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PROFESSIONAL SOLUTIONS INSURANCE COMPANY BRINGS YOU PRACTICAL TIPS FOR AVOIDING A MALPRACTICE ALLEGATION ISSUE 5 • 2012

Accountable Care Organizations

Are the Rewards Worth the Risks?

INSIDE THIS ISSUE:

Accountable Care Organizations (ACOs) were created in the 2010 Patient Protection and Affordable Care Act[1] with the intent of moving away from a fee-based healthcare delivery model toward one that promotes evidence-based, cost-effective and patient-centered care.

Its objectives are:

- Improve outcomes through a proactive, coordinated approach to managing chronic diseases (e.g., diabetes and coronary artery disease)
- Reduce unnecessary tests and procedures
- Reduce the cost of providing the care
- Improve the overall health of the target population

ACOs that meet quality performance standards and have lower growth of healthcare costs will receive financial rewards—shared savings—for their efforts. However, these programs are not without extra costs and risks. Consider the following scenarios.

Scenario #1: Good Health Family Practice was a member of a six-physician, two-PA-C family practice group that recently signed a contract with a newly formed ACO. The ACO included the two local hospitals where the group had privileges, a local surgical center, a walk-in clinic, and several other medical and surgical physician groups within a 10-mile radius. The practice manager assured the physicians it was a win-win for the group and its patients. The ACO

affiliation would not require much of an investment of time or money, and the physicians could continue to take the same approach to patient care.

Within a few months of signing, it became apparent that the group's participation in the ACO was anything but seamless and easy. Contrary to the sales pitch, the group found itself having to scrap a three-year-old EHR system for one that was better integrated into the ACO's EHR, e-prescribing, billing and data reporting systems. This required a considerable amount of money, time, and retraining of the group's entire clinical and administrative staff.

Scenario #2: John Potter, M.D., was a founding member of a 15-physician internal medicine group that was part of an ACO responsible for more than 15,000 Medicare fee-for-service patients. The ACO Quality Assurance Committee had notified the group and Dr. Potter more than once that Dr. Potter was not complying with the ACO's standards for individual patient care plans, based on evidence-based medicine. In addition, his patient satisfaction scores were consistently the lowest in the group. When confronted by his colleagues, Dr. Potter maintained he was providing "the same quality of patient care on which this practice was built," and that the longevity of the practice and its reputation in the community should be "evidence enough for anyone."

When one of his patients brought a medical malpractice action against Dr. Potter, his non-compliance with the

Continued on Page 2

Participation in an ACO is purely voluntary, and Medicare is not doing away with fee-for-service payments.

Continued from Page 1

ACO's standards made his defense especially difficult. The patient alleged that Dr. Potter's care did not meet the usual standard of care for an internist, nor did it meet the standards of care or quality performance indicators set forth by the physician's ACO.

How Does Participation in an ACO Work?

As the above scenarios illustrate, participating in an ACO is not without risk. Physicians must be aware that once an ACO has been approved for the program, the Centers for Medicare and Medicaid Services (CMS) will routinely monitor the ACO to ensure continued compliance with the program requirements. An ACO's claims, quality and financial data will be monitored through site visits, patient care experience surveys, and, if necessary, audits. An ACO's failure to comply with the program requirements or quality standards can result in termination of its agreement.

The ACO regulations include 33 performance indicators in the following four domains (See box on following page):[2]

1. Patient/Caregiver Care Experiences
2. Care Coordination/Patient Safety
3. Preventive Health
4. At-Risk Population/Frail Elderly Health

The first three domains target improved care for individuals.[3] The last domain, "At-Risk Population/Frail Elderly Health," is further divided into five chronic disease categories:

1. Diabetes Mellitus
2. Heart Failure
3. Coronary Artery Disease
4. Hypertension
5. Ischemic Vascular Disease

Initially, ACOs will be required to report on all quality measures as benchmarks for future improvement measurement. The higher the quality of care delivered—as demonstrated by their reported quality measures—the more shared savings their ACO may earn, provided they also have a lower growth in health care expenditures. It is also expected that CMS will add additional measures and increase performance standards over time.

Weighing your Options

CMS is encouraging providers to review the final rule and consider participating, and ACOs across the country are taking advantage of the program. At first glance, the idea of shared savings and having Medicare return money to providers sounds like a dream come true. However, there are definite risks associated with participation that should be weighed against the potential benefits to a practice, its physicians and its patients.

Keep in mind that participation in an ACO is purely voluntary, and Medicare is

Required Elements for ACO Inclusion in the CMS Shared Savings Program

For inclusion in the Shared Savings Program, an ACO must have the following elements:

- A formal legal structure to receive and distribute shared savings
- A governing body that is representative of the ACO's service providers, suppliers and Medicare beneficiaries
- A sufficient number of primary care professionals for the number of assigned beneficiaries (at least 5,000)
- A three-year program participation agreement
- Sufficient data about the professionals taking part in the ACO to determine the level of support required for beneficiary assignment and for shared savings payment determinations
- A leadership and management structure that encompasses clinical and administrative systems
- Defined processes to:
  - Promote evidenced-based medicine
  - Report the necessary data to evaluate quality and cost measures (this could incorporate requirements of other programs, such as the physician quality reporting systems, electronic prescribing and EHRs
  - Coordinate care
- Routine self-assessment, monitoring and reporting of the care delivered and to use the information to continually improve the care delivered to Medicare beneficiaries
- Evidence demonstrating that the ACO meets patient-centeredness criteria, as determined by the Secretary of HHS

Source: CMS/Office of Legislation, Medicare "Accountable Care Organizations" Shared Savings Program, New Section 1899 of Title XVIII, Preliminary Questions & Answers. www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/ACO_QualityMeasures.pdf

not doing away with the traditional fee-for-service model of payment. Therefore, there is no reason for a practice to rush to join an ACO without first doing some research. As you conduct your due diligence, it is important to consider the following factors associated with signing on with an ACO:

- **A potentially significant upfront technology investment.** The ACO's quality of care model and coordination of patient-centered care is only possible if a patient's complete and current medical history and records are available at the time of care. Therefore, the practice's system must be able to share patient data, billing systems, EHRs and quality performance reporting with the other ACO providers and CMS with minimal effort and maximum security. In addition, the ACO and its participants must demonstrate meaningful use of the EHR. All of this requires highly sophisticated technology, which can carry a high price tag.
- **Possible loss of revenue.** A practice must be prepared to gain or lose patients, based on the ACO's beneficiary assignment. What's more, the practice may lose revenue, based on the collective performance of fellow ACO providers. Initially, it appears that an individual participant's financial risk will be limited because the majority of ACO participants will continue on a fee-for-service model. However, the Secretary of HHS has the option to introduce a partial capitation type of reimbursement model. This increases the potential for adverse financial impact on the ACO and its participating providers.
- **Potential increase in medical malpractice liability.** Ideally, all providers in the ACO should be adequately insured with similar limits of coverage. Providers need to ask if the ACO—in meeting the CMS eligibility requirements for evidence-based care and quality performance measures—is establishing or agreeing to a higher standard of care than the practice can provide.
- **Potential liability of the ACO as a separate entity.** It is important to determine whether the ACO carries its own liability coverage for its inherent governance and administrative exposures, e.g., provider credentialing, peer review issues, enterprise liability, directors and officers (D&O), and general premises liability. Also, is the ACO self-insured, taking on very large amounts of risk that could jeopardize the financial success of the ACO? Or, in the event of a complete failure of the self-insurance program, will all liability fall on the individual ACO providers?
- **Possible conflicts of interest between various providers.** The ACO should have policies in place to prevent one provider in the ACO from dominating another in the decision-making process (e.g., the hospital versus the physician component). The intent should be to prevent dominant players from influencing ACO policies and procedures so the ACO can function in the best interest of all of its providers and patients.
- **Unequal commitment by ACO providers.** To improve the overall wellness of the beneficiaries, all participants in the ACO must be committed to providing focused,

33 Measures for Use in Establishing Quality Performance Standards ACOs Must Meet for Shared Savings

AIM: Better Care for Individuals:

Patient/Caregiver Care Experiences (7 measures)
- Getting Timely Care, Appointments and Information
- How Well Your Doctors Communicate
- Patients' Rating of Doctor
- Access to Specialists
- Health Promotion and Education
- Shared Decision Making
- Health Status/Functional Status

Care Coordination/Patient Safety (6 measures)
- Risk-Standardized, All Condition Readmission
- Ambulatory Sensitive Conditions Admissions: Chronic Obstructive Pulmonary Disease or Asthma in Older Adults
- Ambulatory Sensitive Conditions Admissions: Congestive Heart Failure
- Percent of Primary Care Physicians Who Successfully Qualify for an EHR Program Incentive Payment
- Medication Reconciliation: Reconciliation after Discharge from an Inpatient Facility
- Falls: Screening for Fall Risk

AIM: Better Health for Populations:

Preventive Health (8 measures)
- Influenza Immunization
- Pneumococcal Vaccination
- Adult Weight Screening and Follow up
- Tobacco Use Assessment and Tobacco Cessation Intervention
- Depression Screening
- Colorectal Cancer Screening
- Mammography Screening
- Screening for High Blood Pressure

At-Risk Population/Frail Elderly Health (12 measures, further categorized into 5 chronic disease categories)
- Diabetes—Diabetes Composite (All-or-Nothing Scoring):
  - Hemoglobin A1c Control (<8 percent)
  - Low Density Lipoprotein (<100)
  - Blood Pressure <140/90
  - Tobacco Non Use
  - Aspirin Use
  - Hemoglobin A1c Poor Control (>9 percent)
- Hypertension
  - Controlling High Blood Pressure
- Ischemic Vascular Disease
  - Complete Lipid Panel and LDL Control (<100 mg/dL)
  - Use of Aspirin or Another Antithrombotic
- Heart Failure
  - Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)
- Coronary Artery Disease—Coronary Artery Disease (CAD) Composite: All-or-Nothing Scoring:
  - Drug Therapy for Lowering LDL Cholesterol
  - Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Patients with CAD and Diabetes and/or Left Ventricular Systolic Dysfunction (LVSD)

Source: *Accountable Care Organization 2012 Program Analysis: Quality Performance Standards Narrative Measure Specifications, Final Report*. December 12, 2012. Prepared for CMS Quality Measurement & Health Assessment Group by RTI International and Telligen. www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Quality_Measures_Standards.html

Continued on Page 4

Continued from Page 3

patient-centered care that eliminates unnecessary treatment and tests. One "weak link" is all that's needed to jeopardize the success of the ACO, the shared savings of the ACO's providers, and the care outcomes and safety of its patients.

- **Lack of safeguards to prevent the underutilization of services** or the "dumping" of higher risk patients to keep costs down. Treatment decisions should be made based on patient need. Withholding needed medical care, services, or referrals for financial reasons is not appropriate, increases liability risk and raises the potential for patient injury.
- **Policies and procedures.** Administrative policies and procedures, evidence-based treatment standards, and risk management tools must be developed, disseminated and implemented to help individual providers provide consistent, high quality care to the beneficiaries of the ACO. In addition, procedures should be put in place to ensure and enforce compliance with applicable laws and regulations and ACO standards of care.
- **Potential cyber security issues and HIPAA privacy and security violations.** Due to shared IT, shared data, data reporting and data aggregation, privacy and security issues are even more important to address. HIPAA and HITECH regulations must be taken into consideration and compliance must be ensured. Providers in the ACO must demonstrate meaningful use of EHRs and have the necessary technology in place to allow for real-time data sharing and coordination of care.

Comprehensive fact finding can help you determine if this is the right move for you, your practice and your patients. Consult with other physicians in your community who are considering ACO participation or have already joined one. Ask the ACO for a list of its providers to determine if they have physicians on board you respect and can work with professionally. Talk to these physicians to find out why they opted to join this particular ACO and whether they are still confident they chose wisely. Ask questions of the organizers about the potential risk exposures to determine if the ACO has taken appropriate steps to mitigate those risks.

Resources

Centers for Medicare and Medicaid
ACO initiatives at CMS: www.cms.gov/aco

Shared Savings Program Final Rule: www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/index.html

Information about applying to participate in the Shared Savings Program: www.cms.hhs.gov/sharedsavingsprogram/

Medicare Shared Savings Program and FAQs: www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/FAQ.html

Final Rule Fact Sheets: www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/News.html

- Summary of Final Rule Provisions for Accountable Care Organizations under the Medicare Shared Savings Program
- Federal Agencies Address Legal Issues Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program
- Improving Quality of Care for Medicare Patients: Accountable Care Organizations
- Advance Payment Accountable Care Organization (ACO) Model
- Accountable Care Organizations: What Providers Need to Know

Guide to Participation of CMS Accountable Care Organizations in the 2012 Physician Quality Reporting System and 2012 Electronic Prescribing Incentive Program Group Practice Reporting Option: www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Quality_Measures_Standards.html

American Medical Association
ACOs, CO-OPs and other options: A "how-to" manual for physicians navigating a post-health reform world, 2nd edition. American Medical Association: www.ama-assn.org/resources/doc/psa/physician-how-to-manual.pdf

American Academy of Family Practice
FAQs about ACOs: www.aafp.org/online/en/home/practicemgt/specialtopics/designs/practiceaffiliationoptions/faq.html

AAFP/AAP/ACP/AOA
Joint Principles for Accountable Care Organizations: www.aafp.org/online/en/home/media/releases/2010b/aco-jointprinciples.html

[1] Pub. L. No. 111-148 (Mar. 23, 2010); CMS-1345-P, pp. 180-181.
[2] The Final Rule for ACOs in the Medicare Shared Savings Program. Federal Register 76(212): 67802-67990, November 2, 2011.
[3] The individual quality performance measures in each domain category can be found at: www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Quality_Measures_Standards.html

Questions?

If you have any questions you'd like our Connection experts to answer, please e-mail them to riskmanagement@psicinsurance.com

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