ACO: RISK MANAGEMENT AND MITIGATION

ABA eHealth Privacy and Security Interest Group
"Americans would be... appalled if they knew the degree to which treatment took place every day in this country in the absence of all the relevant information necessary to care for the patient"

We're living in a particularly dangerous world right now because we're part paper, part electronic. People cling to the paper because it's familiar and they want it, .... and information is not congruent between electronic and the paper records."

*CEO of a large hospital system
HEALTHCARE DELIVERY ASYSTOLE

WHAT DOES THIS HAVE TO DO WITH ACCOUNTABLE CARE ORGANIZATIONS?
HEALTHCARE DELIVERY
ASYSTOLE

- Baby Boomers - Reaching Unsustainability
- Fee for Service
- Defensive Medicine
- Healthcare Reform Law - ACO improve rewards, incentives and thus quality
- Hope – integrate a fragmented system – success immense change
LEARNING OBJECTIVES

- CMS and the Pioneer ACO - early adapters and lessons learned
- Focus on Patient Health and Quality of Care
- New view of patient care as a continuum involving technical, operational and cultural changes resulting in a shift in the importance of risk assessment
- Establishing a Strategic Risk Management Process
LEARNING OBJECTIVES

- Combining Policies and Procedures with Governmental Compliance
- Designing an Effective Insurance Plan
- Final Frontier - Aligning Risk Management with Patient Health and Quality of Care
TERMS DEFINED

- ACO and PPACA and MSSP
- FFS, PPO and HMO
- DUA
- BBA
- FQHC
- PQRS and GPRO
ACO DEFINED

- ACO is a distinct legal entity
- Involving one or more Medicare providers identified by their TIN
- Who “agree to become accountable for the quality, cost and overall care”
- Of the Medicare beneficiaries assigned to the ACO
- 3 year agreement with CMS
REQUIRED ACO FUNCTIONS

- Establish and maintain ongoing quality assurance and improvement programs led by qualified healthcare professional
- Promote evidence-based medicine
- Promote patient engagement
- Report on quality and cost measures
- Promote care coordination across acute and post-acute providers
- Drive patient-centeredness
DESCRIBE THE ELEPHANT
EARLY ADAPTERS
CMS AND PIONEER ACO
PIONEER ACO

- Accountable care organizations (ACOs) burst onto the health care scene in 2011
- Federal healthcare reform's Medicare Shared Savings (MSSP) program called for creation of ACOs
- The Pioneer ACO model was tailored specifically for health care professionals/organizations already experienced in coordinating care for patients across settings and presumably prepared to take on great financial risk.
- The network is paid to provide coordinated, comprehensive care to patients and assumes responsibility for the cost and quality of that care.
PIONEER ACO

- 2013-ACO model suffered - Of the 32 participants in the Pioneer ACO Model, 9 dropped out

- 7 of the 9 Pioneer "dropouts" switched to the Medicare Shared Savings Program; though the MSSP carries less risk (and therefore less reward, it also emphasizes more coordinated care)

- The Medicare Shared Savings program, Section 1899 of the Social Security Act, is designed to achieve three goals: Better health for populations, better care for individuals, and lower growth in expenditures

- Of the original 32, only 13 Pioneer ACOs saved enough to share savings with Medicare

- 606 ACOs in the United States as of December 2013
FOCUS ON PATIENT HEALTH
QUALITY OF CARE
QUALITY OF PATIENT CARE

- **2014 GPRO Measures Using the Web Interface Reporting Method**
  - Use Web Interface to determine PQRS incentive eligibility and performance rates for the measures
  - Twenty-two 2014 GPRO Web Interface GPRO reporting method measures

- **2014 GPRO Registry Method**
  - Group practices (referred to as GPROs) may also report PQRS via the registry reporting method rather than the Web Interface
NEW CONTINUUM OF CARE
SHIFT IN RISK EXPOSURE
HEALTHCARE LEGAL RISK EXPOSURE

- Antitrust – DOJ and FTC look to unfair collusions of supposed competitors - “clinical integration exception”
- Stark Law – federal physician self referral law – ACO navigation – applies only to Medicare
- Anti-kickback Law – federal and state laws – ACO remuneration flowing to a person or entity in a position to benefit from that referral
- Civil Monetary Penalties Law – Medicare/Medicaid payments from hospital to physicians
- Privacy and Security Rule of Title II of HIPAA
- Common Law Malpractice Issues

- **STAY TUNED FOR ACO WAIVERS**
RX FOR ACO RISK

- Organizational mission and population served
- Governance and leadership
- Partnerships
- Information technology and related infrastructure
- Managing clinical care
- Performance reporting
- Finance and contracts
- Legal and regulatory issues, barriers, and risk tolerance,
- Overall assessment
ACO GOVERNANCE

42 CFR 425.106 - SHARED GOVERNANCE

§ 425.106 Shared governance. (a) General rule. An ACO must maintain an identifiable governing body with authority to execute the functions of an ACO as defined under this part, including but not limited to, the processes defined under § 425.112 to promote evidence-based medicine and patient engagement, report on quality and cost measures, and coordinate care.

(b) Responsibilities of the governing body and its members.

(1) The governing body must have responsibility for oversight and strategic direction of the ACO, holding ACO management accountable for the ACO's activities as described in this part.

(2) The governing body must have transparency

(3) The governing body members must have a fiduciary duty to the ACO and must act consistent with that fiduciary duty.

(4) The governing body of the ACO must be separate and unique to the ACO in cases where the ACO comprises multiple, otherwise independent ACO participants.

(5) If the ACO is an existing entity, the ACO governing body may be the same as the governing body of that existing entity... if satisfies ...requirements
ACO GOVERNANCE

(c) Composition and control of the governing body.

(1) The ACO must provide for meaningful participation in the composition and control of the ACO's

(2) The ACO governing body must include a Medicare beneficiary representative(s) served by the ACO who does not have a conflict of interest with the ACO, and who has no immediate family member with conflict of interest with the ACO.

(3) At least 75 percent control of the ACO's governing body must be held by ACO participants.

(4) The governing body members may serve in a similar or complementary manner for an ACO participant.

(5) In cases in which the composition of the ACO's governing body does not meet the requirements of paragraphs (c)(2) and (c)(3) of this section, the ACO must describe why it seeks to differ from these requirements and how the ACO will involve ACO participants in innovative ways in ACO governance or provide meaningful representation in ACO governance by Medicare beneficiaries.
ACO GOVERNANCE

(d) Conflict of interest. The ACO governing body must have a conflict of interest policy that applies to members of the governing body. The conflict of interest policy must—

(1) Require each member of the governing body to disclose relevant financial interests; and

(2) Provide a procedure to determine whether a conflict of interest exists and set forth a process to address any conflicts that arise.

(3) The conflict of interest policy must address remedial action for members of the governing body that fail to comply with the policy.
ACO AND TECHNOLOGY

- Healthcare Needs **Data Analytics** for the ACO Model to Succeed – to avoid the fate of HMOs – lacked data.

- By the end of 2014, about half of the nation's hospitals will be participating in an accountable care organization (ACO).

- Jump from 18 percent in the fall of 2013 and less than 5 percent in the spring of 2012.

- Dramatic growth suggests that the ACO model, with its emphasis on coordinated care and shared financial risk, will play a vital role in paving way to healthcare reform.

- When physicians, specialists and hospitalists work together — and aren't beholden to the fee-for-service model — it's expected that overall costs go down while the quality of care improves.

- Role of technology in this growth?
ACO AND RELATED INFRASTRUCTURE

- EMR improve healthcare
- Interoperability and standardization are key
- But what's the government's role, if any, in trying to harmonize the health IT space?
- ONC and FDA find balance between regulation and innovation
- To assume financial responsibility for care and meet quality goals, an ACO requires an advanced IT infrastructure that enables the ACO to manage the health of its population
- ACO Infrastructure must: optimize preventive and chronic disease care, improve care coordination, make effective use of automation, engage patients in their own care, monitor utilization, and evaluate the ACO's performance on cost and quality indicators.
PATIENT-CENTEREDNESS

42 CFR 425.112 - REQUIRED PROCESSES AND PATIENT-CENTEREDNESS CRITERIA.

(i) Promote evidence-based medicine and beneficiary engagement, internally report on quality and cost metrics, and coordinate care;

(ii) Adopt a focus on patient centeredness

(iii) Have defined processes to fulfill these requirements.

(2) An ACO must have a qualified healthcare professional responsible for the ACO's quality assurance

(3) For each process specified in paragraphs (b)(1) through (4) of this section, the ACO must—

(i) Explain how it will require ACO participants and ACO providers/suppliers compliance

(ii) Explain how it will employ its internal assessments of cost and quality of care to improve continuously the ACO's care practices.
PATIENT CRITERIA

(b) Required processes: The ACO must define, establish, implement, evaluate, and periodically update processes to accomplish the following:

(1) Promote evidence-based medicine. These processes must cover diagnoses with significant potential for the ACO to achieve quality improvements taking into account the circumstances of individual beneficiaries.

(2) Promote patient engagement. These processes must address the following areas:

(i) Compliance with patient experience of care survey requirements in § 425.500.

(ii) Compliance with beneficiary representative requirements in § 425.106.

(iii) A process for evaluating the health needs of the ACO's population, including consideration of diversity in its patient populations, and a plan to address the needs and partner with community stakeholders.
PATIENT CRITERIA

(B) An ACO stakeholder organization serving on its governing body will be deemed to have satisfied the requirement to partner with community stakeholders.

(iv) Communication of clinical knowledge/evidence-based medicine to beneficiaries in a way that is understandable to them.

(v) Beneficiary engagement and shared decision-making that takes into account the beneficiaries' unique needs, preferences, values, and priorities;

(vi) Written standards in place for beneficiary access and communication, and a process in place for beneficiaries to access their medical record.

(C) Describe additional target populations that would benefit from individualized care plans. Individual care plans must take into account the community resources available to the individual.
PATIENT CRITERIA

(3) Develop an infrastructure for its ACO participants and ACO providers/suppliers to internally report on quality and cost metrics that enables the ACO to monitor and provide feedback on success.

(4) Coordinate care across and among primary care physicians, specialists, and acute and post-acute providers and suppliers. The ACO must—

(i) Define its methods and processes established to coordinate care throughout an episode of care and during its transitions, i.e. discharge or transition of care.

(ii) Submit a description of its individualized care program, along with a sample individual care plan, and explain how this program is used to promote improved outcomes for, at a minimum, its high-risk and multiple chronic condition patients.
PATIENT CARE MANAGEMENT
ACO AND MANAGING CARE

- Simple concept - a pool of patients - government benchmarks determine the amount of money the organization receives from public and private payers to care for those patients - any money the organization saves gets shared among its members.

- More effective model to provide higher quality care to more people for less money"

- Think of HMO of past – relied on capitation - which sets a fixed amount of revenue for a healthcare provider. Success under capitation means managing risk and practicing preventive healthcare, as preventing illness costs less than treating it.

- Capitation failed for the lack of data to measure their own performance, IDC Health Insights wrote in last year's report, Business Strategy: Analytics Leads Accountable Care Investment Priority.

- It was virtually impossible for physicians to understand their own practice patterns and determine how their performance needed to be modified
ACO AND REGULATIONS

- Active collaboration among the various stakeholders in the health IT field — a large ecosystem that includes healthcare providers, insurers, developers and vendors and patient advocates.

- Federal government has been working actively on the standards front in health IT — “meaningful use”

- But the meaningful use certification is a more cautious regulatory step than if the government mandating specific technology standards — and ban others — in medical devices and applications.

- Government – balance regulation and innovation

- Technology to support policy or policy to support technology?
I will manage my diabetes and get help when I have questions.
Patient engagement = Technology + Empathy

Digitizing medical records — and making them portable and interoperable - to empower patients to take a more active role in their healthcare.

Push a regulation or pull from patient choice - it's not about the physician any longer, it's about the patients

Patients start making choices

Patient can opt in or opt out – they can veto the sharing of their Medicare claims data with ACOs

Under the final rule, PCPs must inform patient that their Medicare claims may be shared with ACO to better coordinate care – if they chose to opt out - keep list for privacy purposes

CMS states has legal authority to share Medicare claims data with ACO...choose to give patients a right to chose
code of federal regulations
QUALITY ASSESSMENT

42 CFR 425.500 - MEASURES TO ASSESS THE QUALITY OF CARE FURNISHED BY AN ACO. Measures to assess the quality of care furnished by an ACO.

(a) General. CMS establishes quality performance measures to assess the quality of care furnished by the ACO. – meet requirements share in savings

(b) Selecting measures.

(1) CMS selects the measures designated to determine an ACO’s success in promoting the aims of better care for individuals, better health for populations, and lower growth in expenditures.

(2) CMS designates the measures for use in the calculation of the quality performance standard.

(3) CMS seeks to improve the quality of care furnished by ACOs over time by specifying higher standards, new measures, or both.

(c) ACOs must submit data on the measures determined under paragraph (b) of this section according to the method of submission established by CMS.

(d) Patient experience of care survey. For performance years beginning in 2014 and for subsequent performance years, ACOs must select a CMS-certified vendor to administer the survey and report the results accordingly.

(e) Audit and validation of data. CMS retains the right to audit and validate quality data reported by an ACO.
QUALITY ASSESSMENT

(1) In an audit, the ACO will provide beneficiary medical records data if requested by CMS.

(2) The audit will consist of three phases of medical record review.

(3) If, at the conclusion of the third audit process there is a discrepancy greater than 10 percent between the quality data reported and the medical records provided, the ACO will not be given credit for meeting the quality target for any measures for which this mismatch rate exists.

(f) Failure to report quality measure data accurately, completely, and timely (or to timely correct such data) may subject the ACO to termination or other sanctions, as described in §§ 425.216 and 425.218.
MONITORING ACOS

42 CFR 425.316 - MONITORING OF ACOS.

(1) In order to ensure compliance CMS may monitor ACOs, their ACO participants, and ACO providers/suppliers.

(2) CMS employs a range of methods to monitor and assess the performance of ACOs, ACO participants, and ACO providers/suppliers, including but not limited to any of the following, as appropriate:

(i) Analysis of specific financial and quality measurement data reported by the ACO as well as aggregate annual and quarterly reports.

(ii) Analysis of beneficiary and provider complaints.

(iii) Audits (including, for example, analysis of claims, chart review (medical record), beneficiary survey reviews, coding audits, on-site compliance reviews).

(b) Monitoring ACO avoidance of at-risk beneficiaries. - CMS may use one or more of the methods described in paragraph (a)(2) of this section (as appropriate) to identify trends and patterns suggesting that an ACO has avoided at-risk beneficiaries. The results of these analyses may subsequently require further investigation and follow-up with beneficiaries or the ACO and its ACO participants, ACO providers/suppliers, or other individuals or entities performing functions or services related to the ACO’s activities, in order to substantiate cases of beneficiary avoidance.
MONITORING ACOS

(i) CMS, at its sole discretion, may take any of the pre-termination actions set forth in § 425.216(a)(1) or immediately terminate, if it determines that an ACO, its ACO participants, any ACO providers/suppliers, or other individuals or entities performing functions or services related to the ACO's activities avoids at-risk beneficiaries.

(c) Monitoring ACO compliance with quality performance standards. CMS may request additional documentation from an ACO, ACO participants, or ACO providers/suppliers, as appropriate. If an ACO does not meet quality performance standards or fails to report on one or more quality measures, in addition to actions set forth at §§ 425.216 and 425.218, CMS will take the following actions:

(1) The ACO may be given a warning for the first time it fails to meet the minimum attainment level in one or more domains as determined under § 425.502 and may be subject to a CAP. CMS, may forgo the issuance of the warning letter depending on the nature and severity of the noncompliance and instead subject the ACO to actions set forth at § 425.216 or immediately terminate the ACO's participation agreement under § 425.218.

(2) The ACO's compliance with the quality performance standards will be re-evaluated the following year. If the ACO continues to fail to meet quality performance standards in the following year, the agreement will be terminated.
ACO AND TINS

42 CFR 425.306 - PARTICIPATION AGREEMENT AND EXCLUSIVITY OF ACO PARTICIPANT TINS.

§ 425.306 Participation agreement and exclusivity of ACO participant TINs.

(a) For purposes of the Shared Savings Program, each ACO participant TIN is required to commit to a participation agreement with CMS.

(b) Each ACO participant TIN upon which beneficiary assignment is dependent must be exclusive to one Medicare Shared Savings Program ACO for purposes of Medicare beneficiary assignment. ACO participant TINs upon which beneficiary assignment is not dependent are not required to be exclusive to one Medicare Shared Savings Program ACO.
Researchers compared the growth rate in Medicare spending for beneficiaries aligned with a Pioneer ACO to two comparison groups: fee-for-service (FFS) patients not assigned to a Medicare ACO in a particular Pioneer ACO's local market and FFS Medicare patients in a similar market where Medicare ACOs were not present.

According to a Jan. 30 press release from CMS (www.hhs.gov), "Pioneer ACOs generated gross savings of (nearly) $147 million in their first year while continuing to deliver high-quality care "On average, spending was approximately $20 less per beneficiary per month than it would have been had those beneficiaries not been aligned with a Pioneer ACO"
NEXT STEPS

- Researchers said they intend to follow the key drivers for ACO success and progress.
- Explore the extent of system integration and the level of cooperation between an ACO and hospitals or hospital systems.
- Assess ability to identify and monitor patients through the "continuum of care".
- Capacity to encourage physicians and other health care professionals to deliver high-quality care while maintaining a cost-conscious attitude.
- Level of leadership and organizational culture of ACOs.
- Effect of demand-side pressures from other purchasers for ACO-like care delivery.
DATA SHARED - DATA BREACHED

LOOSE LIPS SINK SHIPS
SECURITY RISKS

- Patient care - sensors that are located in a patient’s home or that interface with the patient’s body to detect safety issues may inadvertently transmit sensitive information about household activities.

- Similarly, routine data transmissions from an app or medical device, such as an insulin pump, may be shared with third-party advertisers – leading to data breach.

- Although some federal and state guidelines for Security and privacy have been established, many gaps remain. No federal agency currently has authority to enact privacy and security requirements to cover the “telehealth ecosystem”, for example.

- Privacy risks and security threats to ACO abound: an article from Medical News Today contains data from Workshare’s “Workforce Mobilization” report, including the fact that 72% of healthcare professionals use their personal devices for work and 55% use free file-sharing services to collaborate.
SECURITY RISKS

Five ways to MINIMIZE CHANCE of data breach:

- Conduct an annual HIPAA security risk analysis
- Encrypt data at rest
- Conduct frequent vulnerability and penetration testing
- Situational training for employees - social media
- Stronger BAA – engagement with business associates
COLLABORATION
COLLABORATIVE COMPLIANCE

- The final rules also set forth requirements for ACO compliance programs
- The ACO must employ a compliance officer that reports to the ACO’s governing body.
- The compliance program must establish procedures to allow ACO employees, contractors, and participants to report any compliance issues.
- The compliance program must provide compliance education to everyone involved with the ACO.
- The ACO must have a policy requiring all ACO employees, contractors, and participants to report violations of the law to the appropriate law enforcement agency.
- CMS recommends that ACOs develop their compliance programs through the collaborative efforts of the ACO participants and contractors.
- The individual compliance officers within each participating organization also should work together to develop a general compliance program for the entire ACO.
Forming an ACO Has Its Benefits But Also Creates a Whole New Set of Financial and Administrative Risks:

- ACOs should provide higher quality care at a lower cost.
- CMS is encouraging providers to combine into a larger organization — the ACO — through which ACO participants could provide patients with various levels of care, from primary to acute care.
- CMS recently published final rules for ACO eligibility requirements and participation in the Medicare Shared Savings Program.

**ELIGIBILITY CONSIDERATIONS**

- Under the final rules, ACOs must develop policies and procedures that aim to satisfy CMS’ key goals and to comply with the agency’s requirements for participation and provide this in its application.
- Thus, according to the final rule, ACO participants will need to work together to develop an administration capable of overseeing numerous providers and suppliers who will furnish services and products to thousands of Medicare beneficiaries.
- Furthermore, this administration will be charged with ensuring compliance with CMS’ rules throughout the entire organization.
- Providers and suppliers should consider the following: How will the ACO coordinate patient care across ACO participants, including primary care physicians, specialists, and acute-care physicians?
COLLABORATIVE COMPLIANCE

- How will the ACO be governed, and who will lead this governing body?
- How will the ACO determine the number of professionals needed to provide high-quality care to thousands of patients and periodically account for all the ACO professionals organization adjusts meet patients’ needs?
- How will the ACO create and update a quality assurance improvement program?
- How will the ACO create a mechanism to encourage “evidence-based medicine,” which ACO professionals can apply in their decision making?
- How will the ACO encourage patients and their families to take a more active role in their medical decisions, and implement a mechanism to rate patient experience?
- How will the ACO monitor and report its quality improvement and cost reduction efforts?
- How will the ACO maintain a “meaningful commitment” to the ACO’s goals and compliance to CMS requirements (i.e., through investing in software products, equipment, and/or additional staff)?
- These considerations should not be made by one executive alone. Rather, the task should be a collaborative effort by executives, department heads, and compliance officer
FRAUD PREVENTION

DOJ, HHS and the FTC, and state partners met to determine how to reduce fraud in Health Insurance Marketplace:

- A Marketplace call center with trained staff refers consumer threats, complaints and fraud concerns to FTC’s Consumer Sentinel Network.
- Use HealthCare.gov to connect consumers to FTC’s complaint assistant.
- Create a system to route complaints through the FTC’s Consumer Sentinel Network for analysis and referral as needed.
- Develop a rapid response system for addressing privacy and cyber security threats.
- Improve public education of consumers and assisters to avoid scams.
- Federal law enforcement officials will have the ability to monitor complaint activity for trends within all 50 states. Consumer fraud experts from state and federal agencies plan to meet on a regular basis to monitor potential fraud in the Health Insurance Marketplace.
ACO WAIVERS AND FRAUD AND ABUSE LAWS

Each waiver contains a very detailed list of things which must be true for the waiver to apply:

- An "ACO pre-participation" waiver of the Physician Self-Referral Law, the federal Anti-Kickback Statute, and the Gainsharing CMP that applies to ACO-related start-up arrangements in anticipation of participating in the Shared Savings Program;

- An "ACO participation" waiver of the Physician Self-Referral Law, federal Anti-Kickback Statute, and the Gainsharing CMP that applies broadly to ACO-related arrangements during the term of the ACO's participation agreement under the Shared Savings Program and for a specified time thereafter;

- A "shared savings distributions" waiver of the Physician Self-Referral Law, federal Anti-Kickback Statute, and Gainsharing CMP that applies to distributions and uses of shared savings payments earned under the Shared Savings Program;

- A "compliance with the Physician Self-Referral Law" waiver of the Gainsharing CMP and the federal Anti-Kickback Statute for ACO arrangements that implicate the Physician Self-Referral Law and meet an existing exception; and

- A "patient incentive" waiver of the Beneficiary Inducements CMP and the federal Anti-Kickback Statute for medically related incentives offered by ACOs under the Shared Savings Program to beneficiaries to encourage preventive care and compliance with treatment regimes

BUT THIS WAIVERS DO NOT APPLY TO ANY OTHER LAWS OR REGULATIONS OR TO STATE LAWS...........OR AMA ETHICAL OPINION REPORTS
ACO WAIVER
APPLICABILITY

- Jury is still out

- What defense would the ACO waivers have against a ethical complaint about a doctor

- ACO waivers have no effect on state laws – Texas has the “Illegal Remuneration Statute” (state anti-kickback law)

- Administrative risk
Privac/Security
Risk Considerations

- Accountable Care Organizations that will be formed to coordinate treatment of some Medicare patients must take steps to comply with HIPAA, including conducting risk assessments, as they share patient data among participating providers.

- ACO Rule emphasizes multiple times that all data sharing has to be in compliance with HIPAA requirements.

- Newly formed ACOs, and their participating provider organizations, should conduct RISK ASSESSMENTS "to identify where all the new types of risk will exist with the new information sharing capabilities."

- Sharing information among all caregivers ... truly is at the heart of making ACOs work - by what means will ACOs share PHI - HIEs

- IF YOU SHARE INFO -------YOU SHARE RISK
ACO RISK ASSESSMENT

- Changing cultures and structures
  - Data involved in four separate domains:
    - Patient/Caregiver Experience
    - Care Coordination/Patient Safety
    - Preventive Health
    - At Risk Populations
  - 33 measures divided within these 4 domains
  - MUST report all measures in a domain to meet quality performance requirements
  - 70% attainment is the “passing rate”

- Audits – CMS may audit and validate the data reported by an ACO – medical record review

- A 10% gap between quality data reported and records reviewed - ACO will not receive credit for those cases

- Participant review - ACO participants, providers and suppliers will be reviewed during the Shared Savings Program and periodically thereafter... is this credentialing?
RETURN TO OUR NINE CATEGORIES:

- Organizational mission and population served
- Governance and leadership
- Partnerships,
- Information technology and related infrastructure
- Managing clinical care
- Performance reporting
- Finance and contracts
- Legal and regulatory issues, barriers, and risk tolerance,
- Overall assessment
WITH CHANGE COMES RISK

JOINING A NETWORK:

- New standalone legal entities
- Joint ventures
- Formal partnerships based on contractual relationships
- Loose alliances and networks
HOW ENTITIES DIFFER?

CONTROL
INTERSECTION POINTS OF “NEW RISK”

- Establishing Provider Networks
- Entering into Payer Contracts
- Developing Transitional Care Models
- Data Sharing
- Physician Integration
IMPROVED RESPONSIVENESS

- Training and Education
- Inclusive onsite patient reviews
- Root Cause Analysis
- Communication, Communication, Communication
ENDPOINT: SECURITY

- Network security to external devices and all endpoints
- The primary requirements are for securing servers, desktop PCs, laptops and other mobile devices, but this will need to be extended to an ever-growing range of endpoints, such as smart grids, medical devices and cars.
- As the range of endpoint devices expands, so will the threat surface, increasing the risk of breaches dramatically.
- Need an end to end security stance that combines network and endpoint security will enable you to capture intelligence from each host or device, which can be assessed in the context of the network layer, providing for greater automated intelligence and network-layer awareness.
- Best practices you can apply to achieve real-time situational awareness to improve security and allow for better-informed decision-making.
DOMAINS OF RISK

- Legal
- Financial
- Technology
- Operations
- Human Capital
TRANSLATION OF DOMAINS OF RISK

- Accountability of sharing organization on data quality and timeliness
- Accountability of consuming organizations in usage or sharing of that data with non members of ACO
- Compromised financials due to bad data - collecting retroactively
- Collecting and managing consent for HIPAA compliance for ACO with independence of individual participants
- Business stewardship, business ownership and upkeep over long periods of time
ACO FINAL OBSERVATIONS

- Early adopters – only 46 percent of organizations that joined a Medicare ACO program before fall 2012 involved a hospital

- Trend toward physician-led ACOs - hesitancy shown by hospital and health system executives to jump into the model

- Physician led models

- Partnerships between hospitals and physician groups have formed to create ACOs, but they are more in the form of joint ventures or physician-hospital organizations.

- Limited movement towards full risk for providers
Faced with possible competition from government, private healthcare makes a momentous concession...

"Fine. We'll take sick people."

"I hate sick people!"

"They're so unhealthy."
Thank you, Marlowe Schaeffer-Polk, JD, DO
REFERENCES

- **42 CFR 425.210 - APPLICATION OF AGREEMENT TO ACO PARTICIPANTS, ACO PROVIDERS/SUPPLIERS, AND OTHERS**
- **42 CFR 425.306 - PARTICIPATION AGREEMENT AND EXCLUSIVITY OF ACO PARTICIPANT TINS**
- **42 CFR 425.316 - MONITORING OF ACOS.**
- https://www.google.com/#q=executive+order+13636%E2%80%94improving+critical+infrastructure+cybersecurity
- Jan. 30 press release from CMS(www.hhs.gov),