ACOs in the Rural Setting

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


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International Comparison of Spending on Health, 1980–2012

Average spending on health per capita ($US PPP)

Total health expenditures as percent of GDP

Note: PPP = Purchasing power parity.
Source: Commonwealth Fund, based on OECD Health Data 2014.
### Exhibit 9. Select Population Health Outcomes and Risk Factors

<table>
<thead>
<tr>
<th></th>
<th>Life exp. at birth, 2013&lt;sup&gt;a&lt;/sup&gt;</th>
<th>Infant mortality, per 1,000 live births, 2013&lt;sup&gt;a&lt;/sup&gt;</th>
<th>Percent of pop. age 65+ with two or more chronic conditions, 2014&lt;sup&gt;b&lt;/sup&gt;</th>
<th>Obesity rate (BMI&gt;30), 2013&lt;sup&gt;a,c&lt;/sup&gt;</th>
<th>Percent of pop. (age 15+) who are daily smokers, 2013&lt;sup&gt;a&lt;/sup&gt;</th>
<th>Percent of pop. age 65+</th>
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<tr>
<td>Australia</td>
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<td>3.6</td>
<td>54</td>
<td>28.3&lt;sup&gt;e&lt;/sup&gt;</td>
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<tr>
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<td>2.1</td>
<td>–</td>
<td>3.7</td>
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<td>42</td>
<td>11.7</td>
<td>10.7</td>
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<td>20.4&lt;sup&gt;d&lt;/sup&gt;</td>
<td>17.3</td>
</tr>
<tr>
<td>United Kingdom</td>
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<td>3.8</td>
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<td>24.9</td>
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<td>United States</td>
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<td>35.3&lt;sup&gt;d&lt;/sup&gt;</td>
<td>13.7</td>
<td>14.1</td>
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<tr>
<td>OECD median</td>
<td>81.2</td>
<td>3.5</td>
<td>–</td>
<td>28.3</td>
<td>18.9</td>
<td>17.0</td>
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</tbody>
</table>

<sup>a</sup> Source: OECD Health Data 2015.<br/>
<sup>b</sup> 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.<br/>
<sup>c</sup> DEN, FR, NETH, NOR, SWE, and SWIZ based on self-reported data; all other countries based on measured data.<br/>
<sup>d</sup> 2012.  <sup>e</sup> 2011.
Growth of HealthCare Costs

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 $\geq 30$, or about 30 lbs. overweight for 5’4” person)

• 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**

**Diabetes**

- **1994**
- **2000**
- **2010**

International Health Institute – Triple Aim

- Improve Health
- Lower Costs
- Better Care
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 as of April 2016
The ACO Landscape Today

Health Systems Rapidly Adopting Care Transformation Business Models

Total Number of Operating ACOs
January 2014

- Pioneer ACO Model: 23
- 2012 MSSP Cohorts: 114
- 2013 MSSP Cohort: 106
- 2014 MSSP Cohort: 123
- Private Sector ACOs: 240
- Total: 606

Widening Reach of ACOs

- 52% Portion of US population living in a primary care service area with an ACO
- 14% Portion of US population treated by an ACO
- 5.3M Medicare FFS beneficiaries treated by an ACO

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

State-Based Medicaid Accountable Care Organizations
Effective December 2016

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 Charting a Path Toward Greater Risk

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

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

**Increasing Financial Risk**
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

<table>
<thead>
<tr>
<th>Year</th>
<th>2015</th>
<th>2016</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target</td>
<td>20%</td>
<td>30%</td>
<td>50%</td>
</tr>
</tbody>
</table>

**FFS Increasingly Tied to Value**
Percent of Medicare Payments Tied to Quality

<table>
<thead>
<tr>
<th>Year</th>
<th>2015</th>
<th>2016</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target</td>
<td>80%</td>
<td>85%</td>
<td>90%</td>
</tr>
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</table>

**Examples of Qualifying Risk Models**

- Medicare Shared Savings Program
- Bundled Payments for Care Improvement Initiative
- Patient-Centered Medical Home

**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

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

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 your 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
Why Consider an ACO

• 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!
• 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

Risk Adjustment Calculation

Demographic Factors

Health Factors

Marginal Contribution to Total Risk

Source: The Advisory Board

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

- In Medicare Advantage (MA): plans paid each month for HCC risk-adjusted beneficiaries
- In MSSP², 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

Source: The Advisory Board

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

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