

Building a Post-Acute Network: Care Management and ACOs

A high-level summary of proposed rules for ACOs and the shared savings program most relevant to post-acute providers.

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INTRODUCTION

On March 31, 2011, the Centers for Medicare and Medicaid Service (CMS) released proposed rules for accountable care organization (ACO) provisions of the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 (ACA). According to CMS, ACOs create incentives for health care providers to treat an individual patient across care settings: physician offices, hospitals, post-acute, and long-term and outpatient settings. Incentives will be a shared savings program, which rewards ACOs for lower growth in health care costs while meeting performance standards for quality care and putting patients first.

The proposed rules amplify the statutory requirements for ACOs; however, over the past several years a substantial number of articles and papers have been published outlining models for ACOs. Based on models proposed by various ACO thought leaders,^{1 2 3} health systems, physician groups, insurers, and post-acute providers have been preparing to develop and implement ACOs or ACO-like models wherein a legal entity comprised of health care providers assumes responsibility for Medicare Part A and Part B services for a defined population. The legal entity utilizes electronic health records, care coordination and management, preventive care, outcome reporting, and patient engagement to drive down overall annual health care costs for Medicare fee for service beneficiaries as well as improve their care experience.

¹ *Accountable Care Organizations: AHA Research Synthesis Report*. American Hospital Association Committee on Research, June 2010.

² *Implementing Accountable Care Organizations*. Shortell, Stephen M, Casalino, Lawrence P, and Fisher, Elliott, Berkeley Center on Health, Economic & Family Security, BerkeleyLaw, University of California, May 2010.

³ *Accountable Care Organizations in California: Lessons for the National Debate on Delivery System Reform*. Robinson, James C and Dolan, Emma L. Integrated Healthcare Association, 2010.

In this document, we provide a high-level summary of proposed rules for ACOs and the shared savings program most relevant to post-acute providers. We also provide examples of how three leading post-acute provider organizations are preparing to be part of a new health care delivery and payment model.

ACOs and the Shared Savings Program: Proposed Rules

In general, an ACO is a legal entity of eligible providers and suppliers working together by means of a joint governance model to coordinate care for Medicare beneficiaries. Providers and suppliers participating in an ACO would continue to be reimbursed by Medicare under existing law; however, the ACO would also be eligible to receive a portion of the money it saves Medicare through its improved use of health resources and improving the health of its Medicare members.

ACO Eligibility and Organization

The statute calls for four types of health care entities authorized to form an ACO:

- Group practices of “ACO professionals” (physicians and physician extenders).
- ACO professionals in networks of individual practices.
- Partnerships or joint ventures between hospitals and ACO professionals.
- Hospitals employing ACO professionals.

In addition to the above entities, the law also allows “such other providers of services or suppliers as the Secretary determines appropriate.”⁴ Proposed rules add certain critical access hospitals (CAHs) and emphasize that while other providers and suppliers (e.g., federally qualified health centers, rural health centers, skilled nursing facilities, nursing homes, and long-term care hospitals) cannot form an ACO on their own, it is possible for them to participate in an ACO and share in any relevant savings or losses.

The ACO must satisfy a number of operational elements, including:

- At least 75 percent control of the ACO’s governing body must be held by ACO participants.
- Overall operation must be managed by an executive whose appointment or removal is under control of the governing body.

⁴ 111th Congress. *Public Law 111-148, The Patient Protection and Affordable Care Act*. March 23, 2010

- Clinical aspects of an ACO must be managed by a board certified physician who is licensed and present in that state.
- There must be a physician-directed quality assurance and improvement program.
- Evidence-based medical practice or clinical guidelines must be implemented that are consistent with better care for individuals, better health for populations, and that result in lower growth in expenditures.
- There must be an IT infrastructure to collect, evaluate, and share data with providers and suppliers throughout the entire organization.

Finally, ACO participants must certify they will be accountable for a three-year period and report to CMS on the quality, cost, and overall care for minimum of 5,000 Medicare fee for service beneficiaries assigned to the ACO.

Membership by Attribution

Medicare fee for service beneficiaries will be assigned to an ACO based on their utilization of primary care services provided by physician ACO participants. Thus, primary care physicians would be required to belong exclusively to one ACO while other provider types could belong to multiple ACOs. The ACO must notify a beneficiary that s/he is a member of the ACO. Beneficiaries who choose not to be a member of the ACO in which the primary care physician participates must select a different primary care provider not affiliated with that ACO.

Quality Reporting

Sixty-five quality measures covering five areas are included in the proposed rule; in the first year, an ACO must report on these quality measures. In future years, in order to receive any share of potential savings (the Shared Savings Program), an ACO must meet either a total performance score or a threshold established by CMS. Quality measures focus on five domains:

- Improved patient/caregiver experiences.
- Care coordination.
- Patient safety.
- Preventative health.
- At-risk population/frail elderly.

Post-acute and long-term care providers can play an important role in assisting the ACO in meeting quality requirements in these domains. For example, the care coordination domain includes measures of potentially avoidable hospital admissions for short-term complications and uncontrolled diabetes, chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), dehydration, bacterial

pneumonia, and urinary infections. The patient safety domain includes health care acquired conditions such as pressure ulcers, catheter associated urinary tract infection, and falls. The at-risk population/frail elderly domain includes effective medical and nursing management of diabetes, heart failure, and coronary artery disease. Post-acute and long-term care providers with robust programs that demonstrate positive outcomes for these quality measures would be attractive partners for ACOs.

Determining Shared Savings

An ACO may elect a two-sided model of shared savings at the start or may elect a one-sided model for the first two years, with mandatory conversion to the two-sided model in year three. Under the one-sided model, an ACO shares savings but is not at risk for aggregate payment *increases*. In the two-sided model, an ACO is eligible to receive shared savings but is also liable for spending above the benchmark. Both the savings and liability levels are capped; however, the one-sided model is eligible for 50 percent of the shared savings while the two-model is eligible for 60 percent of the shared savings.

To be eligible for shared savings, the ACO must achieve a minimum threshold of savings, the “minimum savings rate” (MSR), above a yearly established benchmark amount. The percentage of savings the ACO may receive is the “sharing rate.”

To determine the annual threshold, CMS will set an expenditure benchmark, which is a projection of Medicare expenditures for the ACO potential population if the ACO did not exist. Next, an MSR is established for the ACO: for the one-sided model, the MSR ranges from 3.9 percent for ACOs with a low volume of members (but at least 5,000) to 2 percent for ACOs with a large member volume; the two-sided model is eligible for shared savings on the first dollar after an MSR of 2 percent, across the board, is met. ACOs that serve rural or underserved populations may be exempt from the MSR and share in the entire savings if they meet specific characteristics.

CMS has worked with other federal agencies to facilitate participation in the Shared Savings Program by coordinating federal fraud and abuse requirements, tax guidance, and antitrust considerations. However, certain Medicare Conditions of Participation (CoPs) for post-acute providers that may now serve as barriers to reducing costs of care for Medicare beneficiaries (e.g., the greater than 25-day length of stay for LTACH patients, the three-day prior hospital stay eligibility requirement for skilled nursing facilities) were not addressed in the proposed rule.

Leading Post-Acute Provider ACO Strategies

Three leading post-acute care providers shared their strategies for creating a crucial role in their post-acute care continuum for ACOs. Strategies are summarized under five broad topics.

Diversified Post-Acute Network

Each of the three providers has transitioned from a single venue (i.e., skilled nursing facility) to post-acute continuum providers. Acknowledging that subacute skilled nursing and home health care are the lowest cost venue/service providers in the post-acute arena (which also includes long-term acute care hospitals [LTACHs] and inpatient rehabilitation units and hospitals [IRFs]), leading edge providers are expanding their continuum to include services that support a post-acute network such as home health, hospice, assisted living (including short-term “community reentry” venues), medical adult day care, pharmacy, diagnostic ancillaries, and inpatient/outpatient rehabilitation. These enhancements to post-acute networks are through ownership and/or preferred partnerships.

One of the three providers has developed and acquired PACE (Program of All Inclusive Care for the Elderly) sites in two states. With a focus on comprehensive and preventative care for dual eligibles age 55+ that meet criteria for nursing facility placement, PACE providers accept full capitated risk for this most vulnerable population. Grounded in a medical adult day center, all services to enable PACE participants to remain healthy in their homes are furnished through a network of providers. Results are reduced hospitalizations, emergency room visits, re-hospitalizations, and nursing facility placements. Through PACE, this provider is learning to manage risk and create a person-centered program of care.

Capabilities for Managing High Acuity Patients

Subacute and home health providers anticipate that ACOs will desire partners that can effectively manage high acuity patients after either a short-stay in the hospital or without a hospital stay, i.e., direct admissions from Patient Centered Medical Homes (PCMHs) and emergency rooms. Leading providers are embarking on multiple initiatives that ensure their facilities and agencies have clinical expertise and physician/extender management for achieving excellent patient outcomes, minimal hospital admissions and readmissions, and no emergency room visits.

Initiatives include a higher ratio of RNs in subacute settings as well as RN case managers for home health; 24/7 coverage by physicians/extenders in subacute venues; intensive leadership development of directors of nursing (DONs) to convert their role to that of executive manager; care protocols and pathways developed by

physicians and RNs that extend from hospital to subacute and subacute to home health; and use of technology.

Technology usage among leading providers encompass electronic medical records, hand held devices for caregivers, and sensor technologies in subacute and long-term care as well as in the patient's home, and telehealth devices in the patient's home. Sensor and biometric technology allow for early detection of potential patient issues that can be addressed before they become "problems," thus reducing hospital admissions and readmissions as well as emergency room visits.

Leading providers are also developing new purpose-built subacute facilities and/or significantly remodeling existing facilities to be able to effectively become a look-alike for today's community hospitals but with a rehabilitation/discharge to home emphasis. Purpose-built and remodeled facilities have private rooms, distinct spaces for certain populations (e.g., in-ceiling lifts for bariatric patients), physician/ extender spaces for documentation, care conferences and family counseling, and equipped procedure rooms wherein physicians can safely perform some procedures for which patients/residents previously were sent by ambulance to the emergency room (e.g., g-tube reinsertions).

Data Driven Organizations

In recognition of the importance of demonstrating patient outcomes and understanding costs for purposes of decreasing them where possible as well as for negotiation with ACOs and having the ability to "sync" with ACO participants' electronic health records, leading providers are investing in robust software programs and user-friendly and accessible input/reporting hardware and devices. Data management in real time, as well as trend reports, improves both cost management and care management. For example, drug utilization management is key to reducing costs while tracking 30-day re-hospitalizations at a granular level, allowing for root-cause analysis. Trending and reporting is important for demonstrating the value proposition of preferred provider relationships with ACOs.

One provider is using data obtained, through intensive research, on potential health system partners in markets in which this provider owns multiple skilled nursing facilities as well as home health and hospice agencies (thus providing a cluster for a comprehensive post-acute care network in the market). In addition to assessing the health system in light of an array of preferred partner criteria (e.g., system quality indicators, volume and locations of aligned physicians, etc.), this provider plans to develop or add subacute facilities to assure adequate coverage for the entire health systems' hospital and physician group locations as well as to ensure that the provider's home health and hospice agencies cover market areas in which the

Medicare fee for service population is likely to become members of that health system's ACO.

Care Transitions Management

Keeping in mind CMS's "triple aim" intent for ACOs (better care, better population health, and lower growth in expenditures for the Medicare program), leading edge providers are now embarking on care transition programs to reduce hospital readmissions during the period of time that high-risk patients are most vulnerable: on transfer from hospital to subacute, subacute to home health, or hospital to home with home health. Because a successful hospital to subacute and hospital to home with home health program requires participation and buy in from a hospital, post-acute providers are engaging in dialogue with both hospital executives as well as Medicare managed care plans to pilot proven care transition programs, including measurement of results.

To minimize the risk of medication issues for subacute patients who are discharged home, one provider is now requesting that the subacute patient's family bring in all medications from home so that reconciliation can occur during the subacute stay.

Beyond Post-Acute Care

One provider is expending resources to manage high-risk older adults beyond the episode of acute-post-acute care. This provider has positioned itself as an advisor to federal and state agencies developing care models, especially for high-risk dual eligibles. For example, the state of Vermont is evaluating models of care for dual eligibles: this provider is participating in planning committees to assure operational and reporting synergies with existing post-acute and long-term care venues, both institutional and home-based.

This provider is also integrating housing and health care options by building health care capacity into senior living through care transitions, personal care/concierge services, and enhanced care coordination. New projects and renovations include clinic space (in anticipation of PCMHs, which will be foundational for ACOs), therapy and fitness space, and larger communal areas to accommodate seniors from the community-at-large.

Conclusion

By law, ACOs will be operational on January 1, 2012. Proposed rules suggest that CMS anticipates there will be between 75 and 150 ACOs in the Shared Savings Program. Three of the nation's leading post-acute providers are preparing full engagement and involvement with the hospitals and physician groups that are most likely to be "winners" in this new health delivery system. The strategies they have shared provide the outline for other post-acute and long-term care providers

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