ACO Strategy and Organizational Structure

Health Care Group

Tax & Benefits Group

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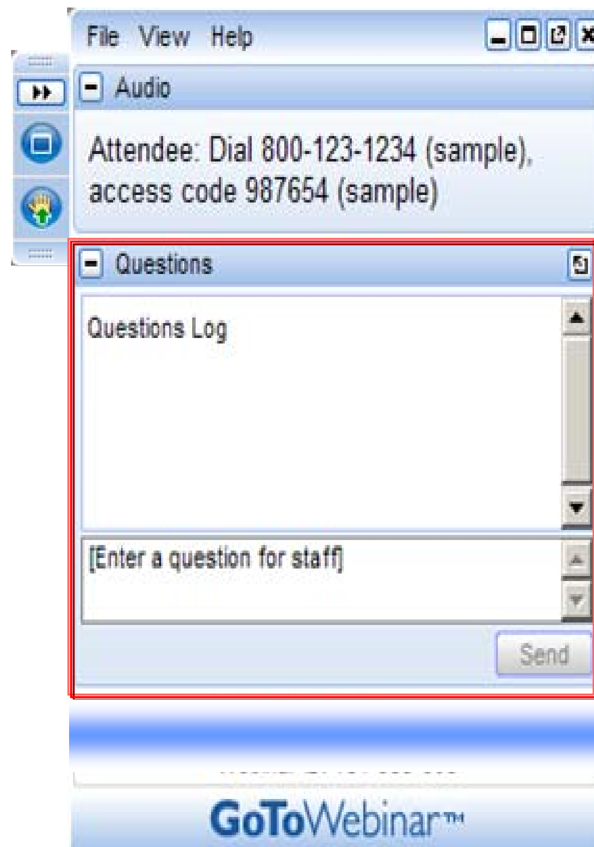


How to Participate

- Dial the conference number located in your Audio Pane.
- Submit your text question using the Questions Pane.
- Your line will be muted.

Agenda

- Brief Overview of Accountable Care Organizations (ACOs) under PPACA
- Strategic Considerations for Forming an ACO
- Tools to Achieve Strategic Goals
- NCQA Draft ACO Criteria
- Capital Requirements
- Role of Health Plans
- ACO Governance Principles
- ACO Tax Issues -- Overview
- Models for Organizational Structure of ACOs

Brief Overview of ACOs
under PPACA

ACOs under the Patient Protection and Affordable Care Act (PPACA)

- Section 3022 of PPACA promotes development of Accountable Care Organizations (ACOs) and establishes financial incentives for ACO development through the Medicare Shared Savings Program effective January 1, 2012.
- Definition of ACO under PPACA:
  - An organization whose primary care providers are accountable for coordinating care for at least 5,000 Medicare beneficiaries.
  - The ACO may include group practices, networks of practices, hospitals, hospital-physician joint ventures, and other groups.

Medicare Shared Savings Program (Section 3022); Subsection 1899 (a)(1)

ACOs Under the Patient Protection and Affordable Care Act (PPACA) (cont'd)

- Stated Rationale for ACO Model
  - Promotes accountability for a patient population
  - Permits coordination of items and services reimbursable under both Medicare parts A and B
  - Encourages investment in infrastructure
  - Redesigns care processes for high quality, transparent, and efficient service delivery
  - Promotes meaningful, performance-based incentives

Medicare Shared Savings Program (Section 3022); Subsection 1899 (a)(1)

Criteria for Participation in Medicare Shared Savings Program

- Agree to become accountable for the care of Medicare fee-for-service (FFS) beneficiaries
- Agree to a 3-year participation in the ACO program
- Create a formal legal structure that would allow the organization to receive and distribute bonuses to participating providers
- Include PCPs for at least 5,000 Medicare FFS beneficiaries
- Institute a leadership and management structure
- Promote evidence-based medicine, report on quality and cost measures, and coordinate care
- Demonstrate that the ACO meets patient-centered criteria as determined by the Secretary

Medicare Shared Savings Program (Section 3022); Subsection 1899 (b)(2)

ACO Payments & Savings

- ACOs will share a percentage of savings with the federal government if:
  1) The ACO’s estimated average per capita Medicare expenditures, adjusted for beneficiary characteristics, is below the benchmark rate; and
  2) The ACO meets the quality performance standards established by the Secretary
- The Secretary is allowed flexibility in awarding contracts

Medicare Shared Savings Program (Section 3022); Subsection 1899 (d)

ACO Data Reporting Requirements

- The Centers for Medicare and Medicaid Services (CMS) may incorporate reporting requirements, incentive payments, and penalties based on:
  - Electronic prescribing
  - Electronic Health Records
  - Physician quality reporting
  - Any other data reporting requirements that CMS deems necessary

Medicare Shared Savings Program (Section 3022); Subsection 1899 (c)

Fraud and Abuse Laws and ACOs

- PPACA grants the Secretary the authority to waive the requirements of the following fraud and abuse laws with respect to ACOs:
  - Civil Monetary Penalty Statute's prohibition on payments to reduce or limit care, 42 U.S.C. 1320a-7a(b)
  - Stark Law, 42 U.S.C. 1395nn
  - Anti-kickback Statute, 42 U.S.C. 1320a-7b(b)(1) and (2)
  - Medicare prohibition on beneficiary inducement 42 U.S.C. 1320a-7a(a)(5)
  - Prohibitions against collecting more than Medicare allowed amount, 42 U.S.C. 1320a-7a(a)(2)

Medicare Shared Savings Program (Section 3022); Subsection 1899 (c)

ACO Timelines

2010

Patient-Centered Outcomes Research (PPACA, § 6301)

Community Transformation Grants (PPACA, § 4201)

Medicaid Global Payment System Demonstration (PPACA, § 3027)

2011

National Strategy for Improvement in Health (PPACA, § 3011)

Establishment of Center for Medicare and Medicaid Innovation (PPACA, § 3021)

2012

Medicare Shared Savings Program (PPACA, §3022) January 1, 2012

Hospital Value-Based Purchasing Program (PPACA, § 3001)

Hospital Readmissions Reduction Program (PPACA § 3025)

Independence at Home Demonstration Program (PPACA § 3024)

2013

National Pilot Program on Payment Bundling (PPACA, § 3023)

2014

Quality Reporting from Long Term Care Hospitals, Inpatient Rehabilitation Hospitals and Hospice Programs (PPACA, § 3004)

2015

Payment Adjustment for Conditions Acquired in Hospitals (PPACA, § 3008)

Improvements to Physician Quality Reporting System (PPACA, § 3002)

Strategic Considerations for Forming an ACO

Strategic Goals for ACO Formation

- Engaged provider network
  - Selective inclusion of high-performing providers
  - Committed to use evidence-based best practices, continuous quality improvement, reduce variation and improve efficiency
  - Consequences to address underperformance
- Physician alignment
  - Opportunity to obtain additional funds by reducing hospital utilization (i.e., making hospitals cost centers)
- Potential to shift hospital volume
  - Medicare accounts for one-third to one-half of hospital business
  - Gain in volume and avoidance of volume loss to competitors
  - Volume shift to cover fixed costs

Strategic Goals for ACO Formation (cont'd)

- Quality improvement and cost savings
  - Reducing hospital stays, readmissions and high cost services while improving quality
  - Improved customer service
- Clinical integration and effective medical management across the continuum of care
- Payer contracting
  - Participate in insurance exchanges
  - Manage global payments and episode of illness payments
  - Align government and commercial insurer payment methodologies and performance measures

Strategic Goals for ACO Formation (cont'd)

- Allocating payments among the ACO providers without hospital subsidies
- PCP Involvement
  - Medicare beneficiaries are assigned to ACOs based on the beneficiaries' choice of PCPs
  - PCPs anchor Medical Homes which can steer volume to ACO sponsors
  - PCP involvement and leadership in governance is critical
- Specialists
  - Sufficient participation by specialists to ensure access and maximize care coordination

Integrating Specialists in the ACO

- PCP-Specialist coordination is necessary to reduce inappropriate care, prevent complications.
- To improve quality and lower costs across the full spectrum of care, ACOs need to promote higher-value specialty care through:
  - Use of patient registries, EHRs to provide timely, meaningful data
  - Payment models that encourage PCP-specialist coordination
- Performance Measures should address specialty care by moving toward measuring outcomes and value-based payment for episodes of care.

Strategic Conundrum of Investing in an ACO

- A successful ACO will reduce utilization and hospital revenue.
- Increased hospital volume through competitive advantage is necessary to offset reductions in utilization.
- The status quo (doing nothing) may result in loss of volume to a competitor hospital which does establish an ACO.
- Failure of hospital to engage physicians may result in physician-only ACO with hospital receiving no share of savings from reduced utilization.

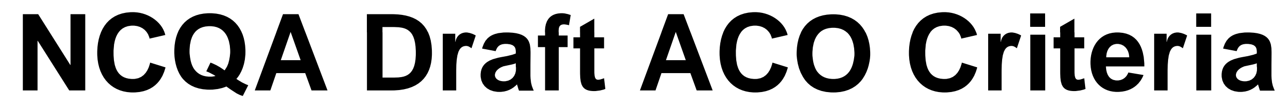
The Tools to Achieve
Strategic Goals

The Tools to Achieve Strategic Goals

- Administrative and clinical leadership and management
- Common IT infrastructure
  - EMR for clinical management and care coordination of patients
  - Improved patient-provider and provider-provider communication
- Financial and analytic capabilities
  - Modeling best practices
  - Reporting capability

The Tools to Achieve Strategic Goals (cont'd)

- Administrative infrastructure
  - Staffing
  - Capability to receive and distribute shared savings
- Capital to fund development, cash flow and reserves
- Risk Management
- Clinical Management


NCQA Draft ACO Criteria

NCQA Draft ACO Criteria

- Sets forth core capabilities ACOs should possess to qualify and to be scored in ongoing monitoring.

Category	Criteria
1. Program Structure Operation	• Clearly defined organizational and leadership structure. • Capability to manage resources effectively. • Arranges for health care services and determines payment arrangements.
2. Access and Availability	• Sufficient numbers of primary and specialty care providers.
3. Primary Care	• PCPs provide patient-centered care.

NCQA Draft ACO Criteria (cont'd)

Category	Criteria
4. Care Management	• Data collected and integrated for clinical and administrative purposes. • Initial assessment of new patients' health. • Use of appropriate identification of population health needs and program implementation. • Supports use of patient care registries, electronic prescribing, and patient self-management.
5. Care Coordination and Transitions	• Timely information exchange between PCPs, specialists and hospitals.
6. Patient Rights and Responsibilities	• Policy to respect patient rights and privacy. Methods to handle patient complaints.
7. Performance Reporting	• Measures and reports clinical quality, patient experience and cost. • Annual measurement of ACO performance.

Capital Requirements

Capital Requirements to Establish and Operate an ACO

- Costs of creating the infrastructure, reserves (for downside risk and business losses: satisfaction of state laws) and operational cash flow
- Physicians are central to ACOs, which are designed to be provider-driven
- Physicians, even large multispecialty groups and networks, may not be able to provide sufficient capital to establish an ACO or even fund a proportionate share of their interest in an ACO
- Generation of shared savings payments from Medicare may take up to two years from the date of initial capital investment

Capital Requirements to Establish and Operate an ACO (cont'd)

- Access to the debt and equity markets independent of sponsoring organization(s)
  - for-profit ACOs
  - not-for-profit ACOs
  - Private Equity Market
  - ROI
- Cautionary tale: remember physician practice management companies

Possible Solutions to Capital Requirements

- The ACO may also participate in shared savings programs with commercial payers to provide cash flow to fund operations until Medicare shared savings payments become available
- Organizational structure that allows the hospital-member of the ACO to fund a disproportionate amount of initial capital needs of the ACO

The Role of Health Plans

The Role of Health Plans

- Health plans are catalyzing the formation of ACOs
- Health plans will need to:
  - Respond in innovative ways to the increased focus on value
  - Manage clinical and administrative costs consistent with the new medical loss ratio requirements
- Funds flow mechanism for meeting quality and efficiency targets with no downside risk
- Funding mechanism that generates reserves for the ACO

The Role of Health Plans (cont'd)

- ACO pods should be incentivized individually and collectively
  - ACOs may have groupings of physician-hospital pods at the different hospital sites or pods made up of individual physician groups
- Risk of diminished role for the health plan in care management and provider network management
- Self-insured employers can bypass the health plan and go straight to the ACO

ACO Governance Principles

The Principles of Governance

- Physician input
- Shared governance
- Members
  - Reserved Powers
- The Board
  - Physician representation:
    - PCPs and specialists
    - Employed and voluntary
  - Quorum
  - Vote

The Principles of Governance (cont’d)

- Exclusivity
  - PCPs exclusively participate in one ACO
  - Specialists may participate in more than one ACO
- Right of first opportunity to negotiate payer contracts

ACO Tax Issues -- Overview

ACO Tax Issues

- Tax-exemption for the ACO
  - Community benefit test
  - Integral part test
- Private inurement / private benefit
- Intermediate sanctions
- Joint venture rules
- Private use issues

ACO Tax Issues (cont'd)

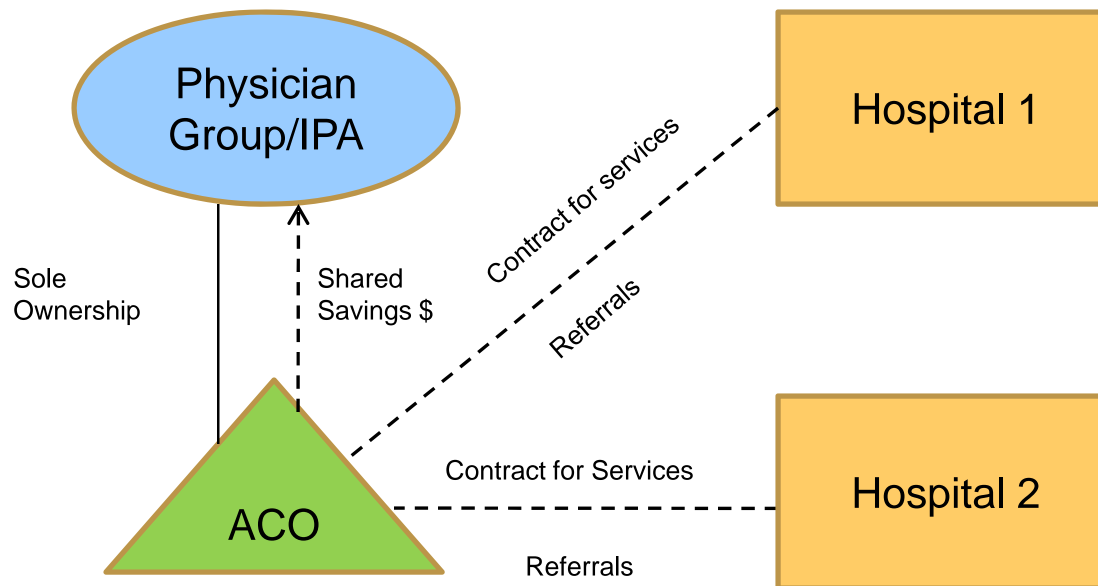
- Unrelated business taxable income (UBTI)
- Timing of income; Internal Revenue Code (IRC) § 277
- IRC § 457(f)
- IRC § 409A
- Property Taxes
- Employment Taxes

Models for Organizational
Structure of ACOs

Summary of Models

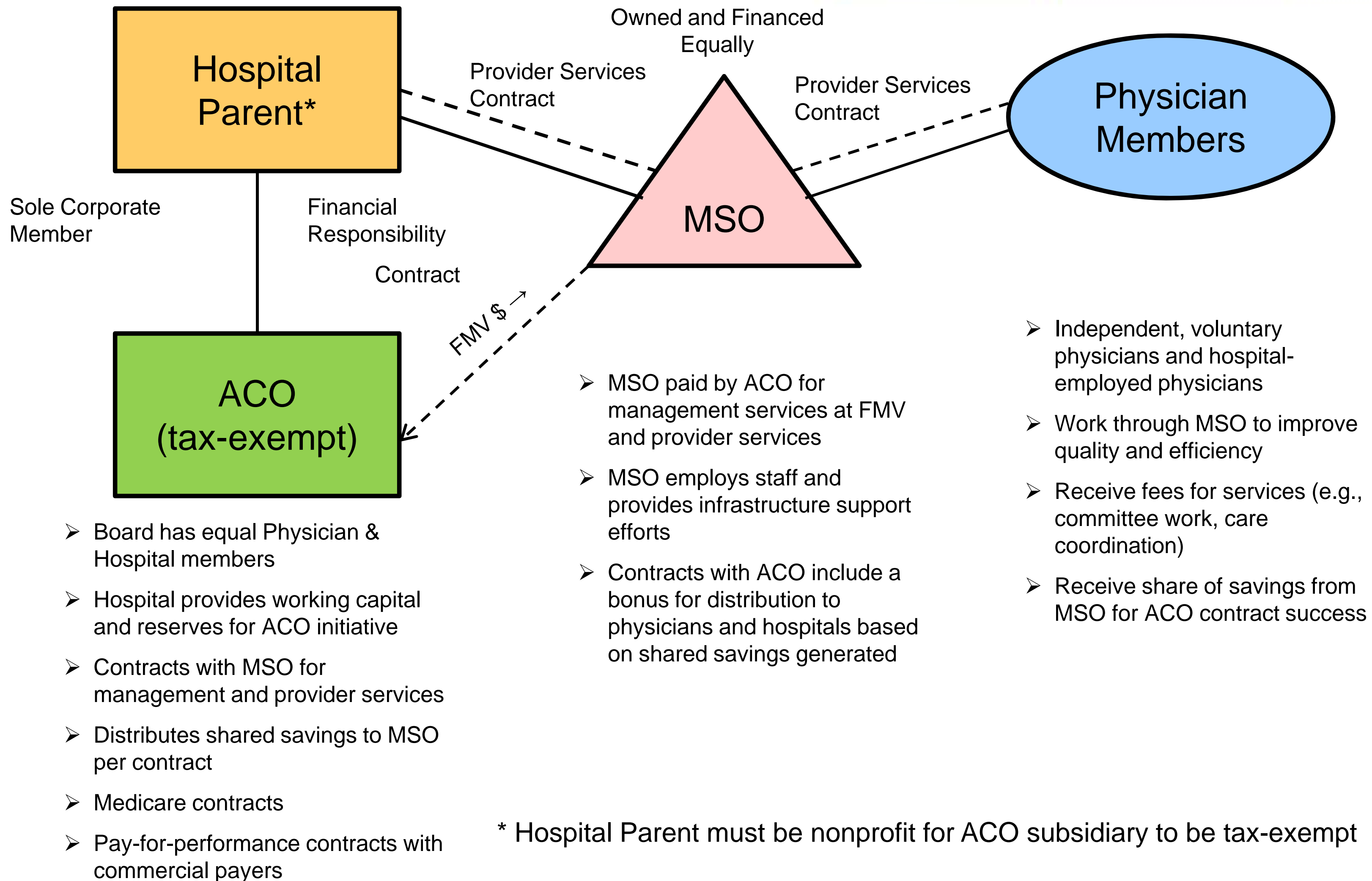
- Physician-only ACO
- Nonprofit tax-exempt corporation
- For-profit corporation
- LLC Model
- Hospital Division or Single-Member LLC

Physician-Only ACO Model



- ACO sends volume to lowest cost hospital (while maintaining quality)
- Hospitals receive no portion of shared savings from reduced utilization
- ACO could be LLC, for-profit, or nonprofit taxable corporation

Nonprofit Tax-Exempt Model



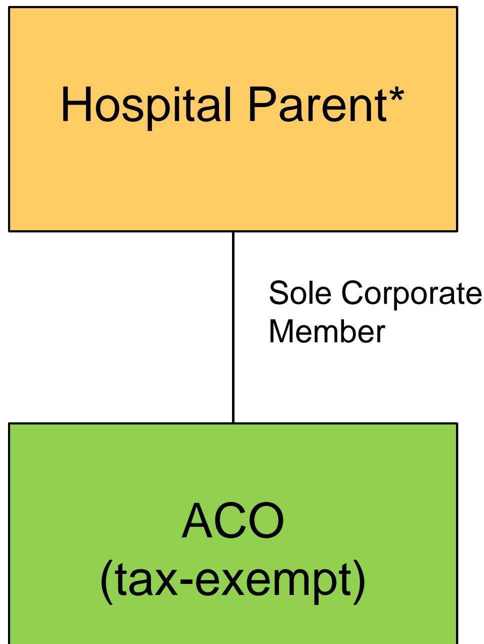
- Board has equal Physician & Hospital members
- Hospital provides working capital and reserves for ACO initiative
- Contracts with MSO for management and provider services
- Distributes shared savings to MSO per contract
- Medicare contracts
- Pay-for-performance contracts with commercial payers

- MSO paid by ACO for management services at FMV and provider services
- MSO employs staff and provides infrastructure support efforts
- Contracts with ACO include a bonus for distribution to physicians and hospitals based on shared savings generated

- Independent, voluntary physicians and hospital-employed physicians
- Work through MSO to improve quality and efficiency
- Receive fees for services (e.g., committee work, care coordination)
- Receive share of savings from MSO for ACO contract success

* Hospital Parent must be nonprofit for ACO subsidiary to be tax-exempt

Nonprofit Tax-Exempt Model: Governance



Powers of Sole Corporate Member:

1. Approve amendments to governing documents
2. Approve sale of substantially all the assets; dissolution; or liquidation
3. Appoint/remove directors from slate proposed by physician members and Hospital
4. Approve outside auditors recommended by Board

Board of Directors:

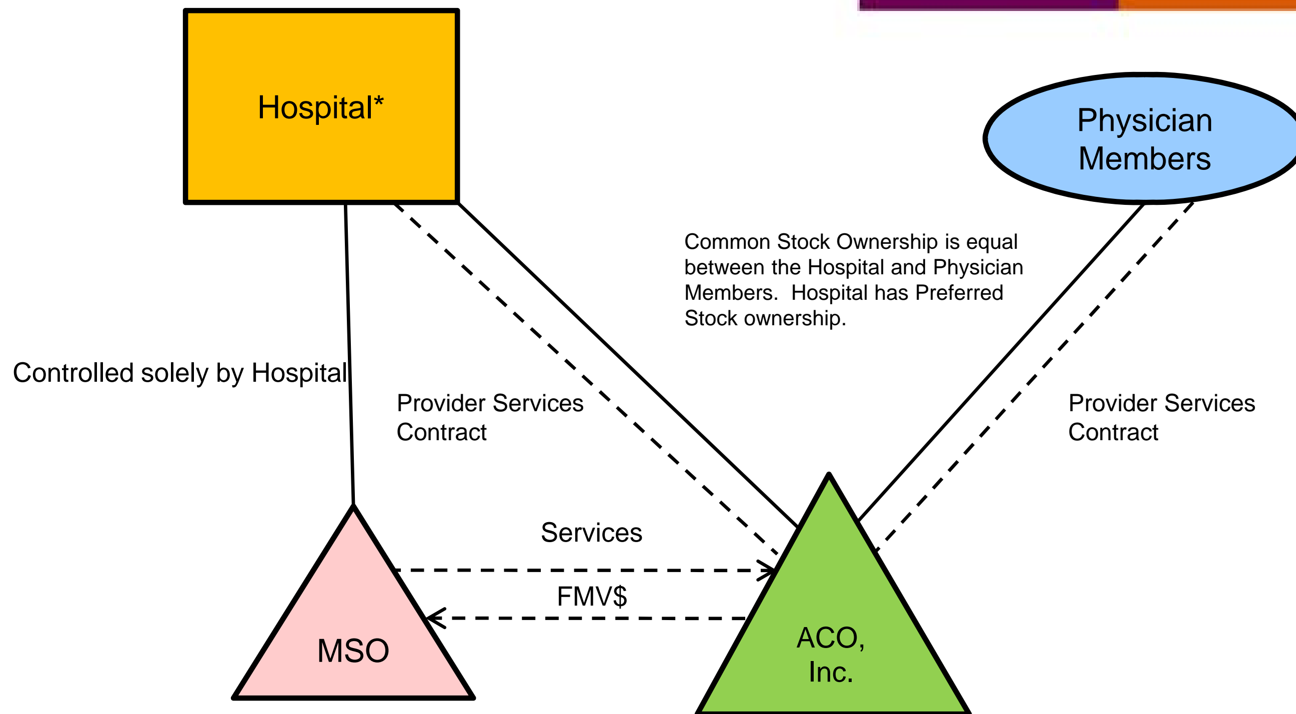
- Exercise oversight of ACO subject to reserved powers of Hospital as Sole Corporate Member
- Appoint executive director/medical director
- Approve funds flow
- Recommend outside auditor
- Appoint Committees: Finance; Contracting; Quality

* Hospital Parent must be nonprofit for ACO subsidiary to be tax-exempt

Nonprofit Tax-Exempt Model: Pros/Cons

- PROS:
  - Income is tax-exempt to the ACO
  - Simultaneously responsive to Hospital mission and need for greater physician involvement
  - Provides clear lines of accountability and financial transparency
  - Hospital and physicians have equal partnership on risk and pay for performance contracts
- CONS:
  - Unclear whether tax-exemption will be available
  - If exemption not available, net income will be taxable
  - Difficult to have Hospital as sole member but have sufficient physician involvement in governance under “integral part test”
  - Cost and time involved in obtaining tax-exempt status for ACO
  - Physicians may resist participation where Hospital is dominant member

For-Profit Corporation Model



- Hospital provides a substantial amount of working capital and reserves through Preferred Stock ownership or loan to ACO
- Contracts with MSO for Management Services
- Distributes shared savings to Hospital and physician members
- Medicare and commercial contracts

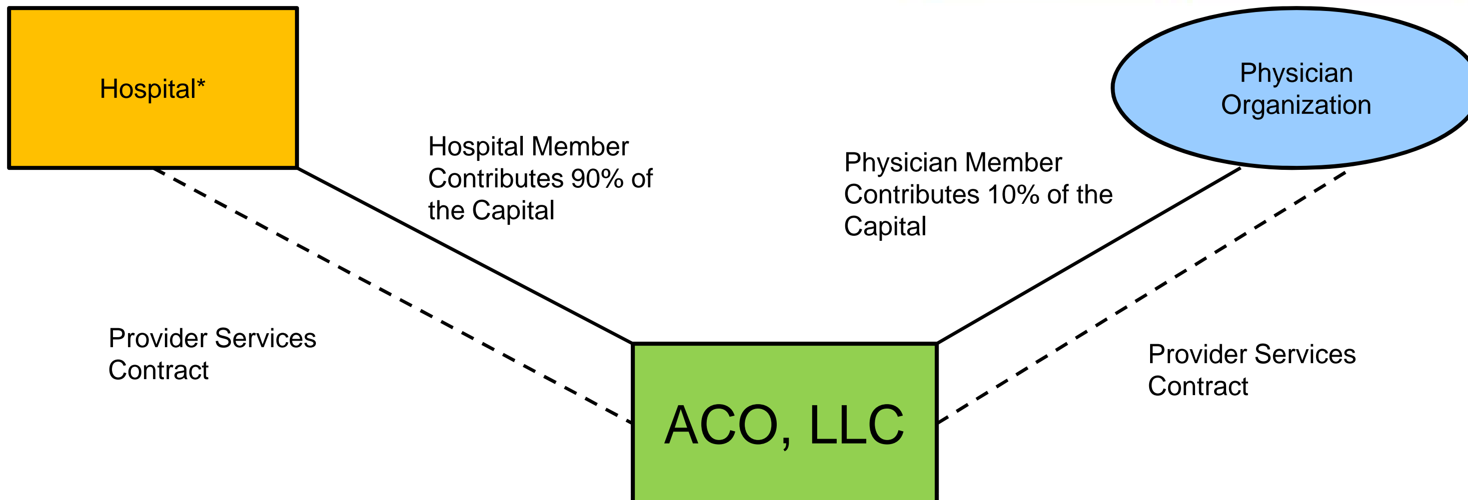
- MSO paid by ACO for management services at FMV
- MSO employs staff and provides infrastructure

* Hospital may be nonprofit or for-profit

For-Profit Corporation Model: Pros/Cons

- PROS:
  - Separate profits and losses from stockholder entities
  - Hospital can fund disproportionate share of capital expenses through preferred stock, but still have substantial physician involvement in governance
  - Hospital and physicians have equal partnership on risk and pay for performance contracts
- CONS:
  - Taxation of net income
  - Does the offering of stock constitute the sale of a security under federal or your state's laws?

LLC Model



- Operates in support of the charitable, medical and educational purposes of the Hospital.
- Allocations of profits, losses and distributions of cash are made in conformity with Membership Percentage Interest.
- Board has equal representation from Hospital and Physician Members. Board Powers set forth in Slide 48.
- Reserved powers only in Hospital Member. See Slides 46-47.
- ACO distributes shared savings to Hospital and Physician Organization as an expense before cash distributions.
- May use in conjunction with an MSO structure.

* Hospital may be nonprofit or for-profit

LLC Model: Reserved Powers of Hospital Member

- Election and removal of ACO Board of Managers.
  - Physician-nominated Board members shall be elected except if Hospital has cause otherwise.
- Approve or initiate the sale, lease, merger, consolidation or other transfer of the ACO.
- Approve or initiate the sale, lease, transfer, assignment, encumbrance or disposition of ACO assets greater than $X.
- Approve or incur debt in excess of a certain dollar amount.
- Approve or initiate the dissolution or liquidation of the ACO or initiate insolvency or bankruptcy proceedings.
- Approve amendments to the organizational documents of the ACO with some member protections.
  - Affected Member’s approval required for changes to the Member’s allocation, amendments involving manner Board of Managers is nominated or elected

LLC Model: Reserved Powers of Hospital Member (cont'd)

- Approve or initiate a material change in the nature of the ACO's business or lines of service.
- Approve, amend or terminate the Management Agreement with the MSO (if any) and other material contracts.
- Approve and establish annual operating budgets and strategic plans.
- Approve or initiate additional capital calls from members or approve a private placement or similar financing of the ACO.
- Approve distributions of cash or shared savings payments.
- Approve new providers to participate in the ACO.
- Approve settlements or litigate materials claims against the ACO.

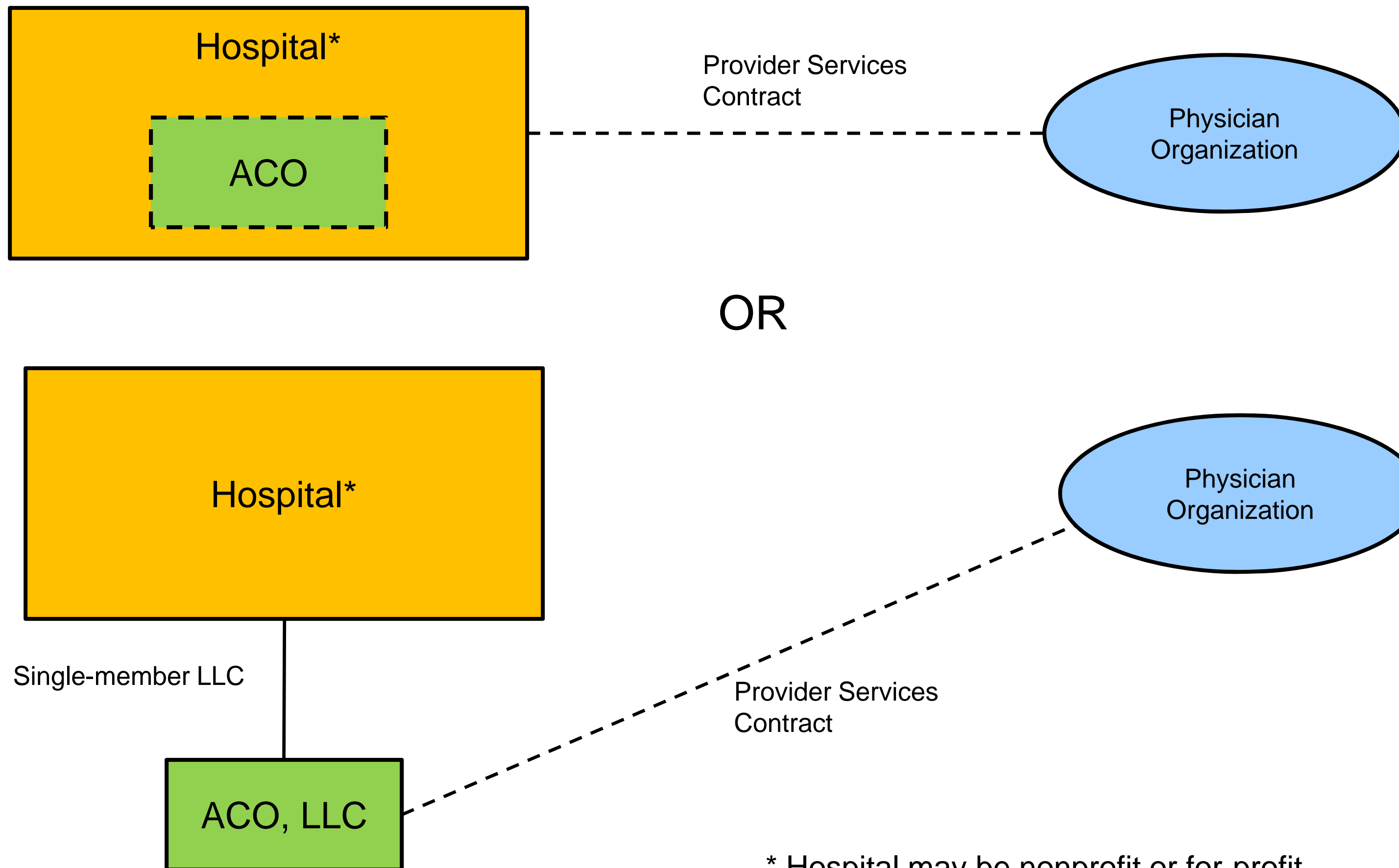
LLC Model: Powers of the Board (equal representation)

- Appointment of ACO officers and leadership positions.
- Approval of the sale, lease, transfer, encumbrance, assignment or disposition of ACO assets less than $X or a Member's interest in the ACO.
- Approval of financial risk sharing compensation models.
- Approval of new classes of health care provider Members of the ACO.
- Approval of the entry of new Members into the ACO.
- Retention of consulting, legal, accounting or actuarial services.
- Approval of contracts with third parties of less than a certain dollar threshold.

LLC Model: Pros/Cons

- PROS:
  - ACO activities would be a related activity to the exempt purpose of a tax-exempt hospital member
  - Hospital can fund disproportionate share of capital expenses, but still have substantial physician involvement in governance
  - Responsive to Hospital mission and need for greater physician involvement
  - Provides clear lines of accountability and financial transparency
  - Hospital and physicians have equal partnership on risk and pay for performance contracts
- CONS:
  - Risk of jeopardizing tax-exempt entity's tax-exempt status where ACO also includes for-profit members
  - Physicians may resist participation where Hospital is dominant member
  - Does the offering of a membership interest constitute the sale of a security under federal or your state's laws?
  - Schedule K-1 filing obligation

Hospital Division Model / Single-Member LLC Model



* Hospital may be nonprofit or for-profit

Hospital Division Model: Pros/Cons

- PROS:
  - Allows Hospital to disproportionately fund capital expenses.
  - Hospital-owned, single member LLC can be disregarded entity or can be structured as a pass-through entity if there is risk-sharing.
- CONS:
  - This structure is not a true 50/50 Hospital/Physician venture. PPACA and draft NCQA standards favor physician-driven ACOs.
  - ACO revenues treated as Hospital revenues, thus subject to Hospital loan agreements/Hospital creditors.
  - No independent accounting oversight. Need for greater financial transparency.
  - Stark Law / Anti-kickback Statute: difficult to fit within applicable exceptions or safe harbors (unless hospital employs physicians or payments are for quality-related services only rather than shared savings, efficiency or utilization measures).
  - Tax and Tax-exempt issues: private benefit and inurement; private use.

CLE Information

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