

ACCOUNTABLE CARE ORGANIZATIONS: OPERATIONAL RISK AND FINANCIAL RESPONSIBILITY

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UNCERTAINTY CALLING OUT FOR INSURANCE SOLUTIONS

As the Patient Protection and Affordable Care Act (PPACA) of 2010 is implemented, the likelihood of changes in payment models that reward provider performance and enhance coordination of care continues to be high.¹ The Centers for Medicare and Medicaid Services (CMS) have made it abundantly clear that their focus is on controlling *aggregate costs* for all beneficiaries (i.e., not just the payment rate) and *service volume decreases* (readmissions, returns to ERs, preventable hospitalizations and overuse of specialists). CMS refers to “shared savings” reforms as having a three-part aim of:

1. Better care for individuals
2. Better health for populations
3. Slower growth in expenditures

Accountable Care Organizations are viewed by many as the solution to these three “better/better/slower” challenges: better care, better population health and slower growth in medical costs. System Transformation, aka Provider Alignment, is CMS’ unspoken but perhaps most important goal. It is the condition precedent to achieving goals number 2 and number 3.

WHAT'S AN ACCOUNTABLE CARE ORGANIZATION?

An **Accountable Care Organization (ACO)** is a formal legal structure through which health care providers across the continuum of care (preventive, primary, specialty, emergency, acute and post-acute) become clinically and financially accountable for a population of patients. These patients become aligned with an ACO as one payer



Smoothing out the risks of uncertainty is the domain of risk transfer – normally through insurance or contractual language. The governing body of an ACO may not have insurance requirements at the top of its list, but every risk manager serving an ACO, every board member and every other stakeholder associated with an ACO certainly should.

(here, pursuant to the Medicare Shared Savings Program [MSSP] administered by the Centers for Medicare and Medicaid Services [CMS]).²

The MSSP ACO model is a way for a group of health care providers to potentially and gradually transform into ACOs that assume more of the risk. The CMS Innovation Center’s “Pioneer ACO Model” is designed to test the effectiveness of a particular payment model – full risk capitation. Full risk capitation means that the ACO must accept a guaranteed payment per participant that is not adjusted based on services provided. The Innovation Center believes that Pioneer Model ACOs will be more effective in producing gains in CMS’ three-part aim if they fully commit to a business model based on financial and performance accountability. Pioneer Model ACOs are required to enter similar contracts with other payers (commercial insurers, employer health plans, and Medicaid) and more than 50% of the ACO’s revenues will be derived from such arrangements by the end of the second year in business (the “Performance Period”).³ The Urban Institute reported in November 2011 that at least eight private health plans have entered into ACO contracts with providers using a shared risk payment model, and at least 27 more have entered into shared savings contracts.⁴

Many commentators and legal reviewers have raised fundamental questions regarding the organizational, operational, financial and legal perils inherent in ACO formation and management. Although there have been ACO demonstration projects focused on measuring potential cost savings, the issue of potential liabilities for ACOs still requires meaningful and creative examination. Smoothing out the risks of uncertainty is the domain of risk transfer – normally through insurance or contractual language. The governing body of an ACO may not have insurance requirements at the top of its list, but every risk manager serving an ACO, every board member and every other stakeholder associated with an ACO certainly should.

THE ACO AND FORESEEABLE RISKS

Section 3022 of the Patient Protection and Affordable Care Act (PPACA)⁵, which creates the Medicare Shared Savings Program, requires that an MSSP ACO must:

- Accept responsibility for the quality, cost and overall care of its aligned Medicare beneficiaries
- Enter into minimum of a three-year agreement
- **Have a formal legal structure to receive and distribute shared savings payments to participants** (emphasis added)
- Include a sufficient number of primary care professionals for the number of assigned beneficiaries (MSSP minimum is 5,000; Pioneer Model minimum is 15,000)
- **Have a leadership and management structure that includes clinical and administrative systems** (emphasis added)
- Define processes to promote evidence-based medicine and patient engagement
- Report on quality and cost measures (as predetermined by CMS)
- Coordinate care
- Demonstrate to CMS that the ACO delivers patient-centered care
- Be paid on a Fee For Service basis for services under Medicare A and B

If the ACO meets the quality performance criteria of CMS, it may receive a shared savings payment (and may also have financial responsibility for shared losses). The payment would be a calculation based on the percentage of difference between 1) estimated average per capita Medicare expenditures in a year and 2) the per capita benchmark established by CMS for that same timeframe.

The vision expressed for the ACO model in the Act and the ACO final regulations clearly contemplates a substantial capital investment in operational necessities, such as sophisticated IT and electronic health record (EHR) systems. It envisions a closely coordinated patient

treatment and management process, toward the larger goal of reducing total health care expenditures for a defined population – in this case, Medicare beneficiaries.

It is likely that the ACO will be a multidisciplinary collaboration between numerous institutional and individual providers along the continuum of care. The demands for efficiency and enhanced care coordination have the potential to increase both the frequency and severity of loss exposure for the ACO. Such losses could include, for example, a massive EHR security breach, vicarious liability exposure for all participants in the ACO continuum or executive liability for poor execution of the ACO business plan. The exposure for the ACO is compounded by the continued uncertainty surrounding the application of anti-trust law,⁶ anti-kickback law, physician self-referral law, and false claims law.⁷ The “untested waters” associated with interpretation of the Interim Final Rules regarding waivers of Stark, Kickback and Civil Monetary Penalties at both the federal and state level, as well as the challenge of deciphering new fraud and abuse waiver regulations and other policy statements that have been recently issued by federal regulatory agencies, causes additional uncertainty.

What Keeps ACOs Up At Night?



The untested sustainability of the ACO model on a long-term basis, combined with the large capital investment necessary to operate effectively,⁸ requires ACO executives to employ a well-conceived risk management and insurance strategy. In the ACO *Four Quadrants of Risk* shown above, the business and risk management challenges confronting ACOs vary from Strategic (doing the right things) to Operational (doing the things right) to Financial (impact on financial statement) to Hazard (man-made and natural disasters). Risks in the Hazard quadrant are insurable, but risks in the other quadrants are generally not – mitigated yes, but not normally transferred. (Sample solutions relevant to each quadrant’s risks are boxed beneath the quadrant.) Particularly in the early years when skepticism about ACO viability may likely impede capital access, ACOs should demonstrate financial responsibility by transferring risks for a reasonable and appropriate premium when they can and when it makes sense in accomplishing their mission. **Simply put, ACO capital is too scarce to deploy in lieu of reasonably priced risk transfer; i.e., insurance.**



DISCOVERING AN ACO'S RISK SOPHISTICATION – QUESTIONS FOR ITS LEADERSHIP

CEO: Have you formed a separate legal entity for this ACO? Is there one organization with the controlling interest?

CEO: Were any liability/employee benefits issues uncovered by your physician acquisition due diligence aside from medical malpractice tail liability concerns and insurance placement responsibility going forward?

- Are any of your acquired physicians in states that ban the Corporate Practice of Medicine (CPOM)?
- Do the PCs in CPOM states meet the definition of subsidiary in your insurance policies?
- Should the physician employees of the PCs that the ACO owns or manages sue their sponsoring lay entities for mismanagement, what policy would respond?

CEO: Has legal advice been obtained regarding the application of fraud and abuse waivers under federal regulations and guidance?

CFO: Medicare ACOs may propose shared savings methodologies that involve a “risk corridor,” that is, a credit or debit off the capitated charge

- How do you know when it's time to shift to a risk bearing contract?
- How soon do you see the shift happening? In months? In years?

CFO: Have any ACO participants experienced a breach of protected health information?

- If so, was the breach reported to HHS in compliance with their guidelines and did the government impose financial penalties?
- Pre-claim notice and monitoring, required in all 50 states, averages \$73 per member record breached.⁹ Did cyber/network liability insurance cover the pre-claim expenses of the breach?

CFO: Where are you getting your capital for the significant infrastructure you must build?

- What is the amount of your capital investment or line of credit dedicated to the ACO?
- Private equity investors are approaching CEOs and CFOs. Do you have a strategy or response formulated?

CEO: Who have you designated as your ACO's insurance professional and risk manager and do you have an incident/claim reporting process in place?

We pose these questions to direct focus to an ACO's financing philosophy for insurable risks, together with its strategy for managing uninsurable risks. Because the liability insurance marketplace reflects the same hesitancy toward ACO operations that we hear from ACO sponsors themselves, coverage options are relatively undeveloped. In light of the differing ACO underwriting views out there (from “it's a PHO with only a vicarious med mal exposure” to “no... it's a direct medical malpractice risk”) we are sensitive that available policies must fit together. To this end, Willis offers observations on improving the boilerplate insurance policy language available, with the goal of increasing the probability that the ACO's policies fit together, the ACO is protected and insurable losses get paid.

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IMPROVING ACO LIABILITY INSURANCE CONTRACT CERTAINTY

ACO OPERATIONS/RISKS	TYPICALLY COVERED BY	HOW DOES POLICY ADDRESS...
Formal legal structure to receive and distribute savings—and later, medical cost risk/shareholder lawsuits	Directors & Officers (D&O)	<ul style="list-style-type: none"> ■ Outside directors need written instructions from “home” boards ■ Insured vs insured exclusion (one insured cannot sue another—e.g., insured specialists can’t sue ACO for “unfair distribution of bonus pool”)
Sufficient primary care physicians for # assigned beneficiaries/ direct medical services	Direct & Vicarious Medical Malpractice; D&O	<ul style="list-style-type: none"> ■ E&O excludes direct care by insured ■ Corporate practice of medicine constraints if applicable to ACO: Who is the First Named Insured? Do PCs meet “subsidiary” definitions? ■ Tail rating basis (individual tail purchases vs. rolling FTE tail so long as institutional employer policy is maintained)
Employment Practices	D&O/Employment Practices Liability	<ul style="list-style-type: none"> ■ Wrongful economic credentialing or discrimination (e.g., can your PCP and/or Medical Home team leader be a Nurse Practitioner?)
Pressure to be accessible leads to practice “north of scope”/ patient info breach in email	Network Security & Privacy	<ul style="list-style-type: none"> ■ Is the “other insurance” condition triggered when payer’s member info is breached by ACO whose providers carry no cyber limits?
Theft of, or Disappearance of, laptop containing provider credentialing information	Network Security & Privacy, MCO E&O	<ul style="list-style-type: none"> ■ Pre-claim notice and monitoring expense: Even if laptop is encrypted, notice and monitoring costs are steep ■ MCO E&O does not extend to employee privacy breach
Negotiating contracts with insurance companies and directly w/ local employers	D&O, E&O	<ul style="list-style-type: none"> ■ Doing business without a license exclusion? State regulation of “doing business of insurance” applies if ACO is direct contracting with employer
Regulatory scrutiny: subpoenas and enforcement actions	MCO E&O	<ul style="list-style-type: none"> ■ Scope of regulatory coverage grant
Higher per capita cost for non-Medicare patients served by Medicare ACO suggests weakened market competition/anti-trust	D&O, MCO E&O	<ul style="list-style-type: none"> ■ Scope of anti-trust coverage grants
Shared losses excess of benchmark targets: capital access and accumulation	Provider Excess of Loss (excess of stipulated threshold, this coverage transfers medical costs risk assumed by a provider)	<ul style="list-style-type: none"> ■ Reinsurance contract terms: who drafts the language?

CONCLUSION

In conclusion, we agree that ACOs face key implementation challenges.¹⁰ Some ACOs will not succeed, and their indemnification agreements may end up worthless. Insurance, however, is an asset that can survive business failure and encourages informed risk-taking. Which pieces of paper – indemnity agreements from an organization with no track record or well crafted insurance policies from an A rated carrier – do contracting payers and other stakeholders want to see the ACO provide as evidence of financial responsibility?

CONTACTS

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The observations, comments and suggestions we have made in this report are advisory and are not intended nor should they be taken as medical/legal advice. Please contact your own medical/legal adviser for an analysis of your specific facts and circumstances.

¹ Deloitte, *Accountable Care Organizations: A new model for sustainable innovation 2010*, p.3.

² Final Rule for Medicare Shared Savings Program and ACOs 76 Federal Register 67802, 11/2/11.

³ CMS, *Pioneer ACO Model General Fact Sheet, 12/19/11 p6-7*. Additional information about the Pioneer ACO Model is available on the Pioneer ACO Model website - <http://www.innovations.cms.gov/initiatives/aco/pioneer>.

⁴ Berenson Robert and Burton, Rachel, *Accountable Care Organizations in Medicare and the Private Sector: A Status Update*, Urban Institute, November 2011, p.3.

⁵ Section 1899 (b)(2) of U.S.C. 1395 et seq.

⁶ Final Statement of Antitrust Enforcement Policy Regarding ACOs 76 Federal Register 67026, 10/28/11.

⁷ Interim Final Rule Regarding Waivers of Stark, Kickback and CMP 76 Federal Register 67992, 11/2/11.

⁸ Downloaded 12/20/11 from <http://www.fiercehealthcare.com>, K Cheung, October 26, 2011: the ACO budget ranges from CMS' low of \$1.7M per ACO to AHA's \$5.3M-\$12M, depending on hospital size.

⁹ Zurich Executive Webinar November 9, 2011, Peter Foster citing Ponemon Institute 2011 statistics.

¹⁰ Deloitte, *Accountable Care Organizations: A new model for sustainable innovation 2010*, p.5.

