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FAMSS
30th Annual Education Conference

The Impact of Accountable Care Organizations (ACOs) and Health Care Reform on Credentialing, Privileging and Peer Review

May 4-7, 2011

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What is an ACO?

- An organization of healthcare providers that agrees to be accountable for the quality, cost, and overall care of Medicare beneficiaries who are enrolled in the traditional fee-for-service program who are assigned to it.
- For ACO purposes, "assigned" means those beneficiaries for whom the professionals in the ACO provide the bulk of primary care services. Assignment will be invisible to the beneficiary, and will not affect their guaranteed benefits or choice of doctor. A beneficiary may continue to seek services from the physicians and other providers of their choice, whether or not the physician or provider is a part of an ACO.

What forms of organizations may become an ACO?

- Physicians and other ACO professionals in group practices
- Physicians and other ACO professionals in networks of practices
- Partnerships or joint venture arrangements between hospitals and ACO professionals
- Hospitals employing physicians/professionals
- Other forms that the Secretary of Health and Human Services may determine appropriate

ACO requirements

- Have a formal legal and governance structure to receive and distribute shared savings that is recognized under state law
- Have a sufficient number of primary care professionals for the number of assigned beneficiaries (to be 5,000 at a minimum)
- Agree to participate in the program for not less than a 3-year period
- Have sufficient information regarding participating ACO healthcare professionals as the Secretary determines necessary to support beneficiary assignment and for the determination of payments for shared savings

ACO requirements

- Have a management structure that includes clinical and administrative systems
- Have defined processes to:
  - Promote evidenced-based medicine
  - Report the necessary data to evaluate quality and cost measures; this could incorporate requirements of other programs, such as the Physician Quality Reporting Initiative (PQRI), Electronic Prescribing (eRx), and Electronic Health Records (EHR)
  - Coordinate care

ACO requirements (cont'd.)

- Demonstrate it meets patient-centeredness criteria, as determined by the Secretary
- Quality assurance program must establish internal performance standards for quality, costs and outcomes improvements and hold ACO providers accountable, including termination

How will ACOs qualify for shared savings?

- Consistent with the overall purpose of the Affordable Care Act, the intent of the Shared Savings Program is to achieve high-quality health care for patients in a cost-effective manner. As part of CMS's goal to provide better care for individuals, defined as "safe, effective, patient-centered, timely, efficient, and equitable," the regulations propose:
  - Measures to assess the quality of care furnished by an ACO;
  - Requirements for data submission by ACOs;
  - Quality performance standards
  - Incorporation of reporting requirements under the Physician Quality Reporting System; and
  - Requirements for public reporting by ACOs.

How will ACOs qualify for shared savings? (cont'd.)

- ACOs that do not meet quality performance thresholds for all measures would not be eligible for shared savings, regardless of how much per capita costs were reduced.

Proposed Quality Measures for ACO Quality Performance Standard

- The Proposed Rule proposes 65 quality measures that must be reported to CMS based on data submitted by ACOs, which must meet applicable performance criteria for all three years. (See pp. 19571–19591 of the April 7, 2011, Federal Register.)
- In year one, an ACO must provide full and accurate measures reporting with respect to all 65 measures.
- In years two and three and thereafter, the quality performance standard will be based on a measures scale with a minimum attainment level described in the Proposed Rule.

Proposed Quality Measures for ACO Quality Performance Standard (cont'd.)

- Measures are divided into five domains:
  - Patient/caregiver experience (7 measures)
  - Care coordination (16 measures)
  - Patient safety (2 measures)
  - Preventative health (9 measures)
  - At-risk population/frail elderly health (31 measures relating to diabetes, heart failure, coronary artery disease, hypertension, chronic obstructive pulmonary disorder and frail elderly)

Impact of Failure to Comply

- Where an ACO fails to meet the minimum attainment level for one or more domains, the ACO would receive a warning and a requirement to reevaluate the following year. If the ACO continues to underperform on the quality performance standard in the following year, the ACO agreement will be terminated.
- If an ACO fails to report one or more measures, a written request would be sent to the ACO requiring the submission of the required data and a reasonable explanation for the delay in reporting. If the ACO continues to fail to report without a reasonable explanation, the ACO agreement will be immediately terminated.

Impact of Failure to Comply (cont'd.)

- ACOs that exhibit a pattern of inaccurate or incomplete recording or failure to make timely corrections following a notice to resubmit may be terminated from the Shared Savings Program and would be disqualified from sharing in savings in each year in which they underperform.
- Measures are expected to evolve over time to include other highly prevalent patient conditions as well as additional measures for hospital-based care and quality measures for care furnished in other settings such as home health services and nursing homes.

Requirements for Quality Measures Data Submission by ACOs

- CMS proposes to make available a CMS-specified data collection tool and a survey tool for the 65 identified measures, although some are already being reported through methods such as the Physician Quality Reporting System, eRx, HITECH program data and Hospital Compare.
- The expectation is that the random sample for measures reported must consist of at least 411 assigned beneficiaries per measures set for each domain.

Requirements for Quality Measures Data Submission by ACOs (cont'd.)

- The government retains the right to validate data entered into the system and to audit for compliance. Failure to report quality measure data accurately, completely and timely or to timely track such data may subject an ACO to termination or other sanctions.
- Assuming compliance with all other requirements, an ACO that obtains the total potential points for all five domains within the quality performance standard will share in 60% of the savings generated under the two-sided model, versus 50% under the one-sided model.

Requirements for Quality Measures Data Submission by ACOs (cont'd.)

- The first year only requires complete and accurate reporting of all quality measures. Thereafter, savings will vary based on an ACO's actual performance on measures as compared with identified benchmarks.

Value-Based Purchasing Program

- On January 13, 2011, the Centers for Medicare and Medicaid Services (CMS) issued a proposed rule to implement a Hospital Value-Based Purchasing Program (VBP Program) as required by section 3001(a) of the Patient Protection and Affordable Care Act (ACA).

- Under the VBP Program, CMS would pay not just for reporting quality data but for a hospital's performance with respect to the data.

Value-Based Purchasing Program

- Under the VBP Program, beginning in FY 2013, CMS will pay acute care inpatient prospective payment system (IPPS) hospitals value-based incentive payments for meeting minimum performance standards for certain quality measures with respect to a performance period designated for each fiscal year.

Value-Based Purchasing Program – A Broad Overview (cont'd)

- Excludes from the definition of "hospital," with respect to a particular fiscal year:
  - a hospital that is subject to certain payment reductions related to the Hospital Inpatient Quality Reporting or IQR program;
  - a hospital cited for deficiencies characterized as posing "immediate jeopardy" to the health and safety of patients; and
  - A hospital not having a minimum number of applicable performance measures or cases for such applicable measures for the performance period in a given fiscal year.

Proposed VBP Program Measures

- For the FY 20130 Hospital VBP Program, CMS proposes to use 17 clinical process-of-care measures as well as eight measures from the Hospital Consumer Assessment of Healthcare Providers and Systems, (HCAHPS) survey that document patients' experience of care.

Clinical Process of Care Measures

- Acute myocardial infarction
- Heart Failure
- Pneumonia
- Healthcare-associated infections
- Surgeries

Survey Measures

- Communication with Nurses
- Communication with Doctors
- Responsiveness of Hospital Staff
- Pain Management
- Communication About Medicines
- Cleanliness and Quietness of Hospital Environment
- Discharge Information
- Overall Rating of Hospital

Other Criteria to be Considered

- Eight Hospital Acquired Condition Measures

- Nine-AHRQ Patient Safety Indicators (PSIs), Inpatient Quality Indicators (IQIs), and Composite Measures

Geisinger Health System

An Integrated Health Service Organization

- Geisinger Medical Center
  - Hospital for Advanced Medicine, Janet Weis Women's & Children's Hospital, Level I & II Trauma Center
- Geisinger Northeast (2 campuses)
  - Geisinger Wyoming Valley Medical Center with Heart Hospital, Henry Cancer Center, Level II Trauma Center
  - South Wilkes-Barre Ambulatory Surgery, Adult & Pediatric Urgent Care, Pain Medicine, Sleep Medicine
- Marworth Alcohol & Chemical Dependency Treatment Center
- 2 outpatient surgery centers
- > 48K admissions/OBS & SORU
- ~820 licensed inpatient beds

- Multispecialty group
- ~860 physician
- ~460 advanced practitioner FTEs
- 62 primary & specialty clinic sites (37 community practice sites)
- 1 outpatient surgery center
- > 2.0 million clinic outpatient visits
- ~350 resident & fellow FTEs

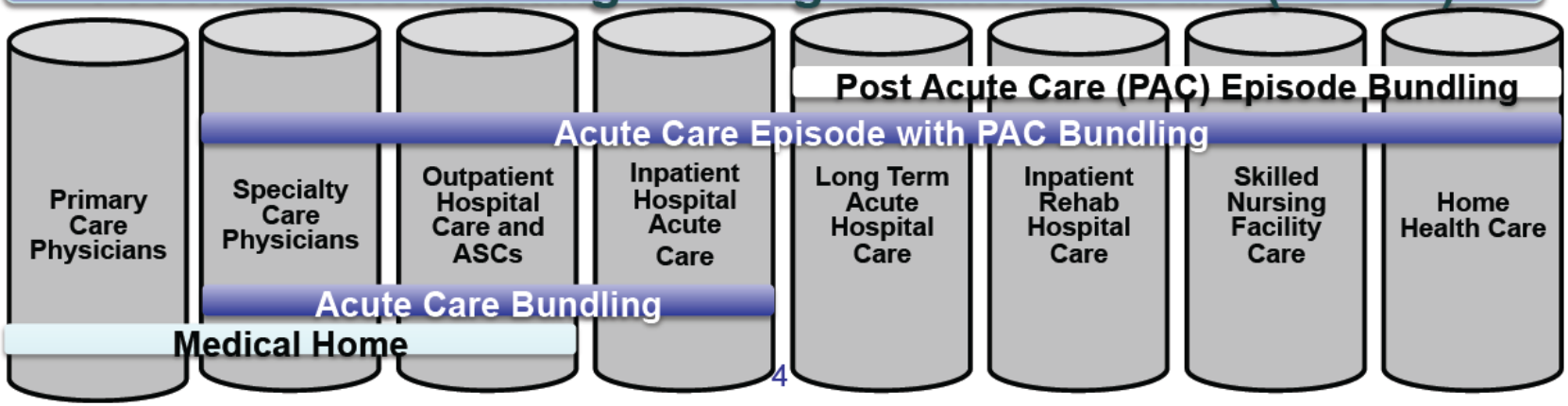
- ~250,000 members (including ~49,000 Medicare Advantage members)
- Diversified products
- >25,000 contracted providers/facilities
- 42 PA counties

PURCHASERS

	2010	2019
Non-Elderly/Elderly Population	267M + 41M = 308M	282M + 52M = 339M
Medicare	13%	15%
Medicaid/CHIP	13%	15%
Employer	49%	47%
Non-Group/Other	9%	7%
Exchange	0	7%
Uninsured	16%	6%

Health Insurance Companies

Providers Rethinking the Organization of Care (ACO's)



ACO Core Principles

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- Total Health/ Primary Care
- Physician Leadership
- Culture and Mission
- Aligned Incentives
- Teams/ Coordination
- Information Technology
- Clinical Guidelines

- Focus on primary care and total health
- Physician leadership
- Aligned culture and mission
- Aligned incentives
- Integration, care coordination, and population management
- Integrated information technology, performance improvement, and reporting
- Clinical guidelines and evidence-based medicine

Collaborative Cardiac Care Service (CCCS) at Kaiser Permanente

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Coordination among:

- Nursing team
- Cardiac rehabilitation program
- Pharmacy team

Patients enrolled in CCCS experienced a reduced incidence of all-cause mortality by 89% and cardiac-related mortality by 88%.

Estimated that 280 emergency interventions are prevented annually.

Breast Cancer Screening at Kaiser Permanente

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Total Health/ Primary Care	Culture and Mission	Teams/ Coordination	Information Technology

- **Comprehensive outreach campaign to reach and screen all women meeting HEDIS age criteria for mammograms not screened in last 18 months**
- **Key Features:**
  - **Information**
  - **Monitoring**
  - **Outreach**
- **Impact:**
  - **2008: KP Southern CA ranked #1 nationally in breast cancer screening by NCQA**
  - **All KP Regions at or near 90th percentile**
  - **Time between screening result and diagnosis decreased from 19 to 9 days**

Health Bones Model of Care at Kaiser Permanente

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Physician Leadership	Culture and Mission	Aligned Incentives	Information Technology	Clinical Guidelines

- **Healthy Bones – Identification, Screening, Treatment for Osteoporosis**
  - **37% reduction in rate of hip fractures, including a 60% reduction in the best-performing medical center.**
  - **If widely adopted across US with 25% reduction in the rate of hip fractures nationally, would prevent 75,000 hip fractures in the US per year.**
  - **Required data to identify and stratify members at risk; Care Manager to provide "just in time" osteoporosis evaluation; access to diagnostic technology; outreach/in-reach system; performance reporting.**

The next horizon - accountable care organizations

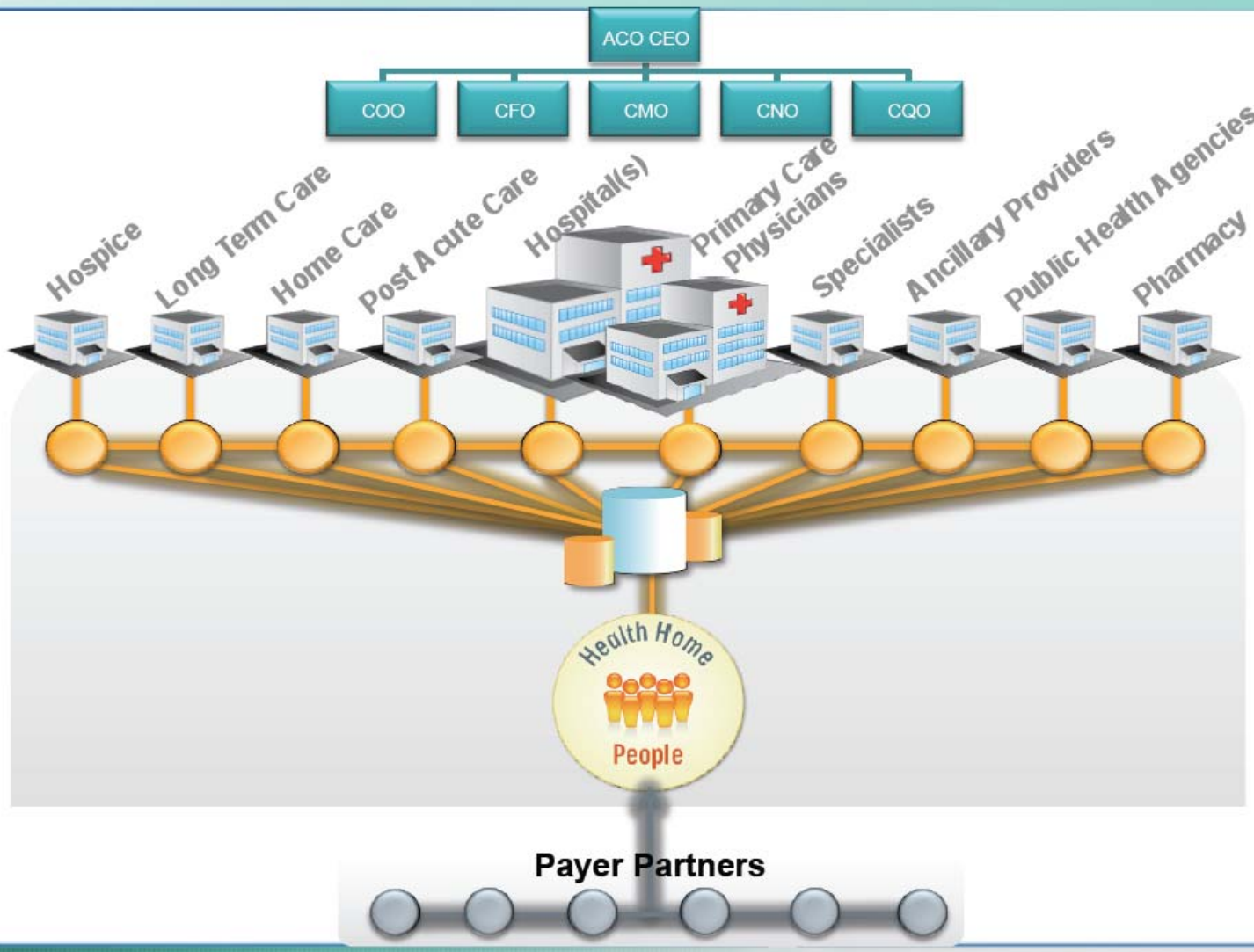
Payer Partners:

- Insurers
- CMS
- Employers

….And legal barriers must be overcome

- In initial contracting, CMS should:
  - Give preference to ACOs already working with providers who can share data, initiate quality improvement and demonstrate patient-centeredness
  - Recognize many different ACO structural models
  - Recognize PAs, nurse practitioners, etc as eligible for bonuses
  - Educate the public, and notify them when they have been assigned to ACOs
  - Allow ACOs to contact people to increase engagement and improve care
  - Allow more than one ACO in an area
  - Leverage existing measures and transparently disclose them from the outset
  - Commit to share data across Parts A, B and D with ACOs in a timely manner
  - Allow multiple payment models (FFS +bonus, global payment, capitation,etc.)
  - Provide a safe harbor from anti-trust, Stark and CMP laws for all CMS ACOs

Complete view of an operational ACO



So, Now What?

- Compliance with these quality performance standards will be mandated in order to remain eligible for the Shared Savings Program and will affect the percentage of savings that can be shared among ACO participants.

- Compliance may also have a direct or indirect impact on provider responsibilities under accreditation standards, doctrine of corporate negligence and related civil liability theories, and DOJ/OIG expectations on board responsibility for delivering quality health care services, which could trigger False Claims Act exposure.

So, Now What? (Cont'd)

- ACOs and participating providers therefore need to incorporate these quality metrics and standards—minimally at the ACO entity level, but possibly at the local provider level as well (e.g., participating hospitals, physician groups, ASCs).
- Standards need to be developed that track the 65 measures, and ensure that they are communicated to providers and then monitored for compliance.
- Providers need to receive periodic reports regarding their individual and comparative performances.

So, Now What? (Cont'd)

- Remedial action plans need to be developed that are designed to assist providers in meeting standards but can include the ability to suspend or terminate participation, at least at the ACO entity level, and possibly at the local provider level.

- Performance results should be taken into consideration at the time of appointment, reappointment and contract renewal, and some internal administrative process/fair hearing for participants who are excluded should be provided.

So, Now What? (Cont'd)

- It is important that an ACO evaluate its processes and procedures, reports, analyses, etc., so as to maximize available confidentiality and immunity protections under state and federal law (e.g., participation in a Patient Safety Organization under Patient Safety Act of 2005).