

Development of Accountable Care Organizations (ACOs) and Other Changes in Government Program Reimbursement Under Health Care Reform: What is your Hospital's Response?

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Jill Gordon, Esq.
213.633.6800
jillgordon@dwt.com

Kenneth Yood, Esq.
310.228.3708
kyood@sheppardmullin.com

Adam Romney, Esq.
213.633.6800
adamromney@dwt.com

Overview

- **PPACA New payment methodologies**
- **Value-Based Purchasing**
- **Bundled Payments**
- **ACOs and Other Alignment Strategies**
- **How to get from here to there**

Patient Protection and Affordable Care Act

Goals:

- Provide meaningful insurance coverage to approximately 32 million people
- Improve quality of care
- Reduce medical errors
- Create savings in federal healthcare expenditures
- “Bend” the cost curve

System Reform & Outcomes-Focused Medicine

Areas of primary focus:

- Increased importance of primary care
- Overall care coordination among providers/institutions
 - Movement towards clinical integration among providers
 - Establishment of a “medical home”
 - Establishment of accountable care organizations
- Use and further increased use of information technology for sharing of “best practices” and achievement of quality metrics

System Reform & Outcomes-Focused Medicine (con't)

Areas of primary focus:

- Risk-based payment to providers
 - Bundled payments
 - Shared savings
- New Payments
 - Primary care services
 - Preventive services
 - Initiatives
- New Payment Penalties
 - Quality reporting
 - Hospital acquired conditions
 - Hospital readmissions
- Value-Based Purchasing
- State experiments with payment reform

New Payments, Initiatives and Penalties

New payments

- Expanded payments for primary care services under Medicare and Medicaid
- Expanded Medicare coverage of preventive care services

New funding for payment-related initiatives

New Payment Penalties

- Hospital acquired conditions (“HACs”)
- Preventable readmissions

New Payments

New Primary Care Reimbursement:

- Medicaid payment rates to primary care physicians providing primary care services can be no less than 100% of Medicare Part B payment rates for 2013 and 2014
 - Federal government assumes 100% of the costs incurred by states to meet this requirement
 - A five-year, 5% Medicare bonus payment for select evaluation and management codes furnished by physicians and other primary care providers beginning on January 1, 2011
 - Bonus is 10% for providers in HPSAs
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New Payments

Preventive Care Services:

- New Medicare Physician Fee Schedule payments for personalized preventive services
 - Covered services include a health risk assessment entailing:
 - Update of individual and family medical history
 - Measurement of height, weight, BMI, blood pressure and other routine measurements
 - Detection of cognitive impairments
 - Establishment of a screening schedule
 - Advice and referrals regarding weight loss, physical activity, smoking cessation, fall prevention and nutrition
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New Payments

New Funding for Initiatives:

- Center for Medicare and Medicaid Innovation
- Comparative Effectiveness Research a.k.a. Patient Centered Outcomes Research
- Prevention and Wellness Trust Fund

New Payment Penalties

Quality Reporting:

- Beginning in 2014, LTCH, Rehab and Hospice entities not meeting quality reporting requirements will be penalized with 2% reductions in market basket updates
- Quality measures will be determined by HHS in 2012
- Quality measures must be endorsed by a consensus-based entity such as the National Quality Forum

New Payment Penalties

Hospital Acquired Conditions – “HACs”:

- Beginning in 2015, CMS will impose a 1% penalty on all discharges for hospitals in the top quartile for hospital-acquired conditions
- “Hospital acquired conditions” are those defined at 42 U.S.C. 1395ww(d)(4)(D)(iv) and others to be identified by HHS.
- HAC penalties will apply to Medicaid hospital admissions as well.

New Payment Penalties

Hospital Acquired Conditions – “HACs” (cont.):

- All hospitals will be subject to HAC penalties, except:
 - Psychiatric hospitals
 - Rehabilitation hospitals
 - Children’s hospitals
 - LTCHs
 - Hospitals participating in demonstration projects
- HHS will study expansion to inpatient rehab, LTCHs, outpatient departments, SNFs, ASCs and clinics.

New Payment Penalties

Preventable Readmissions:

- Effective October 1, 2012, payments for all DRGs to hospitals are reduced to account for “excess, preventable readmissions.”
- Reduction is limited to 1%, 2% and 3% in initial years.
- Defining applicable “readmissions”
 - Will be based on National Quality Forum endorsed measures
 - Will exclude readmissions unrelated to prior discharge
 - Readmissions time window to be specified by HHS (30 days?)
 - Initially applies only to heart attack, heart failure and pneumonia

Value-Based Purchasing

Patient Protection and Affordable Care Act:

- PPACA states that “the Secretary shall establish a hospital value-based purchasing program...under which value-based incentives are made in a fiscal year to hospitals that meet the performance standards.”
- Value-based purchasing provisions do not go into effect until fiscal year 2013.
- However, payment adjustments will be based upon performance periods that begin on July 1, 2011.

Value-Based Purchasing

- Final regulations were available on the internet on April 29, 2011 and are to be formally published in the Federal Register on May 6, 2011.
- Hospitals will receive reimbursement incentives for either achieving a baseline performance score or for achieving a specific level of improvement relative to their baseline score
- Funding is based on DRG payment withholds which began at 1% for fiscal year 2013 and ramp up to 2% by fiscal year 2017

Value-Based Purchasing: Covered Conditions

- The clinical measures used for incentive payments made during the fiscal year 2013 must cover at least the following conditions and procedures:
 - Clinical Process of Care Measures:
 - Acute myocardial infarction
 - Heart failure
 - Pneumonia
 - Surgical care improvement
 - Healthcare-associated infections
 - Patient Experience of Care Measures
 - HCAHPS—Hospital Consumer Assessment of Healthcare Providers and Systems Survey.

Value-Based Purchasing: Quality Measures

- The quality measures CMS proposes to use for the FY 2013 hospital value-based purchasing program include:
 - Two measures for heart attack care,
 - One measure for heart failure care,
 - Two measures for pneumonia care,
 - Seven measures for surgical care.
 - Four of the surgical care measures fulfill the ACA requirement that the VBP program include healthcare-associated infection measures.
- In addition, there is one patient experience of care measure:
 - HCAHPS—Hospital Consumer Assessment of Healthcare Providers and Systems Survey
- CMS also proposes to adopt three mortality outcome measures, eight Hospital Acquired Condition measures, and nine Agency for Healthcare Research and Quality measures for the FY 2014 Hospital VBP program.

Value-Based Purchasing: Quality Measures

- The 12 clinical process of care measures for FY 2013 include:
 - Acute myocardial infarction: Aspirin prescribed at discharge; Primary PCI received within 90 minutes of hospital arrival.
 - Healthcare-associated infections: Prophylactic antibiotic received within one hour prior to surgical incision; Prophylactic antibiotics discontinued within 24 hours after surgery end time.
- The measures for FY 2014 include:
 - Mortality Measures: acute myocardial infarction; heart failure; pneumonia.
 - Inpatient quality indicators.
 - Hospital Acquired Condition Measures:
 - Foreign object retained after surgery.
 - Air embolism.
 - Blood incompatibility.
 - Pressure ulcers.
 - Falls and trauma.

Value-Based Purchasing: Performance Standards

- CMS proposes that performance standards for each clinical process-of-care measure and HCAHPS should be based on how well hospitals performed on the measure during the same three quarters in the baseline period (July 1, 2009 through March 31, 2010).
- For the clinical process-of-care measures, the achievement performance standard (achievement threshold) for each proposed measure will be the median of hospital performance (50th percentile) during the proposed baseline period, while the improvement performance standard will be set at each specific hospital's performance on the measure during the proposed baseline period.

Value Based Purchasing: Scoring Methods

- CMS proposes to score each hospital on relative achievement and improvement ranges for each applicable measure.
- A hospital's performance on each quality measure would be evaluated based on the higher of an achievement score in the performance period or an improvement score, which is determined by comparing the hospital's score in the performance period with its score during a baseline period of performance.
- CMS would calculate a Total Performance Score for each hospital by combining the scores for the clinical process of care and the HCAHPS domains. Scores on all of the measures within each domain would be multiplied by the proposed weight.

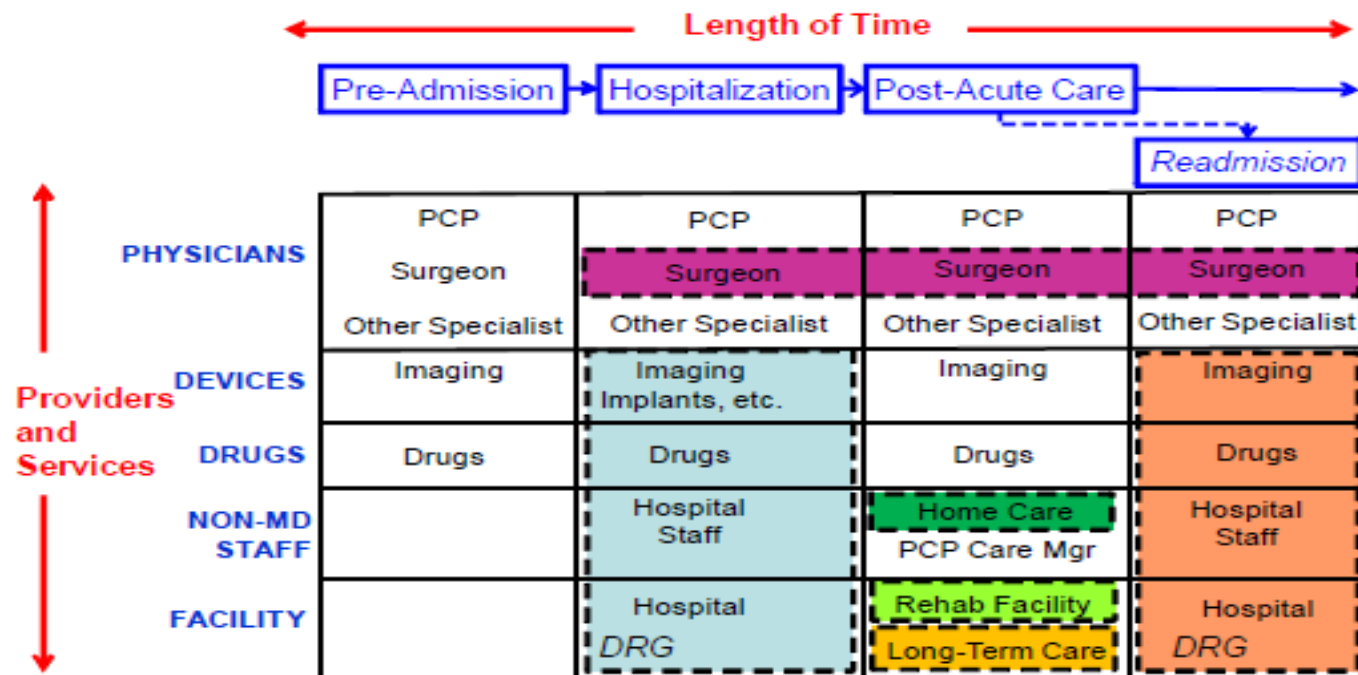
Value Based Purchasing: Incentive Payment

- For a hospital that meets or exceeds the performance standards for a fiscal year, CMS will increase the base operating DRG payment amount, as determined after application of a payment adjustment for a hospital, for each discharge occurring in the fiscal year by the value-based incentive payment amount.
- Each hospital has a value-based incentive payment percentage for each fiscal year as set by CMS.
 - The value-based incentive payment percentage will be specified by the Secretary based on a hospital's performance score for the fiscal year, with a goal of ensuring that the
 - total amount of value-based incentive payments made to all hospitals in a fiscal year will equal the total amount available for such payments for such fiscal year as estimated by the Secretary.

Bundled payments: What Are They?

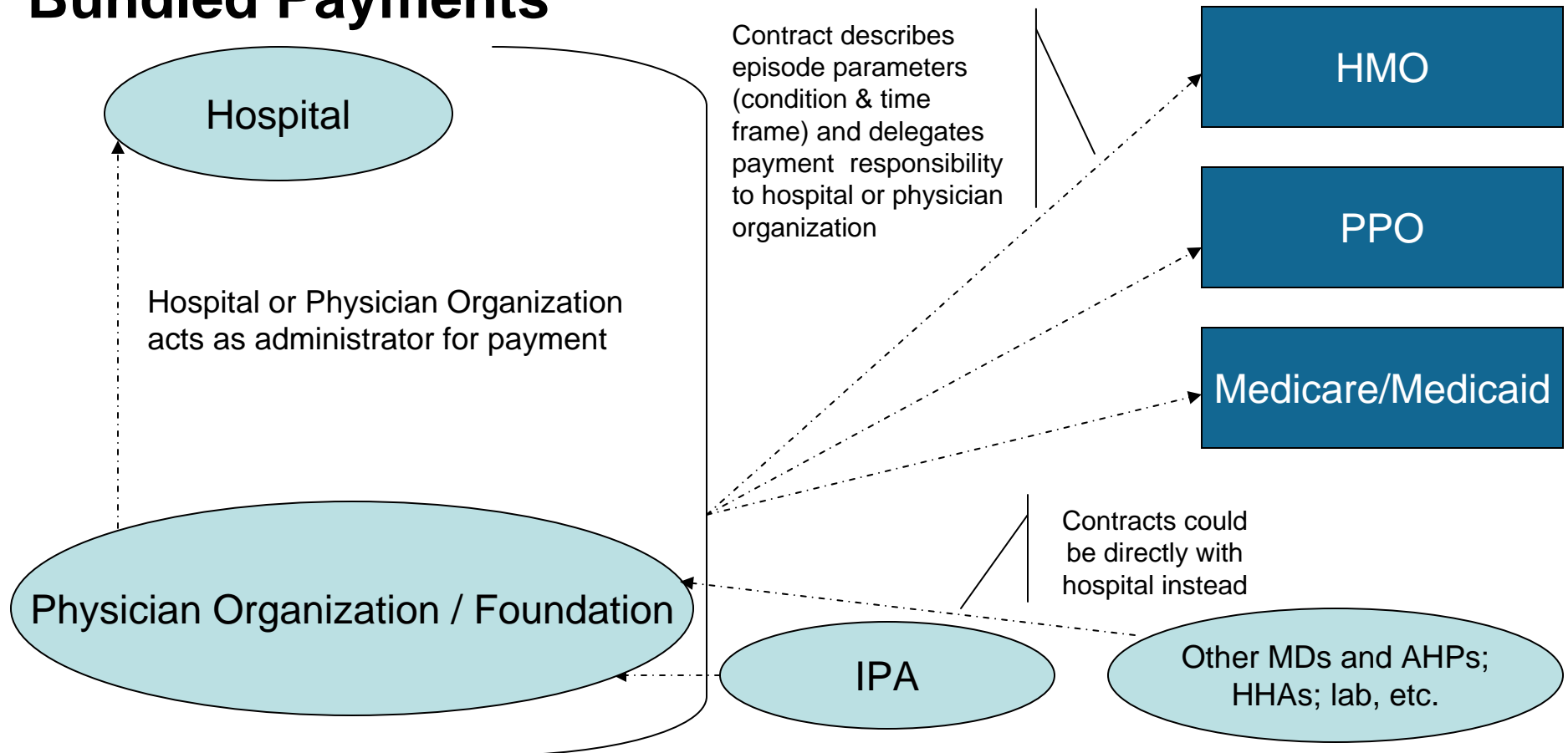
- A single prospective price for all services needed by the patient over an episode of care
- Defined on parameters of time and services

Potential Elements of an Episode Payment for Major Acute Care, including Components Already Paid on an Episode/Case Rate Basis

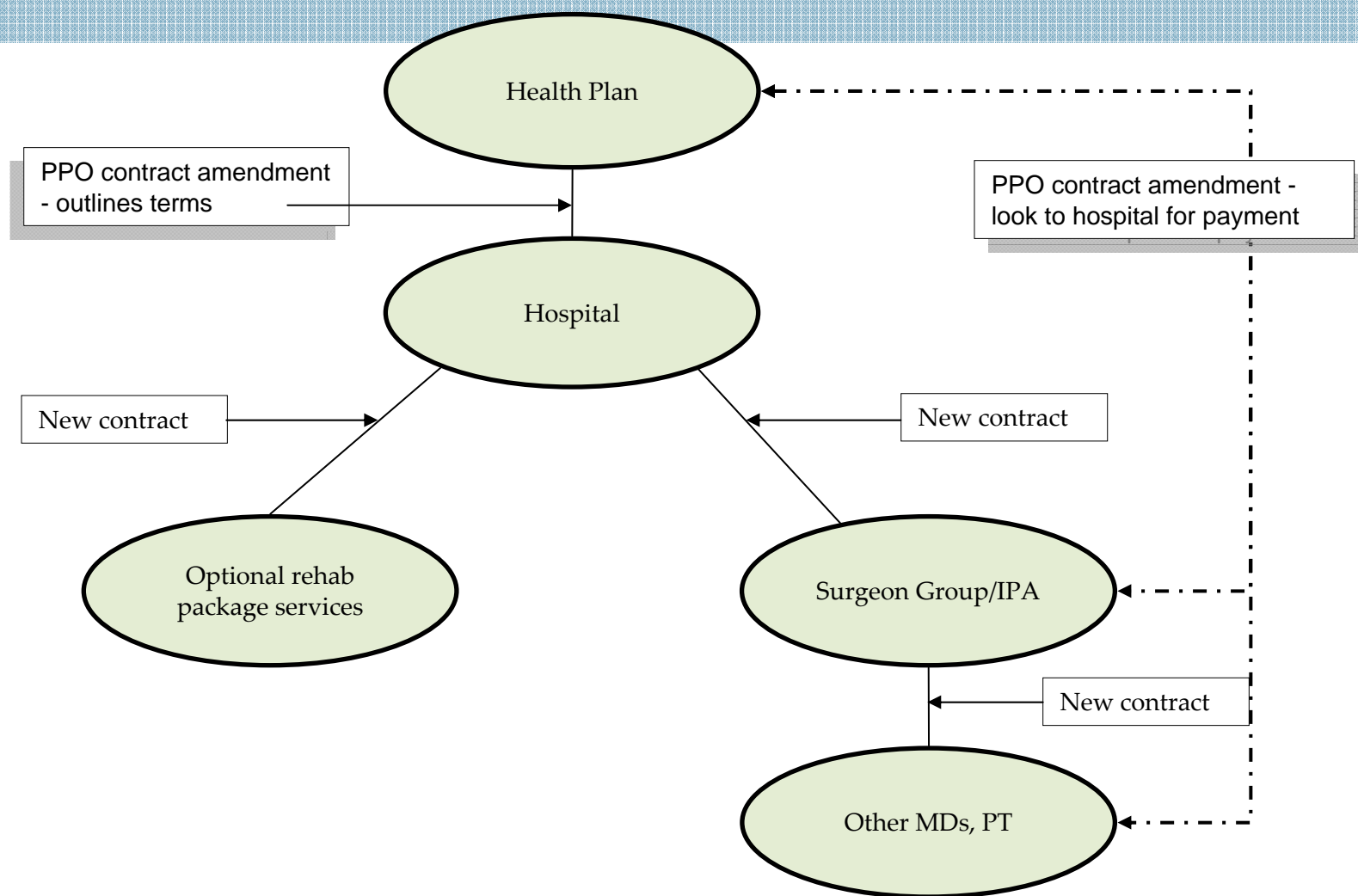


New Payment Methodologies – Bundled Payments

Bundled Payments



Bundled Payments – a closer view

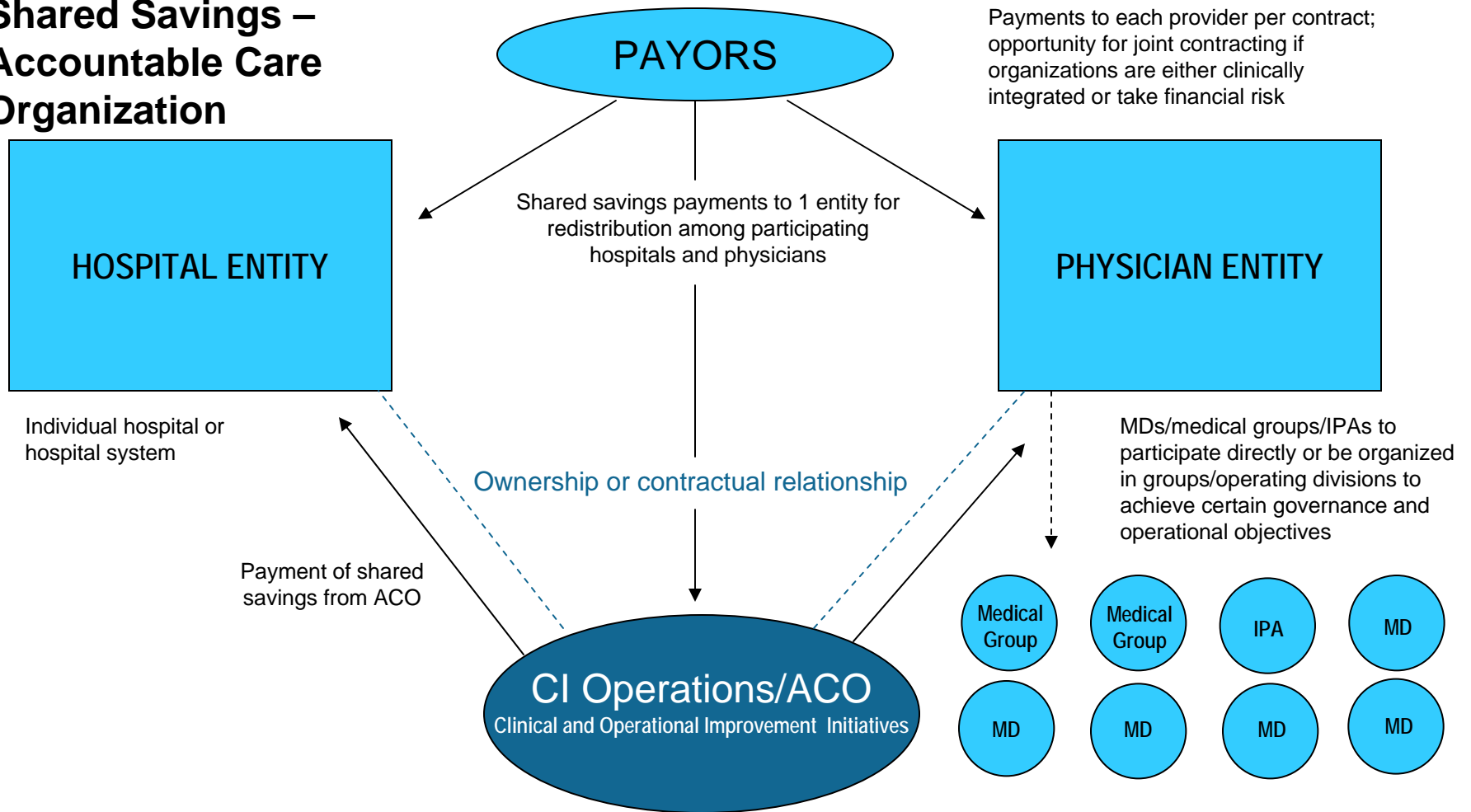


IHA Demonstration Project

- **Focus:** Major procedures and acute conditions, orthopedic first → cardiac and other
- **First participants:** Monarch HealthCare, Cedars-Sinai, Hoag Hospital, Saddleback Memorial, Tenet, UCLA, Aetna, Blue Shield, CIGNA, HealthNet → all California
- **First populations:** Commercial PPO → HMO, Medicaid Managed Care and Medicare Advantage
- **Episode definition:** Date of surgery + 90 days, includes acute and routine follow-up, complications within 90-days, related readmits

New Payment Methodologies - ACOs

Shared Savings – Accountable Care Organization



ACOs: What we know so far

- PPACA statutory language in connection with the shared savings program
- CMS Q & A released in June
- Joint FTC/CMS workshop October 5th
- CMS issued proposed ACO regulations in March, 2011
- Program to commence January 1, 2012

ACOs: Proposed Regulations

March 31, 2011 – CMS publishes proposed regulations for the Medicare Shared Savings Program

Also released concurrently:

- Joint CMS and OIG notice with proposals for Stark, AKS and CMP waiver;
- Joint FTC and DOJ “Proposed Statement of Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program; and
- IRS notice regarding the need for guidance on participation by tax-exempt organizations in ACOs.

ACOs: Proposed Regulations – “Highlights”

- Application and acceptance
 - ACOs must complete an application and be accepted
 - ACOs may be terminated from program
- Governance
 - CMS allows for flexible governance structures
 - All ACO participants, as well as beneficiaries, must have some representation within governance structure

ACOs: Proposed Regulations – “Highlights”

Beneficiary Attribution:

- Beneficiaries can seek care from any provider
- Provider must give notice if it participates in an ACO
- Beneficiaries are retroactively assigned to an ACO if they received a “plurality” of primary care services from that ACO’s providers
- Beneficiaries may opt out of ACO

ACOs: Proposed Regulations – “Highlights”

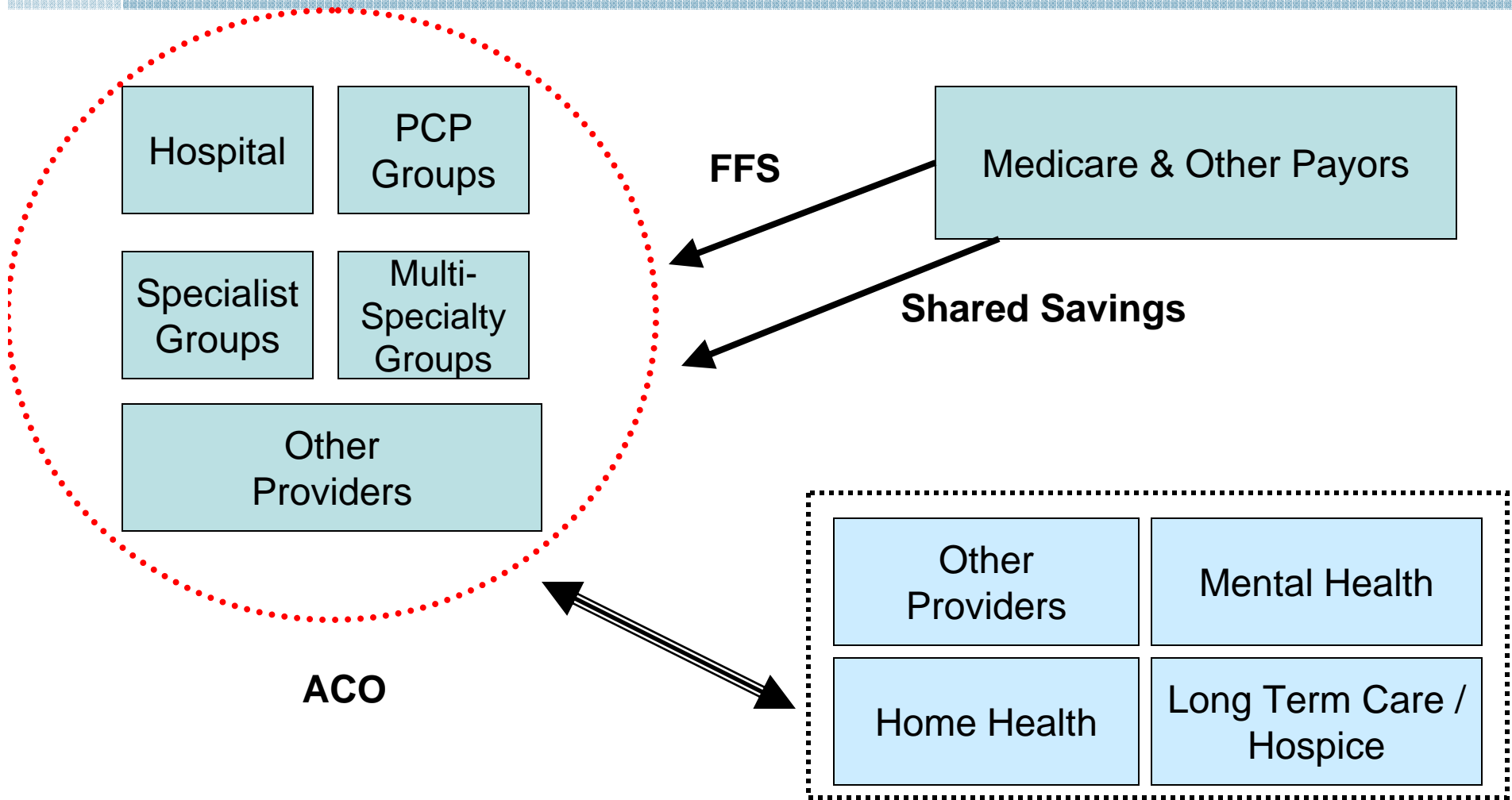
Quality Reporting and Performance:

- 65 quality performance metrics divided among five categories:
 - Patient experience of care
 - Care coordination
 - Patient safety
 - Preventive health
 - At-risk population/frail elderly health
- Year one: reporting only
- Year two: must meet quality metrics
- Additional measures to be developed in future years

ACOs: Proposed Regulations – “Highlights”

- Health information technology (HIT)
 - At least 50% of the primary care physicians within an ACO must be “meaningful EHR users” by 2nd year
- Antitrust review
 - ACOs must perform detailed analysis of their market shares
 - If shares exceed a 50% threshold, the ACO must obtain FTC approval to participate in shared savings program
- Limited Stark, anti-kickback and CMP waivers
 - Agencies asking for additional comment on whether and how to broaden the proposed waiver in order to encourage more participation

ACOs: Macro View



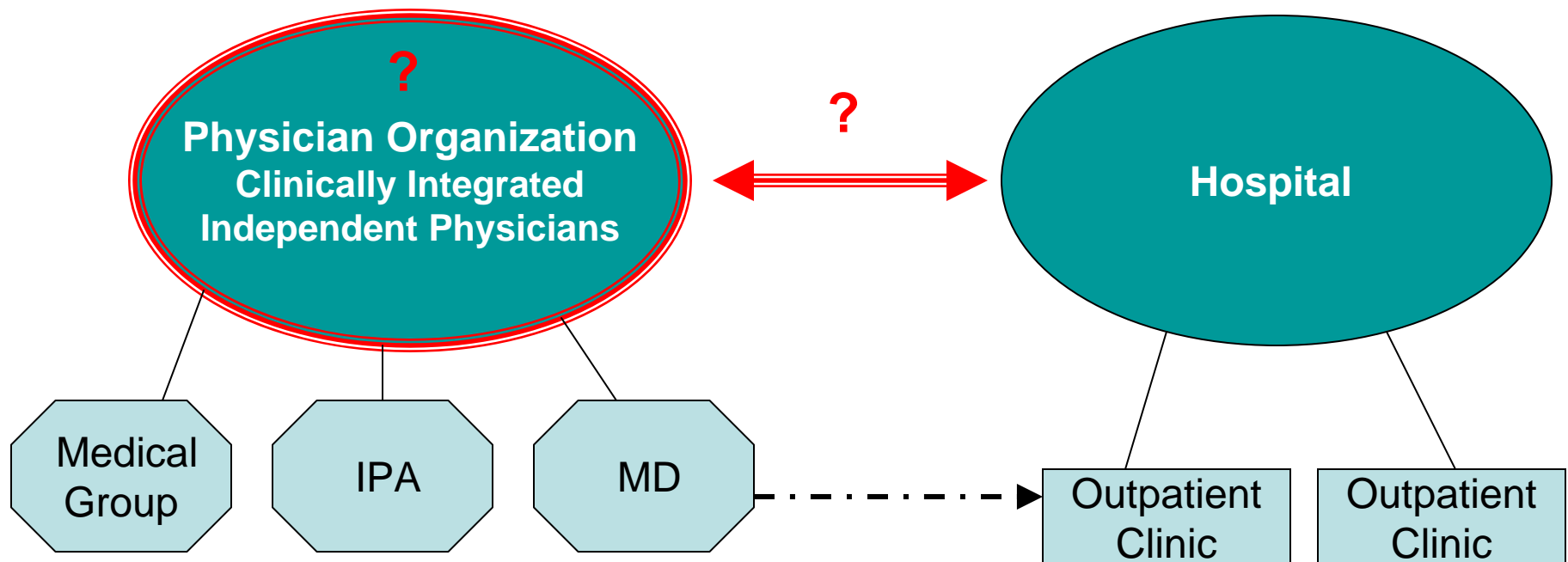
New Payment Methodologies

	P4P	PCMH	ACOs	Bundled Payments
Focus	<ul style="list-style-type: none"> Quality/outcomes. Cost savings. Standardization. 	<ul style="list-style-type: none"> Chronic care. Coordinated care. Cost savings. 	<ul style="list-style-type: none"> Quality. Cost savings. Performance metrics. 	<ul style="list-style-type: none"> Inpatient episodes of care. Implantable procedures. Cost savings.
Payment	Incentive payment for meeting or exceeding quality benchmark standards.	<ul style="list-style-type: none"> FFS. PMPM or management fee. Quality incentive. Cost-savings incentive. 	Based on calculated savings compared to established benchmarks.	<ul style="list-style-type: none"> One payment. Patient incentive. Gainsharing.
Outcomes	<ul style="list-style-type: none"> Ten physician groups awarded \$16.7 million in incentive payments in 2008. Sacred Heart: received \$400,000 in June 2008. 	<ul style="list-style-type: none"> Group Health: 29% decrease in ED visits, 11% in hospital admissions, and 6% in office visits. NC: \$200 million in total cost savings over 3 years for diabetic and asthmatic patients. 	Identifying program participants.	<ul style="list-style-type: none"> Hillcrest: 4.4% savings for heart transplant and joint replacement surgeries. Acute Care Episode (ACE) demonstration project.

ACOs: Physician – Hospital Model

What Creates the Relationship Among the Physicians?

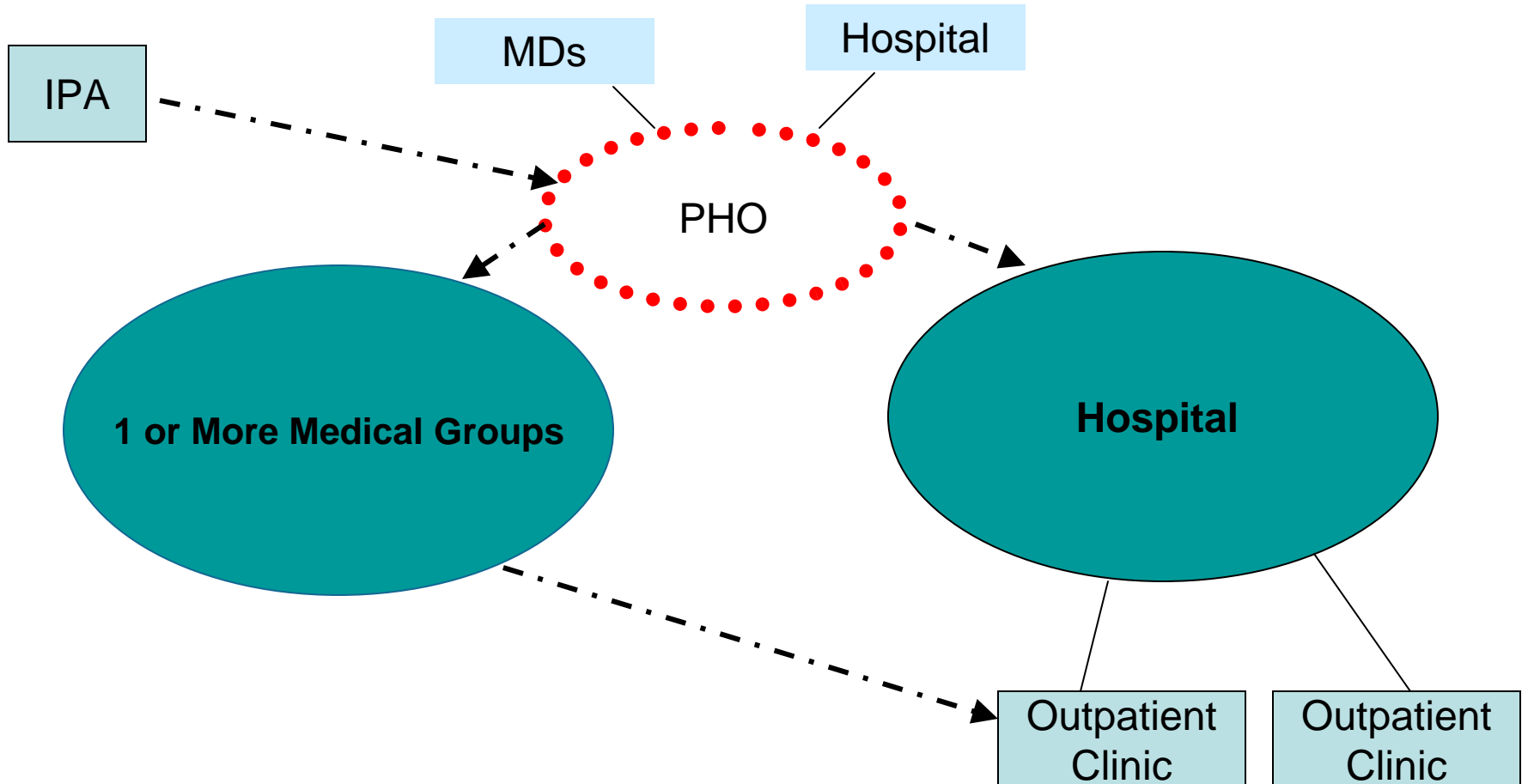
What Creates the Relationship Between the Hospital and Physicians?



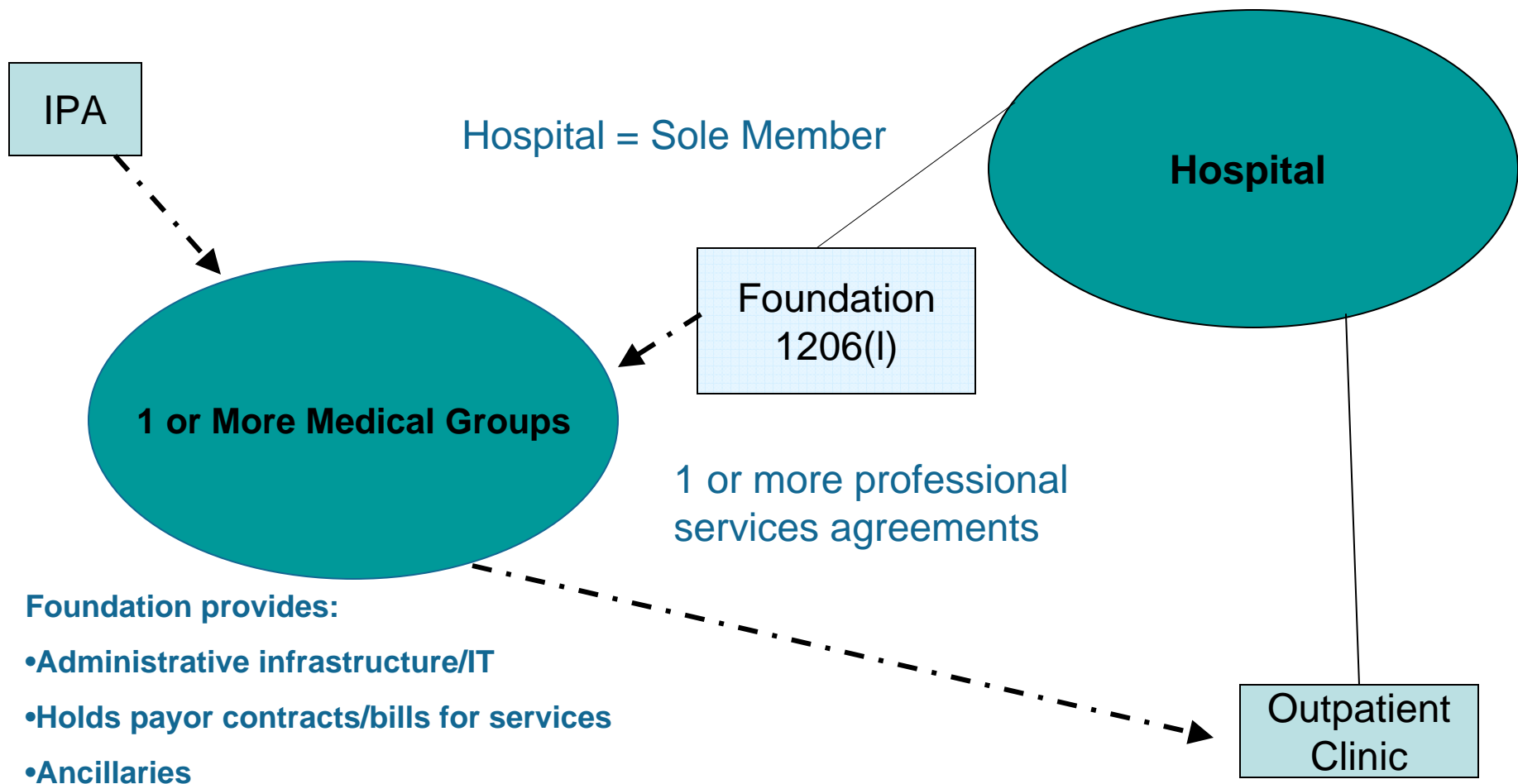
Creating Hospital / Physician Alignment

- Foundation or other type of clinic
- Shared risk payments
- Bonuses (quality and/or cost savings)
- Joint marketing / branding
- Shared / integrated IT

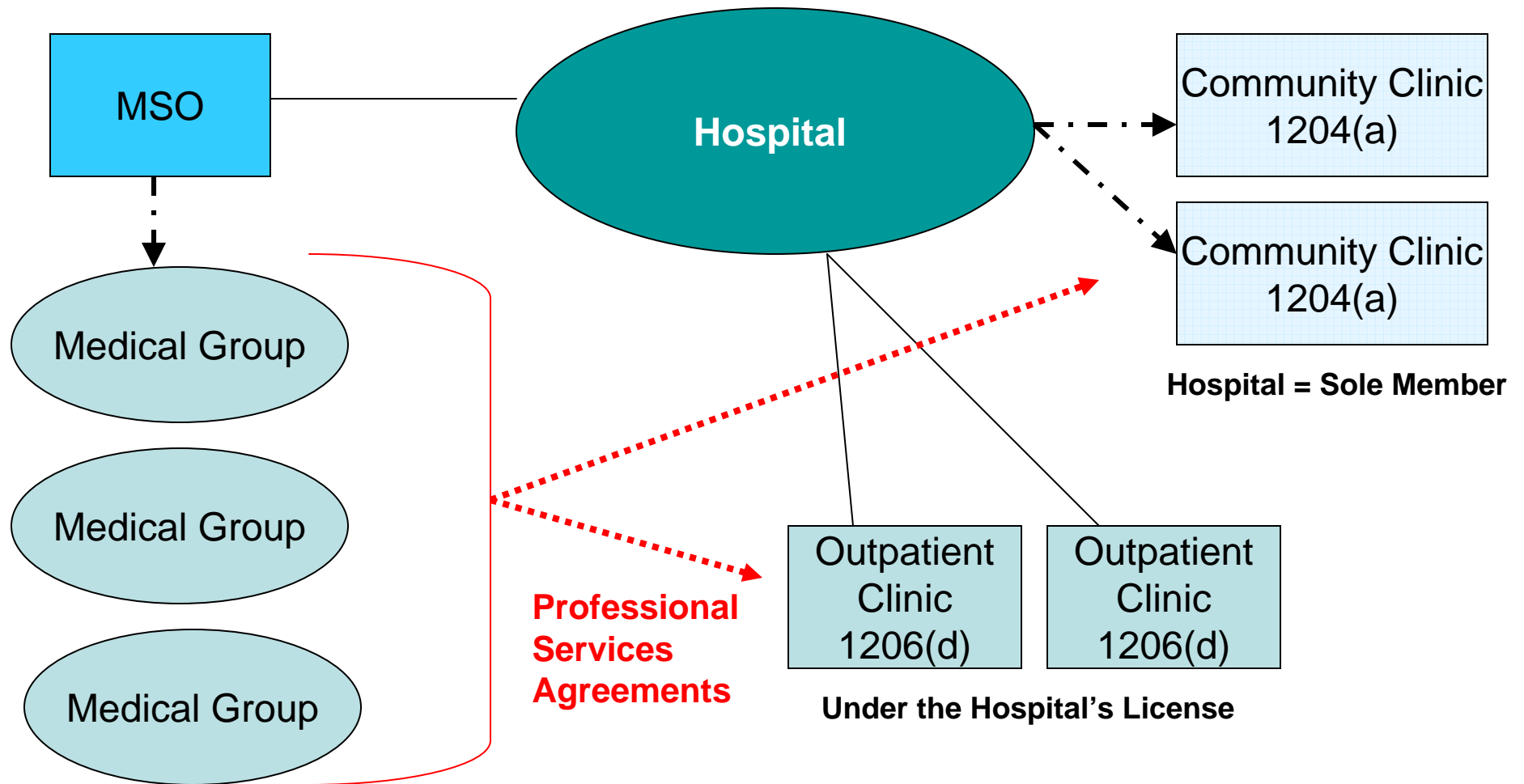
Creating Alignment – PHO



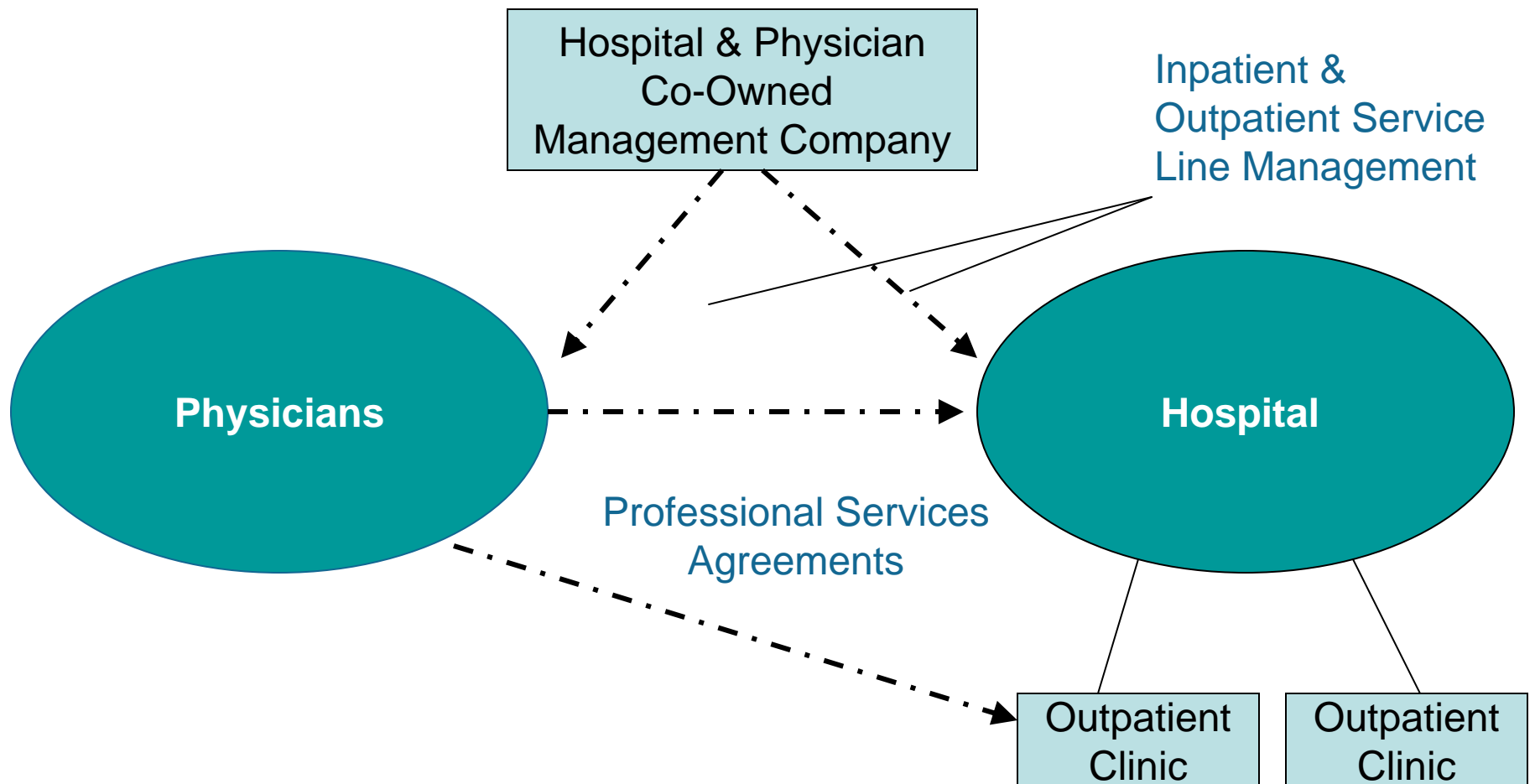
Creating Alignment – Foundation Model



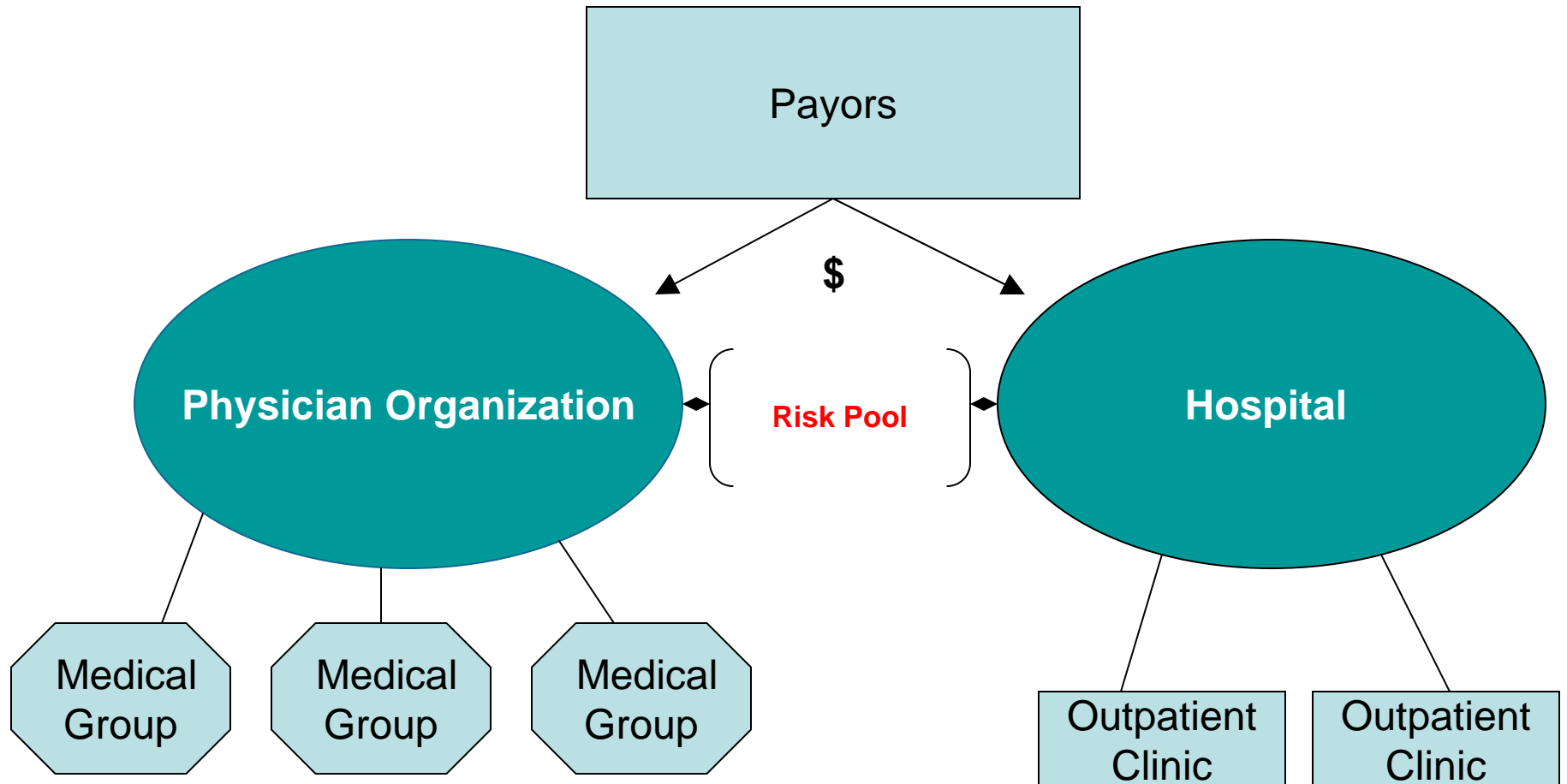
Creating Alignment – Clinic Model



Creating Alignment – Service Line Model



Creating Alignment – Shared Risk



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