

The background of the slide is a light blue-tinted image. On the left side, there is a semi-circular view of the United States Capitol building. On the right side, there is a semi-circular view of a globe showing the Americas. A dark blue horizontal bar is positioned at the top of the slide, partially overlapping the globe.

Healthcare Reform: Its Impact on Employers, Payors and Providers

**The Greater Scranton Chamber of Commerce
Health Care Reform Panel Discussion**

October 18th

The University of Scranton DeNaples Center

Doug Hastings

Mark Lutes

Adam Solander

Epstein Becker & Green, P.C.

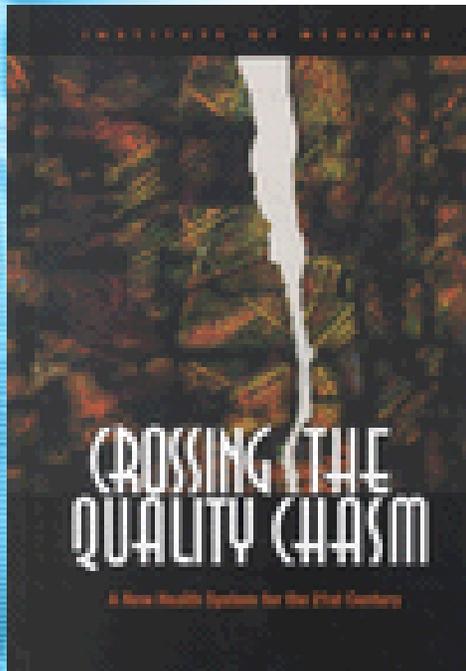


**OVERVIEW OF
HEALTH CARE REFORM**

U.S. Health Care System Realities

- Mixed public and private system
- Health care is a huge component of the U.S. economy
- Health care system is extraordinarily advanced, yet inefficient, uneven, and too often unsafe
- Improvement will require collaboration, integrated care, and aligned incentives
- Regulatory system and enforcement priorities are not necessarily aligned with policy needs and operational realities
- Three key issues: Quality, Cost, Access

Quality of Care: The Need For Change



“The American health care delivery system is in need of fundamental change. Many patients, doctors, nurses, and health care leaders are concerned that the care delivered is not, essentially, the care we should receive...Quality problems are everywhere affecting many patients. Between the health care we have and the care we could have lies not just a gap, but a chasm.”

-Institute of Medicine, 2001

The IOM's Six Aims

Quality defined as care that is:

- Safe
- Effective
- Efficient
- Patient-Centered
- Equitable
- Timely

Quality of Care: Results of the National Scorecard on U.S. Health System Performance

- The National Scorecard measures quality, access, equity, outcomes, and efficiency in the U.S. health care system
- Based on these measures, the overall U.S. score was 65 out of a possible 100
- Efficiency was the single worst score among the five dimensions

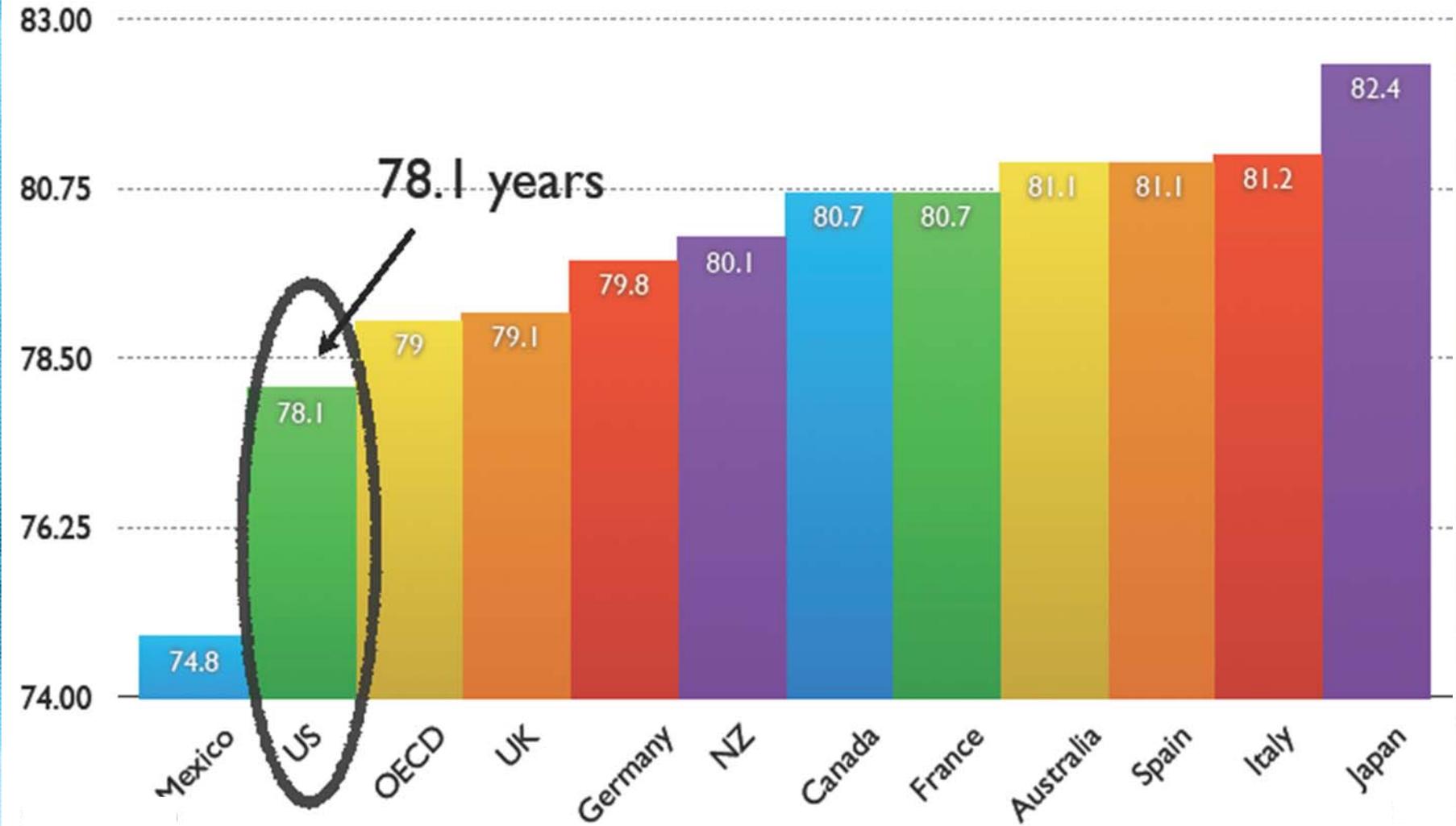
Quality of Care: Results of the National Scorecard on U.S. Health System Performance

- U.S. ranked in last place among 19 industrialized countries in mortality attributable to health care services
- Up to 101,000 fewer people would die prematurely each year resulting from problems with health care if the U.S. could achieve comparable mortality rates to other leading countries
- Less than half of U.S. adults with health problems were able to get a rapid appointment with a physician when sick
- One-third of adults with health problems reported mistakes in medical care
- Rates of visits to physicians or emergency departments for adverse drug effects increasing

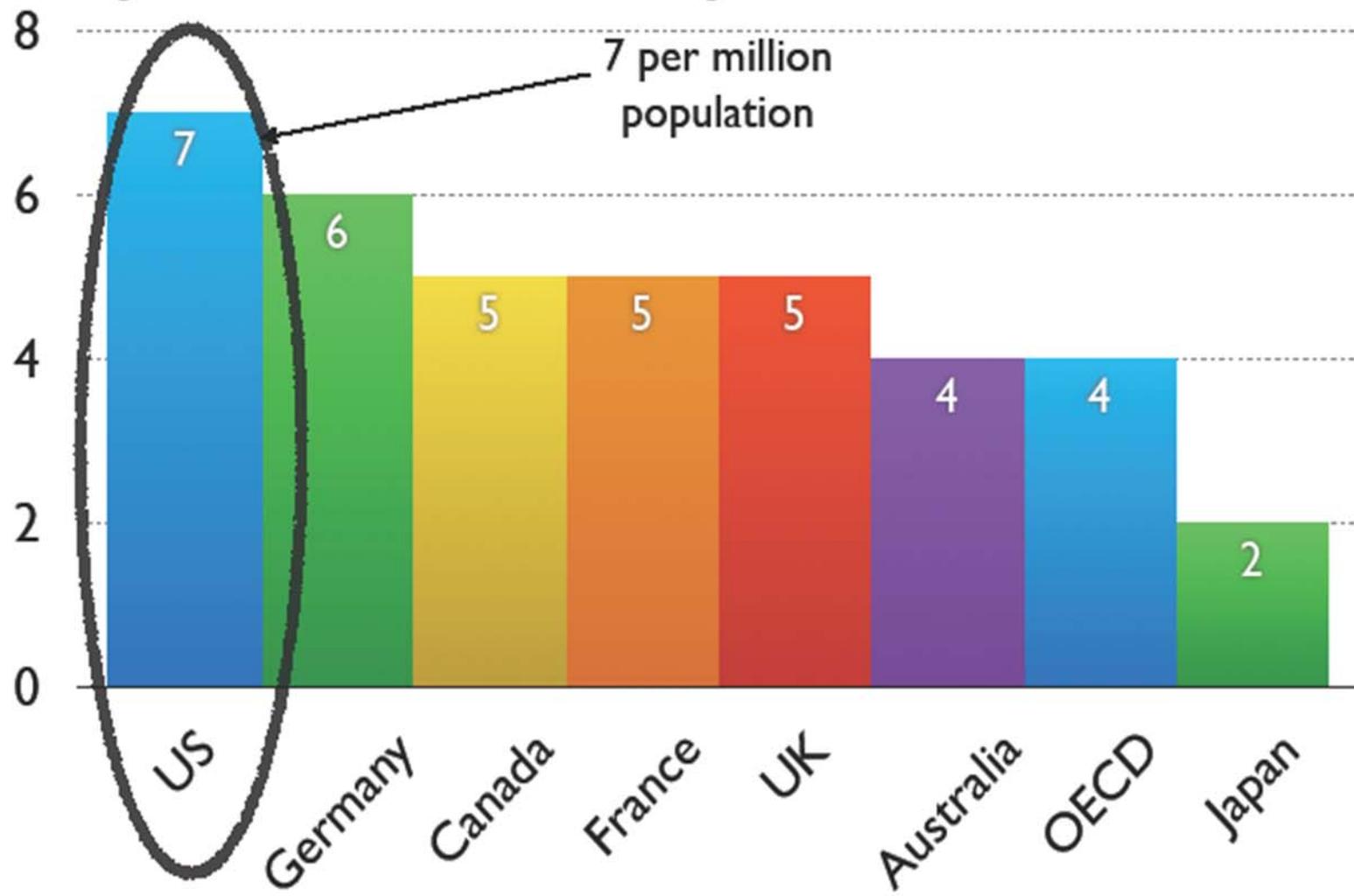
Quality of Care: Hospital Readmissions

- 19.6% of all hospital patients were rehospitalized within 30 days and 34% within 90 days
- For 50% of the patients discharged with a medical diagnosis and who were rehospitalized, there was **NO** intervening physician service

Quality of Care: Life Expectancy



Quality of Care: Deaths Due to Surgical or Medical Mishaps per 1,000,000 Population in 2004



Quality vs. Cost?

“Right from the start it has been one of the great illusions in the reign of quality that quality and cost go in opposite directions. There remains very little evidence of that. There may be some innovations that raise costs while raising quality, but many, many improvements reduce costs.”

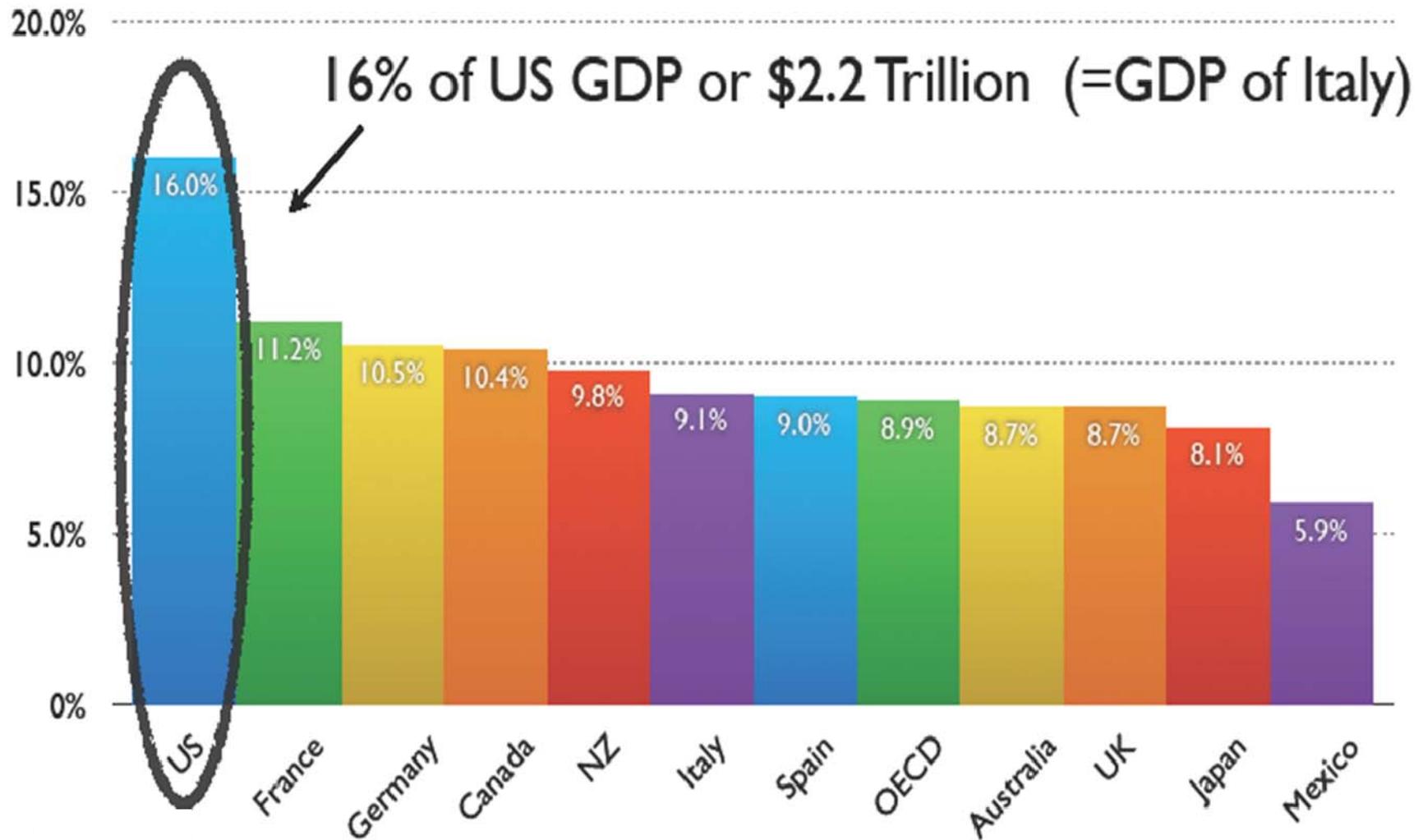
- Don Berwick

Health Affairs, October 2005

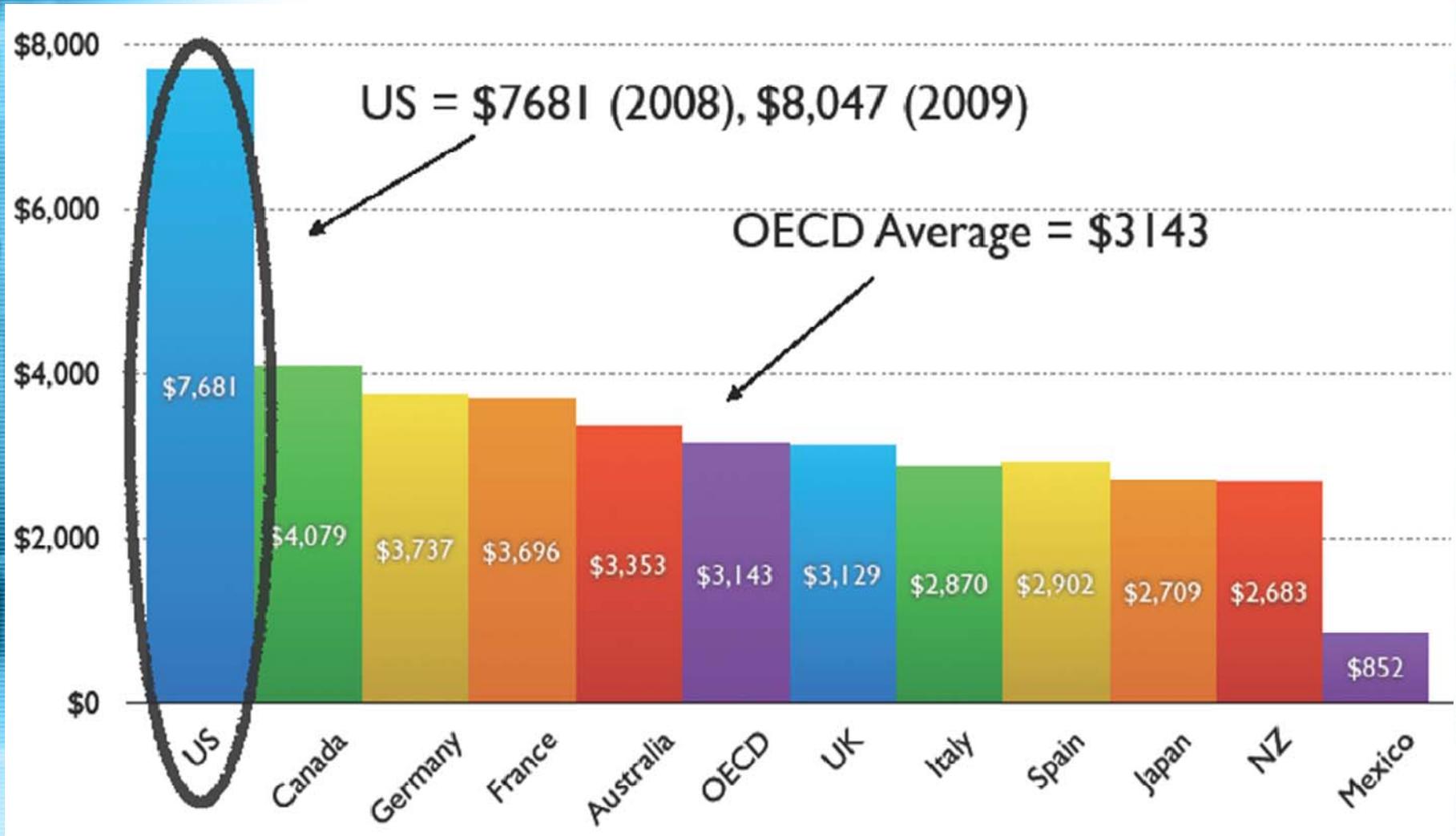
Cost of Care: National Health Expenditures



Cost of Care: Percent GDP Spent on Health Care in 2008



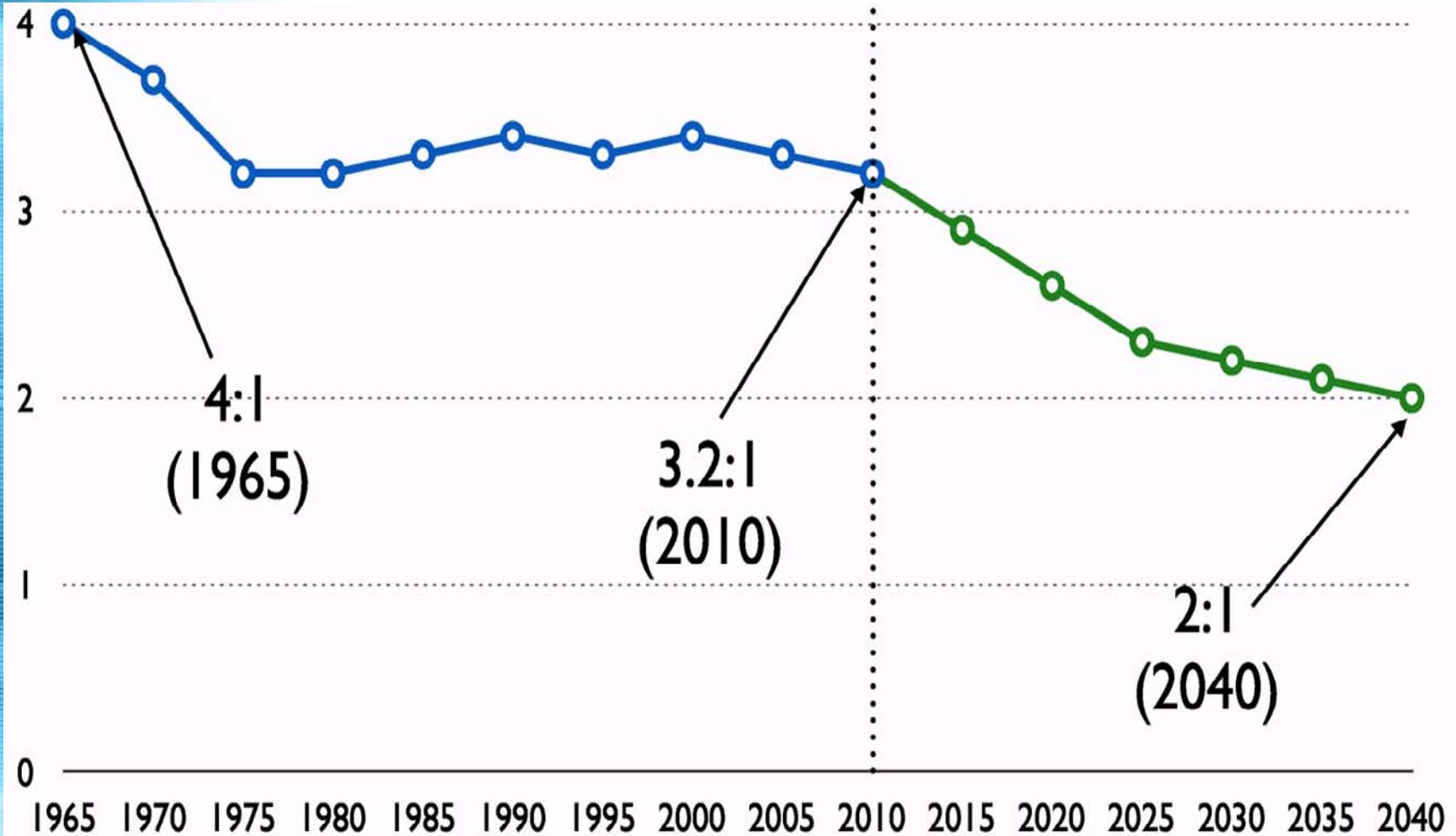
Cost of Care: National Health Expenditures per Capita, 2008



Cost of Care: Medicare

- Began in 1965 as an acute care program providing hospital and physician insurance for those 65 and over
- Average life expectancy was 67 years old, now it is 78 years old
- Baby boomers are aging. Who will pay for them?

Cost of Care: Workers to Medicare Beneficiaries

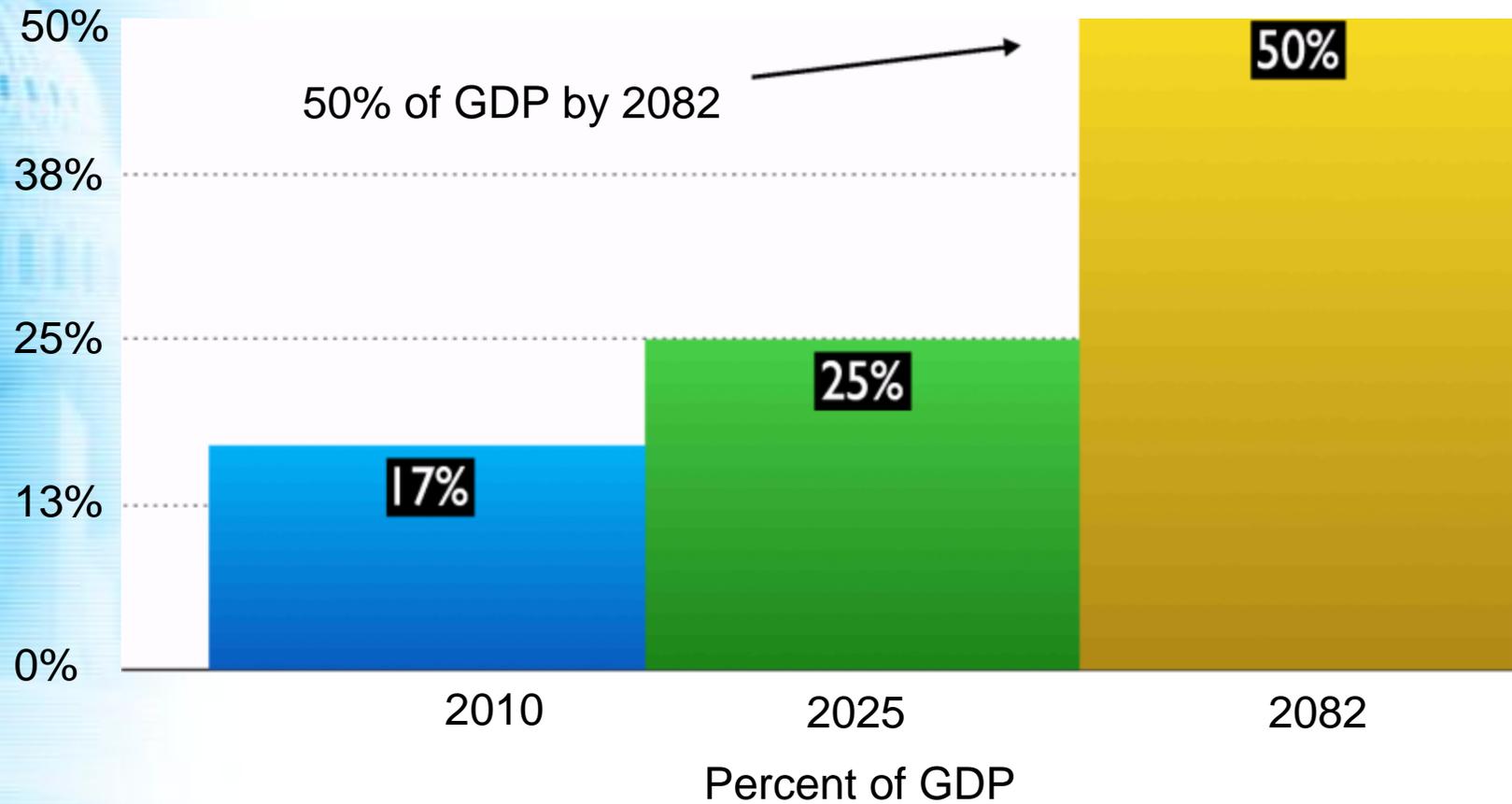


Cost of Care: Chronic Care

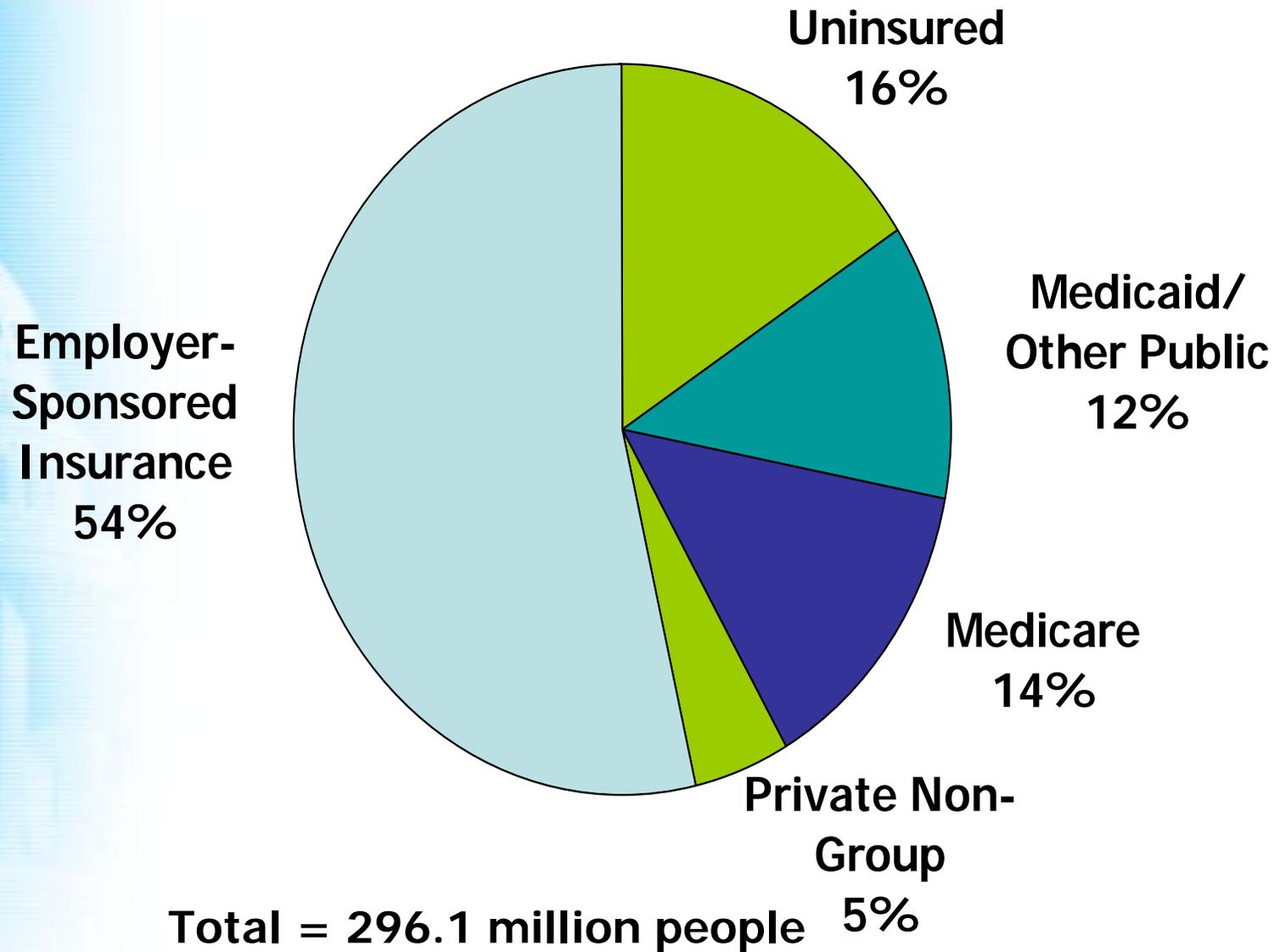
- 23% of all Medicare Beneficiaries
 - Have 5 or more chronic conditions
 - See 12 or more physicians a year
 - Take 50 or more prescriptions a year
 - Cost 68% of the Medicare budget

Cost of Care: Projected Growth

National Health Expenditures

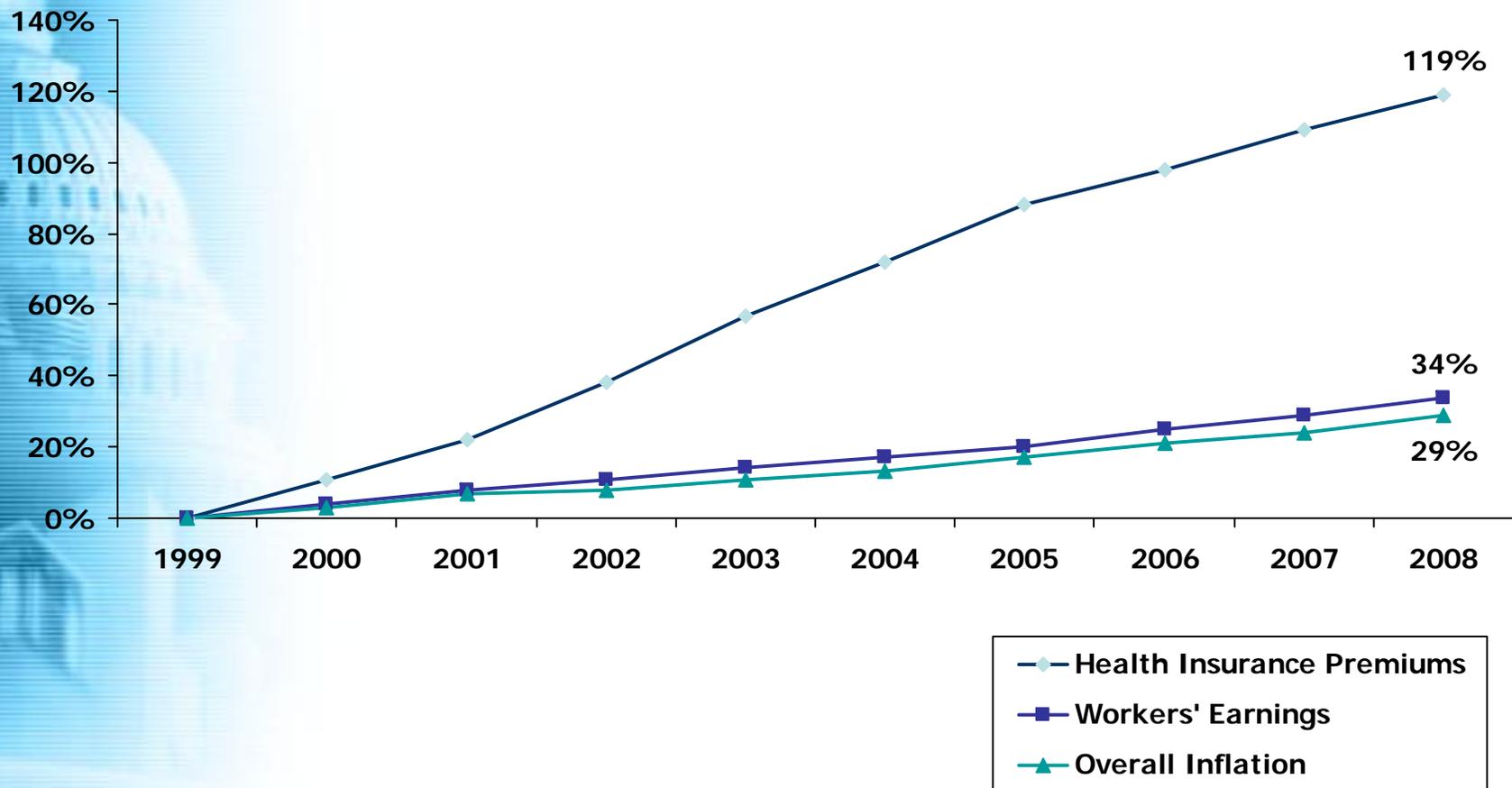


Snapshot of Health Insurance Coverage

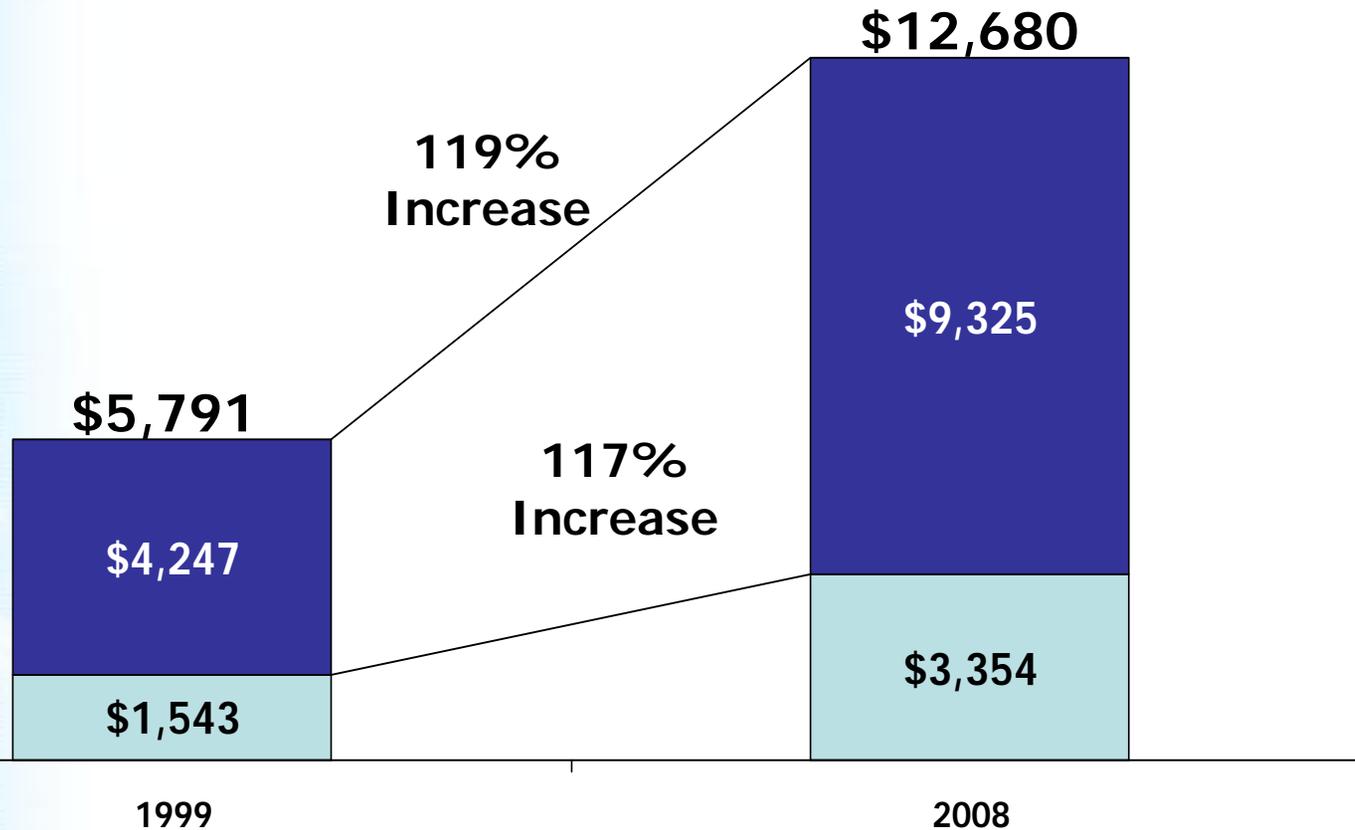


Rising Cost: Skyrocketing Costs of Health Care

Health insurance premium increases consistently outpace inflation and the growth in workers' earnings.



Rising Cost: Average Health Insurance Premiums and Worker Contributions for Family Coverage, 1999-2008



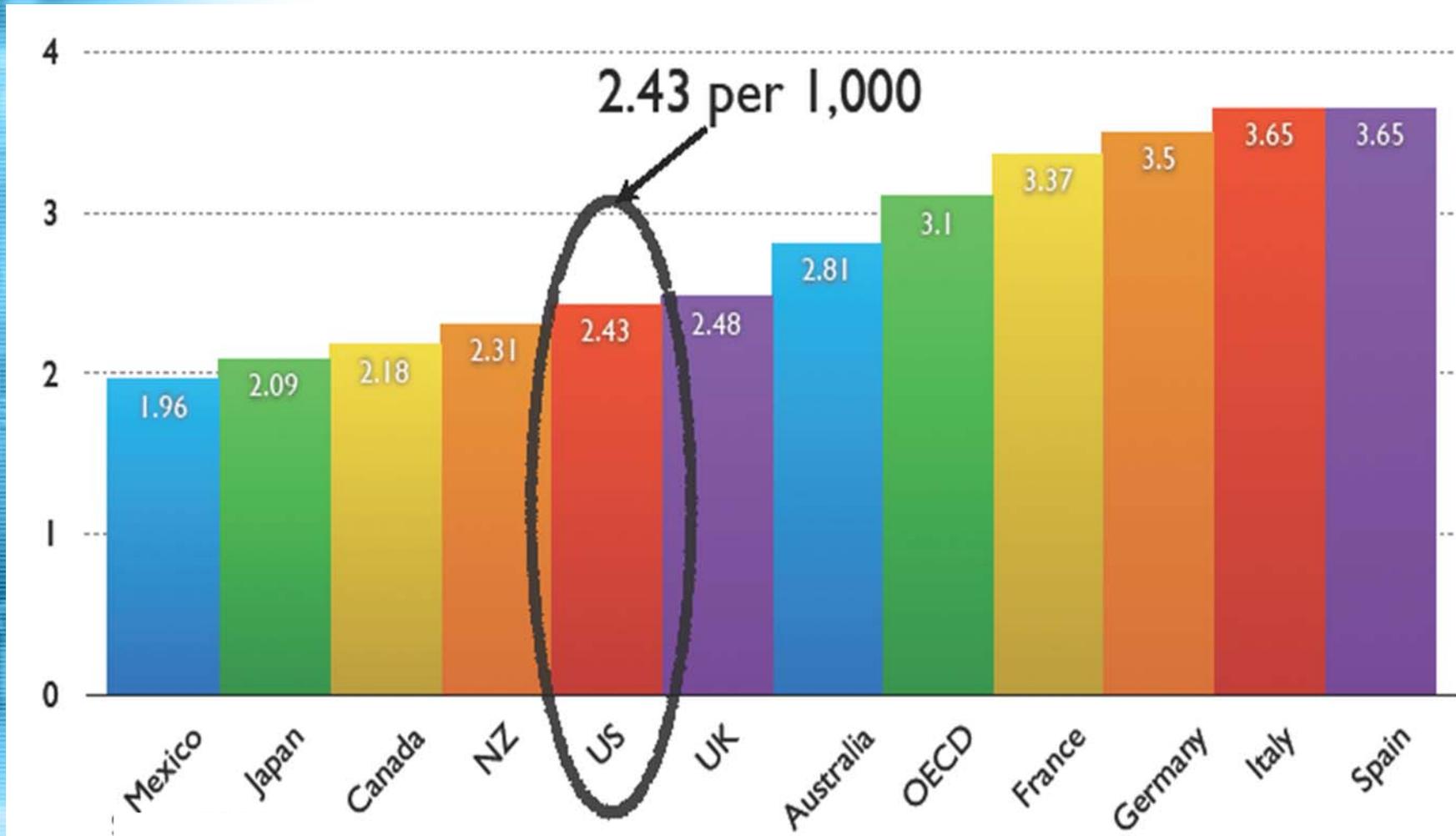
Note: The average worker contribution and the average employer contribution do not add to the average total premium due to rounding.

■ Employer Contribution
■ Worker Contribution

Access to Care: The Problem of the Un and Underinsured

- Currently, 47 million Americans – including nearly 9 million children – lack health insurance.
- In 2007, 75 million working-age adults (42%) were either uninsured or underinsured, an increase from 61 million (35%) in 2003
- Underinsured is defined as having out of pocket medical expenses that exceed 10% of family income, or 5% for those whose incomes amount to less than twice the federal poverty level or insurance deductibles alone are 5% or more of their income).

Access to Care: Physicians per 1,000



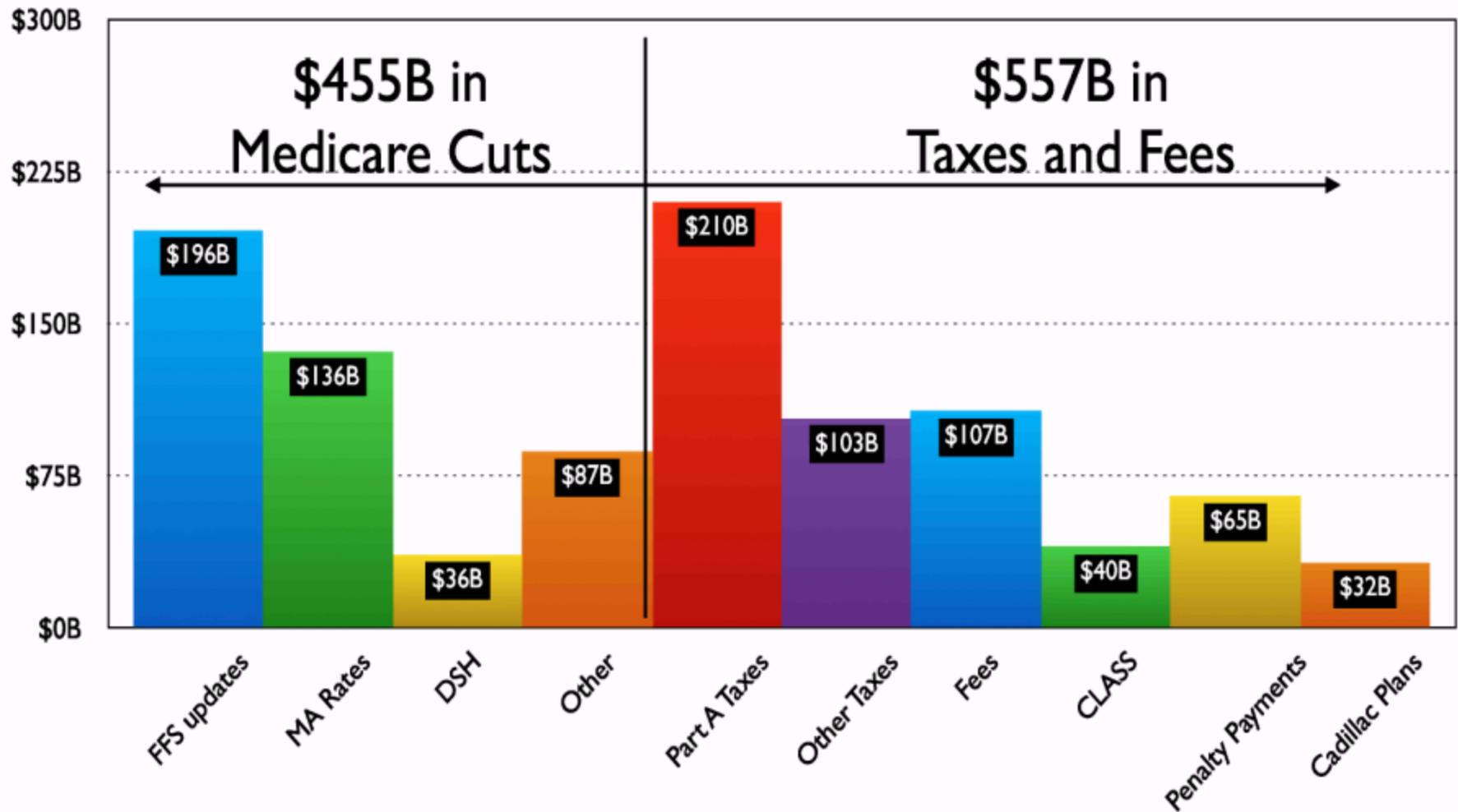
Access to Care: Physician Shortage

- 212,000 physician openings by 2014 due to growth and net replacement of retiring physicians. That number represents more than 25% of the current physician work force
- Approximately 95% of the hospital CEOs said there was a shortage of physicians, with a vacancy rate of 11%, meaning a little more than one in 10 physician job openings are unfilled.

Access to Insurance Under Health Reform

- **Change the Medicaid Requirements**
 - Include Childless Adults
 - Increase Income Thresholds to 133% FPL (helps 17.1M adults)
- **Provide Subsidies for Non-Medicaid Eligible up to 400% FPL**
- **Create State Insurance Exchanges for Individuals Who Can't Get Insurance Elsewhere**

Paying for Increased Access



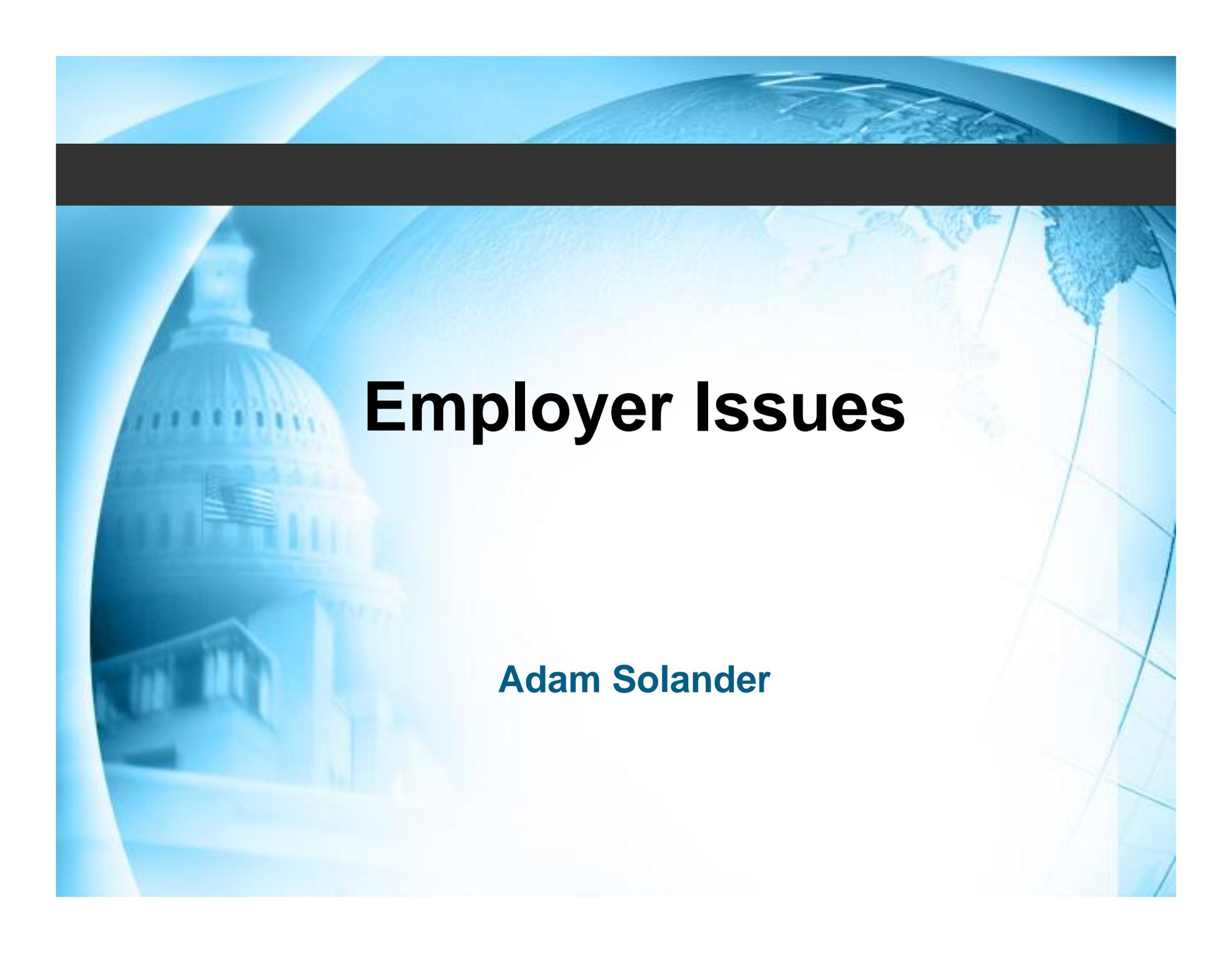
Provider Reimbursement

- Increasing pressure to be efficient - "productivity adjustment" off of market basket (\$ 196B in savings over 10 years)
- Reduced Medicare and Medicaid reimbursement, except for primary care physicians
- Increased Medicaid enrollment (+20.4M / 10 yrs), with Medicaid reimbursement rarely covering hospital costs
- Less DSH payments for hospitals (\$50B / 10 yrs)

RESULT: 15% more institutional providers will go bankrupt by 2019

Next Steps

- Medicare legislation still necessary
 - Physician Fee Fix for 23% cut, in December
- CMS and HHS implement thousands of changes
- Focus on pilot programs to address Medicare's antiquated payments



Employer Issues

Adam Solander

Legislation

- President Signed Patient Protection and Affordable Care Act (“PPACA”) on March 23, 2010
- Reconciliation signed on March 30, 2010
 - Consolidated bill now available
 - No legislative history

Timeline

Plan Years After September 23, 2010

- Coverage for adult children up to age 26;
- No lifetime limits and no restrictive annual limits on “essential benefits”;
- No discrimination in favor of highly compensated employees;
- No rescissions;
- First dollar coverage for certain preventive services;
- Claims and appeals;
- No preexisting conditions for children 19 and under

Timeline

Starting in 2011

- Report aggregate value of health coverage on W-2*;
- CLASS Act;
- HSA penalty increased for non-qualifying medical expenses;
- No reimbursement for non-prescription drugs (FSA, HRA, Employer).

Timeline

No Later than March 23, 2012

- Issue 1099 for goods or services over \$600*
- Provide uniform explanation of benefits and coverage
- Provide 60 days notice for material modifications to plans

Timeline

Effective 2014

- Not impose preexisting conditions
- Free rider surcharges/ individual obligations
- Wyden choice
- Exchanges open to groups under 100 and individuals
- No excessive waiting periods
- Wellness changes

Timeline

Effective 2018

Cadillac Tax

- \$10,200 for an individual or \$27,500 for a family, including worker and employer contributions to flexible spending or health savings accounts. Does not include stand-alone vision or dental benefits.
- 40% tax on premiums in excess of thresholds

Grandfathering

- Grandfathered Plan: Is a plan in existence on March 23, 2010
- Grandfathered plans are exempt from certain Title I “market reforms” including:
 - Preventive coverage
 - Claims and appeals
 - Non-discrimination in favor of highly compensated (insured plans only)
 - Cost sharing guidelines

Grandfathering

Grandfathered Plans Must:

- Not impose lifetime or annual limits
- Not rescind coverage
- Extend dependant coverage to age 26
- Not impose pre-existing condition exclusions
- Not institute excessive waiting periods
- Provide uniform coverage explanations
- Provide 60 days notice before material modifications
- Auto enroll
- Cap FSAs
- Not reimburse non-prescription drugs

Grandfathering Regulation

TABLE 3—ESTIMATES OF THE CUMULATIVE PERCENTAGE OF EMPLOYER PLANS RELINQUISHING THEIR GRANDFATHERED STATUS, 2011–2013

	2011	2012	2013
Low-end Estimate			
• Small Employer Plans	20%	36%	49%
• Large Employer Plans	13%	24%	34%
• All Employer Plans	15%	28%	39%
Mid-range Estimate			
• Small Employer Plans	30%	51%	66%
• Large Employer Plans	18%	33%	45%
• All Employer Plans	22%	38%	51%
High-end Estimate			
• Small Employer Plans	42%	66%	80%
• Large Employer Plans	29%	50%	64%
• All Employer Plans	33%	55%	69%

Grandfathering Regulation

- **Elimination of a benefit** - If a plan eliminates all or substantially all benefits to diagnose or treat a particular condition the plan will lose grandfathered status. (no longer covers polio)
- **Increase in a cost-sharing percentage** - Any increase in a percentage cost-sharing requirement will cause a health plan to lose grandfathered status. (10% of hospital bills)
- **Increase in a fixed-amount cost-sharing requirement other than a copayment** - Any increase in a fixed-amount cost-sharing requirement other than a copayment will cause a plan to lose grandfather status if the total percentage increase in the cost-sharing requirement exceeds the rate of medical inflation plus 15 percentage points. (deductible)

Grandfathering Regulation

- **Increase in a fixed-amount copayment** - Any increase in a fixed-amount copayment, will cause a group health to lose grandfathered status if the total increase exceeds the greater of: \$5 increased by medical inflation; or the rate of medical inflation plus 15 percentage points.
- **Decrease in contribution rate by employers and employee organizations** - A group health plan will lose grandfather status if the employer decreases its contribution rate for any class of “similarly situated individual by more than five percent.
- **Changes in annual limits**
- **Change in insurance carrier**

Preparation For PPACA

- Grandfathered or not?
- Plan evaluation:
 - Does your plan cover dependents?
 - Does your plan cover all preventive services listed?
 - Does your plan have a conforming claims and appeals process?
 - Conduct recissions and when is it appropriate?
 - Does your plan have annual and life time limits?
- Big Picture:
 - Can your plan make these changes, cost, resources?
 - Are the exchanges a viable option?
 - Do the reasons for providing health benefits change with PPACA?

Free Rider

If an employer fails to provide coverage or fails to provide affordable coverage then subject to a “free rider surcharge”

- Employer = greater than 50 full time employees
 - Full time = 30 hours* per week or full time equivalent
 - Full time equivalent =

$$\# \text{ of employees} \times \# \text{ hrs (monthly)} / 120$$

Free Rider

- Coverage = Minimum essential coverage (not less than 60% of the covered health care expenses under the plan)
- Affordable Coverage = Less than 9.5% of house hold income
- Free Rider Surcharge =
 - Failure to provide coverage=\$2,000 per year per employee
 - Failure to provide affordable coverage= \$3,000 per year, per full time employee for whom coverage is unaffordable and receives a subsidy

Wyden Choice

Employer providing minimum coverage must provide “free choice vouchers” to employees

- Making less than 400% FPL
- Whose premium contribution is between 8% and 9.8% of income
 - Voucher = employers contribution
 - Employee can keep excess

Auto Enrollment

- Employers with more than 200 full time employees must provide for automatic enrollment of new employees
 - Employee must “opt out”
 - Subject to waiting periods (less than 90 days)

FSA/HSA Changes

FSAs

- Limited to \$2,500 indexed for inflation
- No over-the counter drugs w/o prescription

HSAs

- No over-the-counter drugs w/o prescription
- Penalty raised from 10% to 20%

CLASS Act

Community Living Assistance Services and Supports

- Voluntary insurance program for purchasing community living services for the functionally disabled
- Monthly payroll deductions and auto-enrollment
- Alternative pathway for employees whose employer chooses not to participate
- No less than \$50 a day
- 2 or more ADLs and 5 years of payments
- Five year lag
- Self sufficient?

Wellness

HIPAA incentives to participate in a wellness program increased from 20% of premiums to 30%

- GINA: No incentive for “genetic information”
- GINA Title II: Potential conflict w/ PPACA

Exchanges

2014 - Individuals and small groups may enter exchange

2017 - Maybe large employers

– Depending upon adverse selection “fix”

Small Employer Credit

- An Eligible Small Employer (ESE) may apply for a tax credit equal to a portion of its health insurance premium expenses.
- ESE- Employer must: (i) have fewer than 25 full-time equivalent employees; (ii) have average annual wages of less than \$50,000 per employee; and (iii) maintain a “qualifying arrangement.”
- A “qualifying arrangement” is when employer pays at least 50% of the premiums for each employee enrolled in health care coverage offered by employer.

Small Employer Credit

- Which employees count?
 - All employees count, except seasonal employees who work 120 days or less during the year, partners, business owners and their family members.
- How many “full-time equivalent employees” (FTEs) are there?
 - the aggregate number of hours for which each employee is paid, including up to 160 hours of vacation, sick leave etc., capped at 2,080 per employee and divide by 2,080. The whole number rounded down is the number of “full-time equivalent employees.”
- What is the average annual wages paid per FTE?
 - Total wages paid during taxable year divided by the number of FTEs.
- What premiums are eligible for the credit?
 - Only the employer’s share of of the premium is counted.
 - Premiums paid under a salary reduction arrangement under a cafeteria plan do not count.
 - Premiums capped at average premium under small group market in State in which employer offers coverage. See Rev. Rul. 2010-13 for list of rates for each State.

Small Employer Credit

- What is the maximum amount of credit available?
 - 2010 through 2013, the maximum credit is 35% of the credit-eligible premiums (25% for tax-exempt ESEs).
 - After 2013, the maximum credit is 50% of premium contributions to State-based exchanges (35% for tax-exempt ESEs).
 - Credit is capped at “net premium payment” which is the ESE’s premium payment net of any State credit or subsidy
- How to claim credit?
 - Credit is claimed on annual income tax return. Unused credit is carried back one year or forward 20 years (except 2010 unused credit must be carried forward).
- 2010 Transition Relief
 - For 2010 only, ESEs will maintain qualifying arrangement if it pays 50% of single coverage premium, even if it pays less than 50% of family coverage premium.

ERRP

- Employers who provide coverage for pre-Medicare retirees eligible
- Subsidy pays 80% of claims between \$15,000 and \$90,000
- \$5 billion in funding
- How long will it last?

Individual Mandate

The individual mandate requires that all individuals who can afford health care insurance purchase it

- Above poverty line and cost no more than 8% of monthly income

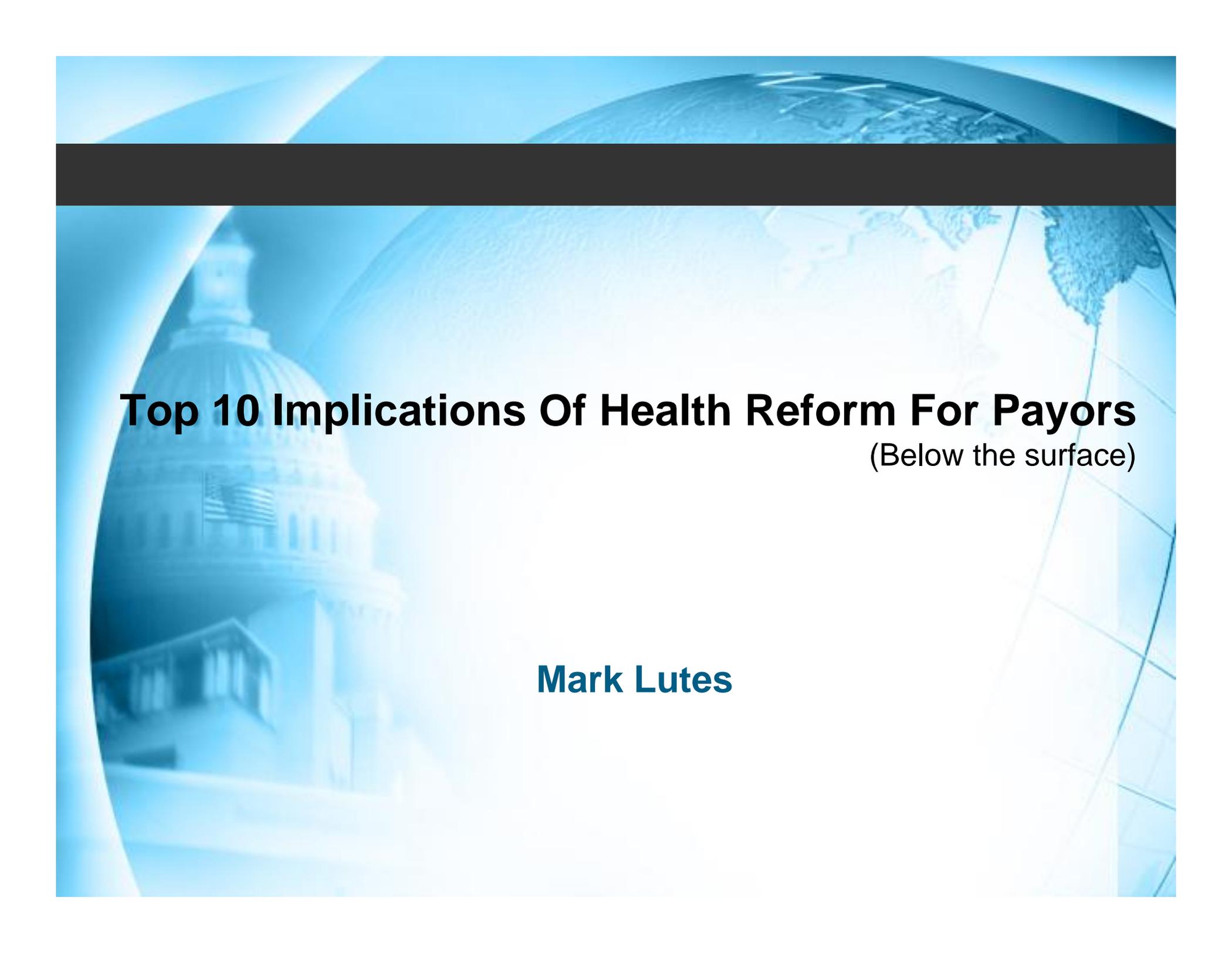
Phase in:

- 2014: Greater of \$95 or 1% of income
- 2015: Greater of \$325 or 2% of income
- 2016: Greater of \$695 or 2.5% of income

What's Next?

“Now this is not the end. It is not even the beginning of the end. But it is, perhaps, the end of the beginning.”

-Winston Churchill



Top 10 Implications Of Health Reform For Payors

(Below the surface)

Mark Lutes

Reform's Payor Impact on the Surface

- Wins:
 - 24M new enrollees (Medicaid and Exchange)
 - Apparently no creation of “public option” to compete with private insurance
 - Exchanges reduce cost of sale in individual and group market

Reform's Payor Impact on Surface

- **Select Losses:**
 - Political scapegoat
 - Annual fee (\$8B in 2014;\$14B by 2018)
 - \$100B in Medicare Advantage cuts
 - 40% excise tax on “cadillac plans” by 2018

But What is Below the Surface?

- Threat to industry profits (MLR regulation and new price regulation)
- Change in market composition – government markets will grow (exchange and Medicaid) carry lower profit margins
- MLR and other regs may lead to stronger preference for self-funded business, again lower margins
- Need to develop direct to consumer sales capacity rather than historic group sales expertise
- Provider consolidation impacting bargaining balance
- Provider networks eventually disintermediate?

Lets Drill Down

- Exploring ten select ACA drivers of change in the payor market

#1: “Living with MLR Regulation”

- Requirement that insurers refund premium to the extent 85% (large group) or 80% (small group) is not spent for claims or quality
 - Pressure on suppliers?
 - Mergers to increase scale efficiencies?
 - Drive preference for selling ASO (self-funded) business?
- Will it cause payor interest in MLR sensitive provider payment methodologies?
- New partnerships with providers?
- Strategic advantage for provider-sponsored managed care?

#2: “Living with Heightened Rate Review”

- New attention to rate review at DOIs
- Battles in MA, CA, PA, NM, IA, ME, etc.
- Federal funding of state review
- Federal review of “unreasonable” rate increases not limited to traditional markets reviewed
- Balance with traditional solvency concerns
- Unclear how to account for provider pricing as driver of “unreasonable” rate increases

#3: “Living with Exchange Mediated Environment”

- New “Qualified Health Plan” regulation—CA law indicates the potential for exchanges to be selective (more price pressure)
- Individual Market morphs to individual exchange
- Small group market—SHOP exchange (15% loss?)
- How many employers go the voucher route? (boosting exchange’s influence through individual market)
- Branding and product differentiation challenges on the exchanges
 - B2C sale/disintermediation of brokers?
 - Price sensitivity of consumers
- Risk pool challenges in exchange markets due to guaranteed issue and new participants in the risk pool
- Consolidation pressures

#4: “Living with Changes in Risk Pool”

- Guaranteed issue/renewability
- No Pre-X, annual or lifetime benefit limit
- Modified community rating
 - Opportunity for risk adjustment said to reduced 75% (vs health status underwriting)
- Chronic care management imperative
- Provider delegation and vertical integration solutions?

#5: “Living with Federal Benefit Regulation”

- Grandfathered market fast dwindling?
- Essential benefits for exchange-mediated products and non-exchange individual and small group markets
- Minimum essential coverage for satisfying individual and employer “mandates”

#6: “Living with Explosion in Government Mediated Markets”

- Exchange mediated segment (16-24M projected/CBO) but could be much larger if employers flee to defined contribution
- Medicaid expansion (16M new enrollees/CBO)
- CHIP
- New programs for duals
- Age wave growth in Medicare (11M new beneficiaries)
- State option federally-funded, non-Medicaid state plan for people with incomes above Medicaid eligibility (133 percent FPL) but below 200 percent FPL. Requires a state to contract with multiple health plans
- Whither Medicare Advantage?
 - Actually looking relatively unscathed? (risk pool known, sales patterns unaltered, premium change is predictable)
 - Younger generation more likely to join MA plans?

#7: “Living with the Specter of Cadillac Plan Tax”

- Effect on plan designs
- Renewed interest in consumer directed design?
- Driver of supplemental coverages?

#8: “Living with Interstate Health Insurance”

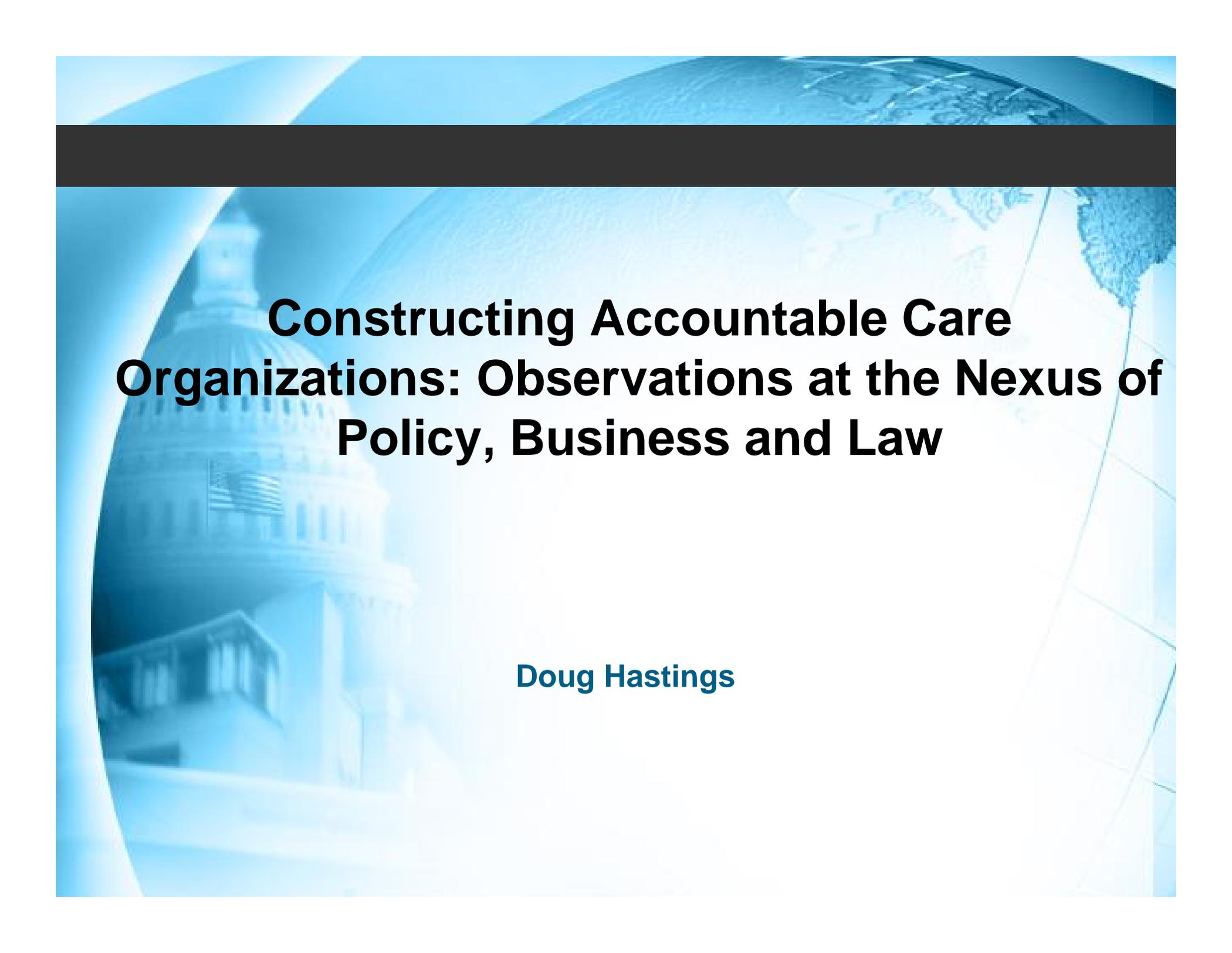
- Regional Health Care Choice Compacts:
 - NAIC rules by 2013
 - 2016, states compacts would allow purchase of individual insurance across state lines
 - Consider relationship to multistate exchanges
- National Office of Personnel Management Plans
- National plans preempting state benefit mandates (single, uniform benefit package)

#9: “Living with the New Regulation Mosaic”

- Office of Consumer Information and Insurance Oversight (“Big Brother”)
 - Rate and other oversight, default exchanges and rules for others, standardized information, quality and innovation reporting
- Exchanges (“Little Brother 1?”)
- DOIs (“Little Brother 2?”)
- Interstate Compacts
- National Plans

#10: “Living with Provider Awakening”

- ACA inducing increased consolidation in hospital and physician markets?
 - Changes to bargaining dynamic
 - Will Medicare reimbursement cut increase cost shift?
- Demands for shared savings
- Competition from provider-sponsored plans on exchanges and other markets
- Partnership options
- Are payors equipped to “bend the cost curve” without closer economic alignment with providers?



**Constructing Accountable Care
Organizations: Observations at the Nexus of
Policy, Business and Law**

Doug Hastings

The Case for Payment and Delivery Reform

- **The Problem:**

- Fragmented Care
- Uneven, Unsafe Practices
- Unsustainable Costs

“Our fee-for-service system, doling out separate payments for everything and everyone involved in a patient’s care, has all the wrong incentives: it rewards doing more over doing right, it increases paperwork and the duplication of efforts, and it discourages clinicians from working together for the best possible results.”

— Atul Gawande, “Testing, Testing,” The New Yorker, 12/14/09

The Case for Payment and Delivery Reform

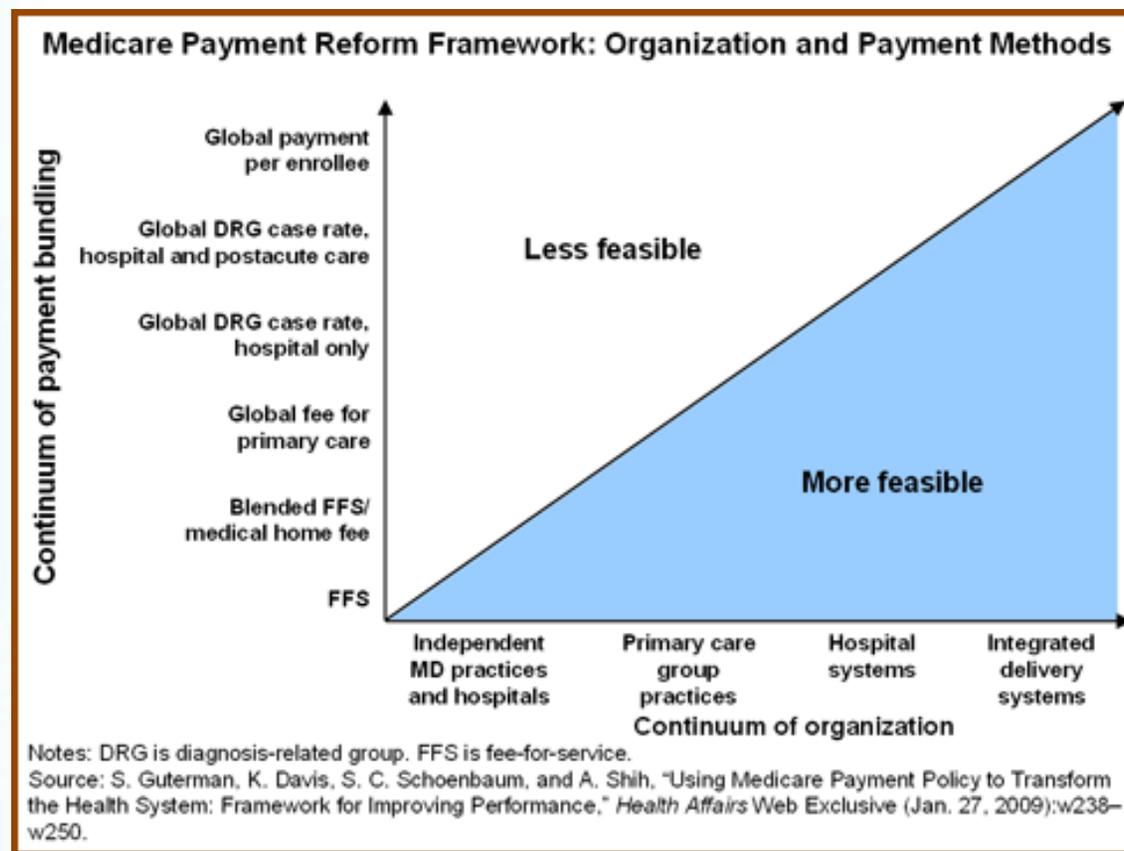
- **The Solution:**

- Better coordinated care, more transparent to the consumer, using evidence-based measures to achieve better outcomes, greater patient satisfaction and improved cost efficiency
- Or, in other words, “accountable care”
- An “accountable care organization” (“ACO”) is a provider-based organization comprised of multiple providers with a level of clinical integration sufficient to deliver accountable care
- Both the payment system and delivery system (in both the public and private sectors) need to change together to achieve accountable care

In Search of Accountable Care – Part II

- Why might ACOs work now when similar concepts did not in the 1990s?
 - There is greater recognition of the urgency of the cost and quality problems
 - The applicability of evidence-based medicine is more widely understood and accepted
 - There is greater understanding that good outcomes, patient satisfaction and cost-efficiency are linked
 - We have learned from past experience with provider integration efforts and risk contracting
 - Consensus measures and IT infrastructure have advanced significantly
 - Early pilots and demonstrations have shown promise

The Accountable Care Framework



“To change the way health care is organized and delivered, we need to change the way it is paid for — to move from fee-for-service payments to bundled payments.”

– Guterman, Davis, Schoenbaum and Shih, 2009

Recent Proposal to Divide ACOs Into Three Tiers

- **Level I** - No financial risk, but eligible to receive shared savings; minimum number of PCPs; able to report on basic set of measures
- **Level II** - Greater upside on savings, but some risk for higher costs and/or bundled payments; more comprehensive performance measures; minimum cash reserves
- **Level III** - Full or partial capitation; full public reporting on comprehensive measure set; more stringent financial requirements and reserves

The Benefits of Pilots and Demonstrations

“The history of American agriculture suggests that you can have transformation...without knowing all the answers up front.... Transforming health care everywhere starts with transforming it somewhere.”

— Atul Gawande, “Testing, Testing,” The New Yorker, 12/14/09

ACA Accountable Care: Innovation Opportunities

- **Sec. 3021. Establishment of Center for Medicare and Medicaid Innovation within CMS.**
 - Creates a Center for Medicare and Medicaid Innovation (“CMI”) within CMS to test innovative payment and service delivery models to reduce program expenditures while preserving or increasing the quality of care
 - Instructs CMI to use open door forums or other mechanisms to seek input from interested parties
 - Models to be tested include medical homes; risk-based contracting; coordinated care models like ACOs; and improved post-acute care models
 - \$10 billion in funding, 2011 to 2019
 - To be up and operating by January 1, 2011

ACA Accountable Care: Innovation Opportunities

- **Sec. 3022. Medicare Shared Savings Program.**
 - Directs the Secretary to create a shared savings program by January 1, 2012 that will promote accountability, coordinate services between Parts A and B
 - ACOs that feature shared governance and meet quality performance standards can receive payments for shared savings
 - Eligible ACOs include:
 - Physicians and other professionals in group practice arrangements;
 - Networks of individual physicians;
 - Partnerships or joint ventures between hospitals and physicians;
 - Hospitals employing physicians; and
 - Other groups the Secretary deems appropriate
 - Savings to be shared based on actual costs compared to the benchmark set by the Secretary
 - Allows the Secretary discretion in implementing a partial capitation model for ACOs

Section 3022 Criteria for ACOs

- Agree to become accountable for overall care of assigned Medicare fee-for-service beneficiaries
- Enter into 3-year agreement with HHS
- Have a formal legal structure that will allow the organization to receive and distribute payments to participating providers
- Include sufficient primary care physicians for at least 5,000 Medicare fee-for-service beneficiaries
- Have arrangements in place with sufficient specialist physicians
- Have in place a leadership and management structure including clinical and administrative systems
- Define processes to promote evidence-based medicine, report on quality and cost measures, and coordinate care
- Demonstrate patient-centeredness

ACA Accountable Care: Innovation Opportunities

- **Sec. 3023. National Pilot Program on Payment Bundling.**
 - Creates a voluntary pilot program implementing bundled payments surrounding hospitalizations in order to improve coordination, quality and efficiency of care
 - To be established by January 1, 2013
 - Can be expanded if it is found to improve quality and reduce costs
 - Bundle to include acute, inpatient hospital services, physician services and post-acute services for episode of care beginning 3 days prior to hospitalization and 30 days post-discharge

Other ACA Accountable Care Related Provisions

- 2010
 - Section 6301: Patient-Centered Outcomes Research
 - Section 4201: Community Transformation Grants
 - Section 3027: Extension of Gainsharing Demonstration
 - Section 2705: Medicaid Global Payment System Demonstration
- 2011
 - Section 3011: National Strategy for Improvement in Health Care
 - Sections 3006: Plans for Value-Based Purchasing Programs for Skilled Nursing Facilities, Home Health Agencies and Ambulatory Surgical Centers
 - Section 10333: Community-Based Collaborative Care Networks

Other ACA Accountable Care Related Provisions

- 2012
 - Section 3001: Hospital Value-Based Purchasing Program
 - Section 3025: Hospital Readmissions Reduction Program
 - Section 3024: Independence at Home Demonstration Program
 - Section 2706: Pediatric Accountable Care Organization Demonstration Project
 - Section 2704: Demonstration Project to Evaluate Integrated Care Around a Hospitalization

Other ACA Accountable Care Related Provisions

- 2014
 - Section 3004: Quality Reporting for Long-Term Care Hospitals, Inpatient Rehabilitation Hospitals and Hospice Programs
- 2015
 - Section 3008: Payment Adjustment for Conditions Acquired in Hospitals
 - Section 3002: Improvements to the Physician Quality Reporting System

Questions for CMS Related to the ACO Program

- How will “formal legal structure” and “shared governance” be interpreted?
- How will Medicare beneficiaries be assigned to ACOs?
- How transparent will the ACO-patient relationship be?
- How will the ACO benchmarks be set?
- How will savings be allocated between the ACO and Medicare?
- What quality measures will be used?
- Will CMS use partial capitation or other alternative payment methods?
- How will this program relate to the value-based purchasing program?
- Will there be guidance to states regarding the potential regulation of provider risk sharing?

ACO Legal Issues

- Stark, anti-kickback, CMP
- Antitrust
- Exempt organization tax law
- Corporate practice of medicine
- State regulation of risk transfer
- Medical liability
- Quality reporting, auditing and compliance

Key Fraud and Abuse and Antitrust Questions

- Do we need a new definition of fraud and abuse?
- Will the Secretary use the waiver authority conferred in the ACA?
- Will federal qualification as an ACO serve as formal legal recognition that the ACO provider components are clinically integrated?
- How will market power issues be resolved?
- October 5 CMS, FTC, OIG, workshop on ACOs

Board Fiduciary Duty and Quality

- Medicare fee-for-service payments are declining
- Payment changes will further reduce reimbursement to hospitals with high readmissions and poor scores on quality measures
- Shift to bundled or global payments will require infrastructure investments
- Increasing focus on quality reporting may result in “fraud and abuse” enforcement against providers making claims to public payers for care deemed substandard
- Greater quality data reporting and transparency will require oversight, including assurance that reporting is accurate

Activities in the Marketplace

- Emphasis on primary care/medical homes/team-oriented care
- Providers reassessing health plan ownership
- Renewed payer/provider discussions – each looking for opportunities to experiment and to determine future role
- Providers looking at demonstrations with their own employees and other self-funded employers
- Acute/post-acute arrangements and joint ventures
- Medicaid state waivers
- PHOs, IPAs and clinical integration are hot topics again
- Physician organizations positioning to be ACOs
- Purchaser concern about ACO market power

Is Your Organization Ready to Become an ACO? - 10 Questions

- How will developing an ACO benefit the community you serve?
- Do you have the right provider components in place?
- Do you have an organizational and contracting structure that will create the necessary ownership, employment, joint venture and/or network relationships – and sufficient clinical integration – to succeed?
- Does your current board have the right mix of individuals to provide oversight in the accountable care era?
- What is your level of experience with clinical pathway development, care coordination and measuring and reporting on quality, cost and outcomes?

Is Your Organization Ready to Become an ACO? - 10 Questions (cont.)

- Do you have sufficient IT infrastructure?
- How do you plan to navigate the transition away from fee-for-service payment and have you considered the level of capital and reserves that may be required to manage the financial risk of bundled and/or global payments?
- Are you assessing provider-payer linkages (through ownership or contract) that would provide experience in new accountable care payment methodologies?
- Are you exploring pilot programs or demonstration project opportunities with CMS, state governments and private payers?
- Do you have access to timely information about developments at CMS, on the Hill and at the state level to benefit from opportunities?