Population Health & ACOs
What is or is not working?

HFMA Lone Star Chapter

Presented by
Christie Lawrence
VP, Sales/Business Development
KPN Health, Inc.
Objectives

• Population Health via the MSSP ACO Model
  • Growth of ACOs Nationwide
  • MSSP ACO Tracks
  • How ACOs Get Paid

• Overview of the Winners & Losers
  • What is Working?
  • What is Not Working?

• Considerations for Your Organization.
Value-Based Reimbursement

The HHS Goal: The Dept. of Health and Human Services has set a goal of moving 50% of payments toward alternative models by 2018.
Triple Aim – An ACO’s Target

by Institute of Healthcare Improvement
Total Number of ACOs

Number of Public & Private ACOs, 2011 to January 2015

Source: Leavitt Partners Center for Accountable Care Intelligence
People Covered ACO Arrangements

Number of ACO covered lives, 2011 to January 2015

- 7.8 million are part of the Medicare ACO programs (Pioneer & MSSP)
- Majority of volume is coming from commercial and Medicaid sectors
- 16 states have passed Medicaid ACO legislation or ACO-like pilot programs

Source: Leavitt Partners Center for Accountable Care Intelligence
Number of ACOs by State

Number of ACOs by state, 2011 to January 2015

Source: Leavitt Partners Center for Accountable Care Intelligence
Leavitt Partners predicts ACOs will cover 70 Million people by 2020 and more than 150 million people in 2025.
New MSSP ACO Tracks

2015 CMS final MSSP ACO rules were refined to encourage continued and enhanced stakeholder participation. Key changes:

- Track 1 MSSP ACOs can renew for another 3 years in Track 1.
- Added Track 3 with up to 75% sharing rate.
- Previously terminated Track 1 ACOs can reapply.

<table>
<thead>
<tr>
<th>Track</th>
<th>Sharing Rate</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1:</td>
<td>50% Sharing Rate</td>
<td>No risk, UP to 50% of savings but no penalty for higher costs, 98% of all MSSP ACOs</td>
</tr>
<tr>
<td>2:</td>
<td>60% Sharing Rate</td>
<td>ACO shares the risk, UP to 60% of savings, Several symmetrical MSR/MLR* options, 3% of all MSSP ACOs</td>
</tr>
<tr>
<td>3:</td>
<td>75% Sharing Rate</td>
<td>ACO shares the risk, UP to 75% of savings, Opportunity for waiver of 3-day inpatient stay SNF rule, Several symmetrical MSR/MLR* options</td>
</tr>
</tbody>
</table>

* MSR – Minimum Savings Rate
* MLR – Minimum Loss Rate
How do MSSP ACOs get shared Savings?

- Reduce cost below ACO’s benchmark
- Reporting on 33 quality measures
- CAPHS survey reporting – patient satisfaction

<table>
<thead>
<tr>
<th>MSSP ACO Track 1 – No Risk</th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Data Reporting Only</td>
<td>Data Reporting &amp; Outcomes</td>
<td>Data Reporting &amp; Outcomes</td>
</tr>
<tr>
<td>Pay for Performance Measures</td>
<td>0</td>
<td>25</td>
<td>32</td>
</tr>
<tr>
<td>Pay for Reporting Measures</td>
<td>33</td>
<td>8</td>
<td>1</td>
</tr>
<tr>
<td>TOTAL</td>
<td>33</td>
<td>33</td>
<td>33</td>
</tr>
</tbody>
</table>

*Metrics really matter in year 2 & 3!*
Healthy behaviors are the biggest impact influencing a person’s health; yet only 4% is spent on prevention – something has got to change!

MSSP ACO Quality Domains

- Patient/Caregiver Experience
  - Diabetes
  - Hypertension
  - Ischemic Vascular Disease
  - Heart Failure
  - Coronary Artery Disease
  - Depression

- Care Coordination / Patient Safety

- Preventative Health

- At Risk Populations
Are ACOs Succeeding?

As of Sept. 2014, savings from MSSP ACOs exceed $700 million and CMS payouts are over $300 million.

- 53.63% (118/220) were able to reduce spending below their benchmark.

<table>
<thead>
<tr>
<th>Breakdown of MSSP ACOs Reducing &amp; Increasing Spending</th>
<th>52</th>
<th>23.63% got $$$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduced spending enough to earn shared savings</td>
<td>52</td>
<td>- 23.63% got $$$</td>
</tr>
<tr>
<td>Reduced spending enough to earn shared savings, but</td>
<td>6</td>
<td>- 2.72% - small ACOs</td>
</tr>
<tr>
<td>failed to satisfactorily report quality metrics</td>
<td></td>
<td>- Left $941,236 to $10.62 million on table</td>
</tr>
<tr>
<td>Reduced spending, but not enough to earn shared</td>
<td>60</td>
<td>- 27.27%</td>
</tr>
<tr>
<td>savings</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Increased spending, but not enough to have shared</td>
<td>101</td>
<td>- 45.90%</td>
</tr>
<tr>
<td>losses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Significantly overspent budget and had shared losses</td>
<td>1</td>
<td>- Shared in losses of $4 million</td>
</tr>
<tr>
<td>TOTAL Participants</td>
<td>220</td>
<td></td>
</tr>
</tbody>
</table>

Source: Healthaffairs.org/blog/2015/01/22
Average ACO Savings in States with at least 5 MSSP participants:

Source: Healthaffairs.org/blog/2015/01/22
Shared Savings by # of Lives

- Large ACOs generally did not have an advantage in financial performance
- ACOs < 8,000 lives had a higher average savings rate

Source: Healthaffairs.org/blog/2015/01/22
## TOP MSSP ACO Savings (Medicare Shared Savings Program)

<table>
<thead>
<tr>
<th>ACO</th>
<th>States</th>
<th>Total Savings</th>
<th>ACO Share</th>
</tr>
</thead>
<tbody>
<tr>
<td>Memorial Hermann Accountable Care Organization (Houston, TX)</td>
<td>TX</td>
<td>$57.83 M</td>
<td>$28.34 M</td>
</tr>
<tr>
<td>Palm Beach Accountable Care Organization, LLC</td>
<td>FL</td>
<td>$39.57 M</td>
<td>$19.34 M</td>
</tr>
<tr>
<td>Catholic Medical Partners-Accountable Care IPA, Inc.</td>
<td>NY</td>
<td>$27.92 M</td>
<td>$13.68 M</td>
</tr>
<tr>
<td>Southeast Michigan Accountable Care, Inc.</td>
<td>MI</td>
<td>$24.68 M</td>
<td>$12.09 M</td>
</tr>
<tr>
<td>RGV ACO Health Providers, LLC (Donna, TX)</td>
<td>TX</td>
<td>$20.24 M</td>
<td>$11.90 M</td>
</tr>
<tr>
<td>ProHEALTH Accountable Care Medical Group, PLLC</td>
<td>NY</td>
<td>$21.91 M</td>
<td>$10.74 M</td>
</tr>
<tr>
<td>Triad Healthcare Network, LLC (KPN Health’s client)</td>
<td>NC</td>
<td>$21.51 M</td>
<td>$10.54 M</td>
</tr>
<tr>
<td>WellStar Health Network, LLC</td>
<td>GA</td>
<td>$19.88 M</td>
<td>$9.74 M</td>
</tr>
<tr>
<td>Accountable Care Coalition of Texas, Inc. (Houston, TX)</td>
<td>TX</td>
<td>$19.10 M</td>
<td>$9.36 M</td>
</tr>
</tbody>
</table>
Continuous Improvement Counts

Efficiency and continuous improvement are critical to long term ACO success according to MHMD (Memorial Hermann Physician Network), the #1 ranked MSSP ACO based upon 2013 outcomes.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>2013</th>
<th>2014</th>
<th>Improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Days/1000</td>
<td>208</td>
<td>236</td>
<td>12.18%</td>
</tr>
<tr>
<td>Average length of stay</td>
<td>3.5</td>
<td>3.9</td>
<td>9.36%</td>
</tr>
<tr>
<td>Re-admission rates</td>
<td>5.1%</td>
<td>6.0%</td>
<td>9.32%</td>
</tr>
</tbody>
</table>
| ER visits/1000                | 164   | 180   | 25.38%      

MHMD: Memorial Hermann Physician Network
ACO: Accountable Care Organization
MSSP: Medicare Shared Savings Program
What Did Winning ACOs Do?

• **Care Management** –
  - Inpatient care management coordinated with ACO care managers at discharge
  - Care Management home assessments and interventions – very effective
  - Non-Medical Interventions (i.e., transportation, meals, HVAC, housing, literacy, and finances) had surprising impact on reducing cost
  - Reduced Re-admission Rates and Length of Stay Rates
  - 7-day Post-Acute follow-up visit with PCP
  - Focused efforts on high-cost areas (i.e., COPD, Home Health, Hospice, Palliative Care and SNFs)

• **Provider / Staff Education & Engagement** –
  - Educated providers / staff on quality measures & cost reduction
  - Got engagement from physicians / staff – collaborative “team” mindset
  - Helped practices achieve PCMH recognition
  - Communicated metrics in a way that was not perceived as “punitive”

• **IT Infrastructure** –
  - Negotiated discount for practices to purchase or switch to an approved EMR
  - Provided clinical decision support tool, Point of Care Report, that identified gaps in care
  - Found way to capture and report required GPRO data
Lessons Learned: Importance of Home Assessments

• Referred to THN Pharmacist for medication reconciliation and to help determine a way to afford medications
• CHF, DM, COPD, anxiety, HTN, depression, MVA resulting in chronic headaches
• Upon questioning about migraines, he brought out a bag of medications

Source: Triad HealthCare Network

Total of 9 bags of expired OTC and prescription medications
Care Management & Coordination

Keeping people healthy & managing high risk patients are key.
What Caused ACOs to Lose?

- **Care Management** –
  - Inability to reduce the cost of care below the CMS benchmark
  - High leakage rate to non-ACO partners / specialists
  - Not following their patients / knowing where they are
  - Lack of SNF & Palliative Care programs
  - Top heavy with RN care managers – not always need an RN

- **Provider / Staff Education & Engagement** –
  - Did not require practices to change / transform – “it’s optional” mindset
  - Did not communicate with or educate providers / staff – especially on quality metrics
  - No support given to practices for PCMH (Patient-centered Medical Home) recognition

- **IT Infrastructure** –
  - Spent all the money on the IT infrastructure – no reinvestment
  - No or poor documentation; therefore, didn’t have data for GPRO reporting
  - Underestimated time involved or complexity of GPRO reporting process
  - Relyed only on claims data – 3 months behind care spend

- **Administrative** –
  - Not prepared for running ACO and its complexities
Factors driving an ACO performance in the MSSP model:

• **Historical Trend During Benchmark Setting Years**
  - High regional trend creates an additional hurdle to overcome with a flat national trend
  - Low regional trend, and in many cases, negative regional trend helps ACOs

• **Relative Benchmark Payment Levels**
  - Higher benchmark payment levels reflect more opportunities to improve efficient care delivery
  - Lower benchmark payments either suggest under-delivery of care or historically more efficient markets

• **Attribution**
  - High rates of churn impact ability to get credit for care coordination on final population
  - High rates of churn also have indicated healthier populations leaving ACO attribution lists
  - Rule of thumb – CMS’ attribution averages 1/3 of the lives you think you have

• **Care Coordination**
  - Groups with history of managing populations under Medicare Advantage tend to do better than those without
  - Engagement level of providers and beneficiaries impacts the continuously attributed population results

Source: Collaborative Health Systems
Considerations for Your Organization

Some things to consider regarding participation in an ACO:

• CINs / Commercial ACOs are less erroneous and a good place to start
• NAACOS study - $1.5 million a year average ACO management costs
• You will need strong ACO physician leadership as well as ACO administration
• Data really matters because it is hard to monitor what you can’t measure
• The ACO is a great way to get ready for capitation and/or becoming a Medicare Advantage Plan
• Pick 5-6 EMRs and require all ACO providers to switch – negotiate a discounted rate and/or provide $$ to help providers make the switch
• Kick providers out if they are non-compliant
• Limit your network partners
Thank you for your time and interest! Please let me know if you have any additional questions.

Christie Lawrence  
VP, Sales / Business Development  
KPN Health, Inc.  
W: 214-593-6926  
C: 214-681-2987  
Christie.Lawrence@kpnhealth.com  
www.kpnhealth.com

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