Renaissance growing as ACO provider

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WAYNE — Marc Malloy, after being invited to testify before the Senate Finance Committee, called up his dad earlier this year to brag a little.

He didn't quite get the reaction he wanted.

"He said, 'What did you do,'" recalled Malloy, president and CEO of Renaissance Medical Management Co., a doctor-owned physician practice management company.

Malloy wasn't in any kind of trouble. Instead he was invited along with a handful of other health-care executives to talk about innovations in health-care delivery and new payment models.

At the end of last year, Renaissance was one of 32 health-care providers selected by the Centers for Medicare & Medicaid Services to participate in the Pioneer Accountable Care Organizations initiative for Medicare beneficiaries.

ACOs, which are a major component of the Affordable Care Act, encourage primary-care doctors, specialists, hospitals and other caregivers to work together to provide better, more coordinated care for populations of patients. CMS estimates the model could save Medicare, which covers health costs of the elderly, up to $1.1 billion over five years.

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Marc Malloy heads the region's lone ACO.

Under the initiative, the Medicare program will reward health-care providers that have formed ACOs based on how well they improve health outcomes and curb health care costs. Renaissance was the only local provider that applied to participate, and was selected for, the program.

"It's drawn a lot of attention to the work we've been doing here for the past 14 years," Malloy said.

David Glusman, the Philadelphia partner-in-charge for the national health-care accounting and consulting firm Marcum LLP, said he did not believe CMS offered enough financial incentives for the region's large health systems to take part in the Pioneer ACO program.

"[The doctors] at Renaissance are not beholden to a hospital, they work with the hospitals," said Glusman, who has worked with the company. "They believe, as primary-care physicians, they are in the best position to get boots on the ground as well as see the view from 30,000 feet."

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Marcum LLP

Glusman noted that while health systems didn't bite on the Medicare ACO program, they continue to work with health insurers on payment models that incorporate many of the components of an ACO. In particular, he noted, several health systems in the region have created, or are in the process of creating, co-management models with physician practices to oversee and monitor the care of heart disease patients to reduce hospital readmission rates.

Renaissance, a physician-owned company founded in 1998 by a group of private practice physicians on the Main Line, began as a multispecialty physician practice group known as an Independent Practice Association IPA. The group initially banded together to negotiate contracts with managed-care organizations.

In its second year, the doctors forged a business relationship with Keystone Health Plan East that led to the creation of a pay-for-performance arrangement between the two organizations. That experience, Malloy said, put Renaissance ahead of the curve in meeting the requirements contained in the CMS regulations governing ACOs.

Over the years, Renaissance morphed into a clinical integration group comprised mostly of primary-care practices in the Philadelphia suburbs.

When CMS selected the group for the ACO program, Malloy said, Renaissance was in the process of recruiting additional doctors. During the past year, the group grew to 250 from just under 200 physicians.

The company, which was assigned by CMS responsibility for between 25,000 and 26,000 patients, has historically had doctors from the four suburban counties that ring Philadelphia. Malloy expects in 2013 they will start adding city physicians to the group.

The company also doubled its in-house nursing staff, which help monitor patient compliance with medication adherence and follow-up care, to 15 from seven.

"When a patient gets discharged from the hospital they get a stack of paper [with care instructions] and told they should be taking all these medicines and to follow up with their family doctor," Malloy said. "Most of these patients have been through trying times and they don't understand all of that. We work with the patients and try to avoid re-admissions, most of which happen in the first 30 days."

Malloy said the company had to revamp its software to ensure it was tracking the 22 clinical measurements required by CMS. It also restructured its compensation system to include a pay-for-per formance mechanism to reward doctors for the extra work they were being asked to do.

He said for the ACO model to work, all providers will have to improve communications with each other.

"We still continue to work on the disconnect across the health-care continuum," Malloy said. "We still have situations where a patient is admitted to the hospital then discharged, and his or her primary-care doctor has no idea it happened."

On the horizon

More provisions of the Patient Protection and Affordable Care Act kick in during 2013, and two big decisions are looming for state governments — one of which has a deadline of next week. Those provisions and decisions include:

- **Insurance exchanges:** States have until Dec. 14 to decide whether to operate their own insurance exchanges, defined as a competitive marketplace where individuals and small businesses will be able to compare and purchase private health insurance coverage (and have the same insurance choices as members of Congress). States have the opportunity to tailor their exchange to meet their needs. The federal government will operate exchanges for states that opt not to participate.

- **Expanding Medicaid:** States are also wrestling with whether to expand their Medicaid programs by allowing a large group (adults earning under 138 percent of the federal poverty level) of residents to qualify. No deadline has been imposed for making the decision. Under the law, the federal government will cover a state's entire cost of Medicaid coverage for newly eligible beneficiaries from 2014 to 2016. Then, the federal government will decrease its share to 95 percent in 2017, 94 percent in 2018, 93 percent in 2019 and 90 percent in 2020 and all following years.

- **Device Tax:** The law imposes an excise tax of 2.3 percent on the sale of taxable medical devices. The measure is strongly opposed by the medical-device industry, which seeks to lobby for its repeal.

- **Bundled payments:** The law establishes a national pilot program that takes effect in 2013 to encourage hospitals, doctors and other providers to work together to improve the coordination and quality of patient care. Under payment "bundling," hospitals, doctors and providers are paid a flat rate for an episode of care, rather than the current fragmented system where each service or test is billed separately to Medicare. Savings are shared between providers and the Medicare program.

- **Drug Coverage Gap:** The law calls for closing the Medicare Drug Coverage gap, beginning Jan. 1, by phasing-in federal subsidies for brand-name prescriptions filled under Medicare Part D.

- **Itemized deduction:** The law raises the starting point for the itemized deductions for unreimbursed medical expenses from 7.5 percent of adjusted gross income to 10 percent. The increase will not apply to individuals age 65 and older for tax years 2013 through 2016.

- **CHIP:** States, effective Oct. 1, will receive two more years of funding for the Children's Health Insurance Program to continue coverage for children not eligible for Medicaid.

Source: Department of Health and Human Services.

MODEL: 300 practices in IBC's network are now medical homes

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tional costs.

IBC has also created similar pay-for-performance models for health systems and the primary-care doctors and specialists they employ. Snyder said about 80 percent of the health systems it has contracts with have an "accountable-care type of payment system" in place.

Greater patient tracking and monitoring means medical home model practices rely more on technology.

IBC took a step to help providers use technology more effectively in February when the company teamed up with Pittsburgh-based Highmark and Horizon Blue Cross Blue Shield of New Jersey plus health information technology provider Lumeris Corp. to acquire Navinet, a real-time communication network for physicians, hospitals and health insurers.

Over the past four years, IBC's experiment with the patient-centered medical home model has yielded significant improvements in the health status of patients with conditions such as diabetes, high cholesterol or high blood pressure, according to the company's data. The percentage of patients who have a plan for managing asthma, for example, has increased 69 percent since 2008, while the percentage of patients getting flu vaccines has increased 43 percent. More diabetics are regularly measuring their blood sugar levels or checking their feet for sores, and IBC has observed improvements in diabetic patients' blood pressure levels and percentage of LDL, the "bad" cholesterol.

Later this month, IBC expects to release the results of studies on cost savings achieved through the initiative.