Accountable Care and the Laboratory Value Proposition

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Agenda

• The Goals and Status of Delivery System Reform and Alternative Payment Models
• Accountable Care Organizations Defined
• ACO Detail and Areas of Focus
• Care Coordination, Post-Acute Care, and Quality Measurement
• Laboratory
• Questions
CMS’ Explicit Goals to Move to VBP

Category 1: Payment not linked to quality
Category 2: FFS with payment linked to quality
Category 3: APMs build on FFS architecture
Category 4: Population-based payment
CMS Program Overlap – Evident, Confusing, and Complex

- Given this overlap, hospitals and physicians are often placed in opposition, (e.g., physician-managed bundles take precedence over hospital-based bundles, and ACOs overlap with bundling)

- Overlay of MACRA?

Note:
BPCI is Bundled Payments for Care Improvement.
CCJR is Comprehensive Care for Joint Replacement. LEJR is Lower Extremity Joint Replacement.
MSPB is Medicare Spending Per Beneficiary. MACRA is Medicare Access and CHIP Authorization Act.
Accountable Care Organization - Defined

• ACOs bring physicians, nurses, hospitals and other health care providers together to share responsibility for keeping patients healthy and optimizing their health status. The goal of an ACO is to work to demonstrably and measurably improve the total cost, quality and experience of a defined population’s care.

• Target population typically straight Medicare only or dual eligible. 10% of the ACO population is below the age of 65.
ACO Programs Growing

- Medicare Shared Saving Program (MSSP) ACO – January 1, 2014
  - 35,000 Medicare Beneficiaries
  - Upside Risk Only
- Various Types of ACO Programs
  - Pioneer ACOs – 32 ACOs – January 1, 2012
  - MSSP ACOs – Typically Upside Risk Only – 400+
    - April 1, 2012 – 27
    - July 1, 2012 – 89
    - January 1, 2013 – 106
    - January 1, 2014 – 123
    - January 1, 2015 – 106
    - January 1, 2016 - 100
  - Next Generation ACOs started January 1, 2016 - 21
Current State and Past Results

As of January 1, 2016:
- Around 400 Accountable Care Organizations with 8 million beneficiaries in 49 states

2014 Results:
- $383 million in net savings
  - 27% of MSSPs generated savings in 2015
  - 54% that generated savings changed inpatient utilization and cost were in the lowest quartile in inpatient expenses

2015 Results due this summer
Next Generation ACO

- This ACO model provides for greater engagement of beneficiaries, a more predictable, prospective financial model, and more tools to coordinate care for beneficiaries.
- Stable, predictable benchmark and Medicare beneficiary population.
- Medicare benefit enhancements otherwise known as waivers.
  - 3-day SNF rule waiver
  - Telehealth expansion waiver
  - Post-discharge home visit waiver
- **Greater financial risk but also greater upside when savings is achieved.**
Medicare Beneficiary Attribution

How are members assigned to an ACO?

- Tax Identification Numbers of Provider organizations participating in the ACO submitted to CMS.
- Beneficiaries assigned based on plurality of services with Providers.
- MSSP attribution updated quarterly
- Next Generation ACO attribution annually with no changes during the year.
Achieving MSSP Shared Savings

- A reduction in hospitalization is impacted by improved complex case management, coordination of care, and improved access to primary care.
- 40,000 beneficiaries @ $8,000 PMPY = $320 million total spend
- Baseline rate of 300 admissions/1,000 MBs
- 300 admissions x 40 = 12,000 admissions/year
- 10% reduction in admissions = 1,200 fewer admissions/year
- Average admission cost = $12,000
- Savings generated by reduced admissions = 1,200 x $12,000 = $14.4 million
  - This is a 4.5% reduction in the overall costs associated with the 40,000 Medicare beneficiaries
  - With 300 primary care providers, on average each provider would need to avoid the admission of at least one Medicare patient every quarter
ACO Standard Areas of Focus

• Reduction of Inpatient Admissions/Readmissions
• Reduction of ED Visits
• Primary Care Office Transformation
  – Primary Care Access
  – Medicare Annual Wellness Visits
  – Longitudinal versus Episodic Care
  – Advanced Planning Initiatives
  – Evidenced Based Medicine
• Care Management for High and Risking Risk Patients
• Post Acute Care Network (PACN)
  – Right place, right time, best outcome, best cost
Sample MB Spending

0.6% >$100,000
Chronically Sick
Palliative Care & Hospice

27% - $5K to $100K
Sick, Frequent Flyers, Rising Risk – Managed by NCM & PCP through Disease Registries & frequent office and home visits.

72%<$5,000 Spend
Relatively Healthy, Low Spend, Maintained by PCP through AWVs.
Best Practice Components of Care Coordination Programs

**Patient-Driven** – Patients drive what the issues he/she wants to focus and work on. They could be medical, social, or financial in nature. NCM takes the patient’s lead.

**Care Coordination** – Teamwork across professionals with the beneficiary and their family. Includes medication reconciliation; managing communication across providers and professionals; making sure everyone is on the same page around beneficiary stated health goals.

**Disease Management** – Disease specific protocols to make sure beneficiaries are receiving recommended evidence-based care and are educated to better manage those aspects of their condition that they can. NCM provide valuable feedback to medical providers to refine disease management approach.

**Personalized Preventive Interventions** – Strong focus on health promotion and education around weight management, diet and nutrition, and exercise to prevent complications and new conditions from presenting.
ACO Care Management Challenges

- Lack of sufficient coordination of care – referral, follow-up and ongoing coordination with specialists.
- Patients are on lots of medications – many of which put them at risk for falls or other injury
- Medication reconciliation – what the patient indicates they are taking does not match the PCP EMR
- Tendency to refer to Nurse Care Manager to assist in discussion around palliative care and/or hospice but reluctance on part of practitioners to have frank discussion about goals with patient
- Behavioral health issues and kidney disease with a number of these patients.
  - Higher utilization of ED among those with behavioral health problems
ACOs Focusing on Post-Acute Providers

Post Acute Providers represent almost 20% of the spend

- SNFs 9%
- IRFs 4%
- HHAs 4%
- Hospice 2%
- LTACHs 1%

- Understanding and reducing variation that exist among PAC providers in the ACO footprint.
- Commitment to working together to achieve the triple aim—improved patient experience and care outcomes at lower cost.
- Better medical management at the time of admission, during stay, and after discharge.
- Developing preferred PACN with the goal of improving quality and increasing volume among those SNFs deemed to be meeting established performance measures.
ACO – PACN Collaborative Work

- SNF Summits/Education – Patient Tracking solutions; Root Cause Analysis; Heart Failure, Concurrent Reviews
- Meeting with corporate groups to review commitment to improvement and specific areas where improvement is expected
- Identifying PACs with an appetite for risk arrangements with the ACO
- Frequent site visits to review specific cases and data.
- Introduction of telemedicine opportunity to SNFs.
- Home Health 1:1 meetings, and quarterly group meetings
- Providing multiple education opportunities for SNF staff (POLST training for example).
2015 Quality Measures

- 33 Quality measures reported on as part of the Shared Savings Program.
- **Without successful completion of GPRO reporting on the following measures, no shared savings is received regardless of performance**
- Measures include:
  - Patient/Caregiver Experience (8 measures)
  - Care Coordination/Patient Safety (10 measures)
  - Preventative Care (8 measures)
  - At Risk Population (6 measures and a diabetes composite consisting of 7 measures)
- First year ACOs receive full credit for completing reporting in Program Year 1.
- Program Year 2 is a performance year. Quality score results impact the amount of generated shared savings received.
- **SNF 30 Day All-Cause Readmissions** is a quality measure for 2016.
2015 Quality Measures

Patient/Caregiver Experience (7 measures)
01: CAHPS: Getting timely care, appointments, and information
02: CAHPS: How well your providers communicate
03: CAHPS: Patients’ rating of provider
04: CAHPS: Access to specialists
05: CAHPS: Health promotion and education
06: CAHPS: Shared decision making
07: CAHPS: Health status/functional status

Care Coordination/Patient Safety (6 measures)
08: Risk-standardized, All condition readmission
09: Ambulatory sensitive conditions admissions: COPD or Asthma in older adults
10: Ambulatory sensitive conditions admissions: Heart Failure
11: Percent of primary care physicians who successfully qualify for EHR Incentive
12: Medication reconciliation
13: Falls: Screening for future fall risk
2015 Quality Measures

Preventative Care (8 measures)
14: Influenza immunization
15: Pneumonia vaccination for patients 65 years and older
16: Body mass index (BMI) screening and follow-up
17: Tobacco use: screening and cessation intervention
18: Screening for clinical depression and follow-up plan
19: Colorectal cancer screening
20: Screening mammography
21: Screening for high blood pressure

At Risk Population (5 measures and 2 composite consisting of 7 measures)
22 - 27: Diabetes composites (various) All or nothing
28: Hypertension: Controlling high blood pressure
29: Ischemic Vascular Disease: Complete lipid profile and low density lipoprotein (LDL-C) control
30: Ischemic Vascular Disease: Use of aspirin or another antithrombotic
31: Heart Failure: Beta-blocker therapy for left ventricular systolic dysfunction
32: Coronary Artery Disease: Lipid control
33: Coronary Artery Disease: Angiotensin-converting enzyme (ACE) inhibitor or
    Angiotensin receptor blocker (ARB therapy – Diabetes or left ventricular systolic
dysfunction (LVEF<40%)
Wait......

What have we missed?
Laboratory!
Sample ACO LAB Expenditures

Outpatient Labs (Hospitals) $4M
Professional - Pathology/Labs (Physicians) .7M
Professional - Pathology Facilities 3.2M
Total $8.0M

Laboratory and Other Tests % of ACO Spend 1.9 -2.4%

Lab Expenses just not on the Radar
What is the laboratory value proposition for ACOs?
ACO Lab Value Proposition

• DATA
  – Timely delivery of results
  – Improved integration to EMRs

• Quality
  – Consistent Results – Ensure Standards for Common Lab Tests?

• Partnering with Physicians
  – Continuing education - Enhanced training for Physicians to understand and interpret results correctly
  – Recommendations from Labs to eliminate expensive unnecessary testing or outdated testing requests.
ACO Lab Value Proposition

• Innovation
  – Enhanced POC Testing
  – Patient Alerts to help close gaps in care
  – Coordination of discharge instructions with hospitals to ensure follow up testing is completed
  – Standard Panel for Annual Wellness Visits?
  – Recommended panels for specific illness types
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