

# REHAB perspectives

## STANDING OUT FROM THE CROWD

Post-Acute Care and ACOs

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# CONTENTS

## President's Message

On March 31, the Centers for Medicare & Medicaid Services (CMS) issued its proposed rule for Accountable Care Organizations (ACOs). Although a final rule is not expected for some months, the eagerly awaited details about how CMS intends to structure ACOs have big implications for the entire healthcare community, including providers of rehabilitative therapies and skilled nursing. The future of your traditional Medicare business may depend on your understanding of what ACOs are and whether or not you join one.



The proposed ACO regulation represents the first major healthcare reform initiative since the Patient Protection and Affordable Care Act was enacted in March 2010. The next-generation of the "patient-centered medical home" concept, the ACO model is intended to ensure that the healthcare traditional Medicare patients receive is efficient, effective and, consequently, less expensive than it might otherwise be. ACOs that succeed in this endeavor will share in cost savings.

For skilled nursing facilities (SNFs) and rehabilitation therapy providers, specifically, ACOs represent an opportunity to enhance patient care as well as the bottom line, which is a clear win-win for providers. But there's a catch: Providers will have to prove they can achieve superlative results — clinically and operationally — to be invited to join an ACO by its other founding members. To be sure, much remains unknown about these organizations. But the proposed rule issued by CMS has given SNFs and rehab providers enough information to be absolutely sure that there are steps they can take now to prepare for the ACO environment.

In this issue of *Rehab Perspectives*, we provide a brief overview of ACOs and draw upon the experience of Aegis Therapies and Golden Living to share tips for how you may be able to position your organization for success.

Martha Schram  
President  
Aegis Therapies



## 3 The ABCs of ACOs

*What you need to know about accountable care organizations, based on rules proposed by CMS*

## 6 Get Ready for ACOs

*Top-notch healthcare providers seeking ACO partners will choose those with effective clinical and business processes*

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# THE ABCs OF ACOs

What you need to know about accountable care organizations, based on rules proposed by CMS



Since the Patient Protection and Affordable Care Act of 2010, providers across the country have eagerly anticipated details about the Medicare Shared Savings Program, an initiative designed to improve health outcomes and reduce costs by promoting collaboration between all of a patient's caregivers. On March 31, the Centers for Medicare & Medicaid Services (CMS) released a proposed rule describing how it would like to implement the program, which will be built upon newly created entities called accountable care organizations (ACOs).

In the simplest terms, an ACO is a group of healthcare professionals and facilities spanning the continuum of care that agree to work together to make sure the patients for whom they are responsible receive the right care at the right time and in the right place. In this way, the ACO is designed to fulfill CMS' vision of a patient-centered medical home, where preventive medicine is emphasized and where interventions, when necessary, happen quickly and consequently are more effective and less costly. In exchange for their combined vigilance and efficiency, the providers in an ACO get to share in the savings.

**Many providers are exploring potential ACO partnerships.**

CMS' 429-page proposed rule describes in detail the entities that will be eligible to form and participate in ACOs, the way ACOs will be structured and governed, and the manner in which ACO participants will share cost savings. However, the regulation is merely a proposal. CMS will be tasked with considering and possibly incorporating the feedback it has been receiving (and will continue to receive) through the rule-making process from numerous organizations — including physicians, hospitals, home health and hospice providers, and skilled nursing facilities, among others — before finalizing the program for a start date of Jan. 1, 2012. That said, it is possible to get a general idea of how ACOs will work and to understand steps healthcare providers can take to make themselves attractive as potential participants in such organizations.

## Legal Structure and Governance

As proposed by CMS, ACOs will be separate legal entities, each with a formal governance framework that allows every participating



As proposed by CMS, ACOs must have at least 5,000 members.

caregiver a proportionate role in the ACO's decision-making. An ACO can be a corporation, partnership, foundation, limited liability company or any other legal entity recognized by the state in which it operates. To be approved by CMS, an ACO must, among other things, be able to receive and distribute shared savings and repay shared losses; have enough healthcare professionals in its network to handle the patients assigned to it (ACOs can have no fewer than 5,000 members); agree to operate for at least three years; and comply with performance standards and other healthcare quality criteria. While specific performance standards have not yet been developed, CMS has said that these standards will fall into five categories: patient/care giver experience; care coordination; patient safety; preventive health; and at-risk population/frail elderly health. The ACO must promote evidence-based medicine, and report data on quality and cost measures, and have an infrastructure that allows for electronic prescribing and electronic health records.

CMS has determined that each ACO will have a governing body that will oversee administrative, financial and clinical operations. Provider participants will have at least 75% control of the governing body, but the governing body also must include Medicare beneficiary representation. A community stakeholder organization can serve on the governing body, an arrangement that would satisfy another CMS requirement that the ACO partner in some way with the community it serves.

### Who Can Join?

The regulation released by CMS identifies the entities that are permitted to form ACOs. These include physicians and other professionals in group practices or in networks of practices; partnership or joint venture arrangements between hospitals and physicians and other professionals (i.e. physicians assistants, nurse practitioners, clinical nurse specialists); hospitals employing physicians/professionals; and certain critical access hospitals (CAHs). With permission from CMS, other Medicare providers and suppliers may participate in ACOs, although they may not form them. These include safety-net providers, post-acute care facilities, federally qualified health centers, rural health clinics and certain CAHs. However, the details of the form "participation" may take is one of the areas that CMS has, as of now, left largely undefined.



SNFs are not yet certain exactly how skilled care will fit into the ACO model.

### How Will Savings Be Shared?

It's important to note that ACO participants will continue to be paid for the care they provide under the traditional Medicare fee-for-service program under Parts A and B. The Shared Savings Program therefore denotes the ways in which ACO participants can realize additional payments upon meeting quality standards and savings benchmarks.

To assess savings, CMS will use as a benchmark the per capita Medicare Parts A and B expenditures for beneficiaries who would have been assigned to the ACO in any of the three most recent available years (adjusted for growth and beneficiary characteristics). The amount an ACO's average per capita Medicare expenditures must fall below the benchmark for a performance year will depend on the number of beneficiaries it has and on whether or not it has agreed to share the risk for any potential losses. Accordingly, CMS proposes two "tracks" that ACOs can join. ACOs that join Track 1 will be responsible for losses only during the third year of the three-year term, a more gradual "on ramp" for the providers who feel hesitant, whereas those that join Track 2 will assume risk during all three years. However, ACOs in Track 2 will be rewarded for assuming greater risk by enjoying higher sharing rates than those in Track 1.

### Questions Persist

The regulation released by CMS in March gives healthcare providers interested in ACO participation a general idea of what to expect, but uncertainties about the program linger. Chief among these are the number of potential ACO participants that will want to participate in the program, which is expected initially to attract established integrated health systems, and the extent to which ACO participants such as skilled nursing facilities and other entities permitted to join (but not form) these organizations can establish a leadership role once on board with an ACO. Moreover, because Medicare beneficiaries will not be required to receive all of their services from the ACO but can continue to choose their providers, ACO participants will have questions about the way patients are shepherded through the healthcare continuum.

CMS will be accepting comments on the proposed rule until June 6 and will hold a listening session to hear stakeholder ideas about ACOs this summer. CMS said it will provide more details on the program in a Notice of Proposed Rulemaking this fall. ■



# GET READY FOR ACOs

**Top-notch healthcare providers seeking ACO partners will choose those with effective clinical and business processes**



Just as the development of the Medicare Shared Savings Program has been guided by the reality that patient outcomes improve when care is delivered at the right time and in the most appropriate setting, the formation of ACOs across the country will be determined by the individual clinical and business performance of potential provider participants. Providers across the healthcare spectrum, from primary care physicians to hospitals to skilled nursing facilities (SNFs), are evaluating potential provider partners based on their capacity to provide efficient, high-quality care and thus maximize the ACO's chances of realizing "shared savings" to its provider participants.

Nationwide, providers already are in the process of reaching out to others with whom they would like to form ACOs, so there is no time to lose for entities wishing to position themselves as desirable candidates for membership. Right now, ACO hopefuls should be

**Providers seeking partnerships with ACOs should examine their clinical and business outcomes and make necessary changes. Care coordination — both within a care setting and between care settings will be even more important.**

reviewing their clinical and business outcomes carefully in order to highlight their strengths and make necessary improvements.

Here, we look to areas to focus on based on the experience of Golden Living, a family of companies that specialize in recovery care. The Golden Living family of companies includes Golden LivingCenters, Aegis Therapies, AseraCare Hospice and Home Health, and 360 Healthcare Staffing.

## Assess Outcomes

"It's critical to measure and report what you do and how well you do it," notes Mark Besch, Vice President of Clinical Operations for Aegis Therapies. He recommends that providers collect as much



tangible clinical evidence as possible on everything from specific patient details to lifestyle ratings to quality indicators and clinical outcomes, adding that “this will be a differentiator when it comes to standing out as a strong ACO partner.”

Aegis Therapies has collected patient outcomes data since the late 1990s and now has a database with more than 5 million patient records — the largest database of SNF-based rehab therapy outcomes in the industry. Therapists collect data on each patient’s functional abilities upon admission and during the course of treatment using a program called Rehabilitation Outcomes Measures (ROM). ROM’s impact goes beyond the individual patient. Because Aegis has amassed such a large database of patient outcomes records, it now has an incredibly rich repository of data that, when examined in aggregate, allows clinicians to identify best practices that can be adopted by Aegis therapists across the country.

Besch says that partnering with providers that use outcomes-tracking tools will give ACOs “tremendous confidence that care is being informed by proven, effective techniques.” One tool every SNF can use to collect data on outcomes — particularly for Medicare Part A patients — is the new Minimum Data Set (MDS) 3.0, which introduced changes that gather more patient information, such as scripted patient interviews.

### Leverage IT

While only time and trial-and-error will reveal the composition of successful ACOs, one thing is indisputable: They will have robust and comprehensive information technology platforms.

“ACO members will need to be able to integrate and share data across settings,” says Besch. “This will be a huge challenge for many providers.”

Golden Living is the first post-acute care organization to adopt Microsoft’s Amalga™ Unified Intelligence System (UIS) — a data management system used in some of the most advanced hospitals in the country. This system collects important patient data from different sources and combines it in one location, enabling caregivers to view this information all at once. This accessibility and organization is helping Golden Living deliver even better care to all of its patients, including those with chronic conditions and complex medical issues. Not only has Amalga helped reduce the time clinicians spend on administrative tasks and data collection, but it also has increased communication between physicians and family members, reduced healthcare costs, and aided patients’ transitions to different care settings.

By giving clinicians access to up-to-the-minute patient information from different care settings, Golden Living’s use of Amalga has established a model for how data can be shared across an entire ACO.

“Amalga allows for conversation around patient information and a unilateral health record to drive better care and the appropriate treatment,” says Brandon Ribar, Golden Living’s Senior Vice President of Corporate Strategy. He adds that companies that do not have the “fundamental” ability to share information across acute and post-acute treatment settings will not be able to participate in ACOs.



**Rehabilitation therapy and other services that may help prevent rehospitalizations will take on greater importance as the U.S. government seeks to trim healthcare spending.**

### Prevent Rehospitalizations

Preventing the rehospitalization of patients will be one of the overriding objectives of any ACO, and will require a multi-pronged effort characterized by vigilance on the part of all providers in the organization.

Measuring and learning from outcomes to inform care practices and care plans is one strategy. According to Bill Goulding, National Director of Outcomes and Reimbursement for Aegis Therapies, providers also should aggressively follow up with discharged patients — especially those who return to a community setting — to ensure that they are adhering to medication, therapy and lifestyle protocols, and to provide clarification or advice where needed, adding that the outreach can go a long way toward decreasing patients’ chances of rehospitalization.

“SNFs should look seriously at follow-up with patients who are discharged,” he says, even though the ACO participant that ultimately assumes responsibility for patient follow-up may not necessarily be the last facility to treat the patient. “Care coordination is an important part of the ACO initiative. Follow-up enhances the patient-caregiver experience and forwards the goals of patient safety and preventive health, particularly among at-risk populations.”

In addition to patient follow-up after discharge, SNFs also should assess their ability to provide patients with appropriate medication at all times.

“Facilities are facing new pressures from hospitals to take patients with more acute conditions, and to take them at all hours of the day and night,” observes Robert Warnock, DPh, Senior Vice President of Pharmacy Services for Golden Living.

The absence of appropriate medication could result in the rehospitalization of a patient — something an ACO is determined to avoid. Warnock said SNFs that want to participate in an ACO might consider remote dispensing technologies that would enable



**SNFs seeking to partner with an ACO should prepare to care for higher-acuity patients, and to admit patients in the evenings and on weekends.**

SNFs to dispense pharmacy-approved medications (with active physician orders) on-site.

According to Warnock, SNFs also should focus on ways to reduce adverse events related to medications, which should help to keep patients out of the hospital as well as to reduce medication-related costs.

To help with this effort at Golden Living, the company has established an in-house consulting pharmacy company that is focusing on improving medication safety and patient outcomes. Golden Clinical Rx Solutions makes certified geriatric pharmacists part of the interdisciplinary clinical teams that care for Golden LivingCenter patients and leverages technology to improve patient outcomes.

The approach is unique in the long-term industry, but — as shown in Golden Living pilot studies — it has helped reduce falls, rehospitalizations, medication errors, and the number of medications that patients are prescribed.

### Have Competent Staff

As the business of skilled nursing evolves, SNFs are receiving more inquiries regarding medically complex patient care needs. Moreover, the push to discharge patients from the hospital faster means that, increasingly, SNFs are serving higher acuity patients even earlier in their recovery process. This pressure will continue as ACOs aim to keep the flow of patients within the network, thereby accessing a smaller number of high-quality SNF providers, says John Perticone, Division Director of Managed Care and National Director of Strategic Partnerships for Golden Living. He goes on to say that admissions will no longer follow a predictable schedule and may even come from referral sources such as emergency departments and physician offices. Hospitals increasingly discharge patients to rehab facilities in the evenings and on weekends, and SNFs must prepare for this.

Providers should not take on patients without the capacity to meet their needs, which means they must match the skills and competency of their clinicians to patient profiles. SNFs also must plan to have a range of clinicians and therapists on staff at heretofore “unconventional” times to meet the needs of the patients.

### Deliver Consistent Care

As successful national retail franchises have repeatedly proven, providing consumers with a consistent product can net big market gains. Consistency, either in goods or services, often yields higher quality products and increased consumer confidence, and the healthcare sector is no different. In fact, the pursuit of clinical “best practices” stems from an understanding that good techniques should be repeated and that high quality lowers costs.

Consistency, therefore, should be a goal of any prospective ACO participant.

“If you want to compete for ACO patients, you want to have clinical care paths in place so that you can comfortably say that a resident diagnosis is going to be treated and approached the same in all of your facilities,” says Besch.

ACO partners, he says by way of illustration, will want to know that every heart failure patient will be assessed with the same tools, treated with the same protocols and monitored with attention to the same triggers.

“If you’re the administrator of a health plan, you want to have an idea of a care map your beneficiaries will progress through and you want decision points that help you authorize care,” Besch points out. This is important, he says, because ACOs, as networks of service providers, will need to persuade health plans and payers to place the care of their beneficiaries into the ACO’s hands. Having structured care coordination plans in place will make for a convincing argument.

### Embrace New Paradigms

“It’s important for SNFs to understand that participating in an ACO translates into a need to focus patient flow in perhaps a different way,” says Perticone. “As part of a continuum of Medicare-certified services, SNFs have to be part of a process of managing patients better in a shorter period of time.”

This close coordination will prompt ACO partners to want greater oversight and knowledge of one another’s clinical activities, and SNFs should be prepared for the possibility that ACO management will place physicians and nurse practitioners in their facilities to make rounds and observe care. Moreover, as hospitals try to keep traditional Medicare business within the ACO, they likely will send Medicare patients only to the SNFs with which they partner, which means some SNFs may be asked to care for many more patients.

While the task of getting ready for ACO participation may seem daunting, so is the prospect of losing Medicare business to facilities that do the hard work of streamlining and improving their clinical and operational processes to remain competitive. Realigning, retooling, training, coordinating — these are the buzz words that should serve as guides to preparing for success in an ACO environment. ■



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