

Accountable Care Payors: What Are the New Rules of Engagement for Hospice and Palliative Care Providers?

## Accountable Care Payors: What Are the New Rules of Engagement for Hospice and Palliative Care Providers?

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### Discussion Topics

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Understanding the Dynamics of Health Care Reform

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Focus on ACOs

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Continuing Care Network Development

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Case Study: Franciscan Alliance ACO

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***"If you think you can run your company the next ten years the way you ran it the last ten years, you are out of your mind..."***

**CEO  
Coca-Cola**

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### The Four Camps of Health Care Organizations

Greater ↑ Resiliency ↓ Lower	Paralyzed by Confusion	Embracing the Opportunities
	Happily Existing in Denial	Resigned to Acceptance
	← Lower	Greater →
	Understanding	

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### Health Care Reform Drives Movement to Risk-Based Payment

<p><b>Bundled Payment Includes PAC</b></p> <ul style="list-style-type: none"> <li>• 343 bundled pilots across all models in 26 states</li> <li>• CMS now seeking additional bundlers</li> </ul>	<p><b>Explosive Growth in Medicare ACOs</b></p> <ul style="list-style-type: none"> <li>• 374 Medicare ACOs serving 5M+ attributed lives in 45 states</li> <li>• And as many private sector ACOs</li> </ul>	<p><b>Medicaid Comes to Managed Care</b></p> <ul style="list-style-type: none"> <li>• 20 states applied for dual eligible demonstrations</li> <li>• 8 states approved to move forward</li> <li>• Additional states pursuing Medicaid-only programs</li> </ul>
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### Health Care Reform Paths

**Lead with Culture/Care Transformation:**

- Build care management model
- Implement care model broadly
- Obtain value-based payment once model is proven

**Lead with Payment Transformation:**

- Accept risk-based contracts
- Grow number of covered lives
- Adapt care model in targeted and measured steps

Adapted from slide produced by The Advisory Board Company, 2012

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### It's a Whole New World Dynamic

New Relationships, New Partnerships, New Players


- Health plans are purchasing physician groups
- Hospitals are purchasing health plans
- Your referral sources can become your competitors
- Your referral sources can become your partners
- Networks and integrators are emerging

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### New Companies Emerge to Provide Networks and Navigation for Patients



- **Premier navigator and bundler** of post-acute services
- **Accepts financial risk** through capitated contracts from health plans; bundled payment arrangements with hospitals/health systems and CMS
- **Manages patients and risk** via robust predictive analytics tools, proprietary patient assessment tools that match patient characteristics to resource needs, and field-based case managers who serve as resources to facility staff



- **Offers extra layer of support for patients** suffering from serious illnesses such as cancer, CHF, COPD, kidney failure, liver failure, advanced dementia, and ALS
- **Creates a company** (through new company or purchase) that provides palliative care, physician services, and nurse practitioner
- **Partners with home care and hospice companies** to provide additional services; partnerships will vary by market

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### Understanding At-Risk Hospitals and ACOs

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### Who Are Accountable Care Payors?

Hospitals/  
Health  
Systems  
(when at risk  
for care)

Accountable  
Care  
Organizations  
(ACOs)

Medicare  
Advantage  
Health Plans


Medicare and  
Medicaid  
Dual Eligible  
Plans

*Value-based partnerships means a relationship where payment is directly tied to expected outcomes (quality and cost)*

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### ACOs Continue to Explode...

**Accountable Care Organization:**  
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




**Fast Facts:**

- Just over 600 ACOs nationally, including Medicare and Commercial Insurance
- 374 Medicare ACOs, 5.5 million lives
- And it's not just Medicare—explosive growth in private plan ACOs

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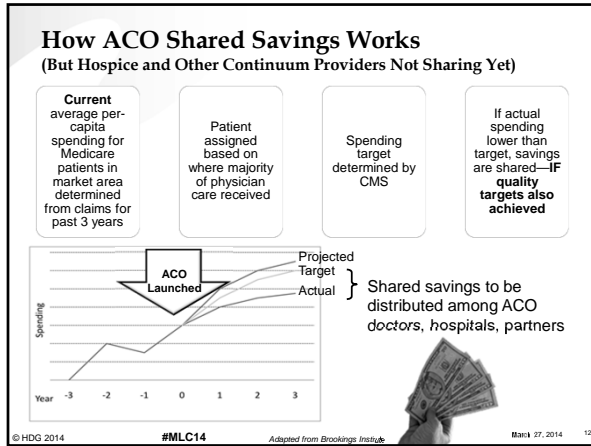
### 374 Medicare ACOs and More to Come



- MSSP ACOs (32 states)
- Both MSSP and Pioneer ACOs (13 states)
- No Medicare ACOs (5 states)

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- ### What Are the ACOs Doing NOW?
- 1 • **Attribution Risk Stratification:** sorting out which beneficiaries require intensive management and monitoring
  - 2 • **Longitudinal Care Management Implementation:** developing model by which these beneficiaries will be managed (at home)
  - 3 • **Developing Network of Post-Discharge Continuum Providers:** turning attention now to continuing care networks
  - 4 • **Palliative Care Expansion:** improving integration of palliative care services in both acute and post-acute settings
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### First-Year Savings from ACO & Pioneer ACO Programs

114 ACOs generated:

Savings to Medicare trust fund	\$128 million
Shared savings	\$126 million
<b>TOTAL SAVINGS</b>	<b>\$254 MILLION</b>

ACOs not generating savings	60
ACOs with shared savings of \$126 million	29
ACOs with lower spending than benchmark but not shared savings	25
<b>Total ACOs</b>	<b>114</b>

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### Pioneer ACO First-Year Savings

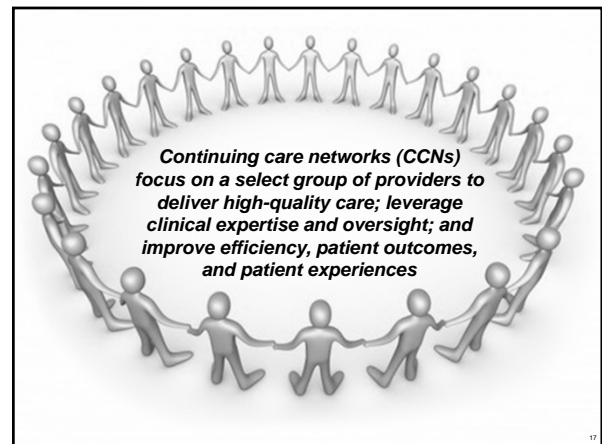
- 23 Pioneer ACOs generated gross Medicare savings of **\$147 MILLION**
- Pioneer-aligned ACOs had
  - Higher average spending for SNF and home health, but
  - Unchanged hospice spending

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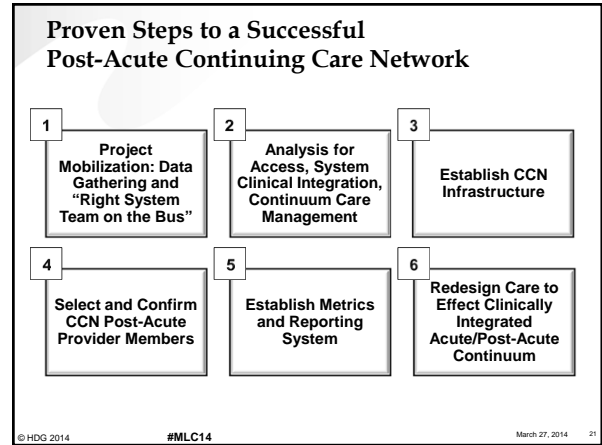
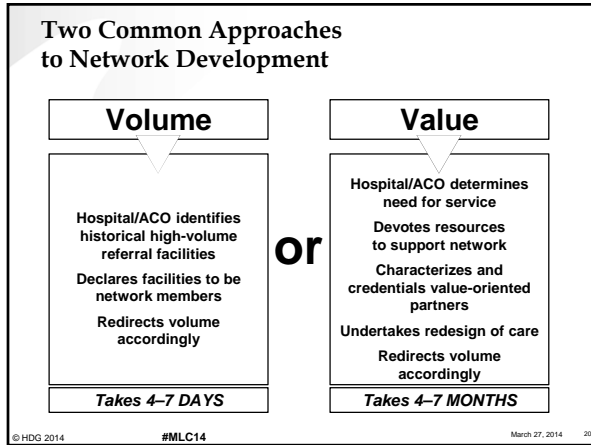
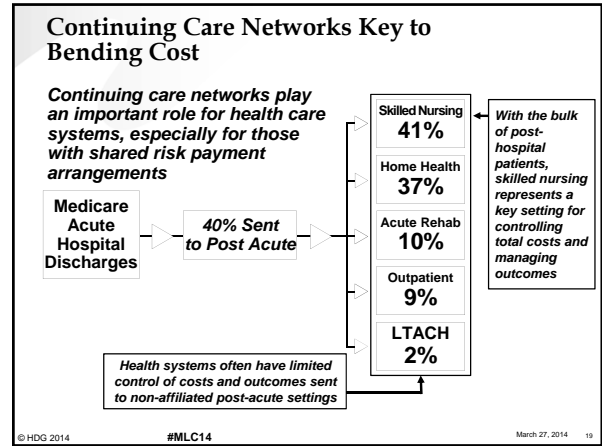
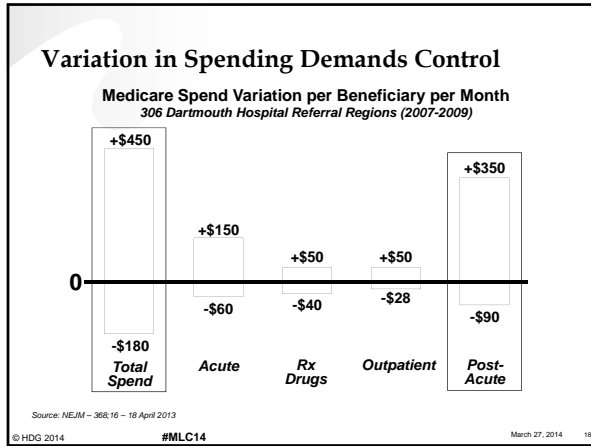
### The Need for Narrow Networks

Continuing Care Network Development

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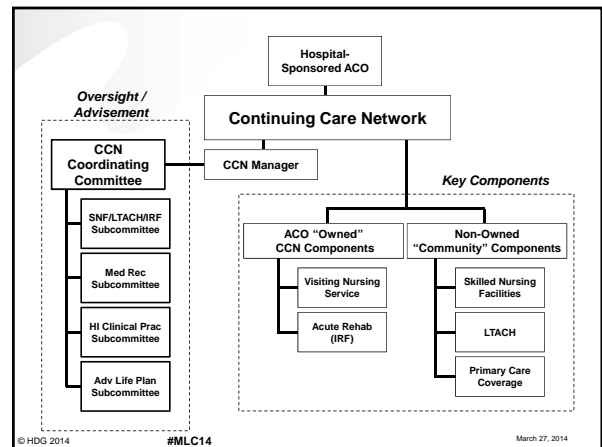


### 6 Redesigning Care

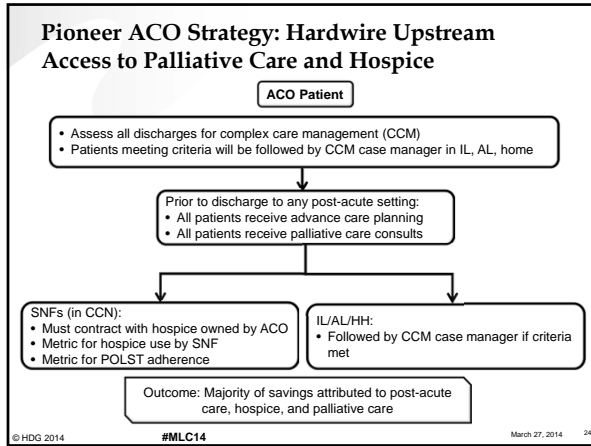
Value-oriented networks emphasize care redesign as the central component of long-term success

- Process redesign can encompass a variety of acute/post-acute and transition areas, such as:
  - ✓ Early identification of, and CCN information to, post-acute discharges
  - ✓ Warm hand-offs in all settings (doctor to doctor, nurse to nurse, PCP integration in process)
  - ✓ Integration with hospital/system-owned home health or medically complex, care management programs
- Referrals to hospice and palliative care is embedded into the delivery system at every level of care

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### Preferred Provider Selection Is a Gateway to Other Opportunities



- Bundled payment partnerships
- Managed Medicaid/Medicare Advantage networks
- Medically complex care management and population health

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### Summing It Up

Access to Palliative Care Across the Continuum Gains Traction with Value-Based Payors

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### Evidence Abounds That Palliative Care Is Central to Improving the Value Equation

**INNOVATION PROFILE**

**Changing The Conversation In California About Care Near The End Of Life**

*Source: Kaiser Permanente, unpublished data from November 2009 through September 2010 show that 50 patients who enrolled in 2010 and 50 patients who were not enrolled in 2010 were followed for 30 days after enrollment compared with the 30 days before. For the patients who enrolled and lived at least 30 days, there were 50 percent fewer hospital admissions compared with the 30 days before. Overall, the average savings per patient was about \$2,000 a month.*

**COST SAVING**

**Cost Saving Associated With US Hospital Palliative Care Consultation Programs**

*Background: Hospital palliative care consultation teams have been shown to improve care for adults with serious illness. This study examined the effect of palliative care consultation on costs per admission and per hospital day.*


**Methods:** We studied administrative data from 15 hospitals with palliative care programs for the years 2002 through 2004. Patients with palliative care were matched by appropriate case to patients receiving usual care. Controlled time models were estimated to assess per admission and per hospital day.

**Results:** Of the 200 palliative care patients who were discharged alive, 153 had palliative care primary (90% were male) and 47 had usual care primary, and of the 200 patients who were not discharged alive, 153 had usual care primary and 47 had palliative care primary. In patients who were discharged alive but not discharged to home, the average of \$100 in direct costs per admission (P < .001) and \$170 in direct costs per day (P < .001) including up-

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### The Future of Palliative Care


- Access in hospitals is increasing, but most care is provided at home and in communities
- Home palliative care is needed to impact value equation
- Access to palliative care should be provided across all settings and stages of illness
- Impact on hospice utilization?



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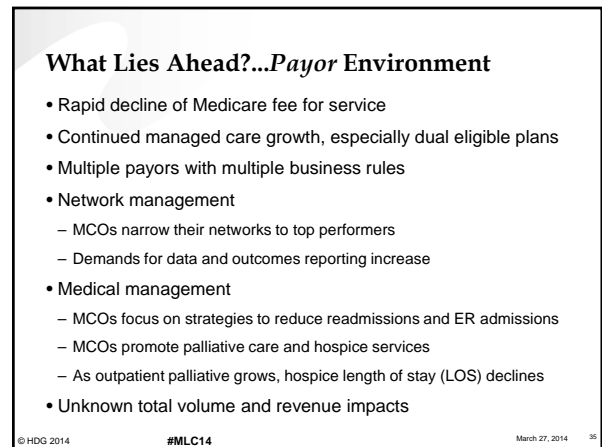
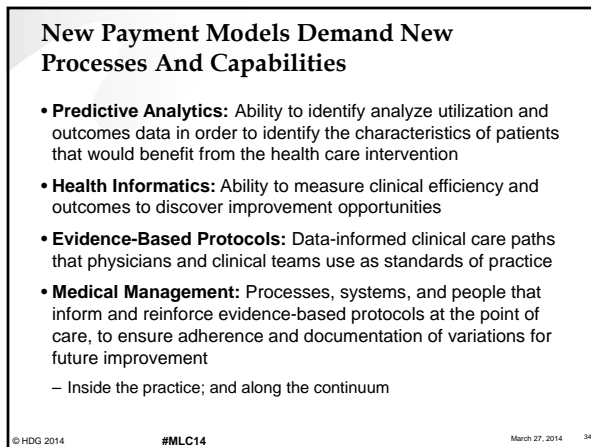
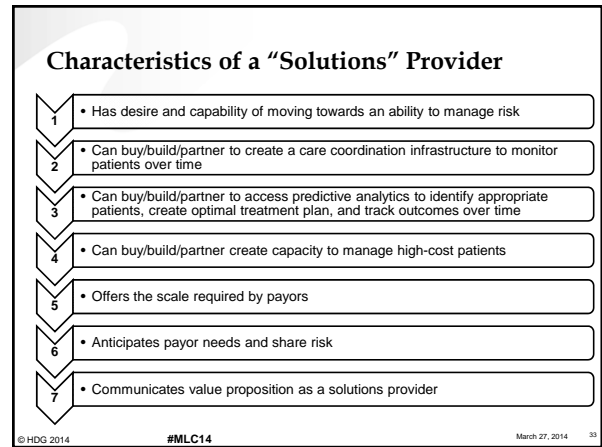
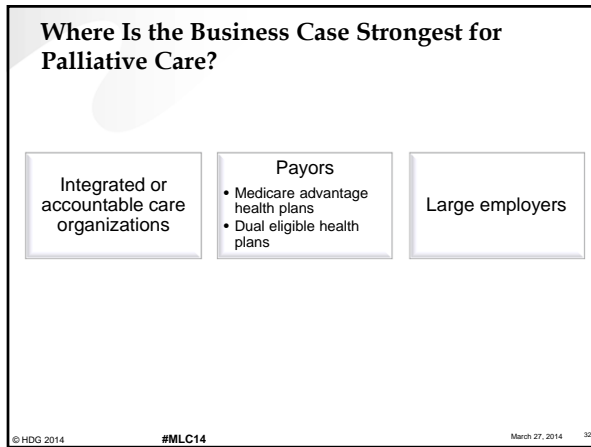
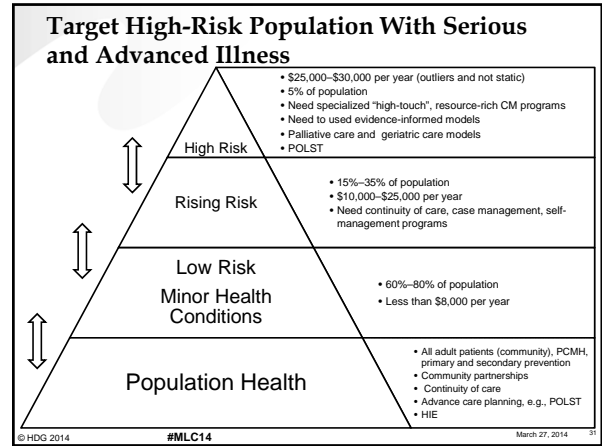
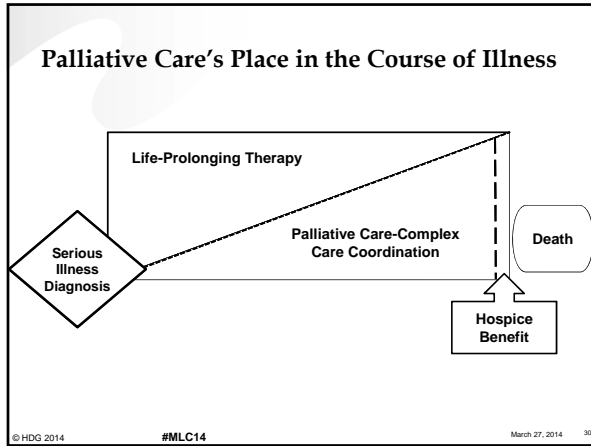
### Compassionate Care for Those With Serious and Advanced Illness

- "Slow medicine"
- Don't ask "what is wrong with me", ask "What matters to me?"
- Advanced care planning at all stages
- Need to move palliative care principles upstream and downstream
- Home health care and hospice should not exist as "silos"



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### What Lies Ahead?... Provider Environment

- Disappearing FFS revenue; all Medicare becomes contracted revenue that is medically managed
- Hospitals and physicians becoming ACOs and value-based purchasers and accepting population risk
- Hospitals transition from *referral source* to *gatekeeper*, steering patients to preferred PAC partners, including hospices
- With risk, providers take on payor characteristics and become medical manager for Medicare patients




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### Summing It Up

- Sustainable post-acute providers will find ways to participate in the **value** game and be **rewarded for efficiency of care**
- Doing so will require **new skills and capabilities** that have not been required before:
  - Network management
  - Care management: Before, during, and after
  - Analytics and predictive tools
  - Complex revenue cycle management

**Time really is money**



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"For the majority of people with advanced illness, better care is not defined as simply more medical interventions. **Rather, it is care that protects, preserves and defends, and extends their personal goals and preferences**—often with less medical intervention and more quality of life driven support."

*Bruce Chernof, MD  
President/CEO, Scan Foundation*

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## Franciscan Alliance ACO

### Nick Priscu, MD

Medical Director of Hospice and Palliative Care,  
Physician Advisor for Integrated Case Management, and  
Assistant Medical Director for the Franciscan Pioneer ACO

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## Topics

- \* Background on Franciscan ACO
- \* CCN Journey
  - \* How we infused advanced care principles into the CCN
  - \* Role of hospice and palliative care in emerging ACO environment

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## Topics (continued)

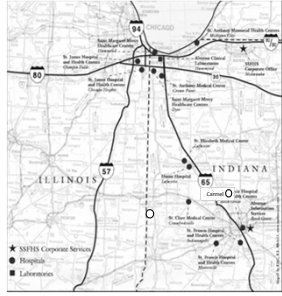
- \* New Models of Care and Integration Within Franciscan System
  - \* Complex case management program
  - \* Outpatient palliative care in ACO context
- \* Toggling Between Now and the Future
  - \* How Franciscan is balancing demands of FFS versus managed care/ACO
  - \* Future role of hospice and palliative care when ACOs and population-based health dominates

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### Franciscan Alliance Snapshot

- \* Has rich history of serving local communities for over 135 years
- \* Operates in 4 regions throughout Indiana and Illinois with 13 hospitals and several healthcare support companies
- \* Employs over 600 providers (Franciscan Physician Network)
- \* Completed transition to Epic electronic medical record system during 2013 in all regions



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### Accountable Care Organizations: Overview

- \* **ACOs:** organizations that agree to be accountable for overall cost, quality, and outcomes of care for defined population, over a defined period of time
- \* **ACO providers:** accept joint responsibility for care over the entire continuum, regardless of where the patient seeks care, and must report on 33 quality metrics

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### Franciscan Alliance Pioneer ACO

- \* Comprises more than 1,000 providers across Indiana
- \* Serves nearly 50,000 Medicare beneficiaries
- \* Saved Medicare more than **\$13 MILLION** in 2012 via care management and care coordination programs
- \* 50% of those dollars were returned to the ACO and were:
  - \* Distributed to ACO participants
  - \* Reinvested into new ACO care management programs

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### PAC CCN Background

- \* Missing key pieces prevented/inhibited meeting needs, wants, and desires of those who entrust us with their care
- \* Readmissions were significant driver of creating PAC CCN
- \* Franciscan Alliance committed to assuring clinical integration across the continuum
- \* **Expected outcome:** seamless handover at each transition of care; and high-quality and safe care delivery across the continuum

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### CCN Launched February 2013

2 LTACHs	1 IRF*
PAC CCN	
9 SNFs	Franciscan VNS

\* Inpatient acute rehab unit at Franciscan St. Francis Medical Center

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### The Journey

January 2013 PAC site visits included assessment of the following:

* Processes for admission and flow	* Advance directives
* Registered nurse (RN) staffing	* Medication reconciliation processes
* Current status of quality data collected at each facility	* Practitioner coverage
* Handover (transition) processes	* Therapy availability on weekends and holidays
	* Care plan/team meetings

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## Advance Care Planning Subcommittee

Addresses clinical, operational, beneficiary management / interchange, and infrastructure issues specific to the ACP, which includes but is not limited to:

- \* Palliative and hospice utilization
- \* Advance directives
- \* Healthcare representation
- \* Out-of-hospital do not resuscitate (DNR)
- \* Education

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## Ah-Ha Moment!

**Fundamentals in place were not a guarantee of clinical integration and optimal beneficiary outcomes**

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## Results

- \* Achieving 80% discharge to PAC CCN
- \* Excellent patient and family satisfaction
- \* Significant reduction in 30-day readmission rates
  - \* 1.8% in months 9–11 of operations
- \* Significant reduction in ED visits from PAC settings

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## Franciscan Alliance ACO: Expected Outcomes

**We expect** a seamless handover at each transition of care

**We expect** delivery of high-quality and safe care across the continuum


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## Discussion and Questions?




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## Thank You!



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