NHA Rural QI Residency

Alternative Payment Models - Accountable Care Organizations

January 14, 2022

Anne Hansen MSN, RN, GERO-BC, CPHQ

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)

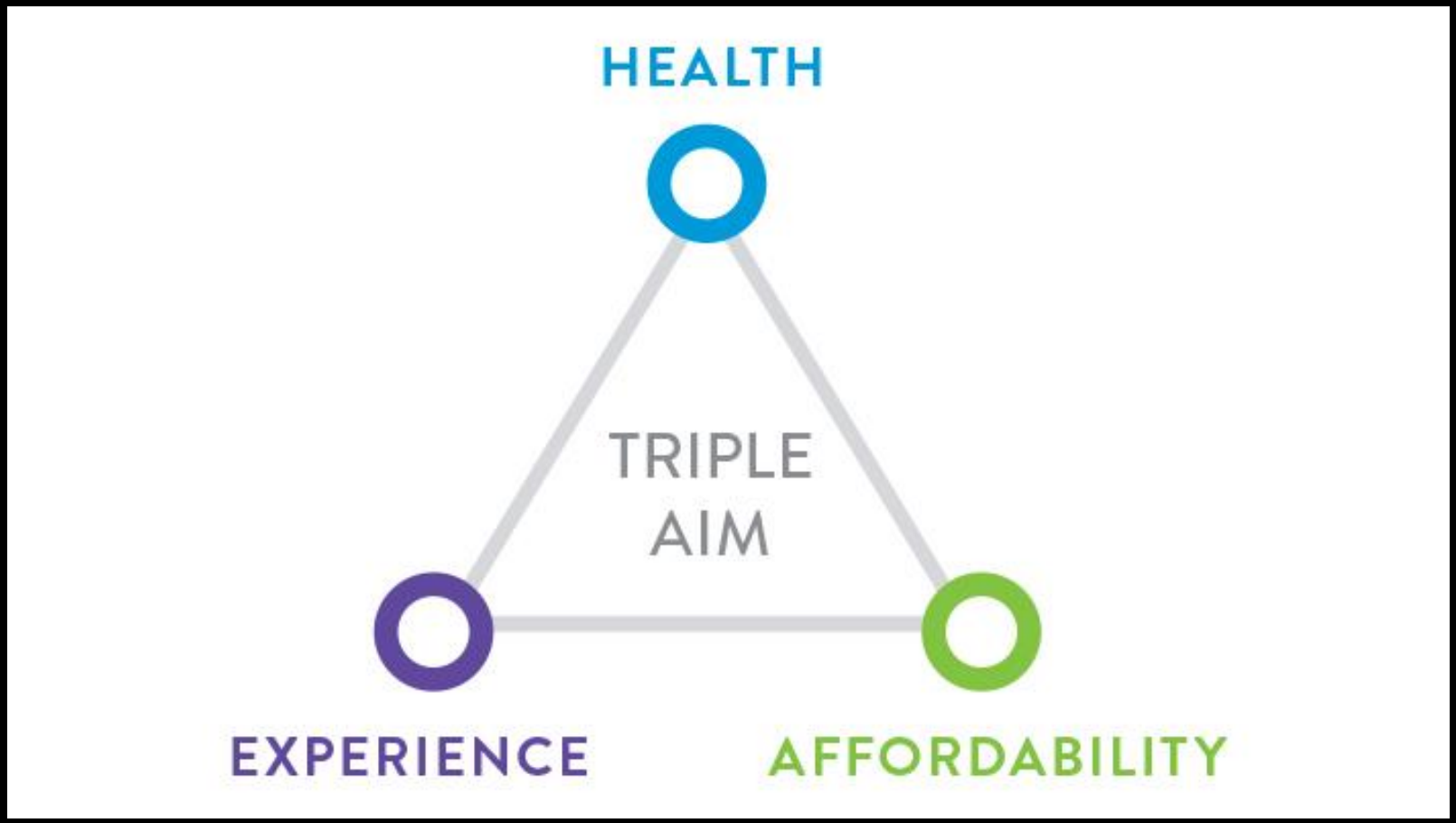
- Unnecessary medical services

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.

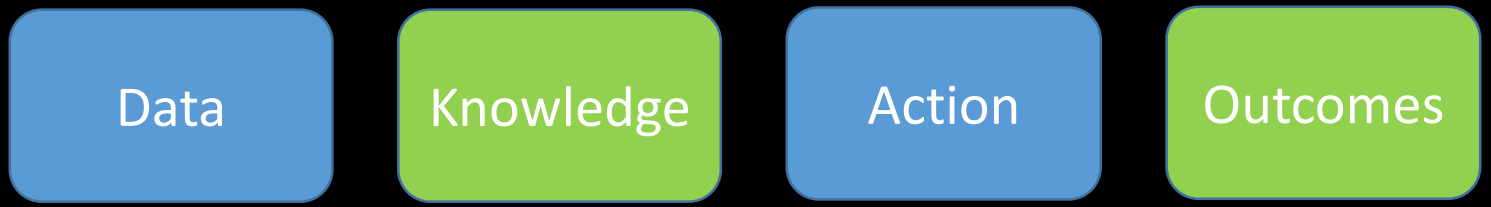
The move toward value-based care has increased the need for accountability and transparency.

Consumers shop around – and are savvy and mobile.

Hospital and Provider data specific to quality and experience are available online, and this is 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)

CMS Medicare Shared Savings Program
Accountable Care Organization

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

CMS Medicare Shared Savings Program

~~Pathways to Success~~ (no longer referred to as this)

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

CMS Medicare Shared Savings Program

ACO Impact: Public Health Emergency Covid-19

Federal Register – April 30, 2020

Option to elect to remain in 2020 level (track) for payment year 2021.

- Allowed for ACO's not in risk to have an additional year of no downside financial risk.
- Provided ACO Participants an additional year of learning.

Option to decline the advancement deferral and advance to next level (Basic C) as per our CMS agreement, moving into downside risk.

Exit the Medicare Shared Savings Program (MSSP).

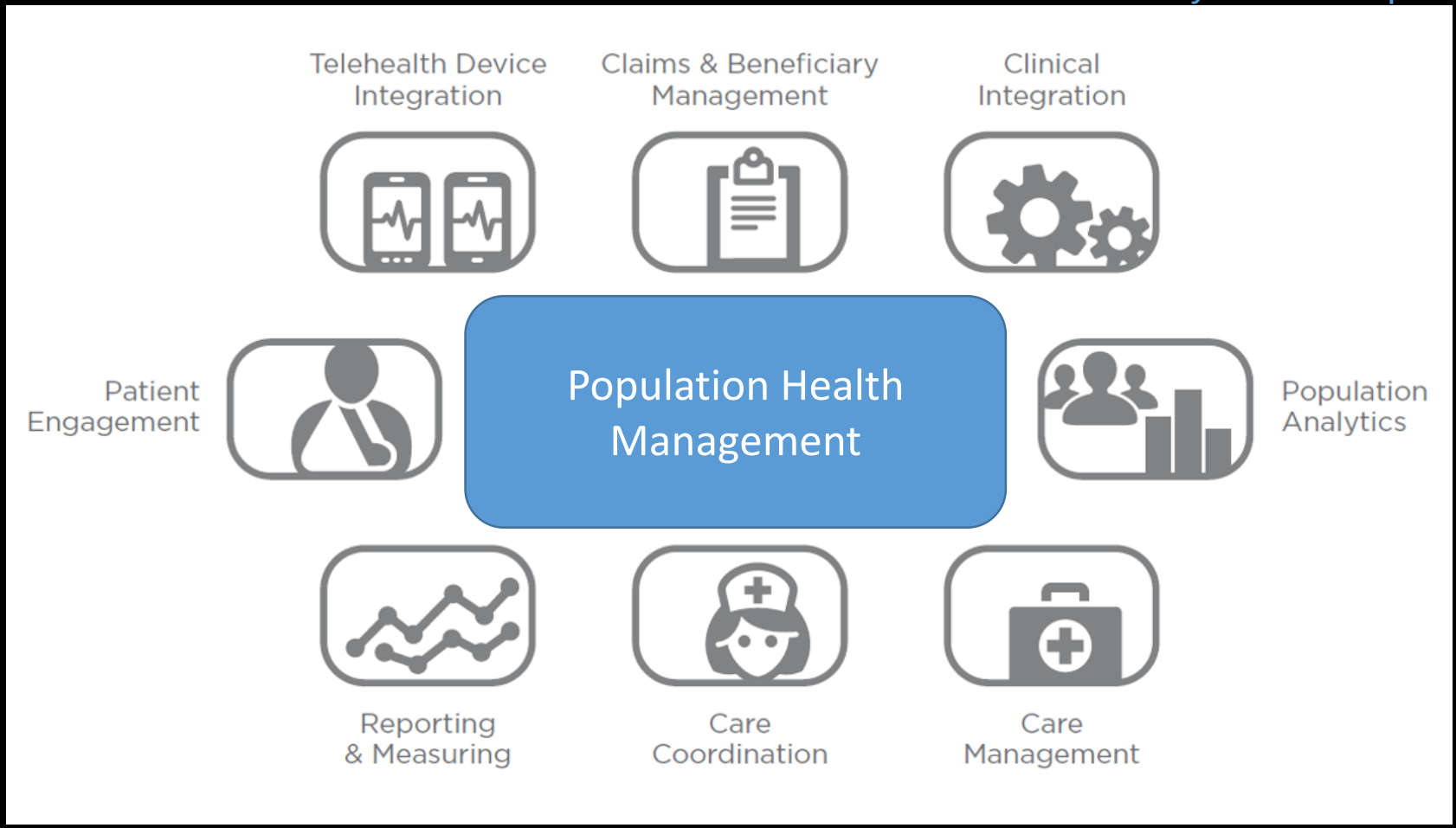
CMS expanded the option to delay risk in both 2021 and 2022 performance years due to the ongoing impact of the pandemic.

Care Coordination and Data Analytics in Advanced Payment Models

Population Health Strategies

Remote Patient Monitoring - Telehealth

Community Partnerships



Annual Wellness Visits
(Revenue opportunity)

Chronic Care Management
(Revenue opportunity)

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

Achieve optimal outcomes

Ensure patients have the resources and knowledge needed

Reactive Care

Medication dose increased due to high blood sugar levels due to inappropriate diet choices and poor understanding of nutritional information related to high sugar foods.

Treated in the ED for CHF exacerbation due to an increase in SOB over past 72 hours and unidentified weight gain of 5 lbs. over 24 hours.

Readmitted to the hospital with a hypotensive episode due to starting a new medication prescribed upon hospital discharge and not discontinuing a previously prescribed medication, as instructed.

Preventative Care

Care coordination and education.
Patient develops strong self-care ability and knowledge of disease processes.

Appropriate support services in place.

Discharge planning started upon admission and teach back utilized to verify understanding of instructions upon discharge.
Post discharge call/visit to review instructions and to assess further needs.

Readmissions, ED Utilization and Exacerbations occur frequently

Reduce or Prevent Readmissions, ED Utilization and Exacerbations

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.

Many types of risk adjustment methodologies exist. CMS uses HCC codes to determine Risk-Adjusted Factor (RAF) scores

Hierarchical Condition Category and Benchmark Impact

Recode	Recode all removed diagnoses that are still applicable
Verify	Verify all new and current applicable dx are coded at the visit
Specificity	Verify HCC diagnoses with disease progression are coded at the most applicable level
Care	Care plan in place to manage applicable diagnoses

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.

Mock ACO Financial Scenario

TIN	Count of Attributed	Average of HCCScore	Average of HCC Benchmark	Average of Total Spend	Sum of Total Spend
Hospital A	1,598	1.46	$14,563.53	$11,871.12	$18,970,057.15
Hospital B	528	1.22	$12,178.69	$12,914.42	$6,818,815.27
Hospital C	1,102	1.28	$12,850.25	$12,077.97	$13,309,920.89
Hospital D	1,606	1.18	$11,840.19	$10,233.46	$16,434,936.58
Hospital E	1,165	1.20	$12,043.40	$12,709.32	$14,806,354.67
Hospital F	1,263	1.07	$10,714.20	$9,681.22	$12,227,384.36
Hospital G	2,080	1.11	$11,084.28	$12,594.37	$26,196,284.69
Hospital H	690	1.26	$12,623.12	$12,668.18	$8,741,044.48
Hospital I	821	1.20	$12,002.14	$9,874.68	$8,107,116.11
Hospital J	1,483	1.23	$12,312.93	$12,822.31	$19,015,487.26
ACO Total	**12,336**	**1.22**	**$12,185.55**	**$11,724.01**	**$144,627,401.46**

Gross Savings/(Loss) Percentage
3.79%

Example – Mock data for demonstration only

Dashboard – Provider Performance Data

	# Patients with claims	# Costly Patients	Average 2018 HCC Score	Average 2019 HCC Score	Average Change in HCC Score 2018 to 2019	Average Diagnosis Recapture Rate 2018 to 2019	Average 2019 HCC Benchmark	Average 2019 Per Patient Spend	Average Change in Spend 2018 vs 2019	Average Percent of Benchmark Used	Average AWV Completion
HOSPITAL A	**1,769**	**111**	**1.2**	**1.4**	**11.5**	**72.7**	**$12,372**	**$9,702**	**-5.4**	**75.5**	**33.6**
Provider A , MD	318	33	1.1	0.9	-16.2	100.0	$8,566	$2,123	-62.2	24.8	50.0
Provider B, MD	472	27	0.9	1.1	22.0	74.4	$9,952	$6,150	-13.0	61.8	29.6
Provider C, PA-C	397	21	1.2	1.6	30.7	78.1	$14,417	$13,730	32.2	95.2	30.3
Provider D, APRN	283	18	1.1	1.3	24.1	72.2	$11,805	$11,274	36.0	95.5	29.0
Provider E, MD	299	12	1.4	1.5	8.5	74.6	$13,511	$11,491	7.7	85.1	23.7

HCC: 1.0 is an average patient

<1.0 = Less sick
>1.0 = Sicker or less well

Mock data for demonstration only

Template Source: Health Endeavors

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

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

  Group Practice Reporting Option

QUALITY

In future years will be required to report quality data via eCQM's.

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.

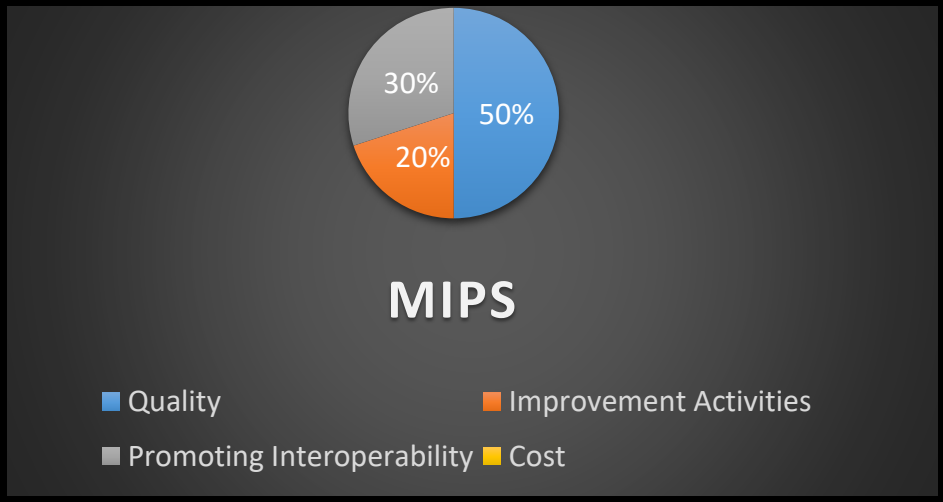
- Do providers and staff understand the specifications?
- If specifications change, is everyone made aware?

- 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?

MIPS APM
(Merit-Based Incentive Payment System Alternative Payment Model)

CMS calculates one MIPS composite performance score for the ACO. This score is applied to all MIPS eligible clinicians in the group. MIPS payment adjustments are applied at the unique TIN/National Provider Identifier (NPI) level for each MIPS-eligible clinician in the APM Entity group.



CMS CMMI Strategic Objectives: October 2021

Future 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.

Lead the way. Participate in programs and be an active leader in community outreach.

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!

Anne Hansen MSN, RN, GERO-BC, CPHQ
Director – Quality and Population Health
Prairie Health Ventures
anne.hansen@phvne.com
712.420.3203