Accountable Care: What Are ACO's and Why Should I Care? The Move From Volume to Value

HCANJ

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Learning Objectives

- What is the current environment causing us to look at ACO's
- What is an ACO structure
- What payers are creating ACO's and in what situations
- The role of senior living providers and other providers will play in an ACO
- How to position your organization to part of an ACO

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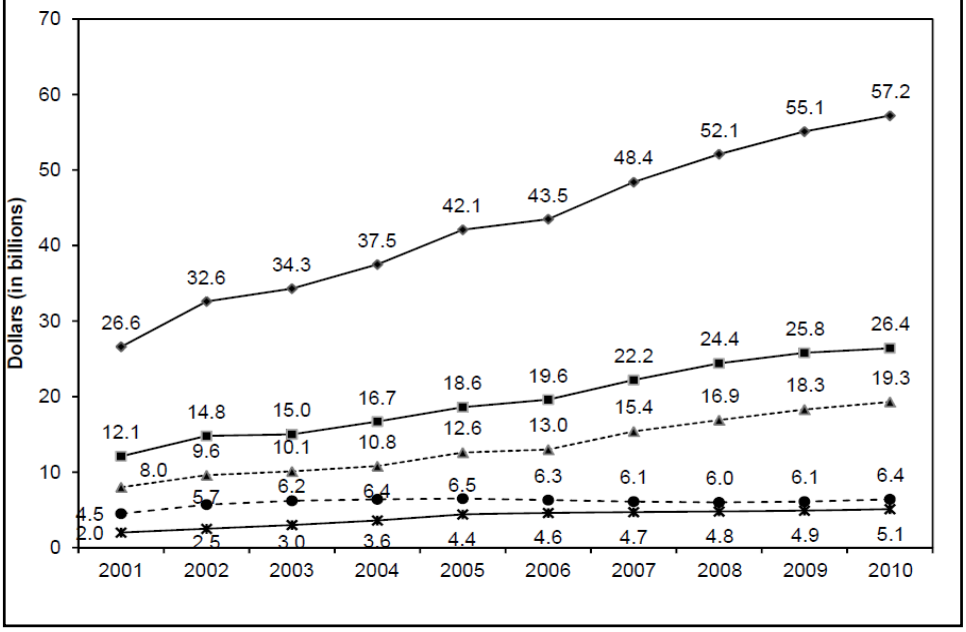
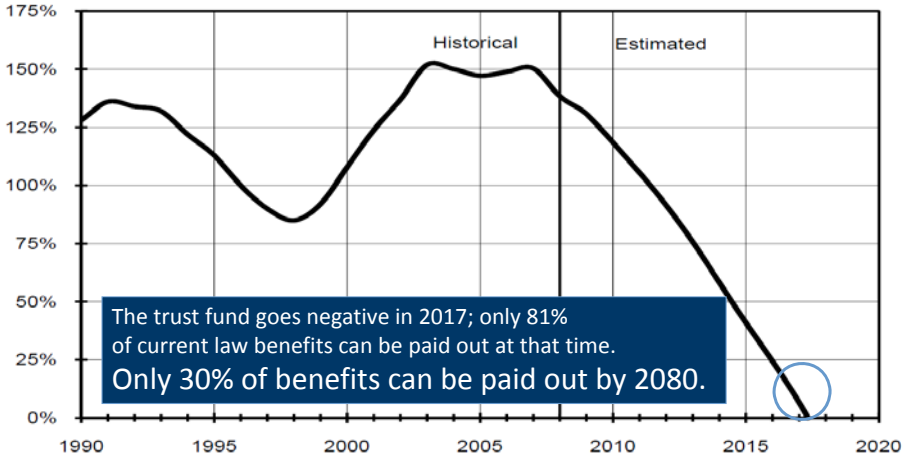
THE WORLD WE LIVE IN…

Growth is Unsustainable…



And Medicare is Running out of Money…

Figure II.E1.—HI Trust Fund Balance at Beginning of Year as a Percentage of Annual Expenditures



Source: 2009 Trustees Report, CMS, page 17

Threads of Reform

- Reduce hospital readmissions
- Patient-centered care/experience
- Improved care transitions
- Health information sharing/exchange
- Prevention/wellness
- Chronic care management
- Total cost of care
- Integrated, coordinated, seamless care
- Higher quality, cost effective care
- Value-based payment to replace FFS
- Targeting high-cost, high-risk patients

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Message to Aging Service Providers: Critical Issues to Address

1. **Conducting business** under a reformed health care model
   - *New relationships, requirements of accountability; volume to value; rural vs. metro; multiple and changing payment streams; acceptance of risk*
2. Changing perceptions and buying habits of **consumers**
   - *Adaptability and flexibility; Blending the need for hospitality (short stay) with a desire for a residential feel (long term)*
3. Implications and applications of **technology**
   - *Treatment technologies; Information exchange; Predictive treatments; Consistency of delivery methods*
4. **Accessing Capital** in a post-recessionary environment
   - *Planning and positioning in advance of need*

Health Care Reform Activities

- Patient Protection and Affordable Care Act
  - A "bend the curve" approach to systemic change
  - Currently being reviewed by the Supreme Court
- Commercial Payer, Self-Insured Employer, and CMS payment reform activity
  - Changes to policy design
  - Population health management
- **Accountable Care Organizations and Health Systems**
  - **Centered around the triple aim**
  - **Re-aligned incentives**
  - **Selling their own insurance (ex., Kaiser, Steward)**

Supreme Court Examines Constitutionality

U.S. Supreme Court Ruling: June 28, 2012

Individual Mandate
- Constitutional

Whole Law
- Stands

Medicaid Expansion
-State Option

Supreme Court Action Irrelevant:
The market is driving reform not PPACA

- According to a Dec. 2011 Payor Market Survey conducted by HealthEdge, of the 100 payors responding :
  - 48% plan on leveraging value-based benefit design plans
  - 51% plan on utilizing pay-for-performance models
  - 55% plan on participating in accountable care organizations

Examples

- Cigna has set a goal of 1.4 million enrolled in ACOs by 2014 (currently have 17 ACO arrangements covering 100,000 lives)
- UnitedHealth Group has new value-based contracts for hospitals and physicians based upon quality and efficient care metrics. Payments are withheld if certain standards aren't met.

Source: Press Release from HealthEdge, as accessed on 04/13/12 at: http://www.healthedge.com/pages/news_events/press_releases/111214-2011_Market_Survey.htm ; and : "5 New ACOs Announced This Year; What Does the Future Hold for Accountable Care?" – as accessed on 04/13/2012 at : http://www.beckershospitalreview.com/hospital-physician-relationships/5-new-acos-announced-this-year-what-does-the-future-hold-for-accountable-care.html

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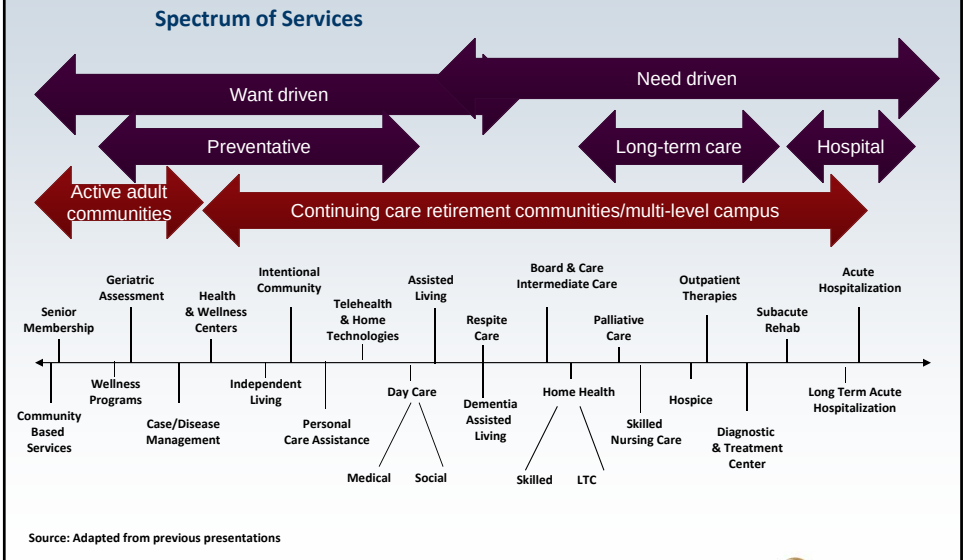
The Field of Aging Services is Evolving:
Where will *YOU* fit?



Source: Adapted from previous presentations

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HEALTH CARE REFORM: WHAT? HOW? WHEN?

Reform at the Core: The Triple Aim Goals

- **Better Care**
  - Improve/maintain quality and patient outcomes
  - Eliminate avoidable re/admissions
  - Eliminate potentially preventable conditions (e.g., never events)
- **Better Health**
  - Primary Care Driven
  - Focus on Prevention & Wellness
- **Reduce Cost**
  - Reduce/eliminate duplication
  - Improved coordination

Initiatives to Watch…

- ACOs and Integrated Care Delivery Systems
- Value-Based Purchasing
- Bundled Payments for Care Improvement
- Rehospitalizations and Quality Measures
- Commercial Market Activity

While much is uncertain, in general, the market will follow Medicare…

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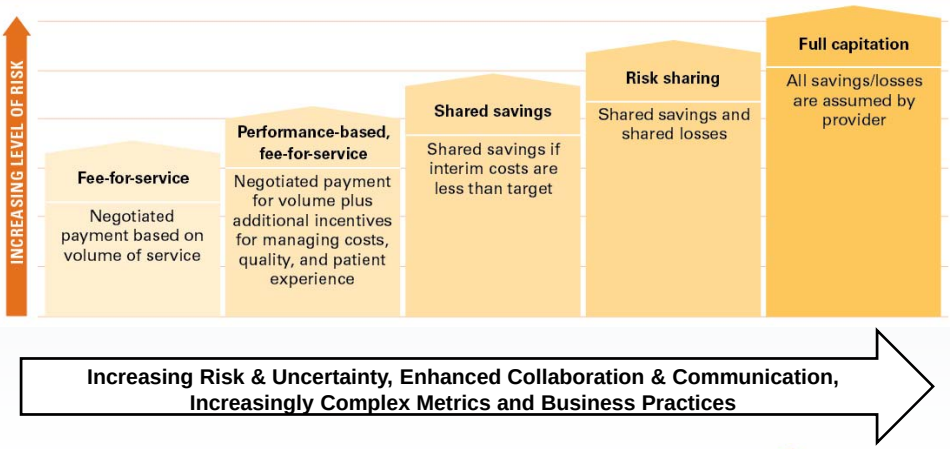
New Payment Models
Spectrum of Payment Options

Spectrum of Payment Models for Health Plans and Providers



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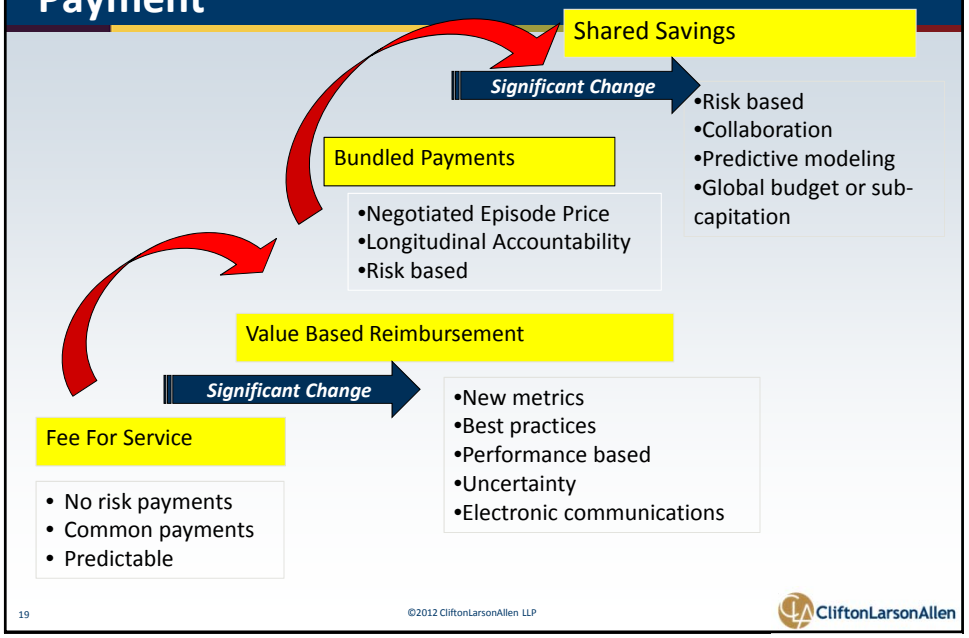
Making the Transition to Performance Based Payment



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Post-Acute Provider of Choice

Low/no hospital readmissions

Meaningful Use of Electronic Health Record

Past success partnering with other providers

High Quality

- **Top of Class in Nursing Home or Home Health Compare**
- **High patient satisfaction**
- **Robust continuous quality improvement**
- **Innovative care delivery approaches**
- **Good community reputation**

Demonstrated patient-centered approach to care

Cost of Care is lowest in comparison to peers with comparable quality.

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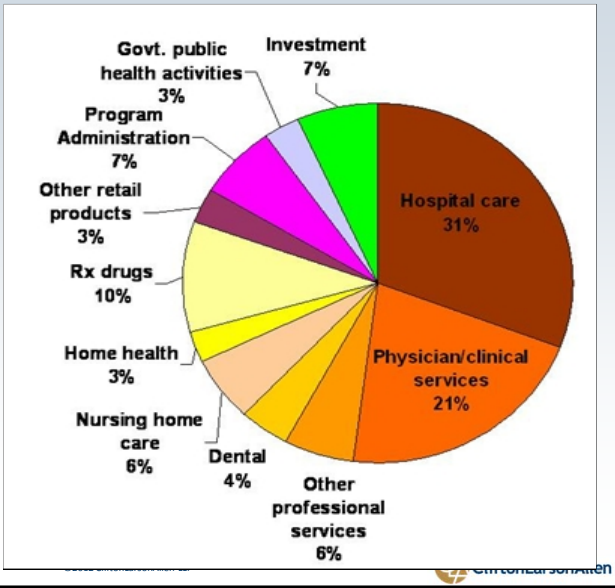
Why Isn't Post-Acute a Burning Issue?

Here's Why:

SNF care (or home health for that matter accounts for very small fraction of the total healthcare dollar in any given market.

They'll get to us.

Will you be ready?



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ACOs & the Total Cost of Care

A group of health care providers working together to manage and coordinate care for a defined population, that share in the risk and reward relative to the total cost of care and patient outcomes.

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Key Aspects of Medicare ACO Rules

- **ACO Participants Defined**
  - Hospital, including Critical Access Hospitals
  - Physician groups
  - SNFs, comprehensive outpatient rehabilitation facility, home health agency, or a hospice
  - FQHCs and Regional Health Centers
- **ACO Exclusivity**
  - Primary care providers = yes
  - All other providers/suppliers = no

$1.7M is CMS estimate for total average start-up investment and the first year of operating expenses

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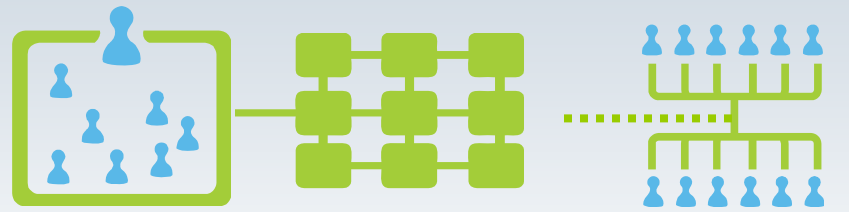
Health Care Delivery: ACO Network

ACO Network



ACO Providers: Bonus-Eligible	Non-ACO Preferred Providers	Non-Preferred Providers
Primary Care Practitioners Hospitals	"Value" Providers	Low Quality, High Cost Providers

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Medicare ACO Programs

Medicare Shared Savings Program (MSSP)

- Original intent – to be established no later than January 1, 2012
- Program requires the participating providers to form an ACO
- 5,000 Medicare beneficiary minimum for participation
- Two tracks: Winnings only, Winnings/Losses
- Two 2012 start dates: 4/1/2012 & 7/1/2012

Pioneer ACO Program

- For organizations with prior ACO-like experience
- Requires participants to enter into outcomes-based contracts with multiple payers.
- Assignment of minimum of 15,000 Medicare beneficiaries
- Model transitions to greater financial accountability(risk) faster.

Medicare ACO Requirements

Requirements:

- Accountable for quality, cost and care
- Legal structure to receive/distribute incentives
- Sufficiency of PCPs to accept a minimum of 5,000
- Promote evidence-based medicine & patient engagement
- Patient-centered care processes
- Leadership and management structure
- Report on quality measures and other performance data
- Three-year agreement

Final Medicare ACO Rules:
Beneficiary Assignment

Beneficiary assignment is:

- **Prospective** at the beginning of each performance year
- **Updated quarterly** based upon most recent 12 months of data
- **Reconciled** at the end of the performance year

Methodology

- Identify all primary care services provided by physicians within most recent 12 months
  - FQHCs/RHCs primary care services included if meet certain criteria
- Beneficiary assigned to the ACO whose PCP provided the greatest portion of primary care services
- For unassigned beneficiaries, they will look at primary care services received by other non-primary care physicians and/or other ACO professionals such as nurse practitioners.

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Medicare ACO: Quality and Reporting

- **Performance assessment is the same for MSSP, Pioneer & Advance Payment models**
- **ACOs Must Meet Minimum Quality for 33 Measures**
- **Year One Quality Metrics Fall Into Four Domains**
  - Patient/caregiver experience (7)
  - Care Coordination/Patient Safety (6)
  - Preventive Health(8)
  - At-Risk Population(12)

- **Must report on quality measures in all 3 years of contract**
  - **Year 1:** Pay for "complete and accurate" reporting of on all 33 measures
  - **Year 2 :** Pay for performance on 25 measures, pay for reporting on 8 measures.
  - **Year 3**: Pay for performance on 32 measures, pay for reporting on functional status measure.
- National ACO quality benchmarks to be released at beginning for 2nd performance year.

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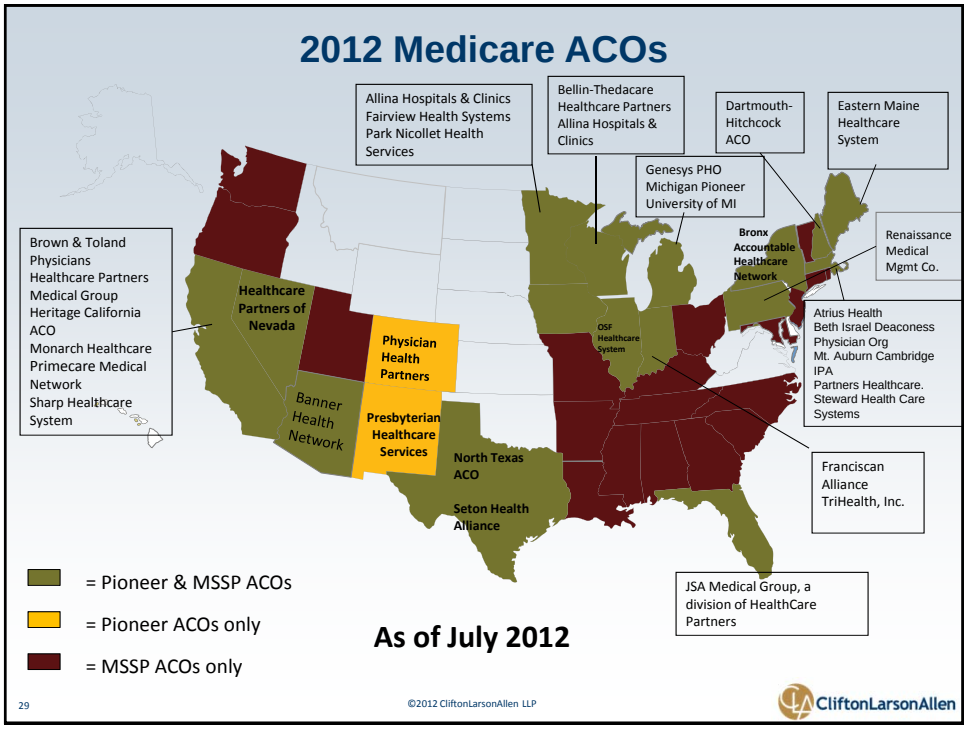


Commercial ACOs Announced in 2012 in US

- **Westmed Medical Group:** a multi-specialty practice based in Purchase, N.Y., which includes more than 220 physicians
  - Plan partners: UnitedHealthcare and Optum.
  - Received level-3 recognition for its patient-centered medical home from the NCQA.
- **Fairview Health Services** (Minneapolis, MN): April 1, 2012 launched a collaborative ACO with Minneapolis-based Medica health plan and includes 350 clinics and seven hospitals . Fairview is also a Medicare Pioneer ACO.
- **Hoag Memorial Hospital Presbyterian (Newport, CA)**formed an ACO with Blue Shield of California and Greater Newport Physicians Medical Group, operational July 1, 2012. This will be Blue Shield of California's sixth commercial ACO in CA.
- **Weill Cornell Physician Organization(NYC)** launched a patient-centered ACO with Cigna and its roughly 71 primary care physicians. This is the first NYC-based patient-centered ACO between a payor and a physician organization.

Source: "5 New ACOs Announced This Year; What Does the Future Hold for Accountable Care?" – as accessed on 04/13/2012 at : http://www.beckershospitalreview.com/hospital-physician-relationships/5-new-acos-announced-this-year-what-does-the-future-hold-for-accountable-care.html

What are the ACOs Doing?

- **Many of the ACOs are focused right now in two major tasks:**
  1. **Attribution** – sorting out which Medicare beneficiaries may be "IN" or "OUT' of the ACO.
  2. **Physician Participation** – figuring out which primary care physicians are going to participate**.**

Secondarily

Some are still sorting out IT/EMR issues, quality management, communication and so on.

Post-acute care, while recognizably important, is not far up on the priority list for many.

Value-Based Purchasing

Providers receive a financial reward for achieving or exceeding an established outcome for pre-defined measures

Types of Performance Measures
- Cost of care
- Process of care
- Outcomes of care
- Structural
- Patient satisfaction

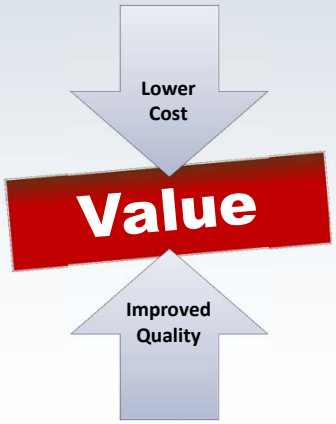
The Foundation: Value-Based Payment

Value Based Payment: *"a reform initiative whereby health care providers will receive payment for service based on their performance or the potential outcomes of the service"*

Tying payment to performance is perhaps the most significant aspect of health care reform.

The de facto definition of "value" in health care reform is the intersection of lower cost and improved quality.

Providers who can lower costs and deliver quality will be measured as "value-based providers"



Bundled Payment: General Definition

A single, fixed per person payment paid to provider(s) for the provision of all services and expenses for an episode of care or for the management of a chronic condition for an individual.

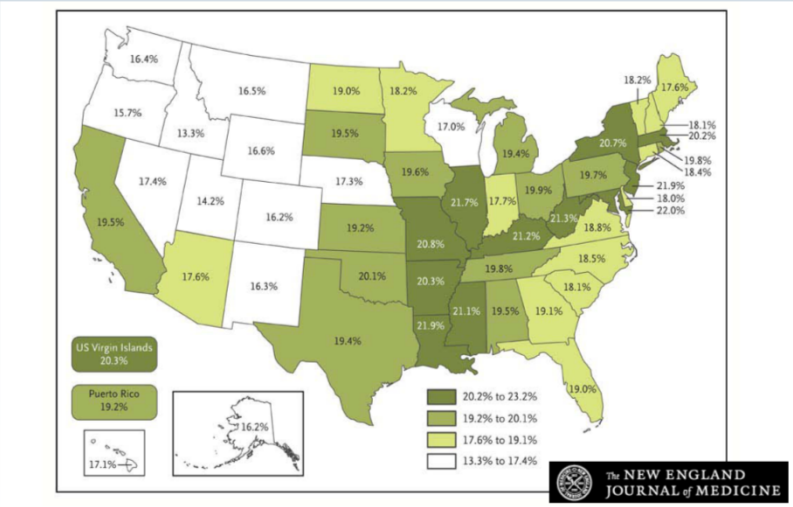
Bundled Payments for Care Improvement Initiative

- Announced on August 23, 2011, the Centers for Medicare & Medicaid Services (CMS) announced its first bundled payment framework for testing out of the Center for Innovation
  - **The Bundled Payments for Care Improvement Initiative**
    - ◊ Tests four models of bundled payment related to an inpatient stay
      - Two models look only at the inpatient stay itself
      - Two models look at post-acute services
      - One model is prospective payment vs. the other three which are retrospective
      - Target price must be set based upon individual provider's cost history.
    - ◊ Goal is to redesign care to deliver the Triple Aim
      - Gainsharing to align provider incentives will be permitted
- Applications due ~~April 30, 2012~~ ~~May 16, 2012~~ June 28, 2012

Reducing Hospital Readmissions – Oct. 1, 2012

- CMS will rank hospitals based on 30-day readmission rate for heart attack, heart failure and pneumonia
  - Not limited to preventable, avoidable readmissions
  - Applies even if readmitted to another hospital
- Those in bottom quartile (nationally) from prior year will have a % of **total** Medicare payments withheld
  - **FY2013: Up to 1%** ***PENALTIES ASSIGNED AUG. 2012***
  - **FY2015: Up to 3%**
- Allows Secretary to expand policy to additional conditions in future years.
- Requires Secretary to publish patient hospital readmission rates for certain conditions.
- Does not apply to critical access hospitals

Hospital Readmission Rates Vary Across the Country!



Jencks S, Williams MV, Coleman EA. et al. N Engl J Med 2009;360:1418-1428

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Understanding Bundle Characteristics

Total Indexed Admissions	**1,000**
Total Admissions	**1,327**

Service	Including Readmissions: Indexed Avg Cost	Including Readmissions: Total Cost	Indexed Admissions: Indexed Avg Cost	Indexed Admissions: Total Cost
Hospital	$ 12,040	$ 12,040,359	$ 8,662	$ 8,661,981
SNF	3,134	3,133,676	-	-
HHA	2,169	2,168,509	-	-
MD	3,535	3,535,248	1,975	1,975,175
All Other	654	653,696	-	-
Total Costs	**$ 21,531**	**$ 21,531,488**	**$ 10,637**	**$ 10,637,156**

Bundle Risk: Approximately 51% of total bundle costs occurred post-discharge!

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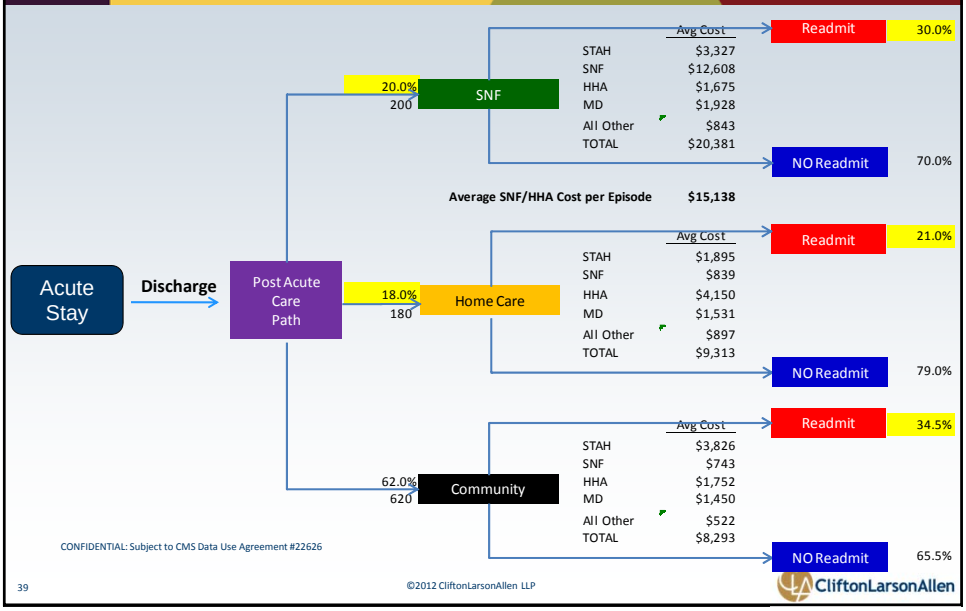
The Post Acute Care Path and Impact on Bundle



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Preferred or Select Provider Networks

- The development of "preferred" or "select" provider networks is taking center stage in many markets around the country.
  - Many organizations have stated publicly that they "work with too many nursing homes right now" and expect that they will refer to a "much smaller group of facilities in the future".
  - Other organizations have already identified groupings of "select" providers and are actively working with them to develop skills, encourage measurement and improve communication.
  - And a very select group of organizations have established networks, developed evaluative criteria, gone through iterations of revision and created models for others to follow.

In all of these scenarios, some degree of measurement plays a key role in determining if you are on the field or on the bench.

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RESPONDING TO REFORM

Strategies for Aging Services Providers

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Responding to Reform

The BIG Picture

Decide: lead, follow, resist

Prepare to assume risk

Use technology better

Align providers interests

Connect quality to value

Build new relationships

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Evolving Tools to Track and Trend Data

- **To become value-based providers, we must develop platforms for both capturing and trending outcome data.**
  - Surveillance tools to monitor readmission issues, identify high-risk patients and establish protocols for intervention
  - Effective surveys or consumer interfaces to gather real-time (or near-to-real-time) data about patient perceptions of care and quality
  - Systems that can measure and report actual patient improvement from admission to discharge: functional status improvement

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The Post-Acute Provider Value Proposition

Hospitals and ACOs need to know what differentiates you from your competitors. How can you be their low cost, high quality value provider of post-acute services?

Mine Your Data

- 30-Day Readmission Rates
  - By MS-DRG
- Average time to place patient
- Average LOS
- Quality Measures
  - Ex., Pressure Ulcers, UTIs, Restrains
- Programmatic foci
- Chronic Disease Management Outcomes
- Resident and Family Satisfaction

Tell Your Story

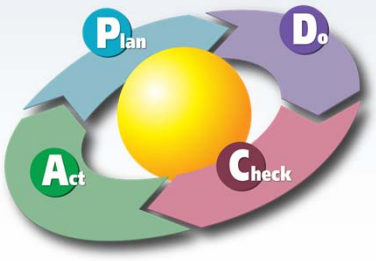
- Where do your referrals come from?
- What MS-DRGs do your referral sources send you?
- How do your currently admit and discharge patients?
- How many MD or mid-level hours are available to your patients?
- How do you prepare patients for discharge?
- How do you monitor patients after discharge?
- ***Ask about and listen to their needs.***

Use Dashboards to Articulate Value

Can You Build a Dashboard?

1. Pick the data points and start measuring.
2. At the outset, benchmark against yourself, month-to-month.
3. Identify the problem areas and work to correct them; embrace Deming: Plan-Do-Check-Act

"Cease dependence on <u>inspection</u> to achieve quality. Eliminate the need for massive inspection by building quality into the product in the first place."



Potential Aging Services Provider Strategies

- Develop a distinctive advantage through:
  - ✓ Integration across sites of service
  - ✓ Creating better customer experiences
  - ✓ Being the employer of choice
  - ✓ Demonstrated quality outcomes
- Build technology infrastructure to support workflow and quality measurement
- Integrate and/or offer community based services
- Quality initiatives should incorporate best practices and go beyond compliance
- Develop business process improvements that will increase efficiencies and effectiveness
- Influence and participate in the development of public policy
  - ✓ Certificate of Need/Moratorium Exception
  - ✓ Capacity analysis
  - ✓ Eligibility criteria and service coverage for governmental payers
  - ✓ Reimbursement models
  - ✓ Demonstration projects
- Understand the interrelationships of the various demand influencers

Growing Clinical and Patient Management Skill

- **For many of us, growing clinical skill will require new ways of thinking and clinical training.**
  - Developing clinical pathways for common patient types, like CHF, COPD, Pneumonia, Stroke and other diagnoses.
  - Increasing or evolving current physician strategies to support around-the-clock coverage
  - Adopting evidence-based protocols, like INTERACT2, to better manage high-acuity patients
  - Evolving to or partnering for post-discharge management: Care Transitions, Health Coaching or geriatric care management.

Continuum Management of Patients

- **Senior care in the future will be tied less to "locations" and more to "services".**
  - In effect, the providers that can continue to evolve beyond their real estate will likely be best positioned in the future.
  - Evolving community continuums will emphasize home and community-based services to keep people health and independent at home.
  - Organizations can approach continuum management through two general approaches:
    1. "Own" a continuum through internal development of services
    2. "Partner" a continuum through relationships with other, similar community-oriented organizations

Relationships Are Mandatory Going Forward

- **Growing new relationships sometimes poses a challenge for us, and you can't be an island in the future.**
  - What is the role and function of business development in your organization?
  - How well do you really KNOW your major referring organizations? Who really holds the relationships?
  - Are there other providers with whom you can collaborate or partner?
  - With whom are you willing to share risk?

Up to Your Knees, or Up to Your Neck?

Ask Yourself:

How Far Do You Want to Get In?

What is your current business strategy?

How much Medicare do you currently manage?

What is your level of diversification?

Do you have capacity to grow or expand?

Can you partner or affiliate with others?

Do you have **energy** to take it all on?

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IN CONCLUSION…

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"Strawman" Strategic Priorities for Health Care Providers

1. In each market in which you operate, position your organization to be #1 or 2 for key referral sources and collaborative partners
2. Develop / coordinate / collaborate to create a full continuum of capabilities in each market
3. Continue to investing technology and update physical plants to meet contemporary requirements
4. Improve operating performance and build balance sheet

***Overall focus**: assemble basic performance data – tighten pre- and post-acute network – focus on developing relationships with Providers that will ultimately control or influence flow of funds*

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Q&A

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Thank you!

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