Accountable Care Organizations – Will They Transform Our Healthcare Delivery System?

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November 12, 2010
Discussion Items

• ACOs and their role in Health Reform

• Many Unanswered Questions – Insights on the Inter-Agency Meetings in DC

• Some Organizational and Structural Options for ACOs

• What are “Bundled Payments” and how do they impact ACOs?

• Practical Guidance on how to begin preparing for ACOs

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Accountable Care Organizations (ACOs)- The Future of Health Care Delivery?

Is this the only real reform of the health care delivery system in the Patient Protection and Affordable Care Act (PPACA)?
What The PPACA Does

• Insures 35 million uninsured Americans by adding 20 million to Medicaid and creating the state health benefit exchanges to expand the market for individuals and small business.

• Adds extensive new federal regulation of private health insurance plans.

• Expands quality, innovation and efficiency efforts through new demonstration projects and pilot programs.
What The PPACA Does Not Do

• **Does not** insure every person in the country.
  – 23 million will remain uninsured

• **Does not** create a new payment system.
  – Medicaid, Medicare, employer-provided, medigap, and state exchange-based insurance will coexist; fee-for-service payment will still be the standard.

• **Does not** restructure the delivery of health care, but sets in motion a potentially significant change-the ACO.

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What is an ACO?

• Sections 3022 and 10307 of the PPACA (PL 1110-148) set out the framework for Medicare ACOs to be implemented by January 1, 2012. However, CMS still has to issue rules before stakeholders can decide to participate. A proposed rule is to be issued by the end of 2010.

• The basic premise for ACOs is that they can facilitate medical care coordination among providers to improve the quality of care for Medicare beneficiaries and reduce unnecessary spending. Private health plans could also find ways to work with Medicare qualified ACOs.

• The ACO provisions are part of the law’s Medicare “Shared Savings” programs, sending the clear signal that ACOs will be expected to reduce Medicare spending.

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Administration Sees the ACO as a Key Element in Health Reform

• White House has hosted meetings on ACOs.

• White House is pushing regulators (CMS, OIG, FTC and others) to find ways to make ACOs work.

• White House is pushing CMS to have listening sessions with stakeholders before writing the draft rules and has set an aggressive rulemaking schedule.
Here Is What the PPACA Says About ACOs

• An Accountable Care Organization is defined as an organization of health care providers that agrees to be accountable for the quality, cost, and overall care of Medicare beneficiaries enrolled in the traditional fee-for-service program who are assigned to it.

• For ACO purposes, “assigned” means those beneficiaries for who the professionals in the ACO provide the bulk of primary care services. Assignment will be invisible to the beneficiary, and will not affect their guaranteed benefits or choice of doctor.

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Here Is what the PPACA Says About ACOs (continued)

• A beneficiary may continue to seek services from the physicians and other providers of their choice, whether or not the physician or provider is a part of an ACO.

• Organizations that may become a Medicare recognized ACO include:
  – Physicians and other professionals in group practices;
  – Physicians and other professionals in networks of practices;
  – Partnerships or joint venture arrangements between hospitals and physicians/professionals;
  – Hospitals employing physicians/professionals; and
  – Other forms that HHS may determine to be appropriate.
More PPACA Requirements

• Requirements an organization will have to meet to be a Medicare ACO
  – Have a formal legal structure to receive and distribute shared savings;
  – Have a sufficient number of primary care professionals for the number of assigned beneficiaries, which will be 5,000 at a minimum;
  – Agree to participate in the program for at least a 3-year period;
  – Have sufficient information regarding participating ACO health care professionals as the Secretary determines necessary to support beneficiary assignment and for the determination of payments for shared savings;
  – Have a leadership and management structure that includes clinical and administrative systems;
  – Have defined processes to (a) promote evidenced-based medicine, (b) report the necessary data to evaluate quality and cost measures (this could incorporate requirements of other programs, such as the Physician Quality Reporting Initiative (PQRI), Electronic Prescribing (eRx), and Electronic Health Records (EHR)), and (c) coordinate care; and,
  – Demonstrate it meets patient-centeredness criteria, as determined by the Secretary, such as the use of individualized care plans.
More PPACA Requirements (continued)

• Qualifying for Shared Savings
  
  – CMS will set annual Medicare savings benchmarks for ACOs based on previous per-beneficiary expenditures for Parts A and B services. The benchmark for each ACO will be adjusted for beneficiary characteristics and other factors determined appropriate by the Secretary, and updated by the projected absolute amount of growth in national per capita expenditures for Part A and B.
  
  – ACOs that meet the specified quality performance standards will be eligible to receive a share of any savings if the actual per capita expenditures of their assigned Medicare beneficiaries are a sufficient percentage below their specified benchmark amount. There are no penalties for ACOs that do not meet the savings targets.
Potential Legal Conflicts

• ACOs could run afoul of several federal laws
  – Stark
  – Anti-kickback
  – Civil money penalties
  – Antitrust
  – Federal Trade Commission
Will the Legal Conflicts Be Resolved?

• The Secretary of HHS has authority to waive many Medicare requirements that might impede the development of ACOs but must seek cooperation of other agencies to waive other laws.

• FTC, OIG and CMS held a public meeting to discuss these problems and hear from stakeholders.

• Requires complex, nearly simultaneous rulemaking to avoid conflicts and encourage participation.
Other Issues to be Resolved

- The lack of specificity in the statute and the limited real world experience with ACOs means that there are many important questions that will need to be addressed by federal regulators and potential participants.
  - Will the shared savings justify the costs of becoming an ACO?
  - Can ACOs control costs and maintain quality if they don’t control all of the patient’s medical services?
  - What mechanism will CMS use to assign beneficiaries to ACOs?
  - What criteria will CMS use to determine who qualifies to be an ACO?
  - How is CMS going to assess quality across diverse organizations with different patient populations?
  - On what basis will CMS attribute savings?
  - How will specialists participate in ACOs?
  - Are there state and federal tax implications if for-profit medical practices and not-for-profit hospitals and other institutions try to form joint venture ACOs?
  - Keep an eye on MedPac and the Physician Group Participation (PGP) Demonstration Project

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Section 3022 “Shared Savings”
Medicare ACO

Non-ACO Providers

Primary Care Services

“Assigned” Beneficiaries

Hospital
Home Health
DME
Drugs

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ACOs: Legally Flexible Concept

• Example of existing entities that can qualify (“morph into ACOs”):
  – An IDS with hospitals, physicians and other providers under common control
  – Affiliated Provider Network (clinically and/or financially integrated)
  – An MSO Integration Model (EMR deployment) with Affiliated IPA
  – Multispecialty Group Practice
  – IPA
  – PHO
  – A joint venture of two or more of the aforementioned

• Many proposals envision the ACO to be a separate and distinct legal entity
Affiliated Physician Organization ACO Model

Health System Parent

- Hospital
- ACO
- Affiliated Group Practice

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Physician-Hospital Organization (PHO)-ACO Model
MSO Integration ACO Model

System Parent

Payor

MSO/ACO

Hospital

IPA

MD

MD

MD

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Hospital Physician Employment ACO Model
Comprehensive Health System ACO Model

Health System

- Affiliated Medical Group
- Hospital
- Home Health
- Clinics
- SNF

IPA

ACO

Payors

Community Physicians

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Episode-Based Bundled Payments: The Concept

- EBP bundles all costs of care across a clinical condition for a defined period of time and for all settings involved in direct and indirect care to the patient.

- Patient-centric (not provider-centric)

- Includes several levels and types of providers and a number of venues (outpatient, inpatient, rehab, pharmacy, home health).

- Assumption of financial risk post-hospitalization

- Alignment with evidence based best practices (clinical guidelines and quality measures)

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Bundled (Part A+B) “ACE” Hospital Payment Model

Payer provides single prospective payment intended to cover costs of entire patient hospitalization episode.
Hospital Bundled Episode Payments (A+B+PAC) – Will Require Strategic Care Coordination

$6,500

High

Hospitalization Episode

Rehabilitation Hospitalization

Readmission

Hospitalization

Home Health Services

Medicare Payment for Hospitalization Episode Bundled at $6,500

X = Physician Visit

Episode-Based Bundled Payments: Implementation Challenges

• What services are included in the episode “grouping” (Medstat Medical Episode Grouper)?

• Which provider is ultimately responsible for managing the episode?

• “Managing Provider” - held accountable for quality (new liability risks?).

• How should the bundled episode reimbursement be allocated across providers (pre-admission, inpatient, post-admission)?

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Bundled Hospital-Physician Payments: Stark

- What Stark exceptions are available for these payments from ACO to participants?

- Employment?
- Risk Sharing?
- Personal Services/FMV/Indirect Compensation?
Bundled Hospital-Physician Payments: AKS

• What Safe Harbors are available for ACO payments to providers?

- Employment?
- Risk Sharing?
- Personal Services/Management Contract Safe Harbor (set in Advance, FMV, not based on V/V of referrals or other business)?
Bundled Hospital-Physician Payments: CMP

- Is Hospital payment involved?
  - Physician Incentive Payment Rules (PIP)?
  - Need additional flexibility for new ACO Models

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Existing Legal Paradigm Outdated – Making Reform Challenging

- New Stark exceptions (bundled performance payments).
- New safe harbors for shared savings programs needed.
- New stand alone exceptions to CMP violations for bundled payment arrangements required.
- New "Integrated Providers" and Medicare enrollment changes.
- Anti-trust issues.
- New "Enterprise" liability issues.
- HIPAA and “comingled” patient data challenges.

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Key Practical Questions in Forming an ACO

• Which “essential” Providers need to be brought in an ACO?

• How many primary care physicians are needed?

• Whether hospital participation is fundamental to ACOs?
  – (about 30% of healthcare expenditures are hospital services; hospitals provide a source of capital needed for ACO formation)

• Can the existing integrated systems (e.g. Mayo Clinic, Geisinger, Cleveland Clinic), which formed the model for ACOs, be replicated in different organizational models?

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What is the ACO supposed to do?

• Coordinate Care across Providers/Settings

• Pay for outcomes rather than units of service

• Be Accountable for quality and cost of care delivered (performance vs. insurance risk)

• Simultaneously alter financing and delivery to align incentives (need to change the payment to providers to implement the new delivery model)

• Save on Medicare expenditures for Parts A and B (Medicare Shared Savings Program does not make ACOs responsible for Part D—but stay tuned)
Policy Factors Driving the “Design” of ACOs

• Limit Payor “interference” between Providers and patients (Secretary shall determine an appropriate method to “assign” Medicare FFS beneficiaries to an ACO based on their utilization of primary care services by ACO professionals)

• HMO managed care public backlash (Medicare beneficiaries not required to sign up to join a plan – they may never know that they were assigned to an ACO)

• No in-network/out-of-network pricing differentials

• So, how will the ACO save money? (hint: physicians control directly or indirectly almost 90% of health care spending).

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Anticipated Savings Will Come From:

• Reduction in hospital use
• Limiting unnecessary (duplicative) services and tests provided/ordered by physicians
• Improved information flows within the ACO (HIT)
• Benefit from economies of scale in purchase of goods and services
• Promotion of lower-cost treatment options (and use of physician “extenders”)
• Movement away from sickness to a wellness delivery model

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ACO Shared Savings Payments:

Bonus Contingent upon Meeting Quality Metrics

- Savings Pool

Alternative Bonus Structure

- Efficiency Pool
  - Actual Cost Savings (above target):
    - Automation
    - Economics of Scale
    - Process Improvements

- Quality Pool
  - Metrics:
    - Mortality Rates
    - Readmissions
    - Patient Safety Issues
    - Patient Experience Surveys
ACO Challenges: Financial & Governance

- Multiple Payors providing inconsistent incentives
- Cost of Infrastructure/EMR
- Decisions on Dollar Allocations (Key to Success: Must get the financial incentives right)
- Composition of ACO Governing Board (Strong Physician Leadership needed)
- Key Decision-making Committees (Compensation, Finance, Quality, Technology)
- Be prepared to move from Shared Savings model (Level I ACO) to Bundled (hospital-physician) and eventually Capitation (Level III ACO) Payments

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What We Are Seeing in the Marketplace – Significant Transactional Responses to Reform

• Hospital-Physician (vertical) Integration
• Hospital-Hospital (horizontal) Integration
• A Race to ACO Formation
• Strategic Discussions between Acute and Post-acute Providers
• Next Generation PPM/MSO Companies – Utilizing EMR Strategies (forming virtual group practices)
• New Players on the Scene
  – Transitional care providers; remote patient monitoring companies; HIT software offering “cost and care” modeling programs
• New Strategic IT Partners (GE, Intel)

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Next Steps:

• Assess your “Accountable Care Capabilities”
• What Scope of Services will (should) be offered through the ACO?
• Which Providers and Care Settings should be involved?
• What is your Clinical Integration status (processes and technology – EMR/EH strategies)?
• What is your geographic market (any Antitrust Market Power concerns)?
• Consider actively participating in ACO Rule Making Process
• Begin exploring possible ACO Models
• Assess commercial payor interest to test innovate payment projects through the ACO
• Assess your system’s ability to assume risk through an ACO model
• Consider participating in Demonstration/Pilot programs (“First-Mover Advantages”)

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Questions and Discussion