Pioneer Accountable Care

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Geriatric Grand Rounds
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Disclosures

- No reportable conflicts of interest
Key Points

- The learner will become familiar with fiscal imperatives to improve the cost trend curve in US health care expenditures.

- The learner will be knowledgeable about the Pioneer ACO Shared Savings Model.

- The learner will understand examples of population management strategies and risk stratification related to achieving the triple aim.
The Triple Aim*

• Better care for individuals
  +
• Better health for populations
  +
• Lower per capita costs

________________________________________
= Greater Value for your healthcare dollar

* Institute for Health Improvement
The Fiscal Challenge
US Expenditures

Federal Spending, Fiscal Year 2012 (in billions)

- Health: 23.7%
- Social Security: 19.2%
- Defense: 15.3%
- Interest: 8.6%
- Income Security: 6.3%
- Education: 21.8%
- Environment: All Other
Predicted Growth in Medicare Expenditures Over Time

Medicare spending projected to grow 6.7% annually between 2014-2021\(^1\)
Projected Contributions of Rise in Health Care Costs as a Percent of GDP

Sources for Savings
Medicare Benefit Payments Distribution

NOTES: Totals do not include administrative expenses and are net of recoveries. Other Services include hospice services; durable medical equipment; ambulance services; independent, physician in-office, and hospital outpatient department laboratory services; hospital outpatient services that are not paid for using the prospective payment system (PPS); Part B prescription drugs; rural health clinic services; outpatient dialysis; and benefit payments not allocated to specific services, including adjustments to reflect year-to-date spending (2010) and savings from the Independent Payment Advisory Board (2020).

SOURCE: Congressional Budget Office, Medicare Baseline, August 2010.
Disproportionate Expenses for Complex Chronic Illnesses

- 23% of beneficiaries account for 6+ conditions.
- 32% of beneficiaries account for 4 to 5 conditions.
- 32% of beneficiaries account for 2 to 3 conditions.
- 7% of beneficiaries account for 0 to 1 condition.

Percent of Beneficiaries

Percent of Total Medicare Spending
Structure of Medicare
QUICK REVIEW OF MEDICARE REIMBURSEMENT

To understand budget targets and population management strategies of ACOs, one must understand basic Medicare:

- Medicare A
- Medicare B
- Medicare C (Medicare Advantage)
Fee For Service Medicare

• Medicare A:
  • pays DRG for hospital care
  • pays daily rate for post acute SNF by RUG within benefit limit
  • pays episode of illness payments to Home Health VNA
  • pays for Hospice program
Fee for Service Medicare

• Medicare B:
  ▪ pays for physician visits
  ▪ pays for outpatient diagnostics
  ▪ pays for outpatient therapy
  ▪ pays 80% of “allowable” for each service
  ▪ “Allowable” recommended by RUC (ACA is changing that)
  ▪ Pays for DME (CPAP, O2, Wheelchairs, orthotics…)
Medicare Capitation

- Medicare Advantage or Medicare C:
  - Contracted health plan pays for all Medicare benefits including pharmaceuticals plus
  - Benefit contracted health plan receives monthly revenue from Medicare based on the case-mix determined by ICD-9 diagnoses
  - Pace programs have a “frailty” adjuster added
One Solution: Shared Savings
Methodology of Medicare Shared Savings Programs

1. Medicare identifies a target population

2. Medicare creates a target budget for that population

3. Medicare adjusts that budget to account for potential confounders like mortality, health care cost trends

4. Medicare compares actual total medical expense for defined population to the adjusted targeted budget

5. Medicare shares savings adjusted by quality score
Defining the Population

• Medicare A and B beneficiaries in a geographic area of an organized health care system contracted with HHS for ACO Shared Savings.
Identifying Patients with an ACO

- Aligning Beneficiaries: ACO submits NPI/TIN’s of Primary Care and specialist providers for Alignment by CMS.

- Medicare matches patients to providers based on E&M visits over a three year period, and on TIN/NPI combination in a 2 step process.

- Using 3 years of historical claims weighted most heavily to most recent year (10%, 30%, 60%)
Aligning Beneficiaries Methodology for Pioneer ACO

- If the TIN/NPI primary care designated group accounts for >10% of the weighted claims, the beneficiary is aligned with the ACO that submitted that TIN/NPI. (Primary Care Providers can only participate in 1 ACO)

- If the weighted claims are <10% of the total, then a secondary alignment process ensues whereby the specialist group TIN/NPI with the preponderance of the claims charges match the patient to the ACO.
Primary Care NPIs

- General Practice
- Family Practice
- Internal Medicine
- Geriatric Medicine
- Nurse Practitioner
- Physician Assistant
- Pediatric Medicine
Specialist NPI

- Cardiology
- Neurology
- Endocrinology
- Pulmonology
- Rheumatology
- Oncology
- Nephrology
What Does That Mean

- Same patient see PCP more than outside specialist, and
- This accounts for >10% of claims dollars
- Patient would be aligned to BIDCO ACO

OR

- Patient has PCP at BIDMC and specialist at Partners.
- See’s specialist more often over past 3 yrs
- Will be aligned to the Partners ACO
Additional Implications

• Patients may align with your ACO and get most of their care elsewhere! “This is not my patient, Dr. Abrams.”
• The budget target is based on the adjusted expenditures of the aligned population at the end of the program year
• The budget target changes because of reference cohort changes as well as the excluded beneficiaries each year
  - joining a Medicare Advantage program
  - moving out of the area
N.B: Mortality does not eliminate beneficiary from that program year budget
Baseline Budget

- Shared savings success measured on Baseline Budget
- Baseline Budget is calculated by the following:
  1) Average of 2 years of real claims for aligned population adjusted for
     a) National Medicare cost trend of matched cohort (Reference Population)
     b) Actual average cost increase for the reference population
     c) Decedent adjustment
Reference Population

- Age and gender matched controls from national FFS Medicare beneficiaries adjusted for those who are:
  - without ESRD
  - disabled without ESRD
  - current ESRD
## Targeted Budget Example

<table>
<thead>
<tr>
<th></th>
<th>ACO Population</th>
<th>Change</th>
<th>Adjusted Reference Population</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>PY2 Baseline</td>
<td>CY2012</td>
<td>Dollar</td>
<td>Percent</td>
</tr>
<tr>
<td>Capped expenditure PBPY²</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 All PY2 aligned³</td>
<td>10,301</td>
<td>11,600</td>
<td>1,299</td>
<td>12.6%</td>
</tr>
<tr>
<td>2 PY2 aligned 2009-2011⁴</td>
<td>10,353</td>
<td>11,663</td>
<td>1,310</td>
<td>12.7%</td>
</tr>
<tr>
<td>3 PY2 aligned 2012 only⁵</td>
<td>9,052</td>
<td>10,083</td>
<td>1,031</td>
<td>11.4%</td>
</tr>
<tr>
<td>4 Total Baseline Decedents⁶</td>
<td>46,018</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 CY2011 Baseline Decedents⁷</td>
<td>65,607</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6 CY2012 Baseline Decedents⁸</td>
<td>36,574</td>
<td>66,129</td>
<td>33,555</td>
<td>97.2%</td>
</tr>
<tr>
<td>7 CY2013 Baseline Decedents⁹</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8 Total¹⁰</td>
<td>12,169</td>
<td>12,659</td>
<td>491</td>
<td>4.0%</td>
</tr>
<tr>
<td>Benchmark</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9 Expenditure PBPY</td>
<td>12,169</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10 Absolute change component</td>
<td>490</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11 Percent change</td>
<td>4.9%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12 Trend component</td>
<td>594</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13 Change to baseline</td>
<td>542</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14 Benchmark</td>
<td>12,711</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Creating the Baseline and Program Year Budget Targets

• Creating and then managing the budget depends upon ongoing claims analysis

• BIDCO feeds claims to data base management programs to analyze where costs and clinical opportunities overlap to better achieve the triple aim

• CMS provides quarterly reports for all Pioneer programs on utilization patterns based on their claims (including the opt outs)
Population Management Success Elements

- Data and analytics to measure and monitor quality and utilization
- Coordination of care among other specialists, providers, hospitals
- Predictive modeling to identify and target high risk patients
- Registry functionality to plan and track patient care and ensure follow up
- Resources to support patient education and self-management
- MD with sufficient time to diagnose, plan treatment, follow up
Cost Analysis Example

Medicare - By Reporting Category
12-Month Trend

Prior 12 Months
Current 12 Months
12-Month Trend

- Inpatient
- Inpatient excluding SNF
- SNF
- Observation
- OP Procedures
- Emergency
- Radiology
- Visits
- Diagnostics
- Lab
- PT/AT/ST/OT
- Ancillary

- $520
- $333
- $125
- $180
- $22
- $20
- $54
- $459
- $378
- $141
- $104
- $16
- $36
- $23
- $56
- 13.0%
- 11.0%
- 2.6%
- -0.4%
- -2.4%
- -6.3%
- 1.4%
- -1.4%
- -7.4%
- 27.9%

Beth Israel Deaconess
CARE ORGANIZATION LLC
Affiliated with
Beth Israel Deaconess Medical Center
HARVARD MEDICAL SCHOOL
TEACHING HOSPITAL
Managing the Budget

- Medicare provides claims data monthly to the ACO on the aligned beneficiaries

EXCEPT......
Access to Claims Data “Data Sharing”

• Aligned patients are sent a CMS approved letter by us introducing them to the program and giving them the option to opt out of sharing data (NOT whether to be aligned!!)

• Data excludes alcohol/substance abuse, but includes other mental health claims, and pharmacy/medication information, not costs

• The data informs practices on outcomes driven medical expense and quality metrics
Getting Opt-outs to Opt In

Current enrollment: 65,000 aligned beneficiaries
~6,000 opted out of data sharing

Practices will need to reach out to patients who have opted out of data sharing.

BIDCO will provide:

- Listing of your patients who have opted out;
- CMS approved letter to patients explaining why sharing their data is important to their own care;
- CMS Consent to Change Personal Health Information Preference
Implementing Strategies at BIDCO

Predictive Modeling
Predictive Risk Modeling

- BIDCO contracts with OPTUM iPro and sends claims to create risk profiles and registries including mortality risk, risk of hospitalization, disease management profiles, future cost risk

- BIDCO then sends these risk scores and registries of aligned patients to the Pods

- BIDCO offers RNCMs, BIDCO NP Medical Housecalls, and 3 Disease Management Programs to support PCPs
Coordination Among Providers

• ER initiatives: UTI and Falls at BIDMC as example

• SNF initiatives: LOS as contribution to TME

• RN Care Managers for practices: support all of the above and more

• NP Housecall model: Results to date

• Disease Management: Hospice care example
# Urinary Tract Infection/Falls Admissions

**BIDMC UTI over 65 Jan-June 2013**

<table>
<thead>
<tr>
<th>ED Diagnosis</th>
<th>Volume of admitted patients</th>
<th>Number of 1 day LOS</th>
<th>Ave Cost of DRG</th>
<th>Potential Savings at 30% reduction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Falls</td>
<td>554</td>
<td>242</td>
<td>$10,000</td>
<td></td>
</tr>
<tr>
<td>UTI</td>
<td>419</td>
<td>143</td>
<td>$10,000</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>973</td>
<td>385</td>
<td></td>
<td>$1.3 Million</td>
</tr>
</tbody>
</table>
ER Admission Project Cost Contribution

- 2013 BIDCO Pioneer has 37,000 aligned beneficiaries

- If $12,000 per patient per year is assumed, the total budget is about $440M

- 2013 PY target of 1% this year would require a minimum savings of $4.4M.

ER contribution to savings for 2 short stay diagnoses could be 25% of savings goal for the year
Skilled Nursing Facility Care

- Contribute to acute hospital utilization through high readmission rates within 30 days of over 22%
- Average SNF LOS for ACO patients currently 27 days
- Represent at least 50% or more of the total cost of an acute episode of illness for many common diagnoses
- Regional differences in post-acute care for many diagnoses. We admit 34% of acute hospital ACO patients to SNFs prior to going home.
## Facility Profile: Average Hospital

<table>
<thead>
<tr>
<th></th>
<th>Cases</th>
<th>Index Adm.</th>
<th>PAC</th>
<th>% PAC</th>
</tr>
</thead>
<tbody>
<tr>
<td>AMI</td>
<td>50</td>
<td>$10,609</td>
<td>$18,261</td>
<td>63%</td>
</tr>
<tr>
<td>CABG</td>
<td>13</td>
<td>$39,126</td>
<td>$15,194</td>
<td>28%</td>
</tr>
<tr>
<td>CHF</td>
<td>145</td>
<td>$9,414</td>
<td>$22,344</td>
<td>70%</td>
</tr>
<tr>
<td>COPD</td>
<td>125</td>
<td>$5,585</td>
<td>$11,288</td>
<td>67%</td>
</tr>
<tr>
<td>Total Joint</td>
<td>155</td>
<td>$13,011</td>
<td>$12,457</td>
<td>49%</td>
</tr>
<tr>
<td># Episodes</td>
<td>488</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Cases</td>
<td>3,300</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percent</td>
<td>14.8%</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
End of Life Care

• Contributes disproportionately to medical expense in the last 6 months of life and especially the last month

• Hospice care at the end of life is 50% less expensive on average in our Pioneer population

• Hospital setting accounts for the vast majority of deaths even in patients with expected mortality
BIDCO Experience with End of Life Care

• Mortality rate for the Pioneer population is around 5%

• Of anticipated 3250 patient deaths, 1625 patients of the who expire need to be in Hospice in 2015 in order to achieve our target of 50% for the program year.

• Risk Unit Meetings provide updated monthly report by Pod of the total number of deaths and percent in hospice at the end of life for Pioneer ACO patients.
Approaches to Care for Advanced Illness

- BIDCO NPs provide Housecalls Medicine model of care for highest risk patients with known positive impact on hospitalizations at the end of life.

- Levine scores in the future may provide PCPs with basis for advanced care planning discussions and documentation

- Improve information and referral processes for practices

- Advanced Illness Disease Management Education
Geriatric Primary Care

• Based 2012 results, Geriatric Primary Care had the highest risk cohort of patients based on their target budget total medical expense

• Geriatric Primary Care delivered greater savings to their budget than any other practice
Quality Metric Scores

• Improve care to individuals

• Improve outcomes for populations

• Determine the shared savings or loss
Quality Measures

Success on 33 quality measures determines final percentage of surplus or deficit BIDCO will have in each year

- Going forward quality score is based on achieving targets for each quality measure
  - Most of the Measures are PCP based
  - Many measures overlap with other contracts
- Performance is based on a random sample
  - CMS software will allow ACOs to submit clinical information from EHRs, registries, and administrative data sources required for measurement reporting
  - Manual data extraction will be necessary to complete reporting
- ACO Quality measures replace PQRS reporting, with the exception of e-Prescribing (we are working with CMS on details).
Quality Metric Scoring

- Year 1: Reporting Only
- Year 2: 8 pay for reporting, 25 pay for performance
- Year 3: 32 pay for performance, health status functional status is pay for reporting
- Minimum Requirement: 30th percentile or better on 70% of the measures
- Each measure has maximum score of 2pts
Quality Measures - Summary

• Total of 33 ACO quality measures
  ▪ 7 Patient Survey
  ▪ 4 Claims Based
  ▪ 22 Clinical Quality Measures (EHR based)

• The 22 Clinical Quality Measures cover 3 domains of care
  ▪ Care coordination/patient safety (2 measures)
  ▪ Preventive care and screening (8 measures)
  ▪ At-risk population (12 measures)
    • Diabetes (1 five-component composite measure + 1 individual measure)
    • Hypertension (1 measure)
    • Ischemic Vascular Disease (2 measures)
    • Heart Failure (1 measure)
    • Coronary Artery Disease (1 two-component CAD composite measure)
  ▪ Six will be reporting only, remainder are performance based
Quality Metric Scoring

• Each Domain contributes 25% to score
• CMS’s “Sliding Scale Measure Scoring Approach”
• ACO Performance Level Quality Points
  • 90+ percentile FFS/MA Rate or 90+ percent 2 points
  • 80+ percentile FFS/MA Rate or 80+ percent 1.8 points
  • 70+ percentile FFS/MA Rate or 70+ percent 1.7 points
  • 60+ percentile FFS/MA Rate or 60+ percent 1.55 points
  • 50+ percentile FFS/MA Rate or 50+ percent 1.4 points
  • 40+ percentile FFS/MA Rate or 40+ percent 1.25 points
  • 30+ percentile FFS/MA Rate or 30+ percent 1.10 points
  • <30 percentile FFS/MA Rate or <30 percent No point
## Quality Metric Scoring

<table>
<thead>
<tr>
<th>Total Points for Measures</th>
<th>Possible Pts.</th>
<th>Obtained Pts.</th>
<th>Domain%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient/Caregiver</td>
<td>7</td>
<td>4</td>
<td>3.1</td>
</tr>
<tr>
<td>Experience</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Care Coordination/</td>
<td>6</td>
<td>14</td>
<td>9.3</td>
</tr>
<tr>
<td>Patient Safety</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preventive Health</td>
<td>8</td>
<td>16</td>
<td>13.6</td>
</tr>
<tr>
<td>At-Risk Populations</td>
<td>12</td>
<td>14</td>
<td>9</td>
</tr>
<tr>
<td><strong>Average</strong></td>
<td></td>
<td></td>
<td><strong>73.25</strong></td>
</tr>
</tbody>
</table>
Effect of Quality Scores on Shared Savings

- If you score in the 73.25th percentile overall;
  AND
- If you achieve your contracted savings target*

Then: Multiply your shared savings rate by your percentile rank = percent of savings CMS will provide the organization

* BIDCO ACO target minimum is 1% total medical expense
## Shared Savings Options

<table>
<thead>
<tr>
<th>Payment Option</th>
<th>Performance Yr 1</th>
<th>Performance Yr 2</th>
<th>Performance Yr 3,4,5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Core Option</td>
<td>Up to 60% shared savings or losses; 10% maximum</td>
<td>Up to 70% shared savings or losses; 15% maximum</td>
<td>Population based payment up to 70% shared savings/losses; 15% maximum</td>
</tr>
<tr>
<td>Option A</td>
<td>Up to 50% shared savings or losses; 5% maximum</td>
<td>Up to 60% shared savings or losses; 10% maximum</td>
<td>Population based payments as in the Core Payment Arrangement</td>
</tr>
<tr>
<td>Option B</td>
<td>Up to 70% shared savings or losses; 15% maximum</td>
<td>Up to 75% shared savings or losses; 15% maximum</td>
<td>Population based payments up to 20% shared savings/losses; 15% maximum</td>
</tr>
</tbody>
</table>
# Pioneer ACO Model Participants

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Allina Health <em>(formerly Allina Hospitals &amp; Clinics)</em></td>
</tr>
<tr>
<td>2.</td>
<td>Atrius Healthdf</td>
</tr>
<tr>
<td>3.</td>
<td>Banner Health Network</td>
</tr>
<tr>
<td>4.</td>
<td>Beacon Health <em>(formerly Eastern Maine Healthcare System)</em></td>
</tr>
<tr>
<td>5.</td>
<td>Bellin-Thedacare Healthcare Partners</td>
</tr>
<tr>
<td>6.</td>
<td>Beth Israel Deaconess Physician Organization</td>
</tr>
<tr>
<td>7.</td>
<td>Brown &amp; Toland Physicians</td>
</tr>
<tr>
<td>8.</td>
<td>Dartmouth-Hitchcock ACO</td>
</tr>
<tr>
<td>9.</td>
<td>Fairview Health Systems</td>
</tr>
<tr>
<td>10.</td>
<td>Franciscan Alliance</td>
</tr>
<tr>
<td>11.</td>
<td>Genesys PHO</td>
</tr>
<tr>
<td>12.</td>
<td>Healthcare Partners Medical Group <em>(alternative name: Healthcare Partners of California)</em></td>
</tr>
<tr>
<td>13.</td>
<td>Healthcare Partners of Nevada</td>
</tr>
<tr>
<td>14.</td>
<td>Heritage California ACO</td>
</tr>
<tr>
<td>15.</td>
<td>JSA Medical Group, a division of HealthCare Partners</td>
</tr>
<tr>
<td>16.</td>
<td>Michigan Pioneer ACO</td>
</tr>
<tr>
<td>17.</td>
<td>Monarch Healthcare</td>
</tr>
<tr>
<td>18.</td>
<td>Montefiore ACO <em>(formerly Bronx Accountable Healthcare Network (BAHN))</em></td>
</tr>
<tr>
<td>19.</td>
<td>Mount Auburn Cambridge Independent Practice Association (MACIPA)</td>
</tr>
<tr>
<td>20.</td>
<td>OSF Healthcare System</td>
</tr>
<tr>
<td>21.</td>
<td>Park Nicollet Health Services</td>
</tr>
<tr>
<td>22.</td>
<td>Partners Healthcare</td>
</tr>
<tr>
<td>23.</td>
<td>Physician Health Partners</td>
</tr>
<tr>
<td>24.</td>
<td>Plus <em>(formerly North Texas ACO)</em></td>
</tr>
<tr>
<td>25.</td>
<td>Presbyterian Healthcare Services <em>(formerly Presbyterian Healthcare Services Central New Mexico Pioneer Accountable Care Organization)</em></td>
</tr>
<tr>
<td>26.</td>
<td>Primecare Medical Network</td>
</tr>
<tr>
<td>27.</td>
<td>Renaissance Health Network <em>(formerly Renaissance Medical Management Company)</em></td>
</tr>
<tr>
<td>28.</td>
<td>Seton Health Alliance</td>
</tr>
<tr>
<td>29.</td>
<td>Sharp Healthcare System</td>
</tr>
<tr>
<td>30.</td>
<td>Steward Health Care System</td>
</tr>
<tr>
<td>31.</td>
<td>Trinity Pioneer ACO, LC <em>(formerly TriHealth, Inc.)</em></td>
</tr>
<tr>
<td>32.</td>
<td>University of Michigan</td>
</tr>
</tbody>
</table>
Summary

• Fiscal imperatives in our healthcare system require improvements in value for money spent;

• Shared savings under Medicare aligns financial incentives with better clinical outcomes and quality scores

• Pioneer ACO is one of the Shared Savings models

• Examples of patient management strategies that can improve patient care and reduce costs
Strategies to Reduce Medical Expense for ACO

• Identify the highest risk patients and provide care management
• Reduce hospital admissions through PCP and ER initiatives
• Reduce readmissions within 30 days by partnering with SNFs and Home Health agencies
• Reduce SNF LOS
• Reduce SNF based post-acute episodes of care
• Improve patient engagement in self care
• Advanced Illness/Palliative Care/Advanced Care Goal determination
Strategies for Improvement

- Disease Management programs
- Nurse Care Managers
- Housecalls Medicine
- Transitions in Care
- Evidence Based CDSM programs
- Practice Redesign
Be Prepared

• Eventually, when you get good at this, consider innovative contracting
• Make sure to have primary care clinicians from key ACOs credentialed in your building and active
• Minimize hospital leakage….work with the ambulances too
• Clarify your requirements of nursing and primary care handoffs both with the hospital and community
• Work with the therapies on goals of care the day of admission
Be Prepared

• Share data with ACO partners such as LOS/Readmission rates/special programs and successes
• ACOs will direct choice while not eliminating choice
• Review each readmission and its root cause
• Consider warm handoffs
• Use the Interact tool and Sbar approach
• Treat in place and work with ER to assure patients who can be sent back are

<table>
<thead>
<tr>
<th>Service</th>
<th>Percent With Claim</th>
<th>Mean Cost Per Service User</th>
</tr>
</thead>
<tbody>
<tr>
<td>Index Admission</td>
<td>100.0%</td>
<td>$11,079</td>
</tr>
<tr>
<td>Rehab</td>
<td>12.7%</td>
<td>$13,021</td>
</tr>
<tr>
<td>SNF</td>
<td>39.4%</td>
<td>$9,347</td>
</tr>
<tr>
<td>LTAC</td>
<td>0.3%</td>
<td>$32,298</td>
</tr>
<tr>
<td>Home Health</td>
<td>68.6%</td>
<td>$3,538</td>
</tr>
</tbody>
</table>

Total Cost of Episode of Illness

- Hospitalization DRG plus (average around $10,000)
- SNF care plus (average around $10,000)
- Home Health costs ($3000)
- __________________
- CHF or Pneumonia costs $23,000 in facility/agency fees to get back home safely currently
Data Sharing

• Each year, BIDCO receives an alignment list of new beneficiaries. Each new beneficiary receives a letter asking them if they want to opt out of their claims data sharing.

• Message to patients is that Medicare is sharing claims data with other BIDCO providers, not detailed information such as conditions.

• The more data we have about patient utilization of services, the more likely we can successfully achieve outcomes, quality, and cost goals.

• Beneficiaries can opt back into data sharing by signing a form even after initially opting out of data sharing.
SNF Care Partnerships with ACOs

- Studies show that SNF care trends are geographic
- Same diagnosis/better outcomes for several diagnoses going straight home in other parts of the country
- Home Health agencies admit patients and start treatment as quickly as SNFs
- Reduce LOS from 27 average to 20 average
- Improve direct discharges to home
- Waiver of 3 day hospital stay will increase SNF volume