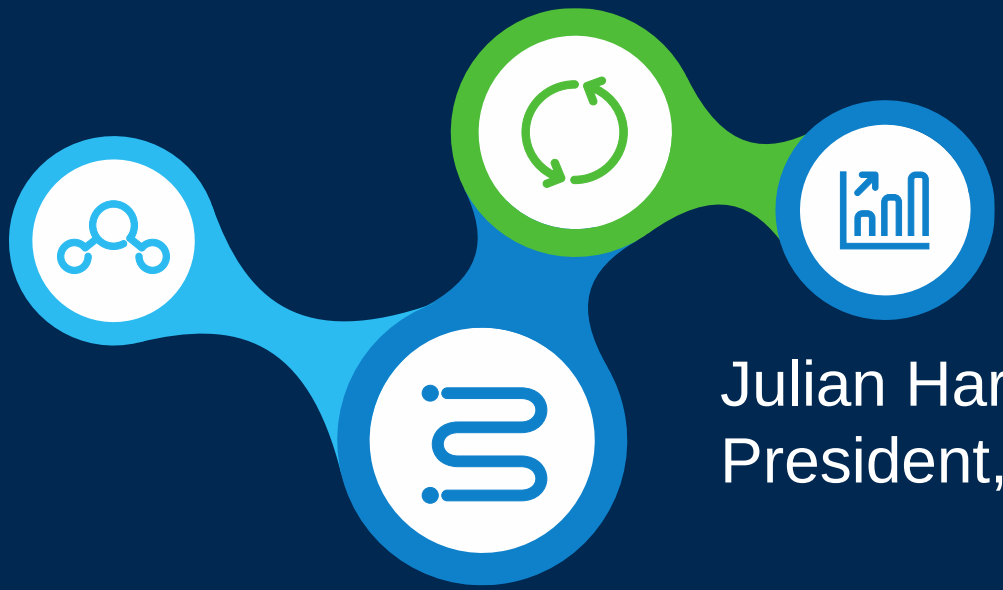
Roundtable on Quality Care for People with Serious Illness

National Academies of Sciences, Engineering, and Medicine



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CareAllies®

Why Focus on a Move From Fee-For-Service (FFS) to Fee-For-Value (FFV)?

1. Health care cost growth is adversely affecting employers' and the US economy's ability to compete and there is significant opportunity to improve quality
2. Incentives provided through The Affordable Care Act (ACA) for new payment models that encourage coordination of care across providers (e.g. ACOs)
3. Big data and technology developments have improved clinical and financial data systems, enabling improved data aggregation, analytics and exchange to help providers treat patients more effectively
4. HHS' announcement of value-based reimbursement goals and passage of the Medicare Access & CHIP Reauthorization Act (MACRA) signaled to the industry that value-based reimbursement is the future

Major Health Care Cost Drivers Today[1]

- High utilization of expensive services (e.g., MRI)
- Provider market power due to consolidation
- Rising prescription (particularly specialty) drug costs
- Overtreatment, particularly in end-of-life care
- Unhealthy behaviors leading to a high level of chronic illness
- Practicing defensive medicine to avoid lawsuits
- A high level of delivery system fragmentation, leading to poor quality, higher costs, and lower patient satisfaction
- High levels of fraud, waste, and abuse in the health care system

[1] A Report by the State Health Care Cost Containment Commission, *The Miller Canter – University of Virginia*, "Cracking the Code on Health Care Costs," January 2014.

Overview of Medicare Reform Efforts

Medicare Shared Savings Program	Groups of doctors, hospitals, and other health care providers come together to provide coordinated high quality care to their Medicare patients
Chronic Care Management Program	Physicians are reimbursed for providing non-face-to-face care coordination services to eligible Medicare patients with multiple chronic conditions
Bundled Payments for Care Improvement (BPCI)	Meant to lead to higher quality and more coordinated care at a lower cost, organizations enter into payment arrangements that include financial and performance accountability for all of the services within an episode of care
Hospital Readmissions Reduction Program	Financially penalizes hospitals with relatively high rates of Medicare readmission; within 30 days of discharge for heart attack, heart failure, pneumonia, COPD, elective hip or knee replacement, or coronary artery bypass graft
Value Based Insurance Design (VBID)	Allows MA plans to offer supplemental benefits or reduced cost sharing to enrollees with diabetes, congestive heart failure, COPD, past stroke, hypertension, coronary artery disease, mood disorders, dementia, or rheumatoid arthritis

Overview of Medicaid Reform Efforts

State Innovation Model (SIM)	Initiative to advance multi-payer health care payment and delivery system reform models in order to achieve better quality of care, lower costs, and improved health for the state's population
Duals Demonstrations	The financial alignment demonstrations offer a capitated model (prospective blended payment to provide comprehensive coordinated care) and a managed FFS model (state can benefit from savings from initiatives to improve quality and reduce costs).
Accountable Care Organizations	States see ACOs as an effective way to improve outcomes and control costs, and CMS encourages Medicaid focused ACOs through the Nursing Home Value Based Purchasing Demonstration and the Vermont All-Payer ACO Model
Comprehensive Primary Care Initiative (CPC)	Multi-payer initiative collaborating with commercial and State health insurance plans to offer population-based care management fees and shared savings to participating primary care practices
Delivery System Reform Incentive Program (DSRIP)	Section 1115 waiver allowing the state to pool a portion of hospital uncompensated care funds to reward providers for successful delivery system and payment reform projects

Private Companies are Also Contributing to Reform

- One emerging technology focused company is concentrating on value-based care for urban populations with complex health needs
  - Works to provide Medicaid and lower-income Medicare beneficiaries access to personalized health services
- Partners with community-based organizations, health plans, and provider organizations
- Combines custom-built technology with care models that fully integrate primary care, behavioral health, and social services
- Innovations like this have spun off from a parent organization focused on other health related topics, such as how facets of a city system including transportation and food access can affect health

This model is comprised of a "personalized care team" for each member, which includes doctors, coaches, and technology tools, and members can also join a "neighborhood health hub" allowing them to connect with their care team.

Caring for Complex Patients – Case Studies

Background	Action Plan	Results
• 63-year-old female patient with multiple chronic conditions • 4 acute admits between Aug 2016 – Jan 2017, incl. one for behavioral health • Complains of ongoing pain and needs help with med. adherence • Spouse recently had open-heart surgery	• Enrolled in care transition coaching program, including home visit • Transition to chronic case management • Medication counseling, behavioral health referral, pain management • Referral to TX Department of Aging and Disability Services	• Since assessment, has not had any unplanned admissions • Patient has verbalized better understanding of the importance of taking medications
• 74-year-old male with multiple chronic conditions who had a recent laryngectomy surgery • Post-surgery complications led to 7 ER visits and 2 acute admissions	• Enrolled in respiratory case management program • Assisted patient in setting up visit with a pulmonologist • Case manager assisted in securing a home health referral for physical therapy	• Since assessment, the patient has had no admissions or ER visits
• Patient with End Stage Liver Disease had consistently been hospitalized on a monthly basis • Primary driver of patient's hospitalizations was an inability to pay for her medications	• Care coordination team located a medication assistance program that could potentially meet the patient's financial need • Worked with the patient's supervising physician to get her approved to received medication free of charge ($2,000+ monthly savings)	• Since the patient was approved for assistance, she has not been hospitalized again

CareAllies information as of October 2017.

The CareAllies Approach to Complex Care

Our Model

A comprehensive, integrated (end-to-end), team-based (multidisciplinary) approach to the management of patients across the spectrum of care with chronic, complex, and disease specific care needs.

Complete Health Team

- A deployment strategy of market-based clinical and non-clinical support resources
- Arranged around independent physician associations (IPA)
- Designed to provide collaboration and coordination throughout customer transitions and continuums of care
- Meetings are held weekly to discuss clinical issues, complex chronic customers, and chronic programs available
- The team formulates care plans that meet the need of each patient

Home-Based Services

- Physician-led model of care in which CareAllies providers are adjuncts to the PCP
- Home visits primarily performed by nurse practitioners, under the supervision of physicians
- Acuity-based intensity program – frequency of visits driven by patient's needs/changes in condition
- Helps overcome barriers to care – including geographic distance, lack of access to transportation, and/or diminished mobility