

What's Ahead for Post-Acute and Chronic Care?

Panelists

- Jeff Kincheloe, V.P. for Government Affairs, NAHC
- Dr. Peter Boling, Professor of Medicine, VCU
- Mara Benner, V.P. for Government Affairs, Gentiva
- Bill Borne, Chief Executive Officer, Amedisys

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Jeff Kincheloe

Vice President for Government Affairs
National Association for Home Care & Hospice

Key Provisions in Health Care Reform Legislation
Affecting Post-Acute and Chronic Care

(Patient Protection and Affordable Care Act (H.R. 3590; Public Law No. 111-148) as amended by the Manager's Amendment (S.AMDT. 2786) and the Health Care and Education Reconciliation Act of 2010 (H.R. 4872)

Medicaid

- Community First Choice Option (Sec. 2401)
- Medicaid and State Waiver Programs (Sec. 2402)
- Money Follows the Person (Sec. 2403)
- Spousal Impoverishment Protections (Sec. 2404)

Medicaid Continued

- Sense of the Senate on Long Term Care (Sec. 2406)
- Medicaid Health Homes (Sec. 2703)
- Medicaid Bundled Payment (Sec. 2704)

Medicare

- Shared Saving Accountable Care Organizations (Sec. 3022)
- Medicare Bundled Payment Pilot (Sec. 3023)
- Independence at Home Demonstration (Sec. 3024)

Medicare Continued

- Community-Based Care Transitions Program (Sec. 3026)
- Vulnerable Patient Study and Demonstration Project (Sec. 10315 of the Manager's Amendment)

CLASS Act Program (Sec. 8001-8002)

- Voluntary National Long Term Care Insurance Program
- Emphasis on Home and Community-Based Care
- Non Medical Services and Supports

Independence at Home: Patient Centered Care

Peter A. Boling, MD
Professor of Medicine
Virginia Commonwealth University
pboling@mcvh-vcu.edu

Independence At Home Concept

- New federal legislation
 - Section 3024
- Based on house call practice model
 - Extended interdisciplinary team
 - Longitudinal care
- Gain-sharing (pays for itself)
- Focus on 3-4 million sickest individuals
 - Multi-morbid, high cost, function-limited

Specifics of IAH

- Demonstration
- Regulations to be written
- 3-year agreement with IAH programs
- Annual reconciliation of predicted and actual costs
- Independent evaluation
- Best and brightest needed at first
 - Prove the case → permanent program

Patient Selection

- Your sickest patients, not average patients
- Two or more advanced chronic illnesses
 - CHF, COPD, diabetes, Alzheimer's, stroke
 - CAD, PVD, pressure ulcers, neurodegenerative
- High-risk (utilization), high cost
 - Hospitalization (within 12 months)
 - Plus post-acute care (Part A)
- Functional impairment
- NOT required
 - Homebound
 - Skilled need

Exclusions

- PACE enrollees
- CCIP demo enrollees
- Chronic NH resident (90 days or more)
- Unsafe home

IAH Scope of Service

- At least 150 patients per site
- Comprehensive assessment
- Coordination of care
- Longitudinal care
 - not short term, intermittent
- Response 24-7-365 for urgent needs
- Electronic health record
- Mobile diagnostics

IAH Providers

- IAH Team led by physician or NP
- Interdisciplinary
- Team structure = decided by IAH entity
 - HHA – Physician / NP partnerships are key
 - NPs or PAs likely to be prevalent
 - Many options for extended networks

IAH Finance and Coverage

- Patients enroll in IAH
 - May disenroll at any time
- Medicare A and B continue unchanged
- Costs are predicted
- IAH providers paid usual fee-for-service
- Actual costs compared to predicted costs
- Gain-sharing determined

IAH Gain Sharing and Risk

- Medicare costs below predicted
 - Medicare keeps 5% (minimum savings)
 - IAH entity gets portion of remaining difference
 - Incentive to control Part A (hospital) costs
 - Invest in infrastructure (HIT, diagnostics)
 - Reward clinicians
- Medicare costs exceed 95% of predicted
 - No gain sharing for IAH entity
 - Keep usual Medicare payments (current rate)

IAH Organizational Structure

- IAH program can be based in
 - Medical group practice, small or large
 - Home health agency
 - Hospital or health system
 - Insurance company
- Can be small (e.g. group practice)

IAH Medical Providers

- Qualifications (boards, certificates)
- At least one year of experience providing and coordinating medical and related services for individuals in their homes

IAH Protection Against Under-service

- Beneficiary can withdraw at any time
- Satisfaction measure
- Risk-adjusted clinical quality indicators, condition-specific
- Ineffective IAH programs dropped within 3 years

IAH Workforce Development

- New incentive for best and brightest physicians, NPs, and PAs to pursue geriatrics
- Teams should prosper, while giving better care
- Build from ground up
 - Start with existing community provider teams
 - Does not require large capital investment

IAH Business Options for HHAs

- Work as if under Part A (current)
- Add contractual services for IAH
 - Longitudinal care of patients
 - Ad hoc visits
 - Infrastructure support (IT, scheduling)
- Partner with medical providers
 - Participate in gain sharing

Key IAH Attributes

- Voluntary
- Serves sickest patients
- Medical care in the home → real access
- Medically led, adjust to changing condition
- Longitudinal, continuous, comprehensive
- Care where you want it, when you need it
- Less time in ER, hospital = better for patient
- Self-funded = accountable
 - **No added cost for CMS**
 - **Anticipate immediate savings (within 1 to 2 years)**

IAH Development Team

- AAHCP IAH development team
 - Gresham Bayne, MD
 - Peter Boling, MD
 - Eric DeJonge, MD
 - James Pyles, Esq.
 - Constance Row, FACHE
 - George Taler, MD
- Key Legislators
 - Ed Markey (MA) and staff
 - Ron Wyden (OR) and staff

How You Can Help

- Join AAHCP (www.aahcp.org)
- Contribute to IAH campaign (501-c-4)

***Home Care Medicine
Action Fund***

Mara Benner
Gentiva Health Services

Key Themes

- Avoidable Hospitalizations
- Physician Engagement
- Care Transitions/Care Coordination
- Geriatric Assessments
- Chronic Care Management
- Medication Reconciliation
- Community Based Care/Medical Home
- Patient-Centered Care

Value-Added Proposition

Home health services are a critical component to our nation's healthcare delivery system:

- Cost-Effective
- Clinically-Sophisticated
- Patient-Preferred

Home Health Quality Initiative

- Goal: Focus on Home Health Quality
- Two-Year Campaign
- Key Areas: Physician Engagement, Care Transitions, Avoidable Hospitalizations, Chronic Illnesses and Medication Reconciliation
- Measured by ACH and Oral Medications
- Physician Steering Committee

QIO Care Transitions Project

- Goal: Reduce Rehospitalizations
- Colorado QIO is Spearheading
- 14 States: AL, CO, FL, GA, IN, LA, MI, NE, NJ, NY, PA, RI, TX, WA
- Includes Home and Skilled Nursing Facilities
- Will Incorporate Findings into HHQI

Post-Acute Care Demonstration

- Goal: Originally, to Inform Hospital Discharge Planners of Options
- Uniformed Assessment, Reimbursement, HIT Adoption
- 11 Markets Beginning in March 2008
- 148 Providers – 45,000 Assessments
- Technical Expert Panel
- Report to Congress in 2011

Patient-Centered Medical Home

- Pilot Programs Underway in Several States
<http://www.pcpcc.net/pcpcc-pilot-projects>
- Community Health Teams to Support the Patient-Centered Medical Home
- State Option for Medicaid Recipients with Chronic Conditions in Health Homes