

Accountable Care Organizations

Medical Society of New Jersey

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OVERVIEW
SHARED SAVINGS PROGRAM
&
ACOs

Shared Savings Program



- **PPACA established a “Shared Savings Program”:**
 - **Promote accountability for Medicare beneficiaries**
 - **Improve coordination of FFS items/services under Medicare Parts A & B**
 - **Encourages investment in infrastructure and re-designed care processes for high quality and efficient service delivery**
 - **Incent higher value care**
- **Providers work together to manage and coordinate care for Medicare fee-for-services beneficiaries through “Accountable Care Organizations”**

Shared Savings Program

3-Part Aim

- **Better care for individuals**
 - **Safety**
 - **Effectiveness**
 - **Patient-centeredness**
 - **Timeliness**
 - **Efficiency**
 - **Equity**
- **Better health**
 - **Education**
 - **Preventive services**
- **Lower growth in expenditures**

What is an ACO?

- An accountable care organization (ACO) is a *legal entity* recognized and authorized under applicable State law, as identified by a *Taxpayer Identification Number (TIN)*, and comprised of an “*eligible group of ACO participants*” that work together to manage and coordinate care for Medicare fee-for-service beneficiaries and have established a mechanism for “*shared governance*” that provides all ACO participants with an appropriate proportionate control over the ACO’s decision-making process.

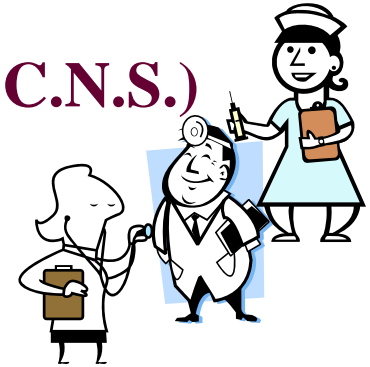




ACO FORMATION

What is an “Eligible Group of ACO Participants”?

1. **ACO professionals (M.D., D.O., P.A., N.P., C.N.S.) in a group practice arrangement**
2. **Network of individual practices of ACO professionals**
3. **Partnership or joint venture arrangement between hospitals and ACO Professionals**
4. **Hospital (Acute care) employing ACO professionals**
5. **Providers/suppliers designated by the Secretary**



Legal Structure



- **Corporation, partnership, LLC, foundation or other entity**
- **No need to form new entity if:**
 - **Existing entity meets eligibility requirements**
 - **Able to receive and distribute savings to participants**
 - **Maintains shared governance**
- **Concern that an existing entity may be difficult to audit and assess performance**

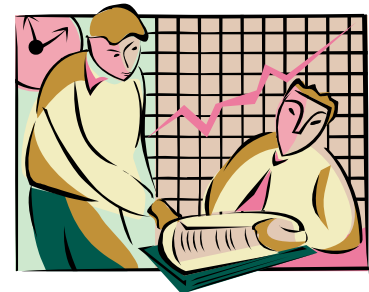
What is “Shared Governance”?

- **ACOs are to be Provider Driven and Patient Centered**
 - **ACO participants must have at least 75% control of the governing body**
 - **Each participant chooses a representative within its organization**
 - **Must have at least 1 Medicare beneficiary**



ACO Must be Capable of:

- **Receiving and distributing shared savings**
- **Repaying shared losses**
- **Establishing, reporting and ensuring ACO participants & providers comply with program requirements (including quality standards)**
- **Perform other ACO functions (including shared governance)**



ACO Goals

- **Beneficiary/family at the Center of all its activities**
- **Ensure coordination of care**
- **Attend carefully to care transitions**
- **Manage resources carefully/respectfully**
- **Patient reminders/advice**
- **Collect, evaluate and use data on processes/outcomes**
- **Use of IT, advanced models of care**
- **Invest in the development of its workforce**





Leadership and Management Including Clinical & Administrative Systems

- **Operations managed by Executive whose appointment/removal controlled by governing body**
- **Senior level Medical Director, licensed + board certified in the state where ACO is located**
- **Participants/Providers must have a meaningful commitment to ACO's clinical integration, i.e., financial or human investment**
- **Physician-directed quality assurance & process improvement committee**
- **Implement evidence-based medical practice clinical guidelines and processes for care delivery**
- **Participants/providers subject to performance evaluation and remedial action**
- **IT including EHR infrastructure**

ACOs and Primary Care Physicians

- **3-year commitment to CMS by ACO and by each Provider**
- **Must have a sufficient # of PCP with a minimum of 5,000 beneficiaries**
- **Each PCP assigned to 1 ACO, specialists can be attached to more than 1 ACO**



ACO PROCESSES

Required Processes

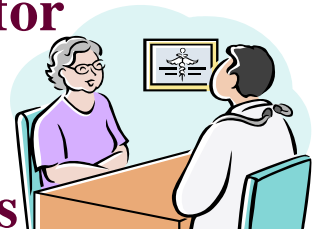
- **Promote evidence based guidelines – regular assessment and updating for continuous quality improvement**
- **Measures to promote patient engagement in decision making**
- **Internally report on quality and cost measures**
- **Coordination of care: telehealth, case manager, transition of care program, EHR**



Focus is on Patient Centeredness

■ Criteria

- **Beneficiary experience of care survey**
- **Patient involvement in ACO governance**
- **Evaluate the health needs of assigned population**
- **Identify high-risk patients and develop individual care plans**
- **Shared decision making with patients to account for individual needs, preferences, values**
- **Coordination of care**
- **Communicate evidence based medicine to patients**
- **Patient access and communication /access to records**
- **Internal process to measure clinical and/or service performance by physician**



ACO Must Describe to CMS

- How it will use shared savings payments, including criteria for distribution to participants
- How it will achieve its goals
- How it will achieve general aim of better care to individuals, better health for population and lower expenditures





Assignment of Medicare Beneficiaries

- Patients assigned to an ACO in retrospect based on plurality of their primary care services at the end of each performance year
- Plurality determined by the sum of allowed charges from PCP
- ACO will not know whose care they are managing
- ACO (not provider) is responsible for patient care management and quality of all Medicare FFS patients not just those assigned to ACO
- Patients free to seek care anywhere outside of the ACO and ACO cannot limit care to ACO providers





PAYMENTS AND TREATMENT **OF SAVINGS**

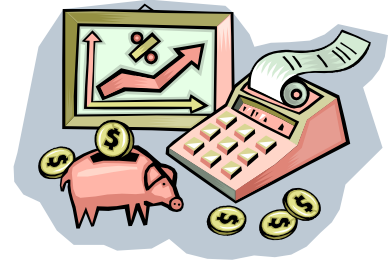
Payment Models

- **All providers continue to receive fee-for-service payments**

- **Shared savings model**

- **CMS establishes a benchmark for ACO based on 6 months claims run out**
- **Using claims data, CMS computes per capita expenditures for the year – adjusted for growth and health status**

- **PQRI Payments to ACO**



Eligibility for Shared Savings

- **Meet all contractual requirements of ACO Agreement with CMS**
- **Meet the quality performance standards**
- **Realize savings compared to the Expenditure Benchmark that exceeds the Minimum Savings Ratio**

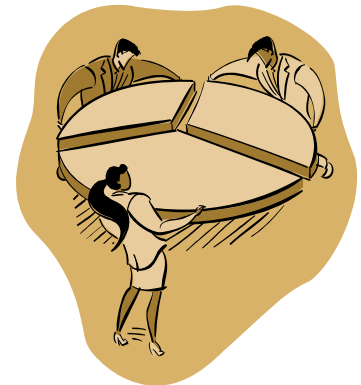
Two Financial Risk Sharing Models

1. 1-Sided Risk Model

- Share only in savings for Years 1 & 2
- Year 3, share in both savings and losses (if costs exceed Medicare benchmark)
- Higher reimbursement in year 3
- Cap on both savings and losses

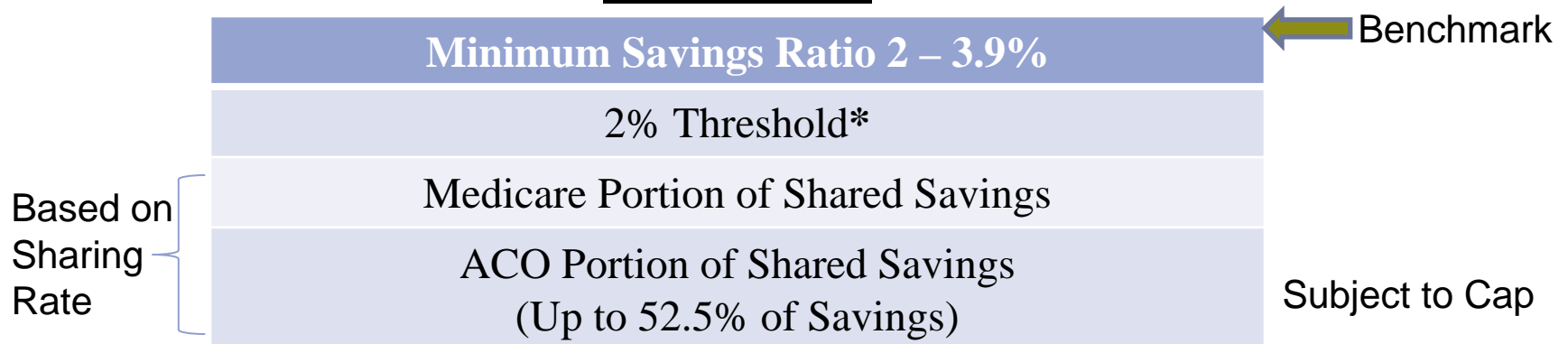
2. 2-Sided Risk Model

- Share in savings and losses from Year 1
- Greater reimbursement for savings
- Higher cap on savings and smaller cap on losses



Shared Savings

1-Sided Model



*Waived if: All ACO Participants are physicians; or
75% of beneficiaries reside in counties outside MSA
or 50% had 1+ encounters with a FQHC or RHC

Treatment of Savings/Loss

	<u>1-Sided</u>	<u>2-Sided</u>
Maximum Savings Ratio	<u>52.5% of Savings</u>	<u>65% of Savings</u>
Quality Performance Sharing Rate	Up to 50%	Up to 60%
If FQHC/RHC participate in ACO	Up to 2.5%	Up to 5%
Minimum Savings Ratio	3.9 – 2% Based on # of beneficiary assigned	Flat 2%
Minimum Loss Ratio	None – Year 1/2	2%
Maximum Savings Cap	7.5% of its Benchmark	10% of its Benchmark
Shared Savings	Once MSR met, unless exempted, share of savings net of 2% threshold; up to 52.5% of Net savings up to Cap	Once MSR shared savings excluded; up to 65% of gross savings up to Cap
Maximum Shared Loss Cap.	Year 3 = 5%	Year 1 = 5%
		Year 2 = 7.5%
		Year 3 = 10%

Quality of Care Measures

- **CMS to select Quality Measures to be reported by ACO**
- **Grouped into 5 domains:**
 - **Patient/caregiver experience**
 - **Care coordination**
 - **Patient safety**
 - **Preventative health**
 - **At risk population/frail elderly health**



Quality Performance Measurements

- **CMS to designate measures including performance benchmarks and minimum attainment levels & a point scale for certain measures**
- **1st Year: Complete and Accurate Reporting**
- **Subsequent Years: measure scores**
- **Must report all measures within a domain**
- **CMS scores individual measures & adds them up within a domain**
- **Must attain the minimum level of all measures within a domain**
- **Will receive payment if ACO satisfies the quality measures for 1+ domains + realizes shared savings**

Payment of Losses to CMS

- **Losses to be paid within 30 days of notice**
- **CMS to withhold 25% of any savings payments (to be paid at end of 3 year agreement)**
- **ACO must:**
 - **Obtain reinsurance**
 - **Place funds in escrow**
 - **Obtain surety bond**
 - **Line of credit**
 - **Some other mechanism**



Downside Risk Exception

Example:

- Benchmark = \$8000 per capita per assigned beneficiary
- Cap = 5% (Year 1)
- \$800 annual per capita losses

<u>Sharing Rate</u>	<u>Annual Per Capita Loss</u>	<u>1st Year Cap (5%)</u>	<u>Payment Due CMS</u>
40%	$\$800 (1 - .4) = \480	$\$8000 \times .5 = \400	\$400

DATA SHARING

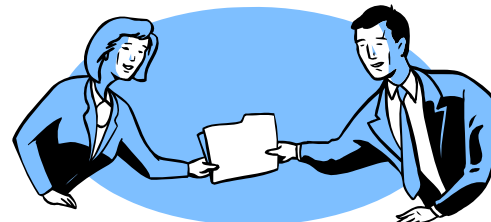
Data Sharing

- **ACO needs data to be accountable for care**
- **CMS will share aggregate and beneficiary identifiable data**



Sharing Aggregate Data

- **CMS to provide de-identified data at the start of the agreement & each quarter based on 12 month data for beneficiaries that could be assigned to ACO**
- **To provide financial performance, quality performance scores, aggregate numbers on the assigned beneficiary population, utilization data used to determine benchmarks**



Historically Assigned Beneficiaries

- Upon request, CMS will disclose name/DOB/sex & HIC of historically assigned beneficiaries
- At beginning of Agreement & at the end of each performance period to generate 3 year benchmark
- Will enable ACO's to review records and identify care processes that may need to change & improve care coordination strategies



Sharing Beneficiary Identifiable Data

- **CMS will also provide, upon request, monthly claims data with potentially assigned beneficiaries**

- **ACO to use data to:**

- **Evaluate provider performance**
- **Perform quality assessment/improvement activities**
- **Conduct population-based activities relating to improved health**



Sharing Beneficiary Identifiable Data

- **Beneficiary Option to Opt-Out of Data Sharing**



- **ACO must inform beneficiary that it may request information and how it will be used**

- **PCPs to provide opt-out form for beneficiary**





CMS MONITORING AND **TERMINATION**

Monitoring of ACO's

- **CMS to monitor & assess performance of ACOs and their providers:**
 - **Avoidance of at-risk beneficiary, “Cherry Picking”**
 - **Ability to meet quality performance standards**
 - **ACO eligibility**
 - **Beneficiary notice of data sharing**
 - **Marketing materials - activities**



CMS Actions Prior to Termination

- **Written warning of specific performance issue**
- **Request a Corrective Action Plan (CAP)***
- **Place ACO on monitoring Plan**



***Not eligible to receive shared savings if under a CAP**

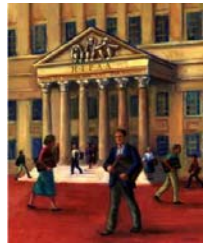
Grounds for ACO Termination

- **Avoidance of at-risk beneficiary**
- **Failing to meet quality performance standards**
- **Fail to accurately/complete information or to make timely corrections**
- **Failure to meet eligibility requirements**
- **Failure to make required changes after given opportunity for a CAP**
- **Failure to notify Beneficiary of ACO provider participation**
- **Noncompliance with public reporting or other requirements**
- **Failure to submit CAP, failure to implement CAP, or failure to demonstrate improved performance under CAP**



Grounds for CMS to Terminate an ACO

- **Violation of Stark, Anti-kickback, CMP or other Anti-fraud, Anti-trust or other applicable laws**
- **Submits false, inaccurate or incomplete data**
- **Uses non-approved marketing materials**
- **Failure to maintain a beneficiary population of at least 5000**
- **Failure to offer beneficiaries the option to opt-out**
- **Limiting or restricting internally compiled summary of care or medical records from other providers**
- **Improper use/disclosure of claims information from CMS in violation of HIPAA or other State privacy laws**
- **Failure to show or maintain resources to repay losses**



Reconsideration Review Process

- **ACO cannot seek reconsideration/appeal of the following:**
 - **Quality/performance standards**
 - **Assessment of Quality of Care by ACO/failure to meet**
 - **Assignment of beneficiaries**
 - **Eligibility or amount of shared savings**
 - **Determination that anti-trust agency will challenge the ACO**

- **2 levels of review: reconsideration and “on the record” review during which ACO can operate**





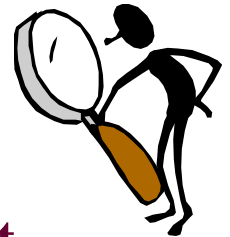
FRAUD & ABUSE ANTI-TRUST

Fraud and Abuse Issue

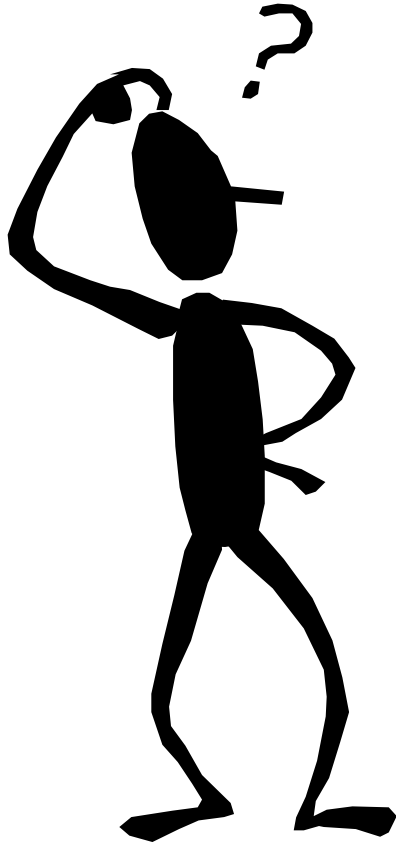
- **All ACO's must have a compliance plan**
- **Stark/Anti-kickback waived for:**
 - **Shared savings payments to participants/providers**
 - **Activities necessary for/ related to ACO participation & operations**
- **CMP waived for shared savings distributions from hospitals to providers (if both ACO participants) provided payment is not to reduce or limit medically necessary services**

Anti-Trust

- **Concern is for Powerful ACOs**
- **Different requirements for ACOs based on Primary Service Area Share (PSA) for a “common service”**
- **ACO to perform detailed analysis of PSA Share (lowest # of zip codes where it draws 75% of patients)**
 - **If exceeds 50%, mandatory FTC review**
 - **If 30% or under and non-exclusive (able to contract directly with payors or through other ACOs) – safety zone**
 - **If 31 – 50%, “limbo”:** have the option to seek FTC review, but could be excluded if anti-trust concerns identified



QUESTIONS??



QUESTIONS



QUESTIONS



**Are there any
QUESTIONS**

