

HBS *Update*

FALL
2010 RHC
Update Seminars

Healthcare Reform Implications

Electronic Medical Records Stimulus Payments

RHC Billing

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LOCATIONS / DATES

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HBS Rural Health Clinic Billing Seminar

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Healthcare Reform

How Reform Effects Physician Practices and Rural Health Clinics



Mark Lynn

Healthcare Business Specialists

(423) 899 - 0945

www.ruralhealthclinic.com

This is a sample of the presentation on healthcare reform that will be presented as a part of the RHC Update Seminars this Fall. This is not the final nor is it the complete presentation.



What is Healthcare Reform?

Healthcare reform is derived of several different bills enacted by the Obama Administration.

First, on Feb. 13, 2009, Congress passed the American Recovery and Reinvestment Act of 2009 at the urging of President Obama, who signed it into law four days later. A direct response to the economic crisis, the Recovery Act has provided \$27 billion of stimulus payments to hospitals and physicians to encourage the adoption of electronic health records and another 1.1 billion to provide comparative effectiveness research in healthcare.

On March 23, 2010, President Obama signed into law the Affordable Care Act. The law puts into place comprehensive health insurance reforms that will hold insurance companies more accountable and will lower health care costs, guarantee more health care choices, and enhance the quality of health care for all Americans.

The Act will not be implemented all at once. Portions of the law have already taken effect. Other changes will be implemented through 2014 and beyond.



The Patient Protection and Affordable Care Act (PPACA), Public Law 111-148 is 906 pages and its companion bill is called The Health Care and Education Reconciliation Act of 2010 signed into law on March 30, 2010 and is 55 pages. The laws are included in Tab 3 of your CD as PDFs.



Introduction

This is from the Annals of Internal Medicine and provides a good introduction to the law. Here is the link for the full text of the article.

<http://www.annals.org/content/early/2010/08/23/0003-4819-153-8-201010190-00274.1.full?aimhp#abstract-1>

“The Affordable Care Act is a once-in-a-generation change to the U.S. health system. It guarantees access to health care for all Americans, creates new incentives to change clinical practice to foster better coordination and quality, gives physicians more information to make them better clinicians and patients more information to make them more value-conscious consumers, and changes the payment system to reward value. The Act and the health information technology provisions in the American Recovery and Reinvestment Act removes many barriers to delivering high-quality care, such as unnecessary administrative complexity, inaccessible clinical data, and insufficient access to primary care and allied health providers.

To realize the full benefits of the Affordable Care Act, physicians will need to embrace rather than resist change. The economic forces put in motion by the Act are likely to lead to vertical organization of providers and accelerate physician employment by hospitals and aggregation into larger physician groups. The most successful physicians will be those who most effectively collaborate with other providers to improve outcomes, care productivity, and patient experience.





Key Summary Points

How the Affordable Care Act and the American Recovery and Reinvestment Act Are Likely to Affect the Practice of Medicine:

- Focusing care around exceptional patient experience and shared clinical outcome goals.
- Expanding the use of electronic health records with capacity for drug reconciliation, guidelines, alerts, and other decision supports.
- Redesigning care to include a team of nonphysician providers, such as nurse practitioners, physician assistants, care coordinators, and dietitians.
- Establishing, with physician colleagues, patient care teams to take part in bundled payments and incentive programs, such as accountable care organizations and patient-centered medical homes.
- Proactively managing preventive care—reaching out to patients to assure they get recommended tests and follow-up interventions.
- Collaborating with hospitals to dramatically reduce readmissions and hospital-acquired infections.
- Engaging in shared decision-making discussions regarding treatment goals and approaches.
- Redesigning medical office processes to capture savings from administrative simplification.
- Developing approaches to engage and monitor patients outside of the office (e.g., electronically, home visits, other team members).
- Incorporating patient-centered outcomes research to tailor care appropriate for specific patient populations.



The Act guarantees access to health care for all Americans, providing physicians with incentives and information to change the way that they deliver care, offering patients new and better information about practitioners and treatment options, creating strong incentives to improve quality and reliability both in hospitals and throughout the continuum of care, and implementing policies that will slow the rate of cost growth to make health care more affordable. Although full implementation will take a decade, many of the most important patient protection and delivery system provisions either have already been implemented or will be enacted in the next year. For this reason, it is important that physicians make themselves aware of the objectives, major provisions, and physician implications of the Affordable Care Act.”

Table. Summary of Affordable Care Act Objectives, Major Provisions, and Physician Implications

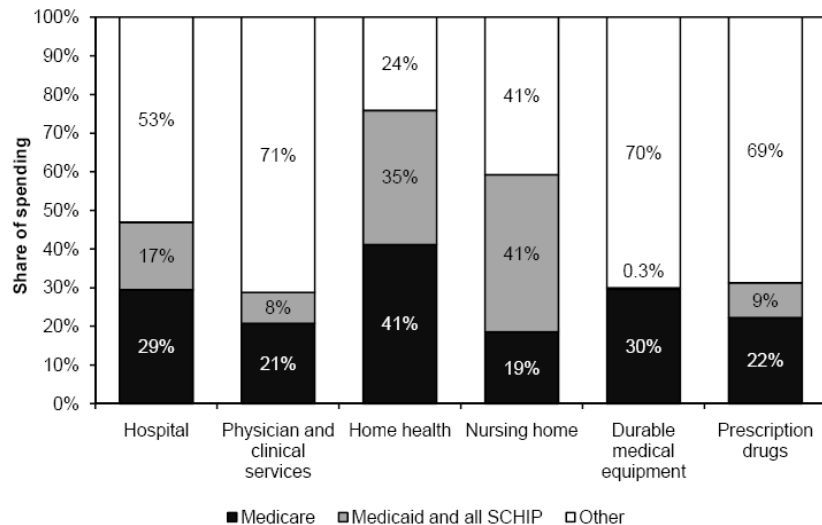
Objectives	Major Provisions	Physician Implications
Guaranteeing access to health care for all Americans	<ul style="list-style-type: none"> Subsidized coverage and Medicaid expansion Eliminates Medicare drug “donut hole” Removes annual and lifetime limits on coverage Outlaws rescissions Eliminates preexisting condition exclusions for children Temporary high-risk insurance pool 	<ul style="list-style-type: none"> To meet expanded demand for health care: <ul style="list-style-type: none"> Redesign care to include a team of nonphysician providers, such as nurse practitioners, physician assistants, care coordinators, and dietitians Develop approaches to engage and monitor patients outside of the office
Improving information and creating incentives to change clinical practice	<ul style="list-style-type: none"> Offers free preventive care Creates Patient Centered Outcomes Research Institute Incentives to create patient-centered medical homes and accountable care organizations Pilots of bundled and alternative payment models Funding to adopt electronic health records Incentives to reduce readmissions and hospital-acquired infections Expands access to physician, hospital, drug, and device quality and safety data 	<ul style="list-style-type: none"> To meet the quality, productivity, information transparency, and payment reform requirements: <ul style="list-style-type: none"> Focus care around exceptional patient experience and shared clinical outcome goals Engage in shared decision-making discussions regarding treatment goals and approaches Proactively manage preventive care Establish teams to take part in bundled payments and incentive programs Expand use of electronic health records Collaborate with hospitals to dramatically reduce readmissions and hospital-acquired infections Incorporate patient-centered outcomes research to tailor care
Removing barriers	<ul style="list-style-type: none"> Removes unnecessary administrative and billing complexity Expands National Health Service Corps and increases amount of loan repayment Expands primary care residency slots Increases funding for medical and allied health professional training Increases pay for primary care by 10% 	<ul style="list-style-type: none"> To capture value: <ul style="list-style-type: none"> Redesign medical office processes to capture savings from administrative simplification



Medicare's Share of Current Spending

When health reform discussions started, Medicare was not a large part of the talks; however, Medicare provides 29% of the funding to hospitals and 21% to physicians. In addition Medicaid provides 17% of the funding to hospitals and 8% to physicians. Medicare reform soon became a bi-product of this process.

Chart 1-4. Medicare's share of total spending varies by type of service, 2008



Note: SCHIP (State Children's Health Insurance Program). Personal health spending includes spending for clinical and professional services received by patients. It excludes administrative costs and profits. Totals may not sum to 100 percent due to rounding. Other includes private health insurance, out-of-pocket spending, and other private and public spending.

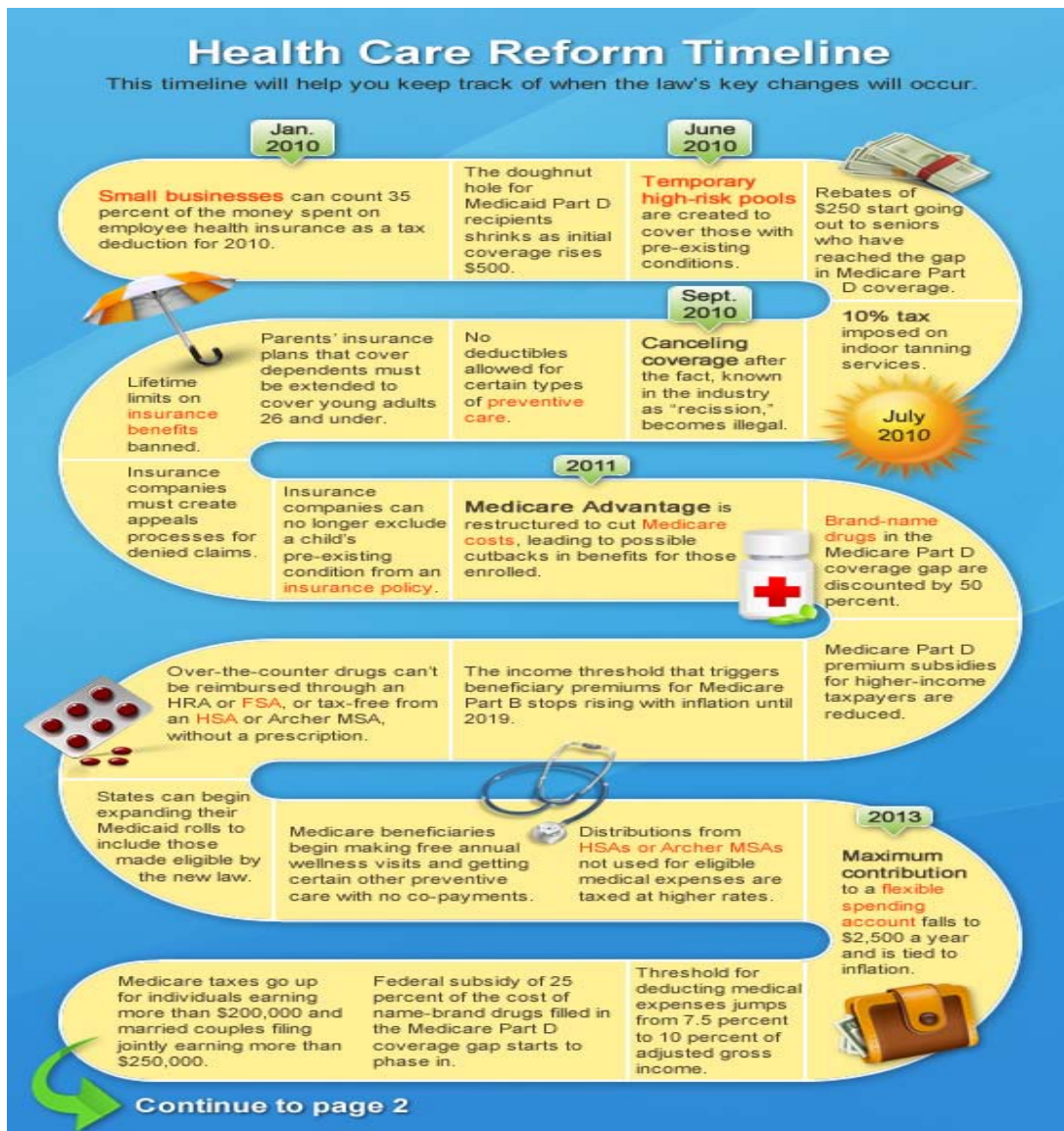
Source: CMS, Office of the Actuary, National Health Expenditure Accounts, 2010.

- The level and distribution of spending differ between Medicare and other payers, largely because Medicare covers an older, sicker population and does not cover services such as long-term care.
- In 2008, Medicare accounted for 29 percent of spending on hospital care, 21 percent of physician and clinical services, 41 percent of home health services, 19 percent of nursing home care, 30 percent of durable medical equipment, and 22 percent of prescription drugs.



When is does Health Care Reform Occur?

<http://www.bankrate.com/finance/insurance/timeline-for-health-care-reform-1.aspx>





Health Care Reform Timeline

(Continued)

2014

State-based insurance exchanges for individuals and small businesses will be online with four standard levels of coverage.

Tax credits are issued to help the uninsured earning from 100% to 400% of the federal poverty line to buy insurance.



States expand their Medicaid programs to include newly eligible beneficiaries.

Insurance plans can't exclude pre-existing conditions or consider them when setting rates and deciding whom to cover.

Tax penalty begins phasing in for those without insurance. Tax starts at \$95 per year in 2014, or 1 percent of taxable income.

Maximum small-business tax credit for buying employees insurance jumps to 50 percent.

Medicaid covers children, parents and childless adults not under Medicare who earn up to 133 percent of the poverty line.

Employees who get insurance through their employers can opt to receive a voucher for the exchanges instead.



Insurance plans can no longer place annual dollar limits on the amount of coverage a participant can receive.

2015

Maximum tax penalty for not having insurance rises to \$325 a year, or 2 percent of taxable income.

Businesses with more than 50 employees are required to provide health insurance to employees or pay hefty fees.



2016

Maximum tax penalty for not having insurance rises to \$695 a year, or 2.5 percent of taxable income.

Businesses with more than 100 employees can shop for health insurance on state insurance exchanges.

2017

2018

Excise tax begins on health plans costing more than \$27,500 for families and \$10,200 for individuals.

2020

Drug makers' discounts and government subsidies rise on brand-name drugs for Medicare recipients, closing the "doughnut hole."



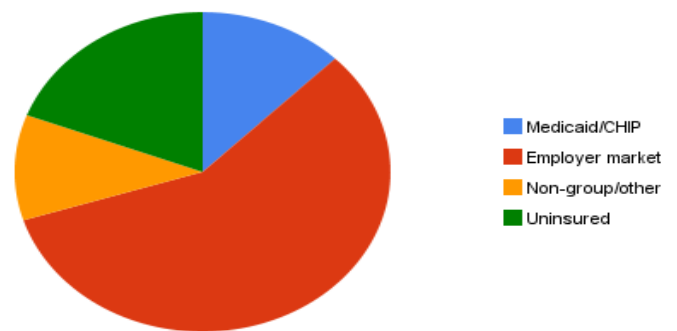
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How will Reform affect Insurance coverage?¹

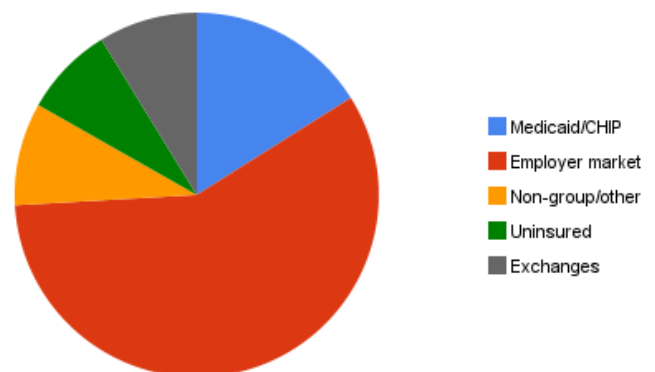
The graph shows the predicted insurance situation (numbers come from [this CBO report](#)) for non-elderly Americans if health-care reform didn't pass. It's not a pretty graph, but it'll do the trick. You're seeing 162 million people in the employer market, 54 million uninsured, 35 million people on Medicaid or the Children's Health Insurance Program, and 30 million people in the non-group/other market (this contains not just the individual market but small public plans). To put that slightly differently: No insurance is predicted to be the second-most common arrangement. Compare that to the post-reform prediction:

Insurance coverage in 2019: No reform



Here you're seeing 159 million Americans on the employer market, 44 million on Medicaid or the Children's Health Insurance Program, 25 million on the non-group/other market, 24 million in the exchanges, and 22 million left uninsured. The uninsured category has gone from the second largest to

Insurance coverage in 2019: With reform



¹ This information is from an article by Ezra Klein.

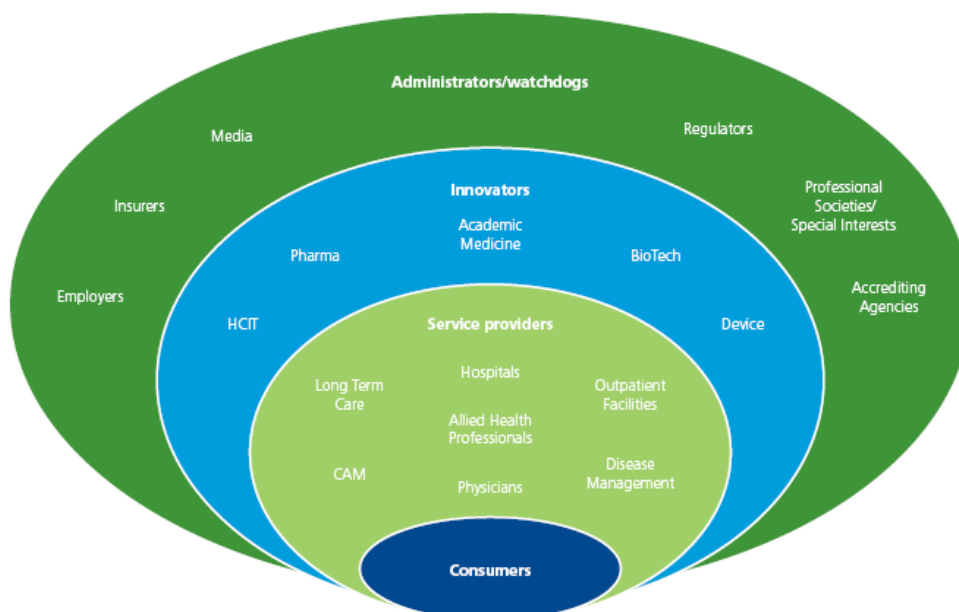


the absolute smallest. And though there's no public option, there are a lot more people eligible for public programs. But all in all, only 40 million Americans are in a different insurance situation than would otherwise have been the case. Three-quarters of them would've been otherwise uninsured, and a few more would've been on the individual markets or getting insurance through a small business who's now using the exchange.

But some of you have asked why there's an uninsured category at all. There are a couple of reasons. About a third of the remaining uninsured are illegal immigrants, who are ineligible for coverage through the program. Then there are some folks who have incomes below the individual mandate threshold. Under the terms of the individual mandate, if coverage would cost more than 8 percent of their monthly income, they can skip it. Other people will decide to pay the individual mandate's \$750 penalty rather than purchase insurance. Still others will be eligible for public programs such as Medicaid but won't sign up.

So the population of the uninsured will be far reduced, and primarily composed of illegal immigrants, the few people who can't afford their insurance and aren't getting subsidies to help them purchase it, and people who have decided to pay the penalty rather than purchase insurance.

Context: The U.S. health system is big, complex, fragmented, expensive





Who are the Winners and Losers

The most frequent question I am asked as I travel is “who are the winners and losers in the reform bill”. Most often, the questioner seeks a sector-by-sector answer, hoping one stands out as the “victim” of reform.

The answer is not quite so simple. I’ve thought about it a lot. I have methodically read through the bill six times pad and pen in hand. I follow the daily rulemaking, committee hearings etc. to know where winners and losers might be. My conclusions at this point are two:

First, the “bill” is only part of the set of federal and state mandates, rules and regulations that will be written in coming weeks and months, so it is probably too soon to know. The devil is in the detail to follow.

Second, in all likelihood, there will be winners and losers in each sector. Health insurance plans face enormous hurdles in the new normal but many will survive and thrive as the insurance market expands and diversified offerings emerge. Hospitals face incredible challenges: accountable care, physician alignment, bundled payments, Medicare cuts and more while meeting deadlines for ICD-10 and electronic health record adoption. The suppliers to the industry—drug companies, biotech, medical device, durable medical equipment etc.—their customers face declining margins and pressure to cut costs. Long-term care must navigate in a world where their performance is transparent and costs more tightly managed while demand is explosive. And physicians—no fix to the payment formula apparent, no liability reform in the near term, increased transparency and limitations on conflicts of interest, and seemingly every element of PPACA encouraging integration over independence and autonomy.



My take: there's no way to know for sure yet. Organizations that are adaptive to change, innovative in strategy and execution, and willing to take risk will survive and thrive. Others will fail. Each sector will face new rules, new realities and new challenges resulting from PPACA and its cadre of follow-on rules and regulations. Some organizations will focus exclusively on PPACA; others will consider it alongside increased demand for improved value, better service, lower costs, new solutions and demonstration of quality.

Winners and losers? Hard to say, but safe to say in every sector, there will be both. And it's prudent to recall that changes of this magnitude in other industries and in health care historically have resulted in a host of new winners. Stay tuned.²



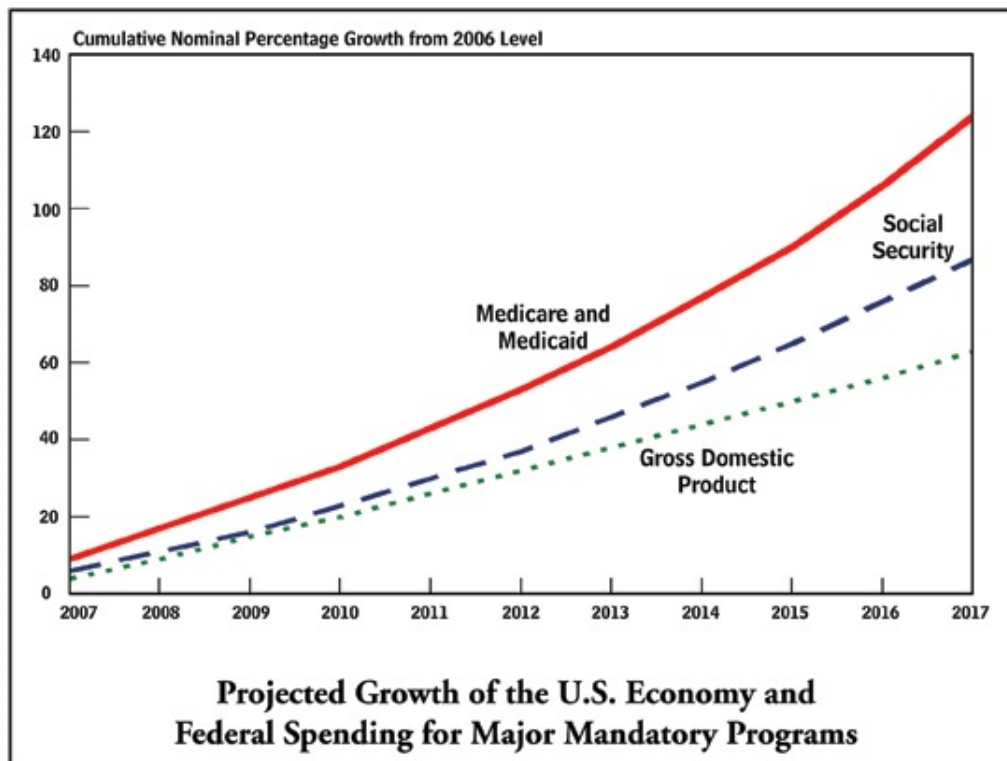
"You telling the Governor or should I?"

² This information is from [Paul Keckley, Ph.D.](#)
Executive Director, Center for Health Solutions



Bending the Cost Curve

One of the promises of healthcare reform is to reduce the spending growth rate from 6.8% to 5.5% percent over a 10 year period of time. The plan is projected to reduce the federal deficit by \$132 billion³ over the next 10 years and cost a projected \$940 billion over the same period of time. The savings are projected to extend the life of the Medicare trust fund by 12 years.



³ http://www.cbo.gov/ftpdocs/113xx/doc11307/Reid_Letter_HR3590.pdf



The Medicare Trustees Report - 2010⁴

“The outlook for Medicare has improved substantially because of program changes made in the Patient Protection and Affordable Care Act as amended by the Health Care and Education Reconciliation Act of 2010 (the "Affordable Care Act" or ACA). Despite lower near-term revenues resulting from the economic recession, the Hospital Insurance (HI) Trust Fund is now expected to remain solvent until 2029, *12 years longer than was projected last year, and the 75-year HI financial shortfall has been reduced to 0.66 percent of taxable payroll from 3.88 percent in last year's report. Nearly all of this improvement in HI finances is due to the ACA.* The ACA is also expected to substantially reduce costs for the Medicare Supplementary Medical Insurance (SMI) program; projected program costs as a share of GDP over the next 75 years are down 23 percent relative to the costs projected for the 2009 report.

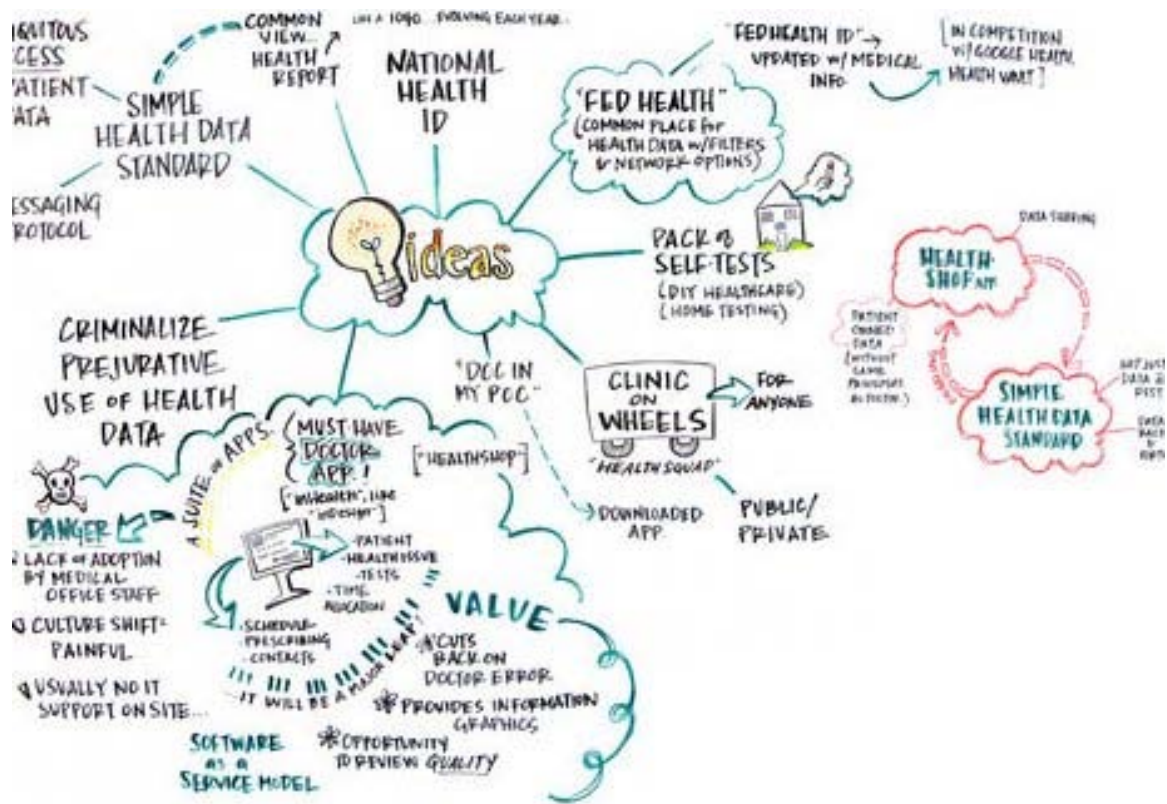
Much of the projected improvement in Medicare finances is due to a provision of the ACA that reduces payment updates for most Medicare goods and services other than physicians' services and drugs by measured total economy multifactor productivity growth, which is projected to increase at a 1.1 percent annual rate on average. This provision is premised on the assumption that productivity growth in the health care sector can match that in the economy overall, rather than lag behind as has been the case in the past.

This report notes that achieving this objective for long periods of time may prove difficult, and will probably require that payment and health care delivery systems be made more efficient than they are currently. To facilitate this outcome, the ACA establishes a broad program of research on innovative

⁴ <http://www.ssa.gov/OACT/TRSUM/index.html>



new delivery and payment models to improve the quality and cost-effectiveness of health care for Medicare – and, by extension, for the nation as a whole. The improvement in Medicare’s finances projected in this report highlights the importance of making every effort to make sure that ACA is successfully implemented. If health care efficiency cannot be substantially improved through productivity gains or other measures, then over time the statutory Medicare payment rates would become inadequate. In that situation, the payment update reductions might be suspended, in which case actual long-range costs would be larger than those projected under current law.”





Quotable

Medicare

"Health insurance companies hate insuring people who need health care."

Medicare

"Prices are determined not by quality; but, by leverage. The larger hospital and physician groups charge more because they can."

Medicare



Accountable Care Organizations⁵

“The accountable care organization has been a model for health care reform, yet its modest success has been limited to a handful of health care systems across the country. However, the accountable care organization model has recently taken on far greater significance since being introduced as one of Medicare’s pilot programs in the Senate’s health reform bill.

The phrase is attributed to [Dr. Elliot Fisher](#) of Dartmouth Medical School. Dr. Fisher has led the Dartmouth Atlas Project – a project that has, for the last 30 years, painstakingly documented the variation in care across the United States. (Click [here](#) for an interactive map of some of the Dartmouth Atlas results). The Dartmouth Atlas has focused on both the quality of health care as well as its cost. More importantly, they have reported on the relationship between the two, and their findings are nothing short of an indictment of our current paradigm.

Specifically, [their findings](#) illustrate that there exists wide variations in the cost of care across the country, and profoundly, that the regions that spend more per patient do not necessarily obtain better outcomes. So what to do? Dr. Fisher believes he has found at least part of the answer: the Accountable Care Organization, known as an “ACO”.

What is an ACO, and How Does it Differ from Other Payment Reforms?

In his paper “[Creating Accountable Care Organizations: The Extended Hospital Medical Staff](#),” Dr. Fisher acknowledges that the term ACO “grew out of an exchange between he and Dr. Glenn Hackbarth at a MedPAC

⁵ A Guide to Accountable Care Organizations, and Their Role in the Senate’s Health Reform Bill, March 11, 2010 by [Jordan T. Cohen](#)



meeting in November of 2006". (Fisher, 2006 n. 7). Dr. Fisher's purpose in writing the aforementioned paper was to help identify the proper "locus for shared accountability" for a patient's health care. HMO's and other health insurers are obvious candidates, but as Dr. Fisher notes, HMOs only comprise a small percentage of the current market, and health plans in general have focused on negotiating favorable prices within relatively open networks of providers. (Fisher, 2006, p. 45). The "[medical home](#)" (also referred to as a Patient Centered Medical Home or PCMH) is another candidate, but is taken out of the running by Dr. Fisher because of the untested nature of medical homes, and their requirement of new payment mechanisms. (Id.).

Dr. Fisher notes that a better option already exists: "virtual" organizations consisting of the various physicians that are associated with local acute care hospitals. As Dr. Fisher notes, these physicians are either directly affiliated with such hospitals through their inpatient work, or through the care patterns of the patients they serve. Dr. Fisher refers to these multi-speciality group practices that are bunched around local hospitals as an "extended hospital medical staff." He argues that improving quality and lowering cost should be realized by fostering greater accountability on the part of this "extended medical staff."

In a recent Urban Institute paper on ACOs by Kelly Devers and Robert Berenson (pdf summary [here](#), full pdf [here](#)), the authors point to three essential characteristics of ACOs:

1. The ability to provide, and manage with patients, the continuum of care across different institutional settings, including at least ambulatory and inpatient hospital care and possibly post acute care;
2. The capability of prospectively planning budgets and resource needs; and
3. Sufficient size to support comprehensive, valid, and reliable performance measurement. (Berenson, p. 2.).

In exchange for investing in this reformed health care provider structure, the ACO members will share in the savings that results from their cooperation



and coordination. Thus, ACOs can—theoretically—act as a reform tool by incentivizing more efficient and effective care. This would help to combat the current perverse incentives of overutilization and overbuilding of health care facilities and technology.

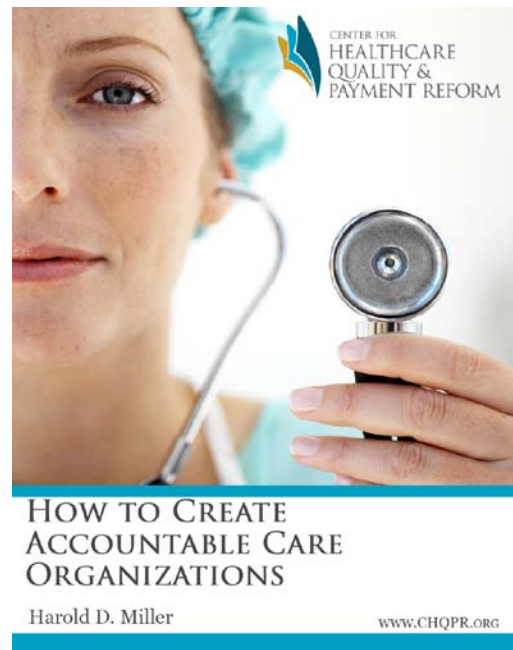
In 2007, Dartmouth’s Institute for Health Policy and Clinical Practice headed by Dr. Fisher and Dr. James Weinstein, teamed up with the Brookings Institution’s Mark McClellan to create The [Brookings-Dartmouth ACO Learning Network](#). The ACO Learning Network will serve as a support tool for providers looking to transition to the ACO framework. In the [“Overview” section of their site](#) (available as a pdf [here](#)), the Brookings-Dartmouth team provide a useful chart comparing the ACO model to other payment reform models such as “bundled payments,” “medical homes” and capitation.

How to Create Accountable Care Organizations

Here are a couple of resources on how you can create an accountable care organization. The first is the executive summary which is 8 pages and the next link is the full report which is 58 pages. Both of these PDF files are on your Seminar CD.

<http://www.chqpr.org/downloads/HowtoCreateAccountableCareOrganizationsExecutiveSummary.pdf>

<http://www.chqpr.org/downloads/HowtoCreateAccountableCareOrganizations.pdf>





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Table 1
Comparison of Payment Reform Models

	Accountable Care Organization (Shared Savings)	Primary Care Medical Home	Bundled Payments	Partial Capitation	Full Capitation
General strengths and weaknesses	Makes providers accountable for total per-capita costs and does not require patient "lock-in." Reinforced by other reforms that promote coordinated, lower-cost care	Supports new efforts by primary-care physicians to coordinate care, but does not provide accountability for total per-capita costs	Promotes efficiency and care coordination within an episode, but does not provide accountability for total per-capita costs	Provides "upfront" payments that can be used to improve infrastructure and process, but provides accountability only for services/providers that fall under partial capitation, and may be viewed as too risky by many providers/patients	Provides "upfront" payments for infrastructure and process improvement and makes providers accountable for per-capita costs, but requires patient "lock-in" and may be viewed as too risky by many providers/patients
Strengthens primary care directly or indirectly	Yes – Provides incentive to focus on disease management within primary care. Can be strengthened by medical home or partial capitation to primary-care physicians	Yes – Changes care delivery model for primary-care physicians allowing for better care coordination and disease management	Yes/No – Only for bundled payments that result in greater support for primary-care physicians	Yes – Assuming that primary care services are included in the partial capitation model allows for infrastructure, process improvement, and a new model for care delivery	Yes – Gives providers "upfront" payments and changes the care delivery model for primary-care physicians
Fosters coordination among all participating providers	Yes – Significant incentive to coordinate among participating providers	No – Specialists, hospitals and other providers are not incentivized to participate in care coordination	Yes (for those within the bundle) – Depending on how the payment is structured, can improve care coordination	Yes – Strong incentive to coordinate and take other steps to reduce overall costs	Yes – Strong incentive to coordinate and take other steps to reduce overall costs
Removes payment incentives to increase volume	Yes – Adds an incentive based on value, not volume	No – There is no incentive in the medical home to decrease volume	No, outside the bundle – There are strong incentives to increase the number of bundles and to shift costs outside	Yes/No – Strong efficiency incentive for services that fall within the partial capitation model	Yes – Very strong efficiency incentive
Fosters accountability for total per-capita costs	Yes – In the form of shared savings based on total per-capita costs	No – Incentives are not aligned across provider, no global accountability	No, outside the bundle, no accountability for total per-capita cost	Yes/No – Strong efficiency incentive for services that fall within partial capitation	Yes – Very strong accountability for per-capita cost
Requires providers to bear risk for excess costs	No – While there might be risk-sharing in some models, the model does not have to include provider risk	No – No risk for providers continuing to increase volume and intensity	Yes, within episode – Providers are given a fixed payment per episode and bear the risk of costs within the episode being higher than the payment	Yes – Only for services inside the partial capitation model	Yes – Providers are responsible for costs that are greater than the payment
Requires "lock-in" of patients to specific providers	No – Patients can be assigned based on previous care patterns, but includes incentives to provide services within participating providers	Yes – To give providers a PMPM payment, patients must be assigned	No – Bundled payments are for a specific duration or procedure and do not require patient "lock-in" outside of the episode	Yes (for some) – Depending on the model, patients might need to be assigned to a primary-care physician	Yes – To calculate appropriate payments, patients must be assigned



Exhibit 1. Accountable Care System Models and Core Capabilities

<u>Accountable Care System Models</u>	Redesign Care Processes	Teamwork	Care Coordination	<u>Core Capabilities</u>			
				Performance Accountability	Information Technology	Knowledge Management	Change Management
(1) Multi-Specialty Group Practice (MSGP) ^a	High	High	High	High	High	High	Medium
(2) Hospital Medical Staff Organization (HMSO) ^b	Medium	Medium	High	High	High	Low to Medium	Low to Medium
(3) Physician Hospital Organization (PHO) ^c	Medium	Medium	Medium	High	High	Medium	Medium
(4) Interdependent Provider Organization (IPO) ^d	Low	Low	Low to Medium	Medium	Low	Low	Low
(5) Health Plan Provider Organization / Network (HPPO/HPPN) ^e	Medium	Low to Medium	Low to Medium	Medium to High	Low to Medium	Low to Medium	Low to Medium

^a 17-26 percent of practicing physicians in groups of 100 plus including institutionally based; 35 percent in groups of 20 plus

^b Almost all 718,000 practicing physicians

^c Estimated 37 percent of practicing physicians; see text

^d 48% of office-based in solo or 2 person partnership; 89% in arrangements of 10 physicians or less; 38% members of IPA's

^e 38% members of IPA's



Accountable Care Organizations - Regulations

‘SHARED SAVINGS PROGRAM

‘Sec. 1899. (a) Establishment-

‘(1) IN GENERAL- Not later than January 1, 2012, the Secretary shall establish a shared savings program (in this section referred to as the ‘program’) that promotes accountability for a patient population and coordinates items and services under parts A and B, and encourages investment in infrastructure and redesigned care processes for high quality and efficient service delivery. Under such program--

- ‘(A) 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 in this section as an ‘ACO’); and*
- ‘(B) ACOs that meet quality performance standards established by the Secretary are eligible to receive payments for shared savings under subsection (d)(2).*

‘(b) Eligible ACOs-

‘(1) IN GENERAL- Subject to the succeeding provisions of this subsection, as determined appropriate by the Secretary, 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 program under this section:

- ‘(A) ACO professionals in group practice arrangements.*
- ‘(B) Networks of individual practices of ACO professionals.*
- ‘(C) Partnerships or joint venture arrangements between hospitals and ACO professionals.*
- ‘(D) Hospitals employing ACO professionals.*
- ‘(E) Such other groups of providers of services and suppliers as the Secretary determines appropriate.*

‘(2) REQUIREMENTS- An ACO shall meet the following requirements:

- ‘(A) 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.*
- ‘(B) 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 in this section as the ‘agreement period’).*
- ‘(C) The ACO shall have a formal legal structure that would allow the organization to receive and distribute payments for shared savings under subsection (d)(2) to participating providers of services and suppliers.*
- ‘(D) The ACO shall include primary care ACO professionals that are sufficient for the number of Medicare fee-for-service beneficiaries assigned to the ACO under subsection (c). At a minimum, the ACO shall have at least 5,000 such beneficiaries assigned to it under subsection (c) in order to be eligible to participate in the ACO program.*
- ‘(E) The ACO shall provide the Secretary with such information regarding ACO professionals participating in the ACO as the Secretary determines necessary to support*



the assignment of Medicare fee-for-service beneficiaries to an ACO, the implementation of quality and other reporting requirements under paragraph (3), and the determination of payments for shared savings under subsection (d)(2).

‘(F) The ACO shall have in place a leadership and management structure that includes clinical and administrative systems.

‘(G) The ACO shall define processes to promote evidence-based medicine and patient engagement, report on quality and cost measures, and coordinate care, such as through the use of telehealth, remote patient monitoring, and other such enabling technologies.

‘(H) The ACO shall demonstrate to the Secretary that it meets patient-centeredness criteria specified by the Secretary, such as the use of patient and caregiver assessments or the use of individualized care plans.

‘(3) QUALITY AND OTHER REPORTING REQUIREMENTS-

‘(A) IN GENERAL- The Secretary shall determine appropriate measures to assess the quality of care furnished by the ACO, such as measures of-

‘(i) clinical processes and outcomes;

‘(ii) patient and, where practicable, caregiver experience of care; and

‘(iii) utilization (such as rates of hospital admissions for ambulatory care sensitive conditions).

‘(B) REPORTING REQUIREMENTS- An ACO shall submit data in a form and manner specified by the Secretary on measures the Secretary determines necessary for the ACO to report in order to evaluate the quality of care furnished by the ACO. Such data may include care transitions across health care settings, including hospital discharge planning and post-hospital discharge follow-up by ACO professionals, as the Secretary determines appropriate.

‘(C) QUALITY PERFORMANCE STANDARDS- The Secretary shall establish quality performance standards to assess the quality of care furnished by ACOs. The Secretary shall seek to improve the quality of care furnished by ACOs over time by specifying higher standards, new measures, or both for purposes of assessing such quality of care.

‘(D) OTHER REPORTING REQUIREMENTS- The Secretary may, as the Secretary determines appropriate, incorporate reporting requirements and incentive payments related to the physician quality reporting initiative (PQRI) under section 1848, including such requirements and such payments related to electronic prescribing, electronic health records, and other similar initiatives under section 1848, and may use alternative criteria than would otherwise apply under such section for determining whether to make such payments. The incentive payments described in the preceding sentence shall not be taken into consideration when calculating any payments otherwise made under subsection (d).

‘(4) NO DUPLICATION IN PARTICIPATION IN SHARED SAVINGS PROGRAMS- *A provider of services or supplier that participates in any of the following shall not be eligible to participate in an ACO under this section:*

‘(A) A model tested or expanded under section 1115A that involves shared savings under this title, or any other program or demonstration project that involves such shared savings.

‘(B) The independence at home medical practice pilot program under section 1866E.



‘(c) Assignment of Medicare Fee-for-service Beneficiaries to ACOs- The Secretary shall determine an appropriate method to assign Medicare fee-for-service beneficiaries to an ACO based on their utilization of primary care services provided under this title by an ACO professional described in subsection (b)(1)(A).

‘(d) Payments and Treatment of Savings-

‘(1) PAYMENTS-

‘(A) IN GENERAL- Under the program, subject to paragraph (3), payments 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 paragraph (2) if-

‘(i) the ACO meets quality performance standards established by the Secretary under subsection (b)(3); and

‘(ii) the ACO meets the requirement under subparagraph (B)(i).

‘(B) SAVINGS REQUIREMENT AND BENCHMARK-

‘(i) DETERMINING SAVINGS- In each year of the agreement period, an ACO shall be eligible to receive payment for shared savings under paragraph (2) 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 below the applicable benchmark under clause (ii). The Secretary shall determine the appropriate percent described in the preceding sentence to account for normal variation in expenditures under this title, based upon the number of Medicare fee-for-service beneficiaries assigned to an ACO.

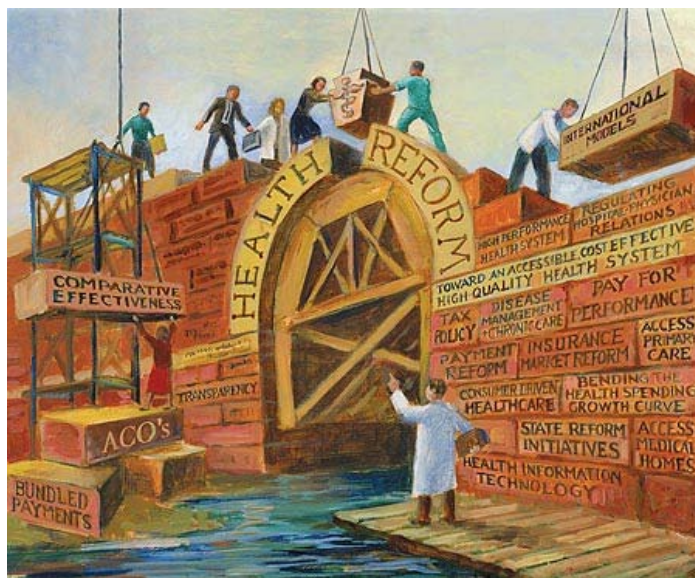
‘(ii) ESTABLISH AND UPDATE BENCHMARK- The Secretary shall estimate a benchmark for each agreement period for each ACO using the most recent available 3 years of per-beneficiary expenditures for parts A and B services for Medicare fee-for-service beneficiaries assigned to the ACO. Such benchmark shall be adjusted for beneficiary characteristics and such other factors as the Secretary determines appropriate and updated by the projected absolute amount of growth in national per capita expenditures for parts A and B services under the original Medicare fee-for-service program, as estimated by the Secretary. Such benchmark shall be reset at the start of each agreement period.

‘(2) PAYMENTS FOR SHARED SAVINGS- Subject to performance with respect to the quality performance standards established by the Secretary under subsection (b)(3), if an ACO meets the requirements under paragraph (1), a percent (as determined appropriate by the Secretary) of the difference between such estimated average per capita Medicare expenditures in a year, adjusted for beneficiary characteristics, under the ACO and such benchmark for the ACO may be paid to the ACO as shared savings and the remainder of such difference shall be retained by the program under this title. The Secretary shall establish limits on the total amount of shared savings that may be paid to an ACO under this paragraph.

‘(3) 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.



- '(4) TERMINATION- The Secretary may terminate an agreement with an ACO if it does not meet the quality performance standards established by the Secretary under subsection (b)(3).*
- '(e) Administration- Chapter 35 of title 44, United States Code, shall not apply to the program.*
- '(f) Waiver Authority- The Secretary may waive such requirements of sections 1128A and 1128B and title XVIII of this Act as may be necessary to carry out the provisions of this section.*
- '(g) Limitations on Review- There shall be no administrative or judicial review under section 1869, section 1878, or otherwise of--*
- '(1) the specification of criteria under subsection (a)(1)(B);*
 - '(2) the assessment of the quality of care furnished by an ACO and the establishment of performance standards under subsection (b)(3);*
 - '(3) the assignment of Medicare fee-for-service beneficiaries to an ACO under subsection (c);*
 - '(4) the determination of whether an ACO is eligible for shared savings under subsection (d)(2) and the amount of such shared savings, including the determination of the estimated average per capita Medicare expenditures under the ACO for Medicare fee-for-service beneficiaries assigned to the ACO and the average benchmark for the ACO under subsection (d)(1)(B);*
 - '(5) the percent of shared savings specified by the Secretary under subsection (d)(2) and any limit on the total amount of shared savings established by the Secretary under such subsection; and*
 - '(6) the termination of an ACO under subsection (d)(4).*
- '(h) Definitions- In this section:*
- '(1) ACO PROFESSIONAL- The term 'ACO professional' means--*
 - '(A) a physician (as defined in section 1861(r)(1)); and*
 - '(B) a practitioner described in section 1842(b)(18)(C)(i).*
 - '(2) HOSPITAL- The term 'hospital' means a subsection (d) hospital (as defined in section 1886(d)(1)(B)).*
 - '(3) MEDICARE FEE-FOR-SERVICE BENEFICIARY- The term 'Medicare fee-for-service beneficiary' means an individual who is enrolled in the original Medicare fee-for-service program under parts A and B and is not enrolled in an MA plan under part C, an eligible organization under section 1876, or a PACE program under section 1894.'*





Electronic Health Records-Meaningful Use

If you are not familiar with the regional extension center (RECs) which provide Electronic Health Records consulting services to physician clinics, hospitals, and rural health clinics and are funded from Recovery funds, thus providing either free or minimal cost consulting services here is a listing of the centers. Here is a link to the listing of RECs:

http://healthit.hhs.gov/portal/server.pt?open=512&objID=1495&parentname=CommunityPage&parentid=11&mode=2&in_hi_userid=10741&cached=true

These Centers provide excellent information on the implementation of the Electronic Health Records Stimulus payment program as for example, this form developed by the Iowa REC (<http://www.IowaHITREC.org>).



EHR Implementation Roadmap

Assessment	Planning	Selection	Implementation	Evaluation	Improvement
<ol style="list-style-type: none"> Learn about HITREC program and how meaningful use will benefit your practice and patients Complete Practice Assessments: <ul style="list-style-type: none"> Practice Readiness Assessment Practice Profile Office Staff Survey Patient Survey Feedback Hold regular staff meetings and select your project team 	<ol style="list-style-type: none"> Review practice data: <ul style="list-style-type: none"> Practice Assessment Office Staff Survey Patient Survey Feedback Identify and target improvement opportunities Define EHR implementation goals Prepare practice for change <ul style="list-style-type: none"> Education on meaningful use criteria Utilize project tools and optimize shared learning 	<ol style="list-style-type: none"> Understand and review available EHR solutions Define EHR system requirements Begin to prepare staff and office for an EHR system Select EHR system, solution, and vendor that meets goals and meaningful use criteria Prepare practice for change Utilize project tools and optimize shared learning 	<ol style="list-style-type: none"> Create EHR system implementation plan and timetable to achieve meaningful use criteria Install and configure hardware Install and configure EHR system Prepare staff and office for EHR implementation Complete pre-implementation baseline evaluation Go-live with EHR system Utilize project tools and optimize shared learning 	<ol style="list-style-type: none"> Conduct post go-live reviews of implementation Conduct post go-live EHR staff training Complete post-implementation evaluation Capture and submit meaningful use measures according to CMS requirements Utilize project tools and optimize shared learning 	<ol style="list-style-type: none"> Review EHR implementation impact analysis Utilize meaningful use criteria for quality improvement Utilize EHR to practice evidence-based medicine Identify and target additional care management and process improvement opportunities Utilize project tools

Tools, templates and training materials will be provided to participants throughout the duration of the project.



15 Core Objectives – Required for All EPs

No.	Objective	Measure	Old Threshold	New Threshold
1	Record Patient Demographics	Gender, race, ethnicity, DOB, and preferred language as structured data	80%	50%
2	Record Vital Signs and Chart Changes	Height, weight, blood pressure, BMI, and growth charts for children as structured data	80%	50%
3	Maintain Up-to-date Problem List	One entry recorded as structured data	80%	80%
4	Maintain Active Medication List	One entry recorded as structured data	80%	80%
5	Maintain Active Medication Allergy List	One entry recorded as structured data	80%	80%
6	Record Smoking Status	Patients age 13 and older as structured data	80%	50%
7	Provide Patients with Clinical Summaries	For each office visit to patients within 3 business days	80%	50%
8	Electronic Copy of Health Information, upon request	Upon request, including diagnostic test results, problem list, medication list, and medication allergies	80% within 48 hours of request	50% within 3 business days of request
9	Generate and Transmit Permissible Prescriptions Electronically	Using a certified EHR technology (<i>Controlled Substance Permissible 6.1.2010</i>)	75%	40%
10	Computerized Provider Order Entry (CPOE)	Patients with at least one medication in their medication list must have at least one medication ordered through CPOE	80% of All Orders	30% of Medication Orders Only
11	Implement Drug-Drug and Drug-Allergy Interaction Checks	Enable functionality	Entire Reporting Period	Entire Reporting Period
12	Implement Ability to Exchange Key Clinical Information	Electronically among providers and patient-authorized entities	1 Test	1 Test
13	Implement Clinical Decision Support and Track Compliance	One Rule implemented and tracked compliance	5 Rules	1 Rule
14	Implement Systems to Protect Privacy and Security of Patient Data	Conduct/review a security risk analysis; implement security updates as necessary and correct security deficiencies	During Reporting Period	During Reporting Period
15	Report Clinical Quality Measures (CQM)	To CMS or states; number of measures reduced from 99 to 44; all quality measures are NQF and have electronic specifications to map code for electronic transmission; 3 Core (and 3 alternative core) and 38 menu	CY2011 provide aggregate numerator / denominator through attestation; CY2012 electronic submission of measures	CY2011 provide aggregate numerator/denominator through attestation; CY2012 electronic submission of measures



10 Menu Objectives – EPs Must Choose 5

	Objective	Measure	Old Threshold	New Threshold
1	Implement Drug Formulary Checks	Must be implemented and must access at least one internal or external drug formulary	During Reporting Period	During Reporting Period
2	Incorporate Clinical Lab Test Results into EHR	Incorporated as structured data – positive/negative or numerical format – within the EHR	50%	40%
3	Generate Lists of Patients by Condition	For use in quality improvement, reduction of disparities, research or outreach.	1 List with a Specific Condition	1 List with a Specific Condition
4	Use EHR for Patient-Specific Education Resources	Provide patient-specific education resources to patients, as appropriate	Did Not Exist	10%
5	Perform Medication Reconciliation	During transitions of care	80% of relevant encounters and transitions of care	50% during transitions of care
6	Provide Summary of Care Record	Patients referred or transitioned to another provider or setting	80%	50%
7	Submission of Electronic Immunization Data to Registry/Information Systems*	Submission and follow-up submission (where registries can accept electronic submissions)	One Test	One Test
8	Submission of Electronic Syndromic Surveillance Data*	Data submission and follow-up submission to Public Health agencies (where agencies can accept electronic data)	One Test	One Test
9	Send Reminders to Patients	Preventative and follow-up care for patients aged 65+ or age 5 or less	50% of All Patients	20%
10	Timely Electronic Access to Health Information	Including lab results, problem list, medication list, medication allergies – within 4 days of being updated in the EHR	10%	10%

**Note: At least 1 public health objective must be selected.*



Electronic Health Records-Stimulus Payments

Calendar Year	First Calendar Year in which the EP Receives an Incentive Payment				2015 and subsequent years
	2011	2012	2013	2014	
2011	\$18,000				
2012	\$12,000	\$18,000			
2013	\$8,000	\$12,000	\$15,000		
2014	\$4,000	\$8,000	\$12,000	\$12,000	
2015	\$2,000	\$4,000	\$8,000	\$8,000	\$0
2016		\$2,000	\$4,000	\$4,000	\$0
TOTAL	\$44,000	\$44,000	\$39,000	\$24,000	\$0
<i>Shortage Area Totals*</i>	<i>\$48,400</i>	<i>\$48,400</i>	<i>\$42,900</i>	<i>\$26,400</i>	<i>\$0</i>

** Providers practicing in a federally identified shortage area are eligible for a 10% increase.*



Conclusion

Thanks for taking a look at our presentation on healthcare reform. This is a sample of the presentation and the type of materials that will be presented this Fall. These materials are in their draft form and may be updated and will be added to when we present our material this fall. Please sign up for the seminars if we are in your area. If you would like to subscribe to our newsletter, go to our website at www.ruralhealthclinic.com and complete the newsletter subscription information. Additionally, the sign up information for our seminars is included on the home page or you can just click the link below for a seminar close to you. Thanks again and best regards.

Mark R. Lynn

RHC Consultant

Suite 214, 502 Shadow Parkway

Chattanooga, TN 37421

Telephone: (423) 899-0945

Fax: (800) 268-5055

Email: la_vita_nouva@hotmail.com

Website: www.ruralhealthclinic.com

Business Email: marklynn@healthcarebusinessspecialists.com

Website: www.healthcarebusinessspecialists.com

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