Alliance Learning Collaborative
The Role of Home Health in Accountable Care Organizations

May 27, 2015
About the Alliance

• 501(c)(3) non-profit research foundation

• Mission: To support research and education on the value home health care can offer to patients and the U.S. health care system. Working with researchers, key experts and thought leaders, and providers across the spectrum of care, we strive to foster solutions that will improve health care in America.

• [www.ahhqi.org](http://www.ahhqi.org)
Today’s Speakers

David Introcaso, Ph.D.
Vice President of Policy and Operations, National Association of ACOs

Dr. Introcaso has had a long career in health care delivery, research, and policy in Washington, D.C. His prior experience includes time spent at DC General working in acute care and consulting with the National Hospice and Palliative Care Organization in post-acute care. He has served as the Agency for Healthcare Research and Quality’s evaluation officer and as a public health analyst in the Office of the Assistant Secretary for Planning and Evaluation at DHHS. Dr. Introcaso worked on the Hill in the Office of the House Majority Leader (Congressman Steny Hoyer) and has consulted with a long list of clients including the American Heart Association, the American Public Health Association, the National Institute of Nursing Research and the UnitedHealth Group. His community work addresses adult literacy, adult survivors of childhood sexual abuse, food banking, midwifery services and other issues. Among other awards, Dr. Introcaso was a four-year W. K. Kellogg Foundation National Leadership Fellow. He has taught as an adjunct at the University of Chicago and The George Washington University and he completed his undergrad and graduate studies at Arizona State and Rutgers University.
Today’s Speakers

Clif Gaus  
CEO, National Association of ACOs

Clif recently help found the National Association of ACOs (www.naacos.com) and is its current CEO. He also has founded a number of other organizations during his career, including the Georgetown University Health Policy Center, the Association for Health Services Research (now Academy Health) and HealthReformUSA.

Clif has a diverse background as a public servant, entrepreneur and health executive. He served in senior health positions under Presidents Nixon, Ford, Carter, and Clinton. In the 1970’s and 80’s, as Associate Administrator of HCFA (now CMS), he directed the development of a broad range of innovations in health care financing and delivery, including the DRG hospital payment system, RBRVS physician payment system, Medicare Hospice Programs and Medicare payment of Physician Assistants. From 1994 to 1997 he was the Administrator of the Agency for Health Care Policy and Research (now AHRQ) reporting directly to the Secretary of HHS.

In the late 90’s he held the position of Executive Vice President and Chief Administrative Officer of WellPoint Health Networks Inc., managing a staff of over 3000 employees responsible for all of WellPoint’s physician and hospital networks, medical policy, public affairs, human resources, market research and product branding. Prior to WellPoint, he was Senior Vice President of the national Kaiser Permanente Health System in Oakland, California. From 2002-10 he served on the Board of Directors of the Lucile Packard Children’s Hospital, Stanford University. In recent years Clif has consulted for a number of prominent organizations, including a six month engagement with the Administrator of CMS working on the ACO regulations and the start-up of Center for Medicare and Medicaid Innovation (CMMI).

He holds a master’s degree in health administration (MHA) from the University of Michigan and a Doctorate of Science (Sc.D.) in health care management from The Johns Hopkins University.
Today’s Webinar

• During the presentation submit questions to “Teresa Lee” at the Fuze Chat Box.
• Slides will be posted on the “Webinars” portion of the Alliance website. We are also recording the webinar for playback on the website.
Overview of the Medicare Shared Savings (ACO) Program with an Emphasis on Home Health

Clif Gaus, President and CEO
David Introcaso, Vice-President of Policy

May 27, 2015
Medicare Shared Savings Program

• The MSSP was authorized under Section 3022 of the ACA. The MSSP final rule was published 11/2/11.
• Pioneer ACOs: Initiated as a CMMI demonstration (est. under ACA Section 3021). The Pioneer demo was “certified” in April by CMS, i.e., the Pioneer model is expanded in scope and duration.
• Next Generation ACOs: A CMMI demo announced in March 2015 (begins in ‘16)
What is NAACOS?

- NAACOS is a 501(c) non-profit organization.
- Governed by ACOs from around the country.
- Facilitates ACOs increase quality, lower costs and improve the health of the community.
- Participate with federal agencies and Congress in development & implementation of public policy.
- Represents over 140 ACOs in 27 states and over 2.5 million covered Medicare lives.
- Majority are physician owned and directed.
- Supported through membership, business partners, conferences, and in-kind contributions from its members.
What is an ACO?
MSSP: Explained Simply

- Medicare patients are assigned based on preponderance of utilization over previous year (Part A and B).
- An ACO has a financial benchmark established based on immediate 3 years previous utilization (weighted at 10-30-60). (Benchmarks are “updated” in PY2 & 3.)
- To earn 50% of shared savings (Track 1), ACO must spend less than the PY benchmark. Shared savings can be reduced by an imperfect quality score on 33 measures (quality performance acts as a multiplier)
- (Patients are not assigned as an MA, therefore, patients must leave or enter an ACO in any one PY.)
How Fast is it Growing?

MA/ACO Covered Lives (in millions)


<table>
<thead>
<tr>
<th>Year</th>
<th>ACO Beneficiaries</th>
<th>MA Beneficiaries</th>
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<tbody>
<tr>
<td>2012</td>
<td>2.1</td>
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<tr>
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<td>3.7</td>
<td>14.4</td>
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<tr>
<td>2014</td>
<td>5.2</td>
<td>15.7</td>
</tr>
<tr>
<td>2015*</td>
<td>7.8 Estimated</td>
<td>17</td>
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*Estimated
There are 405 MSSP ACOs, 400 are Track 1 ACOs, 5 are Track 2.
There are currently 19 Pioneer ACOs (demo began in ‘12 with 32).
CMS expects 15-20 provider groups will participate in the Next Generation ACO demonstration.
There are an estimated 340 commercial and both commercial and government ACOs.
Total ACOs number 744 with 7.8 million Medicare lives and 20m lives total.
ACOs vary by physician group (37%), hospital led (28%) and mixed (35%).
Performance Data to Date

• PY1 MSSP ACOs (220):
  • 52 earned shared savings or saved $315m in shared savings (12 earned half of all savings)
  • 119 fell within the MSR & 43 were below the negative MSR, or lost approximately $230m
  • 29 or 59% of the 52 that earned savings had quality scores below the mean

• Pioneers (data for all 32):
  • Saved $384m in ‘12 and ’13. 10 saved significantly over two years (in ’12, 3 accounted for 27% of savings and in ’13, three accounted for 70% of savings), 10 saved significantly in only one year and 12 had no significant savings or loses
  • While quality scores improved between ‘12 and ‘13, there was little relationship between savings and high and low CAHPS scores.
What Explains Success or Shared Savings?

Those that earned share savings:

- Saved 6% per beneficiary
- Reduced in-patient by -9.5% (v. -2.7% for all 220 ACOs), readmissions by -7% (v. -4.2%), SNF by -19.8% (v. 3.7%), HH by -5.25% (v. 1%), ambulance by -9.1% (v. 2.2%) & DME by -13% (v. -8.5%)
- In PY1 Pioneer aligned beneficiaries had higher average spending for HH (& SNF): HH spending avg $.84 (stat. sig.) (per bene. per month) compared to local market & avg $.81 compared to a separate market (suggests acute substitution).
If Growing So Fast What's The Problem?

Will you stay in the MSSP for another contract year?

- **Highly unlikely**: 54%
- **Highly unlikely to sign and may not finish first 3 years**: 8%
- **Somewhat unlikely**: 4%
- **Undecided**: 26%
- **Highly likely**: 4%
- **Somewhat likely**: 4%
Current MSSP Program Problems

- Financial incentives are inadequate.
- Patient assignment should be liberalized.
- Financial benchmarking needs improvements.
- Payment waivers should serve as incentives.
- Inability to create patient affinity.
- Quality measures are only punitive.
Program Currently in Flux

(MSSP Proposed Rule Expected to Be Finalized in June)

Possible improvements to the MSSP:

• Inclusion of NPs, Pas, and CNS’s in patient assignment.
• Re: incentives, beyond higher shared savings % (as in Pioneer & Next Gen.) changes to financial benchmarking and payment waivers (SNF, HH, discharge referral and telehealth).
• Allowing patients to “attest” or affirm their participation in an ACO.
• Greater reward for exceptional quality performance (likely via the proposed ‘16 physician fee schedule rule)
• Improvements in risk adjustment and the MSR.
ACOs and Home Health

• Issue: Home health has the largest geographic variation in spending among all PAC types.
• Chronic Care Management Fee: Pays $40 per month for at least 20 min. for qualifying patients, e.g. 2 more conditions, at sig. risk with a comprehensive care plan.
• HH Waiver: Would waive the home-bound requirement.
• What ACOs look for: Ratings via Home Health Compare; clean record (no CIAs or CIDs), accredited, ability to handle complex cases, use of technology, innovative programs and 24/7 access.
Home Health Agency as ACO Participant

- Can one of a group of providers/suppliers along with e.g. a hospital, that is identified by that ACO’s participant Medicare TIN.
- The HH entity would have to agree to participate and comply with MSSP regs.
- Agreement w/or among participants must be executed before an ACO submits its application.
- The ACO is required to describe participants rights and obligations in re: quality, EBM, etc.
- The ACO must not require ACO beneficiaries be referred to ACO participants.
Discussion & Questions

• Submit questions to “Teresa Lee” at the Fuze Chat Box.

• Presentation slides and video replay will be available at http://ahhqi.org/education/webinars
Thank You!