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ACOs, Reimbursement and the Revenue Cycle: A Game Changer

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Agenda

- Introduction & Background – *Brian Sherin*
- Reimbursement Issues under the ACO Model – *Greg Everett*
- Operational Issues under the ACO Model - *Jim Hoffman*
- The Provider Perspective – *Paul Marmora*



ACO Introduction & Background



ACO Introduction & Background

Section 3022, **Patient Protection and Affordable Care Act (PPACA)** signed into law in the United States by President Barack Obama – March 23, 2010

MEDICARE SHARED SAVINGS PROGRAM

Concept of Accountable Care Organization (ACO)

- *Not later than January 1, 2012, the Secretary shall establish a shared savings program (in this section referred to as the „program“) that promotes accountability for a patient population and coordinates items and services under parts A and B, and encourages investment in infrastructure and redesigned care processes for high quality and efficient service delivery.*



PPACA

Key Tenets

- “Groups of providers of services and suppliers...work together to manage and coordinate care for Medicare fee-for-service beneficiaries.”
- Eligible to receive payment related to shared savings if specific quality performance standards are met.
- ACOs will be groups of providers of services and suppliers which have established a mechanism for shared governance.
- Includes “ACO professionals” in group practices, networks of individual ACO professional practices, partnerships/joint ventures between hospitals and ACO professionals, hospitals employing ACO professionals and other providers/suppliers as determined by the Secretary

What is an ACO professional?

- Physician: MD, DO
- Practitioner: Physician Assistant, Nurse Practitioner, or Clinical Nurse Specialist
- Hospital: Subsection (d) hospital [SSA1886(d)(1)(B)] – excludes psychiatric, rehabilitation, children’s, long term care, and certain other hospitals



Unknowns and Concerns

“ACO shall be willing to become accountable for the quality, cost, and overall care of the Medicare fee-for-service beneficiaries assigned to it.” (PPACA)

- Vagueness in terminology and understanding. PPACA provides little detail beyond concept.
- Goal is better quality at lower cost, with “savings” being shared among participants.
- Past efforts have not achieved similar goals, namely HMOs.
- Little initial “insurance” risk but it appears that the intent is to eventually shift risk to the providers of care but with a potentially much smaller population than that of HMOs. This may not be feasible for smaller ACOs (minimum beneficiaries of 5,000).



Originating Concepts

- The term “ACO” originated with Dr. Elliott Fisher (Director of Center for Health Policy Research, Dartmouth Medical School) at a MedPAC meeting in November of 2006.
- ACO – “comprising local hospitals and the physicians who work within and around them.”¹ A “locus for shared accountability” for a patient’s health care.
- An extended hospital medical staff: “hospital-associated multi-specialty group practice that is empirically defined by physicians’ direct or indirect referral patterns to a hospital.”¹
- “Virtually all physicians are either directly or indirectly affiliated with a local acute care hospital, whether through their own inpatient work or through the care patterns of the patients they serve.”¹

¹ **Creating Accountable Care Organizations: The Extended Hospital Medical Staff**
Elliott S. Fisher, Douglas O. Staiger, Julie P.W. Bynum and Daniel J. Gottlieb, 2007



Concept Evolving

- Original focus was on an organization that included a hospital.
- PPACA structure does not require a hospital but rather focuses on primary care.
- Jeff Stensland, PhD, Principal Policy Analyst, MedPac
 - *The ACOs can take many forms, but the common element is they have a core group of primary care physicians that serve at least 5,000 fee-for-service Medicare beneficiaries. While an ACO must have these primary care providers, having a hospital or a specialist is optional.*²

² MedPac Meeting Minutes, 9/13/10



Shared Savings and Risk

Shared Savings

- *The basic thrust of an ACO design is to give physicians and possibly a hospital joint responsibility for the quality and cost of care delivered to the population of patients. They get a bonus if they keep cost growth below a fixed dollar target. For example, if the growth in spending target was \$500 per beneficiary per year in an area with an average input cost index, that would mean that the ACO would get a bonus if it keeps quality high and restrains cost growth to less than \$500 per beneficiary per year.*²

² MedPac Meeting Minutes, 9/13/10



Shared Savings and Risk

Risk

- *One important characteristic of Medicare ACOs is that the ACO's patients are still free to use providers outside of the ACO, and if they choose to use a specialist or a hospital that is outside the ACO, the ACO remains responsible for their spending. The net effect of this incentive is to convince the patients -- is that the ACO has an incentive to convince its patients that it's delivering the highest quality care. If the patients don't believe the ACO physicians are providing the best care, they will use physicians outside the ACO and the ACO physicians will then lose their control over the patient's resource use.²*

² MedPac Meeting Minutes, 9/13/10



Shared Savings and Risk

Risk

Possible Alternate Payment Models Under PPACA:

- Partial capitation model in which an ACO is at financial risk for some, but not all, of the items and services covered under parts A and B, such as at risk for some or all physicians' services or all items and services under part B. The Secretary may limit a partial capitation model to highly integrated ACOs.
- Any payment model that the Secretary determines will improve the quality and efficiency of items and services furnished under this title.
 - Models cannot result in additional Program expenditures as compared to payments had the model not been implemented.



Strategy

- Regardless of what the final decision may be, hospitals should be evaluating the potential for an ACO in their current environment.
- Establish a strategy around healthcare reform in general, including an ACO assessment.
 - **Environment:** target market, potential ACOs/competitors (what steps are they taking?)
 - **Potential partners:** PCPs, specialists, ASCs, etc.
 - **IT capabilities:** clinical, financial
 - **Costs/Efficiency:** current, benchmark, opportunities
 - **Quality:** capabilities, outcomes
 - **Culture:** hospital, physicians, community

Reimbursement Issues under the ACO Model



Bundled Payment and ACOs

- What is a bundled payment/Episode of Care?
- ACE program description
- Major private sector Episode of Care players
- Prometheus Payment™ Discussion
- Questions To Ask In Considering A Bundled Payment Scheme
- Summary



Episode of Care Definition

- Multiple Definitions
 - Inpatient Hospital + Physician Services Related to Inpatient Procedure
 - All Hospital Services + All Physician Services Related to Any Procedure Or Condition
 - All Hospital Services + All Physician Services + Ancillary Services to Any Procedure or Condition



Episode of Care Definition continued..

- Common Concepts Defined
 - Diagnosis and/or Procedure Code presence on claims to group claims together
 - Related claims from unrelated claims
 - UB-04 and CMS 1500 Combined Reimbursement
 - Defined Duration for Episodes
 - Look forward and look back periods
 - Varied lengths for medical or procedural episodes



Acute Care Episode (Demo)

- “The Acute Care Episode (ACE) Demonstration will provide global payments for acute care episodes within Medicare fee-for-service (FFS). The focus is on select orthopedic and cardiovascular inpatient procedures.” CMS



ACE Demonstration continued...

- ACE Demonstration goals are to:
 - “Improve quality for FFS Medicare beneficiaries”,
 - “Produce savings for providers, beneficiaries, and Medicare using market-based mechanisms”,
 - “Improve price and quality transparency for improved decision making”,
 - “Increase collaboration among providers.” CMS



ACE Demonstration continued...

- Hospital Systems Involved
 - Baptist Health System in San Antonio
 - Hillcrest Medical Center in Tulsa, OK
 - Oklahoma Heart Hospital, LLC in Oklahoma City
 - Exempla Saint Joseph Hospital in Denver
 - Lovelace Health System in Albuquerque, NM
- Southwest Medicare Administrative Contractor (MAC) was chosen because it believed that it could administer this program



How ACE Works

- Step 1: Hospital “Bids” A Hospital/Physician Combined Fee (usually PHO arrangement)
- Step 2: Hospital Bills normal process for the Procedures That are Part of the Demonstration Project
- Step 3: Physicians who are “appointed” as participating physicians bill CMS and Hospital Entity for procedure
- Step 4: Fiscal Intermediary ignores physicians’ claims
- Step 5: Fiscal Intermediary pays hospital or hospital entity “Bundled Fee”



How Ace Works continued...

- Step 6: Hospital pays physicians
- Step 7: CMS pays beneficiary up to 50% of shared savings
- Step 8: Hospital pays physician pro rata “gain sharing” bonus up to 25% of opportunity

- Results: Still too early.



Major Players



Thompson Reuters

- Medical Episode Grouper (MEG)®
 - 555 disease categories
 - Enables researchers to analyze patient treatments, evaluate quality of care, and manage associated costs. It does so by grouping inpatient, outpatient, and pharmaceutical claims into clinically homogeneous units of analysis called episodes.
 - Each episode describes a patient's complete course of treatment for a single illness or condition.
 - Usually integrated with MedStat product.
 - Not yet a reimbursement system.



Ingenix Symmetry

- Symmetry Episode Treatment Groups® (ETGs®)
 - A condition classification of nearly 600 clinical groups and episode building methodology.
 - Combines ambulatory, inpatient, and pharmacy claims to build a complete treatment episode for a patient.
 - Case mix adjustments account for differences in patient severity, including variations in patient age, complicating conditions, comorbidities, and major surgeries.
 - Not yet a reimbursement system.



Prometheus Payment™ Model

- Model attempts to segregate technical risk (care) from probability risk
- Risk Adjusted Model For Each Patient
 - Significant increase in reimbursement for risk factors for each patient
- “Budgets” created for individual conditions procedures through Evidence Informed Case Rates (ECRs)™
- An ECR is a condition such as diabetes or a procedure such as a knee replacement



Prometheus Model continued...

- All care (inpatient/outpatient, hospital/physician/ancillary, pharmacy) related to an ECR™ is considered.
- ECRs™ are broken down into Typical Care and PACs™ (Potentially Avoidable Complications)
- Goal is to reduce PACs™.
 - Prometheus analysis shows that 40% to 60% of the cost of diabetes is unnecessary.



How Prometheus works

- Step 1: Obtain 2 years of Health Data
- Step 2: Choose ECRs to Model - Chronic
- Step 3: Determine risk factors from prior claims
- Step 4: Create Budgets for each ECR for each patients in the new plan year.
- Step 5: Accumulate claim charges and allowed amounts in the model.
- Step 6: Care is defined as Typical or PACs



How Prometheus Works continued...

- Step 7: 3 year Phased Approach
 - 1st year - create only upside bonus opportunity – no downside for providers. Learning year.
 - 2nd year – create goals to reduce PACS that has some withhold
 - 3rd year – reimburse based on budgets. Full impact of PAC elimination in payment realized.
- Step 8: Reconciliation of budgets to quality care measures



Episode Groupers and CMS

- CMS has awarded grants for companies to create an Episode Grouper by Jan. 1, 2012
 - 3M
 - Thomson Reuters
 - Lewin Group – Ingenix
 - Brandeis University – Prometheus Payment Inc.™



Discussion on ACOs

Some Questions To Ask
Organizations Considering ACOs
and Incorporating A Bundled
Payment Scheme



ACOs and Bundled Payment

- Will bundled payment schemes help providers work together to manage and coordinate care for Medicare beneficiaries more effectively within an ACO?
- Will bundled payment schemes help ACOs focus on quality performance standards in order to eligible to receive additional Medicare payments?
- Does a bundled payment scheme create better accountability for care?



ACOs and Bundled Payment

- Does a bundled payment scheme help providers migrate from volume of care to efficiency of care: margins vs. top line revenue?



ACOs Summary

- Episode of care will likely be a significant reimbursement scheme in ACOs for certain procedures or conditions.
 - Fee for service isn't working for the government, payers, or employers.
 - Outcome measurement can be more effectively tied to an episode than transactions alone.
 - Primarily, procedures (surgeries) will be paid using an Episode scheme because care can be coordinated more efficiently.



Operational Issues Under the ACO Model



Regulatory Requirements - Financial

- Manage the receipt and distribution of shared-savings payments
- Calculate the expected shared saving amount
- Validate ACO cost benchmarks



Regulatory Requirements - IT

- Facilitate patient and caregiver assessments
- Provide reports to CMS regarding participating ACO professionals
- Provide reports to CMS to assist in the assignment of patients to the ACO
- Track beneficiaries assigned to the ACO



Regulatory Requirements - Clinical

- Facilitate the use of individualized care plans
- Track and report on:
 - clinical processes and outcomes
 - quality and cost measures
- Demonstrate that the ACO has not attempted to avoid at-risk patients
- Promote patient-centeredness



Track and Report on Clinical Processes, Outcomes, Quality and Cost Measures

- 65 measures across five domains proposed for the first year performance period – expected to change over time
- The overall score on the reported quality measures drives the level of shared savings
- The first year requirement is reporting-only
- Detailed specifications not yet available – will be available before the start of the program on the CMS website
- Data submitted via claims, GPRO tool and surveys



Track and Report on Clinical Processes, Outcomes, Quality and Cost Measures

- Each measure is scored on a sliding scale from 30th to 90th+ percentile of Medicare FFS or MA. If the score on a measure is under 30th percentile, that measure is not achieved. All measures must achieve at least the 30th percentile for the ACO to qualify for shared savings starting in year two.
- All scores are weighted equally. The sum of the points scored on the measures divided by the total possible points is the quality percentage achieved.
- If all quality criteria are not met, the ACO is not eligible for shared savings regardless of any cost reductions. If even one measure is not achieved starting in the second year, the ACO is not eligible for shared savings in that year and is given a warning. A second year of non-achievement will result in termination.
- Some measures are all or nothing (e.g. diabetes and coronary care composite measures)



Track and Report on Clinical Processes, Outcomes, Quality and Cost Measures

- The existing GPRO data collection tool will be refined and “built out.” CMS will provide the ACO with a pre-populated database of sample beneficiaries for which the ACO would provide the remaining information to calculate the measure. The sample will consist of at least 411 assigned beneficiaries per domain (or 100% of the applicable beneficiaries if fewer than 411). This new tool will be designed to integrate with EHRs to ease the administrative burden.
- Failure to report accurate measures in a timely manner may lead to termination of the ACO agreement
- 50% of the ACO’s primary care physicians must be HITECH “meaningful EHR users” by the start of the second year of the ACO agreement.
- CMS is committed to aligning measures, where possible, across various CMS programs on a go-forward basis



Calculate and Validate ACO Cost Benchmarks

- Benchmarks will be calculated based on the beneficiaries that would have been assigned to the ACO participants in the most recently available 3 years of data
- Benchmark data will be risk-adjusted by the CMS-HCC risk model and trended for cost increases
- The more recent years in the benchmark data set are weighted more heavily
- Benchmark will be adjusted by the “projected absolute amount of growth in national per capita expenditures” for each year in the agreement
- Benchmark cases will not be changed during the ACO agreement period, so actual and benchmark populations will likely diverge
- CMS will provide beneficiary identifying data and aggregate information for benchmark beneficiaries, but it’s unclear whether enough detail will be provided to recreate the benchmark calculations



Calculate the Expected Shared Savings Amount

Two Shared Savings Models Being Proposed:

One-Sided: Shared Savings
Converts to Two-Sided model after 2 years

Two-Sided: Shared Savings / Loss
Greater Upside Potential

25 % of shared savings will be withheld against future shared losses and as an incentive to complete the 3 year obligation – forfeited if the agreement is terminated. Otherwise, paid at end of the three year agreement.



Calculate the Expected Shared Savings Amount

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
FQHC/RHC Participation Incentives	Up to 2.5 percentage points	Up to 5 percentage points
Minimum Savings Rate	Varies by ACO population (2% to 3.9%)	Flat 2 % regardless of Size



Calculate the Expected Shared Savings Amount

Design Element	One-Sided Model (performance years 1 & 2)	Two-Sided Model
Minimum Loss Rate	N/A	Flat 2 percent regardless of size
Maximum Sharing Cap	Payment capped at 7.5% of benchmark	Payments capped at 10% of benchmark
Shared Savings	Savings shared once MSR is exceeded; unless exempted, share in savings net of a 2 percent threshold	Savings shared once MSR is exceeded
Shared Losses	None	First dollar shared losses once the minimum loss rate is exceeded. Cap on the amount of losses to be shared phased in over three years: starting 5% / 7.5% / 10% years 1 / 2 / 3



Manage the Receipt and Distribution of Shared Savings Payments

- No guidance as to how the money should be distributed – this appears to be an administrative option within the ACO
- No mention as to whether an ACO may share any of the savings with beneficiaries
- The ACO's application must indicate how the shared savings will be used
- Payment requires a written request with certification that the ACO has adhered to all guidelines and requirements of the program



Provide Reports to CMS Regarding Participating ACO Professionals

- Report all TINs and NPIs at time of application and update on an annual basis
- ACO participants may not be added during the 3 year period
- ACO participants may be removed. This requires notice to CMS within 30 days and may trigger
 - The need for a new ACO application
 - An antitrust review
 - Termination of the ACO agreement
- Primary care physicians may belong to only a single ACO
- Specialists and facilities such as RHCs and FQHCs are able to participate in multiple ACOs, but must be committed to the 3 year agreement of each one



Provide Reports to CMS to Assist in the Assignment of Patients to the ACO

- Assignment will be based on primary care services furnished by primary care physicians (internal medicine, general practice, family practice, and geriatric medicine)
- Beneficiaries will be assigned based on the primary care physician that provided the plurality of primary care services based on allowed charges for a specific list of HCPCS codes
- CMS refers to assignment as “alignment” - doesn’t want to give the impression that free choice of providers is affected



Provide Reports to CMS to Assist in the Assignment of Patients to the ACO

- Assignment is retrospective for accuracy of calculations and to create incentives to treat all patients equally
- Beneficiaries will receive communications from CMS related to the Shared Savings Program in general, their potential assignment to an ACO and the possible use of their data
- ACOs will be required to post signs in the facilities of participating ACO providers/suppliers indicating their participation in the Shared Savings Program and to make available standardized written information to the Medicare FFS beneficiaries they serve
- Assigned ACO beneficiaries must be notified by the ACO if the ACO terminates its agreement with CMS



Demonstrate that the ACO has not Attempted to Avoid At-risk Patients

What is an at-risk patient?

- has high risk score on the CMS-HCC risk adjustment model
- has two or more hospitalizations or emergency room visits each year
- is dually eligible for Medicare and Medicaid
- has a high utilization pattern
- has one or more chronic conditions (diabetes, heart failure, coronary artery disease, chronic obstructive pulmonary disease, depression, dementia, end stage renal disease as examples)
- have a recent diagnosis (for example, newly diagnosed cancer) that is expected to result in an increased cost

CMS will attempt to identify avoidance of at-risk patients through claims analysis, reviews of surveys, audits of medical records and investigations of patient complaints.



Promote Patient-Centeredness

- Frequent reminders that ACO beneficiaries have freedom of choice among Medicare providers, regardless of the provider's association with an ACO
- Establish process to communicate clinical knowledge to beneficiaries in an understandable way
- Requirement to have an ACO beneficiary (with no conflict of interest) on the ACO's governing body
- Adhere to strict guidelines for marketing and patient communications
- Communication of ACO activities, data usage and data opt-out process to beneficiaries
- CMS is requiring the use of the Clinician and Group CAHPS survey from AHRQ



Track Beneficiaries Assigned to the ACO

- Assignment to an ACO will be retrospective, but limited demographic data on likely ACO beneficiaries will be provided at the start of an ACO's first year
- As performance is calculated, aggregate data will be provided along with metrics and utilization data
- CMS will provide quarterly reports of aggregated data for potentially assigned beneficiaries, and make claims data available monthly in a standardized data set
- CMS assumes that ACOs will have an integrated Electronic Health Record for use in clinical decision support efforts
- Part D data will be released to an ACO upon request



Public Reporting Requirements

- Based on a standardized form to be made available in later guidance
- Required reporting elements:
 - Name and location
 - Primary contact
 - ACO participants
 - Identification of the ACO participant representatives on its governing body
 - Committees and committee leadership
 - Quality performance standard scores
 - Shared savings performance payment received by the ACO or shared losses payable to CMS
 - Description of the uses of the shared savings, including the proportion distributed among ACO participants.



Application Requirements

- Evidence that the ACO is recognized as a legal entity in the state in which it was established and that it is authorized to conduct business in each state in which it operates
- A description of the ACO's governing body, including beneficiary representation
- Organizational chart, including a list of committees (including names of board committee members)
- ACO documents (for example, participation agreements, employment contracts and operating policies)
- Documents that describe the scope and scale of the ACO's quality assurance and clinical integration programs



Application Requirements (continued)

- Evidence that the ACO has a board-certified physician as its medical director
- Evidence that the governing body includes persons who represent the ACO participants, and that these ACO participants hold at least 75 percent control of the governing body
- Certification from an ACO executive that the ACO participants are willing to become accountable for, and to report to CMS on, the quality, cost, and overall care of the Medicare FFS beneficiaries assigned to the ACO
- An indication of how potential shared savings would be used to promote accountability for the ACO's Medicare population and the coordination of their care as well as how they might be invested in infrastructure and redesigned care processes for high quality and efficient health care service delivery



Application Requirements (continued)

- The criteria the ACO plans to employ for distributing shared savings among ACO participants and ACO providers/suppliers
- A description of plans to (1) promote evidence-based medicine; (2) promote beneficiary engagement; (3) report internally on quality and cost metrics; and (4) coordinate care.
- A sample of the beneficiary experience of care survey in place and a description of how the ACO will use the results to improve care over time
- A copy of the written standards for beneficiary access and communication
- A description of the ACO's process for beneficiaries to access their medical record



Application Requirements (continued)

- A description of how the ACO will use patient survey results to improve care over time
- A description of the process for evaluating the health needs of the ACO's Medicare population, including consideration of diversity, and a plan to address the needs of the ACO's Medicare population
- A sample individualized care program, along with an explanation of how this program is used to promote improved outcomes
- A description of the target populations that would benefit from individualized care plans
- A description of how the ACO will partner with community stakeholders



Application Requirements (continued)

- Job descriptions for senior administrative and clinical leaders
- An appropriate plan describing how the ACO will repay any shared losses
- An antitrust review letter, depending on the ACO's market conditions
- Lists of ACO participant TINs and NPIs
- Optionally, a request for beneficiary data that would be used in the creation of shared savings benchmarks.



Other Points of Interest

- CMS expects the formation of 75-150 ACOs serving up to 5 million beneficiaries
- The GAO estimates approximately \$1.75M in first year operating expenditures for an ACO
- New CMS ACO Website: <http://www.cms.gov/sharedsavingsprogram/>
- Important documents related to the ACO Proposed Regulations (available at the URL above):
 - Joint CMS / OIG notice: “Medicare Program; Waiver Designs in Connection with the Medicare Shared Savings Program and the Innovation Center.”
 - IRS Notice 2011-20, requesting comments regarding the need for guidance on participation by tax-exempt organizations in the Medicare Shared Savings Program through ACOs.
 - A joint FTC and DOJ Proposed Statement of Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program (Antitrust Policy Statement).
- CMS strongly encourages comments throughout the proposed regulations





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