

risk RX



The ABCs of HCOs and ACO Risk

What Risk Managers Should Keep on the Radar Screen

Fall 2011

In this issue:

- 1** *ABCs of ACOs--What Risk Managers Should Keep on the Radar Screen*
- 4** *Integro Moves Up*
- 5** *Ask the Risk Pros*
- 7** *Disclosure, Apology and Early Offer White Paper Published*
- 8** *IMAC Conference*

On October 20, 2011, The Centers for Medicare and Medicaid (CMS) released the long-awaited final rule for the Medicare Shared Savings Program (MSSP) which was signed into law last year under the Patient Protection and Affordable Care Act. The MSSP relies on the Accountable Care Organization (ACO) model in order to generate savings. ACOs, which have been a major topic of discussion in American health policy circles, are simply groups of physicians, hospitals, and other healthcare providers willing to assume shared responsibility for the quality and cost of healthcare for a group of Medicare beneficiaries.

The 696-page final rule provides clear guidance to how healthcare organizations will be required to set up and participate in ACOs.

If ACOs are successful, CMS predicts an upside of shared savings payments for healthcare organizations.

Risk managers of healthcare organizations contemplating forming or participating in ACOs should explore and identify upside and downside risk during the planning phases of ACO development and implementation. Time is of essence since the first ACOs could register and begin implementation in early 2012.

Continued...

riskRX 2

For purposes of this review, we will focus on risks familiar to healthcare risk managers and explore a few others that one might consider “back from the future” – in other words, risks that we dealt with as managed care organizations blossomed in the US in the late 1980s and early 1990s. Many of these risks developed and necessitated risk transfer solutions for the “managing” of care and treatment. ACOs are designed to provide similar controls to “manage” care.

ACO Basics

The final rule defines an ACO as a separate legal entity that is recognized under applicable state, federal, or tribal law, is identified by a Taxpayer Identification Number, and is formed by one or more participants that serve Medicare Fee-for-Service beneficiaries. At a minimum, ACOs must serve 5,000 beneficiaries enrolled in Medicare Part A and Part B. To be approved by CMS, an ACO must have at least one approved participant, have a mechanism for governance, and a formal legal structure that can receive and distribute savings, repay

ACOs may involve the following groups of providers and suppliers:

- ACO professionals, which include physicians and practitioners networks of individual practices.
- Partnerships or joint venture arrangements between acute care hospitals and ACO professionals.
- Acute care hospitals employing ACO professionals.
- Critical access hospitals (CAHs), federally qualified health centers (FQHCs), and rural health clinics (RHCs).

Management Liability

Considering an ACO will be a new legal entity that will receive and distribute savings, repay losses to CMS, and ensure compliance with quality measures, management liability will be a key driver of an ACO’s risk management profile. Since the final rule requires that ACO provider participants have a 75% share of the ACO governing body membership and that its board must have Medicare beneficiary representatives, some members of the ACO’s governing body may not have had any previous board or management experience. Management liability coverage decisions will require a great deal of attention.

Risk managers would be best served to fully analyze the ACO’s operations and determine the needs for management risk protection. If the ACO has a major participant with a sophisticated risk management program, should that participant provide coverage to the ACO (entity) and Board? Should a separate stand-alone program be designed which address D&O exposure, fiduciary, and crime coverage? Should the ACO consider coverage to protect it when faced with claims related to employment practices?

Management liability will be a key driver of an ACO’s risk management profile.

Continued...

Not unlike MCOs did over the past twenty-five years, ACOs may be faced with questions and resulting claims related solely to decision making regarding the “management” of care and decisions related to “controlling access” (utilization) to care and treatment.

Professional Liability

Under the ACO model of coordinating and delivering care, there will be a heightened awareness of professional liability (medical malpractice) risks in light of expectations that ACOs will incentivize providers to minimize unnecessary care. There will likely be causes of actions focused on “under-utilization” or claims that a physician is not properly coordinating care and not appropriately referring patients to specialists or out of their ACO network for further intervention.

In addition, there are those who believe there will be increased exposure with respect to ACO vicarious liability, being held to higher standards of care, and with increased requirements for patient education and informed consent.

On the other hand, ACOs may provide an ideal platform to better coordinate professional liability programs, risk management and loss prevention efforts, and joint defense in defending claims made against any member of the ACO. For instance, hospitals and other larger ACO participants with self-insurance programs (captives, RRGs, and other alternative risk financing vehicles) should investigate the development of malpractice protection to address the exposures

ACOs may provide an ideal platform to better coordinate professional liability programs.

of the integrated “shared savings” model. Currently, even in so-called integrated delivery systems, many moving parts of the system are insured by different vehicles for professional liability protection.

Provider Excess, Contractual, and Stop Loss Coverage

In the final rule, CMS surprised the healthcare community by introducing two shared savings tracks for ACOs: Track One offers limited shared savings and no downside and Track Two offers a greater opportunity for shared savings *and* losses. Healthcare providers have been familiar with risk sharing arrangements for years beginning with global capitation and being held responsible both financially and clinically for patient outcomes.

As a provider member of an ACO that elects to participate in Track Two, there will be downside risks – especially for high-end physician specialists whose care typically contributes to extreme costs.

Treating beneficiaries with chronic conditions or cancer requires extraordinary resources and close care coordination – both of which will prove financially challenging.

ACOs and specialized providers should explore products known as “provider excess” or “provider stop loss” which may assist the ACO with catastrophic loss (single patient costs) or cash flow issues based on fee arrangements with CMS. While ACOs will be paid on a fee-for-service basis at the outset, experts agree that ACO arrangements will likely migrate towards the ACO accepting increased financial risk for quality outcomes, rather than for volume (fee-for-service).

Continued...

Government Billing Errors and Omissions

Government audits focused on healthcare contracts, care provided, and billing practices have increased significantly in the past few years. This focus, according to CMS, is a result of the increasing number of investigations which uncovered fraud against the federal government's healthcare programs.

In addition to fighting fraud, the government has significant authority to conduct routine audits to recoup improper claim payments made to health care providers. This will not change with the development of ACOs. In fact, if anything, the new model may provide "fuel" to investigators to find more intentional and unintentional fraud in billing. In 2006, CMS launched the Recovery Audit Contractor (RAC) program which is designed to uncover improper payments in the Medicare program.

Given this increase in recovery efforts, the Property and Casualty insurance industry has developed products to protect healthcare organizations with defense cost as well as fines, penalties, and settlements. Risk managers should investigate these newly developed products for their ACO insurance portfolio.

Other Risks to Consider

In the final rule, CMS and the Office of Inspector General issued five waivers to address federal anti-kickback statutes for physicians. Although the waivers appear to remove the risk of penalties for organizations participating in ACOs, risk managers should review current compliance plans, as well as current insurance coverage in place, which may be designed to trigger when claims of antitrust or fraud occur. At the very least, defense of such claims should be contemplated in a mature insurance program.



Conclusion

The final rule issued by CMS has provided greater clarity around the set-up and operation of ACOs and addressed many of the challenges identified by healthcare providers. However, as these new rules are tested by ACO pioneers, risk managers of participating organizations have yet another set of responsibilities on their collective plates. Entering into an ACO will most certainly alter the risk profile of their healthcare organization and require additional insurance coverage to address new exposures. As providers move forward to establish ACOs, as with any new business venture, a risk manager's due diligence must include a detailed analysis of risks and insurance responses that protect the potential financial viability of their organization.

Author: William J. McDonough, MPAH, ARM, FASHRM

Managing Principal, Executive Broker

617.531.6850 or William.McDonough@integrogrou.com

Integro Moves Up

Integro jumped *eight spots*—to 31st from last year's 39th (and 50th as recently as 2009)—in *Business Insurance* magazine's 2011 rankings of top United States insurance brokers.

Despite a stubbornly challenging economy, Integro recorded overall year-over-year revenue growth of 24%—to \$83 million in 2010 from \$67 million in 2009.



Ask the Risk Pros...

"Our organization is planning to sponsor and exhibit a community health fair. Are there risks that we should be aware of including contractual risks?"

Yes, there are several risks that your department should consider and review prior to the health fair. While sponsoring this event is good for the community and important as respects to image, due diligence should be performed to assure that all parties are protected. The following (representative) steps should be taken or questions answered and documented:

- Review all contracts and agreements for requirements for insurance coverage or risk transfer. Pay special attention to hold harmless agreements and any requirements for named insured status, additional insured status, and/or evidence of coverage requirements generally.
- Evaluate all patient education and consent requirements (forms) if the Health Fair includes any type of screenings or other treatments.
- Safety and security adequacy. Is the location of the health fair appropriate to maintain a safe and secure environment (physical plant, privacy considerations, seating arrangements for patients, etc.)?
- Review training, credentialing, and certification of staff providing services at the health fair. Should all staff be BLS or ALS certified? Is staff competent to manage emergencies, and are there equipment/supplies to assist in an emergency?
- Will temporary use of laptops and possible paper forms used to gather/access patient information meet HIPAA standards? Will patient information be secure outside the normal controlled healthcare setting?

With good risk management and loss prevention planning, the health fair should be a success while at the same time protecting the sponsor from liability.

"Our leadership team has asked me to research risks related to social media and make recommendation about using it to market our practice. Where should we start?"

There are many risks to consider as you formally review your organization's position on social media. The power of social media platforms such as Facebook (which topped one trillion page views in June, 2011), Twitter (with 100 million active users monthly), and LinkedIn (with nearly 34 million visitors, up 63% from a year earlier) should not be ignored.

Continued...

riskRX6

These platforms provide an enormous opportunity for all companies including healthcare providers to build employee and brand loyalty, communicate with customers, and increase their customer base. Some of the risks include:

- Reputational and Brand Risk – employees who use social media appropriately can be an asset to your organization, but those who do not can cause major damage. There is little locus of control – an organization cannot generally control what an employee will share/post.
- Information Security Risk – technical attacks into databases or warehouses have been documented where the “attacker” uses a social media platform to take control of a user’s computer and then hack personal health information or financial data.
- Libel and Slander – employees may find themselves facing a claim of libel or slander by posting statements or information about another person which causes emotional distress.

To mitigate these risks, healthcare organizations should consider pulling together a task force or team to review social media and produce guidelines for employees including:

- Developing and implementing, or updating a formal social media policy
- Providing training if social media is an approved platform for staff
- Engaging your chief information officer or IT staff to determine if improved information security is needed
- Reviewing the need to purchase Cyber insurance coverage
- Monitoring activity regularly

“We would like to update our position on guests, including observers, in the operating room or in other areas where care and treatment is provided. What should be thinking about as we review our current policy and procedure?”

Here are several recommendations on allowing “guests” into any treatment area of a healthcare facility:

- Bring together a task force to review current procedures. This task force should include clinicians who are responsible for treatment areas.
- Every healthcare facility should have a written protocol to address issues surrounding visitors in the OR and other treatment areas. Ideally this protocol should be reviewed at least every three years and address sales persons, other clinicians, family members, and educators/students.
- Patients must be advised whenever there is an observer in the OR or other treatment area. Many organizations require written consent from patients acknowledging that a guest will witness their care. Patients should be given the option to refuse any guests witnessing their care.
- All guests in the OR or treatment area should sign a confidentiality agreement.
- The written protocol should address when it is appropriate and at who’s request that a guest be asked to leave a treatment area immediately.
- It is also important to document in a patient’s record that guests were present during treatment and include the guest names.

Disclosure, Apology and Early Offer White Paper Released

Integro Healthcare Practice members Bill McDonough and Ruth Kilduff have penned a white paper entitled *Disclosure, Apology and Early Offer* which examines the related measures healthcare organizations are taking to lower claims following medical errors.

Early adopters of disclosure, apology, and early offer programs have reported fewer malpractice claims and cases in litigation, positive responses from physicians, and positive responses from plaintiff lawyers.

The white paper is available on the Integro web site at www.integrogroup.com or from your Integro Healthcare Practice client executive.

Other recent Integro white papers posted on the site include: *Cybersecurity Disclosure Options* and *A Hard Market Looms—Are You Prepared?*

IMAC 2011--Meet us at IMAC

Integro Healthcare Practice members will be attending IMAC's (the Insurance Managers Association of Cayman) Cayman Captive Forum 2011. This year we are proud to sponsor the fireworks at Thursday's Beach Reception in memory of our good friend and Integro Founder, Bob Clements.

Joanne Wankmiller, Integro's Senior Care Practice Leader, will head the "*Senior Care - Operating in Soft Market Conditions*" panel which includes discussion on the constant analysis and choices made by those operating Senior Care captives. The panel is expected to touch on loss portfolio transfer, M&A activity, and risk management. Issues discussed, case studies and recommendations will apply equally to other healthcare captives. Panelists include:

Bruce Mackey - Five Star Quality Care

Edward Wrobel - Towers Watson

Jen Ziolkowski - Opis Management Resources, LLC

riskRX is the quarterly electronic newsletter produced by Integro's Healthcare Practice.

While the information contained in this publication is based on sources we believe to be reliable, Integro cannot guarantee the accuracy of this content. The information contained in this publication is provided as a general overview only, and it is not intended for nor should it be relied upon as advice for any individual situation. Please contact Integro if you are seeking specific risk management or insurance advice. Integro does not provide tax and/or legal advice.

INTEGRO
INSURANCE BROKERS