



# California Rural Health ACO Update

# Accountable Care Organizations

## The ACO Stack



According to CMS, an ACO is "an organization of health care providers that agrees to be accountable for the quality, cost, and overall care of Medicare beneficiaries who are enrolled in the traditional fee-for-service program who are assigned to it."

- 1) Provider-led organizations with a strong base of primary care that are collectively accountable for quality and total per capita costs across the full continuum of care for a population of patients;
- 2) Payments linked to quality improvements that also reduce overall costs
- 3) Reliable and progressively more sophisticated performance measurement, to support improvement and provide confidence that savings are achieved through improvements in care.

# ACO's *Proposed* Rulemaking

- ❑ Comments are critically important – in your own words!
  - ❑ Due June 6, 2011
  - ❑ Companion (FTC/IRS) Legislation comments due May 31, 2011
- ❑ Several interesting opportunities for rural to participate
- ❑ CMMI welcomes alternate models, particularly for the safety net



# ACO's *Proposed* Rulemaking

- ❑ Winners will be flexible, prepared, wired and collaborative
- ❑ Final rule will probably be easier/more generous
- ❑ May be repealed by the GOP





# Eligibility

Legal entity comprised of “eligible group” of ACO participants

ACO participants can be any Medicare providers or suppliers

Must have “ACO professionals” - primary care physicians who bill under Part B for a plurality of primary care services for at least 5000 Medicare beneficiaries

PCPs in RHCs, FQHCs and Method 1 CAHs do not qualify (COMMENT!!)



**Comment: Rural could assign beneficiaries based on same 75% PSA rule used by FTC for rural exception that gives safety zone**

# Governance

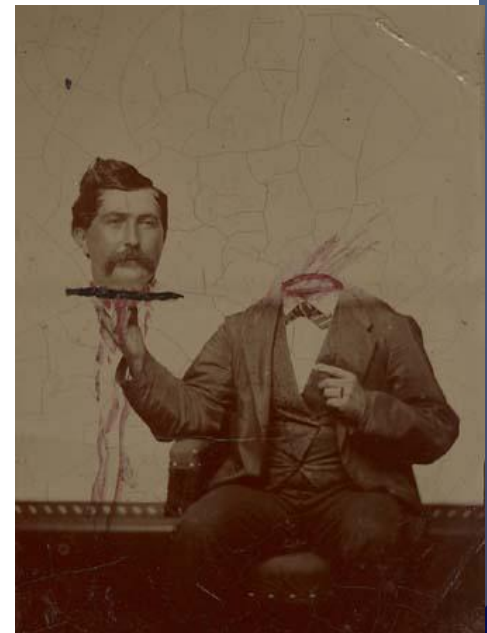
- ❑ Governing body must be proportional to ACO participants
- ❑ Participants must control 75% of board
- ❑ Management, Medical Director and committee requirements



# Shared Savings – Rural Model

- ❑ One-Sided Model (sort of...)
  - ❑ Participate in savings only in year 1-2
  - ❑ Participate in risks in year 3
  - ❑ First dollar participation
  - ❑ Maximum participation is 52.5% of savings
  
- ❑ Two-Sided Model
  - ❑ Participate in risks and savings for all 3 years
  - ❑ First dollar participation
  - ❑ Maximum participation is 65% of savings
  - ❑ Not recommended for inexperienced, smaller ACOs

**Comment:  
Rural needs  
a non-  
capitated  
model!**



# Shared Savings – Rural Model

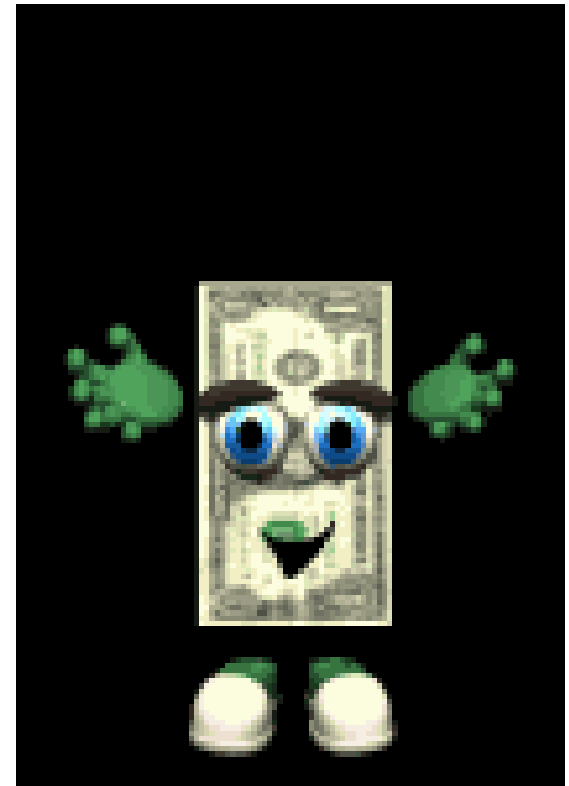
- ❑ Limits on upside and downside
  - ❑ One-Sided Model
    - ❑ 7.5% Upside limit (14% total)
    - ❑ Year 3 transitions to Year 1 Two-Sided Model
  - ❑ Two-Sided Model
    - ❑ 10% Upside limit (15% total)
    - ❑ Escalating downside limit
      - ❑ Yr 1: 5% (One-Sided Model)
      - ❑ Yr 2: 7.5%
      - ❑ Yr 3: 10%
    - ❑ Discounts for Quality (up to 60%) and rural (up to 5%)
- ❑ 25% withhold against future losses



**Comment:**  
Rural should not be liable for more than 25% withhold in two-sided model.

# The Rural Bonus: First Dollar Sharing

- ❑ ACO's that have less than 10,000 beneficiaries
  - ❑ with 75% outside MSAs (you know you are rural...) *OR*
  - ❑ 50% of beneficiaries were assigned because of Method II CAH *OR*
  - ❑ 50% of beneficiaries had one visit with an FQHC or RHC
- ❑ Non-rural ACOs subject to 2%-3.9% corridors
- ❑ For a \$50M ACO = \$1M



**Comment: Important to preserve this aspect of the rule!**

# The Rural Bonus: Increased Percentage Points

Percentage of ACO Assigned Beneficiaries with 1 or more visits to an ACO Participant RHC/FQHC	Percentage Point Increase in Shared Savings Rate (1-sided/2-sided)	Potential Benefit Based on \$50 Million Shared Savings (1-sided/2-sided/2-sided loss)
1-10%	0.5%/1%	\$250K/\$500K/\$500K
11-20%	1%/2%	\$500K/\$1M/\$1M
21-30%	1.5%/3%	\$750K/\$1.5M/\$1.5M
31-40%	2%/4%	\$1M/\$2M/\$2M
41-50%	2.5%/5%	\$1.25M/\$2.5M/\$2.5M

**Comment: Do not allow ACOs to split rural communities – all providers in the community should be allowed to participate, and beneficiaries need to be assigned based on PSA.**

# Rural Options



- ❑ Do nothing
- ❑ Get ready
  - ❑ Establish MU, HIE and Medical Home to implement quality requirements over the next 12 months (maximize your value)
  - ❑ Wait for the final rule before limiting your options (required to be non-exclusive for now)
- ❑ Likely Options
  - ❑ Partner with urban ACOs for a fixed fee (no downside)
  - ❑ Partner with a few carefully selected communities to meet minimum requirements (data and culture driven)
  - ❑ Form an all-rural ACO built on CAREHIN infrastructure
  - ❑ Propose rural demonstration project to CMMI built on CAREHIN

# What Would an All-Rural ACO Look Like?

- ❑ About 50 HSA's/Districts that wouldn't qualify on their own
- ❑ Total Medicare Beneficiaries = 125,000
- ❑ Total Medicare Spending = \$1 billion
- ❑ 10% reduction in Spending = \$2 million per HSA per year
- ❑ Tertiary care hospitals and urban specialists would lose most of the revenue
- ❑ HSA admissions and discharges would probably decrease by about 10%

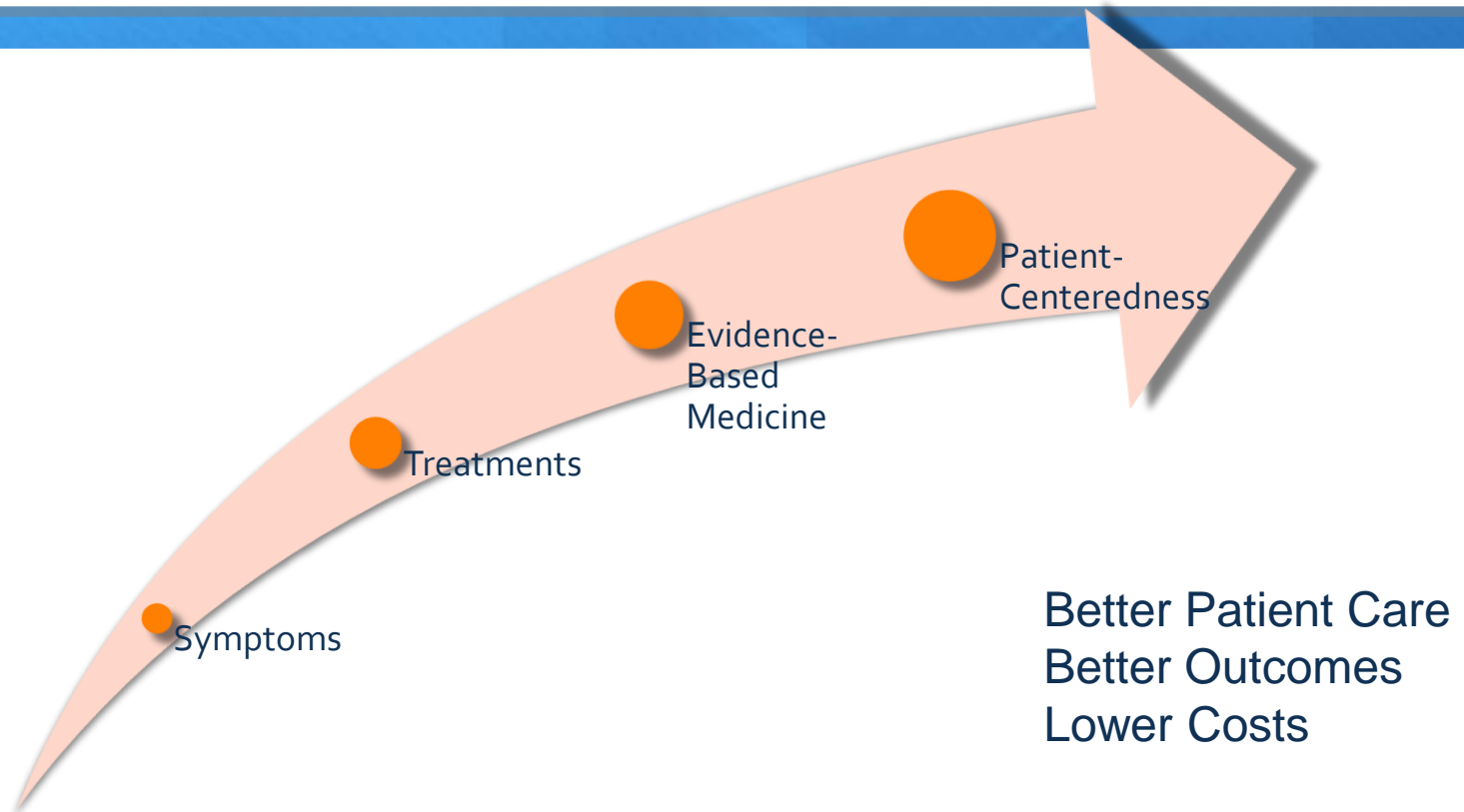


# What do You Need to Do in the Next 12 Months to Take Every Advantage?

- + Become a meaningful user on both the inpatient and outpatient side
- + Join a Health Information Exchange
- + Implement the required quality measures – MEDICAL HOME!



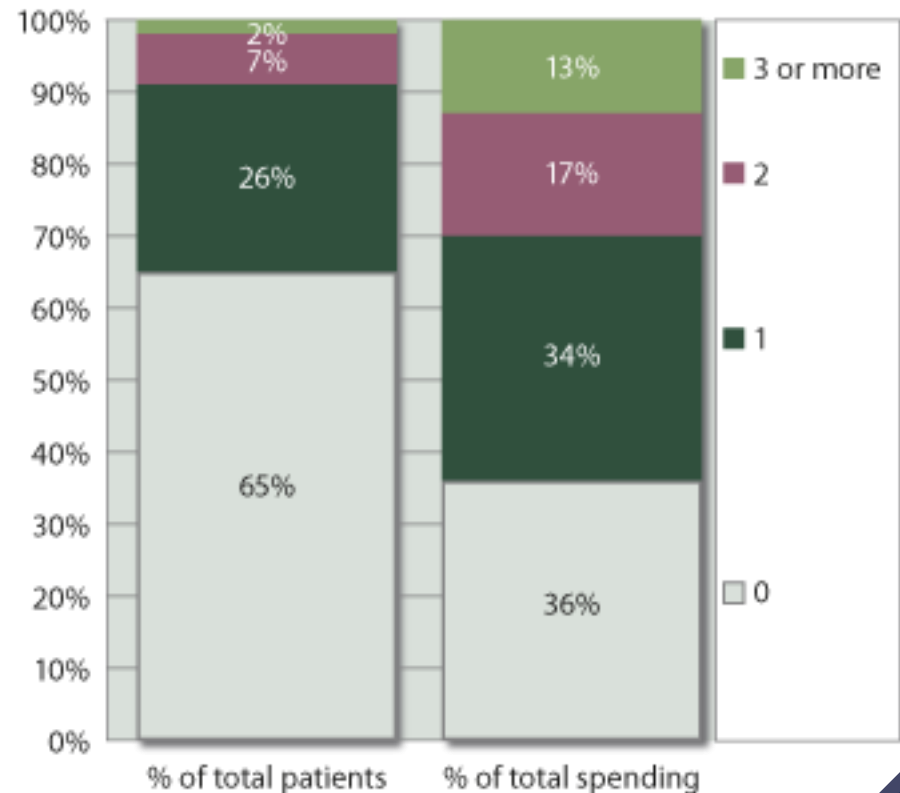
# Care Transformation: Can You Do It?



# 65 “Quality” Measures

- ❑ Road map to shared savings
- ❑ Focused on Chronic Disease Management
- ❑ No hint of rationing

Patients and Costs by Number of Chronic Conditions, Ages 18–64, CHRT.ORG



# Patient/Caregiver Experience

- ❑ Getting timely care, appointments and information
- ❑ How well your Doctors communicate
- ❑ Helpful, courteous, respectful office staff
- ❑ Patient's rating of Doctor
- ❑ Health promotion and education
- ❑ Shared decision making
- ❑ Health status/functional status



# Care Coordination/Transitions

- ❑ 30-day acute care hospital readmissions - claims
- ❑ 30-day post discharge physician visit
- ❑ 60-day post discharge medication reconciliation
- ❑ Patient experience (self-care, medications, preferences)
- ❑ Admissions rate for PCP failures: uncontrolled Diabetes and/or complications, COPD, CHF, dehydration, pneumonia, UTI (ambulatory sensitive admissions) – claims

# Care Coordination/Information Systems

- ❑ % of all physicians meeting Stage 1 meaningful use
- ❑ % of PCPs meeting Stage 1 meaningful use
- ❑ % of PCPs using clinical decision support (MU core measure)
- ❑ % of PCPs using eRx (MU core measure)
- ❑ Use of patient registry (MU menu set measure)



# Patient Safety

- ❑ Composite score for healthcare acquired conditions (accidents, infections, mistakes, bedsores, etc..) – claims/CDC
- ❑ ICU Central Line Bundle – claims/CDC



# Population Health



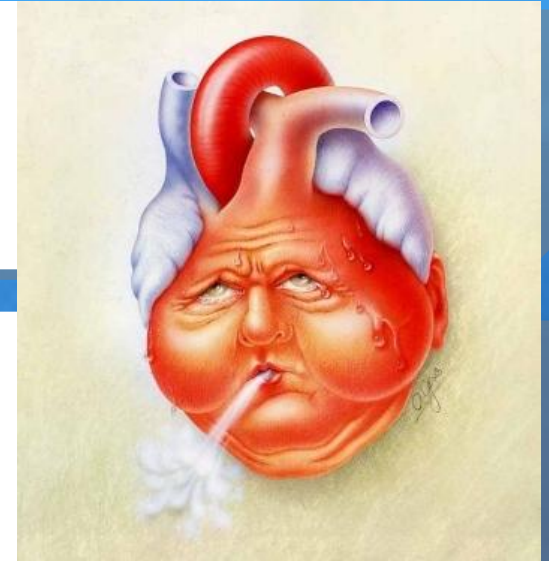
- ❑ % of 50+ patients with flu vaccine during season
- ❑ % of 65+ patients with pneumococcal vaccine
- ❑ % of 40-69 females with mammogram within 2 years
- ❑ % of 50-75 patients with appropriate colorectal cancer screen
- ❑ % of 18-75 cardiovascular pts with LDL-C <100 mg/dl
- ❑ % of pts with normal BMI or documented plan to address
- ❑ % of pts >18 with hypertension who have BP recorded

# Population Health



- ❑ % of patients queried for tobacco and % interventions
- ❑ % of patients screened for depression and % interventions
- ❑ Diabetes Composite (all or nothing- HbA<sub>1c</sub> <8%, LDL <100mg, BP<140/90, no smoking, aspirin use) and individual rates above and below threshold
- ❑ Diabetes screening to prevent blindness, ESRD and amputation

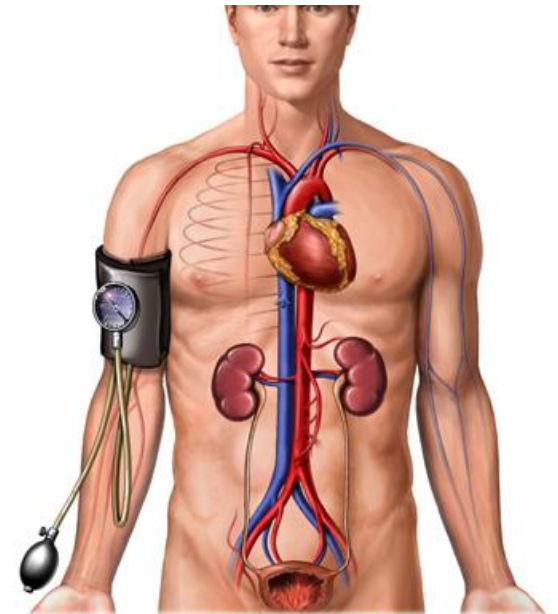
# Population Health-CHF



- ❑ CHF – % LVF Assessment
- ❑ CHF - % LVF within one year of CHF admission
- ❑ CHF – % of patients with weight recorded
- ❑ CHF - % of patients educated in self-management past year
- ❑ CHF - % of patients with LVF <40% on beta-blocker
- ❑ CHF - % of patients with LVF <40% on ACE inhibitor or Angiotensin Receptor Blocker (ARB)
- ❑ CHF - % of patients with Atrial Fibrillation on Warfarin

# Population Health

- ❑ CAD Composite - (all or nothing- antiplatelets, statins, beta blockers, ACE inhibitors or ARB prn, LDL<100mg/dl) and individual rates
- ❑ Hypertension - % of patients <140/90
- ❑ Hypertension - % of patients >140/90 with plan of care
- ❑ COPD - % of smokers who received counseling
- ❑ COPD - % of patients >18 whose forced expiratory volume in 1 second (*FEV<sub>1</sub>*) forced vital capacity (*FVC*) ratio <70% prescribed inhaled bronchodilator



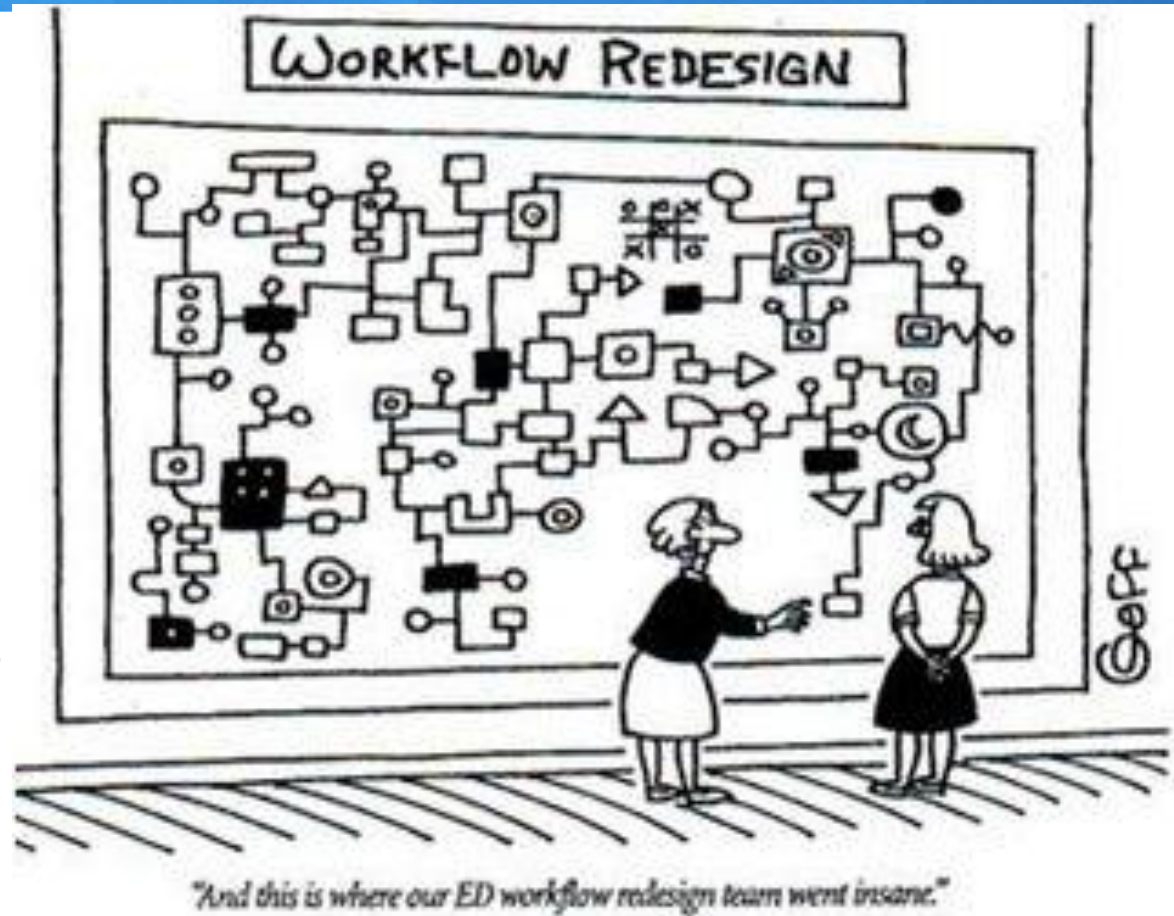
# Population Health

- ❑ Frail Elderly - % of 65+ patients screened for fall risk in last year
- ❑ Frail Elderly - % of 65+ women screened for bone mineral density or given osteoporosis drug within 6 months of fracture
- ❑ Frail Elderly – % of months that an International Normalized Ratio (INR) was not obtained for Warfarin patients - claims



# What do you need to do?

- ❑ Clinical workflow redesign: Build new processes to care for the chronically ill
- ❑ Become a meaningful user: Use technology to record and exchange electronic health data



# ACO Demonstration Project

Summary Results of the Physician Group Practice Demonstration, Performance Years 1–4.\*

Physician Group Practice	Percentage of Quality Goals Attained				Shared Savings Payments (\$)			
	Year 1	Year 2	Year 3	Year 4	Year 1	Year 2	Year 3	Year 4
Billings Clinic, Billings, MT	90.91	97.78	98.11	92.45	0	0	0	0
Dartmouth–Hitchcock Clinic, Lebanon, NH	95.45	97.78	92.45	94.34	0	6,689,879	3,570,173	328,798
Everett Clinic, Everett, WA	86.36	95.56	94.34	94.34	0	129,268	0	0
Forsyth Medical Group, Winston-Salem, NC	100.00	100.00	96.23	96.23	0	0	0	0
Geisinger Clinic, Danville, PA	72.73	100.00	100.00	100.00	0	0	1,950,649	1,788,196
Marshfield Clinic, Marshfield, WI	81.82	100.00	98.11	100.00	4,565,327	5,781,573	13,816,922	16,154,242
Middlesex Health System, Middletown, CT	86.36	95.56	92.45	94.34	0	0	0	0
Park Nicollet Clinic, St. Louis Park, MN	95.45	97.78	100.00	100.00	0	0	0	0
St. John's Clinic, Springfield, MO	100.00	100.00	96.23	98.11	0	0	3,143,044	8,185,757
University of Michigan Faculty Group Practice, Ann Arbor	95.45	100.00	94.34	96.23	2,758,370	1,239,294	2,798,006	5,222,852

\* Because the CMS applied different weights to each of the quality measures, the agency calculated the quality goals attained as percentages, rather than absolute numbers of measures. Data are from RTI International.

# Marshfield Clinic ACO

- 9 rural and 3 smaller urban hospitals
- 55,000 people
- 7655 Beneficiaries
- Started at \$8292/beneficiary
- Total spending = \$63.5 million/year
- Total savings over 4 years = \$40 million



# Marshfield Clinic Group Practice

- + 775 physicians in 54 locations
- + HMO experienced
- + *Controlled the specialist network*
- + Affiliated with St. Joseph's system
- + Average savings per physician = \$53,000



# ACO NPRM-Four More Programs

- + Independence at Home Medical Practices – all savings >5% for practice enrollees
- + State Option to provide health homes for chronically ill
- + Establish CMMI to explore alternative ACO models – solid infrastructure must be in place to participate
- + HSA Community Health Teams – Medicare grants and contracts – Get Ready!



# Comments to CMS due June 6th

## *Do it Today!*



- ❑ Assign beneficiaries in rural and sole provider communities based on 75% PSA Zip Codes
- ❑ Allow rural to participate on a non-capitated basis – permanent one-sided model
- ❑ Do not allow ACOs to split rural communities – all providers in the community should be allowed to participate
- ❑ Rural should not be liable for more than 25% withhold
- ❑ First dollar sharing and increased percentage points are very important to get rural participation
- ❑ Many other areas to comment – please read and respond at <http://www.regulations.gov/#!documentDetail;D=CMS-2010-0259-0425>