

Navigate Your Practice: Future of Accountable Care, ACOs & Payment Reform

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State of Healthcare

● Healthcare Reform/ Transformation

- 25% Medicare rate cut averted for 2011 but 29.5% cut pending for 2012
 - 2011 “fix” cost \$18B but 2012/ 2013 “fix” could cost \$54B
- Health Reform Legislation
 - New CBO estimate puts the cost well in excess of \$1.3 trillion over next decade
 - Leverages health IT to improve patient safety, use of the best clinical practices, evidence based medicine as well as wellness and health promotion activities
 - This new Congress to focus on 3-4 areas to reduce spending and create long-term fix

● Focus on Product and Process Breakthrough's

- Mother Teresa's/ Dr. Shetty's Pediatric Surgery Center
 - Open Heart Surgery \$2K vs. \$20K-\$100K in U.S.

● Beginning the Shift to Paying for Reporting & Quality

- Accountable Care Organizations (ACOs) & PCMHs
- Preventive medicine & wellness. Significant shift by 2013

State of ARRA & HITECH Act

● EHR Meaningful Use

- Over \$27B available with no cap. Protected in Medicare Trust Fund
- Criteria well within expectations ~ 14/15 Core Measures & 5/10 Menu
- Incentives are front-loaded so begin as soon as you can
- As of August, over 80,000 care providers registered for Meaningful Use
- Over \$400 Million in incentives paid out to eligible providers already!
 - Over \$2 Million just to Nurse Practitioners under Medicaid

● EHR Certification

- 6 ONC-ATCB Certifying Entities
- CCHIT remains industry gold standard

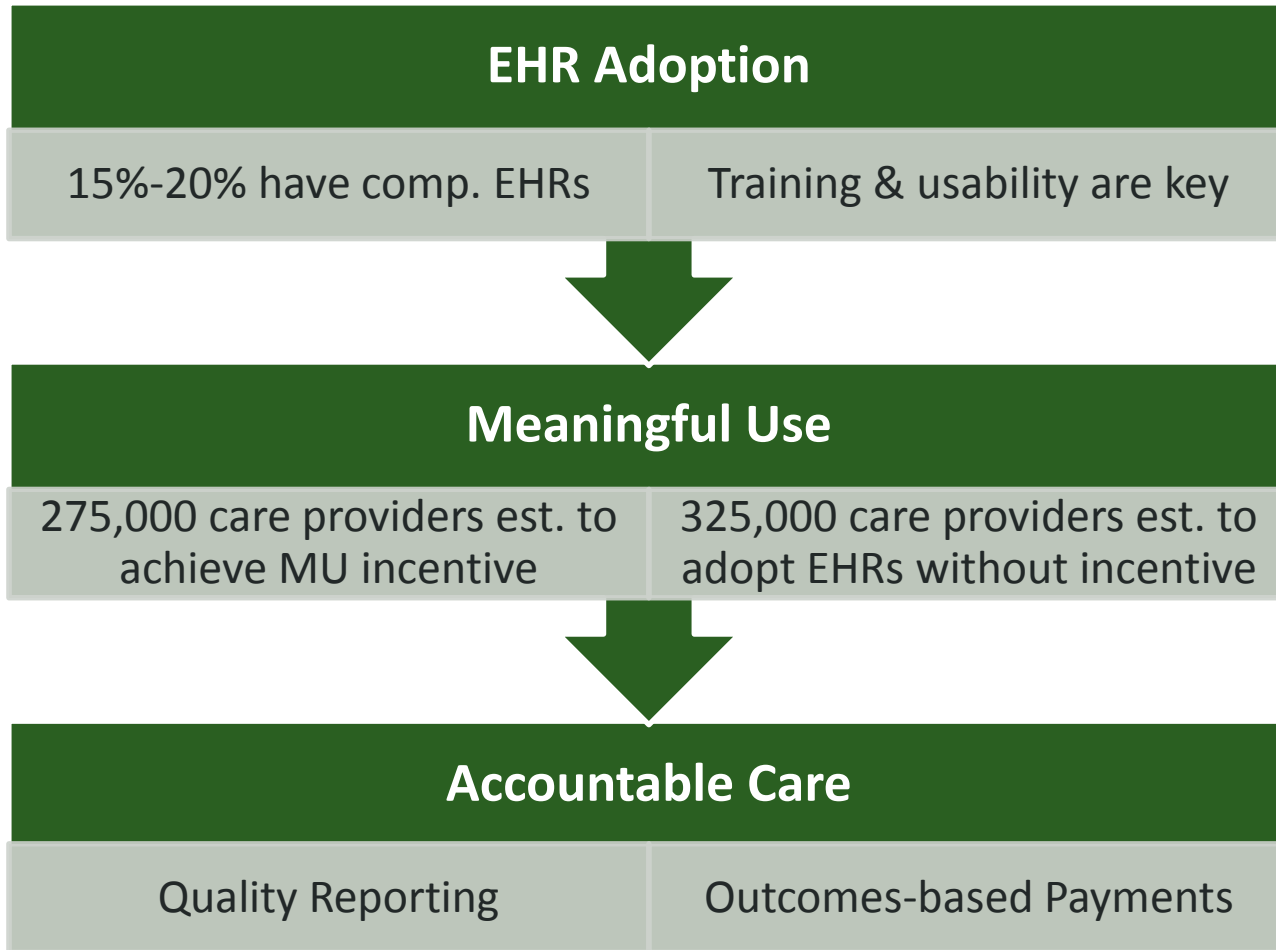
● Regional Extension Centers

- Operations underway at various levels of execution

● Health Information Exchanges

- Operations underway at various levels of operation

The Evolution



...essential building blocks for a sustainable healthcare system

CMS Shared Savings Program to create Accountable Care Organizations

NPRM out 3/31. Final Rule potentially as early as September, 2011

AAFP Study: 34 bills from 19 state legislatures to “define, study, promote or create” ACO projects

- ACOs to begin Jan. 1, 2012
- Voluntary for providers and patients
 - Patients can be assigned retrospectively based on primary care history
- Proposes a minimum of 5,000 patients, 3-year commitment
- Builds on existing Meaningful Use and PQRS programs
- Maintains Medicare Part A and B Fee For Service

Purpose and Goals: Healthcare vs Sick Care

- To harness growing healthcare costs annually approaching \$2.5 trillion
- Targets America's approx. 47 million Medicare patients to advance EHR-driven preventive medicine, care coordination and wellness focusing on each patient's care continuum as a Patient-Centered Medical Home (PCMH) concept
 - Currently 1 in 5 Medicare patients are readmitted within 30 days
 - The majority of Medicare patients suffer from multiple chronic ailments
 - Recent study ~ 1/3 of patients admitted are harmed by our healthcare system

Purpose and Goals: Healthcare vs Sick Care

- The ability to collect and analyze clinical, claims and payer data to enable quality monitoring and reporting
 - ACOs and CMS enter data-sharing agreements
 - Proposal requires that data be available to providers
- Promotes remote monitoring and telehealth also to develop the Patient Centered Medical Home objective
 - Proposal advances the communication of care plans to patients
- Stresses the need for development of Health Information Exchanges (HIEs)
 - Proposal continues the trend of standard data exchange protocols and language

New Updates and Opportunities

Center for Medicare & Medicaid Innovation

- **Pioneer ACO Model**, for existing care coordinating entities across care settings
 - Allows rapid movement from Shared Saving to population-based payment model
 - Allows greater coordination with private payers
 - Offers heightened risk/reward and more flexible payment methods
- **Advance Payment**
 - Initiative to gauge the enrollment gains of pre-payment
 - Based on per-beneficiary model
 - Funds received used to increase care coordination abilities
- **Accelerated Development Learning Program**
 - Executive Leadership sessions
 - Four free seminars in 2011, found at <https://acoregister.rti.org/>

All programs found at <http://innovations.cms.gov/>

Commercial, private ACO Models are underway

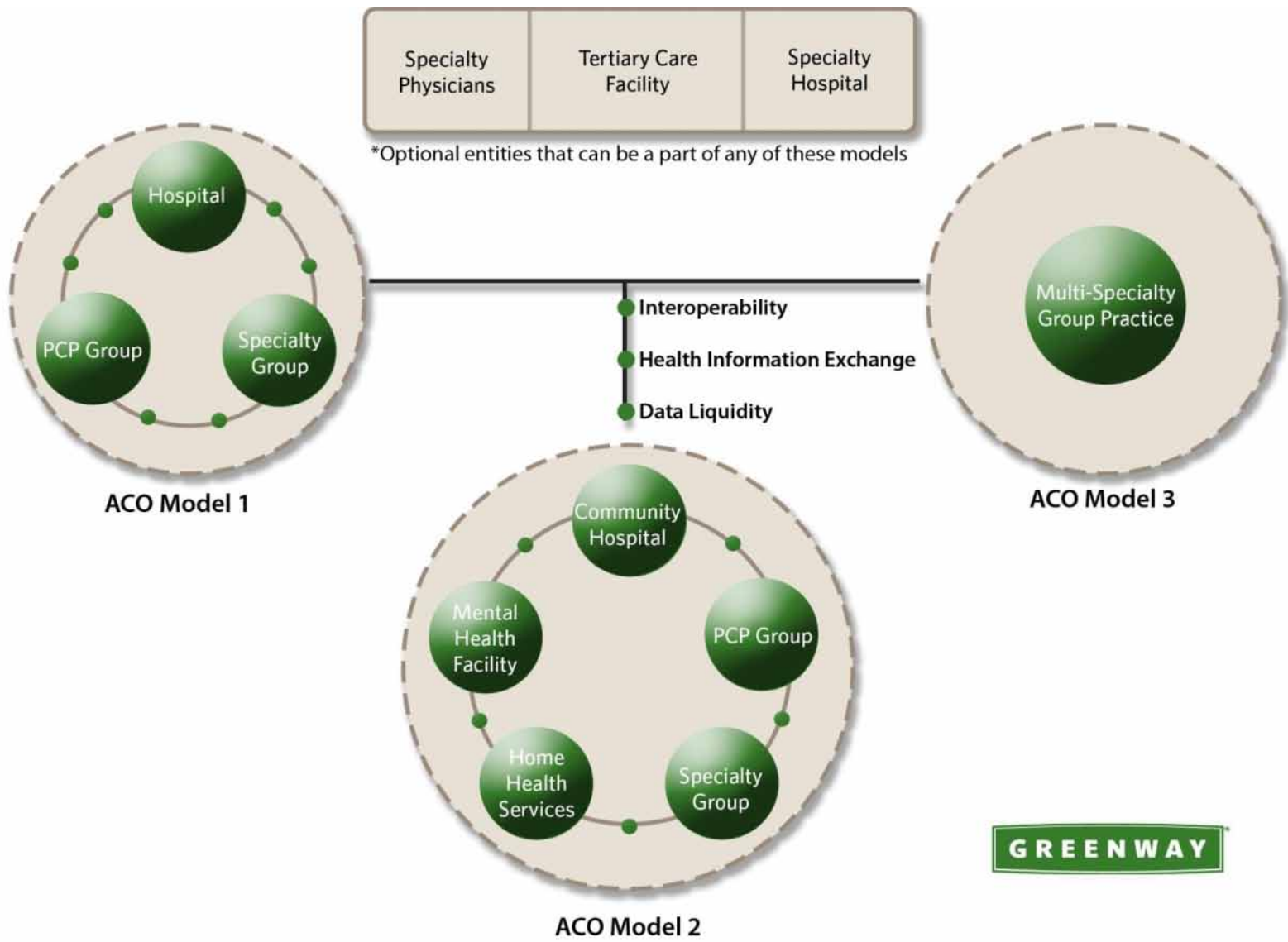
- Advocate Physician Partners and Blue Cross Blue Shield of Illinois
- 5 national pilots through the Engelberg Center for Health Care Reform at Brookings and The Dartmouth Institute for Health Policy and Clinical Practice
 - Norton Healthcare, Louisville, KY
 - Carilion Clinic, Roanoke, VA
 - Tucson Medical Center, Tucson, AZ
 - HealthCare Partners Medical Group, Torrance, CA
 - Monarch HealthCare, Irvine, CA
 - Citizens Health Initiative, Concord, NH
 - Aria Health (18 Healthcare Organizations), Philadelphia, PA

Models of Eligible ACOs

- ACO professionals (physicians, physician assistants, nurse practitioners and clinical nurse specialists) in group practice arrangement
- Networks of individual practices of ACO professionals
- Partnership of joint venture arrangements between hospitals and ACO professionals
- Hospitals employing ACO professionals
- Critical Access Hospitals that bill under Method II

**Provisions also exist to include FQHCs, RHCs*

Community Accountable Care Models



CMS Physician Group Practice (PGP) Demonstration Project

- 10 physician practice models the current Shared Savings Program structure expands upon
- To date, incentive payments of \$29.4M to four practice models, total Medicare savings \$36.2M
- 7 practice models achieved benchmark performance on all 32 measures
- Beginning January 1, 2011, all 10 models expanded to a new two-year PGP Transition Demonstration

Shared Savings Differs from former HMO models

- Providers, not payers, responsible for quality of care and accountability
- ACOs structured to contract with provider organizations, not health plans
- Flexible system of care models, including allowing health plans as entity within an ACO
- Based on Health IT utilization

**Tracking concerns of shifting cost to Consumer, Private Payers*

Alignment with existing MU and PQRS via Quality Measures

- Shared Savings: 65 proposed Quality Measures within 5 Care Categories
- Meaningful Use: 44 current Stage 1 Measures within Core and Menu Criteria
- PQRS: 179 measures in 13 categories

**Currently 26 QMs are shared by ACO and MU criteria;
30 by ACO and PQRS, expanding emphasis on
Standard Data Measures**

Aligned with Meaningful Use

- Proposes that 50 percent of primary care providers be meaningful users of EHRs by the second ACO year
- Proposes the reporting only of Quality Measures in Year One, followed by Attestation of QM Performance in later years
- Allows reporting through EHRs and EHR registries via Group Practice Reporting Option (GPRO) like that of PQRS

Flexibility in NPRM Language

- Proposal alludes to rolling start dates beginning in January 2012
- Allows the removal or addition of providers within a contained ACO year
- Allows for inclusion in multiple ACOs for specialists, hospitals, and other considerations
- For rural communities, consideration for models with less than 5,000 patients

Shared Savings Compensation

- Annual quality measure point system based on annual benchmarking (Per capita Parts A & B FFS expenditures), beginning upon reaching minimum savings rate (MSR). ACOs choose between two risk-based tracks:
- **One-sided Approach:** ACOs eligible for funds and not responsible for losses in first 2 of 3-year commitment, which transitions to Two-sided Approach in year 3 which carries losses below MSR
- **Two-sided Approach:** ACOs eligible for higher percentage of funds, but also responsible for shared losses all 3 years

Design Element	One-Sided Model (performance years 1&2)	Two-sided Model
Maximum sharing rate	52.5 percent	65 percent
Quality scoring	Sharing rate up to 50 percent based on quality performance	Sharing rate up to 60 percent based on quality performance
Minimum savings rate	Varies by population	Flat 2 percent regardless of size
Minimum loss ratio	None	Flat 2 percent regardless of size
Maximum sharing cap	Payment capped at 7.5 percent ACOs benchmark	Savings share once MSR is exceeded; up to 65 percent of gross savings up to cap
Shared Savings	Savings shared once MSR is exceeded; unless exempted, share in savings net of a 2 percent threshold; up to 52.5 percent of net savings up to cap	Savings shared once MSR is exceeded; up to 65 percent of gross savings up to cap
Shared Losses	None	First dollar shared losses once the minimum loss rate is exceeded.

Evolution of Care Coordination

Table 2. Stages of Care Coordination

	Phase 1: Basic	Phase 2: Early Coordination	Phase 3: Strong Coordination
Organizational Structure	<ul style="list-style-type: none"> ▪ Single hospital ▪ Independent physician office 	<ul style="list-style-type: none"> ▪ Hospital system ▪ Physician group ▪ Integrated delivery network (IDN) 	<ul style="list-style-type: none"> ▪ RHIO/HIN ▪ Group model HMO ▪ ACO in the U.S. ▪ National Health System
Financing	<ul style="list-style-type: none"> ▪ Fee for service ▪ Salary 	<ul style="list-style-type: none"> ▪ Discounted fee for service ▪ Episodic payment ▪ Risk pools 	<ul style="list-style-type: none"> ▪ Capitation ▪ Bundled payment ▪ Transaction fees
Functions	<ul style="list-style-type: none"> ▪ Scheduling ▪ Billing 	<ul style="list-style-type: none"> ▪ Patient billing ▪ Claims payment ▪ Business process automation ▪ Case management ▪ Post-acute care 	<ul style="list-style-type: none"> ▪ Disease management ▪ Care coordination ▪ Community-based care ▪ Complexity management ▪ Outcomes tracking
Technologies and Solutions	<ul style="list-style-type: none"> ▪ Paper-based ▪ Stand-alone billing and scheduling 	<ul style="list-style-type: none"> ▪ Financial systems ▪ EHR ▪ ePrescribing ▪ Mobile point of care ▪ Imaging 	<ul style="list-style-type: none"> ▪ Health information exchange (HIE) ▪ Longitudinal health record ▪ Service oriented architecture (SOA) ▪ Telehealth ▪ Secure cloud

Governance, Legal & Organizational Highlights

● Governance

- 75% of governing body must be ACO participants
- One beneficiary patient must reside on governing body
- Must include a clinician-directed QA committee

● Organizational

- ACO application to include written evidence-based medicine plan
- Includes beneficiary care experience survey
- Process for identifying high-risk patients and care plans
- Clinical summary patient communication plan

● Legal

- Market share regulatory and anti-trust exemptions: Less than 30% = safety zone; 50% triggers DOJ/FTC clearance ACO formed as a corporation, LLC, foundation or partnership
- Existing tax exempt organizations can participate



Accountable Care

Accountable for what?

- Electronification / Health IT & EHR Utilization
- Interoperability
- Coordinating Care (with Care Team)
- Best Practices
- Quality Improvement/ Outcomes Improvement
- Patient Education
- Patient Satisfaction
- Cost Containment
- Cost Reduction (to increase Shared Savings)

Managing the Patient...

- **Patient Engagement, Empowerment & Management Strategies**
 - Produce analytics on patient/ consumer population
- **Sample Functionality...**
 - Phone & “text” reminders
 - eMail calendar invites
 - Customized (automatic) patient education materials that incorporate video and “smart” self-help tools
- **Robust Patient “CRM”-type Strategies and Functionality**
 - Analytics comparing and contrasting outcomes & quality reports
 - eMail marketing tools & “smart” patient education materials

What are your Goals?

- Do you have a 3-5 year Operating or Growth Plan?
- If you are approached by a local Accountable Care Plan or ACO...
 - Financial incentives to join ACO?
 - Strategic incentives to join ACO?
 - Will you have access to bi-directional data/ interoperability?
 - What data requirements are they asking of you?
 - Binding? Non-binding?

Payment Reform

- Healthcare financing mechanisms today do not align with the goals of disease prevention, improved health outcomes, and reduced costs.
- Perversions of the concepts of insurance and information technology contribute to the payment misalignment
- Due to the lack of accountability in the current system, lack of available information on which to make responsible care decisions and disengaged stakeholders, we must create a competitive functioning market

Payment Reform

Six Recommendations to Fix the System

- Require and pay for predictive care paths and other evidence based medicine
- Change the basis for paying primary care physicians and expand the role for other professionals
- Increase consumer engagement and personal responsibility, reducing the abuse of the system by consumers
- Reduce fraud and abuse in the system
- Stimulate private insurance competition and provide consumers with greater product options
- Accelerate government's role as 'enabler' not 'architect' of new industry business models

Capitol Hill Engagement



Be part of the conversation

In Congress today....

22 Physicians | 300+ Attorneys

Your Congressperson & Senators want to hear from you

- Educate them on the life of a care provider & small business
- Offer to host a site visit on one of their “district days”
- They should be able to assist with HHS relationships
- They may even ask you to be on a Panel or in a Hearing
- Let us know how we can help

GREENWAY

Additional Resources

Greenway's Government Affairs Updates



EHR Meaningful Use Microsite (www.meaningfuluse-emr.com)

EHR MU Navigation (<http://tiny.cc/vxvd1>)

Gov't Affairs www.greenwaymedical.com/learn-more/govt-industry-affairs

Important Government & HHS Sites



CMS Meaningful Use Page (<http://www.cms.gov/EHRIncentivePrograms>)

HHS Breach Notification Rule (<http://tiny.cc/xytg5>)

HHS Privacy Rule (www.hhs.gov/healthprivacy/)

Agency ACO Sites



Joint CMS and OIG Proposed Rule (<http://tiny.cc/mnghh>)

FTC and DOJ Proposed Antitrust Policy Statement (<http://www.ftc.gov/opp/aco/>)

CMS ACO/ Shared Savings Page (<http://www.cms.gov/sharedsavingsprogram>)

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QUESTIONS OR COMMENTS?



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