The “Value” of an ACO

Presenter-

- Senior Consultant
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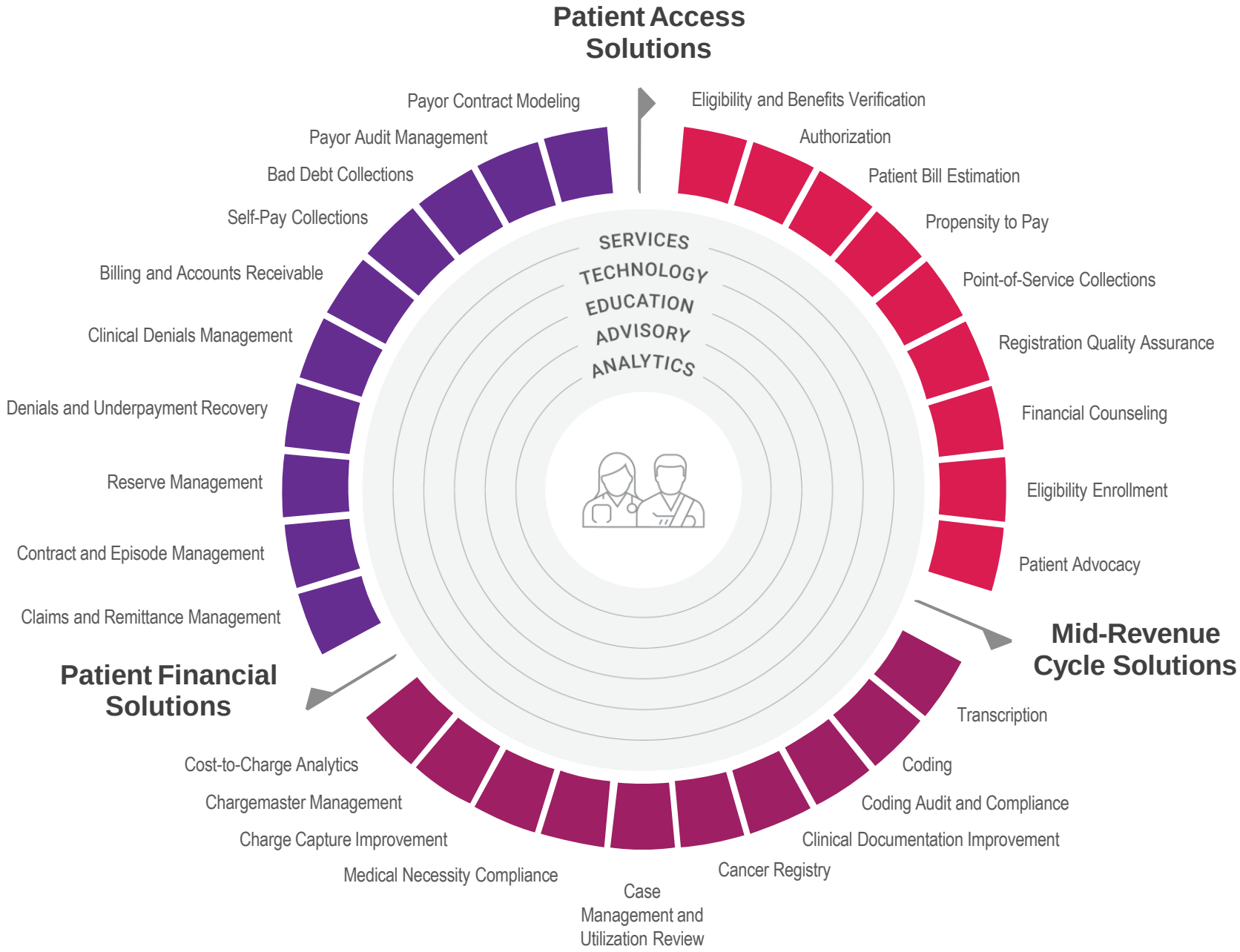
nThrive Capabilities Span Patient-to-Payment℠



AGENDA –
THE “VALUE” OF AN ACO

- The Model of an ACO
- Types of ACOs
- Why Join an ACO?
- ACO Reporting and Components
- How to Prepare to be in an ACO

THE MODEL OF AN ACO

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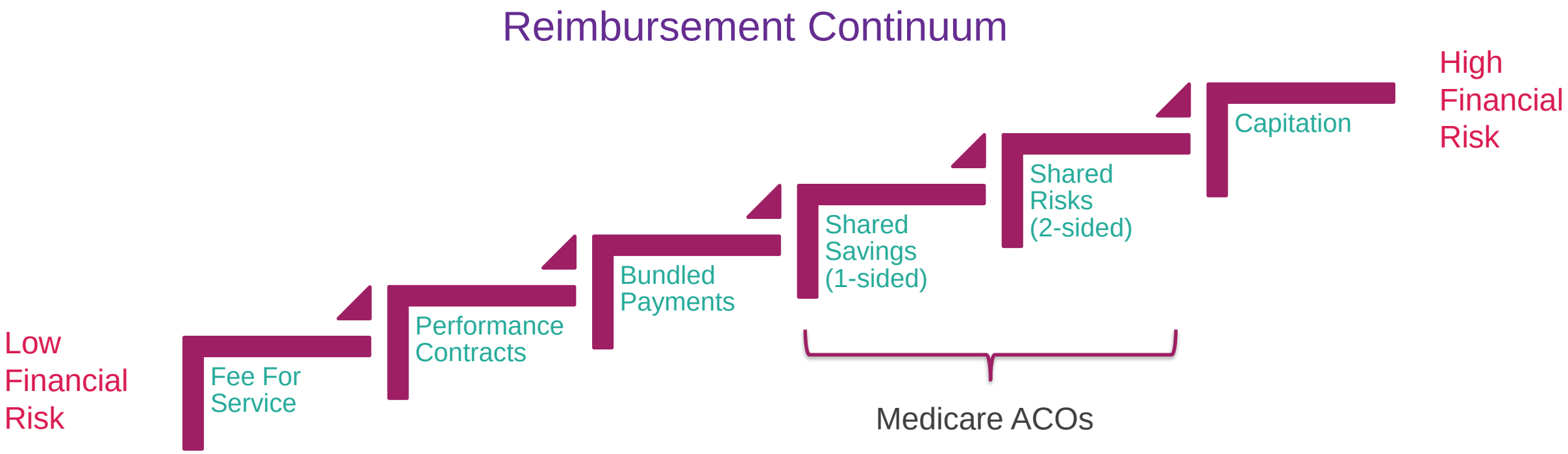
The Model of an ACO

- “an ACO refers to a group of Medicare providers and suppliers (e.g., hospitals, physicians, and others involved in patient care) that will work together to coordinate care for the Medicare Fee-For-Service patients they serve.”

The Model of an ACO



The Model of an ACO

- Medicare ACOs
  - ESRD –End Stage Renal
  - CPC+ (Comprehensive Primary Care +)
  - Next Generation ACO
  - Shared Savings
    - Advanced Payment ACO Model
    - Track 1+,2,3
  - Oncology Care Model
  - Care for Joint Replacement
- Private Payer ACOs

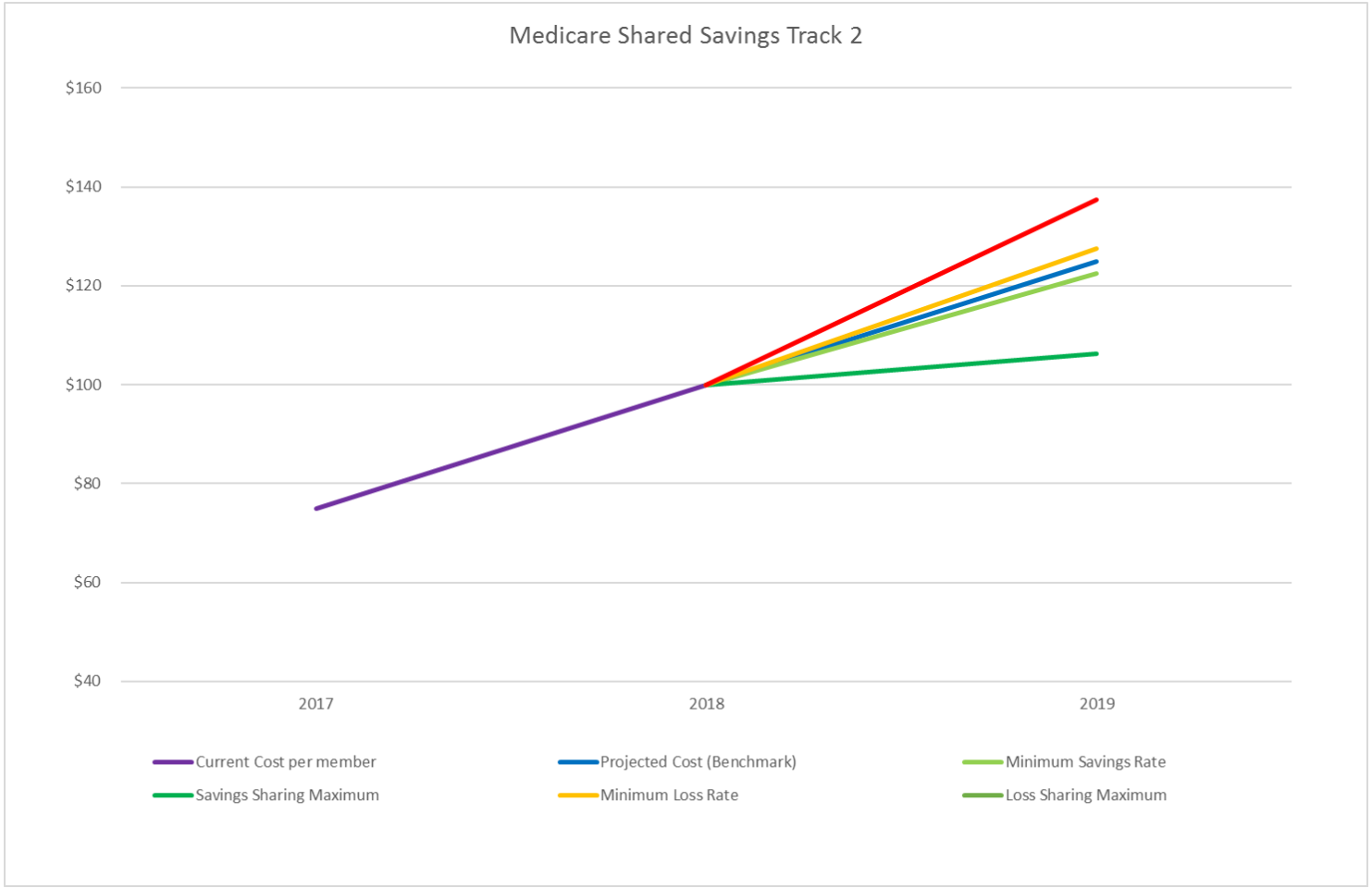
561 Shared Savings Program ACOs in 50 states (plus Washington, D.C., Puerto Rico, and other U.S. territories) are providing care to 10.5 million beneficiaries in 2018.

 # Number of ACOs in the area.
NOTE: This area may cover organizations serving beneficiaries across multiple states.

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

The Model of an ACO

Financial Mechanics of an ACO



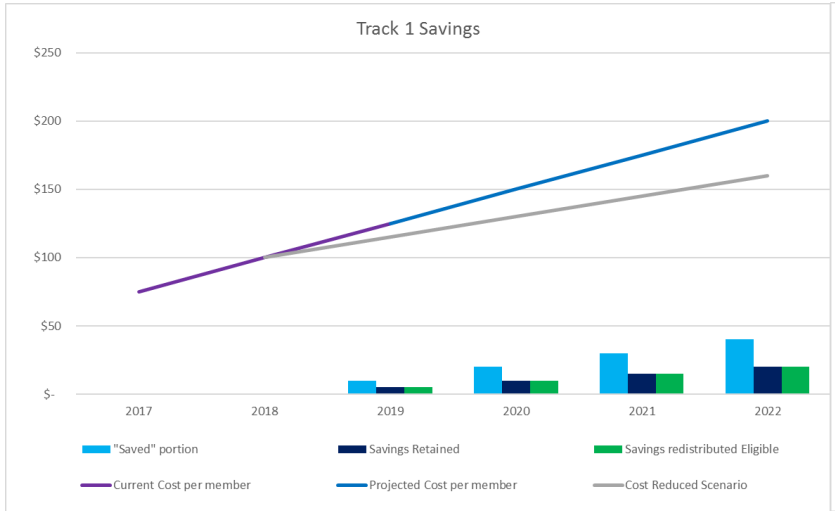
	Track 1	Track 2	Track 3
Minimum Savings Rate (MSR)	Variable	Choose up to 2%	Choose up to 2%
Maximum Shared Savings	10%	15%	20%
Portion of Savings	50%	60%	70%
Minimum Loss Rate	N/A	Choose up to 2%	Choose up to 2%
Loss Sharing Limit	N/A	5, 7.5, 10	15%

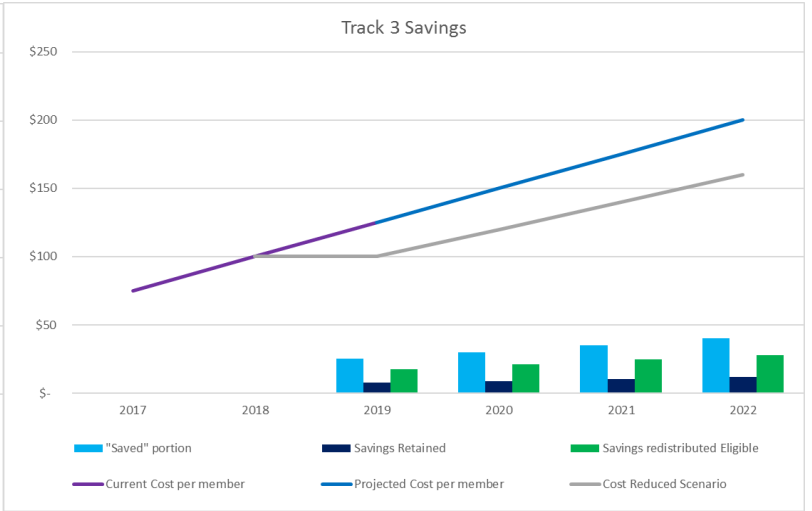
The Model of an ACO

Shared Savings

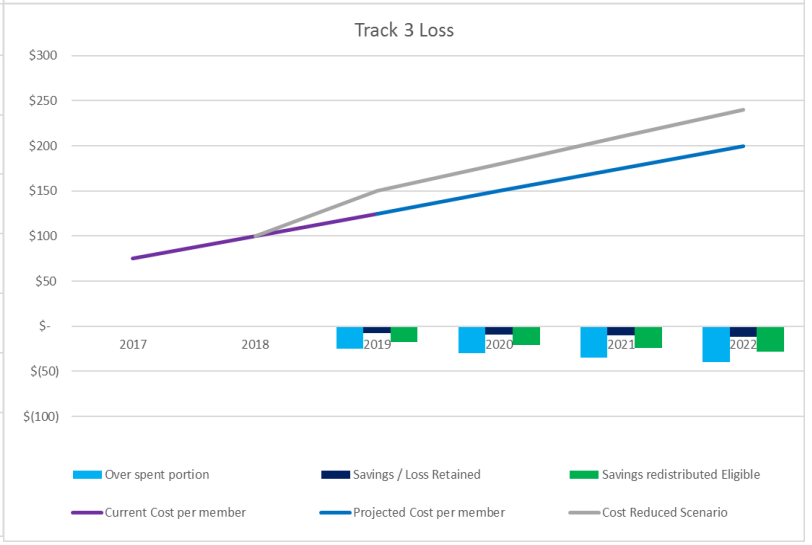
Shared Risks

Saving Scenario





Loss Scenario



ACO REPORTING AND COMPONENTS

ACO Reporting

- Medicare ACO Measures
  - 4 Domains
    - Patient/Caregiver Experiences
    - Care Coordination / Patient Safety
    - Preventive Health
    - At Risk Populations
- Private ACO Measures
  - "Wild West"
    - Usually related to Medicare Measures

Table: 33 ACO Quality Measures

Domain	Measure	Description	Pay-for-Performance Phase In R= Reporting P= Performance		
			PY1	PY2	PY3
Patient/Caregiver Experience	ACO #1	Getting Timely Care, Appointments, and Information	R	P	P
Patient/Caregiver Experience	ACO #2	How Well Your Doctors Communicate	R	P	P
Patient/Caregiver Experience	ACO #3	Patients' Rating of Doctor	R	P	P
Patient/Caregiver Experience	ACO #4	Access to Specialists	R	P	P
Patient/Caregiver Experience	ACO #5	Health Promotion and Education	R	P	P
Patient/Caregiver Experience	ACO #6	Shared Decision Making	R	P	P
Patient/Caregiver Experience	ACO #7	Health Status/Functional Status	R	R	R
Care Coordination/Patient Safety	ACO #8	Risk Standardized, All Condition Readmissions	R	R	P
Care Coordination/Patient Safety	ACO #9	ASC Admissions: COPD or Asthma in Older Adults	R	P	P
Care Coordination/Patient Safety	ACO #10	ASC Admission: Heart Failure	R	P	P
Care Coordination/Patient Safety	ACO #11	Percent of PCPs who Qualified for EHR Incentive Payment	R	P	P
Care Coordination/Patient Safety	ACO #12	Medication Reconciliation	R	P	P
Care Coordination/Patient Safety	ACO #13	Falls: Screening for Fall Risk	R	P	P
Preventive Health	ACO #14	Influenza Immunization	R	P	P
Preventive Health	ACO #15	Pneumococcal Vaccination	R	P	P
Preventive Health	ACO #16	Adult Weight Screening and Follow-up	R	P	P
Preventive Health	ACO #17	Tobacco Use Assessment and Cessation Intervention	R	P	P
Preventive Health	ACO #18	Depression Screening	R	P	P
Preventive Health	ACO #19	Colorectal Cancer Screening	R	R	P
Preventive Health	ACO #20	Mammography Screening	R	R	P
Preventive Health	ACO #21	Proportion of Adults who had blood pressure screened in past 2 years	R	R	P
At-Risk Population Diabetes	Diabetes Composite ACO #22 – 26	ACO #22. Hemoglobin A1c Control (HbA1c) (<8 percent) ACO #23. Low Density Lipoprotein (LDL) (<100 mg/dL) ACO #24. Blood Pressure (BP) < 140/90 ACO #25. Tobacco Non Use ACO #26. Aspirin Use	R	P	P
At-Risk Population Diabetes	ACO #27	Percent of beneficiaries with diabetes whose HbA1c in poor control (>9 percent)	R	P	P
At-Risk Population Hypertension	ACO #28	Percent of beneficiaries with hypertension whose BP < 140/90	R	P	P
At-Risk Population IVD	ACO #29	Percent of beneficiaries with IVD with complete lipid profile and LDL control < 100mg/dl	R	P	P
At-Risk Population IVD	ACO #30	Percent of beneficiaries with IVD who use Aspirin or other antithrombotic	R	P	P
At-Risk Population HF	ACO #31	Beta-Blocker Therapy for LVSD	R	R	P
At-Risk Population CAD	CAD Composite ACO #32 – 33	ACO #32. Drug Therapy for Lowering LDL Cholesterol ACO #33. ACE Inhibitor or ARB Therapy for Patients with CAD and Diabetes and/or LVSD	R	R	P

Notes: PY = Performance Year

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ACO Reporting

- Patient Satisfaction
  - Doctor ratings
  - Access to specialists
  - Doctor communication
  - Shared decision making

	Provider Organization	Payer	Patient
Fee For Service	Only important if it strongly (negatively) affects your public image	Payers want providers with higher satisfaction scores to be in network	Minimal recourse for poor provider interactions
Accountable Care Organization	Negative scores can have immediate financial impact	Happier Patients = Happier Payer	Better interactions with provider

ACO Reporting

- Coordination of Care
  - Readmission rates
  - Ambulatory Sensitive Conditions
    - HF, COPD, Asthma
  - Medication reconciliation

	Provider Organization	Payer	Patient
Fee For Service	No reason or Incentive to coordinate	This can be costly to the Payer	This can be costly to the patient and results in care that is less focused or specialized to needs
Accountable Care Organization	Working with patient can minimize utilization and maximize outcomes	ACOs can reduce costs	Reduced costs and medical plans that are focused on my needs

ACO Reporting

- Preventive Health
  - Vaccinations
  - Screenings

	Provider Organization	Payer	Patient
Fee For Service	Minimal reasons or incentive to prevent costs	Paying for Preventable costs	Time, effort, energy and money wasted.
Accountable Care Organization	Financial opportunites to minimize cost and retain some revenue	Reduction of Cost, and redundancy	Early detection = Higher survivability

ACO Reporting

- At-Risk Populations
  - Diabetes
  - Hypertension
  - Heart Failure

	Provider Organization	Payer	Patient
Fee For Service	More care needs are better for business	Paying More in the long run	Less accountable to insurance or Medical Professionals
Accountable Care Organization	Financial ties to helping maintain a healthier at risk population	Reduction of overall cost of a condition	Better preventive care = Better long term results

WHY JOIN AN ACO?

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Why Join an ACO?

MACRA

Choose Payment Pathway

Quality Payment Program (QPP)

MIPS

Merit-based incentive payment program

FUTURE: MIPS FINAL SCORE

1 composite score and report with **4** categories:

- **Quality**
- ✚
- **Resource Use**
- ✚
- **Clinical Practice Improvements**
- ✚
- **Advancing Care Information (MU)**

APMs

Alternative Payment Models

OPTIONS

- **ACOs**
- **Bundles**
- **Medical Home**
- **Other Models**

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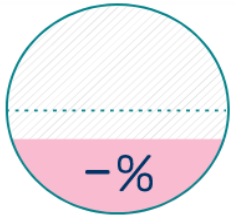
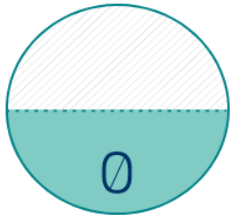
Why Join an ACO?



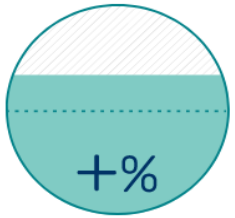
NOT PARTICIPATING IN THE QUALITY PAYMENT PROGRAM:

If you don't send in any 2017 data, then you receive a negative 4% payment adjustment.



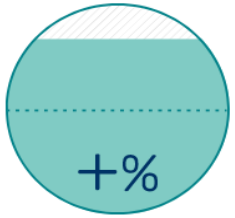
TEST:

If you submit a minimum amount of 2017 data to Medicare (for example, one quality measure or one improvement activity for any point in 2017), you can avoid a downward payment adjustment.



PARTIAL:

If you submit 90 days of 2017 data to Medicare, you may earn a neutral or positive payment adjustment and may even earn the max adjustment.



FULL:

If you submit a full year of 2017 data to Medicare, you may earn a positive payment adjustment.

Participate in the Advanced APM path:

If you receive 25% of Medicare payments or see 20% of your Medicare patients through an Advanced APM in 2017, then you earn a 5% incentive payment in 2019.

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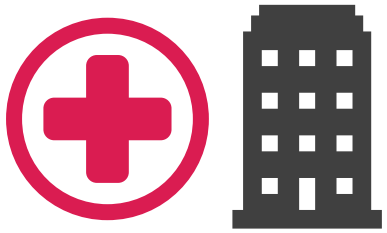
Why Join an ACO?



Advanced Alternative Payment Models

Are you a QP?

Qualified Participant

In 2019, clinicians can qualify as QPs by leveraging participation in advanced models managed by payers other than Medicare. This is known as **the "All Payer Combination Option."**

Distinguishing APMs for Advanced APMs

Yes

- **25%** of Medicare part B payment through APM.

OR

- **20%** of Medicare patients through APM.

- Receive **5%** bonus from CMS.
- No MIPS reporting.

Partial

- **20%** of Medicare part B payments through APM.

OR

- 10% of Medicare patients through APM

Opt Out

- Do nothing. No positive or negative adjustment.

Opt In

- Report MIPS. Potential positive adjustment.

No

- Report MIPS. Positive or Negative Adjustment.

Determinations made on:

- March 31
- June 30
- August 31

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Why Join an ACO?

- “We currently deliver $54 billion in care annually through value-based contracts, representing about one-third of our total payments to physicians and hospitals, and are on course to raise that to $65 billion by 2018.”

-United Healthcare’s Webpage

HOW TO PREPARE TO BE IN AN ACO

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How to Prepare to be in an ACO?

- Client Stories- Home Grown, Starting once they had the capabilities
  - “The process of figuring out how to work with an ACO is intrinsically valuable”
  - Multi-Departmental Taskforce
- “Medicare Shared Savings Program and Rural Providers” document for FQHC and RHC to create ACO
- Advanced Payment ACO
  - Designed with Rural Healthcare providers in mind
- Risk Stratification
  - Adjusted Clinical Groups (ACG)
  - Minnesota Tiering (MN)
  - Charlson Comorbidity Measure
  - Elder Risk Assessment (ERA)
  - Chronic Comorbidity Count (CCC)
- Measure Early and Measure Often
  - Fail fast, Fail cheap
- Financial Implications
  - Risk and rewards

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Incentive Alignment

Calculation and distribution of incentives to physicians occurs after performance is achieved, typically as a result of cost savings or quality and efficiency programs.

Elements of Compensation	Current PCP Compensation	Value-based PCP Compensation
Productivity	4864 RVUs	Panel of 2500 Patients
Compensation Rate	$41	N/A
Productivity-based Compensation	$199,424	N/A
Guaranteed Salary	None	$136,924
Incentive-based Compensation	$7,500	$60,000
For Service Quality	$2,500	$10,000
For Clinical Quality	$5,000	$50,000
Per Patient Per Month Management Fee	None	$4.00 (x 2500 patients) = $10,000
Total Compensation	$206,924	$206,924

Primary Care Quality Compensation Report

Reporting Period: 2017

Provider Name
Smith, Jane MD

Member Months
2073

Performance Percentile
APM Median: 75%
You: 100%

Access Measure	Goal	Actual	% Possible	% Earned
Panel Size	50-100		5%	**20%**
Panel Size	101-199		10%	
Panel Size	200+	250	20%	
Net New Patients	1-25		5%	
Net New Patients	26-99		10%	
Net New Patients	100+		20%	

Quality Measures	Goal	Actual	Achieved Y/N	Points Possible	Points Earned
Colorectal Cancer Screen	35%	35%	Y	5	5
Effective Contraceptive Use	38%	38%	Y	5	5
SBIRT Full Screen	6.3%	6.3%	Y	5	5
Depression Screening with Follow up	25%	25%	Y	5	5
A1c Poor Control	≤ 34%	≤ 34%	Y	5	5
Adolescent Wellcare	26%	26%	Y	5	5
Hypertension Control	64%	64%	Y	3	3
Access to Care Survey Results	85%	85%	Y	3	3
Satisfaction with Care Survey Results	85%	85%	Y	3	3
PCPCH	Y/N	Y/N	Y	3	3
PCP Visits (per 1000)	≥ 2337	≥ 2337	Y	3	3
ER Visits Level 1&2	≤ 203	≤ 203	Y	3	3
Citizenship (Participation w/ AllCare Health)	1-3	1-3	Y	3	3
Follow Up Appt. w/in 14 Days of Discharge	50%	50%	Y	2	2
Preventive (per 1000)	≥ 1738	≥ 1738	Y	2	2
Lipid Profile for Diabetics	80%	80%	Y	1	1
Bonus Points					
Data Electronically Submitted	Y/N	Y	Y	5	5
Total Points					**61**

Performance Score

Tier 1 (55%)	14-28 Points	Access Achieved: 20%
Tier 2 (65%)	29-42 Points	Quality Achieved: 80%
Tier 3 (80%)	43+ Points	**Overall Achieved: 100%**

Our MACRA Solution Methodology

Strategic planning, education, technology and clinician services will be required to transition from FFS to MIPS to APMs.

Current:
Fee for Service

Future:
Fee for Value

Advise	Educate	Benchmark	Monitor	Improve	Report
Goal development to optimize capabilities, manage risk and drive growth down to practice level.	On-demand education to ramp up anyone on MACRA, MIPS, and AAPMs	Quickly assess and benchmark clinicians' quality performance	Benchmark and monitor quality performance and reimbursement key performance indicators	Utilize change management to improve quality performance and Medicare reimbursement	Submit quality, cost, clinical practice improvement, and advancing care data to CMS instantly and seamlessly

Reach out!

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