Accountable Care Organization (ACO)
A Perspective from North Dakota Participants

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PRESENTATION AGENDA

• Medicare and the typical payment model
• What is an ACO and why do they exist?
• Attributes of an ACO
• North Dakota participation
  • High Sierras Northern Plains ACO
  • SMC/CCCHC
  • Heart of America Medical Center
  • McKenzie County Healthcare Systems
• Questions/Discussions
Projected Change in Medicare Enrollment

Projected change in Medicare enrollment from 2000 to 2050

- 2000: 40 million
- 2010: 47.5 million
- 2020: 63.9 million
- 2030: 80.8 million
- 2040: 88.3 million
- 2050: 92.8 million
Projected Medicare Spending 2013 - 2023

Medicare Spending in Billions

- 2013: $586
- 2014: $597
- 2015: $615
- 2016: $671
- 2017: $695
- 2018: $722
- 2019: $794
- 2020: $849
- 2021: $911
- 2022: $1,018
- 2023: $1,064
Medicare Cost Per Beneficiary

Source: Kaiser Family Foundation analysis of mandatory Medicare outlays and Medicare enrollment data from CBO Medicare baseline projections, 2010-2014; 2014 estimates based on August 2014 baseline.
MEDICARE PART A TRUST FUND BALANCE % OF ANNUAL EXPENDITURES

*In billions:*
MEDICARE SPENDING

CHRONIC CONDITIONS ACCOUNT FOR MOST SPENDING

More than 94% of Medicare fee-for-service money spent on seniors is on patients with at least two chronic conditions. In 2012, the sickest 4 million represented 15% of Medicare’s senior population, but accounted for more than half the spending on that group.

- **TOTAL MEDICARE MEDICAL SPENDING:** $324 billion
- **MEDICARE SPENDING ON 65+ POPULATION:** $261 billion
- **65+ WITH 2 OR MORE CHRONIC CONDITIONS:** $246 billion
- **65+ WITH 6 OR MORE CHRONIC CONDITIONS:** $135 billion

- 34 million
- 28 million
- 19 million
- 4 million
Two-thirds of Medicare spending is for people with five or more chronic conditions.

- Ninety-nine percent of Medicare expenditures are for beneficiaries with at least one chronic condition.
- Ninety-eight percent of Medicare expenditures involve individuals with multiple chronic conditions.

Source: Medicare Standard Analytic File, 2007
Accountable Care Organization (ACO)??
Accountable Care Organization (ACO)

- ACO Guidelines established in the Affordable Care Act (ACA)
- CMS Initiative to Shift from Volume to Value Based Payment
- Accountable Care Organization (ACO)
  - “A group of health care providers who come together to coordinate the quality and cost of care provided to patients attributed to the ACO”
- Types of ACOs
  - Pioneer ACO
  - Advanced Payment ACO
  - Medicare Shared Savings Program
  - Next Generation
  - Medicare/Medicaid ACO
ACOs continued…

• ACO must establish appropriate legal and governance structures, cooperative clinical and administrative systems and a shared savings distribution method.

• Provider-led organizations with a strong base of primary care that are collectively accountable for quality and per capita costs across the continuum of care

• Under the program, ACOs accept a minimum of 5,000 beneficiaries. The provider network is required to include sufficient primary care physicians to serve its enrollees.

• The ACO must define processes to promote evidence-based medicine and patient engagement, monitor and evaluate quality and cost measures, meet patient-centeredness criteria and coordinate care across the care continuum.

• Reliable and increasingly sophisticated performance measurement, to support improvement and provide confidence that savings are achieved through care improvements. (Clinical Measures)
Medicare Shared Savings Program

• MSSP is a three-year program during which ACOs accept responsibility for the overall quality, cost and care of a defined group of Medicare Fee-For-Services (FFS) beneficiaries.

• MSSP Models
  o One-Sided (Share in Savings)
  o Two-Sided (Share in Savings and Losses)
  o Both models incorporate quality metrics
    ➢ Patient experience, care coordination, population health

• ACO Investment Model (AIM)
  o Prepayment from CMS for future savings
  o Encouraged ACO participation of rural providers
Attributes of the Value Model

• Benefits
  o Annual Wellness Visits
  o Care Coordination
  o Transitions of Care
  o Quadruple Aim
    ➢ Improve Patient Outcomes
    ➢ Improve Patient Experience / Satisfaction
    ➢ Lower Costs
    ➢ Improve Provider / Care Team Satisfaction

• Additional Results
  o Improved coordination of care between all transitions of care
  o Long term care quality measures coming – ER visits, Readmissions, etc.
Clinical Quality Measures

- Quality Outcomes
  - Potentially Preventable ER visits
  - Potentially Preventable Admissions
  - Patient Satisfaction Surveys
  - Claims Data
  - Health Outcomes
    - At risk population
    - Chronic disease management
    - Preventative health screens and services
    - Immunizations throughout the lifespan
    - Wellness promotion for all...
Data Analytics – Medicare Claims Data

- Cost by type of service provided
  - Acute, ER, Nursing Home, Hospice, Clinic
- Cost by provider organization
  - Local Provider, Tertiary, Nursing Home, Etc.
- Encounters by provider
  - Physician – Primary Care, Specialist
- Encounter data by Diagnosis
Medicare Shared Savings Program

• How Does Payment Work in the One-Sided Model
• Shared Savings
• Payment
  o Fee for Service or Cost Based Reimbursement
  o Historical Benchmark data used to determine future savings
  o Access to utilization, cost and trends
  o Share in savings realized by Medicare
How Does “Shared Savings” Work?

<table>
<thead>
<tr>
<th>ACO Programs</th>
<th>ACO’s Baseline Spending per Patient - based on previous 3 years, for all ACO participants</th>
<th>$10,000</th>
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<tbody>
<tr>
<td>ACO’s Year 1 Spending per Patient</td>
<td>$9,500</td>
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<tr>
<td>Savings</td>
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<tr>
<td>Shared Savings (50%)</td>
<td>$250</td>
<td></td>
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<tr>
<td>Quality Score Adjusted Shared Savings</td>
<td>$200</td>
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All existing reimbursement stays the same!
Medicare Shared Savings Program ACO Assigned Beneficiary Population by ACO by County (counties with more than 1 percent of an ACO’s assigned beneficiaries)
High Sierras
Northern Plains ACO

- Started January 1, 2016
- North Dakota and California providers grouped to meet attribution
- One sided risk Medicare Shared Savings (MSSP)
- Received CMS AIM Funding
  - ACO Investment Model (AIM)
  - 45 ACOs approved, 23 with Caravan Health
  - Prepaid Shared Savings
  - Encouraged rural participation in the ACO model
- Board of Directors that manage the ACO
- ACO Champions that lead the ACO work
High Sierras
Northern Plains ACO

• **North Dakota Participants**
  - First Care Health Center
  - Heart of America Medical Center
  - McKenzie County Healthcare Systems
  - Sakakawea Medical Center/CCCHC
  - Southwest Healthcare Services

• **California Participants**
  - Barton Health, Mammoth Hospital, Ridgecrest Regional Hospital, Truckee Tahoe Medical Medical Group

• **Arizona Participants**
  - Gila Health Resources
Beulah/Hazen Community

- CAH and FQHC in Beulah and Hazen participating jointly in ACO
- Sakakawea Medical Center
  - 13 Bed Critical Access Hospital in Hazen
  - Home Health, Hospice, Basic Care
- Coal Country Community Health Center
  - Federally Qualified Health Center (FQHC) in Beulah
  - Service Delivery Sites in Beulah, Hazen, Center, Killdeer
SMC/CCCHC Comprehensive Care Coordination

- Primary Care RN Care Coordinators
  - Pre-visiting planning – AWVs, LTC, Consults/Referrals
  - Visiting Specialists (psych, cards, ortho, OB/GYN)
  - Pharmacy – medication management
- RN Community Care Coordinator and CHW
- Behavioral Health Care Coordinator
  - MAT – Suboxone; BH Integration with Primary Care
- Public Health Nurse
- Hospital RN Care Coordinator
  - Transitions of Care back to Primary Care
  - ER Discharge and Follow-up through Care Coordination
  - Home Health
Heart of America Medical Center

- CAH and RHC participating jointly in ACO
- Heart of America Medical Center
  - 25 Bed Critical Access Hospital in Rugby
  - SNF, Basic Care, Assisted Living, Hospice
- Rural Health Clinic
  - Service Delivery Sites in Rugby, Maddock, Dunseith, and adding Towner in the Spring of 2018
A BRIEF HISTORY OF TIME

• SUMMER OF 2010
  • ACO CONCEPT IN PPACA

• SUMMER OF 2015
  • RURAL ACO CONCEPT
  • HAMC SIGNS ON TO “NO RISK” TRIAL

• JANUARY 2016
  • HAMC BECOMES PART OF RURAL ACO
  • YEAR OF LEARNING

• JANUARY 2017
  • THE SHIFT FROM ACCIDENTAL TO PURPOSEFUL

• TODAY
  • TANGIBLE BENEFITS AND FUTURE STRATEGY
CHALLENGES

• DATA, INFORMATION, KNOWLEDGE
• DATA RELIABILITY
• MEDICAL STAFF RESISTANCE
• LACK OF STANDARDIZATION
• TOO MANY COOKS
DATA, INFORMATION, KNOWLEDGE, RELIABILITY

• DATA IS INTERESTING BUT RELATIVELY MEANINGLESS
• INFORMATION IS THE COMPILATION OF DATA INTO A USEABLE FORMAT
• KNOWLEDGE IS ANALYSIS OF INFORMATION INTO ACTION
• RELIABILITY OF INFORMATION AND KNOWLEDGE WILL ALWAYS BE QUESTIONED IF THE DATA IS FLAWED
TOO MANY COOKS

Dozens of people with data entry authority but only a few with extraction and compilation authority = spoiled broth
Only in Rugby:

- The scientific method applies to medicine only
- If the data is bad, I cannot trust the result
- It is a waste of my time to work on a beta concept, bring it back only when it is 100% reliable
- Non-clinicians are making judgments about the results
OVERCOMING RESISTANCE AND ACHIEVING BUY-IN

• STANDARDIZATION!
• MAKE NEW HABITS
• ENGAGE THE MEDICAL STAFF EARLY AND OFTEN IN THE PROCESS
  • ANNUAL WELLNESS VISITS
• EVIDENCE-BASED MEDICINE
Building a Healthy Community
• WHY DID MCHS JOIN THE HIGH SIERRAS-NORTHERN PLAINS ACO?

• DARROLD ASKED
• WHY DID MCHS JOIN THE HIGH SIERRAS-NORTHERN PLAINS ACO?
  • DARROLD TOLD ME TO!!!
  • SERIOUSLY I BELIEVED THIS IS THE WAY THAT REIMBURSEMENT IS GOING.
• WHY PARTICIPATE IN AN ACO WHEN:
  • YOU MAKE MONEY BY OFFERING MORE SERVICES
  • INCENTIVES ARE NOT LIKELY TO BE ADEQUATE TO COVER LOST REVENUES

CONSIDERATIONS:
• 1. INEVITABLE THAT CHANGE TO ELIMINATE INEFFICIENCIES WILL CONTINUE
• 2. SHIFT FROM FEE FOR SERVICES TO AT-RISKS PAYMENTS WILL OCCUR
• 3. LOST REVENUE FROM ELIMINATING INEFFICIENCIES WILL HAVE TO BE MADE UP THROUGH INCREASING MARKET SHARE OR OFFERING OTHER SERVICES
CONSIDERATIONS WHY YOU SHOULD PARTICIPATE-
CONTINUED

• 4. PROVIDERS BEST ABLE TO COORDINATE CARE WITH
HIGHEST QUALITY AND LOWEST COST WILL BE BEST
EQUIPPED TO TRANSITION TO AT-RISK PAYMENTS

• 5. OPPORTUNITY TO HELP PHYSICIANS ON YOUR MEDICAL
STAFF SUPPLEMENT THEIR INCOMES
WHAT IS AN ACO?

• An ACO is a collaboration of physicians and other health care providers to coordinate patient care.

• Monitors quality and cost.

• Eligible to receive additional payments for achieving quality and cost savings goals.
ACO OPERATIONS

- Compliance Plan is required
  - Compliance Officer is a required position

- Waivers-ACOs granted waivers from Anti-kickback, Stark and Civil Monetary Penalties.

- Quality factors can change throughout the program but not within a performance year.
  - ACOs with better quality scores obtain higher shared savings payments.

- Skill set from Medicare ACO program can be transferred into commercial market ACOs and vice versa.
ACO OPERATIONS

✓ Successful population health management requires care management programs and trained professionals that are integrated with care team. 2009 study: almost 10% of Medicare beneficiaries readmitted within 30 days of discharge and 34% re-hospitalized within 90 days.

✓ Embedded case managers serving as patient point of contact upon admission, discharge, and transition between organizations and care settings can link patients to resources that result in improvement in clinical outcomes.

✓ Successful Care Coordination and patient management needs access to timely, accurate and complete information.
ACO OPERATIONS

Without HIT when a patient presents in an emergency room outside of the ACO, an ACO may not learn of that episode of care until it receives retroactive claims data by CMS by which time the patient may have incurred significant costs which are attributed to the ACO and affect ACO performance on cost and quality measures.

Patient Engagement- While technology is a necessary component of a patient engagement strategy, successful patient engagement and self-management programs require trained professionals (nurses, social workers and physicians) investing time and effort to help patients become engaged in meeting their health objectives.
CHALLENGES

- Working Capital for data and care management infrastructure
- HIT and data aggregation demands
- Staffing skills and resources
- Legal-Data Use
- Network-Participating Providers
- Managing/pacing so much change at one time
- Managing expectations of Medicare cost savings
LESSONS LEARNED

Too many to count!

• Persistence pays
• Have a flexible strategy/plan
• Stay on message
• Collective impact framework has been helpful
• Data is essential and doesn’t have to be expensive
• Learning curve is steep-pace is important
• One size does not fit all
• Communicate-Communicate-Communicate
COMING IN 2018!
Questions