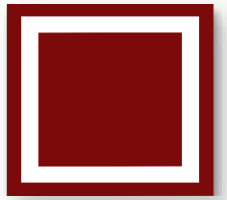

ACOs: A Tool to Achieve Quality, Savings, and a Return on Your Investment

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Value Based Care and Physician Engagement

RHPTP HELP Webinar
February 2nd, 2022

Objectives

- Describe how ACOs contribute to Value Based Care
- Name the key elements in ACO success
- Explain the value in documenting risk
- Identify the benefits of transitional care management and ED follow-up

What is Value Based Care?

Care based on quality and not quantity.

$$\frac{Quality + Outcomes + Satisfaction}{Cost} = Value$$

What are ACOs?

ACOs are one method to implement Value Based Care

- *"ACOs are groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high-quality care to their Medicare patients."*
- *"The goal of coordinated care is to ensure that patients get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors."*
- *"When an ACO succeeds both in delivering high-quality care and spending health care dollars more wisely, the ACO will share in the savings it achieves for the Medicare program."*

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ACO

Elements for Success in an ACO Shared Savings Program

- Data
- Tools
- Workflow
- Teamwork

The Tools for Success

- Wellness visits
- Coding for risk
- Chronic Care Management
- Transitional Care Management
- ED Follow-up
- Team and provider buy-in

Wellness Visits

What is an Annual Wellness Visit (AWV)?

- Once yearly, prevention focused visit that includes a health risk assessment and a preventive care plan
- An important opportunity to engage with patients and focus on their long-term health outside of acute/chronic visits

Health Risk Assessment + Preventive Care Plan = AWV

The Annual Wellness Visit

What it is not

- Not an annual complete physical exam, with screening lab work
- Not an office visit that requires the typical documentation to support selected E&M charges

What it is

- A once yearly, prevention focused visit that includes a health risk assessment and a preventive care plan
- An important opportunity to engage with patients and focus on their long-term health outside of acute/chronic visits

Association of Medicare Annual Wellness Visit With Healthcare Quality and Costs

The authors examined the association of an annual wellness visit (AWV) with healthcare costs and clinical quality measures. The sample included 8917 Medicare beneficiaries attributed to providers across 44 primary care clinics participating in 2 accountable care organizations.

RETROSPECTIVE COHORT STUDY, 2014-2016

AWVs were associated with

significantly reduced hospital spending

$30 acute care | $20 outpatient nonemergency care
savings per member per month

AWV patients had

5.7% reduction
in adjusted total healthcare costs

$175 Reimbursement for Medicare AWV

$456 cost decrease per member per year

Savings effects were most pronounced among the highest-risk quartile of patients.

There was a reduction in adjusted total healthcare costs over the next 11 months following AWV.

AWV patients had

70 percentage points higher screening rates
for fall risk and depression

AWVs were associated with higher rates of:

Blood pressure control | A1C control
breast cancer screening | colorectal cancer screening
tobacco use screening/cessation intervention

Limitations include that the study design was not randomized and that these findings will not necessarily translate to all primary care settings.

AJMC Managed Markets Network

https://www.ajmc.com/view/medicare-annual-wellness-visit-association-with-healthcare-quality-and-costs

Beckman et al, 2019

Why Focus on Medicare Wellness Visits?

1. Good for patients to focus on prevention
2. Increase accuracy of Medicare's rating of acuity of patient panel
3. Increase attribution
4. Promote culture of improvement among participants
5. Begin to align practices to population health: building skills of outreach and active management of panel

Bonus: Provides a 34% fee-for-service increase

https://www.nachc.org/wp-content/uploads/2020/03/Payment-Reimb.-Tips_IPPE-April-2021.pdf

Who Should Come in for a Wellness Visit?

- All Medicare patients
- Three types of visits are available depending on the situation:
  - Welcome to Medicare G0402 – within the first year of Medicare B
  - First Annual Medicare Wellness Visit G0438 – one year after the welcome to Medicare
  - Subsequent Annual Medicare Wellness Visit G0439 – one year after the First Annual Medicare Wellness
- A specific diagnosis code is not required for an AWV – any, and all appropriate diagnosis codes will do.

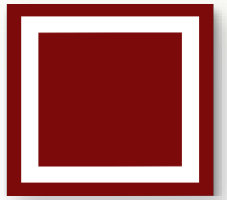
Annual Wellness Visits

What have providers discovered doing AWVs?

- When you start completing AWVs, you may notice instances where your patients:
  - See multiple specialists and you do not understand the purpose. Sometimes these are for things you could do
  - Will have no records from those specialists or the results from screenings performed
  - Will be on multiple medications and be unaware of what is prescribed or the purpose of the medication
  - Will have been admitted to a hospital and you were not aware
  - Will have no records from a hospital admission

Ways to Capture AWVs

- **Standalone AWV**
  + Great time to talk about what the patient wants
  – Need to convince the patient to come for another visit
- **Add on AWV**
  + Is allowed for CHC's- included in AWV payment
  + Capture patients who haven't come in for a stand-alone AWV
  Needs responsive team to keep the flow
  – Misses high risk patients who do not come to office
- **Flip to AWV**
  + Patient can get a free visit
  Needs the team to capture this up front



Representing Risk

What is Risk Coding?

- Risk coding is the process of accurately and thoroughly communicating to Medicare and other payers the complexity of your patient panel. This level of complexity is described through the submission of ICD-10 diagnosis codes.

- Risk adjustment is the process of modifying payments for a patient or population based on their degree of illness.

https://www.aafp.org/fpm/2016/0900/p24.html

Creating a Patient Risk Score

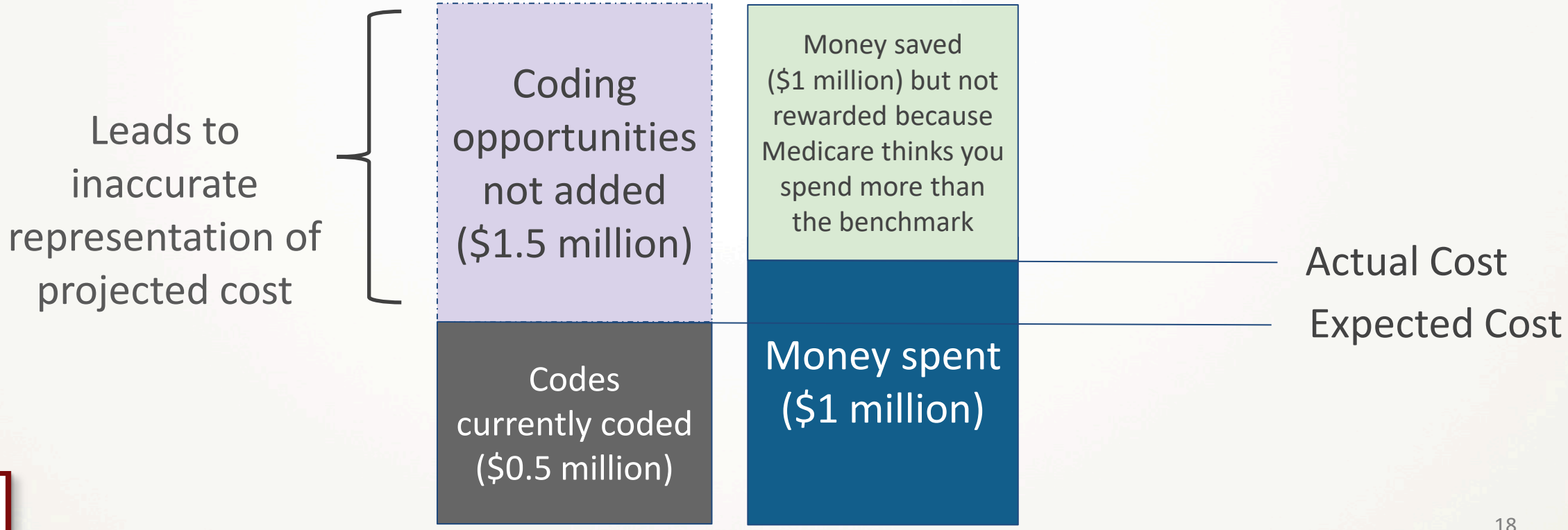
Medicare calculates a risk score ("Risk Adjustment Factor or RAF") for each beneficiary based on:

- **Demographic Factors**
  - Age
  - Sex
  - Medicaid Dual Eligibility
  - Disability status
- **Diagnoses submitted to Medicare**
  - Is a sum of the weights of all the diagnosis codes submitted during the year
- Scores from a patient's risk categories are additive; the higher the score, the more CMS expects the patient to cost. That leads to an opportunity to capture savings when the care costs less than expected.

Risk Coding Impact

If you **under-code:**

An inaccurate representation of projected costs leads Medicare and other payers to think your patients are less sick or complex than they actually are. Even though ACO lowered costs, the payers believe you spent more than expected.



Risk Coding Impact (cont.)

If you **accurately code**:

Medicare now understands how sick your patient REALLY is and how much they should cost, so you are rewarded for great care at decreased costs!

HCC Financial Differences in Coding Specificity

(Adapted from American Academy of Professional Coders, AAPC.org)

No conditions coded (Demographics Only)		Some conditions coded		All conditions coded	
76 year-old female	0.468	76 year-old female	0.468	76 year-old female	0.468
Medicaid eligible	0.177	Medicaid eligible	0.177	Medicaid eligible	0.177
Major Depression		Major Depression (F32.9) No Weight	0.0	Major Depression (F32.0)	0.395
DM not coded		DM (no manifestations)	0.118	DM with complications	0.368
Vascular Disease not coded		Vascular Disease without complication	0.299	Vascular Disease with complication	0.41
CHF not coded		CHF not coded		CHF coded	0.368
No interaction		No interaction		+ disease interaction bonus (DM + CHF)	0.182
Patient Total Risk Score	0.645	Patient Total Risk Score	1.062	Patient Total Risk Score	2.368
Yearly Reserve for Care	**$6,450**	**Yearly Reserve for Care**	**$10,062**	**Yearly Reserve for Care**	**$23,680**

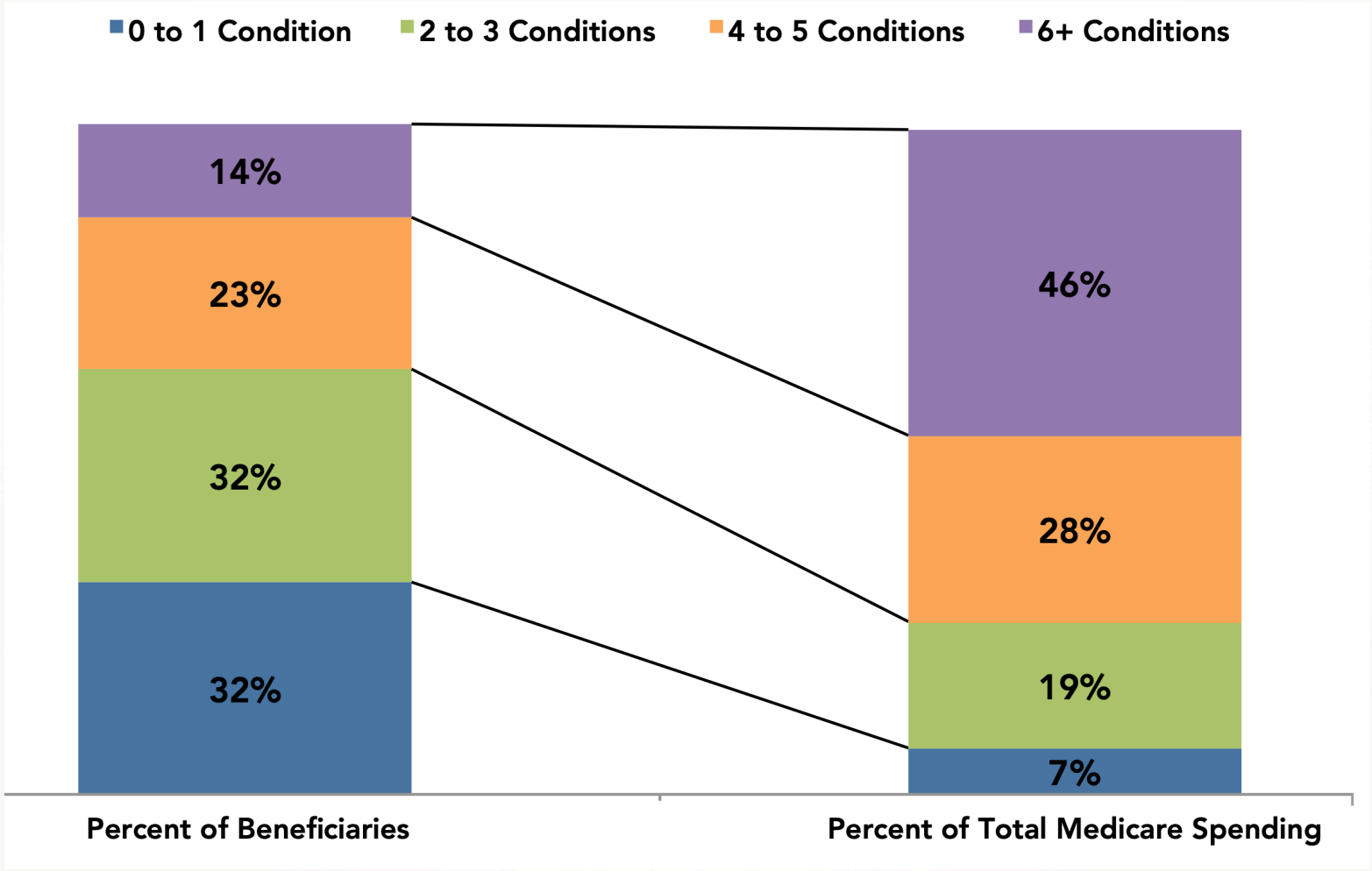
Note: These risk weights are an example. They have been modified for 2022

Chronic Care Management

What is Chronic Care Management (CCM)?

- CCM is the care coordination that is outside of the regular office visit for patients with multiple (two or more) chronic conditions that:
  - Are expected to last at least 12 months or until the death of the patient,
  - Place the patient at significant risk of death, acute exacerbation or decompensation, or functional decline
  - Can be delivered to people with many different types of health conditions.

“Beneficiaries with multiple chronic conditions accounted for a disproportionate share of Medicare spending”



http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Chronic-Conditions/Downloads/2012Chartbook.pdf

Best Practices in Care Management

Chronic Care Model

Edward Wagner, MD, MPH

Incorporates self-management support, delivery system redesign, clinical information systems/decision support, and community resources to provide higher quality care

+

Chronic Disease Self-Management Model

Kate Lorig, RN, DrPh

Focuses on increasing one's self-efficacy and confidence in their ability to manage their conditions independently, maintain function, and reduce health decline

Demonstrated success in reducing hospital utilization, decreasing hospital costs, improving health behaviors, and increasing patient satisfaction.

- Bodenheimer, T., Wagner, E., & Grumbach, K. (2002). Improving Primary Care for Patients With Chronic Illness. JAMA , 288 (15), 1909-1914.
- Lorig, K., Sobel, D., Ritter, P., Laurent, D., & Hobbs, M. (2001). Effect of a Self-Management Program on Patients with Chronic Disease. Effective Clinical Practice , 4, 256-262

Chronic Care Management Requirements

- Two or more chronic conditions expected to last at least 12 months
- Patient consent (verbal or signed)
- Personalized care plan with a copy provided to patient
- 24/7 patient access to a member of the care team for urgent needs
- Enhanced non-face-to-face communication between patient and care team
- Management of care transitions
- At least 20 minutes of clinical staff time per calendar month spent on non-face-to-face CCM services directed by physician or qualified health care professional

https://www.aafp.org/family-physician/practice-and-career/getting-paid/coding/chronic-care-management.html

Chronic Care Management Elements

- Covered services include, but are not limited to:
  - Management of chronic conditions
  - Management of referrals to other providers
  - Management of prescriptions
  - Ongoing review of patient status

https://www.aafp.org/family-physician/practice-and-career/getting-paid/coding/chronic-care-management.html

Why Chronic Care Management… from the Care Manager's Perspective

- "You get to **establish a relationship** with the patient that cannot be achieved with just in-office visits."
- "We can follow-up up with the patient to find out **what they are struggling with** and help them to overcome their barriers."
- "We get to **encourage the patient** and remind them that they are doing a great job."
- "Patients feel a **sense of security** in knowing that they can contact someone in this office anytime of the day."
- "It **decreases ED visits**."
- "It **promotes wellness** in our patients."
- "It puts **patients at the center** of their care."

Transitional Care

What is Transitional Care Management (TCM)?

TCM services address the hand-off period between the inpatient and community setting.

- **Examples of Inpatient:**
  - Inpatient acute care hospital
  - Long-term acute care hospital
  - Skilled nursing facility/nursing facility
  - Inpatient rehabilitation facility
  - Hospital observation status or partial hospitalization
- **Examples of Community Settings:**
  - Home
  - Domiciliary
  - Nursing home
  - Assisted living facility

https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/transitional-care-management-services-fact-sheet-icn908628.pdf

Components of a TCM Visit

- Contact the beneficiary or caregiver within two business days following a discharge
- Conduct a follow-up visit within 7 or 14 days of discharge
- Perform medication reconciliation
- Obtain and review discharge information
- Review diagnostic tests and treatments and follow up on any that are pending
- Educate the patient, family member, caregiver or guardian
- Manage any referrals with community providers and services
- Schedule follow-up visits with providers and services

https://www.aafp.org/family-physician/practice-and-career/getting-paid/coding/transitional-care-management.html

TCMs Significantly Reduce Readmissions Compared to E&Ms Post-Discharge

TABLE 1. Comparison of 30-Day Readmission Rates of TCM Medicare Beneficiaries vs Those Without TCM and Those With No Follow-up Visit[a]

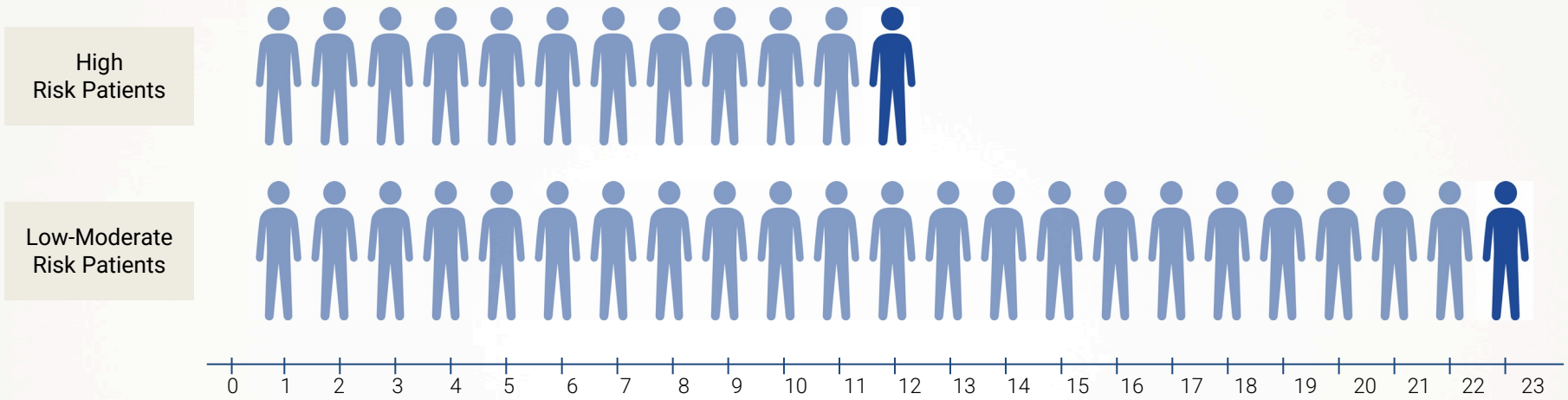
Group	No. of live discharges	No. of readmissions within 30 days	% of readmissions within 30 days	*P*
TCM	1099	128	11.65%	–
Non-TCM PCP	1099	167	15.20%	.0073
No visit	1098	241	21.95%	<.0001

PCP, primary care provider; TCM, transitional care management.

[a]Index discharge period: January 1, 2016, to December 31, 2017.

https://www.ajmc.com/view/transitional-care-management-visits-to-improve-coordination-of-care

TCMs have the Greatest Impact on High-Risk Patients



- For **high-risk patients** being discharged from a hospital, Aledade observed that **1 in every 12 TCMs prevents a readmission.**
- However, for **low to moderate-risk patients** being discharged from the hospital, Aledade observed that **it takes 23 TCMs to prevent 1 readmission.**

Source: October 2018 Aledade analysis of Medicare Claims data

The TCM Timeline

Day 1
Patient Discharge

Day 7
High complexity Face-to-Face Visit Deadline

Day 30
TCM Service Period Complete

(Business) **Day 2**
Interactive Contact Deadline

Day 14
Moderate complexity Face-to-Face Visit Deadline

ED Follow-up

Unnecessary ED Utilization Leads to Lower Value and Costly Care that Can be Prevented

- Studies have shown that overuse of the ED is responsible for approximately $38 billion in healthcare spending in 2007.
- “A lack of access to timely primary care services is a major driver for ED overutilization.”
- Approximately a quarter of all ED visits are non-emergent. An “estimated 13.7-27.1% of all ED visits could be managed at retail clinics or Urgent Care Centers.”

Network for Excellence in Health Innovation. “A Matter of Urgency: Reducing Emergency Department Overuse,” March 30, 2010. https://www.nehi-us.org/writable/publication_files/file/nehi_ed_overuse_issue_brief_032610finaledits.pdf

Weinick, Robin M., Rachel M. Burns, and Ateev Mehrotra. “Many Emergency Department Visits Could Be Managed at Urgent Care Centers and Retail Clinics.”Health Affairs (Project Hope) 29, no. 9 (September 2010): 1630–36. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3412873/pdf/nihms359490.pdf

ED Follow-up Calls Reduce ED Recurrence

Reduce ED Recurrence!
One visit to the ED costs approximately $3000

Study Results from one Primary Care ACO

Patients who were contacted through a follow-up call had a statistically significant decrease in ED recurrence within 30 and 90 days of the patients' first ED visit when compared to patients who did not receive a post-ED follow-up call.

1 in 12 successful ED follow-up calls prevents an ED visit within **30 days**

1 in 13 successful ED follow-up calls prevents an ED visit within **90 days**

~$85 in savings to practice per completed call & completed calls take **only ~10 min**

What are the Top Reasons Medicare Patients Visit the ED Without Admission?

Top 5 Reasons one ACO's Patients visit the ED (without admission)

1. Urinary Tract Infection
2. Other, Chest Pain
3. Essential Primary Hypertension
4. Low Back Pain
5. Dizziness and giddiness

   [lightheadedness]

Many of these conditions can be treated by PCP.

Benefits of ED follow-up calls include:

- Provide a space where patients can express their concerns
- Empower the practice to personalize interventions that will reduce repeat ED utilization
- Increase chances that patients will call their PCP prior to attending the ED

**Based on claims data for ACO attributed Medicare patients, who went to the ED and were not admitted between 11/16/17 to 11/15/18*

What to do on an ED Follow-up Call

- **Preparing for the call:**
  - How many ED and Inpatient (IP) visits within the last 6 months?
  - Is there an upcoming appointment that has already been scheduled?
  - Was the patient admitted to the Emergency Department during office hours?
  - Was the patient seen, or scheduled to be seen, shortly before the ED visit?
- **Ask:**
  - When did the issue begin?
  - Were you able to reach us before going to the ED?
  - Are you feeling any better?
  - What kind of follow-up was recommended?
  - Would you like to speak with someone now?
  - Do you know that we offer same-day appointments?

Things You May Learn

- Patient was not aware that the same day appointments were an option
- Patient felt that the phone tree options confusing or recommending that they call 911
- Patient did not have transportation so called 911
- Patient went to an urgent care center first and was sent to the ED

ED Follow-Up Calls Identify Opportunities to Improve Access to the Practice

- **Honest patient feedback helps practices understand the patient experience:**
  - "I have been going to the office for years and **had no idea I could call after hours** for help"
  - "I left a message that I was not feeling well and needed an appt. **No one called me back**"
  - "I tried to make an appointment, but **the soonest appointment was weeks away**"
  - "I can't ever talk to anyone at the clinic, I just get **sent from the front desk to voicemail**. It is hard to talk to anyone during the day, unsure they will actually answer a call at night"

- **Small access process improvements can make a big difference:**
  - Optimize phone tree
  - Standardize voicemail greetings
  - Define standard timing and owners for returning voicemails
  - Develop protocol for scheduling appointments
  - Educate patients about after hours call line & same day appointments

Patient Benefits

- **Post-ED follow-up calls focus on helping patients get the right care in the right setting by:**
  - Identifying **barriers** to care
  - Addressing clinic **access** barriers
  - Scheduling needed **follow-up** appointments
  - Determining necessity of new specialist **referrals**
  - Identifying high risk patients who need additional **care management** support
- **Providing patient education:**
  - Highlighting **same-day appointment** and after-hours access to the clinic
  - Enabling patients to better **navigate** the healthcare system
  - Providing personalized post-ED **care coordination** and/or clinical guidance
  - Decreasing additional **cost**
- **Improving patient satisfaction:**
  - Driving **practice improvement** through patient feedback regarding ease of access
  - **Engaging patients** as an integral part of the care team
  - Building foundation for **trusting relationships** with primary care practice

In Review

- Tools:
  - Annual wellness visits
  - Documenting risk
  - Chronic Care Management
  - Transitional Care Management
  - ED follow-up

ACO Success is for Everyone

- Everyone needs to know the value of the:
  - Focus on Prevention
  - Focus on Quality
  - Focus on Cost and Utilization
  - Capture of Risk through accurate coding
- And they also need to know the “how”
  - This creates a whole new way of doing things and that it’s a team effort
- Next time we will talk about processes for success

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Questions?

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