NHA Rural QI Residency

Alternative Payment Models - Accountable Care Organizations

November 4, 2022

Presentation Objectives

- Explain the history and importance of value-based care today, and in the future.
- Identify the various value-based models (Alternative Payment Models), including Accountable Care Organizations (ACO's).
- Identify the impact of Population Health when in a value-based model.
- Recognize the importance of care coordination in relation to ACO's.
- Understand the meaning of risk and how it impacts and applies to ACO's.
- Understand the important role Quality plays in value-based care/ACO's.

High healthcare costs. Why?

Paying healthcare professionals more to do more (volume)

- Fee-for-Service model

Defensive medicine

- Protect against litigation

Lack of price transparency

- Consumer is not usually the payer

Direct-to-consumer advertising

- Encourages patients to ask for drugs, devices, diagnostics or procedures

Quality issues

- Readmissions, hospital-acquired conditions

Over utilization or duplicative medical services

- Imaging

Lack of data interoperability (ability of systems to work together in order to communicate and exchange information)

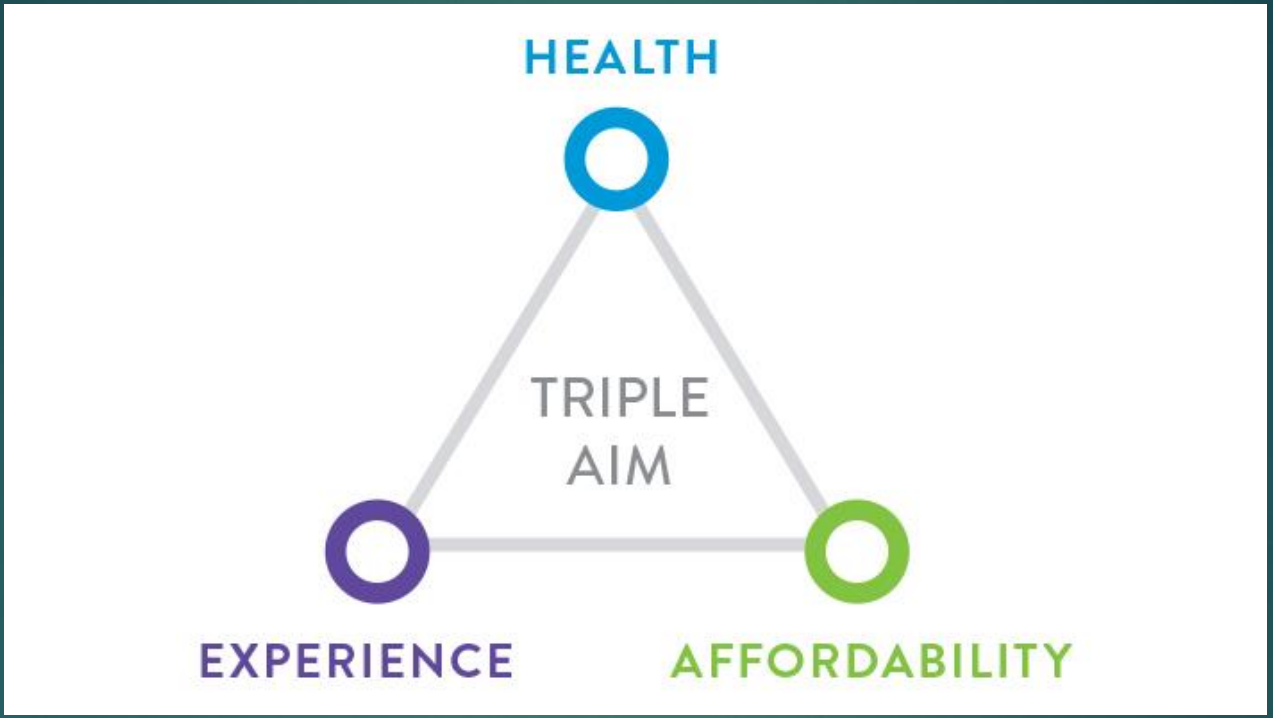
- Unnecessary medical services

The Drivers…

- Recognition that health resources, personal health values, and the environment of a community drives its health status.
- Powerful consequence of chronic conditions on the total cost of healthcare.
- Patient Protection and Affordable Care Act
- Realignment of payment and incentives toward prevention and value and away from volume.
- Commitment to technology (Electronic Medical Records & registries) for tracking patients, quality and outcomes.

Value Based Care

CMS Triple Aim: Transition from Volume to Value



VALUE = Improved Quality + Improved Experience + Reduced Cost
(Health Outcomes) (Patient and Provider) (Healthcare)

Value-Based Reimbursement

What are value-based programs?

Value-based programs reward health care providers with incentive payments for the quality of care they give to patients. These programs are part of a quality strategy to reform how health care is delivered and paid for. Value-based programs also support a three-part aim:

- Better care for individuals
- Better health for populations
- Lower cost

Population Health encompasses a shift in focus from providing care when individuals are sick to a more comprehensive view which includes enhancing and improving the health of a population to impact wellness.

The Need to Demonstrate Value

Data analytics is arguably the most significant transformation in healthcare in the last 10 years.

The move toward value-based care has increased the need for accountability and transparency.

Consumers shop around – and are savvy and mobile.

Hospital and Provider data specific to quality and experience are available online, and this continues to grow.

Data availability is important to consumers and payers.

Impact of word of mouth from a marketing standpoint (+/-).

Alternative Payment Model

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.

Examples:

- Accountable Care Organizations
- Pay for Performance Models
- Bundled Payment Models (Hips/Knees)
- Global budget/Capitation

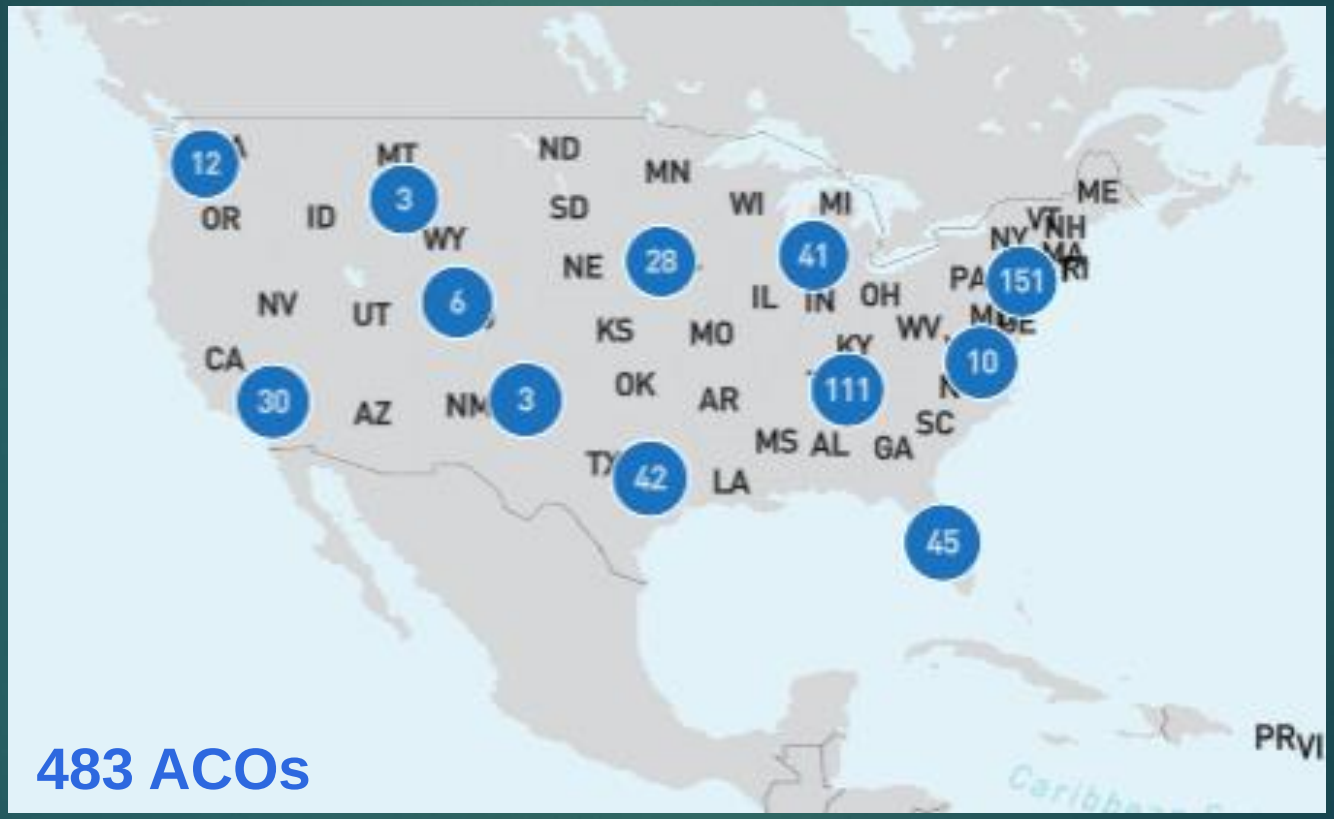
Alternative Payment Models (APMs) Overview - QPP (cms.gov)

Accountable Care Organization

An Accountable Care Organization (ACO) is a **group of health care providers**, with collective responsibility for patient care that helps coordinate services – delivering high quality care while holding down costs

CMS Medicare Shared Savings Program Accountable Care Organization

2022 CMS Medicare Shared Savings Program Accountable Care Organizations



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

CMS Medicare Shared Savings Program

THEN (2012 until run out of CMS participation agreements)

ACO Tracks
- Tracks 1, 1+, 2, 3 and Next Generation ACO model
- 3-year participation agreement
- Various levels of financial risk

Requirement of at least 5,000 attributed lives to participate

NOW (As of 2019)

Basic Track
- Basic glide path offers 5 levels (A thru E) with incremental approach to transition eligible ACOs to higher levels of risk and reward
- No down-side financial risk in levels A & B
- Basic glide path automatically advances at start of each performance year with ability to elect higher levels of risk
- 5-year participation agreement

Enhanced Track
- Enhanced Path allows for the highest level of risk and reward

Care Coordination and Data Analytics in Advanced Payment Models

Population Health Strategies

Telehealth

Community Partnerships

Annual Wellness Visits

Chronic Care Management

Center for Medicare and Medicaid Services (CMS)

Annual Wellness Visits (AWV) and Chronic Care Management (CCM)

AWV

The Medicare Annual Wellness Visit includes a review of the patient's medical history, review of risk factors, and formation of a personalized prevention plan.

CCM

Chronic Care Management is a service provided to Medicare patients with two or more chronic conditions who are at significant risk of death, Acute exacerbation - decompensation, or functional decline.

https://www.cms.gov/About-CMS/Agency-Information/OMH/equity-initiatives/chronic-care-management

Care Coordination

Chronic Care Management and Annual Wellness Visits

SATISFACTION

- Patient happier with care
- Improved self-care ability
- Patient-Provider relations
- Staff satisfaction

COST OF CARE

- Reduce PMPM rates
- Duplicative tests and treatment
- Control downstream spend
- Revenue opportunities

QUALITY MEASURES

- Readmission rates
- CAHPS scores
- ED Utilization rates
- Quality measures and gaps in care

Source: Bing online image

Risk Score

Risk

Risk score is a measure of how sick and costly a patient or population is now or anticipated to be in the future.

A risk score is used to calculate a **financial benchmark**.

- A financial benchmark is a dollar amount of spend allocated for a patient, provider or facility.
- If the risk score is wrong, then the benchmark is wrong.

Why the Risk Score Matters

The risk score accounts for changes in a population. The higher the risk score, the sicker the population and conversely, the lower the risk score, the healthier the population.

One would expect that a healthier population would cost less than a sicker population and therefore the Hierarchical Condition Categories (HCC) are used to risk adjust financial benchmarks.

When participating in an ACO or other value-based care contract it is important that pertinent codes are recaptured on claims year over year to accurately depict the complexity of the patient and for compliance in coding.

Alternative Payment Model Performance Pathway (APP)
Quality Measure Reporting

Quality Measures are broken down into four domains:

Patient and Caregiver Experience
- ❑CAHPS survey (via CMS approved vendor)

Care Coordination and Patient Safety
- ✓Acute Admission Rates
- ✓Readmissions
- ○Screening for Future Fall Risk

Preventive Health
- ○Influenza,
- ○Tobacco screening
- ○Depression screening
- ○Colorectal Cancer Screening
- ○Breast Cancer Screening
- ○Statin Therapy

At Risk Populations
- ○Depression Remission
- ○Diabetes HbA1C
- ○Hypertension Control

QUALITY

Required reporting sources
- ❑ CAHPS
- ✓ Claims-Based
- ○ Web-Based (GPRO)

  Group Practice Reporting Option

Data: Quality Measure Reporting

Different value-based care models may focus on different quality measures, in part due to the needs of the target population.

Quality plays an important role in every model.

The success of a value-based program is dependent on high quality care – closing "gaps in care".

A gap in care is a discrepancy between recommended best practices and the care that is actually provided.

- Do providers and staff understand the specifications?
- If specifications change, is everyone made aware?

- How is data captured?
- Is care documented in discrete fields so reports can be pulled versus free text, progress notes, etc.?

- Routine evaluation?
- Routine performance updates?
- Drill into opportunities?

CMS CMMI Strategic Objectives: October 2021

Focus:

All Medicare & most Medicaid beneficiaries in accountable model(s) that address quality and total cost of care by 2030.

Embed health equity in every aspect of models and increase focus on underserved populations.

Utilize a range of methods that enable acceleration of best practices and achievement of patient outcomes.

Encourage strategies to address pricing, affordability, and that reduce unnecessary or duplicative care.

Priorities and policies across CMS and pursue multi-payer alignment.

Source: https://innovation.cms.gov

CMS CMMI Strategic Objectives: October 2021

Total cost of care is primary focus

Shift from taking on risk to getting beneficiaries in value arrangements

Progression to 2-sided risk remains but will be slower for vulnerable communities and providers

Addressing health equity and social determinants of health will be rewarded and incented

New approaches for incenting adoption in Medicaid, Medicare Advantage and by other payers

Source: https://innovation.cms.gov

Transition to Value Based Care

Create an awareness across your organization and throughout the community sharing the critical role of population health and a focus on value-based care strategies.

Guide change in processes and models of care to include a focus on population health and value-based care.

Ensure strategic planning incorporates population health and collaboration with community partners to coordinate approaches aimed at improving the health of the population.

Utilize data.

Begin the Alternative Payment Model journey before it is required. It takes time to learn and understand the models and methodologies.

Questions? Thank you!

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