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ACCOUNTABLE CARE ORGANIZATIONS - WHAT THEY ARE AND WHAT THEY CAN BE

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The Accountable Care Organization (ACO) is a relatively new label given to the strategy of rewarding providers for achieving cost savings and quality care goals. The federal government has developed its own ACO program applicable to Medicare patients. Practically, ACOs are networks of physicians and other providers who are paid based upon how they handle the cost and quality of a full continuum of care delivered to a specified group of patients. In theory, the providers can earn a profit beyond a normal fee for service rate if the network attains certain financial and/or quality goals. How ACOs started and where they are going is the topic of this article.

Historically, organizations like Kaiser Permanente and the Mayo Clinic have attempted to organize physicians and hospitals to coordinate (by themselves) the overall care of patients in an effort to achieve certain financial and quality of care objectives. These arrangements have taken the form of hospital physician joint ventures (PHOs), independent practice associations (IPAs) and a variety of other similar organizations. Frequently these efforts were funded through Health Maintenance Organizations (a form of a state licensed insurance company) which were granted favorable capital and surplus requirements by the various state insurance commissioners. Ultimately, however, most of these models attempted to restrict the access patients had to various providers. Patient resistance to limited provider

choices, coupled with relatively manageable insurance premiums kept the provider industry from achieving some of the objectives that are now the goals of the ACO.

Recently, the Affordable Care Act authorized the federal government, through the Medicare program, to enter into contracts with ACOs to become what is called the Medicare Shared Savings Program. The Centers for Medicare and Medicaid Services (CMS) was given the authority to decide the rules and standards for this ACO program and that agency issued final regulations in October of 2011. In May of 2011, the government also formed a new Pioneer ACO model targeted at a specific population of organizations that had historically managed financial risk and had created standards for accountability for quality related performance. Approximately 32 healthcare organizations participated in the Pioneer program and the program continues through the date of this article. A unique aspect of the Pioneer ACO is that although the providers will be eligible for large bonuses if they control healthcare expenditures, they are at risk to repay Medicare substantial amounts if they end up increasing costs or accelerating the growth of government spending.

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Under certain ACO programs it is anticipated that providers can receive 50%-60% of the savings they generate from patient care in the form of bonuses. However, under the federal ACO program, those bonuses are capped at 10%-15% of the spending target. In order to receive the higher returns, providers must remain at financial risk in the event the amount of spending exceeds projections. ACOs must also submit written plans to CMS explaining how they intend to promote beneficiary engagement, coordinate care and satisfy the other criteria.

According to the new Medicare Shared Savings Program, CMS will monitor 33 quality measures relating to care coordination, preventative health, patient/caregiver experience, and patient safety. If providers do not perform appropriately under these various categories, they will not be eligible for any of the shared savings. As a change from historical strategies, patients are able to continue to see any physician they desire regardless of whether the patient is part of the ACO pool. However, the fewer controls the providers have over the specific patient population, the harder it is for the providers to achieve cost savings. Therefore, most providers believe the cost/risk is too great to be part of the federal ACO programs.

Another difficulty with the new ACO program is that patients do not have a specific incentive to be part of any organized program. Nothing in the law automatically reduces the cost of care for the patient. There are questions whether the ACOs will improve or exacerbate health disparities among racial and socioeconomic groups. The concern is that attempts to control patient care may drive ACOs to work in areas where a higher proportion of the population has private insurance and where providers receive reimbursement at a higher level. This could decrease access to minorities and other groups that may have adverse medical profiles.

Despite these issues, the private sector is developing ACOs. The most successful ACOs will be ACOs where both the insurance company or other payor and the providers work together to mitigate the cost of care. A critical component will be strategies for communicating directly with

patients to change patient behavior. The providers will develop best practices and other protocols for handling specific disease states and patient conditions. Through the development of communication centers, patients will be contacted and encouraged to not only report adverse medical conditions that if treated immediately may reduce future costs but will also be encouraged to take steps to prevent adverse occurrences through various wellness initiatives.

With the increase in the availability of telemedicine and other electronic transmissions of health information, it is expected that successful ACOs will be monitoring patient health not only through direct patient contact but through at home monitoring devices tied to provider information systems that will notify providers if there is a material adverse change in the physical condition of a patient. Again, all of these initiatives will require the patients to cooperate and be engaged in these new healthcare delivery strategies.

Almost everyone agrees that fee for service medicine (a system where providers are paid for every procedure that they perform) will be mitigated if not eliminated by the new Shared Savings Programs. Providers will be paid for achieving quality indicators as well as meeting financial budgets. The key for providers and payors is to assure that the design of the financial strategy creates incentives for the providers to reduce the cost of care and enhance the quality of care. The result is to reduce the number of procedures and inpatient hospital days. Thus, providers who fail to be part of one of these programs could encounter significant financial problems.

Healthcare providers looking to form or become part of ACOs must carefully review the federal Stark laws, anti-kickback regulations and the anti-trust rules. The

federal government has attempted to address safe harbors from each of these three types of legal mandates for Medicare certified ACOs. The question remains how these three types of laws will affect private ACOs. The general concern is that by sharing risk and sharing funds, providers will have the incentive to self-refer, will have a financial incentive to refer patients to other providers within the ACO and may have the ability to use a collective bargaining power to set prices in the marketplace. Designing ACO strategies that can avoid the pitfalls of these major federal regulations require the skill of a knowledgeable healthcare attorney and other advisors.

In April of 2012 the Centers for Innovation will be announcing millions of dollars in grants to selected organizations, many of which will be developing new types of ACO models. Any time the federal government begins developing new programs or starts new initiatives that impact the private sector, entrepreneurial individuals try to develop new types of programs that profit from these opportunities. It is anticipated that once the grants from the Centers for Innovation are announced, there will be multiple new programs and new delivery strategies for providers to explore. Clearly, the goal for everyone is to reduce the cost of health care while increasing the quality of health care. The challenge is to find a way to reach both of those objectives while retaining enough financial incentives to keep quality providers in the business of medicine.

The good news is that we are only beginning to see what will be new strategies for the delivery of health care services and the financing of health care services. The new ideas that are being developed and the new programs that are being promoted are anticipated to drastically change the patient experience and create opportunities for providers of all types to succeed in the business as well as the practice of medicine.

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We could use some help!

If you are interested in joining the Publication Committee or would be interested in writing an article, please contact one of the above committee members.

Deadline for submission of articles for the next newsletter is May 15, 2012.