Quality Series: ACOs

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Agenda

1. **MACRA's impact on ACOs**
2. **ACO Quality Measures**
3. **Points of Pain for MCOs**
4. **Next Steps**

Robust Changes to the Healthcare Landscape

- The Patient Protection and Affordable Care Act
  - Commonly called the Affordable Care Act or ACA
  - Signed into law by President Obama on March 23, 2010
  - On June 28, 2012, the Supreme Court upheld the law
- MACRA – Medicare Access and CHIP Reauthorization Act
  - Increased emphasis on physician participation in Alternative Payment Models (APMs)
  - APMs – Accountable Care Organizations (ACOs), Bundled Payment

Push for greater adoption of APMs

- January 26, 2015 – HHS Secretary Sylvia M. Burwell announced measureable goals and a timeline to move the Medicare program towards paying for Quality rather than Quantity
  - Goals
    - 30% of all fee-for-service Medicare payments will be through an APM
    - 50% of all payments will be through these models by 2018
    - http://www.hhs.gov/news/press/2015pres/01/20150126a.html

MACRA Early Impact

- "Doc Fix" bill. Repeals SGR Methodology
- Sunsets current physician payment adjustments
  - PQRS (Physician Quality Reporting System)
  - Value-Based Payment Modifier (Begins 2015)
  - Electronic Health Record (EHR) Incentive Program
  - Maximum potential penalties grows to 8% by 2018
  - 2019 – Merit-Based Incentive Payment System (MIPS) replaces these models

MACRA Early Impact (Cont.)

- Eligible Providers (EPs) will be subject to an initial 4% payment adjustment
- 2019, which grows to 9% in 2022 and later
  - Merit-based Incentive Payment System (MIPS)
  - EPs that meet the APM threshold are exempt and receive a lump sum incentive payment instead of being subject to a potential MIPS penalty

MACRA Financial Incentives

- Eligible Providers that meet the required threshold for APM participation
  - Receive a 5% lump sum incentive payment based on the estimated aggregate of Part B covered professional services for the preceding year
  - 2019 – 2020: EPs must have 25% of their payments through APMs
  - 2021 – 2022: EPs must have 50% of their payments through APMs

APM - Accountable Care Organizations

- “Accountable Care Organizations (ACOs) are groups of doctors, hospitals, and other health care providers who come together voluntarily to give coordinated care to Medicare Beneficiaries.”
  - CMS

ACO Goals

- Provide coordinated care to an attributed set of Medicare Fee-for-Service beneficiaries which results in improved health outcomes and reduced health care expenditures

ACO Incentive

- When an ACO succeeds in improving health outcomes and reducing costs, it will share in the savings.
- Prior to ACOs there was not a mechanism for CMS to share savings with providers that have improved outcomes and lower costs.
  - System maintained a reverse financial incentive

ACO Programs

- Medicare Shared Savings Program (MSSP)
  - Most Common
  - Hundreds of Participants
- Pioneer ACO Model
  - 19 remaining participants
- Next Generation ACO Model
  - Awards are expected by January 1, 2016
  - Full-Risk Model

Attribution Process

- MSSP ACO applications accepted each July
- New MSSP ACOs begin January of the following Year
  - July 2015 applicants will begin January 1, 2016
- All providers in the ACO submit their Tax ID Number (TIN)
- 3-year look back of all beneficiaries served by the PCPs in the ACO
- Consumers are attributed to the provider that provided the majority of paid primary care services

Hospital and Specialist role in an ACO

- Consumers are attributed based on preponderance of primary care claims paid to a participating ACO primary care provider
  - Primary care providers can only participate in 1 ACO
- Specialists do not attribute beneficiaries, unless the beneficiary had NO primary care claims
- Hospitals do not attribute beneficiaries
  - Specialists and hospitals can participate in more than one ACO

Share of Savings

- MSSP ACOs can earn up to 60% of the savings they create, depending on how they perform on 33 quality measures
  - Initially, MSSP ACOs are not required to take risk
  - Risk will be required after a 5 year participation period
- Pioneer ACOs can earn up to 75% of the savings they create
  - All Pioneer ACOs must take risk for losses at this time

What Makes Up the Cost Analysis?

- Included Costs
  - Medicare Part A Expenditures
  - Medicare Part B Expenditures
- Excluded Costs
  - Medicare Part D
  - Medicaid Costs
  - Medicaid LTSS
  - Medicaid HCBS

Medicare Part A Benefits

- Medicare Part A covers the following services:
  - Inpatient Hospital Care
  - Skilled Nursing Care
  - Home Health Care
  - Hospice Care

Medicare Part B Benefits

- Medicare Part B covers the following services:
  - Medically Necessary Outpatient Services
  - Preventive Health Services
  - Doctor Visits
  - Ambulance Services
  - Supplies
  - Durable Medical Equipment (Wheelchairs, Walkers, Etc.)

Medicaid

- The Medicaid program is jointly funded by the federal government and states. The federal government pays states for a specified percentage of program expenditures, called the Federal Medical Assistance Percentage (FMAP)
- For dual eligibles
  - Medicare: Primary
  - Medicaid: Secondary

Duals

- 20% of Medicare beneficiaries are dual eligibles
- Duals have a significantly higher per capita expense than non-duals
  - MedPac, June 2013, Pg. 153: Per capita spending on dual-eligible beneficiaries in FFS was $15,743 compared to $8,081 for non-duals
- ACOs receive a separate report showing the percentage of duals they have compared to other ACOs and the requisite costs
- Medicare is the primary payer for duals

Duals and Shared Savings

- Population is high risk due to the their overall higher costs
- Potential increases in utilization and costs, for duals in an ACO, directly impacts the success or failure of an ACO
- Many ACOs develop a specific strategy just to address the Duals because of the high costs attributed to them
- Medicaid HCBS has been shown to reduce Medicare costs by reducing institutionalization

Shared Savings and Quality

- Each year, ACOs must submit quality data to CMS
  - ACO quality measure reporting period is generally between January & March
- There are 33 quality measures that are analyzed
- If an ACO does not meet the minimum quality measure threshold, they are not eligible or their share of savings.

4 Quality Measure Domains

- Patient/Caregiver Experience
- Care Coordination/Patient Safety
- Preventive Health
- At-Risk Population Health Management
  - Diabetes Mellitus
  - Hypertension
  - Ischemic Vascular Disease
  - Coronary Artery Disease

ACO Quality Measures

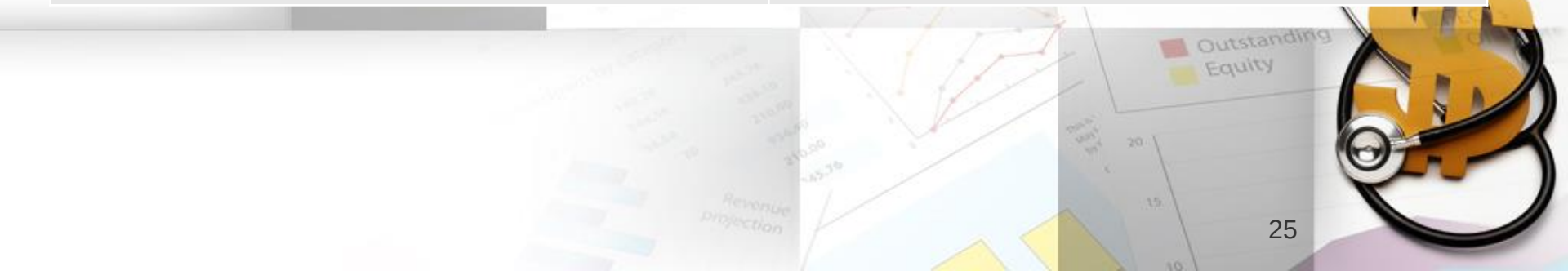
Domain	Measure Title
Patient/Caregiver Experience	Getting Timely Care, appointments and information
Patient/Caregiver Experience	How well your doctors communicate
Patient/Caregiver Experience	Patient's rating of doctor
Patient/Caregiver Experience	Access to specialists
Patient/Caregiver Experience	Health promotion and education
Patient/Caregiver Experience	Shared decision making
Patient/Caregiver Experience	Health Status/Functional Status

ACO Quality Measures (Cont.)

Domain	Measure Title
Care Coordination/Patient Safety	All Cause Readmissions
Care Coordination/Patient Safety	Ambulatory Sensitive Admissions: COPD, Asthma
Care Coordination/Patient Safety	Ambulatory Sensitive Admissions: Congestive Heart Failure
Care Coordination/Patient Safety	Percent of PCPs that meet meaningful use standards
Care Coordination/Patient Safety	Medication reconciliation after discharge from an inpatient facility
Care Coordination/Patient Safety	Screening for Fall Risk

ACO Quality Measures (Cont.)

Domain	Measure Title
Preventive Health	Influenza Immunization
Preventive Health	Penumococcal Vaccination
Preventive Health	Adult Weight Screening and Follow-up
Preventive Health	Tobacco Use Assessment and Intervention
Preventive Health	Depression Screening
Preventive Health	Colorectal Cancer Screening
Preventive Health	Mammography Screening
Preventive Health	Screening for High Blood Pressure

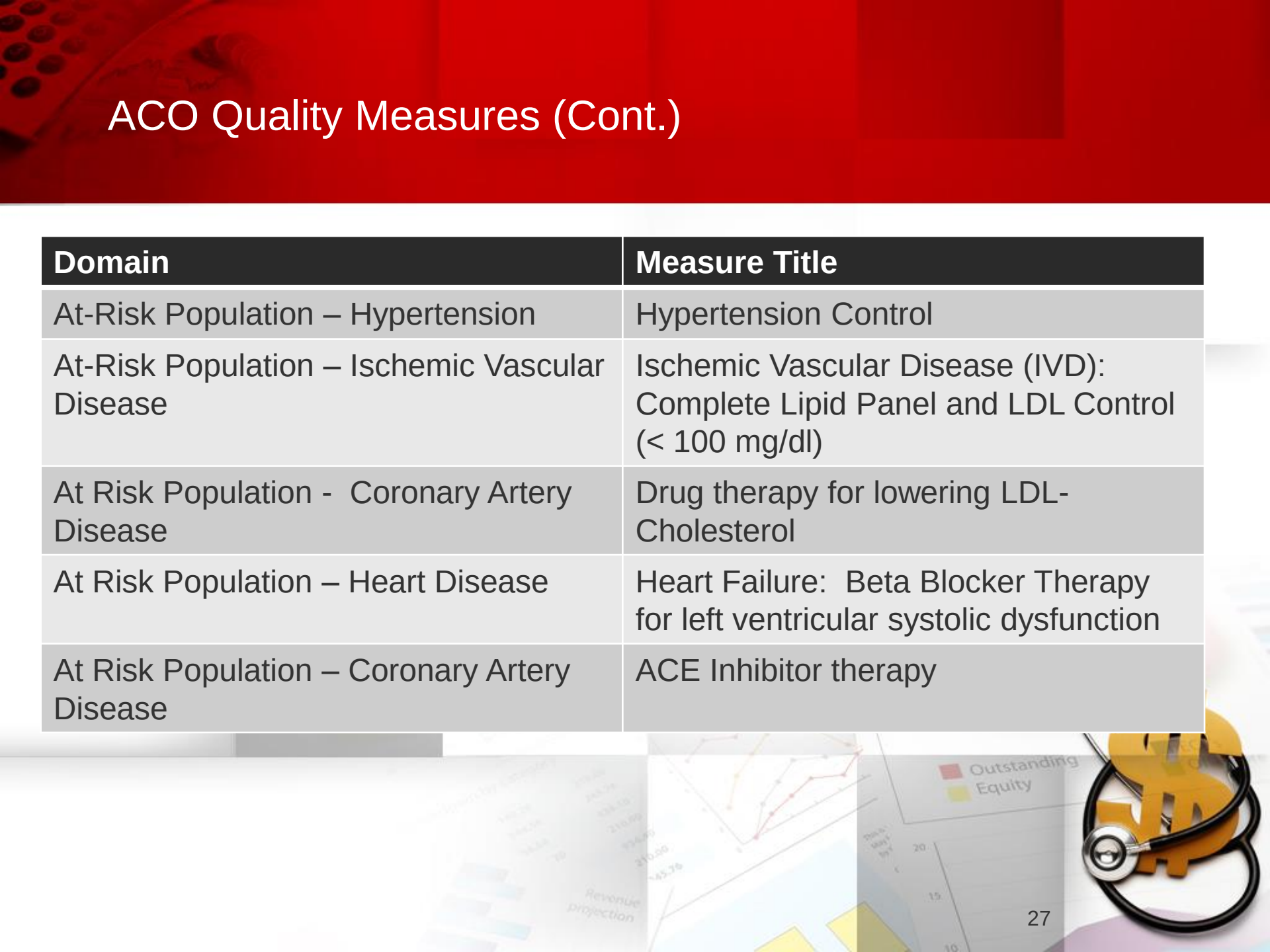


ACO Quality Measures (Cont.)

Domain	Measure Title
At Risk Population – Diabetes	Diabetes composite Hemoglobin A1C Control (< 8%)
At Risk Population – Diabetes	Composite: LDL (< 100)
At Risk Population – Diabetes	Composite: Tobacco Non Use
At Risk Population – Diabetes	Composite: Aspirin Use
At Risk Population – Diabetes	Diabetes Mellitus: Hemoglobin A1c Poor Control (> 9 %)

ACO Quality Measures (Cont.)

Domain	Measure Title
At-Risk Population – Hypertension	Hypertension Control
At-Risk Population – Ischemic Vascular Disease	Ischemic Vascular Disease (IVD): Complete Lipid Panel and LDL Control (< 100 mg/dl)
At Risk Population - Coronary Artery Disease	Drug therapy for lowering LDL-Cholesterol
At Risk Population – Heart Disease	Heart Failure: Beta Blocker Therapy for left ventricular systolic dysfunction
At Risk Population – Coronary Artery Disease	ACE Inhibitor therapy



Quality Benchmarks

Domain	Weight
Patient/Caregiver Experience	25%
Care Coordination/Patient Safety	25%
Preventive Health	25%
At-Risk Population	25%
Total	100%

Sliding Scale Measure Scoring Approach

- Points are earned based on a comparison of the individual ACO scores compared with the performance of all ACOs
- Total points earned in each domain are summed and divided by total points available
- Total points in each domain are averaged together to obtain a final overall quality score

Score Analysis

- For most measures, the higher the level of performance, the higher the number of points
  - Lower score is better for the following measures
    - Risk Standardized, All condition readmissions
    - Ambulatory sensitive conditions admissions: COPD, Asthma
    - Ambulatory sensitive conditions admissions: CHF
    - Diabetes: Hgb A1c poor control

Sliding Scale Measure Scoring Approach

ACO Performance Level	Quality Points
90+ Percentile	2.00 Points
80+ Percentile	1.85 Points
70+ Percentile	1.70 Points
60+ Percentile	1.55 Points
50+ Percentile	1.40 Points
40+ Percentile	1.25 Points
30+ Percentile	1.10 Points
< 30 Percentile	No Points

2014 Mean Performance Rate for All ACOs

- Falls: Screening for fall risk: 46.71%
- Influenza Immunization: 58.27%
- Pneumococcal Vaccination: 56.31%
- Depression Screening: 40.46%
- Adult Weight screening and Follow-Up 66.82%
- Health Promotion and Education 58.40%
- All Condition Readmissions (Lower is better) 15.16%
- Medication Reconciliation 82.66%

Sliding Scale Measure Scoring Approach

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2014 Mean Performance Rate for All ACOs (Cont.)

- Diabetes Composite (ACO 22-26) 26.07%
  - Hemoglobin A1c Control < 8%
  - LDL < 100 mg/dL
  - Blood Pressure < 140/90
  - Tobacco Non-Use
  - Aspirin Use
- Hemoglobin A1c Poor Control > 9% 19.99%
  - (Lower is better)
- Proportion of Adults who had blood 60.00%
- pressure screened in Past 2 years
- CAD Composite 75.34%
  - Drug Therapy for Lowering LDL
  - Cholesterol
  - ACE Inhibitor or ARB Therapy for
  - Patients with CAD and Diabetes and/or
  - LVSD

Sliding Scale Measure Scoring Approach

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Alternative Payment Models: Points of Pain

- MedPac Report to Congress. June 2013. Pg 106
  - "There is concern that hospitals serving large shares of poor patients tend to have higher readmission rates and that hospitals serving these patients will be more likely to pay readmission penalties."
- MedPac Report to Congress. June 2013. Pg 107
  - "We found that hospitals with high shares of poor patients (as indicated by their share of Medicare patients on SSI) tended to have higher readmission rates and thus higher penalties."

Result of MedPac Report on Socioeconomic Status

- Senate Bill S. 2501
- Sponsor: Sen. Joe Manchin, III (D-WV)
- Read twice and referred to the Committee on Finance
- Provides a mandate for CMS to develop a special risk adjustment to account for patient socioeconomic status

Separate House Bill Addressing Socioeconomic Status

- H.R. 1343
- Establishing Beneficiary Equity in the Hospital Readmission Program Act of 2015
- Bill referred to the House Committee on Ways and Means
- Requires the HHS Secretary to make a risk adjustment based on the proportion of in-patients who are full-benefit dual eligibles
- Requires the HHS Secretary to take in account the socioeconomic status of the population of patients served by a particular hospital in calculating readmissions

CMS Study of Socioeconomic Factors on Star Ratings

- Released September 8, 2015
- Beneficiaries with low socioeconomic status assessed based on Low-Income Subsidy (LIS) receipt and/or Dual Eligible (DE) status
- Study found that 12 out of the 16 Star measures have a statistically significant negative association with LIS/DE status
  - All Cause Readmissions
  - Medication Adherence
  - Diabetes/Heart Disease Measures

Seize the Opportunity

- Stratify the population
- Identify the need of the consumer that matches your strengths
- Population that unanimously has been cited as a point of pain
  - Consumers with low socioeconomic status
  - Duals
  - Consumers eligible for Medicaid HCBS that are at risk for institutionalization

What do beneficiaries need?

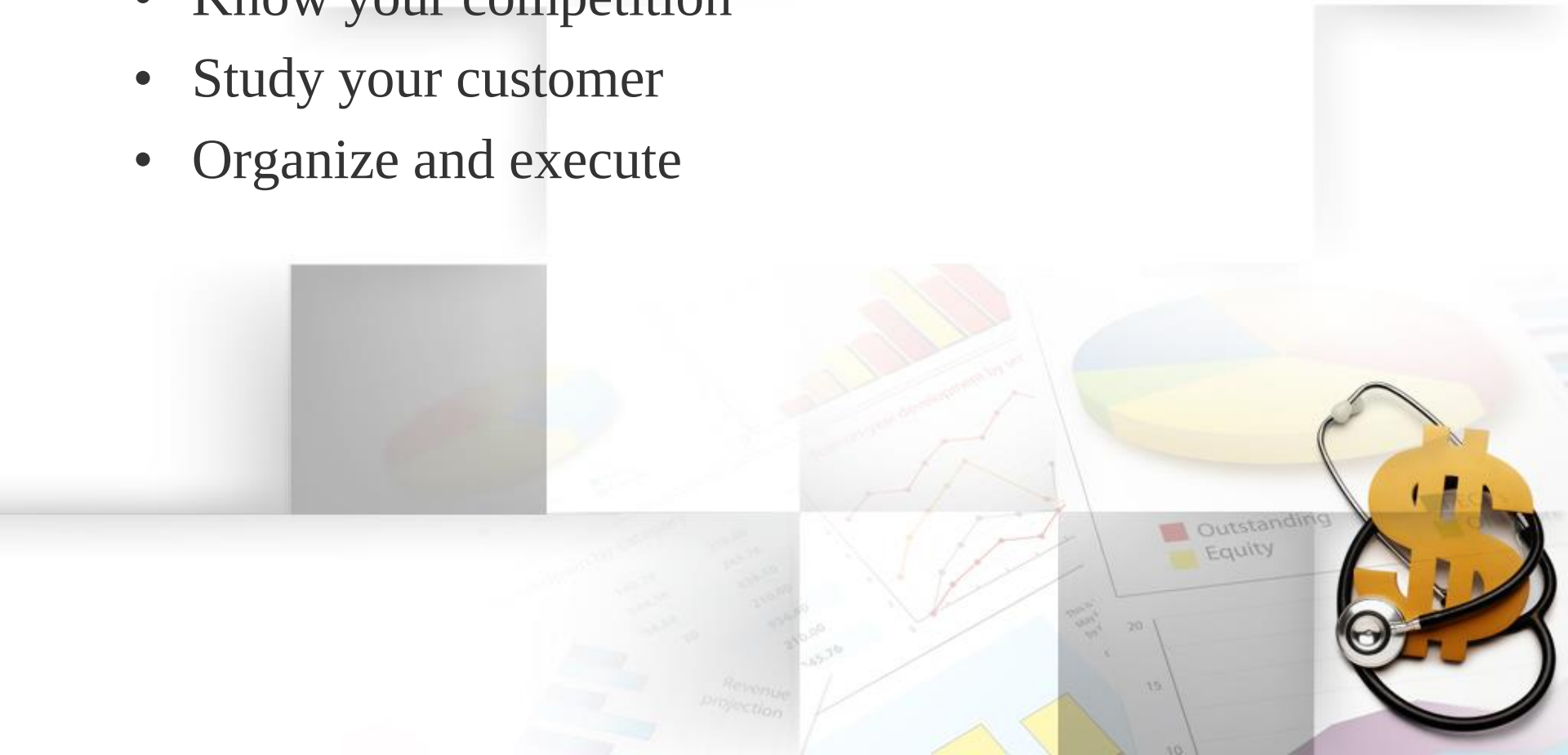
- Services that meet medical necessity to support them in meeting their health-care and community living goals in the least restrictive environment possible.

What does the customer/contracting organization need?

- Data
- Data
- More data
- Integrated Care Organizations have performance goals to meet
  - Financial and quality risks
- How do you contribute to improving quality and reducing financial risk?
  - If you are not, why should they contract with you?

Next Steps

- Know your market
- Know your competition
- Study your customer
- Organize and execute



Questions

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