Accountable Care Organizations: Lessons Learned from the ACO Process and Applications

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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

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

ACO

$ Shared Savings

Medicare & Other Payors

Bundled or Capitated Payments

Other Providers
- Mental Health
- Home Health
- Long Term Care / Hospice

Other Providers
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
Results of First Year of Pioneer ACO Initiative

- All 32 participants improved the quality of patient care and rated high on patient satisfaction

- 25 of 32 participants reduced hospital readmissions against benchmarks

- 18 achieved cost savings but only 13 saved enough to share savings with Medicare
  - 13 received $76 million in savings
  - 2 will owe Medicare $4 million
Results of First Year of Pioneer ACO Initiative (cont.)

- Pioneer ACOs combined for $140 million in total savings and $52.4 million in total losses

- 9 of the 32 are switching to the Medicare shared savings ACO program
Lessons for Pioneer ACOs

1. **Manage expectations** – it takes time to develop the culture, processes and capabilities to coordinate care to achieve significant cost reductions.

2. **Importance of Interoperability** – ACOs experienced problems with lack of IT interoperability.
   - need for functionality to comply with "meaningful use" requirements
   - EHR systems have to be able to trade information with all other software systems
   - varying connection speeds
Lessons for Pioneer ACOs (cont.)

3. Be Realistic with Capabilities –
   • Pioneer program intended for more established coordinated care systems and has more financial risk and rewards
   • Participants are expected to transition to capitated payment for all or part of patient's care
   • Some of Pioneer ACOs may have overestimated their capabilities relative to their financial risks.

4. Big Picture – Pioneer ACOs appear to be doing a good job at increasing patient satisfaction and bending the cost curve.
Lessons Learned from Medicare Shared Savings ACOs

Application Process:

1. Reference ACO Toolkit while completing application.

2. ACO Participation Agreements must be in place prior to submitting an application.

3. ACO participants must have at least 75% control of the governing body.
Lessons Learned (cont.)

4. **Taxpayer Identification Numbers (TINs)** -
   - Are collected for all ACO participants
   - ACO participant TIN upon which beneficiary assignment is based is exclusive to one ACO
   - Plurality of primary codes determines beneficiary assignment to an ACO
   - Primary care practices will be exclusive to an ACO
   - One physician in a group can attribute entire group because group TIN determines exclusivity
   - Specialists could be required to be exclusive if providing primary care codes
Lessons Learned (cont.)

5. Pay close attention to regulations as they relate to legal structure, governing body and agreement with ACO and participants.

6. Required Medicare beneficiary on the governing board may not be an ACO participant.
7. Specifically address your ACO's remedial process if a participant is non-compliant with the ACO requirements.

8. If you answer "yes" to the question, "whether you jointly negotiate contracts with private payors", then CMS will share your information with FTC and DOJ.
Lessons Learned (cont.)

Structural Considerations:

1. Most ACOs are being formed as LLCs.

2. Most ACOs will likely not apply for tax-exempt status.
   - IRS applying rigid views of tax exemption and not clear how it will apply standards
   - Tax-exempt ACO will need to be nonprofit corporation. Private parties generally prefer LLC taxed as a partnership
Lessons Learned (cont.)

3. Governance is not required to be tied to ownership.
   - Reserved powers can be used to alter control

4. Leadership is the key to an ACO's success and an ACO will need attention of the leaders selected.
Lessons Learned (cont.)

Operational:

1. **Compliance Plan**
   - Required
   - Compliance officer is a required position

2. **Waivers** – ACOs granted waivers from Anti-kickback, Stark and CMP. Only apply to operations within ACO.
   - Start-up Waiver – one party can disproportionately fund ACO start-up costs but make sure not funding broader initiatives for physician, e.g., electronic health records outside of ACO
Lessons Learned (cont.)

2. **Waivers (cont.)**
   - Operational Waiver – ensure only funding ACO efforts
   - Patient Incentive Waiver – very narrow. Even though would be more useful to provide more incentives to patients only have a very narrow exception
   - Shared Savings Distributions – only applies to Medicare and not distributions from private payors
Lessons Learned (cont.)

3. Designers of ACO concept agree it does not work unless it is applied to both commercial and Medicare patients yet combining both in one ACO may not be practical.

4. Need to instill a sense of operational compliance in employees handling reporting functions.
   • As organizations press down on employees to improve performance, the risk of misrepresenting data inputs that impact the ACO's performance increases, e.g., employee's bonuses tied to performance might encourage misreporting
   • Need to meet reporting standards and employees need to appropriately document standards are met
Lessons Learned (cont.)

5. If beneficiary attribution drops below 5,000, ACO can be removed from program. Small ACO close to 5,000 has to watch and ensure sufficient participant agreements stay in place to attribute beneficiaries.

- Beneficiaries can come in and out of ACO so make sure have well over 5,000 members
Lessons Learned (cont.)

6. **One-Sided and Two-Sided Models** - ACOs often start with one-sided model with no downside risk. Required to go into two-sided risk model after first term.
   - Reinsurance is an option in two-sided model but must be listed in the ACO application
   - Consider addressing risk assumption in ACO documents and participation agreements
Lessons Learned (cont.)

7. **Quality factors** - Can change throughout the program but not within a performance year.
   - You may want to select or incentivize other quality measures
   - Meaningful use of EHR double counted
   - ACOs with better quality scores obtain higher shared savings payment
Lessons Learned (cont.)

8. **Focus on IT solutions.**
   - Connectivity issues
   - Platforms to analyze data
   - HIPPA applies – ACO are business associates of participants, rather than covered entities

9. **Skill set from Medicare ACO program can be transferred into commercial market ACOs and vice versa.**
Lessons Learned (cont.)

10. Need management programs and trained professionals integrated with care team to effectively manage patient populations.
   • 2009 study: almost 10% of Medicare beneficiaries readmitted within 30 days of discharge and 34% re-hospitalized within 90 days
   • Embedded case managers serving as patient point of contact upon admission, discharge and transition between organizations and care settings can link patients to resources that result in improvements in clinical outcomes
     - One pilot program had 50% fewer hospital days per 1,000 patients, 45% fewer admissions and 56% fewer readmissions after embedding case managers
Lessons Learned (cont.)

11. Need access to timely, accurate and complete health information.
   • Health information technology ("HIT") and health information exchanges ("HIE") make possible proactive management of the ACO's population
   • Example: Informing ACO and patient care teams of patient emergency department visits and hospital admissions at both ACO and non-ACO facilities
Lessons Learned (cont.)

11. Need access to timely, accurate and complete health information (cont).
   • Without HIT when a patient presents in an emergency room outside of the ACO, the ACO may not learn of that episode of care until it receives retroactive claims data from CMS by which time the patient may have incurred significant additional costs which are attributed to ACO and affect ACOs performance on cost and quality measures
   • One study found intervention that began with hospitalization and follow the patients through discharge reduced subsequent hospitalizations within 30 days by 30%
Lessons Learned (cont.)

11. Need access to timely, accurate and complete health information (cont).

- Another study found early post-discharge follow up has been shown to reduce overall hospitalizations by 25%
- A recent study found that providers with HIE performed better on quality measures and incurred savings attributable to reduced hospitalizations and duplicative lab and radiology orders
- Another study found providers achieved significant cost savings from utilizing the HIE network rather than transmitting data through fax and mail
Lessons Learned (cont.)

12. **Patient Engagement** - Successful patient engagement and self-management programs require trained professionals (from nurses, social workers and physicians) investing time and effort to help patients become engaged in meeting their health objectives.
Lessons Learned (cont.)

13. **Integrating Data** - ACO providers have to develop fully integrated clinical and administrative systems to report and analyze data about individual providers.
   - ACOs must be capable of integrating CMS patient identifiable claims data with their own clinical and administrative information
   - CMS has been slow to provide patient identifiable data

14. **Liability Risks** – ACO cooperative relationships may expand liability risks and insurance coverages should be sufficient to cover relationship risks
   - Malpractice
   - HIPAA violations / data breach
Why Participate in an ACO When:

1. You are working to reduce your core revenue system

2. ACO incentives are not likely to be adequate to cover lost revenues
Why You Should Consider Participating:

1. Inevitable that efforts to reduce costs and unnecessary hospital admissions will continue

2. Very likely that shift from fee-for-service to at-risk payments will occur

3. Hospital lost revenue from eliminating inefficiencies will likely need to be replaced by increasing market share and developing the ability to participate in capitated payment systems
Why You Should Consider Participating (cont.)

4. Highest value providers (highest quality service at lowest cost) will be best equipped to transition to at-risk payments

5. Opportunity to help physicians on your medical staff supplement their incomes with incentives from the program
APPENDIX

1. ACO Models

2. Final Regulations Overview

3. Tax Exemption for ACO
ACO Models

1. Hospital Controlled Model

2. Hospital Network Joint Venture

3. Hospital/Physician Network Joint Venture
1. Hospital Controlled Model

- Hospital
  - Employed Physician Network
  - Clinics
  - Independent Physicians
  - ACO
    - $ from CMS
    - $ from Other Providers/Suppliers
2. Hospital Network Joint Venture

- Hospital
- Employed Physician Network
  - Clinics
- ACO
  - $ from Employed Physician Network
  - $ from Independent Physicians
  - $ from Other Providers/Suppliers
- Developer/Manager (Private Equity)
- CMS
3. Hospital/Physician Network Joint Venture

Diagram:
- Physician Network
- Clinics
- Hospital
- ACO
- CMS
- Hospital
- Other Providers/Suppliers

Flows:
- $ from Clinics to ACO
- $ from ACO to Hospital
- $ from Hospital to ACO
- $ from ACO to CMS
- $ from CMS to ACO
- $ from ACO to Other Providers/Suppliers
Final Regulations 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

## One-Sided Model
- **Upside Saving Only**
- Share up to 50% savings based on maximum quality score
- 2.0-3.9% depending on number of assigned beneficiaries

## Two-Sided Model
- **Savings & Losses**
- Share up to 60% savings based on maximum quality score
- 2%
## Shared Savings (cont.)

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<tr>
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<th>One-Sided Model</th>
<th>Two-Sided Model</th>
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<tr>
<td><strong>Payment Limitation</strong></td>
<td>• 10% of Benchmark</td>
<td>• 15% of Benchmark</td>
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<tr>
<td><strong>Minimum Loss Rate</strong></td>
<td>• n/a</td>
<td>• 2%</td>
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<td><strong>Loss Sharing Limit</strong></td>
<td>• n/a</td>
<td>• 5% in year 1</td>
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<td>• 7.5% in year 2</td>
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<td>• 10% in year 3</td>
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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.