CASE STUDY

Palm Beach Accountable Care Organization Leverages Real-Time Alerts to Capture More Transitional Care Management Revenue and Savings

Palm Beach Accountable Care Organization worked with the Florida health information exchange (Florida HIE) to deliver the Encounter Notification Service® (ENS®), powered by Audacious Inquiry, allowing them to capture 10% more Transitional Care Management revenue, which generated $30 million in savings.

Physician-Owned Accountable Care Organization Focuses on Primary Care Services

Palm Beach Accountable Care Organization (PBACO) is a is a wholly physician-owned and operated organization that consists of 275 primary care providers (PCPs) and 175 specialist physicians in the Palm Beach area of Florida. The organization was founded in 2012 and is responsible for more than 79,000 Medicare patients.

With so many Medicare patients, PBACO aims to capture revenue from Transitional Care Management (TCM). In 2013, Centers for Medicare & Medicaid (CMS) began reimbursing healthcare facilities for certain transitional care services for Medicare patients in the 30 days following a hospital discharge to improve care coordination. .

In September of 2015, PBACO started receiving admit, discharge, and transfer (ADT) data feeds from Florida HIE Services, to drive an increase in follow-up visits and reduce expenses post-discharge.

After adopting ENS, Palm Beach ACO became the second-highest earner of shared savings towards the MSSP program, contributing a 10% increase in Transitional Care Management revenue captured—generating $30 million in savings for the ACO.

The Challenge: Reducing Readmissions for Medicare Patients

Reducing readmissions is a priority for ACOs, payers and other at-risk entities. Likewise, CMS has been trying to reduce the readmission rates for Medicare patients discharged from an acute care facility or inpatient stay for over a decade. Nearly 20% of Medicare patients discharged from the hospital are readmitted within 30 days, costing $17.4 billion a year. The high cost of readmissions is one of the reasons CMS implemented the TCM program to incentivize healthcare providers to focus on care coordination post-discharge by

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reimbursing the cost of transitional care services within the 30-day period following discharge from an acute care facility.

Research shows that Medicare patients receiving TCM services have lower readmission rates. One study published in 2019 in the Journal of American Medical Quality found that Medicare patients receiving TCM services had an 86.6% lower chance of readmission in the 30 days after a hospital discharge than those who were not. Only 3.7% of Medicare patients included in the study experienced a readmission. Another study about the impact of transitional care coordinators (TCCs) on readmissions published in Contemporary Clinical Trials in 2019 found that patients receiving TCC support had lower rates of readmission and reduced costs at both 30- and 90-days post-discharge.

However, to provide these transitional care services, the patient's care team needs to be informed when there has been an admission or discharge from an acute care or inpatient facility. Relying on claims data can take too long, while putting the burden of clinical communication on a patient is not a reasonable solution. Receiving TCM revenue from Medicare requires providers to meet strict deadlines for outreach, so losing a few days between discharge and notification of the encounter can be detrimental to capturing the TCM billing opportunities.

This is where admit, discharge, and transfer (ADT) data from a health information exchange (HIE) can prove to be the ideal solution for healthcare providers who want to capture more TCM revenue and provide timely outreach to Medicare patients following an encounter with a hospital or other inpatient facility. A provider can work with a health IT company to set up alerts in their electronic health record (EHR) to notify them when a patient is admitted, discharged, or transferred to provide coordinated care and outreach.

ADT Feeds Enable Better TCM Opportunities

In September of 2015, PBACO started receiving ADT data feeds with Audacious Inquiry's Encounter Notification Service® (ENS®) in collaboration with Florida HIE Services, letting them know when their Medicare patients were admitted, discharged home or transferred to another healthcare facility. The goal of the ADT feeds program was to increase follow-up communication and visits, minimize the risk of a readmission, and reduce expenses post-discharge. The ADT feed allowed PBACO to capture TCM revenue across all discharge types—saving on average $1,882 (up to $2,092 within one week) and if TCM was captured after inpatient admissions, potential savings would be $3,149 (limit $3,427 within one week).

Outcomes: Lowered Readmission Rates, Higher Shared Savings

After adopting ENS, PBACO became the second-highest earner of shared savings toward the Medicare Shared Savings Program (MSSP) program from 2013 to 2015, and during the 2016 period, the organization was identified as the **top earner of Medicare savings out of 432 ACOs.**[1] PBACO contributed $62 million to the MSSP in 2016, which earned the ACO **$30 million in savings**.[2]

With ADT alerts, patients are placed at the center of care when their providers have access to their health information and are better able to share that information with one another. As a result of more proactive coordinated care, patient satisfaction and outcomes increased, and PBACO's patient satisfaction score is 96.2%. They were also **ranked #4 out of 37 ACOs in Florida for quality of care.**

Having access to patient counter alerts in real-time through ENS allows providers to capture $250 for each telephone follow-up within 48 hours of discharge and office visit within 7 days post-discharge. Across all discharge types, the largest opportunity to leverage TCM was found to be within one week from an inpatient discharge, which **lowers the readmission rate by 12% from 40% to 28%.** [3]

> **"ENS is our single most valuable service and allows us to provide point of care interventions that we would not have otherwise known existed. After having ENS, we can't imagine operating an ACO without it.**
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> **— DAVID KLEBONIS CHIEF OPERATING OFFICER PALM BEACH ACCOUNTABLE CARE ORGANIZATION**

[1] Mandros, A. (2016, September 19). Who Are The 'Big Winners' of Medicare ACO Bonus Payments? [Blog post]. Retrieved from Open Minds website: https://www.openminds.com/market-intelligence/executive-briefings/acos-leading-way/

[2] Morse, S. (2017, October 30). OCT 30, 2017MORE ON ACCOUNTABLE CAREA third of Shared Savings ACOs earned more than $700 million in savings [Blog post].Retrieved from Healthcare Finance website: http://www.healthcarefinancenews.com/news/third-shared-savings-acos-earned-more-700-million-savings

[3] Zucker, H., Gray, C., Kotch, A., & Klebonis, D. (2017, October). Post-Acute Care Costs: Overcoming a Roadblock on the Path to Shared Savings. Presented at FLAACOS Conference, Orlando, FL.