CBOs & The Business of Healthcare: Oregon Edition

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Changes Healthcare Landscape

Bundled Payment Waiver

CMMI Initiatives

Next Steps
Robust Changes to the Healthcare Landscape

• The Patient Protection and Affordable Care Act
  – Health Reform. Commonly called the Affordable Care Act or ACA
  – Signed into law by President Obama on March 23, 2010
  – On June 28, 2012, the Supreme Court rendered a final decision to uphold the law

• MACRA – Medicare Access and CHIP Reauthorization Act

• Oregon Medicaid Waiver
  – Coordinated Care Organizations
Implications of Payment Reform on Hospitals

• Hospitals must develop a population health approach
• Coordinated Care Organization (Medicaid) objectives align with Medicare payment reform initiatives
• Population Health Requirements
  – Reduced Readmissions
  – Financial incentives skew to wellness
  – Prevention and Wellness essential to success
CBOs Strengths

- Established, trusted providers servings older adults and persons with disabilities in community settings
- Array of Evidence-Based programs and services
- Proven outcomes
- Wellness occurs in the community not in the hospital.
- Programs that support beneficiaries to live in the least restrictive environment as possible -- for as long as possible
CBO Weaknesses

- Lack of Health IT systems that integrate with healthcare providers
- Lack of clinical oversight to provide value added services that achieve clear, measurable health improvement and cost reduction outcomes
- Limited ability to produce analytics to target services and evaluate impact of services rendered
- Limited business acumen
- Major Shift in Culture Required
May 2013, ACL launched a learning collaborative to provide expanded TA to networks of community-based aging and disability organizations (CBOs) to improve their Business Acumen.

- Create Regional Management Services Organizations
- Nine (9) Networks selected
- 2015 – Eleven (11) Networks participating
Business Acumen Goals

• Provide targeted TA to selected sites
• Support their local efforts to secure at least one contract with an integrated care organization
  – Create a Sustainable infrastructure to support direct contracting
  – Accountable Care Organizations (ACOs)
  – Medicaid Managed Care Organizations (MCOs)
  – Medicare Advantage
Bundled Payments for Care Improvement Initiative

• Initiative first awards were announced January 31, 2013
• Under this initiative, organizations enter into payment arrangements that include financial and performance accountability for episodes of care
• Episode of Care
  – Key component of the initiative
  – All services rendered are bundled into one payment for an episode of care
  – Provides a financial incentive for the org. to keep costs down
BPCI Models

- Four Models – Each model links payments for multiple services serving beneficiaries
  - Model 1 – Retrospective Acute Care Hospital Stay Only
  - Model 2 – Retrospective Acute Care Hospital Stay Plus Post-Acute Care
  - Model 3 – Retrospective Post-Acute Care Only
  - Model 4 – Prospective Acute Care Hospital Stay Only
Bundled Payment for Care Initiative (BPCI)

• Most Bundled Payment activity in Oregon is Model 2 & 3

• Under the CMS Model 3 BPCI Initiative:
  – Medicare Beneficiary with one of the 48 conditions automatically enters Bundled Payment – if the facility that he or she enters has opted to participate
  – Facility paid a flat-rate for up to 90 days (episode)
  – All Post-Acute Care costs are deducted from the total bundled payment amount
Post Acute Care and Bundled Payment

- Model 3 Bundled Payment success is hinged on the ability to manage the post acute care period.
- Organization receives one rate for 90 days.
- For a SNF, if the beneficiary stays in the facility for the full 90 days, they will likely lose money.
Southern Oregon Orthopedics, Inc
Saint Alphonsus Medical Center
Ontario Neurospine Institute LLC
Slocum Orthopedics Pc
Orthopedic And Fracture Clinic, Pc
Peacehealth Sacred Heart - Riverbend
Model 3

- Model 3 – 32 Participants in Oregon
- Primarily Skilled Nursing Facilities
- Includes 48 conditions in most cases
- 90-day bundled payment risk period
Example – Merrimack Valley, MA

- Community-Based Area Agency on Aging
  - Care Transitions
  - Diabetes Self-Management Education
  - Chronic Disease Self-Management Education
  - Depression Screening and Counseling
  - Long-term Care Support – HCBS

- Program proved their ability to reduce costs and defined the return on investment for their programs
• United Healthcare Dual-SNP Plan
  – Hospital ADT data shared with CBO
  – CBO provides care transitions services
  – CBO collects health risk data and completes a medication review
  – Outcome data (aggregate) and individual data submitted back to MCO
ACO Contract - Merrimack

- ACO risk stratified their population of consumers with diabetes and pre-diabetes
- List of consumers with diabetes referred to CBO for diabetes self-management education
- Outcome from DSMT reported back to primary care physician and ACO
Florida Example - Accountable Care Community Model

- Hospitals / Health Systems
- Patient Centered Medical Home (PCMH)
- Community Support Infrastructure as an extension of the PCMH
  - Community Support Multi-disciplinary team
    - Registered Nurses
    - Licensed Clinical Social Workers
    - Registered Dietitians
    - Community Health Workers
Patient Centered Model of Care

- Member with two or more Chronic Diseases
  - Hospital/Specialists
  - PCMH
  - Care Manager
  - Health Coach
Five Roles of a Health Coach

*American Academy of Family Physicians

- Self-Management Support
  - Providing Information
  - Teaching disease-specific skills
  - Promoting behavior change
- Bridge Between Clinician and Patient
  - Local patient liaison
  - Support for PCP disease management plan
- Navigation of the Health Care System
- Emotional Support
- Continuity
• American Academy of Family Physicians Data
  – 50% of patients leave primary care visits reporting they do not understand what their doctor told them
  – 9% of patients participate in health decisions
  – Medication adherence rates are estimated at 50%
  – 10% of patients are able to make recommended lifestyle changes
Why Use a Health Coaching Model

• Integrated Health Coaching has been shown to reduce complications and lower overall costs
  – Multiple randomized trials
  – Evidenced-based Intervention
  – Many leading Healthcare institutions have begun using health coaches
Additional Benefits of a Health Coaching Model

• Benefits seen most with persons with 2 or more chronic diseases
• Provides increased support for moderate to high-risk groups
• Increased consumer satisfaction
Health Coaching Program process

- Members will be identified by claims data analysis and internal referrals
- Targeted members will be contacted and have a patient-centered health risk assessment
- A patient-centered health education plan will be developed
- Health Coach will work with member to achieve health goals – community extension of Disease/Case mgmt
- Members will be linked with community-based wellness programs
- Post intervention analysis of cost and quality improvement
Population Risk Stratification Plan

- Johns Hopkins ACG® system
  - Population/patient case-mix adjustment system
  - Developed by researchers at Johns Hopkins University
  - Patented Predictive modeling algorithm
- Future Costs
- Future Hospitalizations
- Unexpected High Pharmacy Use
ACG ® Algorithm

• ACG ® Algorithm assesses multiple variables
  – Morbidity
  – Risk of morbidity
  – Consumption of healthcare resources
  – Risk of mortality
ACG Morbidity Categories

- ACG® system stratifies consumers into morbidity categories, termed Resource Utilization Bands (RUB)

- ACG® RUB Categories
  - 0: Non-Users
  - 1: Health Users
  - 2: Low Morbidity
  - 3: Moderate
  - 4: High
  - 5: Very High
Target Population

• Beneficiaries with two or more chronic diseases
  – With complications:
    • Frequent hospitalizations
    • Recent hospitalization
    • Recent SNF admission
    • Presence of a disease-related complication(s)
    • Poor clinical quality measures for disease
    • History of Falls or high-risk for falls
Population Stratification

- 5% High Risk
  - (AvMed @ Home)
- 15% Moderate Risk
  - (AvMed Health Coaching)
- 80% Medium/Low Risk
Target Population for Health Coaching Model

- **Low Risk**
  - Healthy – Active with one or less chronic diseases

- **Medium Risk**
  - 2 or more chronic diseases with no complications

- **Moderate Risk**
  - 15% Health Coaching

- **High Risk**
  - 5% AvMed at Home

- **Highest Risk Beneficiaries:**
  - In-home supportive services

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**Risk Levels:**
- **Low Risk**
- **Medium Risk**
- **Moderate Risk**
- **High Risk**
- **Highest Risk**
Community-Based Wellness Programs

• Health Coach will support the member in accessing the following programs
  – Diabetes Self-Management
    • Stanford Model: Evidence Based
  – Chronic Disease Self Management
    • Stanford Model: Evidence-Based
  – Online Chronic Disease Self-Management Program
    • Stanford Model: Evidence-Based
  – EnhancedFitness
    • Evidence Based activity program
  – Matter of Balance
    • Evidence Based fall prevention
Questions

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