How To Pinpoint ACOs Prime For Partnership

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PRESENTATION OUTLINE

- Why ACOs?
- ACO Program Mechanics
- The ACO Marketplace
- Costs and Benefits of Contracting with ACOs
- Why Payors May Be Essential to ACOs
- Legal and Financial Risks of ACOs
- Identifying the Right ACO Partner

"The accountable care organization is like a unicorn, a fantastic creature that is vested with mythical powers. But no one has actually seen one."

- Mark Smith, M.D., M.B.A., President and CEO of California Healthcare Foundation

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WHY ACOs?

Why ACOs?

- Medicare is predicted to go bankrupt in 2017.
- The Center for Medicare and Medicaid Services (CMS) has battled increasing costs through cutting reimbursements to providers.
- Accountable care organizations (ACOs) are intended to use another strategy to "bend the cost curve":
  - Move away from paying for fee for services (FFS) to rewarding health care providers for savings on costs.
  - The Medicare Shared Savings Program (MSSP) is expected to save Medicare $960 million over the first three years.

Why ACOs?

- "HMOs on steroids"
- "Accountant and consultant opportunity"
- Driven by what Ellis M. "Mac" Knight (Palmetto Health) calls the 4 Ps:
  - Patients
  - Providers
  - Payors

  - Politicians
- He might have added a 5th P – perspective.

Why ACOs?

- ACOs, if they prove financially feasible, may revolutionize our perspective on patient care
  - FFS replaced by payments driven by savings and value
  - Quality of care instead of quantity of services
  - Emphasis on wellness as opposed to emphasizing acute care
  - Collaboration among service providers v. legal limitations on collaboration
  - Coordinated care through one entity instead of individual treatments from separate providers

ACO PROGRAM MECHANICS

ACO Program Mechanics

- Medicare will start contracting with ACOs in January 2012.
- ACOs have a 3-year contract with CMS.
- 65 quality measures:
  - patient/caregiver experience of care
  - care coordination
  - patient safety
  - preventative health
  - at-risk population/frail elderly health

ACO Program Mechanics

- ACOs report measures in first year and are evaluated on measures in second and third year.
- Failure to meet threshold on any measure makes the ACO ineligible for shared savings in that year.
- 2-sided savings
  - ACO gets 60% above 2% savings threshold
  - Risk of loss all 3 years

ACO Program Mechanics

- 1-sided savings
  - 50% above 2% threshold
  - Risk of loss in only year 3
- 25% of shared savings will be withheld to ensure that future losses are repaid.
- Patients will be assigned to ACOs retrospectively to keep the ACOs from cherry picking.
  - Planning will be difficult because target costs and performance benchmarks can realistically be done only if the patient population is known in advance.

ACO Program Mechanics

- Savings are based on coming in under anticipated costs.

- Primary care physicians may be part of only one ACO. Specialist physicians, long-term and home care providers, hospitals, and ambulatory surgery centers may be part of more than one and may contract with other commercial payors.
- At least 50% of the physicians in an ACO must demonstrate "meaningful use" of electronic health records by January 1, 2013.
- ACO applicants much state how they would repay CMS for losses.
  - e.g., through escrow, line of credit, surety bond, or reinsurance

ACO Program Mechanics

- Failure to show that the ACO has the resources to cover losses is a ground for CMS to terminate the ACO contract and keep the shared savings.
- When the regulations were released and the downside risk became clear, Vince Kuraitis – a healthcare consultant in Idaho – cut his estimate of the number of ACOs from 750 - 1,000 to 75 – 150.

THE ACO MARKETPLACE

The ACO Marketplace

Possible ACO configurations:

- Professionals in group practices.
  - Professionals include physicians, physician assistants, nurse practitioners, and clinical nurse specialists.
- Networks of individual practitioners.
- Joint ventures between hospitals and professionals.
- Hospitals employing professionals.
- Critical access hospitals that submit Medicare bills for both professionals' services and the facility itself.

The ACO Marketplace

Possible ACO configurations:

- Hospitals not necessary for ACOs.
- Neither federally qualified health centers nor Rural Health Centers may form ACOs without other eligible partners.

The ACO Marketplace

Quasi-ACO Examples:

- Superior Health Partners, a collaboration between Marquette General Hospital and Bell Hospital, in the Upper Peninsula of Michigan.
  - Planning to apply for ACO status.
  - Goals
    - Serve an expanded patient population;
    - Collaborative effects to recruit physicians;
    - Joint operational expense management; and
    - Develop strong IT infrastructure.

The ACO Marketplace

Several provider/payor alliances are being formed on the ACO model:

- Franciscan Alliance (an integrated health system headquartered in Indianapolis, Indiana) has contracted with Anthem Blue Cross and Blue Shield to serve 28,000 Medicaid beneficiaries.
- CIGNA has a similar arrangement with Piedmont Physicians Group (Atlanta), covering 10,000 members of CIGNA and involving over 100 physicians.
- Anthem Blue Cross Blue Shield launched an ACO pilot with Dartmouth –Hitchcock Medical Center, the biggest healthcare provider in New Hampshire, under which the hospital and physicians would manage costs and quality of care for a segment of Anthem's membership.

The ACO Marketplace

The Carillon Clinic

- Biggest provider in southwestern Virginia
- Developing an ACO with Aetna
  - Aetna will provide administrative services – for a fee – to oversee Medicare Advantage.
  - Aetna will be the administrator of Carillon's employee health benefit plan.

The ACO Marketplace

- Blue Cross Blue Shield of Massachusetts launched the Alternative Quality Contract in January 2009.
  - Providers are paid for caring for a patient over a set time period.
  - Under this payment arrangement, quality goals are mandated and budget increases for providers are limited.
  - In the first year of the program, every participating provider earned substantial quality bonuses.

COSTS AND BENEFITS OF CONTRACTING WITH ACOs

Costs and Benefits of Contracting with ACOs

Xcenda polled managed care advisors to get a payor perspective on ACOs.

- 20% were already contracting with an ACO.
- More than 1/3 planned to within the next year.
- Of those that had or planned to have an ACO contract in the next year:
  - 91% expected their biggest challenge to be creating payment incentives for every provider in the ACO.
  - 76% said that the main benefit would be having a single payment, thereby reducing administrative costs and complexity.

Costs and Benefits of Contracting with ACOs

Possible costs to private payors in contracting with ACOs:

- Increased governmental oversight.
- Self-insured employers have started contracting with ACOs or their progenitors, leaving out payors except in the role of a claims adjuster, which is a low-margin business.
- Payors may have to compete for ACO business and may have to play an active part (e.g., through providing IT support).

Costs and Benefits of Contracting with ACOs

Benefits

- ACOs may well be the wave of the future, even if the Patient Protection and Affordable Care Act (PPACA) is repealed.
- ACOs bear the risks of controlling quality and costs.
- Payors share in the savings.
- Contracting with ACOs is simpler and cheaper than contracting separately with each provider in an ACO.
- ACOs may link you with providers you may not have contracted with otherwise.

Costs and Benefits of Contracting with ACOs

PPACA puts new burdens on commercial payors:

- Payors may no longer exclude or rescind the insurance of people due to pre-existing conditions.
- States and CMS will put additional pressure on payors to limit annual premium rate increases.
- Payors are subject to minimum "medical loss ratio" (MLR) requirements.
- Health insurance exchanges are to start in 2014.

Costs and Benefits of Contracting with ACOs

In short, PPACA's insurance market reforms place tremendous cost pressures on payors.

- The MLR requirements would go into effect immediately.
  - Requires payors in the individual or small group market to spend 80% of their premium dollars on healthcare claims and quality improvement.
  - Payors in the large group market would be required to spend 85% of their premium revenue on claims and quality improvement.
    - The remaining 15% - 20% is reserved for profits and administrative expenses.

Costs and Benefits of Contracting with ACOs

- If payors miss the MLR targets, they must rebate premiums to the employers-enrollees, who must then pay the rebates to the employees.

- MLRs give issuers of health insurance a huge incentive to increase their activities and expenses devoted to "direct care for patients and efforts to improve care quality."
  - Healthcare quality improvement activities
    - Improve health outcomes
    - Prevent hospital readmissions by a hospital discharge program
    - Improve patient safety and reduce medical errors
    - Wellness and health promotion
    - The use of HIT

Costs and Benefits of Contracting with ACOs

- Bonus payments to ACOs would be treated as claims dollars for MLR purposes and help payors meet the 80% and 85% minimums.
- Insurance Premium Review
  - States and the Department of Health and Human Services are charged with reviewing "unreasonable increases in premiums for health insurance coverage."
    - Increases in 2011 in the individual and small group market would be subject to review.
      - That is, the payor would have to announce the rate increase to the public before it took effect and then have to defend it if it crossed the 10% threshold.

Costs and Benefits of Contracting with ACOs

- Thus, ACOs that control costs and reduce the need to increase premiums will be attractive to payors.

- In 2014, states will launch insurance exchanges covering individuals and small groups.
  - Consumers will be able to compare premiums as never before.
  - Payors will be required to offer packages of "essential health benefits" covering a wide variety of medical services.

- ACOs may be instrumental in offering a spectrum of services and the keeping down of costs and premiums.

WHY PAYORS MAY BE ESSENTIAL TO ACOs

Why Payors May Be Essential to ACOs

"There is in health care an astonishing degree of mutual contempt for the component parts of the system – doctors hate hospital administrators, nurses hate doctors, and everyone hates insurance companies, especially the patients and the government."

"… Despite all that, [insurers] actually do things that other actors (particularly hospitals and doctors) are pathetic at or incapable of, such as eligibility monitoring, enrollment management, administration of benefits and, some would say, predictive modeling, population health management, case management, technology assessment and, of course, risk management."

Ian Morrison, "Chasing Unicorns - The Future of ACOs," HHN Magazine (January 3, 2011)

Why Payors May Be Essential to ACOs

Issue:

Individual providers are seen as responsible for their patients' healthcare even when the patients see multiple providers.

- ACOs are a possible answer because providers in different specialties in the same ACO will be able to treat the same patients.
- But often providers don't know the scope of treatments patients get.

Role of the Payor:

The claim data of a patient gives a good snapshot of the patient's procedures, medications, and general treatment from different providers.

- Current Procedural Terminology (CPT) and ICD-9 billing codes

Why Payors May Be Essential to ACOs

Issue:

How can ACOs redesign systems and patient care to meet CMS targets?

Role of the Payor:

- Payors can help retool information systems so that the components in an ACO can share data.
- Payors can provide access to – or assist the ACO in adopting – electronic health records.

Why Payors May Be Essential to ACOs

Role of the Payor (cont.):

- Payors can provide ACOs with information that will enable them to see how they perform when compared with other providers in the country.
- Payors can provide an electronic infrastructure that will reduce duplication of patient services and cut surgery times and the number of procedures.
- Payors can provide capital and even marketing expertise.

Why Payors May Be Essential to ACOs

Issue:

How to determine an ACO's financial budget?

Role of the Payor:

- Payors can help ACOs develop cost metrics and actuarial projections.
- Payors can give incentives to reduce avoidable readmissions and provide appropriate care.
  - Johns Hopkins University owns Johns Hopkins Healthcare, a payor/managed care plan with 280,000 members.
    - The plan studied healthcare delivery and disease management.
      - Generated millions of dollars in profits

LEGAL AND FINANCIAL RISKS OF ACOs

"Sirs or Maams, I cannot fully comprehend the scope of such blathery that is this regulation. Is it your goal to make the delivery of health care in this country so difficult as to make it next to impossible to actually receive medical attention? If that is your goal then you are succeeding on a grand scale."

- Comment posted responding to the Proposed Rule on ACOs

Legal and Financial Risks of ACOs

Legal Risks for Providers

- Antitrust
  - The regulations create a Safety Zone for ACO participants if, in total, they provide no more than 30% of a "common service" in a "primary service area."
  - Over 30% market share is subject to review and may be allowed.
- Stark and Anti-Kickback
  - Regulations permit waivers
- Tax-exempt status of provider
- HIPAA

Legal and Financial Risks of ACOs

Legal Risks for Providers

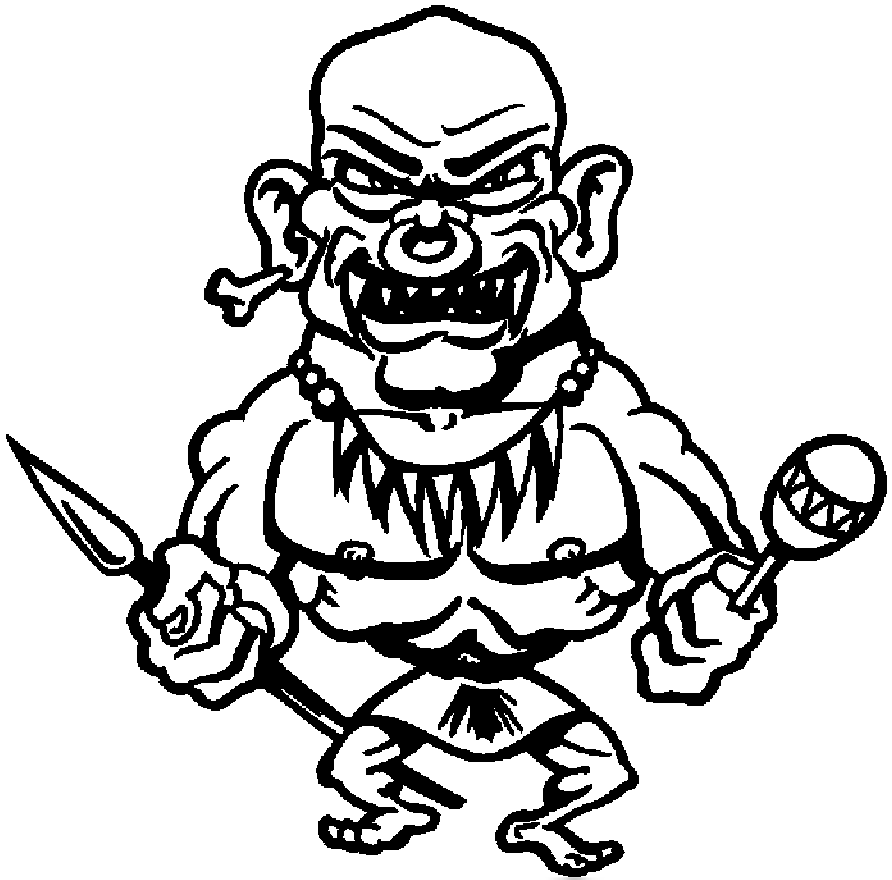
Non-MSSP ACOs that have a tax-exempt provider may put the provider's tax-exempt status at risk.

- For example, shared savings models between private health, insures and providers may get special scrutiny from the IRS because the IRS' Notice 2011 – 20 gives a (fairly) clean bill of health only to statutory ACOs (on the ground that they are designed to lessen the burdens on government).

Legal and Financial Risks of ACOs

State Law Issues

- State versions of Stark and Anti-Kickback
- Laws prohibiting the corporate practice of medicine
  - State statutes may limit or prohibit providers from being employees of non-providers.
    - In California, hospitals may not employ physicians.
  - ACOs in those states may have to take the form of medical foundations that are affiliated with hospitals
  - Indiana example
- State fee-splitting statutes



Legal and Financial Risks of ACOs

Financial Risks for Providers

- Cannibalism
- Large up-front costs (especially IT)
  - The Government Accounting Office estimates that start-up costs plus operating expenses during the first year will average $1.7 million.
  - Uncertain payback
  - An article in the New England Journal of Medicine (March 28, 2011) projected that ACOs would need a 20% margin over the three years of an ACO contract in order to break even.

Legal and Financial Risks of ACOs

New England Journal of Medicine Analysis

"… the limited data suggest that most organizations will lose money in the first 3 years under the ACO model.

The high up-front investments [$1.7 million on average] make the model a poor fit for most physician group practices; the time frame in which one can expect a reasonable return on the initial investment is more than 5 years; and even the majority of large, experienced, integrated physician group practices [in the demonstration project] could not recover their initial investment within the first 3 years."

- Note: The ACOs in the demonstration project (1) had patient populations of at least 20,000 not 5,000, (2) had 32 quality measures, not 65, and (3) had upside potential only.

Legal and Financial Risks of ACOs

- The demonstration project showed:
  - Only 2 participants got payments for shared savings in the first year.
  - By the third year, only 5 qualified.
  - The president of one of the groups in the study was skeptical of the 5,000 patient requirement for ACO: "We believe it probably needs to be 10 times that amount to be financially feasible."

Legal and Financial Risks of ACOs

- The chief medical officer of another pilot study on ACOs that began in 2009 talked about how hard it was to estimate savings before starting an ACO: "It's very difficult to approach it as a math problem. I think you have to approach it with a degree of faith."

- Uncertain payback
- If: (i) PPACA is repealed; (ii) the ACO terminates its contract before the end of the three-year term; or (iii) the ACO fails to meet quality or cost targets during the ACO contract, then the up-front costs will become non-recoverable sunk costs that, in hindsight, may not be worth it.

Legal and Financial Risks of ACOs

Geisinger Health System

- Nonprofit health system in northeastern Pennsylvania
  - 800 physicians
  - 4 hospitals
  - 38 locations for outpatients
  - A health plan with 230,000 members
- Often cited as an ACO model
- Noted for its sophisticated IT
  - Proactive patient care management
  - Decreasing hospital admissions
    - Driving down healthcare costs
- But in 2009, Geisinger lost $50 million

Legal and Financial Risks of ACOs

- Will ACOs be cost-effective after the first or second 3-year term when most savings will have been realized?

Paul Roemer:

"I like the concept of an ACO, but I also like the concept of living on Mars. Until such a time as a single provider knows what a single procedure costs, how can they allocate costs? Without knowing costs, how in turn can they talk about savings? Certainly, they can like the idea of savings, but can anyone tell you what a hip replacement costs, or what will be saved under an ACO model?"

IDENTIFYING THE RIGHT ACO PARTNER

Identifying the Right ACO Partner

- What is the patient population?
- How big is the ACO?
  - MedPAC estimates that an ACO covering 5,000 patients will need at least 50 physicians.

"A house divided against itself cannot stand."

-Abraham Lincoln (1858), quoting Matthew 12:25

Identifying the Right ACO Partner

- Who are members of the ACO?
  - Have you worked with them before?
  - How well do they work together?
  - Does their alignment make strategic sense?
  - What is their track record?

Identifying the Right ACO Partner

- Do they collectively and individually have the financial means to absorb the costs even if they share no savings?
- What investment will the participants make in IT for quality control and cost reporting?
- Are you willing to work with the ACO partners and what role do they envision for you?

Thanks for listening.

Feel free to contact me if you have questions.