ACCOUNTABLE CARE ORGANIZATIONS:

CREATION, CAPITALIZATION, AND CONTRACTING

FACULTY

- Belinda P. Coleman – CEO, The Coleman Group
- Barry S. Herrin, FACHE – Founder, Herrin Health Law, P.C.
- Todd A. Zigrang, FACHE – President, Health Capital Consultants

BELINDA P. COLEMAN

Ms. Coleman is President and CEO of The Coleman Group. She has twenty-eight years of experience in systems engineering, information technology, and program management. Her vision and eighteen years of leadership experience in informatics and policy development has guided the strategic growth of The Coleman Group into a competitive forward thinking business with a reputation for delivering quality and value. As President and CEO, Mrs. Coleman is responsible for a professional workforce that supports a client base that crosses multiple federal agencies, state and local governments; and universities. Under her leadership, The Coleman Group is providing information technology solutions and services in cyber security, health care informatics, procurement management solutions, software development solutions, and security services. Mrs. Coleman is a graduate of Spelman College in Atlanta, Georgia with a Bachelor of Science in Computer Science and Mathematics. Her postgraduate degree is from The George Washington University, Washington, DC in Information Systems. She serves as on the Board of Directors for University System of Maryland, Universities at Shady Grove and is a member of the Small Business AFCEA Bethesda Chapter. She belongs to numerous industry advisory boards and organizations. Her affiliations and memberships include: Women In Transportation (WTS); Security Industry Association (SIA); Women in Technology (WIT); Technology Council of Maryland; Small and Emerging Contractors Advisory Forum (SECAF); National Contract Management Association; Conference of Minority Transportation Officials (COMTO); American Public Transportation Association (APTA); The Presidents' Roundtable (PRT); Industry Advisory Council (IAC); Healthcare Information Management Systems Society (HIMMS); and Women's Business Enterprise National Council (WBENC).

BARRY S. HERRIN, FAHIMA, FACHE, ESQ.

Mr. Herrin is the Founder of Herrin Health Law, P.C., a boutique law practice dedicated to the needs of health care providers. He regularly represents health care providers in all segments of the industry and advises on a wide variety of regulatory and operational issues, including hospital and health care operations and compliance, medical information privacy and confidentiality, managed care contracting, and hospital-physician collaboration. He is admitted to the bars of Florida, Georgia, and North Carolina. Mr. Herrin is a Fellow of the American College of Healthcare Executives and a Fellow of the American Health Information Management Association. Mr. Herrin received both his undergraduate and law degrees from Georgia State University in Atlanta, graduating each time with honors. He has served as a faculty member for numerous state and national meetings and symposia across the country and has authored or co-authored numerous articles on health law compliance for regional and national publications. He currently serves on the Board of Directors of the Georgia Chapter of the Health Information Management Systems Society.

TODD A. ZIGRANG, MBA, MHA, FACHE, ASA

Mr. Zigrang is the President of Health Capital Consultants (HCC), where he focuses on the areas of valuation and financial analysis for hospitals, physician practices, and other healthcare enterprises. Mr. Zigrang has over 20 years of experience providing valuation, financial, transaction and strategic advisory services nationwide in over 1,000 transactions and joint ventures involving acute care hospitals and health systems; physician practices; ambulatory surgery centers; diagnostic imaging centers; accountable care organizations, managed care organizations, and other third-party payors; dialysis centers; home health agencies; long-term care facilities; and, numerous other ancillary healthcare service businesses. Mr. Zigrang is also considered an expert in the field of healthcare compensation for physicians, executives and other professionals. Mr. Zigrang holds a Master of Science in Health Administration (MHA) and a Master of Business Administration (MBA) from the University of Missouri at Columbia. He is a Fellow of the American College of Healthcare Executives (FACHE) and holds the Accredited Senior Appraiser (ASA) designation from the American Society of Appraisers, where he has served as President of the St. Louis Chapter, and is the current Chair of the ASA Healthcare Special Interest Group (HSIG) committee.

ITEMS ON THE AGENDA

- Types of Accountable Care Organizations
- Qualifying as an ACO
- Antitrust Considerations – What You Can and Can't Do
- Funding for ACO Activities – How You Pay For It While Waiting For the Feds to Pay Up
- Data Requirements and Dashboarding
- Computing Shared Savings
- Tax Issues for Nonprofit Hospitals in the ACO Business

FEDERAL "TRADITIONAL" ACOS

- Governed by the Medicare Shared Savings Program (MSSP)
  - Implements the **Value-Based Purchasing Theory**
    - The notion that purchasers hold healthcare providers accountable for both the quality and cost of care
- Experience risk through their *shared savings payments*, which may be *managed* under either:
  - A one-sided distribution model (savings only, no risk)
  - A two-sided distribution model (savings and risk for overspending)

"Accountable Care Organizations: Value Metrics and Capital Formation" By Robert James Cimasi, MHA, ASA, FRICS, MCBA, AVA, CM&AA, Boca Raton, FL: Taylor & Francis Group, LLC, 2013, p. 25-26.
Glossary of Terms Commonly used in Health Care, AcademyHealth, 2004 Edition.
"Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations" Federal Register Vol. 76, No. 212 (November 2, 2011), p. 67985-67987.

NEXT GENERATION ACOS

- Announced by CMS in March 2015
- *Next generation ACOs* (NGACOs) can opt for either 80% shared savings/losses rate, or *"full performance risk"* option, i.e., ACO receives 100% of shared savings/losses
- Introduces *"benefit enhancement tools"* to improve ACO's ability to engage with patients
- NGACOs provide a choice of two risk arrangements that outline a "*portion of the savings or losses"*
- In addition to traditional fee-for-service payments, NGACOs have access to *alternate payment mechanisms*, including:
  - *Per-beneficiary-per month* (PBPM) infrastructure payments that must be repaid to CMS
  - Full capitation (available in 2017)

"Next Generation ACO Model" Centers for Medicare & Medicaid Services, http://innovation.cms.gov/initiatives/Next-Generation-ACO-Model/ (Accessed 3/18/2015); "Next Generation ACO Model: Model Overview Presentation" Centers for Medicare & Medicaid Services, March 17, 2015, http://innovation.cms.gov/Files/slides/nextgenaco-odf1slides.pdf (Accessed 3/20/2015); "Next Generation ACO Model: Request for Applications" Centers for Medicare & Medicaid Services, http://innovation.cms.gov/Files/x/nextgenacorfa.pdf (Accessed 3/20/2015); "CMS preps 'next generation' ACO model" By Melanie Evans, Modern Healthcare, March 10, 2015, http://www.modernhealthcare.com/article/20150310/NEWS/150319994?template=print (Accessed 3/18/2015); "Next Generation ACO Model: Frequently Asked Questions" Centers for Medicare & Medicaid Services, April 5, 2016, https://innovation.cms.gov/Files/x/nextgenacofaq.pdf (Accessed 4/22/2016).

COMMERCIAL ACOS

- Governed by state insurance and federal antitrust laws
  - In essence, a network contract that places some payments at risk
  - Focused primarily on reducing the “total medical spend” for an attributed population
  - Works best in insured (vs. self-insured) markets due to requirements to pay “new money” after closure of the plan year
  - TPAs will pay a percentage of their “success bonus” in self-insured plan administration to commercial ACOs
- There are NO waivers for commercial ACOs

MEDICARE SHARED SAVINGS PROGRAM

What is a MSSP?

The Centers for Medicare & Medicaid Services (CMS) has established a Medicare Shared Savings Program (MSSP) to facilitate coordination and cooperation among providers to improve the quality of care for Medicare Fee-For-Service (FFS) beneficiaries and reduce unnecessary costs.

How does it work?

- Eligible providers, hospitals, and suppliers may participate in the MSSP by **creating or participating in an ACO**
- The ACO must bill for **primary care** services
- An ACO PCP participant must be **exclusive** to a single MSSP ACO
- To participate, the ACO must have at least **5,000 Medicare FFS beneficiaries** assigned to them
- Each ACO participant TIN is required to agree to a **3 year contract**

What are the benefits?

- Accountability for care of Medicare FFS beneficiaries
- Coordinated care supporting improved patient outcomes
- Shared savings or gainshare opportunity for physicians
- Population health infrastructure and redesigned care process
- Investment in technology to support community needs
- Improved physician alignment
- ACO pre-participation waiver to cover technology and care management investment

ANTITRUST CONSIDERATIONS

- Medicare ACOs are “deemed” to be clinically integrated for purposes of the MSSP
- ACOs can achieve “carry-over” deemed clinical integration in commercial managed care markets
  - Same governance, administration, structures, functions, measurements, etc.
  - Stay within safety zones for percentages of each specialty
- Commercial ACOs must be ACTUALLY clinically integrated or financially integrated BEFORE joint managed care contracting activity can begin – there is no “deemer” status

FUNDING FOR ACOS

OR, HOW YOU OPERATE WHILE WAITING FOR THE FEDS TO PAY UP

FEDERAL ACO FINANCING OPTIONS NO LONGER AVAILABLE

Medicare Advance Payment Initiative – Ended December 2015

- For small, rural, or modestly funded healthcare enterprises in the *Medicare Shared Savings Program* (MSSP) with less access to capital
- Funded 35 ACOs that generate less than $80 million in yearly revenue through 3 distinct types of payments:
    - An *upfront, fixed payment* of $250,000
    - An *upfront variable payment* of $36 per "*preliminary, prospectively assigned*" beneficiary
    - A *monthly payment* of $8 per "*preliminary, prospectively assigned*" beneficiary
- The first 2 payments are delivered to the organization in the first month of operation

"CMS Announces 123 New ACOs; Doubles Down on Pioneer ACO Program" By Andrew Shin, Mondaq Business Briefing 2 Business Insights: Essentials, January 2, 2014, http://bi.galegroup.com.ezp.slu.edu/essentials/article/GALE%7CA354446065/14c394303b18da9d6be499fd3220cd1b?u=sain44199 (Accessed 8/4/14). "Advance Payment Solicitation," Center for Medicare & Medicaid Innovation, http://innovation.cms.gov/Files/x/Advance-Payment-Model-ACO-solicitation-doc.pdf (Accessed 8/19/14). "Advance Payment ACO Model" Centers for Medicare and Medicaid Services, February 19, 2016, https://innovation.cms.gov/initiatives/Advance-Payment-ACO-Model/ (Accessed 8/29/16).

TYPICAL FUNDING FOR HOSPITAL-CENTRIC ACOS

It's pretty simple:

(1) The hospital writes a check for start-up expenses, unless it can't (or won't).

- Hospitals that are participants in ACOs can share information technology infrastructure with physician practice participants at no cost
- ACOs must be mindful that actual clinical integration MUST be achieved at some point, AND that the MSSP cannot be a pretext for commercial managed care market manipulation – the ACO must be bona fide

(2) The hospital writes a check for ongoing operating expenses, unless it can't (or won't).

CAPITAL FINANCING OF ACOS - FUNDING CONCERNS

- Do ACO participants have adequate capital to execute the proposed ACO business plan?
- A sustainable financial model requires robust analyses of the complex *challenges* and *opportunities* necessary to support ACO investment
- Funding will require a strategy that generates start up capital costs, as well as sufficient income to cover operational expenses
- Operational funding can be achieved by increasing efficiency and maximizing reimbursement revenue
- Funding source(s) should be secure and reliable enough to avoid capital shortfalls

"The Accountable Care Organization: Whatever Its Growing Pains, the Concept Is Too Vitally Important to Fail" By Francis J Crosson, Health Affairs, Vol. 30, No. 7, (July 11, 2011), p. 152.

CAPITAL FINANCING OF ACOS

- Capital funding sources depend upon:
  - Size and makeup of organization
  - Types of financing
  - Tax posture of the entity
    - Tax shield benefits arising from the use of debt in an enterprise's capital structure incentivizes firms to consider at least partially financing the enterprises though interest-bearing debt
- Adequate capital funding sources are an integral component of a healthcare organization's long-term financial sustainability
  - Sources of capital for healthcare organizations have evolved with the healthcare industry
- Customarily, 50% of a healthcare organization's assets have been financed with equity and the remainder by debt
  - Ratio differs among various types of healthcare delivery entities

"Financing Issues for Healthcare Providers and Companies" By Deborah Gordon and Lisa Lenderman, Seyfarth Shaw, LLP and MidCap Financial, LLC, American Health Lawyers Association Annual Meeting: Boston, MA, June 27, 2011; "Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations" Federal Register, Vol. 76, No. 212 (November 2, 2011), p. 67835. "Capital Finance and Ownership Conversions in Health Care" By James C. Robinson, Health Affairs, Vol. 19, No. 1, 2000, p. 57.

CAPITAL FINANCING OF ACOS

Sources of Capital for For-Profit Entities:

- Debt
- Equity
- Internally generated operating surpluses

Sources of Capital for Non-Profit Entities:

- Donations
- Government grants / tax breaks
- Traditional debt
- Investments from non-profit entity
- Tax-Subsidized operating surpluses

"Conversion of HMOs and Hospitals: What's at Stake?" By Bradford H. Gray, Health Affairs, Vol. 16, No. 2, 1997, p. 31. "Financing Issues for Healthcare Providers and Companies" By Deborah Gordon and Lisa Lenderman, Seyfarth Shaw, LLP and MidCap Financial, LLC, American Health Lawyers Association Annual Meeting: Boston, MA, June 27, 2011; "Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations" Federal Register, Vol. 76, No. 212 (November 2, 2011), p. 67835.

CAPITAL FINANCING OF ACOS

Sources of capital for both non-profit and for-profit entities:

- Capital leases
- Bond financing
- Mezzanine lending
- Commercial lending
- Equity
- Sale-leaseback
- Seller "*take back*" financing
- Conduit lending structures, such as *Municipal Backed* Bond Issuances
- Tax increment financing (TIF) programs

May also enter private capital markets through:

- Venture Capital Investors
- Private Equity Investors
- Private Real Estate Investment Trusts (REITs)

"Conversion of HMOs and Hospitals: What's at Stake?" By Bradford H. Gray, Health Affairs, Vol. 16, No. 2, 1997, p. 31. "Financing Issues for Healthcare Providers and Companies" By Deborah Gordon and Lisa Lenderman, Seyfarth Shaw, LLP and MidCap Financial, LLC, American Health Lawyers Association Annual Meeting: Boston, MA, June 27, 2011; "Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations" Federal Register, Vol. 76, No. 212 (November 2, 2011), p. 67835. "An Examination of Contemporary Financing Practices and the Global Financial Crisis on Nonprofit Multi-Hospital Health Systems" By Louis J. Stewart and Pamela C. Smith, Journal of Health Care Finance, Vol. 37, No. 3, 2011, p. 5.

OVERVIEW OF CAPITAL BUDGETING - HOSPITALS

Large, integrated health systems may be more willing to form an ACO

- Better-equipped to handle the risk
- More likely to have the needed technology in place
- Access to more capital, resources, providers, & management staff

Approximately 20 percent of hospitals participate in an ACO, with large and medium-sized hospitals constituting over 85 percent of total hospitals participating in an ACO

"Accountable Care Organizations: Value Metrics and Capital Formation" By Robert James Cimasi, Productivity Press, June 5, 2013, p. 130; “Hospitals Participating in ACOs Tend to be Large and Urban, Allowing Access to Capital and Data” By Carrie H. Colla, et al., Health Affairs, Vol. 35, No. 3 (March 2016) p. 434.

INITIAL CAPITAL INVESTMENT FOR ACO DEVELOPMENT

- ACO development will initially require significant levels of capital investment to establish necessary infrastructure, including:
  - Network Development and Management
  - Care Coordination, Quality Improvement and Utilization Management
  - Clinical Information Systems
  - Data Analytics

"Accountable Care Organizations: 10 Things You Need to Know about Accountable Care" By Eleanor Burton and Virginia Traweek, Institute for Health Technology Transformation, 2011, pp.24-25; "The Work Ahead: Activities and Costs to Develop an Accountable Care Organization" By American Hospital Association, Chicago, IL, April 2011; "National ACO Survey: Conducted November 2013" National Association of ACOs, January 21, 2014, https://www.naacos.com/pdf/ACOSurveyFinal012114.pdf (Accessed 8/6/14).

INITIAL CAPITAL INVESTMENT FOR ACO DEVELOPMENT

- CMS initial estimated ACO startup costs – $1.7 million
- *American Hospital Association* (AHA) estimated ACO startup costs – $5.3 million (for a smaller hospital system) to $12 million (for a larger hospital system)
- Actual average ACO start-up costs - $2 million (for first year of operation of federal ACOs), per 2013 NAACOs Survey
  - Lower start-up costs may be due to participation of those healthcare entities that were most prepared for ACO in terms of integration
- Initial capital requirements will be significant compared to continued operational expenses

"Accountable Care Organizations: 10 Things You Need to Know about Accountable Care" By Eleanor Burton and Virginia Traweek, Institute for Health Technology Transformation, 2011, pp.24-25; "The Work Ahead: Activities and Costs to Develop an Accountable Care Organization" By American Hospital Association, Chicago, IL, April 2011; "National ACO Survey: Conducted November 2013" National Association of ACOs, January 21, 2014, https://www.naacos.com/pdf/ACOSurveyFinal012114.pdf (Accessed 8/6/14).

INITIAL CAPITAL INVESTMENT - NETWORK DEVELOPMENT AND MANAGEMENT

- Capital for *network development* will likely be focused on fostering relationships between ACO participants and merging their various, divergent goals
- *Network development* and *management* includes provision of:
  - Management & staff
  - Legal & consulting support
  - Contracting proficiency
  - Management resources
  - Primary care professionals
  - Financial & management information support systems
  - Compensation to physician executives

"The Work Ahead: Activities and Costs to Develop an Accountable Care Organization" By American Hospital Association, Chicago, IL, April 2011.

INITIAL CAPITAL INVESTMENT - CARE COORDINATION, QUALITY IMPROVEMENT, UTILIZATION MANAGEMENT

- ACOs may require capital contributions in order to coordinate care, improve quality, and manage healthcare utilization rates among patients through programs such as:
  - Disease registries
  - Hospitalists
  - Care coordination and follow-up post-discharge
  - Attaining designation as a patient-centered medical home
- May be developed internally or through an outside management services organization

"Early Adopters of the Accountable Care Model: A Field Report on Improvements in Health Care Delivery," Sharon Silow-Carroll & Jennifer N. Edwards, The Commonwealth Fund (2013), p. 10.

INITIAL CAPITAL INVESTMENT - CLINICAL INFORMATION SYSTEMS

- Includes programs such as:
  - Electronic health records (EHR)
    - Implementation expected to account for a vast majority of clinical information systems costs
  - EHR interoperability
  - EHRs to health information exchanges (HIE)
- 43% of enterprises anticipate telecommunications and IT spending to account for largest part of 2014-15 capital budgets
- Average initial HIT capital requirement may total around $850,000
  - Roughly $500,000 for smaller ACOs (5,000-10,000 beneficiaries)
  - Over $1.6 million for larger ACOs (16,000-25,000 beneficiaries)

"Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations and Medicare Program: Waiver Designs in Connection with the Medicare Shared Savings Program and the Innovation Center; Proposed Rule and Notice" Federal Register, Vol. 76, No. 67 (April 7, 2011), pp. 19599-19600; "Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations" Federal Register, Vol. 76, No. 212 (November 2, 2011), p. 67902; "National ACO Survey: Conducted November 2013" National Association of ACOs, January 21, 2014, https://www.naacos.com/pdf/ACOSurveyFinal012114.pdf (Accessed 8/6/14); "Healthcare trends from the C-Suite" Premier, Inc., Economic Outlook Spring 2014, (Spring 2014), p.1-6.

INITIAL CAPITAL INVESTMENT - DATA ANALYTICS

- Defined as the nonclinical data management of a healthcare entity
- Includes:
  - Analysis of care patterns
  - Quality reporting costs
  - Other activities and costs
- CMS's ACO quality measures require data collection and analysis for reporting progress on outcomes and claims
- Likely to require capital for separate data analytics systems designed to monitor necessary data regarding quality measures

"The Work Ahead: Activities and Costs to Develop an Accountable Care Organization" By American Hospital Association, Chicago, IL, April 2011, p. 2.

EXPENSES RELATED TO ONGOING ACO OPERATION

EXPENSES RELATED TO ONGOING ACO OPERATION - NETWORK DEVELOPMENT AND MANAGEMENT

- Includes a variety of services and infrastructures that must be maintained in order to keep the organization functional
- Many ACOs are adding staff to aid in managing *population health*
  - Social workers
  - Outreach coordinators
  - Resource specialists
  - Behavior specialists
  - Coders
  - Technical experts
  - Psychiatrists
  - Nurses

"The Work Ahead: Activities and Costs to Develop an Accountable Care Organization" By American Hospital Association, Chicago, IL, April 2011, p. 2.

EXPENSES RELATED TO ONGOING ACO OPERATION - CARE COORDINATION, QUALITY IMPROVEMENT, UTILIZATION MANAGEMENT

ACOs may experience ongoing expenses associated with:

- Specialty-specific disease management
- Integration of inpatient and ambulatory approaches in service lines
- Patient education and support
- Medication management

"The Work Ahead: Activities and Costs to Develop an Accountable Care Organization" By American Hospital Association, Chicago, IL, April 2011, p. 4.

EXPENSES RELATED TO ONGOING ACO OPERATION - CLINICAL INFORMATION SYSTEMS

- ACOs must maintain clinical information systems in order to function properly
- Needed to:
  - Coherently maintain all of the patient information that is constantly created and exchanged
  - Be able to keep up with the organization's daily management needs

"The Work Ahead: Activities and Costs to Develop an Accountable Care Organization" By American Hospital Association, Chicago, IL, April 2011, p. 4

EXPENSES RELATED TO ONGOING ACO OPERATION - DATA ANALYTICS

- The utilization of technology to collect and analyze data will likely increase as healthcare enterprises seek to evaluate new forms of information to:
  - Target potential cost savings
  - Track quality measures for reporting
  - Manage population health
- Important to target potential cost savings and track quality measures
- Estimated that it will require approximately four years of data mining to gather data for meaningful information

"The Work Ahead: Activities and Costs to Develop an Accountable Care Organization" By American Hospital Association, Chicago, IL, April 2011; "Getting Ready for Accountable Care Organizations" By Joseph Goedert, Health Data Management, April 1, 2011, http://www.healthdatamanagement.com/issues/19_4/getting-ready-for-accountable-care-organizations-42230-1.html?zkPrintable=1&nopagination=1 (Accessed 1/13/2012).

BIG DATA AND DASHBOARDING

Source: AFP (Retour), 2013

WHAT IS BIG DATA?

- **In 2011 we created 1.8 zettabytes (or 1.8 trillion GBs) of information. In 2012 it reached 2.8 zettabytes and IDC now forecasts that we will generate 40 zettabytes (ZB) by 2020**

Source : International Data Corporation, 2015

- **According to computer giant IBM, 2.5 Exabytes - that's 2.5 billion gigabytes (GB) - of data was generated every day in 2014. That's big by anyone's standards.**
- **IDC says that in 2011 we created 1.8 zettabytes (or 1.8 trillion GBs) of information. In 2012 it reached 2.8 zettabytes and IDC now forecasts that we will generate 40 zettabytes (ZB) by 2020**
- **Source: International Data Corporation, 2016**

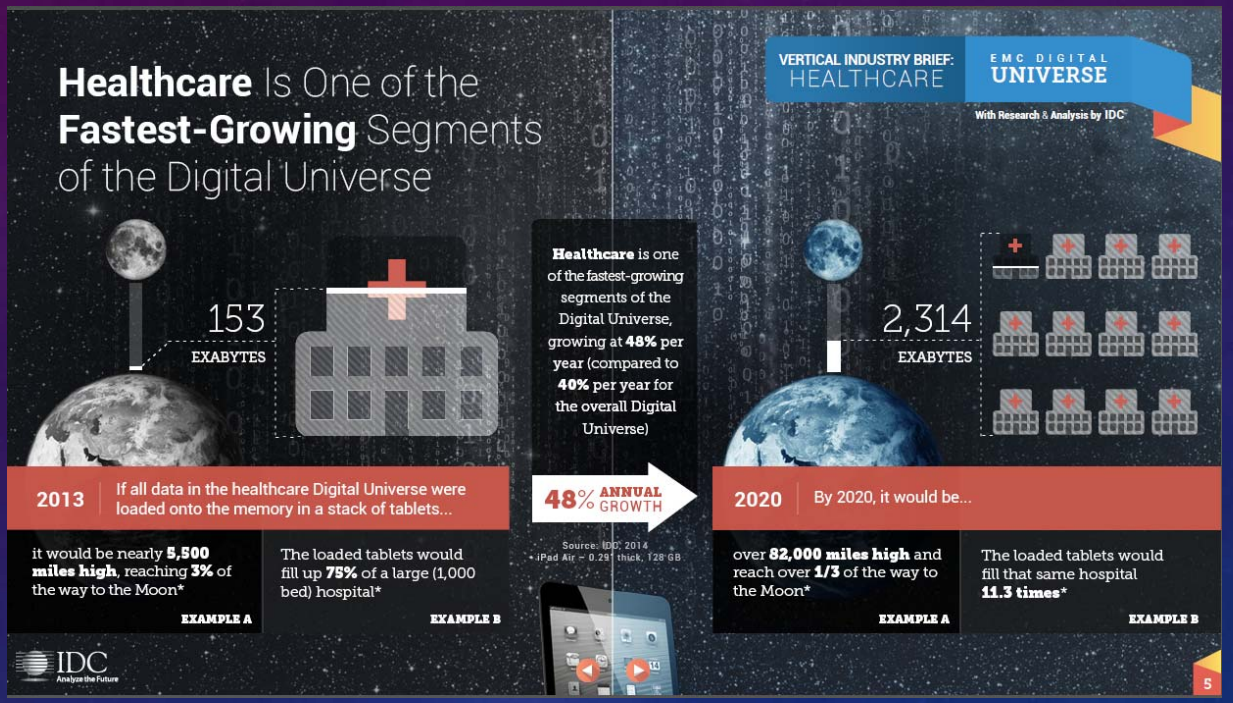
DATA IS A COMMODITY

- **The** US government's open data project already offers more than **120,000 publicly available datasets**

WHAT CAN WE DO WITH BIG DATA? WHAT'S THE BIG DEAL?

- Big data can help you discover new things
- We can fundamentally do things we could not do before: new patterns
- It can help you make decisions more intelligently: deliver healthcare in a more effective and efficient way

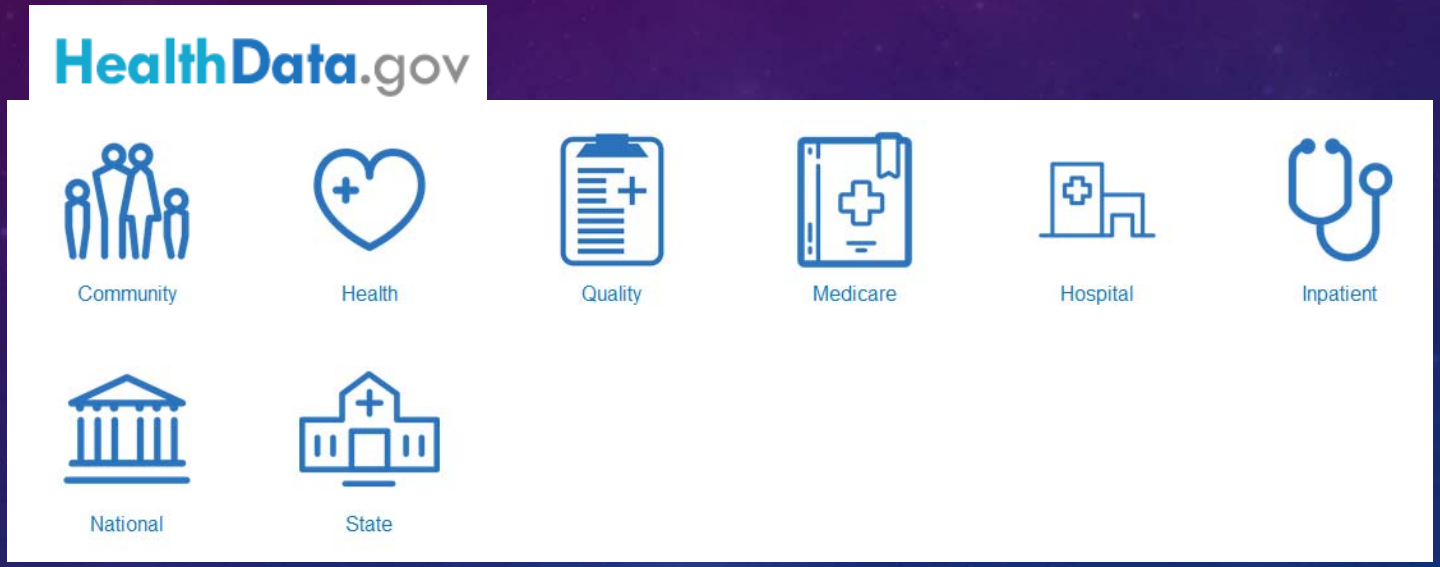
HEALTHCARE DATA = BIG DATA



In fact, if all the data in the healthcare digital universe were loaded onto the memory in a stack of tablets, it would be nearly 5,500 miles high, and loaded tablets would fill up 75 percent of a large hospital, the research estimated. And predicting its exponential growth, by 2020, the loaded tablets would fill the same hospital 11.3 times.

Source: Mass.-based EMC Corporation

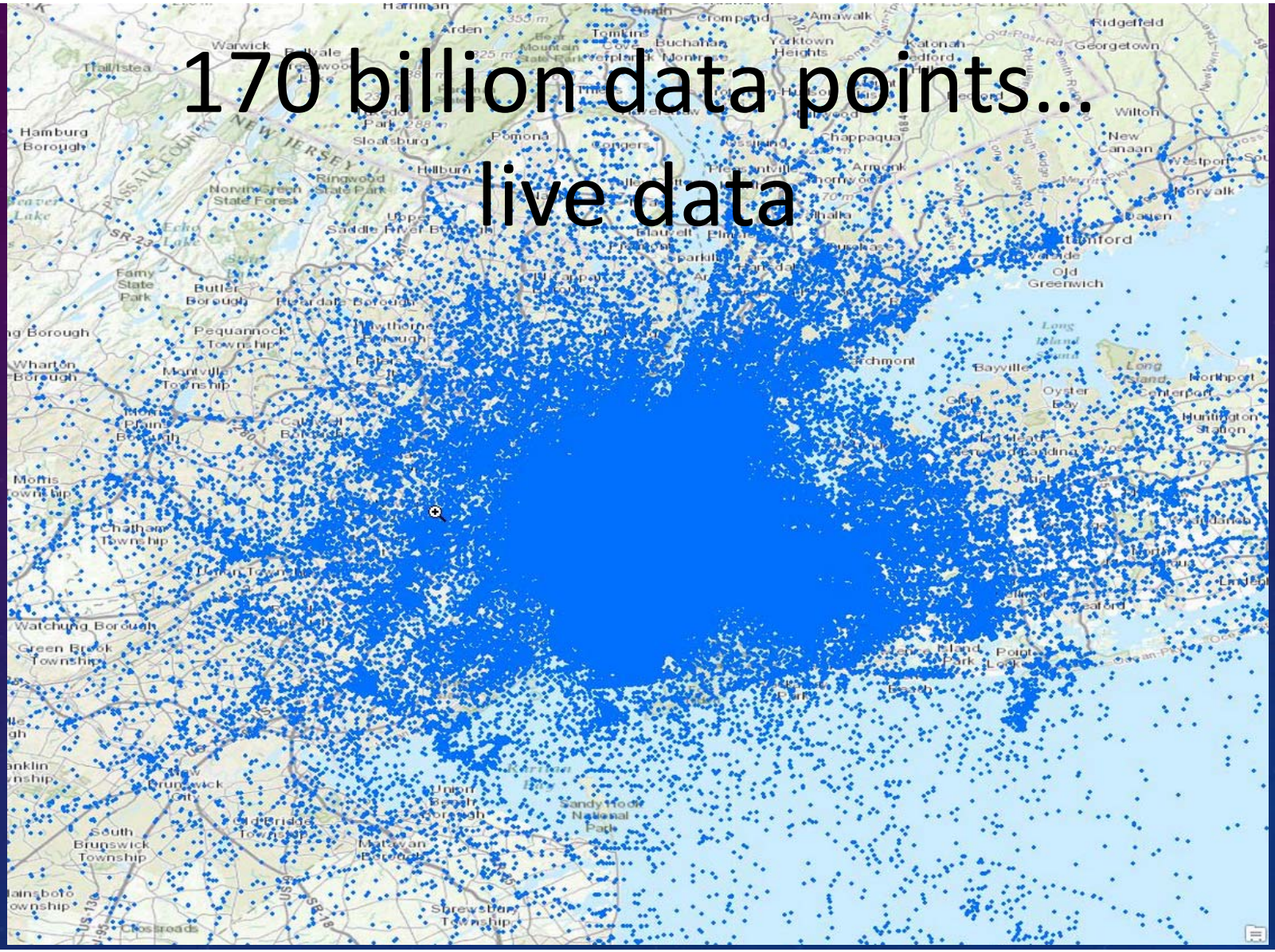
ACCESSING HEALTHCARE PUBLIC DATA?



STATIC VS DYNAMIC

170 billion data points…

live data

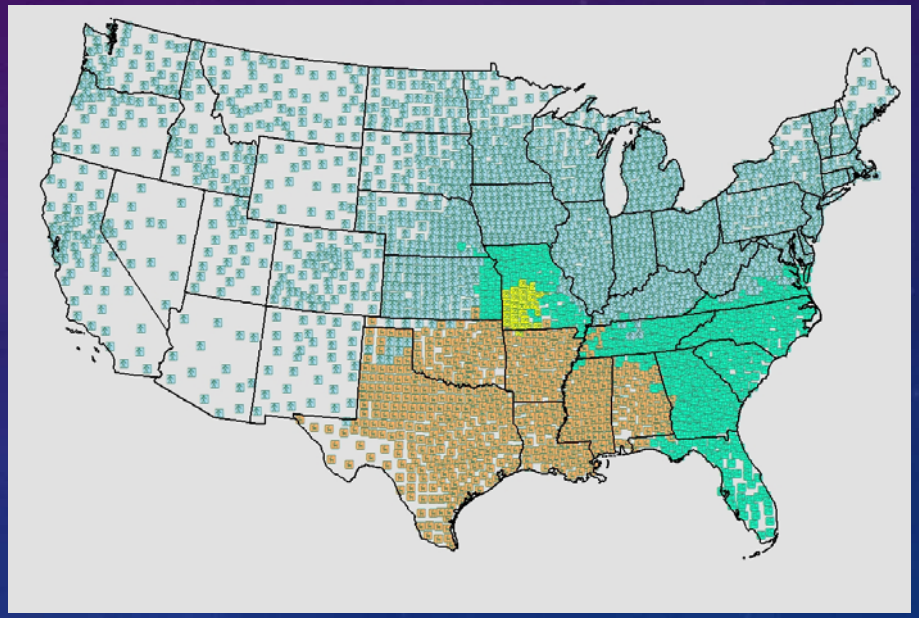


REAL-TIME OPERATIONAL AND LOCATION AWARENESS

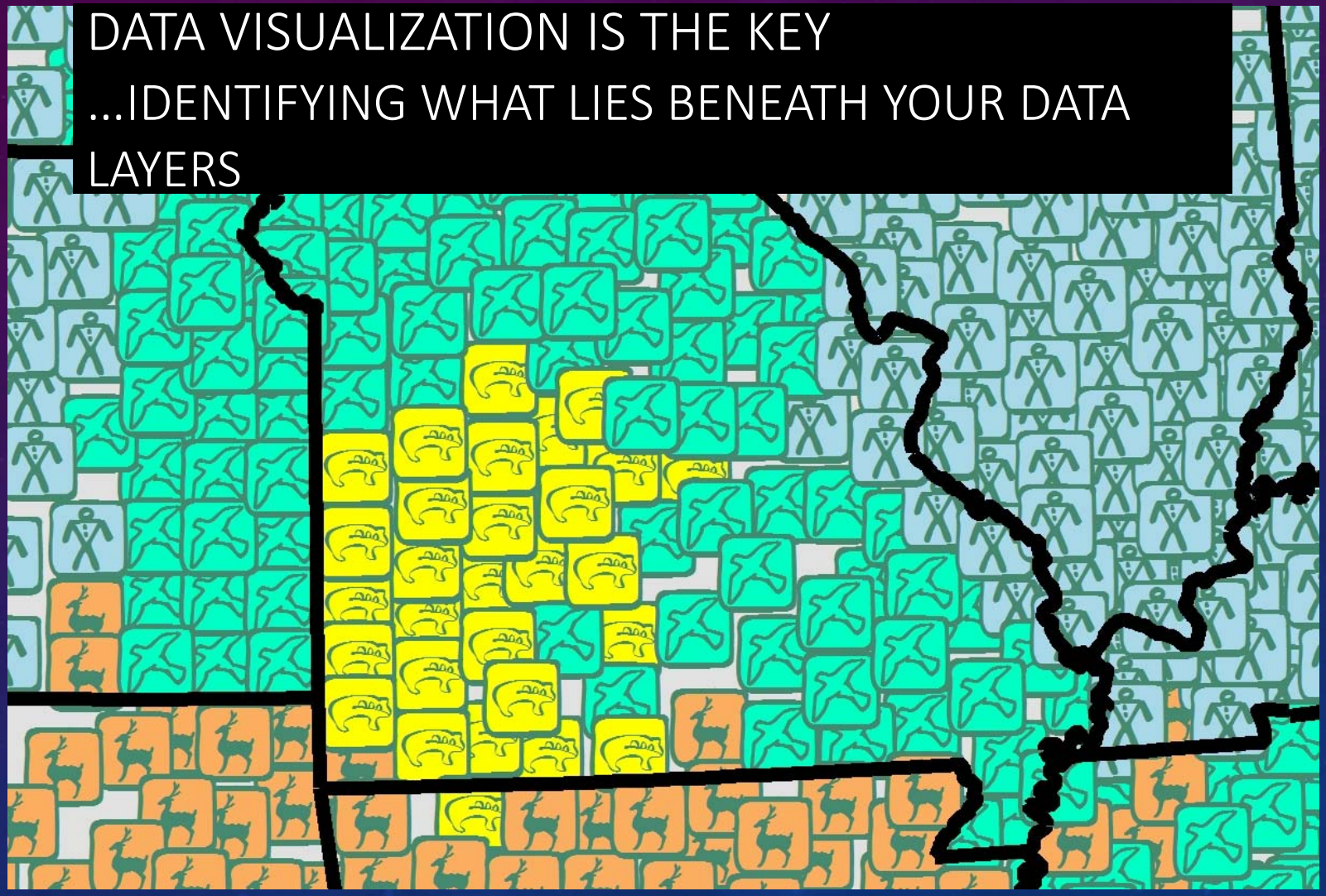
ESRI

DATA VISUALIZATION IS THE KEY
DRILLING DOWN…AND FINDING YOUR…

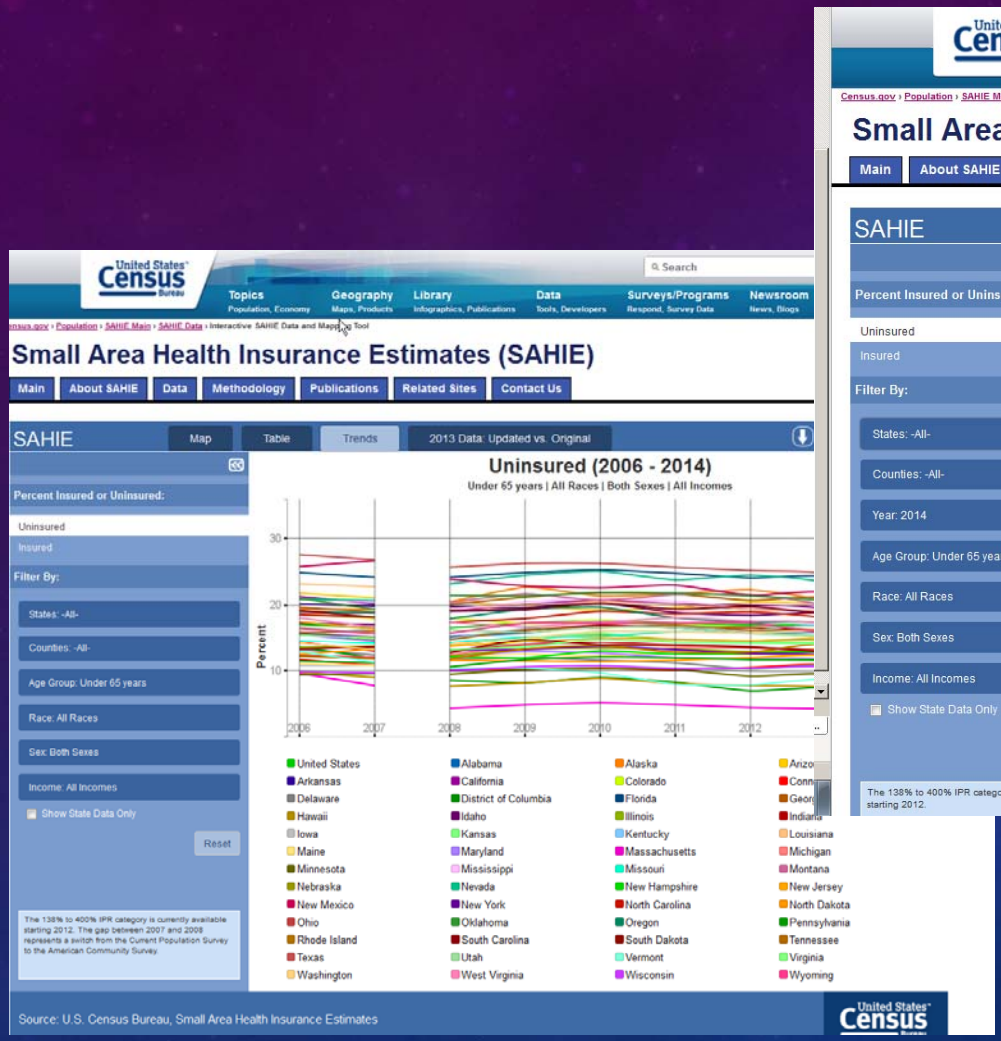
- Mastering the Data Deluge
- Data Dashboard using Geography to make sense of your data…
- How? Data should be patient-centric…wherever the patient goes, data follows…a geocentric healthcare/patientcare system: easy to understand, easy to interpret, and easy to illustrate

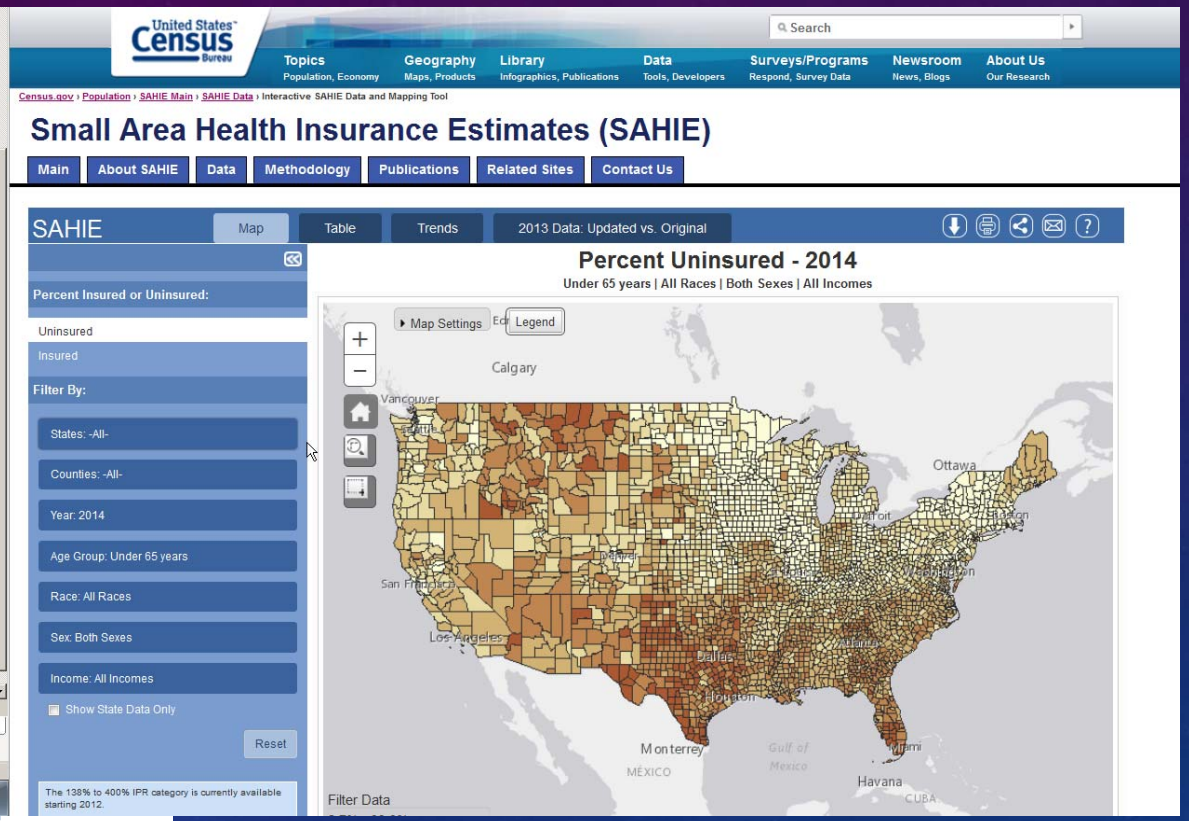


DATA VISUALIZATION IS THE KEY
…IDENTIFYING WHAT LIES BENEATH YOUR DATA LAYERS



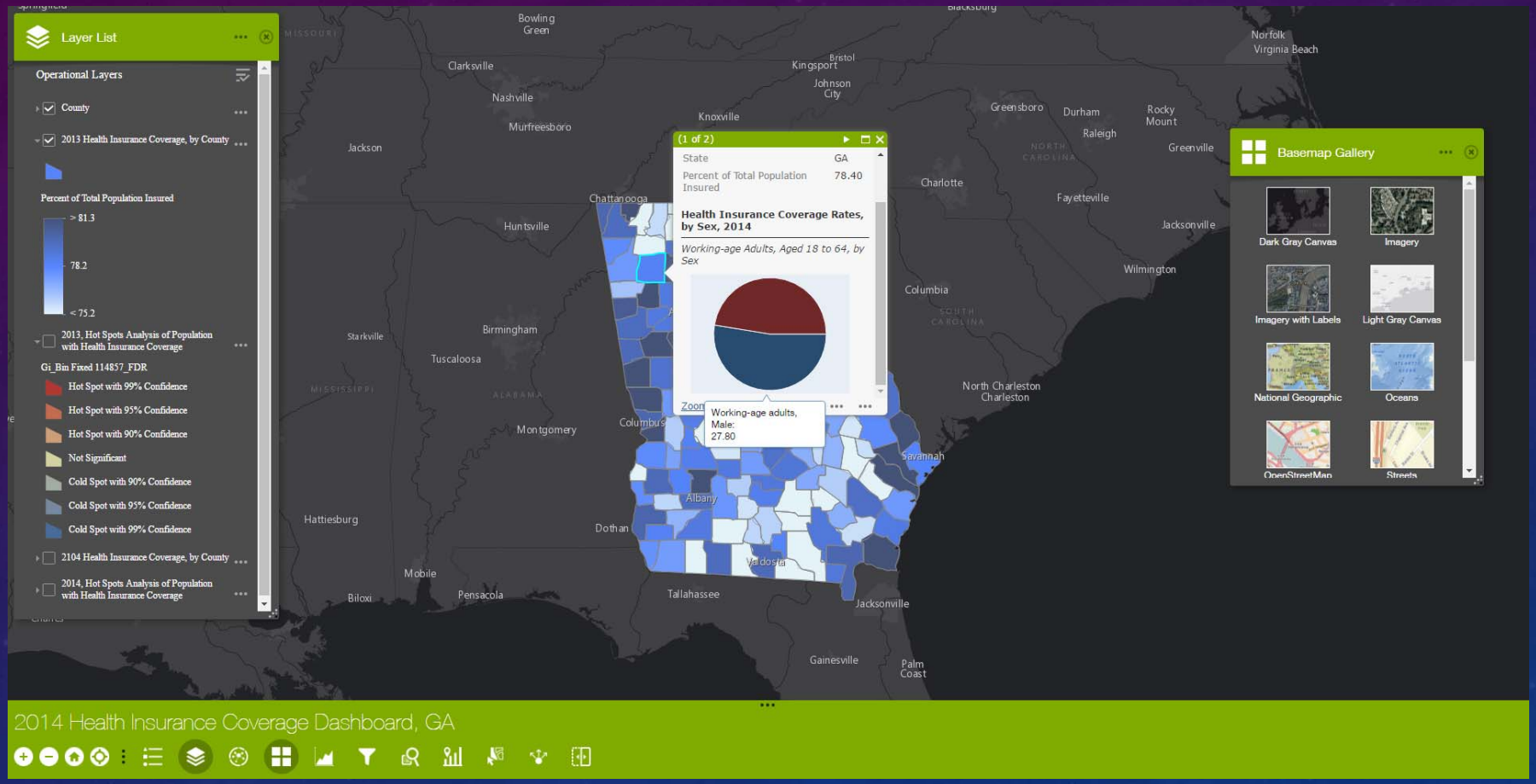
ANATOMY OF A DASHBOARD





Live Demo…

HEALTHCARE DASHBOARD STRATEGY



COMPUTING SHARED SAVINGS - FEDERAL ACOS

	A	B	C	D
	Issue	**Track 1: One-sided**	**Track 2: Two-sided**	**Proposed Track 3: Two-sided**
1	Minimum Savings Rate	2.0-3.9%, depending on number of beneficiaries	Choice of a symmetrical MSR/MLR: • No MSR/MLR • 0.5%-2.0% in 0.5% increments • MSR/MLR to vary depending on number of beneficiaries	Choice of a symmetrical MSR/MLR: • No MSR/MLR • 0.5%-2.0% in 0.5% increments • MSR/MLR to vary depending on number of beneficiaries
2	Minimum Loss Rate	N/A		
3	Amount of Shared Savings Given to ACO	50%	60%	75%
4	Amount of Shared Savings Kept by CMS	50%	40%	25%
5	Performance Payment Limit	10%	15%	20%
6	Loss Sharing Limit	N/A	5-10%, depending on years of participation	15%

"Finalized Changes to the Medicare Shared Savings Program Regulations" Centers for Medicare and Medicaid Services, June 4, 2015, https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-06-04.html (Accessed 4/25/2016); "Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations; Proposed Rule" Federal Register Vol. 79, No. 235 (December 8, 2014), p. 72845.

COMPUTING SHARED SAVINGS – NEXT GEN ACOS

	A	B	C
	Issue	**Arrangement A**	**Arrangement B**
1	Minimum Savings Rate	N/A	N/A
2	Minimum Loss Rate	N/A	N/A
3	Amount of Shared Savings Given to ACO	80% (PY1-3) 85% (PY4-5)	100%
4	Amount of Shared Savings Kept by CMS	20% (PY1-3) 15% (PY4-5)	0%
5	Performance Payment Limit	15%	15%
6	Loss Sharing Limit	15%	15%

"Next Generation ACO Model – Financial & Alignment Frequently Asked Questions" Centers for Medicare & Medicaid Services, https://innovation.cms.gov/initiatives/Next-Generation-ACO-Model/nextgenaco-fnclalgnfaqs.html (Accessed 4/25/2016); "Next Generation ACO Model Benchmarking Methods" Centers for Medicare & Medicaid Services, December 15, 2015, https://innovation.cms.gov/Files/x/nextgenaco-methodology.pdf (Accessed 4/25/2016); "Next Generation ACO Model: Request for Applications" Centers for Medicare & Medicaid Services, https://innovation.cms.gov/Files/x/nextgenacorfa.pdf (Accessed 4/26/2016).

SPECIAL CONSIDERATIONS FOR TAX-EXEMPT ENTITIES

- March 2011 IRS Guidance for tax-exempt organizations participating in MSSP
  - A hospital or health system's participation in an ACO can generally be linked to the charitable purpose of "lessening the burdens of government.“
  - Under this premise, the IRS has said participation in the MSSP should not result in unrelated business taxable income (UBTI) for tax-exempt organizations.
  - All transactions among participants must be fair market value and **the tax-exempt organization's share of economic benefits from the ACO should be proportional to its contributions to the ACO.**
- Although the IRS has said MSSP participation can be interpreted as a charitable purpose, the agency did not provide examples of charitable and non-charitable activities.
  - Especially significant for ACOs negotiating with commercial payors.
  - The IRS is still seeking comment to further define this exemption, so what specific activities unrelated to MSSP are considered “charitable” remains unclear.

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