What Could the Medicare Shared Savings Program Initiative Mean for Your Organization?

EpsteinBeckerGreen

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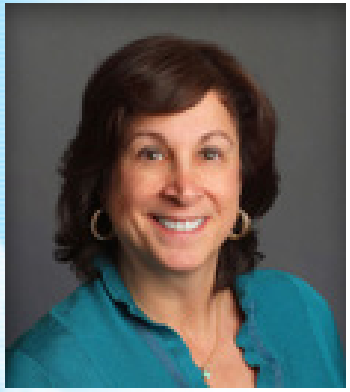
Agenda

- Federal Landscape – 1st Qrtr 2012
- Provider Sponsored Plans Look at MSSP
- MSSP Final Rule—What will it Take to Succeed?
- Dualing Policy Approaches? (MSSP/Pioneer v. FFS Medicare/VBP
- Questions/Discussion

Today's Speakers



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Setting the Stage

Entitlement Reform

Supreme Court Challenge

Time Check on Payment Reforms

Major Medicare Program Initiatives

- Major Payment Reform Initiatives from the Center for Medicare and the Center for Medicare and Medicaid Innovation Include:
  - Medicare Shared Savings Program (MSSP)
  - Pioneer Accountable Care Organization (ACO) Model
  - Value-Based Purchasing
  - Bundled Payments Initiative
  - Health Care Innovation Challenge
- These Initiatives Must be Considered in the Broader Context of Health Reform and Medicare Payment Cuts
  - Litigation Challenging the Constitutionality of Health Reform Law (ACA)
  - Budget Deficit Reduction Proposals

Debt Ceiling Legislation – Medicare Sequestration

- On August 2, 2011, President Obama signed into law the new debt ceiling legislation to reduce the deficit and avoid default on the national debt
- The agreement:
  - Cuts $917 billion over 10 years in exchange for increasing the debt limit by $900 billion
  - Established a joint committee of Congress tasked with producing debt reduction legislation by November 23, 2011 to cut up to $1.5 trillion over the coming 10 years and be passed by December 23, 2011
    - **The joint committee failed**
  - Now Congress can grant a $1.2 trillion increase in the debt ceiling but this would trigger across the board cuts ("sequestration") of spending equally split between defense and non-defense programs
    - Across the board cuts would apply to mandatory and discretionary spending in the years 2013 to 2021
    - Across the board cuts would apply to Medicare, but not to Social Security, Medicaid, civil and military employee pay, or veterans
  - The debt ceiling may be increased an additional $1.5 trillion if either one of the following two conditions are met:
    - A balanced budget amendment is sent to the states
    - The joint committee cuts spending by a greater amount than the requested debt ceiling increase
  - This summary assumes no further laws enacted on these subjects between now and January 1, 2013

Entitlement Reforms under Deficit Reduction

- Common themes for cutting Medicare/Medicaid spending:

Increase efforts to curb Medicare fraud and abuse	Nursing homes/home health cuts
Raise the Medicare eligibility age	Premium support pilot program
Restructure Medicare benefits	Medicaid block grants
New rules for Medigap plans	Medicaid “blended” matching rate
Raise Medicare Part B premiums	Drug rebates for Medicare-Medicaid “dual eligibles”
Cut hospital payments for bad debts	Repeal the CLASS Act

- Various Proposals:
  - Ryan-Wyden “Premium Support” Plan for Medicare (Dec. 2011)
  - The President’s Plan for Economic Growth and Deficit Reduction (Sept. 2011)
  - Bi Partisan Commissions (Rivlin-Domenici Plan, Nov. 2010; Bowles-Simpson Plan, December 2010)
  - Ryan Medicare Proposal (Nov. 2010)

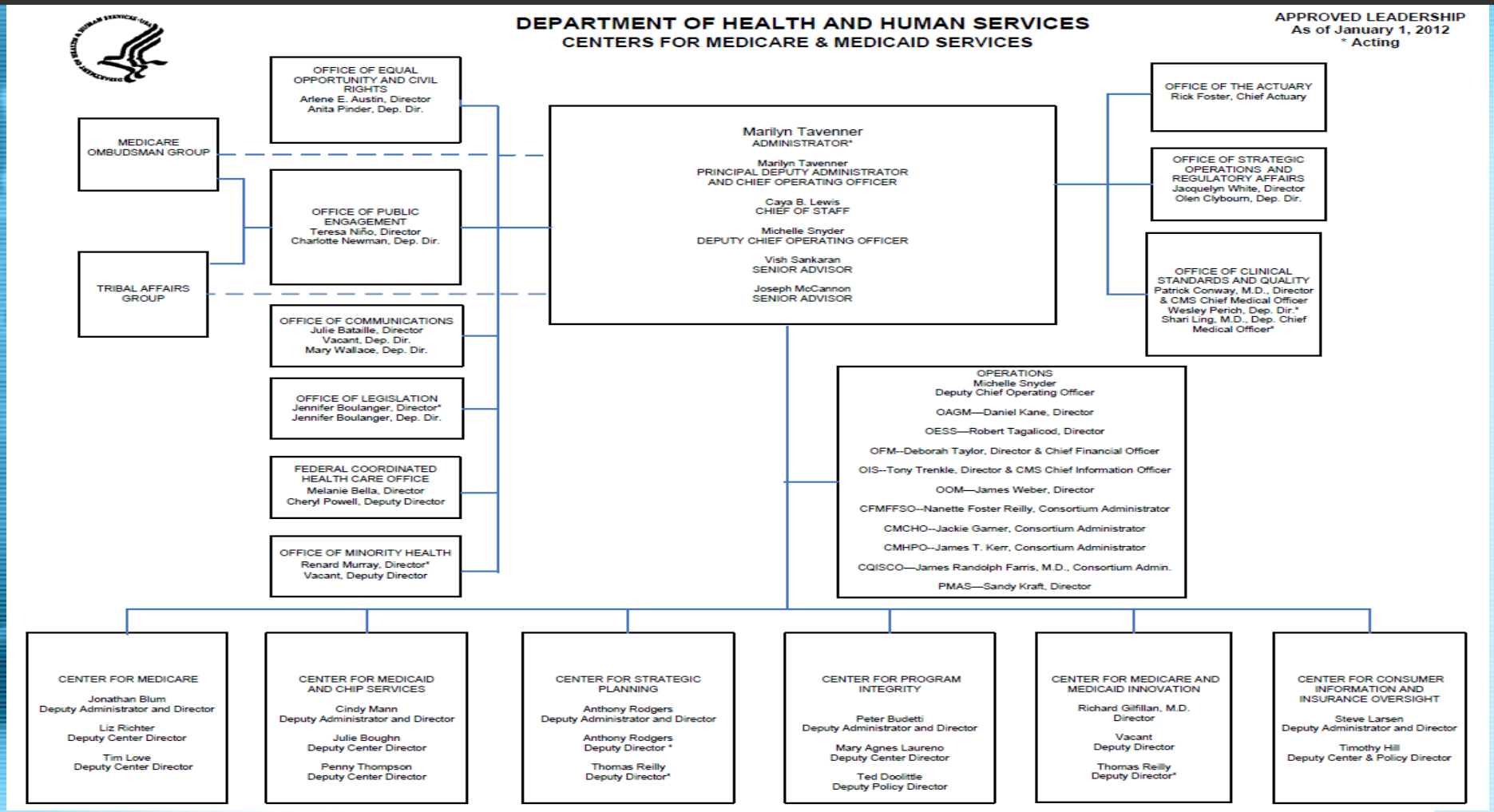
Medicare Payment Reductions

- The Patient Protection and Affordable Care Act (PPACA) includes Medicare payment reductions for Part A providers, Part B suppliers, and Part C plans, including reductions to annual market basket updates and productivity "adjustments"
- Additional reductions for hospitals:
  - FY 2013
    - 1% reduction to fund value based payments
    - Payment reduction if there are excessive readmissions within 30 days for 3 conditions (heart attack, heart failure, pneumonia)
  - FY 2014
    - Reduction in Medicare Disproportionate Share Hospital (DSH) payments
  - FY 2015
    - Reduction if the hospital does not have meaningful use of health IT
    - Reductions for hospitals with high rates of healthcare acquired conditions
- Medicare Payments to Physicians:
  - Application of the SGR has led to negative updates every year since 2002
  - Congress acted in December 2011 to provide a 2-month reprieve from the negative update expected to take effect on January 1, 2012
    - The law freezes physician payments at current rates for two months
    - If further regulatory or Congressional action is not taken, payments will be reduced by 27.4% on March 1, 2012

Challenges to the Federal Health Reform Law

- The Supreme Court will provide the final word on the law's constitutionality
  - The Supreme Court granted certiorari on November 14, 2011 to review the decision of the Eleventh Circuit in *Florida v. The Department of Health and Human Services*
  - Four key issues that the Court will review:
    - Did Congress exceed its enumerated powers by enacting the minimum coverage provision?
    - Did Congress exceed its authority under the spending clause by expanding the Medicaid Program and "coercing" States into accepting onerous conditions that Congress could not impose directly?
    - Is the suit brought by respondents to challenge the minimum coverage provision barred by the Anti-Injunction Act (26 U.S.C. §7421)?
    - Is the minimum coverage provision severable from the remainder of the law?
  - Oral arguments are scheduled for 5 ½ hours over three days (March 26-28, 2012) with a decision expected by June 2012
- Proposed legislation to amend the Anti-Injunction Act
- Implications for the Presidential Election
- A group of state lawmakers associated with the Progressive States Network are considering state-based legislation to encourage residents to buy insurance
- Some states already ban an individual mandate

Most Recently Available CMS Organizational Chart



NOTE: new offices created under Federal health reform include the Federal Coordinated Health Care Office, the Center for Medicare and Medicaid Innovation, and the Center for Consumer Information and Insurance Oversight

Time Check: Select CMS Payment Initiatives – Medicare Menu

- **Center for Medicare Initiatives**
  - Medicare Shared Savings Program – starting April 1 or July 1, 2012
    - **Applications due: January 20, 2012 or March 30, 2012** (depending on start date)
  - Community-Based Care Transitions Program (Partnership for Patients) – starting second quarter 2011
- **Center for Medicare & Medicaid Innovation Initiatives**
  - Hospital Engagement Contractors (Partnership for Patients) – starting October 2011
  - Health Care Innovation Challenge—LOI 12/19/11; applications due 1/27/12
  - Innovation Advisors Program – starting December 2011
    - 73 individuals from 27 states and DC were announced on January 3, 2012
  - Pioneer ACO Model – announced 12/19/11; starting fourth quarter 2011
  - Advance Payment ACO Model – starting April 1 or July 1, 2012
    - **Applications due: February 1, 2012 or March 30, 2012** (depending on MSSP start date)
  - Bundled Payments for Care Improvement – starting first and second quarter 2012 (depending on model)
    - **Letters of Intent due: October 6 or November 4, 2011** (depending on model)
    - **Applications due: November 18, 2011 or April 30, 2012** (depending on model)
  - Comprehensive Primary Care Initiative starting second quarter 2012
    - **LOI: November 15, 2011; Applications: January 17, 2012**

Pioneer ACO Model

- The Pioneer ACO Model is designed to support organizations with experience operating as ACOs or in similar arrangements in providing more coordinated, patient-centered care at a lower cost to Medicare
  - The Pioneer ACO Model tests shared savings and shared losses payment arrangements with higher levels of reward and risk than in the MSSP
  - The Pioneer ACO Model also will test population-based payment arrangements in year three of the program
  - Pioneer ACOs must enter into similar contracts with other payers (such as insurers, employer health plans, and Medicaid)
    - More than 50% of the Pioneer ACO's revenues must be derived from outcomes-based payment arrangements by the end of the second performance period
- On December 19, 2011, CMMI published the list of 32 organizations selected to participate in the Pioneer ACO Model
  - The first performance period began on January 1, 2012

Innovation Advisors Program Participants

- CMMI launched the Innovation Advisors Program in October 2011 to enable health professionals to expand their skills and apply what they learn to drive improvements to patient care and reduce costs
  - The initiative will enable these health professionals to enhance skills in health care economics and finance, population health, systems analysis, and operations research
- On January 3, 2012, CMMI announced that it selected 73 health professionals to participate in the program
  - The 73 individuals include clinicians, allied health professionals, health administrators and others
- Among other duties, the Advisors will be expected to support CMMI in testing new models of care delivery, to form partnerships with local organizations to drive delivery system reform, and to improve their own health systems so their communities will have better health and better care at a lower cost

Medicare Shared Savings Program:

How Might Provider Sponsored Plans Play?

Understanding the Eligibility Requirements

- Entities that may form an ACO as a joint venture:
  - Hospitals
  - ACO professionals (physicians, nurse practitioners, physician assistants, clinical nurse specialists)
  - Group practices
  - Hospitals employing ACO professionals
  - Certain Critical Access Hospitals (those billing under method II)
  - Networks of ACO professionals
  - Federally Qualified Health Centers (FQHCs)
  - Rural Health Clinics (RHCs)

- Some Highlighted Changes from the Proposed Rule
  - FQHCs and RHCs added to list of entities that may form an ACO
  - Unspecified Medicare-enrolled providers may join an ACO formed by at least one eligible participant
  - Additional flexibility to add to or subtract from the list of ACO participants during the performance year

Where Do An ACO's "members" come from?

- Beneficiary Assignment & Qualification Criteria
  - A minimum of 5,000 beneficiaries must receive a plurality of their primary care from the ACO in order to be "assigned" to the ACO
  - CMS has adopted a preliminary form of prospective assignment of Medicare beneficiaries
    - Actual assignment for purposes of calculating savings remains retrospective
    - ACOs will be provided with quarterly reports listing beneficiaries who are on track to be assigned to the ACO
  - CMS has expanded the primary care services counted toward beneficiary assignment from primary care physician services only to include primary care services provided by specialists, physician assistants, and nurse practitioners

- Data Sharing/Beneficiary Outreach
  - CMS will share Medicare beneficiary claims data with an ACO upon request to assist with:
    - Managing population health
    - Coordinating care
    - Improving quality and efficiency
  - An ACO may contact Medicare beneficiaries before they are seen by an ACO participating provider, using the quarterly list provided by CMS

The Case for PSP Involvement

- What Is It? What Must It Become?
  - An ACO must be a legal entity capable of receiving and distributing shared savings, repaying losses, and reporting quality performance data
  - Risk assumption requirements open issue
    - State insurance law not preempted
    - But does it apply where
      - ACO collects no premium?
      - Makes no coverage promises?
      - Providers will all be paid in full?
      - Only down-side liability is a limited contigent payment for failure to meet service goals?

Alignment with PSP's other business

- PSP might align its delegated care management strategy
- PSP might look for synergies with its network:
  - quality goals
  - surplus distribution or commercial or MA population
  - Data base, more population under care management protocols
- Bring scale to PSP's own investments

How Do Provider-Sponsored Plans Fit In?

- There are a number of ways for the provider-sponsored plan to position itself in an ACO environment
- Provider-sponsored plans (PSPs) bring expertise around understanding utilization data and episodes of care, analyzing populations and risk profiles, developing provider networks and provider contracts, providing case management and disease management, utilizing population management tools, etc.
- Provider-sponsored plans should consider opportunities to:
  - Establish management company relationships
  - Be “a la carte” service providers
  - Rent FTEs for care management
  - Provide IT backbone
  - Invest in the ACO

Investment (participating loan?)

- **ACOs are likely to be capital challenged**
  - Some traditional capital needs not present: e.g., enrollment, marketing; license reserves (at outset in Track 1)
  - However, capital is needed for data analytics, care management, IT support for care management
  - Extended period prior to income (1st yr 18 month then settlement)
- **Provider sponsored plans are logical capital partner**
  - Have skill sets that ACO needs to achieve savings as well as quality prerequisites
  - Could charge market rates for those services
    - However, ACO will have no current income to pay for services
    - Payback will take time and be speculative
  - At risk service provider might be a solution
  - PSP may have collateral interest in building care management skills in the network for the PSP's lives (MA or commercial)

Are there limitations on Provider Sponsored Plan Investment?

- "75% of Governance by Participants"
  - What does it mean?
    - Not a rule, but a presumption of the way it should be,
    - Opportunity to demonstrate that alternative governance structures satisfy CMS goals
    - Might a non-participant investor get board representation by contract?
  - What might protect a minority investor short of majority control?
    - Debt covenants?
    - Super-majority rights?
      - Limited to financial issues?
  - Medicare beneficiary representation needed as well

Contract-only relationships

- Mix and Match
  - Development services
  - Management services
    - HR, payroll, IT, contract management
    - Financial modeling and reporting
    - Compliance functions (HIPAA and otherwise)
  - Provider contracting
    - risk and care management provisions only
  - Population analytics
  - Care management services
  - Disease management services
  - Care management reporting
  - Product development for future contracts
    - E.g., bundles

What are the time Line Demands for Application?

- Regs Effective: Jan. 3, 2012
  - Start dates in 2012 are April 1, 2012 and July 1, 2012
    - For 2013 and beyond, January 1 start date

	April 1, 2012	July 1, 2012
Notice of Intent Accepted	Nov. 1, 2011 – Jan. 6, 2012	Nov. 1, 2011 – Feb. 17, 2012
2012 Applications Accepted	Dec. 1, 2011 – Jan. 20, 2012	Mar. 1, 2012 – Mar. 30, 2012
2012 Application Approval/Denial	Mar. 16, 2012	May 31, 2012
Reconsideration Review Deadline	Mar. 23, 2012	Jun. 15, 2012

  - Certifications and supporting documentation supplied to CMS include:
    - Plan to implement patient-centeredness criteria
    - Organization and management structure
    - Compliance plan
    - Description of how shared savings will be used to achieve the “Triple Aim”

MSSP Final Rule

Does it Make this a Business You Want to Be in or Service?

When would an investment pay off?

Comparison of Shared Savings Methodology in Proposed and Final Rules

Variable	Risk Model	Proposed	Final
Maximum Percentage of Shared Savings	Track 1	52.5%*	50%
	Track 2	65%*	60%
Minimum Savings Rate	Track 1	2.0-3.9%	2.0-3.9%
	Track 2	2%	2%
Shared Savings Cap (payment limit)	Track 1	7.5%	10%
	Track 2	10%	15%
Shared Losses Cap (loss limit)	Track 1	5% (year 3)	N/A
	Track 2	5% in year 1; 7.5% in year 2; 10% in year 3	5% in year 1; 7.5% in year 2; 10% in year 3

*(maximum percentage would be 50% and 60% excluding incentives for FQHC/RHC participation)

Equation for Entitlement to a Shared Savings Payment

Medicare Parts A and B Fixed Historical Benchmark >

Medicare Parts A and B Estimated Expenditures –

Minimum Savings Rate =

Shared Savings

Subject to a Cap, the Final Sharing Rate with CMS, Minimum Quality Performance Standards, and Subject to Eligibility Compliance Requirements

Can you help the ACO beat the Benchmark?

- CMS Benchmark Determinations
  - For each performance year, CMS determines whether the estimated average per capita Medicare expenditures under the ACO for potentially assigned Medicare fee-for-service beneficiaries for Parts A and B services are below the applicable updated fixed historical benchmark established by CMS prior to the agreement period
- Average Per Capita Expenditures
  - CMS establishes the fixed historical benchmark adjusted for historical growth and beneficiary characteristics
    - CMS determines the estimated Medicare fee-for-service expenditures for beneficiaries that would have been assigned to the ACO in any of the 3 most recent years prior to the agreement period
    - CMS uses a 3-month claims run out with a completion factor
    - CMS adjusts expenditures using prospective Hierarchal Condition Category (HCC) risk scores for variation in case complexity and severity—but fixed for duration of contract
  - CMS modifies the benchmark
    - CMS "updates" the historical benchmark annually for each year in the three year agreement period
    - CMS resets the benchmark at the start of each new agreement period

Before Your Joint Venture or Client Sees Savings: performance bogeys

- **In order to receive shared savings**
  - First year – complete and accurate reporting of all 33 quality measures
  - Second year – achieve minimum attainment levels for 25 of the 33 quality measures and full reporting
  - Third year – achieve minimum attainment levels for 32 of the 33 quality measures and full reporting
- **33 Quality Measures in Four Quality Domains**
  - 7 patient/caregiver experience measures
  - 6 care coordination/patient safety measures
  - 8 preventive health measures
  - 12 at-risk population measures
- **EHR incentive program participation**
  - Double weighted quality measure
  - Replaces the proposed requirement that 50% of ACO physicians be “meaningful users” of EHR

Understanding the Quality Performance Standards (cont.)

To determine percentage of shared savings (up to 50% for Track 1 or up to 60% for Track 2):

- Performance benchmark
  - Defined by national Medicare fee-for-service claims data, Medicare Advantage quality data, or a national flat percentage if claims/quality data are not available in certain circumstances
- Minimum attainment level set at 30% or 30th percentile of performance benchmark
- Point scale for each measure
  - Performance < minimum attainment level = 0 points
  - Performance =/> minimum attainment level = points on sliding scale
    - 0 – 2 points for all measures except EHR measures
    - 0 – 4 points for EHR measures
- Individual measure scores aggregated to determine domain score
  - Must score above the minimum attainment level on 70% of the measures in a domain
- Domain scores averaged to get performance rate used to determine final percentage of shared savings
  - 4 domains are weighted equally

Antitrust Compliance—lower barrier to participation

- FTC and DOJ eliminated the requirement that 2 or more independent participants having a collective market share of greater than 50% for shared services must request an antitrust review
- A presumptive "rule of reason" treatment will be applied to concerted action of provider groups that are eligible and intend or have been approved to participate in MSSP
- FTC and DOJ have created a safety zone for certain ACOs if they meet the standards required by CMS and independent participants do not have a collective market share for shared services of greater than 30%
- Five types of conduct may raise competitive concerns
  1. Improper sharing of competitively sensitive information
  2. Preventing or discouraging private payers from directing or incentivizing patients to choose certain providers
  3. Tying sales (either explicitly or implicitly through pricing policies) of the ACO's services to the private payer's purchase of other services from providers outside the ACO
  4. Exclusive contracting with ACO providers, thereby preventing or discouraging those providers from contracting with private payers outside the ACO
  5. Restricting a private payer's ability to make available to its health plan enrollees cost, quality, efficiency, and performance information

Fraud and Abuse Guidance--progress

- Interim Final Rule with Comment Period
  - Comments are due January 3, 2012
- Five Waivers

1. An "ACO pre-participation" waiver of the Stark Law, the Anti-Kickback Statute, and the Gainsharing Civil Money Penalty (CMP) that applies to ACO-related start-up arrangements in anticipation of participating in the MSSP, subject to certain limitations, including limits on the duration of the waiver and the types of parties covered
2. An "ACO participation" waiver of the Stark Law, the Anti-Kickback Statute, and the Gainsharing CMP that applies broadly to ACO-related arrangements during the term of the ACO's participation agreement under the MSSP and for a specified time thereafter
3. A "shared savings distributions" waiver of the Stark Law, Anti-Kickback Statute, and Gainsharing CMP that applies to distributions and uses of shared savings payments earned under the MSSP
4. A "compliance with the Physician Self-Referral Law" waiver of the Gainsharing CMP and the Anti-Kickback Statute for ACO arrangements that implicate the Stark Law and meet an existing exception
5. A "patient incentive" waiver of the Beneficiary Inducements CMP and the Anti-Kickback Statute for medically related incentives offered by ACOs under the MSSP to beneficiaries to encourage preventive care and compliance with treatment regimes.

IRS – Tax-Exempt Organization Guidance-again, clearing the way

- Fact Sheet (FS-2011-11) updates and clarifies the initial analysis provided in Notice 2011-20 published in April 2011
  - Clarifies the list of factors that demonstrate a tax-exempt organization's participation in an ACO will not result in private inurement or private benefit
    - Whether impermissible inurement or private benefit occurred will depend on the entirety of facts and circumstances and not compliance with all factors or strict or literal compliance with the factors
  - Indicates that IRS will be reasonably flexible in determining whether non-MSSP activities of a joint venture ACO jeopardize exemption or create unrelated business taxable income (UBTI) for tax exempt participant
    - Broader set of examples articulated in Fact Sheet than in Notice

Business Line Considerations

- Would the business align with PSP' sponsorship's goals?
- Would the business align with PSP's population health management goals?
  - Would the network correspond to the PSP's network to leverage care management
  - Would the surplus sharing act synergistically with PSP's incentive systems?

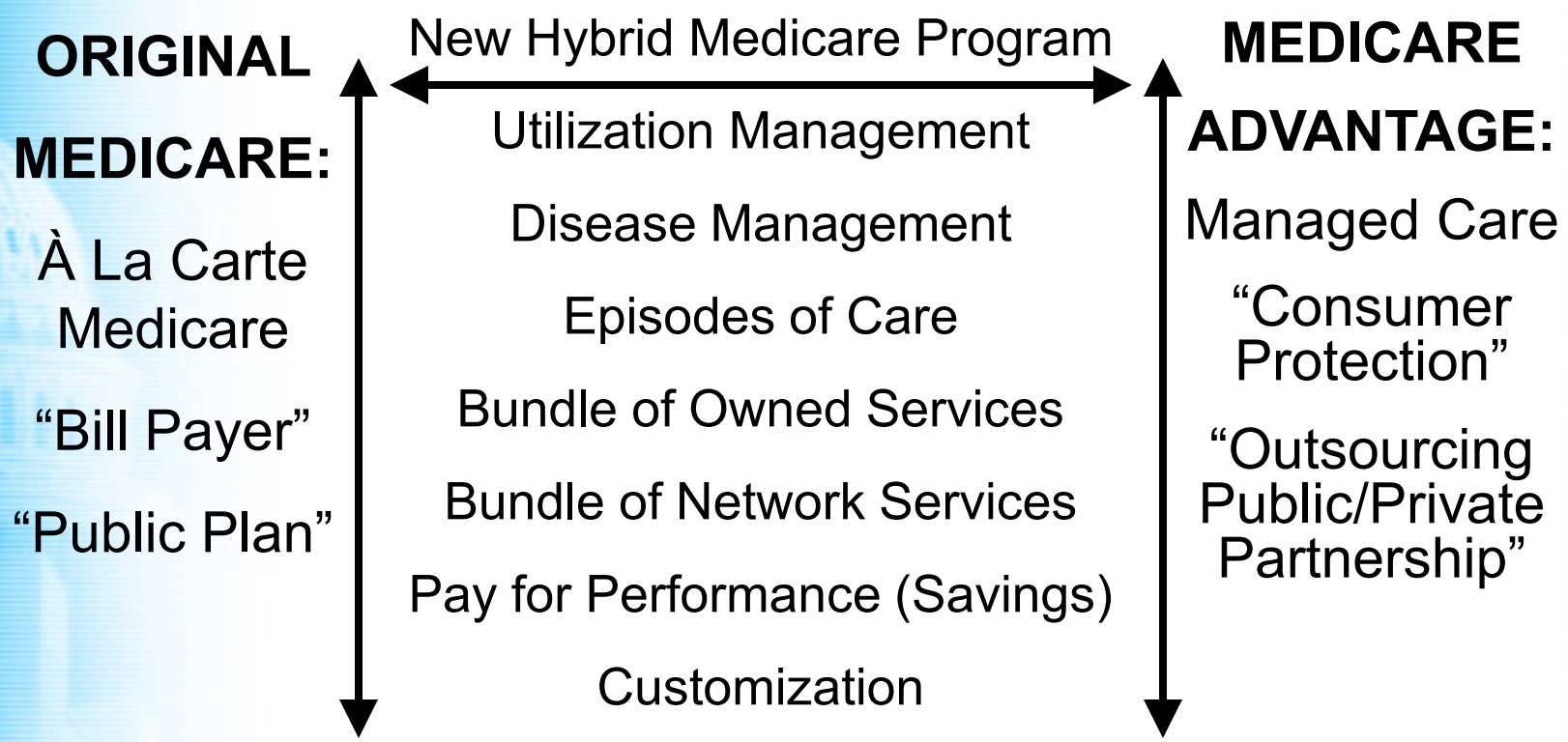
- Can your client/joint venture ACO achieve savings?
  - Benchmark
  - Prior HCC history
  - No beneficiary lock-in
  - Current care management experience
    - Does it correspond to major cost drivers in ACO population?

Future of Medicare Policy:

Medicare Advantage or

Medicare FFS/Pioneer-MSSP

Themes for the Medicare Program

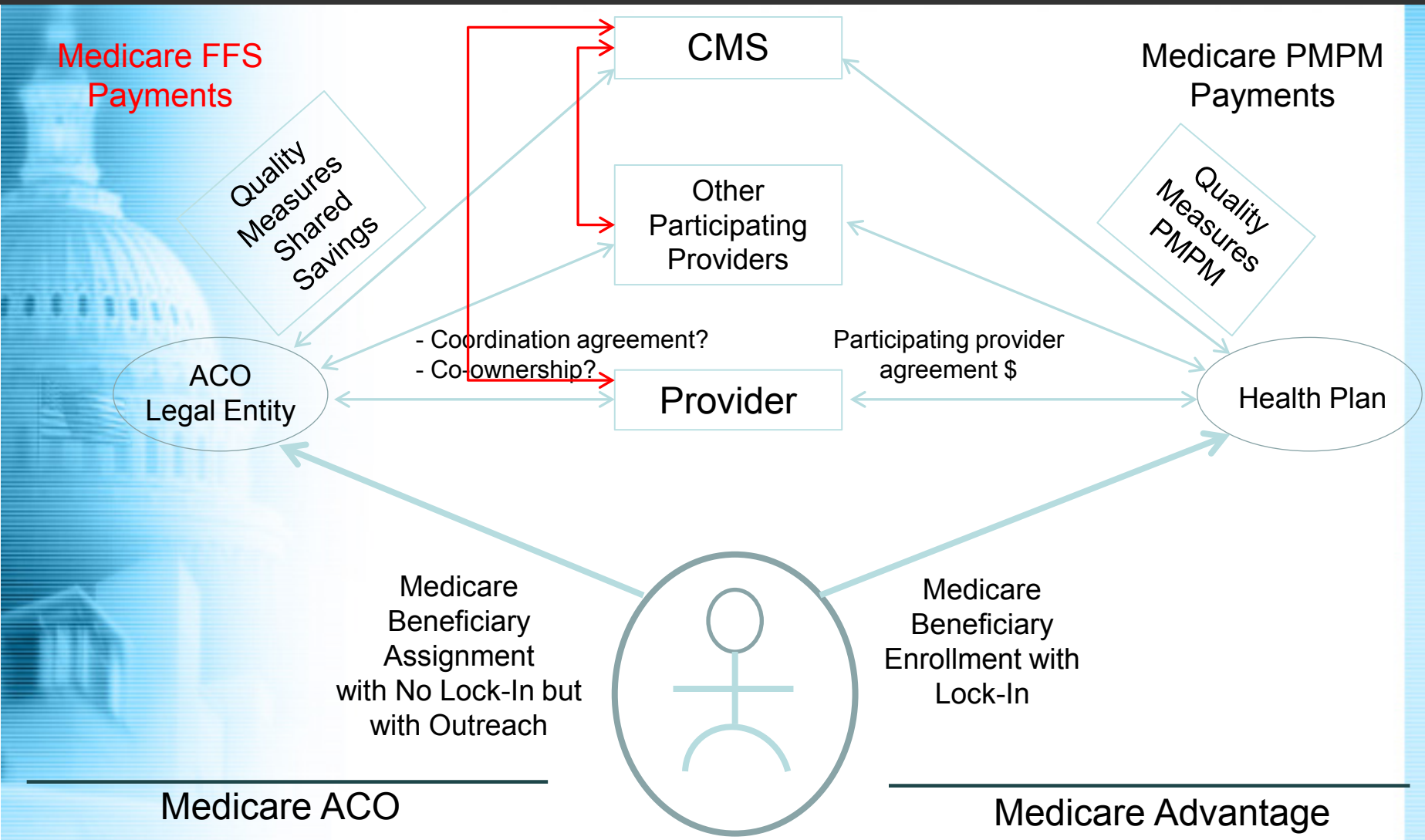


Medicare *"as we know it"*

Medicare Advantage Enrollment

- In 2011, more than 12 million Medicare beneficiaries enrolled in Medicare Advantage plans
  - Approximately 25% of all Medicare beneficiaries are enrolled in Medicare Advantage plans
    - Enrollment has risen by 6% from 2010
  - Premiums have dropped by 6% for 2011
  - The number of beneficiaries who are now in four- and five-star Medicare Advantage contracts has grown by 5%
- In 2012, enrollment is expected to increase by 10%
  - On average, premiums will be 4% lower in 2012 than in 2011 (and 11.5% below premiums in 2010)
  - Medicare Advantage plans will be required to cover preventive services without cost-sharing
  - Open enrollment for 2012: October 15 through December 7, 2011

ACOs v Medicare Advantage



Food for Thought

- Health plans and ACOs may be on a collision course
  - Patients to choose either Medicare Advantage or to remain in FFS and then perhaps to opt out of MSSP
    - Those enrolled in Medicare Advantage are not supposed to be contacted in any ACO outreach to beneficiaries
    - ACO models could result in less enrollment for health plans
- Or health plan may be part of group forming an ACO (under MSSP)
  - Provided 75% provider driven governance goal is addressed

State Medicaid ACO Initiatives

- At least 11 states are adding ACOs or ACO-like integrated delivery system initiatives to their Medicaid programs
  - States include California, Colorado, Massachusetts, Minnesota, New Jersey, New York, North Carolina, Oklahoma, Oregon, Utah, and Washington
  - Models vary in the extent to which provider payments are tied to patient outcomes, the risk that providers have to assume, and the geographic and patient population limitations allowed
- Additionally, 13 states have submitted Medicaid state plan amendments to CMS to implement new medical home models
  - These models include similar ACO concepts aimed at integrating services and providers, coordinating care, and reducing costs
- Section 2706 of PPACA established a Medicaid Pediatric ACO Demonstration to permit states to make incentive payments to pediatric medical providers organized as an ACO
  - The program is authorized for years 2012-2016 but funds have not been appropriated

The Intersection of Dual Eligibles and Medicare ACOs

- Although CMS's goal is to promote complete integration of care and align incentives whether care is provided under Medicare, Medicaid, or both, the MSSP is only to assure greater coordination of care for Medicare Parts A and B
- The ACO final rule does NOT include additional financial incentives for the care of dual eligibles
- CMS intends to study the effect of assignment of dual eligibles to Medicare ACOs on Medicaid expenditures for future demonstrations in CMMI
- For further opportunities to integrate care and financing across both Medicare and Medicaid programs, there are demonstrations underway at CMMI in partnership with the Medicare-Medicaid Coordination Office

According to the Center for Health Care Strategies, Inc.

- We spend approximately $250 billion* annually in Medicare and Medicaid payments for the nearly 9 million dual eligibles
- These expenditures are approaching half of all Medicaid expenditures and a quarter of all Medicare outlays annually
- 80% of the dual eligibles are in uncoordinated fee-for-service systems
- Four solutions are offered:
  - Special Needs Plans;
  - Program for All-Inclusive Care for the Elderly (PACE);
  - Shared Savings Models; and
  - States as Integrated Care Entities

* CMS recently reported that the amount spent annually on dual eligibles is now approximately $300 billion – *see* Center for Medicare & Medicaid Innovation, State Demonstrations to Integrate Care for Dual Eligible Individuals, *available at* http://innovations.cms.gov/areas-of-focus/seamless-and-coordinated-care-models/state-demonstrations-to-integrate-care-for-dual-eligible-individuals/.

Opportunities for Better Coordinated Care for Dual Eligibles

- ACA created the Federal Coordinated Health Care Office to better integrate Medicare and Medicaid benefits and improve coordination between federal and state governments
- On May 16, 2011, CMS issued a request for information seeking comments on opportunities to more effectively align benefits, prevent cost-shifting, and improve access to care under Medicare and Medicaid for dual eligible beneficiaries
  - Opportunities for alignment, based on identification of conflicting requirements in Medicare and Medicaid, include:
    - Coordinated care
    - Fee-for-service benefits
    - Prescription drugs
    - Cost sharing
    - Enrollment
    - Appeals
  - Comments were due July 11, 2011 (*see* 76 Fed. Reg. 28,196 (May 16, 2011))

Demonstration Projects Related to Care for Dual Eligibles

- On July 8, 2011, CMS announced three initiatives related to improving quality and lowering the cost of care for dual eligibles:
  - A demonstration program to test two new financial models designed to help states improve quality and share in lower costs resulting from better coordinated care for dual eligible beneficiaries
    - The two models include:
      - A state, CMS, and health plan enter into a three-way contract where the managed care plan receives a prospective blended payment to provide comprehensive, coordinated care
      - A state and CMS enter into an agreement by which the state would be eligible to benefit from savings resulting from managed fee-for-service initiatives designed to improve quality and reduce costs for both Medicare and Medicaid
  - A demonstration program to help states improve the quality of care for people in nursing homes by focusing on reducing preventable inpatient hospitalizations
  - A technical resource center available to all states to help them improve care for high-need, high-cost beneficiaries
- CMS also launched initiatives to support state demonstrations in up to 15 states to integrate care for dual eligible individuals and to provide states with access to Medicare Parts A, B and D data

State Demonstrations to Integrate Care for Dual Eligibles

- Under Section 2602 of PPACA, 15 states have been awarded contracts to support the design of demonstration projects that will aim to improve the coordination of care for people with Medicare and Medicaid coverage
- Each of the selected states will receive up to $1 million to develop patient-centered demonstration projects that focus on coordinating primary, acute, behavioral, and long-term care and services for dual eligibles

State Demonstrations to Integrate Care for Dual Eligibles (cont.)

15 States Selected to Participate in Demonstration Projects for Dual Eligibles Under Section 2602 of PPACA

Selected States	
California*	Oklahoma
Colorado	Oregon
Connecticut	South Carolina
Massachusetts	Tennessee
Michigan	Vermont
Minnesota	Washington
New York*	Wisconsin
North Carolina	

* 6 states, including California and New York, represent approximately 50% of the 32 million uninsured targeted to go into the State Exchanges or Medicaid

Source: Lynn Shapiro Snyder and Amy F. Lerman, EpsteinBeckerGreen, CMS Announces State Demonstration Project Initiative for Dual Eligibles: Is Your State on the List? (Apr. 25, 2011), *available at* http://www.ebglaw.com/showclientalert.aspx?Show=14249.

Independence at Home Demonstration

- Section 3024 of PPACA established the Medicare Independence at Home Demonstration Program to test a payment incentive and service delivery model that utilizes physician and nurse practitioner-directed home-based primary care teams
  - The demonstration program will allow up to 50 practices serving at least 200 fee-for-service Medicare or dual eligible beneficiaries to receive payments for providing home-based care, and to share Medicare savings that exceed the 5 percent minimum savings threshold
  - Dual eligibles are likely to comprise a large portion of beneficiaries eligible for the program
    - CMS expects the participating medical practices to coordinate care across Medicare and Medicaid to the greatest extent and to work with the states
    - While the savings calculation is based upon Medicare spending for the dual eligibles, CMS will evaluate the impact of the demonstration on Medicaid costs
  - Applications for participation in the three-year demonstration program are due February 6, 2012 (or May 4, 2012 if establishing a consortium of providers)

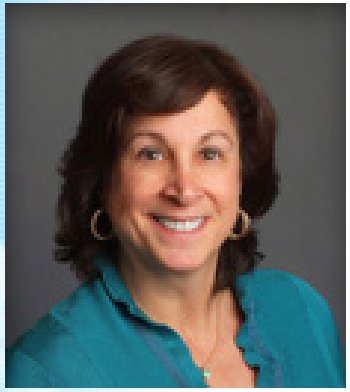
What Can Make a Difference for All Health Care Costs?

- Shifts in the health status of the population
- Changes in the way health services are delivered
- Payment methods that bundle payments; pay for efficiencies or "savings"; aggregate payments
- Malpractice reform
- Changes in consumer engagement and consumer preferences (e.g., end-of-life services)
- Advances in medical technology (disruption and adoption)
- Advances in timely access to quality and cost data of patient services
- Transparency/individual responsibility
- Health care workforce
- Political/fiscal discipline (e.g., Independent Payment Advisory Board)

EBG Alerts

- Visit the www.ebglaw.com website for the various alerts we have published on a wide range of issues related to health reform and the Medicare program

Questions & Answers



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Appendix

Legal Challenges to ACA
CMS Payment Initiatives
Pioneer Participants
Innovation Advisor Participants
FQHC Opportunities
Implications for Board Members/Trustees

Legal Challenges to ACA

Circuit	Deciding Judges	Ruling
6th Circuit *Thomas More Law Center v. Obama*	Boyce Martin Jr. (Dem. appointee) – wrote the opinion upholding the law Jeffrey Sutton (Rep. appointee) – concurred in the decision James Graham (Rep. appointee) – dissented	Ruled that the law's requirement for most Americans to carry insurance or pay a penalty does not exceed Congress's powers under the Commerce Clause Plaintiffs filed a petition for writ of certiorari with the Supreme Court on July 27, 2011 DOJ filed a response on September 28, 2011 asking the Court to hold the petition until the Court reviewed the Eleventh Circuit decision
11th Circuit *State of Florida v. U.S. Dept. of Health and Human Services*	Joel Dubina (Rep. appointee) – wrote the opinion striking down the mandate Frank Hull (Dem. appointee) – joined the majority opinion Stanley Marcus (Dem. appointee) – dissented	Ruled that Congress exceeded its constitutional powers when it required individuals to purchase health insurance or pay a penalty; however, the unconstitutional insurance mandate could be severed from the rest of the law, with other provisions remaining "legally operative" Three certiorari petitions were filed on September 28, 2011 by the National Federation of Independent Business and two individual plaintiffs in the case, the 26 states that are plaintiffs, and the DOJ The Supreme Court granted certiorari on November 14, 2011; oral arguments will be held March 26-28, 2012

Legal Challenges to ACA

Circuit	Deciding Judges	Ruling
4th Circuit *Liberty University v. Geithner* *Virginia v. Sebelius*	Diana G. Motz (Dem. appointee) – wrote the opinion Andre M. Davis (Dem. appointee) – joined the opinion James A. Wynn Jr. (Dem. appointee) – joined the opinion	Ruled that the Anti-Injunction Act barred it from reviewing Liberty's case until the individual mandate was in place in 2014 Ruled that the State of Virginia does not have a legal right to sue over the law's requirement that most people buy insurance Liberty University filed a certiorari petition on October 7, 2011
D.C. Circuit *Susan Seven-Sky v. Holder*	Laurence Silberman (Rep. appointee) – wrote the opinion upholding the law Harry Edwards (Dem. appointee) – concurred in the decision Brett Kavanaugh (Rep. appointee) - dissented	Ruled that the minimum essential coverage provisions do not exceed Congress's authority under the Commerce Clause and the Necessary and Proper Clause as a regulation of economic activity Ruled that the Anti-Injunction Act did not pose a jurisdictional bar to review of the case

Legal Challenges to ACA

Circuit	Deciding Judges	Ruling
3rd Circuit *New Jersey Physicians, Inc. v. President of the U.S.*	Michael Chagares (Rep. appointee) – wrote the opinion dismissing the challenge Joseph Greenaway Jr. (Dem. appointee) – joined the opinion Kent Jordan (Rep. appointee) – joined the opinion	Upheld a lower court ruling that a group of New Jersey physicians and a patient don't have the right to challenge the constitutionality of the individual mandate and employer requirements The judge's ruling did not address the merits of the case
9th Circuit *Steve Baldwin and Pacific Justice Institute v. Sebelius*	Pamela Ann Rymer (Rep. appointee) – wrote the opinion dismissing the challenge Ferdinand Francis Fernandez (Rep. appointee) – joined the opinion Richard Tallman (Dem. appointee) – joined the opinion	Upheld the dismissal of a suit challenging the individual mandate provision, ruling a former California legislator and a nonprofit group lacked standing to bring the suit because they had not alleged an actual injury

CMS Timeline for Payment Initiatives – Medicare Menu

Center for Medicare		Center for Medicare & Medicaid Innovation	
Program	Implementation Date	Program	Implementation Date
Medicare Shared Savings Program Encourages formation of accountable care organizations that coordinate care across the care continuum and share in Medicare savings	April 1 or July 1, 2012 **Applications due January 20 or March 30, 2012 (depending on start date)**	**Hospital Engagement Contractors (Partnership for Patients)** Provides funding for contractors to design programs, conduct training, and provide technical assistance to support hospitals in making care safer and reduce hospital-acquired conditions	October 2011
Community-Based Care Transitions Program (Partnership for Patients) Provides funding to test models for improving care transitions from the inpatient hospital setting to other care settings	Second Quarter 2011	**Innovation Advisors Program** Select individuals in the health care system (clinicians, health care executives, etc.) to test and refine new models of payment and care delivery focusing on healthcare finance; population health; systems analysis; and operations research	December 2011 Individuals selected January 3, 2012
		Pioneer ACO Model Tests alternative payment models that include escalating levels of financial accountability and share in Medicare savings • Organizations participating in the Pioneer ACO Model will not be eligible to participate in the Medicare Shared Savings Program	Fourth Quarter 2011 Organizations selected December 19, 2011
		Advance Payment ACO Model Participants in the Medicare Shared Savings Program to receive advanced payments to be recouped from shared savings earned • Only available to ACOs that enter the Shared Savings Program in April or July 2012	April 1 or July 1, 2012 **Applications due February 1 or March 30, 2012 (depending on MSSP start date)**
		Bundled Payments for Care Improvement Tests four models that combine payment for physician, hospital, and other provider services of a predetermined amount during an episode of care	First & Second Quarter 2012 (depending on model) **Letters of Intent due October 6 or November 4, 2011 (depending on model)** **Applications due November 18, 2011 or April 30, 2012 (depending on model)**
		Comprehensive Primary Care Initiative Multi-payer initiative that will pay primary care providers for improved and comprehensive care management, and an opportunity to share in savings generated • Markets participating in Multi-payer Advanced Primary Care Practice demonstration not eligible	Second Quarter 2012 **Letters of Intent due November 15, 2011** **Applications due January 17, 2012**

Pioneer ACO Model Participants

- The following is a list of the 32 organizations selected to participate in the Pioneer ACO Model

Organization	Service Area
Allina Hospitals & Clinics	Minnesota and Western Wisconsin
Atrius Health Services	Eastern and Central Massachusetts
Banner Health Network	Phoenix, Arizona Metropolitan Area (Maricopa and Pinal Counties)
Bellin-Thedacare Healthcare Partners	Northeast Wisconsin
Beth Israel Deaconess Physician Organization	Eastern Massachusetts
Bronx Accountable Healthcare Network (BAHN)	New York City (the Bronx) and lower Westchester County, NY
Brown & Toland Physicians	San Francisco Bay Area, CA
Dartmouth-Hitchcock ACO	New Hampshire and Eastern Vermont
Eastern Maine Healthcare System	Central, Eastern, and Northern Maine
Fairview Health Systems	Minneapolis, MN Metropolitan Area
Franciscan Health System	Indianapolis and Central Indiana
Genesys PHO	Southeastern Michigan
Healthcare Partners Medical Group	Los Angeles and Orange Counties, CA
Healthcare Partners of Nevada	Clark and Nye Counties, NV
Heritage California ACO	Southern, Central, and Costal California
JSA Medical Group, a division of HealthCare Partners	Orlando, Tampa Bay, and surrounding South Florida

Pioneer ACO Model Participants (cont.)

Organization	Service Area
Michigan Pioneer ACO	Southeastern Michigan
Monarch Healthcare	Orange County, CA
Mount Auburn Cambridge Independent Practice Association (MACIPA)	Eastern Massachusetts
North Texas Specialty Physicians	Tarrant, Johnson and Parker counties in North Texas
OSF Healthcare System	Central Illinois
Park Nicollet Health Services	Minneapolis, MN Metropolitan Area
Partners Healthcare	Eastern Massachusetts
Physician Health Partners	Denver, CO Metropolitan Area
Presbyterian Healthcare Services – Central New Mexico Pioneer Accountable Care Organization	Central New Mexico
Primecare Medical Network	Southern California (San Bernardino and Riverside Counties)
Renaissance Medical Management Company	Southeastern Pennsylvania
Seton Health Alliance	Central Texas (11 county area including Austin)
Sharp Health Care System	San Diego County
Steward Health Care System	Eastern Massachusetts
TriHealth, Inc.	Northwest Central Iowa
University of Michigan	Southeastern Michigan

Innovation Advisors Program Participants

- The following is a list of the 73 individuals selected to participate in the Innovation Advisors Program

Innovation Advisors Program Participants		
Dr. Clay Ackerly, Massachusetts General Hospital, Boston, MA	Ms. Anna Marie Butrie, Catholic Health East, Newtown, PA	Dr. Erin DuPree, The Mount Sinai Medical Center, New York, NY
Dr. Parag Agnihotri, Medical Clinic of Sacramento Inc., Sacramento, CA	Mr. Gary Christensen, Rhode Island Quality Institute, Providence, RI	Dr. Zahra Esmail, White Memorial Medical Center, Los Angeles, CA
Mr. Rod Baird, Geriatric Practice Management, Inc., Asheville, NC	Dr. Beverly Christie, Fairview Health Services, St. Paul, MN	Dr. Anna Flattau, Montefiore Medical Center, Bronx, NY
Dr. David Baker, LifeBridge Health System, Baltimore, MD	Ms. Erin Conklin, Genesys Health System, Grand Blanc, MI	Dr. Christian Furman, University of Louisville Research Foundation, Inc., Louisville, KY
Ms. Christine Baker, St. Mary's Hospital, Madison, WI	Ms. Laura Conley, Children's Memorial Hospital, Chicago, IL	Dr. Corita Grudzen, Mount Sinai Medical Center Department of Emergency Medicine, New York, NY
Dr. Randi Berkowitz, Hebrew SeniorLife, Roslindale, MA	Dr. Yeates Conwell, University of Rochester Medical Center, Rochester, NY	Ms. Kellie Hamblin, Providence Health & Services, Renton, WA
Ms. Barbara Blakeney, Massachusetts General Hospital, Boston, MA	Ms. Diane Curley, Catholic Health Services of Long Island, Smithtown, NY	Ms. Grace Hines, Sentara Healthcare, Norfolk, VA
Ms. Rosemary Botchway, Primary Care Coalition of Montgomery County, MD, Inc., Silver Spring, MD	Ms. Jennifer DeCubellis, Hennepin County, Minneapolis, MN	Dr. Srikant Iyer, Cincinnati Children's Hospital Medical Center, Cincinnati, OH
Ms. Laura Beth Brown, Vanderbilt University Medical Center, Nashville, TN	Ms. Erin Denholm, Centura Health, Denver, CO	Dr. Jonathan Jaffrey, The University of Wisconsin School of Medicine and Public Health, Middleton, WI
Dr. Stephanie Bruce, Washington Hospital Center, Medical House Call Program, Washington, DC	Dr. Pamela Duncan, Wake Forest Baptist Health, Winston Salem, NC	Dr. Daniel Johnson, Kaiser Permanente (Colorado), Aurora, CO

Innovation Advisors Program Participants (cont.)

Innovation Advisors Program Participants		
Dr. Colleen Kraft, Carilion Medical Center, Roanoke, VA	Dr. Janice Pringle, University of Pittsburgh School of Pharmacy, Pittsburgh, PA	Ms. Cristin Sullivan, St. Vincent Hospital, Green Bay, WI
Dr. Candice Lagasse, United States Air Force, Buckley AFB, CO	Dr. Judith Rabig, Masonic Health System of Massachusetts, Leeds, MA	Ms. Paula Suter, Sutter Health, Fairfield, CA
Dr. Suzanne Landis, Mountain Area Health Education Center (MAHEC), Asheville, NC	Dr. Jack Resnick, Empire State Medical Associates, P.C., Roosevelt Island, NY	Dr. Sharon Tapper, Palo Alto Medical Foundation, Santa Cruz, CA
Dr. Larry Lawhorne, Wright State Physicians, Inc., Dayton, OH	Dr. Neil Resnick, University of Pittsburgh Medical Center, Pittsburgh, PA	Ms. Kelly Taylor, Mercy Clinics, Inc., Des Moines, IA
Dr. Barbara Levin, Chota Community Health Services, Inc., Madisonville, TN	Ms. Stevi Riel, Muskegon Community Health Project, Muskegon, MI	Ms. Maureen Thompson, St. Francis Healthcare Services, Wilmington, DE
Ms. Julie Lewis, Amedisys Holding, L.L.C., Baton Rouge, LA	Ms. Nancy Roberts, Kent County Visiting Nurse Association, Warwick, RI	Dr. Thomas Tsang, Office of the Governor, State of Hawaii, Honolulu, HI
Dr. Stephen Liu, Dartmouth-Hitchcock Medical Center, Lebanon, NH	Ms. Jean Sanders, Aquidneck Medical Associates, Inc., Newport, RI	Ms. Maxine Vance, Baltimore Healthy Start, Inc., Baltimore, MD
Ms. Jeanne McAllister, Crotched Mountain Foundation (CMF), Concord, NH	Dr. Michelle Schoepflin Sanders, Providence Health & Services, Portland, OR	Dr. Betty Vohr, Women & Infants Hospital, Providence, RI
Ms. Tonya Moody, AmeriHealth Mercy Health Plan, Philadelphia, PA	Ms. Christina Schwien, Qualis Health, Seattle, WA	Dr. Alen Voskanian, VITAS Innovative Hospice Care, Torrance, CA
Dr. Nancy Murphy, University of Utah, Salt Lake City, UT	Dr. Kathy Scott, ProHealth Care, Inc., Waukesha, WI	Dr. Jay Want, Center for Improving Value in Health Care, Denver, CO
Dr. Maureen Murphy, SSM Healthcare of Wisconsin, Inc., Lake Delton, WI	Dr. Cordelia Sharma, Westchester County Health Care Corporation, Valhalla, NY	Dr. Victoria Wilkins, University of Utah, Salt Lake City, UT
Ms. Margaret Namie, Mercy Health Partners of Southwest Ohio, Cincinnati, OH	Dr. Phyllis Sherard, Cheyenne Regional Medical Center, Cheyenne, WY	Ms. Janet Will, Joseph Richey Hospice, Baltimore, MD
Dr. Zeev Neuwirth, Carolinas Healthcare System, Charlotte, NC	Dr. Jason Stein, Emory Healthcare, Atlanta, GA	Dr. Sarah Woolsey, HealthInsight, Salt Lake City, UT
Dr. Len Nichols, George Mason University, Fairfax, VA	Dr. Winnie Suen, Boston Medical Center, Boston, MA	Dr. Richard Young, JPS Physician's Group, Fort Worth, TX
Ms. Deborah Peartree, Monroe Plan for Medical Care, Inc., Pittsford, NY		

Background on FQHCs

- FQHCs are public and private non-profit health care organizations that meet certain criteria under the Medicare and Medicaid Programs (Sections 1861(aa)(4) and 1905(l)(2)(B) of the Social Security Act) and receive funds under the Health Center Program (Section 330 of the Public Health Service Act)
  - FQHC Look-Alikes are health centers that meet the definition of "health center" under Section 330 of the Public Health Service Act but do not receive grant funding under Section 330
- FQHCs qualify for enhanced reimbursement from Medicare and Medicaid if they:
  - Are located in or serve a high need community (designated Medically Underserved Area or Population)
  - Are governed by a community board composed of a majority (51% or more) of health center patients who represent the population served
  - Provide comprehensive primary health care services as well as supportive services (education, translation and transportation, etc.) that promote access to health care
  - Provide services available to all with fees adjusted based on ability to pay
  - Meet other performance and accountability requirements regarding administrative, clinical, and financial operations
- Other benefits to being an FQHC include medical malpractice coverage through the Federal Tort Claims Act, eligibility to purchase prescription and non-prescription medications for outpatients through the 340B Drug Pricing Program, access to National Health Service Corps, access to the Vaccine for Children Program, and eligibility for various other federal grants and programs

Unique Medicare ACO Issues Related to FQHCs

- FQHCs now eligible to form ACOs independently
  - Primary care services submitted by FQHCs can be considered in the Medicare beneficiary assignment process for any ACO that includes an FQHC
    - However, under those circumstances, the exclusivity rules of ACO participants upon which a beneficiary assignment is dependent also extends to the TINs of the FQHC upon which beneficiary assignment is made
  - But can FQHCs qualify as ACOs?
    - Checklist for capability to meet all the criteria
    - Requires high level of technical and organizational sophistication
    - Greater integration with hospitals, physician practices, post-acute care providers
    - Infrastructure, start-up costs
- FQHC assignment process modifications recognize the different payment methods and claims data as compared to those used for physician offices/clinics that are paid under the physician fee schedule
- All references to FQHCs include both section 330 grantees and so-called “look-alikes” under 42 C.F.R. § 405.2401

FQHC Medicare Demonstration

- FQHC Advanced Primary Care Practice Demonstration
  - 3-year demonstration period (starting November 1, 2011)
  - Pay care coordination and management fees for FQHC to provide care coordination and management
    - $18 prospective care management fee per each beneficiary (quarterly)
    - Paid automatically without need to submit claim
    - In addition to all-inclusive payment
  - Evaluation to determine whether FQHCs that deliver advanced primary care can improve access and quality, reduce health care costs
  - No indication that a provider cannot participate both in this demonstration and the MSSP
    - Not specifically referenced in MSSP Final Rule (for example, rule specifically indicates that providers participating in the Multipayer Advanced Primary Care Practice or the PGP Transition Demonstration to name just two cannot participate in MSSP)

Unique Medicare Issues Related to Dual Eligibles

- "Dual eligible" individuals
  - Persons who are entitled to Medicare (Part A and/or Part B) and who are also eligible for Medicaid
    - Chronically ill frail elderly
  - Total number – 9.2 million in 2008
    - 15% of total Medicaid Beneficiaries, but 39% of Medicaid spending in 2007
    - 16% of total Medicare Beneficiaries, but 27% of Medicare spending in 2006

Source: CMS Fact Sheet, Details for: People Enrolled in Medicare and Medicaid (May 11, 2011), *available at* http://www.cms.gov/apps/media/press/factsheet.asp?Counter=3954&intNumPerPage=10&checkDate=&checkKey=&srchType=1&numDays=3500&srchOpt=0&srchData=&keywordType=All&chkNewsType=6&intPage=&showAll=&pYear=&year=&desc=&cboOrder=date.

Getting Board Members and Trustees of Providers and Suppliers Prepared

- Business Judgment Rule Considerations – Education is Needed
  - Past decade has brought a revolution in corporate governance (Sarbanes-Oxley; Dodd-Frank)
    - Directors must be active participants in oversight, not mere passive recipients of information by:
      - Demanding enough to rattle cages when necessary
      - Being knowledgeable enough to set direction
      - Acting bold enough to add value through hard questions
      - Being vigorous enough to assure that the organization's plans are conscientiously prepared to have the best shot at success
    - Managing Board expectations is the responsibility of chairs and senior management by recognizing the difference between fiduciary and managerial responsibilities
- ***See* Lynn Shapiro Snyder and Robert D. Reif, *Answering the Call: Understanding the Duties, Risks and Rewards of Corporate Governance* (4th ed. 2011).**

Getting Board Members and Trustees of Providers and Suppliers Prepared (cont.)

- The Starting Point for Boards – A Snap Shot of the Provider/Supplier's Payer Mix Data
  - Current payer mix (with current cross-subsidization of costs)
  - Expected reductions or increases in payments across all payers
    - Medicare and Medicaid cuts
    - Unreasonable premium increase regulatory scheme for private payors
      - Applicable to premium increases of 10% or greater
  - Demographic Trends for Medicare and Medicaid in particular
  - Medicare Menu of customized payment programs
  - Realistic assessment of the landscape for providers and suppliers
    - Providers and suppliers face costly capital decisions (*e.g.*, IT upgrades) in a time of tremendous economic uncertainty
    - Government payors represented almost half of the spending on personal health care in 2009 – that percentage is only growing
    - The government reimbursement system is legislatively required to reduce health care spending – the impact will likely be catastrophic on provider margins

Changing Face of Governance

- Various models of the MSSP may require changes or additions to the board composition with the CMS contracting entity
  - The Pioneer ACO Model calls for the inclusion of a "consumer advocate"
  - The general ACO Model calls for the inclusion of a "Medicare beneficiary representative(s) served by the ACO who does not have a conflict of interest with the ACO, and who has no immediate family member with conflict of interest with the ACO"
- The NCQA accreditation criteria for ACOs state that the physician or clinical leader of the ACO "must participate on or advise the board"
- Many of the new pilot structures will require case management and possible partnership with current payors – who may expect shared governance
- The governing body may be a cross section of representatives of payors, physicians, hospitals, and consumers
  - This will create its own unique challenges as the new board learns to direct a potentially broader and more diverse system delivery or care and community wellness
- Raises the possible need for alternate or expanded committee structure to oversee the effectiveness, efficiency, and patient centeredness of the system

Enterprise Risk Assessment Facilitates Fiduciary Decision-Making

What are the High Risk Areas? What Risk Mitigation Exists? How has the CMS Contracting Organization, such as an ACO, prepared for these High Risk Areas?

– Top Ten Questions management should address to its boards:

1. What are the marketplace risks for establishing the ACO as it relates to current patient demand patterns?
2. What are the vehicles under consideration for protecting the ACO and its sponsors from liability for shared losses? (*e.g.*, reinsurance, escrow, surety bonds, lines of credit, key terms in the ACO participant agreements)
3. What is the governance structure of the ACO as the CMS contracting organization and how does that structure affect the sponsors' commitments for capital and compensation related matters?
4. What is the ACO's capabilities and plans for reporting and satisfying the 33 quality measures in the four quality domains since these outcomes will now have significant financial consequences?
5. What are the processes in place to assure that anything submitted to CMS in the context of the ACO program is "accurate, complete, and truthful" and is recorded in a chron file so that there is institutional memory? For example, what processes are in place for the legal representative of the ACO to be capable of giving CMS the certifications required regarding the eligibility requirements? Does the ACO have the necessary back- up documentation?
   – Some of this data may be displayed by CMS to the public under the transparency provisions

Enterprise Risk Assessment Facilitates Fiduciary Decision-Making (cont.)

What are the High Risk Areas? What Risk Mitigation Exists? How has the CMS Contracting Organization, such as an ACO, prepared for these High Risk Areas?

– Top Ten Questions management should address to its boards (cont.):

6. What will be the ACO's conflict of interest policy? Who will be the decision-maker in this regard?
7. What is the compliance plan for making sure that the plan for developing and executing the ACO is in legal compliance with the key areas of antitrust, fraud and abuse, and tax exempt issues, among other legal issues? How does that compliance plan fit into the broader corporate compliance program for the affiliates of the ACO?
8. What is the compliance plan for protecting the personal health information of the ACO patients when there is going to be so much sharing of this data across independent organizations? Is the ACO prepared for the contractual obligations that arise under a data utilization agreement with CMS – which is required under the ACO program?
9. What remedial processes and penalties will be in place to apply if an ACO provider/supplier fails to comply with or fails to implement the desired ACO processes? Who will be the decision-maker in this regard?
10. What are the data assumptions in the proposed benchmarks and what are the patient/provider changes that are expected to make a difference in achieving the savings? What is the ACO's likelihood of success in this regard?