Physician Care: Understanding the Physician's Role in an Accountable Care Model

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- Physician's role in an Accountable Care Organization (ACO)
- Collaboration structures and methodologies to ensure greater accountability
- Independent vs. employed physician's role
- How to engage both independent and employee physicians as members of an ACO

- Organization of physicians and other institutional health care providers accountable for overall care of traditional fee-for-service Medicare beneficiaries who are assigned by CMS to an ACO
- Promotes accountability for patient population, minimum of 5,000 lives
- Coordinates items and services under Medicare parts A and B
- Encourages investment in infrastructure and redesigned care processes for high quality and efficient service delivery

- ACOs that meet quality performance standards will be eligible to receive additional Medicare payments based on risk-adjusted shared savings against historical benchmarks
- Inter- and multi-disciplinary care coordination
- Built on collaboration and shared responsibility/accountability

ACO Requirements

- Each ACO must have:
  - Minimum three-year agreement with HHS
  - Formal legal structure to be able to receive and distribute payments for shared savings to participating providers/suppliers
  - Sufficient number of PCPs
  - Integrated clinical and administrative systems
  - Processes to promote evidence-based medicine, reporting on quality and cost measures and coordination of care
  - Met “patient-centeredness criteria”

Organization of ACOs

- Group practice arrangements
- Networks of individuals and groups
- Joint ventures between groups and hospitals
- Hospitals employing ACO professionals
- Contractual relationships between ACOs and hospitals/groups
- Rural Health Clinics (“RHCs”)
- Federally Qualified Health Center (“FQHCs”)
- Other models

- Long-Term: ACOs created to move from fee-for-service reimbursement to placing risk on providers
- Short-Term: Payments will continue to be made under current Medicare programs – continue parts A & B reimbursement
- Only participating ACO (and its “participants”) will be eligible to receive payments for shared savings

- Physicians will be core element for all ACOs
- While a physician group that is unaffiliated with a hospital can be certified as an ACO, a hospital without affiliated physicians cannot
- The Final Rule on ACOs (passed in October 2011) makes ACO models more attractive to all providers

Proposed Rule vs. Final Rule

- Significant changes made to attract providers to the program:
  - Decreased financial risk
  - Decreased the number of required quality measures
  - Lowered the thresholds to share in the savings
  - Eliminated the requirement of providers to use EHR
  - Broadened participant eligibility
  - Provided for advanced payment for small or rural ACOs

Proposed Rule vs. Final Rule

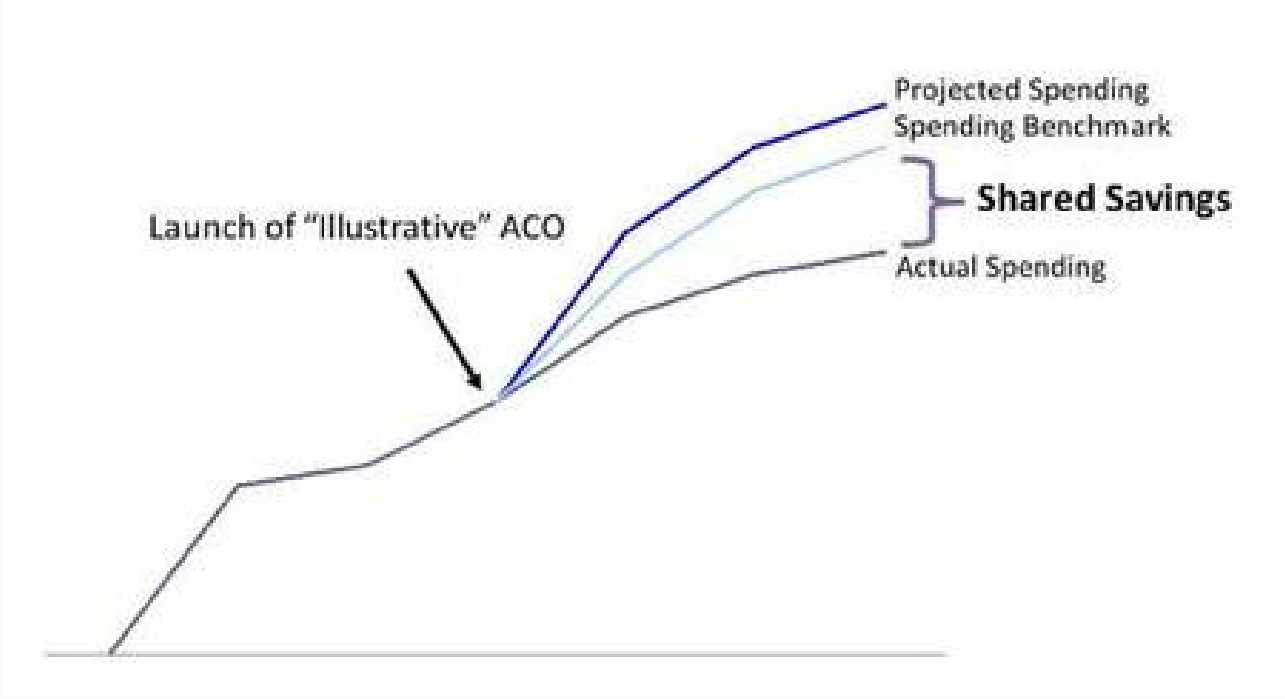
- Risk Models:
  - Proposed Rule:
    - Two Models:
      - One-Sided Risk: ACO shares only in potential savings for the first two years; third year ACO shares in savings and losses
      - Two-Sided Risk: ACO shares in savings and losses in all three years
  - Final Rule:
    - Two Models:
      - One-Sided Risk : ACO shares only in potential savings for all three years
      - Two-Sided Risk : ACO shares in savings and losses in all three years (unchanged)
- By eliminating the possibility of sharing in losses in the One-Sided Risk Model, Final Rule encourages ACO participation and experimentation.

Proposed Rule vs. Final Rule

- Fewer Quality Measures:
  - Proposed Rule:
    - 65 measures across 5 domains
  - Final Rule:
    - 33 Measures across 4 domains
      - 7 related to patient/caregiver experience
      - 6 related to care coordination/patient safety
      - 8 related to preventative health
      - 12 related to at-risk populations
- Reduces burden of participation

Proposed Rule vs. Final Rule

- Shared Savings Threshold



Accountable Care Organization: Learning Network available at http://www.acolearningnetwork.org/why-we-exist/aco-model-principles

Proposed Rule vs. Final Rule

- Shared Savings Threshold (cont.)
  - Proposed Rule:
    - One-Sided Risk Model: shared savings begin at 2%, with some exceptions for small, physician-only and rural ACOs
    - Two-Sided Risk Model: Sharing from first dollar
  - Final Rule:
    - Sharing from first dollar for ALL ACOs in both models once minimum savings rate has been achieved
- Eliminates bias in favor of Two-Sided Risk Model

Proposed Rule vs. Final Rule

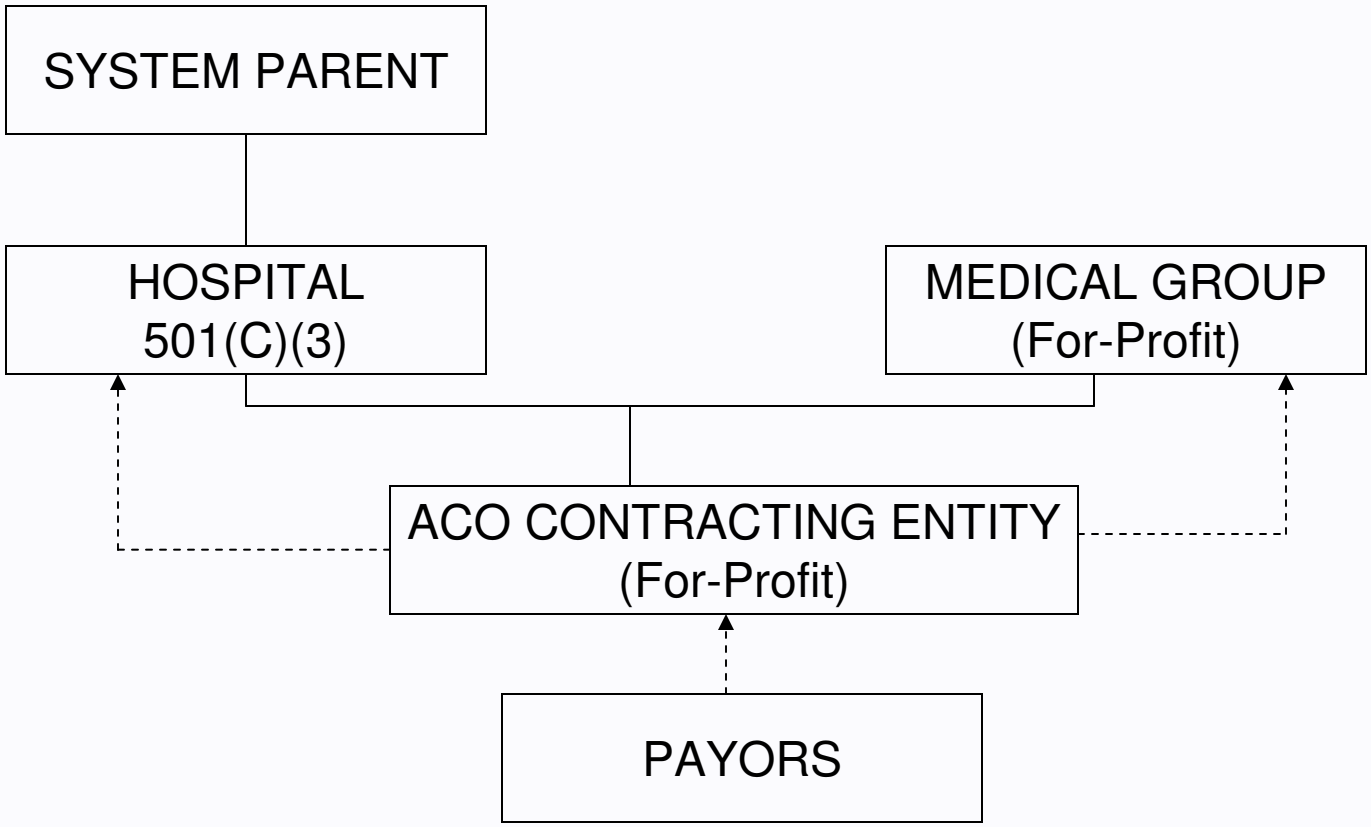
- EHR Requirements
  - Proposed Rule:
    - Required at least 50% of an ACO's primary care physicians be defined as "meaningful users" of Electronic Health Records
  - Final Rule:
    - 50% threshold requirement eliminated
- Removes this requirement as a barrier to entry

Proposed Rule vs. Final Rule

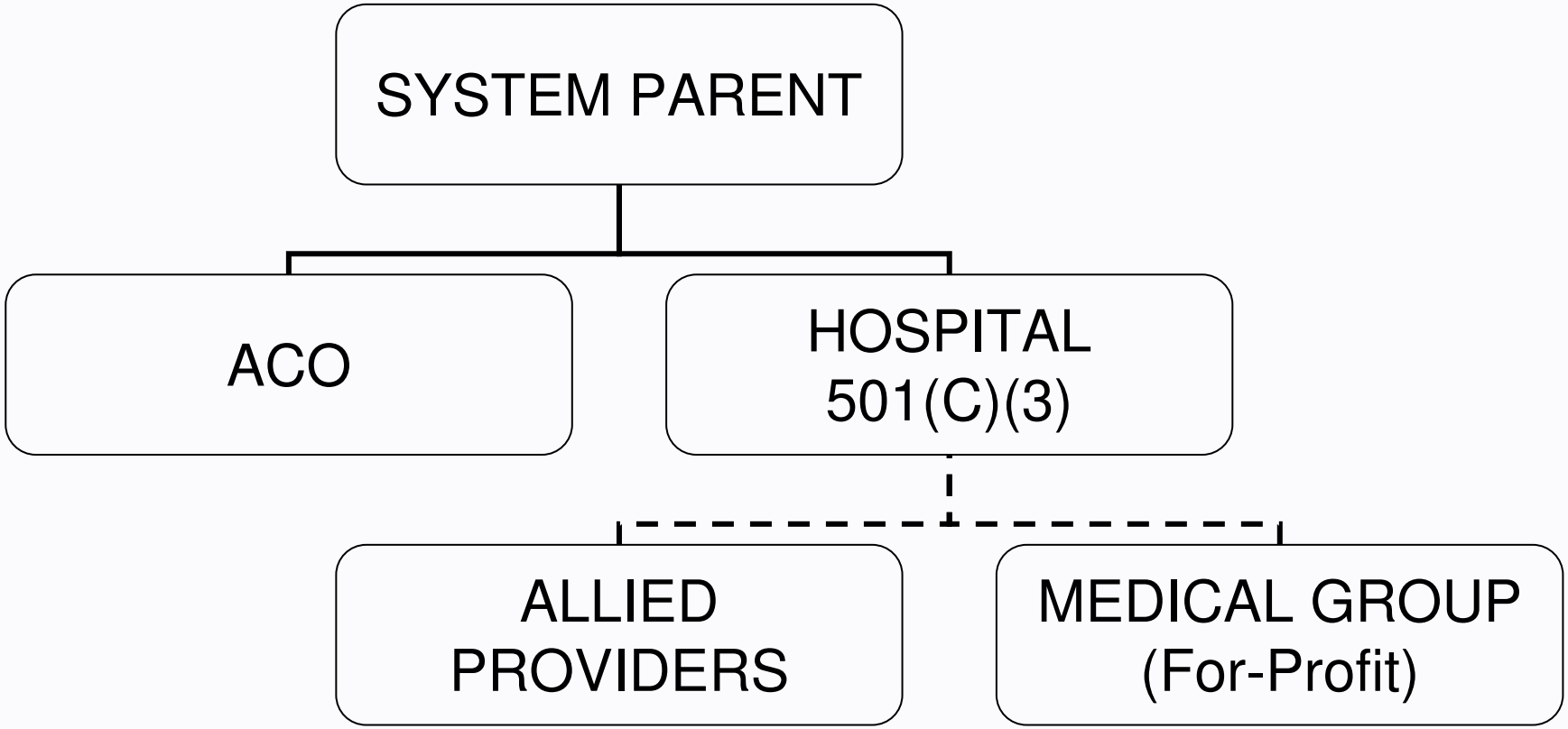
- Advanced Payment Model
  - Provides additional support to physician-owned and rural providers
  - Advance payments would be recovered from any future shared savings achieved by the ACO
  - Under this model, ACOs would receive three types of payments:
    - Upfront fixed payment
    - Upfront payment based on number of its historically-assigned beneficiaries
    - Monthly payment based on number of its historically-assigned beneficiaries

Proposed Rule vs. Final Rule

- Advanced Payment Model (cont.)
  - Model only available to two types of organizations participating in the Shared Savings Program:
    - ACOs that do not include any inpatient facilities AND have less than $50 million in total annual revenue
    - 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
  - ACOs that are co-owned with a health plan will be ineligible, regardless of whether they also fall into one of the above categories


SYSTEM PARENT
HOSPITAL
501(C)(3)
MEDICAL GROUP
(For-Profit)
ACO CONTRACTING ENTITY
(For-Profit)
PAYORS

Practice Affiliation Model



Independent vs. Employed Physician

- Physician's independent involvement in provider-based ACO models
- Hurdles
  - Cost saving requirements
  - Receiving/distributing payments among primary care physicians and specialists
  - Costs of employing EHR and IT requirements
  - Need for central ACO governing body
  - Clinical, administrative and fiscal cooperation between potential competitors
  - Division of profits among physicians and specialists

Independent vs. Employed Physician

- Physician's involvement in joint venture and hospital-based ACO models as an employee
  - Job responsibilities
  - Distribution of shared savings received by hospital
  - Compensation for ACO-related leadership and management responsibilities
    - Revising employment agreements to comply with Anti-Kickback and Stark Law waivers

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