ACOs in the Rural Setting

Ralph J. Llewellyn, CPA, CHFP
Partner
rllewellyn@eidebailly.com
701.239.8594

Overview of Today's Presentation

- What are we seeing as the current state/trend of HC
- Lessons learned from our involvement with MSSP ACOs
- Future considerations

Involvement in AIM Funded MSSP ACOs

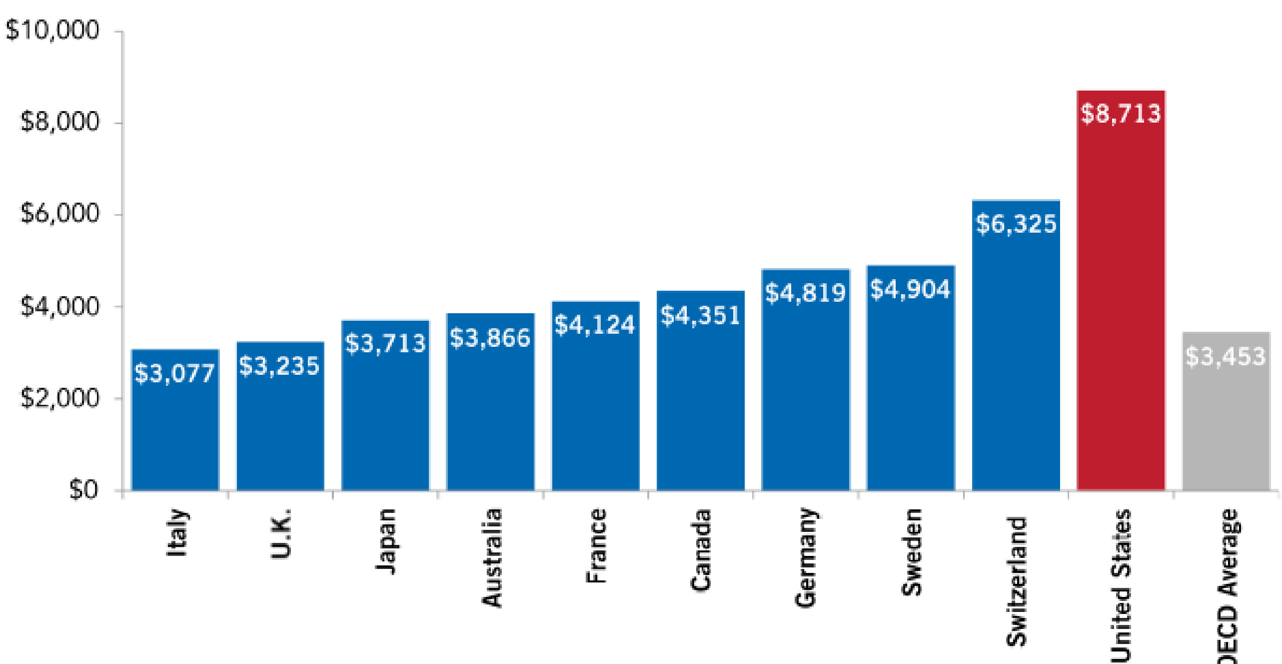
- 150+ facilities across the country are involved
- 3 Year Aim Funded Grant
- Some are now in their third year of experience (experience before AIM funding)
- Over 20 different ACOs
- 5,000 minimum beneficiary attribution
- 54 different facilities in 15 states which are part of 12 different ACOs
- 2015 results were reduced costs of 44 million system wide
- More facilities were added for 2017
- PTN/TCPI for future ACO members

Caravan Health Participants

OREGON
IDAHO
NEVADA
ARIZONA
SOUTH DAKOTA
San Diego
Ottawa
Toronto
MA
Boston
CT
RI
New York
DE
NJ
Gulf of California
Gulf of Mexico
Google

Per Capita Costs Comparison

United States per capita healthcare spending is more than twice the average of other developed countries



SOURCE: Organization for Economic Cooperation and Development, *OECD Health Statistics 2015*, November 2015. Compiled by PGPF.
NOTE: Data are for 2013 or latest available. Chart uses purchasing power parities to convert data into U.S. dollars.

© 2016 Peter G. Peterson Foundation

PGPF.ORG

Spending

International Comparison of Spending on Health, 1980–2012

2

Average spending on health per capita ($US PPP)

US
SWIZ
GER
CAN
FR
SWE
JPN
UK

Total health expenditures as percent of GDP

US
FR
SWIZ
GER
CAN
JPN
SWE
UK

Note: PPP = Purchasing power parity.
Source: Commonwealth Fund, based on OECD Health Data 2014.

The Commonwealth Fund

Quality Comparisons Worldwide

Exhibit 9. Select Population Health Outcomes and Risk Factors

	Life exp. at birth, 2013[a]	Infant mortality, per 1,000 live births, 2013[a]	Percent of pop. age 65+ with two or more chronic conditions, 2014[b]	Obesity rate (BMI>30), 2013[a,c]	Percent of pop. (age 15+) who are daily smokers, 2013[a]	Percent of pop. age 65+
Australia	82.2	3.6	54	28.3[e]	12.8	14.4
Canada	81.5[e]	4.8[e]	56	25.8	14.9	15.2
Denmark	80.4	3.5	–	14.2	17.0	17.8
France	82.3	3.6	43	14.5[d]	24.1[d]	17.7
Germany	80.9	3.3	49	23.6	20.9	21.1
Japan	83.4	2.1	–	3.7	19.3	25.1
Netherlands	81.4	3.8	46	11.8	18.5	16.8
New Zealand	81.4	5.2[e]	37	30.6	15.5	14.2
Norway	81.8	2.4	43	10.0[d]	15.0	15.6
Sweden	82.0	2.7	42	11.7	10.7	19.0
Switzerland	82.9	3.9	44	10.3[d]	20.4[d]	17.3
United Kingdom	81.1	3.8	33	24.9	20.0[d]	17.1
United States	78.8	6.1[e]	68	35.3[d]	13.7	14.1
OECD median	81.2	3.5	–	28.3	18.9	17.0

[a] Source: OECD Health Data 2015.
[b] Includes: hypertension or high blood pressure, heart disease, diabetes, lung problems, mental health problems, cancer, and joint pain/arthritis. Source: Commonwealth Fund International Health Policy Survey of Older Adults, 2014.
[c] DEN, FR, NETH, NOR, SWE, and SWIZ based on self-reported data; all other countries based on measured data.
[d] 2012. [e] 2011.

Growth of HealthCare Costs

Health Insurance Premiums
Workers' Contribution to Premiums
Workers' Earnings
Overall Inflation

180%
160%
140%
120%
100%
80%
60%
40%
20%
0%

1999 2000 2001 2002 2003 2004 2005 2006 2007 2008 2009 2010 2011

98%
93%
24%
21%
168%
160%
50%
38%

Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2011. Bureau of Labor Statistics, Consumer Price Index, U.S. City Average of Annual Inflation (April to April), 1999-2011; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey, 1999-2011 (April to April).

Obesity and Diabetes Epidemic

- Correlation between obesity and diabetes
- Epidemic trend over the last 30+ Years

Obesity Trends* Among U.S. Adults BRFSS, 1990, 2000, 2010

(*BMI ≥30, or about 30 lbs. overweight for 5'4" person)

1990

2000

2010

No Data	<10%	10%–14%	15%–19%	20%–24%	25%–29%	≥30%

Obesity Trends* Among U.S. Adults BRFSS, 1990, 2000, 2010

- In 1990, **10** states had a prevalence of obesity less than 10% and no state had prevalence equal to or greater than 15%.

- By 2000, no state had a prevalence of obesity less than 10%, **23** states had a prevalence between 20–24%, and no state had prevalence equal to or greater than 25%.

- In 2010, no state had a prevalence of obesity less than 20%, **36** states had a prevalence equal to or greater than 25%; **12** of these states had a prevalence equal to or greater than 30%.

Age-Adjusted Prevalence of Obesity and Diagnosed Diabetes Among U.S. Adults Aged 18 Years or older

Obesity (BMI ≥30 kg/m²)

1994 | 2000 | 2010

No Data | <14.0% | 14.0-17.9% | 18.0-21.9% | 22.0-25.9% | ≥26.0%

Diabetes

1994 | 2000 | 2010

No Data | <4.5% | 4.5-5.9% | 6.0-7.4% | 7.5-8.9% | ≥9.0%

CDC's Division of Diabetes Translation. National Diabetes Surveillance System available at http://www.cdc.gov/diabetes/statistics

International Health Institute – Triple Aim

Medicare Spending

- 94% of Medicare spending is on seniors with 2 or more chronic conditions
- 52% of Medicare spending is on seniors with 6 or more chronic conditions, which is 14% of the people
- 6% of Medicare spending is on seniors with less than 2 chronic conditions which is 32% of the people
- 19% of total Medicare spending is on people less than 65, which are 18% of the total people on Medicare

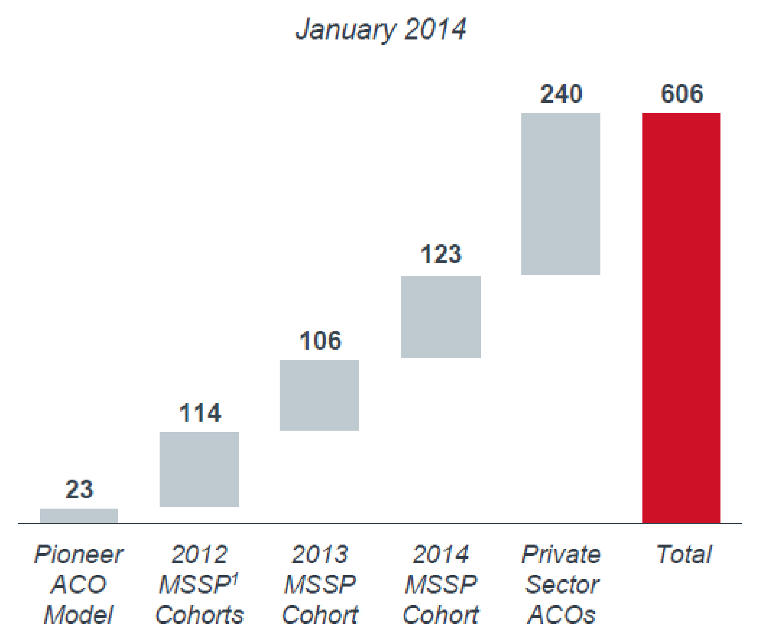
Medicare ACOs as of April 2016

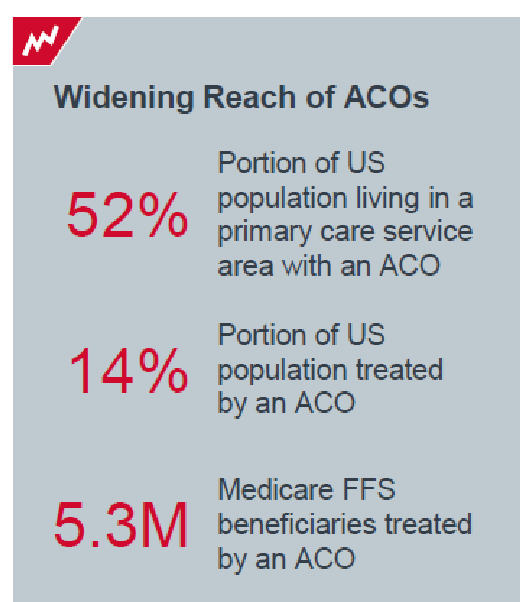
Where the Medicare ACOs Are

9 Pioneer, 433 Shared Savings Program, and 20 Next Generation ACOs[1] as of April 2016

The ACO Landscape Today

Health Systems Rapidly Adopting Care Transformation Business Models





1 Medicare Shared Savings Program.

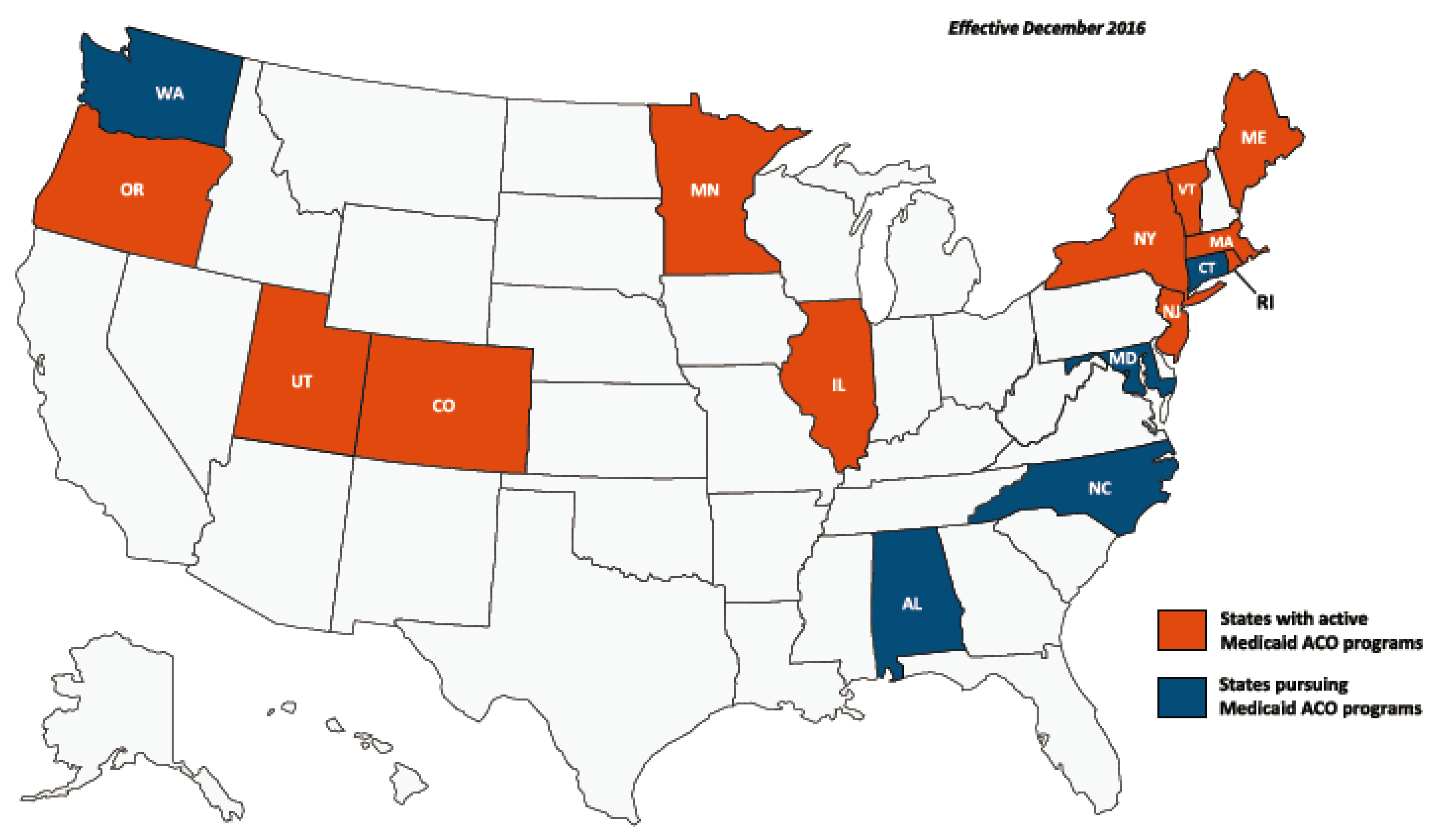
Source: CMS, "More Partnerships Between Doctors and Hospitals Strengthen Coordinated Care for Medicare Beneficiaries," December 23, 2013; Muhlestein D, "Accountable Care Growth In 2014: A Look Ahead," Health Affairs Blog, January 29, 2014; Oliver Wyman, "Accountable Care Organizations Now Serve 14% of Americans," February 19, 2013; Health Care Advisory Board interviews and analysis.

014 The Advisory Board Company • advisory.com • 29392C

Medicaid ACO's

- Medicaid programs emerging as states continue to struggle financially
- Desire to shift the risk to the providers
- Anticipate continued growth
- Concern over managing this portion of the population
- Need for solid systems and processes to be successful
- Need to carefully evaluate risk models and what will be within your control

Medicaid ACO's



Source: Center for Health Care Strategies, Inc.

Commercial/Private ACOs

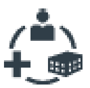
- Terms vary dependent on the individual ACO
- One of the advantageous of participating in a Medicare MSSP ACO is being prepared for the commercial/private payers when they come knocking
- Different patient population and different issues but similar concepts

CMS Evolution

CMS Charting a Path Toward Greater Risk

CJR, Track 3, and Next Gen ACO Filling Out the Continuum

Continuum of Medicare Risk Models



Pay-for-Performance	Bundled Payments	Shared Savings	Shared Risk	Full Risk
• Hospital VBP Program • Hospital Readmissions Reduction Program • HAC Reduction Program • Merit-Based Incentive Payment System	• Bundled Payments for Care Improvement Initiative (BPCI) • Comprehensive Care for Joint Replacement (CJR) Model	• MSSP Track 1 (50% sharing)	• MSSP Track 2 (60% sharing) • MSSP Track 3 (up to 75% sharing) • Next Generation ACO Model (80-85% shared savings option)	• Next Generation ACO Model (full risk option) • Medicare Advantage (provider-sponsored)

Increasing Financial Risk

©2016 The Advisory Board Company • advisory.com • 31491A

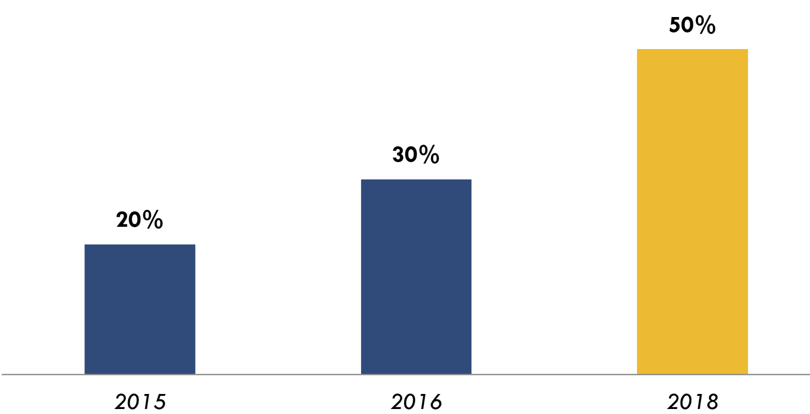
Source: Health Care Advisory Board interviews and analysis.

CMS Sets Targets for Value-Based Payments

Payment Targets Demonstrate Commitment to FFS1 Alternatives

Aggressive Targets for Transition to Risk

Percent of Medicare Payments Tied to Risk Models



Examples of Qualifying Risk Models

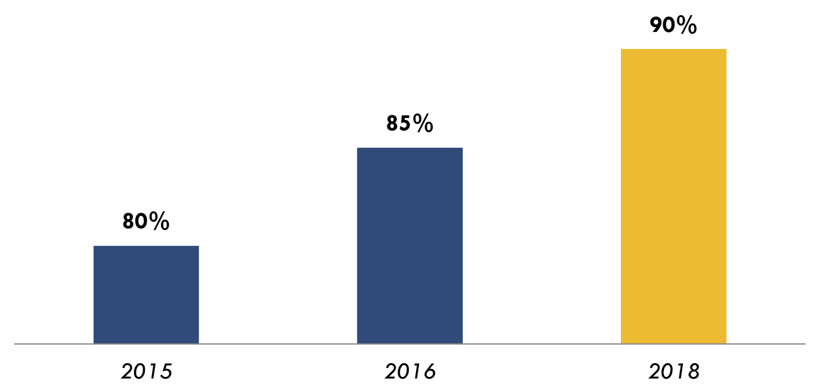
Medicare Shared Savings Program

Bundled Payments for Care Improvement Initiative

Patient-Centered Medical Home

FFS Increasingly Tied to Value

Percent of Medicare Payments Tied to Quality



Examples of Quality/ Value Programs

Hospital-Acquired Condition Reduction Program

Hospital Value-Based Purchasing Program

Hospital Readmissions Reduction Program

Merit-Based Incentive Payment System

Bundled Payment Models

- New models
  - Acute Myocardial Infarction Model
  - Coronary Artery Bypass Graft Model
  - Surgical Hip and Femur Fracture Model
- Updates to existing model
  - Comprehensive Joint Replacement Model
- Mandatory for selected Metropolitan Statistical Areas (MSA)
- While focusing on MSAs, impact is also felt in rural areas

Comprehensive Care Joint Replacement

Exhibit 1—Spending Variation by Episode

DRG 470 – Knee Replacements

Payments per Episode

$50,000
$45,000
$40,000
$35,000
$30,000
$25,000
$20,000
$15,000
$10,000
$5,000
$0

Anchor Admission | Readmission | Inpatient Rehab | HHA | SNF | Professional | Outpatient

Source: DataGen Healthcare Analytics Whitepaper - 7 things every PAC Provider should know about CCJR.

Comprehensive Care Joint Replacement

Exhibit 2—Average Episode Spending by First PAC Setting

DRG 470

Source: DataGen Healthcare Analytics Whitepaper - 7 things every PAC Provider should know about CCJR.

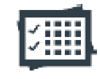
How does coordination work?

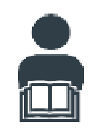
Focusing Our Patient Engagement Efforts

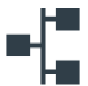
More Than a Self-Management Challenge

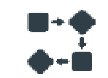
Shared Goals for Chronic Condition Management Across Patient Segments

Segment	Description
High-Cost Patients Top 5%	Managing multiple chronic conditions
Rising-Risk Patients 15-35%	Managing two or more chronic conditions, comorbidities
Low-Risk Patients 60-80%	Managing risk factors, some managing one chronic condition









Source: The Advisory Board

Lessons Learned

- The game has changed permanently
- The country is no longer willing to wait for us to react
- There will be winners/survivors and losers/closed facilities
- Changes needed:
  - Cultural
  - Vision
  - Mission and Strategic
  - Operational

What Strategy Changes will be Needed

- At the Highest Levels
  - Cultural Changes – do you have the right leaders on board?
  - Vision – where do you see yourselves in 5 years?
  - Mission – does this change you mission?
  - Strategies – what specific strategies will you need to pursue to achieve your vision?
    - Who do you want to be and who will you be partnering with?
    - What specific strategies are you currently pursuing and will these need to be modified?
    - What new strategies should you be considering?
    - What current strategies will need to be given up?

Why Consider an ACO

- For Your Community
  - Improved health
  - Reduced cost to maintain health status
  - Keep more care local
  - Improved life style of patients and families

- Hospital
  - Improved employee and provider satisfaction
  - Long term sustainability improved
  - Improved financial performance of local system(s)
  - What is the total health care spend in your service area?
    - What if you could double your current revenue while reducing the total spend?

Why Consider an ACO

- Hospital
  - It is a question of when, not if, some form of population health will penetrate your market
  - Early adopters will have opportunity to develop competitive advantage
    - Mindsets
      - Physicians
      - Staff
      - Patients
    - Systems
    - Processes
    - Cost
    - Profitability
    - Health of community
    - Public relations
  - It fits with your mission

Clinical Integration Defined

- Clinical delivery of care, technology, and operations are interactive processes, with technology being the enabler. Clinical processes should really be our primary focus, above and beyond technology.

- Patient satisfaction AND clinical care coordination are both the goal and achievement for EVERY episode of care!

Clinical Integration – Care Coordination

- Care Coordination
  - Physician led health care teams
  - Patient assessments
  - Defined clinical care plans
  - Data shared among providers (physicians, hospitals, post acute, other)
  - Medication reconciliation at every step – CRITICAL
  - Informed patients fully engaged in care decisions
  - Patient navigators/Case management-nurse teams handling transitions in care – AWV, TCM, CCM. ACP
  - Care team providing follow up and education on "red flags"

Clinical Integration/Care Coordination Benefits

- With an effective model for care coordination in place, health systems can benefit from
  - Increased referrals/order
  - Improved revenue and hospital utilization
  - Lower cost of IT infrastructure
  - Improved margins
  - Increased patient satisfaction

Source: Athena Health Whitepaper: Making Care Coordination Work: A Sustainable Model to Benefit the Whole Community, February 2012

Clinical Integration/Care Coordination Benefits

- With an effective model for care coordination in place, health systems can benefit from
  - Greater visibility into and understanding of referral patterns
  - Increased market share
  - Simplified, streamlined go-to-market strategy to coordinate care with community physicians
  - Incremental acquisitions replaced by more effective physician outreach

Source: Athena Health Whitepaper: Making Care Coordination Work: A Sustainable Model to Benefit the Whole Community, February 2012

What Operational Changes will be Needed?

- Day to day impact
  - Connecting with your patients – attribution
    - Based on allowed charges for primary care services
  - Clinic process flow
  - Annual wellness screening
  - Chronic Care Management
  - Transitions of Care Management

What Operational Changes will be Needed?

- Day to day impact
  - Revenue cycle changes
    - Documentation
    - Coding
    - Billing
    - Hierarchical Category Coding (HCC)
  - Impact on physician compensation
  - Data analysis
  - Negotiating where your referrals go
  - Clinical Integration across the spectrum

Lessons Learned

- It takes a dedicated team
  - One person cannot do it all!
  - Clinical
    - Physicians
    - Mid-Levels
    - Nursing
  - Financial
  - Leadership

Lessons Learned

- Physician/Mid-Level buy-in is critical and challenging
  - Providers are already busy
    - Some preventative services take time to provide
  - Have to answer the question - Why would I do things to reduce my volume?
  - Don't believe change is possible
  - Bad data

Lessons Learned

- Data is key!
  - Need software/system
  - Need analysts
    - Impact of changes
    - Identify high cost patients (opportunities)
      - $ spent
      - Emergency room visits
  - You get ALL the data
    - Bonus marketing opportunity
    - Market leakage

Lessons Learned

- Annual wellness visits are confusing
  - Not a physical
  - 2.43 wRVUs initial visit
  - 1.50 wRVUs subsequent visits
  - Promotes screenings, etc., that can be done locally

Lessons Learned

- It appears that wellness pays!
  - Increased physician visits
  - Increased ancillaries
  - Increased local services
  - Most of cost avoidance is often external
    - Tertiary facilities
    - Post acute care
    - Pharmacy

Lessons Learned

- Great variation in post acute care costs
  - CAH swing bed versus PPS swing bed and nursing homes
    - Cost per day
      - Higher in CAH swing bed
    - Length of stay
      - Shorter in swing bed
      - Longer in for profit nursing homes
  - Limitations to access for Home Health and Hospice can have a big impact on SNF costs

Lessons Learned

- The patient success stories are amazing
  - Frequent ER patient
  - Uncontrolled Diabetic
  - 5 Medicare patients
  - Etc.

How does the ACO affect our Reimbursement?

- Providers continue to get normal Medicare reimbursement (PPS or cost) during the year
- Benchmarked cost based on historical cost of patients attributed
- Savings/losses are calculated after the fact with the appropriate settlement
- HCC Risk Adjusted Factors

What is Risk Adjustment?

The Goal is to Reflect Actuarial Burden of Plan Enrollees

Risk Adjustment In Brief

- Risk adjustment models are used to predict health care costs based on the relative actuarial risk of risk-based plan enrollees
- Accurate risk adjustment payment relies on comprehensive medical record documentation and diagnosis coding
- Risk adjustment was mandated under the ACA[1] to mitigate the impacts of potential adverse selection and to stabilize premiums

www.cms.gov; Advisory Board Company interviews and analysis.

Risk Adjustment Calculation

Demographic Factors

Health Factors

Marginal Contribution to Total Risk

Source: The Advisory Board

How is Risk Adjustment Calculated?

Three Steps CMS Uses to Calculate Provider Payment Using HCCs

Calculating Individual Risk Scores

Key Inputs:

- **Disease Burden** (i.e. HCCs coded, mapped from ICDs)
- **Disease Interactions**
- **Demographics** (e.g. age, sex, disability, Medicare status)

Determining Plan Average Risk Score

- Risk scores are aggregated across beneficiaries
- Risk scores are prospective (prior year risk scores used for future payments, benchmarks)

Setting Corresponding Adjustments, Benchmarks[1]

- **In Medicare Advantage (MA):** plans paid each month for HCC risk-adjusted beneficiaries
- **In MSSP[2], Next Generation ACOs:** HCCs are used to risk-adjust financial benchmarks

HCC Coding Impact

- If providers don't code appropriately and to the highest degree of specificity, aggregated HCC codes will not capture the full risk burden and expected costs of beneficiaries
- If disease burden is under represented, risk adjustment factors (RAFs), financial benchmarks, and per member per month (PMPM) payments will all be lower
- A lower benchmark means it is more difficult to achieve savings in shared savings programs

www.cms.gov CMS-HCC risk adjustment is also used to determine reimbursement for the Hospital Value-Based Purchasing program. Medicare Shared Savings Program.

Source: The Advisory Board

Hierarchical Category Coding

- This is a big deal – ACO or not
- Significant fluctuation between providers
  - 0.70 – 1.50
  - Greater fluctuation than has traditionally been seen in case mix index
- Recent audits show that many chronic issues are being missed on an annual basis

Future Considerations

- New way of doing business – Value versus Volume
  - Need to add data integrity/analytics
    - An immense amount of new data
      - Internal and external reporting
  - Must improve utilization of your EHR
  - Must be open to standardization
    - Clinical pathways
    - Processes
    - Can be driven by local providers versus "cookbook"
  - Monitor and improve coding
    - Current claim reimbursement impact versus future impact
    - RHC, FQHC, Provider Based, or Free Standing

Future Considerations

- New way of doing business – Value versus Volume
  - Impact on Physician Compensation
    - WRVUs
    - Shared Savings
- Other Program from CMS
  - CPC+
  - MACRA/QPP
  - Other Forms
- Other Payers
  - Medical Homes
  - Capitated or Risk Based Sharing Programs

Future Considerations

- More out of the box thinking, less traditional limitations
- Less restrictions from legislative constraints for creative arrangements
- Change at a faster rate than ever, will be the new constant!!

Questions

This presentation is presented with the understanding that the information contained does not constitute legal, accounting or other professional advice. It is not intended to be responsive to any individual situation or concerns, as the contents of this presentation are intended for general informational purposes only. Viewers are urged not to act upon the information contained in this presentation without first consulting competent legal, accounting or other professional advice regarding implications of a particular factual situation. Questions and additional information can be submitted to your Eide Bailly representative, or to the presenter of this session.