Impact of ACOs on Physician/Provider Membership Decisions

Overview and Legal Context

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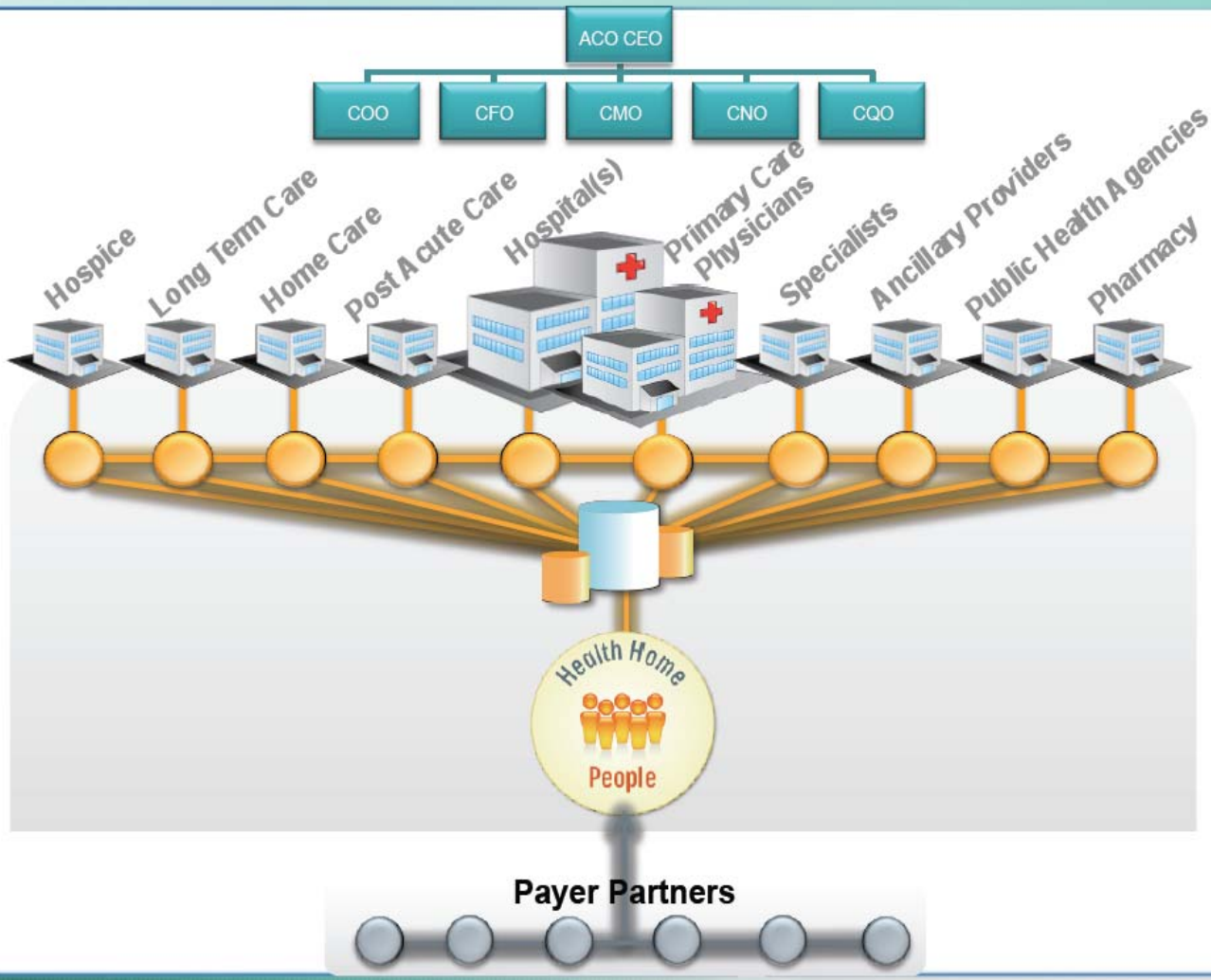
Complete view of an operational ACO



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.

ACO requirements

- 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

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

  - Incorporation of reporting requirements under the Physician Quality Reporting System; and
  - Requirements for public reporting by ACOs.

- 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)

Value Based Purchasing Program Measures

- For the FY 2013 Hospital VBP Program, CMS adopted final rules on April 30th, effective July 1st, on the use of clinical process-of-care measures as well as 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
  - Primary PCI received within 90 minutes of hospital arrival
- Heart Failure
  - Discharge Instructions
- Pneumonia
  - Blood cultures performed in ED prior to initial antibiotic received in hospital

Clinical Process of Care Measures (cont'd)

- Healthcare-associated infections
  - Prophylactic antibiotic received within one hour prior to surgical invasion
- 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 for FY 2014

- Eight Hospital Acquired Condition Measures
  - Foreign object returned after surgery
- AHRQ Patient Safety Indicators (PSIs), Inpatient Quality Indicators (IQIs), and Composite Measures
- Mortality measures

So, Now What?

- Compliance with ACO 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.
- Physicians will likely be required to produce their own quality/utilization report card at time of appointment/reappointment
- Physicians/AHPs likely will be denied membership if not performing up to standards

So, Now What?

- Compliance with VBP standards will affect whether or not hospital receives incentive based payments.
- Compliance may also have a direct or indirect impact on provider responsibilities:
  - under accreditation standards
  - doctrine of corporate negligence and related civil liability theories
  - DOJ/OIG expectations on board responsibility for delivering quality health care services which could trigger False Claims Act exposure. (Azmat case)

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 probably at the local provider level as well (e.g., participating hospitals, physician groups, ASCs).
- Standards need to be developed that track the 65 ACO measures and the VBP 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 and Quality Improvement Act of 2005).
- Is an ACO a "provider" under the Patient Safety and Quality Improvement Act of 2005 a Patient Safety Organization purposes?

So, Now What? (Cont'd)

- Is an ACO a "health care entity" under the Health Care Quality Improvement Act for purposes of:
  - Data Bank query and reporting obligations
  - Immunity protections
- Can an ACO be sued under the Doctrine of Corporate Negligence?
- Should there be an ACO medical/provider staff in lieu of a hospital medical staff?

So, Now What? (Cont'd)

- Will new bylaws, rules, regulations and policies be required given the fact that the ACO must be a legal entity?
- Should the standard hearing procedures remain the same or be modified?
  - Is non-compliance with utilization standards reportable if terminated or if membership denied?
  - Is non-compliance with quality metrics standards reportable if terminated or if membership denied?
  - Should termination from ACO result in termination from a hospital/provider staff and visa versa?

So, Now What? (Cont'd)

- Is economic credentialing the new reality?
- How will existing antitrust standards apply to exclusionary membership decisions?

Effective Medical Staff or Obsolete Medical Staff

Richard A. Sheff, MD, CMSL

Chairman and Executive Director

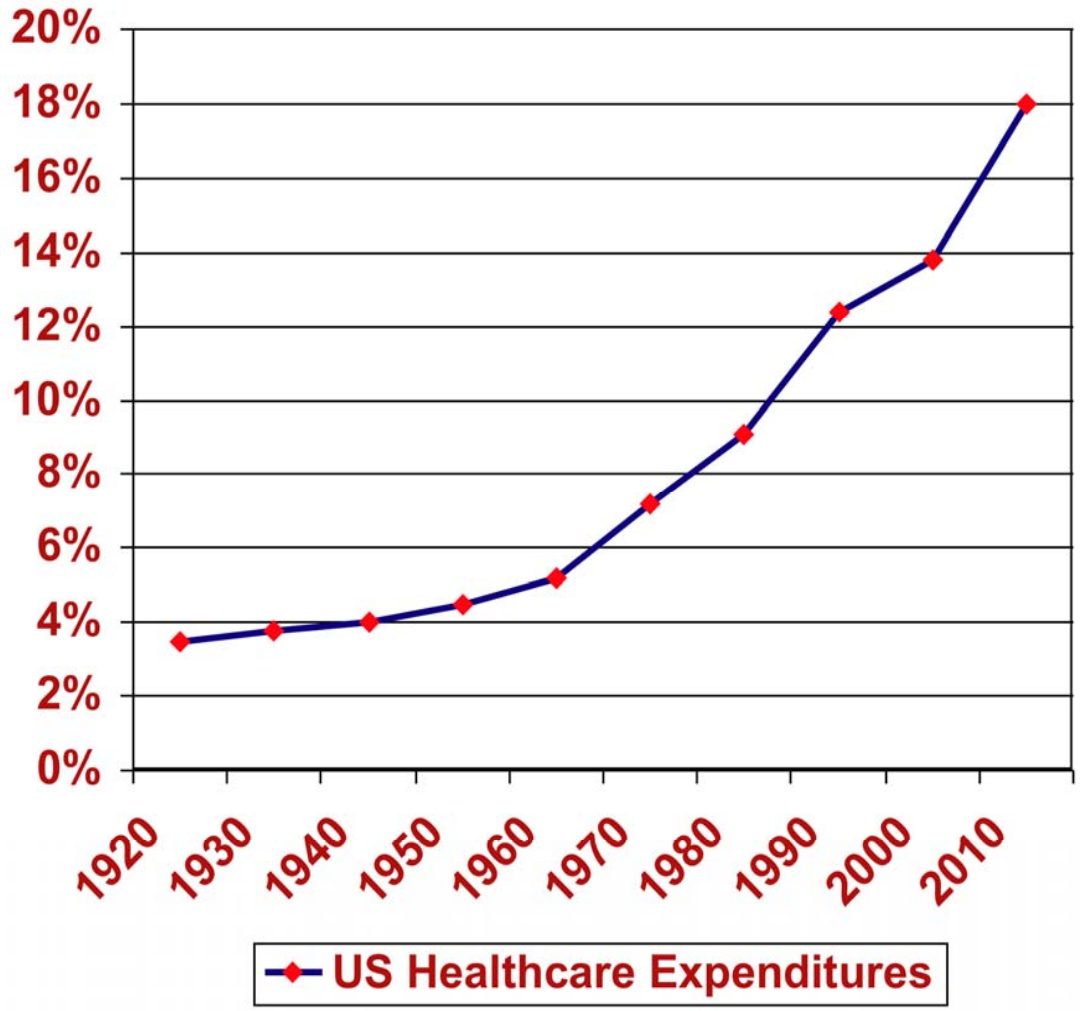
The Greely Company

Will the organized medical staff be relevant to the healthcare challenges of the coming years?

"I was successful because I focused on where the puck was going to be, not where it was at the moment."

—Wayne Gretzky

U.S. Healthcare Expenditures % of GDP



Today's healthcare imperative

Achieve higher quality at lower cost

Whoever figures this out will eat everyone else's lunch!

Is the old model up to today's challenges?

- Patient safety
- Cost containment
- ED call
- Performance on public data
- Pay for performance
- Physician accountability
- Physician competency
- Physician behavior
- Physician-hospital competition
- Physician-hospital collaboration

The most common CEO question today

The old medical staff model is dead!

What's the new model?

Is physician employment the new model?

Yes…

And No

Why?

Because the challenges between physicians and hospitals cannot be "solved" but must be "managed" over time

The need to manage complex, chronic problems is the driver of today's new medical staff models

- Manage loose and manage tight
- Hierarchy and partnership
- Competition and collaboration
- Physician success and hospital success and good patient care

Some candidates for the new model:

- Persistent self-governed medical staff with broad or narrow membership
- Employment
- Contracts
- Service line co-management
- Physician councils
- Physician-nurse dyads
- Joint ventures and physician equity
- Global pricing
- AHPs
- Accountable care organizations

Key questions to answer, especially when multiple models exist in the same medical staff

1. Who is accountable to whom for what?
2. How will accountability be achieved?

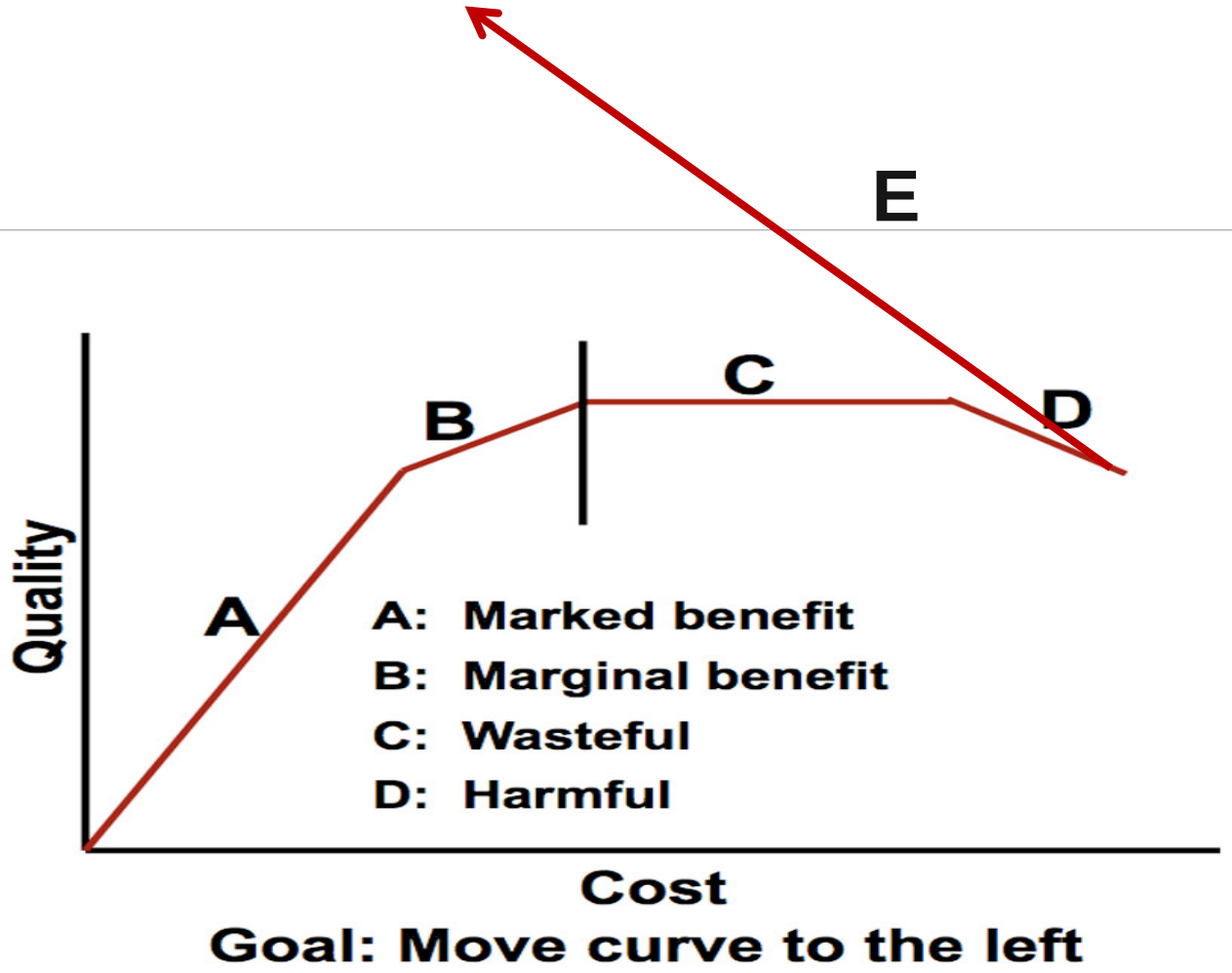
The Power of the Pyramid

Achieving great physician performance

For ACOs, what does competence mean?

- Patient care
- Medical/clinical knowledge
- Practice-based learning and improvement
- Interpersonal and communication skills
- Professionalism
- Systems-based practice

The effective ACO cost-quality curve



Conclusion

- Not every physician on a medical staff will be:
  - Cost effective
  - Responsive to the need to change
  - Collaborative team player
  - Willing to practice in a more “manage tight” manner
- So ACOs will confront new, difficult credentialing challenges

The Antitrust Considerations of Credentialing in ACOs

Christi J. Braun, Esq.

MINTZ LEVIN

Chair, Antitrust Committee,

AHLA ACO Task Force

Who Will Be Asked to Participate?

- Cannot include all providers in the community
  - FTC/DOJ Statement Regarding ACOs
    - >50% creates mandatory review
      - Concerns of market power
        - Over-inclusive vs. necessary coverage
  - Can't include:
    - OIG excluded participants
    - Providers without CMS billing privileges
  - Success of the ACO depends on having high quality providers

Membership & Credentialing Criteria

- Criteria set by:
  - Body with broad representation
  - Consensus (i.e., all representatives are heard)
- Written
  - Policy that is widely distributed
- Objective
  - Reasonable person would understand who is eligible and who is not
- Legally enforceable
  - Not discriminatory or violative of civil rights

Initial Credentialing Decisions

- Meet state and federal (HCQIA) requirements:
  - Formal review body (credentialing committee)
    - Recusals for any conflict of interest
  - Takes action or makes recommendations as part of professional review activity
    - Based on the competence or professional conduct of an individual physician
  - Actions in furtherance of quality care
  - Reasonable effort to obtain the facts
  - Notice and hearing if credentialing denied
  - Action taken on reasonable belief

Clinical Guidelines and Performance Standards

- Standard setting
  - Committee with broad representation
    - No special interests allowed to control
  - All interested parties have an opportunity to comment and provide input
  - Decisions through consensus
- Clinical integration
  - Opportunity for collaboration and sharing of competitive secrets to the benefit of the ACO

Clinical Measures

- Directly related to guidelines and standards
  - Set through similar process, ideally at same time by same committee
- Objective
  - Reasonable person standard
- Sufficient data for accurate and statistically significant results
- Recognition that “quality” of care has significant meaning for members and patients
- May be set by third parties (e.g., payors)

Quality Assurance & Utilization Review

- Essential to clinical integration
- Essential to success under ACO contracts
- Recognition that review of compliance with clinical guidelines and performance standards is a form of peer review
  - Actions should not be taken by competitors or those with a conflict of interest
  - Formal policy that provides for due process prior to sanctions

Terminations for Quality

- Clinically integrated network of high quality providers
  - FTC advisory opinions require option to terminate chronically noncompliant
- CMS Shared Savings Program success
  - Rewards based on quality and cost
- Action by a committee and/or reviewable by the board
  - Requires formal policy with due process rights
- Reportable to the NPDB?

Terminations for "Cause"

- Providers are contractually bound to their ACOs
  - Breach of contract
    - Failure to maintain qualifications
    - Failure to comply with terms of contract
  - Provisions allowing for termination
    - Loss of professional license, DEA license, hospital privileges
    - Commission of a crime related to profession
    - Failure to comply with rules of ACO, including guidelines and performance guidelines
  - Due process rights

Economic Credentialing?

- ACO as a hospital and its employed physicians
- In-network referral policy as performance standard
  - Enforced as part of utilization management
    - Chronically noncompliant terminated
- Efficiency scores
  - Cost per patient episode as compared to peers
    - Least efficient providers subject to termination under heading of utilization management
- Hospital admissions and readmissions, ED admissions, and diagnostic imaging
  - “low hanging fruit” for reducing cost of care

Privileging Cases & Their Application to ACOs

- Most physician's privileging cases are lost due to:
  - No conspiracy
  - No loss of competition
  - Conduct not anticompetitive
  - State action
  - HCQIA immunity
  - Lack of standing
    - Not an efficient enforcer
    - Focused on harm to self as competitor
    - Desire to join in alleged illegal conduct

The Physician Perspective: Quality Measures Matter for Physicians in the ACO Era

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Chair, Physicians Practice Group, AHLA 2011-2012

The Physician Perspective

- Pre-ACO Era quality and credentialing crosshairs
  - JTC FAQ of November 24, 2008
  - OPPE and FPPE
  - MS.06.01.05
    - EP 2, 3 and 10
  - MS.08.01.01
  - CMS “Requirements for Hospital Medical Staff Privileging, November 2004

The Physician Perspective

- Current issues in Economic Credentialing
  - Physician-on-Physician
    - As opposed to Hospital-on-Physician
  - Decisions based on savings
    - As opposed to decisions based on income generated by physician work or referrals to hospital
  - Physicians will have an economic self-interest in making sure other physicians act economically
    - Implementation of quality as veil to economy
  - Competition in multiple or Competing ACOs
  - Greater measurements defeat economic motive

The Physician Perspective

- ACO Performance Indicators
  - Table
    - Five domains
    - Outcome and process measures
  - Delve down – **implementation** of standards is where quality could clash with privileges

The Physician Perspective

- Physician concerns on greater clinical-administrative services
  - How are the quality measures determined
  - Salary / collections impact
  - Many ways to measure within the measurement
  - To whom am I accountable in my accountable care organization?

The Physician Perspective

- Transparency and Confidentiality
  - Physician Liability
  - Peer Review
    - Delegation of analysis to the hospital in order to get the benefit of current protections (HCQIA and state law)
    - Can an ACO itself get HCQIA / state law protection?
      - Process as opposed to entity

The Physician Perspective

- Physician/Physician issues
  - Cross training
  - Collaboration
  - Scope of privileges

The Physician Perspective

- Bylaws
  - Will we see quality standards written into medical staff bylaws, policies and procedures?

The Physician Perspective

- Increase in closed staffs
  - Result of more employed doctors
  - Possible implication: employment agreement (and accompanying employment evaluation) may matter more than bylaws (and privileges / re-credentialing)

The Physician Perspective

- Will the medical staff be a thing of the past?
  - To the contrary, with greater emphasis on medico - administrative work being done by physicians, perhaps the current medical staff structure is the stage on which a dramatic performance of collaboration (physician-physician and hospital-physician) can occur.