Navigating ACO Opportunities and Preparing for Financial Risk

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Annual Community Health Institute
May 9-11, 2012
Resort & Conference Center of Hyannis
Hyannis, MA
Navigating ACO Opportunities and Preparing For Financial Risk

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Agenda

• What do ACOs look like?
• What are the ACO opportunities for health centers?
  • Changing business model– add’l revenue
  • Improve patient access to hospital/specialists
• How do I prepare for taking financial risk?
  • Self-assess value and areas for improvement
  • Choose partners carefully
  • Negotiate, negotiate, negotiate
What the Heck is an ACO?
Accountable Care Organization (ACO)

Accountable Care Organization (ACO)

Primary care

Hospitals

Specialty care

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Financial Incentives under ACOs

Specialty and Hospital Care
- Fewer Hospitalizations
- Few ER visits

Primary Care
- Preventive Care
- Chronic Care
- Coordinated Care
Medicare Shared Savings Program

Payor

Savings

Primary Care

Hospital + Specialists

FFS

FFS

Aligned Incentives?

ACO
Medicare Shared Saving Program

- Administered by CMS Innovations Group
- Start date: April 1, 2012
- Groups of providers, organized as a separate legal entity, who work together to manage and coordinate care for Medicare FFS beneficiaries (called an Accountable Care Organization).
  - Providers continue to submit claims to Medicare under FFS program
- Entities eligible to form ACOs:
  - ACO Professionals (MD, PA, NP, CNS) in group practices
  - Networks of individual practices of ACO Professionals
  - ACO Professional/Hospital Joint Ventures
  - Hospitals employing ACO Professionals
  - Certain CAH
  - FQHCs and RHCs
- FQHC Participation
  - Cannot participate in more than one Medicare ACO
  - Each ACO participant TIN must be exclusive to one ACO
Medicare Shared Saving (ACO) Program

Mechanism for Shared Governance

- ACO participants must control 75% of governing board
- Proportional representation NOT required in final rule

Beneficiary assignment (attribution)

- Based on whether beneficiary receives a plurality of primary care services from provider participating in an ACO
  - Services rendered by primary care physicians with a designation of internal medicine, geriatric medicine, family practice, and general practice
  - Services rendered by other ACO professionals (NPs, PAs, CNSs)
- ACOs must identify physicians who directly provide primary care services in each FQHC that is an ACO participant.
  - CMS will treat service reported on an FQHC claim as a primary care service if NPI of physician on the claim form was identified to ACO and the claim includes a primary care HCPCS or revenue center code.
- CMS uses most recent 12 months of data to identify beneficiaries that could potentially be assigned to ACO
  - Final assignment based on data from end of each year
Medicare Shared Saving Program

Shared Savings Determination
- Benchmark: Estimate of what total Medicare FFS expenditures for ACO beneficiaries would have been in absence of ACO

Risk Models
- One-Sided Model
  - All three years: shared savings only (Proposed rule required risk of loss in third year)
  - Shared savings up to 50%
- Two-Sided Model
  - All three years: shared savings and risk of loss
  - Shared savings up to 60%
- No Increased Savings Incentives for FQHC/RHC patients
  - Proposed rule offered up to 2.5% if 41-50% of beneficiaries in ACO had 1 or more visits to an FQHC or RHC in one-side model
  - Proposed rule offered up to 5% if 41-50% of beneficiaries in ACO had 1 or more visits to an FQHC or RHC in two-sided model
Medicare Shared Saving Program

- **Distribution of Savings and Repayment of Losses**
  - ACO must describe its method of distribution in ACO application
  - Subject to CMS approval, ACO would decide how to fund repayment to CMS of potential losses, e.g., recovering funds from ACO participants, reinsurance, escrowing funds, surety bonds, or line of credit.
  - ACO would be required to disclose in application the percentage of shared losses that each ACO participant would be responsible for repaying.

- **Providers could not participate in MSSP and another shared savings program**
  - FQHC Advanced Primary Care Practice Demonstration is not a shared savings program.

- **Advanced Payment Initiative**
  - “Tests” whether pre-paying portion of future shared savings would increase participation in MSSP.
  - Eligible organizations would receive an advance on shared savings expected to be earned which be recouped through ACO’s earned shared savings.
Pioneer ACO Model

- CMS released RFA on May 17, 2011
- Designed for more experienced organizations
- Providers cannot participate in both MSSP and the Pioneer ACO Model
- Shared savings and losses during first two years
  - Higher levels of savings and losses than MSSP
- Population-based payment (i.e. capitation) beginning in third year, with option for two more years
- Must serve at least 15,000 beneficiaries
- FQHCs were eligible to apply
ACO Opportunities
(and risks)
Today

MCO

FFS

Care Management PMPM or P4P (sometimes)

FFS

FQHC

FFS

Hospital and Specialists
Risk-Based Contracts—Withholds

MCO

FFS (percentage withheld)

Percentage Returned?

FQHC

• Certain percentage withheld from reimbursement
• Ability to “earn it back” through meeting cost or performance metrics
Risk-Based Contracts– Shared Savings

- Benchmark established at targeted level of expenditures for population of patients
- Actual expenditures measured against benchmark
- Difference is “shared” between MCO and provider(s)
Shared Savings

- MCO
- ACO
- FFS

Primary Care

Specialty and Hospital Care

Distribution of Shared Savings

Shared Savings
Risk-Based Contracts: Capitation

- Fixed payment (e.g. Per Member Per Month)
- Covers specified set of services without regard to actual number of services provided
Risk-Based Contracts– Risk Pools

- Fund established prospectively
- Expenditures charged against fund
- Balance remaining is shared among providers
Risk-Based Contracts: Combination

- MCO
- Hospital Pool
- Surplus
- FQHC
- Hospital and Specialists

Capitation
P4P
Aligned Incentives
FQHC- owned MCO

Profits

Cap/PMPM

Pass-thru $$

$$

Full Risk

TPA*

Hospital + Specialists

*Third-Party Administrator

State

FQHCs

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Preparing for Financial Risk
Preparing for Financial Risk

- **General Considerations**
  - Does center have financial reserves or access to capital?
  - Does center have ability to manage / control of risk?
  - Can center monitor utilization and costs?

- **Capitation**
  - What services are included in the cap?
  - Is payment actuarially sound?

- **Shared Savings**
  - Is benchmark risk adjusted?
  - Is there upside risk / downside risk?
  - Are there any risk limits (ceilings)?
Preparing for Financial Risk

• Withholds
  • What percentage is withheld?
  • How do you get it back?

• Risk Pools
  • Which providers’ “charge” against risk pool?
  • Does health center have any influence of services charged against risk pool?
Preparing for Financial Risk

• Operational considerations
  • Does current staff have expertise (and time)?
  • Is current space sufficient?
  • Is the proposed management fee adequate?

• Clinical considerations
  • Is center capable of collecting clinical data?
  • Is center capable of monitoring clinical data in real time?
  • Is center capable of affecting clinical practice?

• Financial considerations
  • Is center capable of collecting medical expense data?
  • Is center capable of identifying patients who have high medical expenses?
Preparing for Financial Risk

• Legal Considerations
• Section 330 Program Expectations
  • Don’t put 330 project at risk!
• Physician Incentive Plan Regulations
  • If arrangement involves substantial financial risk
• State Law – Risk bearing organizations
  • Incurring risk may constitute business of insurance
• Formation of separate legal entity
  • Protects against financial and legal risks
ACO Opportunities: Next Steps

Developing A Business Strategy

• Inventory health center capabilities
  • Temperament to accept risk?
  • Ability to manage risk?
  • Board support?

• Identify potential partners
  • Medicaid Managed Care Plans
  • Safety-Net Plans
  • Blues
  • Others

• Formulate potential collaborations
  • Review financial, operational and legal considerations

• Make proposal to MCOs
Concluding Thoughts

- Adopt (Invest) in **Medical Home** Model
  - Attain Highest-Level Recognition Possible
  - Achieve Meaningful Use Incentive Payments

- Pursue **Collaborations** with Local Providers and Provider Networks to Integrate Care
  - But carefully analyze:
    - Potential risks and rewards
    - Financial incentives for each party

- Engage Public and Private Payors About **New Payment Approaches** that Support and Reward the Value of Effective Primary Care Services
Publications Available on NACHC’s Website

- Accountable Care Organization Learning Network, ACO Toolkit (2011)
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