

PPACA and ACOs:

A Business Shift for Health Care Organizations

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HFMA Chapter – Lubbock, TX

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



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.*



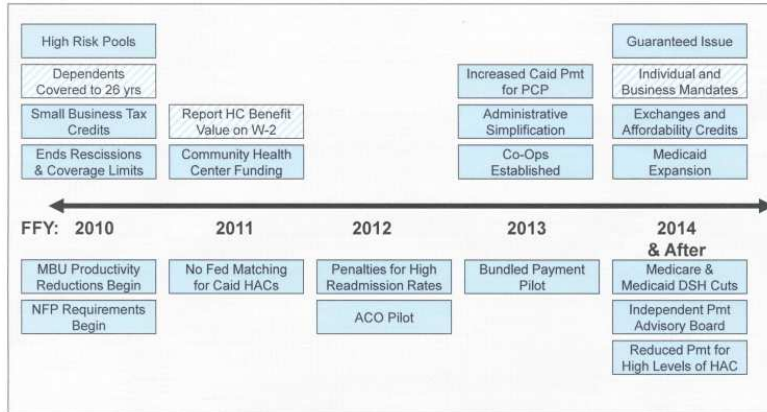
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Incentive Timeline

- 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

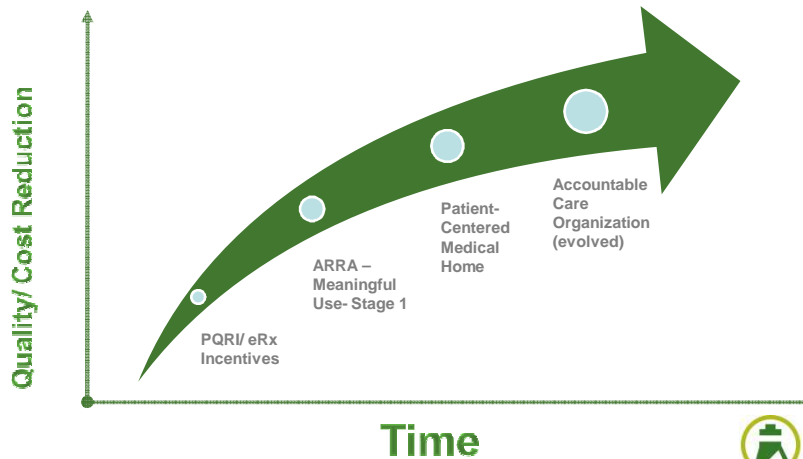


Boxes with diagonal bars indicate reforms that will impact hospitals as insurance providers.



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

Programs

- Expansion of Medicaid
- Creation of co-ops
- Plans administered by the Office of Personnel Management

Market Reforms

- State level exchanges
- Elimination of pre-existing conditions
- Credits for lower and middle income
- Personal and employer mandates



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

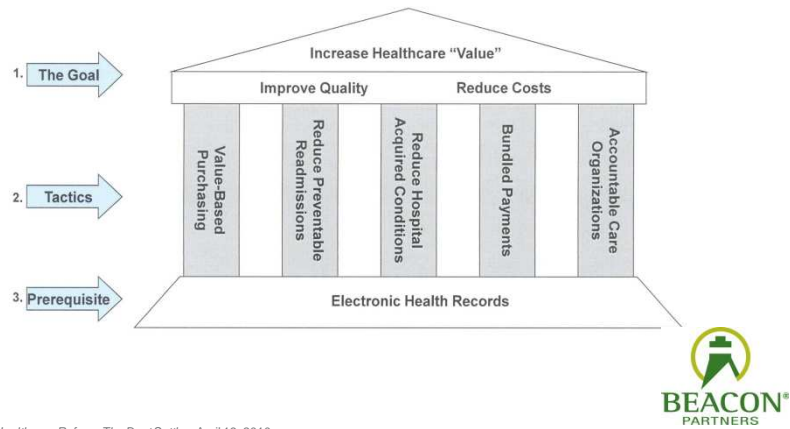
Source: Congressional Budget Office and the staff of the Joint Committee on Taxation - Table 4. Estimated effects of the Insurance coverage provisions of the reconciliation proposal combined with H.R. 3590 (as enacted). Coverage percentages exclude unauthorized immigrants.



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

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?

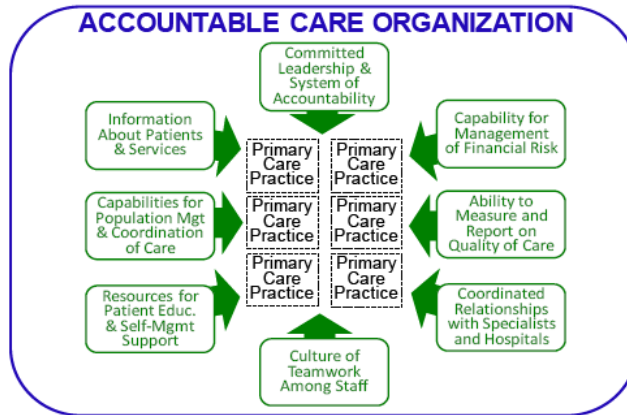
Definition from Health Reform Act:

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)



Predicted Qualifiers for ACO and EHR Impact



Harold D. Miller, *How to Create Accountable Care Organizations*



Goals for ACOs

Promote development of new systems of care

- Change provider culture and incentives from fragmented FFS
- Avoid adverse effects on existing systems that already provide accountable care

Lower costs while improving population health

- Measure quality and financial performance
- Hold provider systems accountable for cost and quality of care for assigned patient populations



Source: Engelberg Center for Health Care Reform published in *Modern Healthcare*, April 25, 2011

ACOs are Evolving

- Federally incentivized
- Community / regionally / system-based
- Focused on improving patient outcomes and controlling costs, not focused on organization structure or internal processes
- Must have formal legal structure
- Initially focused on fee-for-service Medicare participants – 5,000 minimum per ACO
- Minimum of three years enrollment in program
- ACO must define processes to promote evidence-based medicine, reporting, and technologies



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., PQRI, eRx, EHRs
 - Coordinate care
- Demonstrate it meets patient-centeredness criteria as determined by the Secretary of HHS



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 7/1/2011	Data Infrastructure	Profiling	Analyzing 1/1/2012
<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



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



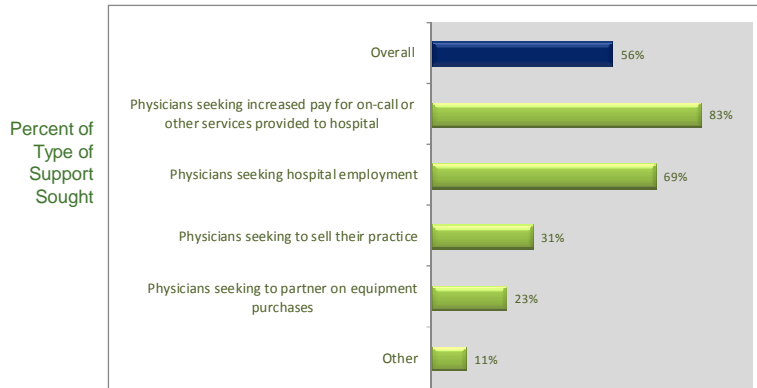
Shared Savings Overview

- 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



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)



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



Top Issues Confronting Hospitals: 2010

	2010	2009	2008
Financial challenges	77%	76%	77%
Healthcare reform implementation ¹	53%	53%	-
Governmental mandates	32%	30%	26%
Patient safety and quality ²	31%	32%	43%
Physician-hospital relations	30%	25%	32%
Care for the uninsured	28%	37%	41%
Patient satisfaction	16%	15%	22%
Personnel shortages	11%	13%	30%
Technology	10%	7%	9%
Capacity	6%	7%	16%
Governance	3%	2%	-
Issues about not-for-profit status	2%	1%	2%
Disaster preparedness ³	<1%	1%	1%

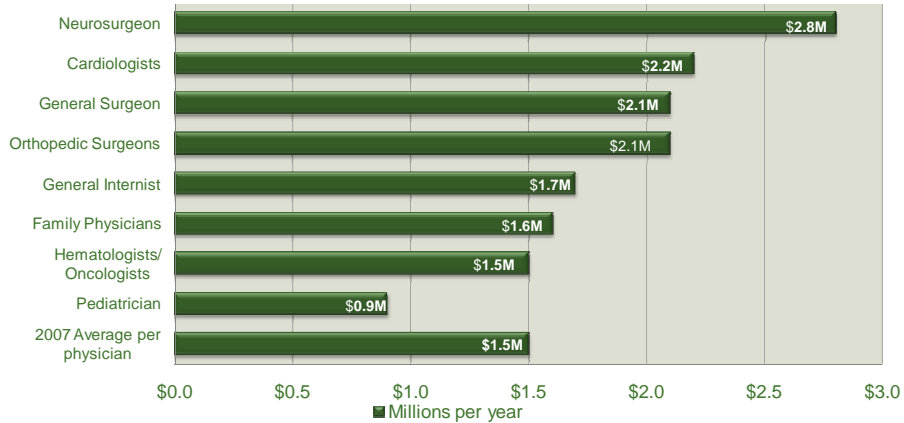
Source: Healthcare Executive, March/April 2011

¹ In 2009 this issue was referred to as "implications of healthcare reform"

² In 2008-2010 this issue was composed of both patient safety and quality. In prior years, they were two unique issues.

³ In 2008 this issue was broadened from "biodisaster" to "disaster preparedness"

Physicians Generate Millions in Revenue for Hospitals



Source: Trustee May 2010 Edition

Have's and Have Not's



Source: Modern Healthcare, May 16, 2011

Risk Considerations

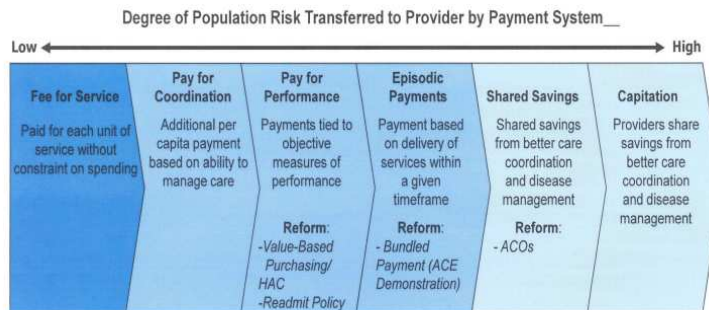
Assumption, Avoidance or Contracting Away?



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Shifting Risk

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

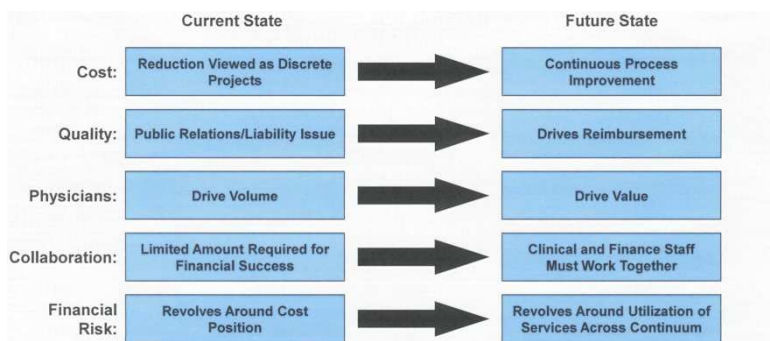


Source: HFMA, *Healthcare Reform: The Dust Settles*, April 13, 2010



Shifting Paradigm

Hospitals need to understand and respond to changing economic incentives



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 Rules 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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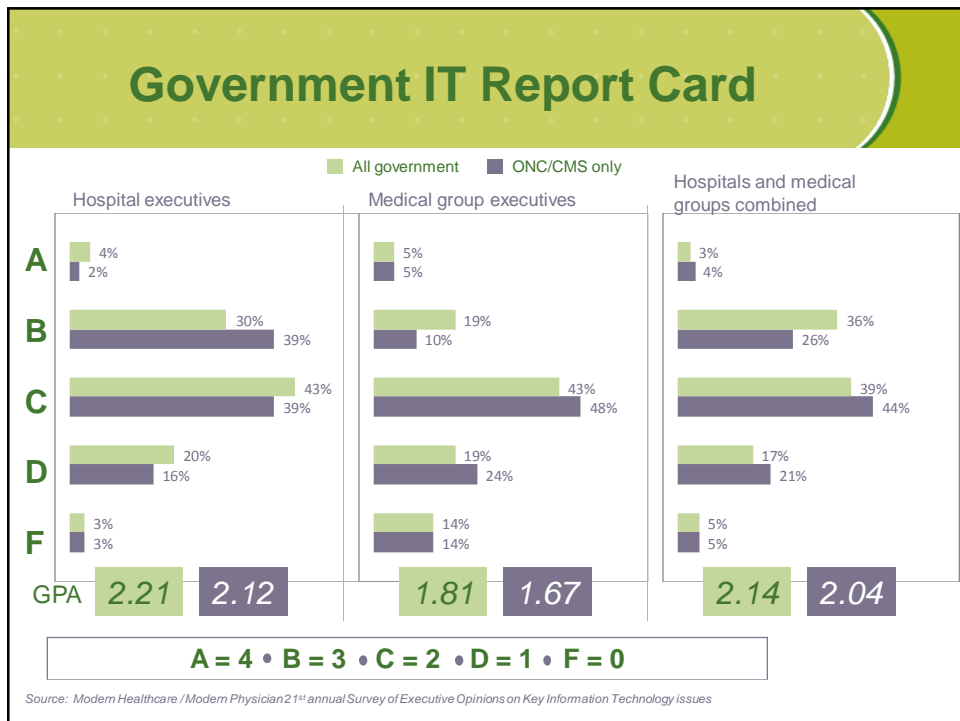
For Release: 03/31/2011

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.350



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

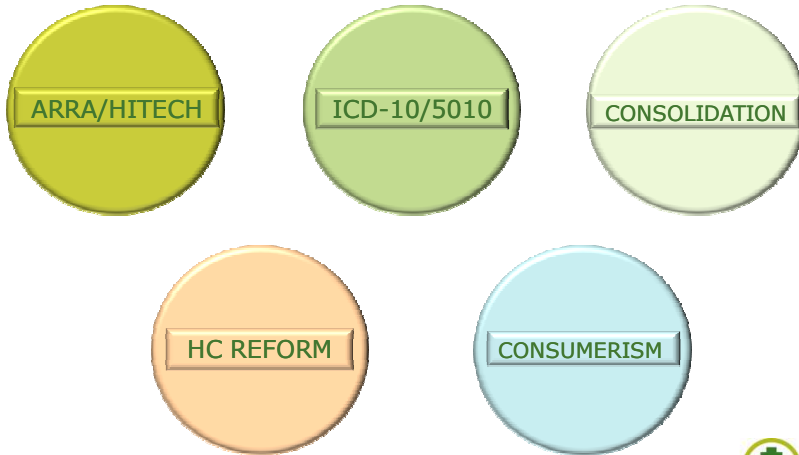


CMS timeline for reform

2010	2011	2012	2013	2014	2015
HIPAA 5010		ICD 10			
PQRI	PQRI (eRx)	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 11/10/2010

Healthcare Information Landscape is Rapidly Changing



Q & A Session



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Inc. 5000 2010, 2009, 2008 and 2007

Boston Business Journal 2010, 2009, 2008 Pacesetter Award

Healthcare Informatics 2010, 2009, 2008 Top 100 List
Leadership, Vision & Strategy for the CIO

ModernHealthcare.com 2008 Top 100 Best Places to Work
2010, 2009, 2008 Top 20 Healthcare Management Consulting Firms

KLAS 2008 Category: Staff Augmentation
Accurate. Honest. Impartial.

CHIME FOUNDATION 2008 Lifetime Achievement Award
Ralph Fagnoli, President and CEO



Thank You!

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