

# Accountable Care Organizations 2.0

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# Today's Roadmap

- An brief overview of ACOs
- June 2015 Final Rule provisions for ACOs
- Overview of the Medicare Shared Savings Program (MSSP)
  - Methodology for determining shared saving and losses
  - Quality measures
- Advance Payment ACO Model
- New June 2016 Final Rule provisions
- Key considerations when considering forming, joining or improving an ACO
- The future

# Overview

# Overview

- The term Accountable Care Organization was first coined in 2006 by Dr. Elliott Fisher, Director of the Center of Health Policy Research at the Dartmouth Medical School.
- The ACO concept is one that is still evolving, but can be generically defined as a group of health care providers, potentially including doctors, hospitals, long-term care facilities, home health care providers, health plans, behavioral health providers and other health care constituents, who voluntarily come together to provide coordinated high-quality care to populations of patients.
- The goal is to ensure that patients and populations – especially the chronically ill – get the right care, at the right time and without harm, while avoiding care that has no proven benefit or represents an unnecessary duplication of services.

# Overview

- According to a *Health Affairs* article by David Muhlestein and Mark McClellan (April 21, 2016), as of January 30, 2016, there were 838 active ACOs across the country with service areas in all 50 states and the District of Columbia.
- Collectively, the count of ACOs has grown by 94 over the past year, an increase of 12.6%.
- Growth is continued to vary across the country and across public and private health insurance programs, with significant growth in most population centers but increasing activity in some rural areas.
- Leavitt Partners estimate that 28.3 million people are now covered by an accountable care arrangement.

# ACOs and the ACA

- The concept of ACOs was adopted by the Affordable Care Act.
- Section 3022 of the ACA amended Title XVIII of the Social Security Act by adding a new section (Section 1899) titled the “Shared Savings Program.”
- Under the Shared Savings Program, an ACO is a network of primary care practitioners, specialists, hospitals, home health care providers, and other essential practitioners that shares financial and medical responsibility for providing coordinated care to patients in hope of limiting unnecessary spending.
- The patient’s primary care physician is the hub of the ACO wheel.

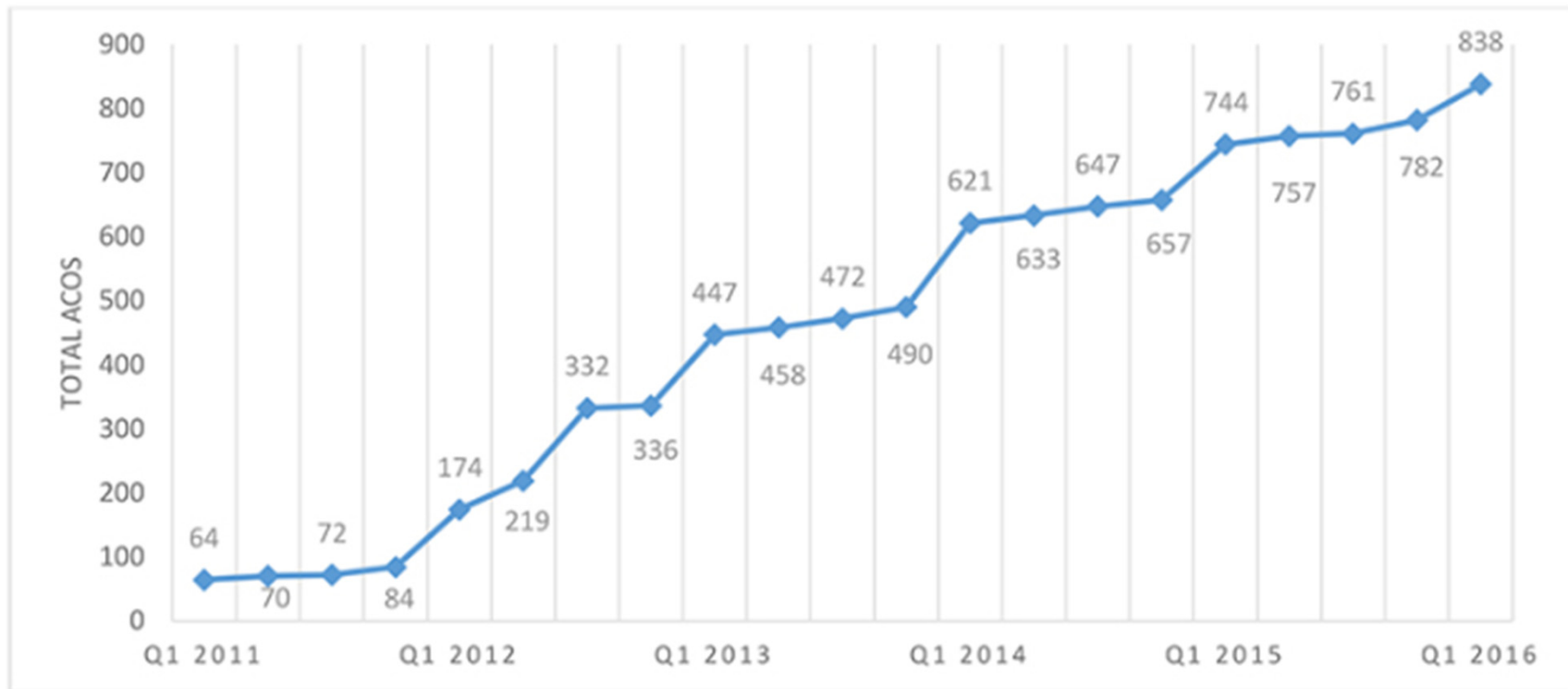
# ACOs and the ACA

- The central idea is that having all aspects of a patient's care working together will limit duplication and improve efficiency thereby lowering the cost of care while improving quality.
- ACOs come in a variety of configurations, including associations of physician groups, hospitals, post-acute care providers, behavioral health providers, and others.
- The common thread is a contract or arrangement that provides incentives for the provider to improve the quality and lower the cost of care of their population.



# ACOs Over Time

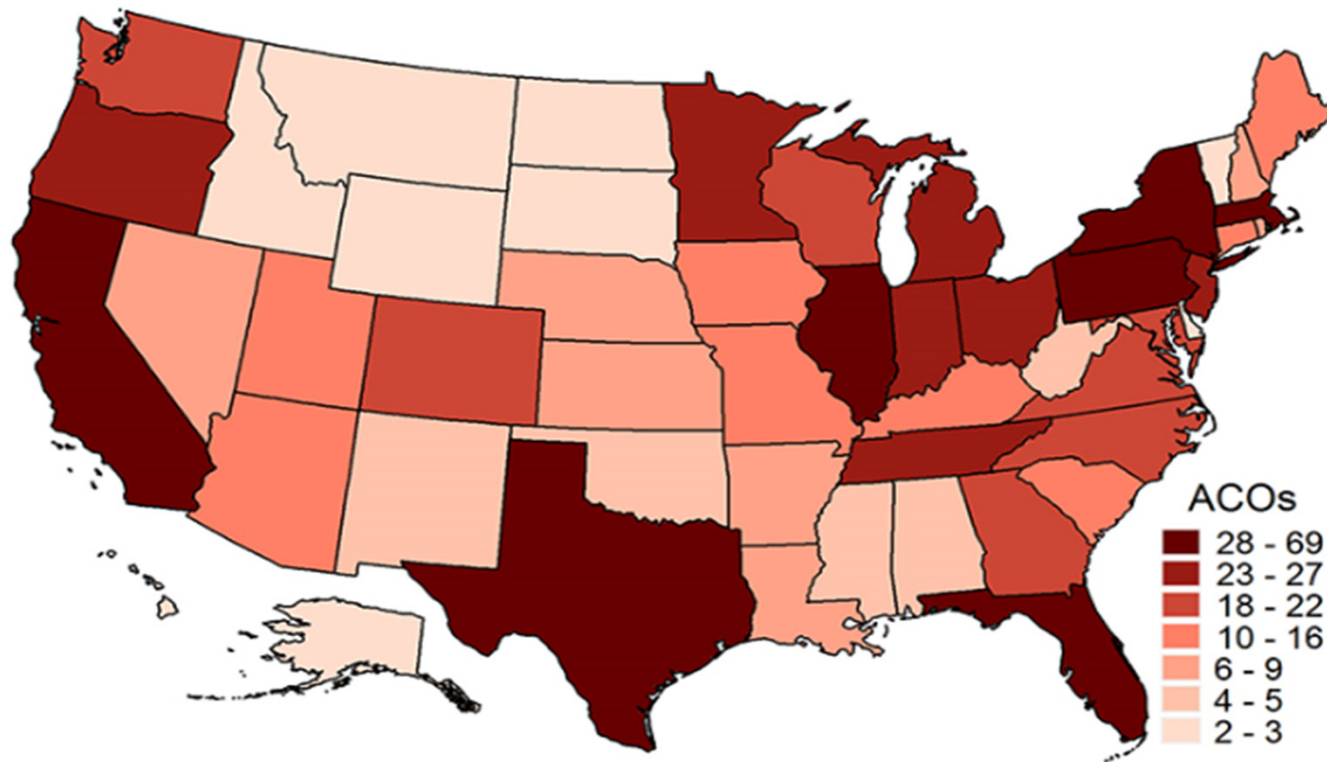
Figure 1 – ACOs Over Time



# ACOs by State

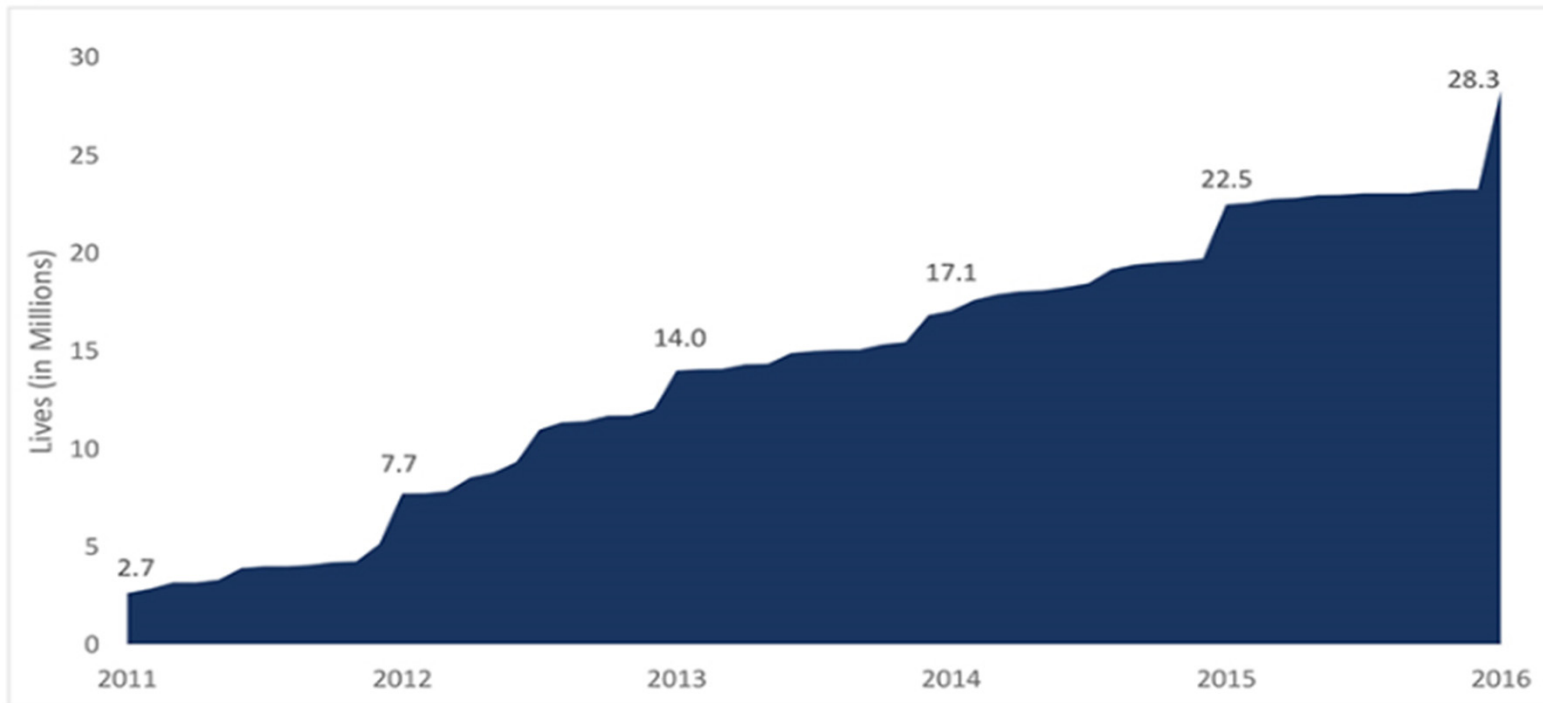
Figure 2 - ACOs By State

## ACOs by State



# ACO Lives Over Time

Figure 4 – ACO Lives Over Time

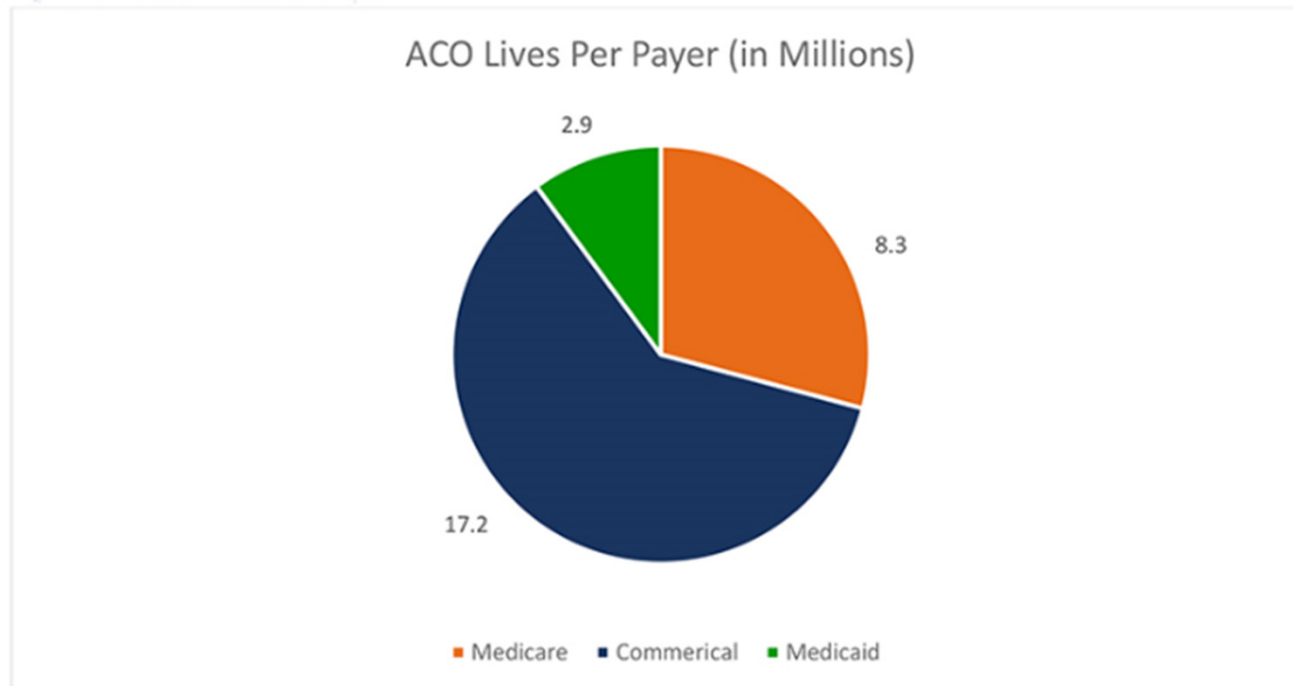


# Trends

- **MSSP has now been in operation for three performance years.**
  - Initial participants have had an opportunity to renew their contracts for another performance period.
- **Of the 220 Medicare ACOs that were eligible for renewal, 147 renewed in the MSSP, 8 transition and to the Next Generation ACO program, and an additional 10 combined or merged with other ACOs.**
- **On net, three-fourths of the early Medicare ACOs are continuing onward with the Medicare ACO program.**
  - In addition, a number of those that left the Medicare program continued to have commercial ACO contracts.
- **And, even though the MSSP receives the most attention, commercial contracts tend to be larger.**
  - They collectively represent a larger portion of a ACO lives, and continued to grow significantly.

# ACO Lives Per Payer

Figure 5 - ACO Lives Per Payer



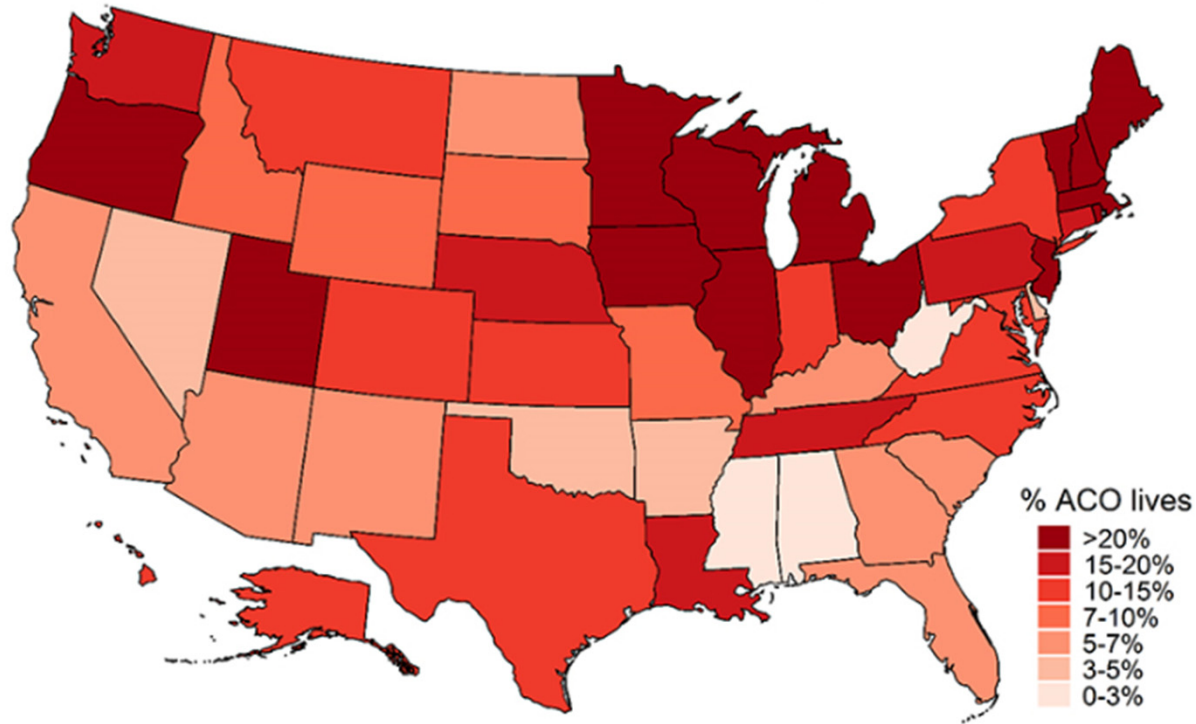
# Trends

- **ACO percentage of lives that are covered by an ACO contract varies widely by geographic region.**
- **States, such as Oregon, that of adopted Medicaid ACOs tend to have higher penetration.**
- **Nationally, 8.9% of the population is covered by ACOs.**
  - **Approximately 22% of Medicare beneficiaries are covered in 477 Medicare ACOs nationwide.**
- **ACOs are a growing model, but are far from the dominant model for health insurance coverage.**

# ACO Penetration by State

Figure 6 - ACO Penetration By State

Estimated ACO Penetration by State



# Typical Attributes of an ACO

- **Doctors of many specialties work together and the ACO provides a good choice of doctors so that the patient can choose among several providers.**
- **Easy access to specialists which reduces delays and facilitates easier care coordination.**
- **All doctor – primary care and specialists – have access to the patient's electronic medical records and can share information through a confidential electronic computer system. The ultimate goal is a fully integrated system in which the electronic medical record is also available for participating hospitals.**



# Typical Attributes of an ACO

- Patients receive supportive services and preventative care (health educators, nurses, nutrition counseling, etc.) easily and directly from his/her doctor's office.
- The group uses medical teams to allow for 24-hour access to medical services and this team has access to a patient's full medical record.
- Ease of obtaining labs, X-rays, physical therapy, and other services, which are located within or near the patient's doctor's office and may also share information and computer systems.
- The group regularly conducts surveys rating the care patients receive and has a means for assessing the quality of care patients receive so that the group and each participating doctor can be held accountable for delivering high quality care.

# Private ACOs

- **ACOs can include hospitals, specialists, post-acute care providers and even private companies like Walgreens. The only must-have element is primary care physicians, who are the linchpins of the program.**
- **In private ACOs, insurers can also play a role (although they are not in charge of medical care).**
  - **Some regions of the country, including parts of California, already have large multi-specialty physician groups that became ACOs on their own by networking with neighboring hospitals.**

# Private ACOs

- In other regions, large hospital systems are scrambling to buy up physician practices with the goal of becoming ACOs that directly employ the majority of their providers.
- Some of the largest health insurers in the country, including a Humana, UnitedHealth and Aetna, have formed their own ACOs for the private market.
  - Insurers say they are essential to the success of an ACO because they track and collect the data on patients that allow systems to evaluate patient care and report on the results.

## Other Aspects

- **ACOs should not be confused with health maintenance organizations (HMOs) because ACO patients are not required to stay in the network and can freely choose doctors outside of the ACO.**
- **ACOs have become pervasive but are not considered the “end game.”**
  - **Most health care policy makers believe the ultimate goal will be for providers to take on full financial responsibility for caring for a population of patients for a fixed payment, which will require a transition beyond ACOs.**

# Medicare ACOs

- Section 3022 of the ACA required the Secretary to create a new type of health care entity, and ACO, that agrees to be held accountable for the quality and experience of care for a population of assigned Medicare beneficiaries while reducing the rate of growth in health care spending for that population.
  - Applies only to Medicare fee-for-service beneficiaries.
- Providers within an ACO are jointly accountable for the health of their patients and receive financial incentives to cooperate and save money by avoiding unnecessary tests and procedures.
- Those that save money while also meeting quality targets keep a portion of the savings.
- Providers can choose to be at risk of losing money if they want to aim for a bigger reward, or they can enter the program with no risk at all.
- In 2014, the third year of the Medicare ACO program, 97 ACOs qualified for shared saving payments of more than \$422 million.

# Pioneer Program

- In addition to the Medicare Shared Savings Program CMS created a secondary strategy, called the Pioneer Program, for high-performing health systems to pocket more of the expected savings in exchange for taking on greater financial risk.
- In 2014, the 20 Medicare Pioneer Program ACOs and the 333 Participants in the Medicare Shared Savings Program generated \$411 million in total savings.
  - However, after paying bonuses, the program resulted in a net loss of \$2.6 million to the Medicare trust fund.

# June 2015 Final Rule Provisions

**FOR ACCOUNTABLE CARE ORGANIZATIONS UNDER THE MEDICARE SHARED SAVINGS PROGRAM (MSSP)**

# June 2015 Final Rule

- **CMS distinguishes between ACOs (serving Medicare fee-for-service beneficiaries) and private managed care plans offered under the Medicare Advantage program.**
  - **ACOs are part of the traditional Medicare fee-for-service program and beneficiaries continue to have the ability to seek any Medicare-enrolled provider they choose.**
- **Under the MSSP, CMS assesses an ACO's quality and financial performance based on a population of assigned beneficiaries to determine whether the ACO has met the quality performance standards and reduced growth and expenditures compared to a historical financial benchmark.**
- **ACOs that meet or exceed the minimum savings rate (MSR) and satisfy minimum quality performance standards are eligible to receive a portion of the savings they generated (shared savings).**



# Notification Requirements

- The regulations require providers and suppliers (ACO participants) to notify beneficiaries that they are participating in an ACO and that the ACO is eligible for additional Medicare payments if it satisfies certain quality performance standards while reducing growth in costs.
  - The beneficiary then may choose to stay with the ACO or seek care elsewhere.
- The ACO must also notify the beneficiary that the beneficiaries Medicare claims data may be shared with the ACO.
  - Beneficiaries may decline data sharing by calling 1-800-MEDICARE
  - Data sharing is limited to the purposes of the MSSP and require compliance with applicable privacy rules and regulations, including HIPAA.

# Eligibility Requirements

- The following types of groups of providers and suppliers may form an ACO:
  - ACO professionals (i.e., physicians and certain non-physician practitioners) in practice group arrangements;
  - Networks of individual practices of ACO professionals;
  - Partnerships or joint venture arrangements between hospitals and ACO professionals;
  - Hospitals employing ACO professionals; or
  - Other Medicare providers and suppliers, as determined by the Secretary.
    - The Secretary has used her discretion to allow certain critical access hospitals, federally qualified health centers, and rural health clinics to form ACOs independent of the MSSP.

# ACL Professional - Definition

- **“ACO professional” means an individual who is Medicare-enrolled and bills for items and services furnished to Medicare fee-for-service beneficiaries under a Medicare billing number assigned to the TIN of an ACO participant in accordance with applicable Medicare regulations and to is either :**
  - 1. A physician or legally authorized to practice medicine and surgery by the State.**
  - 2. A practitioner who is a:**
    - physician assistant (as defined by §410.74(a)(2));
    - nurse practitioner (as defined by §410.75(b)), or
    - clinical nurse specialist (as defined by (§410.76(b)).

# Eligibility Requirements

- **An ACO must have at least 5,000 assigned Medicare fee-for-service beneficiaries to be eligible to participate in the MSSP.**
- **Each ACO is responsible for routine self-assessment, monitoring, and reporting of the care it delivers to continuously improve the care delivered to their Medicare beneficiaries.**

# Eligibility Requirements

- A prospective MSSP ACO must complete an application providing information requested by CMS, including how the ACO plans to deliver high quality care and lower the rate of growth and expenditures.
- If the ACO's application is approved, the ACO must sign an agreement with CMS to participate in the MSSP for a period of at least three years.
  - An ACO will not automatically be accepted into the MSSP.

# Monitoring ACO Performance

- **Monitoring includes:**
  - Analyzing claims and specific financial and quality data, as well as the quarterly and annual aggregate reports;
  - Performing site visits; and
  - Reviewing the results of beneficiary surveys.
- Participation in the program may also include audits, if necessary.
- The failure to comply with eligibility and program requirements, avoidance of at-risk beneficiaries, and failure to meet the quality performance standards may result in termination of the agreement by CMS.

# Tying Payment to an Improved Care at Lower Cost

- Under the program, Medicare continues to pay individual providers and suppliers for specific items and services furnished to Medicare beneficiaries on a fee-for-service payment system.
- In order to determine whether an ACO is to receive shared savings or is responsible for losses (for those ACOs that elected to operate under a two-sided performance-based risk model), CMS develops a financial benchmark based on historical expenditures for beneficiaries assigned to the ACO.
- In addition, the amount of an ACOs shared savings or losses depends on its quality performance.

# Quality Performance Measures

- ACOs must have procedures and processes in place to promote evidence-based medicine, beneficiary engagement, and coordination of care.
- ACOs must report quality measures to CMS and give timely feedback to providers and suppliers for continuous improvement of care to beneficiaries.
- In addition, CMS expects that ACOs invest continuously in the work force and in team-based care.
- To promote transparency, ACOs are required to publicly report certain aspects of the performance and operations. And, CMS publicly reports quality and financial performance data on <https://data.cms.gov> and CMS' Physician Compare website.



# Quality Performance Measures

- Thirty-four individual measures of quality performance are used to determine if an ACO qualifies for shared savings.
  - These 34 measures cover four quality domains:
    1. Patient Experience of Care
    2. Care Coordination/Patient Safety
    3. Preventive Health
    4. At-Risk Populations
- The ACO quality measures align with those used in other CMS quality programs, such as the Physician Quality Reporting System (PQRS) and the Electronic Health Record (EHR) Incentive Programs.
- The 2016 ACO quality measures are available at:  
<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/2016-ACO-NarrativeMeasures-Specs.pdf>

# Quality Performance Standards

- **ACOs that meet the program's quality performance standards may receive a share of the savings if its assigned beneficiary expenditures are below its own specific updated expenditure benchmark by a specified percentage.**
- **Those ACOs that choose to participate in a two-sided performance-based risk model accountable for sharing losses are required to repay Medicare for a portion of losses (expenditures above the ACO's updated benchmark by a specified percentage).**

# Medicare Shared Savings Program

**METHODOLOGY FOR DETERMINING SHARED SAVINGS AND LOSSES**

# Multiple Tracks

- To provide an entry point for organizations with various levels of experience with and willingness to share losses, the new regulations allow an ACO to choose one of two program tracks:
  - **Track 1** allows an ACO to operate on a shared savings only arrangement (with no risk for losses) for the duration of its first agreement. Those ACOs that wish to continue participating in the MSSP beyond the first agreement period must do so in Track 2.
  - Under **Track 2**, the ACO shares in both savings and losses for all years of the agreement. With this model, the ACO will be eligible for a higher sharing rate, with a higher performance payment limit, that is available under the one-sided model.

# Rationale for Two-Track System

- **CMS created two tracks to provide organizations with less experience with risk models, such as some physician-driven organizations or smaller ACOs, to gain experience with population management before transitioning to a risk-based model, while also providing an opportunity for more experienced ACOs that are ready to share in losses to enter a sharing arrangement that provides a greater share of savings, but at the risk of repaying Medicare a portion of any losses.**

# Determining Shared Savings and Losses – Step 1

Under the MSSP, CMS takes the following steps in determining shared savings and losses:

- **Step 1 – establish benchmark and update for each performance year within the agreement.**
  - Benchmarks are established for each agreement using the most recent available 3 years of per-beneficiary expenditures for Parts A and B services for Medicare fee-for-service beneficiaries assigned to the ACO.
  - Benchmarks must also be adjusted for beneficiary characteristics and such other factors as the Secretary determines appropriate and updated by the projected absolute amount of growth in national per capita expenditures for Parts A and B services under the original Medicare fee-for-service program.
    - Surrogate measure for what the Medicare fee-for-service Parts A and B expenditures would otherwise have been in the absence of the ACO.
  - A new benchmark is established at the beginning of each agreement period.

# Determining Shared Savings and Losses

- The original benchmark is risk-adjusted using the CMS Hierarchical Condition Categories (HCC) risk adjustment model that was originally developed in conjunction with the Medicare managed care (Medicare Advantage) program.
- The HCC risk adjustment model is used to calculate expected expenditures for a population of Medicare beneficiaries.
- Although costs for an individual beneficiary may be higher or lower than expected, these variations are likely to balance each other across a population of beneficiaries.
- To minimize variation from catastrophically large claims, CMS truncates an assigned beneficiary's total annual Parts A and B fee for services per capita expenditures at the 99th percentile of national Medicare fee-for-services expenditures as determined for each benchmark year.

# Determining Shared Savings and Losses

- CMS trends the benchmark years forward to the third benchmark year by employing the national growth rate in Medicare Parts A and B expenditures for fee-for-service beneficiaries.
  - CMS weights the most recent year of the benchmark, Benchmark Year 3 (BY 3), at 60%, BY2 at 30%, and BY1 at 10%.
  - This weighting allows CMS to establish lower minimum savings rates (MSRs) since the weighting results in a more accurate benchmark.
- Each year of the agreement period, CMS updates the ACO's benchmark by the projected absolute amount of growth in national per capita expenditures for Parts A and B services under the original Medicare fee-for-service program using data from the CMS Office of the Actuary.



# Determining Shared Savings and Losses – Step 2

- **Step 2 - Compare performance to the benchmark to determine shared savings/losses.**
  - An ACO is only eligible for payment of shared savings if the estimated average per capita Medicare expenditure for Parts A and B services, adjusted for beneficiary characteristics, “is at least the percentage specified by the Secretary below the applicable benchmark.”
  - To account for normal variation, CMS establishes an MSR.

# Determining Shared Savings and Losses – Step 2

- In the one-sided model, the statute requires CMS to establish an MSR that accounts for normal variation based upon the number of assigned beneficiaries.
  - The MSR creates a cushion around the benchmark that must be met or exceeded in order for the ACO to be eligible to share in savings.
- A similar concept is applied in the two-sided model, a Minimum Loss Rate (MLR), to determine if an ACO is responsible for shared losses.
- Under the one-sided model, the MSR varies with the size of the ACO's assigned population such that ACOs with smaller populations (that have more variation and expenditures) have a larger MSR and ACOs with larger populations (that have less variation expenditures) have a smaller MSR.
- Under the one-sided model, MSRs range from 2 - 3.9%
- Under the two-sided model, for which there is no requirement for the MSR to be based on the number of assigned beneficiaries, both the MSR and MLR are set at a flat 2% for all ACOs.

## Determining Shared Savings and Losses – Step 2

- To calculate savings or losses, the ACO's per capita, risk-adjusted Medicare expenditures in each performance year is compared to its updated benchmark.
- If actual expenditures are lower than the updated benchmark and savings meet or exceed the MSR, the ACO may receive shared savings.
- Under the two-sided model only, if actual expenditures are higher than the benchmark and losses meet or exceed the MLR, a loss is incurred.

## Determining Shared Savings and Losses – Step 2

- CMS adjusts the benchmark and performance year expenditures to account for changes in severity and case mix for beneficiaries.
- Full prospective CMS-HCC risk scores are used to adjust each ACO's 3-year historical benchmark.
- For beneficiaries that are newly assigned to the ACO during the performance year, full CMS-HCC prospective risk scores apply to encourage ACOs to continue to accept high risk and complex patients.

# Determining Shared Savings and Losses – Step 3

- **Step 3 – Determining sharing rate and shared savings.**
  - If an ACO meets quality standards and achieves savings according to Step 2 the ACO will share in savings.
  - CMS applies a sharing rate, determined for each ACO based upon its quality performance, that is the difference between the updated benchmark and the actual expenditures for the performance year.
  - An ACO shares in savings at this rate, on a first dollar basis up to the performance payment limit.

# Determining Shared Savings and Losses – Step 3

- **One-Sided Model** - The ACO may earn a sharing rate of up to 50% based on quality performance. The performance payment limit is 10% of the applicable year's Part A and Part B updated benchmark.
- **Two-Sided Model** - The ACO may earn a sharing's rate of up to 60% based on quality performance. The performance payment limit is 15% of the applicable years Part A and Part B updated benchmark.

# Determining Shared Savings and Losses – Step 3

- As noted in previous slides, ACOs in the two-sided model share losses with CMS if the per capita costs for beneficiaries assigned to the ACO in the performance year are above the updated benchmark by an amount equal to or greater than the MLR, which is set at a flat 2% under this model.
- ACOs are liable for up to 60% of the entire difference between the updated benchmark and the actual expenditures for the performance year.
- CMS calculates a final sharing rate, determined for each ACO based on its quality performance in the same manner as if the ACO were sharing and savings.

# Determining Shared Savings and Losses – Step 3

- The shared loss rate is determined based on the inverse of the ACO's final sharing rate. This approach rewards in ACO with a higher quality score by reducing the amount of losses it owes to CMS. Conversely, an ACO with a low quality score owes a larger percentage of shared losses to CMS.
- In addition, CMS implemented a law sharing limit on the total amount owed based on the percentage of the ACOs updated benchmark for the applicable performance year.
  - In the ACO's first performance year under the two-sided model, the loss sharing limit is 5% of the Part A and Part B updated benchmark, 7.5% in the second performance year, and 10% in the third performance year.



# Advance Payment ACO Model

# Advance Payment ACO Model

- **The Advance Payment ACO Model as an initiative developed by the Center for Medicare and Medicaid Innovation (Innovation Center) designed for organizations participating in ACOs in the MSSP.**
- **Through the Advance Payment ACO Model, selected participants in the MSSP receive advance payments that will be recouped from the shared savings they earn. CMS recoups these advance payments from an ACO's shared savings.**

# Advance Payment ACO Model

- **The Advance Payment ACO Model tests:**
  - Whether providing an advance (in the form of upfront payments to be repaid in the future) increases participation in the MSSP; and
  - Whether advance payments allow ACOs to improve care for beneficiaries, generate Medicare savings more quickly, and increased the amount of Medicare savings.

# Advance Payment ACO Model

Under the Advance Payment ACO Model, participating ACOs received three types of payments:

- **An upfront, fixed payment.**
- **An upfront, variable payment .** Each ACO receives a payment based on the number of its historically-assigned beneficiaries.
- **A monthly payment of varying amount depending on the size of the ACO.** Each ACO receives a monthly payment based on the number of its historically-assigned beneficiaries.
  - The structure of these payments is intended to address both the fixed and variable costs associated with forming and ACO.

# Advance Payment ACO Model

- CMS recoups Advanced Payments through an ACOs earned shared savings.
  - ACOs selected to receive advance payments to enter into an agreement with CMS that details the obligation to repay advanced payments.
  - If the ACO does not generate sufficient savings to repay the advanced payments as of the settlement scheduled for MSSP participants midway through the ACO's second performance year, CMS will recoup the balance from the earned shared savings in the subsequent performance year.
  - CMS will not pursue recoupment on any remaining balance of advance payments after the ACO completes the first agreement period.
  - However, CMS will pursue full recoupment of advance payments from any ACO that does not complete the full, initial agreement period of the MSSP.

# Advance Payment ACO Model

- The Advance Payment ACO Modeled is open only to two types of organizations participating in the MSSP:
  1. ACOs that do not include any inpatient facilities and have less than \$50 million in total annual revenue.
  2. ACOs in which the only inpatient facilities are critical access hospitals and/or Medicare low-volume rural hospitals and have less than \$80 million in total annual revenue.
- Only ACOs that entered the MSSP in April 2012 or July 2012 are eligible for advance payments.
- ACOs that are co-owned with a health plan are ineligible, regardless of whether they fall into one of the above categories.
- The scoring criteria for evaluating applications favors ACOs with the least access to capital, ACOs that serve rural populations, and ACOs that serve a significant number of Medicaid beneficiaries.

# June 2016 Final Rule

**REVISED BENCHMARK REBASING METHODOLOGY, FACILITATING TRANSITION TO PERFORMANCE-BASED RISK, AND ADMINISTRATIVE FINALITY OF FINANCIAL CALCULATIONS**

# June 2016 Final Rule

- In June 2016, CMS issued a new final rule pursuant to notice and comment rulemaking addressing changes to the MSSP.
- Technical adjustments designed to improve program function and transparency including:
  - Modifications to the programs benchmarking methodology when resetting (rebasin) the ACO's benchmark for a second or subsequent agreement period to encourage ACOs' continued investment in care coordination and quality improvement;
  - An alternative participation option to encourage ACOs to enter performance-based risk arrangements earlier in their participation under the program; and
  - Policies for reopening of payment determinations to make corrections after financial calculations have been performed and ACO shared savings and shared losses for performance year have been determined.



# Key Considerations

**IN FORMING OR JOINING AN ACO**

# Key Considerations Involving ACOs

The formation of an ACO is a time-consuming and expensive undertaking. Likewise, for individual physicians or practice groups considering joining an ACO, the stakes are high. Accordingly, it is important to consider several key issues, including:

- **Cost**
  - A successful ACO will lower the total expected cost of care provided to beneficiaries over a population and may result in shared savings.
  - However, there are numerous costs involved in forming or joining an ACO.
  - Individual components of cost should be broken down in detail keeping in mind costs that may be needed to improve performance.

# Key Considerations Involving ACOs

- **Physician alignment and integration**
  - The most successful ACOs have strong affiliations between the physicians, with especially strong primary care physicians to coordinate the care of patients within the ACO.
  - To create true integration, physicians within the ACO must overcome attitudes favoring autonomy over coordination.
  - In addition, providers within the ACO must be committed to care coordination, development of teams, shared culture, a consistent and clear vision, and a well-developed strategy - providers in the ACO must agree to a common set of measures to monitor improvement of the quality, safety, and cost effectiveness of care.
  - The ACO must also have certain core competencies, including:
    - leadership
    - operational management to identify and disseminate best practices that promote efficacy of care delivery, improved quality of care, and reduced cost within the organization
    - governance
    - technological know-how

# Key Considerations Involving ACOs

- **Critical Relationships**

- High-acuity diagnoses requiring tertiary referrals and the post-acute care are two critical drivers of health care costs.
- With the increase of bundled payment models and other value-based reimbursements that include the continuum of care, creating relationships with the most efficient providers in these areas is in an ACO's best interest.
- Providers should be evaluated and engaged in discussions around reducing costs while improving the quality of care provided.

# Key Considerations Involving ACOs

- **Health Information Technology**
  - Electronic health records and clinical archiving systems are an essential element of ACOs.
  - An ACO requires seamless communication of medical information between all providers and partnerships (including hospitals, post-acute care providers, suppliers, home health providers, etc.)
  - Key features include:
    - Access to test results and hospital discharge information
    - Ability to track patients with chronic diseases
    - Filling of prescriptions with prompts that identify opportunities for generic substitution
    - Ability to generate report cards on physician performance
    - Ability to submit bills electronically for accelerated payment
    - Ability to track quality metrics and generate reports
    - Ability to predict in track shared savings/losses

# Key Considerations Involving ACOs

- **Legal and Regulatory Issues**
  - Sharing financial incentives across providers and the use of evidence-based protocols can place participating providers at risk of violating federal laws aimed at preventing self-referral of patients and fraud and abuse of federal health care programs.
  - An ACO model, which may require hospitals and other providers to accept one payment for all services and share financial incentives, could be in violation of previous interpretations of the Stark Law, the Anti-Kickback Statute, the Civil Monetary Penalties Law, and antitrust law.
  - Relationships with hospitals and other providers must be properly structured to comply with these laws.

# Looking to the Future

# Policy Drivers

- **In 2015, Secretary Burwell announced HHS's goal to move 50% of Medicare payments to value-based models by 2018.**
  - Earlier this year, HHS announced that they have achieved their interim goal of 30% ahead of schedule.
- **Congress has reinforced the trend toward value based reimbursement with the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA).**
  - The bipartisan bill repealed the unpopular sustainable growth rate formula, but it replaced the fee-for-service payment system for physicians with a framework intended to shift to alternative payment models based on quality and performance outcomes.
  - Under MACRA, fee-for-service payments will be increasingly adjusted based on quality and value performance.
  - The other option for physicians is to move to population-based alternative payment models (APMs) that involve significant financial risk.



# Looking to the Future

- Policy experts almost unanimously predict ACOs will continue to grow.
  - As the passage of MARCA suggests, there is strong bipartisan will to push for the transition of payment models based on the value created.
- More importantly, however, the objective of ACOs is not just payment reform. The ultimate objective is to reform the way in which care is delivered.
  - Multiple factors play a role in the transformation of delivery of care, including payment systems, organizational structure, prior experience, market conditions, and geographic considerations.
  - Accordingly, transforming how medicine is practiced is an ongoing challenge to implementing effective payment reforms.
  - Many organizations, such as the Accountable Care Learning Collaborative are heavily involved in reforming delivery issues.
  - While progress is difficult, there is a steady movement toward reforming the delivery of care to improve population health.

# Looking to the Future

- ACOs face myriad challenges in redesigning care models, including achieving organizational buy-in, using technology to the full extent possible to manage population health, and aligning incentives.
- The key aspect of any ACO is changing how an organization operates.
  - Especially true for the health care industry with its history of fee-for-service payment structure focused on volume as opposed to value.
- Accordingly, we should expect a constant barrage of new initiatives intended to incentivize providers to change how they practice medicine.
- Identifying key data and operationalizing findings is likely the next step that health care providers will be required to implement to improve population health.
- Ultimately, ACO providers will be required to accept responsibility for the care and health outcomes of the broader population.

# Additional Holland & Hart Resources

- Future webinars
  - 8/25/16 **Social Media Use by Healthcare Entities**
  - 9/8/16 **Marketing Limits for Healthcare Providers, Fraud and Abuse, Telemarketing, White Coat Marketing, Direct Contacts with Medicare Beneficiaries**
- *Healthcare Update and Health Law Blog*
  - Under “Publications” at [www.hollandandhart.com](http://www.hollandandhart.com)
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