ACCOUNTABLE CARE ORGANIZATIONS UNDER Healthcare Reform Act of 2010

PRESENTED BY THE LAW OFFICE OF KENNETH JOEL HABER, PC

Healthcare Reform Act 2010 Over 2000 Pages

- This legislation will effect the totality of the Doctor-Patient Relationship once it is effectuated through regulations.
  - In the past the doctor-patient relationship was contractual in nature with Professional Responsibilities establishing the basis of the relationship.
  - Now the relationship will be much more dominated by government regulations in Medicare.
  - Additionally, the government will be involved in defining insurance contracts by setting the Medicare standards and the provisions which private insurance will mirror.

A MAJOR INSTRUMENT FOR CHANGE IN THE PRACTICE OF MEDICINE THROUGH THE REFORM ACT WILL BE ACCOUNTABLE CARE ORGANIZATIONS

You Just Want To Practice Medicine

In the future the government will more intrusively determine how you practice medicine (not just Medicare) based upon payment structures and regulations.

You have a choice for your future

- 1- Fly Blind and Accept What Might Happen to Come Your Way
- 2- Or Learn About the New Programs: the Rewards and Benefits By Adjusting To and Accommodating To Them While Practicing Your Profession

- Choice No. 1

- Choice No. 2

ARE HOSPITALS THE ONLY ONES BEING AFFECTED BY REFORM ACT?

- NO! The Reform Act Has A Special Place For Physicians and the Public. The Administration Promised That It Could Save $500 Billion From Waste, Fraud and Abuse In Order To Pay For The Reform. Where Do You Believe That It Is Coming From?

SEC. 3007. VALUE-BASED PAYMENT MODIFIER UNDER THE MEDICARE PHYSICIAN FEE SCHEDULE.

- Medicare is amended so as to ESTABLISH A VALUE-BASED PAYMENT MODIFIER.
- IN GENERAL.--The Secretary shall establish a payment modifier that provides for differential payment to a physician or a group of physicians under the Medicare fee schedule based upon the quality of care furnished compared to cost during a performance period.

Conceptual Implications: Payment based upon performance with weighing of quality of care in comparison to cost of care.

- This program change is to be characterized by BUDGET NEUTRALITY.--The payment modifier established under this subsection shall be implemented in a budget neutral manner.
- This means by the time it is implemented there will be winners and losers. There will be fewer winners and more losers because the revenue saved will be split between the winners and the government. The money will come from the losers.

Sounds good for some but could be devastating to others.

- Government intends to push more work and variety of work on PCPs; thus, saving revenues paid to specialists. If the Government is to push the work from the specialists, can the PCPs trust the Government?

GLOBAL OFFICE VISIT

- Expect to see more testing and procedures performed by PCPs where sophistication is not required in interpretation and performing. Possibly more simple procedures by PCPs in comparison to those by specialists, assuming the procedure permits. Good for PCPs but bad for specialists? However, PCPs might find themselves on the front line of mass production medicine and the Global Office Visit. The same fee no matter how many procedures or tests are performed.

Could be devastating for everyone: Specialist, PCPs and Patients Could All Suffer.

- Government intends to cut back on use of and reimbursement to specialists and encourage PCP to assume more responsibility for basic testing and procedures. This would theoretically enhance quality to cost ratios, assuming a PCP can appropriately undertake and interpret the tests performed and procedures undertaken.

What tests and procedures will be assigned to the PCPs and what tests will be referred out to specialists?

- Will government only cut back on reimbursements for specialist testing and procedures without adequately compensating PCP for testing and procedures? Will the Government imposed upon PCPs the responsibility to undertake tests and procedures all under a simple Global Office Visit code?

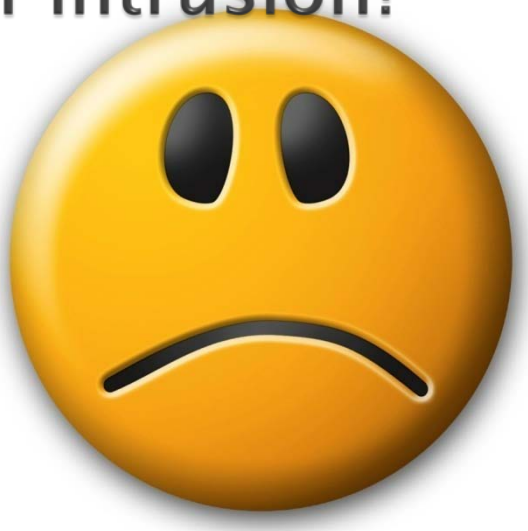
Why Not If You Are CMS?

- If you are Medicare and attempting to save $500 Billion dollars, which the administration assured the public that it could save from fraud, waste and abuse in order to pay for Health Care Reform, then why not impose more responsibility upon the least paid segment of our health care community and pay them less than you would pay the higher paid segments of the community and cut those higher costs.

Any Winners?

- If Medicare regulatory structure is not adjusted to adequately compensate for services performed and recognized as specialized skills, then all can be losers, including the patients and PCPs.
- Patients could have extensive wait times to see specialists who have available specialized testing equipment and skills.

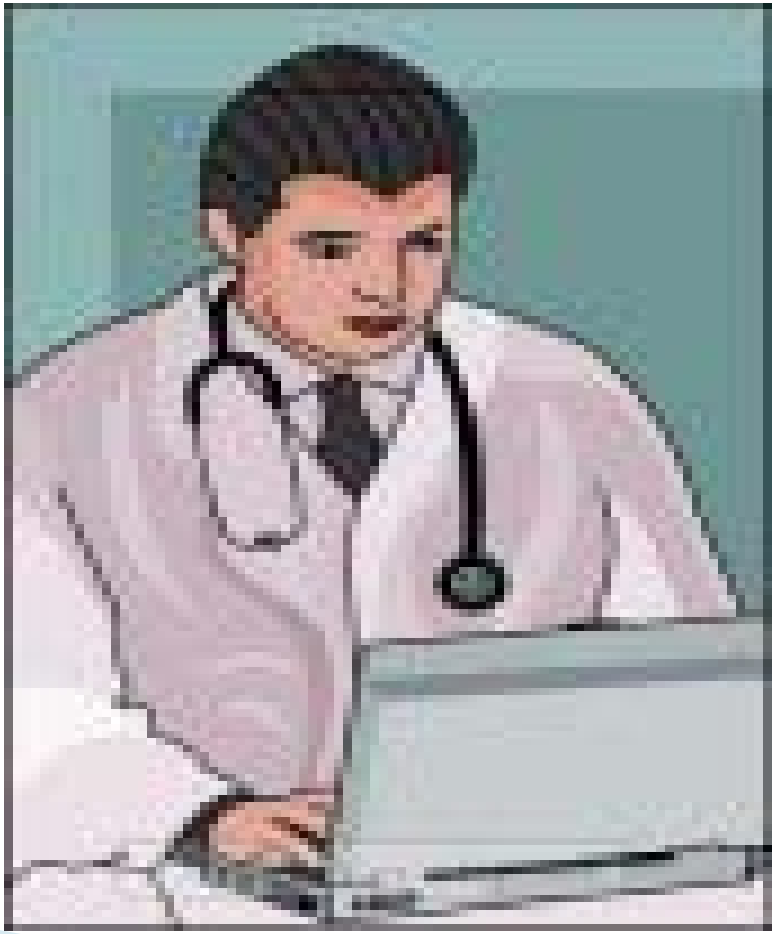
This can also be applied by the private insurance sector because they implement Medicare as Contractors and will develop the application structures. No one is immune from this type of intrusion!



How Can Specialists Offset Their Lost Income?

- How can specialists offset this loss of work and income? Moonlighting? If so, then only the wealthy can afford the type of healthcare that we are currently use to today?
- How can an Accountable Care Organization assist specialists by providing volume work and reduced overhead? [What is an ACO and how can it assist you?] We shall see.

Medicare will now encourage SYSTEMS-BASED CARE



SYSTEMS-BASED CARE

- The Secretary will now apply a payment modifier in a manner that promotes systems-based care. One such system base care entity would be an HMO. However, the Reform Act is not requiring everyone join an HMO. A system based care organization is identified in the Act itself. The Act recognizes the new creature as the Accountable Care Organization (ACO).

Accountable Care Organization?

Accountable Care Organization

- The Reform Act establishes a Medicare SHARED SAVINGS PROGRAM which provides for Accountable Care Organizations [ACO]. This is a program which is established for you to become more efficient in a manner defined by the government and as a result of that efficiency you will have more profit which you are able to share with the government. The government can potentially be generous with HMOs and similar organizations. [Will it?] The ACO is just a new player on the block. The kicker is that the government will be generous with the savings results of providers' own investment and efficiency efforts.

The Reform Act Provides

- Secretary shall establish a Medicare shared savings program that promotes:
- ***accountability*** for a patient ***population***
- ***coordinates*** items and services under parts A and B,
- encourages ***investment*** in ***infrastructure*** and ***redesigned*** care processes for high quality and efficient service delivery: i.e., that is with your money and investment!

The Reform Act Provides

- In the immediate future, ***groups*** of ***providers of services and suppliers*** meeting criteria specified by the Secretary ***may work*** together ***to manage and coordinate care*** for Medicare ***fee-for-service*** beneficiaries through an ***accountable care organization*** (referred to as an 'ACO') [in the future, there will be other mechanisms to determine reimbursement]; and

The Reform Act Provides

- ACOs ***that meet quality performance standards*** established by the Secretary are eligible to ***receive payments for some of its shared savings*** under the Act. The Secretary takes the rest of the savings.

The Reform Act Provides

- IN GENERAL.--Subject to the requirements of the Reform Act and its regulations, the following groups of providers of services and suppliers, which have established a mechanism for shared governance, are eligible to participate as ACOs under the Medicare program:

The Reform Act Provides

- 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.
- Whichever other suppliers and providers the Secretary determines appropriate.

An ACO shall meet the following requirements:

- The ACO shall be willing to become accountable for the quality, cost, and overall care of the Medicare fee-for-service beneficiaries assigned to it.
- The ACO shall enter into an agreement with the Secretary to participate in the program for not less than a 3-year period (referred to as the 'agreement period').

An ACO shall meet the following requirements:

- The ACO shall have a formal legal structure.
- The ACO shall include primary care ACO professionals that are of sufficient number to serve at least 5000 members..
- The ACO shall provide the Secretary with information regarding ACO professionals participating in the ACO.

An ACO shall meet the following requirements:

- The ACO shall have in place a leadership and management structure.
- The ACO shall define and implement certain processes.
- The ACO shall demonstrate that it meets patient-centeredness criteria.

AN ACO SHALL HAVE

- QUALITY AND OTHER REPORTING REQUIREMENTS –
- clinical processes and outcomes;
- patient and, where practicable, caregiver experience of care; and
- utilization (such as rates of hospital admissions for ambulatory care sensitive conditions).

PAYMENTS.--
Under and ACO Program

- IN GENERAL.--Under the program, subject to certain provisions, payments, for now, shall continue to be made to providers of services and suppliers participating in an ACO under the original Medicare fee-for-service program under parts A and B in the same manner as they would otherwise be made except that a participating ACO is eligible to receive payment for shared savings under the Reform Act. Let us see indeed, what payment structures might soon look like.

PAYMENTS.--
Under and ACO Program

The ACO must meet quality and other performance standards established by the Secretary in addition to meeting saving standards established by the Secretary to be eligible for such shared savings payments.

PAYMENTS.--
Under and ACO Program

- DETERMINING SAVINGS.--In each year of the agreement period, an ACO shall be eligible to receive payment for shared savings, for now, only if the estimated average per capita Medicare expenditures under the ACO for Medicare fee-for-service beneficiaries for parts A and B services, adjusted for beneficiary characteristics, is at least the percent specified by the Secretary. Lets see within what restrictions the payment structure will function.

CANNOT AVOID AT-RISK PATIENTS

- MONITORING AVOIDANCE OF AT-RISK PATIENTS.--If the Secretary determines that an ACO has taken steps to avoid patients at risk in order to reduce the likelihood of increasing costs to the ACO the Secretary may impose an appropriate sanction on the ACO, including termination from the program.

What are some of the implications of this system.

- There will be winners and there will be losers. The winner will get onto the ground floor of the changes and control his/her destiny. The loser will be swept by the tides of change with limited control over his/her destiny. A Specialist who gets in on the ground floor of an ACO can make money. The PCP can find him/herself to now be in demand.

Happy PCP Who Is In Demand by an ACO.

Specialist Without An ACO or HMO

- However, if a Specialist becomes one of the excess Specialist without an ACO or other similar organization to affiliate with, the they will lose their sources of referrals for the referrals will be going to the ACO from the ACO PCPs and the ACO hospitals. The Specialist can find him/herself to be on the low end of the feeding chain. The PCP can find him/herself to now be in demand.

Once Again the Government Controls You, The Results of Your Sweat and Toil And You Have No Right of Appeal As to Many of the Issues Facing You.

VALUE BASED PURCHASING [VBP]

You may have heard the term here first. However, you will hear it a lot in the future!

To help address concerns of purchasing healthcare services in a manner viewed by the government as ineffective, CMS has asserted that during the current Administration and with direction from Congress (e.g., through enactment of provisions in the Medicare Modernization Act, Deficit Reduction Act, and other provisions), it has begun to transform itself from a passive payer of services into an active purchaser of higher quality, affordable care.

CMS further asserts that to

To further future efforts to link payment to the quality and efficiency of care provided, CMS would shift Medicare away from paying providers based solely on their volume of services. The catalyst for such change would be grounded in the creation of appropriate incentives encouraging all healthcare providers to deliver higher quality care at lower total costs. This is the underlying principle of value-based purchasing (VBP).

VALUE BASED PURCHASING

The cornerstones of VBP are the development of a broad array of consensus-based clinical measures, effective resource utilization measurement, and the payment system redesign as mentioned above. The overarching goal would be to foster joint clinical and financial accountability in the healthcare system.

That Is Where an ACO Can Come To Assist You!

- An ACO can be organized around your local hospital and/or hospital chain. This will give you and your colleagues an opportunity to organize and partially control your own destiny.
- The government is in the process of developing regulations to effect the waiver of antitrust issues, Stark and anti-kickback issues arising out of and inherent in the referral networks of and sharing of profits by members of ACOs.

CMS RESTRUCTURING

- CMS is developing the restructuring of the major Medicare fee-for-service (FFS) payment systems utilizing t he principles of VBP.
- Physicians and providers would need to reorganize themselves in order to achieve the best clinical and financial outcomes. CMS is in the process of devising mechanisms to restructure the payment systems in order to provide incentives for physicians and providers to work together to develop new ways to deliver high quality, efficient care while maintaining beneficiary access. These restructured payment systems are what will drive the structuring of your delivery systems.

The Transition

CMS has already acknowledged that the road to VBP would begin by working within the currently established payment structure. Incentive payments for quality reporting and performance, efficiency, and eventually value are being developed and incorporated into the current payment systems, which encompass hospital, physician, skilled nursing facilities (SNFs), and other provider types and settings.

ACOs

CMS intends, through provider-based quality incentive and shared savings programs, to increase the provider communities' understanding and appreciation of the need to have joint accountability in their clinical and financial outcomes. Through its financial incentives CMS intends to support further development and expansion of accountable care organizations (ACOs), which are collaborations between physicians, hospitals, and all providers that will be clinically and financially accountable for healthcare delivery in their communities.

ACOs

Members of these ACOs would share a common goal to improve quality and decrease costs in their communities. Large payers, including Medicare, could help these collaborations form by providing quality and cost information for the populations they serve. CMS intends for ACOs to interact with it in VBP payment models that could incorporate principles of competitive bidding for services, shared savings, or payment differentials based on performance.

What Is Your Private Practice Going to Look Like?

Competitive bidding means that ACOs will have to compete with each other. This could be good, if quality is properly defined and emphasized. However, under this type of payment structure, if you are not in an ACO, you may not have a chance.

Production line Medicine?
Maybe and May be Not

CMS Will Even Try Something Different Like Payments Based Upon Cooperative Care

To support these payment systems, CMS would consider appropriate modifications to the physician self-referral rules so that hospitals and other institutional providers may reward physicians for improving quality and efficiency in their local healthcare delivery settings. As an example, CMS could develop units of payment that go beyond the current approach of paying physicians and hospitals for their individual treatments.

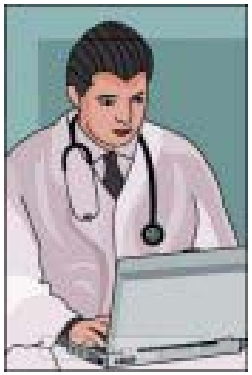
Global Episodic Units of Care ?

Using A Team Approach

Instead of payments for individual treatment units, CMS is developing payment structures for broader bundles of service which eventually could even include entire episodes of care for all involved providers. Physicians and hospitals could then decide how best to provide these services in a more efficient manner on a patient-by-patient basis, and could allocate the payment among themselves in a way that allowed each to share in the savings. This model is already being tested in the current CMS Acute Care Episode demonstration.

There Is A Method to CMS' Madness About EHR

The potential of health information technology to improve people's health and the functioning of the health care system is significant. Electronic health records (EHR) would be an important component of both the data strategy for VBP and for the payment incentives for VBP. EHRs are generally provider and/or physician controlled, allowing them to serve as a tool for easier collection of clinical data, thus reducing burdens on providers and improving accuracy of the data, which in turn add confidence in the VBP programs.



Labels Sometimes Stick

Health information technology also enables physicians and providers to coordinate and collaborate more easily on patient care, which can improve health care outcomes and enable providers to achieve performance standards, which lead to these providers and physicians earning VBP based bonus payments.

If it is digital, it must be true?

Unfortunately, if patients' EHR travels with them, and it will, patients may lose privacy issues and the ability to receive appropriate treatment when they are misdiagnosed by a single physician. There has to be an effective method to correct such misdiagnosis, and there may not be. Physicians may want to avoid challenging their peers' work, especially in rural communities.

What Is Next?

- Different entities are already structuring and organizing ACO for large groups of physicians without regulatory guidance.
- The OIG is reviewing issues of fraud and abuse for ACOs.
- The FTC is reviewing issues of antitrust for ACOs.
- CMS is reviewing general healthcare delivery effectiveness Issues for ACOs.
- Proposed regulations are soon to be issued and then there will be a period for public comment.
- After that, there will be issued interim final regulations that will be subject to change and modification in the future.

What Is Happening Now To Usher In the Future

- As a preliminary structure to assist establishing ACOs, CMS has already instituted a limited number of Chartered Value Exchanges (CVEs) -- local collaborations of health care providers, employers, insurers, and consumers working jointly to improve care and make quality and price information widely available.

- CVEs are a key part of CMS's vision for health care reform, which is built on four cornerstones:
- 1- advancing interoperable health information technology;
- 2- measuring and publishing quality information to enable consumers and providers to make better decisions about health care;
- 3- measuring and publishing price information to give consumers and providers information they need to make health care decisions;
- 4- promoting incentives for high-quality, efficient health care.
- These same cornerstones will be used with ACOs.

Already Established

CVE have already been established in over 25 communities. Some of these include:

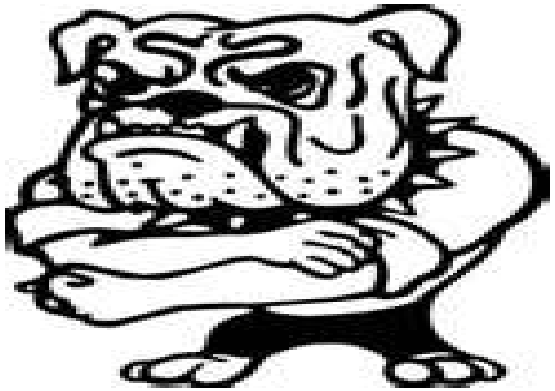
- Aligning Forces for Quality, York, Pa.
- California Chartered Value Exchange, San Francisco, Calif.
- The Colorado Chartered Value Exchange, Denver, Colo.
- eHealth Connecticut, Inc., Middletown, Conn.
- Greater Louisville Value Exchange Partnership, Louisville, Ky.
- Health Improvement Collaborative of Greater Cincinnati and HealthBridge, Cincinnati, Ohio
- Kansas City Quality Improvement Consortium, Kansas City, Mo.
- Michigan Health Information Alliance, Mt. Pleasant, Mich.
- Nevada Partnership for Value-driven Health Care, Las Vegas, Nev.
- Quality Health First program, Managed by the Indiana Health Information Exchange, Indianapolis, Ind.
- Virginia Health Care Alliance, Glen Allen, Va.
- These can readily be converted into ACOs and ACOs are being established as we speak even without the published regulations.

What To Do?

Roll-up your sleeves, become informed, get ready and even be pro-active. Then, you can be one of the winners and not one of the losers. Do not lose faith nor hope. You can be a winner.

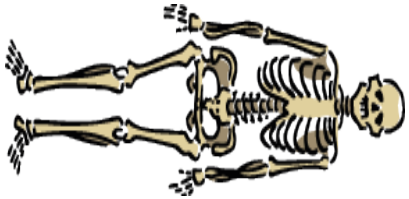
Become Informed.

Prepared Winner



Picked to the Bone

Unprepared Loser



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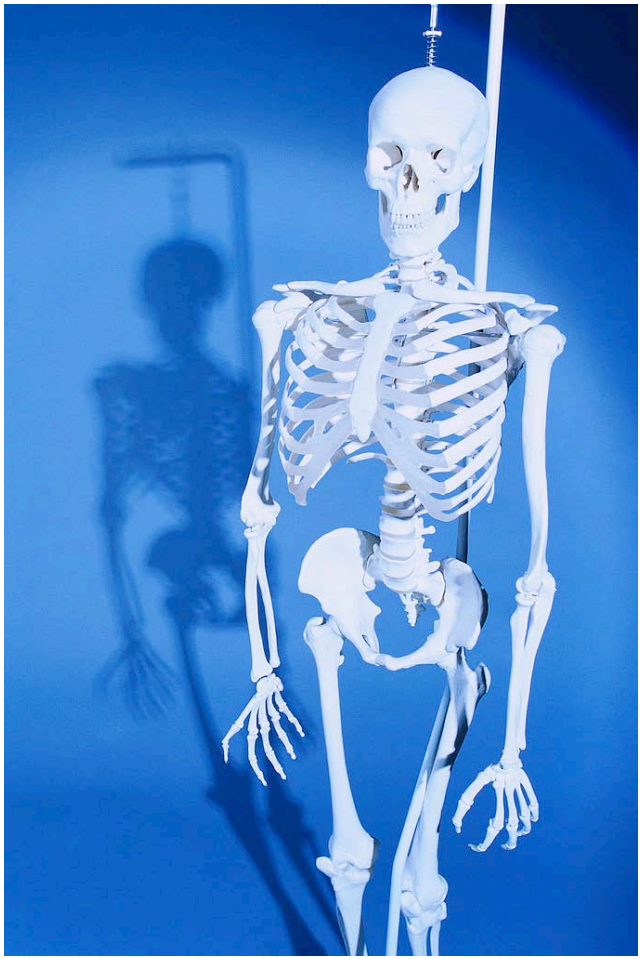
Dedicated To All Of
The Dedicated
Physicians Who Have
Fallen To The System



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