, establish, implement, and periodically update processes and infrastructure for ACO participants and providers/suppliers to internally report on quality and cost measures
- Must report data on 33 quality measures for each year of performance agreement

**Patient-Centered**
- Must adopt a focus on patient-centered care that is promoted by the governing body and integrated into practice by leadership and management

# Medicare Shared Savings Program

## Eligible Entities

<table>
<thead>
<tr>
<th>Final Rule Designation</th>
<th>Potential Provider Organizations</th>
</tr>
</thead>
<tbody>
<tr>
<td>• ACO professionals in group practices</td>
<td>• Primary Care Physician Practices</td>
</tr>
<tr>
<td>• Networks of individual practices of ACO professionals</td>
<td>• Independent Practice Associations (IPA)</td>
</tr>
<tr>
<td>• Partnerships or joint venture arrangements between hospitals and ACO professionals</td>
<td>• Multispecialty Physician Groups (MSPG)</td>
</tr>
<tr>
<td>• Hospitals employing ACO professionals</td>
<td>• Integrated Delivery Networks (IDN)</td>
</tr>
<tr>
<td></td>
<td>• Clinical Integrated Networks (CIN)</td>
</tr>
<tr>
<td></td>
<td>• Hospital Medical Staff Organizations (MSO)</td>
</tr>
<tr>
<td></td>
<td>• Physician Hospital Organizations (PHO)</td>
</tr>
<tr>
<td></td>
<td>• Extended Hospital Medical Staff</td>
</tr>
<tr>
<td></td>
<td>• Critical Access Hospitals (CAHs)</td>
</tr>
<tr>
<td>Such other groups of providers of services and suppliers as the Secretary determines...</td>
<td></td>
</tr>
</tbody>
</table>
Medicare Shared Savings Program

**Becoming an ACO**

Potential ACOs Must Apply and Provide Documentation of Ability to Manage Population Health

<table>
<thead>
<tr>
<th>Application Must Include Documents Outlining:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Agreements describing ACO participants’ rights and obligations in the ACO</td>
</tr>
<tr>
<td>• Organizational and management structure</td>
</tr>
<tr>
<td>• Information regarding all of the ACO participants</td>
</tr>
<tr>
<td>• Methods the ACO will use to achieve “patient centeredness,” including a description of the remedial processes and penalties for failure to comply</td>
</tr>
<tr>
<td>• Ways the ACO’s governing body will adhere to structural requirements, or a description of why the ACO seeks to differ from requirements</td>
</tr>
<tr>
<td>• Any other documents as requested</td>
</tr>
</tbody>
</table>

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Medicare Shared Savings Program

**Legal Structure and Governance**

- May be structured through any state-permitted contract, such as:
  - Corporation
  - Partnership
  - Foundation
- Must be defined by its own unique Taxpayer Identification Number (TIN)
- Must be recognized and authorized to conduct business under applicable state, Federal, or Tribal law

Medicare Shared Savings Program

*Legal Structure and Governance*

For purposes of:

- Repaying shared losses
- Establishing, reporting, and ensuring ACO participant and ACO provider/supplier compliance with program requirements, including the quality performance standards
- Performing other ACO functions identified in the statute

Medicare Shared Savings Program

Leadership and Governance

• An “ACO shall have in place leadership and management structure that includes both clinical and administrative systems”

• “Mechanism for shared governance”
  o Organization must “maintain an identifiable governing body with authority to execute the functions of the ACO”
  o Governing body must be transparent and act in accordance with fiduciary duty to ACO
  o Responsible for strategic direction and oversight

Medicare Shared Savings Program

Leadership and Governance

- Does not require a specific formation for the governing body
- Each individual ACO participant required to have “meaningful participation” in the governing body
- Must have Medicare beneficiary representation in the ACO governing body, with flexibility for “innovative” inclusion

Medicare Shared Savings Program

Leadership and Governance

• ACO operations
  - Managed by an executive, officer, manager, or general partner
  - Appointment and removal are under control of the organization’s governing body
  - Leadership team demonstrated ability to influence or direct clinical practice to improve efficiency processes and outcomes

• Clinical management and oversight
  - Managed by a senior-level medical director who is one of the ACO’s physicians
    - Board-certified physician
    - Licensed in one of the states in which the ACO operates
    - Present at “any clinic, office, or other location participating in the ACO.”

Medicare Shared Savings Program

Primary Care Services Restrictions

• The role of an ACO participant is defined in the MSSP: “Each ACO participant [physician provider working in an ACO] TIN upon which beneficiary assignment is dependent is required to commit to a 3-year agreement with CMS and will be exclusive to one ACO.”

• Participants in the ACO, must follow “required exclusivity,” meaning these participants may only be involved in a single ACO for a specific TIN

• However, providers may participate in multiple ACOs if they have multiple TINs

Medicare Shared Savings Program

The ACO Agreement

• “ACO shall enter into an agreement with the Secretary to participate in the [Shared Savings Program] for not less than a 3-year period...”

• CMS will review applications and approve application from eligible organizations prior to end of calendar year

• ACO’s performance periods will begin on Jan. 1 of each respective year

• Extended agreement periods for ACOs beginning April 1, 2012 and July 1, 2012, of 21 and 18 months

Medicare Shared Savings Program

Assignment of Medicare Beneficiaries

• Based on utilization of primary care services provided by an “ACO professional”, which includes both physicians and non-physician practitioners

• Prospectively assigned to the ACO
  - Final updated assignment will be determined retrospectively based on where beneficiaries receive a plurality of their primary care

• ACOs are responsible for any care received by the beneficiary, even if not received through the ACO
  - e.g., “Snowbirds” example

Medicare Shared Savings Program

Quality Reporting Requirements

• Must determine appropriate measures to assess the quality of care furnished by the ACO, including:
  o Measures of clinical processes and outcomes
  o Patient and caregiver experience of care
  o Utilization rates (e.g., admission for ambulatory sensitive conditions)

• Requires ACO participants to collect clinical and quality data and submit this information to CMS

Medicare Shared Savings Program

Quality Reporting Requirements

33 quality reporting criteria across 4 domains include:

<table>
<thead>
<tr>
<th>Domain</th>
<th>CMS Criteria Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Patient/Caregiver Experience</td>
<td>1-7</td>
</tr>
<tr>
<td>2. Care coordination/Patient Safety</td>
<td>8-13</td>
</tr>
<tr>
<td>3. Preventive Health</td>
<td>14-21</td>
</tr>
<tr>
<td>4. At-Risk Population</td>
<td>22-33</td>
</tr>
</tbody>
</table>

Medicare Shared Savings Program

*Payment Mechanism – Shared Savings*

- ACOs to receive payment for shared Medicare savings provided it
  - Meets the quality performance requirements
  - Demonstrates that it has achieved savings against benchmark of expected average per capita Medicare FFS expenditures

- An ACO shall be eligible for payment of shared savings
  
  “[O]nly if the estimated average per capita Medicare expenditures under the ACO for Medicare FFS beneficiaries for Parts A and B services... is at least the percent specified by the Secretary below the applicable benchmark.”

- ACOs receive bonuses for achieving resource use and quality targets over the course of a year

- ACOs face penalties for failing to meet these requirements

- The final rule sets out two risk models with various incentives for ACOs to receive shared savings payments

# Medicare Shared Savings Program

## Changes from CMS Proposed Rule to Final Rule

<table>
<thead>
<tr>
<th>Provision/Topic</th>
<th>Proposed Rule</th>
<th>Final Rule</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Quality Measures</strong></td>
<td>Five categories with 65 measures of quality. Payment for acceptable reporting the first year, with a transition to pay-for-performance in later years. Proposed measures would eventually reflect quality goals currently utilized on the healthcare market.</td>
<td>Reduced to four categories with 33 quality measures, and a lax transition period for the ACO; full reimbursement in the initial year for reporting, with a mix of reporting and performance in the next two years for reimbursement.</td>
</tr>
<tr>
<td><strong>ACO Reports</strong></td>
<td>Information provided for the ACOs at start of all performance years that contains the following assigned Medicare beneficiaries’ information: name; date of birth; sex; and, health insurance claim number.</td>
<td>The assignment process will occur over two steps: (1) &quot;use plurality of allowed charges for primary care services rendered by primary care physicians&quot; for those &quot;beneficiaries who have received at least one primary care service from a physician,&quot; and (2) for those who have not received primary care services, &quot;use plurality of allowed charges for primary care services rendered by any other ACO professional.&quot;</td>
</tr>
<tr>
<td><strong>Beneficiary Assignment</strong></td>
<td>In the one-step assignment process, beneficiaries will be &quot;assigned on the basis of a plurality of allowed charges for primary care services rendered by primary care physicians.&quot;</td>
<td>The assignment process will occur over two steps: (1) &quot;use plurality of allowed charges for primary care services rendered by primary care physicians&quot; for those &quot;beneficiaries who have received at least one primary care service from a physician,&quot; and (2) for those who have not received primary care services, &quot;use plurality of allowed charges for primary care services rendered by any other ACO professional.&quot;</td>
</tr>
</tbody>
</table>

## Medicare Shared Savings Program

### Changes from CMS Proposed Rule to Final Rule

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</tr>
</thead>
<tbody>
<tr>
<td>Utilization of Electronic Health Records (EHRs)</td>
<td>Fifty percent of primary care physicians must be &quot;meaningful users&quot; by the second performance year.</td>
<td>EHRs/&quot;meaningful users&quot; is no longer a requirement, but is still utilized for quality measures, and carries significant weight.</td>
</tr>
<tr>
<td>Potential ACO Participation Start Date</td>
<td>Three year agreements with same annual start date; Performance year same as calendar year.</td>
<td>According to CMS, &quot;[p]rogram established by January 1, 2012&quot;; first round of applications are due in early 2012. First ACO agreements start 4/1/2012 and 7/1/2012. ACOs will have agreements with a first performance &quot;year&quot; of 18 or 21 months. ACOs starting 4/1/2012 and 7/1/2012 have option for an interim payment if they report quality measures for CY 2013 to quality for first-performance-year shared savings.&quot;</td>
</tr>
<tr>
<td>Beneficiary ACO Assignment</td>
<td>Primary care services utilization would determine which patients are retrospectively assigned to the ACO. Furthermore, a prospective identification of a benchmark population would determine which of the ACO patients are counted toward shared savings.</td>
<td>Initially, prospective-assignment will identify participating Medicare patients each quarter. Lastly, &quot;final reconciliation after each performance year based on patients served by the ACO.&quot;</td>
</tr>
<tr>
<td>Beneficiary Claims Data</td>
<td>Beneficiaries can decline to participate at initial visit. During the first performance year, patients seen by the primary care physician of the ACO are the only ones subjected to shared claims data.</td>
<td>Participating beneficiaries will be offered an opportunity to decline after the ACO contacts them to detail the potential impact.</td>
</tr>
</tbody>
</table>

# Medicare Shared Savings Program

## Changes from CMS Proposed Rule to Final Rule

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</tr>
</thead>
<tbody>
<tr>
<td>One-side and Two-sided and Conversion to Risk</td>
<td>ACOs can choose from either one-sided or two-sided models. One sided comprises two years of shared savings with a required change in the third year. Two-sided would consist of three years performing in regards to the two-sided model. Three year agreement for both tracks.</td>
<td>Two-sided risk eliminated, but two tracks are still available for ACOs depending on where they fall on the spectrum of preparedness. The second model allows for greater reward and greater risk.</td>
</tr>
<tr>
<td>Marketing Guidelines for ACOs</td>
<td>The Centers for Medicare &amp; Medicaid Services must acknowledge and approve all ACO marketing materials.</td>
<td>CMS will provide feedback on acceptable and &quot;approved language,&quot; and the ACO can utilize marketing materials five days after they file materials with CMS, and &quot;after certifying compliance with marketing guidelines.&quot;</td>
</tr>
<tr>
<td>Eligible ACO Entities or Participants</td>
<td>(1) ACO professionals in group practice arrangements, (2) networks of individual practices of ACO professionals, (3) partnerships or joint venture arrangements between hospitals and ACO professionals, and (4) hospitals employing ACO professionals. Lastly, other eligible entities detailed by the Secretary of HHS.</td>
<td>Aside from those detailed in the ACA, eligibility is extended to &quot;Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs).&quot; The only stipulation is FQHCs and RHCs need to detail primary care providers in their facilities who provide services to beneficiaries.</td>
</tr>
<tr>
<td>ACO Shared Savings</td>
<td>One-sided risk model: 2% savings triggers sharing amongst ACO, (small, physician-only and rural ACOs will have some exceptions compared to normal ACOs). Two-Sided risk model: shared savings from the beginning with no 2% savings required to trigger savings.</td>
<td>When the minimum savings rate is achieved, participating ACOs will have shared savings from the &quot;first dollar.&quot;</td>
</tr>
</tbody>
</table>

*"Proposed Rule Versus Final Rule for Accountable Care Organizations (ACOs) in the Medicare Shared Savings Program: Major Changes"*  
Centers for Medicare & Medicaid Services. [https://www.cms.gov/ACO/Downloads/Appendix-ACO-Table.pdf](https://www.cms.gov/ACO/Downloads/Appendix-ACO-Table.pdf) (Accessed 12/28/11);  
"Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations" Vol 76 No 67 Reg. (April 7, 2011).
COST FOR PROVIDERS: DEVELOPMENT AND OPERATION OF ACOs
Potential ACO Structure

*Federal ACOs*
Potential ACO Structure

*Federal ACOs Key*

### Lines
- Threaten ACO Shared Savings Payments
- Negotiate Independent Contracts (ACO may include in MSSP payments, but not included in ACO governance)
- Partnerships or Joint Ventures with designated methodology for distribution of shared saving payments
- Traditional Fee-for-Service Arrangement
- Shared Shavings Contract

### Shading
- Various entities that may partner to form an ACO under MSSP
- Dictates costs and quality measures that ACO is accountable for (i.e., PCPs and CMS)
- Not a provider (not included in MSSP)
- Competition if ACO (most likely hospital) offers similar services, but can also form mutually beneficial contracts to share MSSP payments
- Direct Competition for ACO
Potential ACO Structure

Commercial ACOs

- Hypothetical ACO
  - Integrated Physician Groups
  - Specialty Practices
    - ASCs
    - PCP Practices
  - GPO
  - Vendors
  - Employed PCPs
  - Employed Specialists
  - Hospitals and Health Systems
    - PHOs
    - Competing ASCs
    - Competing Hospitals
    - Competing Specialists
  - Labs
  - Pharmacy
  - Home Health

- Commercial Payors
  - Other Providers
Potential ACO Structure

Commercial ACOs Key

**Lines**
- Negotiate Independent Contracts (may include portions of value payments)
- Clinical integration and/or risk sharing agreement (anywhere on the scale from: merger → partnership → joint venture → contract)
- Traditional Insurance Contract (Most Likely a Fee-for-Service Arrangement)
- Value-Based Purchasing Contract (Anywhere from Fee-for-Service to Full or Partial Capitation)

**Shading**
- Various entities that may partner to form an ACO
- Not a provider (not competition, but not included in ACO risk sharing)
- Direct competition for ACO
Potential Reimbursement Structures

More Risk Borne by Payors
- Cost of Care
- Fee For Service (i.e., RVS, RBRVS - Medicare)
- Pay for Performance (P4P)
- Episodic Bundled Payments
- Population Bundled Payments
- Partial Capitation

More Risk Borne by Providers
- Capitation

Federal ACO Model

Commercial ACOs Models
Cost for Providers

Capital and Operating Requirements

- ACOs will require significant up-front costs
  - Personnel and Intellectual Technology (IT) to satisfy the extensive quality reporting obligations
  - Establish the required governance and management structure
  - Ensure that the majority of the participating providers qualify as “meaningful users” or certified EHR technology by the end of ACO’s first year
- ACOs will require continuing expenses related to reporting
  - Personnel
  - IT Maintenance
  - Continual coordination costs amount the different ACO members

Cost for Providers

**Capital Requirements for ACO Development**

- ACOs are required to establish a self-executing method for repaying losses to the Medicare program by indicating that:
  - Funds may be recouped from Medicare payments to the ACO’s participants
  - ACOs must obtain reinsurance
  - Place funds in escrow
  - Obtain surety bonds
  - Establish a line of credit that Medicare can draw upon, or
  - Establish another appropriate repayment mechanism in order to ensure repayment to the Medicare Program

Cost for Providers

Financial Commitments

• The financial commitment will be quite large, even for more sophisticated ACO participants
• First year start-up and operation costs for all ACOs is anticipated as being between $132 million to $263 million
• The Government Accountability Office (GAO) reported that in 2008 that the participants in the CMS PGP Demonstration invested $1.7 million to meet the requirements of that program through the first year
• Many believe that these investments will not be recouped under the MSSP

Reimbursement Considerations

Potential Value from Shared Savings

ACO Launched

Projected Spending
Target Spending
Shared Savings
Actual Spending

Expenditure

Year: -3 -2 -1 0 1 2 3

Cost for Providers

Start-up Costs: Examples From PGP

Note: these cost are low estimates considering that the provider systems in the demonstration project had already absorbed other integration costs before the project got under way.

- Average up-front payment was $489,000, plus $1.26 million in operating costs for first year.
- None of the 10 participants received any shared savings from Medicare in the first year.
- Therefore, healthcare executives should anticipate losses prior to gains in the implementation of the ACO model.

Cost for Providers  
*Capital Requirements*

Estimates Based on Risk Based Capital Model

<table>
<thead>
<tr>
<th>ACO Payment Method</th>
<th>Expected Costs Levels</th>
<th>Other Assumed Capital</th>
<th>2 x Company Action Level RBC</th>
</tr>
</thead>
<tbody>
<tr>
<td>100% of ACO services are paid FFS</td>
<td>90% of benchmark</td>
<td>None</td>
<td>$27 million</td>
</tr>
<tr>
<td>100% of ACO services are sub-capitated</td>
<td>95% of benchmark</td>
<td>None</td>
<td>$11 million</td>
</tr>
</tbody>
</table>

Required capital is lower if all ACO services are capitated because the capitated providers are assuming the risk

Cost for Providers

AHA’s Hypothetical Models

• Start up costs and operational costs far exceed CMS estimate of $1.7 million
• Factors that determine start-up and ongoing costs:
  o Size and composition of the patient population served
  o Geographic area being served
  o Characteristics of the organization that is undertaking the ACO development
  o Extent to which some of the needed infrastructure is already in place

“From Volume to Value: The Transition to Accountable Care Organizations,” By Keith D. Moore and Dean C. Coddington, American Hospital Association, April 2011.
Cost for Providers

AHA Hypothetical Models: Two Prototype Options

Prototype A
(200 bed, 1-hospital system, 80 PCPs, 150 specialist)

- Total Start-Up Cost: $5,315,000
- Total Annual Costs: $6,300,000

Prototype B
(1,200 bed, 5-hospital system, 250 PCPs, 500 Specialists)

- Total Start-up Costs: $12,000,000
- Total Annual Costs: $14,090,000

"From Volume to Value: The Transition to Accountable Care Organizations," American Hospital Association, April 2011.
# Financial Considerations

## Cost / Benefit Analysis

<table>
<thead>
<tr>
<th>Activity</th>
<th>Start Up Costs</th>
<th>Ongoing (Annual) Costs</th>
<th>Start Up Costs</th>
<th>Ongoing (Annual) Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Group I. Network Development and Management</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Providing ACO management and staff</td>
<td>$550,000</td>
<td>$1,450,000</td>
<td>$600,000</td>
<td>$3,200,000</td>
</tr>
<tr>
<td>2. Leveraging the health system management resources</td>
<td>$250,000</td>
<td>$200,000</td>
<td>$300,000</td>
<td>$250,000</td>
</tr>
<tr>
<td>3. Engaging legal and consulting support</td>
<td>$350,000</td>
<td>$125,000</td>
<td>$500,000</td>
<td>$125,000</td>
</tr>
<tr>
<td>4. Developing financial and management information support systems</td>
<td>$500,000</td>
<td>$80,000</td>
<td>$500,000</td>
<td>$160,000</td>
</tr>
<tr>
<td>5. Recruiting/acquiring primary care professionals, right-sizing practices</td>
<td>$400,000</td>
<td>$80,000</td>
<td>$800,000</td>
<td>$1,600,000</td>
</tr>
<tr>
<td>6. Developing and managing relationships with specialists</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>7. Developing and managing an effective post-acute care network</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>8. Developing contracting capabilities</td>
<td>$150,000</td>
<td>$150,000</td>
<td>$150,000</td>
<td>$150,000</td>
</tr>
<tr>
<td>9. Compensating physician leaders</td>
<td>$75,000</td>
<td>$75,000</td>
<td>$190,000</td>
<td>$190,000</td>
</tr>
<tr>
<td><strong>Group II. Care Coordination, Quality Improvement and Utilization Management</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Disease registries</td>
<td>$75,000</td>
<td>$10,000</td>
<td>$150,000</td>
<td>$20,000</td>
</tr>
<tr>
<td>11. Care coordination and discharge follow-up</td>
<td>$150,000</td>
<td>$1,000,000</td>
<td>$300,000</td>
<td>$3,000,000</td>
</tr>
<tr>
<td>12. Specialty-specific disease management</td>
<td>-</td>
<td>$150,000</td>
<td>-</td>
<td>$300,000</td>
</tr>
<tr>
<td>13. Hospitalists</td>
<td>$80,000</td>
<td>$160,000</td>
<td>$160,000</td>
<td>$320,000</td>
</tr>
<tr>
<td>14. Integration of inpatient and ambulatory approaches in service lines</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>15. Patient education and support</td>
<td>-</td>
<td>$100,000</td>
<td>-</td>
<td>$100,000</td>
</tr>
<tr>
<td>16. Medication management</td>
<td>-</td>
<td>$100,000</td>
<td>-</td>
<td>$100,000</td>
</tr>
<tr>
<td>17. Achieving designation as a patient-centered medical home</td>
<td>$100,000</td>
<td>$15,000</td>
<td>$150,000</td>
<td>$25,000</td>
</tr>
<tr>
<td><strong>Group III. Clinical Information Systems</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18. Electronic health record (EHR)</td>
<td>$2,000,000</td>
<td>$1,200,000</td>
<td>$7,050,000</td>
<td>$3,500,000</td>
</tr>
<tr>
<td>19. Intra-system EHR interoperability (hospitals, medical practices, other)</td>
<td>$200,000</td>
<td>$200,000</td>
<td>$400,000</td>
<td>$200,000</td>
</tr>
<tr>
<td>20. Linking to a health information exchange (HIE)</td>
<td>$150,000</td>
<td>$100,000</td>
<td>$200,000</td>
<td>$200,000</td>
</tr>
<tr>
<td><strong>Group IV. Data Analytics</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>21. Analysis of care patterns</td>
<td>$210,000</td>
<td>$210,000</td>
<td>$450,000</td>
<td>$450,000</td>
</tr>
<tr>
<td>22. Quality reporting costs</td>
<td>$75,000</td>
<td>$75,000</td>
<td>$100,000</td>
<td>$100,000</td>
</tr>
<tr>
<td>23. Other activities and costs</td>
<td>-</td>
<td>$100,000</td>
<td>-</td>
<td>$100,000</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>$5,315,000</td>
<td>$6,300,000</td>
<td>$12,000,000</td>
<td>$14,090,000</td>
</tr>
</tbody>
</table>

*Costs are primarily management and staff and are included in previous elements (1, 2, and 3).

### Financial Considerations

**Cost/Benefit Analysis**

Federal ACO Shared Savings Requirements

<table>
<thead>
<tr>
<th></th>
<th>Small ACOS</th>
<th>Medium ACOs</th>
<th>Large ACOs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Medicare Beneficiaries</td>
<td>5,000</td>
<td>20,000</td>
<td>80,000</td>
</tr>
<tr>
<td>Average Per Beneficiary Capital Cost</td>
<td>$8,400</td>
<td>$8,400</td>
<td>$8,400</td>
</tr>
<tr>
<td>CMS Benchmark (i.e., Predicted Beneficiary Expenditures)</td>
<td>$42,000,000</td>
<td>$168,000,000</td>
<td>$672,000,000</td>
</tr>
</tbody>
</table>

**One-Sided Model**

<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimum Savings Rate (MSR)</td>
<td>3.9%</td>
<td>2.5%</td>
<td>2.0%</td>
</tr>
<tr>
<td>Minimum Amount of Cost Reduction Required to Experience Shared Savings</td>
<td>$1,638,000</td>
<td>$4,200,000</td>
<td>$13,440,000</td>
</tr>
</tbody>
</table>

**Two-Sided Model**

<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimum Savings Rate (MSR)</td>
<td>2.0%</td>
<td>2.0%</td>
<td>2.0%</td>
</tr>
<tr>
<td>Minimum Amount of Cost Reduction Required to Experience Shared Savings</td>
<td>$840,000</td>
<td>$3,360,000</td>
<td>$13,440,000</td>
</tr>
</tbody>
</table>

Feasibility Analysis

Cost / Benefit Analysis: Best Case Scenario

• There is a cap on the amount of shared savings an ACO can achieve
  o One-Sided – 10% of Benchmark
  o Two-Sided – 15% of Benchmark

• Reaching this cap is the best-case scenario for ACO benefits

Feasibility Analysis

Cost / Benefit Analysis: Best Case Scenario

<table>
<thead>
<tr>
<th>Percentage of Shared Savings Given to ACO</th>
<th>Small ACOS</th>
<th>Medium ACOs</th>
<th>Large ACOs</th>
</tr>
</thead>
<tbody>
<tr>
<td>10% for One-Sided ACO</td>
<td>$4,200,000</td>
<td>$16,800,000</td>
<td>$67,200,000</td>
</tr>
<tr>
<td>15% for Two-Sided ACO</td>
<td>$6,300,000</td>
<td>$25,200,000</td>
<td>$100,800,000</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Percentage of Shared Savings Given to ACO</th>
<th>One-Sided Model</th>
<th>Two-Sided Model</th>
</tr>
</thead>
<tbody>
<tr>
<td>Small</td>
<td>$8,400,000</td>
<td>$10,500,000</td>
</tr>
<tr>
<td>Medium</td>
<td>$33,600,000</td>
<td>$42,000,000</td>
</tr>
<tr>
<td>Large</td>
<td>$134,400,000</td>
<td>$168,000,000</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Percentage of Shared Savings Given to ACO</th>
<th>Small</th>
<th>Medium</th>
<th>Large</th>
</tr>
</thead>
<tbody>
<tr>
<td>Small</td>
<td>50.0%</td>
<td>50.0%</td>
<td>50.0%</td>
</tr>
<tr>
<td>Medium</td>
<td>60.0%</td>
<td>60.0%</td>
<td>60.0%</td>
</tr>
<tr>
<td>Large</td>
<td>60.0%</td>
<td>60.0%</td>
<td>60.0%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Cost Reduction Required</th>
<th>One-Sided Model</th>
<th>Two-Sided Model</th>
</tr>
</thead>
<tbody>
<tr>
<td>Small</td>
<td>$33,600,000</td>
<td>$31,500,000</td>
</tr>
<tr>
<td>Medium</td>
<td>$134,400,000</td>
<td>$126,000,000</td>
</tr>
<tr>
<td>Large</td>
<td>$537,600,000</td>
<td>$504,000,000</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Percentage Cost Reduction</th>
<th>One-Sided Model</th>
<th>Two-Sided Model</th>
</tr>
</thead>
<tbody>
<tr>
<td>Small</td>
<td>20%</td>
<td>25%</td>
</tr>
<tr>
<td>Medium</td>
<td>20%</td>
<td>25%</td>
</tr>
<tr>
<td>Large</td>
<td>20%</td>
<td>25%</td>
</tr>
</tbody>
</table>

Feasibility Analysis

NPV Analysis

• NPV analysis may determine at what size a healthcare enterprise should pursue ACO status

• Shared savings justify initial capital investments
  o Incorporates cash flow over three year contract

Feasibility Analysis

NPV Analysis

• Net Present Value (NPV) is ...

  "the difference in amount between initial payment and related future cash inflows after cost of capital adjustments (interest rate), as of a specific date."

• Positive NPV ... ACO will be able to generate sufficient cash flows to offset initial investment cost as well as capital costs

Feasibility Analysis

NPV Analysis

Net Present Value of ACO Investment – One-Sided Model

Feasibility Analysis

NPV Analysis

Net Present Value of ACO Investment – Two-Sided Model

Number of Beneficiaries Required for an ACO to be Profitable

Feasibility Analysis

NPV Analysis

• Positive NPV requires...
  • One-Sided – 39,000 Beneficiaries
  • Two-Sided – 16,000 Beneficiaries

• There is a greater opportunity to have increased shared savings under the two-sided model
  • In exchange, it also exposes ACOs to risk (i.e., potential shared losses)

Feasibility Analysis

NPV Analysis

Break Even Analysis for ACOs of Various Sizes

Percent of Cost Reduction from Benchmark for ACO to Break-Even

Number of Beneficiaries (in thousands)

One-Sided Model
Two-Sided Model
Feasibility Analysis

NPV Analysis

• One-sided
  o Small and Medium (5,000-20,000 beneficiaries)
  o Not feasible

• Two-sided
  o Small (5,000 – 10,000 beneficiaries)
  o Not feasible
Feasibility Analysis

NPV Conclusions

• Large ACOs most likely to succeed
  o 4% reduction in expenditures vs. 22%
  o Added consideration – more likely to have previous integration (i.e., specialties, primary care, healthcare information technology)
  o More likely to meet quality goals and reporting requirements
    ▪ Poor quality can lower shared savings
COST FOR PATIENTS: CONTROLLING HEALTHCARE COSTS
Cost for Patients

Will this Translate to Lower Healthcare Costs for Patients?

- Lower Patient Costs -
Incentives that encourage quality over quantity may theoretically eliminate unnecessary volume by lowering the amount of care needed.

- Higher Patient Costs -
Integration may lead to greater market power for ACOs, leading to provider savings.
Market Power has historically translated to higher consumer prices.

Cost for Patients

Controlling Healthcare Costs

ACOs may provide framework to control costs

“Health care providers sign an agreement to participate with the ACO. Spending targets are set based on past years’ data. If total spending comes in under target, providers share the savings. Savings come from better chronic care management, compliance with preventive care guidelines and better care coordination among ACO providers.”

- Health Policy Expert, Steven Shortell

Cost for Patients

Controlling Healthcare Costs

• Congressional Budget Office estimates potential savings from ACOs could reach approximately $5.3 billion between 2010-2019

• Net savings will not be realized until 2013

Despite These Estimates...

• Demonstration program outcomes: “It is questionable whether the PGP [Physician Group Practice Demonstration] has saved money.”

Cost for Patients

Value Metrics for Accountable Care

• Value is the expectation of future economic benefit

• In healthcare value has two components:
  o **Value to Society**: future benefit to the population as a whole
  o **Value to Providers**: emphasizes economic returns to individual enterprises, assets, and services

"Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations and Medicare Program: Waiver Designs in Connection With the Medicare Shared Savings Program and the Innovation Center; Proposed Rule and Notice" Federal Register, Vol. 76, No. 67 (April 7, 2011), pg. 19531
Cost for Patients

Value Metrics for Accountable Care

Value to Society

Better outcomes for individuals and populations accompanied by lower growth in expenditures

Quality of care can be measured through patient outcomes metrics (i.e. average length of stay; number of readmissions; and, patient satisfaction surveys.)

Value to Providers

Shared Savings Payments; Better Medicare Reimbursement; Greater Market Power

Measured through provider expectations regarding financial returns; practice value; lower practice expenditures (achieved through administrative efficiency, coordinating patient care, and better patient outcomes.)
Providers vs. Patients Costs

<table>
<thead>
<tr>
<th>Provider Positives</th>
<th>Patient Positives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Possible lower practice costs from increased efficiency</td>
<td>Better quality care</td>
</tr>
<tr>
<td>Greater market (negotiating) power</td>
<td>More convenient care</td>
</tr>
<tr>
<td>Possible shared savings payments</td>
<td>Possibly fewer physician visits</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Provider Negatives</th>
<th>Patient Negatives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lower patient volumes equals lower FFS payments</td>
<td>Greater power of providers tends to lead to larger costs for patients</td>
</tr>
<tr>
<td>High IT costs</td>
<td>Confusing beneficiary assignment</td>
</tr>
<tr>
<td>High capital costs</td>
<td></td>
</tr>
</tbody>
</table>

An ACO’s value, either to society or to providers, must be weighed against the prospective costs

IMPACT OF ACOs
The *Four Pillars* of the Healthcare Industry

**Four Pillars of Healthcare Value**

- Healthcare Reform
- Economic Conditions
- Regulatory
- Reimbursement
- Competition
- Technology

**Enterprise | Assets | Services**
SCOTUS Decision

- June, 28, 2012, the Supreme Court of the United States (SCOTUS) handed down its decision which upheld most of the 2010 healthcare reform act, the Patient Protection and Affordable Care Act (ACA)

- This opinion held that the individual mandate was constitutional, relying on a narrow interpretation of Federal taxing authority

- One ACA provision was modified by the ruling; this modification stipulates that Medicaid expansion in the states is no longer mandatory and that states can decide not to receive the expansion with no Federal penalty

- The Court’s 5 to 4 ruling to uphold the Law will allow ACOs and most of the provisions of the reform law to continue implementation as was planned

# Distinguishing Between Federal and Commercial Markets

<table>
<thead>
<tr>
<th>Four Pillars</th>
<th>Federal ACO</th>
<th>Commercial ACOs</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Regulatory</strong></td>
<td>Regulated by the MSSP</td>
<td>Must be compliant with the same rules as non-ACO providers</td>
</tr>
<tr>
<td></td>
<td>Waivers for Stark Law, Anti-kickback, and CMP</td>
<td>As of yet, not eligible for CMS, DOJ, FTC waivers.</td>
</tr>
<tr>
<td></td>
<td>Guidelines and policies available for antitrust</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Accredited by NCQA Standards</td>
<td>Accredited by NCQA Standards</td>
</tr>
<tr>
<td><strong>Reimbursements</strong></td>
<td>Reimbursed through FFS</td>
<td>Reimbursements range from FFS to single capitation models</td>
</tr>
<tr>
<td></td>
<td>Shared Savings under two disbursement options.</td>
<td>Any number of value-based purchasing agreements (to be negotiated between ACO and payor)</td>
</tr>
<tr>
<td></td>
<td>Shared risk based on whether benchmarks are met (only for two sided option) leading to possible shared losses</td>
<td>Shared risk located within overall reimbursement (i.e., capitated payment) or as shared losses (less common for commercial)</td>
</tr>
<tr>
<td></td>
<td>Shared savings only for Medicare population</td>
<td>Shared savings for negotiated population</td>
</tr>
<tr>
<td><strong>Competition</strong></td>
<td>Medicare beneficiaries not required to stay within the ACO, leading to competition</td>
<td>Population may or may not go outside of the ACO depending on the payor contract.</td>
</tr>
<tr>
<td><strong>Technology</strong></td>
<td>Doesn't require EHR, but requires sophisticated data gathering</td>
<td>Doesn't require EHR, but requires sophisticated data gathering</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Some payors help implement telecommunications within the ACO</td>
</tr>
</tbody>
</table>
Regulatory Considerations

• Federal Anti-Kickback Statute (AKS)
• Federal Physician Self-Referral Law (Stark Law)
• Federal Civil Monetary Penalty (CMP)
• Federal Antitrust Law
• Federal Tax Law
• State Regulations
  o Antitrust
  o Fraud and Abuse
  o False Claims
  o Corporate Practice of Medicine
  o Insurance Law
Definition

Prohibition against soliciting, receiving, or paying remuneration in exchange for the referral healthcare service billed to Medicare, Medicaid, or any other federal healthcare program.

ACO Implication

Current safe harbors to potentially shield ACOs from possible violations include:

1. Direct employment;
2. Co-management arrangements; and,
Regulatory Considerations

Federal Stark Law

**Definition**

Prohibition against physician referrals to providers of Designated Health Services (DHS) with whom the referring physician has a financial relationship.

**ACO Implication**

Compliance with the AKS and Stark may be waived, “as may be necessary,” to conduct:

1. Any payment model for ACOs that the Secretary determines will improve the quality and efficiency of items and services furnished under the Medicare program.
2. The bundled payment/episode of care pilot.
Definition

Civil penalties against hospital payments to physicians for:
(1) Reducing length of stay;
(2) Reducing readmission rates; and,
(3) Other forms of fraud and abuse

ACO Implication

HHS has provided a waiver similar to those given for Stark Law and the AKS

"Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations and Medicare Program: Waiver Designs in Connection With the Medicare Shared Savings Program and the Innovation Center; Proposed Rule and Notice" Federal Register, Vol. 76, No. 67 (April 7, 2011).
Regulatory Considerations

**Federal Tax Law**

**Definition**
Integration between providers coordinating care may cause nonprofit, tax exempt providers and for profit, taxable entities, to merge

**ACO Implication**
Tax-exempt participants in ACOs should be able to remain that way as long as ACO furthers charitable purposes

Regulatory Considerations

**Federal Antitrust**

**Definition**

Sherman Act, Section 1 prohibits contracts, combinations and conspiracies that unreasonably restrain trade

Applies to independent, competing providers

Does not apply to:

1. Physicians all within the same group
2. A hospital and its full-time, employed physician
3. A hospital and its controlled subsidiaries

**ACO Implication**

FTC and DOJ released proposed rules governing mandatory antitrust monitoring, based on the percentage of market share an ACO has for any specific service line

Regulatory Considerations

Federal Antitrust

No Risk – “Safety Zone”
1. ACO participants provide 30 percent or less of a specific service within a single ACOs PSA
2. No participating hospitals of ASCs work exclusively with a single ACO
3. Dominant Provider Limitation – A “dominant provider” (any ACO including a participant with more than 50 percent share of a specific service in a PSA) within the ACO must be in a non-exclusive relationship, where the ACO does not restrict their ability to contract/deal with other ACOs or provider networks. Will not lose “safety zone” status solely because it attracts more patients.

Optional Risk
• ACOs that are outside the safety zone, but are not defined as high risk, may obtain an optional review.
• ACO does not impede the functioning of a competitive market will not raise competitive concerns.
• If they are found in violation of antitrust guidelines, they will be prohibited from entering the MSSP program.

High Risk – Mandatory Review
• ACO has greater than 50 percent share of a specific service within a single provider’s PSA (Note: If threshold is met due to a rural facilities, the Rural Exception is triggered and ACO may be in no-risk “safe zone”)
• Must obtain permission to participate in MSSP
Regulatory Considerations

State Laws

• State “Corporate Practice of Medicine” (CPOM) laws prohibit the practice of medicine or the employment of physicians by business corporations

• A variety of care models and structures for hospital-physician relationships have been developed to comply with state statutes, which may not fit easily with the structure or goals of an ACO

• CPOM laws could prevent some ACOs from hiring physicians to work directly with provider participants in managing and better coordinating the provision of health services

Regulatory Considerations

State Regulation

• Physician-self referral, anti-kickback, or related fraud and abuse laws

• Private Inurement/Private Benefit Issues
  - 501(c)(3) organizations cannot be organized or operated for the benefit of private interests

• State Insurance Laws
  - Some states require that health care providers assume financial risks, and that employer groups be regulated as health insurers
    - Can entail risk-based capital reserve requirements and other state law obligations, making it difficult for provider organizations (and ACO components) to enter into risk-sharing agreements

Regulatory Considerations

Fair Market Value and Commercial Reasonableness

• ACOs involve coordinated care covering a variable and wide range of services
  o Quantifying opportunity cost and other marginal costs incurred by physicians during a transition to an ACO
  o Determining the Fair Market Value attributable to the savings that accrue from this new system (which may result in compensation to physicians) may be difficult

• Proposed Stark Law waiver: shared savings earned by ACOs is not subject to FMV and commercially reasonable scrutiny

Reimbursement Considerations

Medicare Reimbursement vs. Operating Costs

Reimbursement Considerations

**Hospitals**

- Large health systems may be in best position to form ACOs
  - Attract more PCPs
  - Vertical Integration will likely aid in transition to ACO
  - May easily meet quality requirements
  - Greater access to capital and IT requirements

- Potential Hurdles:
  - May need to lower cost or increase private insurers’ cost to generate shared savings

Reimbursement Considerations

Physician Practices

Increasing hospital - physician alignment

Good for Physician

- High Overhead and decreasing reimbursements make practices expensive
- Steady Salary and Benefits
- Regulatory Buffer
- Work-Life Balance
- Less financial risk

Good for Hospital

- More market power / market share
- Clinical integration
- ACO participation

Reimbursement Considerations

*ASCs & Outpatient Providers*

- Requires linking clinical and cost systems to the ACO’s information on the patient population through the implementation of electronic health record (EHR) system (Note: expensive proposition as there are no “meaningful use” subsidies for ASCs)

- Volume of services for ASCs may actually increase as providers look for ways to decrease hospital costs, depending on how ACOs react to the incentive to decrease costs


Reimbursement Considerations

Medical Homes

• ACA does not include section specific to Patient-Centered Medical Homes (PCMH), but PCMH’s are promoted throughout health reform legislation

• PCMHs may likely be stepping stone to the formation of an ACO infrastructure

• PCMH structure: team-based model that is run by primary care physicians who are in charge of providing a continuum of care for all aspects of healthcare throughout a patient’s life.
  o Requires streamlined infrastructure

• PCMH primary goal: coordinate the care of a patient while reducing unnecessary duplication of services and therefore increasing cost of care

Reimbursement Considerations

Ancillary Providers and Allied Health Practices

• ACA restricts qualified ACO participants to mid-level providers and practitioners, leaving ancillary providers and allied health practices out

• Push for ACO inclusion:
  - Physical Therapists: CMS should designate PTs as “ACO Professional” in ACA
  - Chiropractors: Using chiropractors in regular patient care cut down on hospitalizations dramatically
  - Pharmacists: Including pharmacists in patient-care teams improve health care quality through direct care from pharmacists
  - Radiologists: May share too much of the risk associated with shared savings and not enough of the savings

“APTA Response to CMS’ Request for Information Regarding ACOs” By R. Scott Ward, American Physical Therapy Association (December 3, 2010).
“ACA Response to CMS’ Request for Information Regarding ACOs” By Rick McMichael, American Chiropractic Association (November 29, 2010).
“Integrating Pharmacists into Accountable Care Organizations and Coordinated Care” By National Community Pharmacists Association (December 7, 2010).
Reimbursement Considerations

Impact on Payers

Private Insurance

• Primary Concerns:
  o Increased market power by providers leading to increased charges to private insurers
  o Insufficient accountable care progress for ACOs contracting with health systems
• Contracts move away from FFS reimbursement models hoping to achieve cost and clinical efficiencies

Government

• Goal to reduce Medicare spending
• Congressional Budget Office CBO estimates ACOs will save Medicare $4.9 billion through 2019, (1% of spending)
Competition Considerations

*Porter’s Five Forces*

- Bargaining Power of Providers
- Competitive Rivalry within an Industry
- Bargaining Power of Patients
- Threat of New Entrants
- Threat of Substitutes
Technology Considerations

• Electronic Medical Records
  o Significant cost
  o Help eliminate silos and increase continuity of care
  o Meaningful use standards

• The technological impacts on providers choosing to participate in an ACO are rooted in the primary issue of purchasing or updating an EHR system
  o Costly
  o Must meet meaningful use standards to be eligible for savings

• EHR integration and alignment among ACO participants is critical to ensure benefits of HIT utilization are obtained

Federal ACO Timeline

June 2009
Report includes an entire chapter of ACOs based on the PGP Demonstration Project. This report is influential in the ACA’s drafting

April 7, 2011
MSSP Proposed Rule Published
This rule lead to over 1,200 comments from concerned providers – Some commenters believed that Federal ACOs were dead in the water

January 1, 2012
CMS ACO Rules Must be Implemented
Under the ACA, CMS has till January 1, 2012 to begin implementing ACOs. CMS created rolling applications deadlines within the final rule to begin at this date

April 10, 2012
27 ACO Applications Accepted
These ACOs are approved to serve an estimated 375,000 beneficiaries in 18 States

December 19, 2011
32 Pioneer ACOs Announced
CMS selected organizations already experienced with providing continuum of care to begin on January 1, 2012 for a minimum of 5 years.

November 2, 2011
MSSP Final Rule Published
Final rule changed many of the most controversial provisions of the proposed rule in favor of provider concerns

April and July 1, 2012
First Federal ACO Agreements Begin
With the final rule, CMS announced that the first ACO agreements would begin on April 1 and July 1, 2012 with subsequent rolling admission to the program

July 9, 2012
89 ACO Applications Accepted
These ACOs are approved to serve an estimated 1.2 million beneficiaries in 40 states

“Improving Incentives in the Medicare Program” Medicare Payment Advisory Commission, June 2009, pg. 39-57;
“Proposed Rule Versus Final Rule for Accountable Care Organizations (ACOs) In the Medicare Shared Savings Program” Centers for Medicare & Medicaid Services.
CONCLUDING REMARKS
Concluding Remarks

• Even with 89 Federal ACOs, the MSSP still projects *theoretical* savings, and very *real* costs. Providers looking to transition to an ACO are more prevalent in the commercial market
  
  o Some insurers negotiating ACO-like contracts include: BCBS MA (the alternative quality contract), Aetna, Human, and Wellpoint

• To succeed, ACOs will need what managed care lacked: public understanding, payor support, partnerships between physicians and hospitals, up-front financial resources, and time for integration

Concluding Remarks

“Love everyone, trust no one, and paddle your own canoe.”