Accountable Care Organizations: Opportunities & Challenges for SNFs

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Today’s Agenda

1. How Reform is Changing Medicare
2. Overview of ACOs
3. Market Realities and SNF Opportunities
4. Q&A
Headed Toward Insolvency?

Projected Health Care Spending
Average Annual Growth Rate

- Federal health expenditures as percentage of GDP, 2008
  - 6.1%
- Projected federal health expenditures as percentage of GDP, 2018
  - 8.1%

Medicare Eligibles (in millions)
- 2009: 45.5
- 2019: 60.3

Governments Limiting Risk Exposure

- Managed Care
- Duals Demonstrations
- MLTSS\(^1\)
- ACOs
- Bundled Payments
- Medical Home

\(^1\) Managed Long-Term Services and Supports
Providers Taking on More Risk

PAC in the Crosshairs

- **MedPAC**
  - Recommendation to rebase SNF rates starting with immediate 4% cut
  - Recommendation to create site neutral payments between IRFs and SNFs for select conditions

- **CMS**
  - Increased scrutiny related to utilization of ultra-high RUGs categories; studies to reform payment for therapy services
  - Expected FY2015 proposed rule in May

- **Congress**
  - Recently passed “doc fix” includes new SNF value-based purchasing/readmissions program
  - Similar programs expected for other PAC providers
Erosion of Medicare Fee-for-Service

Under an aggressive set of expectations, Medicare Advantage enrollment will grow faster than FFS enrollment, while ACOs will gain significant market share by 2019.

Distribution of Medicare Enrollment

2009

- Traditional Fee-for-Service: 76%
- Medicare Advantage: 24%
- N = 45.5 million

2014

- Traditional Fee-for-Service: 53%
- Medicare Advantage: 30%
- ACOs: 14%
- Dual Demos: 4%
- N = 52.0 million

2019 (E)

- Traditional Fee-for-Service: 29%
- Medicare Advantage: 33%
- ACOs: 26%
- Dual Demos: 12%
- N = 60.3 million

Source: Analysis by Avalere Health.
Medicare Turns to Innovation

- CMS Innovation Center (CMMI)
  - Established by Section 1115A of the Social Security Act (added by section 3021 of the ACA)
  - Secretarial authority to expand scope and duration of test models through rulemaking
- Current CMMI Priorities
  - Testing new payment and service delivery models
  - Evaluating results and advancing best practices
  - Engaging broad range of stakeholders to develop additional models for testing
New Jersey Deep into CMMI Demos

Current Initiatives
- Health Care Innovation Awards
- BPCI Model 1
- BPCI Model 2
- BPCI Model 3
- BPCI Model 4
- Community-based Care Transitions Program
- Comprehensive Primary Care Initiative
- FQHC Advanced Primary Care Practice Demonstration
- Innovation Advisors Program
- Strong Start for Mothers & Newborns Initiative

Emerging Market Response

Referral Source in FFS
SNF A
SNF B
SNF C
SNF D
SNF E
SNF H
SNF G
SNF F

Referral Source in Managed Markets
SNF A
SNF B
SNF C
SNF D
SNF E
SNF H
SNF G
SNF F
Changing Business Models

A Shift in Business Priorities

Volume-based → Value-based

The successful business model of the future will be one that keeps patients healthy and at home.

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Defining “ACO”

- The ACA established the ACO model within the Medicare program
- A voluntary program where providers can join together to manage and coordinate care for a population of patients, and accept responsibility for the quality and cost of that care
- Medicare ACOs regulated by the Medicare Shared Savings Program (MSSP) rules: 42 CFR Part 425.

Major Payer Categories of ACOs

- **Medicare**
  - Shared Savings
  - Pioneer ACOs
  - Advanced Payment

- **Medicaid**
  - State Pilots
  - Coordinated Care Organizations
  - Managed Care

- **Private Payer**
  - Insurance Company
  - Collaboration
  - Medicare Advantage

Source: Leavitt Partners.
MSSP Rule Governs Medicare ACOs

- **42 CFR Part 425**
  - Subpart A – General Provisions
  - Subpart B – Shared Savings Program Eligibility Requirements
  - Subpart C – Application Procedures and Participation Agreement
  - Subpart D – Program Requirements and Beneficiary Protections
  - Subpart E – Assignment of Beneficiaries
  - Subpart F – Quality Performance Standards and Reporting
  - Subpart G – Shared Savings and Losses
  - Subpart H – Data Sharing with ACOs
  - Subpart I – Reconsideration Review Process

Clinical & Administrative Requirements

- MSSP rule requires that ACOs:
  - Promote evidence-based medicine
  - Promote beneficiary engagement
  - Report internally on quality and cost metrics
  - Provide coordinated care across and among primary care providers, specialists, and post-acute providers

- Evaluated on 33 quality metrics divided into categories:
  - Patient/caregiver experience
  - Preventive health
  - Care coordination/patient safety
  - At-risk populations
Patient Attribution a Potential Issue

- Beneficiaries are *attributed* to ACOs, not enrolled
- Attribution based on where majority of primary care services are received
- If the primary care physician is part of an ACO, the patient is automatically attributed
- Notification letter to patients and opt-out provision

SNFs May Play Key Role in Attribution

**Study Design and Findings**

- Looked at the effect of E&M codes for primary care services delivered in PAC settings would have on beneficiary assignment in ACOs
- Found that assignment shifts occurred for 27.6% of 25,992 community-dwelling beneficiaries with at least one post-acute SNF stay
- Assignment shifts were most common for those incurring higher Medicare spending
- Assignment shifts constituted only 1.3% of all community-dwelling beneficiaries cared for by large ACO-eligible organizations (n = 535,138), but they accounted for 8.4% of total Medicare spending for this population

Medicare ACO Models

Medicare Shared Savings Program
- Program started January 1, 2012; contracts last a minimum of three years
- MSSP establishes financial accountability for quality and total cost of care for attributed population of beneficiaries
- Physician groups and hospitals eligible to participate, but primary care physicians must be included in any ACO group
- Participating ACOs must serve at least 5,000 Medicare beneficiaries
- Bonus potential to depend on Medicare cost savings, quality metrics
  - Two options available: one with no downside risk until year three, the second with downside risk in all three years

Pioneer ACO Model
- Accelerated pathway to ACO formation designed for organizations able to assume utilization risk immediately
- Participating providers must serve at least 15,000 Medicare beneficiaries
- Offers higher risk, higher reward model; providers can obtain rewards ranging from 50-75% of Medicare savings achieved
- Providers can choose retrospective or prospective patient assignment methodology
- Quality measures to match those in final rule for Medicare Shared Savings Program
- Deadline to apply was in August 2011; CMS selected 32 Pioneer ACOs in 2012.

Where They Are

Medicare Shared Savings and Pioneer ACOs in the United States
January 2014

Source: The Advisory Board Company.
© American Health Care Association 2013
Key Features of Medicare ACO Models

Table Comparing Pioneers to MSSPs

<table>
<thead>
<tr>
<th></th>
<th>Pioneer ACOs</th>
<th>MSSP ACOs</th>
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<tbody>
<tr>
<td><strong>Run by</strong></td>
<td>CMMI</td>
<td>CMS</td>
</tr>
<tr>
<td><strong>Regulated by</strong></td>
<td>MSSP Rule</td>
<td>MSSP Rule</td>
</tr>
<tr>
<td><strong>Minimum beneficiaries</strong></td>
<td>15,000</td>
<td>5,000</td>
</tr>
<tr>
<td><strong>Application Cycle</strong></td>
<td>One-time (may repeat)</td>
<td>Annual</td>
</tr>
<tr>
<td><strong>Contract Length</strong></td>
<td>3 years with option for 2 additional years</td>
<td>3 years</td>
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<td><strong>Risk Model</strong></td>
<td>Must be two-sided; options for greater risk exposure, higher bonus potential</td>
<td>May choose one- or two-sided risk, but both require downside risk in year 3</td>
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The ACO Life Cycle

**MSSP and Pioneers** must enter into three-year agreement with CMS

Pioneers have option for two additional years for their first contract period

After year 3, **Pioneers** may elect to receive partially capitated payments from CMS. Has major implications for participants.

**MSSP ACOs** may sign another three-year agreement with CMS
A General Shift toward Provider Risk

Episodic Cost Accountability
- Traditional Fee-for-Service
- Pay-for-Performance
- Bundled Payments

Total Cost Accountability
- Now - Shared Savings
- 1-3 yrs - Partial Capitation
- 3-5 yrs - Full Capitation

Minimal Provider Risk Substantial

Pioneer ACO First Year Results

- Started January 1, 2012, with 32 ACOs
  - 13 achieved shared savings
  - 2 had shared losses
  - 17 either below threshold for sharing or not at risk for losses in first year
- 9 of 32 ACOs withdrew in July 2013
  - 23 staying in Pioneer demonstration
  - 7 applying to be in MSSP
  - 2 likely will not be Medicare ACOs
Pioneer First-Year Issues

- CMS reports program savings and variation in performance. Would like to know:
  - How much is random variation?
  - Will benchmarking need to be refined?
- What is required for overall savings?
  - Program savings reported to by 0.5%
  - ACOs report the cost of running an ACO 1-2%
  - From provider perspective, is this sustainable?
  - How large do savings need to grow to justify the costs?
  - Will savings increase over time?

The Future of ACOs?

Potential Recommendations

- Base cost benchmarking on overall county spending rather than historical spending on population
- Embed beneficiary incentives by providing lower cost-sharing for in-network ACO providers; “Medigap” Plans specifically for ACO coverage
- Require down-side risk in second contract period for already-established ACOs
- Level the risk adjustment methodology between MA and ACOs
Will ACOs Become Plans?

Pure FFS
- Pay by service
- Silo-based
- Some VBP

ACO
- Mixed payment
- All Part A&B
- Quality Incentive

Medicare Advantage
- Pay for population
- Full capitation
- All Part A&B
- Quality bonus

No risk  Limited risk  Full risk

Payment and delivery system integration

Some States Are Saying “No”

“While innovation in the marketplace is welcome, the purpose of this Bulletin is to remind carriers and their health care provider partners that New Jersey has a regulatory system designed to ensure that delivery systems continue to provide adequate access and incentives for delivering appropriate care, and that entities that bear risk have adequate resources to support those financial promises. New arrangements should be reviewed to ensure compliance with all statutory and regulatory requirements.”
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ACO Adoption is Regionalized

Medicare Shared Savings and Pioneer ACOs in the United States
January 2014

Source: The Advisory Board Company.
Burning Priorities for ACOs to Date

- Aligning physicians and hospitals
- Beneficiary attribution
- Procuring necessary IT systems
- Getting the right data from payers
- Establishing data sharing and communication networks
- Focusing on developing Medical Home models in primary care practices

What about post-acute care?
Why Not Post-Acute?

In health care, SNF care and other PAC spending accounts for very small fraction of the total healthcare spend.

*But the focus is now shifting to post-acute providers.*

![Pie chart showing total spending 2012 = $582 billion](image)

Source: MedPAC data.

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Major Trends

- Hospitals aggressively buying physicians
- Placing tremendous pressure on SNF LOS reductions
- Scrambling to develop PAC provider networks, often using blunt techniques to choose
- Deliberate steering of patients to owned / affiliated facilities
- Some internal development of PAC capabilities (building/buying)
Aggressive Network Narrowing

**Case in Brief: Michigan Pioneer ACO**
- Product of Detroit Medical Center, a 2,000-bed academic health system located in the Midwest
- Stratifies patients into three tiers based on frequency of interaction with system, acuity level
- Within Tier 2, greatest area of focus, further stratifies into high-, medium-, and low-risk
- Home health narrowing process involved collection of cost and quality data as well as a series of in-person interviews
- Uses technology platform to coordinate care between ACO providers, PAC providers, caregivers; gives interested family members access to a limited view of patient’s record

Pared Home Health Partners from 47 down to 8 by evaluation based on:
- **Interest in Partnership:** Orgs responding to invitation to interview
- **Technology:** Orgs with an EMR
- **Quality:** Orgs above state average on five quality measures
- **Cost:** Orgs below cost-per-case threshold
- **Capacity:** Orgs with average daily census > 100

A Look at Massachusetts’ Pioneers

**Pioneer ACOs in Eastern Massachusetts**

**The Players**
- Atrius Health
- Beth Israel Deaconess Physician Organization
- Mount Auburn Cambridge Independent Practice Association
- Partners Healthcare
- Steward Health Care System

**Timeline of Events**
1. Escalating pressures on ACOs to reduce cost in order to be eligible for Year 3 global payments
2. Pioneer ACOs start approaching SNF providers with stringent requirements to reduce LOS, hospital readmissions, in order to receive referrals
3. Massachusetts Senior Care engages ACO leadership to spearhead creation of joint requirements
Over of SNF/ACO Joint Goals

- **General**
  - Staffing
  - System Continuity
  - Quality Improvement Efforts
- **Pre-Admission**
  - Screening/Admission
  - Medical Coverage
  - Care Transitions
- **During Stay**
  - Facility Environment
  - Care Systems
  - Care Planning/Coordination
- **At Discharge/Post-Discharge**
  - Medication Reconciliation
  - Advance Directive Documentation
  - Communication of Discharge Paperwork
  - Standard Discharge Planning Checklist
  - Selection of Transfer Facility

**Reporting Expectations**

What ACOs are looking for in PAC

- **ACOs are looking at specific measures to try and evaluate SNF performance:**
  - Readmission rates
  - Length of stay
  - Return to community (potentially)
- **ACOs want providers who:**
  - Can coordinate care for patients in the PAC setting
  - Can easily share and accept data
  - Can provide full spectrum of PAC services
ACOs Narrowing Their Focus

ACO Priority Metrics

**Length of Stay**
- Know your ALOS for specific conditions and trend over time

**30-day Readmissions**
- Know your 30-day readmission rate by key conditions and be able to show improvement

- Run reports on your facilities across a range of performance and quality metrics
- Generate comparison reports between your facility and your peer group

Building a PAC Network

**Developing a Post-Acute Care Network (PACN)**
- Identify key areas of concerns and gaps in referrer capabilities (i.e., post-discharge patient tracking)
- Identify potential partners in your market to address those gaps
- Market the PACN to potential ACOs or other referring entities

* Consult with legal counsel to assess viable options for forming PACs in your health care market
3-day Stay Waiver an Opportunity for SNFs

- In September, 2013, CMS announced that Pioneer ACOs may apply for a three-day stay waiver for their partner SNFs
- Pioneers may apply for the waiver with CMS, obtain letters of intent from SNFs

**SNF Must...**
- Have a 5-star quality rating of 3 stars or higher
- Not be participating in BPCI Model 3

ACOs by Provider Sponsor

![ACO Trend by Sponsoring Entity](chart)

Source: Leavitt Partners.
Physician-Led ACOs

- SNFs may find particular opportunity in working with physician-led ACOs, as opposed to hospital-led ACOs
- May be more motivated to use SNFs as an alternative to the hospital
- Paired with a waiver of the 3-day stay requirement, may present significant strategic and business advantage for SNFs

Trends in ACO-SNF Contracting
SNF Options to Participate

As an “ACO Participant”
- Regulated under the MSSP Rule
- Part of the ACO’s legal structure
- Guaranteed shared savings

As an “Other Entity”
- Defined under MSSP but less regulated
- Not part of the ACO’s legal structure
- ACO may share in savings but not required

As a Contractor of the ACO
- Regulated by contract, not MSSP Rule
- Not part of the ACO’s legal structure
- ACO may share in savings but not required

Typical ACO Structure in Today’s Market

Primary Care Providers with an Anchor Hospital

Contract Legend
- Risk-based contract with some type of incentive or add-on payments
- Contracts may be risk-based but typically are not. Common types are per diem or negotiated rate
Independent SNF Direct Participation

- **SNF**
- **ACO Contract**
- **ACO**

**“Participant” ACO Contract**
- Medicare Exclusivity
- Included for Attribution, Quality Reporting, Cost Benchmarking

**“Other Entity” ACO Contract**
- No Medicare Exclusivity
- Not Included for Attribution, Quality Reporting, Cost Benchmarking

Independent SNF Indirect Participation

- **SNF**
- **Affiliation Agreement or Preferred Provider Relationship**
- **Hospital**
- **ACO Contract**
- **ACO**

**Elements of Affiliation Agreement**
- Post-Acute Care Committee
- Strategic Planning Committee
- Physician Rounding / Call Service
- No Remuneration
Subacute SNF JV Model – Direct Participation

Sub-Acute SNF JV, LLC

50% 50%

Hospital  SNF Company  ACO

ACO Contract
“Participant” or “Other Entity” Contract

Subacute SNF JV Model – Indirect Participation

Sub-Acute SNF JV, LLC

50% 50%

Hospital  SNF Company  ACO

ACO Contract
“Participant” or “Other Entity” Contract
Horizontal SNF Network Participation

What is AHCA Doing?

- Educational support to member facilities
- Data sharing pilots with ACOs in Massachusetts, elsewhere
- Regulatory lobbying during rulemaking process
- AHCA has developed an ACO Contracting Guide to educate and guide members through the regulatory and contracting environment of ACOs
AHCA’s New ACO Contracting Guide

AHCA’s ACO Webpage

ACO Contracting Guide
- Part 1: Background on Guide and ACO Primer
- Part 2: Preparing for and Contracting with ACOs
- Part 3: Model Contract Terms

Link:
http://www.ahcancal.org/facility_operations/medicare/Pages/Accountable-Care-Organizations.aspx

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1. Setting the Stage for Reform
2. Trends in Accountable Care
3. Imperatives for PAC Providers
4. Q&A