POM ACO Course:

Session 4 - Specialists and ACO Beneficiaries

October 23, 2024

POM ACO

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Welcome to Value-Based Care Essentials: The Role of ACOs!

- Course comprised of four sessions, covering essential topics related to ACOs, including MSSP overview, coding, documentation, care management, and quality measures.
- After the activity, participants will be able to understand the role of ACOs and their functions, as well as apply knowledge learned in the course to better serve patients and fulfill CMS requirements.

Session 1: ACO Basics
September 10, 2024
11 am – 1 pm

Session 2: ACO Quality Measures Essentials
September 25, 2024
11 am – 1 pm

Session 3: Managing the Care of ACO Beneficiaries
October 8, 2024
11 am – 1 pm

Session 4: Specialists and ACO Beneficiaries
October 23, 2024
11 am – 1 pm

**1.75 CE Credits for each session attended*
(7 CE credits for all 4 sessions)

Today's Session

Speakers

- David Serlin, MD, FAAFP
  Medical Director, Physician Organization of Michigan ACO
- William Felton, MD
  Interventional Cardiologist, MyMichigan Health
- Geoffrey Barnes, MD
  Cardiologist and Vascular Medicine Specialist, Michigan Medicine
- Elliot Tapper, MD
  Hepatologist, Academic Chief of Hepatology Michigan Medicine

Objectives

- ✓Define ACOs and the Specialist's role
- ✓Understand the impact of Specialist EMR documentation on ACO programming
- ✓Develop high-level understanding of clinical quality metrics and the Specialists' role
- ✓Panel Discussion: Exploring collaborative approaches to the PCP/Specialist relationship

Engaging Specialists in ACOs

David Serlin, MD, FAAFP

What is Value Based Care?

- Value based care is a healthcare delivery framework that reimburses health care providers for the quality and outcome of care in lieu of the volume of care provided.

The Quadruple Aim of Healthcare

Value-Based Health Care Benefits

Patients	Providers	Payers	Suppliers	Society
Lower Costs & Better Outcomes	Higher Patient Satisfaction Rates & Better Care Efficiencies	Stronger Cost Controls & Reduced Risks	Alignment of Prices with Patient Outcomes	Reduced Healthcare Spending & Better Overall Health

Historical Equation

Value = Quality / Cost

Expanded Equation

Value = (Quality + Outcomes + Patient Experience + Equity) / Cost

The Transition from Volume to Value

Anatomical markers of fee-for-service (FFS) vs. value-based care (VBC)

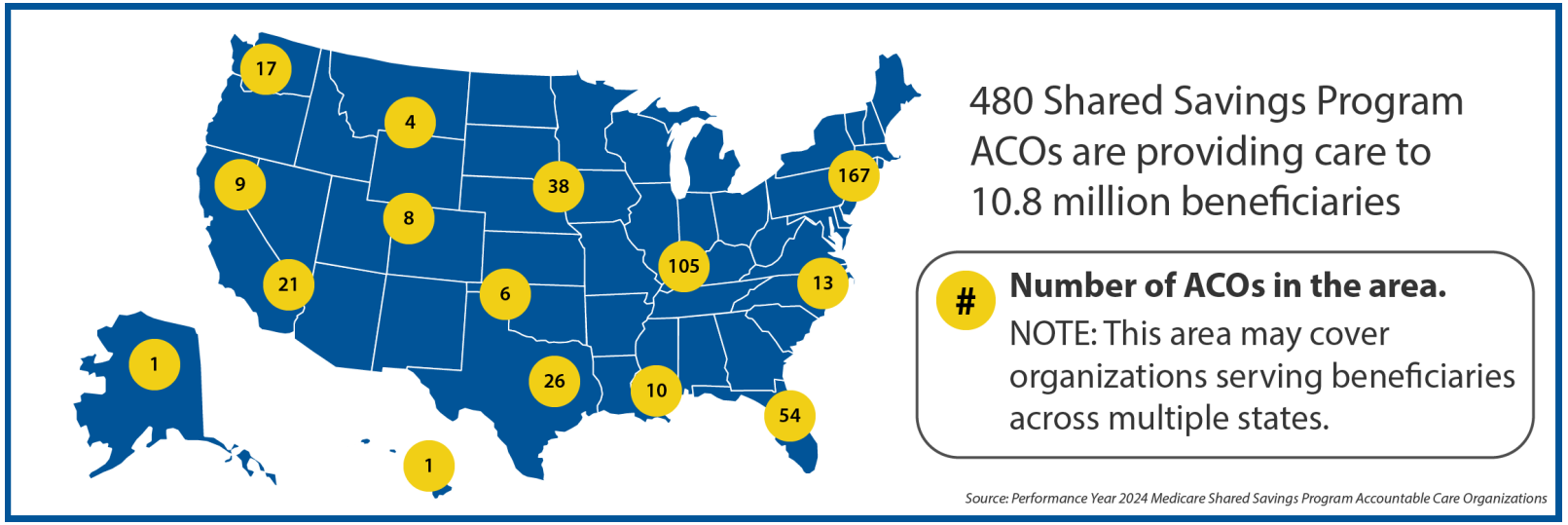
	Fee-For-Service Model **Paid for Volume** An economic model driven by utilization and fee-for-service reimbursement	***Value-Based Model*** **Paid for Value** An economic model driven by lives and the cost of care to provide desired outcomes
Physician Role	Referral generator focused on specialty care	Manager of comprehensive patient health
Hospital Role	Profit centers	Cost centers
Patient Acquisition	Broad referral network	Defined attributed population
Revenue Source	IP admissions, procedures, OP encounters, & above market FFS rates	Capture premium dollar, growing lives, reducing spend, & improving clinical outcomes
Margin Driver	Strategically distributed acute care platform & hospital efficiency/ clinical standardization	High-performing medical management
Core Competencies	Hospital operations, FFS rate negotiation, Mergers & Acquisitions, marketing, revenue cycle	Care Mgmt., In-Network Utilization, PAC & Transitions, Hospital Efficiency, Coding & Documentation, Data & Analytics, Disease Mgmt.

What is an Accountable Care Organization (ACO)?

- ACOs are groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high-quality care to an assigned Medicare fee-for-service beneficiary population.
- Coordinated care helps ensure that patients, especially the chronically ill, get the right care at the right time, with the goal of avoiding unnecessary duplication of services and preventing medical errors.
- When an ACO succeeds in both delivering high-quality care and spending health care dollars more wisely, it will share in the savings it achieves for the Medicare program. In certain models, ACOs may also be liable to pay back losses if their costs exceed their spending benchmarks.
- CMS makes data on Shared Savings Program ACOs publicly available through several resources, including Data.CMS.gov.

What is the Medicare Shared Savings Program?

- Medicare has several ACO programs that participants can choose to participate in.
- The Medicare Shared Savings Program (MSSP) is the primary Medicare ACO program. The MSSP was derived from the Physician Group Demonstration Project, which started during the George W. Bush administration, and the MSSP was permanently authorized by the Affordable Care Act.
- The Shared Savings Program has different participation tracks that allow ACOs to select an arrangement that makes the most sense for their organization.



Key Aspects of the Medicare Shared Savings Program

1. **A Population Management Incentive System**
Medicare's voluntary Shared Savings Program (SSP) enables groups of providers forming accountable care organizations (ACOs) to earn bonuses if they can keep total population health expenditures below a target benchmark.

2. **Primary Care at the Heart of the ACO**
Medicare ACOs will be structured around primary care groups but may include other providers, including hospitals and health systems, who agree to accept utilization risk for a population of patients defined by their primary care utilization.

3. **Program Options With, Without Risk**
Participating providers have two program options to choose from: a financial model with exclusively upside potential for all three years, or a model that involves downside risk in all three contract years in exchange for a more-favorable shared savings rate.

4. **Benchmarks Based on Historical Performance**
An ACOs target expenditure benchmarks will be tied to the historical service utilization of that ACO's patients. The target benchmark will be updated annually by the average national growth in per-beneficiary Medicare expenditures, enabling low-growth providers to more easily achieve shared savings payments.

5. **Preliminary Prospective Assignment Supplemented by Beneficiary-Identifiable Data**
Although an ACO's patient population will still be attributed retrospectively, CMS will make available prospective predictions of those patients. CMS will also provide ACOs regular access to continuum-spanning patient data, unless patients specifically opt to prohibit such data sharing.

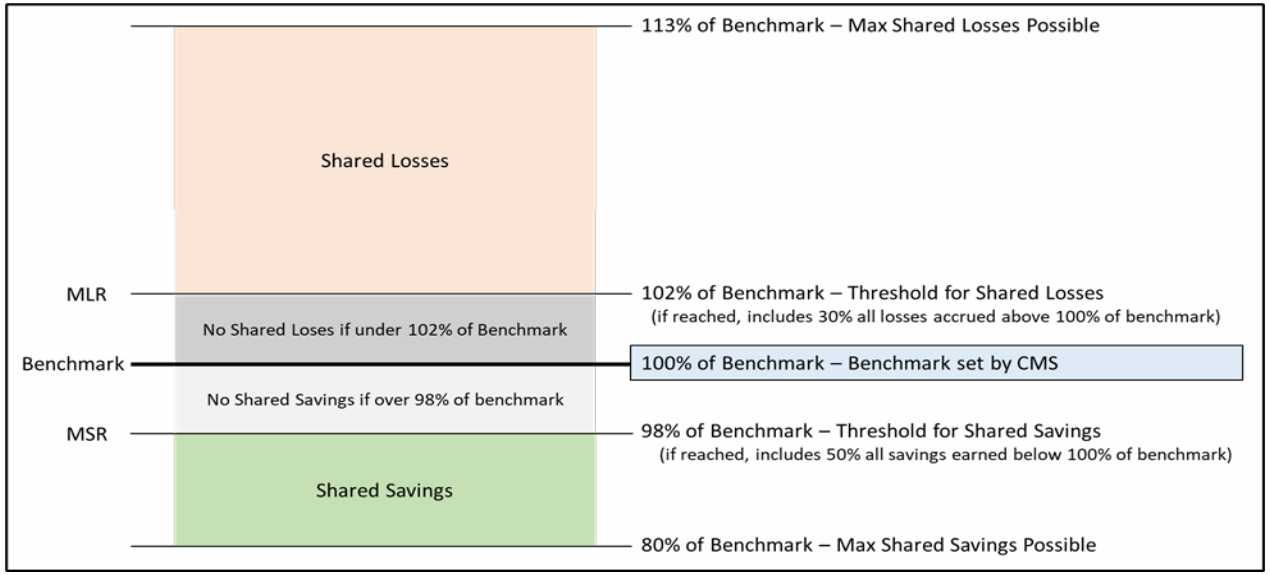
6. **No Restrictions on Patient Choice or Transparency**
Although patients are attributed to ACOs for the purposes of shared savings calculations, providers may not restrict patient provider choice in any way; all patient-centered ACO marketing materials must be approved by CMS, and patients will be notified of their PCP's participation in SSP.

7. **Shared Savings Payments Adjusted for Quality Performance**
ACOs will be evaluated on ACO specific quality measures, and the shared savings earning potential will be tied to an aggregate performance standard. Performance measures will be assessed both on an absolute basis and relative to other providers.

8. **Minimum Savings Rate (MSR) and Minimum Loss Rate (MLR)**
The Minimum Savings Rate and Minimum Loss Rates are thresholds, calculated as a percentage of the ACO's historical benchmark. The ACO must meet or exceed to share in savings or to be liable for shared losses.

ACO Shared Savings / Shared Losses

- CMS calculates benchmarks for each ACO. The benchmark is based on the current participating Tax Identification Numbers (TINs) or Provider/Practice in the ACO, and their historic performance in those benchmark years for their Medicare beneficiaries at that time.
- At the end of a performance year CMS compares the updated historical benchmark to an ACO's assigned beneficiaries' per capita expenditures during the year.



Aligning Specialist Physicians with ACOs

- Education on value-based care
- Performance measurement and reporting
- Systems designed to catalyze PCP-specialist collaboration
- Steering referrals to preferred specialists

Patients Attributed to Specialists

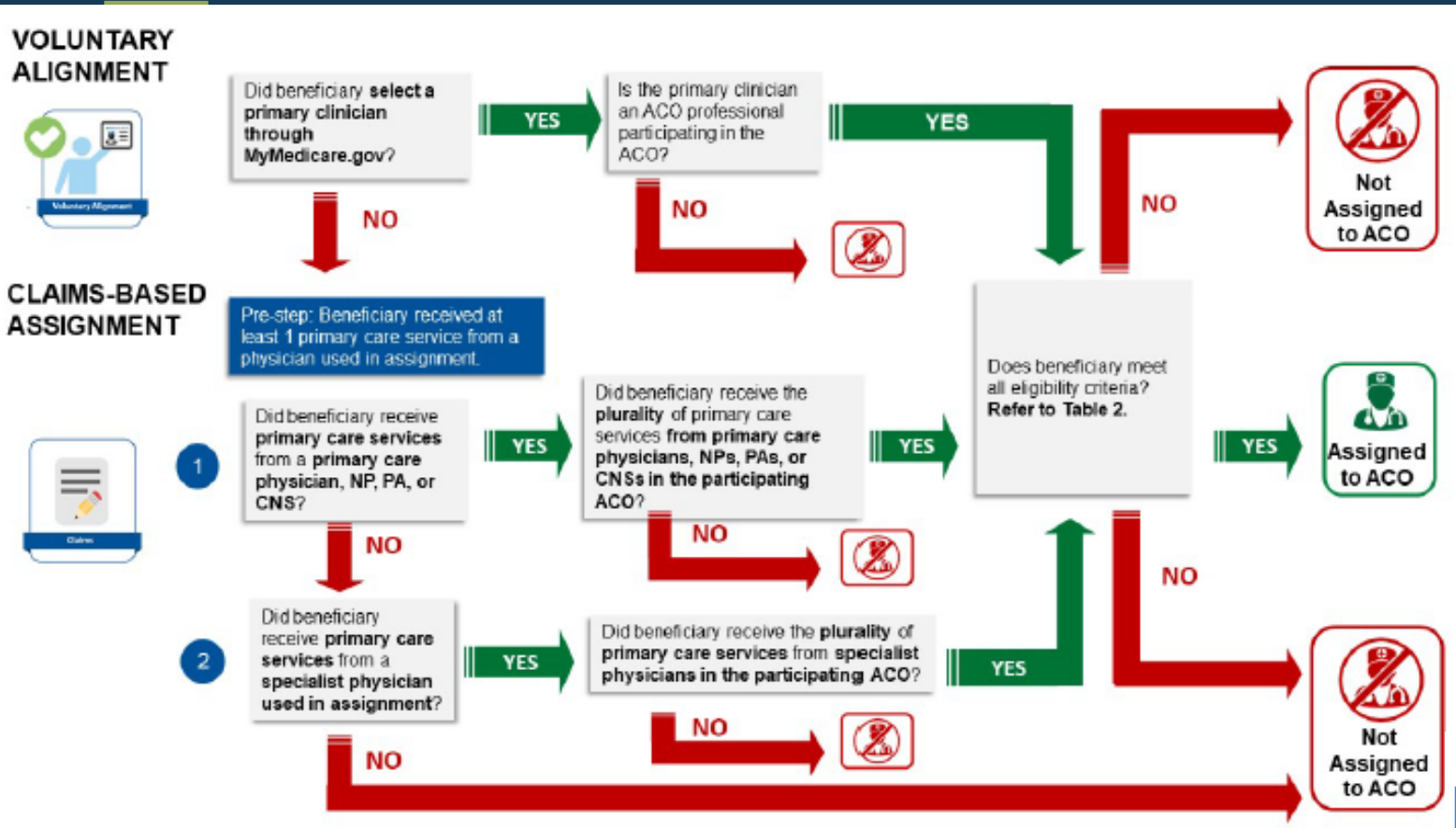
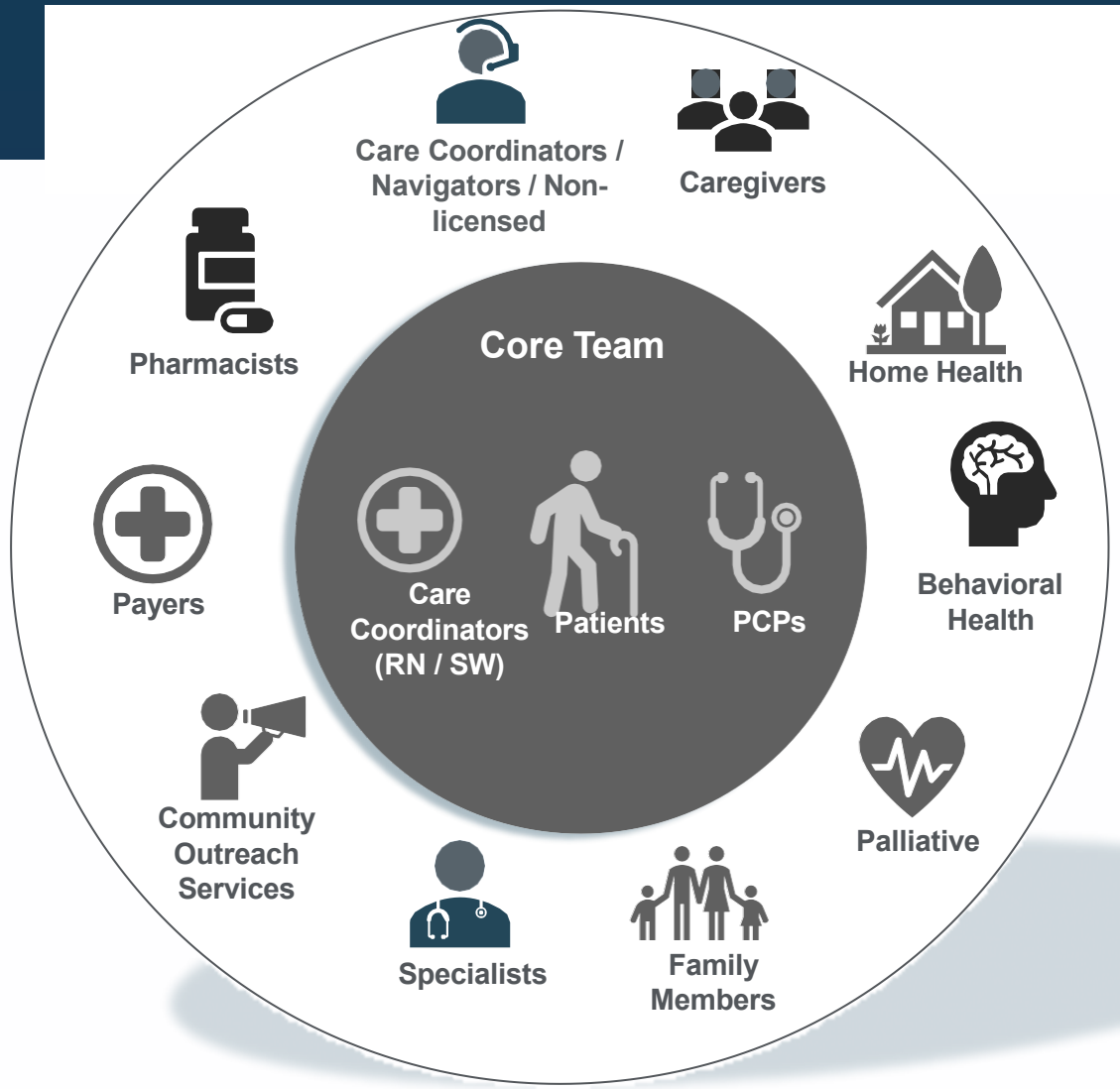


Table 2. Criteria and other factors used to determine a beneficiary's eligibility to be assigned to an ACO

	CRITERIA AND OTHER FACTORS USED TO DETERMINE ELIGIBILITY FOR ASSIGNMENT	MUST BE MET FOR CLAIMS-BASED ASSIGNMENT	MUST BE MET FOR VOLUNTARY ALIGNMENT
A.	Beneficiary must have at least 1 month of Part A and Part B enrollment and cannot have any months of Part A only or Part B only enrollment.[25]	Yes	Yes
B.	Beneficiary does not have any months of Medicare group (private) health plan enrollment.[26] Those enrolled in a Medicare health plan, including beneficiaries enrolled	Yes	Yes

Care Coordination and Transitions



A Team-Based and Goal-Focused Approach to CM:

- ✓ The key to improving health outcomes is leveraging the patient-clinician relationship
- ✓ PCPs coordinate care and the Ambulatory Care Management team acts as an extension of the PCP so that they can reach patients during and between office visits
- ✓ Care Management can be successfully conducted completely virtually with patients, as organizational policy and technology allows
- ✓ Team-based care acknowledges that there are multiple key players treating a patient and that each of them must work with one another in order to drive optimal care outcomes
- ✓ Team-based care can be successful when all members are on the same page and have:
  - A clear, common goal
  - A culture shift that facilitates teamwork
  - Supportive organizational frameworks
  - Effective teamwork, handoffs, and coaching

The Specialist Impact on Documentation and HCC coding

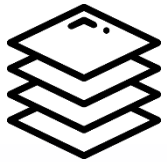
What are HCCs?

- HCCs represent costly chronic health conditions, as well as some severe acute conditions
- As of 2020, there were 86 HCCs, arranged into 19 categories-which incorporate 9,700 + ICD10 codes. In 2024 there are 115 HCCs, including 7770 individual ICD-10 codes
- Some of the top HCC categories include major depressive and bipolar disorders, asthma and pulmonary disease, diabetes, specified heart arrhythmias, congestive heart failure
- The following are NOT associated with HCCs:
  - Fee schedule within fee for service Medicare
  - CPT Codes (Procedures, evaluation, and management services)
  - ICD-10 PCS (Inpatient procedure codes)
  - Some ICD-10 diagnostic codes are not associated with HCC. Not all dx codes link to HCCs—many / most unspecified codes do NOT map to ICD-10 codes which is why level of specificity in diagnostic coding is so important
- Considerations:
  - While it is possible to capture HCCs in the IP setting, the heavy majority of HCCs are captured in the ambulatory setting
  - Primary care is uniquely positioned to capture HCCs, but there is a role for specialists to play in this effort as well specifically those where key acute and persistent conditions are treated (e.g., oncology, cardiology, endocrinology, pulmonology, etc.)

How HCCs and RAF Score Work

RAF Score is made up of three main components

- Demographic information (Age, gender, disability status, etc.)
- Medicaid eligibility (dual status)
- Chronic conditions and disease interactions (HCCs)



HCCs are cumulative throughout the year

- Patients can have multiple HCCs assigned throughout the year by different providers and specialties
- HCCs can be captured during inpatient and outpatient encounters, but the heavy majority are assigned in the ambulatory environment

On January 1st, Medicare resets HCCs back to 0

- Chronic Condition HCCs need to be recaptured year-over-year to appropriately capture and identify a patient's disease burden
- The MA and ACO HCC model is prospective, meaning that it estimates costs for Medicare beneficiaries in the following year

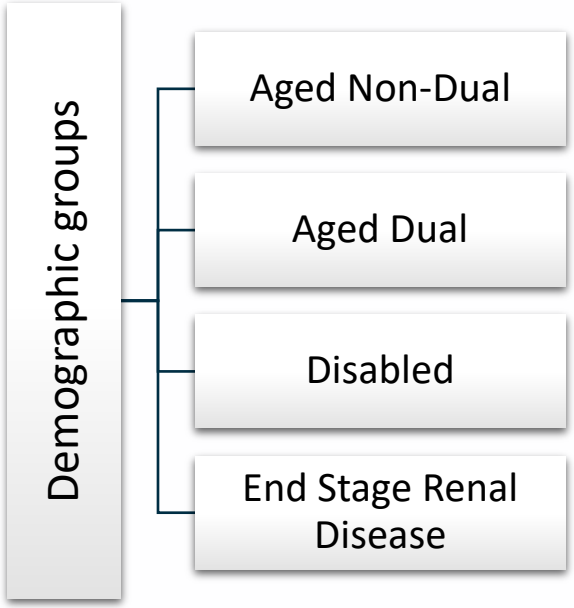
The average CMS patient has an approximate RAF score of 1.00

- Lower RAF scores tend to represent a lower chronic disease burden; & vice versa
- Disease interactions will also increase patient RAF Score
- Not every chronic condition maps to an HCC
- CMS rebases risk scores each year

MSSP Risk Adjustment Process

ACO's participating in MSSP have Financial accountability for their attributed Medicare beneficiary population's medical expenditures. Other Value Based programs have similar mathematical processes. HCC's Risk Score are calculated annually prospectively. This year's HCC scores will be used for next performance year's benchmark adjustment.

1. Assign Demographic Groups



2. Calculate Risk Ratio

1. Beneficiary Risk Score = HCC Risk scores are calculated for each attributed beneficiary
2. Demographic risk score = Average HCC risk score for each demographic group
3. Risk ratio = Beneficiary Risk Score/ Demographic Risk Score

3. Adjust Financial Benchmark

1. Benchmark is adjusted based upon each demographic groups risk ratio
    1. Risk ratio >1 financial benchmark will increase
    2. Risk ratio < 1 financial benchmark will decrease
2. MSSP only allows a total 3% positive adjustment over the contract term

HCC/RAF Impact on ACOs

- The burden of illness as defined by a population's RAF score is a direct driver of how the total cost of care target is calculated. If full burden of illness is not represented accurately, the total cost of care target will be underestimated, making it difficult for organizations to earn shared savings
- ACO based care emphasizes high quality-lower cost and preventive patient care. Rather than be reimbursed for each test ordered, providers have incentives to collaborate and reduce redundant care.
- Hierarchical condition category coding helps communicate patient complexity and paints a picture of the whole patient's health profile. Also enables risk stratification which is used by population health programs to target care coordination and other augmented care to patients.
- In addition to helping predict health care resource utilization, RAF scores are used to risk adjust quality and cost metrics. By accounting for differences in patient complexity, quality and cost clinical performance can be more appropriately measured.

How Specialists Can Help

- Appropriately coding their specialty diagnoses to the highest specificity and HCC value
- Updating problem lists to remove old/outdated diagnoses AND communicate current ones to primary care colleagues
- Effective 2-way communication between primary care and specialist as well as inpatient and outpatient teams

Appropriate Documentation to Support HCC Coding

- **M – Monitoring** signs, symptoms, disease progression, disease regression
- **E – Evaluating** test results, medication effectiveness, response to treatment
- **A – Assessing/Addressing** ordered tests, discussion, review records, counseling
- **T – Treating** medications, therapies, other modalities

Documentation does not have to include all of these, but at least one

Common Primary Care Encounters: HCC Example

- 76 y/o presents with swelling of the left arm, redness, and pain.
- Takes warfarin for atrial fibrillation.
- Also a liver transplant patient.
- Given IM ceftriaxone.
- PT/INR and CBC ordered.

ICD-10	Description	RAF
L03.114	Cellulitis of L upper ext	
I48.91	Unspec afib	.295
Total risk=		**.295**

The average Medicare member is around a 1.0 risk score.

ICD-10	Description	RAF
L03.114	Cellulitis of L upper ext	
I48.2	Chronic afib	.295
Z79.01	Long term anticoag therapy	
Z97.4	Liver transplant status	.891
Total optimized risk=		**1.186**

Note- example coefficients only for reference, relative to average Medicare beneficiary RAF=1.0

Active vs. History of Diagnosis

CANCER

- If cancer is documented **as present**, coding isn't dependent on treatment status; code as **active** cancer
  - Curative or palliative treatment
  - Unresponsive to treatment
  - Observation / watchful waiting
  - Opted for no treatment
  - Ex: C50- malignant neoplasm of breast
- **In remission**: coded as active cancer as long as no contradictory documentation
- Coded as '**history of**' when documentation states
  - No evidence of disease
  - Cancer free
  - Past/prior cancer
  - Ex: Z85.3 personal history of malignant neoplasm of breast
- Routine **surveillance** post-cancer should be coded using 'history of'
- Document intent of adjuvant therapy: curative, palliative, or preventative
  - Preventative may be coded as 'history of' cancer if intent is to keep cancer from reoccurring
- Coding 'history of' doesn't mean the cancer can't be coded as active again; recurrence can be coded as active

Active vs. History of Diagnoses cont.

Details needed to support the specificity for cancer codes.

- Type:
  - Primary, secondary, extension, invasion, metastasis, extranodal, disseminated
- Site:
  - Location, laterality, primary/secondary, metastasis (with primary site known or unknown)
- Behavior
  - Benign, in-situ, malignant, uncertain histologic behavior
- Treatment:
  - Undergoing, completed, refused (document reason), contraindicated (document reason)
  - Radiotherapy, chemotherapy, immunotherapy, hormone therapies, related surgery, observation/surveillance
  - Reason for adjuvant treatment
    - Curative, palliative, preventative, prophylactic
  - Status of today's visit
    - Actice, healed, no evidence of disease, surveillance only, remission (full, partial, not achieved), excised, eradicated, eliminated

Active vs. History of Diagnoses cont.

Documentation needed when cancer is coded as active or as a 'Personal history of'	
Monitoring:	
Active-	Right leg pain due to cancer which has metastasized to femur.
'Personal history of'-	Prostate cancer in remission, continue annual PSA testing for surveillance only.
Evaluating:	
Active-	Patient is fatigued and nauseous following each chemotherapy treatment.
'Personal history of'-	Recent imaging shows no evidence of cancer.
Assessing/Addressing:	
Active-	Recently diagnosed with right upper-outer quadrant breast cancer, discussed treatment options today.
'Personal history of'-	Patient assured no evidence of cancer at this time. Discussed long-term side effects of completed treatments and addressed recurrence concerns.
Treating:	
Active-	Left areola breast cancer, continue current Tamoxifen treatment.
'Personal history of'-	Left breast cancer, status post-surgery/chemo/radiation. No current evidence or disease. Tamoxifen therapy completed.

The Specialist Impact on Quality

Introduction to ACO Quality Programming

- CMS' Quality Payment Program (QPP) is the mechanism through which health care providers are paid by CMS and links payments to the quality of care provided.
  - Two tracks comprise QPP:
    - Merit-based Incentive Payment System (MIPS), or
      - Mimics traditional fee-for-service model
    - Alternative Payment Model (APM)
      - Value-based arrangement which bears financial risk
- ACOs are an Advanced APM (AAP) and have historically reported quality performance via the CMS Web Interface.
  - CMS Web Interface is both a platform and data collection type which facilitates reporting a sample of the ACO's Medicare patients for 10 clinical quality measures.
    - Requires manual abstraction from medical records.
  - In 2025, the CMS Web Interface collection type will be sunset.
    - ACOs must report using one of the following collection types:
      - electronic Clinical Quality Measures (eCQMs), OR
      - Medicare CQMs

Quality Measure Collection Types

Clinical Quality

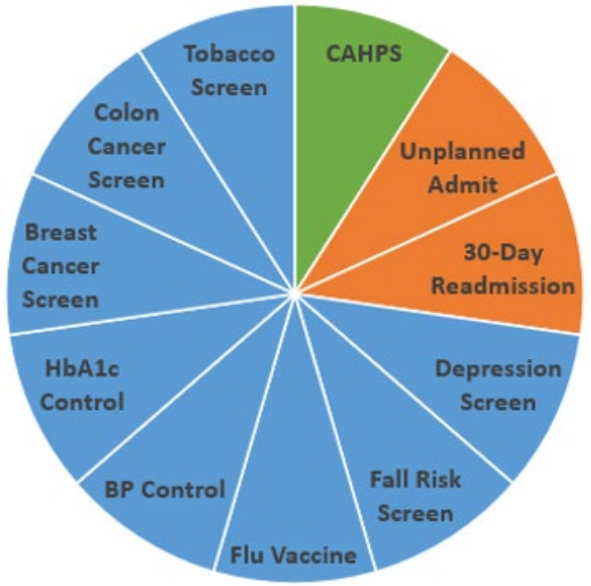
1. CMS Web Interface Measures*
   - Sample of ACO patients
2. Electronic Clinical Quality Measures (eCQMs)
   - All patients, all payors
3. MIPS CQMs**
   - All patients, all payors
4. Medicare CQMs
   - All ACO patients
   - New and temporary

Claims

5. Unplanned Admission Rates for Patients with Multiple Chronic Conditions
   - Medicare Part B Claims
6. Hospital-Wide, 30-Day, All-Cause Unplanned Readmission (HWR) Rate
   - Medicare Part B Claims

Patient Experience

7. CAHPS for MIPS



Example: PY2024 Web Interface Quality Reporting Composition

Clinical Quality Measures

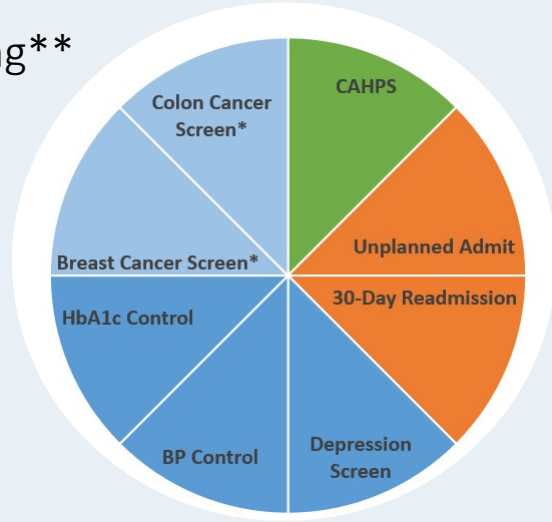
CMS Web Interface

- Diabetes: Hemoglobin A1c (HbA1c) Poor Control
- Preventive Care and Screening: Screening for Depression and Follow-up Plan
- Controlling High Blood Pressure
- Falls: Screening for Future Fall Risk
- Preventive Care and Screening: Influenza Immunization
- Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention
- Colorectal Cancer Screening
- Breast Cancer Screening
- Statin Therapy for the Prevention and Treatment of Cardiovascular Disease*
- Depression Remission at Twelve Months*

*Pay-for-reporting only. Not used in quality performance score calculation.

eCQM/Medicare CQM

- Diabetes: Glycemic Status Assessment Greater than 9%
- Preventive Care and Screening: Screening for Depression and Follow-up Plan
- Controlling High Blood Pressure
- Breast Cancer Screening**
- Colorectal Cancer Screening**



**Proposed for inclusion in 2025 per the 2025 Medicare Physician Fee Schedule Proposed Rule

Clinical Quality and the Impact of the Specialist

- eCQM = all patients, all payors, all providers
  - Quality is not scored at the individual provider level, but the TIN.
    - TIN = Tax Identification Number
      - Example: Medical Center, Medical Group, Independent Practice, etc.
  - The ask of specialists is not to manage the diagnosis, but to help encourage continuity of care and follow up
- In PY2023, POM ACO had a beneficiary population of ~70k, and only 3,200 patients were in the entire sample population for quality reporting.
- In PY2024, one measure has a denominator of **500,000** patients

eCQM Measure Details at a Glance

Diabetes: Glycemic Status Assessment Greater than 9%

- All patients 18-75 with diabetes whose most recent hemoglobin A1c or glucose management indicator was >9%.
- Inverse metric, lower score is better.
- Numerator uses most recent reading in the year.
- Result must be discretely documented in EMR.

Screening for Depression and Follow-up Plan

- All patients 12+ without bipolar disorder must be screened once per calendar year AND if positive, follow-up plan documented.
- Patient refusal and documentation of medical reason for not screening may be used as *exceptions*.
- Exceptions remove that specific encounter from the denominator and must be documented every visit (if applicable) as they do not exclude the patient from the measure in totality.

Controlling High Blood Pressure

- All patients 18-85 years of age who had a diagnosis of essential hypertension whose most recent blood pressure was adequately controlled (<140/<90 mmHg).
- Numerator uses most recent reading in the year from any qualifying visit (including urgent care and specialty office visits).
- If there are multiple blood pressure readings on the same day, the lowest systolic and the lowest diastolic reading will be used.

Breast Cancer Screening*

- All women 50-74 years of age who had a mammogram to screen for breast cancer in the 27 months prior to the end of the performance year.
- Numerator uses primary screenings only.
- Result must be discretely documented in EMR.
- Patient with a history of bilateral mastectomy are excluded.

Colorectal Cancer Screening*

- All patients 45-75 years of age who had appropriate screening for colorectal cancer.
- Appropriate screenings include:
  - Fecal occult blood test (FOBT) – 1 year
  - Stool DNA (sDNA) with FIT test – 3 years
  - Flexible sigmoidoscopy – 5 years
  - CT Colonography – 5 years
  - Colonoscopy – 10 years unless otherwise specified
- Patients with a diagnosis or past history of total colectomy or colorectal cancer are excluded.

CAHPS for MIPS Survey: What You Need to Know

What is the CAHPS survey?

CAHPS = Consumer Assessment of Healthcare Providers and Systems

A national survey to understand patient experience of care.

Administered annually to a random sample of Medicare beneficiaries who received care from the ACO's providers.

Why is it important?

CAHPS is one of the metrics used in calculating the ACO's quality score.

Quality scores are factored into any shared savings payments.

These shared savings are distributed to providers like you.

What topics does it cover?

-Patient's Rating of Provider
-Getting Timely Care, Appointments, and Information
-How Well Your Providers Communicate
-Access to Specialists
-Health Promotion and Education
-Shared Decision Making
-Courteous and Helpful Office Staff
-Care Coordination
-Stewardship of Patient Resources

The Future of Quality Reporting: The Universal Foundation

Domain	Measure Identification Number and Name
Wellness and Prevention	Colorectal Cancer Screening Breast Cancer Screening Adult Immunization Status
Chronic Conditions	Controlling High Blood Pressure Hemoglobin A1c Poor Control (>9%)
Behavioral Health	Screening For Depression & Follow-up Plan Initiation and Engagement of Substance Use Disorder Treatment
Seamless Care Coordination (Claims Measures)	Unplanned All-cause Admission for Chronic Conditions, OR All-cause Hospital Readmissions
Person-centered Care (Patient Experience)	Consumer Assessment of Healthcare Providers & Systems Overall Rating Measures (CAHPS)
Equity	Screening for Social Drivers of Health

Thank you!

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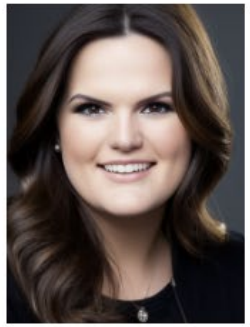

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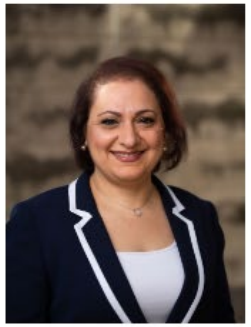

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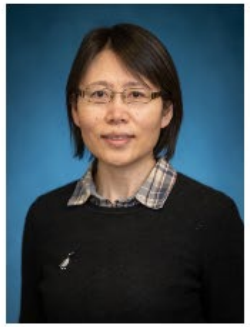

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For questions about the course or how to obtain your CE credits, please contact Eman Sater at emank@med.umich.edu

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