ACOs: Parental Discretion Advised

NJ – PHL HFMA
2011 Annual Institute
October 12, 2011

Today’s Agenda

What’s in it for me?
A. Shared Savings Programs

Shared Savings Programs in PPACA

ACO

ACE

MH

PGP
B. ACO Requirements

Basic Requirements

1. Organization – Approved by state (corporation, partnership, etc.)
2. Governance – Board of Trustees with 75% ACO participants (hospital, physicians, suppliers, members, etc.)
3. Membership – Minimum of 5,000 Medicare beneficiaries by end of 1st year
4. Participants – Physicians, hospitals, SNFs, others.
5. Meaningful Use – 50% of PCPs by end of 1st year
C. ACO Limitations

Limitations

1. **SSP** – Provider participation limited to one – and only one – SSP  
   - If in ACE or PGP demo, cannot do ACO

2. **Risk** – Required in year three for all ACOs  
   - If no savings, ACO repays 1% or more to CMS

3. **Withhold** – 25% withhold for all three years

4. **Withhold Re-payment** – End of third year  
   - What if ACO terminates / is terminated by CMS?
D. Key Elements

Key Elements

1. **Start Date** – January 1, 2012 and annually thereafter.
2. **Program Length** – Three year agreement and annual performance measurements.
3. **Professional Participants** – Combination of providers, physicians and hospitals, in networks, partnerships, joint ventures, or hospital employing ACO professionals.
4. **Primary Care Participation** – PCP are limited to only one ACO.
5. **EHR Participation** – At least 50% of ACO primary care physicians must be meaningful EHR users.
6. **Hospital Participation** – Not limited to one ACO.
**Key Elements (cont)**

7. **Minimum Beneficiary Membership** – Must have at least 5,000 beneficiaries.

8. **Beneficiary Assignment** – Medicare will retroactively assign beneficiaries to ACOs.

9. **Beneficiary Option** – Beneficiaries would be able to receive care from ACO providers (after assignment) or from non-ACO providers. Regardless of the provider, the ACO would be responsible for the beneficiary costs.

10. **Board Representation** – Representation from all ACO participants.

11. **Quality Standards** – Five domains plus 65 measures.

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**Quality = 5 + 65**

1. **Patient/Caregiver Experience** (7 measures)

2. **Care Coordination** (16 measures)

3. **Patient Safety** (2 measures, one being a composite of 17 sub-measures)

4. **Preventive Health** (9 measures)

5. **At-Risk Population/Frail Elderly Health** (31 measures with two all-or-none composites)
E. ACO Risks

Financial risk for Quality

- Financial link to quality scores for ACOs cannot be understated.
- Over 65 quality measures in 5 domains of ACO performance (more than double the array managed in Medicare Advantage) ACO execution risk could be enormous.
ACO Risk

One-sided

- Risk-free for the first 2 years, with down-side risk in year three.
- ACO shares up to 50% of savings, but will not have to refund Medicare if costs exceed their target. Actual share of savings will be prorated by quality scores.
- Converts to two-sided model in 3rd year.

Two-sided

- ACO shares in both savings and losses for 3 years.
- ACO keeps 60% of the savings subject to quality scores.

Estimated Cost

<table>
<thead>
<tr>
<th>AHA</th>
<th>CMS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Estimate of ACO Investment</strong></td>
<td><strong>Average</strong>*</td>
</tr>
<tr>
<td>CMS (based on a range of an estimate of 75-150 ACOs)</td>
<td>$1,800,000</td>
</tr>
<tr>
<td>AHA** (200-bed, single hospital system)</td>
<td>$11,600,000</td>
</tr>
<tr>
<td>AHA** (1200-beds, 5-hospital system)</td>
<td>$26,100,000</td>
</tr>
</tbody>
</table>

*Average amounts represent estimated costs for the start-up and ongoing costs for year 1. **Draft estimates based on pending case studies. Includes start-up and ongoing costs for a typical year. Some costs may have already been incurred or be allocable to other budgets.

- $1.7 M
- No details of cost
F. Rewards

Potential Rewards

- **Early Adopter Advantage** – *Gain experience and ahead of the curve*
  - Must be able to meet requirements
- **Assignment** – *Some / most of 5,000 FFS beneficiaries will be retroactively assigned*
  - But if retroactively assigned, will ACO be at risk for prior medical expenses in year assigned?
- **Single Payment** – *One payment to ACO for all services*
  - ACO responsible for paying participating providers
**FQHC & RHC Rewards**

- For the 1,800 primary care clinics in an underserved area, incentive for ACOs to send beneficiaries to the nearest FQHC for - at least - an annual visit.
- The maximum shared savings under the one-sided model is 7.5% of the benchmark.
- In the third year, the ACO could not incur losses exceeding 5%.

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**Calculating Risk / Reward**

1. **Is ACO eligible for to share savings?**
   - Sliding scale from 4% to 2%

2. **What is maximum net savings amount?**
   - Benchmark rate less MSR.

3. **What is shared savings percentage?**
   - Quality Score x MSR + FQHC / RHC add-on

4. **What is shared savings per beneficiary?**
   - Shared saving x Shared Savings Rate (# 3)
### Track 1 / Year 2

<table>
<thead>
<tr>
<th><strong>STEP</strong></th>
<th><strong>CALCULATION</strong></th>
<th><strong>COMMENT</strong></th>
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<tbody>
<tr>
<td>1. Eligible Shared Savings</td>
<td>Part A + B MSR Adj.</td>
<td>$1,000 ($ 30) ACO eligible for SS if actual savings &gt; MSR – adjusted Benchmark</td>
</tr>
<tr>
<td></td>
<td>Benchmark Act A + B Exp</td>
<td>$970 $ 900</td>
</tr>
<tr>
<td>2. Max Shared Savings Amount</td>
<td>BM less Adj. Act A+B Exp</td>
<td>$980 $ 900 ACO BM of $1,000 reduced by 2% to Max Savings Rate (MSR)</td>
</tr>
<tr>
<td></td>
<td>Max SS Act A+B Exp</td>
<td>$900 $ 80</td>
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<tr>
<td>3. Shared Saving Percent</td>
<td>Quality Score Max SS % QS x Max SS</td>
<td>85.8% 50.0% 42.9% ACO Quality Score (assumed to be 85.8%)</td>
</tr>
<tr>
<td>4. Shared Saving / Beneficiary</td>
<td>Sharable Saving SS Rate ACO SS</td>
<td>$80 $ 42.9% $ 34.32 If primary care in FQHC / RHC, ACO SS increased to 44.4% &amp; $35.53 / Ben</td>
</tr>
<tr>
<td>5. Total SS x 10,000</td>
<td>Total SS</td>
<td>$343,200 Total FQHC $355,300</td>
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### Track 2 / Year 3

<table>
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<td>3. Shared Saving Percent</td>
<td>Quality Score Max SS % QS x Max SS</td>
<td>85.8% 60.0% 51.5% ACO Quality Score (assumed to be 85.8%)</td>
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<td>4. Shared Saving / Beneficiary</td>
<td>Sharable Saving SS Rate ACO SS</td>
<td>$100 $ 51.5% $ 51.50 If primary care in FQHC / RHC, ACO SS increased to 54.5% &amp; $54.48 / Ben</td>
</tr>
<tr>
<td>5. Total SS x 10,000</td>
<td>Total SS</td>
<td>$515,000 SS w/ FQHC $544,800</td>
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### Track 1 / Track 2

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<td>MSR Adj.</td>
<td>-$30</td>
<td>MSR Adj. -$30</td>
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<td>BM less Adj. $980</td>
<td>BM less Adj. $1,000</td>
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<td>Act A+B Exp.</td>
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<td>Max SS $100</td>
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<tr>
<td><strong>3. Shared Saving Percent</strong></td>
<td>Quality Score 85.8%</td>
<td>Quality Score 85.8%</td>
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<tr>
<td>Max SS %</td>
<td>50.0%</td>
<td>Max SS % 60.0%</td>
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<tr>
<td>QS x Max SS</td>
<td>42.9%</td>
<td>QS x Max SS 51.5%</td>
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<td><strong>4. Shared Saving / Beneficiary</strong></td>
<td>Sharable Saving $80</td>
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<td>SS Rate</td>
<td>42.9%</td>
<td>SS Rate 51.5%</td>
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<tr>
<td>ACO SS</td>
<td>$34.32</td>
<td>ACO SS $51.50</td>
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<tr>
<td><strong>5. Total SS x 10,000</strong></td>
<td>Total SS $343,200</td>
<td>Total SS $515,000</td>
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### Losses in Track 2 / Year 2

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</tr>
<tr>
<td>Benchmark</td>
<td>$970</td>
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<tr>
<td>Act A + B Exp.</td>
<td>$1,100</td>
<td></td>
</tr>
<tr>
<td><strong>2. Max Shared Savings Amount</strong></td>
<td>BM less Adj. $1,000</td>
<td>Track 2 ACO shielded from 1st 2% of losses – Minimum Loss Rate (MLR)</td>
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<tr>
<td>Min Loss</td>
<td>$1,020</td>
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<tr>
<td>Act Part A+B</td>
<td>$1,100</td>
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<tr>
<td>Avail SS</td>
<td>$80</td>
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<tr>
<td><strong>3. Shared Saving Percent</strong></td>
<td>Quality Score 85.8%</td>
<td>ACO Quality Score (assumed to be 85.8%)</td>
</tr>
<tr>
<td>Max SS %</td>
<td>60.0%</td>
<td></td>
</tr>
<tr>
<td>QS x Max SS</td>
<td>51.5%</td>
<td></td>
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<tr>
<td><strong>4. Shared Saving / Beneficiary</strong></td>
<td>Sharable Losses $80.00</td>
<td>If primary care in FQHC, ACO loss down to 43.5% or $36.40 / Ben</td>
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<tr>
<td>Loss (1–51.5)</td>
<td>48.5%</td>
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<tr>
<td>ACO Loss / Ben</td>
<td>$38.80</td>
<td></td>
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<tr>
<td><strong>5. Loss x 10,000</strong></td>
<td>Total Loss $368,000</td>
<td>Loss FQHC $364,000</td>
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Oops! Forgot withhold

<table>
<thead>
<tr>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Total</th>
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<tbody>
<tr>
<td>SS = $343,000</td>
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<td>SS = $515,000</td>
<td>$1,201,000</td>
</tr>
<tr>
<td>WH = $86,000</td>
<td>WH = $86,000</td>
<td>WH = $129,000</td>
<td>WH $300,000</td>
</tr>
<tr>
<td>NET = $257,000</td>
<td>NET = $257,000</td>
<td>NET = $386,000</td>
<td>$901,000</td>
</tr>
</tbody>
</table>

WITHHOLD IS RE-PAID AFTER YEAR 3.

When is withhold paid?

10/12/2011
G. Markets beyond Medicare

Markets beyond Medicare

1. Medicare – 5,000 FFS Medicare beneficiaries
2. Managed Care – Might they want the same for their Medicare enrollees?
3. Commercial / MC – Several insurers already sponsoring / co-sponsoring ACOs
4. Medicaid – Might CMS / states expand to FFS Medicaid?
5. CDHP / HDHP – Might this benefit members?
H. Barriers to ACO

Barriers

1. Quality Measurers Reporting – Difficult for providers not already tracking measures to develop for 5,000 Medicare beneficiaries in just one year.

2. High Investment Hurdle – CMS estimates start-up costs of $1.8 M; others suggest $11 M - $24 m. Difficult or impossible for some – possibly most.

3. EHR MU – At least 50% of providers are required to achieve MU by end of first year. If not already in place, could be a costly.

4. Market Share Review – If market share is over 50%, review by DOJ and OIG. Review could be time consuming and expensive.
Barriers

5. **Data** – Available data may be too limited to determine market share.

6. **Risk** – Retrospective assignment of Medicare beneficiaries may increase risk to providers.
   - CMS to randomly and retrospectively assign Medicare beneficiaries to the ACO. As beneficiaries may use any provider, risk may be too great for some providers.

7. **Too Much “DNK”** – Much that is unknown. Too much uncertainty can be uncomfortable.

Decision Framework

- **Physician – Hospital risk sharing** – Already exist? PHO, Health plan, etc.
- **Culture for risk** – Does you have it?
- **Early adopter** – Much? Some? Little?
- **Investment** – Resources available?
- **Risk assumption** – How much can we take?
  - Don’t forget 25% WH
- **Meaningful use** – Achieve in 1st year?
I. Looking @ Bundled Payments

Ardent Health Services

Hillcrest HealthCare System
- 6 hospitals
- 1,159 beds
- 1 teaching hospital
- Multi-specialty physician group

Lovelace Health System
- 4 hospitals
- 580 beds
- 1 Health plan (300,000 members)
- 11 Retail pharmacies
- Medical reference laboratory

- ACE demo site
  - Cardiac
  - Ortho

- ACE demo site
  - Ortho
  - Cardiac (11/01/11)
1. **Eligibility**

- Any Medicare FFS patient is eligible.
  - Medicare Part A primary & Part B
- Automatic participation.

2. **Services**

**CARDIAC**
- Valve (MS-DRG 216 – 221)
- Defibrillator (MS-DRG 226 – 227)
- Coronary Bypass (MS-DRG 231 – 236)
- Pacemaker (MS-DRG 242 – 244 & 258-262)
- PCI (MS-DRG 246 – 251)
- TOTAL = 28 DRGs

**ORTHO**
- Bilateral or multiple joint (MS-DRG 461 & 462)
- Hip/knee Revision & Replacement (MS DRG 466 – 470)
- Knee procedure w/o pdx infection (MS DRG 488 & 489)
- TOTAL = 9 DRGs

* -limb reattachments & ankles not included
3. **Operational Issues**

**CARDIAC**

- Most patients are admitted thru the ER or cath lab, not elective.

**ORTHO**

- Most patients are elective and thus the procedure is scheduled in advance

4. **Governance**

- **Board of Managers**
- **Committees**
  - Finance
  - Quality
  - Gain sharing
5. Payments

- **Part A + B paid to hospital**
  - Hospital distributes per contract with physicians
- **Part A + B discounted from base year**
- **Incentives**
  - Medicare FFS beneficiaries
  - Participating physicians – if they meet / exceed quality performance measures and achieve saving.

Payment Flow

- CMS pays hospital, hospital pays doctors, doctors pay beneficiary.
- Savings are calculated and shared with doctors if quality measures meet threshold to trigger savings to doctors.
**Physician Incentives**

- **Non-employed medical group**
  - Eligible for saving from gain sharing plan
- **Up to 125% of Part B**
  - DRG xxx = $10,000 (Part A $8,000+Part B $2,000)
  - Quality Measures met
  - Incentive = $500
- **Most meet / exceed QM after 1st 6 months.**

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**8. Case management**

- **Case manager required**
  - Identify eligible patients to participate in program
Volumes Up!

ORTHO

Base Year 1 Year 2

CARDIO

Base Year 1 Year 2

10/03/11 (c) 2011 HSML, GWU

Costs down!

ORTHO

Base Year Year 1 Year 2

CARDIAC

Base Year 1 Year 2

10/03/11 (c) 2011 HSML, GWU
**LOS down!**

![Graph showing LOS trends across different years and categories.]

**Challenges**

- **CMS / MAC –**
  - Marketing & Payments
- **Operations –**
  - Claims administration – Now Part B (10,000)
  - Collections - Medicare supplement
  - Cost Accounting System – Major mods needed
  - Gain sharing – Complex
  - Outliers
CMS Bundled Payment Initiative

Model 1
- In-patient Stay Only
- Discounted IPPS payment
- No target price

Model 2
- In-patient plus post discharge
- Retrospective comparison of target price and actual FFS payment

Model 3
- Post-discharge
- Retrospective comparison of target price and actual FFS payments

Model 4
- In-patient stay only
- Prospectively set payment

Model 1
- LOI: Oct 6, 2011
- Application: Nov 18, 2011

Model 2 - 4
- LOI: Nov 4, 2011
- Application: Mar 15, 2012

See Appendix A
Bundled Payment Initiative

When acquiring...

REALITY CHECK AHEAD
## Acquired Health System

**Revenue Summary**

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Net Rev</th>
</tr>
</thead>
<tbody>
<tr>
<td>A – 450</td>
<td>- $5 M</td>
</tr>
<tr>
<td>B – 400</td>
<td>- $14 M</td>
</tr>
<tr>
<td>C – 150</td>
<td>+ $2 M</td>
</tr>
<tr>
<td>D – 250</td>
<td>- $1 M</td>
</tr>
<tr>
<td>Total</td>
<td>- $18 M</td>
</tr>
</tbody>
</table>

Source: AHD 2010 data

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## Acquired Health System

**Revenue and DRG**

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Net Rev</th>
<th>T - DRG</th>
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</tr>
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Source: AHD 2010 data and results for similar providers
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<td>-</td>
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<tr>
<td>EHR</td>
<td></td>
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<td></td>
<td>$ 2.0 M</td>
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<tr>
<td><strong>Total</strong></td>
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<td>$ 3.2 M</td>
<td>$ 2.5 M</td>
<td>+ 32%</td>
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Source: AHD 2010 data and results for similar providers

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<td>$ 1.6 M</td>
<td>$ 0.3 M</td>
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<td>$ 2.2 M</td>
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<td>C – 150</td>
<td>+ $ 2 M</td>
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<td>$ 0.4 M</td>
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<td>- $ 18 M</td>
<td>$ 3.2 M</td>
<td>$ 2.5 M</td>
<td>$ 0.6 M</td>
<td>$ 6.3 M</td>
<td>+ 35%</td>
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Source: AHD 2010 data and results for similar providers
When looking for revenue...

“A good decision made quickly beats a brilliant decision made slowly.”

“Who's Got the D?”, HBR, Jan 2006

Trends...
THANK YOU!

Appendix A
CMS Bundled Payment Initiative

- www.innovations.cms.gov
- www.innovations.cms.gov/bundledpayments/Request_for_Application.pdf
- www.healthcare.gov/center/programs/partnerships/index.html
Further Reading

- “AHA Recommends Grants to ACOs”, AHA Letter, June 17, 2011
- “Accountable Care Fiasco”, WSJ Editorial, June 20, 2011.
- “First Glance at Proposed Medicare ACO Rule: We Must be Missing Something”, CRT Capital Group, April 1, 2011.
- “Medicare ACOs no longer mythical creatures”, Chad Mulvany, HFM, June 2011, p. 96 ff.
- “Heck no. We won’t ACO”, Fierce Health News, May 2011.
- Medicare Shared Savings Program - Proposed Rule, Federal Register, April 7, 2011.
- “Square, ATMs, and Pace of Transformation”, Strategy & Innovation, June 27, 2011.

Contact Info

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Health Services Management & Leadership
The George Washington University
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