ACOs as a Strategy for Health Care Reform

Setting New Expectations

Think of health care reform as developing a new athletic department where everything is started over with new rules and new expected outcomes. ACOs are one strategy and if it fails there will be another to achieve the goals of:
1. Better care
2. Better health
3. Lower total costs

Health Reform Will Drive Tremendous Change

Change is imminent.
- Greater financial risk
- Operational efficiency
- Collaboration
- Technology investments
- Increased quality
- Elevated regulatory risk
- Community-based services and care
The Three Strategic Postures

Shape the future
- Play a leadership role in establishing how the industry operates, for example:
  - setting standards
  - creating demand

Adapt to the future
- Win through speed, agility, and flexibility in recognizing and capturing opportunities in existing markets

Reserve the right to play
- Invest sufficiently to stay in the game but avoid premature commitments

Evolution of Accountable Care * - Current Thinking

PAC can impact at all levels

Health Care Providers Required
- Better Management of Complex & Low Income Patients
- Greater Efficiencies & Improved Outcomes for Inpatient Care
- Improved Outcomes and Efficiency for Major Specialties
- Reduction in Preventable ER Visits & Admissions
- Appropriate use of Testing/Referral
- Prevention & Early Diagnosis

Areas Needing Cost Control & Improvement
- Primary Care Practice
- Primary Care Practice
- Primary Care Practice
- Primary Care Practice
- Primary Care Practice
- Primary Care Practice

Proposed Medicare ACO Rules: The ACO Paradigm

How will we use this model in post-acute care?
Proposed Medicare ACO Rules: Interaction with Other ACA Programs

- Center for Medicare & Medicaid Innovation
  - New innovative payment models that will improve quality, care
  - Models will be used in SSP

- Independence at Home
  - Medical Practices
  - Prevalent & emerging home-based FQHCs/primary care providers
  - Focus on improving health outcomes

- State Option to Provide Health Homes
  - Comprehensive Health services provided to Medicaid beneficiaries with chronic health conditions

- Community Health Teams
  - "Health teams" that will provide
  - Support services to primary care providers, and develop care plans that will improve patient care

Bending the Cost Curve: Baseline vs. Track 1 & 2 Medicare Costs - Midwest Example

Example: 12,000 Beneficiary ACO with 10% Cost Savings by Year 3

- Greater upside opportunities exist for those who enter new markets

To ACO or Not...Reimbursement & Care Delivery Impacts

Whether or not providers apply to become ACOs is unknown, but payers and providers are preparing their organizations for ACO-like changes in reimbursement and care delivery. Here are our predictions of what that means:

- Total cost of care per beneficiary will decline both by price reductions and volume reductions
- Services will likely shift from acute to other sites of care
- Competition will intensify among providers and between sites of service
- Greater upside opportunities exist for those who enter new reimbursement models earlier if value can be created
- Articulating the value of SNFs in the redesigned care model is critical; rewriting the message with new data is essential
Making the Transition – The Financially Savvy Route

Shared Savings
- Risk-based payments
- Collaboration
- Predictive modeling
- Global budget or sub-capitation

Value Based Reimbursement
- New metrics
- Best practices
- Performance-based payments
- Electronic communications

Fee For Service
- No risk payments
- Common payments
- Predictable

How we track performance: Today vs. Reform

**TODAY**
- MDS Quality Indicators
- Nursing Home Compare
- Home Health Compare
- CASPER reports
- Resident Satisfaction Surveys
- Staffing ratios
- Employee turnover
- Nursing home survey
- Occupancy rates
- Waiting list
- FFS

**Under ACOs**
- Reduced hospital readmissions
- Reduced ambulatory sensitive admissions
- Better resident/patient outcomes
- Management of Chronic Disease
- Manage/reduce/limit costs
- Eliminate health care acquired conditions
- Reduce/eliminate medication errors (patient harm metrics)
- Improve care transitions
- Patient-centered care

Telling Our Story - Redefining Value

The performance metrics in aging services (or on NursingHomeCompare, etc.) may not reflect a customer's definition of value expected, but are expected to continue evolving.

1. How would you define value for the services you provide?
2. How do you know what you are doing is of value to customers?
3. How would customers define value?
4. What metrics would you propose be used as an incentive to improve the services provided to older adults?

Many of the Aging Services are mismatched:
- Skilled care – safety vs. social
- Technology – care delivery & safety vs. staying connected & being contemporary
- Skilled Home care – clinical effectiveness vs. personal assistance & return to health
- Personal Care – nutrition, IADL & ADL assistance vs. granddaughter, friend
ACOs - Tracking and Communicate Performance?

How do we ensure proper information flow throughout the continuum so we are providing maximum Value?

Potential Impact of Reductions in Acute Admissions

State Rates of Hospital Admissions for Ambulatory Care Sensitive Conditions Among Medicare Beneficiaries

What impact will reductions in hospital admissions have? Where will the referrals go, housing, home care, SNF, etc.?

Potentially Avoidable Hospitalizations – Dual Eligibles

Many of these diagnoses are the primary reasons SNF, AL and Home Care clients go to the hospital and ER.
A New Business Model – One Example

Mark Eustis, CEO, Fairview Health Services, describes publicly the new FHS model as follows:

Mark Eustis, CEO, Fairview Health Services, describes publicly the new FHS model as follows:

The New Vocabulary

1. Attribution
2. Global Targets
3. Trend Growth
4. Predictive Modeling
5. Performance Influencers
6. Keepage
7. Medical Home
8. Care Transitions
9. Beneficiary Assignment
10. Out of Network
11. Stop-loss
12. Leakage
13. Risk Corridor
14. Value
15. Patience Harm

Evolving Organizational Models

1. Integrated Health System – a health system comprised of organizational elements that cover the majority of the continuum in an “owned” capacity. Geisnger, Mayo and Kaiser Health Systems
2. Physician Hospital Organization – a health care organization that includes acute, physician services and outpatient services and contracts for the remaining services required.
3. Physician Organization – a large group of physicians who can be either primary care only or a multispecialty group that contract for the remaining services required. Boston & Houston markets
4. Collaboration of Providers – typically this is a health system with some physicians and hospitals in a market that are collaborating with a multitude of other providers across the continuum. This can be a blend of the above. Advocate Health in Chicago, and Fairview Health Services in Minneapolis
5. Sub-segment Integration – these are providers in a particular portion of the continuum that are merging or collaborating to contract with other IHS, PHOs, etc. for all of the post-acute care, ambulatory care, etc.
Leading Health Systems

- Use of Skype for patient health questions providing greater & quicker access to physicians
- 24 hour access to a physician/nurse with electronic record available
- Locating more clinical services on senior campuses
- Increased use of Nurse Practice model to manage chronic disease & frailty.
- Case management across the settings coupled with risk assessment
- Increasing prevention & wellness services
- Home visits/on-site visit by RN following acute stays
- Ascension Health Systems is the “most integrated” health system in the US

Key Resulting Issues....

1. Hospitals with empty beds and lower revenues due to quality improvements will explore new revenue sources, including post-acute services.
2. The competition amongst short stay skilled programs, home care providers and other aging services will intensify.
3. ACOs or integrated health systems will increasingly be focused on care & services provided on housing campuses causing some to rethink their services & role in the continuum.
4. Housing providers will be expected to do more… to help residents stay healthy, reduce emergency room use, coordinate care, etc..
5. Common wisdoms about health care may not be true in the future, i.e., home care is less expensive, case management saves money, etc.

Developing Competencies – A Potential Model

**Developing Capabilities:**
- Serving wide range of payers with multiple payment structures
- Integration across sites of services
- Care coordination & health planning
- Scaling programs and services to build on infrastructure
- New services and/or lines of business
- Technology services and capabilities to substitute for other costs
- Increased focus on patient-centered, patient-engaged care

**Financially Savvy Strategies**
Preparing for Change …

Key strategies for health care providers:

1. Creating an understanding of existing patient care delivery patterns
2. Developing robust predictive measurement systems for utilization, quality and costs
3. Developing organizational capabilities for electronic health exchange and communications
4. Identifying and implementing best practices and strategies by diagnoses
5. Determining processes for patient-centered care and patient engagement approaches
6. Define a financially savvy path transitioning to value-based/gainsharing payments
7. Building relationships at the organizational level

Thank you

Thank you for allowing me to present some of the potential changes and challenges on the horizon.

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Accountable Care Organizations:
What Post-Acute Providers Need to Know

Presented by
M. Reagan & P. Deeringer
Hooper, Lundy & Bookman, P.C.
May 18, 2011
Introduction

- Much-anticipated Proposed Rule on the Medicare Shared Savings Program ("SSP") issued on April 7, 2011
- SSP revolves around use of “accountable care organizations” ("ACOs") in the Medicare FFS program
- Goal is to save costs while improving quality and population health
- Proposed Rule dropped several unexpected bombshells, e.g.:
  - Participants bear downside risk under either of the 2 “tracks”
  - Beneficiaries assigned to an ACO retrospectively
  - Limited protections under proposed antitrust, fraud and abuse waivers
- Today’s goal: help post-acute care ("PAC") community understand the Proposed Rule and its relevance for PAC

Introduction

- Role for PAC providers under the SSP is unclear
  - Medicare ACOs are mainly a primary care- and hospital-based program
- Structure of the Proposed Rule would permit PAC providers to be either “owners” or “contractors” to an ACO
  - Most likely would be contractors
- Final Rule hopefully will clarify whether/to what extent participation in an ACO – whether as an owner or a contractor – makes sense for PAC providers

Introduction

- The Regulations are proposed - comments due June 6
- Comments on FTC/DOJ antitrust and IRS tax-exempt status pieces due May 31, 2011
- CMS is considering many options within the Proposed Rule – we anticipate that Final Rule could look very different from Proposed Rule
- Encourage submission of comments
What is an ACO?

- Entity that agrees to be “accountable” for the quality and cost of services to assigned beneficiaries
- Only Medicare fee-for-service beneficiaries
- Intended to help achieve CMS’s “triple aim” of
  - Improved Quality of Care
  - Patient Population Health Care Improvement
  - Cost Reduction

First Look Observations

- Rules are very complex
- ACOs must satisfy many organizational and operational requirements – akin to a health plan’s requirements
- Will require a substantial expenditure of time, resources, and money
- Uncertain (and likely distant) benefits
- Alternative programs (e.g., national payment bundling pilot) may provide more attractive ways to finance the shift toward more integrated models of care

Eligibility

- Who can qualify to be an ACO?
  - Legal entity, recognized under state law and capable of receiving payments from Medicare (probably easiest to use a new, special purpose entity)
  - Composed of “eligible group” of ACO participants
  - ACO participants can be any Medicare providers or suppliers
  - Must include “ACO professionals” (i.e., primary care practitioners) who collectively serve at least 5,000 Medicare FFS beneficiaries
Eligibility

- ACO Participants
  - ACO professionals (i.e., PCPs) must be exclusive to one ACO, and commit to 3 years
  - All other ACO participants cannot be required to be exclusive, and must commit to 3 years

- ACO Agreement with CMS
  - ACO applies to participate, and if approved by CMS, ACO signs 3-year agreement
  - CMS must pre-approve any “marketing materials or activities” (broadly defined) ACO uses
  - ACO must notify Medicare beneficiaries that their ACO providers/suppliers are participating in an ACO

Governance

- ACO must establish and maintain a governing body, which must include:
  - ACO participants (or their representatives)
  - 1+ Medicare beneficiary (no conflict of interest with the ACO)
  - At least 75% of governing body must be controlled by ACO participants
  - The governing body of ACO must be independent and separate from the governing bodies of the ACO participants, unless a single-member ACO

- ACO must have a “C-level” executive or equivalent (executive, officer, manager, general partner)

- ACO must have a “full-time senior-level medical director”

Management/Infrastructure

- ACO participants, providers/suppliers must invest time, effort or money
- Physician-directed quality assurance and process improvement program
- Evidence-based clinical guidelines
- IT infrastructure (including EHR)
- Compliance plan
- Written plan for achieving and distributing shared savings, and improving quality of care
**Beneficiary Assignment**

- Beneficiaries assigned *retrospectively* on annual basis
- Based on plurality of Medicare allowed charges for primary care services of ACO’s PCPs
- Primary care services include HCPCS 99201-15, 99304-349, 99341-50, annual and welcome visits
- Assignment does not affect freedom of choice
- ACO participants must post signs in each of their facilities and provide written notification for beneficiaries about their participation in the ACO

**Quality**

- Shared savings dependent upon quality measures
- 5 equally-weighted quality domains:
  - Patient/care giver experience (20%)
  - Care coordination (20%)
  - Patient safety (20%)
  - Preventive health (20%)
  - At-risk population/frail elderly health (20%)
- 65 performance standards within the domains
- First year compliance based on reporting
- Subsequent compliance based on measure scores

**Quality**

- CMS may audit and validate the quality data
- Failure to report data accurately, completely, and timely can lead to termination or other sanctions
- ACO “eligible professionals” can qualify for Physician Quality Reporting System (PQRS) incentive of 0.5% by reporting quality measures
- 50%+ of ACO’s PCPs must be meaningful EHR users
**Shared Savings and Losses**

- ACOs must share in savings and losses
  - “One-sided model” shares losses beginning in third year
  - “Two-sided model” shares losses from the beginning

- Shared savings greater when ACO bears downside risk
  - Gainsharing is 50% of savings in one-sided model, 60% in two-sided
  - “Add-on” of 2.5% in one-sided, 5% in two-sided if ACO includes FQHC or RHC

- One-sided treated like two-sided after year 2

- Loss sharing is the inverse (1 – shared savings rate), generally 40% of loss

**Gain and Loss Calculations - Overview**

- Shared savings/losses calculated annually

- Gain or loss based on actual per capita expenditures for assigned beneficiaries compared to per capita benchmark

- Subject to minimum savings/loss triggers

- Some shared savings subject to thresholds (deductibles)

- Shared savings payments subject to 25% withhold

**Benchmark**

- Based on per capita expenditures for beneficiaries who would have been assigned to ACO for 3 most recent years

- Fixed benchmark adjusted:
  - For growth/trends in national health expenditures
  - For health status of beneficiary population
  - Benchmark years weighted to emphasize most recent year
  - To eliminate outliers
  - Will not account for certain expenditure increases
**Shared Savings**

- Based on comparison of estimated average per capita Medicare expenditures (Parts A and B), adjusted for beneficiary characteristics, to applicable benchmark
- Truncates expenditures at 99th percentile, to minimize impact of catastrophically large claims
- Savings must exceed minimum savings rate (MSR), which decreases as the number of assigned beneficiaries increases (3.9% - 2.0%)
- Under one-sided model, savings shared only for savings over 2% threshold
- Subject to cap – 7.5% of benchmark under 1-sided model; 10% under 2-sided model

**Shared Losses**

- Applies to one-sided model in third year and after
- Applies immediately to two-sided model
- Has minimum loss rate (2%) trigger (first dollar)
- Shared loss rate is inverse of shared savings rate (1 minus shared savings rate)
- Subject to annually increasing loss cap: 5%, 7.5% and 10% of benchmark

**Shared Savings/Losses Overview**

<table>
<thead>
<tr>
<th>Design Element</th>
<th>One-Sided Model (performance years 1 &amp; 2)</th>
<th>Two-Sided Model</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Maximum Sharing Rate</strong></td>
<td>52.5%</td>
<td>65%</td>
</tr>
<tr>
<td><strong>Quality Scoring</strong></td>
<td>Sharing rate up to 50% based on quality performance</td>
<td>Sharing rate up to 60% based on quality performance</td>
</tr>
<tr>
<td><strong>FQHC/RHC Participation Services</strong></td>
<td>Up to 2.5 percentage points</td>
<td>Up to 5 percentage points</td>
</tr>
<tr>
<td><strong>Minimum Savings Rate</strong></td>
<td>Varies by population</td>
<td>Flat 2% regardless of size</td>
</tr>
<tr>
<td><strong>Minimum Loss Rate</strong></td>
<td>None</td>
<td>Flat 2% regardless of size</td>
</tr>
<tr>
<td><strong>Maximum Sharing Cap</strong></td>
<td>Payment capped at 7.5% of ACO's benchmark</td>
<td>Payments capped at 10% of ACO's benchmark</td>
</tr>
<tr>
<td><strong>Shared Savings</strong></td>
<td>Savings shared once MSR is exceeded; unless exempted, share in savings net of a 2% threshold, up to 52.5% of net savings up to cap.</td>
<td>Savings shared once MSR is exceeded; up to 65% of gross savings up to cap.</td>
</tr>
</tbody>
</table>
Shared Savings/Losses Overview (continued)

<table>
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<th>Design Element</th>
<th>One-Sided Model (performance years 1 &amp; 2)</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Shared Losses</td>
<td>None</td>
<td>First dollar shared losses once the minimum loss rate is exceeded.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Cap on the amount of losses to be shared phased in over three years starting at 5% in year 1; 7.5% in year 2; and 10% in year 3.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Losses in excess of the annual cap would not be shared. Final loss sharing rate will be inverse of final savings sharing rate</td>
</tr>
</tbody>
</table>

Ensuring Repayment of Shared Losses

- CMS can look to 25% shared savings withheld
- Propose requiring self-executing method to repay losses
  - Reinsurance, bonds or line of credit
  - Escrowed funds or similar available repayment methods
- Applies to one-sided plan as well even though it will not take on risk until Year 3
- CMS can carry forward unpaid losses and offset against future shared savings payments

Monitoring ACOs

- ACOs subject to CMS’s usual monitoring tools
- Big concern over ACO avoidance of “at-risk” beneficiaries
- Compliance with quality performance standards
- Other (ACO eligibility, notices to beneficiaries, marketing)
Termination

- Pre-Termination Action (CMS sole discretion)
  - warming notice
  - CAP
  - “special monitoring plan”

- Termination, Suspension, Repayment
  - Several possible grounds for termination/suspension
  - Limited ability to reapply
  - Forfeit 25% withhold
  - Notices to ACO participants, beneficiaries, etc.

Reconsideration Review Process

- **No** reconsideration, appeal or review for:
  - specification of quality and performance standards
  - assessment of quality of care furnished by ACO
  - assignment of beneficiaries
  - calculation of shared savings due to ACO
  - percent of shared savings available and limits on same
  - termination of ACO for failure to meet quality standards
  - determination to challenge ACO by antitrust agency

Reconsideration Review Process (continued)

- All other initial determinations are subject to “reconsideration review”
  - ACO must request review within 15 days
  - there is a somewhat informal process by “reconsideration official”
  - burden of proof is on ACO
  - decision by reconsideration official can be appealed to CMS
  - CMS’s decision after review of reconsideration official’s recommendation is “final and binding”
Audits and Record Retention

- ACO must give CMS broad right to audit the ACO, its participants and contractors
- ACOs and their participants and contracted entities must
  - maintain books and records for 10 years
  - this can be extended another 6 years
    - on 30 days notice, if
    - termination, dispute, allegations of fraud, or similar fault by ACO or its participants or contracted entities
- ACO has ultimate responsibility for these requirements

Antitrust

- Existing antitrust enforcement policies permit joint price negotiation if there is
  - financial integration (N/A to ACOs)
  - clinical integration sufficient to ensure significant efficiencies
- Enforcement agencies have approved several clinically integrated JVs, but no bright-line criteria
- Proposed Rule is accompanied by a proposed Statement of Antitrust Enforcement Policy Regarding ACOs to be issued by the FTC and the DOJ

Antitrust

- “Rule of reason” analysis applies to ACOs
- Proposed policy would create a new “safety zone” for ACOs
  - independent ACO participants providing the same service have a combined share of 30% or less of each common service in each participant’s Primary Service Area (PSA)
- Hospitals and ASCs must be non-exclusive to the ACO, irrespective of market share
Antitrust – Rural Exception

- ACOs within the safety zone may include
  - 1 physician per specialty from each rural county (as defined by Census Bureau)
  - Any Rural Hospital (i.e., a Sole Community Hospital or a Critical Access Hospital)
  - on a non-exclusive basis, even if as a result the ACO’s share of a common service exceeds 30% of a participant’s PSA for that service

Antitrust – Dominant Provider Limitation

- “Dominant provider” has > 50% share in its PSA of any service, and is the sole ACO provider of that service in its PSA
- Dominant providers must be non-exclusive to ACO
- ACO with a dominant provider cannot restrict a commercial payer from contracting with other ACOs or provider networks

Antitrust – Impact of Safety Zone

- Safety zone remains in effect for duration of ACO’s agreement with CMS, unless significant change in provider composition
- ACO that initially qualifies does not lose protection if it exceeds the 30% limitation because it attracts more patients
Antitrust – Mandatory Antitrust Review

- ACOs that don’t qualify for rural exception and that exceed a 50% share for any common service that two or more ACO participants provide in the same PSA must obtain antitrust review
- Agencies will provide review within 90 days, will advise ACO either
  - No present intent to challenge the ACO, or
  - Likely to challenge the ACO if it proceeds
- CMS will require a “no present intent” letter as a condition of eligibility for such ACOs

Antitrust

- ACOs outside safety zone but below 50% mandatory review threshold are not viewed as necessarily anticompetitive, but may be subject to investigation and enforcement action
- Proposed policy would provide guidance on conduct that, if avoided, would significantly reduce the risk of scrutiny
- The ACO may also seek (optional) expedited antitrust review

Antitrust

- Conduct to avoid:
  - Preventing or discouraging payers from directing or incentivizing patients to choose other providers
  - Tying sales to the payer’s purchase of services from non-ACO participants (and vice versa)
  - Exclusive provider contracting (except for PCPs)
  - Restricting availability to payers of cost, quality, efficiency and performance data
  - Sharing competitively sensitive price or other data that could be used to set prices or terms of service outside the ACO
Proposed Fraud and Abuse Waivers

- Joint OIG/CMS notice proposes waivers of 3 fraud and abuse laws as applied to ACOs:
  - Stark (42 U.S.C. 1395nn(a))
  - AKS (42 U.S.C. 1320a-7b(b)(1) and (2))
  - CMP (42 U.S.C. 1320a-7a(b)(1) and (2))

Proposed Fraud and Abuse Waivers

- Waivers to be issued concurrently with CMS publication of final ACO regs
- Waiver authority specific to Medicare ACOs – does not apply to other integrated models or ACOs
- CMS/OIG may consider waivers, exceptions, safe harbors for other types of ACOs and integrated models, financial arrangements at a later date

Proposed Stark Waiver

- Waive application of Stark to distributions of shared savings received by an ACO from CMS under SSP:
  - Within the ACO: To/among qualified ACO participants, ACO providers/suppliers
  - Outside the ACO: Only for activities “necessary for and directly related to” ACO’s participation in and operations under SSP
- Waiver applies only to distribution of shared savings
  - Other financial relationships must meet an existing exception
  - Waiver applies even if distribution occurs after expiration of ACO’s agreement with CMS
Proposed AKS Waiver

- Waive application of AKS in 2 scenarios
  - **Scenario 1**: same criteria as proposed Stark waiver
  - **Scenario 2**: any financial relationship within the ACO "necessary for and directly related to" ACO’s participation in, operations under SSP that implicates Stark and fully complies with an exception
    - Goes beyond Stark ACO exception to protect financial relationships other than distributions of shared savings, if they meet Stark exception
    - However, it does not protect non-physician financial relationships

Proposed CMP Waiver

- Waive application of CMP in 2 scenarios
  - **Scenario 1**: Distribution of shared savings received by ACO from CMS under SSP, where distributions made from hospital to physician, and:
    - Payments not made knowingly to induce physician to reduce/limit medically necessary items or services; and
    - Hospital and physician are ACO participants/providers/suppliers, or were during year in which ACO earned the shared savings
  - Scenario 1 waiver applies to distribution of shared savings, even if distribution occurs after expiration of ACO’s agreement with CMS
  - **Scenario 2**: Same criteria as proposed AKS waiver, Scenario 2: Distributions within ACO, implicates Stark and meets an exception (i.e., payments that are not distributions of shared savings are alright if they meet a Stark exception)

Additional Proposed Waivers

- What is not covered?
  - ACO start-up costs
  - Continuing ACO operating expenses
  - Reimbursement for losses
  - Any financial arrangements that do not involve distribution of shared savings (e.g., shared risk, pooling of resources, incentive payments, etc.)
  - Private payor shared savings distributions
  - Required referrals within ACO
  - Beneficiary inducements
Tax-Exempt Issues

- **Tax-Exempt Issues – IRS Notice 2011-20**
  - ACO participation by tax-exempt entities will not result in private
    inurement or impermissible private benefit where the following are met:
    - Terms are set forth in a written agreement negotiated at arm’s length
    - CMS has accepted and not terminated ACO
    - Tax-exempt economic benefits and losses are based on its
      contribution
    - All contracts among participants are FMV
  - IRS indicated should not result in UBIT, because ACO is related to the
    charitable purpose of lessening burden on government
  - Potential issues related to ACO participation with private payers and
    other programs, which would be analyzed on a case by case basis. If
    such programs are desired, it would be even more important to ensure
    non-profit control
  - IRS also seeking comments – due on before May 31, 2011

State Law Issues

- No express federal pre-emption of state laws
- Corporate Practice
- HMO regulations and related issues
- State anti-kickback laws
- State self-referral laws
- State antitrust

ACOs and Post-Acute Care

- ACOs are responsible for the **cost and quality** of post-
  acute care
- PAC provider must justify value in terms of these
  factors
- Cost of post-acute care is included in the benchmark
  and contract year expenditures compared to
  benchmark
- This “cost” is the expenditure under Medicare Part A
  or Medicare Part B only
- Does not include Medicaid expenditures
ACOs and SNFs

- High quality short-stay SNF with high capability may be able to help keep Medicare expenditures down by allowing patients to go to a lower level of care earlier, get discharged to home, and not readmitted.
- Long-term stay SNF may be cost-effective for the ACO for many patients; most payments for care after Medicare Part A portion of stay are not Medicare expenditures.
- Hospitals may start asking themselves whether it’s better to buy the service or own it.

ACOs and HHAs

- Home health will generally result in lower Medicare expenditures than IRF or SNF care.
- Suggests discharge to home with home health resources as soon as patient can be properly cared for at home without increasing readmission risk.

ACOs and Post-Acute Discharge

- PAC providers can be very important to achievement of various quality measures:
  - Health status/functional status (#7)
  - Rate of readmissions within 30 days of acute discharge (#8)
  - Understanding care transitions (#11)
  - Avoiding admissions for various circumstances, like short-term complications of diabetes (#12-#18)
  - Daily aspirin use for patients with diabetes and cardiovascular disease (#39)
**ACOs Integration of PAC Providers**

- Successful ACO needs a comprehensive post-acute strategy to reduce Medicare expenditures and meet quality measures
- PAC plan should integrate all levels of post-acute services
- Hospitals may begin designing/implementing clinical guidelines to ensure patients are treated at the appropriate level of care
- Can affect admission, discharge, care transition, how care is delivered at each setting
- Hospitals may require all participating or “preferred” post-acute providers agree to comply
- Hospitals may bring post-acute providers into development of networks, clinical, guidelines, information systems

**ACOs Integration of PAC Providers**

- Integrate physicians into post-acute plan
- Integrate discharge planners
- Post-acute providers in ACO network should have EHR solution completely compatible with ACO’s EHR
- Design data collection to measure cost and quality effectiveness of post-acute care to inform future decisions
- Coordinate discharge and admission process throughout PAC continuum
- Avoid patient leakage to non-ACO providers
- Coordinate and strengthen relationships between hospital-based and freestanding services

**Questions?**

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