



# Welcome to TIM Talks: Business Acumen

## *“Developing Meaningful Partnerships with Physician Practices”*

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Developing Meaningful  
Partnerships with Physician  
Practices, PCMHs, &  
FQHCs

**Timothy P. McNeill, RN, MPH**  
Healthcare Consultant

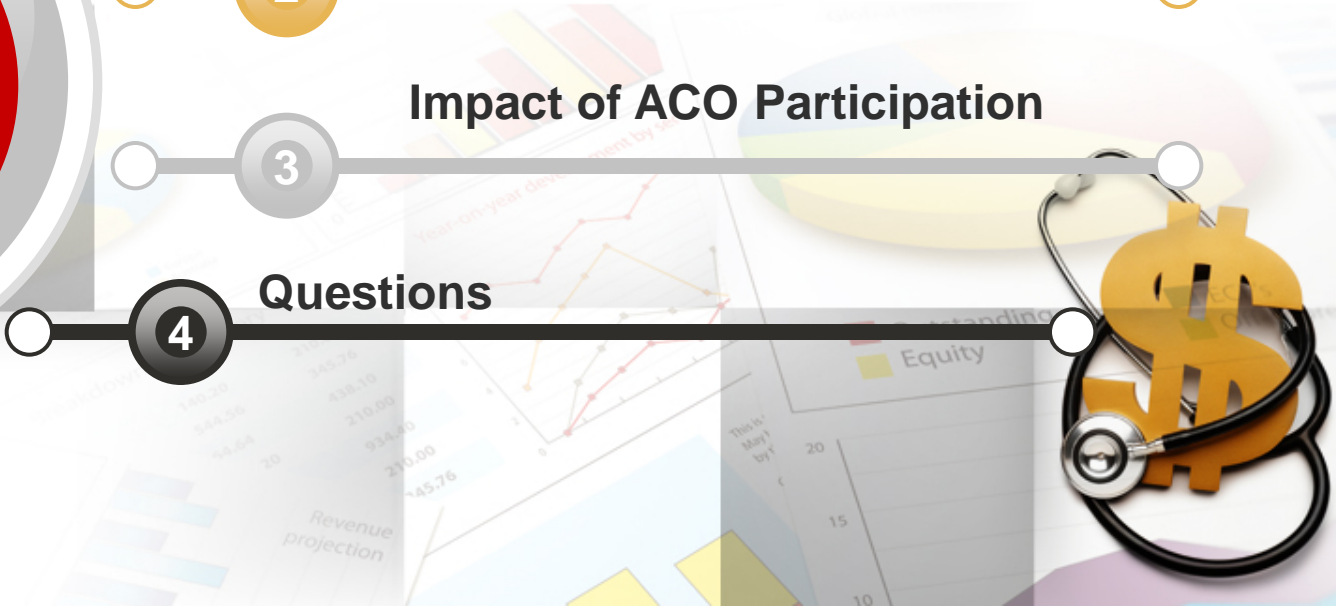


1 Changes to the Medical Practice

2 MACRA Legislation

3 Impact of ACO Participation

4 Questions



# Physician Practices and the Risk Continuum

- Physician Practices, Patient Centered Medical Home Recognition (PCMH), and Federally Qualified Health Centers (FQHCs) receive Medicare payments under the Part B program
  - Hospitals and Skilled Nursing Facilities bill Part A
  - Readmission penalties generally apply to Part A collections
- Increasing competition from hospitals, retail clinics, and urgent care centers
- As providers take on more risk, the more likely they are to engage in a different care delivery model
- Success with APMs will require a redesign of standard care



# Changing Practice Models

- Past: Physician would see patients during the day and round at the local hospital to see patients admitted in the evening
- Current:
  - Increasing use of hospitalists
    - Recent AAFP survey found that only 50% of family physicians maintain hospital privileges
  - Physician practice disconnected from hospitalized patients
  - Coordination of care between the hospitalists and physician practice is limited
  - Many practices report seeing their patients 3 times per year or less



# Challenging Business Environment

- Increase the volume of patients
  - Number of Unique Users
- Increase the number of billable encounters per patient
  - Average number of encounters per patient per year
- Challenges from Retail and Urgent Care Clinics
  - CVS Minute Clinic
  - Rite Aid RediClinic
  - Walgreens Healthcare Clinic
  - Walmart
  - Urgent Care – Patient First



# Independent Practice Challenges

- Remaining viable with all of the payment reform changes and increasing competition
- Desire of hospitals to control the entire care continuum
- Increased administrative burden to obtain reimbursement
- Reducing no-show rates, increasing compliance, and increasing billable revenue



# Hospital-Owned Practices

- An increasing number of physician practices are being purchased by health systems
- Health systems that are taking risk (bundled payment, ACOs, etc.) are moving to purchase practices so they can control the entire integrated care continuum
- The hospital-owned practice will be challenged to meet the needs of the hospital owner





# Patient Centered Medical Home Recognition (PCMH)

- National Committee for Quality Assurance (NCQA) PCMH recognition is the most widely adopted PCMH recognition program
  - Joint Commission also provides a PCMH recognition program
- Some payers still provide enhanced reimbursement for a PCMH
- PCMH recognition requires:
  - Committed resources to support a redesigned model of care
  - Focus on care coordination
  - Generally have a designated nurse care coordinator
    - Nurse usually has a large volume of patients to service



# Federally Qualified Health Centers (FQHCs)

- HRSA 330 Grant-funded clinics
- Traditionally serve a younger Medicaid population
- HRSA supported FQHCs must report an annual UDS Report to HRSA
- FQHC data is publically available from HRSA



# Federally Qualified Health Centers (FQHCs)

- Health Center Profile Data:

<http://bphc.hrsa.gov/uds/datacenter.aspx?q=d>

- Number/Percentage of Medicare patients served each year
- Number/Percentage of patients 65 and older served each year
- Number/Percentage of patient encounters to manage chronic disease
- Number/Percentage of Obstetric encounters provided



# Health Center Profile Data

## 2015 Health Center Profile

### Health Center Program Grantee Profiles

#### Health Center Program Grantee Data

Each year HRSA-funded Health Center Grantees are required to report core set of information, including data on patient demographics, services provided, clinical indicators, utilization rates, costs, and revenues. [View the most recent national data, and browse previous year data.](#)

Click on state or use the dropdown menu to see state data.

Select a state



# Discussion Topics

- What value-added services can your organization provide to support the needs of a medical practice?
- How would you approach the following medical practice types to establish a relationship?
  - Hospital-Owned Practice
  - Independent Practice
  - PCMH
  - FQHC



# Impact of MACRA Legislation

- MACRA

- Medicare Access and CHIP Reauthorization Act
- Bipartisan bill passed separately from ACA
- Requires increased participation in alternative payment models
- APMs
  - Bundled Payment
  - ACOs
  - Risk-bearing contracts for Medicare populations



## 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
  - 2017 – Transition Year to establish benchmark quality metrics
  - Eligible Providers (EPs) will be subject to an initial 4% payment adjustment
  - 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 the ACO succeeds in improving health outcomes and reducing costs, the organization 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
  - 21 Next Gen ACOs selected for 2016
  - Near Full-Risk Model



# Attribution Process

- MSSP ACO applications accepted each July
- New MSSP ACOs begin January of the following Year
  - July 2016 applicants will begin January 1, 2017
  - 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
  - OAA Services
  - VA Choice Services / VD-HCBS



# Dual Eligible Beneficiaries

- 20% of Medicare Beneficiaries are Dual Eligible
- 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 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 for 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



# 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



# 2015 Mean ACO Performance Rate for all ACOs

- Falls: Screening for fall risk: 45.60%
- Influenza Immunization: 57.51%
- Pneumococcal Vaccination: 55.03%
- Depression Screening: 39.27%
- Adult Weight screening and Follow-Up 66.75%
- Health Promotion and Education 58.29%
- All Condition Readmissions (Lower is better) 15.15%
- Medication Reconciliation 82.61%



# 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



# 2015 Mean ACO Performance Rate for all ACOs (Cont.)

- Diabetes Composite (ACO 22-26) 25.41%
  - Hemoglobin A1c Control < 8%
  - LDL < 100 mg/dL
  - Blood Pressure < 140/90
  - Tobacco Non-Use
  - Aspirin Use
- Hemoglobin A1c Poor Control > 9% 20.35%
  - (Lower is better)
- Proportion of Adults who had blood pressure screened in Past 2 years 60.24%
- CAD Composite 66.90%
  - Drug Therapy for Lowering LDL
  - Cholesterol
  - ACE Inhibitor or ARB Therapy for
  - Patients with CAD and Diabetes



## 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.”





# CMS Study of Socioeconomic Factors on Star Ratings

- Released September 8, 2015
- Beneficiaries with low socio-economic status assessed based on Low-Income Subsidy (LIS) receipt and/or Dual Eligible (DE)
- 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 does the Consumer Need

- Strategies to support meeting this objective includes
  - Expanded HCBS for Duals
    - MLTSS and Waiver covered LTSS Services
  - Evidence-Based Programs
    - DSMT
    - HBAI
- Promote how to deliver these programs in a budget-neutral manner



# Questions

