

Accountable Care and Long-Term Care

ADVANCE for Long-Term Care Management

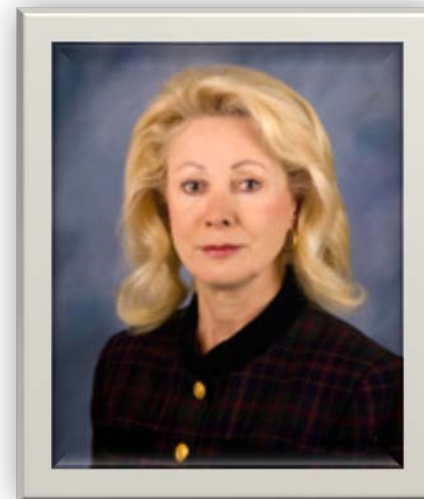
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“This time, like all times, is
a very good one if you
know what to do with it.”

Emerson

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Topics

- Accountable Care Organizations (ACOs)
 - What ACOs are
 - How they work
 - How they get paid
- Post-Acute Providers and ACOs
 - What is the role
 - What is the relationship
 - How payment likely will occur
- for Post-Acute and Long-Term Care Providers
 - Creating value-based partnerships
 - Data to collect and report
 - What will be of value to ACOs
- ACO Strategies

ACOs – One of the Ways Health Care Reform will Bend the Cost Curve



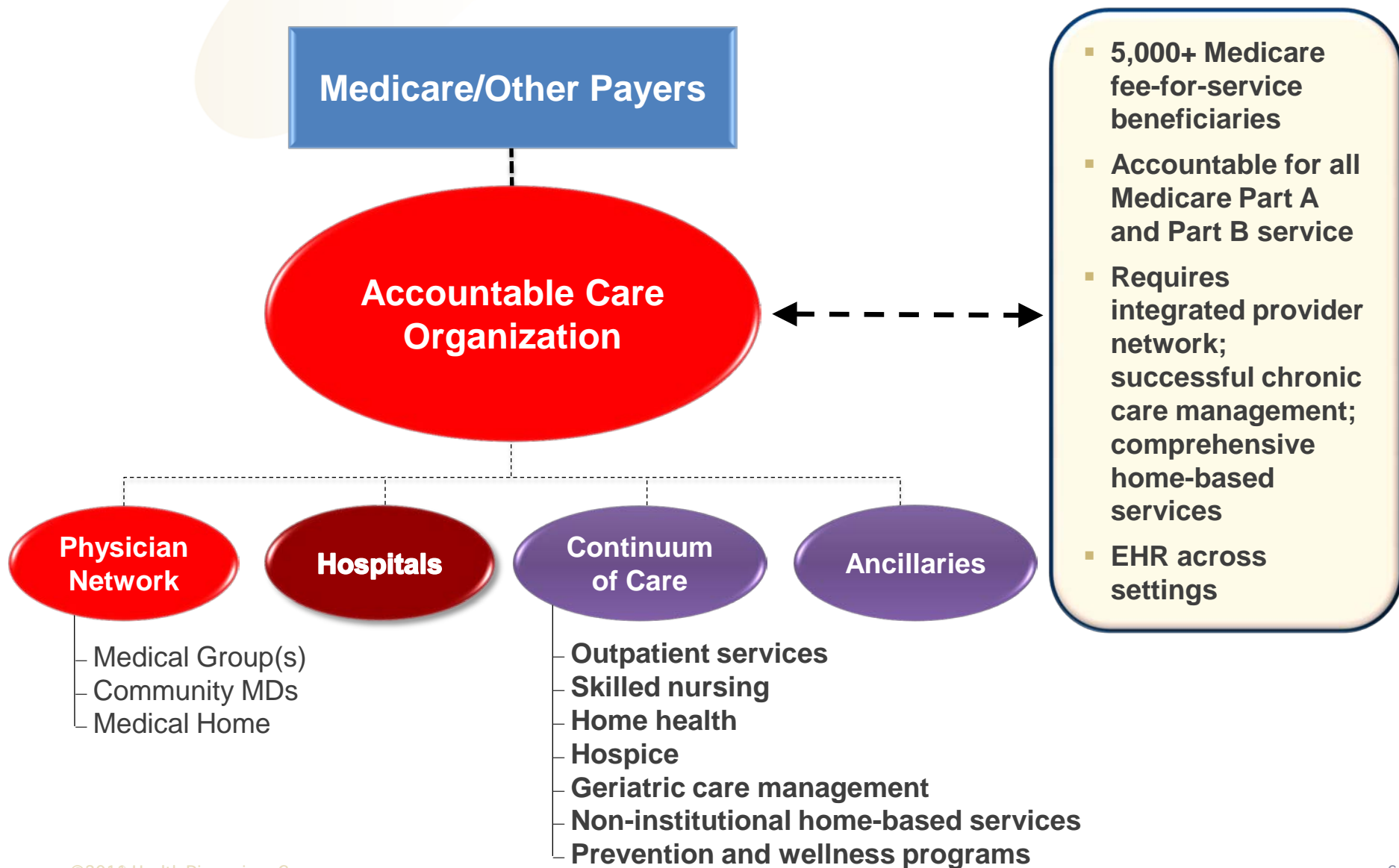
- **Payment Changes**
 - Reimbursement cuts
 - Value-based reimbursement
 - Bundled payments
- **Care Delivery System Changes**
 - **Accountable care organizations**
 - Medical homes
 - Health information exchange

How ACOs Provide Accountable Care in a New Delivery System

- Capacity to deliver continuum of care, grounded in strong primary care and minimal use of high-cost institutional settings
- Payment that rewards slower cost growth so long as combined with improvements in quality
- Reliable measures of a person's health to assure that savings are achieved through improvements in care



Accountable Care Organizations



Medicare ACOs in 2012, But Many ACO Demonstrations Now

3 Medicare Pilot Sites



Roanoke, VA



Louisville, KY



Tucson, AZ

Many Private Payer Pilots



Medica and Insurers



Torrance, CA

Medicare ACO Eligibility

Who Can Be An ACO?

- Group practices
- Networks of individual practices
- Partnerships or JV arrangements between hospitals and ACO professionals
- Hospitals employing ACO professionals
- Such other groups of providers of services and suppliers as the Secretary determines appropriate

ACO Professionals

- Doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State
- Physician assistant, nurse practitioner, or clinical nurse specialist
- Certified registered nurse anesthetist
- Certified nurse-midwife
- Clinical social worker
- Clinical psychologist
- Registered dietitian or nutrition professional

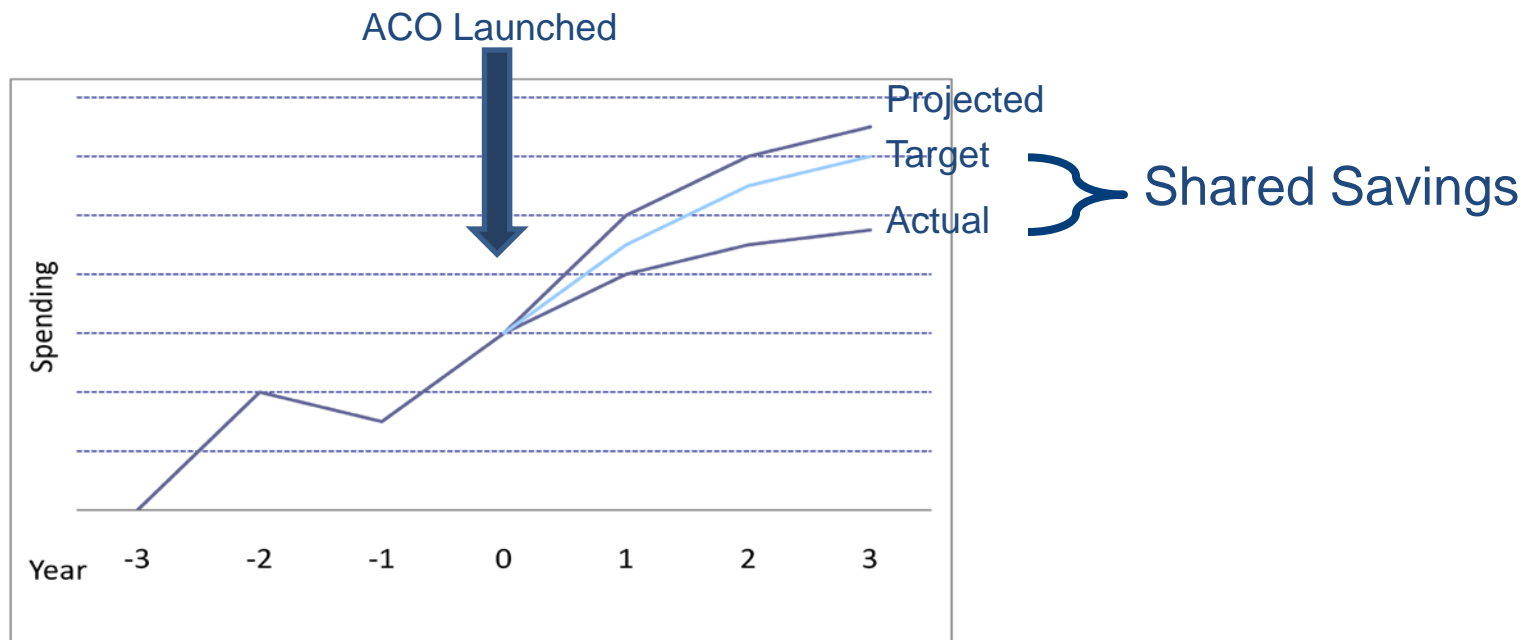
How Do You Qualify as a Medicare ACO?

- Become accountable for quality, cost, and overall care
- Formal legal structure to receive and distribute payments for shared savings
- Have enough primary care physicians
- Have a minimum of 5,000 beneficiaries
- Leadership and management structure that includes clinical and administrative systems
- Processes to promote evidence-based medicine and patient engagement, report on quality/cost measures, and coordinate care
- Meet patient-centeredness criteria
- Minimum three-year contract with Medicare






New Payment Model for Medicare ACOs: Shared Savings

- Current per-capita spending for assigned patients determined from claims for past three years
- Spending target is determined (Medicare)
- If actual spending lower than target, savings are shared
- **IF quality targets are also achieved**



Adapted from Brookings Institute

Sample ACO Calculation

	Year 1	Year 2	Year 3
Quality Standards Met?	Yes	No	Yes
Cost Savings Achieved?	No	Yes*	Yes*
Medicare FFS Payment	Medicare Fee Schedule	Medicare Fee Schedule	Medicare Fee Schedule
			
ACO bonus payment that year?	No	No	Yes X% of Savings**

An organization must meet quality standards AND achieve cost savings to earn bonus payments

* Actual costs for “assigned” population are less than pre-set expected costs based on risk-adjusted trends
 ** PGP demonstration gave groups 80% of savings; actual split for ACOs to be determined

How Will Post-Acute Providers Be Paid By ACOs?

- Shared Savings?

- Unlikely—very difficult to assess the “contribution” to savings by the SNF or HHA

- Bundled Payment?

- More likely—predictable and can incentivize with bonuses

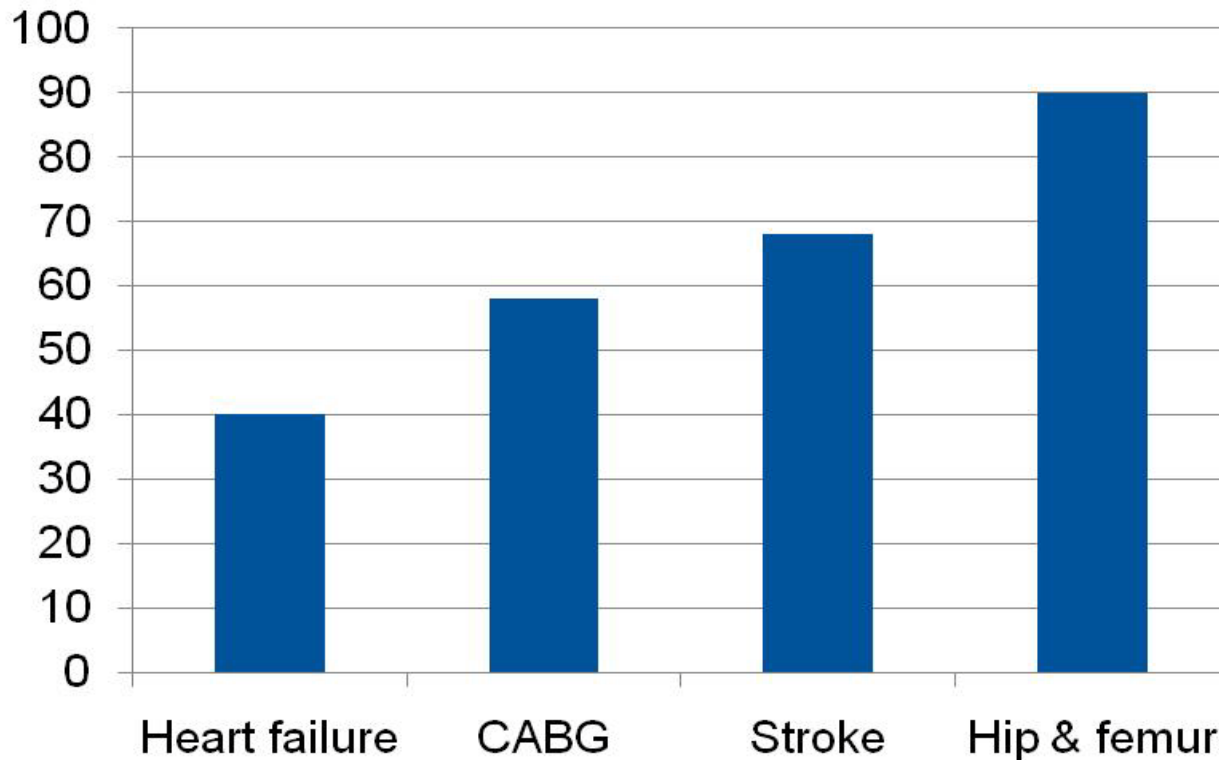
- Just SNF or all post-acute?

- Will vary by market
- One Midwest Health System + PAC Provider Example



Why Post-Acute Is Key to Managing Health Care Costs

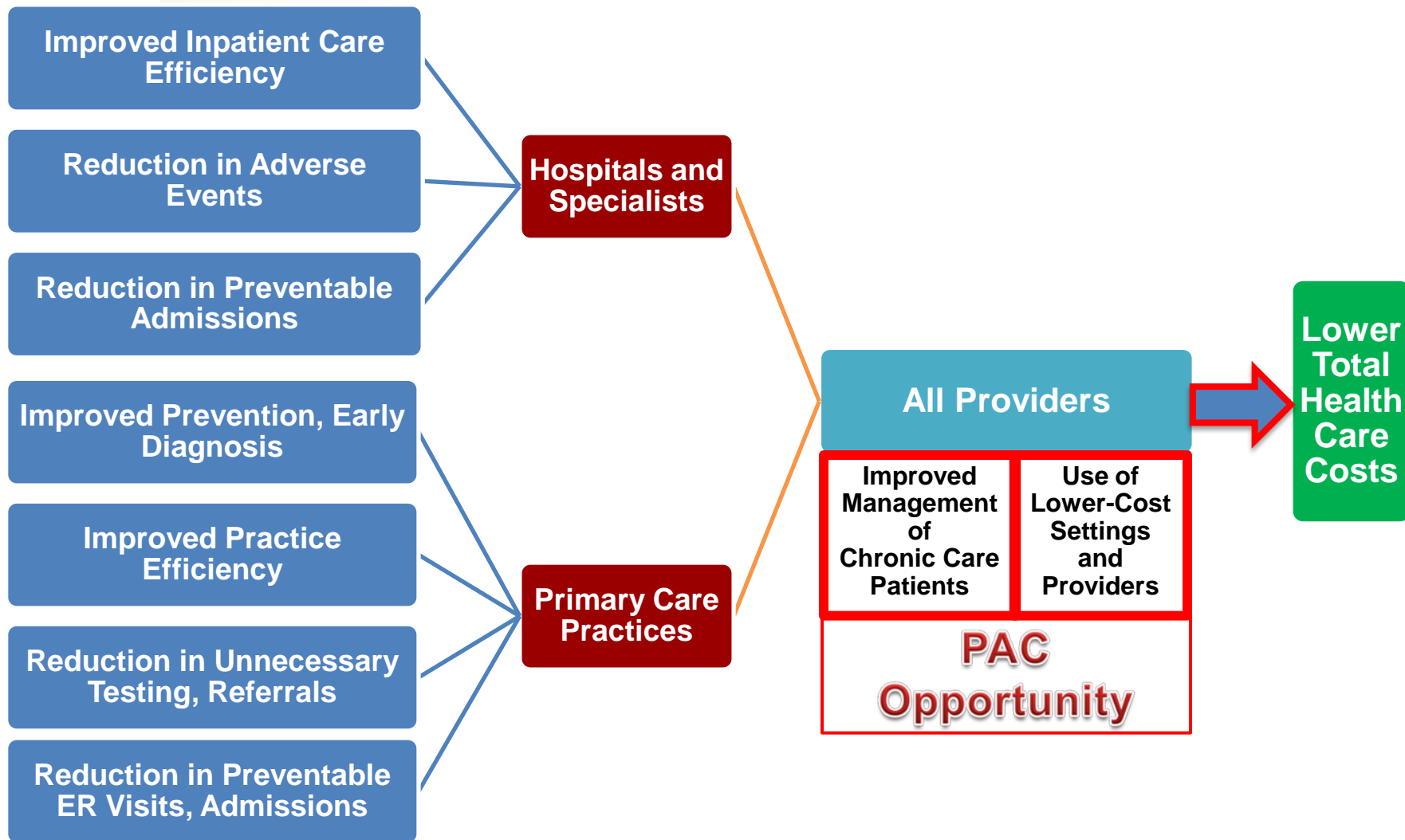
37.5% of Medicare fee-for-service patients use post-acute care



Note: Data are preliminary and subject to change. Rates reflect use within 30 days of discharge. Beneficiaries that die during the hospital stay or within 30 days of discharge are excluded.

Source: MedPAC analysis of 5% Medicare claims files 2004 to 2006. MedPAC, October

Opportunities for Health Care Reduction



Post-Acute Payments by Venue and Condition

In ACO-land, expect greater use of subacute skilled nursing and home health

Hospital Condition	PAC Average	OP Rehab	Home Health	SNF	IRF	LTCH
Stroke	\$10,680	\$569	\$2,478	\$8,527	\$18,923	\$22,070
Hip & Femur Procedures for Trauma	\$10,392	\$1,217	\$2,595	\$8,761	\$16,018	\$22,738
Cardiac Bypass with Catheterization	\$5,230	\$837	\$1,778	\$5,737	\$14,631	\$24,526
Heart Failure	\$4,144	\$612	\$1,611	\$6,462	\$14,698	\$20,236

Note: Data are preliminary and subject to change. Numbers reflect standardized payment rates and therefore do not reflect provider-specific adjustments such as the area wage index or DSH payment adjustments. Spending captures payments for all PAC services that occur within 30 days of discharge from the hospital.

Source: MedPAC analysis of 5% Medicare claims files 2004 to 2006.

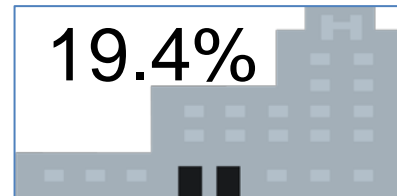
What Do ACOs Want from Post-Acute Care (PAC) and Long-Term Care (LTC) Providers?

- Not likely to be a partner, with “skin in the game”, but rather a contractor
- ACOs will want few PAC provider-contractors who:
 - ✓ Can demonstrate value (quality and cost reductions) with credible data
 - ✚ Few 30-day hospital readmissions
 - High volume of discharges to home
 - ✓ Have evidence-based clinical programs for most common SNF-HHA discharges and a care transitions program between venues
 - ✓ Have facilities/services that are geographically convenient to primary care physicians and hospitals
 - ✓ Already have positive relationship with hospitals and PCPs
 - ✓ Willing and able to be part of health information exchange

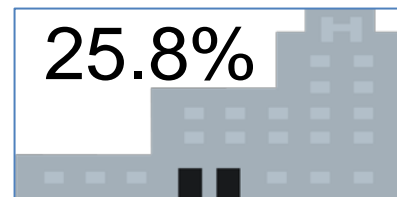
Developing Data-Driven ACO Partnerships

- Demonstrate your 30-day readmission rates by condition and plans to continue to decrease
- Partner with hospitals to meet burning needs, especially concerns about **readmission penalties FY2013: pneumonia, AMI, CHF**; and reduce excess LOS for all conditions discharged to SNFs
- Customize programs to hospitals

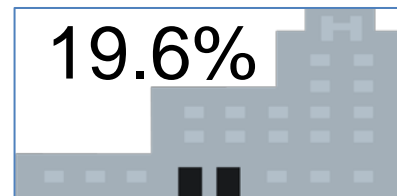
Heart Attack



Heart Failure



Pneumonia



ACO Partnership Takeaways for Skilled Nursing Facilities

- Relationships will be data driven
 - What are your patient outcomes? How many Medicare A go home?
 - What is your 30-day readmission rate by condition, especially those for which hospitals soon will be penalized: AMI, CHF & pneumonia?
- Subacute units must be able to manage patients who typically would be “911”
 - Increased nursing skills and RNs
 - Physician/NP intensive management of subacute patients = coverage 24/7
 - Use of protocols, e.g., Interact2, that help SNFs manage higher-acuity patients



To Be a “Player” in the ACO Arena

- You have to be ahead of the curve in developing relationships with hospitals, primary care physician groups, and even insurers/managed care
- Partnerships must be value-based: what do you bring?
 - Hospital readmission reduction
 - Cost reductions for post-acute episode of care
 - Care coordination across the continuum
 - Chronic care management to reduce ED visits and hospitalizations
 - Electronic information exchange
 - Ability to share payment risk based on outcomes



No Lone Rangers in ACO-Land: Your Risk is Mine; My Success is Yours





NATIONAL SUMMIT

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