WHITE PAPER

Post-Acute/Long-Term Care Planning for Accountable Care Organizations

SCORE©

A Model for Using Incremental Strategic Positioning as a Planning Tool for Participation in Future Healthcare Integrated Delivery Models While Managing Resources & Risk

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INTRODUCTION

Since passage of the Affordable Care Act, a great deal of attention has been given by the media, think tanks and professional services firms to the concept of an Accountable Care Organization (ACO). Most of that attention so far has focused on acute care providers: physicians, hospitals, clinics and outpatient diagnostic testing and treatment centers. The clear directive of the Affordable Care Act, however, is that any meaningful and sustainable cost savings from such integrated health care delivery models will also need to incorporate both post-acute and long-term care into those models.

Post-acute and long-term care organizations are beginning to feel a keen sense of urgency to start planning now lest they be passed up by more proactive competitors. But a large disconnect exists between having a sense of urgency and understanding how best to act upon that urgency. In fact, there is a great deal of uncertainty over what – if anything – post-acute/long-term care organizations should be doing today to prepare for the future of integrated health care delivery.

That uncertainty is amplified by the environmental challenges they already face, which include:

- **Capital constraints.** Very few organizations have access to the kind of capital that would facilitate major organizational repositioning involving new facilities and/or programs.

- **Tight operating margins.** Typically there is very little room with which to “experiment” on new operational initiatives and/or community outreach.

- **Market ambiguity.** Where and how individuals receive post-acute/long-term care continues to be blurred across a variety of settings, while in most markets it is still unknown which, if any, acute care providers may or may not participate in an ACO.

- **Regulatory uncertainty.** While draft regulations on formation of an ACO under Section 3022 of the Patient Protection and Affordable Care Act (i.e., the Medicare Shared Savings Program) are anticipated any day, the congressional and legal threat of Affordable Care Act repeal remains an unsettled concern.

Regardless of the repeal effort’s outcome, what is certain, however, is that the future survival of post-acute/long-term care organizations will depend upon their successful participation in integrated delivery models. So post-acute/long-term care organizations are in a very challenging position. They are realizing they need to begin planning now or be left behind. But how does an organization effectively plan for a future with so little understanding of what it actually is they will be left behind from?
PURPOSE

The purpose of this paper is to address post acute/long-term care organizations’ uncertainty and concerns with the ACO concept and provide some tangible planning tools they can begin to use now without making huge resource commitments.

First, it will provide a brief overview of the ACO concept and ways in which post-acute/long-term care organizations are expected to be participants in ACOs and other such integrated delivery models in the future.

Next, it will suggest an approach to strategically position a post-acute/long-term care organization for a future of integrated health care delivery that creates significant “option value.”

Finally, it describes an actionable planning tool (i.e., the Strategic Comprehensive Organizational Readiness Evaluation – SCORE® – Model) that Dixon Hughes will make available to organizations that want to begin planning and preparing to participate in an ACO, or other similar integrated health care delivery model.

ACO RELEVANCE FROM A POST-ACUTE/LONG-TERM CARE ORGANIZATION’S PERSPECTIVE

The term Accountable Care Organization was formally coined by Dr. Elliott Fisher in a December 2006 Health Affairs article, “Creating Accountable Care Organizations: The Extended Hospital Medical Staff.” The core concepts of integrated and coordinated care delivery, however, can be readily traced back to the 1970s, if not earlier.

The Medicare Payment Advisory Commission (MedPAC) defines an ACO as “a set of providers [which are held] responsible for the health care of a population of Medicare beneficiaries.” In general, the goals of an ACO are to assume clinical risk for a defined population of individuals while improving the quality of care provided to that population at an overall lower cost. A primary reason for the most recent attention being received by the ACO concept is Section 3022 of the Affordable Care Act (PPACA), the “Medicare Shared Savings Program,” which states that, “groups of providers of services and suppliers meeting criteria specified by the Secretary may work together to manage and coordinate care for Medicare fee-for-service beneficiaries through an accountable care organization (referred to in this section as an ‘ACO’); and

ACOs that meet quality performance standards established by the Secretary are eligible to receive payments for shared savings under subsection (d)(2).

ELIGIBLE ACOS.

IN GENERAL.—Subject to the succeeding provisions of this subsection, as determined appropriate by the Secretary, the following groups of providers of services and suppliers which have established a mechanism for shared governance are eligible to participate as ACOs under the program under this section:

A) ACO professionals in group practice arrangements.
B) Networks of individual practices of ACO professionals.
C) Partnerships or joint venture arrangements between hospitals and ACO professionals.
D) Hospitals employing ACO professionals.
E) Such other groups of providers of services and suppliers as the Secretary determines appropriate.”

ACO models have been promoted to proactively address the following trends, which make the current healthcare system unsustainable:

- the trajectory of U.S. health expenditures coupled with the projected growth of the 65+ population.
- diagnostic and treatment technologies and specialization of care that have led to accelerated costs.
- a health care payment system that rewards volume regardless of outcomes.
the belief that substantial cost savings opportunities exist from reducing unnecessary tests and referrals, as well as reducing hospital readmissions and hospital-acquired infections.

As provided above, the purpose of this paper is not to explore the myriad nuances, arguments and debate surrounding what will or will not constitute an ACO and whether such forms of care delivery will be any more or less successful than managed care models of the 1990s. There is a wealth of research, analysis and opinion on that subject available to anyone willing to take the time to search the Internet.

If ACOs are to be successful, however, post-acute/long-term care organizations will ultimately need to play a critical role in that success. The resulting impact on those organizations’ resource commitments will be dramatic. Specifically, post-acute/long-term care organizations will be responsible for:

- providing relatively lower cost settings and treatment options while furnishing a higher level of quality care.
- enabling more effective chronic disease management to reduce re-hospitalizations and emergency room visits.
- facilitating patient recovery, rehabilitation and wellness.
- developing more efficient care transitions across the care continuum.
- being positioned as the primary conduit for moving post-acute and long-term caregiving from institutional settings to individuals’ homes.
- partnering with acute care providers to develop comprehensive approaches to managing delivery around an episode of care.
- aggressively pursuing patient activation strategies (e.g., adherence to treatment protocols, medication management, disease management and wellness activities).
- enabling proactive diagnosis and prevention of post-discharge conditions, leading to fewer emergency room visits and hospital readmissions.

There are also numerous provisions of the Affordable Care Act beyond the Medicare Shared Savings Program that will dramatically impact post-acute/long-term care providers in ways that underscore the critical importance of proactive planning and positioning. Just a few of the more significant examples include:

- **Section 3004**, Quality Reporting for Long-Term Care Hospitals, Inpatient Rehabilitation Hospitals, and Hospice Programs – this presumably will require substantial investments in information technology if systems are not already in place to capture and report this information.
- **Section 3006**, Plans for a Value-Based Purchasing Program for Skilled Nursing Facilities and Home Health Agencies – the Secretary of HHS’s initial findings are to be reported to Congress not later than Oct. 1, 2011, and a new Medicare payment program seeking to reward value over volume could follow within several years.
- **Section 3021**, Establishment of Center for Medicare and Medicaid Innovation – empowers that organization, as of Nov. 16, 2010, to develop and implement various new care delivery programs that will also certainly include post-acute care providers.
Section 3023, National Pilot Program on Payment Bundling – to begin no later than Jan. 1, 2013, and clearly targets post-acute care providers.

Sec. 3025, Hospital Readmissions Reduction Program – to become effective with federal fiscal years beginning on or after Oct. 1, 2012, this program will require hospitals and post-acute/long-term care organizations to form new strategic working alliances.

Sec. 10202, Incentives for States to Offer Home and Community-Based Services as a Long-Term Care Alternative to Nursing Homes – perhaps the best opportunities to achieve diversified new revenue streams are in the area of home and community based services.

Integrated care delivery models offering some combination of incentive/reward and cost/penalty are near-term realities that post-acute/long-term care organizations will need to embrace if they are to survive. Accordingly, while the focus of this paper is on helping those organizations prepare and position for the new realities of integrated health care delivery models (e.g., an ACO), being aware of various other regulatory and programmatic initiatives under the Affordable Care Act will help organizations create option value, as further described below.

Incremental Planning as a Strategic Approach to Positioning

Post-acute/long-term care organizations find themselves in a short-term Catch-22 situation. Note the importance of recognizing it as a short-term situation, because that will decidedly change over the next few years as ACOs and similar integrated care delivery models proliferate and as new technology-enabled caregiving tools evolve.

There is currently a great deal of uncertainty surrounding how ACOs will be created, operated and regulated. Public discussions held by CMS on promulgation of regulations for the Shared Savings Program seem to suggest that post-acute/long-term care organizations will be eligible to participate in that program. Initially, at least, most ACO models will probably consist primarily of hospitals and physicians. Ultimately, however, both post-acute and long-term care will be fundamental components of integrated delivery models, whether as part of ACOs or the myriad other future integrated care delivery models.

Even after regulations are promulgated for the Shared Savings Program, additional clarity will need to be provided by the federal government on how ACOs will or will not be impacted by Stark laws, antitrust legislation, fraud and abuse statutes, as well as the potential impact on tax-exempt status of nonprofit organizations. Beyond legal and regulatory considerations, there are issues of structure, governance, management, establishing and assessing and measuring quality/cost metrics, contractual payment arrangements and business models that will need to be developed. And what actually constitutes an ACO will likely vary substantially from market to market (in some cases, possibly even within markets).

With so much yet to be determined, it is understandable that post-acute/long-term care organizations are hesitant to make investments of time and capital in any type of significant foundational change. But waiting until such clarity exists will, in all likelihood (if market competitors are proactive), not afford those organizations sufficient time to make the changes that will be necessary
if they are to be attractive partners to acute care providers owning and operating those ACOs – or any other types of integrated delivery models.

What post-acute care providers should be doing is learning to plan and position their organizations incrementally, in direct alignment with the advancement of ACO development in their respective markets – all the while creating enterprise option value. The following section of this paper provides a suggested model to help organizations do this type of effective incremental planning.

**Strategic Comprehensive Organizational Readiness Evaluation**

The Strategic Comprehensive Organizational Readiness Evaluation Model (SCORE®) was created to help post-acute/long-term care organizations assess, evaluate and understand how well they are strategically positioned to participate in future integrated health care delivery models. It uses the incremental planning and positioning concept described above by helping an organization understand how it is strategically positioned relative to two broad areas of evaluation:

- Organizational Readiness
- Environmental Readiness

The fundamental approach of the model is two-fold: first, to help the post-acute/long-term care organization understand what planning efforts are needed to help position it for future participation in integrated delivery models (i.e., the assumption being an ACO). Second, it provides a framework for that planning effort so that the organization does not a) over commit valuable resources to such planning efforts before it has to, and/or b) commit resources more than once on the same effort.

**ORGANIZATIONAL READINESS:** This quite simply refers to how well the organization is prepared to transform itself into an entity that can succeed as part of an integrated care delivery model. There will necessarily be gaps between where the organization is today and where it would need to be as an ACO participant. The evaluation model is designed to help organizations identify those gaps, so that they can develop approaches to begin closing them. Specific areas included in the Organizational Readiness assessment include:

- Organizational Culture
- Leadership & Governance
- Market Positioning
- Operational Performance
- Information Technology
- Financial Strength
- Physical Capacity

**ENVIRONMENTAL READINESS:** This largely encompasses those factors and considerations beyond the control of the organization but which will have a critical impact on whether and how successful ACOs will be in that organization’s market. These are organized into the following categories:

- Organizational Culture
- Leadership & Governance
- Market Positioning
- Operational Performance
- Information Technology
- Financial Strength
- Physical Capacity
· Legal & Regulatory Clarity
· Market Acceptance
· Economic Viability
· Partnerships

Dixon Hughes has developed a proprietary evaluation tool to help organizations translate qualitative assessment indicators into a quantitative readiness score based upon the organization’s level of agreement with various assertions, grouped according to the categories provided above. A one-to-six scoring grid is then used to assess and determine the respective levels of organizational and environmental readiness based upon averages of the scores from each category.

The output of this effort will provide the post-acute/long-term care organization with valuable information to direct its planning efforts:

· First, it will identify readiness gaps between where the organization needs to be positioned for ACO participation compared to where it is positioned today; this will help the organization determine:
  > whether ACO participation is a realistic expectation.
  > how to prioritize planning efforts if it is a realistic expectation.
  > how to most effectively and efficiently deploy available resources.

· Second, it will help the organization evaluate the overall environment for successful ACO creation and operation in the post-acute care organization’s market; this will help the organization determine:
  > the progress of legal and regulatory clarity necessary to facilitate ACO models.
  > market acceptance of the ACO concept and likelihood of economic success.
  > area health care providers that the organization should target for potential partnerships (e.g., physicians, physician groups, hospitals, clinics, diagnostic and treatment centers, as well as other post-acute/long-term care organizations).

In addition to determining where – and to what extent – gaps exist in the organization’s readiness and the organization’s environment to be positioned for successful ACO participation, this analysis will also help the organization find balance in its planning efforts.

By using the following Evaluation Model matrix, the post-acute care/long-term care organization can get a sense of whether its current organizational readiness positioning and planning efforts are in sync with its environment. To the extent they are not in sync, the evaluation model provides some fundamental suggested courses of action. The SCORE® model is not designed to be a measure of value, quality, performance or any other type of objective assessment. It is merely a tool to help an organization weigh its positioning relative to its environment in the context of preparing to participate in future integrated care delivery models.

Note that the action steps shown are broad generalizations based upon the assumed levels of readiness. By repeating the assessment over time and comparing iterative results, the post-acute/long-term care organization will be able to create and apply its own unique outcomes assessment for use in its ongoing planning efforts. To help better explain how this might work, several examples are provided below.

Example 1: An organization scores a 2.5 average for Organizational Readiness while its market evidences a 4.5 level of Environmental Readiness. The associated planning directive is to “Accelerate Planning Efforts.” The underlying premise here is that the market is getting close to offering opportunities that competitors may be better positioned to take advantage of, so planning efforts need to increase in reaction to this situation.
Example 2: An organization scores a 4.0 average for Organizational Readiness while its market evidences a 1.5 level of Environmental Readiness. In this case the planning directive is to “Intensify Relationship Building.” This example represents the organization having made substantial progress toward positioning itself to participate in integrated delivery models – but the market is not yet ready to develop and implement such models. Rather than wasting the efforts that have been put forth to that point because the market is not ready, the organization can leverage its progress by demonstrating to potential future healthcare partners how and why it can be the partner of choice in the future – i.e., build valuable relationships in advance.

Example 3: An organization scores a 5.5 average for Organizational Readiness while its market evidences a 1.0 level of Environmental Readiness. As depicted in the SCORE® matrix, even though the market may not yet be ready to embrace integrated delivery models, the high level of achievement made by the post-acute/long-term care organization in preparing itself to be a participant in such models will necessarily open up myriad other market opportunities that should be explored (i.e., taking advantage of the Option Value that has been created).

With a little imagination one can quickly realize how the matrix approach can be modified for unique and/or specific circumstances at different post-acute/long-term care organizations. The important takeaway of this approach will be the organization’s ability to find balance between the resources committed to planning efforts, the risks associated with that resource commitment and the expected return on that investment.
SCORE® EVALUATION MODEL

Position of Jeopardy

Explore Partnership Opportunities

Should be In Active Negotiations

Launch Participation

Seek JV/Partnership Opportunities

Accelerate Planning Efforts

Maintain Current Course

Should be In Active Negotiations

Accelerate Planning Efforts

Maintain Current Course

Focus on Building Option Value

Intensify Relationship Building

Maintain Current Course

Focus on Building Option Value

Intensify Relationship Building

Actively Seek Potential IDM Ventures

ORGANIZATIONAL READINESS

ENVIRONMENTAL READINESS