Accountable Care Organizations and Oncology

Presented by:
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Health Care Spending

Average spending on health per capita ($US PPP)

- United States
- Canada
- Netherlands
- Germany
- Australia
- United Kingdom
- New Zealand

Total expenditures on health as percent of GDP

Note: $US PPP = purchasing power parity.
### Country Rankings

<table>
<thead>
<tr>
<th>Rank Range</th>
<th>Countries</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.00–2.33</td>
<td>107</td>
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<tr>
<td>2.34–4.66</td>
<td>4.67–7.00</td>
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### Quality and Cost

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<tr>
<th>Country</th>
<th>2010</th>
<th>2007</th>
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<tr>
<td>AUS</td>
<td>3</td>
<td>$3,357</td>
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<tr>
<td>CAN</td>
<td>6</td>
<td>$3,895</td>
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<td>GER</td>
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<td>NETH</td>
<td>1</td>
<td>$3,837*</td>
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<tr>
<td>NZ</td>
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<td>$2,454</td>
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<td>UK</td>
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<tr>
<td>US</td>
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<td>$7,290</td>
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**OVERALL RANKING (2010)**

<table>
<thead>
<tr>
<th>Quality Care</th>
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<th>Cost-Related Problem</th>
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<th>Timeliness of Care</th>
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<th>Efficiency</th>
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<th>Long, Healthy, Productive Lives</th>
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| Health Expenditures/Capita, |  |  |  |  |  |  |  |
| 2007 | $3,357 | $3,895 | $3,588 | $3,837* | $2,454 | $2,992 | $7,290 |

**Note:** Estimate. Expenditures shown in $US PPP (purchasing power parity).  
Oncology Responsible for Sizable and Growing Share of Costs

$125B  Spending on cancer services in 2010

Forecast #1

Base Case: Forecast holds incidence, survival and costs steady

$207B  Forecast spending in 2020

66%  10-year Growth rate

Forecast #2

Trend Incidence and Survival: Assumes incidence and survival trends will continue as observed in last years of data

$157B  Forecast spending in 2020

26%  10-year Growth rate

Forecast #3

Cost Increase: 5% increase in costs in initial and last year phases of treatment

$155B  Forecast spending in 2020

24%  10-year Growth rate


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Slide Source: The Advisory Board Company, 2011 Oncology Roundtable
### Oncology Responsible for Sizable and Growing Share of Costs

- **Provenge for the Treatment of Prostate Cancer**:  
  - Months median survival benefit: **4.1**  
  - Cost per treatment course: **$93 K**  
  - Estimated number of eligible patients: **25,000**

- **Provenge for the Treatment of Melanoma**:  
  - Median, survival benefit: **3.6**  
  - Cost per treatment course: **$120 K**  
  - Number of deaths each year from melanoma: **8,700**

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1. Indicated for hormone refractory metastatic prostate cancer.
2. Indicated for unresectable or metastatic melanoma.


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Slide Source: The Advisory Board Company, 2011 Oncology Roundtable
# Oncology Responsible for Sizable and Growing Share of Costs

<table>
<thead>
<tr>
<th>Breast Biopsies</th>
<th>Imaging in Prostate Cancer</th>
<th>Chemotherapy in Metastatic Colon Cancer</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>30%</strong> Breast biopsies that are surgical</td>
<td><strong>36%</strong> Low-risk patients receiving unnecessary MRI, CT or bone scan</td>
<td><strong>13%</strong> Receiving non-evidence-based chemotherapy</td>
</tr>
<tr>
<td><strong>10%</strong> Accepted benchmark</td>
<td><strong>49%</strong> Medium-risk patients receiving unnecessary MRI, CT or bone scan</td>
<td><strong>$2 M</strong> Excess spending across cohort of 140 patients</td>
</tr>
<tr>
<td><strong>2,000</strong> Women receiving unnecessary surgery</td>
<td><strong>39%</strong> High-risk patients not receiving scanning when it is indicated</td>
<td><strong>$14,285</strong> Cost per patient</td>
</tr>
<tr>
<td><strong>$37 M</strong> Costs per year</td>
<td><strong>$35 M</strong> Excess costs per year</td>
<td></td>
</tr>
</tbody>
</table>

National Health Reform: Accelerates Provider Integration

- ACA begins to change payment/delivery paradigm
  - Reward value instead of volume
    - Value based purchasing, shared savings, gainsharing, bundled payments, EOCs, capitation
  - Coordinate care among and across providers
    - ACOs, medical homes, home based chronic care management, community health teams, health care innovation zones
    - New structures promoting actual and virtual integration
    - Oncologists as owners/decision-makers v. vendors
ACOs—The Legislative Framework

- Triple aim: patient-centric care, increase quality, reduce cost
- Align provider incentives toward population management and health through shared savings opportunity
- Voluntary participation by providers/patients
- ACO participating providers continue to be paid by Medicare on a FFS basis
ACOs—The Legislative Framework

- Minimum of 5,000 Medicare beneficiaries
- Benchmark set for expected Medicare Part A&B spending for beneficiaries, based on historic cost in 3 years preceding ACO contract, adjusted annually for the trend in Medicare cost growth
- ACO is paid a portion of Medicare cost savings above a MSR, if quality standards are met
- Cost savings are allocated by ACO to participants, over and above FFS payment
Accountable Care Organizations

Can there be an oncology led ACO?
- Yes, under ACA; No, under the proposed MSSP rules; Maybe, under Pioneer ACO program
- ACA: ACO can be any of the following that have a mechanism for shared governance:
  - ACO professionals in group practice arrangements
  - Networks of individual practices of ACO professionals
  - Partnerships or joint venture arrangements between hospitals and ACO professionals
  - Hospitals employing ACO professionals
  - Such other groups of providers and suppliers as CMS determines appropriate
Accountable Care Organizations

“ACO professionals” are “physicians” (defined in SSA§ 1861(r)(1)) and “practitioners” (defined in SSA§ 1842(b)(18)(C)(i))

ACOs may be integrated delivery systems, PHOs, hospital-physician/provider joint ventures, IPAs, multi or single specialty medical groups, FQHCs, other provider organizations or networks of providers

Or can they?
Proposed ACO Regulations

- No: only beneficiaries of primary care physicians are included in the program
- Few existing organizations will qualify for the Medicare Shared Savings program (75-150)
- Principally fully integrated organizations with a primary care base (not specialist only organizations)
- Principally organizations with the infrastructure, capability and experience to bear substantial risk
- Principally organizations with substantial financial resources (projected $2 million cost)
- None in 2012?/Timing issues
  - No final regulations
  - If ACO participants have combined 50+% market share in PSA, then formal Antitrust clearance required (90+ day process)
Most Will Just Say No

- Physician Group Practice (PGP) demo experience
  - 8 of 10 participants did not receive any performance payments in year 1
  - 6 of 10 received no payments in year 2
  - 5 of 10 received no payments in year 3
  - Participants invested $1.7 million on average, in the first year alone
  - None recovered their investments


Slide Source: Matt Brow, Vice President of Government Relations, and Public Policy McKesson Specialty Care Solutions/US Oncology: The Role of Oncology in Accountable Care Organizations June 8, 2011
Can the PCP-Centric Model Work?
NEJM Study Suggests Not…

On-pathway treatment was 30% ($50-60,000) less expensive with equal or better outcomes


Slide Source: Matt Brow, Vice President of Government Relations, and Public Policy McKesson Specialty Care Solutions/US Oncology: The Role of Oncology in Accountable Care Organizations June 8, 2011
Proposed ACO Regulations: Top 10 Oncology Concerns

- No or limited role in ACO governance – Each ACO participant (with a separate TIN) must have “proportionate control” over governing body decision-making
  - At best, Oncology will be one among many ACO participants
- Oncologists not counted as PCPs, and patients assigned based on plurality of PCP care/allowed charges
  - Oncologist’s patients may be assigned to ACO in which Oncologist does not participate
  - Oncology patients who receive plurality of care from oncologists do not count toward 5,000 patient threshold
Proposed ACO Regulations; Top 10 Oncology Concerns

- If Oncologists do not join the ACO at the outset, they can’t join mid-stream except through an ACO participant
  - Can’t add ACO participants during 3 year program; but ACO participants may add providers to TIN

- Beneficiaries can opt-out from CMS claims data sharing, and if they do, oncology care cannot be managed across providers/sites of care
Proposed ACO Regulations: Top 10 Oncology Concerns

Substantial ACO costs and risks with no assurance that oncologists will be allocated a fair share of any rewards; ACO costs include:

- Human resources, including an experienced Executive Director, a full-time Medical Director, and a Compliance Officer
- Infrastructure that allows the ACO to collect quality/cost data, provide feedback across the entire ACO, and report to CMS (e.g., common IT platform)
  - At least 50% of PCPs must meet meaningful use standards by Y2
- Policies and procedures—clinical guidelines, compliance plan and training, physician directed QA/process improvement processes, clinical integration program, corrective action process, CMS data use agreement, distribution of shared savings
- Patient-centeredness program, including experience of care surveys, ICPs for high-risk patients, coordination of care mechanisms, patient access and communication
- Reserve requirement (1% of expenditures)
- Application costs and process
## Proposed ACO Regulations: Top 10 Oncology Concerns

- Substantial costs/risks (con’t)--No non-risk option

<table>
<thead>
<tr>
<th>Design Element</th>
<th>One-Sided Model (performance years 1 &amp; 2)</th>
<th>Two-Sided Model</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maximum Sharing Rate</td>
<td>50/52.5 percent (w/FQHC or RHC)</td>
<td>60/65 percent (w/FQHC or RHC)</td>
</tr>
<tr>
<td>Quality Scoring</td>
<td>Sharing rate up to 50 percent based on quality performance</td>
<td>Sharing rate up to 60 percent based on quality performance</td>
</tr>
<tr>
<td>FQHC/RHC Participation Incentives</td>
<td>Up to 2.5 percentage points</td>
<td>Up to 5 percentage points</td>
</tr>
<tr>
<td>Minimum Savings Rate</td>
<td>Varies by # of beneficiaries (2-4%)</td>
<td>Flat 2 percent regardless of size</td>
</tr>
<tr>
<td>Minimum Loss Rate</td>
<td>None (first dollar)</td>
<td>Flat 2 percent regardless of size</td>
</tr>
<tr>
<td>Maximum Upside Sharing Cap</td>
<td>Payments capped at 7.5 percent of ACO’s benchmark</td>
<td>Payments capped at 10 percent of ACO’s benchmark</td>
</tr>
<tr>
<td>Design Element</td>
<td>One-Sided Model (performance years 1 &amp; 2)</td>
<td>Two-Sided Model</td>
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</tr>
<tr>
<td>Shared Upside Savings</td>
<td>Savings shared once MRS is exceeded; unless exempted, share in savings net of a 2 percent threshold; up to 50/52.5 percent of net savings up to cap.</td>
<td>Savings shared once MSR is exceeded; up to 60/65 percent of gross savings up to cap,</td>
</tr>
<tr>
<td>Shared Downside Losses</td>
<td>None in years 1&amp;2; Two Sided Model in Year 3 (1 minus final sharing rate), with a 5 percent cap</td>
<td>First dollar shared losses once the 2% minimum loss rate is exceeded. Cap on the amount of losses to be shared phased in over three years starting at 5 percent in year 1; 7.5 percent in year 2; and 10 percent in year 3. Losses in excess of the annual cap would not be shared. Actual amount of shared losses would be based on final sharing rate using the following methodology (1 minus final sharing rates).</td>
</tr>
</tbody>
</table>
Proposed ACO Regulations: Top 10 Oncology Concerns

- **Oncology patients may be less likely to contribute toward cost savings**
  - Median cost of oncology care is $111K/patient
  - Outlier cap under MSSP is 99th percentile (approx. $100K)
  - Growing cost of new chemo drugs/RT technology

- **Patients who develop cancer during the measuring period may increase costs against benchmark and reduce likelihood of ACO realizing cost savings**
  - Benchmark is set prospectively, and is not adjusted for changes in health status or acuity of actual beneficiaries during 3 year term of MSSP (comparing different populations)
  - Risk that historical cost experience for patients will not be predictive of future costs
  - Could create incentive to avoid including oncologists/cancer patients in the ACO
Proposed ACO Regulations: Top 10 Oncology Concerns

- Could incent participating oncologists to avoid higher cost new (and better) oncology diagnostics and therapeutics
  - E.g., genetic testing/personalized medicine
- Cross-cutting alternative payment and FFS incentives create burden and confusion
- No oncology-specific metrics (other than screening); no necessary commitment to track and measure quality of cancer care within ACO
  - 65 quality measures across 5 domains; no shared savings or reduced shared savings if quality measures not met
  - Measures not yet defined
  - No health care system today measures this many standards
- Oncologists may be less likely to be allocated a fair share of any shared savings realized?
  - Each ACO must specify its method of allocating and distributing shared savings dollars, and all specialties do not need to be included or treated equally
Pioneer ACO Option Created after MSSP Regulations
Universally Criticized

ACO interest waned after release of original Shared Savings Program ACO regulations (Mar 2011)
- Likelihood of ACO participation dropped to 28% from 64% before regulations were issued (Health Leaders Media Industry Survey 2011)
- 93% of AMGA members would not enroll in an ACO under current framework
- Sites in the Medicare PGP demo all expressed serious reservations about the economics and complexity of this program

New Pioneer ACO Option (May 2011)
- Targets experienced organizations committed to entering risk sharing contracts with all payers
  - Majority of ACO revenue must come from such contracts by 2013
  - Up to 30 organizations selected
  - 15,000 beneficiary threshold (5,000 for rural areas)
  - MSR of 1%
  - National growth rate applied
  - ACO can include cancer hospitals
  - CMMI more willing to negotiate/offer better payment terms that provide greater levels of financial risk/reward to Pioneer ACOs

CMS wants to demonstrate ACO success and terms will be best for early adopters. Late participants must conform to final regulations, which would be less favorable
Pioneer ACO Model Offers Somewhat More Flexibility and Potential Financial Upside

<table>
<thead>
<tr>
<th></th>
<th>Pioneer ACO</th>
<th>Medicare Shared Savings</th>
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<tbody>
<tr>
<td>Participation Period</td>
<td>Up to 5 years</td>
<td>3 years</td>
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<tr>
<td>Maximum Shared Savings</td>
<td>Up to 75% savings</td>
<td>Up to 60% savings</td>
</tr>
<tr>
<td>Beneficiary Attribution Method</td>
<td>Prospective or retrospective</td>
<td>Retrospective</td>
</tr>
<tr>
<td>Payment Model</td>
<td>Better cash flow option with Prospective PMPM</td>
<td>FFS payment</td>
</tr>
<tr>
<td>Minimum Savings/Loss Shared Savings Hurdle</td>
<td>Beat trend by 1% and share in first dollar savings/losses</td>
<td>Beat trend by 2.0-3.9%</td>
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<tr>
<td>Minimum Beneficiaries</td>
<td>15,000</td>
<td>5,000</td>
</tr>
<tr>
<td>Participation with Other ACO Payors</td>
<td>Yes/50+% by Dec., 2013</td>
<td>No</td>
</tr>
<tr>
<td>Max. Upside Sharing</td>
<td>5%/15%</td>
<td>7.5%/10%</td>
</tr>
<tr>
<td>Max. Downside Risk</td>
<td>5%/15%</td>
<td>5%/10%</td>
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</table>
Pioneer ACO Model: Beneficiary Attribution

- Beneficiary attribution to PCPs and to eligible specialists, including oncologists, if 10% or less of the patient’s care was provided by PCPs.
- ACO may choose either a prospective (care based) or retrospective (claims based) beneficiary alignment:
  - Beneficiaries can voluntarily enroll (affirmative attestation) if they have 12 months of Medicare FFS claims experience (i.e., they are not enrolled in MA and are at least 66).
- Providers are paid 50% of FFS and ACO is paid the other 50% on a pmpm basis; 100% pmpm in year 3 (transition to population management) if MSR is met (1%-5% inversely related to geographic costs):
  - Participating oncologists may/will need supplemental ACO payments for cash flow (e.g., drug purchase) purposes.
  - Payments allocated to oncology participants in discretion of ACO.

Notes:
• Eligible specialties are nephrology, oncology, rheumatology, endocrinology, pulmonology, neurology, and cardiology.
• Pioneer ACO model includes nurse practitioners and physician assistants (not included in MSSP).
Pioneer ACO Model: Payment Arrangements

- Option to select from any one of the core payment arrangements (below) or
- Applicant could propose an alternative payment model that offers “the Pioneer ACO greater levels of financial risk/reward”; CMS to devise a synthesized alternative

<table>
<thead>
<tr>
<th>Core Payment Arrangements</th>
<th>Performance Period 1</th>
<th>Performance Period 2</th>
<th>Performance Periods 3, 4, 5</th>
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<tbody>
<tr>
<td>Core Arrangement OR</td>
<td>Up to 60% shared savings and shared losses 10% maximum</td>
<td>Up to 70% shared savings and shared losses 15% maximum</td>
<td>Population-based payment, with up to 70% shared savings and shared losses 15% maximum</td>
</tr>
<tr>
<td>Core Option A</td>
<td>Up to 50% shared savings and shared losses 5% maximum</td>
<td>Up to 60% shared savings and shared losses 10% maximum</td>
<td>Same as Core Arrangement</td>
</tr>
<tr>
<td>Core Option B</td>
<td>Up to 70% shared savings and shared losses 15% maximum</td>
<td>Up to 75% shared savings and shared losses 15% maximum</td>
<td>Population-based, up to 75% shared savings and shared losses 15% maximum</td>
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</tbody>
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Notes:
Benchmark calculation trended forwarded by 50/50 split of 1) national avg. % per capita spending growth; 2) absolute dollar equivalent
Accountable Care Organizations

Some critical questions:
- Is it worth participating in the MSSP/Pioneer ACO program?
- Can your organization afford to build and operate the requisite ACO infrastructure?
- Will there be an ROI?
- What happens to the ROI if and when payments are rebased?
- Will other payors be willing to contract with your organization on an ACO basis? Will their requirements be different?
ACO Legal Considerations

- ACO arrangements are constrained by applicable federal and state laws
  - Antitrust law – price fixing, boycott, and monopoly limitations
  - Federal and State Anti-Kickback Statutes – financial inducement for referrals
  - Stark Law – financial relationships and self-referrals
  - Civil Monetary Penalty Law – prohibits hospitals from paying physicians to stint on care
  - Corporate practice of medicine – limits direct employment of physicians by certain ACO entities
  - Fee splitting – limits financial arrangements among ACO participants
ACO Legal Considerations

- Legal Constraints (con’t)
  - Facility/clinic license and DON/CON laws – if not wholly owned and controlled by physicians
  - Insurance laws – cannot accept risk contracts from self-insured plan
  - Privacy and security laws – regulates information exchange among ACO providers
  - Tax exemption and intermediate sanctions
ACO Legal Considerations

- Waiver of federal fraud and abuse laws
  - New CMS/OIG Guidance—Waiver available for ACO distributions from participants in MSSP
  - No waiver for participation in commercial insurance programs
  - No waiver of state F&A laws
  - No waiver of other federal or state laws

- New IRS Guidance—only for ACO distributions from participants in MSSP
ACO Legal Considerations

- **New Antitrust Safety Zone**
  - ACO participants in same specialty with combined 30% or less market share in PSA (3 contiguous zip codes); can be exclusive to ACO
  - If ACO participants in same specialty have combined 50% or more market share in PSA, then ACO must obtain FTC/DOJ clearance to participate in MSSP
  - ACO participant with 50% or more market share can only participate in ACO/MSSP on a non-exclusive basis
  - Hospitals and ASCs can only participate in ACO/MSSP on a non-exclusive basis
  - Also applicable to commercial insurance contracting if ACO qualifies to participate in the MSSP
ACO Legal Considerations

- Foley & Lardner white paper: *Transforming Health Care Through ACOs: A Critical Assessment*
- [Foley.com/ACO](Foley.com/ACO)
Conclusion

Strategic Options For Oncologists

- Do nothing
- Form special purpose ACO for Pioneer ACO participation
- Apply to CMMI for an innovation grant for an oncology-only ACO
- Form an oncology supergroup under a single tax id number and try to be indispensable to all ACOs and Medical Homes
- Join a sizable multi-specialty group with a strong primary care base and become a physician-centric ACO/Medical Home
- Become an ACO participant in a local/regional ACO and obtain proportionate role in governance/decision-making
- Form “strong” oncology IPA for risk-contracting
- Clinically integrate with a Hospital/IDS/ACO (e.g., through PSA/Co-management arrangements)
- Sell practice and become employed by a Hospital/IDS/ACO
- Engage in alignment and care transformation process with preferred health care partners
Care Transformation Opportunities

Prevention
- Smoking cessation, diet and lifestyle management
- Pharmaceutical prevention in prostate and breast
- Undertapped opportunity

Screening
- Opportunity to improve outcomes through earlier diagnosis
- Unlikely to destroy demand
- High false positive rate in some screening modalities may add costs

Diagnosis and Treatment Planning
- Providing timely, streamlined access to diagnosis and treatment plan
- Ensuring accurate diagnosis
- Multidisciplinary treatment planning
- Active patient engagement in treatment planning process

Treatment
- Ensuring evidence-based care
- Appropriate enrollment in clinical trials
- Principled alignment of patience and provider acuity
- Active management of side effects to minimize ED, IP utilization

Palliative Care
- Proactive utilization of palliative care and symptom management

End of Life
- Establish treatment goals, update frequently
- Early engagement in end-of-life planning
- Timely referral to hospice

Survivorship
- Creation of treatment summary and survivorship care plan
- Consistent screening for secondary cancer and recurrences
- Active management of late effects

Source: Oncology Roundtable interviews and analysis.