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## The Anatomy of Change

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# The ACOs Are Coming ...

by Michele Hayunga

**Accountable care organizations (ACOs) will become part of Medicare next year as a tool for promoting value over volume. Though the rules applying to ACOs are not yet codified, aging-services providers can begin thinking about how they will interact with and potentially fit into ACOs. Here is a look at the issues involved and how providers can position themselves to thrive in an ACO environment.**

They've been debated in health care circles, hyped in the media and even parodied on YouTube. Yet, despite the buzz, there are still more questions than answers about how accountable care organizations (ACOs) will play out. Here's what we know so far—and what you can do to prepare.

## The ABCs of ACOs

Broadly speaking, ACOs are an approach to care designed to promote value instead of volume. The idea is to create formal arrangements among physicians, hospitals and other providers to coordinate and deliver care needed by a specific set of patients. If an ACO succeeds in cutting costs without sacrificing quality, the providers comprising it will be rewarded financially.

ACOs differ from HMOs in that care coordination is driven by providers, as opposed to insurers. They also offer consumers more choice, because patients don't have to stay in network.

While the ACO approach is relevant to public payers, private insurers and employers, many ACOs will get their feet wet with Medicare. The health reform law created a Medicare Shared Savings Program for ACOs, scheduled to begin Jan. 1, 2012.

Under this program, ACOs must be willing to participate for three years and have the capacity to serve at least 5,000 Medicare beneficiaries. Beyond that, the details will be spelled out in a proposed CMS rule that was expected in February or March of this year. After a comment period, CMS is expected to issue the final rule over the summer.

## Shaping Medicare's ACO Program

One of the biggest decisions for CMS is what the incentive (or incentives) will look like. On one end of the spectrum is a low-risk shared savings approach in which providers receive fee-for-service payments with a modest bonus for achieving quality and cost benchmarks. At the other end is capitation, which offers greater reward but requires providers to assume more risk. Whether CMS offers both choices, or only shared savings, will influence what kinds of providers participate.

Another key question is how CMS will determine the quality benchmarks—and if there will be risk adjustment. "Statistics show that not-for-profits, because of their mission, tend to take care of everyone, as long as there is the need," explained LeadingAge's Peter Notarstefano, director of home and community-based services. "There is not the cherry picking of

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cases that has occurred with some for-profit providers." Not-for-profits will also be looking closely at the incentive, as they tend to spend more on quality initiatives and staff training, he added.

CMS is also grappling with how to assign beneficiaries to ACOs—and ensure that they're informed about the change. Additionally, the agency must balance providers' legitimate need for data with consumer concerns about privacy.

In a December panel discussion at the Center for American Progress, CMS Deputy Administrator Jonathan Blum described the program as one of his agency's highest priorities. "If the ACO program is done well and done right, it's going to change the incentives," he says.

Yet Blum also acknowledged the challenges of regulating uncharted territory. "Our notion here is that we're starting from scratch," he says. He emphasized that CMS is counting on consumers, providers and insurers to offer feedback on the proposed rule.

## What ACOs Mean for Aging-Services Providers

While much remains unknown, experts believe ACOs will create new expectations and opportunities for aging-services providers. Many long-term services and supports (LTSS) providers may find themselves marketing their organizations to ACOs in order to receive referrals. Eventually, some may become formal parts of ACOs with the potential to share in rewards. Even providers in residential settings will likely find themselves interacting with ACOs.

For example, residential providers could see ACO-contracted care managers visiting patients who live in their communities, predicts Nancy Rehkamp, a principal with the health care division of LarsonAllen. ACOs may also want to bring in technology to monitor patients with certain conditions. This could create revenue opportunities for LTSS providers with expertise in wellness, care management and telehealth.

ACOs will be even more engaged with LTSS providers on the skilled care end of the continuum. "Skilled nursing facilities and home-health providers will be included in care planning, best practices implementation and ongoing care monitoring in greater ways than historically," Rehkamp says. "Providers will be expected to work closely with the patient's physician to reduce hospitalizations, emergency room use and readmissions—and to offer wellness and prevention services."

This type of interaction represents a paradigm shift from today's system, where LTSS is often not on the radar of hospitals and physicians. Under the ACO model, these groups will have a much greater stake in the quality of post-acute care.

The emphasis on post-acute care is expected to play out even in regions where ACOs are slow to form. This is because other elements of the health reform law—such as bundled payments and penalties for certain readmissions—also tie reimbursement to outcomes.

## The Hospital Perspective

As ACOs and hospital executives turn their attention to post-acute care, what will they be looking for in their partners? Rehkamp's colleague Greg Hart, a principal with LarsonAllen's hospital practice, anticipates the following questions:

- Which will deliver the best clinical outcomes? For which groups of patients?
- Which will help our hospital avoid unnecessary readmissions? Facilitate effective use of home care services? Avoid infections and falls?
- Which will work best with our hospital care team and case managers to integrate and coordinate care, with planned and measurable protocols and shared data systems?
- Which is willing and able to share risk?
- Which might consider economic integration with our system?

"Simply put, systems will be looking for value, measured by quality and cost," Hart says.

## Strategies for Success

To thrive in an ACO environment, first and foremost, providers will need to demonstrate their value in a tangible way. In the article, Examining Acute/Post-Acute Care Partnerships Under Healthcare Reform, Scot Park, a partner with Dixon Hughes Healthcare Consulting, offers suggestions for how to do that. His insights are based on interviews with hospital CEOs.

"The key takeaway here is to realize and accept that successful post-acute care organizations will need to intensify and

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improve their ability to record, track, quantify, analyze and report on patient care outcomes," Park explains. "And they will need to do this in ways that reflect an effective integration of acute and post-acute care clinical pathways."

From a practical standpoint, hospitals are also looking for partners that have the capacity to serve their geographic market. Park suggests post-acute providers think about how to handle increased volume while maintaining cost efficiencies and quality outcomes. In some cases, this may mean partnering with other LTSS providers.

Financial strength and information technology (IT) capabilities are two other critical elements. Integrating clinical and technology systems can be costly and time-intensive, so hospitals are looking for stable partners who can share some of the investment.

Not surprisingly, hospitals want partners whose mission, vision, values and organizational culture are closely aligned with their own. They're also looking for providers with strong brand awareness in the market, particularly if that brand is associated with quality. Interestingly, many hospital CEOs viewed faith-based sponsorship as a "double-edged sword" when it comes to branding.

## On the Front Lines

Jeffery Lemon is paying close attention to these considerations. As president of Spectrum Health Continuing Care in Western Michigan, he leads the LTSS arm of an integrated delivery network. Lemon is charged with preparing his own portfolio for an ACO environment—and identifying other post-acute partners for Spectrum Health.

"The primary focus for us will be on reducing unnecessary emergency room visits and avoiding re-hospitalizations," he says. Lemon is working with Aging Services of Michigan to develop a standardized tool to evaluate how well post-acute providers achieve those aims. Criteria such as staffing ratios and physician involvement will also be looked at carefully.

Another major consideration will be an organization's size. "We want to deal with providers that have geographic reach, because it's easier to write one check than a hundred," he says. "I'm encouraging my post-acute colleagues to come together and form consortiums." Lemon also echoes Park's comments about financial stability and IT capabilities.

Within his own post-acute portfolio, Lemon is exploring how to improve integration with Spectrum's HMO. "We're finding more and more opportunities to collaborate around at-risk patients on the home and community-based side," he says. Now, when at-risk patients are identified, Spectrum provides a nursing assessment in the home and—when necessary—remote monitoring.

Lemon is also working on increasing providers' ability to respond to clinical complexity. For example, many of Spectrum's skilled nursing centers are installing telemetry units. "We're trying to raise our game clinically, so we can be another stop along the continuum for these patients."

## The First Step

LeadingAge members are at different stages of preparing for the changes under health reform. But one thing every organization can benefit from is becoming more informed. LeadingAge recently released a report on transitions and integrated services, which includes additional perspective on ACOs.

A number of groups are holding conferences and webinars on these topics as well. ACOs will be featured in a session at the upcoming Future of Aging Services Conference & Leadership Summit. Another resource is The Brookings-Dartmouth Accountable Care Organization Learning Network, which offers webinars and conferences for members.

LTSS providers should also focus on strengthening relationships with local hospital systems and physician groups, and be a part of discussions about emerging ACOs. "It's absolutely worthwhile for LTSS providers to be at the table," says Lisa Lehman, president of the consulting firm Holleran. "You can start with a simple phone call, but that has to happen at the right level, which is your CEO and board."

More broadly, providers should be thinking about what kinds of integrated models they want to be a part of and who else in the community will be involved. "The person who writes the first draft has more say in how they're positioned than the person who is just reacting," says LeadingAge Senior Vice President Zachary Sikes. "It's up to our members to create a compelling vision of what success looks like for them, and then work among stakeholders to achieve it."

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