Preparing for an APM

What you need to know

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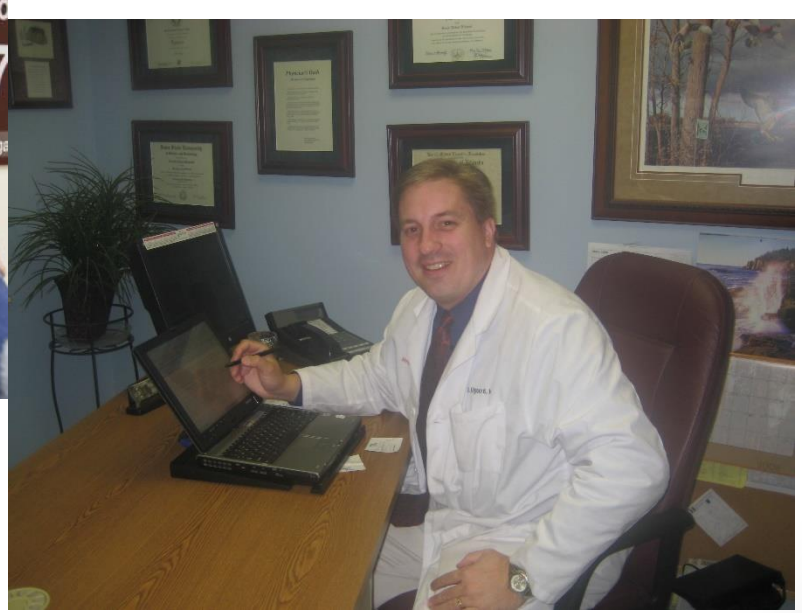
Background and Disclosures

- Practiced full scope, rural Family Medicine in Harlan, Iowa for 16 years
- Served as practice Medical Director throughout that time, including during our practice's participation in the TransforMED NDP from 2006-2008.
- Worked for Accountable Care Associates MSO in 2014-15, as CMO and national Medical Director; work with MSSP ACOs, Medicare Advantage, commercial and full risk contracts
- Involved in organized medicine – AMA, IAFP and AAFP leadership; currently serve on the AAFP Commission on Quality and Practice
- Founding President and Board Chair of Heartland Rural Physician Alliance, an IPA created in 2012 which brings together physicians, practices and hospitals across Iowa to thrive in the changing healthcare environment
- Serving as Board Chair and CMO of Heartland Physicians ACO since 2015.
- CEO and CMO of MedLink Advantange, a healthcare consulting and ACO management firm founded in 2015 to organize and manage ACOs made up of independent physicians, practices and hospitals. Provide consulting services for healthcare organizations of all types – physicians, clinic groups, hospitals, healthcare systems, ACOs, IPAs, associations, CME companies, and healthcare technology firms.
- Currently serve as physician faculty support for TCPI, SIM, HIIN and other projects run by the Iowa Healthcare Collaborative and Compass PTN

While I greatly enjoy ACO development and management, PCMH transformation, and healthcare consulting, as I work in those worlds this is where my heart will always be...



Learning Objectives

- What trends are affecting this move to Value-Based Payment (VBP) and Alternative Payment Models (APMs)?
- How can a practice stay viable in the Fee-For-Service world while preparing to succeed in VBP?
- What are the various APM options and the relative pros/cons of each?
- How do I know if I'm ready to join an ACO, and how would I go about moving ahead when I decide to do so?

National Policy Driver

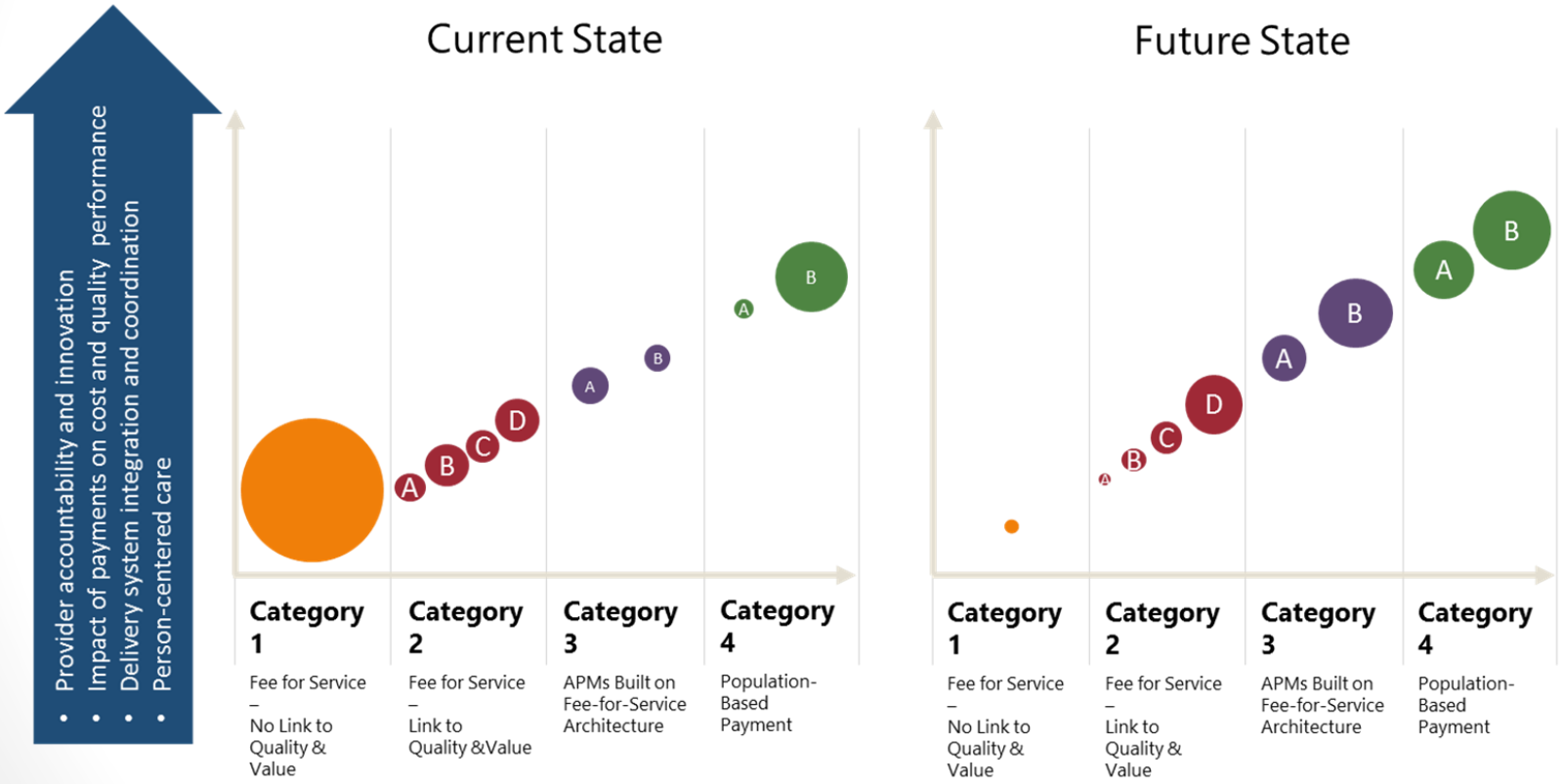
The Triple Aim is Better Care, Smarter Spending, and Healthier People.

The Quadruple Aim adds...Improved Clinician Experience

The Major Underlying Healthcare Payment Trend: Value-based Payment

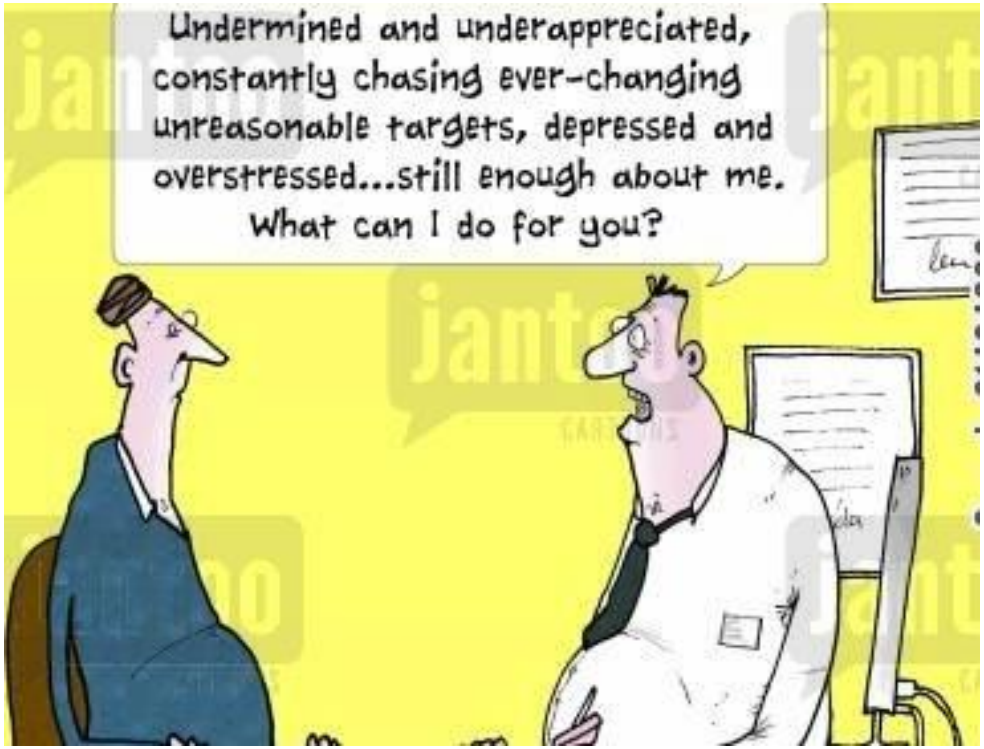
$$\text{Value} = \frac{\text{Quality (Outcomes, Safety, Service)}}{\text{Cost}}$$

CMS Goals for Payment Reform



What this can feel like to a practice

- We are constantly being asked to do more with less (or at least the same)…

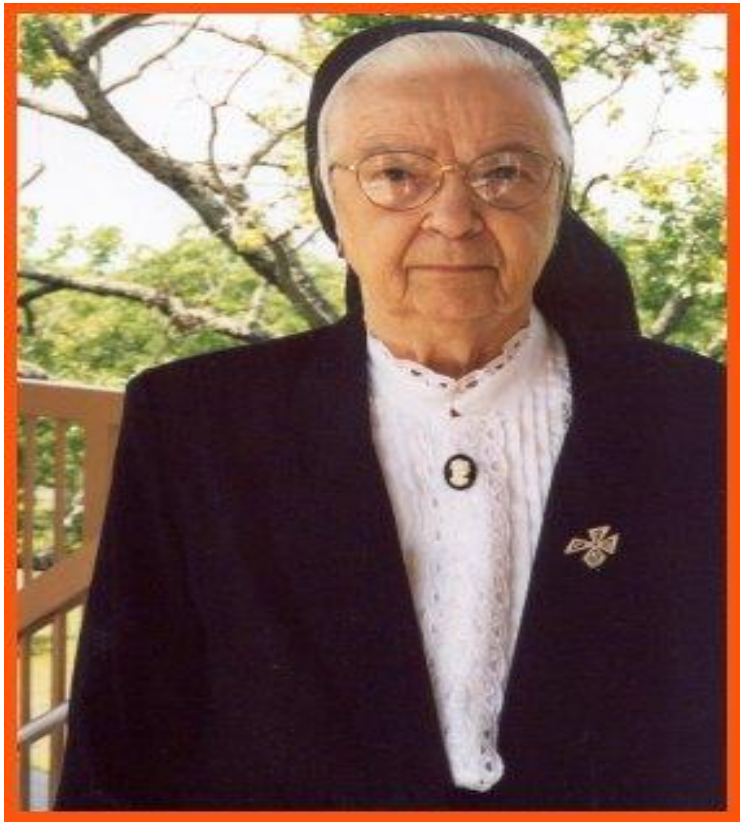


How to stay viable moving ahead? (Key concepts and questions to ask)

- Maximizing FFS revenue (appropriately)
  - How can I maximize FFS revenue streams while I position myself for value-based purchasing?
- Aligning Quality with Cost
  - How can I align the highest quality patient care with efforts to address and reduce cost?
- Positioning for Value-based Purchasing
  - How do my efforts today position my practice for success tomorrow?

No margin, no mission!

-Sister Irene Kraus, Daughters of Charity



Maximizing FFS Opportunities (Appropriately)

- CMS coding opportunities
  - Annual Wellness Visits
  - Transitional Care Management codes
  - Chronic Care Management codes
- Chronic Disease Management, appropriate
  - f/u clinic visits
  - f/u labs
- Copays – are they being collected?

Maximizing FFS Opportunities (Appropriately)

- Preventive services
  - Immunizations
  - Lab screenings
  - Cancer screenings
- Commercial payment changes (pre-ACO)
  - Quality bonuses
  - Pay for reporting
  - Enhanced FFS rates for PCMH

Maximizing FFS Opportunities (Appropriately)

Think about the coding system we are used to in FFS

- Coding is how we communicate with the insurance company about how much work we have done.
- If we are not very accurate, we are essentially telling the insurer that we are doing less work than we actually are
- This translates into less payment, sometimes MUCH less payment

Maximizing FFS Opportunities (Appropriately)

General Types of Coders in Fee For Service:

- **Under-coders**
  - 50% 99212; 50% 99213
- **Lazy coders**
  - almost all 99213
- **"Appropriate" coders**
  - 10% 99212, 58% 99213, 32% 99214

Maximizing FFS Opportunities (Appropriately)

Effects of Appropriate Coding on Income

Code	99212 - $52.75	99213 - $88.85	99214 - $121.62
	Under-coder	Lazy	Correct
Collections	$255,559	$320,712	$345,534
Overhead	$175, 000	$175,000	$175,000
Net Income	$80, 559	$145,712	$170, 534

Maximizing FFS Opportunities (Appropriately)

- Coding Appropriately
  - Are office visits being coded well?
  - Do you do some type of audit to evaluate coding?
  - Are providers given support and education around coding?

This has always been important in FFS, but becomes absolutely crucial in the risk adjustment used in value-based purchasing like ACOs

Aligning Quality with Cost

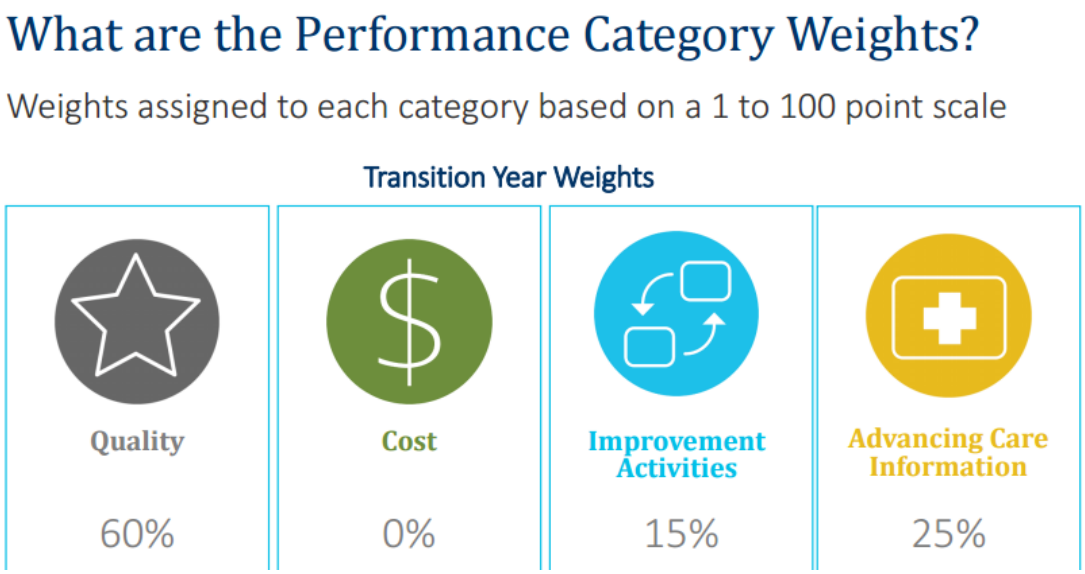
- Higher quality care can often means lower cost – look for these opportunities for synergy between quality and cost
- Some Quality Improvement (QI) efforts/strategies align quite well with FFS revenue streams, and that's a good thing…
  - AWV, TCM, CCM, etc.
  - f/u visits
  - Colonoscopy/mammograms
  - Immunizations

Aligning Quality with Cost

- Quality is a team sport – much quality work in a practice is not physician work
- Include as many hooks as possible to engage providers and staff fully in QI efforts
  - skill building for entire practice team
  - CME/CEU
  - MOC Part IV credit for physicians
  - Recognition/praise – celebrate wins!

Aligning Quality with Cost

- What about MIPS and the CMS Quality Payment Program?
  - Did you report OK for 2017?
  - Were you happy with your results?
  - Do you know what changes occurred in the 2018 program?
  - How does this fit with this discussion of aligning quality with cost?



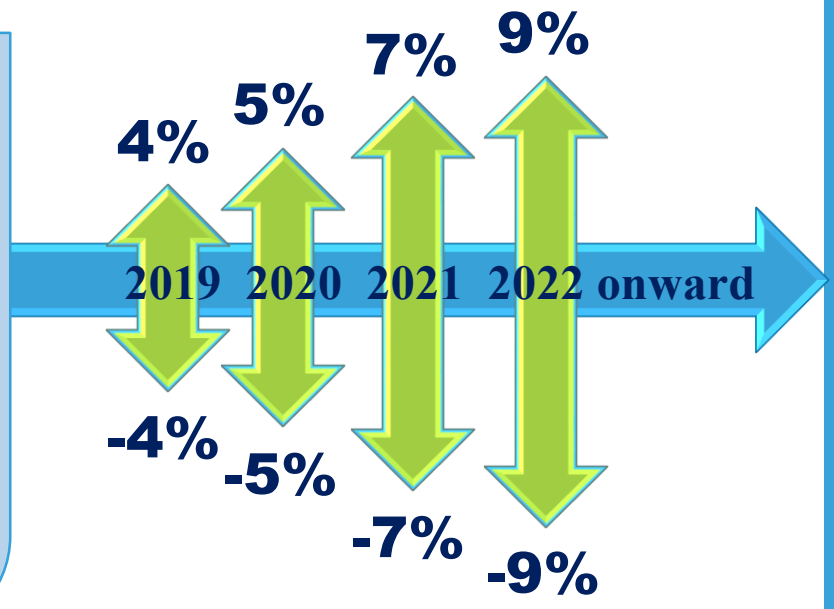
MIPS: Performance Categories

Category	PY 2017	PY 2018	PY 2019 and beyond
Quality	60%	50%	30%
Cost	NA	10%	30%
Improvement Activities	15%	15%	15%
Advancing Care Information	25%	25%	25%

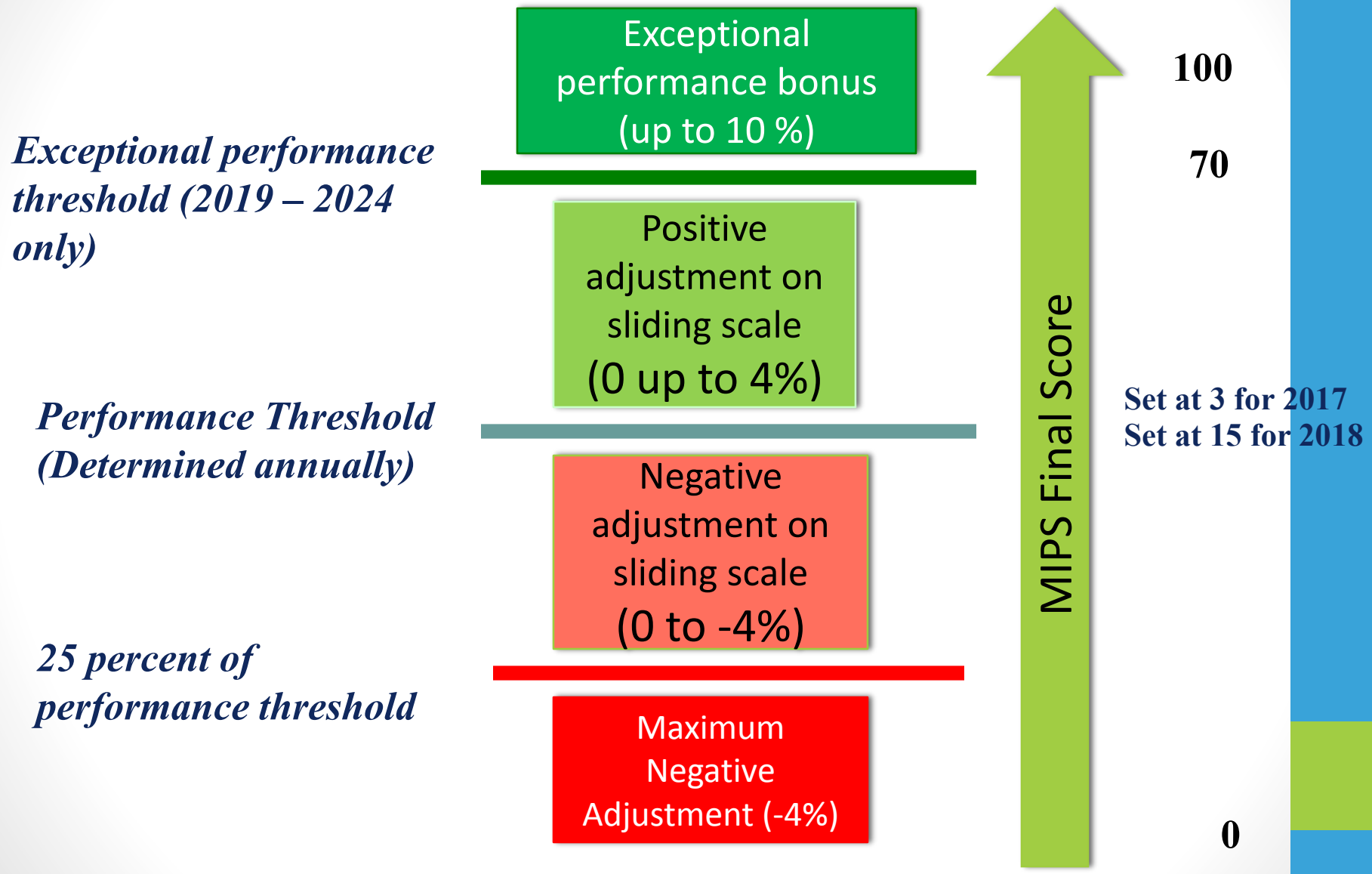
CMS has invoked its statutory flexibility to not score the cost category in the first year. However, that category will increase quickly in subsequent years.

MIPS Sets the Schedule for Significant Payment Adjustments Based on Value

"With respect to positive MIPS adjustment factors…the Secretary shall increase or decrease such adjustment factors by a scaling factor in order to ensure that the budget neutrality requirement…is met"



MIPS: Incentives and Penalties



Aligning Quality with Cost – Key as we move to VBP

Let's look at an example of what this might look like in an ACO:

- **GOAL: Reducing ER visits** – but how does this happen?
  - Better data on who has been in ER
    - Claims data, ACO reports, ADT feeds, direct communication from ERs, etc.
  - Better processes in the office –
    - empower nurse/care coordinator
    - standard procedures and expectations on f/u calls and appts.
    - better CDM protocols and f/u
    - identifying high utilizers of ER and targeting strategies to their needs
  - Better communication with patients
    - Communicate practice capabilities, expectations
    - "Call first" campaigns
    - May need to address culture issues – practice and community

Aligning Quality with Cost – Key as we move to VBP

Let's look at another example of what this might look like in an ACO:

- **GOAL: Reducing SNF costs**– how does this happen?
  - Better data on SNF costs in a practice
    - Claims data, ACO reports, direct communication from hospital and nursing SNFs
    - Which Skilled facilities cost more/less per day?; Average length of stay?; readmissions?
    - What patients in your practice are utilizing Skilled services?
  - Better processes in the office –
    - Tracking who is in skilled care
    - f/u calls to skilled facilities to ask about progress/issues
    - Consider visits to facilities as appropriate
    - Key discussions with facilities who are outliers on cost, quality, or length of stay
  - Better communication with patients
    - What should they expect from the SNF – PT twice daily 7 days a week, etc.
    - What are options for next steps – home health, etc.

Positioning for Value-based Purchasing

- Working on maximizing FFS, while you concurrently build out your practice knowledge base and skill set around quality, cost and risk is a wise transition strategy for practices.

- So the key question, what are the benefits of ACO participation and when am I ready to participate?
  - Let's explore APMs a little deeper to answer tat question.

What are MIPS APMs?

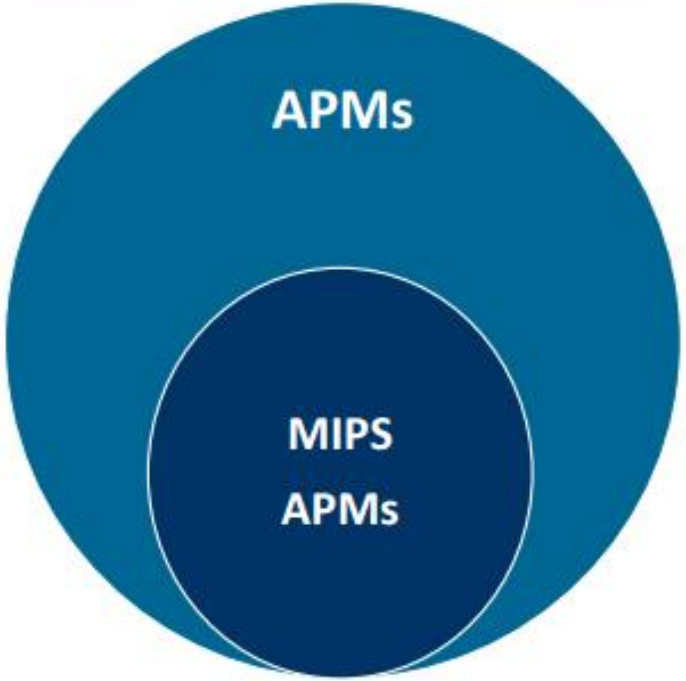
Goals

- Reduce eligible clinician reporting burden.
- Maintain focus on the goals and objectives of APMs.

How does it work?

- Streamlined MIPS reporting and scoring for eligible clinicians in certain APMs.
- Aggregates eligible clinician MIPS scores to the APM Entity level.
- All eligible clinicians in an APM Entity receive the same MIPS final score.
- Uses APM-related performance to the extent practicable.

MIPS APMs are a Subset of APMs



Shared Savings Program (All Tracks) under the APM Scoring Standard

	REPORTING REQUIREMENT	PERFORMANCE SCORE	WEIGHT
Quality	✓ No additional reporting necessary. ACOs submit quality measures to the CMS Web Interface on behalf of their participating MIPS eligible clinicians.	✓ The MIPS quality performance category requirements and benchmarks will be used to score quality at the ACO level.	50%
Cost	✓ MIPS eligible clinicians will not be assessed on cost.	✓ N/A	0%
Improvement Activities	✓ No additional reporting necessary.	✓ CMS will assign a 100% score to each APM Entity group based on the activities required of participants in the Shared Savings Program.	20%
Advancing Care	✓ Each ACO participant TIN in the ACO submits under this category according to MIPS reporting requirements.	✓ All of the ACO participant TIN scores will be aggregated as a weighted average based on the number of MIPS eligible clinicians in each TIN to yield one APM Entity group score.	30%

Track 1 MSSP ACOs

- Qualifies as a MIPS APM – preferential MIPS scoring
- Potential for significant shared savings
- Continue to get current Medicare FFS/cost based reimbursement payments
- No downside risk
- Access to CMS claims and risk data
- Understand local market, referral patterns, leakage, etc.
- Allows practices to participate in and learn to function well in an shared savings ACO before taking any downside risk
- Maximize FFS revenue while preparing for VBP

- Heartland Physicians ACO case study…

APM/ACO Success - The Key Three

The degree of success achieved in value-based healthcare is in large part determined by the degree to which we understand and actively manage these three factors using a thoughtful, balanced approach.

- Quality
- Cost
- Risk

Quality – Key Learnings

- Be broad and holistic in your approach to quality
  - Align efforts with practice values/priorities
  - Use PCMH principles and build practice skills
- Each ACO contract is different which regards to expectations around quality
  - Understand the differences
  - Look for areas of alignment and focus there
- Examine your baseline and look for low-hanging fruit with regards to improvement – be strategic

Quality – Key Learnings

- Higher quality can often means lower cost – look for these opportunities for synergy
- Some QI efforts/strategies align well with FFS revenue streams, and that's a good thing…
  - AWV, TCM, CCM, etc.
  - f/u visits
  - Colonoscopy/mammograms
  - immunizations
- This is a team sport – much quality work is not physician work
- Include as many hooks as possible in QI efforts
  - skill building
  - CME/CEU
  - MOC credit, etc.

Cost – Key Learnings

- Work to get comfortable discussing cost
  - Not natural for many physicians – feels wrong to focus here
  - However, high cost patients are often (maybe even usually) those that need our attention and expertise the most
- Huge overlap between cost/quality
- Claims/cost data isn't perfect, but it doesn't matter
  - Gives us new insights into patients/populations
  - We are good at pattern recognition – start to use those skills here
- Understand your patient population and practice dynamics
  - Many cost buckets are relatively universal – ER, Admissions, SNF, meds…
  - The drivers of these may vary remarkably between practices/communities

Cost – Key Learnings

- Much ACO work will be rightfully directed at cost
- The inherent value of Physician-led ACO efforts is our ability to see cost in the larger context of quality and improved patient care.
- Access to cost data gives us an additional perspective on our ability to impact health care costs. Doesn't mean our decisions will be determined solely on cost, but gives us that piece of information we have previously not had access to when making decisions. Now we can see:
  - Our own patterns of care
  - Differential costs associated with different facilities
  - Differential costs of competing sub-specialists
  - Patient behaviors of which we have been previously unaware and the associated costs
- While we cannot fully control healthcare costs, we do have direct and indirect impact on a large portion of those costs, whether we like it or not…

Risk – Key Learnings

- Educate yourself on Risk Adjustment
- Is often the least understood of the key three, but in many ways one of the most important
  - New knowledge
  - New skills
- Each ACO contract is different which regards to risk adjustment
  - Understand the differences
  - Look for areas of alignment and focus there
- Key understanding is that what we code directly affects the insurers risk adjustment for our ACO patients
  - This didn't need to matter to us in FFS
  - Greatly affects the success of the ACO efforts and is nearly completely in our control, unlike some aspects of quality and cost

Risk – Key Learnings

- Increasingly healthcare providers are being told we need to take on more risk. The term risk can be used to mean a variety of things:
  - Traditional risk management, usually used to describe malpractice risk and efforts to minimize this type of risk exposure
  - Contractual upside/downside risk in an VBP/ACO contract
  - Actuarial risk when looking at healthcare costs of different disease states or populations
  - Payers use forms of risk adjustment to determine estimates for medical spending on a population and therefore set benchmarks or budgets in an ACO or value-based payment contract.

- We don't need to fear the term risk, but we do need to understand what is meant when it is used, and how risk and risk adjustment work in the value-based payment world.

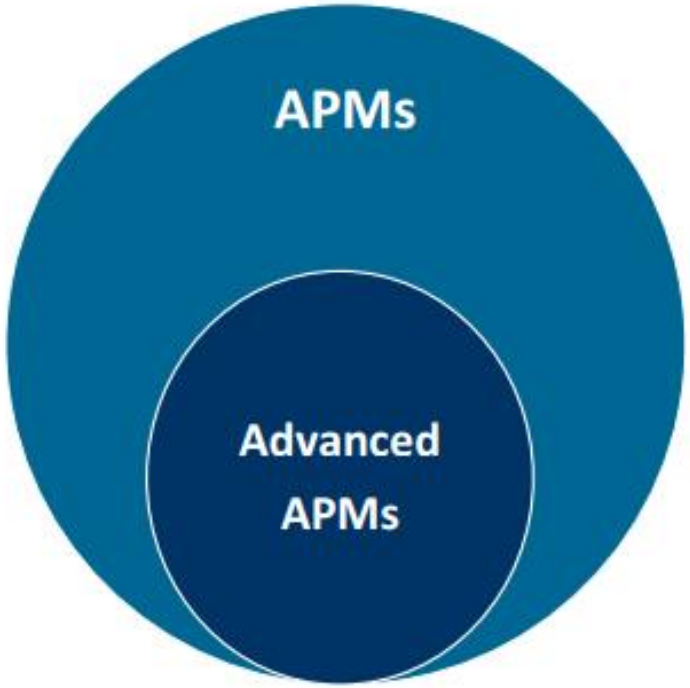
- Let's explore the types of risk in a little more detail…

Alternative Payment Models

- An Alternative Payment Model (APM) is a payment approach, developed in partnership with the clinician community, that provides added incentives to clinicians to provide high-quality and cost-efficient care. APMs can apply to a specific clinical condition, a care episode, or a population.

- APMs may offer significant opportunities to eligible clinicians who are not immediately able or prepared to take on the additional risk and requirements of Advanced APMs.

Advanced APMs are a Subset of APMs



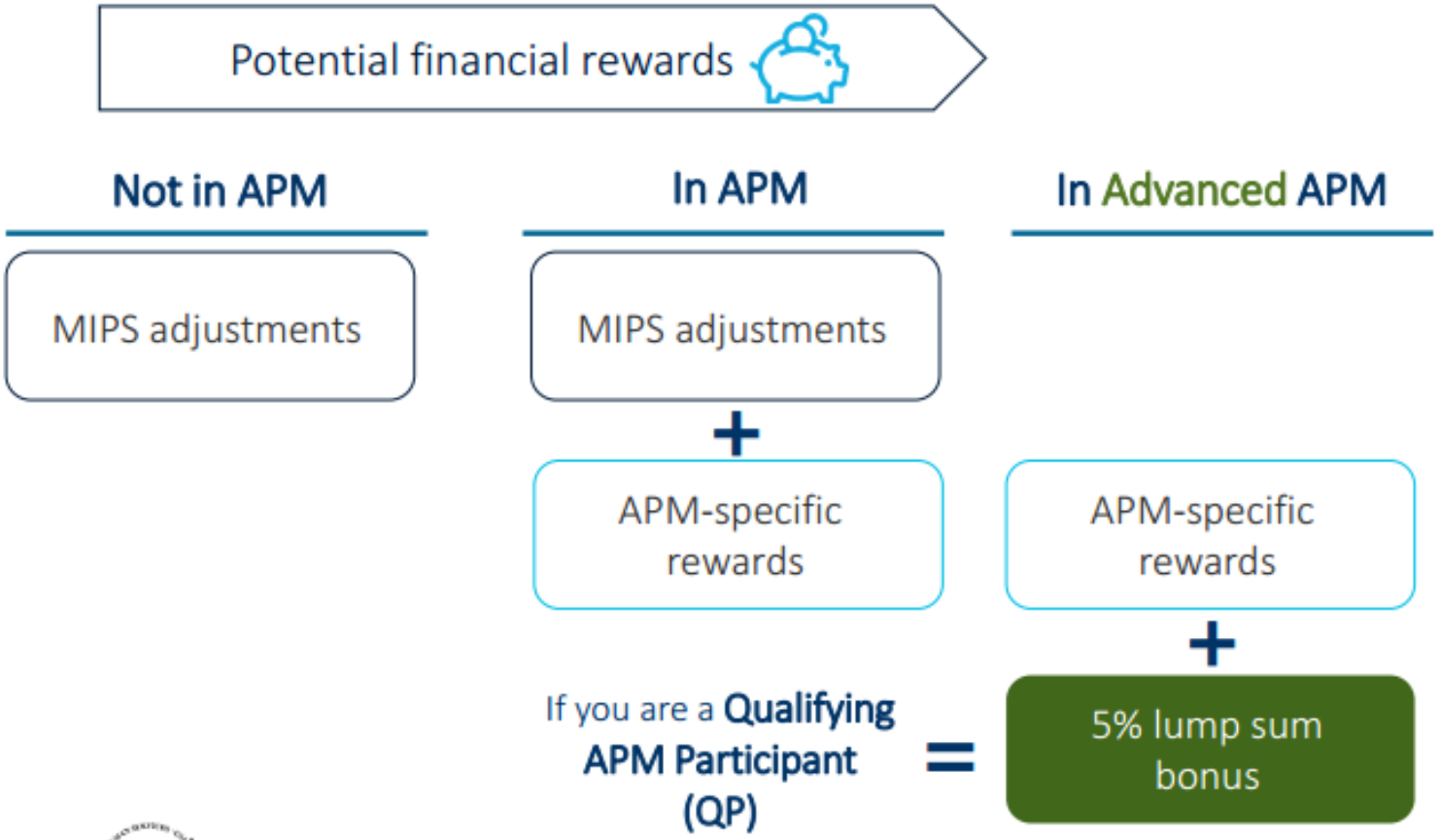
2018 Primary Care Advanced APMs

- Shared Savings Program (Tracks 1+, 2 & 3)
- Next Generation ACO Model
- Comprehensive Primary Care Plus (CPC+)
- Vermont Medicare ACO Initiative (as part of the Vermont All-Payer ACO Model)
- 2018 AAPMs announce as approved

Advanced APM Perks

- Not subject to MIPS
- 5% of Part B charges bonus 2019-2024
- Higher fee schedule update to 0.75% from 2026 onward

The Quality Payment Program provides **additional** rewards for participating in APMs.



How does this all fit together?

What we as physicians and healthcare professionals are used to thinking about:

Now we need to increasingly be comfortable with:

When are ready to join an ACO?

- If you are asking the question, then you probably are.
- The most important factor is the willingness to participate:
  - Look at new data – claims, utilization, risk, quality
  - Think about how to improve the care you provide
  - Collaborate with others – teach and learn together
- You don't have to have it all together and be a highly-functional, high-performing practice up front (most aren't even close!)

How do you join an ACO?

- Consider your options of ACOs to join
  - MSSP/Commercial/Medicaid
  - Health system-led ACO vs. physician-led/independent
  - Upside only vs. downside risk ACO contract
- Some basic questions to ask
  - Who else is in the ACO?
  - How are decisions made?
  - What quality metrics will I be accountable for?
  - What are the upfront costs?
  - What support/data/technology will I receive?
  - What education is provided to physicians/administrators/staff?
  - How are any savings distributed?
- Timing
  - Most ACOs operate on a calendar year basis, with sign-up for the next year ending in July-September

How discussing MACRA, value-based payment, PCMH, and ACOs can make many feel….**Don't give in!**

When struggling to understand all the complexities of healthcare in 2018, remember:

Change is an ongoing process, not an event.

Questions Encouraged

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