


PPACA and ACOs:
A Business Shift for Physician Groups

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DFW HFMA Chapter

- Introduction and overview of agenda
- Alignment strategies and governance models
- Proposed regulations status
- Risk considerations
- Implications for physician groups
- Q&A




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What is an ACO?



*ACOs have been compared to the unicorn:
Everyone seems to know what it looks like,
but nobody's actually seen one.*



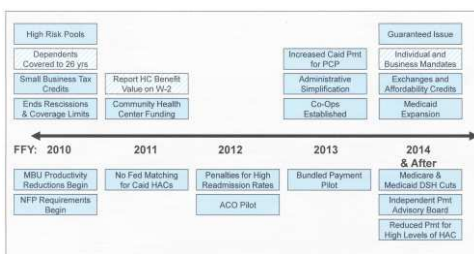
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Incentive Timeline


- CMS has issued draft regulation as of 3/31/2011
- CMS will begin initial contracts in existing group demonstration projects in 2011
- Initial federal incentives are expected to be first available in January 2012 - will evolve over time



Key Reforms and Implementation Dates

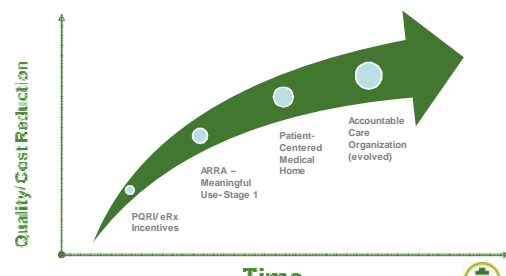



Boxes with diagonal bars indicate reforms that will impact hospitals as insurance providers.



Source: HFMA, Healthcare Reform: The Dust Settles, April 13, 2010

The Road Ahead – Health Reform Initiatives for Cost Reduction/ Quality Improvement





Over 32 Million Covered

- New and existing programs with insurance market reforms are used to expand coverage

<p>Programs</p> <ul style="list-style-type: none"> Expansion of Medicaid Creation of co-ops Plans administered by the Office of Personnel Management 	<p>Market Reforms</p> <ul style="list-style-type: none"> State level exchanges Elimination of pre-existing conditions Credits for lower and middle income Personal and employer mandates
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Source: HFMA, Healthcare Reform: The Dust Settles, April 13, 2010




Insured Population Will Rise to 94% by 2019

Year	Percentage of the Nonelderly Population with Insurance	Number of Nonelderly Uninsured (millions)
2010	83%	50
2014	91%	31
2019	94%	23

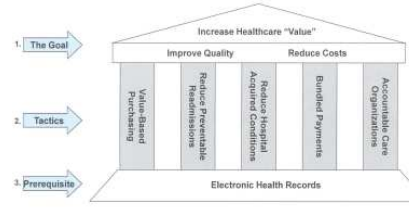
Source: Congressional Budget Office and the staff of the Joint Committee on Taxation - Table 4. Estimated effects of the insurance coverage provisions of the reconciliation proposal combined with H.R. 3500 (as enacted). Coverage percentages exclude unauthorized immigrants.

Source: HFMA, Healthcare Reform: The Dust Settles, April 13, 2010




Healthcare Delivery System Reform

- New and existing programs with insurance market reforms are used to expand coverage




Source: HFMA, Healthcare Reform: The Dust Settles, April 13, 2010



Leadership



Alignment Strategies and Governance Models




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Primary Care Focus

"The core of an Accountable Care Organization is **effective primary care**...*some of the most important mechanisms* for reducing and slowing the growth in specialty and hospital expenditures are prevention, early diagnosis, chronic disease management, and other tools which are delivered through primary care practices."


- Harold D. Miller
How to Create Accountable Care Organizations
First Edition, September 7, 2009




Alphabet Soup



Source: Modern Healthcare 5/15/2011




Who is involved in an ACO?

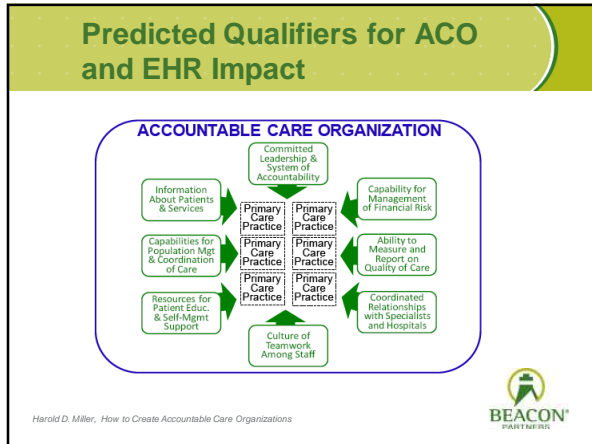


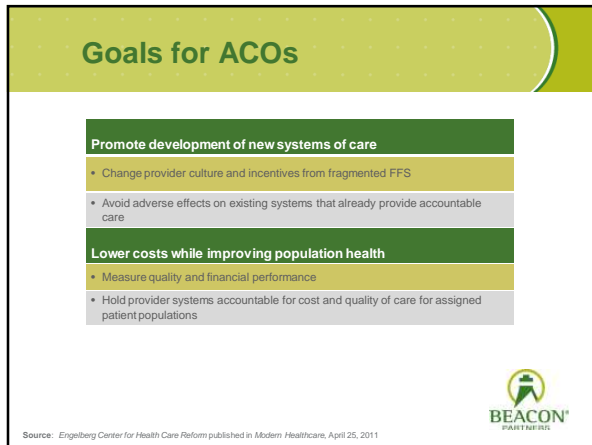
What Exactly is an ACO?

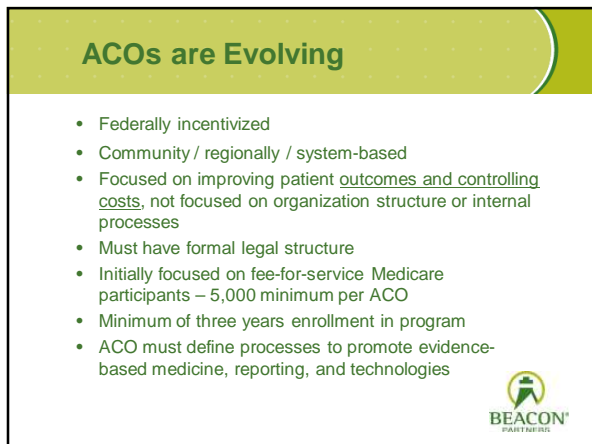
Definition from Health Reform Act:
A group of healthcare providers who give coordinated care, chronic disease management, and thereby improve the quality of care patients get. The organization's payment is tied to achieving healthcare quality goals and outcomes that result in cost savings.

Source: Patient Protection and Affordable Care Act (PPACA) of 2010 (Healthcare.gov)










Physician Influence Over Care Delivery

- Provider-focused care coordination
- ACOs can have various organizational structures
- Investment in IT/ EHR critical
- Must support evidence-based medicine, quality management and performance oversight
- Fee for service still exists in PPACA
- Long Term Goal: Move away from individual DRGs and conventional fee for service medicine
- Some predict episodic basis for reimbursement in future
 - Partial capitation, capitated (*patient transparent*), global fee structures




Basic Requirements

- Organization designated must have a formal legal structure to receive and distribute savings
- Agree to become accountable for the overall care of Medicare fee-for-service beneficiaries
- Have a sufficient number of primary care professionals for the number of assigned beneficiaries which must at a minimum be 5,000
- Agree to participate in program for at least 3 years
- Have a leadership and management structure that includes clinical and administrative systems




Additional Requirements

- Have sufficient information regarding participating ACO healthcare professions as HHS secretary determines necessary to support beneficiary assignment and for the determination of payments and shared savings
- Have defined processes to
 - Promote evidence-based medicine
 - Report the necessary data to evaluate quality and cost measures, i.e., PQR, eRx, EHRs
 - Coordinate care
- Demonstrate it meets patient-centeredness criteria as determined by the secretary of HHW



The Patient Perspective- Invisible Enrollment


- No formal enrollment - unlike capitation model
- Will not be *required* to see physicians in ACO
- Must be notified their provider/supplier is participating
- Payers will define patient population to which the ACO is accountable – Medicare Model



Performance Measurement

ACO examples of quality metrics (claims-based)


Overuse
• Low-back pain: use of imaging studies
Population health
• Cancer screening
Safety
• Annual monitoring for patients on persistent medications
Care coordination
• 30-day all-cause (risk-adjusted) readmission following acute myocardial infarction, heart failure admission, pneumonia hospitalization
Patient experience
• Consumer Assessment of Health Providers and Systems



Source: Norton Healthcare published in Modern Healthcare, April 25, 2011

Proposed Regulation


Highlights and Overview



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CMS ACO Development Timeline

Governance <small>7/1/2011</small>	Data Infrastructure	Profiling	Analyzing <small>1/1/2012</small>
<ul style="list-style-type: none"> • Legal organization • Measures • Incentives • Participants and TINs • Application • Beneficiary representative • Senior medical director • Executive under governing body • Marketing materials must be authorized • PSA determination of ACO 	<ul style="list-style-type: none"> • Claims Data • Quality Data • Reporting • Population ID • Ancillary Data • Disease Registries • Pt Satisfaction (CAHPS) • Summary of care documents • Beneficiary access to med record • Available to public using CMS format 	<ul style="list-style-type: none"> • Recruit members • Establish connectivity • Train on use of reporting tools • Benchmarks 	<ul style="list-style-type: none"> • Pull reports • Verify data • Care management: mechanism for care coordination • Risk Management: ID high risk individuals and develop care plans



Proposed Regulation – 3/31/11

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services
42 CFR Part 425 [CMS-1345-P] RIN 0938-AQ22

Medicare Program; Medicare Shared Savings Program
Accountable Care Organizations


AGENCY
Centers for Medicare & Medicaid Services (CMS), HHS

ACTION
Proposed rule




Eligible Entities

- 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
- FQHC and RHCs not eligible to be ACOs but may be in ACOs (*incentives offered*)
- CAH also eligible




Governance Considerations

- Single legal entity as defined by laws of state in which established
- Existing ACOs do not have to change governance if they meet criteria
- Representation on governing body by beneficiaries
- Makeup of governance structure must be 75% Medicare Providers (*doctors, hospitals, suppliers, etc.*)




Other Key Points

- Accountable for Patient Population Served
- Must report data and achieve quality results and savings to earn bonuses
- Three-year term of participation
- Must have patient-centered criteria




Management and Administrative Structure

- Executive or manager's appointment and removal under control of governing body
- Leadership team with demonstrated ability to direct clinical practice
- Clinical oversight by senior-level medical director
- Physician-directed quality assurance/process improvement committee
- Processes to promote and monitor clinical improvements based on evidence-based practice or clinical guidelines
- Infrastructure to collect evaluate data/provide feedback to providers



Patient-Centered Focus


- Beneficiary Experience-of-Care survey in place
- Patient on the Governing Board
- Process for evaluating the health needs of the population
- Systems to identify high-risk individuals
- Processes for individualized care plans
- Coordination of care mechanisms, e.g., care coordinators
- Electronic exchange, summary of care in care transitions
- Communicating clinical information



Assignment


- CMS proposes a combined approach to assignment*
 - Retrospective beneficiary assignment* for determining Shared Savings eligibility, and
 - Prospectively will provide a list of names, dates of birth, gender, health insurance claim numbers for the assigned population
- Patients assigned where they receive plurality of primary care as determined from claims data, allowed charges

*Assignment: The means by which patients are aligned with an ACO.




What Constitutes an ACO?

- **Who belongs to an ACO?**
 - An ACO consists of a collection of providers in a given geography that can include primary care physicians, hospitals, specialists, home care, etc.
- **What are they responsible for?**
 - 100% of the healthcare and costs for a defined group of patients
- **What functions do they perform?**
 - Coordination of all care activities between the providers in an ACO
 - Measurement and improvement of outcomes and costs
 - Financial management and distribution of cost savings across ACO




Shared Savings Overview

- Shared savings bonus is payable if ACO meets:
 - Quality performance standards
 - Savings against a “target” expenditure
- Actual ACO expenditures are compared to “target” expenditures
- The difference is shared savings or shared losses
- Minimum Savings Rate (MSR) is applied to positive results
- Quality performance score is applied to results to yield shared savings
- Withhold pertains, 25% of shared savings



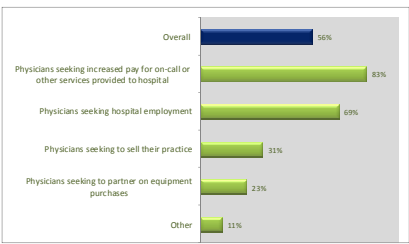
Future ACO Regulations

- ACOs subject to future changes in regulation/ program requirements
- Differences from those stipulated in the initial application process
- These program areas are exempted from eligibility requirements re: structure and governance of ACOs:
 - Calculation of sharing rate
 - Beneficiary assignment
- ACOs have to explain how they will meet changes




Physicians Seeking Financial Help from Hospitals and Health Systems

Percent of hospitals reporting an increase in the degree to which physicians are seeking financial support from hospitals in past 3 months (November 2008)




Type of Support Sought	Percentage
Overall	56%
Physicians seeking increased pay for on-call or other services provided to hospital	83%
Physicians seeking hospital employment	69%
Physicians seeking to sell their practice	31%
Physicians seeking to partner on equipment purchases	23%
Other	11%



Source: AHA, (November 2008), Rapid Response Survey, The Economic Crisis: Impact on Hospitals.
Note: Nationally, the majority of physicians are in private practice and are not employed by hospitals.

Risk Considerations

Assumption, Avoidance or Contracting Away?




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Shifting Risk

Patient system reforms will require providers to bear greater population-based financial risk

Degree of Population Risk Transferred to Provider by Payment System ...

Low ←						→ High
Fee for Service Paid for each unit of service without concern on specialty	Pay for Coordination Additional per-capita payment based on ability to manage care	Pay for Performance Payments tied to objective measures of performance Reform: -Value-based Purchasing/ -HAC -Revised Policy	Epidemic Payments Payment based on delivery of services within a given timeframe Reform: -Bundled Payment (ACE Demonstration)	Shared Savings Shared savings from better care coordination and disease management Reform: -ACOs	Capitation Providers share savings from better care coordination and disease management	




Source: HFMA, Healthcare Reform: The Dust Settles, April 13, 2010

Shifting Paradigm

Hospitals need to understand and respond to changing economic incentives

	Current State	Future State
Cost:	Reduction Viewed as Discrete Projects	Continuous Process Improvement
Quality:	Public Relations/Liability Issue	Drives Reimbursement
Physicians:	Drive Volume	Drive Value
Collaboration:	Limited Amount Required for Financial Success	Clinical and Finance Staff Must Work Together
Financial Risk:	Revolves Around Cost Position	Revolves Around Utilization of Services Across Continuum



Source: HFMA, Healthcare Reform: The Dust Settles, April 13, 2010

Bearing Risk

- Providers will also **bear downside risk** in the pilot
- One-sided risk model (sharing of savings only for the first two years and **sharing of savings and losses** in the third year)
 - Shares savings 50/50 with Medicare
 - Must exceed 2% threshold
- Two-sided risk model (sharing of savings and losses for all three years)
 - Shares savings 60/40 with Medicare
 - "First dollar" savings
- Losses in both models are capped



Proposed CMS ACO guidelines

• ACOs can choose between 2 options:

Track 1

- Shared savings for Year 1 and 2
- Year 3 is shared savings and shared losses (if any) over certain threshold
- Savings and Losses are capped
- Bonus for including a FQHC or RHC
- 50% shared savings up to 7.5% of benchmark

Track 2

- Shared savings and shared loss (if any) all 3 years
- Savings and losses are capped
- Bonus for including a FQHC or RHC
- 60% shared savings up to 10% of benchmark

ACO Proposed Rule 3/31/2011




What Can You Be Doing Now to Prepare for ACOs?

- Keep informed - follow latest updates from CMS
- Provide Comments / Feedback to CMS on Proposed Rule (*Comment period ended 6/4/11*)
- Understand where you are in the ACO development cycle
- Small Independent Providers: Consider joining Independent Practice Associations and Regional Physician Organizations
- Well established infrastructure - EHR/ PCMH: Consider being a Pilot in 2011 to take advantage of 2012 incentives
- Development of Quality of Care Metrics




Challenges


- **Structural Change:** Current system awards provider on service volume
- Shared savings may not offset revenue lost from reduced number of services
- ACO must decide how savings are divided
- Small physician groups need formal systems and structures needed to form ACO
 - Must have “formal legal structure”
- Significant start-up capital needed for IPA
- Will private payers follow Medicare lead?
- Long-term impact: the end of Fee-For-Service as we know it? New payment model?



Overcoming Legal Barriers

- The CMS and OIG has outlined ACO-related exclusions to the following:
 - The Physician Self-Referral Law which prohibits physicians from making referrals for Medicare “designated health services,”
 - The Federal anti-kickback statute which provides criminal penalties for inducing or rewarding the referral of business reimbursable under any Federal health care program
 - The civil monetary penalties law that prohibits a hospital from making a payment, directly or indirectly, to induce a physician to reduce or limit services to Medicare and Medicaid beneficiaries under the physician’s direct care





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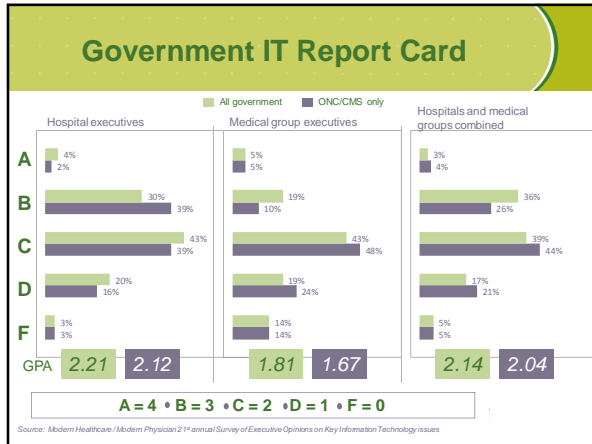
For Release: 03/31/2011

FTC, DOJ Seek Public Comment on Proposed Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations

Provides for Antitrust “Safety Zone” and Expedited Antitrust Review

The Federal Trade Commission and Department of Justice issued a joint statement about how the agencies will enforce U.S. antitrust laws in regard to new Accountable Care Organizations – groups of health care providers that will be collaborating under the Affordable Care Act of 2010 to improve health care quality and reduce costs.

The joint proposed Policy Statement solicits public comment on the antitrust agencies’ proposed guidance to ensure that newly formed collaborative care organizations, known as ACOs, can innovate to serve Medicare beneficiaries and patients with private health insurance, without raising competitive concerns. The proposed Policy Statement would create an antitrust “safety zone” for certain ACOs and establish expedited antitrust reviews for others.



Steps to Prepare for ACOs and New Payment Structures

- Examine your cost structure and become more efficient
- Engage in discussions with your physicians about how to put together an ACO
- Be innovative and take measured risks because you may find a new way to contain costs or improve workflow
- Implement new care-delivery models now. Do not wait for clear direction from the federal government

Source: BEYOND MEANINGFUL USE PREPARING FOR HEALTHCARE REFORM
A CONVERSATION WITH BEACON PARTNERS
Modern Healthcare 6/20/2011

CMS Math: Estimates per ACO, based on 100 ACOs


	Year 1	Year 2	Year 3	Total 3 years
Bonus Payout				\$8,000,000
Cost	\$1,755,251	\$1,265,897	\$1,265,897	\$4,287,075
Bonus left				\$3,712,925

Source: CMS-1345-P Proposed Rule Medicare Shared Savings Program: Accountable Care 3, 31.2011 p.360

Infrastructure Cost Estimates For ACO Prototype


	Start Up	Ongoing
Network Development and Management	\$2,275,000	\$2,900,000
Care Coordination, Quality Improvement and Utilization Management	\$405,000	\$1,515,000
Clinical Information Systems	\$2,350,000	\$1,500,000
Data Analytics	\$285,000	\$385,000
Total	\$5,315,000	\$6,300,000

* White Paper - THE WORK AHEAD: Activities and Costs to Develop an Accountable Care Organization, AHA
+ ACO includes 200 beds, 80 PCPs, 150 SPC




PPACA Penalties

TOTAL CUT	PROGRAM	EFFECTIVE DATE
Hospitals		
1% Medicare pay	Top quartile of healthcare-acquired-condition rates	Fiscal 2014
25% marketbasket update	Electronic health records	Fiscal 2015
3% Medicare pay	Highest quartile of readmissions	2012
Physicians		
1.5%-2% Medicare pay	Physician Quality Reporting System	2015-16
1%-2% Medicare pay	E-prescribing program	2012-14
1%-3% Medicare pay	Electronic health records	2015-17
LTACs, inpatient rehab facilities and hospice		
2% Medicare pay	Quality reporting program	2014




Implications for Physician Groups



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Provider-Led Organization

- Clinical Integration is a physician- and provider-led effort
- Internally motivated to monitor themselves and deliver better quality and higher value – not something that is forced on them from the outside
- Empowerment of the physicians is the key
- Financial incentives are important but not the only motivating factor in a successful ACO
- Need to foster an entrepreneurial attitude and a desire to seek out novel solutions and accept the challenge to explore and learn how to make this work





Multiple Practices/ One IT System

- Pros
 - Practice autonomy
 - Conformity of system modules use
 - Uniform reporting
 - Reduce support and maintenance expense
- Cons
 - Start-up expense
 - Capital requirement
 - Increased license/equipment cost
 - Training


Multiple Practices Multiple IT Systems

- Pros
 - Practice autonomy
- Cons
 - Lack of RC control and system structure
 - Increased maintenance, license and support expense
 - Lack of reporting structure
 - Reliance on Bolt On or interface technology
 - Difficult to monitor



Multiple Practices One System/ CBO

- Pros
 - Control of operations
 - Claim submission
 - Patient statements
 - Auto-payments
 - Appointment templates
 - A/R follow-up
 - Economies of scale
 - Operational structure and compliance
- Cons
 - Decreased practice autonomy




Single vs. Multiple Systems

- Pros
 - Ease of integration to EHR and clinical systems
 - Insurance verification tool
 - P4P information
 - PQRI compliant
 - Managed care contract monitoring
 - Roll-up and practice-specific reporting



How Do You Participate?

- ACOs need to apply and meet CMS criteria
- ACO will not be automatically accepted into the Shared Savings Program
- ACOs must establish a governing body representing ACO providers of services, suppliers and Medicare beneficiaries
- Responsible for monitoring and reporting of the care it delivers
 - Includes analyzing claims and specific financial and quality data



How Primary Care Can Become an ACO – Collaboration

- Ability to manage and coordinate patient care
 - Collective efforts, Independent Practice Association (IPA) or Physician Organization (PO)
- Ability to manage financial risk
 - Collective bargaining with insurers through IPA or other regional collaboration
 - Size should assist small practice providers in *strengthening their hand*
- Ability to measure cost and quality
 - Reportable patient outcomes
 - **Minimum size** - at least 5000 Medicare patients to be *statistically viable*




How a Specialist Organization Can Become an ACO

- Improve care coordination with primary care provider and other specialists
 - Shared information on results, reduction of duplicate tests, improved communication protocols with PCP
- Access to shared medical record
 - Security and Transparency
 - Even if providers are in same organization, they may not have access to the same patient chart
 - Encourage shared platform and access to complete patient chart to enhance medical decision-making



How a Hospital Can be Part of an ACO

- Affiliate with large provider organization
- Integrated delivery system
- Physician - Hospital Organization
- Large systems driving demonstrated savings mode → aligned financial incentives



Tying Payment to Improving Care

- Medicare will continue to pay FFS to individual providers
- CMS will develop a benchmark for savings to be achieved by each ACO based on Parts A and B Expenditure
- ACO would be accountable for meeting or exceeding the quality performance standards to be eligible to receive any shared savings
- In 2012 providers must only report defined quality metrics to receive shared savings if they meet spending benchmarks
- CMS will withhold 25% of ACO's shared savings payment to ensure ACO can pay back future losses if any



Healthcare Reform: Major New Laws – But Not the Last Words

- Healthcare reform has been enacted. President Obama signed The Patient Protection and Affordable Care Act (PPAC) on March 23, 2010 and The Healthcare and Education Reconciliation Act of 2010 (HCERA) on March 30, 2010
- Several state attorneys general have filed suit challenging aspects of the law
- Issues that may require additional legislation
 - Any necessary technical corrections identified
 - Legislation that would address findings of studies or reports required under PPAC
 - Annual appropriations required for elements authorized by PPAC; additional policy changes could be made at that time or in related reauthorizations
 - Assisting or overseeing numerous actions tasked to the states, such as the creation of American Health Benefit Exchanges and requirements for citizens to have health insurance through various modalities
 - From a regulatory standpoint, proposals, comments, rules, and legislative reactions to those rules



Source: HFMA, Healthcare Reform: The Dust Settles, April 13, 2010

Let The Transformation Begin... The End Of Fragmentation?

- Health System Consolidation
 - Significant cuts in reimbursement could force weaker hospitals to join larger systems
- Physician Integration
 - Physician practice acquisition continues
- Bundled Payments
 - Single payments initially to providers for post-acute-care services 30 days post-discharge could expand to chronic care and other services
- Accountable Care Organizations
 - Integrated physician, hospital and health plan models are developing
- Health Insurance Reform
 - Could put pressure on private insurance rate negotiations and alter the "cost shift" dramatically



Source: HFMA, Healthcare Reform: The Dust Settles, April 13, 2010

Let The Transformation Begin...

- **Comparative Effectiveness Research**
 - \$1.1B stimulus to determine which procedures and which drugs are most effective and could reduce coverage and/or rates
- **HITECH Act**
 - \$20B stimulus for certified users of Electronic Health Records technology along with significant privacy and security regulations
- **Regulatory Enforcement**
 - Significant funding focused on fraud, waste, and abuse in Medicare and Medicaid
- **ICD-10**
 - Major conversion in 2013 impacting billing and cash flow for both providers and payers
- **Accountability and Transparency**
 - Personal accountability for health and proposed legislation on transparency for comprehensive reporting on hospital pricing and quality measures/outcomes



Source: HFMA, Healthcare Reform: The Dust Settles, April 13, 2010

CMS timeline for reform

2010	2011	2012	2013	2014	2015
HIPAA 5010		ICD 10			
PQRI	PQRI (cRx)	PQRS		Penalty for non-submission of PQRI	
ARRA		Meaningful Use			Penalty for non-compliance
No Matching Payment		Hospital Acquired Conditions			Reduced Payment for HAC
Accountable Care Organizations					
Penalties for High Rates of Readmissions					
Inpatient Value Based Purchasing Program					
Bundled Payment Pilot					

Source: Kaiser Family Foundation Health Reform 11/15/2010

Healthcare Information Landscape is Rapidly Changing


ARRA/HITECH

ICD-10/5010

CONSOLIDATION

HC REFORM

CONSUMERISM



Q & A Session





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Inc. 500	2010, 2009, 2008 and 2007
Boston Business Journal	2010, 2009, 2008 Pacesetter Award
 <small>Leadership, Vision & Strategy for the CEO</small>	2010, 2009, 2008 Top 100 List
ModernHealthcare.com	2008 Top 100 Best Places to Work 2010, 2009, 2008 Top 20 Healthcare Management Consulting Firms
 <small>Accredited. Honored. Impassioned.</small>	2008 Category: Staff Augmentation
	2008 Lifetime Achievement Award Ralph Fargnoli, President and CEO



Thank You!

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