VINDICET™

# Post-care Networks and LTACs: Finding Your Place in an ACO Model

**Accountable Care Organizations (ACOs) are more than just a fad. Post-care providers and LTACS in particular, will need to give careful thought on how to navigate the changes that ACOs will bring.**

ACOs are already demonstrating success, in large part due to cost reductions that occur instantly rather than over time. From InsideHealthPolicy.com's daily brief (January 2014) –

> *"CMS announced early results from its initiatives on accountable care organization: Nearly half of the 114 ACOs in the Medicare shared Saving Program had lower expenditures than expected, 29 of which received bonuses (shared saving) totaling $126 million in the first year and generate gross saving of 147 million in their first year; and the participants of the physician Group Practice Demonstration earned a total of 108 million in bonuses over five years for improving the quality of care and lowering cost".*

While it's clear that ACOs are here to stay, models for how they will work are still evolving. CMS continues to solicit feedback on the rules governing ACOs. Senator Ron Wyden (widely expected to take over as Finance Committee Chair) has said he would like to replace the current fee-for-service chassis with a capitation approach. This would give doctors a single lump-sum payment; making it easier for them to provide services that might be covered by Medicare but also impacting the utilization of post-acute-care services. Other considerations being looked at include the addition of Medicaid beneficiaries, drug benefits, and a population-based pay model.

© 2010-14 VINDICET LLC. All rights reserved.

For most ACOs the focus to date has been on primary care. But within the last year more attention has been given to post-acute-care with the recognition that this area of the care continuum could yield even greater benefits. With early payment reforms targeting hospital readmissions, success in the new world of population management will depend largely on what happens to the patient following discharge. ACOs recognize that they will need to either affiliate with or create an organized system to provide the firepower needed to manage post discharge patients. As providers specializing in the care of complex patients, LTACs are in an excellent opportunity to take a leadership role in forming these post-acute networks. In order to do so, it's important to have a better understanding of how ACOs differ from previous managed care frameworks, and what business opportunities these afford.

## Why ACO Networks are Not HMOs

Many health executives maintain that ACOs are nothing more than HMOs in new clothes. While there are similarities to be sure, the differences are substantial. In addition to changes in compensation, ACOs are including new key players in their mix. ACOs will expand the role of ambulatory care and make it an essential component of a comprehensive low cost service offering. In this new model, non-hospital sites will play a key role. The ACO model is designed to push patients away from hospital stays. It is a volume based model that will include new partners:

***Retail clinics*** at locations like CVS or Walmart offer patients an attractive alternative to hospital centers with limited hours and long waits. More and more ACOs will partner with them. Cleveland clinic is providing medical directorships for CVS Minute clinics. This creates a streamline for specialty referrals. Retail clinics are becoming the frontline access point for patient-centered medical homes. One of the main ideas behind an ACO is not to be an "episodic encounter" model but a "patient engagement and panel participation" model. Retail can occupy a primary care niche and expand access to keep patients in the network

***Urgent Care Centers (UCCs)*** will be the low cost alternative to overcrowded EDs. For low level care, the UCC can address semi emergent concerns. MedExpress was able to build referral networks within hospital systems. Anthem BCS provides patients a google map to locate Urgent Care Centers and retail clinics in an effort to steer care away from hospital based EED's. This trend will only increase with time.

***Ambulatory Surgery Centers (ASCs)*** are incentivized to drive volume at negotiated high rates, while ACOs are based on limiting utilization and generating savings. However ACOs with sufficiently large panels may be able to direct a steady stream of contracted business to the ASC at guaranteed rates and actuarially-based volumes. ACOs will benefit from ASCs' low cost profile compared to hospitals.

***Freestanding EDs*** have been allowed in several states. Their main appeal is ease of access in large rural areas. A second benefit from an ACO standpoint is a lower inclination to admit patients to drive bed census up. Many feel that admission decisions by Free Standing EDs are more "measured and deliberated," while offering hospital level quality and level of care.

© 2010-14 VINDICET LLC. All rights reserved.

***Home,*** as any patient will tell you, is the best place to be. With the benefit of new technology, home will be the preferred venue for patient care. Some ACOs have increased their home visit volume by 20% without direct reimbursement but have recaptured the cost through shared saving.

***Post-acute care*** players will remain the same; Long term acute care hospitals, Skilled nursing facilities, Inpatient rehab and Home care. Until now these entities have largely worked in silos. An organized post-acute network will enable collaboration and patient tracking between them. In fact we've seen several of our clients initiative just such networks.

## Opportunities for LTACs in an ACO model

With quality and cost saving as the drivers, ACOs will only include post-acute providers that share their same philosophy and patient centered goals.

***Demonstrate Value.*** ACOs are not about withholding service but creating value. Cost reduction is the ultimate goal with patient satisfaction built in. LTACs must be able to demonstrate the cost reduction. They will be asked to provide in depth outcomes reports in real time:

- Long term care mortality rates
- Long term care hospitalization Index
- Total readmission rate within 30 days
- Total readmission rate within 72 hours
- Total short term readmission rate within 30 days

***ACOs are Local.*** While HMOs created large systems that require large bureaucracies, ACO are designed to manage resources at the local level. As an LTAC, you will have to make some strategic decisions. Do you integrate with your local ACO or do you become a center of excellence? There is no straight or simple answer.

***Align Incentives***. Today, HMOs that invest in improving the health of their members do not reap the benefit as members can switch to a different network. For ACOs, financial upside is earned earlier and derived from "shared savings" against predetermined annual targets. For these reasons, a lot of attention will be placed on post-acute care networks with LTACs at the center.

***Collaboration.*** Patient management, case management and population management are programs that will demand a complex level of collaboration across the continuum. LTACs need to be ready to work with other post-care providers in a leadership capacity.

***Capitation is Here to Stay.*** ACOs will offer an array of payment models. However, capitation is here to stay. Facilities will be responsible for cost and managing a limited pool of funds. The payment mechanism will have two major components - fee for service combined with shared savings.

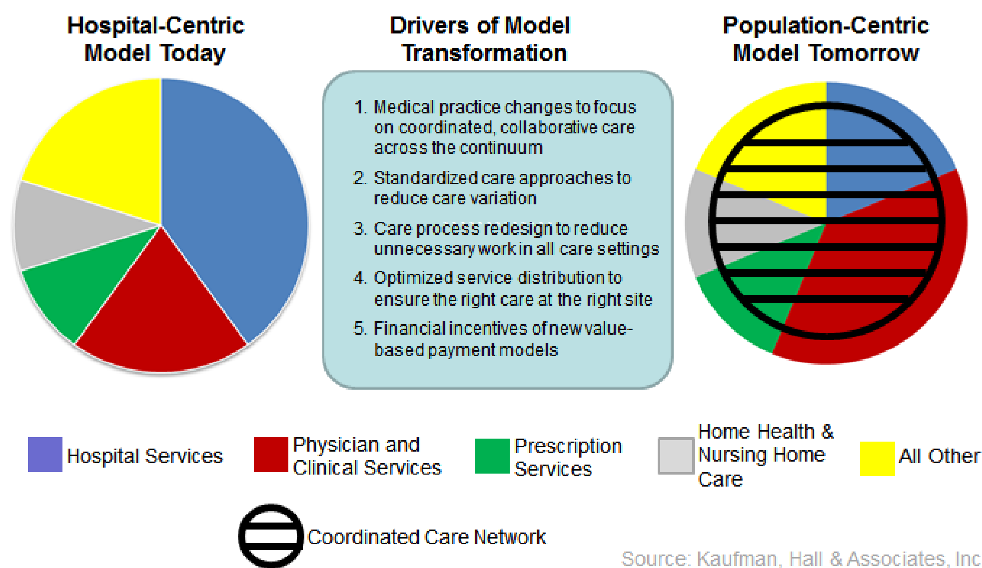
© 2010-14 VINDICET LLC. All rights reserved. 

VINDICET™

***Information technology*.** Population health management will be the main driver behind these ACOs initiatives. Automating processes to manage clinical and financial will be at the center. EMRs will only solve a piece of the equation. Automated tools are required to manage patient populations - aggregate data and use of information to understand trends to assist in the care process will be mandatory.

## Conclusion

A picture is worth a thousand words:




For LTACs to become or stay a player, they will need:

- *Provide collaboration*. Within 24 hours to 48 hours from discharge to a post-acute facility, a care coordinator will ensure that a care plan is being followed. This Care coordination team nurse specialist will monitor quality measures and assist the network participants to implement processes and optimize practices to achieve the expected outcome.
- *Case manager on site*. The ACO post-acute transition care coordinator will work directly with post-acute facilities on design and implementation of a transitional plan of care.
- *Better medication management*. ACOs are piloting programs using pharmacists to conduct medication reconciliation at the time of discharge, and the importance of pharmacists will continue to increase.
- *Staff engagement between acute and post-acute*. Care path and itineraries starting at admission in an acute setting will be carried through to, and modified by post-acute in a collaborative fashion.

© 2010-14 VINDICET LLC. All rights reserved.

As collaborations between health systems and post care providers move forward, there is a lot on the line. The first priority that an ACO will consider as they are choosing partners will be patients' health and safety followed by the need to keep costs under control. Also, transparency will be mandatory by presenting unblinded performance data and use this data to collectively create and implement more efficient processes.

---

**Yann Beaullan-Thong, Vindicet CEO & Founder**

ybeaullan@vindicet.com | 203.404.3168

Yann has 20 years of experience in developing new products, business plans, and strategy. Prior to Vindicet, he served as VP of eBusiness Development & New Ventures at Aetna, where he developed innovative joint offerings with companies including WebMD, J&J, Pfizer, MasterCard and Discovery Health.

© 2010-14 VINDICET LLC. All rights reserved. 