What is an Accountable Care Organization & Why is it Important to Your Home Infusion Company?

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Disclosures

The speaker declares no conflicts of interest or financial interest in any service or product mentioned in this program.

Clinical trials and off-label/investigational uses will not be discussed during this presentation.
Overview

• Eastern Maine Healthcare Systems
• Patient Centered Medical Homes
• Affordable Care Act Health Homes
• Innovation – Pioneer Accountable Care Organization
• Opportunities for Infusion Therapy
Eastern Maine Healthcare Systems (EMHS)

• The mission of EMHS is to maintain and improve the health and well-being of the people of Maine through a well-organized network of local health care providers who together offer high quality, cost-effective services to their communities
• EMHS serves two-thirds of Maine’s geography
• Strong culture of health information technology
EMHS Members

- 8 Hospitals
  - Tertiary Trauma Center
  - Psychiatric Hospital
  - General & Critical Access Hospitals
- 8 Nursing Facilities
- 1 Continuing Care Retirement Community
- Emergency Transportation (Ground & Air)
- Pharmacy
- Physician Practices
- HomeCare & Hospice (Eastern Maine HomeCare & VNA Home Health Hospice)
- Cooperative Member New England Life Care (Home Infusion)
EMHS Innovation

• 2010-2013 one of 17 National Beacon Communities advancing Health Information Technology to improve quality and lower the cost of care

• Participant CMMI Patient Centered Medical Home Multi Payer Demonstration Project

• Affordable Care Act Health Home Participant

• Original CMS Pioneer Accountable Care Organization
OH MY, I am an independent provider.

Will this presentation apply to me???
YES!!!!!
Our Goal for Today

• Deepen your knowledge regarding the accountable care organization (ACO) business model via examining early ACO results and how they are shaping the future of integrated care delivery.

• Understand population health management and current efforts to better manage chronic medical conditions through "medical home" care models.

• Discuss approaches for enhancing the role of your home infusion therapy business in local population health management initiatives.
Patient Centered Medical Homes

“A medical home is not a building, house, or hospital, but rather an approach to providing comprehensive primary care. A medical home is defined as primary care that is accessible, continuous, comprehensive, family centered, coordinated, compassionate, and culturally effective.”

American Academy Pediatrics
Patient Centered Medical Homes History

• 1967 - American Academy of Pediatrics Introduces term “Medical Home”
• 1978 – International Conference on Primary Health Care adopts first international declaration of primary care role in promoting health, support also provided by the World Health Organization
• 1996 – IOM publishes Primary Care: America’s Health in a New Era
• 2002 – Future of Family Medicine project is launched and chronic care model is born
• 2005 – Researcher Dr. Barbara Starfield publishes “Contribution of Primary Care to Health Systems and Health
• 2006 – ACP develops The Advanced Medical Home: patient Centered Physician Guided Model of Health Care
• 2008 – NCQA and JCAHO launch medical home accreditation
• 2010 – Affordable Care Act includes numerous provisions for enhancing primary care and medical homes
• 2010- CMMI Multi-Payer Advanced Primary Care Practice Demonstration Project
PCMH Provider Perspective

http://www.youtube.com/watch?v=2j5imY8yvtA
Traditional Primary Care & PCMH

**Primary Care**
- Fee for Service Drives Productivity
- Focus on physician role in patient care
- Patient individual health status
- Care Coordination external to focus on acute needs of the patient

**PCMH**
- Accountable for Patient Outcomes
- Physician is a member of the health care team
- Health status of population served by the practice
- Coordination of Care is integrated
- Patients are engaged in their care
- Technology is an essential tool
Medical Home Demonstration Projects

• In 2011 CMS Center for Innovation creates “Multi-Payer Advanced Primary Care” (MAPCP) demonstration project

• Eight States selected to participate
  – Maine
  – Rhode Island
  – Vermont
  – New York
  – Pennsylvania
  – North Carolina
  – Pennsylvania
  – Minnesota
  – Michigan
Purpose of the Demonstration Project

- To evaluate advanced primary care when supported by Medicare, Medicaid and private health plans:
  - Reduce variation, utilization and expenditures
  - Improve safety and effectiveness of care
  - Increase participation of beneficiaries in decision making
  - Increase availability and delivery of evidence-based care
CMMI Multi-payer Demonstration Project Model

• Under this demonstration program, Medicare will participate in existing State multi-payer health reform initiatives that currently include participation from both Medicaid and private health plans.

• The demonstration program will pay a monthly care management fee for beneficiaries receiving primary care from APC practices. The care management fee is intended to cover care coordination, improved access, patient education and other services to support chronically ill patients.

• Additionally, each participating state will have mechanisms to offer APC practices community support and linkages to State health promotion and disease prevention initiatives.
Maine CMMI Demo Medical Home Payment

- PCMH Participants Must be NCQA Accredited
- Medicare, MaineCare and Commercial Insurers provide PCMH’s with additional payment
- Medicare Payments – Demonstration Project
  - $7 pmpm to providers,
  - $3 pmpm for community-based care teams
- Maine projections to achieve budget-neutrality (i.e. to reach $10 pmpm savings):
  - 6-7% decrease in inpatient admissions
  - 5% decrease in ED visits
  - 5% decrease in specialty consultations, imaging
NCQA PCMH Designation

- **Enhanced Access & Continuity**: Accommodate patient needs with access and advice during and after hours, give patients and their families information about the medical home and provide team based care
- **Identify and Manage Patient Populations**: Collect and use data for patient management
- **Plan and Manage Care**: Use evidence-based guidelines for preventive, acute and chronic care management including medication management
- **Provide Self-Care Support and Community Resources**: Assist patients and families in self care management with information tools and resources
- **Track and Coordinate Care**: Track and coordinate tests, referrals and transitions in care
- **Measure and Improve Performance**: Use performance and patient experience data for continuous quality improvement
Maine PCMH Core Expectations

1. Demonstrated physician leadership
2. Team-based approach
3. Population risk-stratification and management
4. Practice-integrated care management
5. Same-day access
6. Behavioral-physical health integration
7. Inclusion of patients & families
8. Connection to community / local community resources
9. Commitment to waste reduction
10. Patient-centered HIT
Maine PCMH Sites
CMMI Multi-payer Demonstration Project Model Extended

• September 24, 2014 CMS announced that the demonstration project would be extended for two years for six participating states (Maine, Michigan, North Carolina, New York, Rhode Island and Vermont)

• CMS commented that the extension is to help bridge the gap between the end of the pilot and the start date for the new chronic care management fee codes

• Extension focused on states with community care teams that would not be eligible to bill under the new chronic care codes
PCMH National Success

- PCMH studies continue to demonstrate impressive results improvement

<table>
<thead>
<tr>
<th>PEER-REVIEW/ACADEMIA</th>
<th>Total Studies</th>
<th>Cost Reductions</th>
<th>Fewer ED Visits</th>
<th>Fewer Inpatient Admissions</th>
<th>Fewer Readmissions</th>
<th>Improvement in Population Health</th>
<th>Improved Access</th>
<th>Increase in Preventive Services</th>
<th>Improvement in Satisfaction</th>
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</thead>
<tbody>
<tr>
<td>Reported outcomes</td>
<td>(n=13)</td>
<td>61% (n=8)</td>
<td>61% (n=8)</td>
<td>31% (n=4)</td>
<td>13% (n=1)</td>
<td>31% (n=4)</td>
<td>31% (n=4)</td>
<td>31% (n=4)</td>
<td>23% (n=3)</td>
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</table>

| INDUSTRY REPORTS     | Reported outcomes | 57% (n=4) | 57% (n=4) | 57% (n=4) | 29% (n=2) | 29% (n=2) | 14% (n=1) | 29% (n=2) | 14% (n=1) |

Source: Patient Centered Primary Care Collaborative Annual Update January 2014
National Opportunity Health Homes - 2013

- Included in the Affordable Care Act
- CMS will provide 90/10 match for Health Home services to eligible members for eight quarters
- CMS must approve Medicaid “State Plan Amendment”
- Health Homes may serve individuals with:
  - Two or more chronic conditions
  - One chronic condition and who are at risk for another (Chronic conditions listed in the statute include mental health, substance abuse, asthma, diabetes, heart disease and being overweight. Additional chronic conditions, such as HIV/AIDS, may be considered by CMS for approval)
  - One serious and persistent mental health condition
  - Dual eligible beneficiaries cannot be excluded from Health Home services
Required Health Home services include:

– Comprehensive care management
– Care coordination and health promotion
– Comprehensive transitional care from inpatient to other settings
– Individual and family support
– Referral to community and social support services
– Use of health information technology (HIT)
– Prevention and treatment of mental illness and substance abuse disorders
– Coordination of and access to preventive services, chronic disease management, and long-term care supports
Health Home Providers

States have flexibility, eligible providers include:

• **A designated provider**: May be a physician, clinical/group practice, rural health clinic, community health center, community mental health center, home health agency, pediatrician, OB/GYN, or other provider.

• **A team of health professionals**: May include physicians, nurse care coordinators, nutritionists, social workers, behavioral health professionals, and can be free-standing, virtual, hospital-based, or a community mental health center.

• **A health team**: Must include medical specialists, nurses, pharmacists, nutritionists, dieticians, social workers, behavioral health providers, chiropractors, licensed complementary and alternative practitioners.
States with Approved Health Home Plans

- Alabama
- Idaho
- Iowa
- Maine
- Maryland
- Missouri
- New York
- North Carolina
- Ohio
- Oregon
- Rhode Island
- South Dakota
A New Journey Begins
CMS Pioneer and Shared Savings ACO

• An ACO is a provider-led organization whose mission is to manage the full continuum of care and be accountable for the overall costs and quality of care for a defined population.”
  
  – NEJM and EMHS ACO Executive Steering Committee
The ABCs of ACO
Accountable Care Organization

• ACO is part of the Affordable Care Act (ACA) – national health reform
• ACOs use partnerships between hospitals and physicians to improve the coordination, efficiency, cost, and quality of patient care
• Patients don’t lose choices, rather the ACO assumes responsibility for better coordination of patient care
• The structure of care delivery shifts from how much a provider does to how well the patient does – and will determine how hospitals/doctors are paid for the care they provide
Medicare Affordable Care Act

Pioneer ACO

• Pioneer ACO: Beacon Health (EMHS) – Started in January 2012 with 32 ACO’s today, 19 Pioneer ACO’s continue to participate

• The Pioneer ACO’s represent experienced providers/organizations working together to coordinate care
Pioneer ACO Highlights

• 5 Year Pilot Project
• Medicare attributes patients to the ACO
• The ACO accepts financial risk to reduce the overall cost of care for the Medicare population assigned and meet quality performance standards
• Patients retain ability to choose providers of care
• Participants must also engage in risk based contracting models with other payers during the pilot project period
Shared Savings Baseline

• CMS identifies “attributed population” – Medicare beneficiaries who receive their care with ACO hospital and physician practice

• 3 year trend analysis of spend

• Target per beneficiary expenditure benchmark calculated
### Yearly Preliminary Baseline/Benchmark Report for Pioneer ACOs

**Pioneer ACO P040 - Beacon Health LLC**

**Worksheet 1: Preliminary Prospective Baseline/Benchmark**

**Performance Year 1: Jan 1, 2012 to Dec 31, 2012**

**November 28, 2011**

<table>
<thead>
<tr>
<th>Capped baseline / benchmark calculations</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>3-year baseline</th>
<th>2012</th>
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<tr>
<td><strong>Aligned population</strong></td>
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<tr>
<td>45. 3-year baseline expenditure</td>
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<td>$9,231</td>
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<td><strong>Reference population</strong></td>
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<td>46. 3-year baseline expenditure</td>
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<td><strong>Benchmark calculation</strong></td>
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<td>48. Reference population trend (%)</td>
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<td>10.4%</td>
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<td>49. Trend applied to aligned pop. baseline</td>
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<td>$989</td>
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<td>52. Benchmark</td>
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<td>$10,220</td>
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How do we impact this number?
EMHS ACO Financial Risk Model – Pioneer Core

- Year One 2012 - Annual expenditures for 9,000 beneficiaries: ~ $ 90 million
- Increase accountability for costs over 5 year period
  - YEAR 1
    - 60% two sided risk (varies with quality score) up to a cap of 10% of total part A and part B expenditures (2 sided risk)
    - Must achieve a Minimum Savings Rate of approximately 1
  - YEAR 2
    - 70% two sided risk (varies with quality score) up to a cap of 15% of total part A and part B expenditures 1% Minimum Savings Rate
  - YEAR 3
    - Population based payment 50% of ACO Expected A & B Revenue
    - 70% two sided risk (varies with quality score) up to a cap of 15%, Minimum Savings Rate 1%
  - YEAR 4&5 Same model as year three with updated baselines
Pioneer ACO SNF Waiver – Spring 2014

- EMHS ACO approved to participate in SNF waiver
- CMS waives requirement for 3 hospital overnight stays for ACO participants that otherwise qualify for SNF stay
- Patients directly admitted to SNF from home, physician practice or ED
- Participating patients must have ACO designated physician
- ACO applies to CMS to approve nursing facility participants.
EMHS Pioneer ACO SNF Waiver

• Established quality, utilization and patient experience dashboard
• Thus far 110 participants avoided 3 hospital overnights. Patients admitted to SNF from:
  – Emergency Room 15%
  – Primary Care Provider 13%
  – Home 3%
  – Observation Stay 44%
  – Inpatient Hospital Stay Less than 3 Overnights – 25%
Pioneer ACO’s

Source: Centers for Medicare & Medicaid Services
CMS Shared Savings ACO

• Today 330 Shared Savings ACO’s in 47 States serving 4.9 million Medicare beneficiaries
• Two models - Shared Savings only OR Shared Savings/Risk on Losses
• Must meet minimum savings rate to share in savings
• Fee for Service payment continues
• 33 ACO quality measures
• Quality scores impact shared savings return
Shared Savings ACO’s – CMS Proposal

- In December 2014 CMS released a new proposal to strengthen the shared savings ACO program.
  - Flexibility for ACO’s seeking to renew participation in the program (longer lead time to two sided risk sharing)
  - “Track 3” ACO – Higher rates of shared savings and prospective attribution of beneficiaries at the start of the performance year
  - Emphasis on Primary Care to include PA’s and NP’s
  - Reducing administrative burdens
Map Shared Savings ACO’s
ACO Investment Model

• ACO Investment Model developed in response to concerns that providers lack access to capital needed to invest in infrastructure necessary to assume population management risk.

Participation in the model will have two groups:

• **New Shared Savings Program ACOs joining in 2016** - The ACO Investment Model seeks to encourage uptake of coordinated, accountable care in rural geographies and areas where there has been little ACO activity, by offering pre-payment of shared savings in both upfront and ongoing per beneficiary per month payments.

• **ACOs that joined Shared Savings Program starting in 2012, 2013 and 2014** - The ACO Investment Model will help ACOs succeed in the shared savings program and encourage progression to higher levels of financial risk, ultimately improving care for beneficiaries and generating Medicare savings.
CMS ACO’s & 33 Quality Measures
ACO - 33 Clinical Measures

- 7 dedicated to **Patient Experience** of Care, timeliness of care, doctor communication, access to specialists, health promotion and education, shared decision making, health/functional status.
33 Clinical Measures (continued)

- 6 care coordination and patient safety: Ambulatory Sensitive Conditions, EMR use, medication reconciliation, falls screening
- 8 preventive health: Immunizations, Screenings, Weight, and Tobacco
- 12 at risk population: Diabetics, Hypertension (HTN), Ischemic Vascular Disease (IVD), Coronary Artery Disease (CAD)
National Medicare ACO Preliminary Data
First 12 Months of the Program

• Shared savings ACO’s generated $128 million in savings

• Pioneer ACO’s generated $147 million in total savings
Commercial ACO’s

• Less likely than Medicare to use “up-side” shared savings payment models
• Most commercial ACO payment arrangements use care management fees ($3 to $5 pmpm) or “downside shared savings” where providers face a financial loss if they fail to meet cost and quality targets
• When targets are met, commercial shared savings are often higher than Medicare shared savings percentage
ACO Infusion Therapy Patient Scenario

• 62 yo male with Colostomy/Short Gut Syndrome requiring TPN daily for life

• Team Members: Patient, Son, PCMH PCP and RN Care Coordinator, Home Care, Infusion Therapy

• Care Plan: PICC line, lab draw, dressing changes, daily TPN, IV antibiotics for recurrent endocarditis, IV Lasix for CHF, long term Lovenox for subclavian DVT

• Patient successfully care managed at home. Symptom management, medication adjustments, patient education and overall monitoring provided 1-2 times per week.
Opportunities for Infusion Therapy Providers

• Data, Data, Data – Average Cost of Care, quality metrics, hospital ED and readmission rates for infusion therapy population

• Information Technology – Health Information Exchange and Infusion Therapy Clinical Information

• Understand the ACO population health strategy, PCMH, Care Coordination etc.

• SNF Waiver – Know the participating nursing facility partners

• Commercial Market ACO’s – Understand ACO model with major commercial payers
Opportunity – Health Information Exchange

• Electronic health information exchange (HIE) allows doctors, nurses, pharmacists, other health care providers and patients to appropriately access and securely share a patient’s vital medical information electronically—improving the speed, quality, safety and cost of patient care

• Appropriate, timely sharing of vital patient information can better inform decision making at the point of care and allow providers to
  – Avoid readmissions
  – Avoid medication errors
  – Improve diagnoses
  – Decrease duplicate testing
ONC Evaluation of State HIE’s

![Bar chart showing planned use cases for direct care]

- Transitions of Care: 18 states
- Public Health Reporting: 15 states
- Exchange Lab Results: 15 states
- Interstate Exchange: 15 states
- Sending Information to Patients: 14 states

2015 NHIA Annual Conference & Exposition
LONG-TERM AND POST-ACUTE CARE PROVIDERS ENGAGED IN HEALTH INFORMATION EXCHANGE:

FINAL REPORT

October 2013
Opportunity for Chronic Care Infusion Therapy Management

• 2015 Medicare Physician Fee Schedule includes payment for chronic care management, approximately $42 for the CCM code, no more than once per month for qualified patient

• CCM Services include development and revision of the plan of care, communication with other professionals and medication management

• CMS proposes that practices use electronic health record, HIT or information exchange platform

• Other CCM requirements include
  – Access to care management services 24/7
  – Continuity of Care
  – Care management for chronic conditions
  – Creation of a patient centered care plan document
  – Management of care transitions
Opportunities

• Care Coordination & Care Management Certification
  – Independent Certification
  – Academic Certification
  – NCQA Accreditation
FINAL THOUGHT
Rapid pace transformational change is occurring in health care. No matter where we are going, we can’t go back.
THANK YOU!

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