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
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
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
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.
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

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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.
Figure 3: Payment Reform Goals

**Current State**

- **Category 1**: Fee for Service - No Link to Quality & Value
- **Category 2**: Fee for Service - Link to Quality & Value
- **Category 3**: APMs Built on Fee-for-Service Architecture
- **Category 4**: Population-Based Payment

**Future State**

- **Category 1**: Fee for Service - No Link to Quality & Value
- **Category 2**: Fee for Service - Link to Quality & Value
- **Category 3**: APMs Built on Fee-for-Service Architecture
- **Category 4**: Population-Based Payment
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

Healthcare Dollars Moving to Alternative Payment Models, LAN Finds

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

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

Source: Health Care Payment Learning & Action Network (LAN)
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.
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.
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."
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.
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.
<table>
<thead>
<tr>
<th>Key Components</th>
<th>Goals</th>
<th>Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Global Payments</td>
<td>Increase access to primary and specialty care</td>
<td>5 Hospitals</td>
</tr>
<tr>
<td>Hospital Care Delivery Transformation</td>
<td>Reduce rural health disparities through prevention and wellness</td>
<td>Five Payors</td>
</tr>
<tr>
<td></td>
<td>Decrease deaths of substance abuse</td>
<td>The state of Pennsylvania</td>
</tr>
</tbody>
</table>
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

- **Delivery Reform**
  - Reduced provider/staff burnout
  - Clinicians working at the top of their license

- **Outcome/Result**
  - Better access to primary care
  - Reduced preventable admissions and duplication of services

- **Payment Reform**
  - Lowering total patient spend
  - Payments for care coordination, Prevention, wellness services

**Provider Satisfaction**

**Better Care**

**Better Health**

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

- Reduce duplications of services
- Reduce preventable admissions
- Reduce preventable ER visits

Lower cost
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
### Clinical Measure Values by ACO

| ACO | CAD-ACE-LV | DM-EYE | DM-Hb A1C-9 | HTN-BP | NO-ASA | ASCA-CHF | ASCA-COPD | F | M Edwards | RSACR | AWS | BP2Y | CCS | DS | II | MMS | PV | T | RSAAR | RSAAR | RSAAR | RSAAR | RSAAR |
|-----|-------------|--------|-------------|--------|--------|---------|-----------|---|----------|-------|-----|------|-----|----|----|-----|-----|---|-----|------|------|------|------|------|
| ACO 1 | 70.4 | 33.3 | 18.5 | 14.4 | 32.4 | 52.2 | 5.3 | 11.6 | 70.6 | 13.4 | 21.4 | 26.5 | 2.5 | 35.5 | 50.5 | 20.5 | 26.5 | 16.5 | 56.5 | 62.5 | 100.0 |
| ACO 2 | 68.6 | 31.4 | 25.6 | 40.4 | 36.6 | 53.4 | 9.2 | 21.6 | 79.6 | 18.4 | 44.4 | 17.4 | 2.4 | 42.4 | 49.4 | 44.4 | 57.4 | 28.4 | 81.4 | 72.4 | 100.0 |
| ACO 3 | 53.4 | 40.4 | 0.5 | 40.4 | 44.4 | 66.4 | 2.4 | 5.6 | 97.6 | 21.4 | 36.4 | 18.4 | 0.1 | 36.4 | 61.4 | 22.4 | 38.4 | 41.4 | 75.4 | 75.4 | 86.4 |
| ACO 4 | 67.6 | 36.6 | 24.6 | 100.0 | 11.6 | 37.6 | 2.2 | 4.6 | 77.6 | 14.6 | 17.6 | 45.6 | 0.6 | 36.6 | 65.6 | 33.6 | 41.6 | 34.6 | 89.6 | 73.6 | 71.6 |
| ACO 5 | 82.6 | 36.6 | 55.6 | 99.0 | 69.0 | 63.0 | 34.0 | 52.0 | 91.0 | 100.0 | 32.0 | 39.0 | 74.0 | 0.4 | 53.0 | 64.0 | 77.0 | 94.0 | 0 | 51.0 | 53.0 | 80.0 |
| ACO 6 | 70.6 | 29.6 | 9.1 | 100.0 | 33.0 | 32.0 | 28.0 | 56.0 | 2.9 | 6.2 | 85.0 | 10.0 | 35.0 | 26.0 | 0.5 | 44.0 | 61.0 | 44.0 | 40.0 | 6.5 | 66.5 | 62.5 | 92.5 |

**Quality Varies but Problem Areas are the Same**

[Image: Clinical Measure Values by ACO table]
Population Health Program Strategies

- Workflow and Process
- Prevention and Wellness
- Coding, Documentation and Reporting
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
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 Changes

- Use data to manage patients
- Pre Visit outreach
- Patients seeing the nurse only
- Rooming a patient that is seeing the nurse only
- Hand off from Nurse to Provider
- Who delivers Care Coordination, Care Plans and Annual Wellness Visits
- New type of work for Nurse
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

Population Health Nurse

Wellness Visits ($118/yr)

Cognitive Assessment & Planning ($238/yr)

Chronic Care Management ($45-$90/mo)

Behavioral Health Integration ($126/mo)

Advanced Care Planning ($86/yr)
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

<table>
<thead>
<tr>
<th>Metric Name</th>
<th>Eligible</th>
<th>Measure Met</th>
<th>Performance</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>At-Risk Population Coronary Artery Disease CAD-2 Lipid Control**</td>
<td>11</td>
<td>9</td>
<td>81.82%</td>
<td></td>
</tr>
<tr>
<td>At-Risk Population Coronary Artery Disease CAD-7 ACE or ARB with Diabetes or LVSD</td>
<td>7</td>
<td>5</td>
<td>71.43%</td>
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<tr>
<td>At-Risk Population Coronary Artery Disease CAD-Composite</td>
<td>11</td>
<td>7</td>
<td>63.64%</td>
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<tr>
<td>Care Coordination/Patient Safety CARE-1 Medication Reconciliation**1</td>
<td>2</td>
<td>2</td>
<td>100.00%</td>
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<tr>
<td>Care Coordination/Patient Safety CARE-2 Fall Screening</td>
<td>5</td>
<td>1</td>
<td>20.00%</td>
<td></td>
</tr>
<tr>
<td>At-Risk Population Depression Depression remission 12 months</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>At-Risk Population Diabetes DM-7 Eye Exam</td>
<td>4</td>
<td>2</td>
<td>50.00%</td>
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<tr>
<td>At-Risk Population Diabetes DM-13 High Blood Pressure Control**2</td>
<td>4</td>
<td>2</td>
<td>50.00%</td>
<td></td>
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<tr>
<td>At-Risk Population Diabetes DM-14 LDL-C Control in Diabetes</td>
<td>4</td>
<td>0</td>
<td>0.00%</td>
<td></td>
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<tr>
<td>At-Risk Population Diabetes DM-15 Hemoglobin A1c Control</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>At-Risk Population Diabetes DM-16 Daily Aspirin or Antiplatelet with IVD</td>
<td>1</td>
<td>1</td>
<td>100.00%</td>
<td></td>
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<tr>
<td>At-Risk Population Diabetes DM-17 Tobacco Non-Use**2</td>
<td>4</td>
<td>3</td>
<td>75.00%</td>
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<tr>
<td>At-Risk Population Diabetes DM-2 HA1c Poor Control**3 (lower score)</td>
<td>4</td>
<td>1</td>
<td>25.00%</td>
<td></td>
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<tr>
<td>At-Risk Population Diabetes DM-Composite</td>
<td>4</td>
<td>0</td>
<td>0.00%</td>
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<tr>
<td>At-Risk Population Heart Failure HF-6 Beta-Blocker Therapy for LVSD</td>
<td>5</td>
<td>4</td>
<td>80.00%</td>
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<tr>
<td>At-Risk Population Hypertension HTN-2 Controlling High Blood Pressure</td>
<td>15</td>
<td>9</td>
<td>60.00%</td>
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<tr>
<td>At-Risk Population Ischemic Vascular Disease IVD-1 LDL-C Control**</td>
<td>9</td>
<td>4</td>
<td>44.44%</td>
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<tr>
<td>At-Risk Population Ischemic Vascular Disease IVD-2 Use of Antithrombotic</td>
<td>9</td>
<td>9</td>
<td>100.00%</td>
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<tr>
<td>Preventative Health PREV-05 Breast Screening</td>
<td>32</td>
<td>20</td>
<td>62.50%</td>
<td>37.50%</td>
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<tr>
<td>Preventative Health PREV-06 Colorectal Cancer Screening</td>
<td>36</td>
<td>18</td>
<td>50.00%</td>
<td>32.61%</td>
</tr>
<tr>
<td>Preventative Health PREV-07 Influenza Immunization</td>
<td>16</td>
<td>3</td>
<td>18.75%</td>
<td>44.89%</td>
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<tr>
<td>Preventative Health PREV-08 Pneumonia Vaccination</td>
<td>25</td>
<td>9</td>
<td>36.00%</td>
<td>22.82%</td>
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<tr>
<td>Preventative Health PREV-09 Body Mass Index Screening</td>
<td>21</td>
<td>17</td>
<td>80.95%</td>
<td>7.04%</td>
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<tr>
<td>Preventative Health PREV-10 Tobacco Use Screening</td>
<td>20</td>
<td>20</td>
<td>100.00%</td>
<td></td>
</tr>
<tr>
<td>Preventative Health PREV-11 High Blood Pressure Screening</td>
<td>36</td>
<td>26</td>
<td>72.22%</td>
<td>2.14%</td>
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<tr>
<td>Preventative Health PREV-12 Clinical Depression Screening</td>
<td>19</td>
<td>3</td>
<td>15.79%</td>
<td>59.21%</td>
</tr>
</tbody>
</table>

**Grand Total**

<table>
<thead>
<tr>
<th>Pre-AWV</th>
<th>Post-AWV</th>
</tr>
</thead>
<tbody>
<tr>
<td>304</td>
<td>175</td>
</tr>
<tr>
<td>243</td>
<td>188</td>
</tr>
<tr>
<td>57.57%</td>
<td>77.37%</td>
</tr>
<tr>
<td>19.80%</td>
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</tr>
</tbody>
</table>
### Table 1: Challenges to Small and Rural Physician Practices' Participation in Value-based Payment Models, by Key Area

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

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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