Jennifer Nolty (00:00):

Good afternoon everyone. This is Jennifer Nolty. I am the Director of PCA and Network Relations of the National Association of Community Health Centers. I'd like to welcome you to today's webinar, which is ACO 101. For those of you, this is Accountable Care Organizations 101. So if you were looking for something else that ACO stands for, you can stay on or you can hang up, but we hope that you stay on. But we welcome you. Just so you know, before we get into the actual information of the of the webinar, you have everyone muted as you come into the webinar.

Jennifer Nolty (00:48):

If you do want to ask a question or have any comments, you can do so in the chat function, which is in your lower right-hand corner. Or you can click on the chat at the top there, and it'll bring you to that portion. Okay. There will be time at the end to go through the Q&A that does come up throughout. And if we don't get to everything at that point, what we do is collect the questions and put answers out there for all the participants afterwards.

Jennifer Nolty (01:32):

Secondly, there will be a survey that will pop up at the end, so we do appreciate your feedback for that. Please, we do want your honest feedback, and especially as we move forward into July, and into our new cooperative agreement year as to what we're either on this subject or any other subjects that you would like to hear more about. Then thirdly, the recording of this webinar will be available on MyNACHC sometime in the next two weeks. And you will receive an email when that happens and will be available at that time.

Jennifer Nolty (02:18):

Okay, so at this point, I'd like to start with our objectives for today's webinar. To understand what an ACO is, learn what is expected as a participant within an ACO. Then to determine how success in any ACO is measured. When I'm talking about ACOs, I will talk about Medicare Medicaid, as well as a little bit about third party or what we call commercial. Regardless though, of what the product line or the insurer or who is paying for the services, they all pretty much have the same makeup well, a couple of different nuances.

Jennifer Nolty (03:06):

Why do you want to consider an ACO? Especially since the new administration with some changes within the cabinet. But specifically, if you look at these five bullets here, there's been particularly HHS, Secretary Azar's Five Part Strategic Plan. In particular, his first strategic goal is to reform strengthen and modernize the nation's healthcare system. Within that, he actually has four bullets or four objectives that talk about specifically promoting affordable healthcare, while balancing spending on premiums, deductibles, out-of-pocket costs. But then also being able to expand state's high quality healthcare options, and encouraging innovation and competition.

Jennifer Nolty (04:06):

Improving Americans' access to healthcare and expand the choices of care as well as service options. Then strengthening and expanding the healthcare workforce to meet America's diverse needs. Even though we have a new secretary, pretty much the goals continue as far as being able to access care, and

being able to make it affordable to both the consumer as well as to Medicare, Medicaid, as well as to employers.

Jennifer Nolty (04:43):

Also, 50% of all providers are currently in a Value-based Payment program across the United States. We have seen that happen pretty quickly over the last couple of years. Then also repeal and replace actually does not affect value-based payments. They are still here and many say that they are here to stay. Right now today you still receive fee-for-service or PPS with no downside risk. What we will be seeing though, is that risk will increase over time. It's important that everyone prepares including the health centers.

Jennifer Nolty (05:27):

Funds are available to lessen the upfront and ongoing costs. Whether it's through a third party administrator, whether it's through Medicare, maybe it's even through the state. There's ways to be able to work work through those issues. But under the current law, national health spending is projected to grow at an average rate of 5.5% per year from 2017 to 2026. By 2026, it's going to reach 5.7 trillion.

Jennifer Nolty (06:00):

Health spending is actually projected to grow one percentage point faster than the gross domestic product per year. What that in turn means is that growth and spending from Medicare and Medicaid are both substantial contributors to the rate of this national health expenditure growth. For Medicare, it's an average of 7.5% percent per year and Medicaid is about 5.8 or almost 6%. What's happening is, many ACOs have been showing cost reductions in quality improvement. What happens is it takes, what I'll show you in a few slides is that it actually is showing that over time, that's what happens.

Jennifer Nolty (06:52):

The next couple slides are just showing where we are with ACOs today. This is, on the left-hand side just has obviously the United States. Probably a year, year and a half ago, this looked a little bit different. Right now, every state has at least two ACOs available to people that live in them. Then as the colors get darker, the more are available. On the right-hand side is just showing graphically from 2011 through 2017, the number of ACOs and then the number of lives that are covered. We've seen that growing over time. As you can see there, there's over 32 million lives covered as of 2017 and over 923 ACOs. That's inclusive of all the products so whether it's Medicare, Medicaid or commercial or third party.

Jennifer Nolty (07:59):

This is representative of the Medicare model which is the Medicare Shared Savings Program, which includes all the different tracks. Also this is as of this year and what they call Medicare refers to as the performance year. So even though this is as of January of 2018, these are all the ACOs that have agreed to be in it for this year. The different colored dots represents whether they are in a track one, track two, or track three. That has to do with whether or not the ACO has decided to take upside-only risks, a combination, or a downside risk.

Jennifer Nolty (08:47):

Then there's also the ACO investment model and next generation ACOs. As you can see where they are highly concentrated is more of the right-hand side of the country. That's probably indicative of where a

lot of the Medicare lives are as well. Currently Medicare ACOs attribute about over 8 million lives. That continues to grow.

Jennifer Nolty (09:19):

Medicaid, this is as of February, there's actually 19 states that are represented here. Over 3 million lives are in 11 of those states which are in orange. The orange states actually account for those that have active Medicaid ACO programs. Then those in blue are those nine or 10 states that are actually pursuing the Medicaid ACO programs. I'm going to have, towards the end, some results on Colorado, Minnesota and Vermont on their ACO programs and pretty good information.

Jennifer Nolty (10:05):

What is an ACO? Whatever it is, an ACO, which is an Accountable care Organization, is a group of physicians or healthcare providers who actually accept a shared responsibility for a defined set of patients and are held accountable for the quality and cost of care that's provided. The primary care should always be the foundation of any ACO. What that says is that the patient would be in the middle, the family centered Medical Home is in the model, and looking at primary care as that base.

Jennifer Nolty (10:49):

Give a brief history of ACOs. They were actually developed to move the US healthcare system towards the goals of the Triple aim. What happened was the ACOs were first adopted in Medicare under the Affordable Care Act in 2010. In 2011, the first Medicaid ACO program was launched. ACOs have since become a leading payment and delivery reform model across all payers. As mentioned earlier, over 50% of providers are in a value-based program as of this year. In less than seven years, we've seen 19 states that have either started or in the process of forming a Medicaid ACO.

Jennifer Nolty (11:39):

I found this graphical representation, what happens a lot of times is that people will interchange ACO with Patient Centered Medical Home, and Clinically Integrated Network. Now what's interesting is that this graphical representation came from the Utilization Review Accreditation Commission, or the URAC. It was just very simplistic but yet it really drove home the point of, if you look on the left-hand side are the requirements. If you look at what each of those components, so you look at Medical Home, and then Clinical Integration, and then for all of them, you have Accountable Care.

Jennifer Nolty (12:31):

But one thing I want to drive home is the fact that for Patient-Centered Medical Home, that was actually ... For those of you on the phone that have been in healthcare for a while, Patient-Centered Medical Home is really been the foundation for where we are today in Accountable Care, and in the Medicare Shared Savings Program, in the Medicaid ACOs etc. From a framework perspective, the requirements are listed. What they do is they are really building upon the other. We move into from the Medical Home into Clinical Integration. Then from Clinical Integration into Accountable Care.

Jennifer Nolty (13:21):

Now, a lot of times it seems like it's not as cut and dry. There's a lot of overlap or we may form the Accountable Care Organization, and we might be still trying to achieve Medical Home. We think Clinical

Integration will come later. Really in order for you to be able to to truly become a successful Accountable Care Organization formally, each of these things build upon the other.

Jennifer Nolty (14:00):

We talked about the goals of an ACO. Regardless of the patients, or who the payer is back in, as we talked about in previous slides. Back in 2010, the Triple Aim was the actual goal. We've actually now transitioned into the Quadruple Aim. Ultimate goal is to give the patient better and more coordinated care, improve the quality and efficiency of that care. Also, we have to demonstrate the increased value from those healthcare expenditures. Then ultimately, achieving Clinical Integration.

Jennifer Nolty (14:41):

As a vision, ACOs actually promotes seamless coordinated care. That's really what we're trying to do. You put the beneficiary and their family at the center. Remembers the patients over time and place. Attends carefully to care transitions, Manages the resources carefully and respectfully. Proactively manages the beneficiaries care. Evaluates data to improve the care and the patient outcomes. Innovates around better health, better care and lower growth in costs, through improvement. And invest in team-based care and workforce. So it's not just the individual provider, it really has to be a whole, not just whole person but whole team, from the front office to the back office and everywhere in between.

Jennifer Nolty (15:41):

You talk about the structure of an ACO. The ACO is really a separate legal entity when you have two or more independent participants. They are capable of either receiving or repaying shared savings and/losses. Normally you have to you have a governance component to this. The participants generally control 75% of the board.

Jennifer Nolty (16:17):

No, for instance, with the Medicare ACO, you have to have at least one Medicare beneficiary that's served by that specific ACO on your board. But it's generally recommended that you do that for other ACOs as well. Whether it be Medicaid or for your third party, or your commercial. This is separate from the Health Center Board. But one of the things that I can tell you is that health centers have a lot of experience with boards and the consumer voice on the board. Using that as an advantage and a leverage point is always good.

Jennifer Nolty (17:07):

Leadership and Management. Usually there's a person that's nominated as the operations manager who keeps things moving. Really is like the business person, if you have a third party administrator that is really the group or the company that's really monitoring everything for you as an ACO. You're not doing it on your own. Then that person or that organization generally has an operations manager appointed.

Jennifer Nolty (17:44):

Usually, you would also want to have the clinical manager or an ACO physician. You want to have someone who's either a primary care physician, somebody that you want to start off with a primary care physician. Then as you move into expanding the types of services that you allow or provide within your ACO, you moved from primary care to a multi-specialty. You may want to include another type of

specialty provider as well. But in the majority, you would have a physician from the ACO as your clinical manager.

Jennifer Nolty (18:32):

Then you have the QA and PI, which are your quality Assurance and your Process Improvement initiatives, as well as protocols. Those things are defined. These are generally to be agreed upon, voted upon, and monitored, and then utilized by all the providers and all of the practices that are part of the ACO. That's where we talk about the foundation of being a Clinically Integrated Network. Even going back as far with Patient-Centered Medical Home.

Jennifer Nolty (19:08):

Patient-Centered Medical Home talks about a particular disease, maybe. Using those particular QA and PI initiatives and protocols for that particular disease state. Then moving into how do you do that for other disease states. That's really where you get into Clinical Integration. I know I'm oversimplifying it, but it's just to give an example as then as you move into an overall ACO structure. It's really making sure that everyone agrees, not only agrees upon these, but also implements and will be responsible for those that will not, that they don't decide to follow the implementation.

Jennifer Nolty (19:57):

New participants can be added during the period of the ACO. Normally ACOs are run on a three-year cycle. Even the Medicaid ACOs that we've seen are run on a three-year cycle. Normally what happens there's criteria that's determined by the overall management group or committee. Then they put together a process of evaluation. Then a vote is usually utilized as to whether or not they want them to be part of the voted in or not.

Jennifer Nolty (20:40):

Then there are generally committees that make up the actual ACO. Those start off small and then they grow as the ACO grows and matures. But usually start off with either a governance and/or management team who usually go into a quality component. Then finance. Some will actually have a health and information technology. Then you may even get even into further more weedy committees as well.

Jennifer Nolty (21:18):

When we talk about ACOs, if the goals of the ACO are to center around the care of the patient, then the ACO providers need to know who the patients are, in order to treat and be measured upon those. Then we have to identify a couple things. If we determine the patient population that's being treated, normally there's two ways of determining that: either a prospective or retrospective. There's pros and cons to both ways, so it just depends.

Jennifer Nolty (22:09):

Using data from one year to assign prior to the performance year. That's looking back to see from a claims perspective, what patients have actually received care from the physicians within that ACO. Then moving into and then use then reaching out to those patients. That's who you're responsible for.

Jennifer Nolty (22:36):

Retrospective looks at the end of the performance year, based upon the patients that are actually served during that year. To some practices that can be a little unnerving because they're not sure if that's good or not. Some want to know ahead of time, but then again, there's pros and cons to both.

Jennifer Nolty (23:02):

But both methods look at claims. Generally speaking, it looks at whether it was an MD or DO. From a health center perspective, this has been very difficult because we use a lot of nurse practitioners and physician assistants in the care of our patients. One of the things that there are some changes on the horizon for this, which is going to be a very positive thing. One of the identifiers is that when you're looking at minimums, so for instance, for Medicare Shared Savings ACO, the minimum is 5,000 beneficiaries in the total ACOs.

Jennifer Nolty (23:53):

What we've seen historically, over the last couple of years, is whether it be if it's State PCA that's applying for their own Medicare Shared Savings Program ACO application with CMS. It can range literally anywhere from as little as ... If you take your Medicare numbers that are that are reported on the UDF, it can range anywhere from 10%, all the way up to we've seen as high as 80% of those beneficiaries can be attributed. Just depending upon whether or not the physicians are linked correctly to the practice. whether the patients have an actual claim to one of those physicians. Whether it be an MD or DO within the time period that they're looking back on. Like I said, if it's a prospective lookback, and then also if you're looking at it retrospectively.

Jennifer Nolty (25:01):

One of the new things for Medicare, MSSP ACO this year is what they're calling, and it's actually voluntary alignment for 2018. What that means is generally speaking a patient does not have to formally align themselves, or pick, or say that they are associated with an ACO. But what they are asking more and more is, if you had a choice as a Medicare patient, which provider would you want to align yourself with? If that provider is a Medicare provider, and is aligned with that ACO, and that patient goes out to the Medicare website and picks that provider, they will then be aligned with that provider for that ACO. That is one thing, like I said, this is new for this year. They are trying to see how many patients actually do that, and how many patients actually hold true to that.

Jennifer Nolty (26:20):

What happens with the Medicare ACOs, in the final rule for Medicare Shared Savings Program, the centers for Medicare and Medicaid services actually elected to use a third method which takes the perspective and the retrospective, and actually makes it a hybrid. What they do is they begin with a prospective attribution. Each quarter the patients are given to the providers of the ACO. Then what happens is at the end, they do a retrospect for the most recent 12 months of data to actually ... it's almost to clean it up and to make sure that the patients that we're seeing can be attributed correctly. And that the physicians are giving credit for those patients as well.

Jennifer Nolty (27:23):

Like I said in the beginning of the slides, MSSP Medicare usually does have a minimum threshold of 5,000 beneficiaries. When we look at that, for other lines of business, some from a commercial standpoint may use or even Medicaid may use 1,000 as the as the baseline. The more patients you have, the better. It's easier to distribute the risk in that case. The more that you have that can be not only

retained by the ACO, but also if you can increase your patients over the number of years that the ACO is in existence. That also helps as well.

Jennifer Nolty (28:16):

What happens? The other thing is that the changes for 2019 under the 20th Century Cures Act, especially this is important for the health centers. This is going to allow patients to be assigned to a nurse practitioner or a physician assistant and no longer will need to have a visit or a claim with a medical doctor or DO during that time, which is really going to be really great for us. Like I said, in the past, when we look at the Medicare numbers, the attribution to being able to link can be a really big, anywhere from 10 to 80%. Now we hopefully will see those numbers rise and be a lot bigger, so that we no longer have to.

Jennifer Nolty (29:11):

But for 2018 for anyone who is currently in an MSSP ACO, anyone who is looking to start in January of 2019 with an MSSP ACO, you should still be working towards having at least one visit this calendar year with an MD or DO of your health center. Because those are still being attributed to that methodology. It's not until visits or claims beginning with January of 2019.

Jennifer Nolty (29:59):

Measurement and reporting. Obviously, this becomes a really big component of the ACO. Not only is it understanding who your patients are, but you're held accountable by reporting performance on quality measures. And looking at things in these buckets such as prevention, disease identification, ongoing interventions, patient satisfaction, and total cost of care. What happens is under quality, these can range depending upon whether it's at the state level for Medicaid, whether it be at ... if you're working specifically with a payer, or an insurance company or managed care organization and you're in an ACO with them.

Jennifer Nolty (30:55):

Also, within the MSSP ACO, they currently are at this year for 31 measures that you are responsible for. In the past, it's been 33, but they've reduced that to the 31 measures. Under total cost of care, what happens is a lot of times, those things are broken down into the big bucket items such as ER utilization or emergency room utilization, inpatient and outpatient admission and utilization. Some of the ACOs should be giving, at least if not measuring it, looking at what the total cost of care is for that patient or that patient population.

Jennifer Nolty (31:50):

We talked about benchmarks. Benchmarks are going to be what you are measured against. That could depend upon, again, the payer or the product. If it's Medicaid and the state has determined if you're being held against your own standard against yourself, or you're being held against the standards of all the other type, same type of providers in your state. Or does it not matter an ACO is an ACO is an ACO. So it just depends.

Jennifer Nolty (32:30):

New for Medicare, they are actually moving into you are being compared against yourself. Your benchmarks are now moving to where you're going to just have to ... Instead of being held against everyone, the same across the country, it's now, you have to do better than what you did before.

Jennifer Nolty (32:55):

Basically, if you spend more than what was determined to be the cost allowed, you're considered inefficient as an ACO. If you spend less then you save money and you're efficient. That's the quickest and simplest way. Usually, the definitions can be based on different guidelines. HEDIS, which is Healthcare Effectiveness Data and Information Set. These are the employers and the individuals use these to measure the quality of health plans. Then these get passed down to the different types of measures.

Jennifer Nolty (33:42):

Clinical, they could be clinically based, so maybe for diabetes, there's the clinical ones, maybe the CDC guidelines, etc. Looking at the timeframe, generally speaking, they're all generally based on calendar year, but they may have some different nuances, but you want to know that as well.

Jennifer Nolty (34:07):

The frequency depending upon the type of reports, you could see them coming through monthly, quarterly as well, and then an annual report depending upon this. One of the things to remember is that if your health center is not used to seeing the data among the providers within that health center, they will see that within an ACO. If you're not used to seeing your your health center compared to other health centers, you will in an ACO. So those are things to keep in mind as you move into these value-based conversations, and into these value-based relationships.

Jennifer Nolty (34:52):

Normally, you would have also a reimbursement report, which is where you have final results. Generally speaking, payment usually is available anywhere from six to nine months after the end of the reporting period. Basically, because of claims run out, maybe they may allow for some chart audits or some information to be provided at that time.

Jennifer Nolty (35:22):

Next we talk about the different ways that ACO reimburse or have come together with that. Generally speaking, the two majorities you will see here on the right-hand side in green, over 46% has the combination of fee-for-service plus the care coordination, some type of the ... plus the shared savings. You would get the fee-for-service or your PPS, plus a PMPM or care coordination fee or quality control component plus shared savings, if you met all of your metrics, or a certain amount of your metrics.

Jennifer Nolty (36:06):

32, or almost 33%, in the large purple on the left, is going to be just shared savings only. Again, this might be for ACOs that this is outside of their ... They're not including their everyday fee-for-service or their everyday PPS. They may just be using this to take a portion of that amount and put that into the ACO.

Jennifer Nolty (36:37):

We talk about reimbursement. You have to also consider risk. When we talk about risk in an ACO, I'm talking about financial risk. There's all different types of risk, but when you're talking about financial risk, I have it described on the left-hand side, but as value-based care becomes the name of the game in healthcare, public and private payers are going to push providers to take on more of the financial accountability for their services. They do that through Alternative Payment Models.

Jennifer Nolty (37:12):

In a fee-for-service world, the providers actually receive the reimbursement for every test or procedure performed. They're not penalized or rewarded if these services impacted the patient outcomes or didn't, and the healthcare costs. Under Alternative Payment Models, though, providers actually become financially responsible for the care they provide. The upside risk or what's also considered maybe a track one in Medicare, or one-sided risk model. This actually allows the participants to share in healthcare savings if their services make care delivery more efficient. Again, when I said more efficient that's if they save money.

Jennifer Nolty (37:58):

But in downside risk arrangements, both the providers can also lose healthcare revenue if their care actually exceeds those agreed upon financial and clinical thresholds. Or they could be required to refund their payers if they go over a certain amount for a certain group of services. On the right-hand side, while Alternative Payment Models can include both these types of financial risk, payers are most interested in boosting the two-sided financial risk implementation.

Jennifer Nolty (38:34):

Medicare, one of the things that we're hearing is that's one of the reasons that, for those of you who may be monitoring the Medicare Shared Savings program, they have yet to put out their final information for 2019. Which to not have it out by this time is really very unusual. But the understanding that we been hearing here at NACHC is that a lot of it is based on the conversation around the risk and the tracks.

Jennifer Nolty (39:08):

One of the things that happened last year is that there was supposed to not be anyone who was in a Medicare Shared Savings Program for two cycles or six years. They were supposed to automatically take on downside risk. They were allowing the extension for another three-year cycle of the upside risk only. What we're hearing is that there might be some of that still happening. That's maybe one of the reasons why they're not putting forward the final information for 2019.

Jennifer Nolty (39:54):

The upside and downside risk structure promotes full provider accountability for their care. There's a lot of information that has to be known. There's a lot of information that has to be understood. There's a lot of reporting. There's a lot of data that has to be turned into information that needs to be able to work and be understood.

Jennifer Nolty (40:19):

The image on the right actually shows that as the reimbursement changes, the more financial risk is taken on, or expected by the provider and/or the ACO. You cannot be fully accountable for the patient

population until you're willing to accept financial risk. Because at the end of the day, you're all managing these patients together and you have to share the risks together. So it's not just you within, when we're saying that the providers, it's not just those within the four walls of the health center. It's wherever else the patient receives care. If that's at a hospital, you need to be able to have that information from the hospital. They don't necessarily have to be in your ACO, but you have to be able to get that information and understand it.

Jennifer Nolty (41:16):

Secondarily, as I talked about, you need to have reporting, you need to have the health information for that. This is another example of the stages of the continuum. If you were to superimpose the previous one that I had in the previous slide over this, the more advanced you are. The highest would be full capitation. You should be at the highest level of health, IT infrastructure, and data availability; it should be the most sophisticated.As you are moving from just your individual or your discrete patient encounters, you're moving to the health of the population. You're actually working on the health of the entire population, and that's what you're in charge of.

Jennifer Nolty (42:09):

As you're transitioning to value-based care and Value-based Payment, you ultimately must make these fundamental changes in your daily operations. This is really where we talk about not just transitioning, but transforming. You have to really look at cross functional commitment. Again we talked about team-based care. Team base starts with from the front office, to the people who actually do the billing. It's every point of contact with the family, the caregiver, and the patient.

Jennifer Nolty (42:46):

How these particular programs at the bottom here, whether it be an annual wellness visit, Transitional Care Management, Chronic Care Management, Behavioral Health Integration Services. These are all ways to actually start the engagement process with the patient. A lot of health centers who have been part of the Medicare Shared Savings Program ACO, they not only use the annual wellness visit for the Medicare patients, but they have now implemented for all their patients regardless that they get additional reimbursement. Because of the information that is collected and the relationship that they begin to develop with the patient.

Jennifer Nolty (43:39):

This is just a diagram of the core competences. When you're in an ACO, there are going to be things that are needed on the provider side, what we call a Strategic Partner. Whether that be something that you develop as an independent organization, or if you have a third party that's helping in that. Then what do you do together? These are some items that really ... What should you be good at? What should they be good at? What should you do together and what can you ... It doesn't mean you have to know how to do these, but you should be able to put them in place and work on them together.

Jennifer Nolty (44:28):

The expectations from an ACO are to reach out to the patients. Again, annual wellness exam. Performing Patient Satisfaction surveys and doing these on a regular basis. Then not only collecting the information, but actually doing something with that information that's being collected. If you're looking at something that comes across, maybe it's office hours, or maybe it's the patients, it's something about the risk of

falling or something. What are you actually doing when that information is actually being identified in a patient's chart, or when you're collecting it? How are you closing that loop?

Jennifer Nolty (45:15):

Identifying the high utilizers? How are you getting that information? Who can you get that information from. How can you concentrate in that? What's the workflow? Who are the touch points for that? Getting to know and really knowing where your patients receive their care from. It's really understanding that if you had to choose a hospital, if you had to choose a few specialists today, who would that be and why? Is it because you have an existing relationship with them? Is it because they give good care? Is it because the majority of your patients see them? It's all those and understanding that from the beginning.

Jennifer Nolty (46:03):

Pros and cons. There's a lot of benefits and there can be a lot of drawbacks. It's just obviously looking at these. I mean, these are just a few. But then it's also for your own organization, what is the drawback or what is the benefit of being part of this and not being part of this. Is the investment worth the restriction.

Jennifer Nolty (46:39):

Then to just give you some information on some of the results that have been seen. In the 2016 MSSP ACO results, 2017 will be out in September, so we don't have those. But so far, $652 million in savings has been achieved for Medicare. A third of the ACOs actually have generated those savings. From a quality perspective, 94% is the average quality score. The average performance is increased 10% over five measures which I listed out there. A lot of these things are items that we as health centers actually do with the UDF.

Jennifer Nolty (47:27):

One of the things that I have heard from multiple people, both health centers that have been part of or are currently part of an MSSP ACO, or from third party administrators who have health centers in ACOs. Is that they see a direct correlation between UDFs being increased when they do very well on their ACO results. So there's a direct correlation. What that tells us two things is that primarily that the way that health centers work with their patients is closer and more equal. It doesn't matter what the fiscal line of business is.

Jennifer Nolty (48:29):

If a patient has diabetes, they do the same thing for a patient with Medicare versus someone with another insurance or no insurance. But also what that also shows is the fact that they can put together a great quality program, and really show that the results speak for themselves. That the HEDIS or the way that the measures are defined by Medicare versus the UDFs, are much closer than ever before. We're seeing, again, those direct correlations, which is very promising.

Jennifer Nolty (49:12):

Also, what they're saying is that the longer that the ACO has been in existence, the more the patient outcomes have improved, and the more money has been saved. It's not that they don't see savings

within one or two years of an ACO starting. It's just that when it's over time, that's where you see it. It's not like it's a quick fix, but it does take time, and it does take patience, and it does take work.

Jennifer Nolty (49:40):

From the Medicaid ACO results, just to give you a couple of quick results for Minnesota. In 2010, they started and they currently have 21 ACOs with 410 lives ... 410,000 lives. Their goal is to have half a million lives. But they have had significant savings in the first three years. They have achieved a 14% reduction in inpatient admissions and 7% reduction in ER visits. They have actually been able to receive 85% or more of their quality payments that have been put at risk.

Jennifer Nolty (50:20):

For Oregon, in 2011, their state actually created their CCOs or what are called Coordinated Care Organizations. That's how their state is now broken up, or divided up. They were launched in 2012. What they have found is that in five years, their ER utilization went almost, it almost was cut in half from 14.2% to 6.7%. They have actually held down costs overall to 3.4%. in the past five years. They actually expect to save by 2022, a total of $10.5 billion.

Jennifer Nolty (51:08):

Then in Vermont, this is the newer one of the three states we're going to talk about. In 2014, their ACO began. Currently for their two years, they've had a net aggregate savings of $15.7 million. They have had an improvement in their quality scores. In 2014, it was at 46%. And it went up in 2015 to 57%. They've had about 80,000 Medicaid members that have been impacted by this. So this is some really neat, staggering results, not only for Medicare, but for Medicaid as well.

Jennifer Nolty (51:53):

Next steps. Understand who you are asking to work with. Again, looking at the providers looking at the patients. Understand the measures and how they're defined. But be prepared for and open to the results. Like I said, if you haven't had that conversation, if you're not sharing any kind of data with your providers currently, that's something to really be prepared for.

Jennifer Nolty (52:19):

Set realistic expectations. Understand that the time it takes to achieve on average results. Sometimes it can take as long as like a year and a half before you start to see a turnaround. But you just have to start. Then weighing the benefits to actually being in the ACO versus not. Looking at it from a time commitment, the actual resources, maintain the engagement of staff and patients, especially if there are not shared savings or dollars that come back in the first year or so. How do you continue that engagement? How do you keep moving forward?

Jennifer Nolty (53:08):

All right, thank you. At this point, we have a few minutes. I don't know if we have any questions. We've gotten one through the chat box. How have a ACOs incorporated and paid social determinants of health providers into the ACO?

Jennifer Nolty (53:28):

Actual providers have not been, unless they're actually recognized by the a ACO, then they can achieve payments that way. Otherwise they would not receive payments from that. If that's something that the ACO wants to take on, they can.

Jennifer Nolty (54:07):

Okay, great. We do have the slides, we'll make sure that we get them out to everybody. Just to let you all know, we had sent them out to people that have registered up until yesterday. So we'll make sure that everybody gets a copy of the slides. Again, this recording and the slides will be available on My NACHC in the next two weeks. But yes, we'll definitely get the slides out to you.

Jennifer Nolty (54:41):

Would appreciate if you have any questions afterwards. My information is available here. I appreciate everybody's time. I see there is one more question. Can the FQHC invest in an ACO? Yes, an FQHC can definitely be part of an ACO. It's just that the ACO needs to be its own legal entity.

Jennifer Nolty (55:16):

Any other questions? Okay. Well, I appreciate everyone's time today. Hope you all have a great rest of your day and a Happy Fourth of July. Thank you.