Insights from California's First Health Center-Led Medicare ACO

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JSI Research & Training Institute, Inc. (JSI) is a public health consulting and research organization dedicated to improving the health of individuals and communities in the United States and around the world.

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INTRODUCTION

As the first and only health center-led Medicare Accountable Care Organizations (ACOs) in California, and one of a growing number of provider-led safety-net ACOs nationwide, Redwood Community Care Organization (RCCO) is an early foray into accountable care in the safety net. RCCO was formed in 2012 and was accepted as a Medicare ACO under the Shared Savings program in January of 2014. RCCO provides care for approximately 8,500 Medicare beneficiaries in Sonoma and Napa counties.[1]

Nationally, ACOs are seen as a promising approach to health care and payment transformation.[2] While there are large numbers of commercial and Medicare ACOs in California, few of the state's health centers have entered into ACOs, for either Medicare or Medicaid patients. ACO formation in the California safety net has been slow for a variety of possible reasons. Within Medicare, on average, only 9% of health center patients are Medicare patients,[3] making it difficult for many health centers to reach the 5,000 patient minimum threshold for Medicare ACOs. Unlike in other states,[4] California has not established an explicit policy directive to encourage ACO formation within the Medicaid program (Medi-Cal in California). While Medi-Cal managed care plans could put ACO contracts in place with providers as California-based health plans have in the commercial sector,[5] such contracts have not emerged in the Medi-Cal market. One possible factor is the difficulty of achieving shared savings given that Medi-Cal per capita spending is lower than most other states in the nation,[6] and health center patients have been shown to have lower total cost of care compared to non-health center patients.[7,8] Despite California's lack of adoption of ACOs in the safety net to date, ACOs continue to grow nationally in Medicaid and Medicare,[9] including some ACOs headed by health centers.

ACOs represent a transformation that meets the definition of more advanced value-based payment models[10] that reward providers for cost and quality outcomes of their patients and increasingly ask providers to accept downside risk.

As the push toward value-based payment continues, ACOs will continue to deserve close attention. RCCO's early adoption of the ACO model and subsequent five years of experience can offer California and national health centers valuable insights as they increasingly incorporate care management and coordination for high-risk members into their practices and pursue a variety of value-based payment arrangements with payers.

Background on Redwood Community Health Coalition's ACO Formation

In 2012, California health centers began exploring a variety of potential alternative payment models.[11] Against this backdrop, forward-thinking leaders in the Redwood Community Health Coalition (RCHC), a consortia of health centers in northern California, saw entering a Medicare ACO as a "low-risk opportunity" to develop the population health management skillset necessary for value-based care. This skillset included performing care management and coordination for patients who were at risk of experiencing costly but potentially avoidable hospitalizations. Such a care management program would include using data from inside and outside of primary care in more robust ways than before, forging closer partnerships with hospital partners, and engaging with high-risk patients in new ways.

RCHC leaders also believed that a core principle of payment reform for health centers was that primary care should be rewarded for keeping patients healthy and out of the hospital. They saw the ACO shared savings model as a payment reform that fulfilled this principle. Finally, RCCO leaders were interested in understanding the total cost of care for their patients, and this was a unique opportunity to receive total cost of care data, as well as a chance to see where patients were going for all of their services and what each of those other services cost.

ACOs often bring together independent organizations in new kinds of partnership.[12] This was the case with the RCCO. In order to meet Medicare's minimum of 5,000 eligible patients, multiple health centers had to enter into a partnership. Four founding members – RCHC, Santa Rosa Community Health Centers, West County Health Centers and Petaluma Health Center—incorporated to begin RCCO in 2012. Four additional health centers—Alexander Valley Healthcare, Coastal Health Alliance, Ole Health, and Alliance Medical Center—and one private physician became implementation partners to help the initial group meet the minimum patient threshold. For RCCO, member health centers had a history of collaboration through RCHC. They had strong shared values and similar missions. The member health centers also had recent experience implementing an intensive outpatient care management program (IOPCM), which had built their confidence in performing care management for complex patients. Finally, member health centers viewed the ACO and the prospect of shared savings as a potential opportunity to both put into practice and to finance the infrastructure and systems that could help position them to collectively succeed under future value-based contracts.

Based on interviews with clinical and administrative RCCO leaders and leaders from implementation health centers, this paper highlights key insights from this vanguard health center-led Medicare ACO to help other health centers understand the potential benefits and pitfalls of this transformation approach.

Key Insights for Health Centers Considering ACO Models

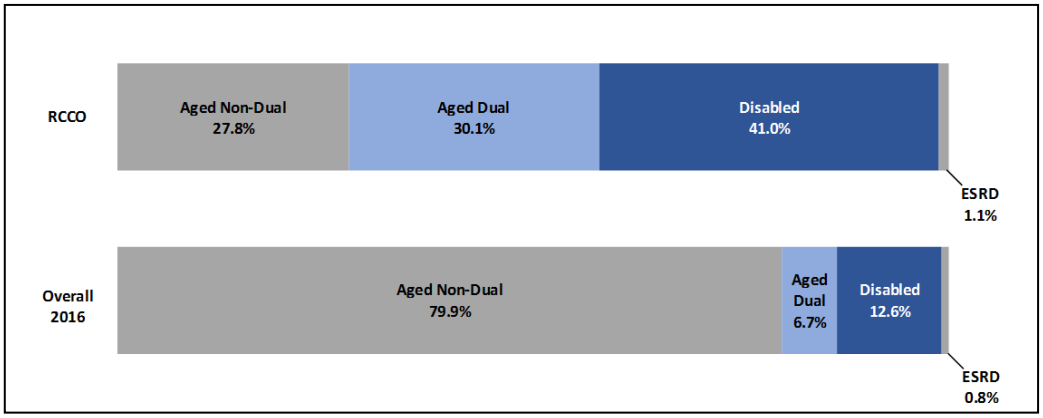
1. Build a claims-based understanding of the complexity of your patient population

Safety-net Medicare ACOs are likely to have more complex patient populations than a typical Medicare ACO. The majority of RCCO patients were dually eligible for both Medicare and Medi-Cal due to being young and disabled or elderly with low income. RCCO leaders were particularly surprised by the degree to which the disability in their Medicare population was psychiatric rather than physical disability, especially in comparison to the overall Medicare ACO population (see Figure 1). Reviewing claims data also revealed that there was much more psychiatric inpatient care than they were previously aware of or had anticipated. Many of these complex and highly disabled patients needed more care than they were receiving. They were disconnected from primary care for a variety of reasons (transportation, mental health, loss of social support, etc.), and many required extensive care coordination between different medical specialists, behavioral health providers, and community-based social services.

Given the combination of physical, behavioral, and social complexity, traditional models of risk stratification may not be sufficient to prioritize patients for extra care management and coordination. RCCO members found it enormously helpful to have an experienced clinician review lists of patients identified through data analysis to determine which patients might most benefit from intervention. An RCCO leader saluted the "soft skills" of their first ACO medical director, which included bringing an experienced safety net clinician's judgement to decisions about which patients would be prioritized for outreach and case management using finite resources.

Patient complexity has staffing implications, both in terms of staff skillsets, training, and necessary ongoing support. Initially, RCCO tasked nurses with managing high-risk patient caseloads. As the program progressed, it turned out that much of the intensive case management that patients required was not medical in nature and could be best accomplished by a lay case worker with social services expertise overseen by a nurse care manager. In addition, RCCO quickly found that case management work meant becoming involved with patients' lives that were deeply affected by a complex mix of medical, mental health, substance use, childhood trauma, housing issues, and other challenges associated with living in poverty. Such work was deeply emotionally taxing for staff. Within one health center, they found they were able to meet patient needs for psycho-social support through their integrated teams. Other health center members within RCCO made a range of adjustments to their care management program staffing, including adding individuals with a social services background, assigning smaller caseloads and offering trauma-informed support to staff.

Figure 1: RCCO Attributed Patient Population Compared to Medicare ACO Population.

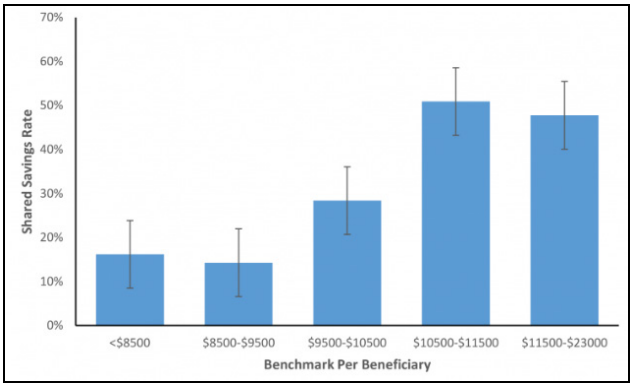


2. Develop a shared understanding of the probability, possibility, and realistic timing of shared savings

Low baseline costs can mean more limited opportunities for generating shared savings. For the purposes of determining shared savings, Medicare looks back at three years of claims data as the first step in setting the total cost of care benchmark to which an ACO population's costs are compared. A thorough understanding of both the benchmarking formula[13] and the underlying utilization and cost data prior to implementing an ACO is essential for estimating savings potential. Looking carefully at past cost and utilization data is also important for revealing cost drivers that a health center intervention might influence.

As depicted in Figure 2, a 2016 national analysis of ACOs shows found that fewer than one in five ACOs with lower benchmarks achieved shared savings. While achieving shared savings is not the only reason that health centers might enter into an ACO arrangement, ACO partners should at least develop a shared understanding of the likelihood that shared savings will occur based on others' prior experience.

Figure 2. Percentage of ACOs Qualifying for Shared Savings Based on Their Benchmark Per Beneficiary.[i]



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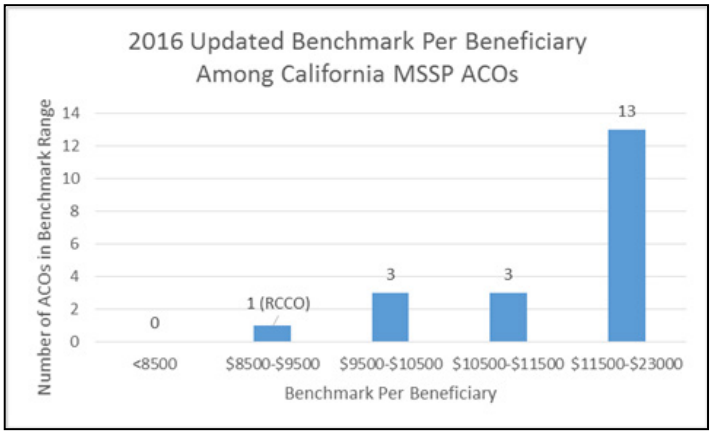
National studies have shown that health center patients are often lower cost than non-health center patients.[14] As RCCO members were exploring the idea of an ACO, the California Primary Care Association had conducted a study showing that regional health center patients had lower total cost of care compared to non-health center patients.[15] However, it was still a surprise to RCCO member health centers when, six months after they started in the program, Medicare sent them historical claims data showing that their patient population was starting at an extremely low cost baseline relative to other providers' populations. In fact, their population was among the ten lowest cost ACOs for baseline years among over 400 ACOs in the Medicare Shared Savings (MSSP) program nationally.[16] Recent data shows that RCCO continues to have the lowest financial benchmark among all MSSP participants in California (Figure 3).[17]

Figure 3: RCCO Compared to Benchmark per Beneficiary in California MSSP ACOs.[ii]



One potential reason for this low baseline cost was that RCCO member health centers had implemented a new IOPCM program in the two years prior to the ACO. Health plan evaluation data for the IOPCM showed RCCO member health centers had reduced inpatient utilization in the years before the ACO began, potentially reducing already low costs even further for the benchmarking process.

[ii] Source: RCCO

For other health centers considering an ACO, clearly understanding baseline costs, including how they compare to the field, could help build an understanding among ACO partners of how likely the ACO is to achieve shared savings and where opportunities to achieve savings lie. Reflecting on their experience, one RCCO leader advised, "I would tell other health centers considering an ACO to hire an actuary or a data expert with claims analytics skills to estimate your probability of shared savings based on how your spend compares to regional historical benchmarks before moving forward."

Health centers will likely need to scrutinize coding practices to ensure accurate risk adjustment of benchmark costs and may still be disadvantaged by the methodology's inability to account for social acuity. RCCO faced a learning curve with respect to the importance of coding for Medicare's risk adjustment of benchmark costs. Medicare uses diagnosis codes to risk adjust past costs in an effort to project a fair benchmark to which an ACO's actual costs are compared for calculating shared savings. As RCCO administrators began to review their attributed patients' historical data going back three years, they identified a disconnect between the clinically observed prevalence and acuity of physical and mental illness and disability in their patient population and what the data reflected. A deeper dive into the data revealed that the codes in the claims data were often missing or inaccurate, leading to a benchmark that reflected a much healthier population than RCCO actually had.

In a health center setting, the organization receives most of its revenue from per-visit prospective payment system (PPS) rates for both Medicare and Medicaid beneficiaries. Thus, health centers have not historically had a financial incentive to accurately code all of a patient's diagnoses and visit acuity. If anything, health center practices may have adopted systematic under-coding habits to protect low-income uninsured or underinsured individuals from high-cost medical bills. By comparison, most Medicare providers that are paid fee-for-service or under Medicare Advantage capitation contracts have developed strong coding practices because their financial livelihood depends on it.

RCCO leaders took away two key lessons from their experience. First, coding both CPT codes and ICD-10 codes accurately would be critical for future benchmarking methodologies. Second, they lamented that there did not seem to be any way in Medicare's risk adjustment methodology to reflect the risks related to social acuity and some behavioral health acuity within their patient population. Indeed, social determinants of health are not included in the Hierarchical Condition Coding risk score methodology that Medicare uses to risk adjust the benchmark costs for ACOs, and thus the risk scoring does not fully reflect the complexity of socially complex patients.

Shared savings may be slow to materialize, if at all. For the 2014, 2015 and 2016 performance years, RCCO has not generated shared savings.[18] In fact, as a result of identifying complex patients and increasing their access to care, costs overall increased in the first year of the ACO. This could be due to the early stage of RCCO, as ACOs appear to generate more savings over time.[19] RCCO is not alone. National data from Centers for Medicare and Medicaid Services (CMS) showed that only 26, 28, and 31 percent of ACOs achieved shared savings in years 2013, 2014, and 2015, respectively.[20] Even so, RCCO leaders were honest in saying that not achieving savings was disappointing. One went so far as to say, "If savings hadn't been a promise, I am not sure we would have done it."

It remains an open question whether RCCO will generate shared savings in the future as their baseline benchmarks are reset. Going forward, CMS has developed a revised methodology for setting ACO benchmarks to use regional rather than ACO-specific benchmarks.[21] This change may benefit high-performing, low-cost ACOs like RCCO. For health centers considering an ACO, it is worthwhile to examine how realistic achieving shared savings might be and how important this is to members.

3. New ACOs should anticipate a host of upfront new activities and significant associated costs

ACO formation requires a significant financial investment, including establishing new infrastructure, funding dedicated ACO staff, training existing staff, and implementing systems change at member health centers. Three health centers made initial contributions of $150,000 each in the ACO, which funded an ACO Director, data analytics platform, and legal start-up costs. This investment was supplemented with significant in-kind contributions of administrative staff time from RCHC and from medical and executive leaders from two of the health centers. ACO members agreed that this initial investment was less than what they would advise that health centers should budget to get a new ACO off the ground. In addition to investing in the ACO infrastructure, member health centers also invested in staff training and systems change at each of their health centers.

Health center ACOs will likely need to invest in new data infrastructure and analytic capacity. RCCO found that putting the data systems and analytics in place to manage CMS claims data was costly and time consuming. Though the ACO benefitted from a strong physician data advocate in one of their health centers, the group did not have the analytics infrastructure in place to look at claims data from the start. RCCO initially worked with their electronic health record (EHR) vendor to try to integrate the Medicare claims data and clinical EHR data into a single online analytics platform. RCCO had to make a significant resource investment in order to turn data into actionable information, including attributing patient data to the primary care provider (rather than the claim provider) to facilitate intervention. RCCO negotiated with their vendor to achieve reporting functionality, but ultimately decided to switch data analytics products entirely to achieve back-end access to the data for greater data analysis flexibility. In addition, the ACO gave health centers access to an enormous amount of data, and they found they needed new staff expertise to understand where to focus.

For health centers who have resolved to start an ACO, RCCO member health centers recommended having a data system in place to analyze and interpret claims data before starting. They also advised that an ACO ensure that it has staff with the ability to navigate large amounts of data, distill what aspects of the data are most important and actionable, and quickly build visual dashboards to make data engaging and actionable for care teams.

Forming an ACO requires significant Medicare-specific knowledge. Just as becoming a 330-funded entity requires building a knowledge set around data reporting, regulations, and compliance in the health center program, RCCO found that there was a large body of Medicare-specific knowledge required to implement the ACO. Examples included understanding how to appropriately register providers in the Medicare system, learning how Medicare accounted for FQHC costs (FQHC costs fall into Medicare Part A rather than Part B where other provider costs are registered), and the methodology for patient attribution. Particularly in safety net settings, attribution is a challenge as CMS attributes patients to individual physicians while many health center patients receive care from a non-physician provider. CMS has now recognized this issue and plans to allow attribution to nurse practitioners and physician assistants starting in 2019.[22] RCCO leadership found that their strategy of having an ACO Director who was dedicated to staying up to date on Medicare regulations and requirements was very helpful.

One RCCO leader summarized advice for other health centers considering an ACO:

> *"Put essential systems and staff in place before starting. This includes needing to hire or identify specific staff, such as a person who understands and can serve as liaison to CMS, a programmer who can translate claims into actionable information, and a clinical leader who can help to implement new standard clinical practices."*

4. Choose ACO partners carefully and forge formal systems of accountability

All RCCO member health centers were aligned in mission, had worked together before, and were excited about building skills in accountable care and the prospect of shared savings. Members intentionally partnered with primary care practices rather than hospital systems as financial partners in the ACO since hospitals might have conflicting financial incentives around reducing hospital utilization. However, RCCO members found that their partnership still faced several challenges.

Without formal clinical governance structures, standardizing care models and securing enduring commitment to change processes is a challenge. RCCO leadership found they had limited authority to standardize care models across health center organizations when it came to implementing new processes. Though this was seen as a limitation, individual health centers also appreciated having the autonomy to design their own case management approaches. For instance, one health center embedded a nurse in each panel care team to allow for better care coordination at the panel level, while another had a centralized nurse case manager who managed a panel of complex patients. Each health center designed their care model to meet the needs of their particular patient population and organizational structure. RCCO leadership advised other health centers considering ACO formation that a neutral facilitator may be needed to bring coalition partners to a consensus on clinical and financial governance models.

Potential ACO partners should consider the portion of their patient population that will be under the ACO contract. For some health centers, the fact that the Medicare ACO was only for a very small portion of their patient population turned out to be a barrier to continued participation. ACO activities required a significant commitment of staff time and energy. Even though member health centers were building care management, care coordination, and quality improvement capacity that could ultimately benefit their whole population, there was also a significant amount of work that only affected the small ACO population. Some health centers' leadership felt they could not justify this level of ongoing effort for so few patients. Others described having difficulty implementing new care pathways for only some patients based on their payer. A medical director from one of the health centers that elected to reduce their participation in the ACO reflected, "This work would feel more meaningful if it was for all of our members."

In general, payment reform has been most successful in catalyzing care transformation when there is either a large portion of patients involved or when there is a large amount of potential savings at stake.[23] For health centers where Medicare produces a small portion of the payer mix, the RCCO experience highlights that clinical and administrative leaders should consider the feasibility of providers changing practices and the challenge of investing disproportionate time in only one segment of the patient population.

Formal accountability systems should document contingencies and exit plans in the event that priorities shift. Despite a strong history of collaboration, the demands of transformation on staff, the small percentage of patients eligible at each health center, and the lack of early financial return created differing levels of engagement and commitment among ACO members. After the first three-year agreement period with CMS (2014-2016), five of the original health centers elected to continue with the MSSP for a second agreement period. Of the five remaining health centers, three have decided to limit their participation in RCCO. They are remaining in the ACO—to ensure the ACO maintains the necessary minimum number of beneficiaries—but they have ceded the data analytics and care management activities to the remaining active health centers. The clinical and financial implications of these shifts have been negotiated along the way. However, RCCO leaders reflected that it would have been preferable to have clear exit protocols in place at the outset.

5. Expect the ACO to catalyze new relationships and new systems

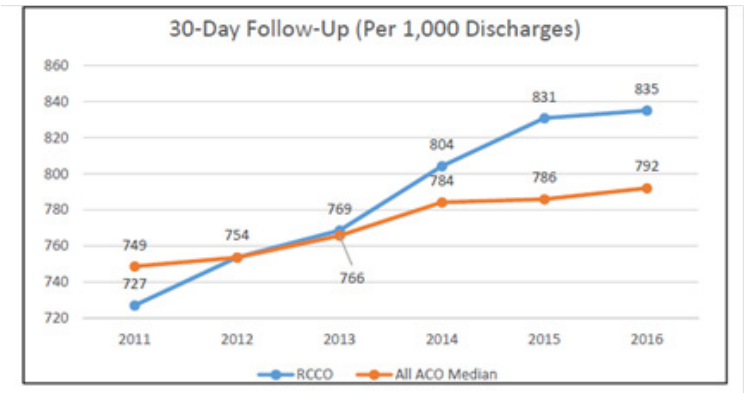
Implementing a safety-net ACO can serve as a catalyst for more productive relationships with hospitals. Forging new relationships with local hospitals was frequently held up by RCCO leaders as one of the biggest positive changes resulting from the ACO. For example, before the ACO, the RCCO health centers did not have a working relationship with a local inpatient psychiatric facility. When the Medicare ACO claims data revealed many inpatient psychiatric stays, health center leaders initiated a relationship with the psychiatric hospital to better coordinate care for their patients. Health center and hospital staff were able to refine referral pathways and establish specific points of contact to improve communication. One RCCO leader reflected on how claims data have informed the relationships forged through the ACO:

> *"Having unprecedented access to patient data allowed us to identify and develop new strategic partnerships. For example, data around inpatient psychiatric admissions led us to partnering with a local psychiatric hospital to improve transitions of care for shared patients. Emergency department claims data allowed us to identify potentially inappropriate ED utilization. This led us to work with a local hospital to develop patient education materials around when to see a primary care provider vs. go to the ED."*

RCCO members also now have monthly meetings with other local hospitals' case management teams and population health leads, new systems of communication for warm handoffs, and improved connectivity through a health information exchange (HIE). An electronic Admission/Discharge/Transfer feed is also planned. RCCO and hospital partners have also identified shared priorities for quality improvement, including identifying and sharing best practices for post-discharge follow-up, patient education, and Advance Care Planning. These new relationships are beneficial to all health center patients, not just those in the Medicare ACO.

These novel relationships with hospitals produced beneficial outcomes for patients. The impact of the ACO on individual RCCO patients' lives have been well documented elsewhere.[24] At the system level, RCCO reported that between 2015 and 2016, psychiatric hospitalization rates—and costs associated with those hospitalizations—decreased while primary care utilization rates increased slightly. RCCO also highlighted improvements in collaboration across the system as evidenced by an increase in 30-day follow up in primary care after hospitalization both over time and relative to other national ACOs (Figure 4).

Figure 4: 30-Day Follow-Up in Primary Care After Hospitalization[iii]



An ACO can provide the impetus for new infrastructure. After overcoming an array of challenges in ramping up data systems for the ACO, RCCO now has an HIE in place that they are using to connect with both hospitals and specialists in the community. Multiple leaders cited the HIE as a highly beneficial by-product catalyzed by the ACO initiative, noting that having this data infrastructure in place benefits all patients, not just those in the ACO. Leaders also see the HIE as foundational infrastructure that will continue to be beneficial for patients and to health centers when they engage in any value-based contracting moving forward.

[iii] Source: RCCO

Looking Ahead

Despite varying levels of commitment from members and not earning shared savings to date, RCCO members have used this experience to embrace learnings related to transforming both care and payment. All participating health centers have found value in the ACO as a "learning lab" in value-based care. The RCCO has given member health centers the chance to test care strategies and learn how to manage cost and utilization outside of primary care. Forming the ACO has also strengthened partnerships and data sharing with local hospitals and the county. Patients also clearly benefit from RCCO's learnings—member health centers have improved across multiple quality measures and have provided patients with care that is more coordinated and better addresses social needs.[25] Finally, RCCO leaders believe that their ACO experience will help them to be better prepared to critically evaluate and perform under future value-based reimbursement arrangements.

Based on their learning, RCCO leaders said they would advise that other health centers embarking on an ACO should: codify excitement among partners into memorandums of understanding and business processes; establish clear clinical and financial governance and accountability for making change; engage legal counsel and/or hire a facilitator to help put contracts into place; and establish clear agreements on how shared savings would be divided, including how upfront and in-kind investments would be repaid.

For health centers considering becoming an ACO, many more ACO implementation resources exist today[26] [27] than existed in 2012 when RCCO was beginning. For example, CMS now has funding for training in case management and coding for community health centers interested in ACOs. CMS has also been learning from the ACO experiment. Benchmarking formulas are being refined to be based on regional spending in order to not disadvantage low-cost, high-quality providers. Providers can also now choose between more types of ACO arrangements, including the Next Generation ACO, which provides upfront funding that is then netted out of shared savings. Health centers considering an ACO can also benefit from RCCO's experience and wisdom developed through their early entry into accountable care.

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