ACCOUNTABLE CARE ORGANIZATIONS

ADDRESSING HEALTH CARE QUALITY AND COSTS

FOLEY

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Introduction

ACOs:

- Flexible Concept Intended to Address the Goals of Increasing Quality and Reducing Health Care Costs
- Intended to Transform How Medicine is Delivered and to "Bend the Cost Curve"

What is an ACO?

ACO is a Group of Health Care Providers that:

- Share Specific Goals for Improving Quality of Care While Controlling Costs
- Have an Organizational Relationship-- by Corporate Affiliation, Contract or Otherwise --that Permits ACO to Make Decisions and Take Actions to Achieve These Goals

What is an ACO? (continued)

- Designed to Make Physicians/Providers (Not Insurance Companies or Administrators) Accountable for Quality and Utilization (Efficiency/Cost) of Health Care
- Focuses on Integration and Coordination of Clinical Care Among Providers throughout Continuum of Care
- Focuses on Eliminating Incentives to Provide More Care Instead of Better Care; Rewards Outcomes
- Providers Are Made Accountable To Determine How Best to Deliver Efficient and Quality Care

What Does an ACO Look Like?

- Not Inherently Defined By Any Particular Structure
- Could be:
  - Multi-Specialty Group Practice
  - Primary Care Clinics
  - Network of Providers Linked by Contractual Agreements (IPA Model)
  - Joint Venture or Other Organization that Combines Providers (Super PHO, MSO Model)
  - Any Combination of Above
  - Fully Integrated Systems (Including Integrated Delivery System Of Controlled Hospitals, Physicians, Ancillary Providers)

What Does an ACO Look Like? (continued)

Structure Depends on What ACO Expected to Do and Under What Conditions

- How Many and Which Payors Will Participate?
- Will it Assume Downside Risk and What Kind?
- Will it Require Extensive Infrastructure?
- Will it Be Based on Carrot of Aligned Interests, or Also Need Baseball Bat to Enforce Compliance?

Structure Also Depends on Legal Issues

What Does a "Starter ACO" Look Like?

If ACO Has Limited Role (e.g., Shared Savings, No Downside Risk, Only Medicare) Structure Could Be Contractual Affiliation or Joint Venture, With Committee-Like Structure Making Decisions

What Does Robust ACO Look Like?

- However, if Expect ACO To Drive Health Care Reform and Concurrently Achieve Cost and Quality Goals, Then:
  - A Fully Integrated System (Clinically, Financially, Organizationally)
  - In Which Physicians Have a Significant Leadership Role
  - Is Best Suited to Meet Challenges Confronting ACO
- Why?

What Does Robust ACO Require?

Centralized Governance/Management Structure Must Permit:

- Broad Participation of Providers Throughout Continuum of Care
- Delivery of Coordinated Health Care
- Ability to Establish Clinical Protocols, Policies and Procedures that Cross Specialties and Levels of Care
- Ability to Impose/Enforce Clinical, Quality and Performance Standards Through Incentives and Penalties that Don't Violate Law

What Does Robust ACO Require? (continued)

- Access to Capital and Ability to Allocate Revenue and Invest Resources Where Most Appropriate
- Ability to Manage and Tolerate Risk
- Ability to Lower Costs of Care Through Greater Efficiencies and Reduced Administrative Costs
- Access to Human Resources – Executive Skills, Medical Management, Peer Review
- IT Infrastructure, Including EHR, to Measure and Monitor Level and Quality of Care Provided

What Does Robust ACO Require? (continued)

- Ability to Not Accept "No Win" Payment Model that Can't be Successful

- Consistent Performance Standards, Measures and Payment Systems Among Payors

ACOs in PPACA (Section 3022)

- HHS Required to Establish Shared Savings Program ("SSP") by Jan. 1, 2012
- Purposes of SSP are to:
  - Promote Accountability of Care for Medicare FFS Beneficiaries
  - Coordinate Services and Items Under Medicare Parts A and B
  - Encourage Investment in Infrastructure and Redesign Care Processes

ACOs in PPACA

- ACOs Are The Vehicle Through Which The Shared Savings Program Will Be Implemented Under PPACA
- Eligible grouips of providers may form an ACO to provide Medicare Parts A ad B services/items to beneficiaries assigned to ACO by HHS

What is an Eligible ACO for PPACA SSP

PPACA Emphasizes Critical Role of Physicians

Under PPACA, ACO May Consist of:

- Physician and Nonphysician Professionals ("ACO Professionals") in Group Practices or in Networks of ACO Professionals
- Hospital and their Employed ACO Professionals
- Joint Ventures of ACO Professionals
- Other Groups of Providers/Suppliers of Parts A and B Services Approved by HHS

Shared Savings Payments

- Each ACO Provider Continues to Submit Claims for Medicare Services, as if it Were Not in ACO
- But, if ACO (a) Meets Quality and Performance Standards and (b) Provides Services at an Annual Cost Below HHS Benchmark, ACO Will Receive a Share of the Savings
- Shared Savings Measured by the Difference Between (a) Estimated Average per Capita Medicare Expenditure in a Year for Services to Medicare Beneficiaries Assigned to ACO, and (b) a Benchmark Set by Secretary Based on Historical Cost
- Shared Savings Paid to ACO to Distribute Among Participants

Alternative SSP Payment Models

- PPACA Gives Secretary Authority to Use Payment Models -- Other Than SSP "Gainsharing" Model -- That Will Improve the Quality and Efficiency of Providing Medicare Services
- Specifically Authorizes Partial Capitation Model that Would Put ACO at Risk for Some, But Not All, Medicare Services
- Example: ACO May Be at Risk (i.e., Receive Capitated Payment for Some or all Medicare Part B Physician Services)
- May Limit Use of Partial Capitation Model to ACOs That Are Highly Integrated Systems of Care and ACOs That Are Capable of Bearing Risk

PPACA Requirements for ACOs In SSP

- Agree to be "Accountable" for Quality, Cost, and Overall Care of Assigned Medicare Population
- Agree to Participate in SSP for at Least 3 Years
- Must Have "*Formal Legal Structure*" with Shared Governance that Allows ACO to Accept and Distribute Payments to Participating Providers/Suppliers in ACO
- Must Have Leadership and Management Structure that Includes Clinical and Administrative Systems
- Must Have at Least 5,000 Medicare Beneficiaries and sufficient PCPs to care for Medicare Population Assigned to ACO

PPACA Requirements for ACOs in SSP (continued)

- ACO Responsible For Defining Processes To Promote Evidence Based Medicine, Report on Quality and Cost Measures and Utilize Technology to Coordinate Care Provided by ACO Participants;
- ACO Must Report Data To Evaluate Its Ability to Meet Performance and Quality Of Care Standards Established by Secretary, Including HHS Patient-Centeredness Criteria (e.g., Caregiver Assessments or Individualized Care Plans)
- Not Participate in Another SSP Under Section 1115A Waiver or Under a Home Medical Practice Pilot Program

Waiver of Laws

- PPACA Gives Secretary of HHS Authority to Waive Provisions of Anti-Kickback Statute, Civil Monetary Penalties Statue, and Any Provisions of Title XVIII (Including Stark) Deemed Necessary to Implement the SSP

PPACA Requires or Authorizes Numerous Pilot or Demonstration Programs to Test Accountable Care

- Pilot Program for Bundling Payments (Section 3023)
- A Demonstration Program to Evaluate Integrated Care Around a Hospitalization (Section 2704)
- A Medicaid Global Payment System Demonstration Project (Section 2705)
- A Pediatric Accountable Care Demonstration Program (Section 2707)
- A Pilot Program testing Pay-for-Performance Programs for Certain Medicare Providers (Section 5206)

PPACA Requires or Authorizes Numerous Pilot or Demonstration Programs to Test Accountable Care

- A Demonstration Program for an Individualized Wellness Plan (Section 4206)
- Continuation of Gainsharing Demonstration Project (Section 3027)
- A Demonstration Program to Integrate Training for Quality Improvement and Patient Safety in Clinical Education Programs for Health Professionals (Section 3508)
- An Extension of Rural Community Hospital Demonstration Program (Section 3123)

Payment Reform

- ACOs to be Effective Will Require Payment Reform
- ACOs Are Designed to Move From Fee-For-Service Payment of Physicians and Other Providers that Rewards More Utilization to a System that Pays for Good Outcomes and Eliminates Unnecessary Care

Payment Reform (continued)

Today, Fee-For-Service Payment of Physicians (There is No Real Management of Medicare Physician Services)

Moving To:

- Shared Savings Programs (Required By 1/1/12)
- Bundled Payments/Case Rates
- Global Payments/Partial Caps

Shared Savings Program

- Logical First Step Transition: Upside Reward without Downside Risk
- ACO Assumes Care for a Population with Projections of Expected Cost of Providing Care
- Paid Fee for Service with Potential for Additional Payments if (A) Quality Performance Standards Met and/or (B) Costs Redirected Below Benchmark

Shared Savings Program

- Among the Key Issues:
  - What services may ACOs provide?
  - What services are covered and which excluded?
  - What are quality standards and what sets them apart?
  - How are cost benchmarks set (adjustments for age, sex, health conditions, severity)? Can they be measured?
  - How will ACO contract with Payors?
  - What if out-of-network services needed?
  - How will ACO be paid? How will ACO share payment?
  - Do benchmarks get rebased?
  - How to assure no stinting on care?
  - What infrastructure is needed?

Bundled Payments/Episodes of Care

- One payment for an Episode of Care, Combining Hospital/Physician and Perhaps Other Services in One Payment
- Downside Risk of Services of Different Providers
- In Essence a Budget is Set for an Episode of Care
- Promotes Integrated Care and Efficient Provision of Care
- Incentivizes Collaboration
- However, No Incentive to Avoid Episodes of Care in the First Place

Bundled Payments/Episodes of Care (continued)

- Key Issues with Bundled Payments:
  - What services are conducive to being paid on an episode of care/bundled payment?
  - What range of services are included in the episode of care?
  - Can ACO participating providers furnish all of the bundled services?
  - How does ACO ensure patient will follow-up with ACO providers and remain in-network?
  - What if patient experiences another medical condition during the treatment period?
  - How is bundled rate set?

Bundled Payments/Episodes of Care (continued)

- Based on what data is bundled rate determined?
- What are quality standards and how are they set?
- Do rates and quality standards adjust over time?
- Who measurers compliance with quality standards and how are they measured?
- How is cost of care during the episode determined?
- What administrative infrastructure is needed to track and measure quantity and cost?
- How to avoid stinting?
- How does ACO share bundled payment among participants (and out-of-network providers)?

Global Payment/Partial Cap

- Payments to Furnish All or Part of (For Example, Physician Only) Care For a Given Population of Patients
- Eliminates Volume-Based Payment Incentives
- A Budgeted Cost/Utilization and Associated Payment for ACOs for All or Part of Care Over a Defined Period
- Often Risk Adjusted Payments (For Such Things as Age, Health Status, etc.) to Help Avoid Providers from Taking "Insurance Risk"
- Still Significant Downside to ACOs and Participants

Global Payment/Partial Cap (continued)

- Key Issues in Global Payments:
  - What services are covered and which are excluded (e.g., vision, dental, mental health, neonatology, pediatric specialty surgery)?
  - What is spectrum of services provided by the ACO and what costs can it control?
  - How will ACO contract for and control/manage out-of-network services?
  - How to utilize outliers?
  - On what data are global payments based?
  - What stop loss and risk corridors apply; is reinsurance available?

Global Payment/Partial Cap (continued)

- How to share payment and risk among ACO participants and at what levels?
- What patient incentives will apply (co-pays, deductibles, in-network incentives)?
- What risk adjusters apply and how?
- How will payments be adjusted to account for changes in demographics and health conditions?
- Are payments adjusted for eligibility and fraudulent identity risks?
- Who determines medical necessity?
- How are quality standards set?
- How to avoid stinting on services?
- How to manage IBNR?

Overriding Payment Issues

- If Goal is to Transform How Health Care is Delivered and Given Expense of Providing Accountable Care, it is Critical that Both Private Payors as Well as Government Programs Participate and Utilize ACOs and Similar Payment Arrangements
- Rates must be Adequate to Fairly Compensate Providers
- What of Unique Attributes of Specific Providers (Children's Hospital, Long Term Acute, Psych Hospital, Sole Community Hospital, CAHs)
- In New Payment Arrangement How Does System Pay for: Capital, Medical Education, Innovation, Geographic Variation - - Adequacy of Payment Issue
- Issues of Cost Shift from Below Cost Providers

Legal Issues

- The Structure and Changes to the Payment and Delivery Systems Inherent in ACOs Cause Issues Under Existing Laws
- Many Health Care Laws are Set Up to Control Abuses of Fee-For-Service System, With its Structure that Pays More for More Care. With Proposed Changes to Payment System, There Will be a Need to Review and Adjust Applicable Laws to Allow for ACO Payment Structures.
- Other Laws Also May be Affected/Violated by ACO Structure and Operations.

Laws Affected

- Antitrust
- Anti Kickback Statute (AKS)
- Stark
- Civil Monetary Penalties
- Gainsharing Limitations
- Corporate Practice of Medicine (in Certain States)

Antitrust Laws

- ACOs Will Often Require Collaborative Activity and Arrangements between Independent Providers
- Issues in Network Creation
- Exclusive Arrangements
- Particular Challenge in Small Markets

Antitrust Laws (continued)

- Effects on Other Market Participants and Avoiding Spillover Collusive Activity
  - Price Fixing
  - Exclusive Dealing
  - Spillover Collusive Activity
- Collaboration to Negotiate Rates for Independent Providers
  - Sufficiency of Shared Financial Risk
  - Clinical Integration
- Issues in Gathering and Maintaining Information and Making Communications

ACOs and Anti Kickback Statute

- ACO Programs are Designed to Reward Physician Practices and Other Physician Organization Models for the Provision of High Quality, Cost-Effective Healthcare Services.
- Among the Tools Utilized in an ACO are Incentive Payments to Physicians to Achieve Those Goals
- Incentive Payments Could be Viewed to be a Kickback – ACOs, by their Very Nature, Could be Viewed as Way to Induce Referrals

ACOs and Stark Law

- Under Stark Law, an ACO would Face Certain Hurdles:
  - If ACO is a hospital-physician group entity with a definite legal structure
    - it can receive and disburse money
    - has sufficient numbers of primary care physicians
    - is able to report its outcomes and streamline patient care and improve quality outcomes
- This Interrelationship and the Cross-Ownership which Would Occur Could Potentially Violate the Stark Law
- Physicians and/or the Hospital Could be Viewed as Having an Ownership Interest in Other and/or in the Referral Process
- Exceptions to the Stark Law, as Presently Written, May Not Provide an Appropriate Exemption from What Would Otherwise be Considered a Violation of the Law

Civil Monetary Penalty Statute

- The OIG Could Impose CMPs, Assessments and Program Exclusions Where it Has Determined the Continued Participation by Entities in a Federal Healthcare Program Could Cause Injury to the Program or Beneficiaries
- In Theory, the CMP Statute, Like the AKS and the Stark Statutes Could be Viewed as Prohibiting Certain Features of a Hospital-Physician Program Such as an ACO – (e.g., CMP for Inducing Reduction in Performance of Services)

Gainsharing – Precursor to ACOs

- In 1999, the OIG Issued a Special Advisory Bulletin: Gainsharing Arrangements and CMPs for Hospital Payments to Physicians to Reduce or Limit Services to Beneficiaries (see 64 Fed. Reg. § 37985)
- OIG has Carved Out a Narrow Path of Approval of Certain Gainsharing Agreements (Which Often are Designed as Shared Savings Programs)
- OIG has Discretion to Approve Gainsharing Arrangements on Case-by-Case Basis
- OIG More Likely to Approve Programs that Contain Substantial Structure, Quality Controls, Accountability and Other Safeguards

Gainsharing – Precursor to ACOs (continued)

- Under Stark, Path for Approval of a Gainsharing Model or ACO is Much Less Clear
- No Specific Exception for These Models Under Stark
- Factors Such as Personal Service Agreements, Fair Market Value, Indirect Compensation, Volume and Value Limitations, Commercial Reasonableness and Other Factors Lead Directly to the Possibility of a Stark Violation in a Gainsharing or ACO Model

Corporate Practice Medicine (CPOM)

- Generally, CPOM Prohibits a Business Corporation to Practice Medicine or to Employ Physicians to Provide Professional Medical Services.
- In Some States, CPOM Prohibitions Include Exceptions Similar to the Stark and Anti Kickback Laws Exceptions and Safe Harbors
- Physicians and Hospitals will Have to Review a CPOM Doctrine in Each Relevant Jurisdiction to See what Effect it Might Have on an ACO's Structure
- Providers May Need to Achieve Control or Management of Services Without Control of Employment Through a Corporate Structure

Possible Solutions To Legal Issues

- Two Possible Avenues the Secretary of Health and Human Services May Utilize in Order to Make it Legal for ACOs to Perform as Intended:
  - Waiver:
    - Blanket Exemption
    - Case-by-case analysis
  - New Regulations
    - New Regulations Could Create a Framework for ACO Programs
- Any Safe Harbor That May be Created Would Only Apply to Those Entities Which Meet the Requirements of Approved ACO

What Can Providers Do Now To Prepare For ACOs?

- Depends on Each Provider's Unique Circumstances
- Active Participation in Demonstration and Pilot Projects
  - Test Your Readiness
- Aggressively Explore Alignment Strategies With Physicians and Other Providers That Will Fill Out Organizations With Proper Provider Components and Permit Care To Be Coordinated
  - Do You Have Proper Providers Available
  - Employment Provides Best Control
  - If Employment Not Available, What Legal Structure Will Work
  - Obtain Services of Best Physicians Who Are Committed To Care Coordination
  - Physician/Hospital Alignment Tools

What To Do Now (continued)

- Develop Clinical Protocols for Provision of Quality Care and Eliminating Unnecessary Care
- Ensure EHR and Systems Are Sufficiently Integrated To Permit Measuring and Monitoring of Quality of Care, Cost of Care and Outcomes
- Review and Adopt Quality Indicators That Will Be Monitored and Measured (Current CMS and Premier Standards May Be Guides)

What To Do Now (continued)

- Consider Methods To Pay Needed Independent Providers in Legally Permissible Manner
- Ensure Administrative Structure in Place to Operate an ACO
- Do You Have Expertise to Know What Global/Bundled Payment is Sufficient to Provide Reasonable Compensation (Need For Actuarial Assistance)

What To Do Now (continued)

- Begin Work With Third Party Payors to Ensure Their Buy-In
- Ensure That Various Participants Have an Understanding and Commitment to Vision of ACO and Its Payment Concepts

Questions and Answers

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