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ACOs: Opportunities and Barriers
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OVERVIEW OF ACCOUNTABLE CARE ORGANIZATIONS:

- History of the ACO Concept
- ACO definitions
- Federal health care reform
- Private ACO initiatives
- The Barriers
- The Opportunities

THE PUSH FOR ACOS

- Traditional Medicare fee for service problems
- Medicare Managed Care problems
- Geographic variations
- The HMO backlash, PPO growth
- Employer benefit cuts
- Budget crunch, cost curves, cut-backs, *etc.*
- Private and governmental payors

Development of the ACO Concept

- Dartmouth Institute for Health Policy and Clinical Practice
- Engelberg Center for Healthcare Reform at the Brookings Institute
- Elliott Fisher, M.D., M.P.H., and Mark McClellan, M.D., Ph.D.
- Medicare Payment Advisory Commission, 2009 Report to Congress
- And many more

Key Features of ACOs

- Local delivery, local accountability
- Physician leadership
- Coordinated, accountable, care, across the continuum of care
- Performance measures (transparency)
- Financial rewards tied to quality (value) more than volume or cost
- Improve health outcomes, slow cost growth

ACO Levels I, II, III

- Medicare shared savings ACOs are only Level I.
- MedPac Report:
 - “possible penalty for low quality and high cost growth”
 - Voluntary ACO + Medigap SELECT model
- Others (those who are ready) advocate global payments a/k/a capitation
- JAMA article, Shortell, Fisher et al.:
 - Level II: bundled payments, episode-of-care payments.
 - Level III: global (partial or full capitation)

Federal Legislation (ACA – 2010)

- Affordable Care Act (ACA)
- a/k/a the Patient Protection and Affordable Care Act (PPACA)
- New 1899, Title XVIII (Medicare): shared savings ACO pilot project to begin 2012
- Contemplates other types of ACOs

Social Security Act 1899

An ACO:

- promotes **accountability** for a **patient population**
- **coordinates items and services** that Medicare pays for
- **encourages investment in infrastructure and**
- **redesigned care processes for high quality and efficient service delivery**
- **groups of providers** of services and suppliers meeting criteria specified by the Secretary **may**
- **work together to manage and coordinate care** for Medicare fee-for-service beneficiaries through an ACO and can be
- Eligible to receive **payments for shared savings** , , , .

The Federal ACO Initiative Means

- What the buzzwords suggest
 - Opening doors to new arrangementsversus
- The legal barriers
- The practical barriers
 - but see:
- What the economics of healthcare point to

Types of ACOs

Noted in the federal legislation:

- Group practices
- Physician networks
- Physician-hospital organizations
- Staff model hospitals
- Others per Secretary

Other Possible ACO Structures

- Medical foundation model
- Medical group consortium
- Academic medical centers
- Multi-system ventures
- Integrated delivery system (IDS)
- Hospital Medical Staff Organiz. (HMSO)
- Health Plan Provider Organiz. (HPPO)

ACO Goals (and Objectives)

- Structures secondary
- “It’s all local”
- Governance
- Legal constraints
- Bet-hedging

Medicare Shared Savings ACOs: Basic Requirements

- Formal legal structure to receive and distribute shared savings
- Primary care physicians sufficient for population
- Minimum 5,000 assigned Medicare beneficiaries
- Minimum 3 year agreement with CMS

More Medicare Shared Savings ACO Requirements

- Provider roster sufficiency
 - to assign Medicare beneficiaries to ACO and
 - measure ACO performance
- Leadership and management structure
 - clinical systems
 - administrative systems
- Demonstrates patient-centered criteria

Defined processes (Medicare Shared Savings and Other ACOs)

- promote evidence based medicine (EBM)
- report necessary data for cost/ value measurement
- coordinate care across the spectrum:
 - Primary care
 - Specialist,
 - Hospital,
 - Ancillary
 - Preventive and Post-Acute

ACOs and Information Technology

- IT critical:
 - to tracking, sharing, measuring, improving
- EHR investment and coordination
- A barrier: an expensive opportunity

Medicare Shared Savings ACOs

- When?
- How much?
- Requirements
- Funding?

Medicare Shared Savings: Definitions

- If meet quality performance standards
- a *percent* (TBD by HHS) of
- the *difference* between such *estimated average* per capita Medicare expenditures in a year, *adjusted* for beneficiary characteristics, under the ACO and
- such benchmark for the ACO

Medicare Shared Savings: Timelines

- July 2010 CMS published Preliminary Questions and Answers for Shared Savings Program
- December 2010 Request for Comments
- Notice of Proposed Rulemaking (NPR) to establish more detailed requirements planned for Winter 2011
- Start date: January 2012
- Priority given to ACOs with operational history

Medicare Shared Savings

- No risk-sharing. Incentives only.
- No “lock in”. All FFS. “Enrollee” free to choose providers.
- No HMO-like enrollment process
- Assignment of Medicare beneficiaries who receive most of care from ACO physicians

Shared Savings Program Questions

- What incentives to enrollees to stay “in-network”
- What incentives allowed within the network
- Any “give-and-take” in the initial assignment process
- When and how add or delete from ACO pool of assigned beneficiaries
- PCPs: only one ACO?

Shared Savings Program Questions

- IT standards, *e.g.*, tested
- Measurement tools?
- What track record? How many ACOs?
- If new, what tolerance for data incompleteness, inconsistencies, etc.?
- Legal questions
- What savings percentage?
- Carve-outs or stop loss?

Medi-Cal Provider-Based ACO

- Section 1115 comprehensive demonstration project waiver
- CCS tertiary care hospitals and hospital-based Special Care Centers
- Subset of CCS population with designated chronic medical conditions, e.g., cystic fibrosis, sickle cell, spina bifida, cardiac conditions

Other federal initiatives

- (All can be features of a Medicare Shared Savings ACO)
- Payment bundling. Up to 10 conditions, Part A and Part B.
- Hospital value-based purchasing. Incentives for meeting quality measures for frequent high cost conditions
- Hospital readmissions reduction
- Extend Physician Quality Reporting Initiative (PQRI)
- Independent Payment Advisory Board for Medicare (IPAB).
Third rails: rationing, beneficiary costs, eligibility and premiums
- PCMH; primary care or patient-centered “medical home”
- Episode-of-care

Private Initiatives

- ACO concept is evolving, multifarious
- Many private initiatives involving physicians, hospitals, health plans, employers under discussion
- A significant number in development
- Some in operation

Existing ACOs: East Coast

- Geisinger ProvenCare:
 - “One fee for the entire identified period of time
 - “Global fee includes 50% share of historical readmission rate (guaranteed payer savings, Geisinger upside based on complication and readmission reduction and efficient care)”
- Massachusetts Blues – Atrius Health Alternative Quality Care (Alliance of 5 multispecialty medical groups). Global payment pmpm, adjusted age, etc. + substantial incentives based on quality, effectiveness, patient satisfaction. www.qualityaffordability.com. “within budget”

ACOs: Midwest

- Advocate Physician Partners
- 10 hospital system
- 2,700 MDs: 800 emp'd by affiliated medical groups, 2,900 in 900 indep. Practices
- Governance: PHOs and System represented, mostly MDs
- 15 years of capitated and FFS contracts
- FTC settlement re PPO contracts
- Series of quality targets
- University of Michigan

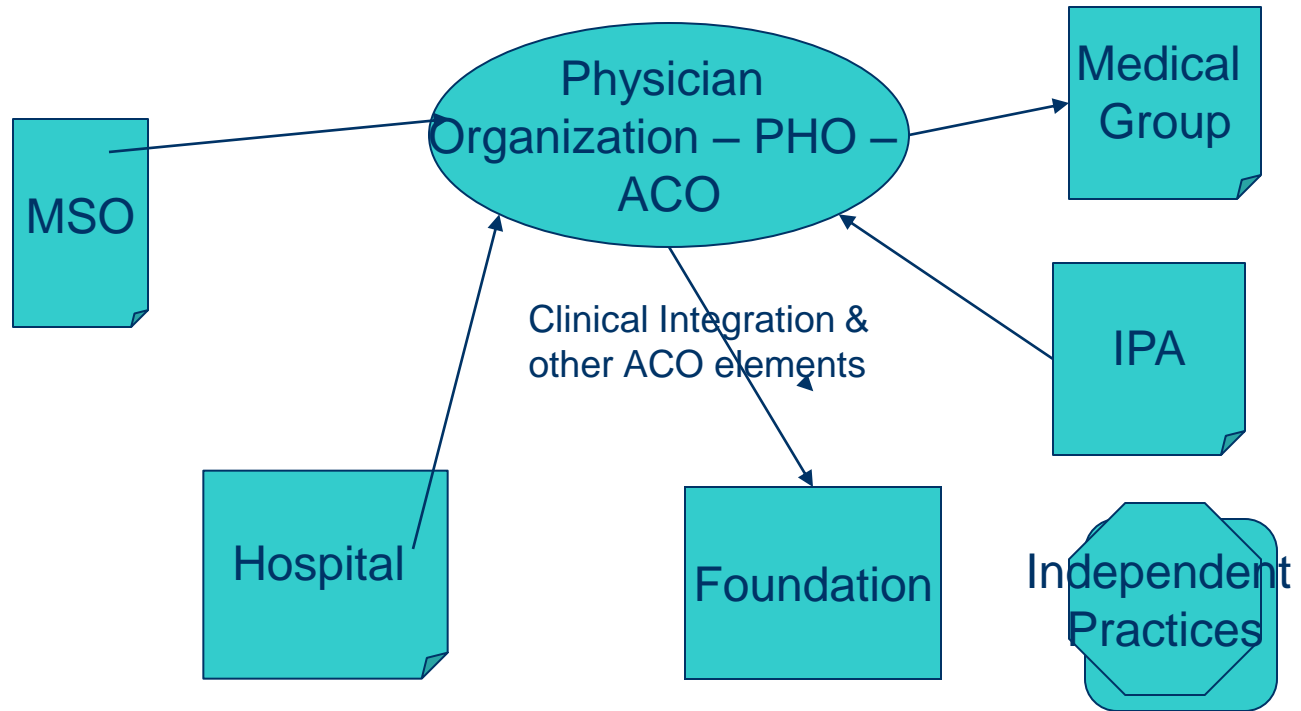
CALIFORNIA ACOs

- CHW – Blue Shield – Hill Physicians.
 - CalPERS: “your Region 1A quality partners: NetValue”.
 - 2010 targets:
 - Quality/satisfaction: readmissions, excessive surgery, out-of-network
 - Cost: hold at prior level \$400 pmpm
- HealthCare Partners – Monarch Healthcare – Anthem Blue Cross. Announced 5/8/10. “Select population.” PPO. A Brookings - Dartmouth pilot project.
- Capitation alive and well in California, e.g., 150 CAPG members

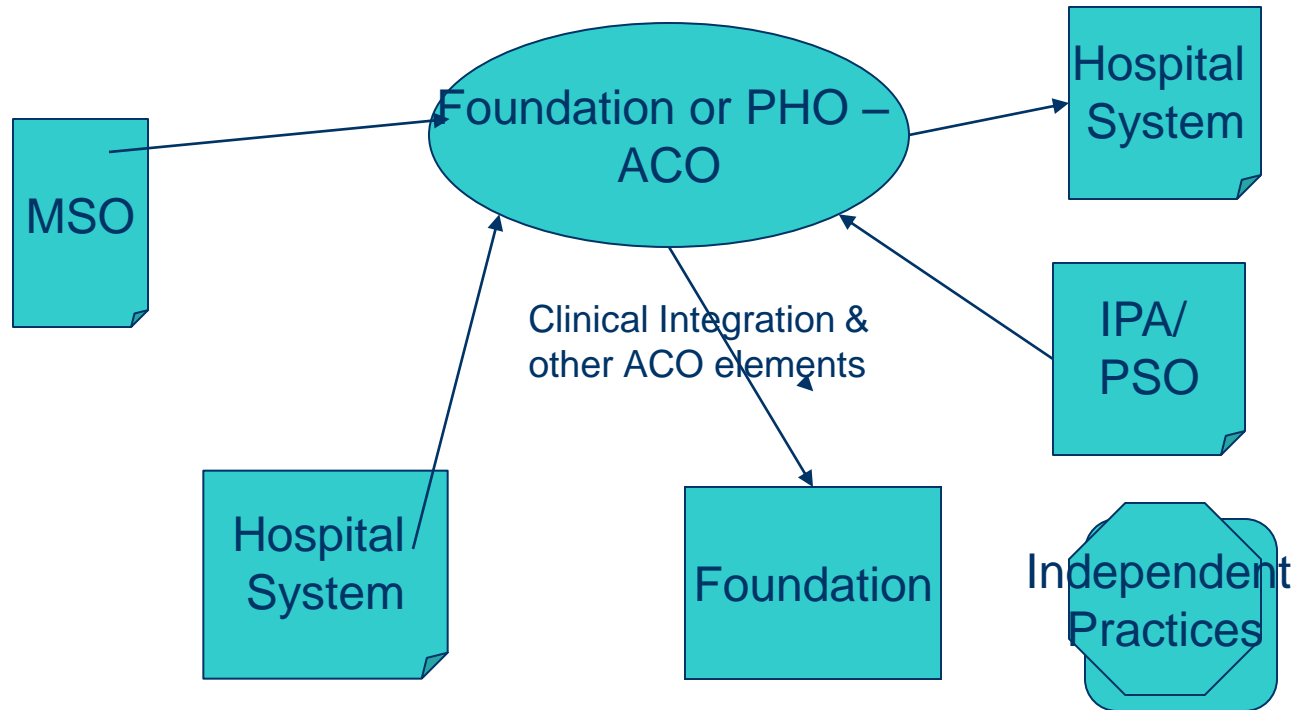
ACO Levels II and III

- CMS pilot projects may include partial capitation, global payments
- Insurer initiatives building on existing extensively capitated networks
- How differ from HMOs? Next generation?
- Medicare Advantage's replacement?

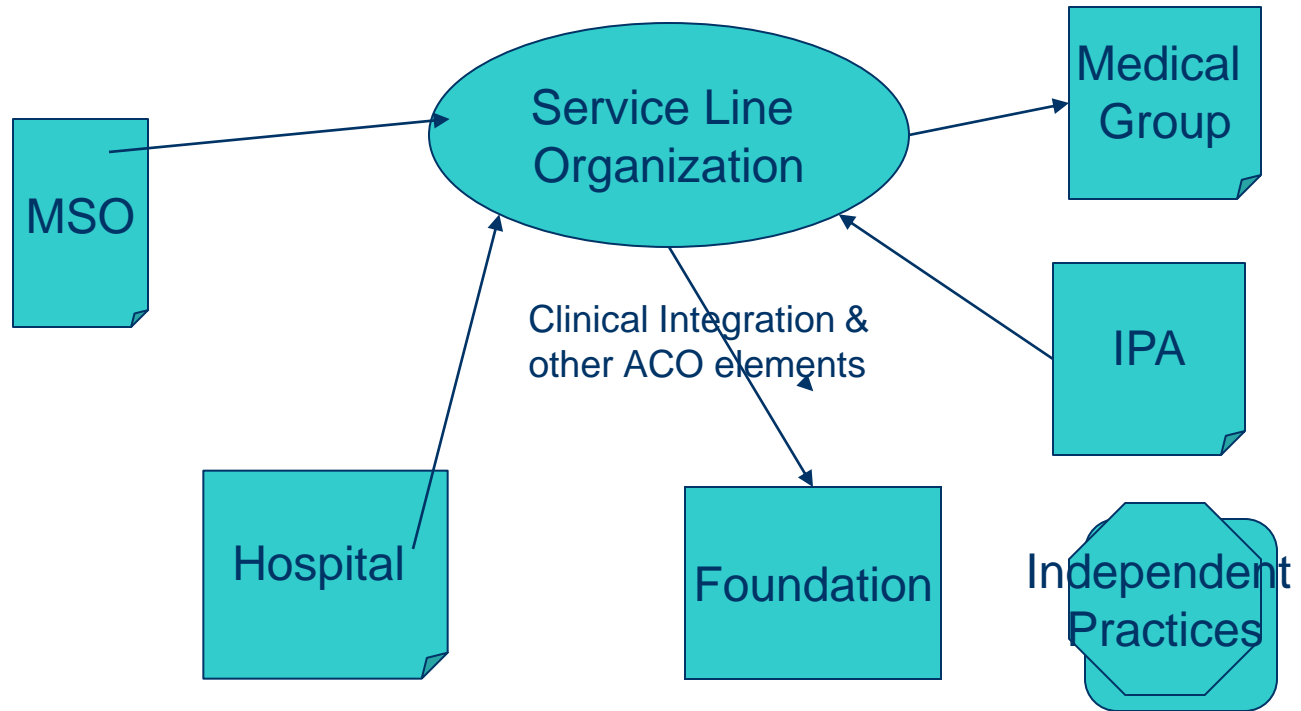
ACO Relationships



ACO Relationships



ACO Relationships



Examples of ACOs in Process

- Two hospital systems – Omaha
 - Meetings, Statement of Principals
 - Employers, insurers, medical staffs, etc.
 - Severability
- Hospital Association of Southern California
 - ACO or Master Medical Foundation
- Baylor Health System
 - bundled payments, etc., for employers

ACO Needs

- Formal, flexible, legal structure
- Continuum of care, from preventive to post-acute
- Physician leadership
- Governance: buy-in by all participants
- Clinical integration: real time sharing of patient information; data; outcomes; clinical standards
- Aligned incentives:
 - Investment, risk, rewards

Room for the solo and small group practitioner

- December 2010 comments to CMS
- AMA, ACP, etc.
- Expense of ACO infrastructure like HER
- Need to mitigate lack of capital through earlier cost savings, and through less onerous barriers to entry

Room for the safety net providers

- Concern that cost savings programs will not take into account patient populations
- Also that quality measures will skew in favor of the less impacted service areas

ACO Needs

- Clinical program tracking
 - by patient, physician, type of case, ACO
- Principled guidelines, e.g., peer benchmarking, tested or recognized standards
- Sharing of patient information across the network
- Sharing of quality measures across the network
- Administrative and clinical management
- IT (EHR, CPOE, disease/condition registries, data warehouses. More than claims payment or billing/business office and UM/authorization systems

ACO Needs

- Explicit, shared goals
- Adjust, improve, realign (like CQI)
- Well-defined identity, with definite value to payors, patients, community.

LEGAL ISSUES

- HMO licensing
- Corporate practice of medicine
- Stark and PORA
- Federal Anti-Kickback Statute and Civil Monetary Penalty Law; similar state laws
- Anti-trust
- Non-profits: private inurement

Prohibited Incentives

- CMP Law: Social Security Act 1128A prohibits hospital payments to physicians to reduce or limit services to Medicare patients
- Medicare Managed Care: SSA 1876: CMS contracts bar incentives to deny or limit medically necessary services for a patient
- Similar prohibition: SSA 1899 for ACOs

HMO Licensure

- If take risk, may be subject to state HMO, insurance, or risk based organization laws
- California example: the Knox Keene definition of health care service plan is very broad, but:
 - Shared savings ACOs: no prepaid or periodic charge
 - Withhold or risk pool or penalty: still FFS
 - Yes, if partial capitation or global payments on a per enrollee basis

HMO Licensing

- Federal preemption: TBD
 - But likely to be extensive
 - Example: Medicare Advantage plans
 - But not outside Medicare

Anti-trust

- A barrier
- Also an opportunity
- Issues: monopolization and price-fixing
- Maricopa and numerous FTC interventions, *e.g.*, Stanislaus County, Palmetto PHO
- But: TriState Health Partners FTC advisory opinion; 4/26/10 DOJ letter re payor provider data sharing

FTC and DOJ Statements

- “clinical integration is an active and ongoing program to evaluate and modify the practice pattern of physicians and create cooperation to control costs and ensure quality”
- California payor-hospital data sharing safeguards against learning competitors’ rates (including by vertically integrating)
- Large numbers assured

Anti-trust

- AMA letter to CMS December 2, 2010 regarding barriers
- FTC and Dept. of Justice Antitrust Division testimony 12/1/10
- Clinical integration: not pro forma
 - investment of time and money for quality and cost-efficiency; real time implementation
- Joint negotiations ancillary to clinical integration
- Can CMS extend protection to negotiations with other third party payors?

Corporate Practice Prohibition

- In some states
- Parallel to Medicare Shared Savings requirements
- Form of organization and governance
- Roles of medical entity, hospital, MSO, and health plan

Stark

- ACO related payments (bonuses or subsidies) may constitute a financial relationship between a hospital and referring physician
 - whether direct or indirect
- Proposed safe harbor for shared savings and incentive payments (Fed. Reg. 7/7/08), e.g.,
 - Gain-sharing, P4P. Replete with requirements

Anti-Kickback Statute and Civil Monetary Penalty Law

- Managed care safe harbors under AKS
- Managed care exceptions under Stark
- Civil Monetary Penalty Law (CMPL): payments to reduce or limit services
- Medicare HMO and ACO prohibitions of delay, deny or reduce care

Safe harbors and waivers

- CMS unlikely to finalize proposed shared savings and incentive exception under Stark
- Instead, waivers for ACO
- OIG: same re AKS safe harbor
- Guidance?
- Waiver process?
- OIG opinions
 - Gain sharing
 - Quality and efficiency

Other legal issues

- HIPAA, Hi-Tech
- Non-profit exemption, *e.g.*, private inurement
- Peer review
- Medical staff
- Liability insurance

ACO LOGISTICAL ISSUES

- Information Technology
- Network development
- Governance
- Ownership and other financial relationships
- Capital
- Risk-sharing, reserves
- Alignment of incentives
- Continuous communication regarding patient care and quality, effectiveness, and efficiency measures
- Marketing, patient satisfaction, and identity
- Improvement and realignment
- Compliance within the network
- Legal compliance

ACO Legal Barriers (or opportunities)

- Anti-trust
- HMO or insurance licensing
- Federal delay, repeal, or non-funding
- Stark, AKS, CMPL, FCA, etc.
- Corporate and contractual (the organizational matrix)

American Health Lawyers Association ACO Task Force Committees

- Organization and Governance
- Task Force Strategy, Strategic Alliances
- ACO Contracting
- Federal Regulatory
- State Regulatory Issues
- Anti-trust
- Payment Mechanisms
- Performance Measures and Accountability
- Taxes

Challenges across spectrum

- To existing integrated and partially integrated systems
- To existing capitated or risk sharing entities
- To hospitals
- To multispecialty medical groups
- To solo and small practice physicians
- And health plans, employers, DMOs, etc.

ACO Levels and Process

- Planning, flexibility, staging
- Liaison with other stake holders
- Structure and governance
- Select 1st, 2d generation targets, relative consensus re treatment, measurable.
- Examples from other ACOs: diabetes, hip/knee, CABG, asthma, other disease management and preventive care, discrete cost areas

Questions

- The answerable
- The not answerable
- Governmental process
- Privative initiative process