ACO CREDENTIALING AND PEER REVIEW

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That’s more than healthcare. That’s smartcare.
Case Study

I. Summa Case Study
   - Overview of Health System Growth
   - Physician Alignment Strategy/Summa Physicians/Joint Ventures
   - Combine Parts of System into ACO
   - Change Care Delivery and Develop New Payment Model

II. Credentialing Process
   - Membership and Network Composition
   - Conditions of Participation
   - Review Quality and Cost Measures

III. Peer Review
   - Corrective Action Plans/Termination

IV. Lessons Learned
Who Is Summa?

- Summa is…
  - An Integrated Delivery System
  - Tertiary, Community and Physician-Owned Hospitals, Multi-Specialty Physician Group, Research Division, Health Plan and Foundation
  - Located in a 5-County Area in Northeast Ohio
  - Working to…
    - Enhance the patient and member experience
    - Create value through a collaborative focus
    - Provide high quality care at low cost
    - Serve the community as the largest employer in our service area
The Integrated Delivery System

Hospitals

Inpatient Facilities
- Tertiary/Academic Campus
- 4 Community Hospitals
- 1 Affiliate Community Hospital
- 2 JV Hospitals with Physicians

Outpatient Facilities
- Multiple ambulatory sites
- Locations in 3 Counties

Service Lines
- Cardiac, Oncology, Neurology, Ortho, Surgery, Behavioral Health, Women’s, Emergency, Seniors

Key Statistics
- 2,000+ Licensed Beds
- 62,000 IP Admissions
- 45,000 Surgeries
- 660,000 OP Visits
- 229,000 ED Visits
- 5,000 Births
- Over 220 Residents

Physicians

Multiple Alignment Options
- Employment
- Joint Ventures
- EMR
- Clinical Integration
- Health Plan

Summa Physicians, Inc.
- 265 Employed Physician Multi-Specialty Group

Summa Health Network
- PHO with over 1,000 physician members
- EMR/Clinical Integration Program

Health Plan

Geographic Reach
- 17 Counties for Commercial
- 18 Counties for Medicare
- 55-hospital Commercial provider network
- 41-hospital Medicare provider network
- National Accounts in 2 States

Foundation

System Foundation Focused On:
- Development
- Education
- Research
- Innovation
- Community Benefit
- Diversity
- Government Relations
- Advocacy

Net Revenues: Over $1.6 Billion
Total Employees: Nearly 11,000
SummaCare

- Health Insurance Company
- Provider Owned
- Four Product Lines
- Total Membership – 150,000 +
- 18 County Northern Ohio Service Area
- Multi-State, National Accounts
- Annual Revenue $400 million
- 300+ Employees
- Large Credentialed Provider Network
Physician Alignment Strategy
Physician Alignment Options

A Multi-Pronged Approach

- **First plank** – Develop Primary Care Network
- **Second plank** – Offer Fully-employed and Physician-Managed Employment Models
- **Third plank** – Joint Ventures
- **Fourth plank** – Clinical and Financial Integration through SHN
- **Fifth plank** – Managed Services Organization
Summa Physicians-Employed Group

Summa Physicians, Inc.
(265 physicians)

- Internal Medicine (38)
- Cardiology (28)
- Behavioral Health (25)
- Palliative Care (6)
- Family Medicine (41)
- Oncology (7)
- Critical Care (11)
- Gastroenterology (4)
- OB/Gyn (21)
- Surgery (35)
- Infectious Disease (7)
- Others (19)
- Geriatrics (11)
- Ortho/Sports (8)
- Endocrinology (4)
# Summa/Physician Current Joint Ventures

<table>
<thead>
<tr>
<th>Joint Venture</th>
<th>% Summa/ % Physicians</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>SummaCare</td>
<td>98/2</td>
<td>Provides insurance and TPA services throughout nation</td>
</tr>
<tr>
<td>Summa Western Reserve Hospital</td>
<td>40/60</td>
<td>Acute Care Hospital located in Northern market. Partnership between Summa Health System and 220 physicians</td>
</tr>
<tr>
<td>Crystal Clinic Orthopaedic Center</td>
<td>50/50</td>
<td>JV Hospital includes inpatient orthopedic surgery at St. Thomas Hospital, ASC in suburban location and 8 hospital based clinics located throughout 3 counties</td>
</tr>
<tr>
<td>Medina ASC</td>
<td>20/80</td>
<td>ASC Surgery Center with 2 ORs and 1 procedure room</td>
</tr>
<tr>
<td>Select Hospital</td>
<td>5/10 (5 AGMC/80 Select)</td>
<td>60-bed LTACH for patients needing additional care after their acute care hospital stay</td>
</tr>
<tr>
<td>Aris Teleradiology</td>
<td>52/48</td>
<td>Teleradiology company provides final reads of radiology exams to hospitals/diagnostic centers across the country</td>
</tr>
<tr>
<td>Digestive Health</td>
<td>5/44 (51 AmSurg)</td>
<td>Outpatient Endoscopy Center</td>
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Physician-Hospitals

- **Summa Western Reserve Hospital ("SWRH")**
  - Joint venture started in June 2009 between Summa Health System and Western Reserve Hospital Partners (a local group of approximately 220 physicians)
  - Commenced operations in June 2009 at the prior Hospital location (conversion of underperforming asset)

- **Crystal Clinic Orthopedic Center ("CCOC")**
  - Orthopaedic Hospital Joint Venture between Summa Health System and Crystal Clinic (a local group of approximately 30 orthopedic surgeons)
  - Commenced operations in May 2009 on the Summa St. Thomas Hospital (Hospital w/in a Hospital)
Combining Parts into an ACO
The Change Process: 2010

ACO Steering Committee
Physician and Executive Strategic Thought Leaders Guiding the Process

IT Work Group
System IT
SummaCare IT
SHN/EMR
CPOE
Data Warehouse

Delivery Network Work Group
PHO
Physician Leaders
JV Partners

Care Model Work Group
Service Lines
Physician Leaders
Primary Care
Nursing
Care Management

Finance Work Group
Entity CFOs
Hospitals
SummaCare

System-Wide Educational Forum
Large-group vehicle for communication and reporting
to key constituencies across the System, including:
Board Leaders, Entity Presidents and Senior Leaders, Physician Leaders from
Entities and the Community, Joint Venture Leadership, All Work Group Members

Co-Chaired by CEO and System VP of Quality

Physician and Administrative Co-Chairs

Included Community-Based Physicians

Educational sessions occurred at Summa and with participating physician groups
Premier Implementation Collaborative
What is the Summa ACO?

Vision Statement: “Summa ACO” is a Clinician-Led Organization that Partners with Communities to Compassionately Care for and serve in an Accountable, Value and Evidence-based manner

Organizational Facts

- **Start Date** – Began operations January 1, 2011
- **Initial Pilot Population** – Approximately 10,000 SummaCare Medicare Advantage members that currently see a participating primary care physician
- **Legal Entity** – Non-profit taxable structure allows for physician majority on the Board
- **Board Composition** – 4 community primary care physicians, 1 medical specialist, 1 surgical specialist, 3 Summa representatives
How Summa Views Accountable Care

- The concept of Accountable Care creates a Burning Platform for Hospitals, Physicians and other Providers along the Care Continuum to work Collaboratively to deliver High-Quality, Coordinated and Cost-effective Care

- Paradigm Shift from Fee-for-Service Medicine to Dr. Berwick’s Triple Aim-Better Care, Better Population Health and Lower Costs
How Summa Views Accountable Care (cont.)

- Accountable Care continues the following transitions:
  - Move away from the current fee-for-service payment system to a new model that incentivizes primary care, wellness and population health
  - Providers become clinically and fiscally accountable for the populations they serve (consistent with our Joint Ventures)
  - Patients become actively engaged to take responsibility for their health
  - Hospitals and physicians build upon their relationships with each other and partner in a deeper way with patients, populations and payers
  - Improve the health of our communities while, at the same time, reduce costs by anticipating health needs and proactively managing chronic care
Why Change How We Provide Care?

Everyone is working in their own silos…, which impedes coordinated care
ACO as the Integrator

Diagram showing the integration of various care settings with the ACO at the center.
ACO Membership Strategy

- **Inclusive, not exclusive**
  - View the ACO as a community collaboration
  - Engage both employed and independent providers
  - Expand to all segments along the care continuum
  - Inclusive of all physicians that want to participate as long as they meet ACO quality and utilization standards as defined in Conditions of Participation in Membership Agreement

- **Initial partners include about 200 PCPs, more than 200 specialists and 7 hospitals**
  - 4 large independent primary care groups
  - 2 employed multi-specialty groups
  - All Summa hospitals
  - SummaCare as the payer partner
ACO Conditions of Participation

Sample of Conditions of Participation in Summa Membership Agreement:

- Comply with Credentialing Requirements of ACO and any Payer
- Participate in ACO Education Initiatives to assist in development of ACO Care Models and Quality Improvement Strategies
- Open practice to new ACO enrollees
- Participate under Single Tax ID
- Provide Timely Care consistent with best practices
- Comply with ACO Policies and Procedures
- Implement and utilize ACO approved EMR consistent with CMS meaningful use guidelines
Sample provisions (cont.):

- Have capacity to exchange clinical and demographic information through secure transaction sets
- Provide patient data to develop care plans consistent with patient choice
- Adhere to ACO protocols to promote improvement in patient outcomes and patient satisfaction
- Make Referrals to other ACO providers when medically necessary and consistent with patient choice
- Protect privacy of patient PHI as required under HIPAA
Care Model Workgroup

- **Care Model Concept**
  - Review High-cost and High-utilization Clinical Conditions
  - Start with Transitions of Care as a way to approach all Care Models—Better Hand-Off of Patients

- **Initial Care Model – Heart Failure**
  - Identified as a Leading Cost and Utilization Driver for the Pilot Population
  - Will serve as an example for how to develop additional Care Models
  - Create Evidenced-based Protocols which are followed by all Providers
  - Target preventable readmissions through better follow-up and monitoring of the patient
Disease-Specific Care Models: CHF as a Use Case

Hospital discharges for heart failure (US: 1979-2006)

Source: NHDS/NCHS and NHLBI
Heart Failure Care Model: Current Elements

- Focus on **Transitions** from Hospital to Home
- Focus on **Patient-Centered Medical Home Management**
- Focus on **Patients’ Ability to Self-Manage**
New Heart Failure Transitional Processes (Hospital to Home)

- Improved notification of PCP at the point of admission and discharge from hospital, with transfer of pertinent clinical information and establishment of a follow-up visit

- Expansion of Transitional Care Nurse Case Management Program across all System Hospitals

- Clinical Guidelines for Post-Discharge Care with utilization of Electronic Health Record where possible
HF Medical Home Management

- Development of visit-based ambulatory guidelines incorporated into the Electronic Health Record

- Enhanced Management of patients with highest risk factors

- Ongoing support with integrated care plan via assignment of case managers to primary care offices

- Proactive identification of patients for home monitoring, other supportive services
HF Patient Activation

- Restructure patient education materials to allow for an individualized, staged approach to patient activation

- Shift in delivery of materials from an “education” perspective to a “coaching” mode with the objective of patient engagement

- Develop and incorporate materials focused on enhancing patients’ self-management and emphasize the patient’s role within the health care team
ACO Success Measures
Quality Measures

- 65 different quality measures around 5 domains (§425.10(a)):
  - Patient/Caregiver Experience (7 measures)
  - Care Coordination (16 measures, including transitions of care, HIT)
  - Patient Safety (2 measures)
  - Preventive Health (9 measures)
  - At-Risk Population/Elderly Health (31 measures)

- Report quality and cost measures through PQRS, eRx, and EHR

- If final ACO regulations include 65 proposed measures, will need significant monitoring/communication plan to ensure achievement of these measures
ACO Financial Model

Payment Pools and Distribution

ACO (set Medical Expenditure Targets and Pools)

Pools

- Hospital, SNF, and Rehabilitation Budgeted Pool
- Outpatient Ancillary Budgeted Pool
- Outpatient Services Budgeted Pool
- Outpatient Diagnostics Budgeted Pool

Pools are established using actuarial data tied to CMS filing

Actual claims expenditures are charged against the pool based on claims paid throughout the year

Surpluses available for distribution/Deficits absorbed by Payer
ACO Financial Model
Surplus Eligibility

- **Practice redesign education**
  - Participation in education sessions or CME activities

- **Advancement of ACO care redesign**
  - Participation in development of care processes
  - Integration of care model templates into practice
  - Completion of annual health risk assessment of patients

- **Patient satisfaction**
  - Achievement of threshold levels for HCAHPS or CG CAHPS

- **Quality/Value measures**
  - HEDIS scores (Diabetes A1c, BP, Diabetics’ LDL)
  - Overall readmission rates (Hospitals)
  - Consult communication standards (Specialists)
Critical Nature of Membership

- ACOs will not receive shared savings distributions if the providers do not meet quality performance metrics and achieve cost reductions.

- Need method for enforcing Conditions of Participation to ensure achieve ACO goals—either by Board, Groups, CMO or other means.

- Physicians will be evaluated based on quality and utilization parameters at time of reappointment or offer of participation in ACO.

- To ensure compliance with metrics, need to create dashboards or other tools to keep Physicians informed of progress.
Performance Standards Highlight the Need for Effective Credentialing
Key Credentialing/ Peer Review Issues

- Should your ACO include all eligible Physicians on your Medical Staff?
- Who will perform credentialing for the ACO?
- What differences exist between Hospital and ACO Credentialing?
- How will Economic Credentialing differ in an ACO versus a Hospital setting?
- How should Peer Review work in an ACO?
- How should an ACO take corrective action with respect to its Members?
- What Governance Documents will apply to ACO members? Bylaws, Conditions of Participation or Employment Agreement?
ACO Membership: First Step

- Determine which providers can achieve the “Triple Aim”? 
  - Provide Better Coordinated Care 
  - Practice according to Evidenced Based Guidelines 
  - Deliver Cost Efficient Care 

- Delivery Network Committee comprised of System administrators and Physicians determine Membership: 
  - All on Hospital’s Medical Staff or Subset of Providers 
  - Assess physicians that can achieve High Quality/Low Cost Care 

- If not, then could face: 
  - Political Issues from Excluding Certain Physicians
Oversight of Provider Behavior

- To whom is a Provider “Accountable”?
- Who will monitor Provider Performance?

  - Full Time Chief Medical Officer-Section 425.5 (“Clinical management and oversight must be managed by Full-Time Senior-Level Medical Director who is physically present on a regular basis, who is a Board-Certified Physician and licensed in State where ACO operates)
  
  - Board of Directors
  - Quality or Peer Review Committee
  - Service Line Heads, Chairs, Partners in Physician Group
ACO Membership & Antitrust Issues

- Antitrust Challenges for Exclusion from ACO
  - Market Power Challenge if include too many Providers
  - Proposed Antitrust Guidance
    - Over 50% - Mandatory Review
    - 30% to 50% - Gray Zone
    - Under 30% - Permissible
- Achieve Clinical & Financial Integration of Providers
ACO Credentialing

- What to do with Physicians that are not:
  - Cost Effective
  - Willing to Adapt to New Paradigms
  - Willing to Incorporate EMR into their practices
  - Willing to Practice under New Models of Care

- Historically, Credentialing focused on Poor Clinical Quality or Bad Behavior

- New Era of Credentialing in ACOs: Review achievement of Economic and Quality Targets under new ACO standards/benchmarks
Hospital vs. ACO Credentialing

- **Hospital Credentialing**: Providers evaluated for their individual competency to perform procedures in Hospital setting—policed by Hospital

- **ACO Credentialing**: Physicians have economic incentive to assure that their peers practice high-quality, cost-effective medicine to achieve shared savings criteria

- Potential Liability for decisions made on behalf of ACO (similar to *Baptist Health* case)
Hospital vs. ACO Credentialing (cont.)

- **Hospital Credentialing**: Physicians have no direct economic interest to protect Hospital from competition by other doctors

- **ACO Credentialing**: Physicians making decisions to impose economic credentialing on their peers

- **Other ACO Credentialing criteria:**
  - Physicians keep Referrals within ACO and its Providers
  - Monitor utilization patterns of providers
Economic Credentialing

- AMA defines Economic Credentialing as “use of economic criteria unrelated to quality of care or professional competence in determining a physician’s qualifications for initial or continuing hospital medical staff membership or privileges.”

- “Loyalty Credentialing” is based on Physician ownership of a competing facility or ACO.

- In the ACO world of Economic or Loyalty Credentialing, Physicians will take action against their colleagues to ensure achievement of shared savings targets.
Delegated Credentialing

- Delegated Credentialing: Could be provided by variety of Entities:
  - Hospital Medical Staff
  - ACO Medical Staff
  - Provider Health Plan
  - Other Payers

- Cross-Termination among different Credentialing bodies

- Liability of the Different Entities taking on Credentialing for the ACO
Credentialing Guidelines

ACOs should consider following guidelines as part of Credentialing Process:

- **CMS Requirements (2004):** Hospital must ensure that all practitioners who provide clinical care are individually evaluated by a Medical Staff and that those practitioners possess current qualifications and demonstrated competencies for the privileges granted.

- **Joint Commission Ongoing Professional Practice Evaluation ("OPPE" 2008):** Require hospitals to review physicians based on criteria that can be viewed as having quality elements and financial elements.

- **M.S. 06.01.05:** The decision to grant or deny privileges is an objective, evidenced based process.
Termination from ACO Membership

Evaluate Reasons for Termination:

- Adverse Decisions should not be taken by a Competitor? ACO should develop Conflict of Interest Policy
- Objective vs. Subjective Criteria for Termination?
- Same or Different Hearing Procedures as Medical Staff?
- Due Process Requirements? Or solely follow Contractual Standards?
- Reportable to National Practitioner Data Bank or State?
ACO Peer Review
ACO PEER REVIEW

- Bylaws or Conditions of Participation should define Peer Review Process and Peer Review Committee.

- Define types of documents that will be subject to Peer Review Protection (e.g. incident reports, quality assurance reports, utilization studies) and ensure proper labeling of documents.

- Consider whether outcome data shared with CMS and among ACO participants may lose confidentiality?

- Open Issues related to Peer Review:
  - If Delegated to Hospital, will this offer greater HCQIA/State Law protection?
Other Vehicles for Peer Review

- Summa uses System Quality Committee to act as Peer Review Committee to review Incident Reports including those involving sentinel events, and to monitor all safety events, patient complaints, claims and lawsuits.

- Can ACO attempt to qualify as Patient Safety Organization (“PSO”)?
ACO Quality Committee

- Sample of Clinical Value Measurement and Resource Management Committee Core Functions:
  - Development and monitoring of routine ad hoc reports of clinical resource/utilization and quality reporting for care
  - Preparation of summary reports with recommendations for strategic direction relative to quality and utilization of clinical resources
  - Oversight of peer review, credentialing and recredentialing of Physicians (either directly or via delegation agreement)
  - Oversight of utilization and care management activities (either directly or via delegation agreements)
Sample of System Quality Committee Charter:

- To act as a Peer Review Committee to receive and review incident reports (and/or unusual reports) including those involving sentinel events and near-misses

- To oversee and facilitate the implementation of an accountable care delivery system within the Accountable Care Organization

- Review Peer Review and Quality Assurance information in accordance with Ohio law, including ORC 2305.24 et. Seq.
Enforcement of ACO Standards

- ACO or Group Enforcement? Chief Medical Officer of ACO?

- Credentialing Action?
  - Suspension/Termination
  - Cure Periods in Employment Agreement
  - Appeal Process/Hearings/Due Process

- Contractual Action?
  - “With” or “Without Cause”
  - Cure Periods
  - No Need for Due Process
Lessons Learned
Lessons Learned

- An ACO needs to be Collaborative, Physician-Led

- Develop and Administer Uniform Metrics to evaluate quality of care and cost effectiveness across the patient population

- Develop tools to evaluate Providers ability to adapt to new care continuum based on improving efficiency, service and quality

- If you include all Physicians on Hospital medical staff as ACO members, evaluate potential impact on shared savings achievement versus strategic/political problems if you exclude certain physicians
Lessons Learned (cont.)

- What Entity or which Providers Determine eligibility criteria for ACO?
  - Hospital’s Medical Staff/System Leaders/Subset of Physicians

- Expect Challenges to Data Upon Which Decisions are Made—Need to establish strong infrastructure and IT for Hospitals and Physicians to:
  - Gather, analyze, report and provide alerts based on clinical data and financial information in real time
  - To support caregivers behavioral change by facilitating immediate high quality care, enabling follow-up and feedback
Questions?

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