PMS®

PRESBYTERIAN MEDICAL SERVICES

*Building a Healthier State®*

# Accountable Care Coalition of New Mexico

## 21st Best Practices Forum
## Boston, MA
## April 2013

# What is an Accountable Care Organization?

- An ACO is a legal entity, typically comprised of a health system or IPA, that enters into an agreement with CMS under the Shared Savings Program with an objective of creating efficiency against historical benchmarks for service delivery.

- In exchange for their efforts, CMS will share a portion of the savings generated by the ACO with the organization.

# What is an Accountable Care Organization?

ACOs were designed with a three-part aim:

1. **Improved overall care in a safe environment, equitable to all who seek it, and always available when needed.**
2. **Improved health accomplished through the practice of proactive, preventive medicine and care coordination.**
3. **Lower per capita cost aimed at reducing the trending of medical costs associated with the Original Medicare population.**

# ACO Basics

- Medicare Fee-For-Service beneficiaries are assigned to the ACO based upon their pattern of utilization
- Minimum 3 year agreement; followed by annual renewals at the discretion of CMS and ACO
- Required to have structure to receive and distribute payments for shared savings

# ACO Basics

- Enough Primary Care Physicians (PCPs) and other providers to care for beneficiaries assigned to the ACO (minimum 5,000)
- PCPs can only participate in one ACO
- Providers continue to be paid Fee-for-Service payments by CMS

# Required Infrastructure

**Sufficient information systems to:**

- Support Medicare FFS beneficiary attribution
- Determine payments for shared savings

**Processes to promote:**

- Evidence-based medicine
- Report data on quality and costs
- Care coordination

**Ability to meet patient-centeredness criteria**

# ACO Challenges



## More than Just a Complex, Expensive Undertaking

*Challenges to Organization Both External, from Within*

### External Obstacles to Change

**Funding**
ACO investments, demand destruction threaten margin

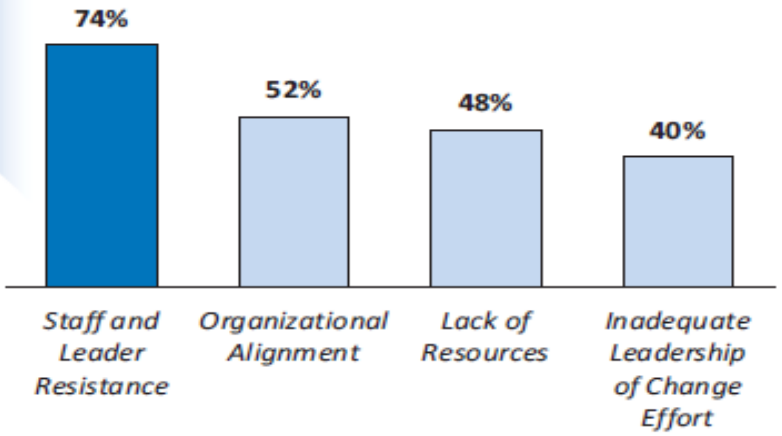
**Stakeholders**
Potential partners' needs often at odds with ACO's

**Mission v. Margin**
Mandate to change not easily aligned with financial interests

**Regulation**
Meeting regulatory requirements a challenging task

### Internal Obstacles to Change

*As Rated by CEOs*






Source: Gates S, "HR's Role in Building a Culture of Innovation," The Conference Board, 2005; Health Care Advisory Board interviews and analysis.

# ACC of New Mexico Partners

**Sangre de Cristo Medical Group (For-Profit):**

- IPA with physician practices in northern and central NM

**Presbyterian Medical Services (Nonprofit):**

- FQHC with 40+ clinics throughout NM

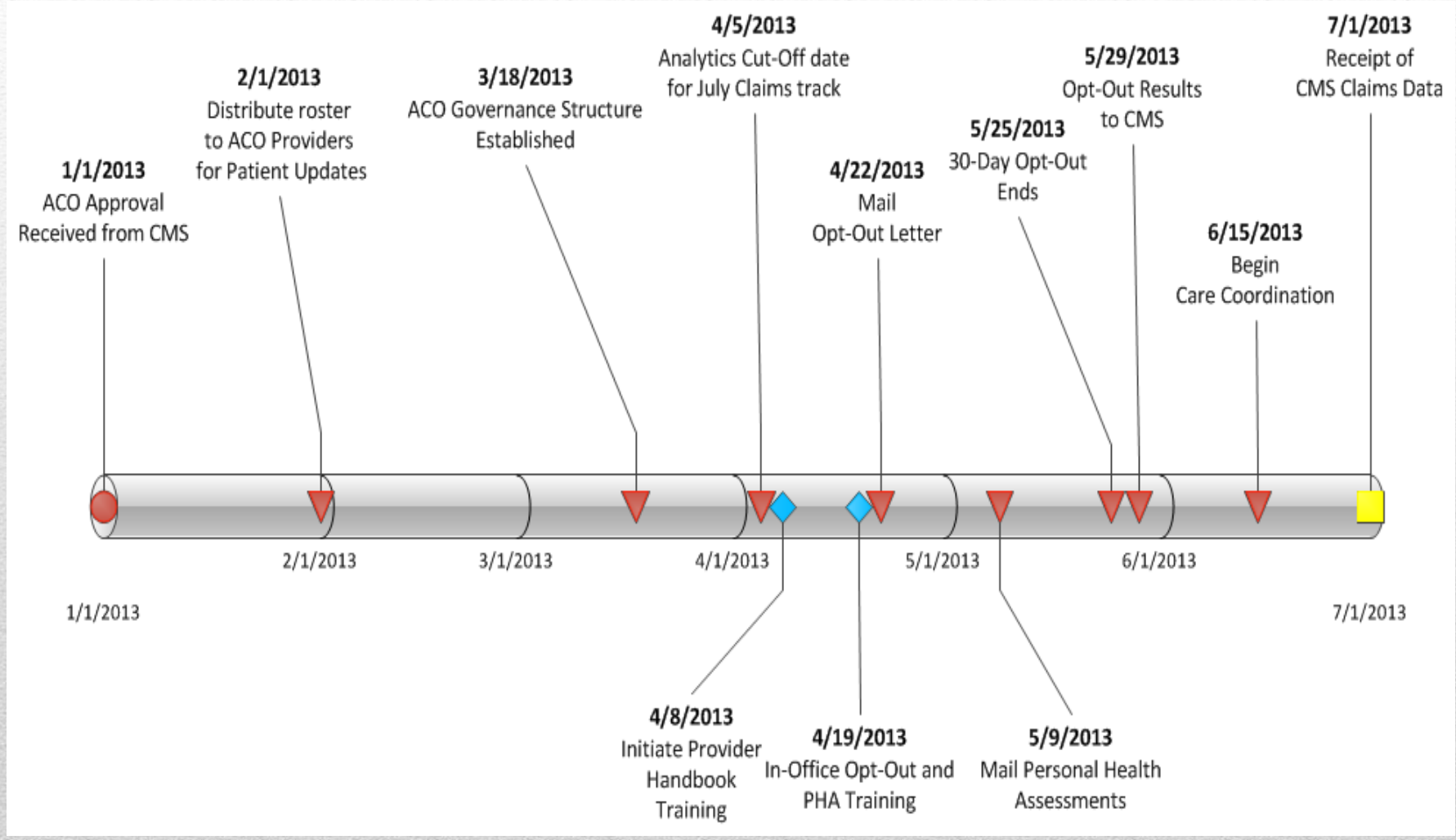
**Collaborative Health Systems (For-Profit):**

- Subsidiary of Universal American Insurance

# Legal Structure & Timeline

- Accountable Care Coalition of New Mexico, LLC
  - New Mexico Limited Liability Company
- Began negotiations in mid-August 2012 and CMS application was due in September 2012
- ACO status awarded by CMS January 2013
- Provider/staff training began April 2013
- Notice of ACO assignment mailed to patients May 2013

# Legal Structure & Timeline



# About Universal American


- Universal American (UAM) is an insurance company company with extensive experience working with Medicare programs, particularly Medicare+Advantage.
- Houston-based health plan, TexanPlus® HMO is contracted exclusively with providers in a risk sharing model, whereby providers benefit from the efficiency generated in the provision of care to enrollees, much like a Medicare shared savings ACO

# About Collaborative Health Systems

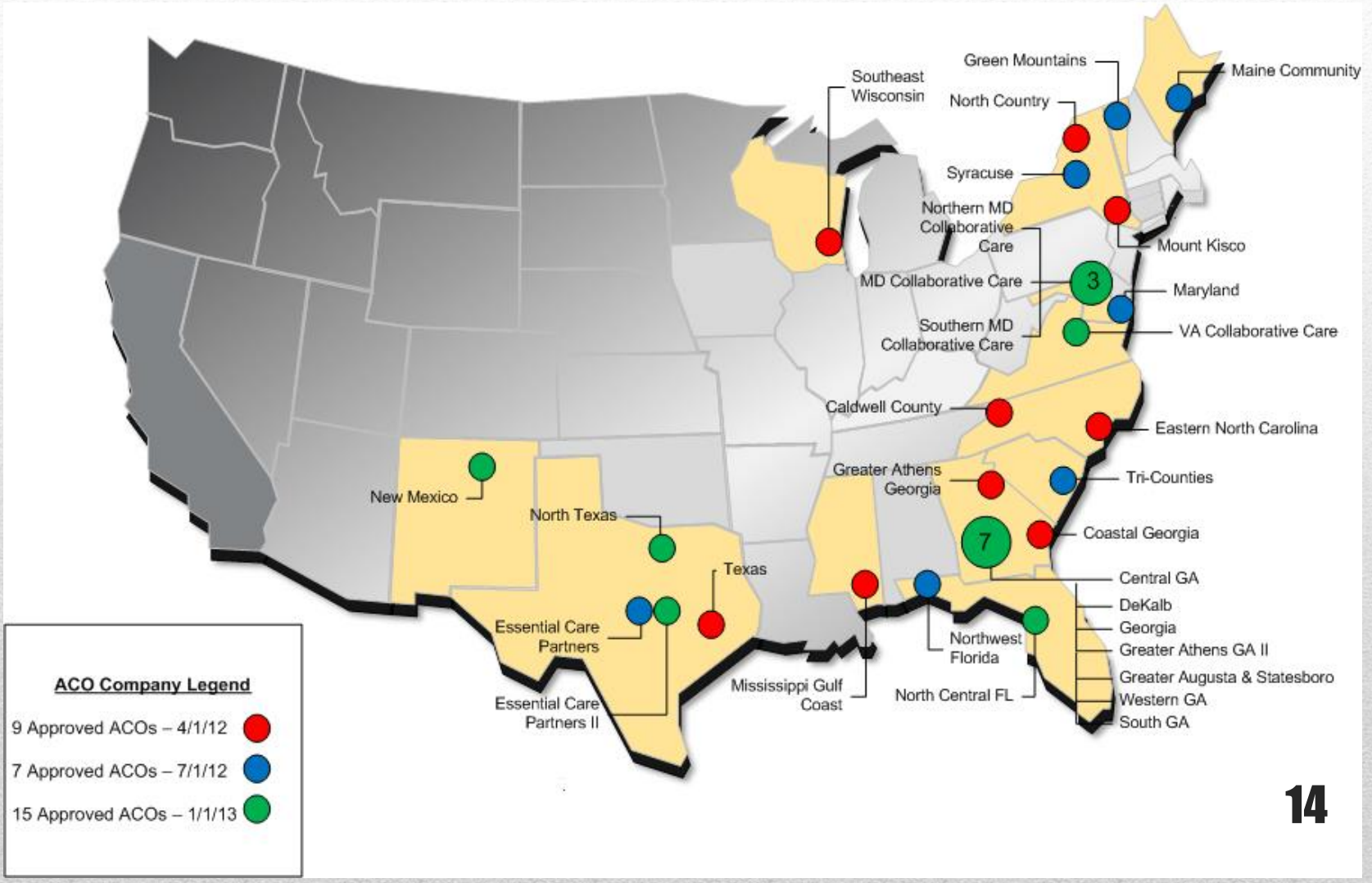
- UAM established subsidiary Collaborative Health Systems (CHS) for the purpose of leveraging core competencies in coordinated care, analytics and risk coordination to partner with providers in the pursuit of the ACO opportunity
  - Website: http://www.collaborativehealthsystems.com/about-us.aspx
- CHS has partnered with entities throughout the country in the development of jointly owned ACOs to participate in the Shared Savings Program (including network of Texas FQHCs)
- Administrative "backbone" of the ACO
  - Staffing
  - Applications/Reporting
  - Compliance
  - Payments
  - IT
  - Insurance

COLLABORATIVE HEALTH SYSTEMS

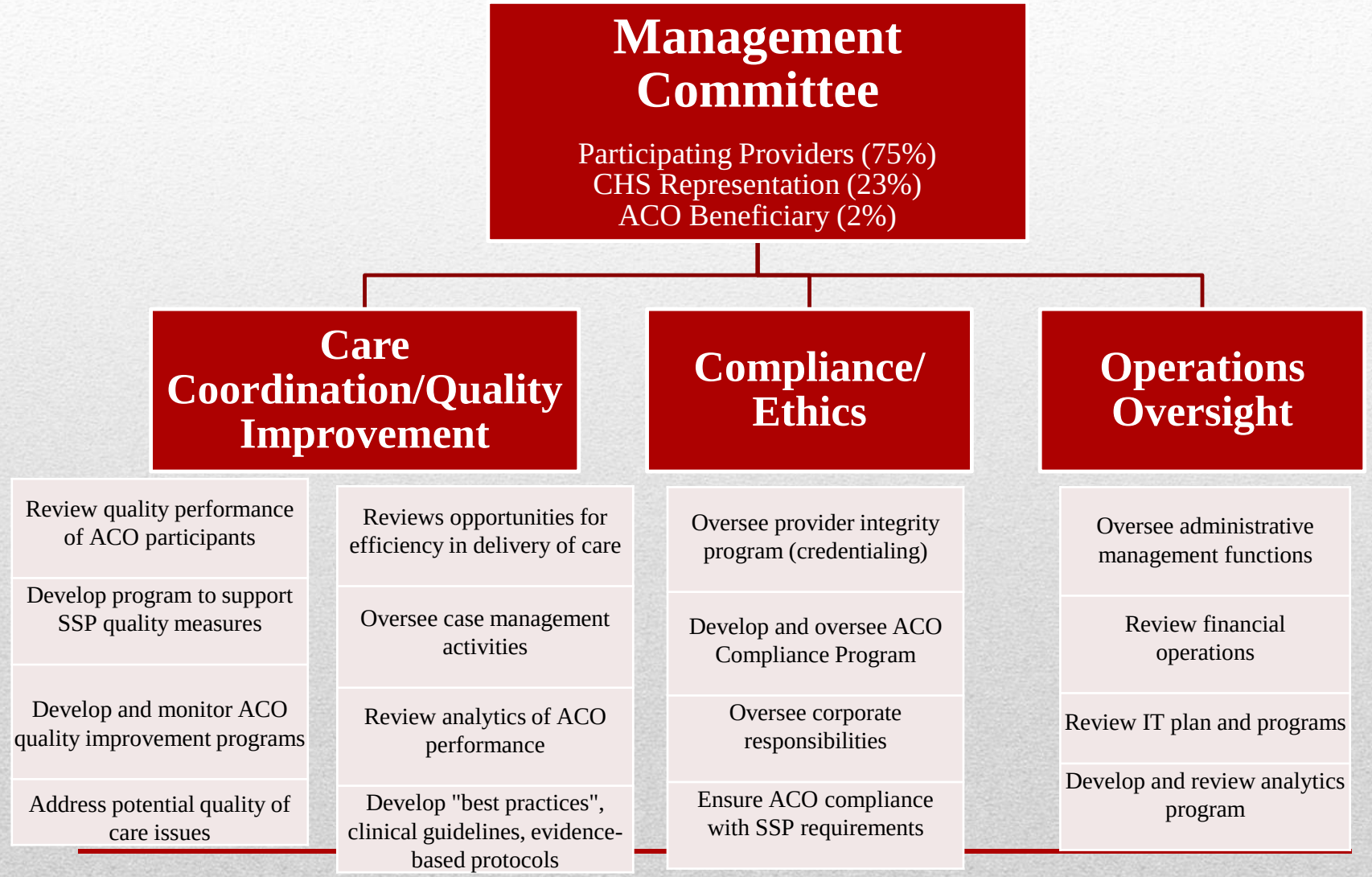
# About Collaborative Health Systems

- CHS currently is largest ACO "sponsor" in the United States
  - Number of ACOs
  - Number of Medicare beneficiaries
- CHS bears the costs of the creation and establishment of the corporate entity to serve as an ACO
  - Expenses reimbursed out of shared savings received by ACO

# CHS Accountable Care Organization Markets



# ACO Governance Structure



Accountable Care Coalition of New Mexico
Established by Sangre de Cristo Medical Group, LLC

# ACO Implementation Project Dashboard

**Implementation Manager:** Mishka Glaser / Melissa Guajardo
**Executive Director:** Jason Garszczynski
**ACO Date:** 1/1/13
**Support Manager:** Trisha Dixon
**Care Coordination:** Maryelle Van Assendelft
**Revision Date:** 3/13/13

| Complete | On Target | Some/Low Risk | Not Started | High Risk |
|---|---|---|---|---|

## ACO Executive Summary

| Milestones | Owner | Finish | Status | Summary |
|---|---|---|---|---|
| **Contracts between ACO & CHS complete.** | CHS– Trinchitella ACCNM- Briggs | 1/01/13 | **Complete** | 1/1/13 ACO |
| **Management Committee & Subcommittees' memberships finalized.** | CHS – ACCNM - | 3/18/13 | **Low Risk** | UWC Completed, Identify Medicare Beneficiary for Class II Member. Care Coordination and QI Subcommittee combined. |
| **CSC Rollout Complete** | CHS – ACCNM - | 3/15/13 | **On Target** | Waiting for finalization of committee members. |
| **Initial Management Committee meeting conducted.** | CHS – Garszczynski ACCNM - | 3/18/13 | **On Target** | Confirmed for March 18, 2013 in Sante Fe, NM. |
| **Initial ACO Subcommittees' meetings conducted.** | CHS – ACCNM - | 5/30/13 | **On Target** | April – Compliance/Ethics<br>May – CC &QI<br>May - Ops Oversight |
| **Provider Handbook & office set-up package distributed.** | CHS - Rintharamy ACCNM – Bruno, Amick | 3/22/13 | **On Target** | Provider handbooks delivered, distribute at provider training or prior. |
| **Initial ACO provider training conducted.** | CHS - ACCNM – Bruno, Piernot | 4/12/13 | **On Target** | Melissa coordinating with Lou and Ellen. Provider training determined from Operations Schedule. |
| **Initial ACO Compliance training conducted.** | CHS - Wilems ACCNM – Amick, Bruno | 3/30/13 | **On Target** | SdeC has been received, PMS expected to provide by 3/13/13. www.chsacotraining.com |
| **Budget estimate shared with the ACO.** | CHS - Christie ACCNM - Chavez | 4/30/13 | **On Target** | |
| **Patient roster received & loaded in Care Coordination system.** | CHS - ACCNM – | 4/15/13 | **On Target** | |
| **Opt Out letters mailed to patients.** | CHS - Carrie ACCNM- TBD | 4/22/13 | **On Target** | ACO currently on July Claims, Ops Schedule |
| **ACO web site and link complete.** | CHS - Bell ACCNM - TBD | 5/15/30 | **On Target** | |

# Care Coordination Team

- Identify and monitor primary and co-existing conditions
- Prevent hospital readmissions and emergency room visits
- Improve health outcomes after discharge
- Coordination of care/removing barriers (transportation, etc)
- Enhance patient and family caregiver satisfaction
- Support the quality requirements of the ACO
- Reduce total healthcare costs

# Care Coordination Activities

- Perform ongoing assessments of clinical and social needs and follow-up as appropriate
- Reconcile medication and monitor compliance
- Assess for home safety, mobility, assistance with ADL needs, and refer as needed
- Educate patient and caregiver on disease process and identification of early signs of change in condition to report as needed to the PCP
- Identify and coordinate DME and Home Health needs
- Assist with scheduling physician appointments and coordinate transportation, as needed
- Coordinate care with PCP and Specialists following discharge from an inpatient facility

# PCC and DM Model: Workflow (Percolator)

- Stratification
  - Based on risk/cost “impactability”
    - Co-morbidities
    - Risk
    - Utilization patterns
    - Predictive models
    - Cost
- Prioritization
  - Generation of targeted outreach queue
    - Lack of essential support system
    - Appropriate follow-ups after an acute event and certain office visits
    - Medication adherence
    - Treatment adherence
    - Lack of essential support system
    - ACO quality  measures

# ACO Financial Model

**Payment Methodology:**

- Medicare establishes average monthly cost per beneficiary using a 3-year "look back period" (weighted average) – **the "baseline"**
- After first 12 months of ACO operation, and annually thereafter, CMS compares "baseline" cost with cost to Medicare post-ACO
- 50% of any savings realized are kept by Medicare, the remaining 50% goes to the ACO

## EXAMPLE:

- Medicare “Baseline” = $700 per FFS beneficiary/month
- 12 months after ACO launch, Medicare cost = $600 per FFS beneficiary/month
- $100 per month/per beneficiary cost savings to Medicare is split between CMS and ACO
- $50 x 5000 beneficiaries = $250K per month to ACO

## ACC of New Mexico:

- ACO's portion of "shared savings" is paid to the ACO entity by CMS
- "Approved" or budgeted expenses deducted off the top
- 50% of remaining sum to PMS and 50% to Sangre de Cristo IPA
- Possible "downside" financial risk in third year (the "two-sided" payment model)

**Future of ACOs:**

- Once established, the ACO may be used as a vehicle to expand into additional opportunities such as:
  - Additional risk based payer contracts in Commercial and Medicare
  - Private label Health Maintenance Organizations (HMOs)
  - Individual and Small Group exchanges
  - Dual-eligible and Medicaid population management
  - Employer group contracting

**Future of ACOs:**

- Much speculation that ACOs and similar collaborative efforts will lead to a new wave of provider consolidation
- FQHCs less susceptible to consolidation due to governance requirements
- Large health plans believe that ACOs are simply a stepping stone to “full risk” contracting

**LESSONS LEARNED:**

- Know your partners
- Align your quality of care initiatives (ACO, PCMH, etc.)
- Reliable and meaningful data is critical
- Understand the regulations and ask questions
- This is new to everyone—no real “experts” yet