Uncharted Waters

Mercy Health System CEO Javon Bea warns that very few hospitals are prepared for the changeover to ACOs.
Jaron Bea has a message for his peers: you can’t put your heads in the sand. Bea is talking about hospital executives who are hoping healthcare reform will be repealed or, if it isn’t, that a contractual alignment with physicians will be enough to get them through the sea change coming in 2014.

Bea is uniquely qualified to speak on this topic. For the past 20 years, he’s been the head of Mercy Health System, which employs 4,200 in its hospitals, specialty centers, clinics, pharmacies, home health services, and a wholly owned and operated insurance company. In addition, he has 15 years of consulting experience helping healthcare organizations develop physician/hospital partnerships.

“ACOs are coming in 2014, and the industry overall, with only a few exceptions, is not prepared,” said Bea. “I think that will become clear in less than a year when Medicare begins its pilot program.”

Mercy Health System was the first vertically integrated health system to receive the coveted Malcolm Baldrige National Quality Award (in 2008). It has signed a professional services agreement with more than 80% of the physicians that admit to the system’s three hospitals. The more than 400 physicians are incented to work like they would in private practice but are technically employees of Mercy Health System.

Although many hospitals now employ physicians, Bea said those hospitals are still missing a critical piece of experience with healthcare insurance. “They don’t have experience controlling medical costs for a defined group of patients, distributing premiums, or using claims data to develop patient care plans and disease management programs,” he said.

Finding a formula
All hospitals, regardless of their level of integration, will experience some turmoil during the transition period when Medicare is paying on a bundled system and other insurers are still using fee for service, said Bea. He expects insurers to quickly follow suit but said the changeover period will be messy.

Some CEOs Bea has talked to are planning to move some physicians to bundled payments and leave some as fee for service. The problem with this plan, he said, is it will limit patient access, bringing back the nightmares of HMOs. “If
I’m on Medicare, and I’ve been seeing Dr. Smith and like him, and he switches to only fee-for-service patients, I will have to leave him, and I will be unhappy.”

Moving all physicians to bundled payments isn’t the answer either, as it means losing acute-care and ancillary dollars from all non-bundled payers during the transition.

To best serve patients and smooth the changeover, all of Mercy’s employed physicians will see both types of patients. Bea and his team have created a formula that will translate the Medicare bundled payments into a fee-for-service productivity credit.

The formula will ensure that physicians working with Medicare patients are compensated fairly for that, so that doctors can see any patient with any type of insurance. As always, physician salaries will be based on hitting goals for productivity, patient satisfaction, following disease management protocols to achieve quality outcomes, and meeting expense targets.

**Claims data needed**

To prepare for bundled payments, Mercy is stepping up its efforts on three fronts: disease management, standardization of care, and right-place treatment.

Climbing the steep learning curve of successful disease management will be critical, said Bea. “It represents a massive behavior change on the part of physicians. Instead of ‘You’re sick, how do I cure you?’ it needs to be ‘How do I keep you well?’”

It starts with sophisticated analysis of claims data to see what works and what doesn’t in getting patients to change behavior to, for example, keep their diabetes under control. Most likely, there will need to be financial incentives for physicians to work with chronic disease patients and lower premiums for patients who follow certain health guidelines.

Having the claims data from the 43,000 members of its health plan will give Mercy a giant leg up in this process, said Bea. He expects hospitals to begin aligning themselves with insurers and warns that these relationships can be difficult. He
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Data of another sort underpins the second focus area: care standards. Mercy is developing care plans based on national benchmarks. For example, if orthopedic surgeons on average have to do a scope on 3.4 patients out of 10 with knee pain to diagnose, and a specific surgeon is scopeing eight out of 10 patients, Mercy will address this.

First, it will advise the physician of the national standard and ask him/her to hit an interim target followed by the 3.4/10 target. If the physician does not hit the targets, he or she will be penalized financially, unless s/he can justify the reason for the extra scopes with a peer group.

Eea noted that this system can only work with physicians who are employed and paid based on key criteria. “We have to change compensation so the doctors are paid to achieve that 3.4 scopes per knee patient. But they can’t have patients complaining of knee pain. They also have patient satisfaction levels to hit,” he explained.

Specific steps
Mercy has already addressed the third component, right-place treatment, by making changes like physically moving its urgent care out of the ED. Treatment centers are located throughout the communities it serves, and their 30-minute guarantee...
encourages patients to visit them for non-emergent conditions. If they are not seen within that time, they receive a gift card.

This frees up Mercy’s EDs for serious trauma and lowers costs, since the health system insures many of the people in its community, said Bea. Lowering costs was also the impetus for building a transition unit in each of its three hospitals. These beds are for patients who no longer need acute care but are not ready to be moved to a long term care facility.

“They can get an extra two weeks of physical therapy and more physician attention than they would in a long term facility,” said Bea. He noted that even when patients are covered under bundled payments, there would still be a benefit to the system in freeing up an acute care bed.

Food for thought
The important thing to realize, said Bea, is that even if the healthcare reform law is modified between now and 2014,
lawmakers on both sides of the aisle have realized that Medicare is simply too costly. That means change is coming, whether or not hospitals are prepared.

He advises hospital executives to look at six key areas as they develop a plan for the next few years. First, identify preferred delivery methods for everything from preventive care and disease management to transitions and home care. Then, engage your physicians—administrators and physicians must work as one, with aligned goals and compensation directly tied to strategic objectives.

Third, make sure quality of care is the driver behind all of your initiatives. “Healthy patients translate into lower medical costs and a robust bottom line,” said Bea. Fourth, develop systems to analyze your data, using it to create disease management programs and integrated care decisions based on facts.

Fifth, work on defining how your organization will treat and manage disease states, working these requirements into all contractual relationships with independent providers. The requirements must include workable communication methods, data sharing, and measurable outcomes with built-in accountability features. Finally, manage risk by bringing together top leadership, physicians, clinical staff, and actuarial staff to refine the way you gather, report, and interpret data.

Simply put, Bea wants hospital executives to face the reality of healthcare reform. “Change is coming our way, whether we like it or not,” he said. “While the ACO model requires fundamental rethinking, now is the time to chart that course.”

—Jill Rose