HCCA 2011 Compliance Institute

Preparing for Accountable Care - The ABCs of ACOs

John Valenta, CPA, MBA
Director, Health Sciences Practice
Deloitte & Touche LLP
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Agenda

Overview of ACOs

Medicare Shared Savings Program

ACO Payment Methodologies

Key Success Factors, Benefits & Challenges of ACOs
Overview of ACOs

Why is everyone talking about ACOs?

ACOs are an emerging concept with potential to drive change.
Overview of ACOs

Accountable Care Organizations (ACOs)

- ACOs are integrated delivery systems that provide organizing connections among disparate parts of the health system and, create efficiencies and reduce redundancies resulting in improved cost controls\(^1,2\)
- An ACO could be made up of a hospital, primary care physicians, and possibly specialists

1. Association of Academic Health Centers

Common ACO Models

- Commonly proposed ACO models generally fall into one of three structures
  - Physician led organizations
    - Examples include the Mayo Clinic, Cleveland Clinic, HealthCare Partners, etc.
  - Integrated Delivery Systems (IDS) – health system driven
    - Employed and contracted physicians
    - Examples include Kaiser, Geisinger
  - Clinically Integrated Networks
    - A combination of physician led organizations and integrated delivery systems
ACO Model Overview

The ACO model is based on the following three key features:

- Local Accountability
  - ACOs are comprised of local delivery systems that manage the full continuum of patients’ care
  - The local systems are responsible for the costs, quality and capacity within the system
  - The ACOs are given a target for expenditures for the patients assigned to them

- Shared Savings
  - ACOs with expenditures below their target are eligible for shared savings payments which are distributed amongst the ACO entities (e.g. hospital, PCP, specialists, etc.)

- Performance Measurement
  - ACOs are asked to report patient experience data as well as clinical process and outcome measures
  - Shared savings payments are based on ACOs meeting certain quality benchmarks
Medicare Shared Savings Program

Definitions

- Accountable care organization (ACO) means a legal entity that is 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 FFS 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.
Medicare Shared Savings Program

Definitions

- ACO participant means a Medicare-enrolled provider of services and/or a supplier

- ACO provider/supplier means a provider of services and/or a supplier that bills for items and services it furnishes to Medicare beneficiaries under a Medicare billing number assigned to the TIN of an ACO participant in accordance with applicable Medicare rules and regulations.

Medicare Shared Savings Program

Qualifying Criteria

1. Define processes to promote care quality, report on costs and coordinate care
2. Develop a management and leadership structure for decision making
3. Develop a formal legal structure that allows the organization to receive/distribute bonuses to participating providers
4. Include the PCPs of at least 5,000 Medicare beneficiaries
Qualifying Criteria (cont.)

5. Provide CMS with a list of participating PCPs and specialists
6. Have contracts in place with a core group of specialist physicians
7. Participate for a minimum of three years

Implementing regulations were expected from CMS in late 2010, however, these regulations were just published on 3/31/2011. ACOs to be implemented January 1, 2012.

Intent of Shared Savings Program

- Better care for individuals based on the six dimensions of quality in the Institute of Medicare report: safety, effectiveness, patient-centeredness, timeliness, efficiency and equity
- Better health for populations based on education of beneficiaries regarding the causes of ill health as well as the importance of preventive services
- Lower growth in expenditures by eliminating waste and inefficiencies while not withholding any needed care that helps beneficiaries
Key Provisions of Shared Savings

- Eligible Entities
- Legal Structure and Governance
- Leadership and Management Structure
  - ACO Executive
  - Medical Director
  - Clinical Integration Program
  - Physician Directed QA Committee
  - Evidence-Based Medical Practice
  - IT Infrastructure

Operation of ACO

- Beneficiaries to be assigned to ACO retrospectively based on if they receive a plurality of their primary care services from primary care docs of the ACO
- ACOs will need to meet quality performance thresholds for all 65 quality measures to be eligible for shared savings
- CMS to set expenditures benchmark based on Parts A and B PPF expenditures of beneficiaries assigned to ACO for prior 3 years
  - Updated for each performance year for projected growth
  - Risk adjusted based on CMS-HCC model used for MA
Shared Savings

- Providers will continue to be paid at Medicare FFS rates with ACOs being eligible to receive payment for shared savings (one-sided model) as well as have risk for losses (two-sided model)
- In order to share in the savings, ACOs will need to achieve savings in excess of the Minimum Savings Rate (MSR) which ranges from 2-3.9%
- If ACO surpasses the MSR, ACO would share in net savings above a 2% threshold
  - One-sided model – 50%
  - Two-sided model – 60%

Additional Payment Considerations

- CMS to apply a flat 25% withhold to any earned shared savings amount due to the ACO annually until the end of the agreement period (3 yrs)
- CMS to implement a “performance payment limit” for maximum amount an ACO can receive in shared savings for each performance period
  - 7.5% of benchmark for one-sided model
  - 10% of benchmark for two-sided model
Key Compliance Provisions

- Compliance plan required focusing on the “seven elements”
- Marketing materials to be approved by CMS
- Certification required as to the accuracy, completeness and truthfulness of application, agreement and information submitted
- Written request for payment of shared savings that certifies ACO’s compliance with program requirements
- Conflicts of Interest provisions

Other ACO Provisions in Health Reform

- National Pilot Program on Payment Bundling (Medicare)
- Demonstration Project to Evaluate Integrated Care Around a Hospitalization (Medicaid)
- Medicaid Global Payment System Demonstration Project
- Pediatric Accountable Care Organization Demonstration Project (Medicaid/CHIP)
Application of Lessons Learned

- ACOs face challenges faced historically by “ACO-type” integrated organizations with respect to governance, leadership and operational management issues
- New quality improvement and cost reduction requirements for ACOs add even further complexity to the historical issues
- Additional challenge related to competing desires to control ACO governance and management roles
Goals of ACO Payment Methodologies

- One of the primary goals of an ACO is to reduce cost while increasing quality
  - Also expected to result in a reduction in utilization
- Some existing ACO pilots underway, however, many questions remain
- What is known is that current health care cost trends are not sustainable
- Providers will need to determine their ability to manage bundled payments as well as their appetite for accepting risk (capitation/penalties)

ACO Payment Methodologies

- Medicare Shared Savings Program represents initial payment reform (low-risk)
- Existing and proposed ACO pilots include bundled payments as well as capitated payments (high-risk)
- ACOs will need to be dynamic and focused on innovation. As ACOs and their payment methodologies continue to evolve, expect to see a transition from paying for better performance to paying for higher value.
Preparing to Manage ACO Payments

- Providers can perform a self-assessment of their ability to manage ACO payments to help identify an action plan for becoming an ACO
- One exercise is to select a high-volume procedure with limited variation in cost based on historical experience and determine the related fee-for-service payments for all providers throughout the continuum of care
  - Procedures may include hip/knee replacement, CABG, and other cardiac and orthopedic surgeries
  - Care providers include PCP visit through post-acute care

Managing ACO Payments (cont.)

- Identify whether ACO includes all potential providers throughout the continuum of care and/or contracting options exist for additional partners
- Determine ability to manage bundled payment or capitation, including distribution of payments to partners as well as incentives and any penalties
- Determine potential for gaining buy-in from physicians and other partners as well as ability to align incentives
- Assess infrastructure for managing financial risk
Key Success Factors, Benefits & Challenges of ACOs

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**Key success factors**

- **Four structures and eight key competencies**

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<tr>
<th>Provider organizations suited to become ACOs...</th>
<th>Core competencies*</th>
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<tr>
<td>A Integrated Health System</td>
<td>1 Leadership</td>
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<td>B Multi-specialty Group</td>
<td>2 Governance</td>
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<td>C Physician Hospital Organization</td>
<td>3 Operational management</td>
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<td>8 Physician Alignment</td>
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*Adapted from Shortell and Casalino 2007


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ACO Benefits

- Foster organizational accountability for local decisions about capacity
  - Ability to identify reasons for over-utilization of services
  - Minimize fragmentation of care
- Ability to monitor/track quality and cost performance at medical group and hospital/medical staff levels
  - Tracking cost and quality measures at the organizational level instead of at the (individual) provider level
- Large medical groups and IDS' have the ability and resources to administer coordinated care while supporting quality improvement

Key Challenges to ACO Implementation

- Physician buy-in
  - A number of physician organizations have stated their support for ACOs
  - Capitation and penalties that impact the physician business case as well as traditional cultural issues such as independence and autonomy will need to be addressed
- Consumer Response
  - ACOs may need to capitalize on consumers’ desire for more coordinated health care to obtain buy-in
  - Mandatory assignment to a medical home might meet stiff resistance from consumers and could unsettle relationships among physicians
Key Challenges (cont.)

- **Payments and Incentives**
  - If the payments move to global payments and partial capitation, how much risk can and/or will providers assume?
  - If a FFS payment structure continues, how will providers react to either levied penalties or reduction in the set FFS?

- **Infrastructure to Manage Risk**
  - Access to information systems, medical management protocols, contracting with health plans/employers, collection and distribution of payments and compliance with regulatory requirements
  - Make or buy decisions plus the ability to manage risks

Coordinated Care Replaces Fragmented Care

Improved cost management and quality through care coordination
Accountable Care Organizations

John Valenta, CPA, MBA,
Director, Deloitte & Touche LLP
Health Sciences Practice
(714) 436-7296
jvalenta@deloitte.com

Contact Information

Deloitte.

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