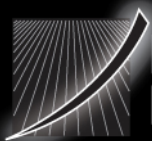


## The Impact of Health Care Reform:

### Considering Accountable Care, Data Management, and Compliancy

Health care IT is expected to facilitate and accelerate health care reform. A major aspect of this is how technology will enable health care organizations to capture and exchange data at every level, creating a system that has true interoperability and can eventually support the goal of personalized medicine. But technology must also work in tandem with coding procedures already in place to make sure information is consistent and meaningful – and ensuring quality medical coding also improves compliance and can prevent fraud, waste, and abuse.



# The Impact of Health Care Reform: Considering Accountable Care, Data Management, and Compliancy

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## Health Care IT: Enabling Data & Connectivity

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Federally sponsored health care reform became a reality in 2010. Enacted legislation, collectively referred to as Health Care Reform (HCR), include a large number of provisions that will take effect over the next several years, covering such issues as Medicaid eligibility, insurance premiums, business health care benefits, coverage and claims based on pre-existing conditions, and health insurance exchanges.

A primary goal of HCR is to leverage health care IT to create a system that can capture health information at a national level, ultimately supporting the National Health Information Network (NHIN). Transportability of information is key, yet common standards and operating guidelines remain elusive and the groundswell of competing systems is already creating obstacles to achieving the national goal. There is competition to create solutions that will provide comprehensive integrated information, analytics, communication, administrative, clinical and revenue-cycle management tasks -- all through a seamless, secure network.

Good healthcare is no longer about just good doctors and good hospitals; it's about connectivity, it's about data, it's about information, it's about speed to treatment. Health care IT is seen as the enabler of reaching these goals. Many people associate health care IT simply with the electronic storage of health records. In reality, health IT is expected to be much more transformative. It's a collection of technologies, analytics, and process innovations that are already revolutionizing the way people receive and manage their care in communities across the nation.

## Accountable Care Organizations

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ACOs are provider-led entities that are clinically integrated for the purpose of participating in performance-based incentive programs with Medicare, Medicaid, commercial health plans, and employers. ACOs may include physicians, hospitals, nurse practitioners and physician assistants, and allied health professionals along with business partners to provide needed operational functions that are not usually part of a provider-led entity. ACOs are legal structures that allow providers to collectively share risk for improved outcomes, enhanced patient experience and satisfaction, reduced costs, and reduced errors. The term "accountable care" represents an over-arching theme central in HCR and is increasingly popular among health plans and employers seeking more value for health expenditures.

Excelling as an ACO will require a broad range of capabilities; much of the success will be determined by the value and integrity of partnering arrangements. These organizations need to seek out partners with expertise, resources, and market position in their local healthcare marketplace which can offer them substantial competitive advantage.

Two sets of core competencies are central to ACOs<sup>1</sup>:

- clinical integration
- risk-based payer contracting

Core Competency	Goal	Core Function
<b>Clinical Integration</b>	<ul style="list-style-type: none"> <li>• Reduce error</li> <li>• Improve safety</li> <li>• Enhance coordination of care</li> <li>• Avoid financial penalties</li> <li>• Advance evidence-based practice goals.</li> </ul>	<ul style="list-style-type: none"> <li>• Governance and physician leadership</li> <li>• Electronic health records (EHR) with clinical decision support</li> <li>• Evidence-based guidelines, pathways, and order sets</li> <li>• Patient care coordination and coaching</li> <li>• Clinical outcome measurement and reporting</li> <li>• Care team coordination</li> <li>• Root cause analysis: error surveillance</li> <li>• Provider performance evaluation and compensation</li> </ul>
<b>Risk-based payer contracting</b>	<ul style="list-style-type: none"> <li>• Align payments with performance</li> <li>• Change incentives: from fee for service to value</li> <li>• Create shared-risk provider environment</li> </ul>	<ul style="list-style-type: none"> <li>• Population segment actuarial analysis</li> <li>• Payer negotiations and cash management</li> <li>• Provider credentialing and profiling</li> <li>• Payment systems to providers</li> <li>• Enrollment and eligibility</li> <li>• Health coaching</li> <li>• Reporting: provider adherence to pathways</li> <li>• Risk management and compliance</li> </ul>

Information management—making sure patients and all healthcare providers have the right information at the point of care—is also a core competency of ACOs. The key differentiator creating the opportunity for the ACO model's success over its predecessors is technology. ACOs that exploit IT to capture information from many sources, aggregate it, extract meaningful data and use it to drive decision making will thrive.

On October 20, 2011, CMS released final regulations for the Medicare Shared Savings ACO program. CMS will start accepting applications for the Medicare Shared Savings Program shortly after January 1, 2012 and provide two application periods for the first year of the program. Applications will be accepted for an April 1, 2012 or July 1, 2012 start date. All ACOs that start in 2012 will have agreement periods ending at the end of 2015.

<sup>1</sup> Listed in "[Special Edition: ACO Medicare Shared Savings Final Rule](#)," Deloitte Center for Health Solutions, Nov. 2011

Four key takeaways from final rule:

- CMS responded to initial concerns about the costs associated with the implementation of ACOs by increasing the benefits for ACO participants and reducing costs associated with compliance, including relaxation of electronic health record (EHR) implementation.
- CMS addressed anti-trust issues by increasing protection for providers who pursue clinical integration.
- CMS reduced the level of risk associated with participation by changing the terms of participation in the one-sided risk model.
- CMS clarified the role of scope of opportunities for business partners to collaborate with provider organizations

The CMS final rule on ACOs reduces some IT burdens for participating entities to qualify for shared savings incentives compared to the initially proposed rules. Still, it is widely understood that technology will play an important role in the initiative.

### **Electronic Health Records**

Although the final rule for ACOs eliminates the proposed requirement that 50 percent of participating primary care physicians would need to show “Meaningful Use” of an EHR, this technology will be vital to the success of accountable care going forward. EHR technology remains necessary in order to collaborate and coordinate care and share information, even if the requirement is less stringent than previously issued. EHR technology is widely expected to provide interoperability between providers, insurers, etc. that is necessary to make ACOs successful.

Currently, there is concern about how EHRs are being coded. One of the overarching goals of HCR is to ensure interoperability of data, and support Comparative Effectiveness Research (CER); yet there are worries that the way EHRs are currently capturing data may not effectively provide information at the level of detail and in an interoperable manner to support those goals.

### **Real-time Information**

In addition to EHR technology, access to constantly updated health information of patients will be vital for health care reform initiatives to succeed. A combination of health information exchange (HIE) capability, "married" clinical and claims data, and platform care coordination would help to make that possible.

All stakeholders in the process will need access to each others’ information; and the quantity of that information will require decision-support tools to help filter what is relevant and important.

ACOs are intended to operate at virtually integrated delivery systems. To achieve this integration, they will need to actively and seamlessly share patient information.

## **Pay for Performance: Transparency, Consumer Rights, and Data Collection**

Data collection to improve health quality is a focus of HCR. There is a goal to increase transparency and enable consumers to register their complaints and compliments in a way the meaningfully captures data. Increased data collection from Comparative Effectiveness Research (CER) is also expected to yield substantial benefits in determining the best treatments and strategies for patients, as well as furthering the goal of “personalized medicine”. Ultimately, much of this information may be used to change the current pay-for-services model to a pay-for-performance model.

The market will need to provide support in the data collection and support phases as well as the analysis and synthesis phases. CER also has the potential to spur a burgeoning **Health Information Systems** market segment. As CER advances, database, analytics, and networks will be required to support a research industry to determine what produces health outcomes.

## **Payment Bundling**

The National pilot program on payment bundling refers to how hospitals and providers are reimbursed. This piece of the bill suggests that rather than insurers using a fee-for-services payment mechanism they could utilize a bundled payment otherwise known as an episode based-payment.

This legislation directs the HHS Secretary to develop a national, voluntary pilot program encouraging hospitals, doctors, and post-acute care providers to improve patient care and achieve savings for the Medicare program through bundled payment models. To take advantage of the financial opportunities resulting from these shared savings and bundled payment programs, providers and suppliers must form new legal structures that align interests and reward outcomes over volume.

## **Future Needs of ACOs**

- ACOs will need business management capabilities that are found in many healthcare payer application suites, making payers a source for business process outsourcing (BPO) opportunities.
- Regulatory and Compliance: Regulatory and compliance are necessary pieces of the ACO administrative environment. A final picture of the regulatory issues surrounding ACOs has yet to be fully established. That said, the ACOs will be required to meet certain standards services to participate in Medicare. These requirements will likely be adapted into payer contracts for commercial or government healthcare businesses.
- The regulatory requirements will also necessitate compliance activities. These compliance activities can relate to specific language needed in contracts through defined grievance and appeal processes. For example, one of the requirements of Medicare Part D shortcuts the appeal process to allow a member the ability to receive

an expedited decision about non-covered prescriptions. This requires immediate action to help providers and members receive fast decisions on unusual cases.

- New provider payment methods are needed to achieve the goals of improving the health of the population, creating an enhanced patient/consumer experience and improving the affordability of healthcare.
- There will be no consistent business model for a successful ACO. Flexibility in application interfaces, business processes and the overall way in which payers relate to an ACO must be paramount.
- IT support must be flexible and agile, as well as capable of quick change and update as required.

## Fraud, Waste & Abuse (FWA)

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As well as provisions designed to enhance data sharing efforts, HCR is imposing stricter penalties to curb FWA. The need is clear: As much as 10 percent of healthcare spending is lost to abuse, according to recent studies, with the federal government alone losing more than \$70 billion to improper Medicare and Medicaid payments, according to the Department of Health and Human Services (HHS)<sup>2</sup>.

The new rules written into HCR are largely devoted to eradicating FWA in Medicare and Medicaid. Increased screening and data sharing efforts are designed to prevent FWA, rather than trying to recoup payments later determined to be the result of a billing error or fraudulent activity (i.e., pay-and-chase). Prevention is the new model. It must be understood that under new circumstances, prepayment FWA avoidance programs are a vital component of payers' strategies to lower costs and improve profitability.

The measures to counteract this loss have created many changes that increase complexities for healthcare providers, both as a result of health care reform and previously directed mandates to implement ICD-10 diagnosis coding. ICD-10 will require providers to change their systems to reflect new codes for thousands of diseases, symptoms, injuries and abnormal findings. Providers who are not prepared to submit claims using ICD-10 face greatly increased possibilities of filing error-filled claims.

Successful reduction of FWA is trending towards **broad payment integrity solutions**—a holistic approach that seek to provide prepayment analysis efforts to prevent mistakes and misfiling from occurring.

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<sup>2</sup> [Medicare Provisions in the Patient Protection and Affordable Care Act \(PPACA\)](#): Summary and Timeline. Congressional Research Service, Nov. 2010.

Health care IT, while an integral part of the solution, isn't enough. The expertise of fraud analysts and investigators, certified claim coders and a medical director, as well as other medical personnel are necessary to implement a successful payment integrity program. Even when fraud is detected prior to payment, there is always a need for discerning and experienced fraud investigators and analysts and medical coders with experience in interpreting the nuances and particulars of claims. The leading technology vendors employ investigative personnel with these broad backgrounds and expertise in FWA that can fully outsource a payer's investigative unit or augment the team already in place.

Detecting erroneous claims through prepayment audits is a strategic way to reduce liabilities and improve their overall financial health. However, many organizations often don't have the depth of information gleaned from analyzing multiple payers' claims data. Support from partners with such experience can mean the difference between successful and unsuccessful programs.

### **Ramping up Enforcement**

Hospitals and other providers are concerned about the administrative burden that comes along with the administration's crackdown on improper payments. Through new pilots, Medicare will conduct prepayment reviews of certain claims, starting in January 2012, with the goal of reducing \$50 billion in improper payments and cutting down on payment errors by half.

Currently, Medicare recovery audit contractors (RAC) conduct reviews after payment. However, effective January 2012, RACs in 11 states will conduct reviews of particular claims before payment. They will focus on inpatient hospital claims.

CMS selected the state, which have historically high populations of fraud- and error-prone providers (Florida, California, Michigan, Texas, New York, Louisiana, and Illinois), as well as those states with high claims volumes of short hospital stays (Pennsylvania, Ohio, North Carolina, and Montana).

### **Continuing to Strengthen Enforcement**

The success of accelerated efforts seems to be paying off. According to reports released in November by the OMB, \$17.6 billion of wasteful payments in 2011 were prevented. Medicaid error rates dropped from 9.4 percent in 2010 to 8.1 percent in 2011, saving roughly \$4 billion since 2009. Thanks to the declining error rates, Medicare fee-for-service avoided \$7 billion in payment errors and Medicare Part C saved almost \$5 billion<sup>3</sup>.

That success has prompted CMS to launch four pilots to further reduce error rates and cut Medicare and Medicaid waste and fraud, the agency announced yesterday.

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<sup>3</sup> ["Agencies Cut Nearly \\$18 Billion.."](#) Whitehouse.gov, Nov. 15, 2011

Acknowledging the success of effective and aggressive use of technology in the prosecution of FWA, HHS Secretary Kathleen Sebelius has stated that HHS will launch four additional pilots to reduce the error rate and cut Medicare and Medicaid waste and fraud. These include:

- **Expanding the use of Recovery Audit Contractors.** The agency will now allow private companies to screen certain hospital payments before they are made, which will prevent improper Medicare payments from happening in the first place.
- **Testing changes to outdated hospital billing systems to help prevent over-billing.** Hospitals sometimes perform services as inpatient that Medicare requires to be outpatient. Right now, when those hospitals bill Medicare, HHS does not allow them to re-bill as outpatient. Under this pilot, HHS will allow some claims that are incorrectly made under the inpatient program to be resubmitted under the outpatient program. This mistake – incorrect billing of services – is a leading cause of error in the Medicare program and wastes time and money in appeals.
- **Changing the process for approving payments for medical equipment with high error rates.** One contributor to the Medicare improper payment rate is incorrect reimbursement for medical equipment that is not medically necessary. This change will allow HHS to pilot a new process for reviewing these medical equipment claims before they are made, thus helping to reduce Medicare improper payments.
- **Working with states to improve fraud detection.** HHS is initiating a pilot project under the Partnership Fund for Program Integrity Innovation to test an automated tool to screen providers for the risk of fraud. Currently, HHS and states lack standardized Medicaid provider data, which hampers detection of potential fraud. If successful, this tool will not only help prevent improper payments by weeding out fraudulent providers, but it will help States focus their resources where fraud is most likely to occur.

There is also a move to provide more monitoring of contractors. Contractors monitor hospitals and other healthcare organizations for fraud, and CMS is meant to monitor the contractors; but an OIG report released in November suggests that federal health officials have failed to adequately supervise fraud contractors for more than a decade.

Although CMS has updated the fraud contractor system, problems still persist. According to the report, the workload data that CMS uses to oversee the Zone Program Integrity Contractors is inaccurate and inconsistent. OIG called on CMS to create effective oversight of the contractors by clarifying workload definitions, performing timely review of data, using and reporting workload statistics in contractor evaluations, and finally, ensuring that contractors have access to all the necessary data to carry out their work in identifying potential fraud and abuse.

## Conclusion

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It continues to be an exciting time in the health care industry. Goals that may have seemed impossible a decade ago now seem realistic; it grows increasingly easy to envision a system that allows the delivery of medical care to be carefully tailored and individualized for every person, as the system benefits from increased data collection and information sharing. At the same time, these high-level goals will be enabled by implementing the best medical coding and compliance practices available—ensuring not only consistency in data capture and exchange, but also making the system work more efficiently overall. Furthermore, these good practices will also allow the increased identification and prevention of fraud, waste, and abuse – a major initiative that is underwriting much of the cost of the work of health care reform. It is up to all stakeholders in the system to participate and engage in this process.