Accountable Care Organizations 101

Iowa Legislative Briefing
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Speakers

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ACO History

• 2006: “Accountable Care Organization” coined at Dartmouth Medical School
  – Health care providers assume financial risk to payment rate to deliver high-quality patient outcomes of a defined population

• Iowa Health System’s (IHS) path to accountable care:
  1. IHS employees and families – System wide (IA and IL)
  2. Pioneer ACO for Medicare – Fort Dodge
  3. Medicare Shared Savings Program (MSSP) – Cedar Rapids, Des Moines, Peoria (IL), Quad Cities/Muscatine, Quincy (IL) and Waterloo
  4. Wellmark ACO – Cedar Rapids, Des Moines, Fort Dodge, Quad Cities/Muscatine and Waterloo
Iowa Health Accountable Care (IHACO)

- 9 Markets
- 222,771 people
- 1700 providers
- $1.3 billion in claims

Updated 11/12/12

Which Payer is Missing?

MEDICAID

- States are exploring ACOS for Medicaid programs
  - Colorado, Minnesota and New Hampshire
- In Iowa: IHS and IME are developing a pilot project for Medicaid recipients in the Fort Dodge region

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What is a Medicaid ACO?

- Whether the payer is Medicaid, Medicare, Wellmark or other insurance:
  - ACO goals are universal
    - Better care
    - Higher quality
    - More value
  - ACO clinical programs are universal
    - Specific programs for target population and specific person, depending upon needs

What a Medicaid ACO is Not

- An HMO or Managed Care
  - Third-party organizations that contract directly with health care providers to offer care to a defined group of patients
  - Per Member Per Month (PMPM) fees to assume all risk/gain with limited quality or success
  - Focus on cost with limited on quality or performance measures
  - Lower cost by denying care and ratcheting down utilization
Why Do We Need a Medicaid ACO?

- Current care delivery is episodic and fragmented
  - Many patients lack a primary care provider
  - Patients are accessing primary care via ED visits
  - No care coordination results in duplicative services and heightened health care costs
  - Behavioral health is not integrated with medical care
  - Patients and providers are frustrated

Current State:
A year in the Life of a Patient

- 6 Social Workers
- 13 Meds
- 5 Hospital Admissions
- 6 Weeks SNF Care
- 37 Nurses
- 4 Occupational Therapists
- 5 Physical Therapists
- 6 Community Referrals
- 2 Nursing Homes
- 2 Home Care Agencies
- 5 Months of Home Care
- 16 Physicians

Source: Johns Hopkins, RWJ 2010 (G Anderson)
ACOs Transform Care Delivery

Current State:
Medicaid patients face challenges of higher acuity levels and more complex disease states

Fee-For Service View:
Acute, episodic care focuses on non-compliant patients

ACO View:
Holistic, patient-centered care shifts focus from non-compliant patients to root causes of delivery system failures

But what about health care costs?
Bending the Cost Curve

U.S. is spending much more for older ages

Medicaid Spend and Enrollment

• IME is the Second Largest Health Care Payer in Iowa
  – Iowa total spend = $4 billion (state and federal $)
  – 2013 projected enrollment = 650,000

• Impact of Optional Medicaid Expansion (138% FPL)
  – Iowa new spend 2014-20 = $171.2-$535.6 million
  – Iowa new enrollment 2014-16 = 110,000-181,000
Medicaid insures 21% of Iowans

Delivery Reform in Medicaid is Needed to Deliver High-Quality Care and Program Efficiency

Proposed Medicaid Pilot

- Built upon success of Pioneer ACO in Fort Dodge and continual improvement from other regions
- Key components:
  - Clinical initiatives proven to deliver high-quality care
  - Collaborative efforts with community partners, including state and county Public Health Departments
  - Financial model transitions from FFS to shared savings with an end goal of global payment
CARE COORDINATION
Tenet to Transform Clinical Care

The Goals of Care Coordination

- The ACO Model encourages health care providers to work together to:
  - coordinate patient care across the care continuum
  - enhance communication with patients and among physicians, providers and community utilities
  - improve access to health care professionals
  - empower patients and families to make informed choices about their care
  - create a more efficient and cost effective care delivery system
BEYOND THEORY
Examples of ACO Clinical Initiatives throughout IHS that Result in High Quality and Efficiency

Fort Dodge - Trinity Pioneer ACO
1 of 32 CMS Pioneer ACO Model sites in the U.S.
1 of 2 rural sites

Population Health Strategies Across Health Stages

Promote and Maintain Health
Prevent Illness and Disability
Provide a Coordinated Care Experience
Manage Population Health
Support Choice Through the Lifespan
Trinity Pioneer ACO Initiatives

- Palliative Care
- Advanced Medical Team
- Medication Therapy Management
- Care at Home – Hospital and Clinic
- Wound Care Coordination
- Readmissions

Trinity Care at Home

Trinity Pioneer ACO Care At Home Results

Reduced Hospital Readmissions
June 2012 Readmission Rate – 14%
July 2012 Readmission Rate – 9%

Comparison to National Average

<table>
<thead>
<tr>
<th>Questions</th>
<th>Pioneer ACO</th>
<th>Iowa State Average</th>
<th>National Average</th>
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<tbody>
<tr>
<td>Number of completed surveys</td>
<td>355</td>
<td></td>
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<tr>
<td>Response rate</td>
<td>46%</td>
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<td>Percent of patients who reported that their home health team gave care in a professional way</td>
<td>90% 89% 88%</td>
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<tr>
<td>Percent of patients who reported that their home health team communicated well with them</td>
<td>90% 86% 85%</td>
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<td></td>
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<tr>
<td>Percent of patients who reported that their home health team discussed medicines, pain, and home safety with them</td>
<td>85% 85% 83%</td>
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<tr>
<td>Percent of patients who gave their home health agency a rating of 9 or 10 on a scale from 0 (lowest) to 10 (highest)</td>
<td>89% 86% 84%</td>
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<tr>
<td>Percent of patients who reported YES, they would definitely recommend the home health agency to friends and family</td>
<td>80% 82% 79%</td>
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Percentages reflect data from April 2011 - March 2012
Information obtained from www.medicare.gov
Waterloo Region
MSSP Participant since July 2012

ADVANCED MEDICAL TEAM (AMT)
• Interprofessional expert team supporting the medical home in the care of a complex, chronically-ill patient population
• AMT services are tapped when standardized, best practice care delivery continues to fail and puts the patient at risk for inappropriate health care utilization
• AMT conducts initial and periodic expert case review
• Case reviews result in highly individualized care plan recommendations

Results of AMT Program
• 54% reduction in hospitalizations
• 75.3% reduction in total hospital utilization costs (avoided hospitalizations and decreased LOS)
• 49.9% reduction in average hospital costs per patient (decreased LOS)
Des Moines Region

MSSP Participant since July 2012

INTEGRATED PALLIATIVE CARE PROGRAM
- Team-based care in support of the patient’s medical home
- Goal: To improve quality of life by providing patients with relief from the symptoms, pain and stress of a terminal or debilitating condition
- Integrated into all health care settings

Results of Integrated Palliative Care Program

- Inpatient reduction in LOS and case margin =
  - $800,000 (first year)
  - $1.8 million (second year)
  - $2.1 million (third year)

- Outpatient = 67% reduction in patient costs
Cedar Rapids Region
MSSP Participant since July 2012

EMERGENCY DEPARTMENT CONSISTENT CARE PROGRAM
• Engaging patients with high ED utilization in the patient-centered plan of care
• Establishing or connection plan of care with a Medical Home
• Reducing higher costs ED utilization and accessing more appropriate care
• Involving social workers to coordinate health, medical and human service needs with community utility services
• Team care shifted from acute episodic care to entire care continuum

E.D. Consistent Care – 6-month Results
In 2 year period from June 2011 to Dec 2012:
• Reduction in ED visits = 1,142
• Reduction in cost = $1,113,728
• 70% reduction in ED visits
• 244 care plans created for patients

Results indicate more than $100,000 per month in cost avoidance
56% of visits are paid for by the Medicaid program
Quad Cities Region

MSSP Participant since July 2012

BEHAVIORAL HEALTH CO-LOCATION PROGRAM

• Primary care providers are the behavioral health provider for up to 50% of all persons seeking behavioral health services
• Behavioral health specialists are located in a primary care or community utility setting and psychiatrists are available for consultation and referral as needed
• Primary care providers are co-located within the community mental health center

2010 PILOT RESULTS

• For 400 SMI patients, less than 1% were hospitalized in any given month, and 89% received annual physicals
PACE Program Results

• Predicated on high-risk population with large % of dual-eligibles
• Reduction in readmission rate 35% (July-Dec 2011) to 18% (Jan-August 2012)
• Progress in hospitalizations – 7.8% (goal < 6%)
• Progress in living situation – 12% reside in nursing homes (goal < 10%)

Dubuque Region

HOME CARE READMISSIONS REDUCTION PROGRAM

• Patient-centered plan of care
• Decrease high cost utilization
• Cross-continuum team planning and collaboration
• Intensive status updates for patients

RESULTS

• Readmission numbers have fallen by 1/3 – far below the national average
Questions?

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