

ACO Governance: Decision-Making and Accountability for ACO Functions

Health Care Group

December 15, 2010

ROPES
& GRAY

Michele M. Garvin

Ropes & Gray

michele.garvin@ropesgray.com

617.951.7495

Prepared with the assistance of:

Alyssa Minsky

alyssa.minsky@ropesgray.com

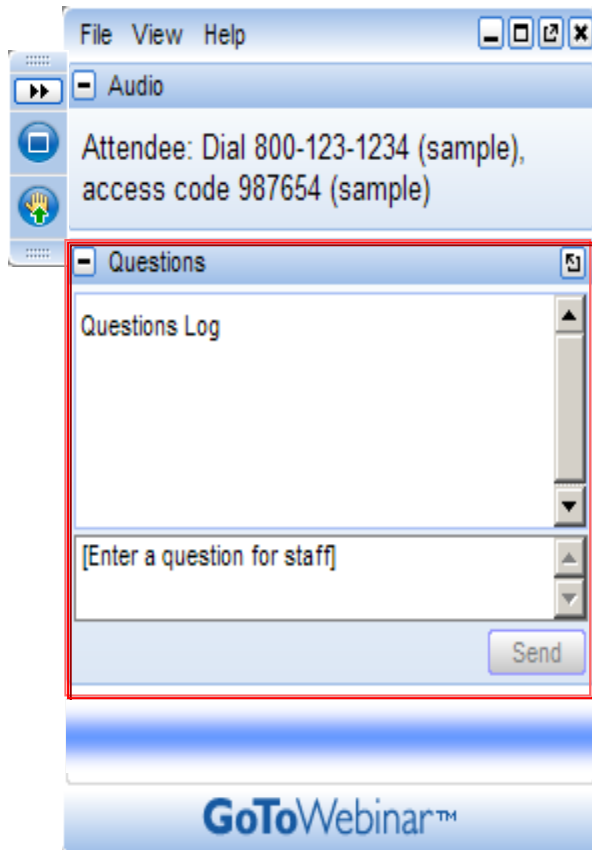
617.951.7232

Andrew Rusczek

andrew.rusczek@ropesgray.com

617.235.4924

Housekeeping



How to Participate

- Dial the conference number located in your Audio Pane.
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Scope of Presentation and Agenda

- Seven-part Webinar series on ACOs
- First presentation focused on ACO strategy, organizational options and tax implications. This presentation addressed governance issues in terms of corporate rights and responsibilities
- Today's presentation will discuss:
 - ACO Competencies
 - Existing Guidance on Governance and Structure
 - ACO Decision-Making and Implications for Governance

CMS's ACO Regulations Expected in Mid-January

- On 12/3/2010, CMS said that rules for forming ACOs will be flexible enough to allow a variety of arrangements, but potential ACOs must demonstrate they are truly committed to changing the way care is delivered
- Jonathan Blum, deputy administrator and director of Medicare at CMS, said, “CMS does not see an ACO as an organization coming into the program to simply roll the dice and to try to earn shared savings”
- According to CMS Administrator Donald M. Berwick:
 - Providers that form ACOs—or take advantage of other opportunities included in the health reform law—must demonstrate “authenticity”



**Defining ACOs:
What are the required competencies of an
ACO?**

Defining ACOs: What is an ACO?

- Organization of providers that is accountable for the quality, cost and overall care of patients
- ACO payment structure differs from the current fee-for-service payment system, which rewards volume
 - ACO goal is to reduce total per capita cost while promoting care coordination and thus, quality of care
- Currently minimal official guidance offered by the federal government regarding ACOs
 - Organizations have offered recommendations

Defining ACOs: Required Competencies for ACOs in Key ACO Literature

REQUIRED ORGANIZATIONAL COMPETENCIES FOR ACOS	KEY LITERATURE ON ACOS					
	HEALTH REFORM (2010)	SHORTELL/ CASALINO (2010)	MCLENNAN/ FISHER (2010)	MILLER (2009)	FISHER/ MCCLELLAN (2009)	MEDPAC (2009)
1. Leadership	x	x	N/A	x	N/A	N/A
2. Organizational culture of teamwork	N/A	x	N/A	x	N/A	x
3. Relationships with other providers	x	x	x	x	x	x
4. IT infrastructure for population management and care coordination	x	x	x	x	x	x
5. Infrastructure for monitoring, managing, and reporting quality	x	x	x	x	x	x
6. Ability to manage financial risk	N/A	x	x	x	x	x
7. Ability to receive and distribute payments or savings	x	x	x	x	x	x
8. Resources for patient education and support	x	x	N/A	x	N/A	N/A

Legend:

- N/A – Indicates that the authors do not explicitly discuss the competency in their literature.
- X – Even though the indicated authors discuss the key competencies, there may be differences in how they perceive the importance and application of the competencies in ACOs.

Source: American Hospital Association Committee on Research, “Accountable Care Organizations: AHA Research Synthesis Report” (June 2010).



Existing Guidance on Governance and Structure

Guidance on Governance and Structure: CMS Preliminary Guidance

- **Seven requirements for ACOs:**
 1. Formal legal structure to receive/distribute savings
 2. Sufficient number of primary care professionals for the number of beneficiaries (5,000 minimum)
 3. Agreement to participate for not less than 3 years
 4. Sufficient information regarding participating ACO professionals to support beneficiary assignment

Guidance on Governance and Structure: CMS Preliminary Guidance (cont'd)

- **Seven requirements for ACOs (cont'd):**
 5. Leadership and management structure that includes clinical and administrative systems
 6. Defined processes to promote evidence-based medicine, report the necessary data to evaluate quality and cost measures, and coordinate care
 7. Meets patient-centeredness criteria

CMS Guidance on Governance and Structure: Organizations that Can Become ACOs

- Physicians and other professionals in **group practices**
- Physicians and other professionals in **networks of practices**
- **Partnerships or joint venture arrangements** between hospitals and physicians/professionals
- **Hospitals** employing physicians/professionals
- **Other forms** that the Secretary of Health and Human Services may determine appropriate

Guidance on Governance and Structure: National Committee for Quality Assurance (NCQA)

- Each ACO is likely to vary with respect to services offered
- NCQA indicates ACOs must include:
 - Group of physicians with a strong primary care base
 - Sufficient other specialties that support the care needs of a defined population of patients
 - Integration of providers to coordinate care for assigned patients
 - Administrative infrastructure to manage budgets, collect data, report performance, make payments related to performance and organize providers around shared goals

Guidance on Governance and Structure: NCQA Criteria for ACO Program Description

- Each organization must clearly define its organizational structure
- Organization's program description (framework within which the business operates) must include:
 - *ACO program structure*: decision-making structure, operational framework, and tasks to support its goals and objectives
 - *ACO governing body*: board of directors, which has responsibility for organizational governance and establishes accountability
 - Specific role, structure and functions of governing body, including meeting frequency
 - Designated physician or clinician leadership with substantial involvement in the ACO

Guidance on Governance and Structure: NCQA Criteria for ACO Program Description (cont'd)

Organization's program description must include (cont'd):

- Defined goals addressing clinical quality, patient experience and cost
- Process to annually review the ACO's overall performance with its governing body
- Process to conduct an organizational assessment and review the results with the governing body

Guidance on Governance and Structure: American Medical Group Association and Massachusetts Medical Society

- Physicians must control medical issues in ACOs.
Rationales:
 - Ensure physicians put patients' interests, not commercial interests, first
 - Physicians are best qualified to diagnose and treat patients
- ACO should be governed by a board of directors that is elected by the ACO professionals
- If a hospital is part of an ACO, the ACO's governing board should be independent from the hospital's governing board

Guidance on Governance and Structure: North Carolina Medical Society

- Recommendations for ACO organization and governance include:
 - Formal legal structure to receive and disburse shared savings payments to providers
 - Participating provider groups adequately represented on each ACO governing board
 - Majority of each board should be physicians
 - Non-profit entity (to discourage windfall profit taking by large ACO shareholders)

Guidance on Governance and Structure: Massachusetts Special Commission

- Massachusetts Special Commission on the Health Care Payment System recommended implementation of a global payment system with ACOs
- Broad definition of ACO
 - Any organization, real (incorporated) or virtual (contractually networked), that accepts responsibility *for all or most of the care that enrollees need*
 - Composed of hospitals, physicians and/or other clinician and non-clinician providers working as a team to manage both the provision and coordination of care

Guidance on Governance and Structure: Massachusetts Special Commission (cont'd)

- On January 5, 2011, the Massachusetts Committee on the Status of Payment Reform Legislation will provide its final recommendations for legislation to implement the new global payment system in Massachusetts



ACO Framework Options

ACO Framework Options: Flexibility in Structure of ACO

- ACO as a separate legal entity: An ACO can be formed as a separate legal entity and take one of several legal forms
 - The legal form of the ACO may depend on the governance structure of, and relationship between, the ACO providers
- Virtual ACO: A virtual ACO is formed without the formation of a new legal entity and instead through contractual arrangements and networks among providers, as long as there is shared governance
 - Massachusetts Committee on the Status of Payment Reform Legislation noted that although CMS requires a “formal legal structure,” this appears to allow a contractually networked ACO

ACO Framework Options: Flexibility in Structure of ACO (cont'd)

- Massachusetts Special Commission on the Health Care Payment System encourages the development of a large number of ACOs of different forms
- ACOs can be for profit or non-profit organizations (tax exempt status)

ACO Framework Options: Two Models of ACOs

1. Clinically Integrated Provider Network*
2. Collaborative Arrangement*

* In its October 19, 2010 letter to CMS (“Premier Letter to CMS”), Premier Healthcare Alliance urged the FTC and DOJ to confirm that collaborative multi-provider network arrangements and clinically integrated provider networks are both acceptable forms of ACOs.

ACO Framework Options: Clinically Integrated ACO Model*

- Single legal entity provides medical services of the ACO
- Corporate integration: single points of accountability for quality and payment
- Shared governance: significant overlap in governing board, management and participant members
- ACO functions may be performed by a separate legal entity or by a virtual ACO

* See Premier Letter to CMS.

ACO Framework Options: Collaborative ACO Model*

- Contractual relationship among ACO's owners and participants
- Not necessary to have a clinically integrated provider network as long as there are coordinated relationships
 - But, need sufficient coordination to address antitrust concerns
- Hospital and ACO have distinct governing bodies
- ACO functions may be performed by a separate legal entity or by a virtual ACO

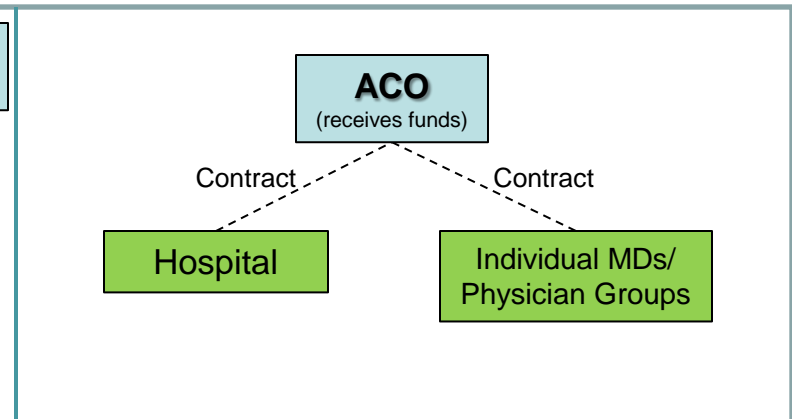
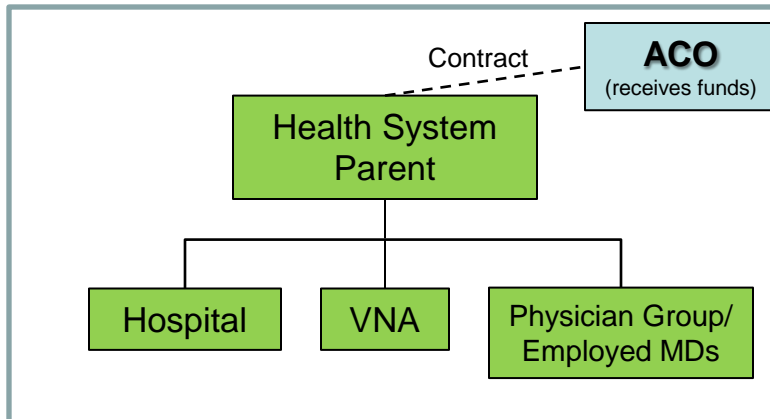
* See Premier Letter to CMS.

ACO Framework Options: Models of ACOs

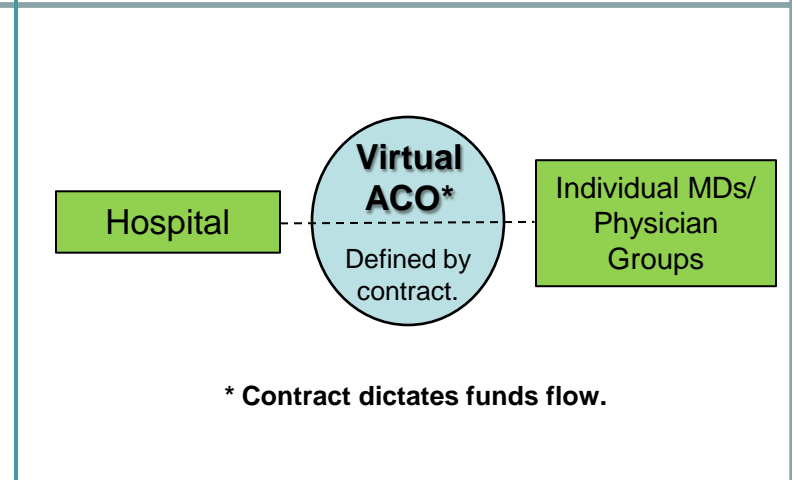
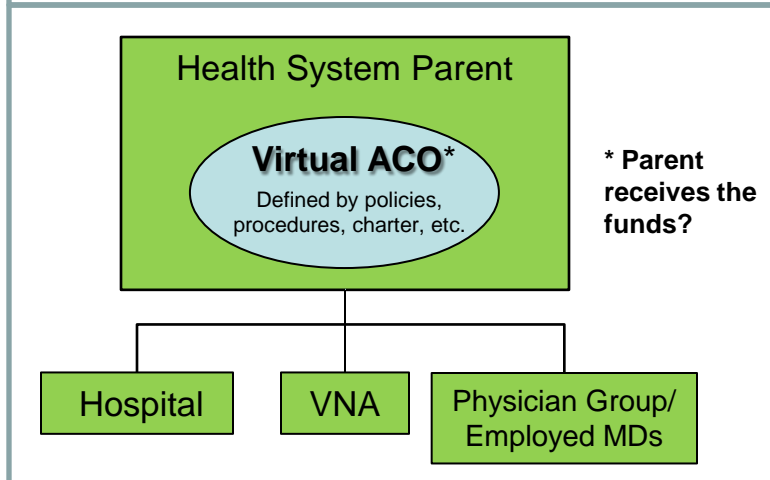
Clinically Integrated Model

Collaborative Model

Separate
Legal
Entity as
ACO



Virtual
ACO



ACO Framework Options: Drivers of Clinically Integrated ACO Model

- Physician practice ownership between 2002 and 2008:
 - Percentage of physician practices that were independent fell from roughly 75% to 50%
 - Percentage of physician practices that were owned by hospitals rose from roughly 25% to 50%*
- Percentage of active physicians employed by hospitals between 2008 and 2012:
 - 2008: 15% of specialists and 31% of PCPs
 - Projected for 2012: 24% of specialists and 40% of PCPs**

* Advisory Board Company, 2010.

** Harris, G., "More Doctors Giving Up Private Practices," *New York Times*, March 25, 2010; Health Care Advisory Board 2008 Survey on Physician Employment; Health Care Advisory Board Interviews and Analysis.



Choosing the Appropriate Governance Framework

Governance Framework: Assessing Current Structure and Goals

- What structures and processes (including governance, payment, quality improvement, etc.) do we currently have in place?
- What structure of ACO is most appropriate given our current structure and processes?
- What do we need to consider as we move forward with creating the ACO?
 - Reduce redundant functions
 - Share information
 - Coordinate efforts

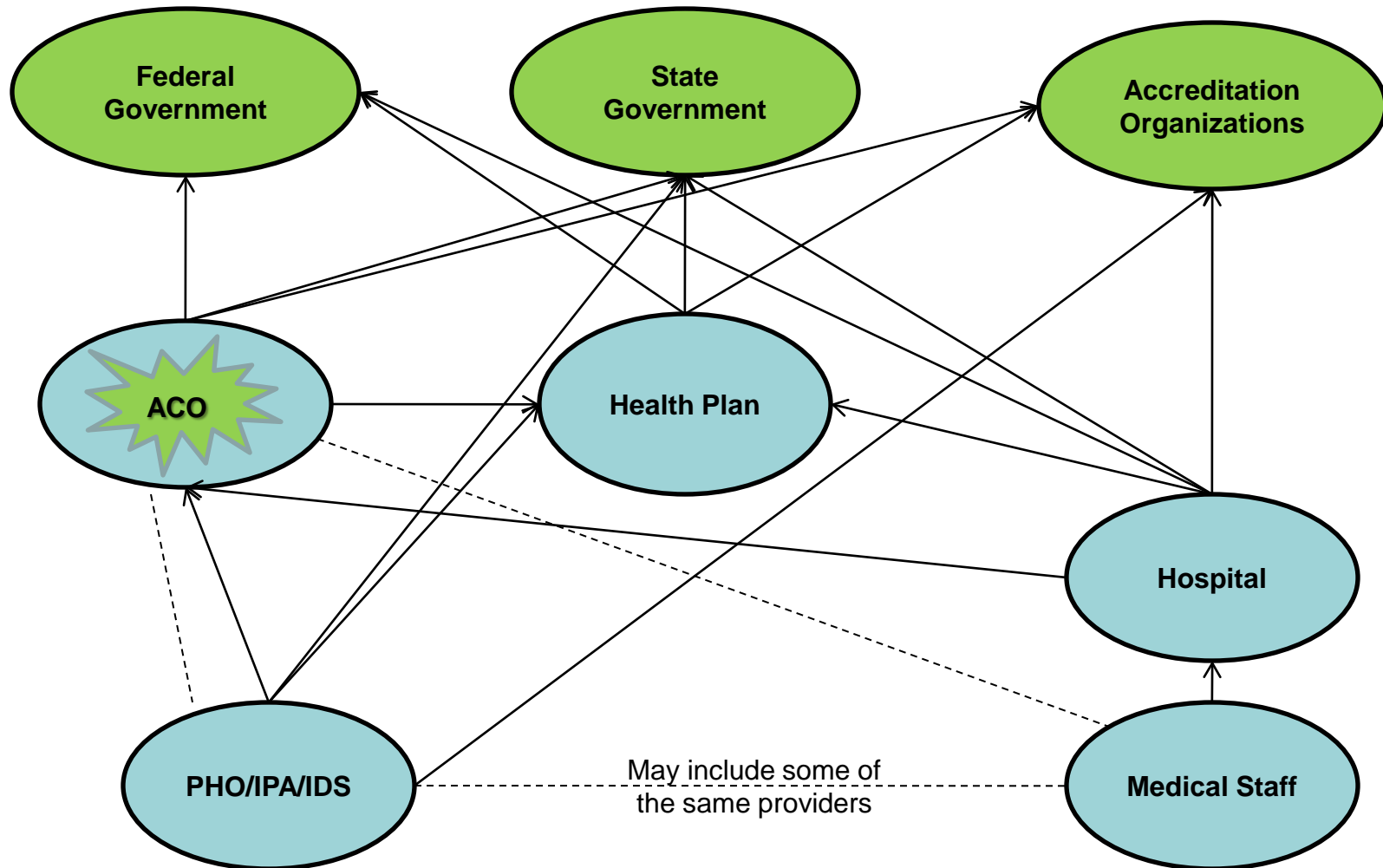
Governance Framework: Reconciling Multiple Accountabilities

	ACO Governing Body (NCQA, CMS)	PHO/IPA/IDS (NCQA, state law)	Hospital Governing Body (Joint Commission, CMS)	Organized Medical Staff (Joint Commission, CMS)
Quality	Monitors quality based on information from PHO/IPA/IDS and hospital	Directly oversees quality and implements quality improvement programs	Ultimately responsible for quality within hospital and receives information from medical staff and hospital departments/systems/processes	Directly oversees quality, implements quality improvement programs, and reports to hospital governing body
Medical Management (Utilization Review, Utilization Management, etc.)	Monitors medical management performed by PHO/IPA/IDS and hospital	If delegated authority from health plan, performs medical management	Performs medical management through medical staff committee or hospital department	If delegated authority from hospital, performs medical management and reports to hospital governing body
Credentialing	Monitors credentialing functions of PHO/IPA/IDS and hospital	If delegated authority from health plan, performs credentialing	Makes ultimate credentialing decisions for medical staff members	Makes credentialing recommendations to hospital governing body

Governance Framework: Reconciling Multiple Accountabilities (cont'd)

	ACO Governing Body (NCQA, CMS)	PHO/IPA/IDS (NCQA, state law)	Hospital Governing Body (Joint Commission, CMS)	Organized Medical Staff (Joint Commission, CMS)
Payment/ Finance	Has authority for payment methodology	Responsible for PHO/IPA/IDS performance	Responsible for hospital performance	Accountable to hospital for cost of care
Reporting	Aggregates data and reports to government and accreditation organizations	Reports to health plans and accreditation organizations	Receives information from medical staff and reports to government and accreditation organizations	Reports to hospital governing body

Governance Framework: Accountabilities and Reporting



Governance Framework: Multiple Accountabilities Raise ACO Governance Questions

- If ACO is a separate legal entity with its own governing board, what decision-making authority does it have over quality, IT and payment systems of its constituent providers?
- To what extent can the hospital governing board delegate licensure and accreditation accountability for quality to an ACO board? To an ACO board that is physician driven?
- How does the definition of the ACO mission (legal entity organized to accept cost-savings versus entity responsible for health outcomes of a defined population) drive governance?

Governance Framework: Multiple Accountabilities Raise ACO Governance Questions (cont'd)

- Is the goal of an integrated ACO to merge multiple accountabilities into a single accountable governing board and management team?
- Under the collaborative ACO model, is the ACO governing board a “standard setting board” built on an existing hospital, medical staff, provider organization or medical group with accountability for quality, efficiency and patient satisfaction?
- Under the collaborative ACO model, what degree of cross-pollination should occur among various entities with similar accountabilities within the ACO?

Governance Framework: Multiple Accountabilities Raise ACO Governance Questions (cont'd)

- How do existing boards of PHOs/IPAs/POs decide between complete metamorphosis into an ACO, joining an ACO, or disbanding? Are they obsolete?
- How do boards of exempt hospital or health systems decide what authority/accountability to provide to an ACO and still meet their own fiduciary obligations to their organization?
- What reporting should a hospital governing board or a medical staff executive committee require, if any, from the ACO board?

Governance Framework: Multiple Accountabilities Raise ACO Governance Questions (cont'd)

- How does the ACO represent competing interests?
 - Patient
 - Community
 - Provider members
 - Payors
- Who is responsible for resolving conflicts of interest between individual and institutional members of the ACO?
 - How should savings and performance dollars be allocated and/or reinvested?
 - To whom does management report?

Governance Framework: Multiple Accountabilities Raise ACO Governance Questions (cont'd)

- Do multiple accountabilities create unintended inefficiency?
- How do you build an ACO that is not simply an additional corporation that is additive but rather one that is capable of demonstrating “authenticity”?

Governance Framework: Bottom-Up Approach to Governance

- “What will be decided” rather than “who will decide” should drive governance
- Defining ACO governance structures starts with defining what decisions the ACO will make with respect to quality of care, payment and infrastructure required of ACO members
- Map entities, governing bodies, and individuals within existing provider networks and health systems that are currently accountable
- Discuss/define how existing accountabilities will change or remain the same

Governance Framework: Bottom-Up Approach to Governance (cont'd)

- Based on existing and new accountabilities, identify where decision-making will reside
- Seek synergy and avoid redundancy and duplication of effort
- Seek consensus
- Educate physician/hospital management of accountabilities through specific examples
- Lay trustees should be involved

Key Upcoming Dates

- **1/5/2011**: Massachusetts Committee on the Status of Payment Reform Legislation will release recommendations for legislation to implement the new global payment system in Massachusetts
- **1/13/2011**: Next Ropes & Gray ACO webinar on capital finance
- **Mid-January, 2011**: CMS releases regulations on ACOs

CLE Information

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Email: professionaldevelopment@ropesgray.com

Fax: +1 617 235 9606

Note: A recording of today's presentation will be made available.