



Accountable Care Organizations: The New Rules Nuts and Bolts in Developing ACOs

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Where We Are

- 75% of health spending is related to chronic disease
- Health costs have increased 2.8% above GDP for 40 years
- Medicare and Social Security going broke sooner
- Baby boomers living longer and needing more care
- Consumers bear little financial risk
- Some risk should be shifted to individuals
- Eat less, take medications, exercise more, make informed medical decisions, act responsibly
- Providers have incentive to increase volume
- Some risk should be shifted to providers
- Increase coordination, efficiency, eliminate duplication, decrease costs, increase quality, EBM



The Future

- Value-based purchasing is a strategy that can help transform the current payment system by rewarding providers for delivering high-quality, efficient clinical care
- Value-based purchasing links payment directly to the quality of care
- Providers should be challenged to reduce costs and improve quality by redesigning health care processes
- Bending the cost-curve

Shared Savings Program - The Three Part AIM

- An ACO must be willing to become accountable for the quality, cost, and overall care of Medicare fee-for-service (FFS) beneficiaries assigned to it.
- The Shared Savings Program is a new approach to the delivery of health care aimed at:
 - ✓ Better care for individuals
 - ✓ Better health for populations
 - ✓ Lower growth in expenditures

Hx--The Regulation of Accountable Care Organizations

- March, 2010 -- Section 1899 of the Affordable Care Act (the Act”) authorized the Shared Savings Program for Medicare Parts A&B
- March 31, 2011-- CMS Proposes new ACO Rules (the”Rules’)
- March 31, 2011 -- IRS issues guidance for exempt organizations that choose to participate in or form an ACO



Hx--The Regulation of Accountable Care Organizations

- March 31, 2011—DOJ and FTC issue joint guidance as to proposed antitrust “safety zone” for the formation of ACOs and an expedited review process
- March 31, 2011—CMS and the OIG issues guidance as to a proposed waiver of certain requirements of Physician Self-Referral Law, the federal Anti-Kickback Statute, and certain requirements regarding Civil and Monetary Penalties

New initiatives announced this week:

- Pioneer ACO Model
- Advanced Payment Model
- State demonstration projects to integrate care for dual eligible individuals
- Accelerated development learning program

What is an ACO?

1. A legal entity recognized and authorized under applicable State law;
2. Identified by a Taxpayer Identification Number (“TIN”);
3. Comprised of a group eligible ACO participants;
4. ACO participants work together to manage and coordinate care for Medicare Part A&B fee-for-service beneficiaries (“FFS”); and
5. Entity must have a mechanism for shared governance providing ACO participants with appropriate proportionate control over decision making.

Who Can Form an ACO?

- The Act lists the following 5 groups of providers as eligible to FORM an ACO:
 - ACO professionals (physicians and practitioners, which includes physician assistants, nurse practitioners, and clinical nurse specialists);
 - Networks of individual practices of ACO professionals;
 - Partnerships or joint venture arrangements between hospitals and ACO professionals;
 - Hospitals employing ACO professionals; and
 - “Hospital” includes only acute care hospitals paid under IPPS;
 - Other providers and suppliers designated by the Secretary.

Existing Integration Models

Model	Characteristics	Examples
Integrated Delivery Systems	<ul style="list-style-type: none"> • Own Hospitals, employ physicians • Aligned Financial Incentives • E-health records, team-based care 	<p>Geisinger Health System Group Health Cooperative Kaiser Permanente</p>
Multispecialty Group Practices	<ul style="list-style-type: none"> • Strong hospital affiliation • Multiple payer contracts • Strong physician leadership • Provides Care Coordination 	<p>Cleveland Clinic Marshfield Clinic Mayo Clinic Virginia Mason Clinic</p>
Physician/Hospital Organizations	<ul style="list-style-type: none"> • Nonemployee or Mixed medical staff • Functions like Multispecialty Group • Reorganize Care Delivery 	<p>Advocate Health (Chicago) Middlesex Hospital Tri-State Child Health Services</p>
Independent Practice Associations	<ul style="list-style-type: none"> • Independent physicians that jointly contract with health plans • Focus on practice redesign, QI 	<p>Atrius Health Hill Physicians Group Monarch Health Care</p>
Virtual physician organizations	<ul style="list-style-type: none"> • Small independent practices • Led by physicians or foundation • Structure that provides leadership and resources 	<p>Community Care of North Carolina Grand Junction Colorado North Dakota Cooperative Network</p>

Who Can Participate?

- While the Act identifies 5 groups eligible to *participate* in an ACO, the proposed rule makes clear that these are simply the groups that can independently *form* an ACO (eligible ACO participants)
- Other Medicare enrolled providers and suppliers can *participate* in ACOs (other providers/suppliers) as long as such participation is in collaboration with one of the 5 entities that are eligible to independently form an ACO

Other providers/suppliers that may participate in an ACO that contains 1 or more of the 5 groups eligible to form an ACO :

- Federally qualified health centers (“FQHCs”);
- Rural health centers (“RHCs”);
- Skilled nursing facilities (“SNFs”) and nursing homes;
- Long-term care hospitals (LTACs);
- Certain Critical Access Hospitals (“CAHs”);
- Other providers/ suppliers designated by CMS.

Barriers to Successful ACO Creation

- Effective Physician-Hospital Collaboration
- Employment does not assure collaboration
- Reengineer delivery of care to meet quality standards and reduce costs
- Data/Systems/Infrastructure
- Minimum 5,000 virtual enrollees

Barriers to Successful ACO Creation

- Legal Barriers
 - Payment
 - Stark
 - Fraud and Abuse (AKS & CMP)
 - HIPPA
 - Permission based data sharing
 - Antitrust – proposed safe harbors
 - 50% Limit
 - Tax Exempt Issues
- Capital Investment vs. Risk & Uncertain Return

Basic Steps to ACO Creation

- Board and Leadership education on ACO formation
- Establish Collaboration Model
- Design and implement legal structures and governance
- Develop the clinical and care coordination systems
- Create data and information infrastructure

Basic Steps to ACO Creation

- Application to CMS Approved
- 3 Year Agreement
- Begins January 1, 2012, or January 1st of each year
- May not add ACO participants during 3 year term (can add other providers/suppliers)

Application Requirements

- Describe how the ACO plans to use shared savings program payments, including the criteria it plans to employ for distributing shared savings among ACO Participants
- Describe how the proposed plan will achieve the specific goals of the program
- Describe how the proposed plan will achieve the triple aim of the Shared Savings Program
 - Better care for individuals
 - Better health for populations
 - Lower growth in Medicare expenditures

Application Requirements

- Describe how it plans to promote EBM
- Describe how it proposes to promote beneficiary engagement
- Describe how it will report internally on quality and cost metrics
- Describe how it will coordinate care

Legal Structure/Governance

- ACOs must have a formal legal structure that allows the organization to receive and distribute payments for shared savings to participating providers; and
- ACOs must have a mechanism for shared governance to enable all participants proportionate control in decision making.



Choice of Legal Entity

- ACOs can be formed or can utilize various appropriate legal entities recognized by State law—corporations, partnerships, limited liability companies, etc.
- CMS will not require existing legal entities to form a separate new legal entity to participate in the Shared Savings Program, provided the existing legal entity is capable of:
 - receiving and distributing shared savings;
 - repaying shared losses;
 - establishing, reporting, and ensuring ACO participant and ACO provider/supplier compliance with program requirements (including quality standards); and
 - performing the other ACO functions identified in the Act (including shared governance).
- The ACO must have its own TIN but is not required to separately enroll in Medicare.

Governance

- ACO must have a “mechanism for shared governance” and a “leadership and management structure that includes clinical and administrative systems” .
- Governance mechanism should allow for appropriate proportionate control for ACO participants, giving each ACO participant a voice in the ACO’s decision-making process.
- The governing body may be a board of directors, board of managers, or any other governing body that provides a mechanism for shared governance and decision-making.

Governance

- CMS wants ACOs to be provider-driven and patient-centered
- ACO participants must have at least 75% control of the ACO's governing body
- Each ACO participant must should be represented on the governing body
- ACOs must partner with community stakeholders and Medicare FFS beneficiaries, such as having community stakeholder Medicare beneficiary representation on the ACO governing body

Management

- CEO appointed by ACO board
- Medical Director – full time senior-level licensed physician on site
- Compliance officer (separate)
- Quality assurance committee (physician – directed)

Assignment of Beneficiaries

- Assign patients to ACO based on where they receive most primary health care services (dollars)
- ACO (not provider & not patient) responsible for patient care management and quality
- Assigned patient population determines benchmark & any shared services

Assignment Strategy

- **Closed network:** assign all patients to provider in network, regardless of history (ex: HMO)
- **Open network:**
 - Prospective: patients assigned based on where they received care in *prior years*
 - Retrospective: assigned *end of year* based on where they received most care
- CMS proposes **retrospective** assignment based on **primary care** utilization

Primary Care Physicians

- ACO must have a sufficient number of primary care professionals
- ACOs must have at least 5,000 beneficiaries assigned to it each year
- If the ACO has at least 5,000 beneficiaries assigned to it CMS will assume there are sufficient primary care physicians in the ACO
- If the ACO's assigned beneficiaries falls below 5,000, CMS would issue a warning and place the ACO on a corrective action plan, which could include a plan to add primary care providers to the ACO

ACOs Committed/Beneficiaries Not Committed

- Patients free to seek care anywhere, including outside of ACO
- ACO still responsible for non-participating patient
- ACO cannot limit beneficiary to certain providers
- ACO cannot use utilization management
- ACO cannot require prior authorization for services

Evidence-Based Medicine

- Use of the best current, state of the art medicine in making medical decisions
- It is based on proven results, such as clinical trials
- ACOs must invest significant resources in assessing the outcomes of care and continually re-designing care delivery to achieve quality standards and cost-savings



Clinical Guidelines

- An ACO must establish and implement:
 - EBM guidelines and regular assessment and updating of these guidelines to promote continuous quality improvement
 - measures to promote patient engagement (active participation of patients and their families in medical decision-making) and health literacy
 - processes to report quality and cost measures
 - Processes to promote coordination of care (telehealth, remote patient monitoring, case managers, transition of care program, EHRs, etc.)

EHRs Improve Clinical Care Processes Through

- Time management and scheduling
- Reviewing diagnostic test results and clinical documents
- Diagnostic test ordering
- Patient encounter documentation
- Electronic prescribing
- Electronic signature
- Clinical decision support
- Disease management
- Data analysis and report generation
- Patient education

Effective E Prescribing

- Decreased adverse drug events
- Decreased medication errors
- Decreased costs
- Improved patient care
- Decreased risks



Disease Management

EHR systems help to coordinate the following five clinical processes:

- Identification and enrollment of individual patients and populations of patients with specific diseases, commonly through a disease registry
- Ongoing assessment and diagnosis of the disease progress and complications
- Care planning and management
- Ongoing monitoring and feedback of the individual patient and disease population
- Patient education

Clinical Decision Support

- Right information (evidence-based and context sensitive).
- In the right intervention format (guideline, order set, reference, alert, relevant data display, or documentation tool).
- To the right stakeholder (including patients).
- Through the right channel (Computer Provider Order Entry (CPOE), EHR, or mobile devices).
- At the right point in work flow to drive improved outcome.

Patient Centeredness Criteria

- Written standards for beneficiary access and communication
- Use of patient assessments
- Use of individualized care plans
- Implement a beneficiary experience of care survey and a plan to use the results to improve care
- Medicare beneficiary on the governing board
- Evaluate the health needs of the ACO's assigned population and create a plan to address the needs of the population
- Implement systems to identify high-risk individuals and processes to develop individualized care plans for those individuals
- Measure clinical success and implement quality of care improvements
- Communicate clinical knowledge/evidence-based medicine to beneficiaries that allows for beneficiary engagement and shared decision-making

Basic Rule for Shared Savings

- To be eligible for shared savings, ACOs must:
 - Meet all contractual requirements of the ACO Agreement
 - Meet the quality performance standards
 - Realize savings compared to the Expenditure Benchmark that exceed the Minimum Savings Rate



Calculating the ACO Quality Performance Score

Measure Domains. CMS groups individual quality performance standards into five domains:

1. Patient/Care giver experience
2. Care coordination
3. Patient Safety
4. Preventive Health
5. At-risk population/frail elderly health

Calculating the ACO Quality Performance Score

- CMS designates quality performance standards for each measure, including a performance benchmark and minimum attainment levels
- Performance below the minimum attainment level will received zero points for that measure

Calculating the ACO Quality Performance Score

- Performance equal to or greater than the minimum attainment level but less than the performance benchmark receives points on a sliding scale
- Those measures designated as all or nothing measures receive the maximum available points if all criteria are met and zero points if at least one of the criteria are not met.

Equal Weight of Domains

- Each of the 5 domains is equally weighted in determining an ACO's overall quality performance score, regardless of whether the ACO is in Track 1 or Track 2.
- All measures within a domain must have a score above the minimum attainment level determined by CMS in order for the domain to be eligible for shared savings.

Quality Measures

- Patient/Caregiver Experience – 7 measures
- Care Coordination – 16 measures
- Patient Safety – 2 measures
- Preventive Health – 9 measures
- At-Risk Population/Frail Elderly – 31 measures



Calculation of Shared Savings

- Establish Expenditure Benchmark
- Determine per capita Medicare expenditures in each performance year of the Agreement period
- Determine applicable Minimum Savings Rate
- Determine applicable Sharing Rate
- Determine applicability of Threshold
- Compare Expenditure Benchmark (Adjusted to Year) to Actual Expenditures
- Compare Amount of Shared Savings Payable to ACO to Sharing Cap

Calculating the Benchmark

- Estimate Expenditure Benchmark for each of previous 3 years and normalize to agreement year
- Uses most recent available 3 years of per beneficiary expenditures for Part A and B services for Medicare FFS beneficiaries assigned to ACO
- Adjust Expenditure Benchmark for beneficiary characteristics and such other factors
- Update the Expenditure Benchmark by the projected absolute amount of growth in the national per capita Part A and B expenditures for Medicare FFS beneficiaries for each year of the 3 year agreement

Proposed Approaches to Setting the Expenditure Benchmark

- CMS considered two options:
 - Option 1: Estimate based upon the Part A and B FFS expenditures of beneficiaries who would have been assigned to the ACO in each of the 3 years prior to the establishment of the ACO
 - Option 2: Estimate based upon the Part A and B FFS expenditures of beneficiaries who are actually assigned to the ACO in each of the 3 years with relevant expenditures being those actually incurred during the last three years
- CMS prefers Option 1, which appears simpler to administer, but will consider Option 2

Adjustments to the Expenditure Benchmark

- Adjustment for using CMS-HCC, which uses beneficiary diagnostic information
- Propose no adjustments for IME and DSH
- Propose retaining geographic payment adjustments in calculating Expenditure Benchmark
- Propose different treatment for bonus payments/penalties depending on statutory source
- Adjust for inflation in Years 2 and 3 (flat dollar increase based upon national inflation)

Shared Savings Options

- Reward Only Option (Track 1)
 - pure one sided
 - attract smaller group participation
 - not enough incentive
- Risk Based Option (Track 2)
 - greater reward for greater responsibility
 - risk viewed as only large ACOs could tolerate

Hybrid Model:

- Track 1
 - One-Sided Model (with a twist)
 - No Downside Years 1 and 2
 - Year 3: add Risk (Loss) and higher reimbursement
- Track 2
 - Two-Sided Model
 - Upside and downside Risk starting Year 1
 - Higher reimbursement starting Year 1

One-Sided Morphs into Two-Sided

- Track 1 – Share in Savings only
- Track 2 – Share in Savings and be held accountable for Losses
- Elect for initial 3 year agreement period
- Years 1 and 2 using One-sided Model reimbursement for SS but no loss risk
- Year 3 higher reimbursement potential for SS but at risk for sharing of Losses
- Year 3 for Track 1 – retain quality standards for Year 3 but otherwise SS as if Year 1 of Track 2

Net Sharing Rate

- CMS rejected first dollar share after MSR for Track 1 ACOs
 - Track 1 ACOs -- CMS will use a threshold equal to 2% of the Expenditure Benchmark (i.e., not the savings)
 - Track 2 ACOs -- CMS will share first dollar savings (i.e., savings above MSR)
- Provides adjustments for small ACOs (>10000)
 - If ACO is comprised only of ACO professionals in group practice arrangements or networks
 - If 75% of the ACO's assigned beneficiaries reside outside a MSA
 - If 50% of the ACO's assigned beneficiaries receive a plurality of primary care from Method II CAH
 - If 50% of more of the ACO's assigned beneficiaries had at least one encounter with an ACO Participant FQHC and/or RHC
- CMS will notify ACO of calculated savings rate and ACO must request payment with certification of compliance

MSR Sliding Scale (based upon number of assigned beneficiaries)

Number of Assigned Beneficiaries	MSR (low end)	MSR (high end)
5000-5999	3.9%	3.6%
6000-6999	3.6%	3.4%
7000-7999	3.4%	2.2%
8000-8999	3.2%	3.1%
9000-9999	3.1%	3.0%
10000-14999	3.0%	2.7%
15000-19999	2.7%	2.5%
20000-49000	2.5%	2.2%
50000-59999	2.2%	2.0%
60000+	2.0%	

The Range of Shared Savings

- Sharing rate is determined based upon quality performance
 - Up to 50% shared savings for Track 1 ACOs
 - Up to 60% shared savings for Track 2 ACOs
- PGP demonstration project shared savings was initially set at 80%
- Opportunity for additional percentage savings

Additional Shared Savings Opportunity

- CMS proposes increasing the net savings rate for the first two years for ACOs with significant assigned beneficiary visits to an ACO Participant FQHC and RHC (0.5 to 2.5% increase)
- Request comments on additional savings for dual eligibles and ACOs in similar arrangements with other payors

Withhold

- CMS proposes an annual 25% withhold of any earned shared savings
- ACO may use the withhold as one option for demonstrating an adequate repayment mechanism in the event they incur sharable losses
- Returned at the end of the 3 year agreement (if meets all requirements)
- If the ACO does not successfully complete its 3 year agreement, the ACO forfeits any withholds

Shared Savings Limit

- Intended to minimize incentives for excessive reductions in utilization
- In the PGP demonstration project, the limit was set at 5% of the organization's expenditure target
- Track 1 ACOs: Proposed 7.5% of the ACO's Expenditure Benchmark for the first two years of the Agreement, which would increase to 10% in the third year once the ACO is operating in the two sided model
- Track 2 ACOs: Proposed 10% of the ACO's Expenditure Benchmark

Two-Sided Model Losses

- ACO accepts downside risk for Losses once the Minimum Loss Rate (MLR) is exceeded
 - actual ACO expenditures exceed the benchmark
- Broad implications for provider relationships leading to heightened monitoring:
 - financial solvency,
 - patient access to care
 - Withhold

Loss Estimates Per Beneficiary

Final Sharing Rate	Annual Per Capita Loss	1st Year Cap (5% of Benchmark)	Payment Due to CMS
40%	$\$800 \times (1-0.4) =$ \$480	$\$8,000 \times 0.5\% =$ \$400	\$400
50%	$\$800 \times (1-0.5) =$ \$400	$\$8,000 \times 0.5\% =$ \$400	\$400
60%	$\$800 \times (1-0.6) =$ \$320	$\$8,000 \times 0.5\% =$ \$400	\$320

Distribution of Savings

- CMS proposes to make any shared savings payments directly to the ACO
- CMS states that while it does not have the authority to direct how shared savings must be distributed, CMS will require the ACO to indicate on its application how it plans to use potential shared savings to promote program plans and distribute savings among the ACO participants

Data Measures/Submission

- Claims Data reporting benchmarks
- Group Practice Reporting Option
- Physician Quality Reporting System
- Electronic Health Record
- Hospital Inpatient Quality Reporting Program
- HITECH Meaningful Use
- Surveys

Program Integrity

- To protect the program from fraud and abuse, CMS proposes program integrity criteria:
 - ACO must have a compliance plan and official
 - ACO must maintain ultimate responsibility for compliance with the ACO agreement
 - All contracts or arrangements between the ACO and its participants must require participants to comply with the ACO agreement
 - An authorized ACO representative must certify the accuracy and truthfulness of the application, agreement, and quality data, and compliance with program requirements when requesting payment

Program Integrity

- CMS proposes to screen ACOs during the application re: program integrity history, sanctions, affiliations with excluded individuals, etc.
- CMS proposes to prohibit ACOs and their participants from conditioning participation in the ACO on referrals of business provided to beneficiaries not assigned to the ACO
- The ACO governing body must have a conflicts of interest policy that applies to members of the governing body

Marketing Guidelines

- CMS wants an ACO to promote coordination of care but is concerned that the potential for shared savings may incentivize ACO participants to confuse or mislead beneficiaries about the program to steer beneficiaries
- CMS proposes to limit and monitor ACO-beneficiary communications and ACO marketing materials and activities and require that all ACO marketing and shared savings program materials be approved by CMS before use
- No need for CMS to approve purely health educational materials that do not market the ACO

Risk vs. Reward?





Sources:

- An Overview of the ACO Proposed Regulations (April 14, 20 & 21, 2011)
 - A. Part I --- Eligibility, Patient Attribution and Participation in Medicaid Shared Savings Program (Washlick, Barnes, Turcotte)
 - B. Part II – Quality Measures Payment Methodology, and Risk Sharing in Medicare’s Shared Savings Program (Bartrum, DeMuro & DeSimone)
 - C. Part III – Waiver provisions, Antitrust & IRS Guidance (The Medicare Shared Savings Programs Overlap with Other Payment Provisions) (Homchick, Braun, & Robinson)
- ACO’s – There Is a Light in the Tunnel (Thomas D. Anthony – April 22, 2011)
- Fragile – Handle With Care – Care Management of the Medicare Population (Michael Barger, M.D. – April 22, 2011)
- Transparency Value and the Transformation of the Delivery System (T.J. Reddington, M.D. April 22, 2011)
- <http://www.frostbrowntodd.com/resources-1311.html>.



Thanks!!!

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