



# WELCOME

## 2010 Midwestern Collaborative

### Care Transitions

# Care Transitions and the Affordable Care Act

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# Care Transitions

- Some Primary objectives
  - Coordination of Care
  - Reduction in unnecessary all-cause hospital MC readmissions, patient dissatisfaction at Dx, and exposure to risk by 2%
  - Improve Outcomes through Re-engineering Care Transitions
  - Enhance community-based transition strategies

# Care Transitions – Addressing the Issues

- Hospital Realignment -
- Geographic Variation – MC 30-Day Hosp Readmissions as a percent of Admissions All states avg – 17.5, Bottom five states avg – 21.8 (Commonwealth Fund State Scorecard on Health system Performance, 2007)
- NHE related to Re-admission – avoiding the “roundtrip to the hospital”
- Discharge satisfaction

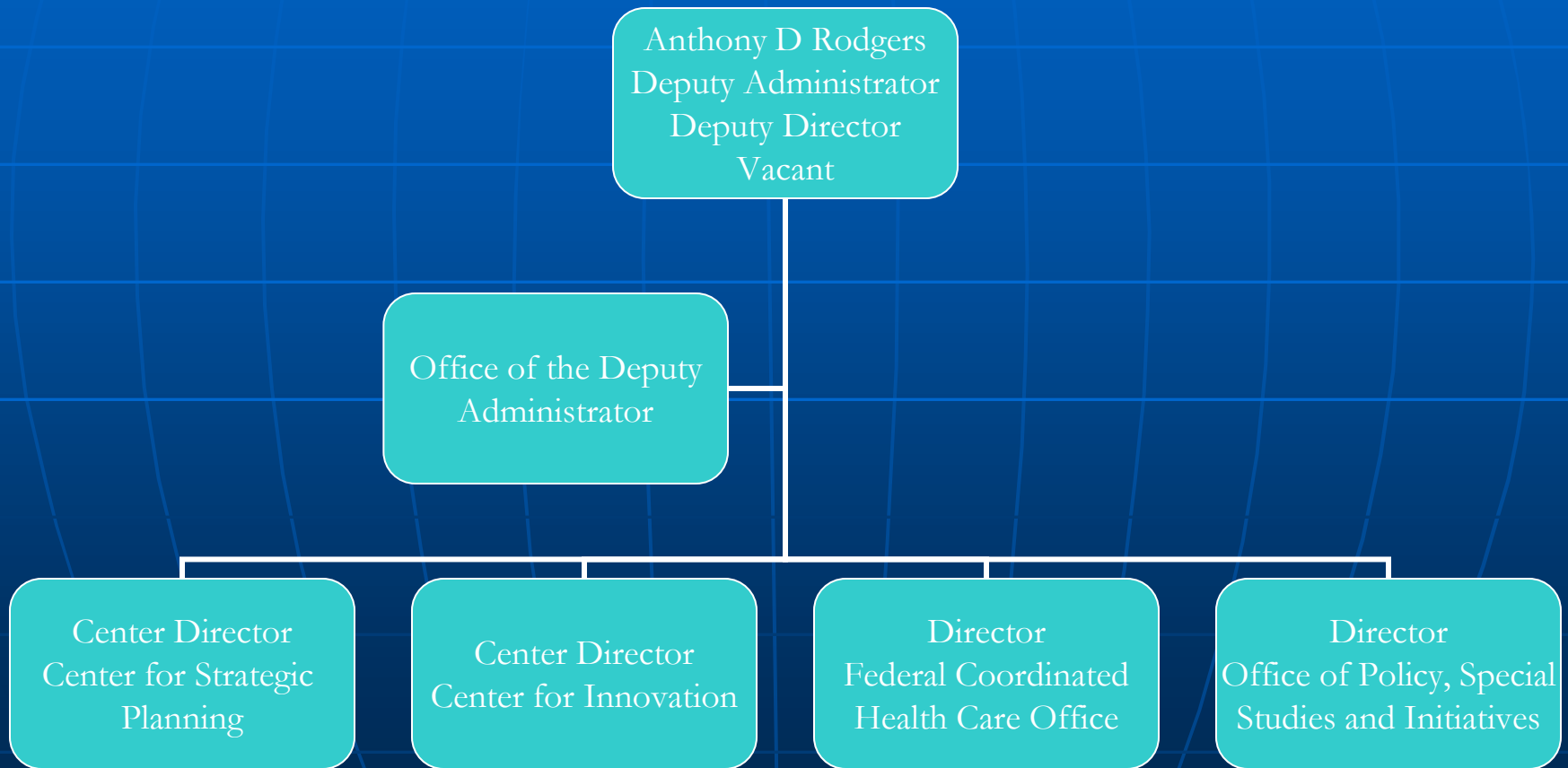
# Care Transitions and The Affordable Care Act

- Improved Emphasis on Quality Initiatives
- New Organizational Structure to support innovation
- Authorization for ACO's

# Organizational Changes

- Organization Structure
- Creating an Effective Strategic Thinking and Valued Strategic Planning Process in CMS
- Framework for Driving Strategic Innovation into the Health Care Delivery System
- Redesigning Integrated Health Care Delivery Systems for Dual Eligible Individuals

# Organization Structure: Centers for Innovation, Strategic Planning and Coordinated Health Care Office



# Purpose and Mission of Center for Innovation

- To test innovative payment and service delivery models to reduce program expenditures under the applicable titles
- At the same time preserving or enhancing the quality of care
- Preference shall be given to models that improve coordination, quality and efficiency of health care services furnished



# Purpose of the Center for Strategic Planning

To create an effective strategic thinking and planning process within CMS that will position the organization as a high performing Medicare and Medicaid/CHIP health care coverage program

- To provide actionable insight that support management decision making
- To create a strategic road map for meeting the CMS strategic five year goals

# Care Transitions and ACO's

- Coordinated Care Organization
- Demonstration Projects
- Authorized in the ACA
- Planning ongoing for start date in 2012

# Shared Savings Program: Sec 1899. (a) Establishment

- No later than January 1, 2012, a shared savings program that promotes accountability for a patient population and coordinates items and services that encourage the investment in infrastructure and redesigned care processes for high quality and efficient service delivery.

# What is an Accountable Care Organization?

According to the ACA law:

- Groups of providers of services and suppliers working together to manage and coordinate for Medicare fee-for service beneficiaries through an accountable care organization (ACO) (Section 1899)(a)(1)
- ACO must meet quality performance standards to receive shared savings (Section 1899)(a)(1)

# What is an Accountable Care Organization?

- An ACO, “couples provider payment and delivery system reforms in an attempt to solve the chicken and egg problem.” (*Carson, Francis 2009*)
- Some argue we must reform the payment system before we can improve quality of care

# Who is eligible to be an ACO?

- Professionals in group practice arrangements
- Networks of individual practices of ACO professional (i.e. a physician or practitioner)
- Partnerships or joint venture arrangements between hospitals and ACO professionals

# Who is eligible to be an ACO?

- Hospitals employing ACO professionals
- Other groups as determined appropriate



# What are the requirements of an ACO?

- Willing to be accountable for the quality, cost and overall care of the Medicare fee-for-service beneficiaries assigned,
- Enter into a three year agreement
- Ability to receive and distribute payments for shared savings to participating providers of services and suppliers
- Include primary care ACO professionals



# What are the requirements of an ACO?

- Sufficient leadership and management structure
- Promote evidence-based medicine and patient engagement
- Promotion of patient centeredness (e.g. individualized care plans)
- Capability to report data (e.g. hospital discharge follow-up)

# Who will oversee the ACO's?

- Secretary of Department of Health and Human Services (DHHS)
- DHHS will appoint an agency (i.e. CMS)
- DHHS will set ACO:
  - Quality performance standards
  - Reporting requirements
  - Incentive payments

# Proponents of ACO contend three characteristics are essential:

- The ability to provide and manage patients for the continuum of care across different settings, at least ambulatory and inpatient hospital care settings.
- The ability to prospectively plan budgets and resource needs
- Large enough to support comprehensive, valid and reliable performance measurement.

*Robert Wood Johnson, Devers and Berenson (2009)*

# Where can I learn more about ACO's?

## ■ *Health Affairs*

- McClellan, McKethan, Lewis, Roski. A National Strategy to Put Accountable Care into Practice. *Health Affairs*. May 2010.
- Fisher, Staiger, Bynum and Gottlieb. Creating Accountable Care Organizations: The Extended Hospital Medical Staff. *Health Affairs*. December 2006.