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Healthcare leaders prep for the ACO model

by Philip Betbeze

Fee-for-service is still the dominant payment system for hospitals and health systems, but only for a few more years, until the implementation of most provisions of the Patient Protection and Affordable Care Act, otherwise known as healthcare reform. But those few years give hospitals time to prepare under the current rules. Ironically, by growing market share now under the FFS system, hospitals will be better positioned to succeed under a reimbursement system that disproportionately rewards so-called accountable care organizations (ACO), which are noble in goal but nebulous in structure.

Regardless of the form that ACOs eventually end up taking—with the hospital, health plans, physicians, or even the government in charge—reconfiguring your hospital organization to take advantage of the new reimbursement will require a measure of imagination and perhaps a double measure of cash.

Cost

The two systems of reimbursement are incompatible. Striving for success under FFS means playing by different rules that won't work under healthcare reform, when hospitals will likely be financially responsible for large portions of a patient's continuum of care. However, to fund the restructuring that will take place over a number of years, you have to deal with what's in place now, says **Gene Diamond**, CEO of the Northern Indiana region of Sisters of Saint Francis Health Services (SSFHS) in Mishawaka, which owns and operates 13 hospital campuses in Indiana and Illinois.

"We're obviously spending a lot of time looking very carefully at the ACO model and trying to figure out what we have to do between now and then to get where we need to be," Diamond says, "and we haven't got the foggiest idea how much this is going to cost us."

Many hospitals are experiencing that dilemma. But Diamond isn't waiting for someone to give him the answer. He says that for months, the leadership team has been visiting more integrated health systems to figure out how they're coordinating care among the nodes of the patient experience, and trying to determine what will work for SSFHS.

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—Gene Diamond

"We're doing a pretty good job of working on improving outcomes, although we don't have the complete infrastructure yet," he says.

But the system is on its way.

SSFHS is a partial owner of Advantage Health Services, a managed care organization and for-profit HMO, which should help the system better manage risk. However, Diamond admits the

ACO model

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HMO will need to be heavily capitalized in order to manage risk in a mission-critical situation where reimbursement is at stake.

SSFHS has also made a large (approximately \$125 million) investment in an Epic clinical information system throughout the system's hospitals and affiliated providers, which Diamond says will move SSFHS toward a single patient information system that is essential to managing the patient experience—whether outpatient, inpatient, or follow-up primary care. It has a number of employed physicians (about 550) but is moving toward more.

Diamond sees huge investments on the horizon, requiring some very critical strategic decision-making.

“We’re very strong financially—AA rated—and our facilities are fairly modern,” he says. “We’re not leveraged up to our eyeteeth, and we don’t feel comfortable taking on a huge amount of debt. But can we make our margins work to begin to fund this massive investment? Our system had about a 4% margin last year, but we’ll need far greater margins than that to finance what’s coming. We’re seeing our commercial payment market shrink, and if anything, that will continue. Right now, we can get some cross-subsidization margins, but that’s disappearing.”

Specialization

In many ways, Chicago’s Sinai Health System is typical of many inner-city hospitals in that its payer mix is poor (60% Medicaid, 20% Medicare, 13% self-pay, and 7% commercial), and so is the neighborhood it inhabits. The 319-staffed-bed hospital system boasts a teaching hospital, a level I trauma center, a level 3 neonatal unit, a 200-physician-owned practice consisting mostly of specialists, and a 100-bed rehab hospital. Because of its diversity, president and CEO **Alan H. Channing** says Sinai has some of the components of an ACO but is staking its future on a couple of big bets.

Still, Channing must live in the here and now, and that’s not very pretty from a reimbursement standpoint. At least he knows he can likely survive until healthcare reform takes effect.

“When I translate our payer mix into cash, roughly 75% of the cash we receive comes from the state,” he says. “That

makes us the state’s largest partner for hospital services, and they’re very cognizant of that.” Still, he can’t afford to sit on his haunches as healthcare reform marches forward.

Sinai has installed Lean manufacturing processes and has empowered about a dozen Six Sigma teams looking at efficiencies that can be gained, from registration to pharmacy distribution.

“If we’re going to survive and be a player in the new world, we have to be in position to take advantage of the pay-for-performance activity, so over the last couple of years, we’ve worked to distinguish ourselves from a quality perspective,” Channing says.

As healthcare coverage for the uninsured ramps up, Sinai is preparing for better cash flow, based largely on the fact that about half to two-thirds of the uninsured who currently make up 13% of its payer mix will get coverage.

New partnerships

Sinai sees its future in carving out specialty areas of excellence in a crowded healthcare marketplace. It has already partnered with several federally qualified health centers (FQHC), which should help it integrate primary and inpatient care protocols for the sickest patients.

Sinai is also working on a project that will incentivize physicians to help transition from an episodic to a holistic model of patient care.

“If you think about how primary care gets used, it’s still pretty episodic because the physician is still incentivized to see a lot of patients in a day’s time,” Channing says.

Through leadership on possible Medicare demonstration projects, Channing hopes to position Sinai as a national leader in what he calls “pre-primary care,” which involves heavy counseling and tracking of patients to address chronic conditions such as diabetes or asthma.

“What we have done is position ourselves to be the hub of an ACO. We’ve done that by creating an integrated delivery system with the employed physician group, with our partnership with the FQHCs, and the community-based work outside the hospital environment,” he says. “We’ve described it focusing on having a medical home for everyone.” ■

Source

Adapted from *HealthLeaders* magazine, September 2010.

The physician's place in the ACO

by Philip Betbeze

Now that healthcare reform has gone from a concept to a law, big changes are ahead for everyone associated with providing healthcare to Americans. But perhaps no other group will need to adapt more than physicians, many of whom fear that their independence will be curtailed. Coupled with that fear is the belief that patients will suffer as the “art” of medicine is replaced by standardization.

Much of that standardization push can be boiled down to a desire by employers and the government to create so-called accountable care organizations (ACO), in the belief that better-organized, standardized care is better care, and that healthcare organizations will deliver better care if it is coordinated and if financial penalties or rewards accrue to those organizations producing better outcomes.

ACOs largely don't exist yet because they haven't been fully defined. The ACO model is but one of many demonstration projects that the federal government will conduct under the Patient Protection and Affordable Care Act. Because the ACO has not been fully defined, there is some flexibility in its construction. And some “integrated” health systems, whose pieces of the care continuum communicate with each other about a single patient's care, have been touted as examples of what the government is seeking with ACOs.

ACOs will include confederations of doctors, specialists, and hospitals working together to administer payments, determine quality and safety benchmarks, measure performance, and distribute shared savings, according to a June 2010 report from the American Hospital Association. Still, organizations are left with making little more than educated guesses about how they might become ACOs.

Amid all this uncertainty, one thing does seem certain: The physician will play a key part—perhaps *the* key part—in whether such organizations are ultimately successful at removing waste from the healthcare payment system.

Accountability to whom?

Before organizations can begin to create ACOs, they have to realize whom such entities are accountable to, says **Tom Enders**, managing director of CSC's Health Sector Group in New York. At first glance, most believe the ACO should be

accountable to the patient. After all, the patient is the reason for any action taken—he or she is the one trying to get well.

“The accountability is not unilateral; it's trilateral, for the management of care across locations and time,” Enders says, explaining that accountability is the responsibility of the provider as well as the payer and patient. That said, most of the penalties for noncompliance will accrue to the provider.

Given this, organization is exceedingly important. A legal and management entity must be in place to take on that shared responsibility, with insurance risk being borne by the payer and delivery risk being borne by the caregiver.

“There is an insufficient supply of primary care that needs to be hammered away not only with physicians, but with advanced nursing and other extended primary care professionals,” says Enders.

To help with that transition, the government has included heavy investment in federally qualified health centers (FQHC) through the health reform act, Enders says. FQHCs are community-based organizations that provide comprehensive primary and preventive care to underserved and underinsured individuals.

Some hospitals and health systems, especially safety net hospitals, already have at least informal arrangements with FQHCs so patients can access follow-up and routine care. But if hospitals hope to be the center of the ACO, those relationships will have to change so the collaboration happens much earlier in the process, reducing the number of chronic conditions that bring patients to the hospital. Whether that arrangement can be profitable, however, is another matter entirely.

The same could be said for physician practices.

“We recognize that continuing to align ourselves with physicians by employing them and [having] joint ventures in some clinical areas look like good opportunities, but long-term prospects are unclear,” says **Gene Diamond**, CEO of the Northern Indiana region of Sisters of Saint Francis Health Services in Mishawaka. “Is there going to be a pay-off? The ACO model might really be no better than when it took the form of a managed care bet in the '90s.”

With so much uncertainty among the large institutions when it comes to ACOs, where does that put physicians?

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The physician's place

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Doctors will lead

There are varying opinions about which entity will be the distributor of a bundled payment that could be directed to an ACO. **Dennis Dahlen**, chief financial officer at Banner Health in Phoenix, thinks his health system would be in the right position to be that distributor, as it employs much of its physician staff and has active contracting relationships with independent physicians.

"The payment reform modeling in the healthcare reform [law] is probably the sugar that makes the medicine go down," Dahlen says. "Whether it's bundling or an ACO, it provides a currency to work with physicians and other providers for that coordination. Absent that currency, we actually mostly have barriers to working cooperatively."

Even though physicians might not directly control how the bundled payment is distributed among the entities responsible for a patient's care, the physician is going to have to be in a key leadership role, says **George Mayzell, MD, MBA**, chief patient care officer at Methodist Le Bonheur Healthcare, a seven-hospital system in Memphis, TN, that also owns home health centers and a number of outpatient facilities in the area.

"Ultimately, [physicians] decide the quality of care and the cost through the mighty pen," Mayzell says. "If it's an IPA of docs who understand it's about the patient and quality and managing that financial risk, why can't they have the money and bring the other players to the table?"

Mayzell says that taking on risk is one way for physicians to fight back against the perception that they cause overutilization and cost increases because they don't communicate well with each other. "If we're focusing on evidence-based care and measuring that, resources have to be part of that decision-making. Overutilization actually provides worse care. Physicians have got to take this on," he says.

At Methodist, Mayzell says one of the biggest challenges to the success of the ACO is "who gets the pot of money, because that can make or break how well this works." Locally, Methodist's physician hospital organization (PHO) will likely be the distributor of payments to the variety of stakeholders involved in the ACO. "If you take a PHO and you give them the bundled payment, they are in a good position to make sure the payment gets shared fairly," he says.

One of the key pieces, says Mayzell, is being able to share medical and financial information across all constituents so they can move toward outcomes as the key metric. That's what many payers attempted to do in the 1980s and 1990s with capitation—an annual fee provided to a medical group for taking care of a certain number of patients. He believes experience with capitation will prove valuable as healthcare organizations progress to ACOs.

"When capitation was in vogue, we didn't have the EMR capacities we have now. We have better tools, and we're better evolved in financial and clinical integration," Mayzell says.

Removing variability

Many physicians worry that healthcare reform legislation will eliminate patient choice and physician independence.

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Critics have another word for independence: variability—in other words, different approaches in treating the same ailment. Variability has been both paraded and pilloried under other terms, such as evidence-based medicine, which opponents like to call “cookbook medicine.” But that debate has already been settled as a majority of experts—physicians themselves—agree that the vast majority of clinical decision-making can and should be standardized. The influence of the individualist physician is likely to be curtailed under ACOs. However, many believe that the influence of physicians as a group will be the key determinant of best practices in patient care.

For instance, **Ron Greeno, MD**, founder and chief medical officer of Cogent Healthcare—a Brentwood, TN, company that provides hospitalist physicians and programming management to hospitals—says healthcare teams, with the physician at the head but with accountability running from the top of the provider food chain to the bottom, will likely form the backbone of the ACO. “The part of medicine that will remain an art will be in managing physician-patient relationships, managing the healthcare team, and managing communications throughout the course of a hospitalization.”

Greeno says small or solo practices will likely become extinct under an ACO model in which physicians have to become risk-bearing entities to some degree. They may

be able to stay independent through independent practice associations, for example, but with a payment methodology that pushes people and institutions to take bundled risk and maybe even capitation under the ACO structure, physicians will have to belong to some type of organization, he says.

The expense of healthcare services—and, more importantly, the rate of inflation associated with those services—means physicians have to move toward limiting their actions to what is known to actually work, he says.

As part of an organization that is accountable to its hospital clients for meeting certain cost and quality targets, Greeno looks forward to more standardization among physicians. Cogent’s business model is essentially bundling, at least as far as Medicare reimbursement is concerned. The hospital pays Cogent in part based on the number of physicians it provides, but a large portion of its compensation comes from how well physicians meet quality and safety targets and coordinate care with other members of the hospital’s medical staff, regardless of whether those members are employees of the hospital.

“We take the Part B dollars that are invested by the hospital in the program and create an incentive model that drives better quality and higher patient satisfaction,” he says. ☒

Can ACOs crack the healthcare payment code?

by Cora Nucci

Whether it’s called “healthcare reform” or “Obamacare,” the multiyear march toward an overhaul of the nation’s healthcare delivery system has begun. Thoughtful people may agree to disagree on the merits of the Patient Protection and Affordable Care Act (PPACA) signed into law this past year, but the effects it will have on physicians, hospitals, and payers will be stressful for all. Expect some discomfort.

An in-depth analysis published by the Intelligence Division of HealthLeaders Media examines the relationship between physicians and hospitals at a critical moment. Healthcare leaders were surveyed for the report just before the first provisions of the new law were about to take effect, while anticipation and speculation about the reform provisions were in high gear.

Those surveyed had one big number on their minds: 32 million. That’s the number of people expected to be newly insured between 2014 and 2016 as a result of Medicaid expansion and federally subsidized insurance coverage through soon-to-be-mandated health exchanges.

Here’s where the discomfort sets in. Nearly half of the healthcare leaders surveyed in the HealthLeaders Intelligence Report *Physician Alignment in an Era of Change* expect that increased numbers of insured patients will strain hospital-physician relations. Twenty-two percent said it will have no effect, and 35% said more patients will improve relations.

“In my view, these differences simply reflect the fact that some see seismic change as a tragedy and others see it as an

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Healthcare payment code

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opportunity,” says **Craig E. Samitt, MD**, lead advisor for the report.

Indeed, one survey respondent noted that “collaboration between hospitals and physicians will be the only way to survive.” I would add payers to that equation. Payers, both public and private, are an integral piece of the healthcare system and must be part of any reform-related collaboration.

It’s not just the volume of patients that will strain the system. More patients means provider organizations need more physicians, and hospitals and systems are willing to fill the void by employing, acquiring, or contracting as necessary. Over the next 12–36 months, 74% of hospital leaders surveyed said they plan to employ a greater number of physicians. Many physicians are already seeking employment, and news of physician groups being acquired is now a regular occurrence.

Under PPACA, there will be a shift away from the FFS model, and providers will be tasked with delivering better care at lower costs. Figuring out how to do that is another pain point, and the work is just getting under way. The patient-centered medical home model and accountable care organizations (ACO) may deliver on both fronts, but they are largely untested.

Samitt, who is president and CEO of Dean Health System in Madison, WI, believes ACOs could facilitate increased collaboration, better patient outcomes, and better value.

And **Paul Keckley**, executive director of the Deloitte Center for Health Solutions, recently wrote in a healthcare reform memo for Deloitte, “It’s plausible to believe that alignment of physicians, hospitals and long-term care providers into local integrated delivery systems, a shift from volume to outcomes-based payments and adoption of a national standard of care based on evidence might bend the curve. Time will tell.” 

PPACA bringing more headaches for providers

Healthcare reform, also known as the Patient Protection and Affordable Care Act (PPACA), continues to bedevil physician practices and other healthcare providers with its details. Months after the passage of PPACA, the likely effects on managed care contracts and reimbursement are finally becoming more clear.

The effects on revenue may bring radical change to physician practices, says **Jim Farrell**, cochair of the Health Care Practice Group of the Florida law firm Shutts & Bowen.

“The day of the solo and small physician practice is rapidly coming to an end,” Farrell says. “Traditionally there has been an absolute inability for practices of that size to negotiate with managed payers, and now we’re seeing a move away from fee-for-service medicine.”

For instance, the cardiovascular surgery demonstration project involves the government providing a lump sum for all treatments of a certain type, which will then be divided up among providers. Physicians on their own will not have the leverage to negotiate reasonable payments for their care if such a practice becomes the norm and will be pushed out of

the market or forced to join a health system, Farrell says.

Even without such a radical change in the reimbursement system, the growing power of managed care providers means that small physician practices are losing what little ability they might have had to negotiate contracts with them, Farrell says. That means the profitability of those practices will continue to decline if they don’t make a change.

“They’ve got to look at merging and integrating their practices with each other, either on a same-specialty basis or a multi-specialty basis,” Farrell says. “That’s necessary to have enough market presence to negotiate, either with the managed care payers or with the hospital health systems or whoever ends up having control over the global payments we’re going to see eventually.”

More focus on quality

PPACA will drive more of a move toward quality-based reimbursement, Farrell says, and that will require providers to capture more data to prove that they’re reaching various quality points. Those kinds of data will be more statistically

convincing when they come from a large group rather than a solo or small practice, he says. “I think we should be looking at a three- to five-year time frame for these changes.”

Physician practices will face different options in the coming years, with hospitals and health systems absorbing practices at a growing rate. Managed care providers and insurers also will adapt to the new regulations, and the government may throw another curveball as the regulations are promulgated, Farrell says.

“There will be a number of options, but status quo will not be one of them,” he says. “They will need to be able to fairly rapidly assess options as they present themselves and decide whether to pursue it.”

Changes in Medicare will drive many of the business decisions for providers, says **David Kloth**, board member and past president of the American Society of Interventional Pain Physicians. Medicare reimbursement rates are certain to change for the worse in the near future, he says, and that will adversely affect any practice that has managed care contracts tied to the Medicare reimbursement rate.

Medicare cuts will hurt

Kloth expects Medicare reimbursement rates to be cut in January. “If I lose 15% of my revenue, for instance, that’s 30% of my income because, remember, my overhead didn’t change,” he says. “Practices will have to find a way to cut costs, and that may come from eliminating employees and closing satellite offices.”

Physicians also may move away from higher-risk procedures so their malpractice premiums will drop, Kloth says.

There is no doubt that revenue will be cut for physician practices, says **Ron Wince**, president and CEO of Guidon Performance Solutions in Mesa, AZ. “We don’t know exactly how much yet, but reimbursement will be cut,” he says. “The question now is how you’re going to respond and keep yourself viable in this business.”

The push for more health IT is going to complicate the situation, Wince says. He’s working with healthcare providers to help them determine how they can invest more in IT at the same time their revenues are being cut.

“We’re seeing more providers gravitate toward a concept called ‘lean IT,’ in which they try to get the most of their IT

upgrades while minimizing the additional costs,” he says.

Providers are also “trying to find ways to reduce the amount of effort and the amount of cost that goes into their daily business,” Wince says. “But at the same time they have to improve quality and the patient experience.”

Some physician practices and hospital systems are considering radical changes in how they do business because of the effects of healthcare reform, he says.

Rather than managing the effects of reform by focusing on the details in their managed care contracts and trying to wring out another dollar here and there, some providers are saying it is time to revamp in a bigger way, Wince says.

“I’ve talked to different physician-owned hospital systems and some integrated hospital systems, and they’re all looking at it from a systems perspective in that they want to change the culture to be more continuous improvement-focused,” he says. “They also want to take a look at how technology is leveraged, not just from the perspective of electronic medical records, but also from the business intelligence perspective, which is how they measure their business and report it back so they can find improvement and cost-reduction opportunities.”

With each passing day, healthcare providers understand more about how PPACA will affect them, and so they will have to be flexible in their planning, Wince says. What seems like an adequate solution now might not be next month if a provision of the law is fleshed out in a way that adds another unexpected twist to managed care contracts and reimbursement.

“The legislative language was so broad and vague that you could drive a truck through it,” Wince says. “But now we’re seeing agencies promulgate the actual rules and regulations based on that legislation, and that’s where we start seeing what the actual effects will be.”

Wince advises keeping a close watch on regulations coming out of Washington.

“The good news is the uncertainty is starting to be eliminated,” he says. “But the bad news is that some people are going to realize they have some catch-up to do to meet the requirements and keep their business viable.” ■

Source

Adapted from *Managed Care Contracting & Reimbursement Advisor*, November 2010.

AMA releases ACO guidelines

by John Commins

Accountable care organizations (ACO) must be physician-led, patient-centric, and ensure voluntary participation from patients and physicians, including independent practitioners, under the AMA's principles for ACOs.

"The AMA is committed to ensuring physicians in all practice sizes can lead and participate successfully in new models that allow them to provide the best care to their patients," said AMA president Cecil B. Wilson, MD.

Wilson wants flexibility in the ACO model so physicians in all practice sizes can participate. "For this to happen, significant barriers must be addressed, including a lack of resources, existing antitrust rules and conflicting federal policies," he says.

Although ACOs and other models of patient care were recently authorized in the new health reform law, the Patient Protection and Affordable Care Act, existing anti-trust and anti-fraud rules can make becoming part of an ACO difficult for physicians, especially those in small practices, the AMA says.

The latest AMA *Physician Practice Information Survey* found that 78% of office-based physicians in the United States work in practices with nine physicians or less. A majority of those are either in solo practices or practices of two to four physicians.

The AMA made its ACO guidelines public at its semi-annual policymaking meeting in 2010. Key provisions of the 13-point set of principles include:

» **Guiding principle**—The goal of an ACO is to increase access to care, improve the quality of care, and ensure the efficient delivery of care. Within an ACO, a physician's

primary ethical and professional obligation is the well-being and safety of the patient.

- » **ACO governance**—ACOs must be physician-led and encourage an environment of collaboration among physicians. Physicians should head ACOs to ensure that a physician's medical decisions are not based on commercial interests, but rather on professional medical judgment that puts patients' interests first.
- » **Patient participation**—Patient participation in an ACO should be voluntary rather than a mandatory assignment by Medicare.
- » **Physician participation**—Any physician organization or any other entity that creates an ACO must obtain the written consent of each physician to participate in the ACO. Physicians should not be required to join an ACO as a condition of contracting with Medicare, Medicaid, or a private payer, or as a condition of being admitted to a hospital medical staff.
- » **The savings and revenues of an ACO**—These should be retained for patient care services and distributed to the ACO participants.
- » **Flexibility in patient referral and antitrust laws**—Federal and state anti-kickback and self-referral laws and the federal Civil Monetary Penalties statute should be flexible to enable physicians to collaborate with hospitals in forming ACOs without being employed by the hospitals or ACOs. This is particularly important for physicians in small and medium-sized practices who may want to remain independent but otherwise integrate and collaborate with other physicians in the ACO. ■

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