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Accountable Care Organizations Preparing for the Future



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Preparing for ACO Future

- ❖ Paradigm shift
- ❖ Dramatically will transform healthcare
 - From Payment /Partnership Model
 - Quality of Care and Costs

Average Medicare payment for Medicare beneficiaries utilizing post-acute care in 2006 was \$30,000



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ACO Evolution

- ❖ Patient Protection and Affordable Care Act of 2010
- ❖ Increased details available for Medicare Shared Savings Program
- ❖ Initiative to improve health related outcomes and reduce costs by promoting collaboration between all patients caregivers



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What is the ACO

- ❖ ACO is a group of healthcare professionals and facilities spanning the continuum of care that agree to work together to ensure patients get the
 - Right care
 - Right time
 - Right Place
 - CMS vision of patient centered medical home where preventive medicine is emphasized



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ACO



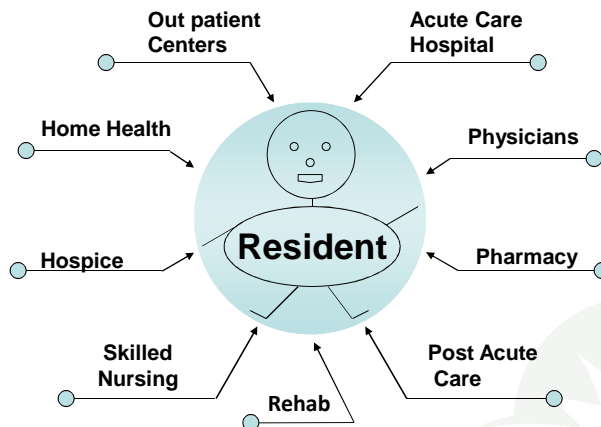
❖ ACO- Connect provider reimbursements to quality metrics and reductions in the total costs of care

– Goal:

- Delivering positive patient outcomes
- Part of the Medicare Shared Savings Program
- Incentivize Providers to work together
- Coordinated Care delivery for Medicare Beneficiaries



Network High Quality/Low Cost Providers



There are many potential players in a integrated ACO system



ACO

- ❖ Hospitals Significant Control
- ❖ Empowered to Partner with Providers who prove they can deliver high quality, low-cost care while minimizing readmissions
- ❖ Long term care-senior living and other post acute providers-relationships with hospitals very important

“Skilled Nursing facilities will be an asset to new ACO as we aim to build a higher-quality, more cost effective experience for those needing care” - Governor Mark Parkinson- President and CEO of AHCA



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ACO Survival

- ❖ Post acute care providers must up their game to prove worthy of aligning with a ACO
- ❖ Ability to deliver high quality patient care efficiently and at reduced costs is the de facto standard for ACO invitation to participate



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ACO

- ❖ Hospitals in the drivers seat
- ❖ Providers must evaluate how to differentiate and best position as a top organization



Post Acute Care Provider

- ❖ Questions?
 - What is our current hospital readmission rate? How can we improve?
 - What is the best way to communicate with hospitals and physicians?
 - How can we reduce costs across our organization?
 - How much can we save through ACOs?
 - How do we get paid?
 - What measures will hospitals and ACO care about?
 - Are we currently providing the best care to our patients and residents?
 - Do we have the right staff? The right skill set? The right ratios?
 - How will we exchange patient information?

New Models for Payment and Care

There are three key provisions of the Accountable Care Act that will have direct impact on post-acute care needs and utilization:

1. Avoidable hospital readmission penalties:

Effective October 1, 2012, hospitals' Medicare payments will be reduced for avoidable readmissions for three conditions, most likely beginning with those now reported by hospitals (AMI, pneumonia, and congestive heart failure-CHF). Post acute settings are key to success in this area.

2. Accountable Care Organizations (ACO)

The ACO Proposed Rule was issued this spring, ACOs will be implemented in 2012, including shared risk, shared savings and significant quality reporting measures

3. Bundled Medicare Payment Models

A pilot project for bundling Medicare payments for all services related to an acute hospital admission, three days prior and 30 days after discharge, will begin on January 1, 2013



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Hospital Readmission Penalties

- ❖ Almost 37% of Medicare hospital admissions utilize a post-acute care venue (long-term acute care hospital-LTACH, inpatient rehabilitation facility-IRF, skilled nursing facility-SNF, or home health agency-HHA).
- ❖ Although the overall incidence of 30-day hospital readmissions has been estimated to be 20%, the Research Triangle Institute reported that acute hospital readmissions from post-acute venues was 30%.
- ❖ Acute hospital readmissions from post-acute venues, according to MedPAC are most frequently from SNFs, followed by HHAs, LTACHs, and IRFs.
- ❖ Hospitals that are not able to control the quality of care and avoidable readmissions from post-acute venues are at great risk for Medicare payment penalties that can reach up to 3% of their aggregate Medicare payments in FY2015.



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Acute Hospital Readmissions from PAC

PAC setting	Percent Discharged from Hospital to PAC Setting	Percent Rehospitalized After Using PAC Setting	Percent Died in PAC Setting	Percent Discharged to a Second PAC Setting	Most Common Second PAC Setting Used
SNF	17.3%	22.0%	5.4%	29.3%	Home Health
Home Health	15.0%	18.1%	0.8%	2.3%	Hospice
Inpatient Rehabilitation	3.2%	9.4%	0.4%	56.8%	Home Health
Hospice	2.1%	4.5%	82.2%	2.4	Home Health
Long-Term Care Hospital	1.0%	10.0%	15.5%	53.4%	SNF
Inpatient Psychiatric	0.5%	8.7%	0.4%	25.4%	SNF
Total	40.0%	18.0%	6.2%	19.8%	

Accountable Care Organizations (ACOs)

- ❖ Beginning January 1, 2012, the new Medicare Shared Savings program will promote accountability for a Medicare fee-for-service patient population.
- ❖ ACO models are designed to coordinate the delivery of items and services under both Medicare Part A and Medicare Part B, allowing CMS to pay one entity (the ACO) to optimize quality and efficiency in health care services delivery.
- ❖ ACOs can include networks of physicians and other providers that have a formal legal structure. Hospitals and physician groups are organizing to participate as ACOs and manage care at all levels of the process with participating partners.

ACO Impact on Post Acute Care

❖ Average Medicare payment for Medicare beneficiaries utilizing post acute care in 2006 was \$30,000

– Rationale

- Many beneficiaries utilizing post acute care utilize more than one post acute venue



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Impact on Post-Acute Care

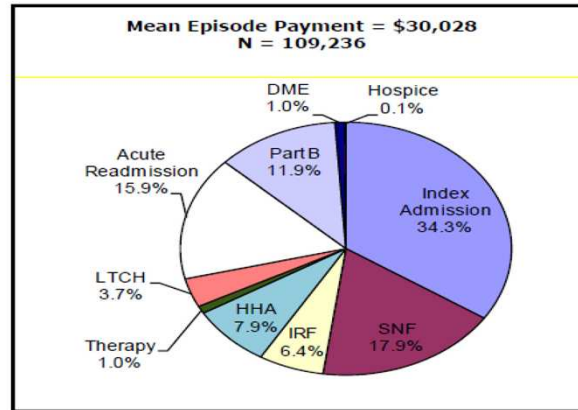
❖ According to RTI, 2009, the average payment for Medicare beneficiaries utilizing post-acute care in 2006 was \$30,000. A key reason for this amount is the fact that many post-acute patients utilize more than one post-acute venue. The table on the next slide shows a breakdown of the average payment.



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Medicare Payments by Service Type

Medicare Payments by Service Type, All Post-Acute Users, 2006



Impact on Post-Acute Care

- ❖ In order to ensure that health care systems that develop ACOs can achieve Medicare payment savings for the gain-sharing, systems effectively manage inpatient, outpatient, and physician costs as well as avoidable readmissions
- ❖ Must be able to control the utilization, cost, quality, and outcome of post-acute venues.

Impact on Post-Acute Care

- ❖ Health systems that anticipate developing ACOs will want to be able to have control of all post-acute venues but particularly home health.
- ❖ Control by means of ownership, joint ventures, management agreements, or preferred provider relationships.
- ❖ Control is most effective if the post-acute entity is fully owned by the hospital or health system that is part of the ACO. Post-acute venues, regardless of their relationship to hospitals and ACOs, must be able to prove that they can manage patients effectively to:
 - Ensure there are minimal, if any, avoidable readmissions;
 - Create a seamless care continuum that transitions patients to the lowest cost setting; and have the best possible patient outcomes.

Bundled Medicare Payment

- ❖ Pilot project for bundling Medicare payments for all services related to an acute hospital admission, three days prior and 30 days after discharge begins January 2013
- ❖ Initial focus on one or more of eight conditions and the single payment will apply to all of the following services provided during the episode

Bundled Medicare Payment

- ❖ The pilot is expected to include use of the Continuity Assessment Record and Evaluation (CARE) tool, or a similar tool, to determine the most clinically appropriate post-acute care venue. Payment will be made either as a single bundled payment or through bids from the entities desiring to participate in the pilot. Such entities must include a hospital, a physician group, a skilled nursing facility, and a home health agency.
- ❖ Assuming that the pilot program shows spending reductions while maintaining quality of care, the program will be expanded before or at least by January 1, 2016.



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Health System Responsibility

- ❖ Healthcare systems that develop ACO must secure payment savings by managing
 - Inpatient
 - Outpatient
 - Physician costs
 - Avoidable re admissions
 - Control utilization, costs, quality and outcome or post-acute venues



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Post Acute Projections

- ❖ Post acute LTACH, IRF, SNF users
 - Decline
 - Post acute HHA users will
 - Increase
 - Home Care technologies, telemedicine, chronic care management and home based services are all encouraged in the new law



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How Will ACOs be Paid?

- ❖ ACOs must be responsible for a minimum of 5,000 Medicare fee-for-services beneficiaries.
- ❖ ACO will enter into a three-year contract with CMS to manage the defined Medicare patient population.
- ❖ ACO providers will be paid Fee For Service Medicare rates.
- ❖ The ACO will be eligible to receive payment for shared savings if the estimated average per capita Medicare expenditures under the ACO for Medicare fee-for-service beneficiaries for Part A and B services, adjusted for beneficiary characteristics, is at least the percent specified below the CMS benchmark.
- ❖ ACOs are also at risk to lose money if costs exceed target levels (no shared savings occur)



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Bundled Medicare Payment

- ❖ Initial focus on one or more of eight conditions and the single payment will apply to all of the following services provided during the episode
 - Acute inpatient services (hospital admission and readmissions)
 - Physician services (in and out of the hospital setting)
 - Outpatient hospital services, including emergency services
 - Post-acute services

Pilot will be using the Continuity Assessment Record and Evaluation too (CARE)



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Bundling

- ❖ Well integrated provider relationships-essential under bundling
- ❖ All members of the ACO must demonstrate success with quality measures
 - Functional status improvement
 - Reducing rates of avoidable hospital admissions
 - Rates of discharge to the community
 - Incidence of health acquired infections
 - Efficiency measures
 - Measures of patient perception of care
 - Other measures including measures of patient outcomes



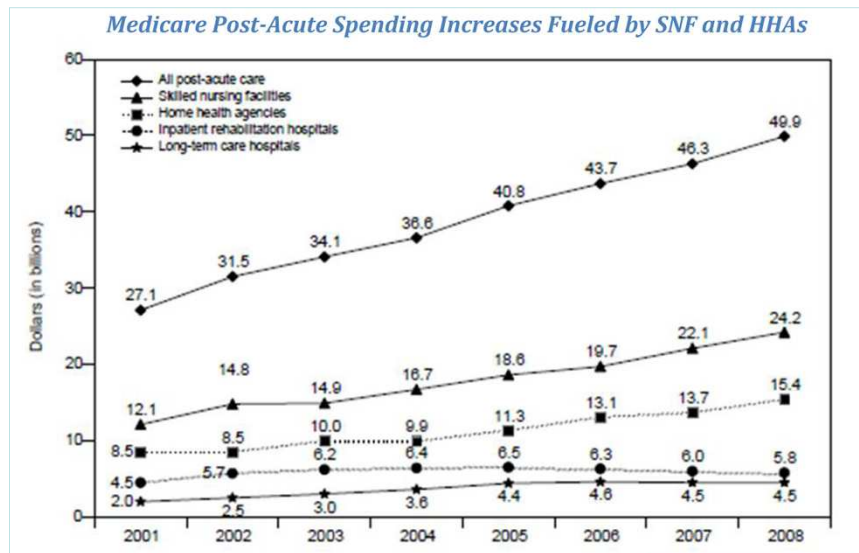
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Impact on Post-Acute Care

- ❖ The law implies that the pilot project will focus on the eight conditions found by Med PAC to have a high rate and volume of avoidable hospital readmissions for Medicare fee-for-service beneficiaries.
- ❖ Membership of an entity that desires to pilot bundled payment for one or more of these conditions: hospital, physician group, skilled nursing facility, and home health agency (emphasis added). Other post-acute providers may also become part of the entity
- ❖ Congress appeared to understand that the fastest rate of Medicare cost increases for post-acute care has been in utilization of skilled nursing and home health, as shown in the table on the next slide.



Impact on Post-Acute Care



Accountable Care Organizations

Each component of the entity that received the episodic bundled payment must rely on each of the other components to achieve the targets for quality measures in order to receive the anticipated amount of Medicare bundled payment for the episode

"No Healthcare provider is an island"

John Donne



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Maintaining Quality Patient Care While Managing Cost Savings

- ❖ Ownership or well integrated preferred provider relationships are essential for success under bundling. All members of the entity that receives the episodic bundled payment— hospital physicians-SNFs-HHAs— must be able to demonstrate success with quality measures, including those mentioned in the law:
 - Functional status improvement
 - Reducing rates of avoidable hospital admissions
 - Rates of discharge to community
 - Rates of admission to an emergency room after hospitalization
 - Incidence of health care acquired infections
 - Efficiency measures
 - Measures of patient perception of care
 - Other measures, including measures of patient outcomes



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Maintaining Quality Patient Care While Managing Cost Savings

- ❖ Each component of the entity that received the episodic bundled payment must rely on each of the other components to achieve the targets for quality measures in order to receive the anticipated amount of bundled Medicare payment for the episode.
- ❖ As is true for ACOs, bundled episodic payment requires that hospitals and health systems are able to manage the utilization, cost, quality, and outcomes for patients in any post-acute venue with one of the targeted conditions for bundling.
- ❖ Ownership of the SNF and HHA provides the best guarantee
- ❖ Joint ventures and preferred provider relationships are other methods for integrating these post-acute venues with hospitals and physicians.



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Evaluating the ACO Model

- ❖ Becoming an ACO and becoming eligible for shared savings may be one of the few methods available to hospitals and health care systems to remain financially viable, particularly as the percentage of Medicare admissions increases due to demographic factors, namely, the aging of America.
- ❖ Hospitals and primary care physician groups are unsure of the ability to profit under the model as laid out in the ACO Proposed Rule.
- ❖ Start up costs, such as information systems and provider networking may be barriers for providers wishing to create an ACO.



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The ACO Challenge for Post Acute Care

- ❖ The ACO will need to effectively manage inpatient, outpatient, and physician costs as well as avoidable readmissions ..
- ❖ ACO control will occur by means of ownership, joint ventures, management agreements, or preferred provider relationships.
- ❖ Post-acute providers must demonstrate that they can minimize **readmissions, create a seamless care continuum that transitions patients to the lowest cost setting; and achieve the best possible measurable patient outcomes.**
- ❖ Evidence of quality and financial outcomes will be critical for all entities.



Why New ACO Models Might Succeed

- ❖ Opportunity to align clinical and business environment
 - Encourages timely patient-focused data and evaluation
 - Anticipates increasing challenges of FFS payment environment while preserving or increasing net revenues – leadership in reforming health care
- ❖ Essential core principles with flexible transition
 - Level I ACOs do not eliminate any existing payments, support establishment of patient-level systems
 - Level II offers more reward/more risk (but still limited)
 - Level III provides partial capitation for more experienced, coordinated organizations to implement more extensive delivery reforms

Key Challenges for ACOs

- ❖ Critical mass of provider participation
- ❖ Critical mass of payer participation
- ❖ Adequate financing for ACO start-up costs – IT, analytic capabilities, clinical support infrastructure, time and effort, etc.
- ❖ Technical issues - patient assignment algorithm, performance measures, and budgeting methodology
 - Good enough to get started? How to improve?
- ❖ Changing provider culture and patient behavior
 - Medicare: No enrollment, no lock-in, no change in benefits
 - Modest financial incentives, at least in Level I



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Impact on Rehab – ACO Ready?

- ❖ Each of the new payment and care delivery models will require the same things from rehab companies:
 - Efficacy of patient care – Deliver what's needed to achieve best result in shortest amount of time and at the lowest cost
 - Optimal measurable clinical outcomes- Must be able to report clinical outcomes readily to the full assortment of ACO network providers. Results must be positive as related to cost and LOS
 - Quality reporting- Each payment model will also be quality driven; providers who can meet quality standards will be sought after as partners in the new models



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Steps to Prepare for the ACO Model

- ❖ Develop effective clinical and quality outcome data collection and reporting
- ❖ Deliver resident-centered care that achieves desired outcomes efficiently and at lowest cost
- ❖ Develop productive relationships with community providers in acute care, physician groups, and others who may be considering creating an ACO
- ❖ Work with major health system providers in each community now to demonstrate the value of our services and ability to deliver care within expected parameters



Accountable Care Organization

- ❖ Requires that hospitals and health systems are able to manage utilization, costs, quality and outcomes for patients in post-acute venues with one of the targeted conditions for bundling
- ❖ Ownership of the SNF and HHA best guarantee of control- not feasible
- ❖ Joint ventures and preferred provider relationships may be best option for integrating post acute care venues with hospital and physicians

ACO Fiasco

- ❖ Wall Street Journal (6/11/11)
- ❖ ACO supposedly the crown jewel of cost saving reform
- ❖ Draft rule is so awful that models for it say they will not participate



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“To secure continued market relevance, providers must position themselves as high quality, low-costs providers to ACO leaders and commit resources to building ACO relationships”

“Partnering with Hospitals in the ACO Era (PartII)”, Long Term Living Magazine April 19, 2011



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❖ References

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- [http://www.ofr.gov/\(X\(1\)S\(ro10qusrygi1y3uuwyjadf0v\)\)/OFRUpload/OFRData/2011-27461_PI.pdf](http://www.ofr.gov/(X(1)S(ro10qusrygi1y3uuwyjadf0v))/OFRUpload/OFRData/2011-27461_PI.pdf)
- NASL

