Accountable Care Organizations
Opportunities and Challenges

October 12, 2010—Web Seminar

Welcome & Program Overview

Liz Mekjavich
California Hospital Association

Agenda

- Health Care Reform—The Big Picture
  - *C. Duane Dauner, President/Chief Executive Officer, California Hospital Association*
- The Political Context and ACO Program Overview
- Strategic Issues Hospitals Should Consider
- State of Play—What Comes Next?
  - *Bruce Merlin Fried, Esq. Partner, SNR Denton*
  - *Mark Hamelburg, Esq, Partner, SNR Denton*

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Health Care Reform—The Big Picture

C. Duane Dauner
California Hospital Association

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Faculty: Bruce Merlin Fried

Mr. Fried is a partner in SNR Denton's Health Care and Public Law and Policy Strategies practice. He has been recognized by *Chambers USA* and *Expert Guides* as one of the leading health care attorneys in the US. Bruce is a health care law and policy expert who counsels and represents health plans, physician organizations, hospital groups, consumer organizations, health care information technology and data companies, pharmaceutical and biotech companies and other health care organizations with regard to Medicare, Medicaid, HIPAA and other federal health care programs and policies.

Bruce has more than thirty years of experience in health care law and policy, both in the public and private sectors. He served as the Health Care Financing Administration's (HCFA, now CMS) Director of the Center for Health Plans and Providers where he was responsible for policy and operations for the Medicare program.

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Faculty: Mark Hamelburg

Mr. Hamelburg has almost twenty years of health law experience in a variety of settings and specialties. Mark's primary focus is on the Medicare Prescription Drug and Medicare Advantage programs.

Prior to joining SNR Denton in 2009, Mark served as director of the Medicare Part C and Part D Analysis Group in the Office of Legislation at the Centers for Medicare and Medicaid Services (CMS) in the US Department of Health and Human Services. In this capacity, he focused on legislative and regulatory matters involving the prescription drug programs and other issues involving private health insurance including the development and analyses of various legislative and regulatory proposals, technical assistance to Congressional staff, preparation of agency witnesses for testimony and strategic planning on a range of issues.

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Accountable Care Organizations Opportunities and Challenges

A webinar for the
California Hospital Association

October 12, 2010

Bruce Merlin Fried, Esq.

Mark Hamelburg, Esq.

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Political Context and ACO Program Overview

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Background

- For Government: Bend the cost curve…or else.
  - –Must move from payment methodologies that incent utilization and a fragmented delivery systems to systems that reward high clinical performance, efficiency and coordinated systems of care
- ACOs are but one strategy among other "value" propositions: bundled payments, value-based purchasing, etc.
- The last alternative to a single payor system?

Why ACOs?

- For Medicare, the best (last?) chance to effectively control the growth of Part A and B
- ACOs provide an opportunity for managed care strategies to be deployed by providers rather than insurers
- Incent investment in infrastructure (human, IT, systems) and redesigned care processes
- ACOs enjoy bi-partisan political support

ACO Program Overview

- Under the Affordable Care Act:
  - –Groups of providers implement legal, leadership and management structure
  - –Agree to become responsible for the full continuum of care for Medicare FFS beneficiaries
  - –Accountable for overall costs and quality

ACO Program Overview *continued*

- Medicare ACOs can be organized by:
  - –ACO professionals in group practice arrangements
  - –Networks of individual practices of ACO professionals
  - –Partnerships or joint venture arrangements between hospitals and ACO professionals
  - –Hospitals employing ACO professionals
  - –Such other groups of providers of services and suppliers as the Secretary determines appropriate

ACO Program Overview *continued*

- Medicare compensates ACOs for:
  - –Achieving cost control,
  - –Meeting quality metrics,
  - –Promoting evidence-based medicine and patient engagement,
  - –Coordinating care, and
  - –Using patient-centeredness criteria

ACO Program Overview *continued*

- Additional requirements include:
  - –Sufficient number of primary care professionals to care for assigned beneficiaries
  - –At least 5,000 assigned beneficiaries
  - –Complying with CMS reporting obligations
  - –A leadership and management structure
  - –Clinical and administrative systems

Fact v. Fiction

- ACO participation is voluntary, not mandatory, for providers and beneficiaries
- Beneficiaries are assigned, not enrolled
- The ACO program is a permanent part of Medicare, not a demonstration or pilot program
- Beneficiaries may choose to use any Medicare provider; they are not locked into an ACO
- The ACO program is effective January 1, 2012. No regulations have been proposed. Nothing has been approved by CMS
- However, infrastructure and care processes can and already have been encouraged by some commercial payers

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Strategic Issues for Hospitals to Consider

Key Unknowns

- What will the regulations say about…
  - –Assignment of beneficiaries
  - –Permissible incentives to encourage use of ACO providers
  - –Design flexibility
  - –Accounting for “out-of-network” use
  - –Marketing by ACOs?

Key Unknowns *continued*

- Shared savings v. partial capitation
- Savings structures
  - –Calculation of savings and payments
  - –Re-setting of the benchmark every three years
  - –Risk adjustment
- Quality metrics and reporting
  - –Required metrics
  - –Reporting requirements

Key Unknowns *continued*

- Key consideration: measurement/reporting costs v. potential shared savings
- Short-term v. long-term considerations
- Center for Medicare/Medicaid Innovation as potential ACO Incubator, source of capital

Key Unknowns Regarding Legal Issues

- Antitrust
  - –Competing concerns
    - Consolidation v. coordination
    - Reduced competition v. improved quality and reduced cost
  - –FTC clinical integration guidance
  - –October 5, 2010 panel discussion

Key Unknowns Regarding Legal Issues *continued*

- Fraud, waste and abuse laws
  - –Physician self-referral (Stark) law
    - ACO arrangements may create direct or indirect compensation arrangements between participating hospitals and physicians
    - A physician cannot refer Medicare patients to a hospital with which it has a "financial relationship" unless an exception applies
      - –The "indirect compensation arrangements," "risk sharing" and/or other exceptions may apply
      - –An ACA "waiver" may provide some protection
    - Analyze carefully: strict liability statute

Key Unknowns Regarding Legal Issues *continued*

- Fraud, waste and abuse laws
  - –Anti-Kickback Law
    - Payments to "induce" (i.e., in exchange for) referrals of federal program patients violate the AKL
    - ACO arrangements involve payments between and among referral sources
    - So:
      - –No "quid pro quos"
      - –Safe harbor arrangements where you can (health plan safe harbor, personal services safe harbor, etc.)
      - –Analyze the risk
      - –Consider obtaining an OIG advisory opinion

Key Unknowns Regarding Legal Issues *continued*

- Fraud, waste and abuse laws
  - –Services reduction civil monetary penalties (CMP) law
    - Generally prohibits hospitals from paying physicians to reduce or limit services for Medicare beneficiaries
    - If shared savings (or other) payments provide such an incentive, CMP could be implicated
    - Potential solutions:
      - –Avoid payments from hospitals to physicians
      - –Avoid payments from hospitals to physicians that implicate law (i.e., provide incentives to reduce/limit services)
      - –Obtain ACA waiver

Key Unknowns Regarding Legal Issues *continued*

- Other
  - –Regulation as a Risk Bearing Entity
    - The Role of DMHC?
  - –Use of Medicare Part A and B funds for non-covered benefits, services?

Implications for Rural Hospitals

- Can "provider managed care" work any better than "insurer managed care" in rural areas?
- Can technology/telehealth overcome the lack of bene/provider concentration in rural areas?
- Providers – Why bother?
- Beneficiaries – Will ACOs matter?
- Costs for launch v. savings to be shared?

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State of Play

State of Play

- CMS key players
  - –Dr. Don Berwick, CMS Administrator
  - –Jonathan Blum, Deputy Administrator, Center for Medicare
  - –Dr. Rick Gilfillan, Acting Director, Center for Medicare/Medicaid Innovation
  - –Performance Based Payment Policy Staff, Center for Medicare
  - –Medicare Demonstrations Program Group, Office of Research, Development and Information

State of Play *continued*

- General Observations about regulatory process, what comes next
- CMS meetings (past and upcoming)
  - –Government interests: payment methodology, antitrust, fraud and abuse, beneficiary assignment, consumer group concerns
- Timing of regulations – End of Year?

State of Play *continued*

- Other HHS office involvement
  - –Peter Lee, Office of Delivery System Reform
  - –OIG?
- White House involvement (including staff with CA connections)
  - –Nancy Ann Deparle
  - –Zeke Emanuel
- FTC involvement

What Should Hospitals Do Now?

- Monitor policy developments closely
- Where does an ACO fit in your larger strategic plan and core mission?
- Consider the larger strategic issues in your marketplace
  - – Achieving "value" will be required whether as an ACO or not
  - – Relations with physicians and physician groups will be critical
  - – What role for payors, both employers and insurers
- Be ready for all possibilities
- Appoint a leader who will "own" the range of issues
  - – How will your hospital position itself for the future, with our without an ACO

What Should Hospitals Do Now?

- **The ACO is a new line of business so…**
  - **Prepare a business plan**
    - What is the opportunity
    - What is the strategy for the ACO to seize the opportunity
    - What hospitals – physicians - other providers will be "inside" the ACO
    - How will the ACO share savings among the partners?
    - How will the ACO coordinate care, deliver quality, achieve savings?
    - What staff will be required? IT systems?
    - Project a three-year budget
    - Project various revenue models
    - If capital is needed, where will it be found
    - Can it work?

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Thank you

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Questions

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Web Seminar Evaluation

Thank you for participating in today's seminar.
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For questions regarding accountable care organizations contact Anne McLeod at (916) 552-7536 or amcleod@calhospital.org.

For education questions, contact Liz Mekjavich at (916) 552-7500 or lmekjavich@calhospital.org.

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