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HackensackAlliance Credits Careful MD Choices For MSSP Success

It's easy to say that a successful accountable care organization owes its success to physician performance, but Medicare Shared Savings Program ACO HackensackAlliance takes it one step further: It believes it owes its success to very carefully selecting its physicians, and then giving them a few tools they needed to perform well.

The ACO, sponsored by Hackensack University Medical Center, saved $10.75 million for CMS in the first reporting period, and as a result took home a check for $5.27 million, executives said in a Jan. 21 webinar sponsored by Premier, Inc., a health alliance that brings together ACOs to share best practices and improve performance.

"Our physicians were selected to be part of the ACO, which we think is one of the keys to our success," said Peter Gross, M.D., chair of the HackensackAlliance Board of Managers. In addition, Gross said, backing from the top is key: "Line up as much support from the C-suite as possible and as soon as possible."

ACO Targets Medical Homes

HackensackAlliance, which joined the MSSP on April 1, 2012 as part of the first group of ACOs, initially contracted with physician practices that had taken steps to become accredited patient-centered medical homes (PCMHs) *(ABN 6/13, p. 10)*. The practices didn't opt for PCMH status because the ACO asked — they actually had decided to do it on their own.

The philosophy to choose these practices was simple, said Edward Gold, M.D., the ACO's vice president and chief medical officer. "We needed physicians who had drunk the Kool Aid. It's better to work with physicians who buy into the ACO and the Triple Aim concepts, and the most likely physicians are the physicians whose offices are recognized as PCMHs by NCQA."

Patient-centered medical homes coordinate tests and orders better, especially with specialists, manage patient care rather than turning over management to specialists, are concerned with the patient's and family's needs and wishes, and comply with the triple aim, Gold said.

HackensackAlliance started out with 12,000 Medicare lives across 15 different practices, including one fully employed group and two others in the hospital network, with about 50 physicians.

In addition to joining MSSP, Hackensack did what other self-insured hospital groups have done: It set up a new shared savings program for Hackensack University Medical Center's own employees' health care. This offered a good opportunity to test accountable care concepts before rolling them out to a wider population.

The ACO employs one care coordinator for every 1,500 Medicare lives, which currently amounts to 10 care coordinators, who are embedded in the larger, private physician offices. The ACO also has added two "patient navigators" inside the hospital, who collaborate with hospital-employed social workers for care transition planning.

Gold said the care coordinators are key to patient engagement, but even before an ACO hires its first care coordinator, it needs to define its vision for patient engagement and create a culture of patient engagement.

To control post-acute care costs, HackensackAlliance has conducted meetings with "key people" in skilled nursing facilities and home health agencies to ask for assistance in monitoring quality, correcting problems, and keeping ACO physicians well informed, Gold said.

Patients Record Vital Signs

The ACO also uses telemonitoring technology; heart failure patients are given an iPad to record vital information and communicate with patient management staff.

Michael Dardia, administrative director for the ACO, said the organization identified some key opportunities to reduce costs. These have included:

- ***Reducing admissions, readmissions and emergency room visits;***
- ***Managing patients at home instead of in nursing homes;***
- ***Switching to generic drugs from branded drugs;***
- ***Reducing inappropriate testing;***
- ***Contracting with a data analytics firm*** (ultimately, the ACO contracted with Verisk Health, a Premier solution);
- ***Encouraging physician practices*** to utilize CMS's new Chronic Care Management fee for managing patients;

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◆ ***Agreement on practice standards***; and

◆ ***Commitment to Active Care Coordination*** — establish a unified care coordination plan across the entire ACO.

Most importantly, Dardia said, "be sure to follow all your assigned beneficiaries — so many do fall through the cracks. It's important to work with your particular practices to ensure this."

The Hackensack Alliance ACO IT infrastructure features a collage of different inpatient and ambulatory electronic medical records, multiple labs, home care agencies, nursing homes, and a regional Health Information Exchange (HIE). The ACO bought an Active Care Coordination and ACO Performance Management Workflow Platform from TEAM of Care that included a private health information exchange to connect the entire care continuum. This allowed the Hackensack Alliance ACO to coordinate tasks and actions between care settings, ensuring that providers and patients all work from a single unified care coordination plan and set of information.

The ACO encountered plenty of problems on its road to MSSP success, Dardia said. For example, its financial resources were not lined up ahead of time, so it took longer to finance projects. Particularly, he said, the IT projects that tied together the offices and the hospital electronic medical record interfaces were behind schedule.

"What must be clearly understood is that the income derived from the Medicare Shared Savings Program is based upon savings," echoed Morey Menaker, D.O., president and CEO of HackensackAlliance. "Therefore, you must have significant concerns about what it costs to change practice patterns to save money."

If new ACOs don't pay attention to this, they could have two problems: The ACO will be in the red, and their physicians will be unhappy, Menaker said.

ACO Started With Skeleton Crew

As part of its approach, HackensackAlliance began operations with a small administrative staff "because we understood these costs could never be recouped on the back end." Key administrative committees included credentialing and compliance, information technology, performance improvement, finance and research, he said.

NCQA accreditation isn't necessary to have a successful ACO, Dardia said, but it definitely helped. "We did this by choice, and we found it really forced us to focus our attention" on areas that required improvement. "It was well worth the investment — it's helpful if you are new at the ACO game."

Spending reductions were noticeable for HackensackAlliance in the first reporting period. The ACO decreased inpatient costs (per assigned beneficiary) by nearly 15%, skilled nursing facility costs by more than 22%, hospital outpatient costs by 12%, Part B physician/supplier costs by 6%, durable medical equipment costs by 7% and hospice by more than 15%. Home health costs went up by nearly 9%, which could reflect the ACO's drive to move patients out of skilled nursing facilities and into home health, if feasible.

The only metrics in which HackensackAlliance failed to beat the average of all MSSP ACOs in the first reporting period were skilled nursing facility costs (the average MSSP ACO saved 23.5%, compared to Hackensack's 22.25%), Part B physician/supplier costs (the average ACO saved 12.78%, compared to Hackensack's 6.12%), and durable medical equipment (the average ACO saved almost 10%, while Hackensack saved just over 7%).

In total, expenditures per assigned beneficiary fell from $12,720 annually in 2011 to $11,385 between April 1, 2012, and March 31, 2013, for savings per beneficiary of $1,335, or 10.49%.

Hackensack Had Higher Costs

Hackensack's per-patient expenditures were above average, both before and during the program. By comparison, the average MSSP beneficiary cost the program $9,832 per year in 2011 and $8,979 between April 1, 2012, and March 31, 2013, for a savings per beneficiary of $832, or 8.67%.

HackensackAlliance's total savings in the first reporting period were $10.74 million, beating the ACO's minimum savings benchmark of 2.6%, or $7.39 million. When the final calculations were complete, CMS cut a check to the ACO for $5.2 million.

Since the hospital had provided the start-up costs, the ACO first reimbursed those costs, and also covered its operating costs, Menacker said. Then, the ACO leadership decided to split the remaining proceeds based on the number of beneficiaries per physician practice, paid to the practice. "We wanted to compensate physicians for being willing to take the risk and invest in patient-centered medical homes and electronic health records," Menacker said.

Next year, if the ACO continues to earn shared savings, it will add other factors such as quality scores and actual cost savings, he said. "Following our initial success, we are diving much, much deeper. But this is a much more complicated process and not necessarily important in the start-up process. It's more important to get buy-in."

Contact Gross at PGross@HackensackUMC.org.

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