Credentialed in the World of ACOs
Credentialing in the World of ACOs

MODERATOR:
Fay A. Rozovsky, JD, MPH, DFASHRM, President, The Rozovsky Group, Inc.

PANELISTS:
Patricia Hughes, RN, MSN, CPHRM, Vice President, Healthcare Risk Management, OneBeacon Professional Insurance
William J. McDonough, PhD, ARM, Managing Principal, Integro Insurance Brokers
Why is this on our AGENDA? Healthcare Spending Growth

CMS Projections for National Healthcare Spending
CY 2003 - 2018

(Amount in Billions)

Source: Centers for Medicaid & Medicare Services - NHE Projections 2008-2018, Forecast Summary and Selected Tables
The Shared Savings Program Fundamentals
Shared Savings Program ACO Defined

A legal entity that is recognized and authorized under applicable State, Federal, or Tribal law, is identified by a Taxpayer Identification Number (TIN), and is formed by one or more ACO participant(s) that is(are) defined at 425.102(a) and may also include any other ACO participants described at 425.102(b).
SSP – ACO Core Elements

- Must be a Legal Entity
- Must have a Governing Body
- With Leadership & Management
- Follow Required Processes
- COI – Conflict of Interest Rules

- Minimum number of 5000 Medicare beneficiaries
- Enough Primary Care Providers
Aside from Caring for Medicare Patients

Medicare Beneficiaries (Patients) are assigned to the ACO by CMS

- Receive + Distribute Shared Savings
- Meet Compliance and Quality Performance Standards
- Has the Ability to REPAY Shared Losses to CMS
- Make Required Quality Reports
### Other Core Components for SSP - ACOs

<table>
<thead>
<tr>
<th>Component</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Beneficiary Assignments &amp; Inducements</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Provider Selection Process</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Marketing Material</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Data Gathering, Data Use Agreement, &amp; “Opt Out”</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Quality Performance Measures</strong></td>
<td></td>
</tr>
<tr>
<td><strong>DATA Retention</strong></td>
<td></td>
</tr>
<tr>
<td><strong>No Beneficiary Cherry-Picking Allowed</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Termination Provisions</strong></td>
<td></td>
</tr>
</tbody>
</table>
The Required ACO Processes

- Significant diagnoses with high impact on quality.
- Discharge & transfer to specialist or specialty care.
- Care plan individualized.
- Shared decision-making.
- Understandable clinical details for beneficiaries.
- ACO board member: at least one beneficiary.
- Internal reporting infrastructure.
- Follow experience of care survey obligations from a certified vendor.
- Evaluate population needs & diversity.
- Written standards for beneficiaries to access medical record information.
More on the Required Processes

- Promote Use of Evidence-Based Medicine
- ACO Beneficiary Engagement
- Develop and Follow ACO Compliance Plan
- Provide Coordinated Beneficiary Care
- Use BOTH Quality and Cost Metrics
Three Year Agreement with CMS

✓ Delineate the ACO participants and their Medicare-enrolled Tax Information Numbers (TINs).

✓ Describes how the ACO plans to use shared-savings.

✓ Describes how the ACO will distribute shared savings among providers and supplies.

…and much more detail……
The Contractual Obligation

“The ACO must agree, as a condition of participating in the program and receiving any shared savings payment, that an individual with the authority to legally bind the ACO will certify the accuracy, completeness, and truthfulness of any data or information requested by or submitted to CMS, including, but not limited to, the application form, etc.”
The “Others” Enforcing SSP - ACOs

- OIG
- FTC
- IRS
- DOJ

- State Law
- Federal criminal law
- False Claims Act
- Anti-Kickback Statute
- Civil Monetary Penalties law
- Physician Self-Referral law
- Antitrust law

...and HIPAA-Office of Civil Rights of HHS
The “Providers” in SSP - ACOs

- Physician
- Nurse Practitioner
- Physician Assistant
- Clinical Nurse Specialist
- Other practitioners recognized by Medicare
“An ACO whose screening reveals a history of program integrity issues and/or affiliations with individuals or entities (including ACO participants and ACO providers/suppliers) that have a history of program integrity issues may be subject to rejection of their Shared Savings Program applications or the imposition of additional safeguards or assurances against program integrity risks.”

Federal Register 76(212): 67955 November 2, 2011.
The SSP – ACO Provider Selection Process-I

425.304 Other program requirements.
(b) Screening of ACO applicants.
“(1) ACOs, ACO participants, and ACO providers/suppliers will be reviewed during the Shared Savings Program application process and periodically thereafter with regard to their program integrity history, including any history of Medicare program exclusions or other sanctions and affiliations with individuals or entities that have a history of program integrity issues.”

Federal Register 76(212): 67981, November 2, 2011.
The SSP-ACO Provider Selection Process-II

425.304 Other program requirements.
(b) Screening of ACO applicants.

“(2) ACOs, ACO participants, or ACO providers/suppliers whose screening reveals a history of program integrity issues or affiliations with individuals or entities that have a history of program integrity issues may be subject to denial of their Shared Savings Program applications or the imposition of additional safeguards or assurances against program integrity risks.”

Federal Register 76(212): 67981, November 2, 2011.
425.204 Content of the application.
(c) Eligibility.
“(i) Documents (for example, participation agreements, employment contracts, and operating policies) sufficient to describe the…ACO providers’/ rights and obligations in and representation by the ACO, including how the opportunity to receive shared savings or other financial arrangements will encourage…ACO providers/suppliers to adhere to the quality assurance and improvement program and evidenced-based clinical guidelines.”

Federal Register 76(212): 67978, November 2, 2011.
425.204 Content of the application.
(c) Eligibility.
“(ii) …descriptions of the remedial processes and penalties (including the potential for expulsion) that will apply if an… ACO provider/supplier fails to comply with and implement these processes.”

Federal Register 76(212): 67978, November 2, 2011.
Credentialing NOT in the ACO Law

Was it an oversight?

Does it mean that “selection” is all that is needed?

Will provider contracting suffice?

Should ACOs use “borrowed” credentialing from member facilities?

Should ACOs do their own credentialing?
The Risk Exposures: The Case for ACO Credentialing
Traditional Credentialing Risk Exposure-I

In ACO “Speak”

- Negligent Selection
- Corporate Liability of the ACO
- ACO Agency Liability (Contracted providers)
Traditional Credentialing Risk Exposure-II

ACO Director and Officer Liability Risk Exposure

“Wrongful” Economic Credentialing by ACO
What About the ACOs Liability Exposure?

Provider Group members unavailable

“Only” credentialed ACO group for cardiothoracic surgery – disabled, called up to active service, etc.

How does the ACO maintain CMS contract?

Medicare – Medicaid Debarment List

ACO compliance plan says “ZERO tolerance” for debarred care providers.

But what about continuity of beneficiary care? CMS contract?
And What About the Loss Column?

Geriatric Practice pushes the ACO into the loss column. High beneficiary satisfaction scores. Good clinical outcomes.

“This is terrible! Just look at the utilization costs here. At the rate they are going this geriatric medical group is going to push us into a huge shared loss. We have no other recourse. Get rid of them-fast.”
The ERM Credentialing Perspective for ACOs
Why ACO ERM Credentialing

Credentialing impacts *many* domains of ACO risk
ERM in Perspective

A business decision-making process instituted and supported by the board of directors, executive administration, and clinical leadership.

Goal: Reduce uncertainty and process variability, promote patient safety and to maximize asset preservation.

ERM Style ACO Credentialing

Human Capital

- Education
- Licensure & DEA status
- Boards/Fellowships
- Clinical competencies
- Quality
- Clinical outcomes
- Language skills
- Technology skills
ERM Style ACO Credentialing

- Credentialing Process
- Outcome measures oversight
- Integrity checking oversight
- Licensure updates
- Medical Malpractice insurance updates
- Health check updates
- Certification updates
ERM Style ACO Credentialing

- Patient complaints/litigation
- Regulatory complaints
- Litigation
- DEA Action
- State licensure action
- Medicare sanctions - program integrity issues
- Medicare debarment
- ACO “job-related” disability
ERM Style ACO Credentialing

- Non-compliance by credentialed provider
- ACO Data Use Agreement – HIPAA violation by credentialed provider or group
- Conflict-of-interest violation
- Negligent credentialing claim
- Corporate liability claim
- Enterprise liability claim
- Wrongful economic credentialing claim
- Shared Loss – credentialed provider-related
- Termination SSP – ACO agreement
ERM Style ACO Credentialing

- **Financial**
  - \( \square \) Shared Losses Preparation:
    - \( \square \) Surety Bonds
    - \( \square \) Line of credit for Medicare
    - \( \square \) Escrow Funds
    - \( \square \) Reinsurance
  - \( \square \) Litigation—cost of defense/judgment costs
  - \( \square \) Business Interruption – Replacing the debarred, credentialed provider
  - \( \square \) Regulatory investigation costs
ERM ACO Credentialing

- “That care provider was a fake. They should have known it.”

- “Medicare Fraud Alleged Against Prominent Physician and Care Organization.”

- “Doctor Claims He was Turfed Out by ACO for Telling the Truth about Lax Care for Medicare Beneficiaries.”
Practical Considerations

Who Will Manage ACO Credentialing?

What Data Will Be Used in ACO Credentialing?

How should the ACO respond if a care provider loses credentials at a member hospital?

Should an ACO provide a due process approach in credentialing & corrective action?
What Risk Transfer or Retention Models Should We Consider?

An ERM Perspective
ACO Risk Analysis

- What are our RISKS with an ACO?
- Do we understand these RISKS?
- Do we have the capacity to retain ACO risk?
  - Captives, RRGs, other self-insurance vehicles
- Do we need to transfer the risk?
  - New RISK = New Policies?
- Monitoring RISK across the ACO continuum - Futurecast
Accountable Care as a Care and Risk Integrator
What are the Risks?

ACO

Care Management

Brand

D&O

Med Mal

Regulatory

Care Management

Network Design

Credentialing

Clinical Protocols

Reputation

Network Design
ACOs and Enterprise Risk – Gaining Control!
# The “Insurance” Conundrum – the Perfect Storm

<table>
<thead>
<tr>
<th>Coverages</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Professional Liability</strong>, Medical Malpractice Exposures including vicarious liability</td>
</tr>
<tr>
<td><strong>Directors and Officers</strong> (Management Risk)</td>
</tr>
<tr>
<td><strong>Managed Care Errors and Omissions</strong> (Back to the Future, acting like a HMO)</td>
</tr>
<tr>
<td><strong>Fiduciary and Crime</strong></td>
</tr>
<tr>
<td><strong>Provider Excess, Catastrophic Medical Reinsurance</strong> (Excess of Medical Loss protection)</td>
</tr>
<tr>
<td><strong>Regulatory Coverage</strong></td>
</tr>
<tr>
<td><strong>Punitive Damage Protection</strong></td>
</tr>
</tbody>
</table>
Coverage/Insurance Considerations

- Understand your (ACO) Risk Profile
- Stress test your current policies
- Develop claim scenarios as educational tools for leadership
- What about Medicaid ACOs? Do they have specific needs in terms of insurance?
- What about the trend toward state-based ACOs and Exchanges like Massachusetts? Are there state-specific insurance requirements for the ACO, the providers and the partnering entities?
Conclusion

• ACOs are not a fad.
• Different models will continue to evolve.
• Credentialing the care providers will involve more than quality.
• Integrity and economic credentialing will be part of the picture.
• Follow an Enterprise Risk Management approach to address ACO credentialing and risk retention or transfer models.
THANK YOU!