NATIONAL
RURAL HEALTH
RESOURCE CENTER

Flex Coordinator
Learning Collaborative 201
Week 3

Accountable Care Organizations
and other Pay for Value Based Programs/Models

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August 14, 2019

The Center's Purpose

The National Rural Health Resource Center (The Center) is a nonprofit organization dedicated to sustaining and improving health care in rural communities. As the nation's leading technical assistance and knowledge center in rural health, The Center focuses on five core areas:

- Transition to Value and Population Health
- Collaboration and Partnership
- Performance Improvement
- Health Information Technology
- Workforce

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Context

- What to expect over the course of the webinar series
  - Understanding components of healthcare transformation
  - How transformation affects CAHs and RHCs
  - Tools and resources for providers to engage in transformation

Today's Agenda

- Applied foundations of pay for value programs
- New CMS Models
- Rural Participation in an Accountable Care Organization (ACO)
- Impact on rural health

Webinar Series

1. ***CMS is leading healthcare Transformation***
   - Understanding Payment and Delivery Reform

2. ***The Paradigm Shift***
   - Transformation from Volume to Value

3. ***Accountable Care Organizations and other pay for value programs***
   - Opportunities, Barriers for Rural providers

4. ***Clinically Integrated Networks***
   - Opportunities, Barriers for Rural Providers

5. ***How to win with the Tyranny of Small Number***
   - Collaborations, Coalitions and Networks

6. ***The Big Picture—Results Matter***

   Demonstrate worth, value and quality

Value Based Payment Models

Alternative Payment Models

An ***Alternative Payment Model*** (APM) is a payment approach that gives *added incentive payments* to provide ***high-quality*** and ***cost-efficient*** care. APMs can apply to a specific clinical condition, a care episode, or a population.

Components of an Alternative Payment Model

1. **Payments for Services**. The APM needs to pay healthcare providers in a way that reduces or eliminates any barriers in the current payment system that impede delivering high-value services to the eligible patients;
2. **Accountability for Spending**. The APM needs a mechanism for assuring patients and payers that avoidable spending will decrease (if the goal of the APM is to achieve savings), or that spending will not increase (if the goal of the APM is to improve quality);
3. **Accountability for Quality**. The APM also needs a mechanism for assuring that patients will receive equal or better quality of care and outcomes as they would with the kind of care they receive under the current payment system; and
4. **Patient Eligibility**. The APM needs a mechanism for determining which patients will be eligible for the services supported by the APM

Types of Medicare Alternative Payment Models

- APMs-
- MIPS-APMs

  - Meet the statutory definition of an APM. MIPS eligible clinicians participating in an APM are also subject to MIPS.
  - MIPS APMs have MIPS eligible clinicians participating in the APM on their CMS-approved participation list.

- Advanced APMs

  - An Advanced APM is a track of the Quality Payment Program that offers a 5 percent incentive for achieving threshold levels of payments or patients through Advanced APMs. If you achieve these thresholds, you are excluded from the MIPS reporting requirements and payment adjustment.

- Advanced & MIPS APMS

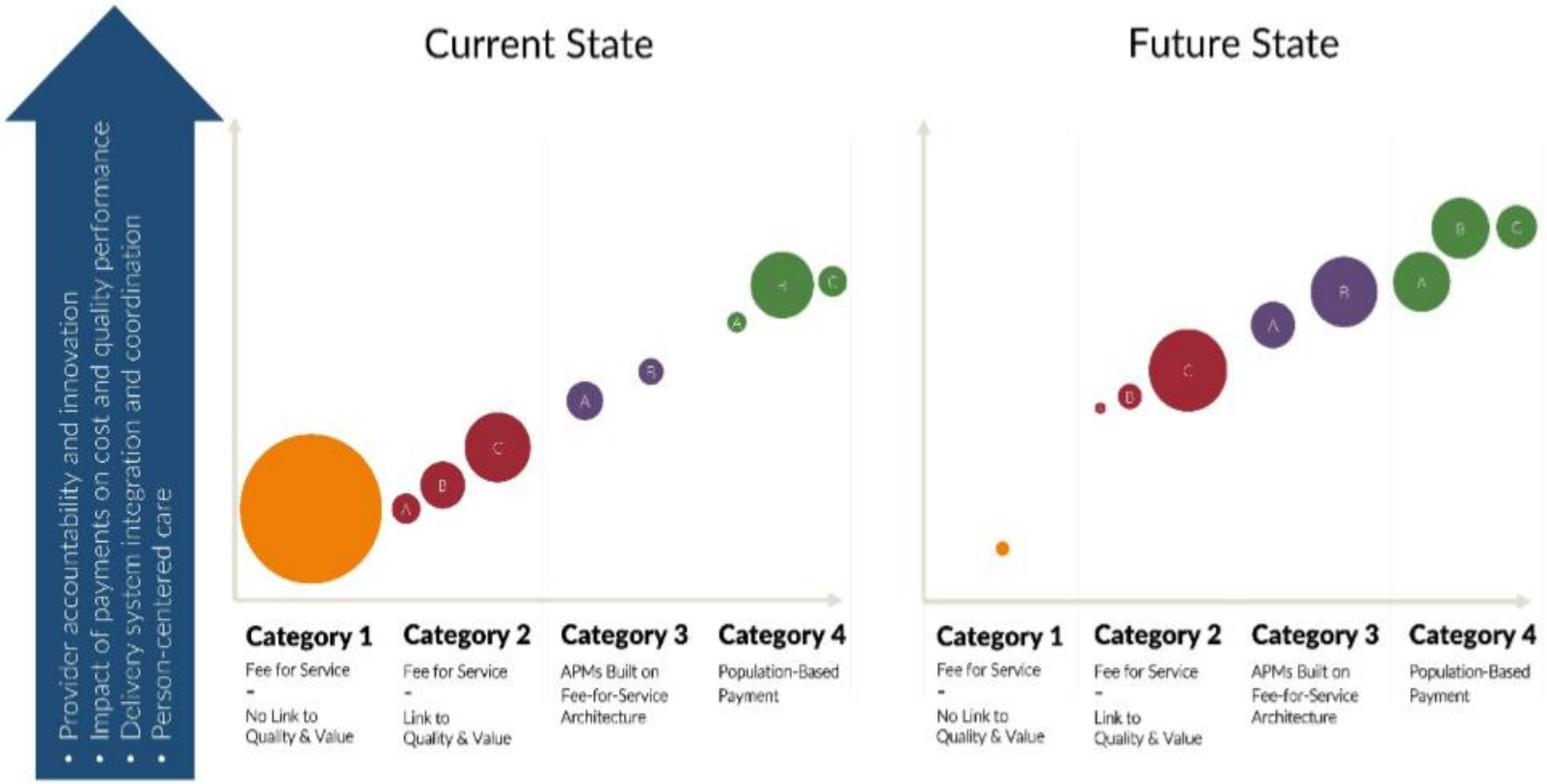
  - Most Advanced APMs are also MIPS APMs. MIPS Eligible clinicians participating in Advanced APMs are included in MIPS if they do not meet the threshold for payments or patients sufficient to become a Qualifying APM Participant (QP). The MIPS eligible clinician will be scored under MIPS according to the APM scoring standard.

- All-Payer/Other Payer options

  - Eligible clinicians will be able to become Qualifying Alternative Payment Model Participant (QPs) through the All-Payer Option. Eligible clinicians must participate in a combination of Advanced APMs with Medicare and Other-Payer Advanced APMs. Other-Payer Advanced APMs are non-Medicare payment arrangements that meet criteria that are similar to Advanced APMs under Medicare.

Payment Reform Goals

Figure 3: Payment Reform Goals



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Quality Payment Program Objectives

- To ***improve*** beneficiary ***population health***
- To ***improve*** the ***care*** received by Medicare beneficiaries
- To ***lower costs*** to the Medicare program through improvement of care and health
- To advance the use of healthcare information between allied providers and patients
- To educate, engage and empower ***patients as members*** of their ***care team***
- To maximize QPP participation with a flexible and transparent design, and easy to use program tools
- To maximize QPP participation through education, outreach and support tailored to the needs of practices, especially those that are small, rural and in underserved areas
- To ***expand Alternative Payment Model participation***
- To provide accurate, timely, and actionable performance data to clinicians, patients and other stakeholders
- To ***continuously improve QPP***, based on participant feedback and collaboration

Participation in Payment Reform Categories

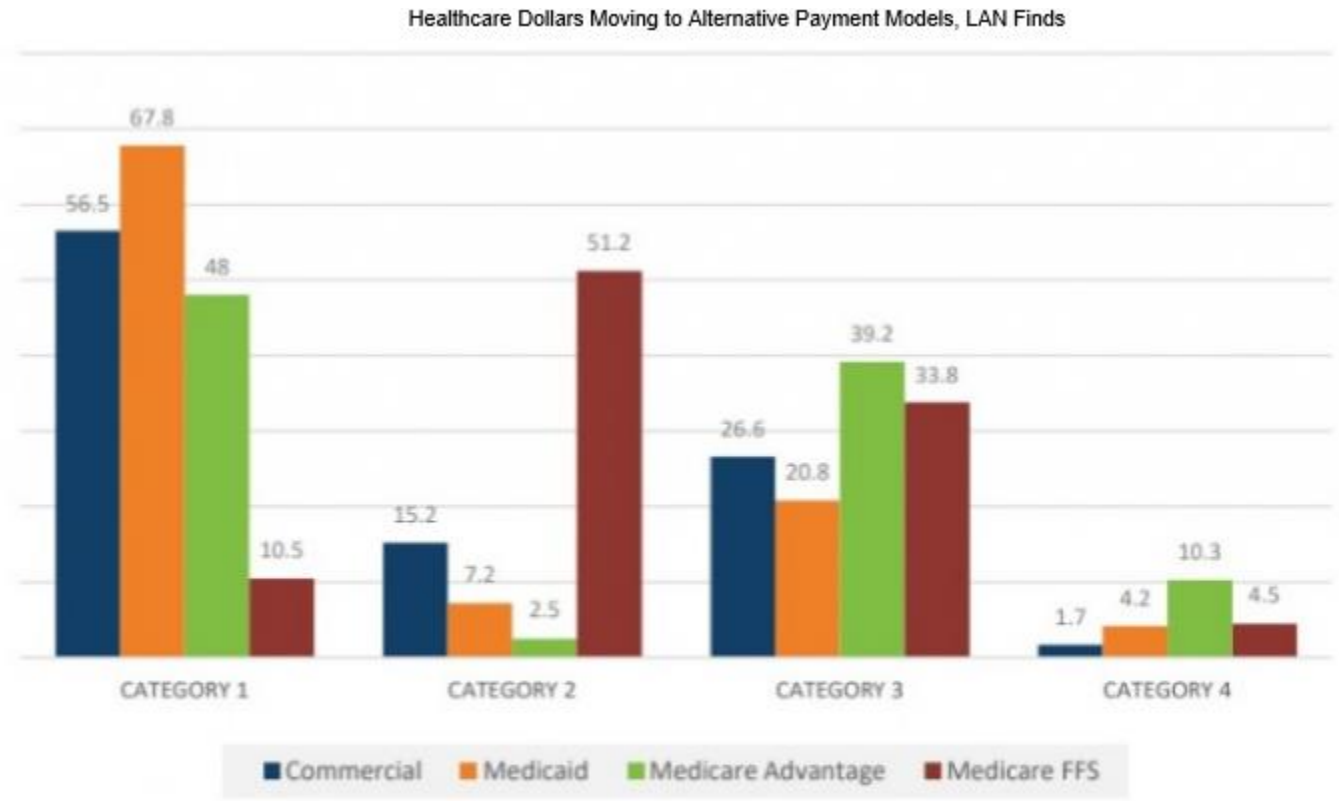


Figure 4 shows each APM category by line of business. Note: total covered lives [12] and total healthcare spending in each line of business varies.

(https://revcycleintelligence.com/images/site/articles/_large/LAN_Chart_1%2C_Healthcare_Payments_by_Category.jpg)

Source: Health Care Payment Learning & Action Network (LAN)

Comparison Data

Figure 2: LAN APM Measurement Effort Results: Comparison between 2015, 2016, and 2017 Payments

Figure 2 compares data from CY 2015, CY 2016, and CY 2017. In 2015, data was collected from 70 plans and 2 managed FFS Medicaid states, which represented 198.9 million lives or 67% of the U.S. covered population. In 2016, the data was collected from 78 plans, 3 managed FFS Medicaid states, and Medicare FFS. This represented 245.4 million lives or 84% of the U.S covered population. In 2017, the data was collected from 61 plans, 3 states, and Medicare FFS, representing 226.3 million lives or 77% of the U.S. covered population.[4]

(https://revcycleintelligence.com/images/site/articles/_large/LAN_Chart_1%2C_Healthcare_Payments_by_Category.jpg)

Source: Health Care Payment Learning & Action Network (LAN)

CMS Alternative Payment Models

Bundled Payments for Care Improvement (BPCI) initiative is a model of care, which links payments for the multiple services beneficiaries receive during a clinical episode of care.

Comprehensive Care for Joint Replacement (CJR) model aims to support better and more efficient care for beneficiaries undergoing the most common inpatient surgeries for Medicare beneficiaries: hip and knee replacements (also called lower extremity joint replacements or LEJR).

Comprehensive ESRD Care (CEC) Model is designed to identify, test, and evaluate new ways to improve care for Medicare beneficiaries with End-Stage Renal Disease (ESRD).

Comprehensive Primary Care Plus (CPC+) is a national advanced primary care medical home model that aims to strengthen primary care through regionally-based multi-payer payment reform and care delivery transformation.

Shared Savings Program (MSSP) is a voluntary program that encourages groups of doctors, hospitals, and other health care providers to come together as an ACO to provide coordinated, high-quality care to their Medicare patients. ACOs may participate in the Shared Savings Program under Tracks 1, 2, or 3, now Basic and Enhanced. Each track varies by their financial risk and portion of savings.

Under the Oncology Care Model (OCM), physician practices have entered into payment arrangements that include financial and performance accountability for episodes of care surrounding chemotherapy administration to cancer patients

CMS Alternative Payment Models continued

Vermont All-Payer Accountable Care Organization (ACO) Model is the Centers for Medicare & Medicaid Services' (CMS) new test of an alternative payment model in which the most significant payers throughout the entire state incentivize health care value and quality under the same payment structure for the majority of providers throughout the state's care delivery system

Maryland All Payor Model and Maryland total Cost of Care- The Centers for Medicare & Medicaid Services (CMS) and the state of Maryland are partnering to test the Maryland Total Cost of Care (TCOC) Model, which sets a per capita limit on Medicare total cost of care.

New Primary Care Models

- CMS anticipates enrolling 25% of Medicare fee-for-service beneficiaries into one of its **two new risk models** that make up its new Primary Cares Initiative:
  - **Primary Care First** is primarily targeted at smaller practices with less experience in value-based payment models. It offers coordination of care payments and other financial support, with performance-based payments and some financial risk. A version of this model will be targeted at the seriously ill population and will provide extra support for patients who need hospice or palliative care services and effective care coordination.
  - **Direct Contracting** is for practices with at least 5,000 Medicare beneficiaries and offers a 50% savings/losses risk-sharing option, a 100% savings/losses risk-sharing option and a total care capitation model, which would provide capitated, risk-adjusted monthly payments for all participants and preferred providers.

PATHWAYS TO SUCCESS: A NEW START FOR MEDICARE ACCOUNTABLE CARE ORGANIZATIONS

With 450+ Medicare ACOs clinging to upside only contracts, CMS has proposed giving the program a major nudge toward shared risk.

WHY?

Six years into the program, CMS believes ACOs aren't moving quickly enough toward risk-based arrangements, citing "weak incentives" for healthcare providers to slow "spiraling costs."

What's new in the overhaul of the ACO program?

Tracks are "Basic" with levels A to E, and "Enhanced," with one level. ACOs would be categorized by status (new, renewing or re-entering), their FFS revenue ratio, and experience level. *Categorization is intended to prevent ACOs from avoiding the new risk policies.*

Limited time in upside risk only from 6 years to only 2.

Shared savings reduced from 50% to 25%.

ACOs must move levels every year until they reach Basic Level E or the Enhanced Track.

The Enhanced Track is the highest risk level. ACOs in this track and Basic Level E qualify as Advanced APMs.

Pennsylvania Rural Health Model

The seeks to test whether care delivery transformation in conjunction with hospital global budgets will

1. increase rural Pennsylvanians' access to high-quality care and improve their health, while also
2. reducing the growth of hospital expenditures across payers, including Medicare, and
3. improving the financial viability of rural Pennsylvania hospitals to
4. improve health outcomes of and maintain continued access to care for Pennsylvania's rural residents.

The Model tests whether the predictable nature of global budgets will enable participating rural hospitals to invest in quality and preventive care, and to tailor their services to better meet the needs of their local communities.

Pennsylvania Rural Health Model continued

Key Components

- Hospital Global Payments
- Hospital Care Delivery Transformation

Goals

- Increase access to primary and specialty care
- Reduce rural health disparities through prevention and wellness
- Decrease deaths of substance abuse

Participants

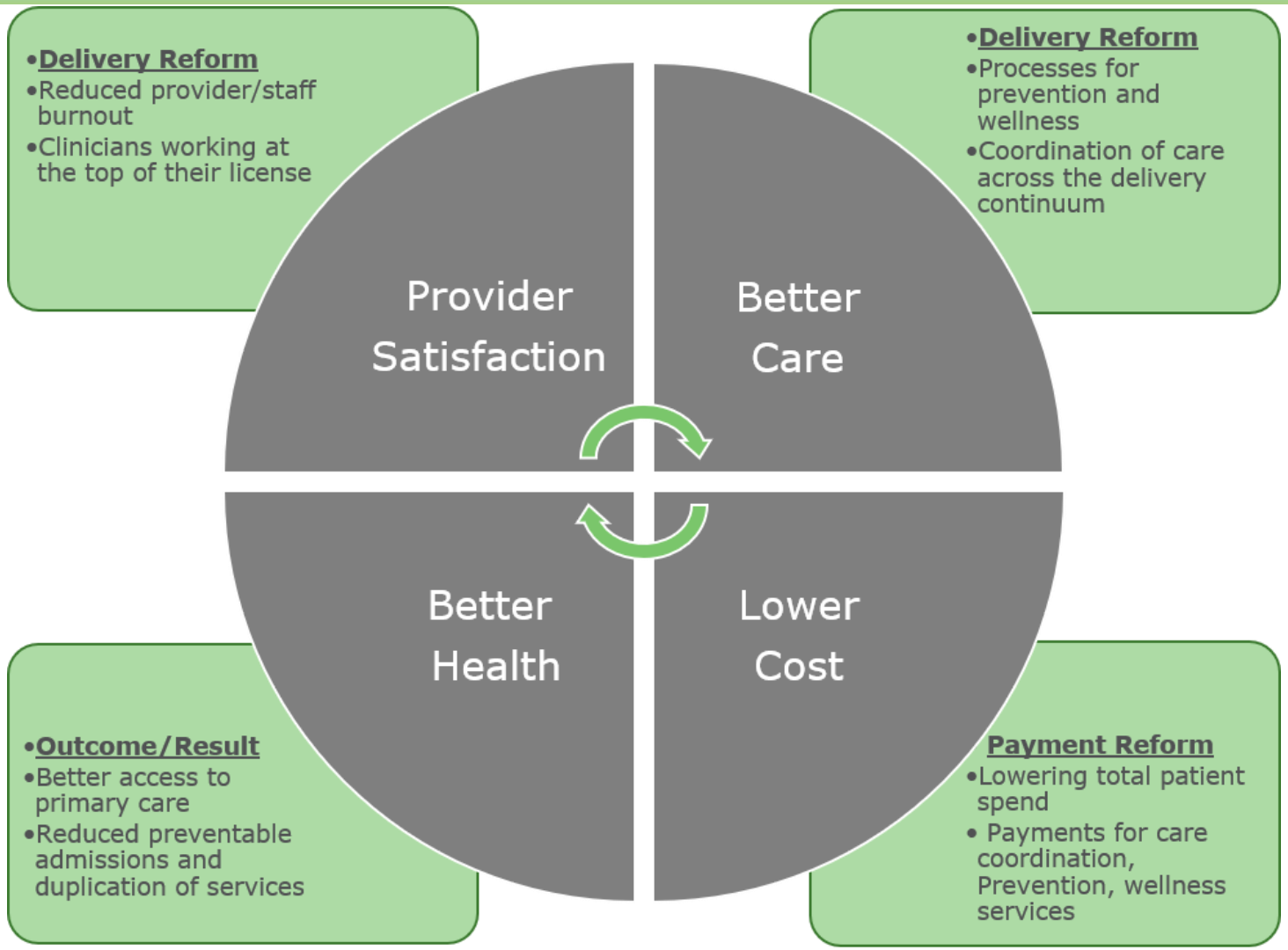
- 5 Hospitals
- Five Payors
- The state of Pennsylvania

ACO Basics

MSSP ACO Participation Requirements

- Legal Structure/ legal entity
- Baseline of number of attributed of lives
- Participating Providers measured on cost and quality of defined population
- Establish average total patient spend (benchmark),Risk adjusted and based on attributed lives
- Manage Shared Savings, Plan to receive, use and distribute shared savings
- Plan for Quality assurance and improvement
- Plan for promoting Evidence Based Medicine
- Plan for Promoting Beneficiary engagement
- Plan for internal reporting on cost and quality

Quadruple AIM



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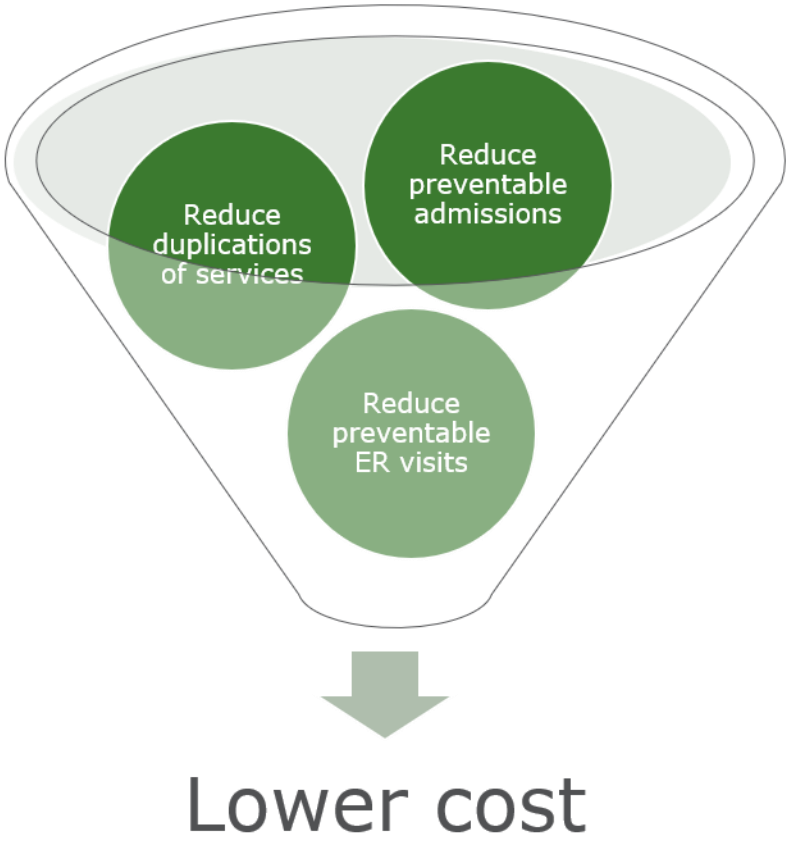
How can practices help lower cost or *reduce total patient spend*?



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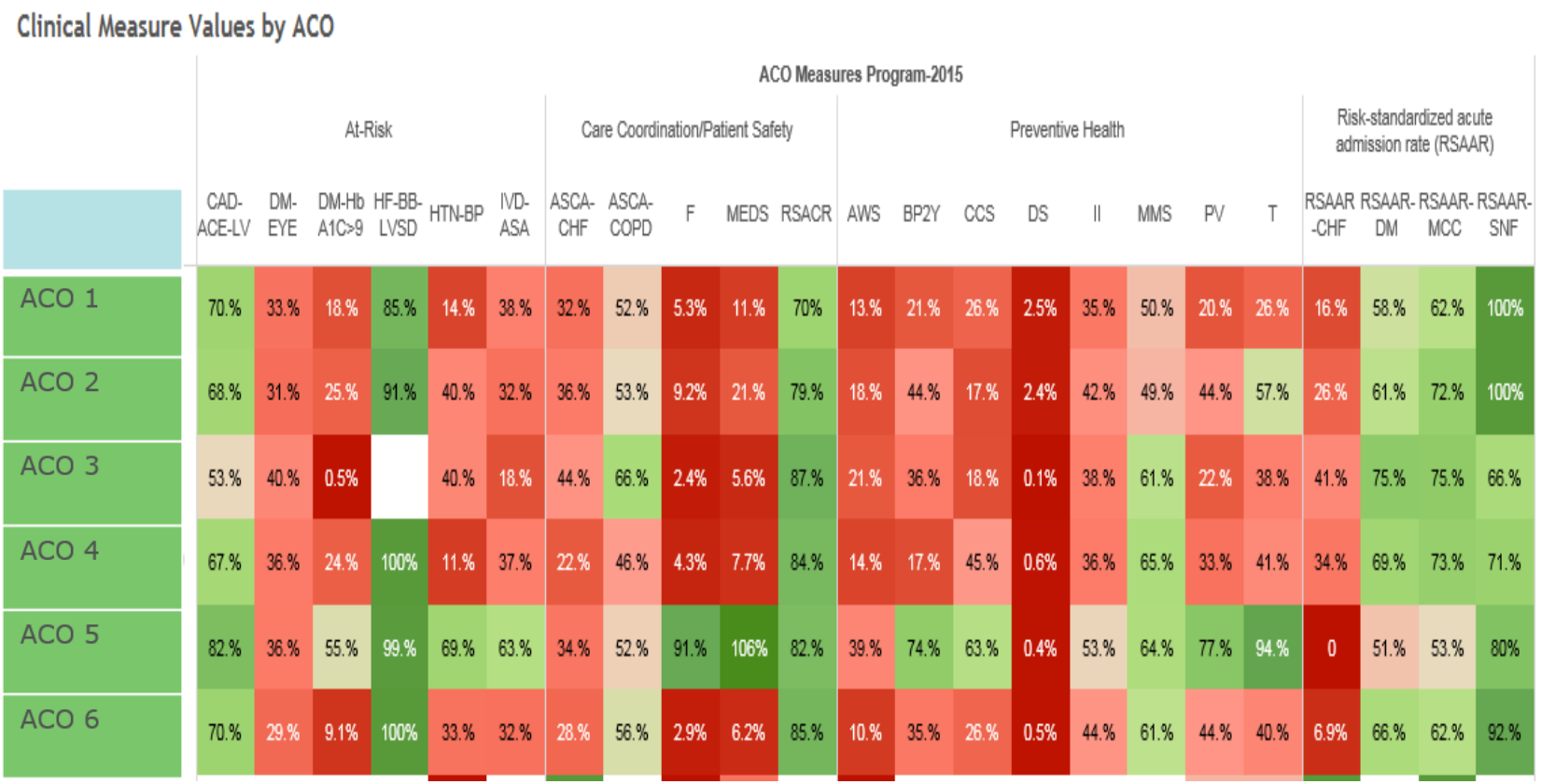
How do practices provide better care or more *"efficient care delivery"?*

- ✓ Provide prevention and wellness services
- ✓ Utilize new codes/services for care management
- ✓ Utilize data to inform you of population and patient needs
- ✓ Document thoroughly

How can practices create better health or *"better health outcomes"?*

- ✓Fill care gaps and create more access for chronically ill
- ✓Manage the patient and disease through consistent evidence-based processes
- ✓Encourage patients to participate in prevention and wellness services

Quality Varies but Problem Areas are the Same



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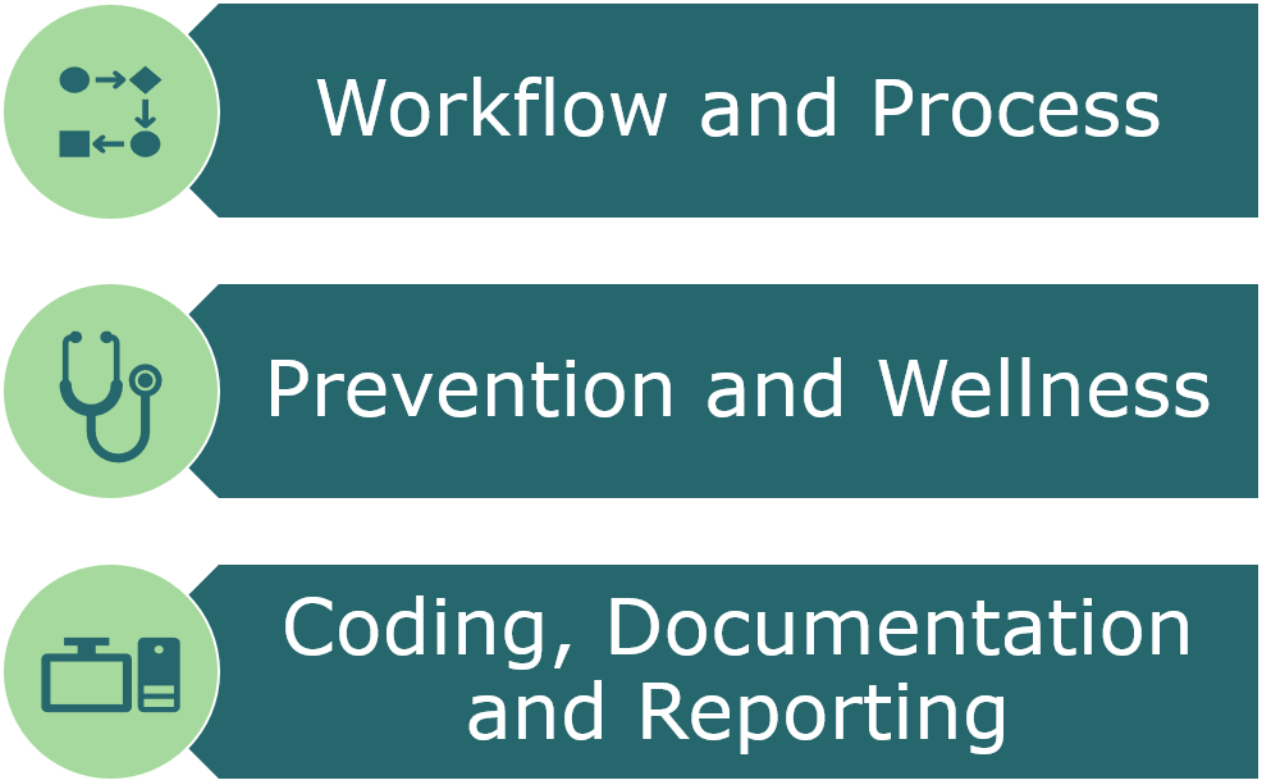
Population Health Program Strategies



Workflow and Process

Change practice workflow to support the quadruple aim

- ✓ Modify workflow to address care gaps
- ✓ Use data to inform the process and continuously improve
- ✓ Implement necessary IT infrastructure
- ✓ Identify patients who are at risk
- ✓ Pre-visit planning
- ✓ Build a primary care relationship with patients

Workflow and Process continued

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Workflow Changes

Prevention and Wellness

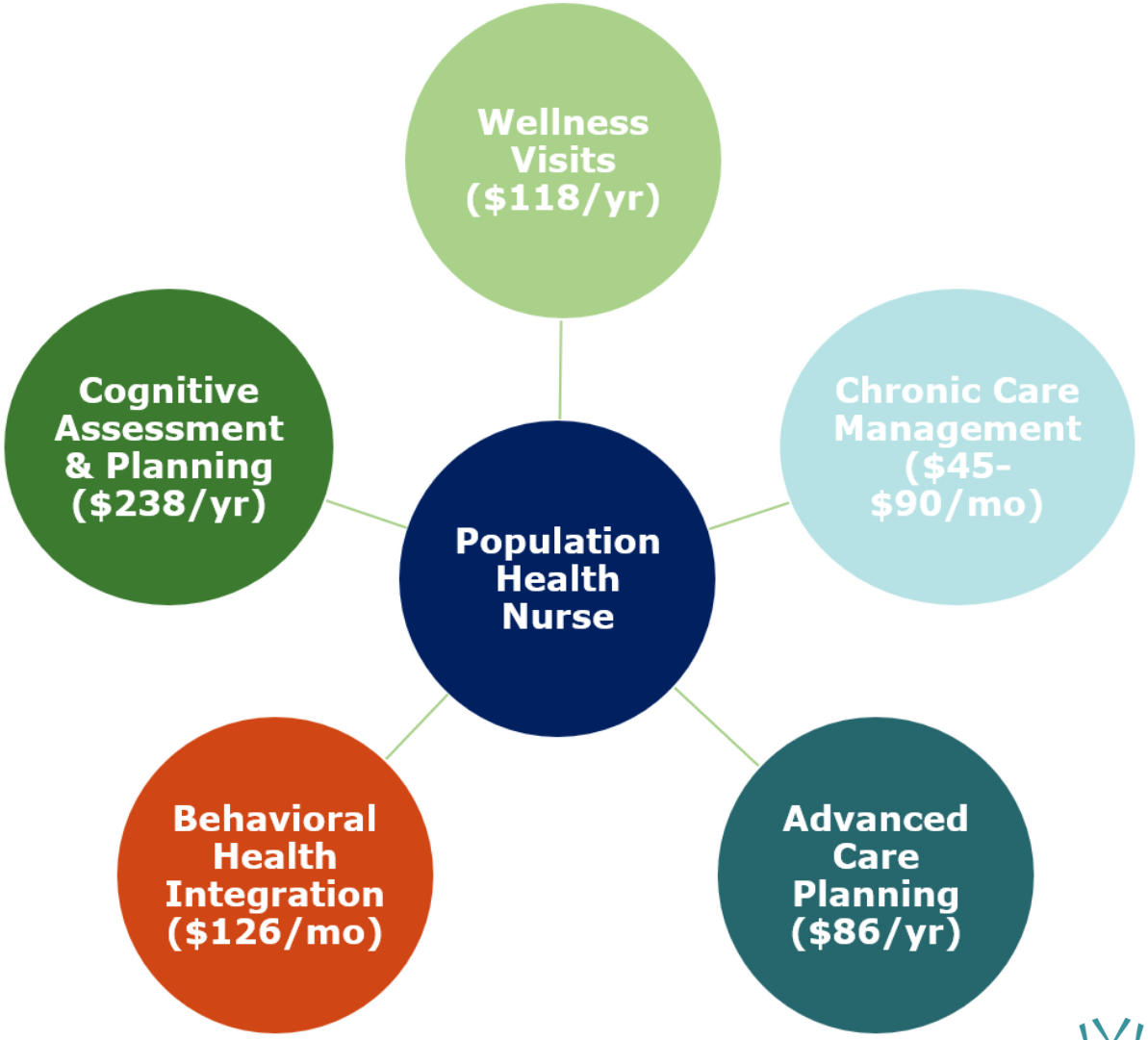
Provide prevention and wellness services

- Annual Wellness Visits
  - ✓ Gather as much information as you can
  - ✓ Include other billable services such as advance care planning,
  - ✓ Refer appropriate follow up services, including care coordination
- Care Coordination
  - ✓ Set up the billable care coordination service
  - ✓ Train, mentor, and deploy Care Coordination Nurses
- Use Nurses to extend the services and care

Population Health Revenue Opportunities

- Initial Preventative Physical Exam
- Annual Wellness Visit, Initial
- Annual Wellness Visit, Subsequent
- Advanced Care Planning
- Chronic Care Management
- Transitions of Care Management
- Integrated Behavioral Health
- Remote Patient Monitoring
- Diabetes Self Management Education
- Telehealth Originating Site Facility
- Preventive Health Screening
  - Depression Screening
  - Alcohol and Drug Screening
  - Alcohol/Substance abuse Assessment and Intervention
  - BMI above Normal
  - Behavioral Therapy for Obesity
  - Tobacco Use Counseling
  - Diabetes Self Management Training

New Population Health Revenue



Coding, Documentation and Reporting

- Code claims properly
  - Any condition is not carried forward from year to year by a payor so each must be documented at least once annually
  - Code with Hierarchal Condition Category Code to demonstrate the severity of the disease state
- Document in the right place
  - Documentation in custom forms in EMRs don't always translate to custom reports
- Be prepared to report quality information
  - Quality payments are tied to identified actions connected to quality measures. If the actions don't show up in the reports you may have to report manually until you can coordinate your documentation with your reporting

25% Wellness Visits = 20%Improvement

		2014			2015			
Domain	**Metric Name**	**Eligible**	**Measure Met**	**Performance**	**Eligible**	**Measure Met**	**Performance**	**Change**
At-Risk Population Coronary Artery Disease	CAD-2 Lipid Control**	11	9	81.82%				
At-Risk Population Coronary Artery Disease	CAD-7 ACE or ARB with Diabetes or LVSD	7	5	71.43%	7	3	42.86%	-28.57%
At-Risk Population Coronary Artery Disease	CAD-Composite	11	7	63.64%				
Care Coordination/Patient Safety	CARE-1 Medication Reconciliation**1	2	2	100.00%	7	5	71.43%	-28.57%
Care Coordination/Patient Safety	CARE-2 Fall Screening	5	1	20.00%	11	10	90.91%	70.91%
At-Risk Population Depression	Depression remission 12 months				4	0	0.00%	
At-Risk Population Diabetes	DM-7 Eye Exam				3	1	33.33%	
At-Risk Population Diabetes	DM-13 High Blood Pressure Control**2	4	2	50.00%				
At-Risk Population Diabetes	DM-14 LDL-C Control in Diabetes	4	2	50.00%				
At-Risk Population Diabetes	DM-15 Hemoglobin A1c Control	4	0	0.00%				
At-Risk Population Diabetes	DM-16 Daily Aspirin or Antiplatelet with IVD	1	1	100.00%	10	7	70.00%	-30.00%
At-Risk Population Diabetes	DM-17 Tobacco Non-Use**2	4	3	75.00%	12	10	83.33%	8.33%
At-Risk Population Diabetes	DM-2 HA1c Poor Control**3 (lower score)	4	1	25.00%	4	2	50.00%	25.00%
At-Risk Population Diabetes	DM-Composite	4	0	0.00%				
At-Risk Population Heart Failure	HF-6 Beta-Blocker Therapy for LVSD	5	4	80.00%	7	7	100.00%	20.00%
At-Risk Population Hypertension	HTN-2 Controlling High Blood Pressure	15	9	60.00%	9	9	100.00%	40.00%
At-Risk Population Ischemic Vascular Disease	IVD-1 LDL-C Control**	9	4	44.44%				
At-Risk Population Ischemic Vascular Disease	IVD-2 Use of Antithrombotic	9	9	100.00%				
Preventative Health	PREV-05 Breast Screening	32	20	62.50%	40	40	100.00%	37.50%
Preventative Health	PREV-06 Colorectal Cancer Screening	36	18	50.00%	23	19	82.61%	32.61%
Preventative Health	PREV-07 Influenza Immunization	16	3	18.75%	11	7	63.64%	44.89%
Preventative Health	PREV-08 Pneumonia Vaccination	25	9	36.00%	17	10	58.82%	22.82%
Preventative Health	PREV-09 Body Mass Index Screening	21	17	80.95%	23	17	73.91%	-7.04%
Preventative Health	PREV-10 Tobacco Use Screening	20	20	100.00%				
Preventative Health	PREV-11 High Blood Pressure Screening	36	26	72.22%	39	29	74.36%	2.14%
Preventative Health	PREV-12 Clinical Depression Screening	19	3	15.79%	16	12	75.00%	59.21%
Grand Total		**304**	**175**	**57.57%**	**243**	**188**	**77.37%**	**19.80%**

Pre-AWV **Post-AWV**

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Participation Barriers

Table 1: Challenges to Small and Rural Physician Practices' Participation in Value-based Payment Models, by Key Area

Key topic area	Challenge
Financial resources and risk management	Limited ability to take on financial risk because of having fewer financial resources/reserves compared with larger providers
	High costs of initial and ongoing investments needed for participation
	Difficulties with recovering investments in a timely manner
Health IT and data	Difficulties with data system interoperability and limited ability to access data outside the practices' own systems
	Difficulties with educating and training staff about EHR systems and the data entry, management, and analysis needed for participation
Population health management care delivery	Patient preferences and geographic location affect practices' ability to implement population health management care delivery and account for total cost of care
	Provider resistance to making adjustments needed for population health management care delivery
Quality and efficiency performance measurement and reporting	Difficulties with receiving timely performance feedback
	Misalignment of quality measures between various value-based payment models and payers
	Performance measurement accuracy for practices with a small number of Medicare patients
Effects of model participation and managing compliance with requirements	Difficulties with maintaining practice independence
	Limited time of staff and physicians to complete administrative duties required for model participation
	Difficulties with understanding and managing compliance with the terms and conditions of waivers related to various fraud and abuse laws
	Difficulties with staying abreast of regulatory changes and managing compliance with multiple requirements of value-based payment models

Source: GAO analysis of literature and stakeholder interviews. | GAO-17-55

Note: Some of these challenges are unique to small and rural physician practices, while other challenges may be experienced by all physician practices during their participation in value-based payment models. Our review did not distinguish between the two.

Measurement of Cost and Quality resides in the Data

data

MUST

reflect your story

in order to demonstrate

value

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