Accountable Care Organizations: Strategies for Success

June 14th 2016
Paul Kleeberg, MD
Disclaimer

• Paul Kleeberg, M.D. is employed by Aledade, Inc.
• Aledade partners with primary care physicians to form ACOs and helps them become successful in the new payment model by assisting them with the needed tools to manage their patient populations and provide the highest quality of care while also slowing or reversing the current trend of rising healthcare costs.
Learning Objectives

1. Understand the changing payment landscape
2. Identify Alternative Payment Models
3. Know the technology required for success
4. Understand to succeed in the new model
The Current Landscape

The Shift to Value-Based Care Isn’t Just Here to Stay; It’s Accelerating

Medicare Payment Reform: Aligning Incentives for Better Care

Modern Healthcare
Where healthcare is now on march to value-based pay

Gov't to Overhaul Medicare Payments to Doctors, Hospitals
2015-2018 Medicare Incentive Programs

• EHR Incentive Program (Meaningful Use)
• Physician Quality Reporting System (PQRS)
• Value-Based Modifier (VBM) Program

Adapted from slides by Candy Hanson, BSN, PHN, LHIT-HP Stratis Health
Meaningful Use

• Stage 2 modifications final for 2015-2017
• 2015 changed from full year to 90 days
• Stage 2 final rule came out with less than 90 days
• Hardship exemptions
• Meaningful Use Stage 3 Final Rule still subject to modifications

Adapted from slides by Candy Hanson, BSN, PHN, LHIT-HP Stratis Health
PQRS Reporting

• A quality reporting system that uses negative payment adjustments to promote reporting of quality information by individual eligible professionals (EPs) and group practices
• Applies to Medicare Physician Fee Schedule (MPFS) services
  • Including FQHC and RHC providers who bill any part B services
• Includes Accountable Care Organizations (ACOs), Medicare Shared Savings Programs (MSSP’s), and Comprehensive Primary Care Practice Sites (CPCPs)

Adapted from slides by Candy Hanson, BSN, PHN, LHIT-HP Stratis Health
What PQRS requires to report

- Nine clinical quality measures across three National Quality Strategy (NQS) domains
- A cross cutting measure for EPs with face to face encounters
Value-Based Modifier Program

• VBM assesses both quality of care and cost of care under the Medicare Physician Fee Schedule.
• VBM includes cost measures, quality measures, and PQRS measures.
  • Phase 1: In 2015 groups of 100+ PQRS EPs (data 2013)
  • Phase 2: In 2016 groups of 10-99 PQRS EPs (data 2014)
  • Phase 3: In 2017 ALL physicians and physician groups (data 2015)

Adapted from slides by Candy Hanson, BSN, PHN, LHIT-HP Stratis Health
Payment Calculation

• Based on cost and quality data
• Quality Resource and Use Reports (QRURs)
• Quality tiering determines the type of adjustment (upward, downward, neutral)
• Includes ALL cost measures (except Part D outpatient prescription costs)

Adapted from slides by Candy Hanson, BSN, PHN, LHIT-HP Stratis Health
Quality Measures for VBM

- 30-day all cause hospital admissions
- Hospital admissions for ambulatory care sensitive conditions - acute care
- Hospital admissions for ambulatory care sensitive conditions - chronic care

Adapted from slides by Candy Hanson, BSN, PHN, LHIT-HP Stratis Health
Cost Measures for VBM

• Total per capita costs for all attributed beneficiaries
• Total per capita costs for beneficiaries with specific chronic conditions:
  • Chronic obstructive pulmonary disease/asthma
  • Coronary artery disease
  • Diabetes
  • Heart failure
• Medicare spending per beneficiary

Adapted from slides by Candy Hanson, BSN, PHN, LHIT-HP Stratis Health
Sample Quality Resource and Use Reports (QRUR)

PERFORMANCE HIGHLIGHTS

Your Quality Composite Score: Average

![Average Range](image)

Standard Deviations from National Mean (Positive Scores Are Better)

Your Cost Composite Score: Average

![Average Range](image)

Standard Deviations from National Mean (Negative Scores Are Better)

Your Performance: Average Quality, Average Cost

![Quality vs Cost Diagram](image)
Leveraging the QRUR/Value Report to Identify Opportunities

- **Areas of opportunity identified in Value Report/QRUR data**
  - Spend by Service Category
    - Chronic Conditions
    - Acute care utilization
    - Referral Network/Specialist care
    - Post-acute care
  - Project good FFS revenue opportunities
  - Explore impact of ER visits and hospitalizations

---

<table>
<thead>
<tr>
<th>Service Category</th>
<th>Number of Your Attributed Beneficiaries Using any Service in this Category</th>
<th>Percentage of Your Attributed Beneficiaries Using any Service in this Category</th>
<th>Per Capita Costs for Your Attributed Beneficiaries</th>
<th>Benchmark Percentage of Beneficiaries Using any Service in this Category</th>
<th>Benchmar k Per Capita Costs</th>
<th>Amount by which Your Costs Were Higher or (Lower) Compared to the Benchmark</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient Evaluation and Management Services, Procedures, and Therapy (excluding emergency department)</td>
<td>1,671</td>
<td>100.00%</td>
<td>$2,783</td>
<td>100.00%</td>
<td>$3,065</td>
<td>($385)</td>
</tr>
<tr>
<td>Billed by Your TIN</td>
<td>1,671</td>
<td>100.00%</td>
<td>$534</td>
<td>99.39%</td>
<td>$454</td>
<td>$50</td>
</tr>
<tr>
<td>Primary Care Physicians</td>
<td>1,665</td>
<td>99.94%</td>
<td>$471</td>
<td>99.13%</td>
<td>$365</td>
<td>$106</td>
</tr>
<tr>
<td>Medical Specialists</td>
<td>11</td>
<td>0.68%</td>
<td>$1</td>
<td>0.07%</td>
<td>$5</td>
<td>$5</td>
</tr>
<tr>
<td>Surgeons</td>
<td>195</td>
<td>11.82%</td>
<td>$15</td>
<td>10.41%</td>
<td>$22</td>
<td>$6</td>
</tr>
<tr>
<td>Other Eligible Professionals</td>
<td>415</td>
<td>24.84%</td>
<td>$47</td>
<td>22.83%</td>
<td>$41</td>
<td>$7</td>
</tr>
<tr>
<td>Billed by Other TINs</td>
<td>1,351</td>
<td>81.00%</td>
<td>$445</td>
<td>84.18%</td>
<td>$875</td>
<td>($204)</td>
</tr>
<tr>
<td>Primary Care Physicians</td>
<td>136</td>
<td>8.15%</td>
<td>$18</td>
<td>20.01%</td>
<td>$48</td>
<td>($30)</td>
</tr>
<tr>
<td>Medical Specialists, Surgeons, and Other Eligible Professionals</td>
<td>1,341</td>
<td>80.40%</td>
<td>$427</td>
<td>82.75%</td>
<td>$920</td>
<td>($173)</td>
</tr>
<tr>
<td>Other Facility-Billed Evaluation &amp; Management Expenses</td>
<td>377</td>
<td>22.80%</td>
<td>$102</td>
<td>17.90%</td>
<td>$134</td>
<td>($40)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Major Procedures Billed by Eligible Professionals</th>
<th>Number of Your Attributed Beneficiaries Using any Service in this Category</th>
<th>Percentage of Your Attributed Beneficiaries Using any Service in this Category</th>
<th>Per Capita Costs for Your Attributed Beneficiaries</th>
<th>Benchmark Percentage of Beneficiaries Using any Service in this Category</th>
<th>Benchmar k Per Capita Costs</th>
<th>Amount by which Your Costs Were Higher or (Lower) Compared to the Benchmark</th>
</tr>
</thead>
<tbody>
<tr>
<td>Billed by Your TIN</td>
<td>14</td>
<td>0.84%</td>
<td>$7</td>
<td>1.53%</td>
<td>$20</td>
<td>($12)</td>
</tr>
<tr>
<td>Primary Care Physicians</td>
<td>3</td>
<td>0.18%</td>
<td>$1</td>
<td>0.25%</td>
<td>$1</td>
<td>$0</td>
</tr>
<tr>
<td>Medical Specialists</td>
<td>0</td>
<td>0.00%</td>
<td>$0</td>
<td>0.00%</td>
<td>$7</td>
<td>($7)</td>
</tr>
<tr>
<td>Surgeons</td>
<td>13</td>
<td>0.73%</td>
<td>$6</td>
<td>0.40%</td>
<td>$5</td>
<td>$0</td>
</tr>
<tr>
<td>Other Eligible Professionals</td>
<td>0</td>
<td>0.00%</td>
<td>$0</td>
<td>0.00%</td>
<td>$5</td>
<td>($5)</td>
</tr>
<tr>
<td>Billed by Other TINs</td>
<td>123</td>
<td>7.32%</td>
<td>$134</td>
<td>8.22%</td>
<td>$154</td>
<td>($20)</td>
</tr>
<tr>
<td>Primary Care Physicians</td>
<td>0</td>
<td>0.00%</td>
<td>$0</td>
<td>0.00%</td>
<td>$2</td>
<td>$2</td>
</tr>
<tr>
<td>Medical Specialists, Surgeons, and Other Eligible Professionals</td>
<td>123</td>
<td>7.32%</td>
<td>$134</td>
<td>8.11%</td>
<td>$152</td>
<td>($18)</td>
</tr>
<tr>
<td>Other Facility-Billed Expenses for Major Procedures</td>
<td>112</td>
<td>6.70%</td>
<td>$440</td>
<td>6.61%</td>
<td>$474</td>
<td>($5)</td>
</tr>
</tbody>
</table>
What’s at risk now

Potential Payment Adjustments

<table>
<thead>
<tr>
<th>Year</th>
<th>VBM</th>
<th>PQRS</th>
<th>MU</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016</td>
<td>-2%</td>
<td>-2%</td>
<td>-2%</td>
</tr>
<tr>
<td>2017</td>
<td>-3%</td>
<td>-2%</td>
<td>-4%</td>
</tr>
<tr>
<td>2018</td>
<td>-4%</td>
<td>-2%</td>
<td>-4%</td>
</tr>
</tbody>
</table>

Adapted from slides by Candy Hanson, BSN, PHN, LHIT-HP Stratis Health
Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)

- Signed into law April 15, 2016
- Ends the sustainable growth rate (SGR) formula
- Rewards providers for providing better care vs more care
- Two paths to choose from: Merit Based Incentive Program (MIPS) or Advanced Alternative Payment Model (APM)

Merit-Based Incentive Program (MIPS)

- Measurement years begin 2017
- Adjustments begin January 1, 2019
- Combines existing programs into one
- Links fee for service payments to quality and value
- Composite performance score (0-100)

MIPS Composite Score

Adapted from slides by Candy Hanson, BSN, PHN, LHIT-HP Stratis Health
Quality (50%)

• Formerly known as PQRS
• Accounts for 50% scoring
• Minimum of six measures and should include:
  • One cross-cutting measure (face to face with one Medicare beneficiary)
  • One outcome measure (if possible)

Adapted from slides by Candy Hanson, BSN, PHN, LHIT-HP Stratis Health
Clinical Practice Improvement Activities (15%)

- Accounts for 15% scoring
- Minimum number of activities
- Some reportable...some not
- 90+ activities to choose from

Adapted from slides by Candy Hanson, BSN, PHN, L_HIT-HP Stratis Health
Clinical Practice Improvement Activities

• Examples include:
  • Expanded practice access
  • Population management
  • Care coordination
  • Beneficiary engagement
  • Patient safety and practice assessment
  • Participation in an Alternative Payment Model (APM)

• Source: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/MACRA-MIPS-and-APMs.html
Resource Use (10%)

- Formerly known as VBM program
- Accounts for 10% scoring
- Claims data only
- Continue two measures from VBM:
  - Per capita costs for all attributed Medicare beneficiaries
  - Medicare spending per beneficiary

Adapted from slides by Candy Hanson, BSN, PHN, LHIT-HP Stratis Health
Advancing Care Information (25%)

• Formerly know as Meaningful Use
• Accounts for 25% scoring
• Gets rid of “all or nothing” reporting
• Base score: provide numerator/denominator or yes/no for six objectives and their measures

Adapted from slides by Candy Hanson, BSN, PHN, LHIT-HP Stratis Health
Advancing Care Information

• Measures include:
  • Protect patient information (Y/N)
  • Patient electronic access (N/D)
  • Coordination of care through patient engagement (N/D)
  • E-Prescribing (N/D)
  • Health Information Exchange (N/D)
  • Public Health Clinical Data Registry Reporting (Y/N)

• Requirements have been relaxed
Other Considerations

• Eligible Clinicians (ECs):
  • Can report as an individual, group, or as an alternative payment model entity group
  • Should know in advance what they need to do to perform well in MIPS
  • Can request targeted review of MIPS calculation

• Public reporting of MIPS will be made available on Physician Compare
MIPS payment adjustment

- Exceptional performance payment (500M set aside-not budget neutral)

Proposed Exemptions from MIPS:

- First year of Medicare Participation
- Below low volume threshold
  - $\leq 100$ Medicare patients AND
  - $\leq $10,000 Medicare FFS revenue
- Participants in Advanced APMs

Note MIPS does not apply to:
- Hospitals or facilities
- Providers in FQHC or RHCs that do not do any Medicare Part B billing above the threshold.

Two Goals for Medicare Fee for Service

**Medicare Fee-for-Service**

**GOAL 1:** 30%
Medicare payments are tied to quality or value through alternative payment models (categories 3-4) by the end of 2016, and 50% by the end of 2018

**GOAL 2:** 85%
Medicare fee-for-service payments are tied to quality or value (categories 2-4) by the end of 2016, and 90% by the end of 2018

Stakeholders:
Consumers | Businesses
Payers | Providers
State Partners

## Alternative Payment Models

<table>
<thead>
<tr>
<th>APMs</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACOs</td>
</tr>
<tr>
<td>Bundled Care Models</td>
</tr>
<tr>
<td>PCMH</td>
</tr>
</tbody>
</table>
Major Alternative Payment Model Categories

Adapted from John Rancourt & Alex Baker, Office of Care Transformation, ONC, HIMSS16 Presentation 2/29/16
Comprehensive Primary Care (CPC)

- CPC
  - A 4 year project that ends in December 2016
  - A medical home involving multiple insurers in the experiment
  - Collaborated with commercial and State health insurance plans in seven U.S. regions
  - Service delivery and payment model designed by CMMI
  - Supports the provision of a core set of five “Comprehensive” primary care functions.
    - Risk-stratified Care Management;
    - Access and Continuity;
    - Planned Care for Chronic Conditions and Preventive Care
    - Patient and Caregiver Engagement
    - Coordination of Care across the Medical Neighborhood.

- CPC+
  - A 5 year multi-payer model starting in January 1, 2017 in 14 regions
  - Up-front incentive payments along with fee-for-service and performance-based payments
  - If they meet the quality and utilization standards set at the beginning of the year, they get to keep the up-front money.
  - Track 1
    - Up-front incentive payments $2.5/bene/month
    - Traditional FFS payments
    - Monthly care management fee $15/bene/month
    - Certified Health IT requirements
  - Track 2
    - Track 1 Plus:
      - Higher up-front incentive $4/bene/month
      - A higher care management fee $28/bene/month
      - A hybrid of reduced Medicare FFS payments and upfront comprehensive primary care payments.
      - Higher Certified Health IT standards
Accountable Care Organizations (ACOs) are groups of providers who assume responsibility for the quality and cost efficiency of the health care for a designated patient population.
Blueprint for an Alternative Payment Model: *Case Study of MSSP*

1. Primary care providers agree to take responsibility for the total costs accrued by a subset of their Medicare patients.

2. Physicians work throughout the year to make sure that their patients receive the best quality care in the right setting and that any chronic diseases are well managed.

3. Medicare tallies up how much those patients spent and compares it to a benchmark from previous years.

4. If the total costs for those patients are less than the benchmark, Medicare splits the difference with the physicians.
Benchmarks

Benchmark determined based on total cost of care over the last three years.
Pioneer Shared Savings Program

- Launched January 2012
- Two sided risk
- Designed for large organizations with more experience
- 5 arrangements
  - Savings / losses from 60 – 75% based on quality scores
- Served as a test bed for MSSP programs
- 2016 Last program year

https://innovation.cms.gov/initiatives/Pioneer-aco-model/
Medicare Shared Savings Programs

- Launched April 2012
- 3-year contract
- As of January 2016:
  - 433 MSSP ACOs total with 7.7 million beneficiaries
  - Minimum 5,000 Medicare FFS Beneficiaries
  - Track 1: 1 sided risk (411)
  - Track 2: 2 sided risk (6)
  - Track 3: 2 sided risk (16)
- Over $341 million paid to 92 ACOs in Sept. 2015 ($3.5 million per)

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/All-Starts-MSSP-ACO.pdf
Medicare Shared-Savings Tracks

- **Track 1:**
  - Upside risk only (Max 50%) with 10% payment limit
  - Was to only be allowed for 3 years, extended in June of 2015 for a 2nd 3 year term.

- **Track 2:**
  - Higher upside risk (Max 60%) with 15% payment limit
  - Includes some “downside” financial risk (5-10% Max
  - Was required after the 3rd year in Track 1

- **Track 3 (started in 2016):**
  - Two-sided risk and greater sharing in savings to 75% with 20% payment limit
  - Losses capped at 15%
  - Waives the 3 day inpatient stay requirement for SNF
  - Prospective Beneficiary Attribution Model beginning in 2017

Increasing Flexibility and Support for Modifications in Clinical Practice
Next Generation ACOs

- Launched January 2016
- Two sided risk
  - Track 1: savings/losses to 80%
  - Track 2: savings/losses to 100%
- More flexibility with
  - Telemedicine
  - Home visits
- Benchmarks set prospectively:
  - Reward quality performance;
  - Reward both attainment of and improvement in cost containment;
- Payment
  - Ultimately transition away from reference to ACO historical expenditures.
  - Ability to move to population-based payments
- 21 Sites participating in 2016

[Source: Centers for Medicare & Medicaid Services]

https://innovation.cms.gov/initiatives/Next-Generation-ACO-Model/
Independent PCPs Consistently Achieve Savings

Medicare Savings Performance by ACO Subgroup (2012 - 2013)


*5% savings calculated off mean spending of $9,942 per beneficiary in the Chernew study.
Who will avoid MACRA – The law

- MACRA financially incents physicians to deliver care via an Advanced Alternative Payment Model.
  - a five percent lump sum payment based on the aggregate physician fee payment amount received for the preceding year.
  - Payment would not be added to determining total ACO reconciled reimbursements.
- Advanced Alternative Payment Models
  - a type of a Medicare Accountable Care Organization or
  - a CMS required demonstration
  - Some Patient Centered Medical Homes.
  - Could be a “Physician-Focused Payment Model” (PFPM).
    - These would be vetted by a MACRA-created Physician-focused Payment Technical Advisory Committee (PTAC)

- The law requires
  - Certified Electronic Health Record (EHR) technology,
  - Payments based on quality performance similar to MIPS
  - Bear “financial risk for monetary losses” “in excess of a “nominal amount.” What is a “nominal amount” will be defined in regulation.
- Other Requirements:
  - In 2019 and 2020 a qualifying APM would also have to receive at least 25 percent of their Medicare reimbursements through an APM,
  - In 2021 and 2022 at least 50 percent
  - In 2023 and subsequent years 75 percent although this percentage can combine Medicare and other APM-like reimbursements.
- Partial APM status is also possible
What qualifies as an Advanced APM – The proposed rule

- The proposed rule includes a list of models that would qualify as Advanced APMs. These include:
  - Medicare Shared Savings Program—Track 2
  - Medicare Shared Savings Program—Track 3
  - Next Generation ACO Model
  - Comprehensive Primary Care Plus (CPC+)
  - Comprehensive ESRD Care Model (Large Dialysis Organization arrangement)
  - Oncology Care Model Two-Sided Risk Arrangement (available in 2018)

Defining financial risk in excess of a nominal amount

Nominal Amount Standard

The **amount of risk** under an Advanced APM must at least meet the following components:

- **Total risk** of at least 4% of expected expenditures
- **Marginal risk** of at least 30%
- **Minimum loss ratio** (MLR) of no more than 4%

Illustration of the amount of risk an APM Entity must bear in an Advanced APM:

Other Models – Do not count as “Advanced” APMs

• Bundled Payments
  • Compensate providers with a single payment for an episode of care, which is defined as a set of services delivered to a patient over a specific time period

• Pay for Performance
  • The most common form of financial incentive in a P4P program is a bonus payment for a provider that meets certain quality goals.
  • May include withholds, penalties, fee schedule adjustments, per-member payments, payments for the provision of a particular service, lack of payment for poor performance, shared savings, quality grants or loans, or payment for participation in certain activities or for reporting on certain activities, such as reporting of outcome measures for hospitals.
  • Cost is not always considered.

• PCMH
  • Facilitates the coordination of care through a patient’s primary care physician
  • Personal physician care, physician-directed medical practice, whole person orientation, coordinated and/or integrated care, high quality and safety in care, enhanced access to care, and payment that supports enhanced services

• Multi-payer Advanced Primary Care Practice
  • 3 year pilot started in 2011, extended through 2016
  • Regional – currently 5 states
  • Service delivery and payment model designed by the states
  • Includes Medicare, Medicaid and private health plans
  • Includes a care management fee is intended to cover care coordination, improved access, patient education and other services to support chronically ill patients

https://innovation.cms.gov/initiatives/Multi-payer-Advanced-Primary-Care-Practice/
The MIPS Timeline

• 2016 is the last year that MU, PQRS, VBM are reported on as stand alone programs
• Performance period is two years behind reporting period
• 2017 is the first performance period for MIPS for 2019
• Choose either MIPS or APM
### Interaction of MIPS and MSSP Track 1

<table>
<thead>
<tr>
<th>Category</th>
<th>Weight</th>
<th>ACO Weight</th>
<th>ACO Description of Measure</th>
<th>Submission Method</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality <em>(Translation: PQRS Style Measures)</em></td>
<td>50%</td>
<td>50%</td>
<td>ACO’s EHR based quality measures replace the MIPS measures Measured against MIPS benchmarks so score will vary from the score in the MSSP</td>
<td>ACO submits through GPRO</td>
</tr>
<tr>
<td>Clinical Practice Improvement Activities</td>
<td>15%</td>
<td>20%</td>
<td>A menu of over 90 activities with different weights (10 points or 20 points). Need 60 points for full credit Practice gets 30 points just for being in an ACO</td>
<td>Same</td>
</tr>
<tr>
<td>Advancing Care Information</td>
<td>25%</td>
<td>30%</td>
<td>12 Total Measures into 3 Categories (11 Required) • Need 100 out of 131 possible points • 50 points for just having one in the numerator of the 11 measures • 80 possible points for performance on the 8 measures • 1 bonus point for reporting the 12th measure</td>
<td>Same</td>
</tr>
<tr>
<td>Resource Use <em>(Translation: Costs)</em></td>
<td>10%</td>
<td>0%</td>
<td>Shared savings takes the place of the cost measure</td>
<td>N/A</td>
</tr>
</tbody>
</table>
Potential Value Based Financial Rewards

- APMs—and eligible APMs in particular—offer greater potential risks and rewards than MIPS.
- In addition to those potential rewards, MACRA provides a bonus payment to providers committed to operating under the most advanced APMs.

<table>
<thead>
<tr>
<th>MIPS only</th>
<th>APMs</th>
<th>eligible APMs</th>
</tr>
</thead>
<tbody>
<tr>
<td>MIPS adjustments</td>
<td>APM-specific rewards + MIPS adjustments</td>
<td>eligible APM-specific rewards + 5% lump sum bonus</td>
</tr>
</tbody>
</table>

Impact on physician payments

Requirements for success in the APMs

• Understand your population
• Identify high risk patients
• Code accurately
• Invest in care management
• Develop a high-value referral network
• Use event notifications
• Engaging Patients
Identifying High Risk Patients

- Multiple chronic diseases
- Frequent ED visits
- Recent hospitalizations
- Polypharmacy
- Welcome to Medicare or Annual Wellness Exam
- Falls risk
- Cognitive impairments
Visibility Beyond the Four Walls

SKILLED NURSING | POST ACUTE | REHAB | HOME HEALTH

15% of beneficiaries comprising 17% of total Medicare cost

IMAGING CENTER

79% of beneficiaries comprising 3% of total Medicare cost

PCP

56% of beneficiaries had plurality of primary care services in the PCP’s office comprising 4% of total Medicare cost

SPECIALIST

66% of beneficiaries comprising 8% of total Medicare cost

ED | HOSPITAL

19% of beneficiaries had an inpatient hospital visit comprising of 30% of total cost

80% of beneficiaries had an outpatient hospital visit comprising 20% of total cost

28% of beneficiaries had an ED visit comprising 2% of total cost

LAB

97% of beneficiaries comprising 4% of total Medicare cost
How can technology help?
# CMS Claims and Claim Line Feed (CCLF) Data

## Inpatient Data
- aco
- aco_id
- practice
- prac_id
- prac_sf_code
- site_name
- site_ccn
- pt_first_name
- pt_last_name
- pt_dob
- pt_medicare_id
- pcp_npi
- pcp_last_name
- pcp_first_name
- visit_from_date
- visit_thru_date
- visit_month
- visit_year
- length_of_stay
- hospital_type
- hospital_ccn
- hospital_name
- hospital_city
- hospital_state
- admtg_dgns_cd
- admtg_dgns_description
- vst_dgns
- vst_dgns_description
- vst_drg
- drg_descr
- drg_type
- ccs_label
- readmission
- orig_ed
- icu_visit
- ccu_visit
- intermed_care_visit
- vst_pmt

## Home Health
- aco_name
- prac_name
- prac_id
- prac_code
- site_name
- pt_last_name
- pt_first_name
- pt_dob
- pt_medicare_id
- pcp_npi
- pcp_last_name
- pcp_first_name
- earliest_hh_visit
- latest_hh_visit
- latest_ordrg_prvdr
- prvdr_last_name
- prvdr_first_name
- latest_org_ccn
- latest_organization_name
- total_hh_days
- authorized_periods
- period_days
- single_days
- total_cost
- days_quartile
- cost_quartile
# Understanding Your Costs

<table>
<thead>
<tr>
<th>TOTAL PATIENT COUNT</th>
<th>ATTRIBUTED PATIENT COUNT</th>
<th>PATIENTS WITH CCLF DATA</th>
<th>AVERAGE HCC SCORE</th>
<th>AVERAGE HCC SCORE (ACO)</th>
</tr>
</thead>
<tbody>
<tr>
<td>353</td>
<td>295</td>
<td>283</td>
<td>1.305</td>
<td>1.305</td>
</tr>
</tbody>
</table>

**TOTAL SPENDING**

<table>
<thead>
<tr>
<th>SPENDING CATEGORY</th>
<th>TOTAL $</th>
<th>ACO TOTAL $</th>
<th>USERS</th>
<th>ACO USERS</th>
<th>PER USER $</th>
<th>ACO PER USER $</th>
<th>BENES</th>
<th>ACO BENES</th>
<th>PER CAPITA $</th>
<th>ACO PER CAPITA $</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total spending</td>
<td>$2,225,050</td>
<td>$2,225,050</td>
<td>222</td>
<td>222</td>
<td>$10,023</td>
<td>$10,023</td>
<td>222</td>
<td>222</td>
<td>$10,023</td>
<td>$10,023</td>
</tr>
<tr>
<td>Acute inpatient hospital</td>
<td>$773,381</td>
<td>$773,381</td>
<td>10</td>
<td>10</td>
<td>$80,968</td>
<td>$77,338</td>
<td>222</td>
<td>222</td>
<td>$3,484</td>
<td>$3,484</td>
</tr>
<tr>
<td>Emergency room</td>
<td>$314,470</td>
<td>$314,470</td>
<td>189</td>
<td>189</td>
<td>$1,667</td>
<td>$1,664</td>
<td>222</td>
<td>222</td>
<td>$1,417</td>
<td>$1,417</td>
</tr>
<tr>
<td>Specialist procedure</td>
<td>$302,006</td>
<td>$302,006</td>
<td>67</td>
<td>67</td>
<td>$4,490</td>
<td>$4,508</td>
<td>222</td>
<td>222</td>
<td>$1,360</td>
<td>$1,360</td>
</tr>
<tr>
<td>Other Part B drugs</td>
<td>$196,018</td>
<td>$196,018</td>
<td>132</td>
<td>132</td>
<td>$1,462</td>
<td>$1,485</td>
<td>222</td>
<td>222</td>
<td>$883</td>
<td>$883</td>
</tr>
<tr>
<td>Inpatient rehab facility</td>
<td>$124,020</td>
<td>$124,020</td>
<td>1</td>
<td>1</td>
<td>$108,937</td>
<td>$124,020</td>
<td>222</td>
<td>222</td>
<td>$559</td>
<td>$559</td>
</tr>
<tr>
<td>Hospice</td>
<td>$110,061</td>
<td>$110,061</td>
<td>1</td>
<td>1</td>
<td>$96,675</td>
<td>$110,061</td>
<td>222</td>
<td>222</td>
<td>$496</td>
<td>$496</td>
</tr>
<tr>
<td>Home health</td>
<td>$82,172</td>
<td>$82,172</td>
<td>0</td>
<td>0</td>
<td>$0</td>
<td>$0</td>
<td>0</td>
<td>0</td>
<td>$0</td>
<td>$0</td>
</tr>
</tbody>
</table>

**DATA YEAR** 2015
Understand Your Patient Costs

TOTAL PATIENT SPEND BY MONTH
Understand Where Your Patients Have Been
### Understand Whom You Are Seeing

#### UPCOMING PATIENTS

<table>
<thead>
<tr>
<th>Name</th>
<th>DOB</th>
<th>Appointment</th>
<th>Provider</th>
<th>CURRENT HCC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bailey, Kathleen</td>
<td>Dec 4, 1943</td>
<td>Jun 11, 2016</td>
<td>Dr. Victor Test</td>
<td>3.782</td>
</tr>
<tr>
<td>Mann, Elsie</td>
<td>Mar 12, 1929</td>
<td>Jun 11, 2016</td>
<td>Dr. Victor Test</td>
<td>2.656</td>
</tr>
<tr>
<td>Sullivan, Louise</td>
<td>Jul 29, 1943</td>
<td>Jun 11, 2016</td>
<td>Dr. Victor Test</td>
<td>1.855</td>
</tr>
<tr>
<td>Lambert, Gail</td>
<td>Nov 4, 1946</td>
<td>Jun 11, 2016</td>
<td>Dr. Victor Test</td>
<td>1.772</td>
</tr>
<tr>
<td>Martin, Nancy</td>
<td>Oct 5, 1948</td>
<td>Jun 11, 2016</td>
<td>Dr. Victor Test</td>
<td>0.560</td>
</tr>
</tbody>
</table>
### Coding Accurately

#### UPCOMING PATIENTS

<table>
<thead>
<tr>
<th>NAME</th>
<th>DOB</th>
<th>APPOINTMENT</th>
<th>PROVIDER</th>
<th>CURRENT HCC</th>
<th>SUGGESTED DIAGNOSIS</th>
<th>OPPORTUNITY TYPE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bailey, Kathleen</td>
<td>Dec 4, 1943</td>
<td>Jun 11, 2016 10:15 AM</td>
<td>Dr. Victor Test</td>
<td>3.782</td>
<td>Major Depressive, Bipolar, and Paranoid Disorders 0.330</td>
<td>not yet billed in 2016</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• F322 - Major depressv disord, single epsd, sev w/o psych features</td>
<td></td>
</tr>
<tr>
<td>Mann, Elsie</td>
<td>Mar 12, 1929</td>
<td>Jun 11, 2016 10:15 AM</td>
<td>Dr. Victor Test</td>
<td>2.656</td>
<td>Specified Heart Arrhythmias 0.295</td>
<td>not yet billed in 2016</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• I4891 - Unspecified atrial fibrillation</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Coagulation Defects and Other Specified Hematological Disorders 0.252</td>
<td>not yet billed in 2016</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• D696 - Thrombocytopenia, unspecified</td>
<td></td>
</tr>
</tbody>
</table>
## Invest in Care Management

### POPULATION

<table>
<thead>
<tr>
<th>PROVIDERS</th>
<th>TO BE REVIEWED</th>
<th>ASSIGN INTERVENTIONS</th>
<th>ENROLL IN RESOURCES</th>
<th>ONGOING MANAGEMENT</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr. Victor Test, M.D.</td>
<td>57</td>
<td>16</td>
<td>29</td>
<td>1</td>
<td>103</td>
</tr>
<tr>
<td>no assigned PCP</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
</tbody>
</table>

### DR. VICTOR TEST, M.D. - TO BE REVIEWED

57 patients

<table>
<thead>
<tr>
<th>NAME</th>
<th>DOB</th>
<th>SCORE</th>
<th>LAST AWV</th>
<th>NEXT APPT</th>
<th>NOTES</th>
<th>YTD COST</th>
</tr>
</thead>
<tbody>
<tr>
<td>Duncan, Lisa</td>
<td>02/21/1946</td>
<td>14.5</td>
<td>10/27/2014</td>
<td>1</td>
<td></td>
<td>$0.00</td>
</tr>
<tr>
<td>Griffin, Joanne</td>
<td>06/19/1948</td>
<td>14.178</td>
<td></td>
<td>1</td>
<td></td>
<td>$4,713.37</td>
</tr>
<tr>
<td>Williams, Mary</td>
<td>02/22/1945</td>
<td>13</td>
<td>02/18/2016</td>
<td>1</td>
<td></td>
<td>$2,677.52</td>
</tr>
<tr>
<td>Benson, Rebecca</td>
<td>07/11/1946</td>
<td>13</td>
<td>03/02/2016</td>
<td>1</td>
<td></td>
<td>$63,394.79</td>
</tr>
</tbody>
</table>
## Identify High Risk Populations

### POPULATION

<table>
<thead>
<tr>
<th>TAG SEARCH</th>
<th>ADD TO</th>
<th>NAME</th>
<th>CREATED</th>
<th>DEFINITION</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>all high risk patients</td>
<td>Jul 24, 2015</td>
<td>show</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CHF with inpatient/ED</td>
<td>Apr 14, 2016</td>
<td>show</td>
</tr>
<tr>
<td></td>
<td></td>
<td>falls risk and medication risks</td>
<td>Apr 14, 2016</td>
<td>show</td>
</tr>
<tr>
<td></td>
<td></td>
<td>frequent ED visit list</td>
<td>May 13, 2016</td>
<td>show</td>
</tr>
<tr>
<td></td>
<td></td>
<td>HCC &gt; 2 and frequent ED</td>
<td>Jun 10, 2016</td>
<td>show</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Higher than expected costs</td>
<td>May 24, 2016</td>
<td>show</td>
</tr>
<tr>
<td></td>
<td></td>
<td>inpatient/ED with behavioral health</td>
<td>Apr 14, 2016</td>
<td>show</td>
</tr>
<tr>
<td></td>
<td></td>
<td>inpatient/ED with medication adherence</td>
<td>Apr 14, 2016</td>
<td>show</td>
</tr>
</tbody>
</table>

### ALL

<table>
<thead>
<tr>
<th>FALL</th>
</tr>
</thead>
</table>

### ONE OR MORE

<table>
<thead>
<tr>
<th>MEDICATION RISKS</th>
</tr>
</thead>
<tbody>
<tr>
<td>HRMED</td>
</tr>
</tbody>
</table>

### 3 MATCHING PATIENTS

<table>
<thead>
<tr>
<th>NAME</th>
<th>DOB</th>
<th>SCORE</th>
<th>LAST AWV</th>
<th>NEXT APPT</th>
<th>NOTES</th>
<th>YTD COST</th>
</tr>
</thead>
<tbody>
<tr>
<td>Schneider, Johnny</td>
<td>02/08/1943</td>
<td>13.5</td>
<td>10/07/2015</td>
<td></td>
<td></td>
<td>$621.77</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>MORE</td>
</tr>
<tr>
<td>Boyd, Lillian</td>
<td>07/05/1943</td>
<td>9.634</td>
<td>07/23/2015</td>
<td></td>
<td></td>
<td>$27,398.50</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>MORE</td>
</tr>
</tbody>
</table>
## Developing a High-Value Referral Network

<table>
<thead>
<tr>
<th>Practice Name</th>
<th>Facility Fees</th>
<th>PET Stress Test Use</th>
<th>Repeat Testing</th>
<th># of Benes with Any Visit</th>
<th>Total # of Visits</th>
<th>% of Total Visits</th>
<th>Yearly Visits per Bene (2015)</th>
<th>Median Echo Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Practice</td>
<td><img src="#" alt="No Access" /></td>
<td><img src="#" alt="High" /></td>
<td><img src="#" alt="High" /></td>
<td>179</td>
<td>570</td>
<td>59.5%</td>
<td>3.2</td>
<td>$362</td>
</tr>
<tr>
<td>2 Practice</td>
<td><img src="#" alt="High" /></td>
<td><img src="#" alt="High" /></td>
<td><img src="#" alt="High" /></td>
<td>22</td>
<td>127</td>
<td>13.3%</td>
<td>5.8</td>
<td>$172</td>
</tr>
<tr>
<td>3 Practice</td>
<td><img src="#" alt="No Access" /></td>
<td><img src="#" alt="High" /></td>
<td><img src="#" alt="High" /></td>
<td>15</td>
<td>46</td>
<td>4.8%</td>
<td>3.1</td>
<td>$174</td>
</tr>
<tr>
<td>4 Practice</td>
<td><img src="#" alt="Low" /></td>
<td><img src="#" alt="High" /></td>
<td><img src="#" alt="Low" /></td>
<td>2</td>
<td>43</td>
<td>4.5%</td>
<td>21.5</td>
<td>N/A</td>
</tr>
<tr>
<td>5 Practice</td>
<td><img src="#" alt="Low" /></td>
<td><img src="#" alt="High" /></td>
<td><img src="#" alt="Low" /></td>
<td>5</td>
<td>27</td>
<td>2.8%</td>
<td>5.4</td>
<td>$174</td>
</tr>
<tr>
<td>6 Practice</td>
<td><img src="#" alt="No Access" /></td>
<td><img src="#" alt="High" /></td>
<td><img src="#" alt="Low" /></td>
<td>6</td>
<td>15</td>
<td>1.6%</td>
<td>2.5</td>
<td>$174</td>
</tr>
<tr>
<td>7 Practice 7</td>
<td><img src="#" alt="No Access" /></td>
<td><img src="#" alt="Low" /></td>
<td><img src="#" alt="Low" /></td>
<td>2</td>
<td>9</td>
<td>0.9%</td>
<td>4.5</td>
<td>$172</td>
</tr>
</tbody>
</table>
Engage Your Patients

• Help them to understand their care plan
• Provide with after visit summaries
• Utilize your staff to reach out to them
  • After going to an emergency room
  • After hospital discharge
• Provide them with 24 hour access to care
Stories

• The Nephrologist who ordered too much

• Homecare and Bingo

• The anxious COPD patient
What you can do now

- Recognize that the move to value-based care delivery will reach all aspects of care
- Collaborate with others based on information from your Quality Use and Resource Report (QRUR)
- Examine the different ACO models
- Focus on:
  - Quality
  - Advancing Care Information (Interoperability and sharing)
  - Clinical Practice Improvement
  - Cost
  - Coding
Resources

• MACRA Proposed Rule:
  • HTML: http://federalregister.gov/a/2016-10032
  • Comments (Open until 6/27/16): https://www.regulations.gov/#!submitComment;D=CMS-2016-0060-0068

• MACRA Proposed Rule Fact Sheet:

• Medicare Shared Savings Programs:
  • https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/index.html

• Next Generation ACOs:
  • https://innovation.cms.gov/initiatives/Next-Generation-ACO-Model/

• Comprehensive Primary Care Plus:
Thank you

Paul Kleeberg, MD, FAAFP, FHIMSS
Medical Director, Aledade

7315 Wisconsin Ave, Suite 1000E
Bethesda, MD 20814

Paul@Aledade.com
www.aledade.com
@aledadeACO