InnovatixCares

Post Acute Care Solutions for Population Health Management

Presented by Craig N DiNapoli, RPh.
Senior Director, Innovatix Network, LLC.

Disclosure

- Craig N DiNapoli, has no actual or potential conflict of interest associated with this presentation.
Learning objectives

Be able to:

✓ Overview of GPO and Preferred Provider Network
✓ Identify steps a providers are taking now to prepare for delivering care in a Population Health Management environment.

Organization: Structure

- Regional Presence
  - 250 hospitals/continuing care facilities
  - New York, New Jersey, Connecticut, and Rhode Island

- National Presence
  - 2,700 hospitals/health systems
  - Owned by nearly 200 hospitals

- Nation's largest non-acute care GPO
- 18,000 alternate site facilities
- Specialty, Infusion, LTC, Retail and Mail Order pharmacies, and Medical Oncologists
Core Business

Innovatix Purchase Volume Trending

<table>
<thead>
<tr>
<th>Year</th>
<th>Innovatix</th>
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<tbody>
<tr>
<td>2003</td>
<td>1,877,935,524</td>
</tr>
<tr>
<td>2004</td>
<td>2,362,225,635</td>
</tr>
<tr>
<td>2005</td>
<td>2,428,911,995</td>
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<tr>
<td>2006</td>
<td>2,942,422,656</td>
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<tr>
<td>2007</td>
<td>2,743,587,641</td>
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<tr>
<td>2008</td>
<td>3,085,781,746</td>
</tr>
<tr>
<td>2009</td>
<td>3,571,195,250</td>
</tr>
<tr>
<td>2010</td>
<td>3,523,519,441</td>
</tr>
<tr>
<td>2011</td>
<td>3,749,878,114</td>
</tr>
<tr>
<td>Summary</td>
<td>$26,265,468,002</td>
</tr>
</tbody>
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Preferred Provider Network - Overview

- Established in 2006, The Innovatix Preferred Provider Network (PPN) has 250 Long Term Care, Assisted Living Facility, Home Infusion and Specialty pharmacy locations

- PPN represents 285,000 SNF beds in 32 states across the country

- Members adjudicated over 14 million claims in Year 2013
PPN Network

A fee-for-service network which aggregates pharmacies together to negotiate favorable and/or enhanced reimbursement rates with payers for prescription drugs dispensed to Medicare Part D beneficiaries.

- Negotiate Medicare Part D long term care and home infusion contracts with the largest PDPs and PBMs
- Staff contracts with and assists pharmacies with issues relating to compliance, general business operations, claim reimbursement, prior authorizations, third party audits, and other CMS & PDP requirements
- Subscription to the PPN Newsletter with important updates from payors, the federal government, and other industry players
- PPN website that includes PDP-specific information including payor sheets and up-to-date industry information
- Delegated Credentialing services with all Payors

Additional Services PPN

- Provide actions a pharmacy can take regarding education, preparation, and execution of deliverables to minimize the impact of audits PDPs.

- Describe how to utilize existing data resources within a pharmacy to monitor MAC reimbursement as well as demonstrate methods for basic negative margin analysis.
  - Spearheaded the proposed CMS 2015 rule regarding MAC transparency for industry
Origin of Population Health Management (PHM)

- The US Department of Health and Human Services (DHHS) proposed the initial set of guidelines for establishment of Accountable Care Organizations (ACOs) under the Medicare Shared Savings Program (Section 3022 of the Patient Protection and Affordable Care Act).
- These guidelines stipulate the necessary steps that voluntary groups of physicians, hospitals, and other health care providers must complete in order to partake in ACOs.

ACO Challenges

- Shared Risk for Patient Outcomes
  - Referral Process Changes
  - Access to ACOs
  - Limited Distribution Product
- Payor Changes
  - Formulary Management Changes
  - Access Issues
  - Contracting Strategy
- Shift in Paradigm
  - Hospitals and Physician Groups
  - 2014 Risk Share Implementation
  - Alternate Care Partnerships
- Patient Management
  - Information Sharing across health continuum
  - Adherence, Compliance, and Outcomes Data
  - Seamless site of care transitions
The models defined

- **Population Health Management**: A network of physicians and other health care providers who work together and accept responsibility to improve quality and reduce the costs of health care services for a defined population.

- **Accountable Care Organization**: A network of physicians and other health care providers who work together and accept responsibility to improve quality and reduce the costs of health care services for a defined Medicare population.

- **Medical Home**: A model or philosophy of primary care that is patient-centered, comprehensive, team-based, coordinated, accessible, and focused on quality and safety.

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### Medicare ACOs

<table>
<thead>
<tr>
<th>Medicare Shared Savings Program</th>
<th>Pioneer ACO Model</th>
</tr>
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<tbody>
<tr>
<td>Minimum Number of Beneficiaries</td>
<td>5,000</td>
</tr>
<tr>
<td>Upside/Downside Risk</td>
<td>Track 1: Upside risk only</td>
</tr>
<tr>
<td>Payment Model</td>
<td>Fee-for-service (FFS) + Shared Savings</td>
</tr>
<tr>
<td>Shared Savings/Losses Potential</td>
<td>Track 1: 50% max shared savings potential; no shared losses</td>
</tr>
<tr>
<td></td>
<td>Track 2: 60% max shared savings potential; 40-60% max shared losses based on quality score</td>
</tr>
<tr>
<td>Beneficiary Assignment</td>
<td>Quarterly preliminary prospective assignment; annual final retrospective reconciliation</td>
</tr>
</tbody>
</table>
PHM/ACO Growth Nationwide

- 360 Medicare ACOs in 43 states operational.
- An additional 123 MSSP ACOs approved on 1/1/14.
- Over 500 PHM/ACOs operating nationwide.
- CMS Bundled Payment initiative has 450+ participants and growing.
Influence of PHMs on healthcare

- **Increasing focus on value and quality.**
  - Ongoing transition to value-based payment models.
  - Increased regulatory complexity will lead to greater transparency.
  - Growth in evidence based medicine (i.e. choosing wisely).

- **Collaboration and consolidation are on the rise.**
  - Blending of delivery systems, health insurance plans, and technology firms.
  - Consolidation of hospitals, health systems, physicians, and the continuum of care.

- **Significant investments in technology to continue.**
  - Information technology will drive data integration and care redesign.

Preparation is critical

- The future of healthcare delivery is PHM and ACO models.
- Failure to prepare for PHM and ACO business will result in the loss of patients for many providers.
- Healthcare providers must establish relationships with PHM and ACO entities now.
- There will be criteria (benchmarks, IT infrastructure, and clinical pathways and disease state management programs) providers will need to adhere to in order to be reimbursed by a PHM or ACO.
- Reimbursement will move away from traditional fee for service methodology.
How to prepare

- **Preparatory** – education, assessment, gap analysis, and operational plan.

- **Transformational** – health informatics, clinical integration, care management, and network development.

- **Implementation** – defined population and payor partner relationships.

- **Expansion** – employee health plan, commercial arrangement, Medicare, Medicaid, employer contracting, and the uninsured.

Transitioning from traditional healthcare to PHM

Traditional Healthcare

- Pay for volume
- Fragmented care
- Fee for service
- Treats sickness
- Adversarial payors
- Disjointed technology
- Duplication and waste

Population Health Management

- Pay for value
- Accountable care
- Global payment
- Fosters wellness
- Payor partners
- Integrated technology platforms
- Right care, right setting, right time
Why does this sound familiar? 
Capitation (1990s) versus ACOs (2010s)

<table>
<thead>
<tr>
<th>HMOs / Capitation</th>
<th>ACOs</th>
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<tbody>
<tr>
<td>Insurance industry driven</td>
<td>Provider driven</td>
</tr>
<tr>
<td>Insurance risk</td>
<td>Performance risk</td>
</tr>
<tr>
<td>Shifts risk to PCPs</td>
<td>Shifts reward and/or risk to aligned, integrated systems</td>
</tr>
<tr>
<td>Measures quality</td>
<td>Pays for quality/improved health</td>
</tr>
<tr>
<td>Enrollment/gate-keeper/lock-in</td>
<td>Attribution/primary care/medical home</td>
</tr>
<tr>
<td>Wellness care</td>
<td>Patient engagement/disease management</td>
</tr>
<tr>
<td>Fragmented delivery system</td>
<td>High value delivery system</td>
</tr>
<tr>
<td>Plans have the population based data</td>
<td>Providers have the population based data</td>
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The vision of Population Health Management

- Integrated leadership
- Clinical integration
- People centered foundation
- Health home
- Payor partnerships
- Population health data management
**PHM impact on utilization**

- Primary care, urgent care, minute clinic visits *increase*
- Home care visits *increase*
- Market share can *increase* (less leakage)
- Emergency department visits *decrease*
- Hospital admissions *decline*
  - Readmissions related to chronic disease
  - Avoidable admissions
  - End of life - palliative care
- Skilled nursing facility volume *decreases*

**Early results show promise**

- **Medicare costs per capita grew 0.8% in 2012** (while pioneers grew at 0.3%). For first time in decades the Medicare per capita growth was below GDP growth.

- Physician Group Practice (PGP) Demonstration Project *reduces cost of dual eligible beneficiaries by $532 per year.*

- All 32 pioneers achieved quality improvements and 2/3 achieved cost savings in 2012.

- **Group Health and Geisinger** report findings that team based *medical homes reduced per capita spending 7-8%.*

- Montefiore achieved $14 million in shared savings in 2012, due in large part to a 10% *decline* in hospital admissions.

- **Oregon’s new Medicaid program** reports early success (*1% decline in per capita costs in first year*).
Questions?

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