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ACO Business News

Timely News and Business Strategies on Accountable Care Organizations

Contents

Editor
Jennifer Lubell
jlubell@aishealth.com

Executive Editor
Jill Brown

Hospitals, Docs Are Assuming Leadership In Majority of ACO Governance Structures

Ask the developer of any accountable care organization how its governance structure works, and most will say that it's the provider entities — the hospitals and physicians — steering the ship, as they work in tandem with insurance carriers through contractual agreements. However, in polling various ACOs across the country, *ABN* found that there is a great deal of variety in how these organizations establish leadership roles among their respective ACO partners.

As it seeks to expand ACO delivery models across the state, Blue Shield of California says it will be using a "shared leadership model" to ensure stability and accountability among the partners of its ACOs. In Minneapolis, Fairview Health Services and Blue Cross and Blue Shield of Minnesota say they have a contractual relationship as opposed to a shared governance structure — yet the two entities do participate in a governance steering committee and related subcommittees.

And further east in Rolling Meadows, Ill., there's Advocate Physician Partners, a joint venture between Advocate Health Care and 4,000 physicians that has provided care under risk and clinically integrated contracts for more than 10 years, explains Mark Shields, M.D., senior medical director for Advocate Physician Partners and vice president for medical management, Advocate Health Care. The venture started ACO or shared savings-type contracts with Blue Cross and Blue Shield of Illinois in January 2011 and plans to start a Medicare Shared Savings Program (MSSP) ACO this summer.

"We have a contractual relationship with Blue Cross, and we share data and performance with their senior leaders, but they have no governance role in Advocate Physician Partners," Shields says.

continued on p. 9

MSSP Participants Should Know Their 'Hurdle Rate,' Health Observer Contends

To participate in the Medicare Shared Savings Program (MSSP) (*ABN 11/11, p. 1*), it's important for providers to know and understand what their "hurdle rate" is — a target that CMS will be using to measure its own projected cost of care compared to the ACO's actual cost of care for an attributed Medicare population, Joel Hoffman, senior vice president, OptumInsight, tells *ABN*.

In an interview with *ABN*, Hoffman clarifies that "hurdle rate" is not an industry term. "I would say every ACO knows they'll be measured against a number, and this number is called the 'hurdle rate' in my mind — the average per member per month (PMPM) medical spend rate they must provide care below for their attributed population. CMS probably sees it as a target or something like that."

CMS to date has released a *formula,* the calculation it will follow to determine what an MSSP ACO's hurdle rate is, Hoffman explains. The agency determines this rate or target by going through its calculations and telling the ACO: "Here's your panel of physicians that you submitted as part of your application. Here are the Medicare ben-

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Insurer and purchaser groups in the meantime would like to see the federal government clamp down on antitrust policy it released in conjunction with the MSSP regulations. These organizations, among them industry trade group America's Health Insurance Plans, have stated that Medicare ACOs may accumulate unfair market power under the federal government's decision to shift from mandatory to voluntary antitrust review as a condition of participation in MSSP (*ABN 11/11, p. 10*).

Five Barriers to Integration Exist

Hatton outlined "five key barriers" to clinical integration, including the federal antitrust statute, which penalizes collusion and price fixing. "It's often difficult, particularly in this current environment, for the antitrust agencies to be able to differentiate between what's alignment for improving quality and efficiency, and what's a conspiracy for price fixing," Hatton said.

The antitrust laws have criminal penalties for price fixing, and the antitrust agencies, the Federal Trade Commission in particular, are "not averse to using those penalties if they think you've got your clinical integration arrangement wrong," she said.

The AHA has been urging the antitrust agencies to come up with comprehensive guidelines to help hospitals and physicians "through this thicket" of antitrust regulations, she said.

There are the fraud and abuse statutes, which "are unbelievably rigid," Hatton continued. These carry civil fines, and one carries criminal penalties, where providers risk debarment from federal programs. "And they're arcane in ways you can only sort of barely understand."

Under the Stark law, for example, which governs self-referral for Medicare and Medicaid patients, a hospital could conceivably violate the statute if it's trying to develop a clinical integration arrangement and reward physicians on the basis of quality and improvement, Hatton said. As the AHA's policy document noted, "a doctor that receives a bonus as part of a clinical integration program that helps patients manage their diabetes according to a well-designed medical protocol, risks being in violation of the Stark law."

If a hospital reduces or withholds services, it's in violation of the Civil Monetary Penalty law. "But let's say you want to incent your physicians to follow evidence-based protocols, and that entails changing or eliminating some of the care that the patients were previously getting. You now have a civil monetary problem."

The anti-kickback statute, "another strain of arcane regulatory landscape," is intended to prevent inappropriate referrals. "The OIG has really managed to stretch the statute to cover almost any financial relationship. But again, if you're paying physicians to try and incent them to improve their care and change their protocols, you're in danger of being considered [to be] paying for referrals. And again, this is actually the one that carries criminal penalties. So when you put these three statutes together, overlaid with the antitrust laws, you can see what kind of a maze you're creating for hospitals," Hatton said.

IRS Didn't Deliver on Clarifying Rule

And then there are Internal Revenue Service (IRS) rules for not-for-profit hospitals, which prevent a tax-exempt institution's assets from being used to benefit any private individual, including doctors. "One question that's been asked is what if you're paying physicians to improve quality? Is that an improper dispensation of assets or not? We had actually hoped that the IRS would answer this question in the [Medicare] ACO regulations," and pave the way for not-for-profit hospitals to at least take one of the worries off their plate, "but it didn't accomplish that," Hatton said. "We were hoping they would be more clear" about this.

Contact Hatton via Marie Watteau at mwatteau@aha.org. ✧

Providers Drive ACO Governance

continued from p. 1

As ACO-type models continue on a fast track across the country, they all must decide the parameters by which they govern their new delivery systems, Phil Gaziano, M.D., CEO of Accountable Care Associates LLC (ACA), in Springfield, Mass., tells *ABN*. He contends that "there definitely are a lot of different models. And that's by design." ACA is a physician-led organization that supports a multitude of providers that want to do ACO-style global capitation.

"We are trying to go through a period of letting different combinations of providers and supporting organizations come together to do these [ACOs]….So there will be some that won't have a payer at all. There will be some that will be led by a payer. There will be some that will have a payer in a support role but be led by a provider group," Gaziano tells *ABN*.

In many instances, payers in these ACO-type arrangements are likely going to be taking on more of an administrative role, observes Deb Mabari, CEO of Cody Consulting Services, Inc., a health care consulting firm in Tampa, Fla. "Obviously the rules CMS created for the ACO almost forces a more provider-centric sort of organization," where the payer sits on the back end and helps with the administrative work such as claims adjudication "because there's clearly economies of scale and scope there that the provider will not be able to obtain on their own," she tells *ABN*.

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president for provider network management, tells *ABN*. That insurer developed a three-way risk sharing ACO model with hospital and physician groups in the state last year (*ABN 9/11, p. 12*), in addition to launching several other ACO arrangements in January and February (see brief, this page). There is a governing board — composed of executive leadership from all the organizations, including Blue Shield — for each of its ACOs, Miranda says, which provides program oversight; makes strategy, contracting and funding decisions; and represents executive leadership from all organizations.

"This model maximizes the opportunity for consensus while providing a path to resolve deadlocks. In addition, an interdisciplinary team of clinical, financial and operational leaders directs work groups that drive each ACO's initiatives," she explains.

ACOs Establish Governance for MSSP

On the Medicare side, several health care observers who spoke with *ABN* on their respective ACO governance models discussed how they were planning to organize or amend their models in order to participate in MSSP.

The final MSSP regulations were released last fall (*ABN 11/11, p. 1*). Under the voluntary program, approved sponsors of Medicare ACOs continue to get Medicare fee-for-service (FFS) payments while qualifying for additional funds by meeting quality and savings requirements. The statute requires each ACO to establish a governing body representing ACO providers of services and suppliers and Medicare beneficiaries.

Prior to applying for the MSSP on July 1, Advocate Physician Partners will make a modification in its governance by adding a beneficiary over the age of 65 to meet the MSSP's requirements. "We will be adding that person before July," Shields says. This will be the governance structure for all of the contracts that the ACO engages in.

Gaziano says his organization, ACA, is setting up a joint venture between 80 primary care physicians and two hospitals to apply for MSSP. These provider organizations essentially got together and said, "we're going to do a joint venture and build a structure which has already been proven with the Medicare Advantage plans and the Alternative Quality Contract and then file an application with CMS" (see story, p. 4).

The governance support or board for the ACO will include representatives for primary care physicians, the two hospitals, the lay community, specialists and two from ACA. Gaziano says that he's assuming a leadership role in the ACO's board of directors. "This is a joint governance, joint operation." In keeping with MSSP requirements, there will also be a Medicare beneficiary on the board.

ACA in the meantime will provide all of the data management, care management and quality oversight functions, he explains. "We've also been setting up the mechanism to meet the compliance regulations," he adds. "We have to make sure that the physician providers are informed…[to] report the quality metrics to the federal government and pay attention to the budget and claims as they come through."

The agency seems favorable to what ACA has come up with, "from what we've exchanged so far. And then we'll be enrolling about 30,000 unmanaged Medicare lives starting July 1," Gaziano says.

Contact Shields via Maureen Daugherty at maureen.daugherty@advocatehealth.com, Gaziano at gazianop@acafirst.com, McCoy via Mary Edwards at medward1@fairview.org, Miranda via Johnny Wong at Johnny.Wong@blueshieldca.com and Mabari at dmabari@codyent.com. ✧

NEWS BRIEFS

◆ **Three Blues health plans — Highmark, Horizon Blue Cross Blue Shield of New Jersey and Independence Blue Cross (IBC) — are partnering with health IT provider Lumeris Corp. to acquire NaviNet, the nation's largest real-time communication network for physicians, hospitals and health insurers, for an undisclosed price.** "The partnership will build on NaviNet's best-in-class network for transactions among health care providers and insurers by launching an unprecedented initiative to deliver critical information and applications to drive accountable, value-based health care," according to a press release from Lumeris, which has been developing software and services for accountable care ventures (*ABN 10/11, p. 9*). According to the release, NaviNet speeds and simplifies more than 50 kinds of administrative, financial and clinical transactions among three-quarters of America's physicians, 3,800 hospitals and dozens of the nation's largest health insurers, including Highmark, Horizon and IBC. The expectation is the acquisition will position NaviNet to expand customers served by its communications network. Read the press release at www.lumeris.com/news/2012/news_feb14.php.