Accountable Care Models: A Summary of the Final Medicare ACO Regulations and ACO Models

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The Future with Health Care Reform

1. Declining Revenues – Medicare and Medicaid systems cannot be sustained.

2. Increasing Administrative Costs
   i) Information technology
   ii) Clinical quality monitoring
   iii) Regulatory compliance

3. Reimbursement Reform – focuses on:
   i) Cost reduction
   ii) Quality initiatives
   iii) Collaboration among providers
What is an ACO?

• An ACO is a collaboration of physicians and other health care providers to coordinate patient care.
• Monitors quality and cost.
• Eligible to receive additional payments for achieving quality and cost savings goals.
• Reimbursement vehicle.
The ACO Concept

ACO

- Hospital
- PCP Groups
- Specialist Groups
- Multi-Specialty Groups
- Other Providers

Medicare & Other Payors

- Bundled or Capitated Payments
- $ Shared Savings

Other Providers

- Mental Health
- Long Term Care / Hospice
- Home Health
ACO Reimbursement Reform
Transition from Fee-For-Service

• Medicare Shared Savings Program – started January 1, 2012

Expected changes:

• Bundled Payments / Episodes of Care
• Global Payment / Partial Capitation
Regulatory Overview

• Governance/Leadership
• Leadership and Management
• Assignment of Beneficiaries
• ACO Entity/Participants
• Required Processes
• Shared Savings
• Data Sharing
• Quality Measures
• Legal Tensions/Waivers
Governance/Leadership

• Governing body with authority to implement the processes to promote evidence-based medicine, patient engagement, report on quality and cost measures, and coordinate care.

• Governing body members must have a fiduciary duty to the ACO and act consistent with that fiduciary duty.

• Governing body must have a transparent governing process.
Composition of the Governing Body

• At least 75% control of the ACO's governing body must be held by ACO participants.

• ACO must provide for meaningful participation on the governing body for ACO participants or their designated representatives.

• Governing body must contain a Medicare beneficiary representative served by the ACO.
Governing Body/Conflicts of Interest

• Governing body must have a conflict of interest policy for its members.
• Governing body members required to disclose relevant financial interests.
• Processes to determine and address any conflicts that arise.
Leadership and Management

• Leadership and management structure to include clinical and administrative systems that support the Shared Savings Program.
• Clinical management and oversight to be managed by a senior-level medical director who is a physician and ACO provider.
• Medical director must be physically present on a regular basis at an office or clinic participating in the ACO.
Primary Care Physicians

• ACO must include a sufficient number of primary care physicians for the number of fee-for-service beneficiaries assigned to the ACO.
• ACO must have at least 5,000 assigned beneficiaries.
Assignment of Beneficiaries

Step One:

- Determine beneficiaries who received primary care services from an ACO primary care physician.
- Beneficiary is assigned to the ACO where patient incurred greatest amount of allowed charges for primary care services from one or more of the ACO's primary care physicians.
Assignment of Beneficiaries (cont.)

Step Two:

- Determine beneficiaries who received primary care services from an ACO specialist but not a primary care physician.
- Beneficiary is assigned to the ACO where patient incurred greatest amount of allowed charges for primary care services from one or more of the ACO's specialist physicians.
ACO Entity/Participants

• Legal entity formed under applicable state, federal or tribal law

• Participants that may form an ACO
  - Physician practice
  - Networks of physician practices
  - Partnerships or joint venture arrangements between hospitals and ACO professionals
  - Hospitals employing ACO professionals
  - Certain critical access hospitals
  - Rural health center
  - Federally qualified health center
Required Processes

An ACO must adopt and periodically update processes to:

• Promote evidence-based medicine for diagnosis with significant potential to achieve quality improvements
• Evaluate health needs of the ACO's population and a plan to address the needs
• Promote patient engagement through surveys, evaluating health needs, communication of processes, and standards for beneficiary access to their medical records
• Internally report on quality and cost metrics.
• Coordinate care across and among primary care, specialists and other providers/suppliers
Shared Savings

• Actual Part A and Part B expenditures are compared to the Benchmark
• Benchmark is comprised of estimated Part A and Part B expenses with risk adjustments for changes in health status and demographics
• 3 month claims run out with a completion factor
• Truncate claims exceeding 99th percentile
• Required to meet minimum quality standards
## Shared Savings

<table>
<thead>
<tr>
<th>Incentive Sharing Rate</th>
<th>One-Sided Model</th>
<th>Two-Sided Model</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Upside Saving Only</td>
<td>Savings &amp; Losses</td>
</tr>
<tr>
<td></td>
<td>Share up to 50% savings based on maximum quality score</td>
<td>Share up to 60% savings based on maximum quality score</td>
</tr>
<tr>
<td>Minimum Savings Rate</td>
<td>2.0-3.9% depending on number of assigned beneficiaries</td>
<td>2%</td>
</tr>
</tbody>
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## Shared Savings (cont.)

<table>
<thead>
<tr>
<th></th>
<th>One-Sided Model</th>
<th>Two-Sided Model</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Payment Limitation</strong></td>
<td>• 10% of Benchmark</td>
<td>• 15% of Benchmark</td>
</tr>
<tr>
<td></td>
<td>• n/a</td>
<td>• 2%</td>
</tr>
<tr>
<td><strong>Minimum Loss Rate</strong></td>
<td>• n/a</td>
<td>• 5% in year 1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>7.5% in year 2</td>
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<tr>
<td></td>
<td></td>
<td>10% in year 3</td>
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</tbody>
</table>
Determining Shared Savings

- Actual Medicare expenditures in the performance year is compared to the Benchmark
- If applicable Minimum Savings Rate and Quality Standard achieved then eligible for Shared Savings
- Calculate applicable Sharing Rate
- Compare Amount of Shared Savings Payable to ACO to Sharing Cap
Data Sharing

• ACO receives aggregate de-identified reports with claims data used to create the benchmark and quarterly updates
• ACO may request beneficiary-identifiable data upon request and execution of a data use agreement
• ACO has to notify beneficiary of request for data
• Beneficiary has right to decline data identification
Quality Measures

• Year 1 – ACO assessed on complete and accurate reporting for all quality measures
• Subsequent years – ACO assessed on reporting and attainment level of quality domain measures
• 30% minimum attainment level for each quality performance benchmark
• ACO will receive points on a sliding scale when performance at or above 30% of performance benchmark
Quality Measures (cont.)

• Performance at or above 90% of performance benchmarks earns maximum points

• 33 quality measures divided into four domains:
  1) Patient/care giver experience
  2) Care Coordinator/patient safety
  3) Preventive health
  4) At-risk population
Quality Measures (cont.)

• ACO must score above 30% on 70% of measures in each domain or subject to corrective action plan

• ACO achieves 30% on at least one measure in each domain and realizes shared savings then it is eligible to receive a proportion of shared savings

• Proportion of shared savings is calculated by points earned to points available in each domain then averaging the ratios for each domain
Legal Tensions

With aligning and incentivizing Physicians to manage care to reduce costs

- 501(c)(3) Standards
  - no payment for referrals, no private benefit
- Anti-Kickback Statute
  - no payment for referrals
- Stark
  - no referrals where prohibited financial relationships
- Anti-Trust laws
  - no market power
- CMP
  - no payment to limit services in hospital setting
  - no payment to beneficiaries as inducement to receive services
Legal Waiver Applicable to ACOs

• Waivers apply to:
  – Anti-Kickback Statute
  – Stark Law
  – Civil Monetary Penalty Statute

• Five waivers cover certain arrangements relative to ACO formation, operation, shared savings distributions and beneficiary incentives

• Waivers protect ACO applicants, service providers, suppliers and participants

• All waivers are tied to the Share Savings Program
Tax Exemption for ACOs

• IRS indicated it will apply "lessening the burdens of government" standard which will allow Medicare ACOs to obtain 501(c)(3) status

• IRS has a concern with private payors added to the ACO

• "Community benefit" standard should be available to allow Medicare and private payor ACOs achieve 501(c)(3) status
Fair Market Value and Compensation Standards

• New standards for compensating physician for achieving quality and cost benchmarks are evolving
Relevance of Physician Networks

• Physicians are essential to manage down costs through clinical initiatives
• Employed networks can be directly managed towards clinical process changes
• Employed physician networks limit potential privacy issues and anti-competitive claims between independent groups
• Employed networks simplify the distribution of shared savings in ACO joint ventures
ACO Models

1. Hospital Controlled Model
2. Hospital Network Joint Venture
3. Physician Controlled ACO
4. Physician Network Joint Venture
5. Hospital/Physician Network Joint Venture
6. Medicaid ACO
1. Hospital Controlled Model
2. Hospital Network Joint Venture

- Hospital
  - Employed Physician Network
  - Clinics
  - Independent Physicians

- ACO
  - $ from Employed Physician Network
  - $ from Clinics
  - $ from Independent Physicians

- Developer/Manager (Private Equity)

- CMS

- Other Providers/Suppliers
3. Physician Controlled ACO
4. Physician Network Joint Venture

- Physician Network
- Clinics
- Hospital
- Other Providers/Suppliers
- ACO
- CMS
- Developer/Manager (Private Equity)

Flows:
- Physician Network to Clinics
- Physician Network to ACO
- ACO to CMS
- ACO to Hospital
- ACO to Other Providers/Suppliers
- Clinics to ACO
- CMS to ACO
- CMS to Other Providers/Suppliers
- Hospital to ACO
5. Hospital/Physician Network Joint Venture
6. Medicaid ACO