Accountable Care: Catholic Hospitals Are Well-Positioned

By WILLIAM J. DeMARCO, M.A., C.M.C.

Debate raged for months over how to coordinate Medicare coverage by means of accountable care organizations (ACOs) before the final rules came out in November 2011. Though some regarded the new medical care and payment model as risky, others suddenly saw ACOs as a potential opportunity. As I will show, I believe Catholic hospitals are well positioned to become part of this health care trend.

Today, there are more than 300 ACOs. Of these, 130 are Medicare Shared Savings Plans (MSSPs), many of which are physician-led; the rest are private plans, usually sponsored by an insurer trying to establish a lead role in building a bundled payment program for a region. The private plans also include physician-led ACO enterprises, such as the Pioneer plans that are multispecialty practices, integrated delivery networks and advance payment plans for which the government has awarded $200 million to smaller practice startup networks.

My health care consulting firm, DeMarco and Associates Inc., and its affiliate Pendulum Healthcare Development Corporation, estimated that by July 1, 2012, more than 10 percent of the Medicare population would be connected to ACOs.

Add to this the Medicare Advantage population that now exceeds 37 percent of the Medicare eligibles in the U.S., and one can see Medicare already has been permanently changed — as has the business model for being a contractor for Medicare business. The final rules are complicated, and rightly so, because statutes for Medicare beneficiaries are protective of this population and the funds that are reserved to pay the bills.

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The complicated nature of the rules, coupled with misunderstandings about ACOs in general, have caused a great deal of indecision and delay in a competitive environment — and that's a precarious position for a hospital. I think Catholic hospitals have several built-in advantages that can put them at the leading edge in the quest for accountable care recognition.

COMMON MISUNDERSTANDINGS

Many hospitals have missed the fact that primary care physicians are allowed to join one and *only one* ACO. This means unless you sign them up first, the primary care doctors on your medical staff are recruiting targets for the hospital across the street that wants to get into the ACO business; for the insurer that wants to own ACOs; and for primary care doctors who want to band together — in fact, the bulk of federal regulations favor physician-owned ACOs, especially those with a strong primary care base.

In California and Florida, there have been cases of hospitals assuming they would be their doctors' chosen ACO partner, only to find that a competing hospital had recruited their medical staff and sent in an ACO application with their physicians' names on it. So a wait-and-see attitude on ACOs may not always be a hospital's best course of action — especially if physicians are asking you about ACO requirements and expressing concern that they may be left out of this shared savings arrangement.

In several cases where insurers and investors are both involved, physicians have been enticed to sign up with an ACO by assurances that they are permitted to "partner" with themselves and keep the bonus money from the federal Center for Medicare and Medicaid Services (CMS) that hospitals think they are supposed to share. That

arrangement can amount to a substantial number of dollars, and non-hospital investors and insurance companies see this opportunity.

As with the clinical integration movement that followed the Clinton administration's reform proposals, many wonder if health reform will require hospitals to reduce admissions and length of stay and, if so, if those required reductions will generate the bonuses and savings needed to propel the ACO forward. The answer is, not necessarily. We have seen many hospitals calculate an estimated 20 percent reduction in admissions to earn the ACO bonus without taking into account the potential for reduced costs. Balancing the potential for revenue reduction is also the possibility of expense reduction, which is the very point of the clinical integration process.

For instance, let's take syncope and collapse as a diagnostic-related group (DRG). It is almost always used as a stand-alone diagnosis, but it's not. Syncope and collapse is a symptom of heart or respiratory problems, and when it is not documented correctly, the hospital cheats itself out of revenue. In one case we found that this and similar mis-documented DRGs were leaving $1.6 million that the hospital could have billed.

Why does this happen? The physicians were taught a specific way of documenting care, one that was adequate a decade ago, but now must measure up to greater scrutiny. It is no longer enough to simply report that a procedure or test was performed; the physician must explain why it was done. This more rigorous documentation is critical to earning bonuses available to ACOs. Savings created through lowered expense comes back to the physicians and hospital beyond Medicare traditional billing. Documentation errors like syncope and collapse are also the triggers for federal Recovery Audit Contract (RAC) audits, yet another expense that can be avoided by tightening medical reporting and protocols.

Further, the additional help physicians can provide in avoiding unnecessary readmissions is a gain in revenue that also keeps beds available for the very acutely ill and chronic populations while extending the reach of the hospital through primary care. In the ACO, savings can be created by better coordination inside and outside the hospital. The post-discharge and transitional care process has been largely ignored as an expense, now that the outpatient recovery of patients is a priority. These dollars are an investment. Patients who can be visited at home by a physician extender or navigator pay for themselves by avoiding unnecessary emergency room visits.

In other words, much of the framework for an ACO may be in place with a local independent practice association or physician-hospital organization that can be the basis for integration and ACO development. Many of the new reforms will require hospitals to join more closely with physicians to improve outcomes, reporting and transitional care follow-up.

Savings gained in these ways, in addition to the current Medicare payments, offer a new revenue line, but this should not be the only reason for creating an ACO. The primary reason is to stay competitive, nimble and to prepare for the future. The government and most private payers are demanding change, and reform is taking place at the local and state level.

Where do the savings come from? The CMS has already established a benchmark for your service area based upon what Medicare now pays for beneficiaries in the area. If your organization can build a more efficient enterprise that produces an outcome below this benchmark that still maintains quality and satisfaction measures written into the law, your ACO will share up to 50 percent of those savings. If the health care system across the street goes above this benchmark, they lose the savings. In effect, the savings in your area are coming from your com-

ACO PLANNING: WHAT TO DO RIGHT NOW

The health care market is shifting with both insured and uninsured patients who are trying to use the emergency room or seek care outside the normal primary care process. Entry by patients with no primary care physician manager assures they will either pick the most expensive means to receive care, or they will not receive needed care due to payment barriers.

If you are accountable for these patients, this uncoordinated care will cost physicians and hospital your bonus.

Your next step is to look at referrals and documentation of admissions by specialists and primary care. Technology can help support this, but referral management and admissions review has been done for years using phone and fax and can still be done that way. Therefore, lacking electronic medical records is not a reason to take a pass on forming an ACO.

Performing a feasibility study to look at the total eligible Medicare populations minus the patients who are already on a Medicare Advantage HMO program is the next step. Obtain the Hospital Referral Region data from CMS for your service area, along with payment levels being made to Medicare HMOs in your area. This information will point you in the direction of what an ACO may look like and what kind of bonus may be available to offset your start-up costs.

You may need to line up outside assistance to help execute and apply an ACO work plan, as well as the evaluation of information technology and capacity.

petitors who are not as efficient as you are. Over time, the benchmark you set for yourself becomes the benchmark to beat as you begin to compete with yourself to drive out more waste and also expand service area and medical staff participation for this MSSP service line. Once the cost and utilization become predictable, you have entered an entirely new world of being able to negotiate with private payers, employers and even manage Medicaid populations with a margin because you have learned to improve the value and predictability of the care your system offers.

That makes you a leading competitor, and building your own licensed product is a sustainable growth strategy.

Economists predict 1 in 4 hospitals will close over the next eight years. To put this in simple terms, it could mean if your hospital cannot gather dollars by outperforming your competition, your competition will gather payments from your hospital to survive.

Catholic hospitals, I believe, have several advantages in this transformation from production-driven to value-driven health care:

■ **Not-for-profit status.** For the most part, Catholic hospitals are not-for-profit, community-based and mission-driven. This is in contrast to for-profits that must prove their shareholders will be rewarded financially. The not-for-profits can align the concepts of improving care for the frail and elderly, holding themselves accountable to the community and positioning for the future as good arguments for their boards to approve a feasibility study for an ACO.

■ **Ethical standards and home health services.** Catholic ethical training for most nursing and home health staff is a plus. It also stands out at a time some smaller, for-profit home health and hospice agencies are being reviewed by CMS and the Department of Justice for overcharges. Most Catholic systems have health and case management outreach programs in place, and home health is a truly underused service in managing patients with transitional care needs. ACOs change that.

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■ **Primary care focus.** As a rule, primary care is a secret weapon for Catholic hospitals, which pride themselves on OB-GYN and pediatrics as well as internal medicine and family practice as strong referral bases. These primary care practitioners are voluntarily drawn to a pro-life facility and can be recruited into an ACO that offers the same mission-oriented goals of coordination and effectiveness, measures required to build and manage a good ACO.

■ **Superior outcomes.** Our research shows repeatedly that Catholic hospitals have superior outcomes. Four of the large Pioneer ACOs are Catholic-sponsored plans. As many hospitals are already engaged in quality measurement and lean engineering, the ACO can be a good framework to continue this process.

So, as a health care consultant, I would urge Catholic health care leaders to ask themselves: Why not leverage all that your hospital is now doing to achieve results under health reform? Change is coming. If you lead in the direction of tangible ACO goals, it can, over time, make your hospital stronger and in a better position for the value-based purchasing requirements expected to go into effect between now and 2014.

While taking this direction may sound very expensive and risky, health reform in general will require the same high level of detailed reporting, reduction in emergency room overuse and denial of payments for readmissions for similar or same diagnosis. These and other reductions in payment for preventable and avoidable care costs are on the top of the list for Medicare, and — as we know — what Medicare sanctions, private payers will include in their contracts.

The challenge may not be so much a reduction in revenue as it will be to right-size the utilization and capacity of your organization to realign both services and incentives.

Hospitals that have not already applied to join the Medicare Shared Savings Program (MSSP) — Notices of Intent were due June 30, 2012 — must now wait until 2013 to begin the process for a fall 2014 ACO startup. Many executives and physicians took a wait-and-see attitude on the Affordable Care Act, and they now find the Supreme Court's decision upholding the law has made deadlines appear closer and focused change on not just Meaningful Use and ICD 10 but on an overall strategy to transform the organization to use the ACO as a means to gather all these fragments into a framework that will be the foundation for the new business model of the future.

If your hospital hasn't already filed a Notice of Intent, consider beginning the ACO journey with your own employees before starting with Medicare. It could be your best opportunity to align physicians and resources for the future of accountability.

In my view, waiting any longer could mean the difference between retaining business or losing patient volume and primary care practitioners to a competitor — a risk no hospital can afford to take.

WILLIAM J. DEMARCO is president and chief executive of Pendulum Health-Care Development Corporation and DeMarco & Associates, Inc., a health care consulting firm based in Rockford, Ill. He is the author of seven books.

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