

ACCOUNTABLE CARE ORGANIZATIONS

Hospital & Health System Association of
Pennsylvania

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Agenda

- > Where Do Accountable Care Organizations Fit in Today's Competitive Market
- > How ACOs Work
- > Strategic Considerations
- > Regulatory Considerations
- > What You Need to Do to Succeed as an ACO
- > Financial Implications
- > Who Should Pursue ACOs and When

Where do ACOs Fit In Today's Competitive Market

Policy makers are desperate to slow Medicare spending growth

- > Medicare ACO
- > Centers for Medicare & Medicaid Innovation
- > Medicare Advantage
- > Independent Payment Advisory Board
- > Vouchers ??

CMS leadership has a vision

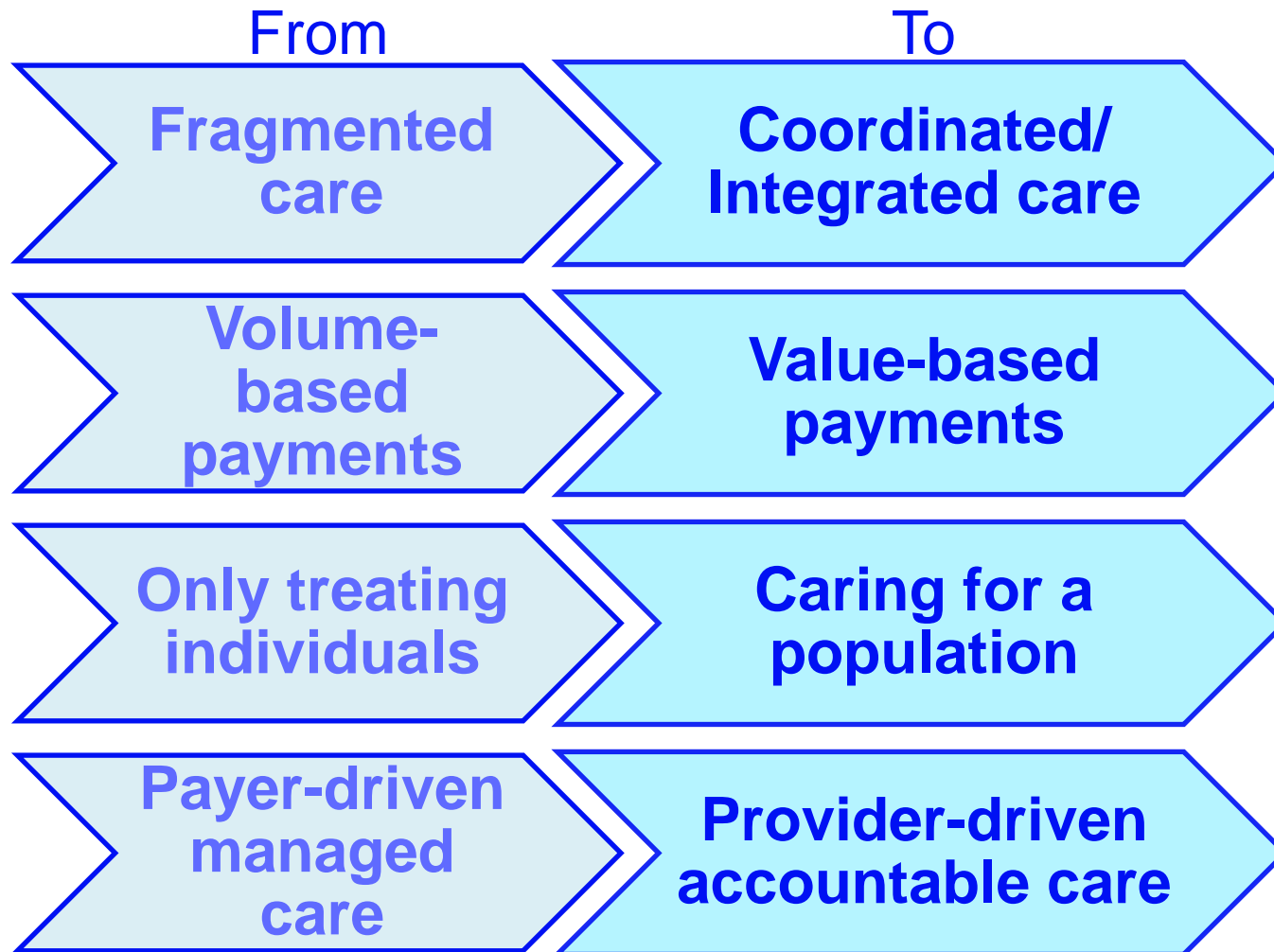
> CMS Triple Aim:

- Better Care for Individuals
- Better Health for Populations
- Lower Cost per capita

> Seeking the transformation of healthcare delivery

- Some models work better than others
- All should perform at achievable levels

CMS leaders see ACOs as a historic opportunity and seek “authentic” change



How ACOs Work

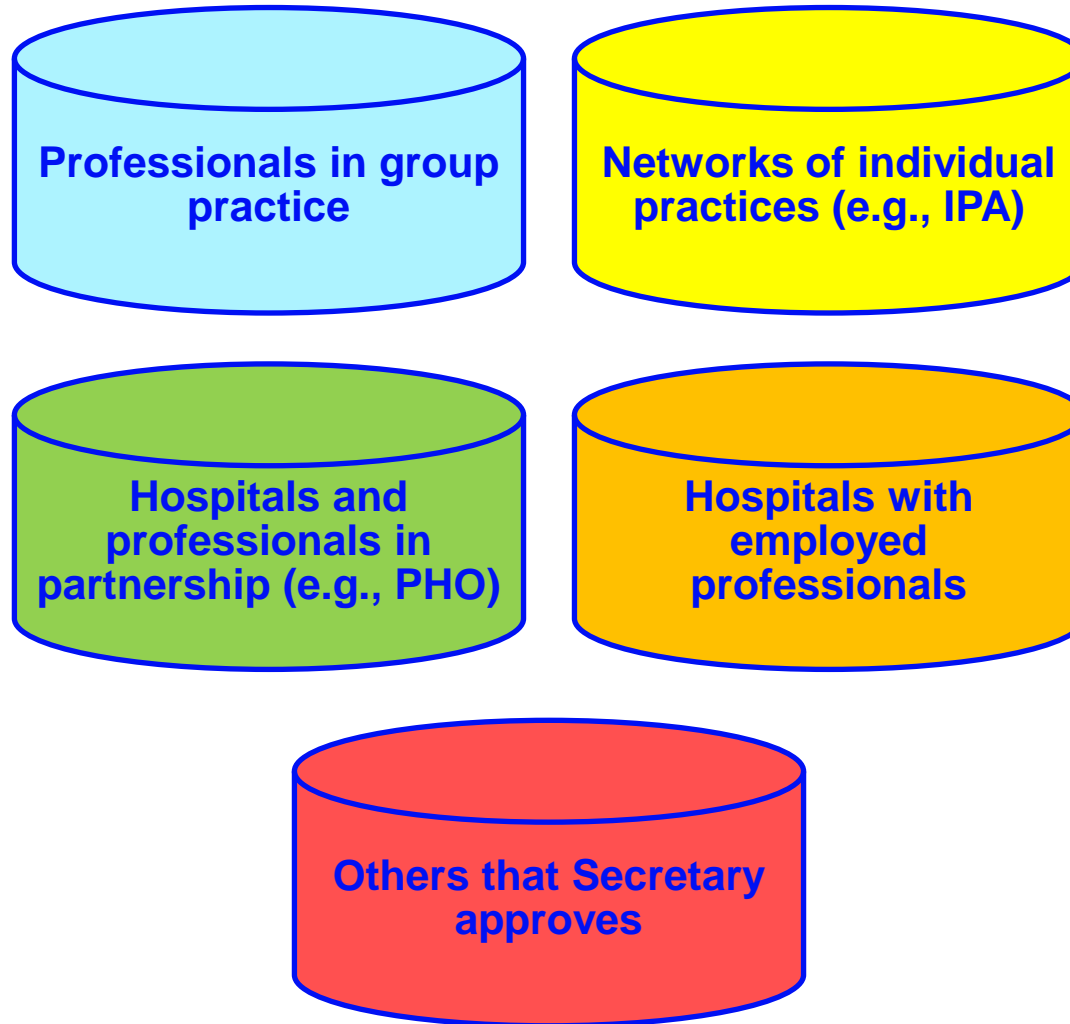
Definition

An ACO is an entity that is clinically and fiscally accountable for the entire continuum of care that a given population of patients may need.

Partners In Health

- > ACOs to be established beginning Jan. 1, 2012
“Medicare’s Shared Savings Program”
- > For Medicare Parts A and B
 - o Serves traditional Medicare beneficiaries

Who can be an ACO?



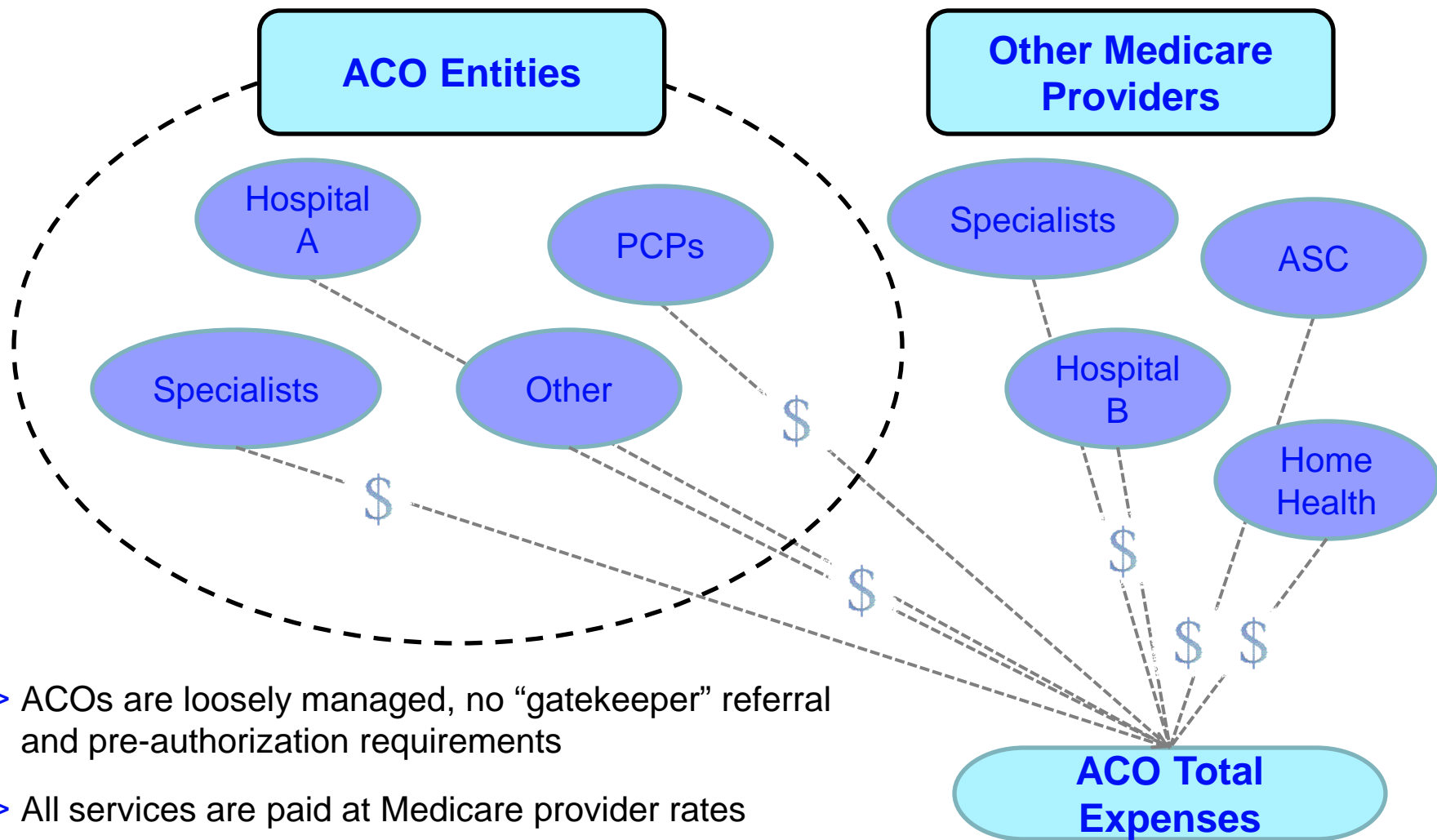
Requirements of a Medicare ACO

ACO CHECKLIST	
Accountable for quality, cost, and overall care	✓
3-year commitment	✓
Legal structure to distribute payments	✓
PCPs caring for at least 5,000 beneficiaries	✓
Report on 65 Quality Measures	✓
Clinical and administrative systems and leadership	✓
Promote evidence-based medicine, patient engagement, care coordination	✓
Meet patient-centeredness criteria	✓
Secretary may prefer ACOs with other contracts	✓

Patient assignment

- > Based on primary care physicians
(not NPs/PAs; not specialists)
- > Based on plurality of primary care services
- > Retrospective for shared savings; prospective to identify
“expected ACO population”

Costs tracked across all providers



- > ACOs are loosely managed, no “gatekeeper” referral and pre-authorization requirements
- > All services are paid at Medicare provider rates
- > All Part A and B costs are accrued on the ACO’s tally

Two tracks are available in the proposed Medicare ACO regulations; Both include downside risk

Track One

ONE SIDED

Upside only
Years 1 & 2

TWO-SIDED

Upside and Downside Risk
Year 3

Track Two

TWO-SIDED

Upside and Downside Risk
All 3 Years

Must Convince CMS
you are
Ready for Risk

Strategic Considerations For Creating an ACO

ACOs raise several strategic questions

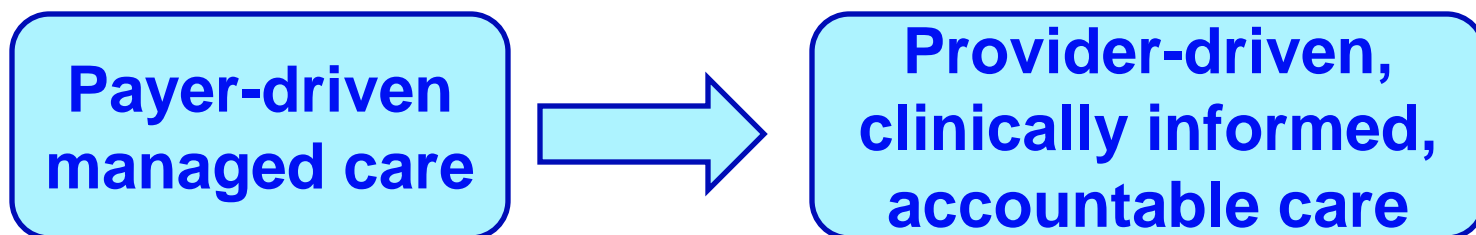
- > Do we want to be an ACO?
- > What would it take to get ready?
- > If we succeed as an ACO, will we drive down our volume and suffer financially?
 - o Can we attract more market share to make up for reduced utilization?
- > Should we pursue commercial “ACO” contracts?
- > Can we succeed on our own, or should we partner?
- > What will the financial impact be? (Investments; impact on operations, etc.)
- > What are our competitors planning?

Hospitals must consider ACOs along side other key strategic initiatives



Some providers may reach tipping point in new model

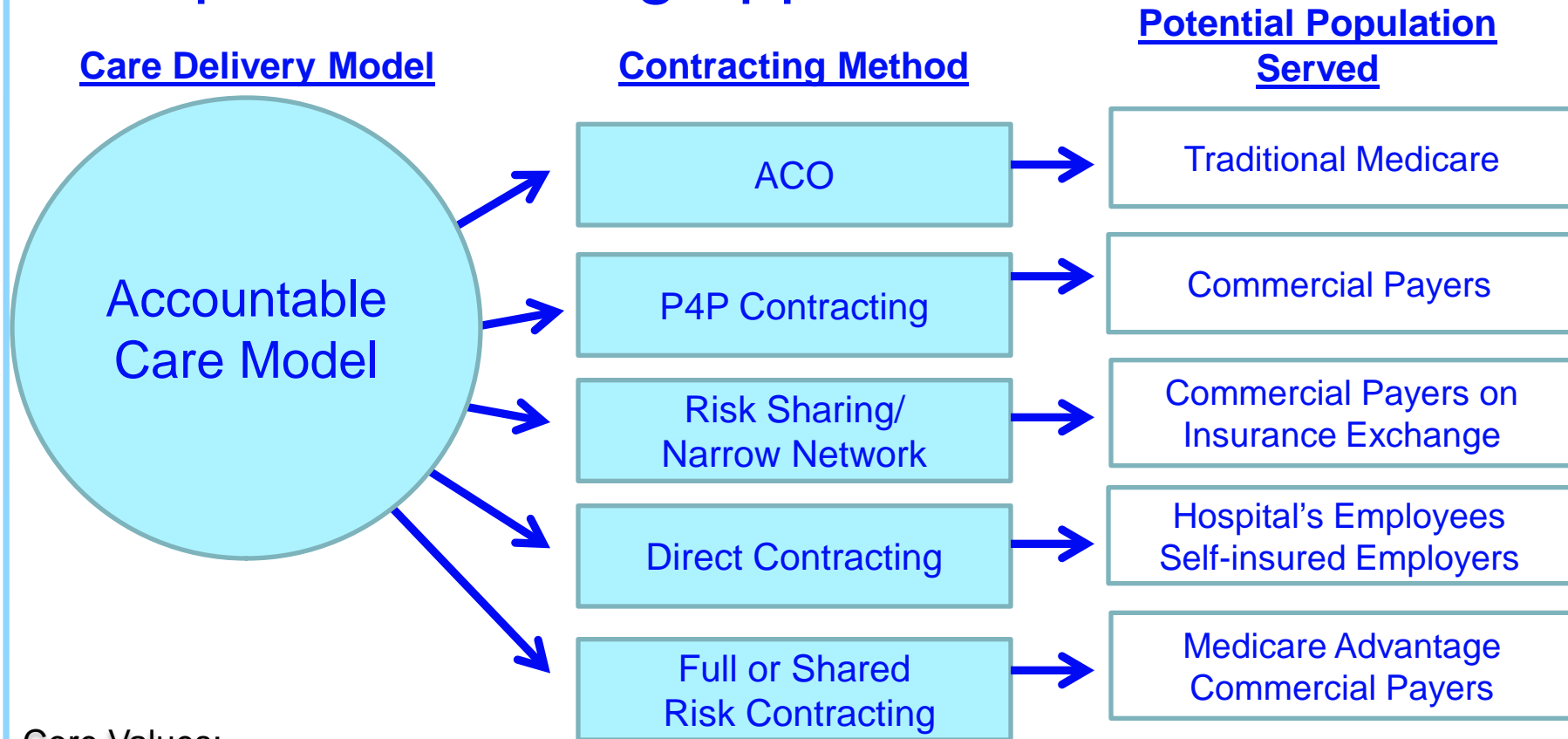
> Possible shift



> Other health reform changes also support this shift

- Health Insurance Exchanges may support narrow network insurance products
- Pressure on health plan administrative cost may lead them to shift care management functions to providers
- Relatively flat fee-for-service payments

Transition to accountable care may involve multiple contracting approaches



Core Values:

- 1) Physicians engaged on quality and cost
- 2) Local, physician-driven medical management
- 3) Critical mass to pursue best practices across board
- 4) Value to purchasers

Medicare ACO timing

Expected Timing	2011				2012				2013			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Regulations Issued	■											
Assume Application Due			■									
Assume Notified if Selected as ACO				■								
Begin Operation as ACO					■	■	■	■	■	■	■	■
Assume Shared Savings Distribution											■	■

- > If you miss the January 2012 opportunity:
 - o First movers may have established themselves, locking in PCPs
- > Could also apply in July 2012, but would have an 18 month first “year”
- > ACOs will need working capital to cover two years until shared savings (if any) are paid
 - o 25% of surplus will be withheld

How are physicians responding

- > Some PCPs are excited
- > Many specialists are concerned
- > Not a very lucrative joint venture
- > Physician-only ACO requires much working capital

Regulatory Considerations

Timing of law and regulations

- > PPACA enacted March 2010
- > Proposed ACO regulations issued 3/31/11
- > Comment period through 6/6/11
 - o Feedback has been loud and negative
- > Final rule timing TBD
- > First ACOs still scheduled to begin 1/1/12

What are the governance requirements to become an ACO under the Medicare Share Savings Program?

- > Must provide for shared governance with ACO participants having proportionate control through selected representatives with ACO participants having at least 75% of governing body
- > Beneficiaries must have a role in governance through governing or advisory board membership
- > Must have its own tax identification number
- > Must have a leadership and management structure including clinical and administrative systems that emphasizes patient centered, best evidence medicine.

Federal regulatory relief for ACOs is not helpful

- > Anti-Trust Considerations
- > Anti-Kickback and Stark
- > IRS Guidelines Relating to Tax-Exempt Status

What are the antitrust guidelines for ACO's?

- > Antitrust considered for each “same service”
 - o Safety zone established for ACO's with less than 30% of the primary service area
 - o “Limbo” between 30% and 50% of primary service area
 - o Required expedited FTC review with over 50% of primary service area
 - o “Rule of Reason” is applied

Clinical integration

- > Clinical integration is developed and driven by physicians through
 - o The promotion of guidelines for best practices
 - o Participation in performance improvement and reporting
 - o Intensive management of high-cost, high-risk patients
- > Can take multiple years
- > Only a handful of organizations have been recognized by the FTC for achieving clinical integration
- > Requires favorable FTC/legal opinions
 - o Clinically integrated providers can negotiate rates with purchasers “as necessary”
- > More recently, the focus has shifted from negotiating leverage to real efforts that integrate and improve care
 - > Organizations seek contractual “add-on” arrangements

Calculation of shared savings

- > Compare expenditure benchmark to actual expenditures and apply shared savings rates and applicable caps as follows:
 - One-sided contract ACO receive up to 52.5% of the savings up to 7.5% of the benchmark
 - Two-sided contract ACO receive 60% of savings up to 10% of the benchmark with a maximum savings rate of 65%
- > ACOs will also receive increases in shared savings percentages for beneficiaries from FQHCs and RHCs

Setting benchmarks

- > Benchmarks are based on both Parts A and B of CMS Fee-For-Service expenditures for beneficiaries who have been assigned to the ACO in each of the three years prior to the start of the ACO assignment period
 - o This does NOT take into account any change in ACO membership in the subsequent years
- > Benchmarks are risk-adjusted by CMS-HCC adjuster
- > Updated each year by absolute amount of growth per capita expenditures for Parts A and B under original Medicare FFS program
- > Benchmark set at 99th percentile to minimize variation from large claims

Additional considerations of Two-Sided contract provisions

- > Voluntary
- > Could apply capitation model
- > Any other model that improves quality/efficiency (lots of creative options here):
 - o Global capitation
 - o Partial capitation (combo with fee for service)

Additional considerations of Two-Sided contract provisions

- > After second year all one side ACO contracts switch to 2 sided contracts
- > Minimum loss rate of 2%, with sharing beginning first dollar thereafter subject to an annual cap — 5%, 7.5%, 10% in years 1, 2, 3 respectively
- > Max loss rate equals 1 minus the applicable savings rate (1-65%=35% shared loss for ACO subject to annual cap of 5% 7.5%, 10%)

Additional considerations of Two-Sided contract provisions

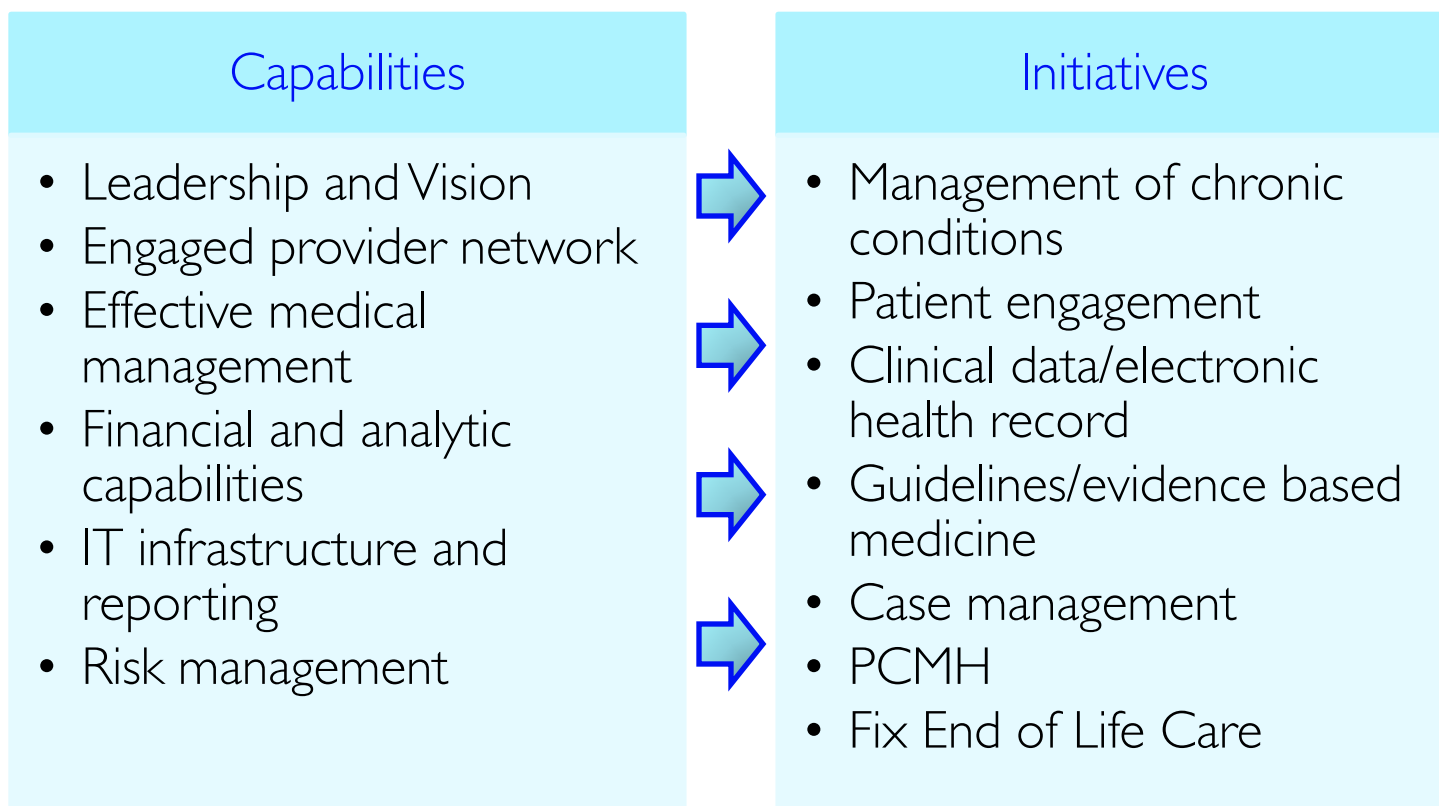
- > Use 25% withhold to offset losses
- > Unpaid losses carry forward to offset against reserves or shared savings
- > Require some form of security — reinsurance, bond, escrow, letter of credit

Notification and data sharing opt-out provisions

- > Providers should post signs in facility indicating they are part of a “Medicare Shared Savings Program”
- > Make standard written materials available to beneficiaries
- > Supply a form allowing beneficiaries to opt-out of having their data shared

What You Need To Do To Succeed

Key capabilities and initiatives needed for accountable care success



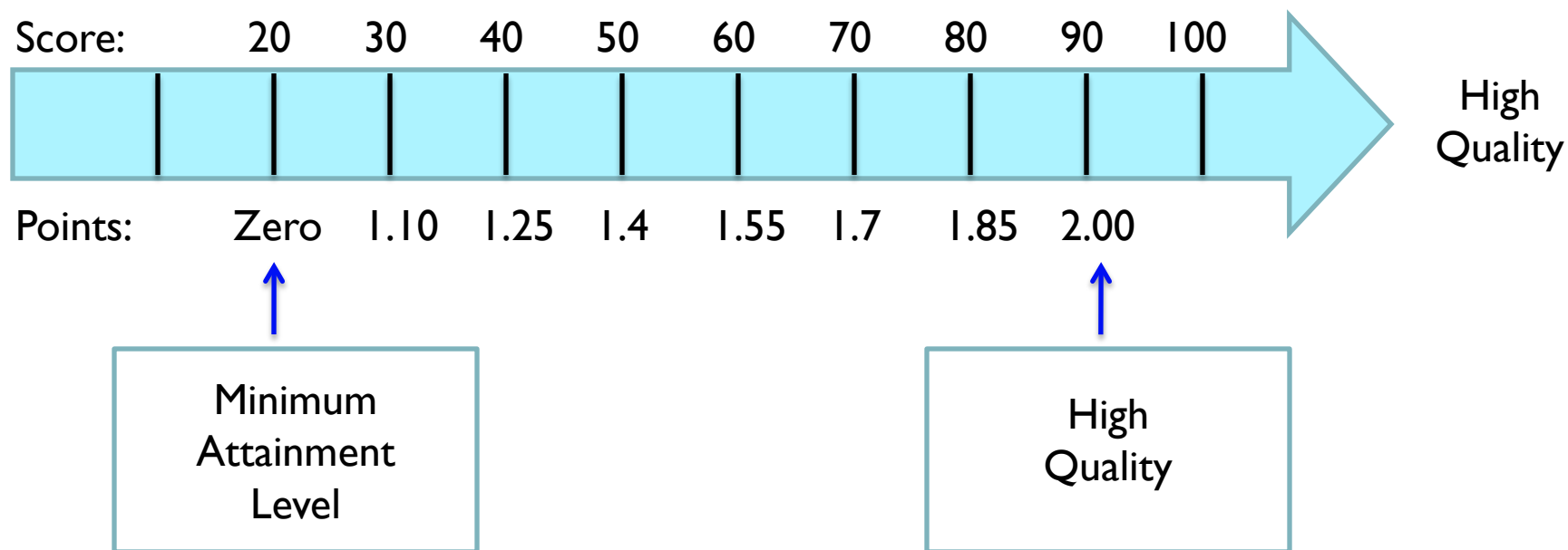
Quality measurements and performance requirements are significant

- > 65 quality measures that must be met to qualify for shared savings
 - o Better Care for Individuals — 25 measures
 - o Better Health for Populations — 40 measures
- > 42 quality measures rely on additional reporting of data through Group Practice Reporting Option (GRPO)

There are 65 quality measures within five areas consistent with current CMS efforts

Aim	Domain	Examples
Better Care for Individuals	Patient/Caregiver Experience (7 Measures)	<ul style="list-style-type: none"> • Patients' Rating of Doctor • Getting Timely Care, Appointments, and Information
	Care Coordination (16 Measures) <ul style="list-style-type: none"> • Transitions • Information Systems 	<ul style="list-style-type: none"> • Readmission Rate • 30 day post-discharge Physician Visit • Medication Reconciliation • Percentage of PCPs Meeting Stage I HITECH • Meaningful Use Requirements
	Patient Safety (2 Measures)	<ul style="list-style-type: none"> • Health Care Acquired Conditions
Better Care for Populations	Preventive Health (9 Measures)	<ul style="list-style-type: none"> • Influenza Immunization • Colorectal Cancer Screening
	At-Risk Population (31 Measures) <ul style="list-style-type: none"> • Diabetes • Heart Failure • Coronary Artery Disease • Hypertension • COPD • Frail Elderly 	<ul style="list-style-type: none"> • Diabetes – Hemoglobin A1c • Diabetes – Foot Exam • Heart Failure – Patient Education on disease management • Coronary Artery Disease (CAD) – Oral Antiplatelet Therapy Prescribed for Patients with CAD • Hypertension (HTN) – Blood Pressure Control • COPD – Smoking Cessation Counseling • Frail Elderly – Screening for Fall Risk

Calculation of quality score for each measure



Score is measured as a percentile of FFS/MA rate or as a percentage, depending on the measure

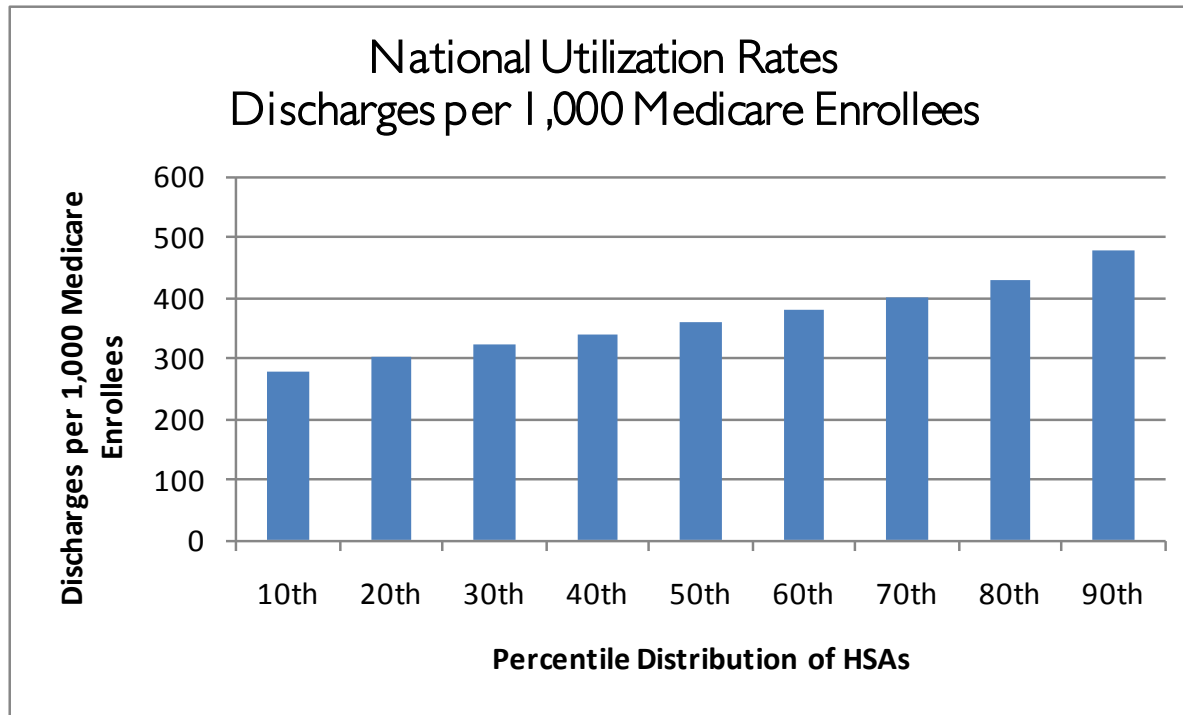
Source: Rope & Gray. "Measuring and Paying for Quality Under the Proposed ACO Rule and Lessons Learned from a Past Demonstration". May 4, 2011

Example Calculation after first year

Domain	Patient / Caregiver Experience	Care Coordination	Patient Safety	Preventative Health	At-Risk Population/ Frail Elderly Health
Measures (CMS may revise)	7 Measures	16 Measures	2 Measures	9 Measures	31 Measures
Total Possible Points	14 Points	32 Points	4 Points	18 Points	62 Points
Domain Score	$11.2 / 14 = 80\%$	$29 / 32 = 90\%$	$4 / 4 = 100\%$	$16.2 / 18 = 90\%$	0% (not minimum attainment for all measures)
Quality Performance Score Percentage	Average (80%, 90%, 100%, 0%) = 72%				
Quality Performance Savings Rate	72% * 50% one-sided maximum = 36%				
	72% * 60% two-sided maximum = 43%				

Source: Rope & Gray. "Measuring and Paying for Quality Under the Proposed ACO Rule and Lessons Learned from a Past Demonstration". May 4, 2011

Discharges per Thousand population is a key indicator



- > Admissions per thousand enrollees per year as they are distributed across the percentiles of Hospital Service Areas
- > The median is 360 discharges per 1,000

Source: Dartmouth Atlas of Healthcare, Hospital Discharges per 1,000 Medicare Enrollees, 2005

Financial Implications

Increasingly, providers need to focus on two levels of profitability

PROVIDER P&L

Revenue

Units x Payment/Unit

Expenses

Fixed Cost: (~60%)

Variable Cost:

Units x Expense/Unit

Profit (Loss)

POPULATION P&L

Revenue

Premium x Population

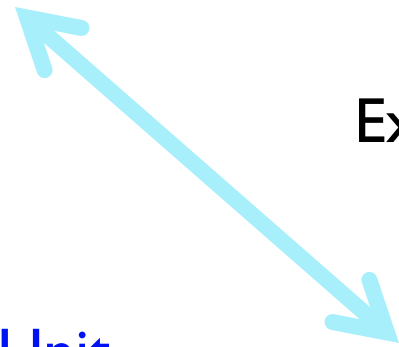
Expenses

Fixed Cost: (~10%)

Variable Cost:

Units x Payment/Unit

Profit (Loss)



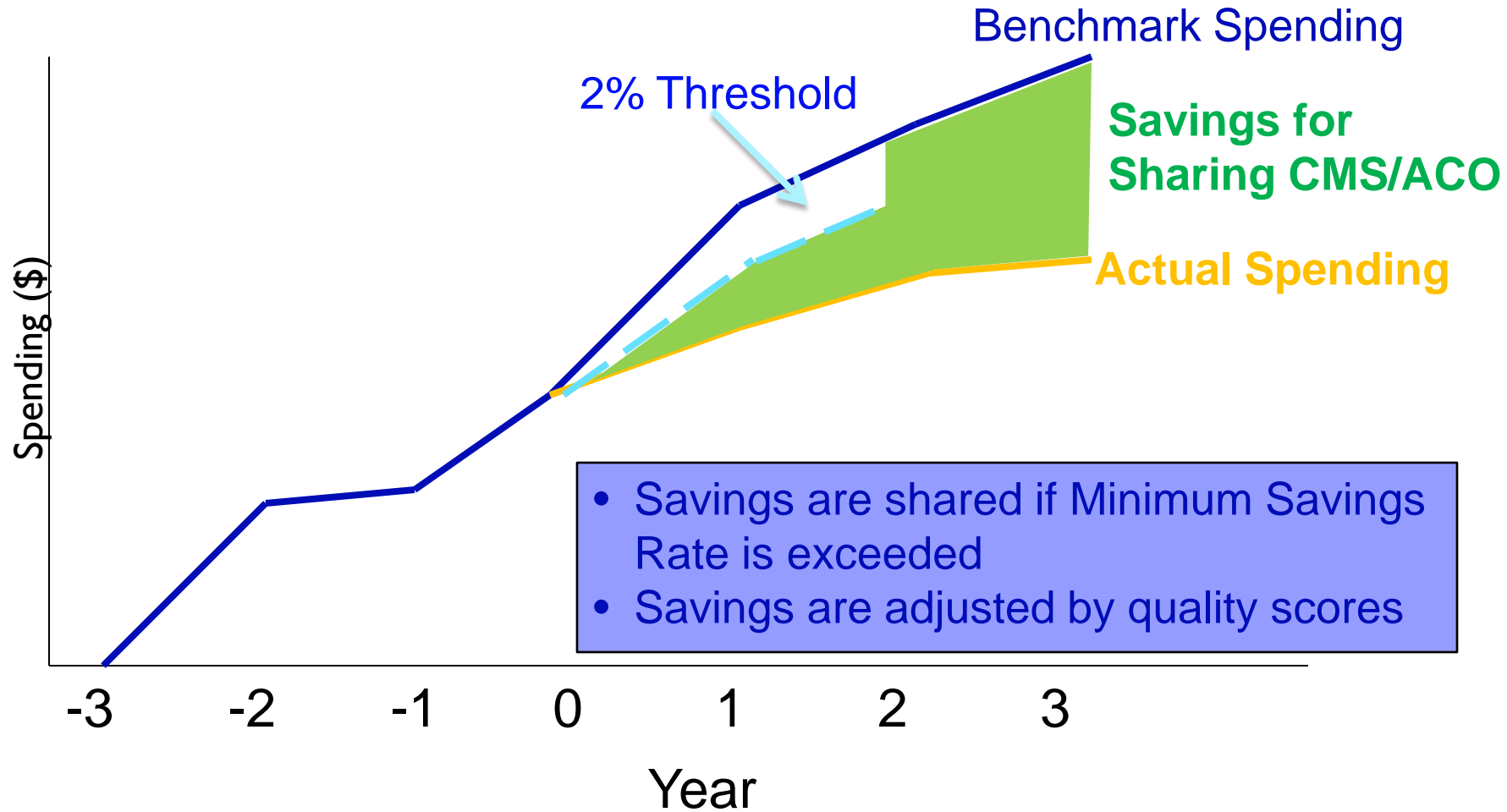
Think about different pots of money

	CMS Calculation of ACO Shared Savings	ACO Revenue Statement	Hospital/Physician Revenue Statement
Revenue	“Revenue” = Medicare Budget for ACO Population	Shared Savings	Patient Services + Share of ACO Surplus/Deficit
Expense	“Expense” = Total Spending for ACO Population (Hospital/Physician/ Other)	ACO Operations	Hospital/Practice Operations
Surplus / Deficit	Shared Savings \$	ACO Surplus/Deficit \$	Surplus/Deficit

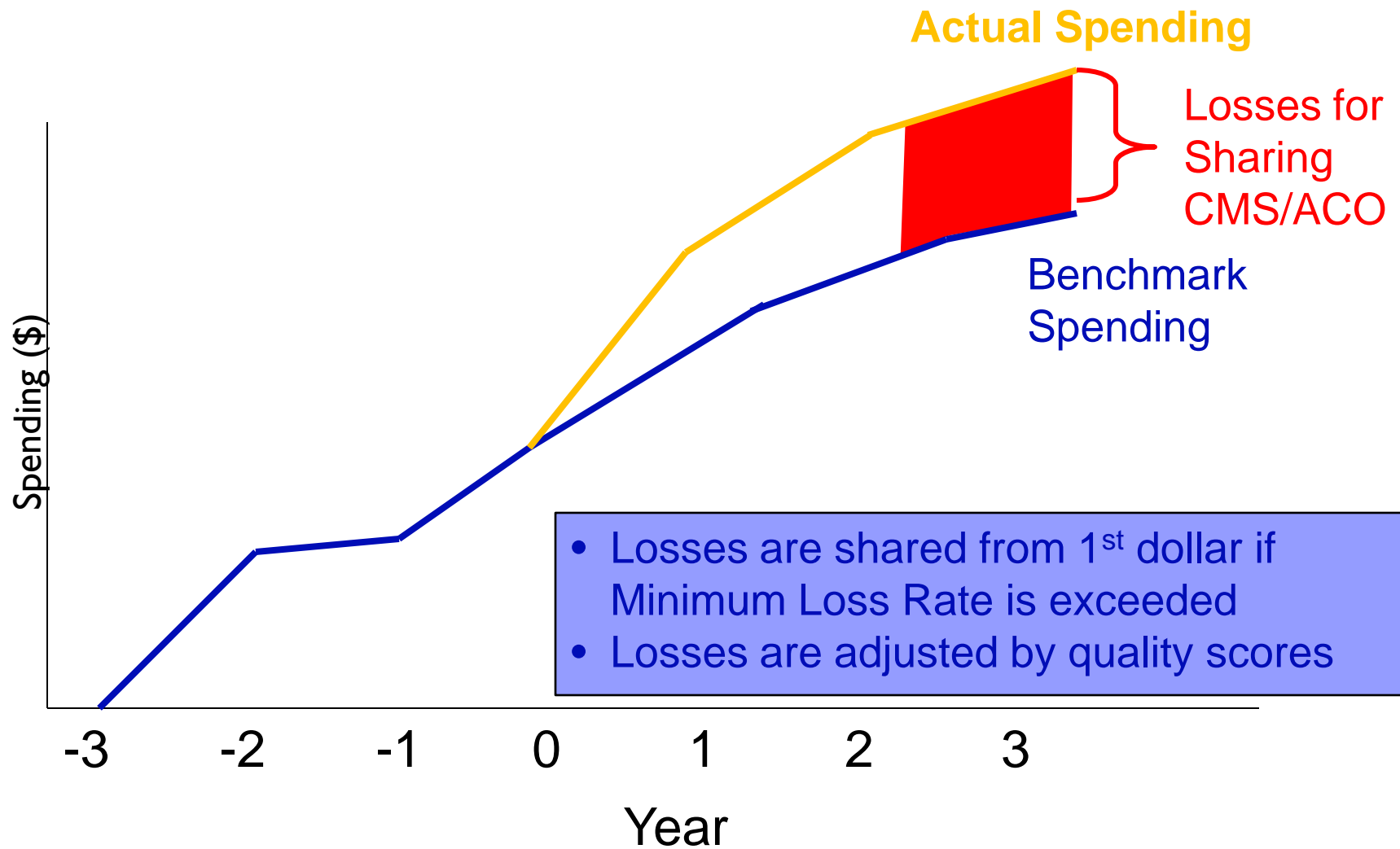
CMS

Physicians

Track 1- Optimistic Scenario



Track 1 – Pessimistic Scenario



The Medicare ACO opportunity can be sizeable

ACO Opportunity – Sample Calculation	
Population	290,000
Medicare Beneficiaries	45,500
Medicare Advantage Enrollees	5,500
Enrollees in Traditional Medicare	40,000
Estimate of Primary Care Physicians Who Will Align with the ACO	50%
Estimated ACO Members	20,000
Average Annual Spending per Member	\$10,000
Total Opportunity	\$200,000,000

Minimum savings rate (MSR) is lower (easier) for larger ACOs

ACO Membership	Minimum Savings Rate
5,000	3.9%
7,000	3.4%
10,000	3.0%
20,000	2.5%
50,000	2.2%
60,000+	2.0%

> Some exceptions apply

Potential share of savings

Change in Total Medicare Spending	Potential ACO Share of Savings	
	% of Total Spending	Annual Amount
Any Increase*	0%	\$0
Decrease <2%	0%	\$0
Decrease 4%	1%	\$2 million
Decrease 6%	2%	\$4 million

- > Shared savings would typically be applied to ACO operating costs, and then shared between physicians, hospitals, and others in ACO

* If costs higher during one-sided, must pay back before you get any shared savings in future years

Baseline: Shared savings calculation (in millions)

ACO Savings	\$10.0
CMS Cushion	(\$4.0)
Amount to be Shared Between CMS and ACO	\$6.0
Shared Savings to ACO (if 50/50)*	\$3.0
ACO Operating Costs	(\$1.0)
Net Savings for Sharing within ACO	\$2.0
Shared Savings Distributed to Hospital (if 50/50 with physicians)	\$1.0

* Assumes perfect quality score

Baseline: Impact on hospital net operating income (in millions)

Reduction in Hospital Revenue (10%)	(\$7.0)
Variable Costs (40%)	\$2.8
Impact on Hospital Operating Income Before Shared Savings	(\$4.2)

Baseline : Pursue ACO, but no market share gain
– Net Impact on Hospital

Hospital Share of Savings from ACO
+\$1.0 million

Impact on Hospital Operating Income
(\$4.2 million)

Net Impact on Hospital
(\$3.2 million)

- > Hospital – reduction of \$3.2 million
- > Physicians – additional income of \$1.0 million plus incentives

Scenario 1: Pursue ACO and retain 5% more inpatient cases at your hospital

Shared Savings Estimates

ACO Savings	\$10.0
CMS Cushion	(\$4.0)
Amount to be Shared Between CMS and ACO	\$6.0
Shared Savings to ACO (if 50/50)	\$3.0
ACO Operating Costs	(\$1.0)
Net Savings for Sharing Within ACO	\$2.0
Shared Savings Distributed to Hospitals (if 50/50 with physicians)	\$1.0

Hospital Impact

Reduction in Hospital Revenue	(\$2.5)
Variable Costs (40%)	\$1.0
Impact on Hospital Operating Income Before Shared Savings	(\$1.5)


$$\mathbf{\$1.0 \text{ million} + (\$1.5 \text{ million}) = (\$0.5 \text{ million})}$$

- > Hospital – reduction of \$0.5 million
- > Physicians – additional income of \$1.0 million

Scenario 2: Pursue ACO and retain 10% more inpatient cases at your hospital

Shared Savings Estimates

ACO Savings	\$10.0
CMS Cushion	(\$4.0)
Amount to be Shared Between CMS and ACO	\$6.0
Shared Savings to ACO (if 50/50)	\$3.0
ACO Operating Costs	(\$1.0)
Net Savings for Sharing Within ACO	\$2.0
Shared Savings Distributed to Hospitals (if 50/50 with physicians)	\$1.0

Hospital Impact

Gain in Hospital Revenue	\$2.0
Variable Costs (40%)	(\$0.8)
Impact on Hospital Operating Income Before Shared Savings	\$1.2


$$\mathbf{\$1.0 \text{ million} + \$1.2 \text{ million} = \$2.2 \text{ million}}$$

- > Hospital – increase of \$2.2 million
- > Physicians – additional income of \$1.0 million plus incentives

Scenario 3: Pursue ACO and retain 5% more inpatient cases at your hospital, but no reduced utilization and no shared savings

Shared Savings Estimates

ACO Savings	\$0.0
CMS Cushion*	
Amount to be Shared Between CMS and ACO	\$0.0
Shared Savings to ACO (if 50/50)*	\$0.0
ACO Operating Costs	(\$1.0)
Net Savings for Sharing within ACO	(\$1.0)
Shared Savings Distributed to Hospitals (if 50/50 with physicians)	(\$0.5)

Hospital Impact

Gain in Hospital Revenue	\$5.0
Variable Costs (40%)	(\$2.0)
Impact on Hospital Operating Income Before Shared Savings	\$3.0

$$(\$0.5 \text{ million}) + \$3.0 \text{ million} = \$2.5 \text{ million}$$

- > Hospital – increase of \$2.5 million
- > Physicians – no additional income; may owe a share of the cost of ACO operations; receive incentives along the way

Medicare ACO net impact on hospitals will depend more on market share than shared savings

- > Due to high fixed costs at hospital, reduced utilization rate and volume has a significant financial effect
- > Increasing market share can offset utilization reductions
 - o More PCPs in the ACO and referring to the hospital
 - o Reduced “leakage” to competing hospitals through the “gentle steering of better coordinated care”

Medicare ACO strategy may tie to broader strategies

- > ACO or P4P contracts with commercial health plans
- > Narrow network insurance products
- > Engaging physicians to better manage hospital costs (through evidence based protocols)
- > Physician Alignment: Physicians may benefit from additional payments for managing care as well as shared savings

Who Should Pursue ACOs And When

What are the issues a hospital must consider

- > Why do an ACO at all?
 - o Form one or join one?
 - o Scale really matters
- > With whom to partner — hospitals, primary care physicians?
 - o Look for the winners or else everyone loses

What are the issues a hospital must consider

- > Appropriate contract that is being sought — one sided or two sided?
- > What is the appropriate legal structure and governance
- > How will the ACO be capitalized?
- > If two-sided, how to get doctors to repay losses?
- > Security/Collateral for losses

Consider an ACO soon IF

- > It fits your broader vision
- > Competitors force your hand
- > You are a large player who can lead the market
- > You are a hospital that employs physicians
- > Final rule is significantly better than proposed rule

QUESTIONS

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