How Ready Is My State?

June 2018

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National Rural Accountable Care Consortium

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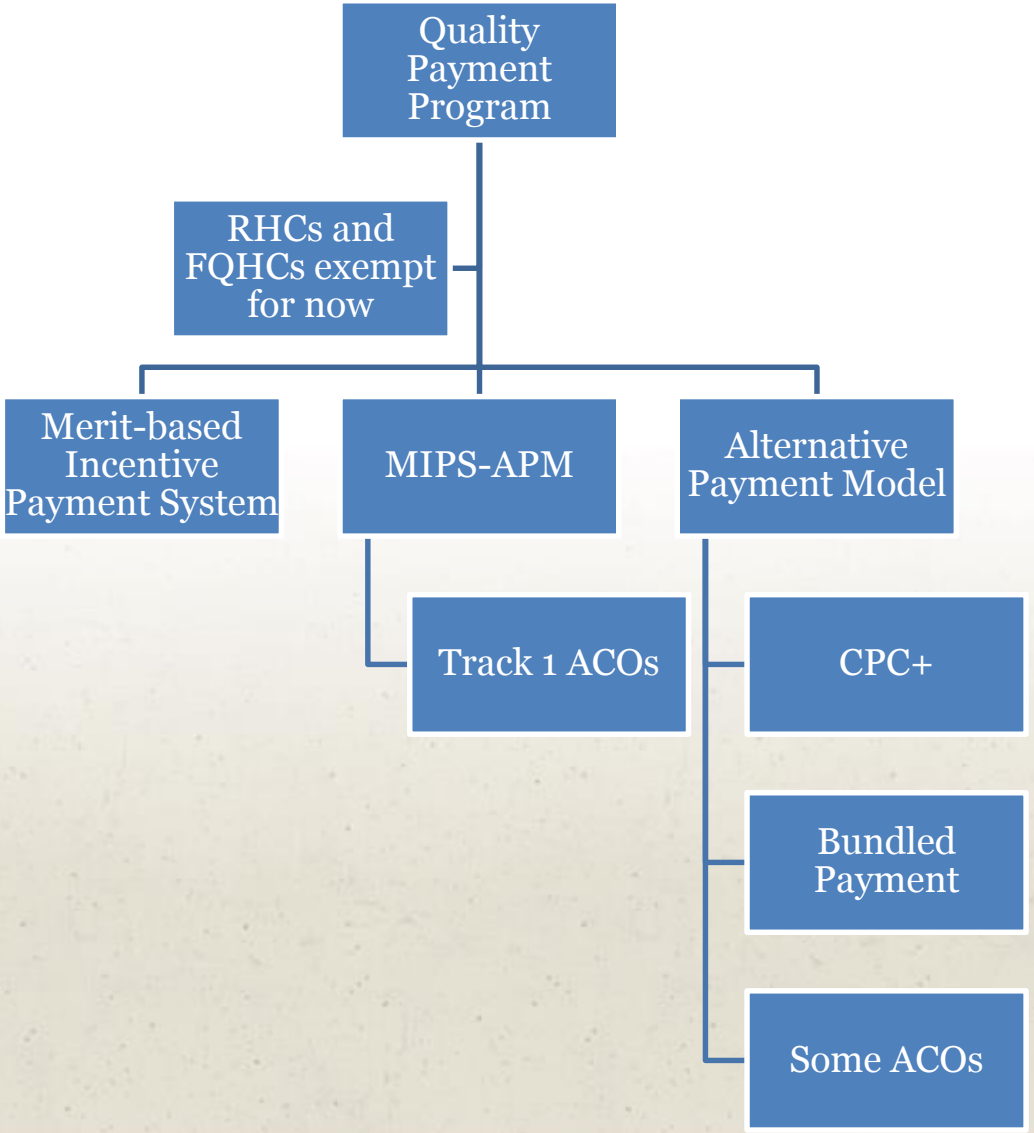
Agenda

- Recap Week 1: APM Options
  - The four options for value based pay
  - Deep Dive: the making of an ACO
  - Prepping for Alternative Payment: the TCPi Program
- Objective 1: Discuss and interpret results of survey to determine starting place
- Objective 2: Identify alternate "data" sources to assess readiness or current work
- *Activity: Complete "Template State Assessment on Value Based Pay"*

There are 4 main options for value-based pay

- Comprehensive Primary Care Plus (Primary Care Only)
- Bundled Payments
- Merit-based Incentive Payment System
- Medicare Shared Savings Program

Current Landscape of the Quality Payment Program



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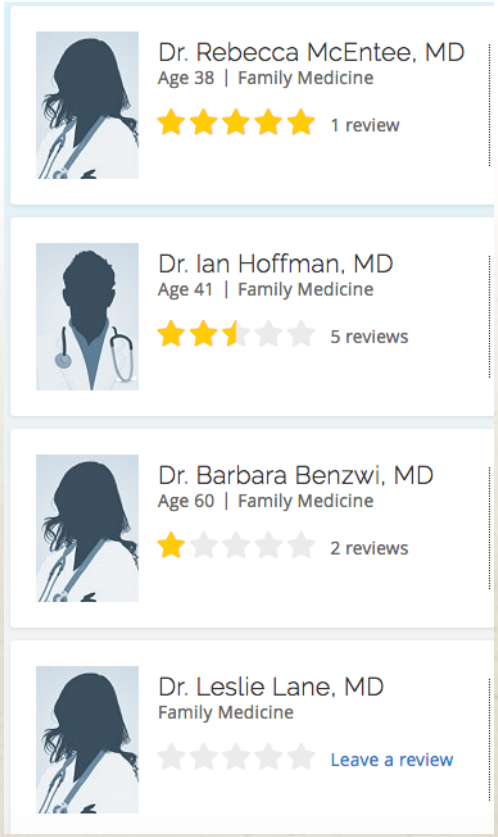
QPP is pushing consumers to high value care



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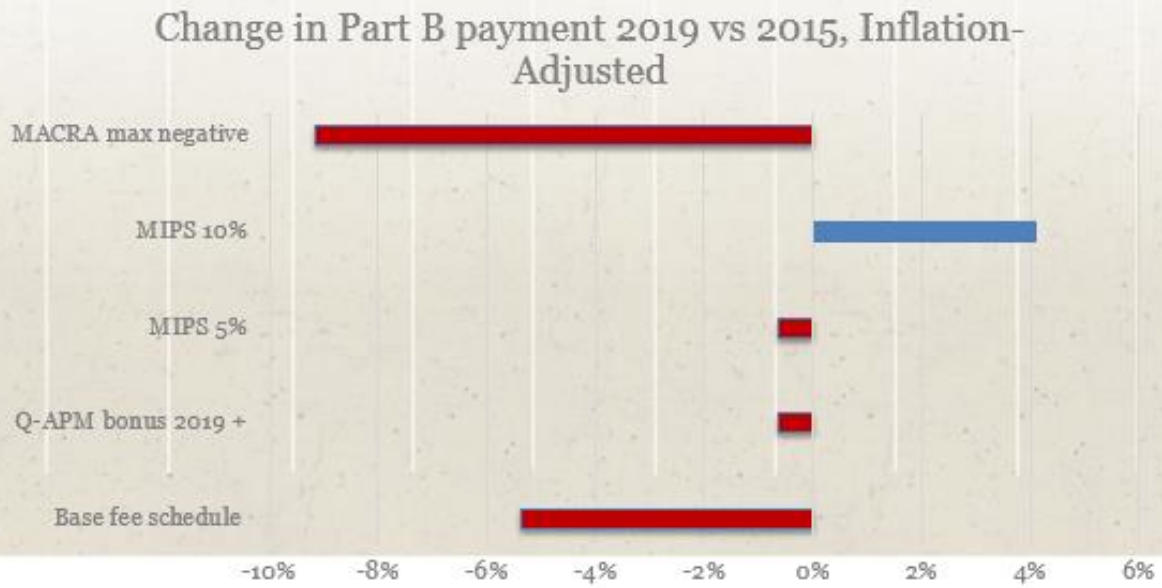
Clinician Fee Schedule Increases Will Not Keep Pace With Inflation

		2015 and earlier	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026 and later
Fee	Fee Schedule Updates		0.5	0.5	0.5	0.5	0	0	0	0	0	0	0.75 QAPMCF* 0.25 N-QAPMCF*



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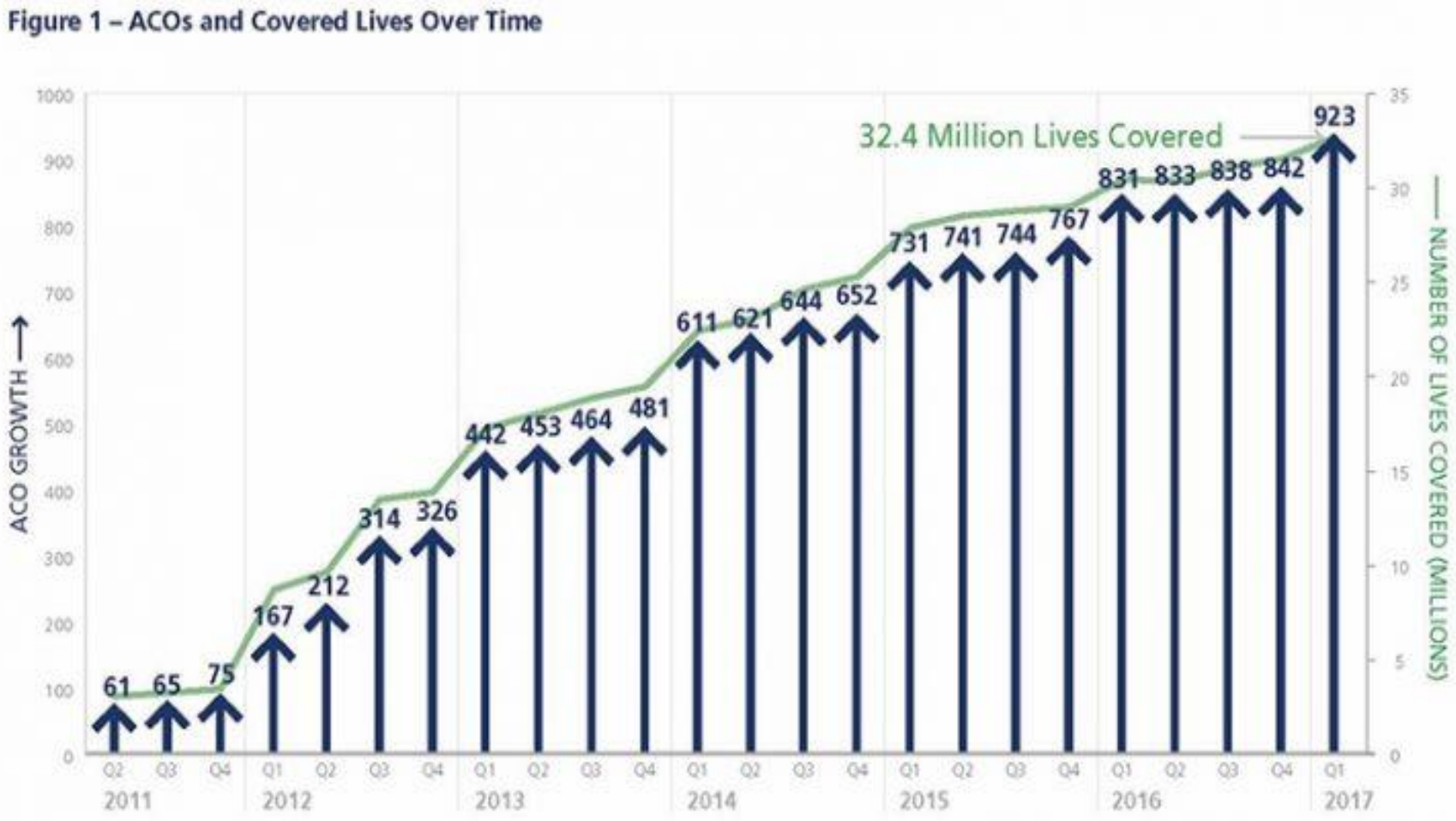
Increases in ACO Participation Overtime



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Despite discussion in Washington, there is strong support for value based pay…

- February's Balanced Budget act expanded possibilities for ACOs
- New Tax Bill did not change ACO provisions specifically, but is likely to change coverage patterns
- Release of CMS rural health strategy last week:

*"Through the implementation of this strategy, CMS and its partners will help make health care in rural America accessible, **accountable**, and affordable – resulting in the highest quality of care."*

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Bundled Payments

From CMS.gov:

- Model 1, the episode of care is defined as the inpatient stay in the acute care hospital. Medicare pays the hospital a discounted amount based on the payment rates established under the Inpatient Prospective Payment System used in the original Medicare program. Medicare continues to pay physicians separately for their services under the Medicare Physician Fee Schedule.

- Model 2, the episode includes the inpatient stay in an acute care hospital plus the post-acute care and all related services up to 90 days after hospital discharge.

- Model 3, the episode of care is triggered by an acute care hospital stay but begins at initiation of post-acute care services with a skilled nursing facility, inpatient rehabilitation facility, long-term care hospital or home health agency. Under these retrospective payment models, Medicare continues to make fee-for-service (FFS) payments; the total expenditures for the episode is later reconciled against a bundled payment amount (the target price) determined by CMS. A payment or recoupment amount is then made by Medicare reflecting the aggregate expenditures compared to the target price.

- Model 4, CMS makes a single, prospectively determined bundled payment to the hospital that encompasses all services furnished by the hospital, physicians, and other practitioners during the episode of care, which lasts the entire inpatient stay.

https://innovation.cms.gov/initiatives/bundled-payments/index.html

Pros and Cons

- Focus on specific conditions
- Can select few or many conditions
- Is preventive
- Low volume is an issue
- Doesn't work well with CAH model because costs are capped

Comprehensive Primary Care Plus

- Started as CPCi in few states
- Expanded as CPC+ in 2017 to 10+ states
- Multipayer initiative
- Care management fee
- Incentive payment for meeting measures
- 5% bonus for advance APM
- RHCs/ FQHCs cannot participate
- Must be primary care

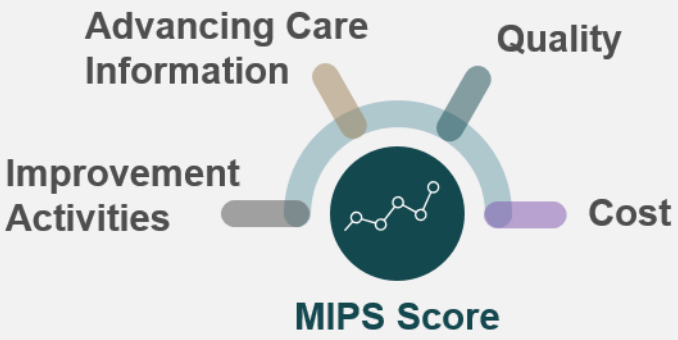
Comprehensive Primary Care Plus

- Multi-payer
- Increased flexibility to deliver care
- Care management fees provided
- Only need 150 Medicare beneficiaries
- Not open to RHCs, FQHCs, specialists
- Rigid requirements
- Can be challenging to implement in rural areas due care delivery requirements

Two Main Options for Most Providers

MIPS

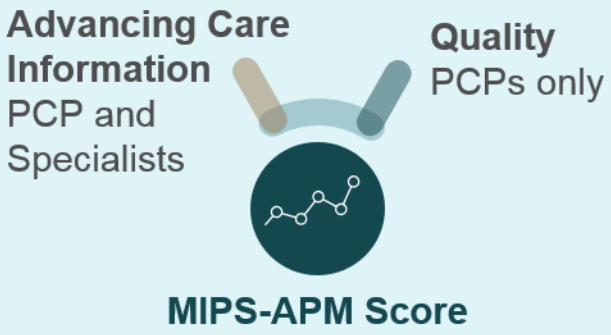
- **2018 Final Rule**: Cost will be 10% of MIPS score in 2018 – average cost will mean maximum score is 95 points
- **MACRA Law 2019:** Cost is 30% of score: max score becomes 85 points
- **All Clinicians Report all Areas**



MIPS-APM

One MIPS score for *all* providers

- Exempt from Cost
- Automatic 100% for CPIA
- Only report Quality and ACI



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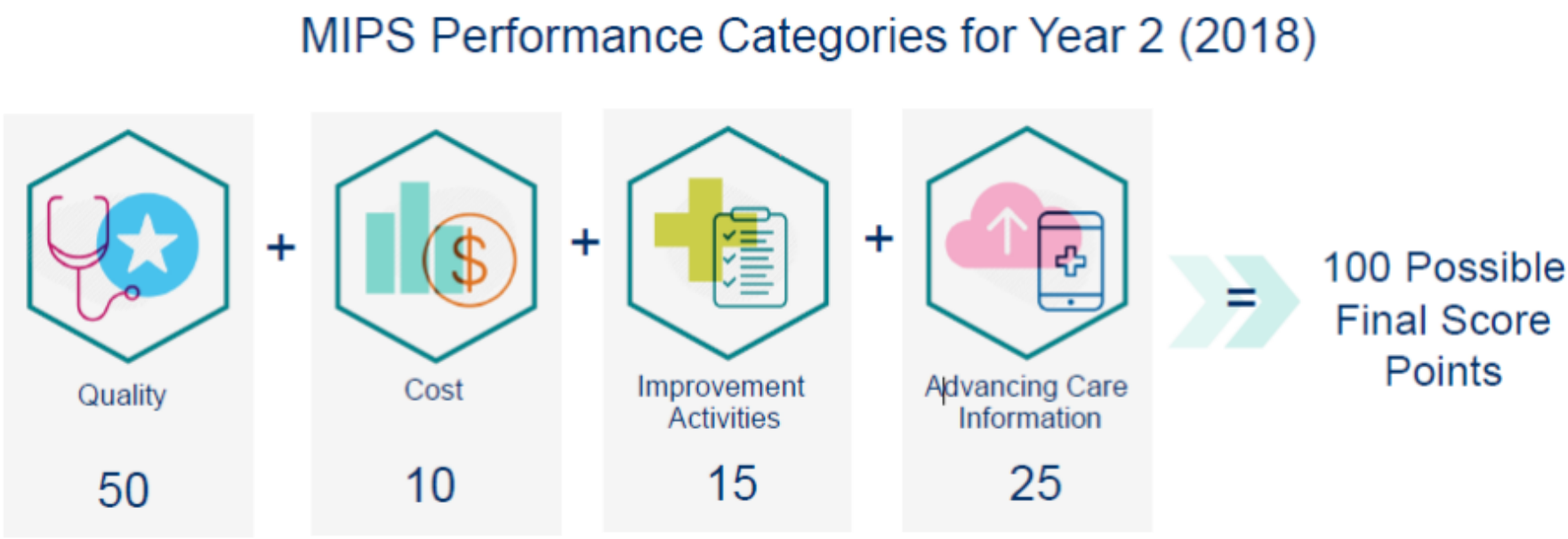
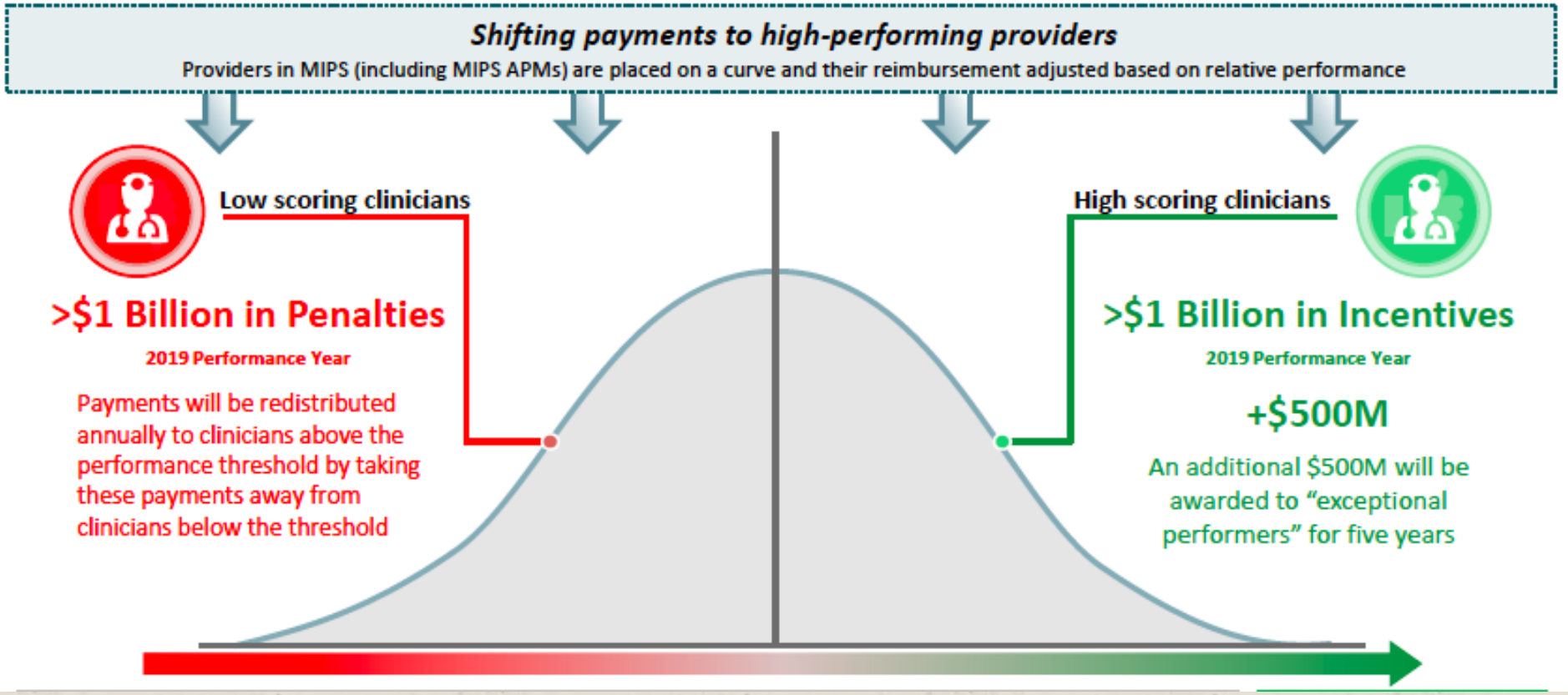
MIPS Overview



https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/QPP-Year-2-Final-Rule-Fact-Sheet.pdf

MIPS Scores Drive Payment and Reputation



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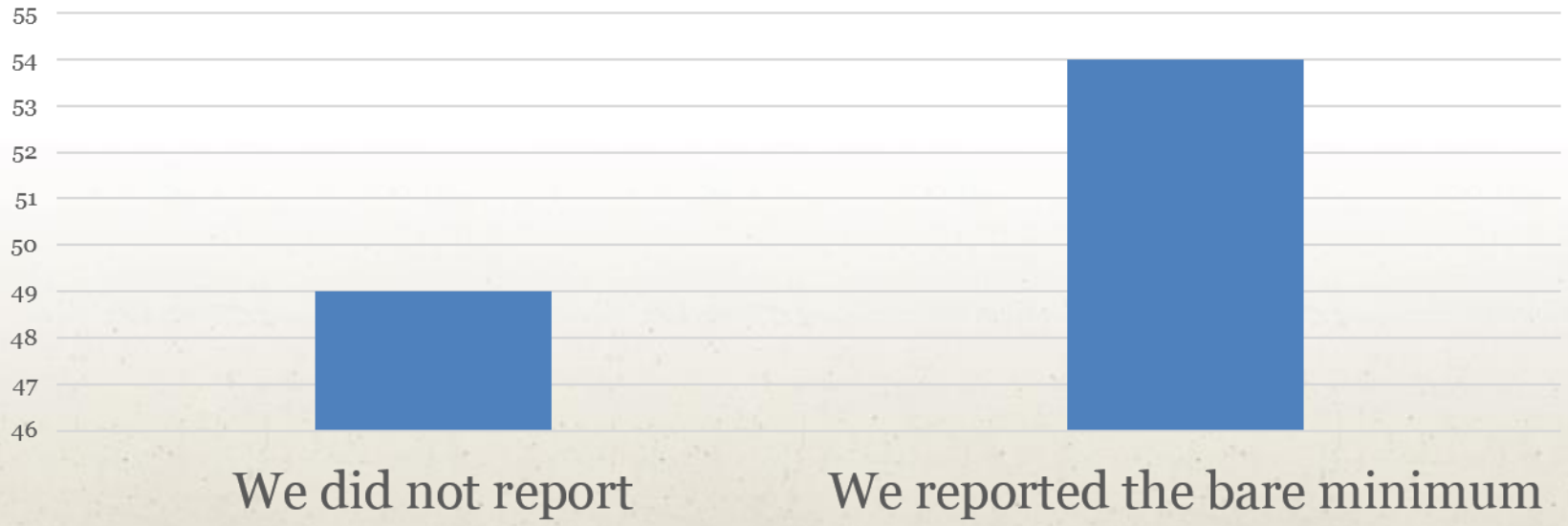
Q3. What was your score in MIPS for PY2017?



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Low volume did not qualify	1
Reported with ACO quality, not MIPS 100% on ACI	1
sixty nine	1
We applied for waiver due to our EMR but changing EMR	1
We did not have to report due to low volume.	1
We have not received 2017 scores	1

The Medicare Shared Savings Program (MSSP) Also Known As ACO

- There are five tracks:
  - 1 (no risk)
  - 1+
  - 2
  - 3
  - Next Gen
- If you can reduce the ACO average annual cost below your ACO benchmark, you may receive shared savings.
- All existing reimbursement stays the same

Basics of ACOs

Established by the Affordable Care Act to facilitate coordination and cooperation among providers to improve the quality of care for Medicare Fee-For-Service (FFS) beneficiaries and reduce unnecessary costs.

ACOs are groups of Medicare providers that work together to coordinate care for the Medicare fee-for-service patients they serve. The goal is to deliver seamless, high-quality care for these beneficiaries, rather than the fragmented care that often results from a fee-for-service payment system.

Eligible providers, hospitals and suppliers may participate in the Shared Savings Program by creating or participating in an Accountable Care Organization (ACO).As of January 2017, 480 ACOs serving about 9 million beneficiaries participate in the Shared Savings Program.[1]

Provides opportunities to learn to effectively manage population health while avoiding unnecessary penalties.

[1] Centers for Medicare and Medicaid, Fast Facts

Forming an ACO

Must serve at least 5,000 Medicare fee-for-service patients.

Agree to participate for at least 3 years, meet other program requirements such as a governing body, processes to promote evidence-based medicine, promote patient engagement, internally report on quality and cost measures and coordinate care.

Multiple models (clinician-led, hospital-led); if an ACO is formed by more than one provider, then the ACO must be a separate legal entity.

Eligible entities

- ACO professionals in group practice arrangements
- Networks of individual practices of ACO professionals
- Partnerships or joint venture arrangements between hospitals and ACO professionals
- Hospitals employing ACO professionals
- Federally qualified health centers
- Rural health clinics

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2018 ACO Quality Measures by Domain

31 Measures

Better Health for Populations

AT RISK
DM HbA1c Poor Control
Diabetic Eye Exam
Diabetes Composite
Hypertension Control
Aspirin for IVD
Depression Remission

PREVENTION
Breast Cancer Screen
Colon Cancer Screen
Flu Vaccine
Pneumonia Vaccine
BMI & Follow Up
Tobacco Use & Follow Up
Depression Screen & Follow Up
Statin Therapy for CVD

RED = ACO Web Interface (WI) Measures. Must be reported using Clinical data NOT Claims into Lightbeam Reporting Module.

Better Care for Individuals

CAREGIVER EXPERIENCE
ACO-CAHPS Survey

Timely Care
Doctor Communication
Patient's Rating of Provider
Access to Specialists
Health Promotion and Education
Shared Decision Making
Health Status/Functional Status
Stewardship of Pt. Resources

CARE COORD. & PT SAFETY
Fall Risk
Medication Rec Post Discharge

Claims Based
Use of Imaging for Low Back Pain
Unplanned Admissions – DM, HF, CC+
Readmissions – All conditions, SNF 30-day
Admissions - Prevention Quality Indicator – Acute composite
Use of Cert. EHR technology

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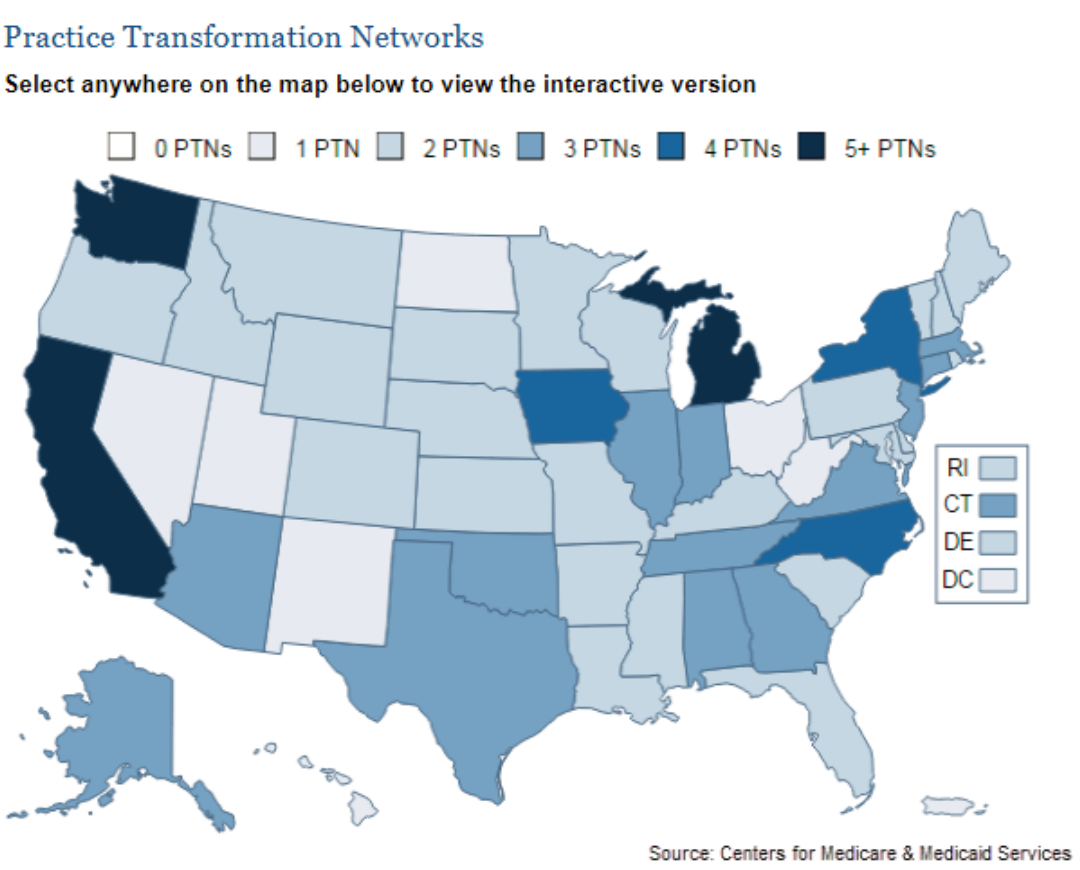
Prepping for Value Based Pay & Core Elements of All APMs

Prepping for APMs: TCPi

The Transforming Clinical Practice Initiative is designed to help clinicians achieve large-scale health transformation.



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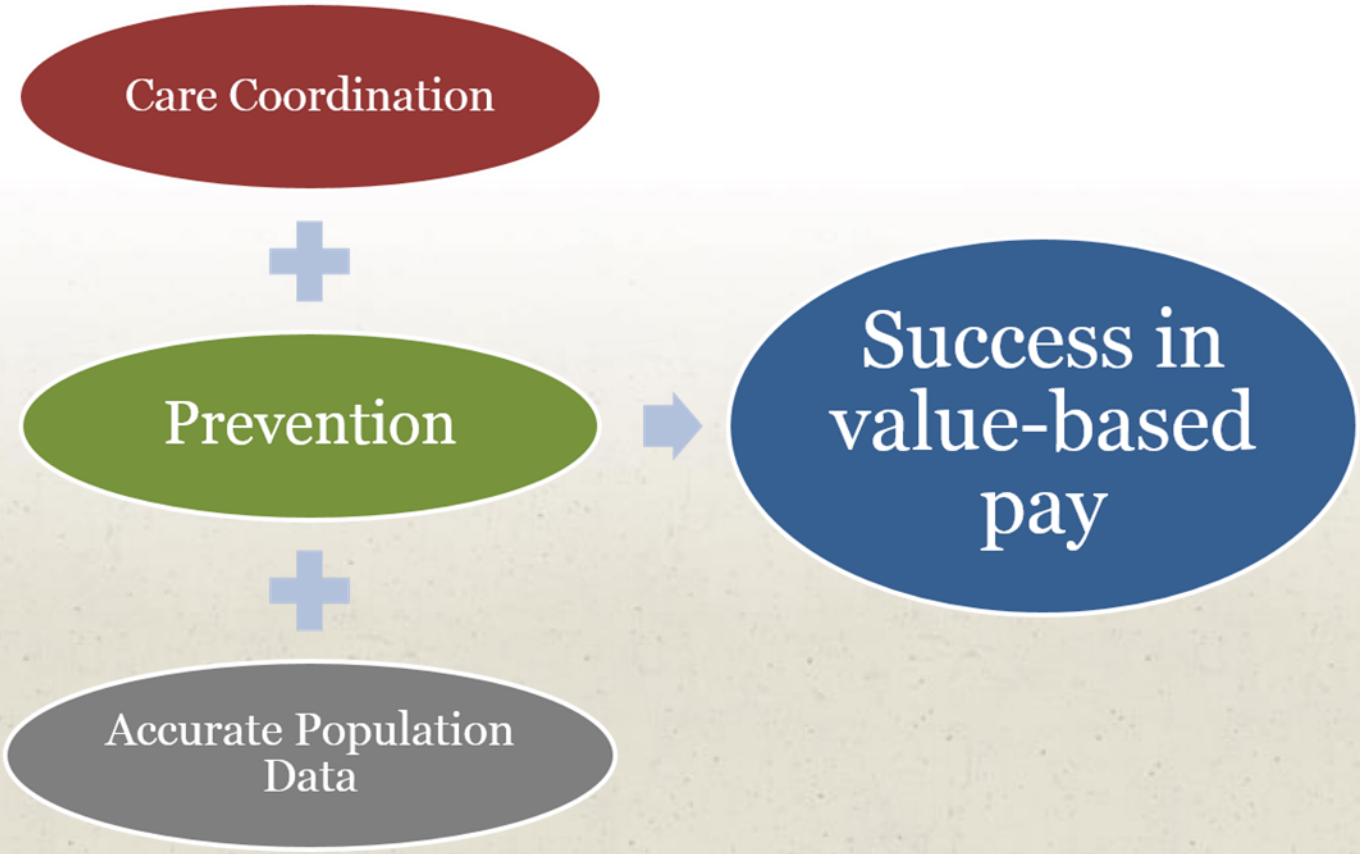
What does NRACC's TCPi Program do?

- Train care coordinators
- Teach BILLABLE population health:
  - Annual Wellness Visits
  - Chronic Care Management
  - Psychiatric Collaborative Care Management + Behavioral Health integration
- Educate on Alternative Payment Choices
- Improve coding and risk adjustment

Core Elements of All APMs



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Category 1: Quality Metrics

- Evidenced-based treatment for chronic conditions prevention
- Wellness visits
- ACOs requirement 30+ Metrics
- CPC+ requires a different number for each payer group
- MIPS requires 6
- Try to get all clinicians in your Tax ID aligned on the same metrics
- Networks have an advantage if there is alignment across a region
- ACOs also have a major advantage in quality reporting simplicity

Prevention

Look for Alignment to Excel in Quality Measures

Increases MIPS score by 15-20%

- Cost exemption (average 15%)
- ACO Quality reporting advantages (average 5-10%)
- If ACO performs well on Advancing Care Information, practice may be eligible for participation in $500 million exceptional performance bonus pool, which can increase Part B payments up to 3 times the amount of the MIPS penalty.

Reduces MIPS administrative burden.

- Unless acting as PCP, will NOT have to do quality reporting!
- Exempt from Clinical Practice Improvement Activity Reporting.
- Only reports Advancing Care Information (MU)

Protect Reputation on Physician Compare

Category 2: Costs (10%)

- Examples of measures:
  - Total Per Capita Cost measure
  - Medicare Spending Per Beneficiary measure
  - https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/2018-Cost-Performance-Category-Fact-Sheet.pdf
- Strategies to impact costs:
  - HCC Coding
  - Care Coordination

Category 3: EHR Requirements/ Advancing Care Information (25%)

- Networks have a major advantage in this area:
  - Collaborative Care Agreements
  - Direct messaging
- Patient Portal Access

Accurate Population Data

Care Coordination

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Category 4: Transformation

- All QPP options require some kind of practice transformation to be successful
- In APMs and MIPS ACOs, transformation is implied
- In MIPS, you have to complete specific availabilities

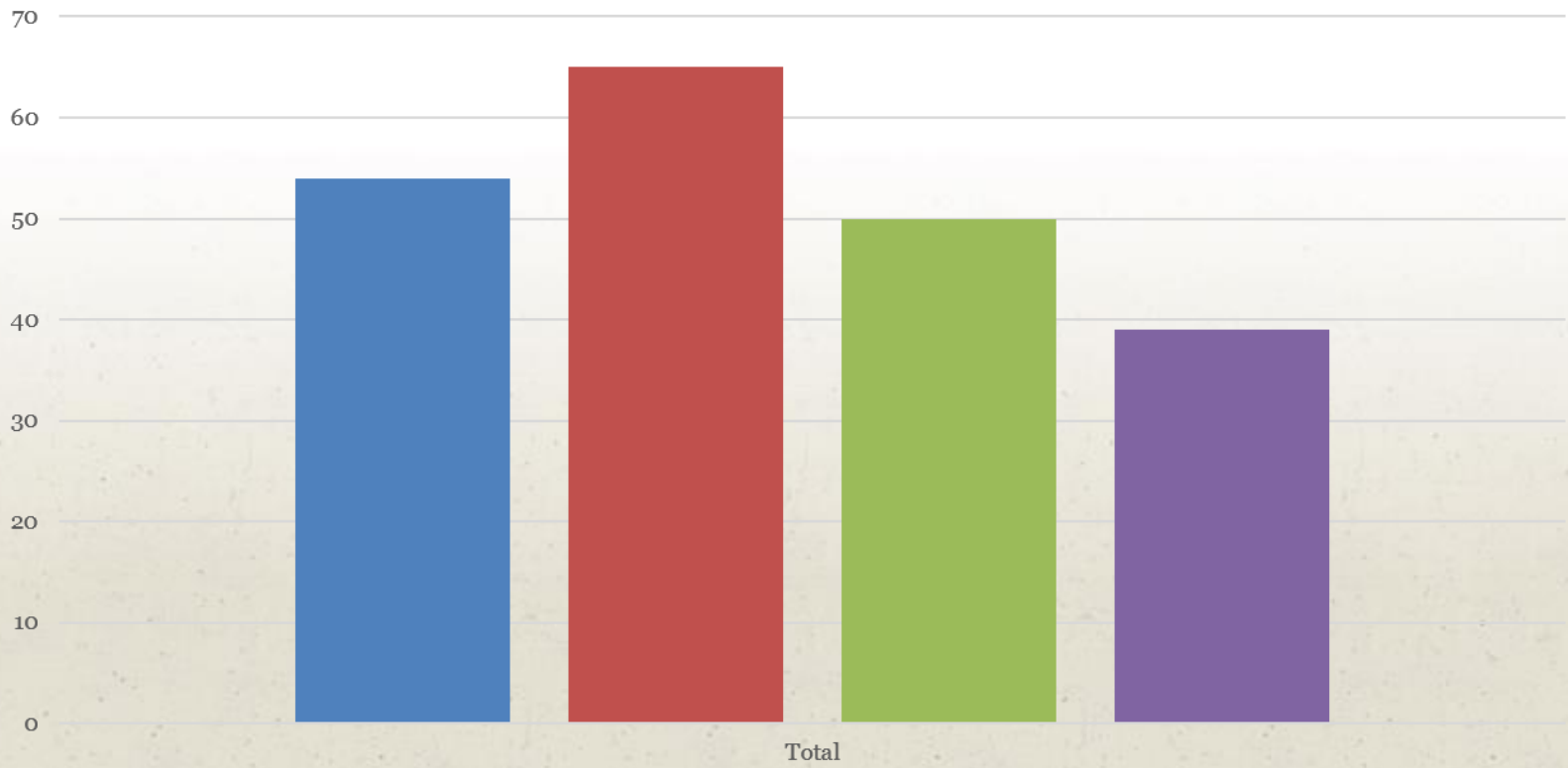
Good News: Transformation is Financially Sustainable

Service	Billing Code	Average National Medicare Payment
IPPE	G0402	$168.68
Initial AWV	G0438	$173.70
Subsequent AWV	G0439	$117.71
Advance Care Planning	99497	$82.90
Depression Screening	G0444	$18.30
Smoking Cessation 3-10 min	99406	$14.71
Smoking Cessation >10 min	99407	$28.35
Chronic Care Management (CCM)	99490	$42.71/ Month
Behavioral Care Management	99484	$48.60/ Month
Psychiatric Collaborative Care Management	99493	$128.88/ Month
Complex CCM	99487	$93.67/Month

Survey + Next Steps

- Link to survey
- Try to have survey complete by next meeting (June 7)

Q2. How far along is your health system in developing a strategy for value based pay?



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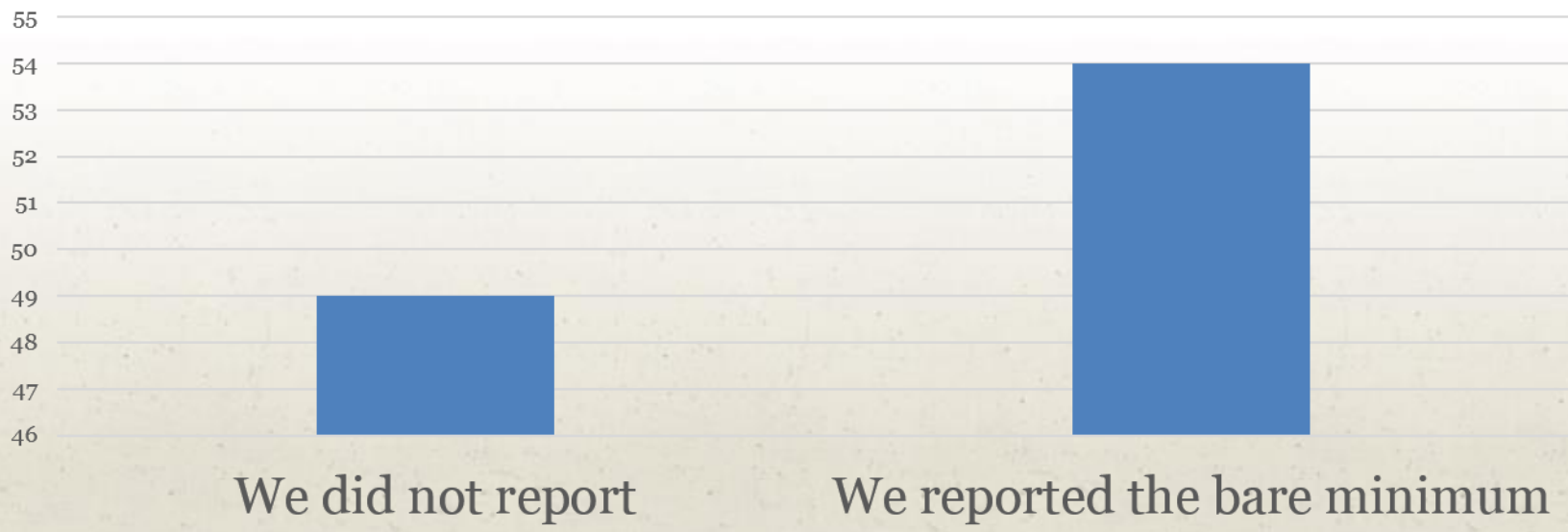

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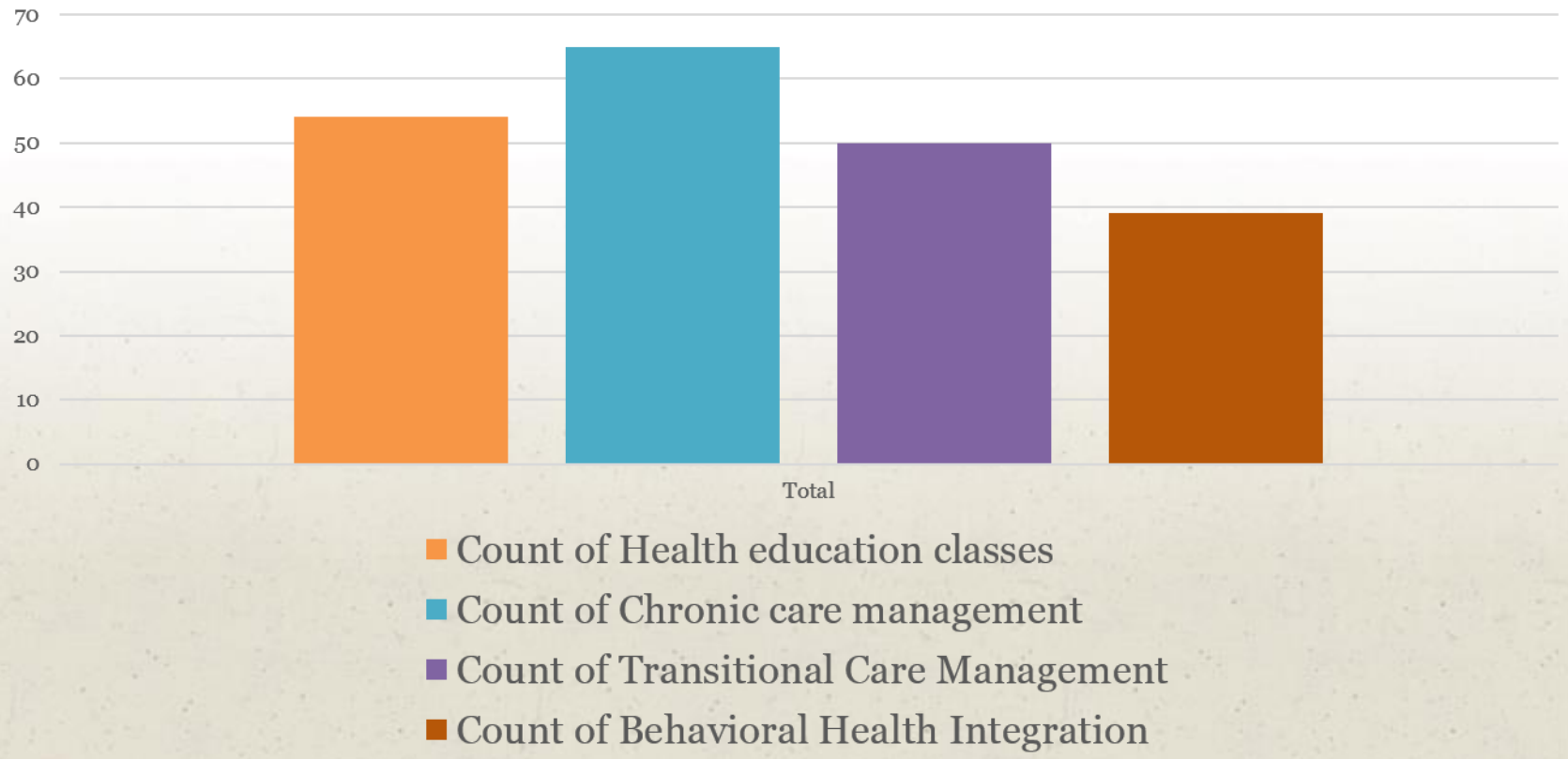
What services are you providing relating to population health?



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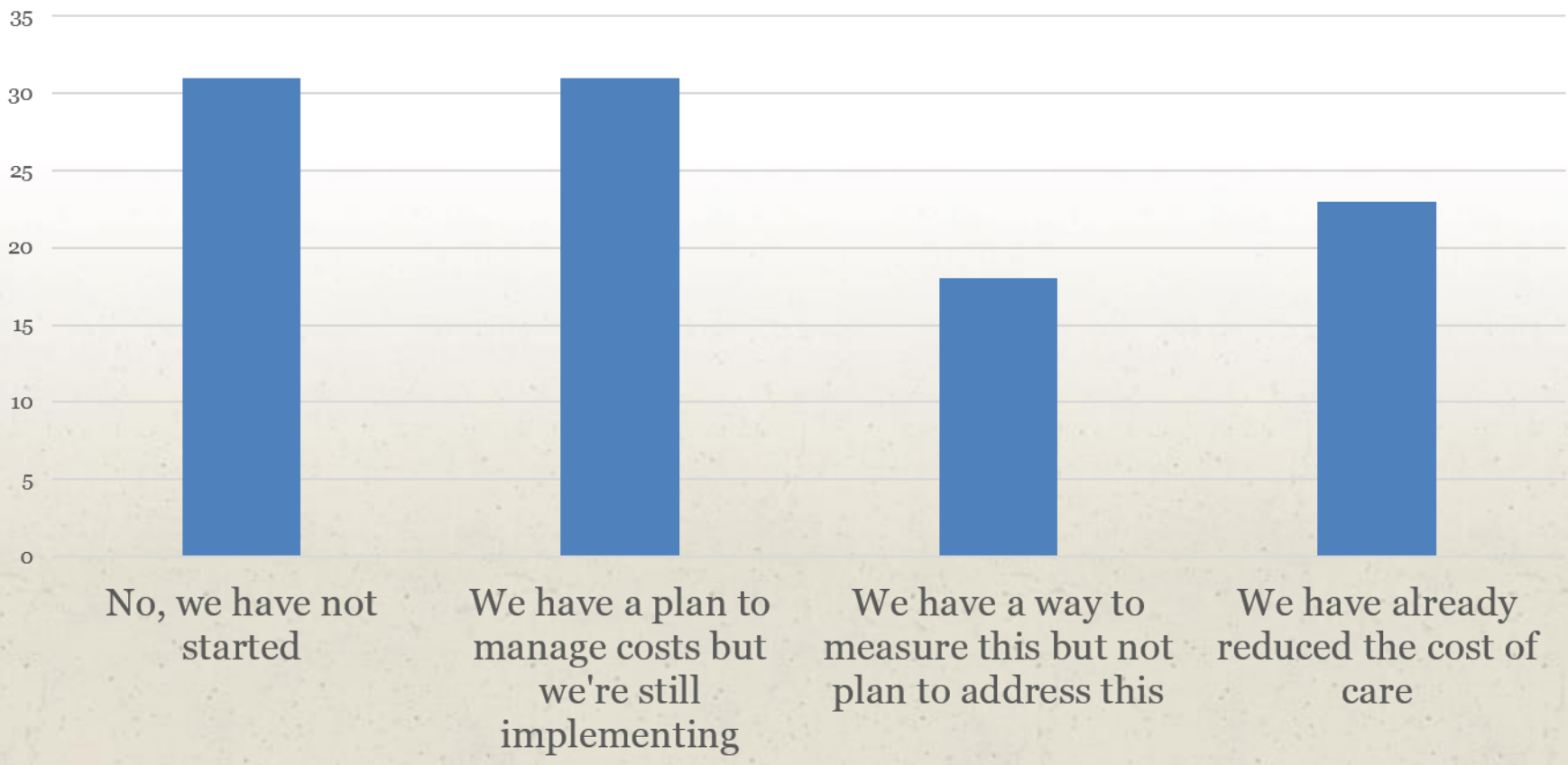
Q5. Does your health system have a plan for managing costs?



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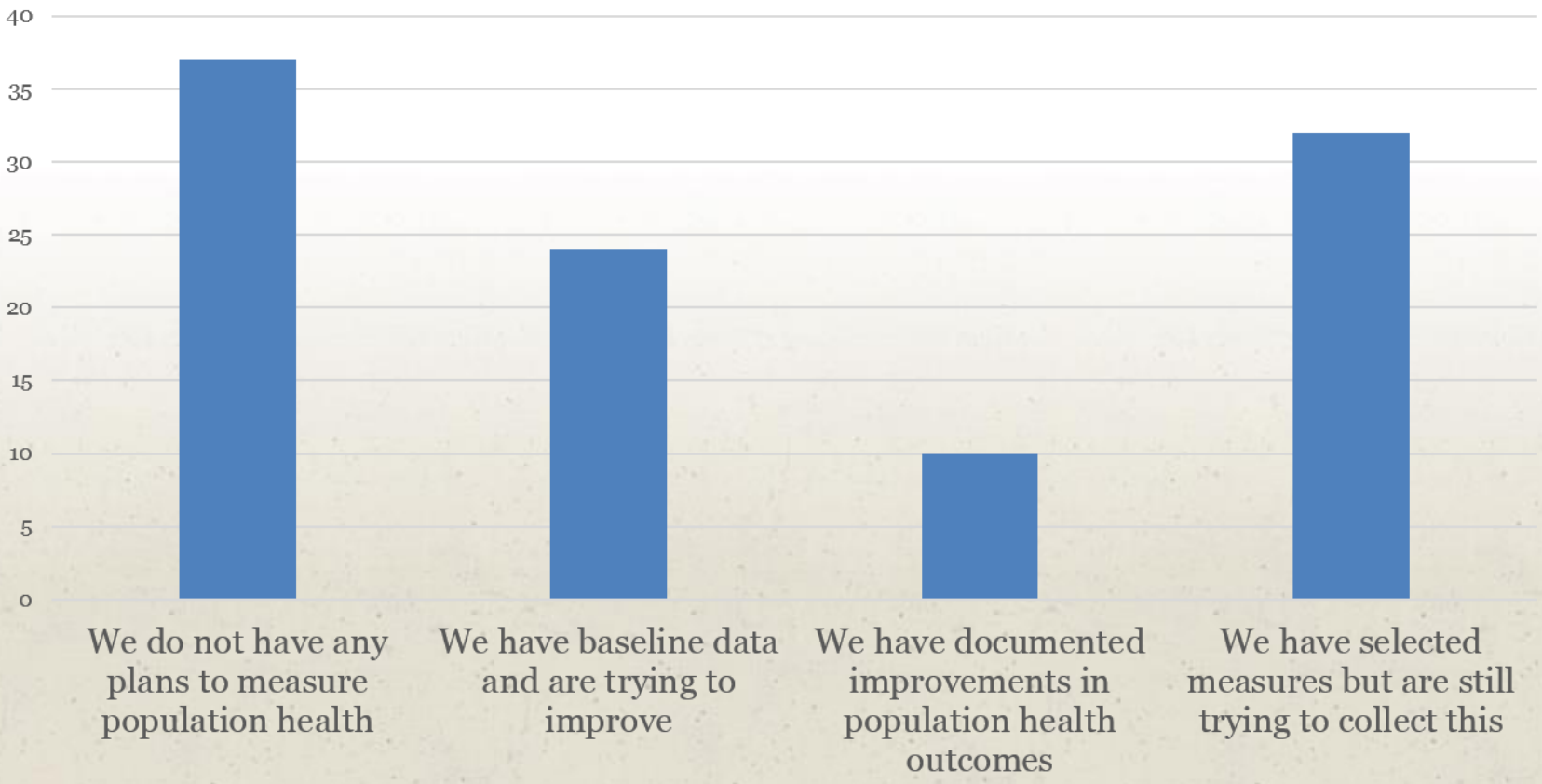
Q6. Does your health system have a specific plan around measurable population health outcomes?



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Additional Data Sources

- Know how many beneficiaries are in your state/ area:
  - https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Medicare-Geographic-Variation/GV_PUF.html
- Scores on quality: MBQIP, Physician Compare
- Quality and Resource Use Reports

Next Step

- Complete mini- analysis of your survey results
- Begin populating *Template State Assessment on Value Based Pay*

Questions?