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ABCs of ACOs

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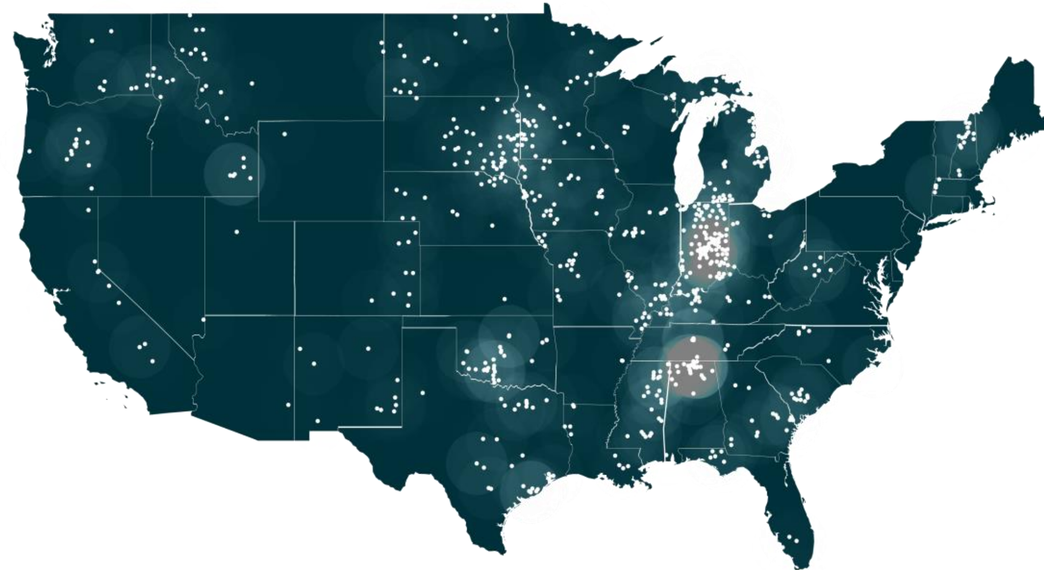
About Caravan Health

Helping Providers Navigate the Challenges of Value-Based Payments

Practice Transformation	Data and Analytics	Network Development	Accountability and Performance Improvement

- **170 employees**
- **17 Accountable Care Organizations ranging from 5,000 to 230,000 attributed lives**
- **CMS Practice Transformation Network**
- **>350 health systems**
- **>14,000 clinicians**
- **>500,000 attributed Medicare lives**



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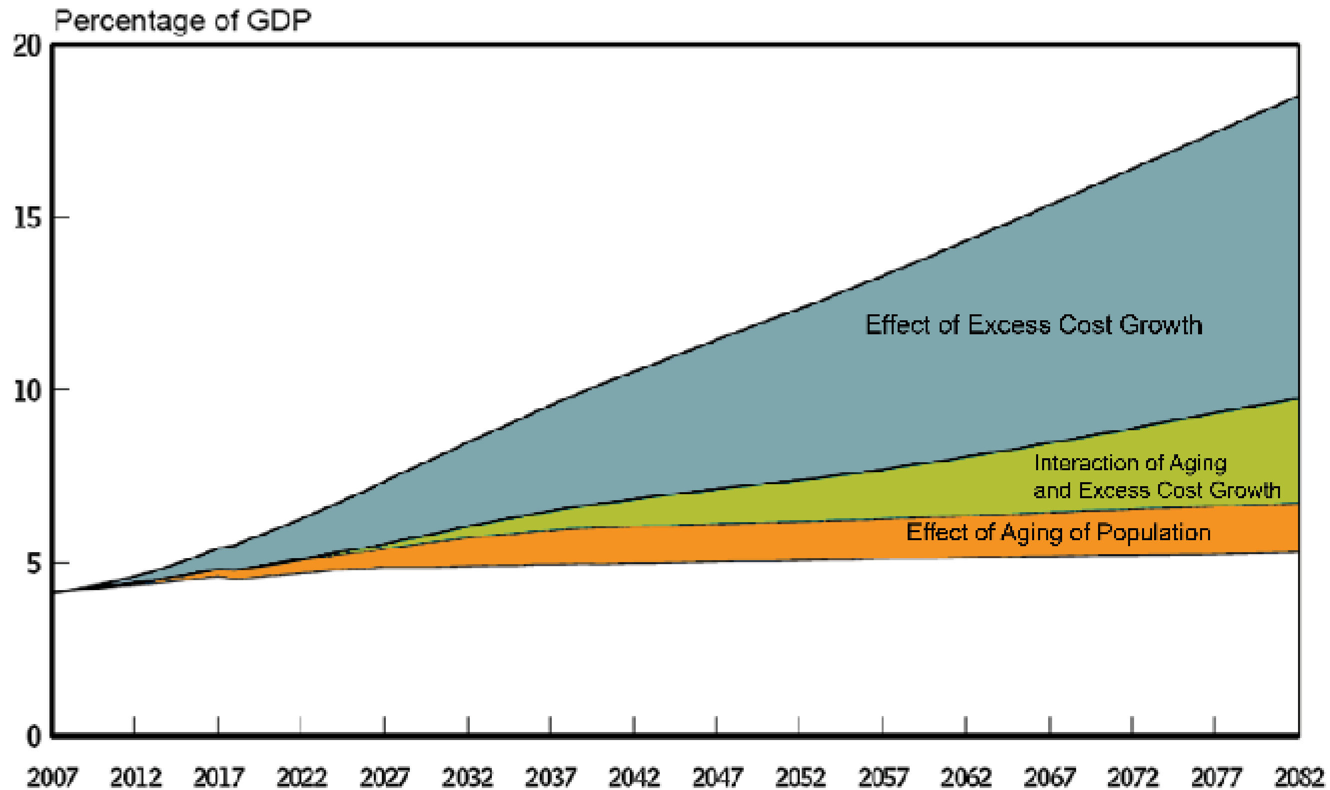
David Latzer

- Regional Vice President at Caravan Health
- Responsible for working with ACO partners in MI, OH, WV, PA, MA, NJ
- 20 years of healthcare experience in revenue cycle analysis, managed care, and analytics
- MPA from New York University, BA from University of Pennsylvania

Objectives

The Transition From Fee-For-Service to Fee-For-Value and ACO Participation Benefits

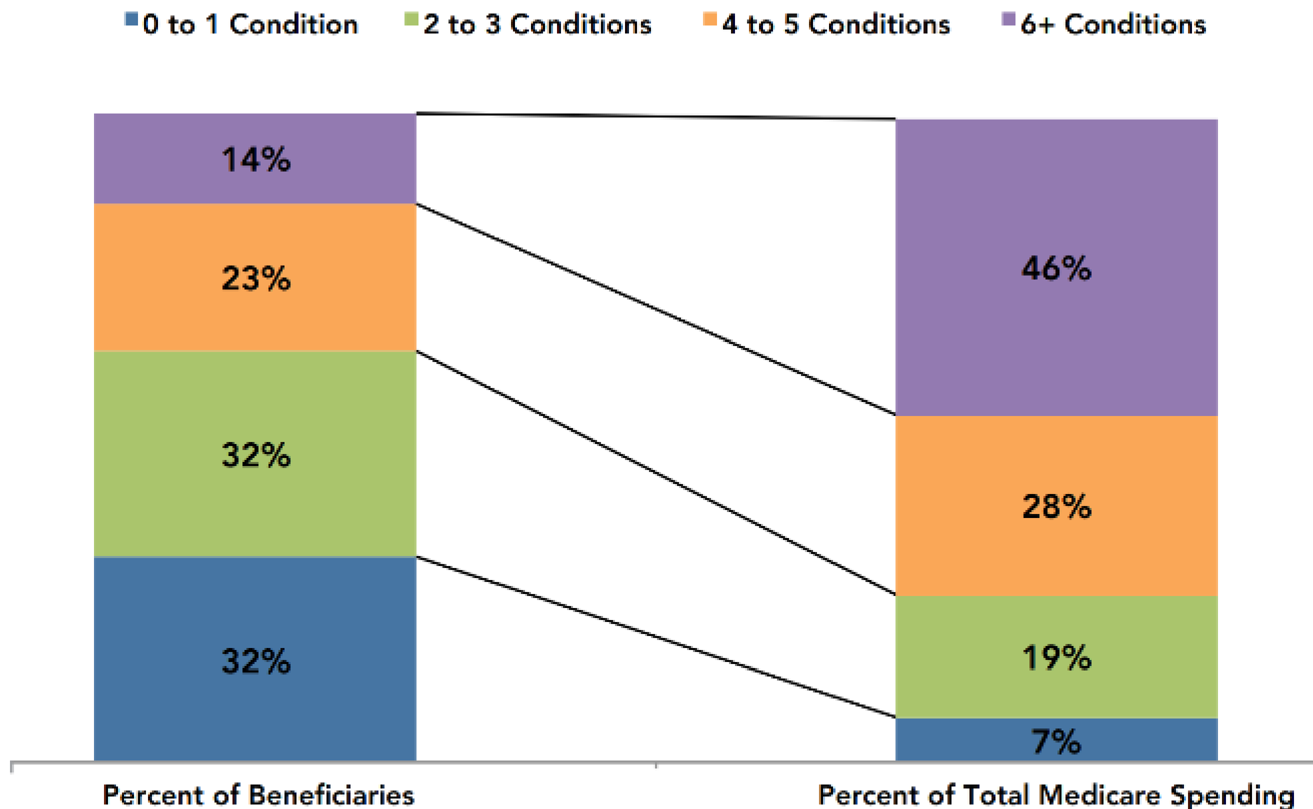
Projected Federal Spending on Medicare and Medicaid (% GDP)



- It is the *rate* of spending per individual that will have the most impact, rather than the quantity / demographics of an aging population.
- "Excess cost growth" refers to the extent to which the increase in health care spending for an average individual exceeds the growth in per capita GDP.
- "Interaction…" refers to effects of excess cost growth and the aging of the population, which result in greater growth in spending than would result from either factor separately.
- "Aging of population" refers to demographic shifts, such as an increasing average population age and life expectancy.

Source: Congressional Budget Office

Chronic Conditions Drive Cost and Need Extra Support



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Healthcare Is Changing

- The Medicare population has changed since 1965 when the program began:

Life expectancy in 1965	Life Expectancy in 2017
70	80

- People are living on average 10 years longer, with *65% having 2+ chronic conditions* - which accounts for 93% of Medicare costs
- Medicare, designed as a safety net for acute medical problems, needs to evolve for our aging population
- Value-based care is part of this movement to make Medicare financially sustainable
- Payment models will require physicians to be accountable for cost and quality

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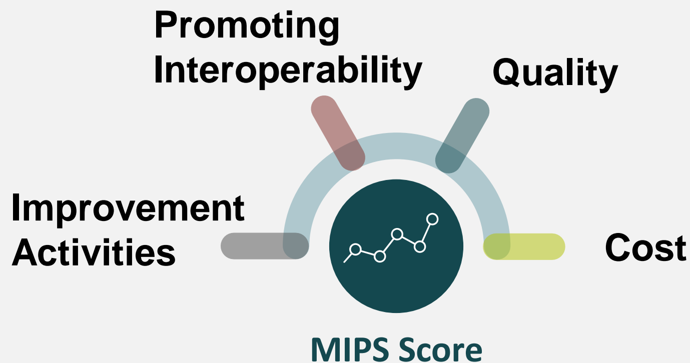
Transitioning to Value Based Care

- Quality reporting and “value” have felt like a tax on many practices
- Medicare has implemented new codes to make wellness, prevention and chronic care management sustainable
- Wide-spread implementation will support increased staffing
- Physicians and providers can do *less* work and have greater success in population-based models
    - Provide leadership for the rest of the primary care team
    - Receive increased support for the most complex patients
- Transforming your practice will guarantee success in all value-based models

MIPS APM Participation Improves Scoring

MIPS

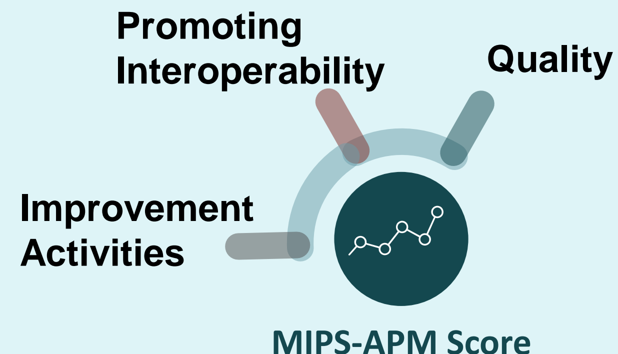
- MACRA: Cost must become 30% of MIPS score by 2021



MIPS-APM

One MIPS score for *all* providers

- Exempt from cost
- Automatic 100% for CPIA
- Weighted average Promoting Operability score
- ACO quality score from PCPs meets quality requirement for all providers



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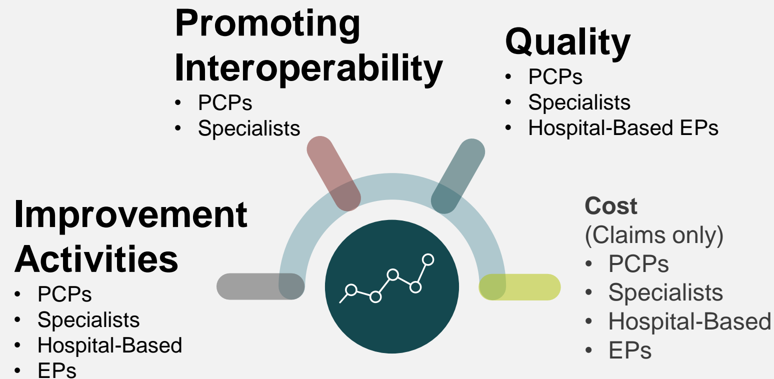
MIPS-APM Participation Also Simplifies MIPS Reporting

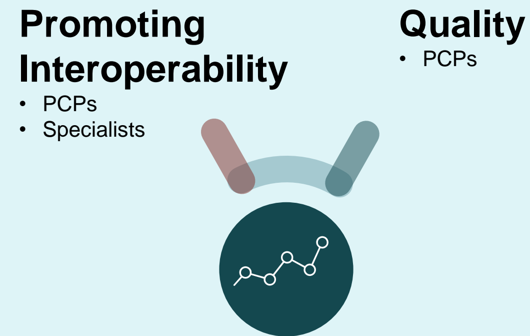
MIPS

- All eligible providers report all categories except Promoting Interoperability (which exempts hospital-based physicians)
- Cost is claims-based and does not require reporting



MIPS-APM

- All TINs report Promoting Interoperability except TINs that *only* include hospital-based physicians
- Only PCPs (and specialists that act like PCPs) report quality on a subset of patients attributed to ACO for primary care



Qualified Advanced APMs Report Nothing!

Benefits of ACO Participation

Clinical and Community

- Receive claims data from CMS and use it to predict and prevent disease progression
- Waivers of Stark, anti-kickback statute, and patient inducement
- Provide coordinated, proactive care for our community
- Engage patients with important wellness visits and preventative care services like mammograms and colonoscopies
- Strengthen local providers' reputation and income
- Sustain a strong local health care system, preventing out-migration

Financial Performance

- Sustain existing fee-for-service reimbursement and avoid unnecessary downside risk
- Grow wellness revenues by $500 to $1,000 annually per Medicare patient
- Maximize MACRA bonuses and quality scores with the least amount of effort
- Protect employed and community physicians from MACRA penalties
- Earn additional financial incentives for improving quality and lowering costs

Review of the Medicare Shared Savings Program

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Bottom Line on Final Rule

Uncertainty finally lifted for Medicare Shared Savings Program- Dec of 2018

Agreement period extended from three to five years and shared savings rate increased significantly to 40% for BASIC levels A - B

CMS follows through on commitment to push risk

- Elimination of Tracks 1, 1+, 2, and 3 and replaced with BASIC and ENHANCED options
- BASIC option begins with one-sided risk but requires participants to take on increasing levels of risk over the agreement period
- Lower revenue (physician, rural, and smaller hospital-affiliated) given extra time in non risk
- Continued expansion of non-financial benefits of risk participation

Several significant but small changes to benchmark calculations finalized

Risk score growth up to 3% over the agreement period will be recognized in updated benchmarks

BASIC Track

The Basic option is available to “new” ACOs or existing ACOs that are inexperienced with risk (i.e. Track 1)

During the five-year agreement term, the ACO must advance at least one level every year, ending with Advanced APM level risk (Level E)

ACOs have the option of accelerating their risk faster, but this does not allow them to later move backwards.

BASIC & ENHANCED ACO Options

	BASIC					ENHANCED
	Level A	Level B	Level C	Level D	Level E	
Risk	Upside only		Two-sided	Two-sided	Two-sided	Two-sided
Shared Savings	1st dollar savings, rate of 40%		1st dollar savings, rate of 50%	1st dollar savings, rate of 50%	1st dollar savings, rate of 50%	1st dollar savings, rate of 75%
Shared Losses	NA		1st dollar losses, rate of 30%, not to exceed 2% of revenue or 1% benchmark	1st dollar losses, rate of 30%, not to exceed 4% of revenue or 2% benchmark	1st dollar losses, rate of 30%, not to exceed nominal risk standard (currently 8% of revenue or 4% of benchmark)	1st dollar losses, rate of 1 minus sharing rate (40-75%), not to exceed 15% of benchmark
QPP Status	MIPS APM				Advanced APM	Advanced APM

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Agreement Cycles

Track 1

2018 was the last application cycle for new Track 1 ACOs

May continue out their term through performance year 2020

Will be allowed to apply for Basic option but must begin at Level B

BASIC Option

Interim cycle for Basic option begins July 1, 2019

Regular cycle to begin January 1, 2020 and annually thereafter

Interim six month “year” does not require Level advancement

Allows up to three and a half years of upside-only risk for new low revenue ACOs

ENHANCED Option (ongoing)

Same timeline as BASIC

No time limit for participation

Required start point for high-revenue ACOs experienced with risk

ACO Basics

Basics of ACOs

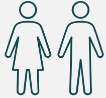
Established by the Affordable Care Act and finalized under MACRA, the MSSP is a permanent payment model created to facilitate coordination and cooperation among providers, to improve the quality of care for Medicare Fee-For-Service (FFS) beneficiaries and reduce unnecessary costs.

ACOs are groups of Medicare providers that work together to coordinate care for the Medicare fee-for-service patients they serve. Patients are attributed based on plurality of primary care services. Patients are attributed preferentially to PCPs.

Eligible clinicians, hospitals and suppliers may participate in the Shared Savings Program by creating or participating in an Accountable Care Organization (ACO) that are governed by the participants. ACOs do not need to be geographically contiguous.

Benchmarks are established based on average spend of attributed patients over the last three years, weighted 10%, 30% and 60%. Each year the benchmark is adjusted by patient mix and fee-for-service trend. If average spending is outside of the risk corridor, ACOs will either receive a check or have to write one to CMS (if at risk).

Forming an ACO



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

Agree to participate for at least 5 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.

ACOs enjoy waivers of Stark, Anti-Kickback Statute and Patient Inducement regulations. They are deemed to be Clinically Integrated Networks by the FTC.

Eligible Participants

- 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

History of the Collaborative ACO Model

- First National Rural ACO (NRACO) became a Medicare Shared Savings Program ACO in 2014 and was comprised of nine hospital members, in three states.
- This model allows smaller providers to collaborate on how to transition from volume to value-based care. It also gave them the requires a base of 5,000 Medicare beneficiaries, which individual provider practices and hospitals would not have been able to garner alone, since they have small patient bases.
- This successful model is now being scaled to 100,000+ life ACOs with sufficient scale to negate statistical variability in performance.

The Collaborative ACO Model

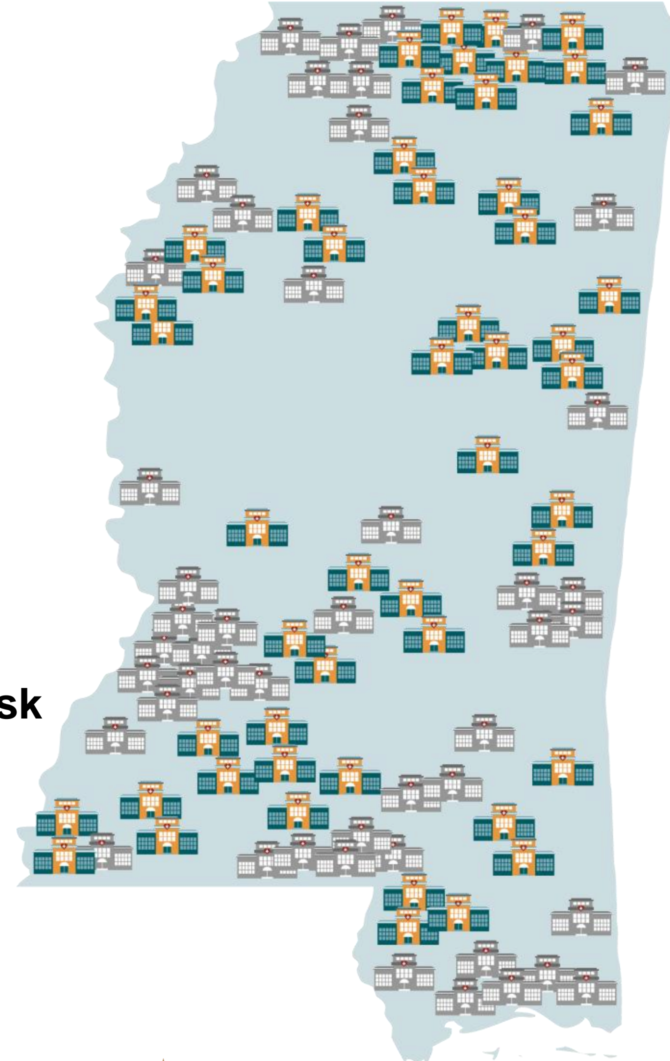
Proven success with accountability and governance with >40 ACO collaboratives, each with 5-15 health systems

Scaling in 2018 to achieve >100,000 lives in each state

- Combined 90% now merged into a single ACO
- Formed first state-wide ACO with the Mississippi Hospital Association

Master core competencies for provider-based risk

- Value-based Purchasing
- MACRA
- Medicare ACO risk
- Medicare Advantage
- Medicaid Managed Care
- Employer plans



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Won’t Those Other Guys Bring Down My Performance?

Failure is an orphan….

- Losing while you’re trying hard is deflating.
- Finger-pointing and blame break out
- Dis-engagement creeps in
- **No participant can ruin your results more than statistical variation.**

While success has many fathers…

- Winning breeds deeper engagement and re-investment
- New initiatives become easier to sell internally
- Consistent results are required. **Sooner or later you will fail if you are too small.**

Shared Governance: Shared Accountability, Local Control

Membership.

Principal participants are Medicare providers that coordinate care across ambulatory, outpatient, acute and post-acute care settings. They support ACO costs on behalf of their own and community clinicians. **Participants** are also accountable for care but are not financially responsible for the ACO operating costs unless shared savings is earned.

Flow of funds.

If shared savings are earned: 1) the ACO earns 10% of the fees if in an upside-only model or 20% if the ACO shares risk; 2) the principal participants recover their fees; 3) the remaining shared savings is paid to the participants based on attribution, quality, and effort. If shared savings are not earned, the ACO has no obligation to repay the fees and the loan is forgiven.

Voting.

Each Principal Participant has one vote. Votes are cast at the Participant Steering Committee and are binding on the board. Participants approve waivers, admit and discharge participants, approve triple aim initiatives recommended by physician leaders, changes in shared savings distributions and manage executive director and vendors.

Expectations.

All participants will be required to promote wellness, prevention and chronic care management and consistently document and tend to chronic conditions. They will be required to report quality measures and comply with program regulations. If not in Basic Level E, they must also report Promoting Interoperability and use 2015 CEHRT.

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ACO Success Strategies

How Do You Win in the MSSP?

You win the MSSP by…

1

Managing your patients better than fee-for-service

- ✓ Wellness
- ✓ Prevention
- ✓ Chronic Care Management
- ✓ Behavioral/Mental Health Support
- ✓ Post-Acute Care

2

Accurately coding chronic conditions every year

3

Having enough lives to reduce statistical variation

Your path to… ***… Shared Savings***

The ACO Practice Transformation Mosaic

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Have a Plan to Execute

Focus on Execution

Don't just have a plan – focus on the end result

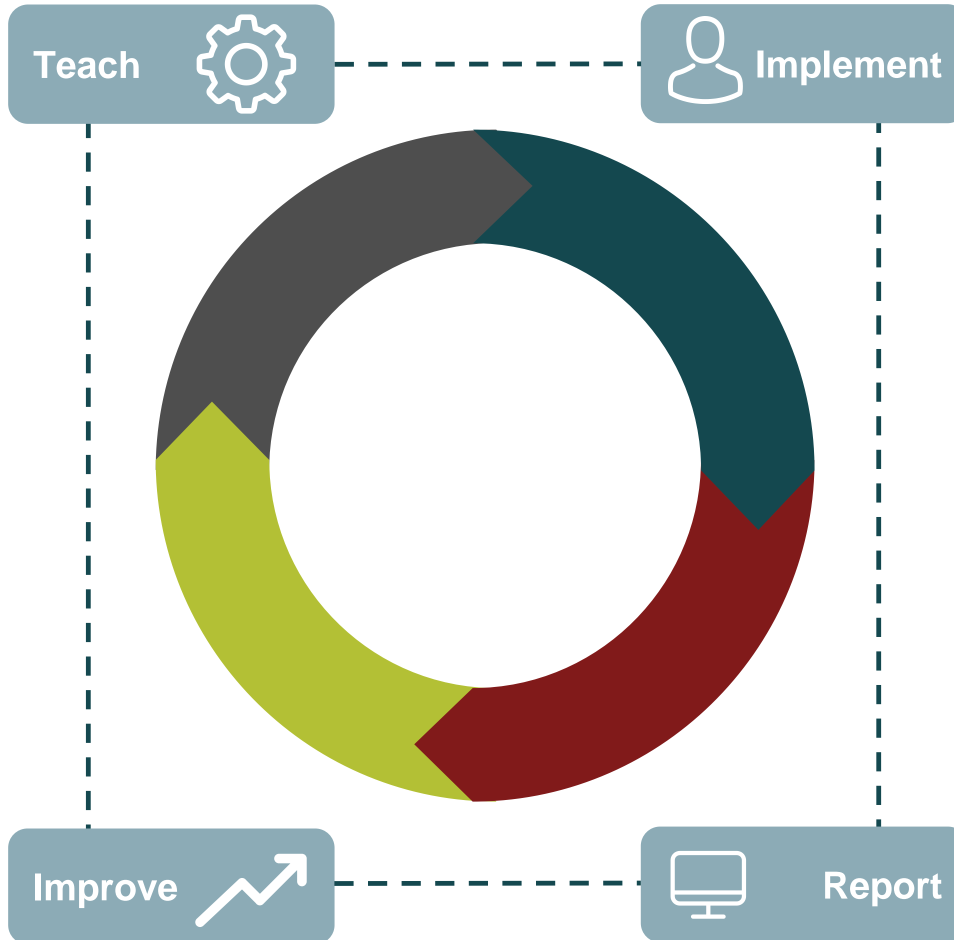
Identify New Resources

Dedicate new resources and technologies to project planning, management and tracking above and beyond clinical staff and technology investments.

Adapt to New Processes

Even if you are a high-performing health system, there is always room for improvement.

Build on Performance



Expertise & Compliance

Guidance through the complex regulatory environment and governance procedures

Practice Transformation

Drive clinical and non-clinical transformation initiatives

Clinical Excellence

Lead the physician engagement aspects of value-based care

Intelligence & Analytics

Healthcare data experts delivering mission-critical insights

Empower Your Nurses

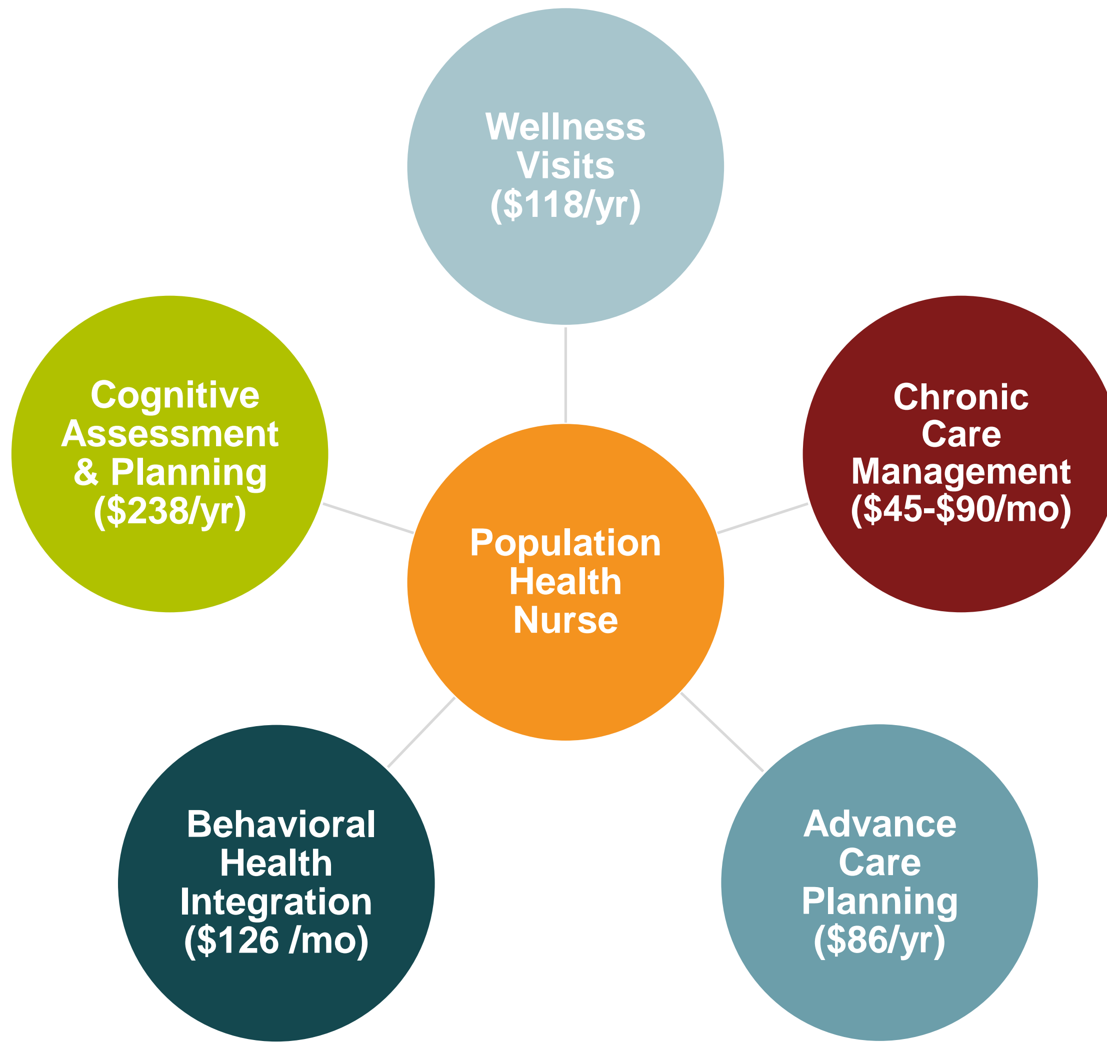
Build your primary care capacity.

Utilize nurses and medical assistants to meet patient needs and provide additional support to providers.

Medicare allows important preventive services to be billed under provider supervision.

Physicians get more time to attend acute patient needs, and patients benefit from more attention overall.

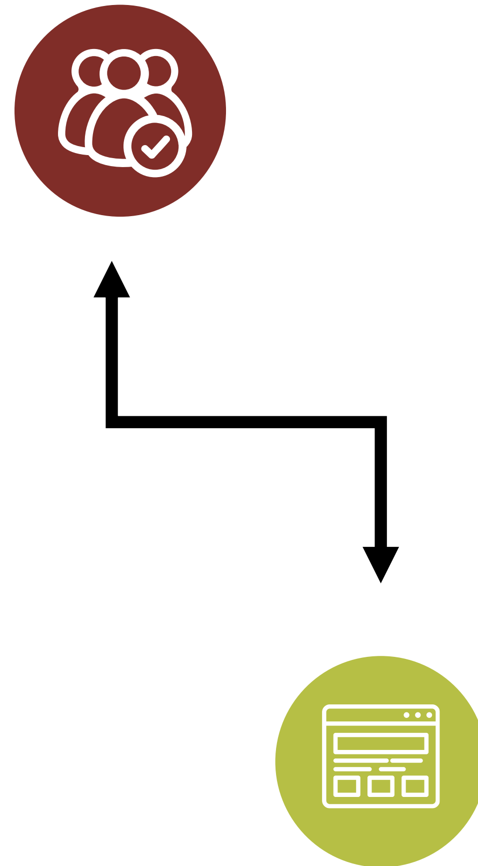
Population Health Nurses Generate Income



Get Your Coding in Order

Ensure you receive credit for the sicker patients you treat

- Appropriate HCC coding is required for value-based payments.
- Numerous ACOs have found that inattention to HCC-coding workflows has been the difference between collecting shared savings and falling below the minimum savings rate.
- Integrating coding best practices into your workflow can help you get credit for caring for sicker patients without driving your clinicians crazy.



Hold Every Participant Accountable

Practice/Community Scorecard

Category	Metric	Q4 2018
Leading Indicators	Population Health Nurse in Place	Yes
	Physician Leader in Place	Yes
	Compliance Contact in Place	No
	Lightbeam Interface Status	Yes
Compliance	Self-Assessment Participation	No
	Self-Assessment Score	No
	Compliance Webcast Attendance	Yes (Extra Credit)
Care Coordination	% of All Patients with AWV - Full Credit for Over 80% Attributed	42%
	% of All Patients in CCM - Full Credit for Over 12% Attributed	7%
	% of Diabetic Patients in Self-Management Service	10%
	% of All Patients in ACP - Full Credit for Over 15% Attributed	7%
	% of All Patients in BHI	3%
Outcomes	Overall Quality Score	92%
	Total Expenditures - vs. benchmark * Extra Credit	-1.70%
	Promoting Interoperability (PI) Estimate Score	92
	HCC Gaps (% Covered)	60%
	In Network Utilization	45%
Staff Engagement	Representative at Previous Board Meeting	No
	Practice Manager at Road Map Call	Yes
	Population Health Nurse at Road Map Call	Yes
	Attendance at Population Heath Nurse Cohort Call	Yes
	Quality Reporting Webcast Attendance	Yes
	Attend Quality Improvement Workshop	Yes
Physician Lead	Attend Quarterly Steering Committee Meeting	Yes
	Attend Physician Leader Cohort Calls	Yes
	Attend Phoenix Symposium Meeting or Follow Up Call	No
	Attend EBM Webinars	Yes
	Attend Cohort Calls	Yes

Use a scorecard to keep focused on goals and pinpoint areas of weakness

Metrics should be based on efforts towards goals such as AWV percentage rate or cohort meeting participation.

Maximize Power of Claims and EHR Data

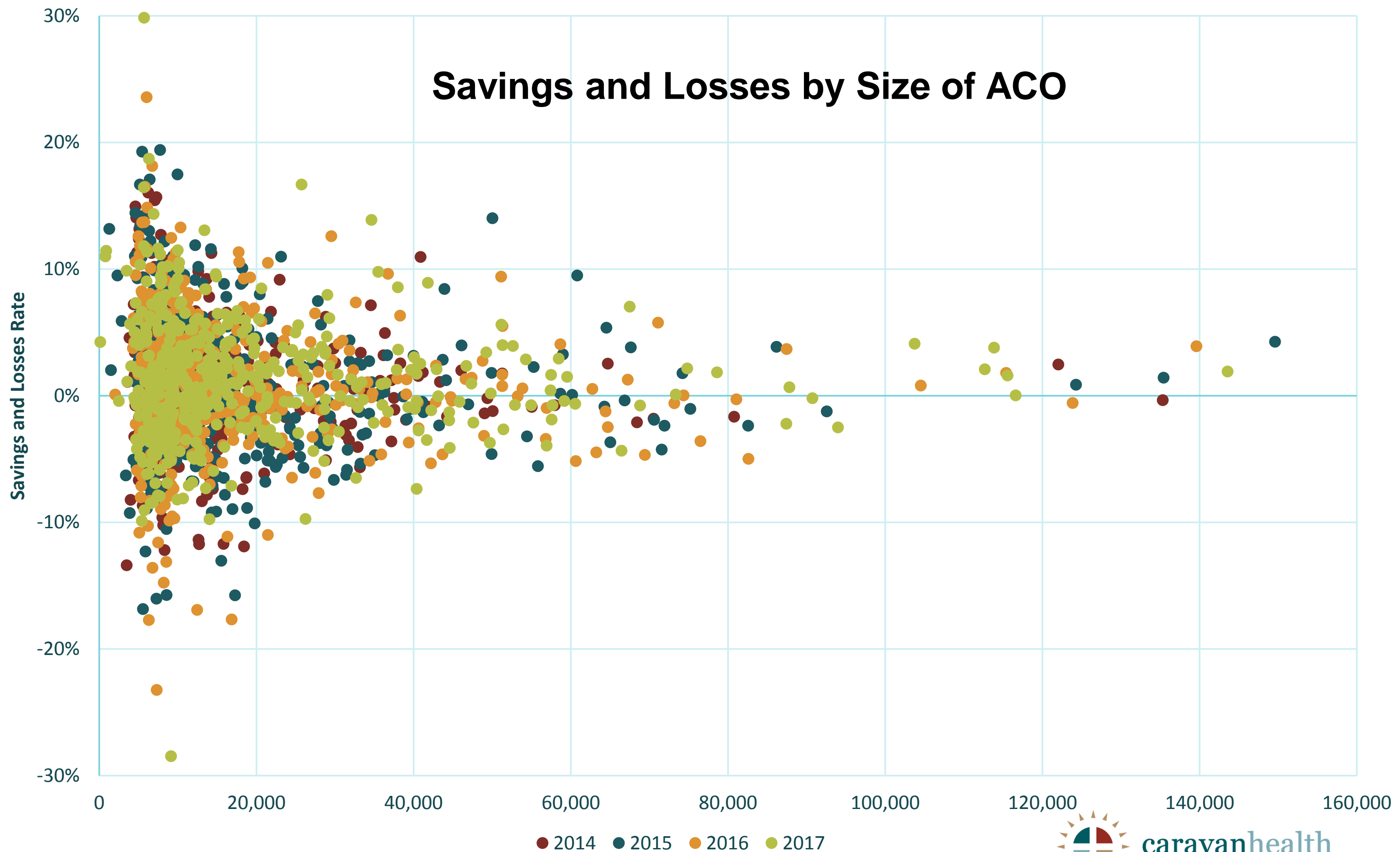
1. Analyze your population to understand prevalence of chronic illness, hospitalizations and related costs.

2. Prioritize areas for improvement and identify where you need additional resources based on which population has the most clinical and financial risk.

3. Plan early for in-house and outsourced expertise.
Ingesting claims data and drawing meaningful reports takes time.

Scale for Success-Unpredictable Results are Unsustainable

Small ACOs experience savings and losses plus or minus 10-30% simply due to statistical variation in health care spend and in HCC coding in performance and benchmark years



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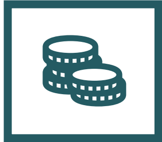
In Summary



Value-based Payment is Here to Stay

More than a third of all providers will participate in these programs. Reducing healthcare cost growth is critical for our future. Get maximum upward adjustments of Part B payments and shared savings to supplement frozen fee for service revenue.

Now is the Time to Take Action

Early adopters reaped the benefit of risk-free participation. The move to risk is accelerating and it is important to gain experience and prepare for the future reimbursement system.

Maximize Value-based Reimbursement

Joining a 100,000+ life ACO increases the likelihood of predictable shared savings, higher MIPS adjustments, reduces risk and sets the stage for future success in value-based payments, clinical integration and provider-based health plans.

Know the Time-lines

CMS deadlines for ACO participation in 2020 are anticipated to begin in June/July of 2019. Start Planning now!

Thank You

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