AMDA PRACTICE MANAGEMENT SECTION

Robert J. Reynolds, MD
Chair, Practice Management Section, Moderator
National Medical Director, BPCI, Post Acute Innovation
TeamHealth

GEHRIMED is the first interoperable, ONC-Certified EHR designed by and exclusively for Long-Term Care/Post-Acute Care practitioners. The mobile, cloud-based EHR enables clinicians to view patient charts, capture encounters, electronically sign and prescribe orders. GEHRIMED includes features like a quality measure reporting platform, clinical speech recognition, automated billing, e-prescribing, custom reports and more. GEHRIMED assists the LTPAC practitioners and multi-provider, multi-location practices by coupling real-time data capture with custom practice management tools. Visit our website to learn more about how GEHRIMED can support your daily workflow at https://www.gehrimed.com/.

Chronic Care Management's solution focuses on “in-between visit” care management activities/tactics. These tactics between doctor visits have not been a focus of our healthcare system—until now. It is now known that focusing on what happens to people in-between their healthcare appointments is one of the most important aspects of the care of people with chronic conditions. Helping deliver better care and reduced total medical expenditures.

CCM provides turnkey solutions to navigate the complexities of chronic care management, while providing a return on investment through programs that support in-between visit care. We specialize in CCM, ACO and risk-based program support.

When you need a partner to deliver optimal in-between visit care to your patients—whether you are thinking about CCM, CPC+, ACO, BH—we can help. We are collaborative partners to practices and organizations helping craft a chronic disease management program that delivers both a clinical and financial value proposition.

PointClickCare Technologies Inc. is helping over 15,000 long-term and post-acute care (LTPAC) providers meet the challenges of senior care by enabling them to achieve the business results that matter – enriching the lives of their residents and patients, improving financial and operational health, and mitigating risk. PointClickCare’s cloud-based software platform is advancing senior care by enabling a person-centered approach to care, connecting healthcare providers across the care continuum with easy to use, regulatory compliant solutions for improved resident outcomes, enhanced financial performance, and staff optimization. For more information on PointClickCare’s ONC certified software solutions, please visit www.pointclickcare.com.

CompMed is a national medical billing company specializing in geriatrics and hospitalist billing across the country. We have been in business for 25 years, and we are 100% U.S. based. CompMed relies on leading-edge technology, including the development of interfaces to receive billing information and custom scrubbing edits by insurance payer. We have developed a custom two-way interface with EHRs for patient registration and charging. We reconcile all patient visits against EHR logs to ensure that all patient visits are billed. We have developed custom workflows in our document management system to optimize our clients’ revenue and cash flow.

To learn more about CompMed, please check out our website at https://www.comp-med.com/.

Payment Models in PALTC

Rod Baird, GPM
MIPS

Ethan Bachrach MD, TeamHealth
MIPS

Jason Feuerman, Genesis
ACO

Cathy Lipton MD, Optum
ISNP

Matt Gray, TeamHealth
BPCI

Kerry Weiner MD, Avante
A-APMs
• What are our best strategies for 2018 and beyond?
• All 3rd party payor programs are measuring performance
  • Risk Adjusted (age, diagnoses, social factors, etc.)
  • Quality Behavior (measures, acute care use, improvement, data)
  • Costs (resource use)
• PALTC Medicine serves 2 distinct populations:
  • Post Acute Care (location specific like a Hospitalist)
  • Long Term Care (PCP for a defined population)
• What options do we have for optimizing performance in each population

Where are we with MIPS?

Rod Baird, MS
President, Geriatric Practice Management

Ethan Bachrach, MD MBI
Chief Medical Informatics Officer
TeamHealth

Speaker Disclosures

Rod Baird is the President of Geriatric Practice Management. He has no financial relationship(s) to disclose.

Ethan Bachrach, MD is the Chief Medical Informatics Officer of TeamHealth. He has no financial relationship(s) to disclose.

Technical Challenges for PALTC Clinicians in MIPS

• The current cost measures (2018 performance year) are not favorable for PALTC providers
• Insufficient MIPS quality measures exist for PALTC clinicians
• Neither category (cost nor quality) compares PALTC performance to like populations

Cost Category: Weighting Evolution

• Weighted at 0% (2017)
• Weighted at 10% (2018)
• Initially legislatively set at 30% for 2019…..
• The continuing resolution (Public Law 114-10) passed on 2.9.18 made the following change
  • CMS will now have discretion (via the rulemaking process) to weight the cost performance category between 10-30% for performance years 2019-2021
Current Cost Measures: MSPB

- Medicare Spending per Beneficiary (MSPB)
- Applies to clinicians who admit patients to an acute hospital
- Must bill the plurality of Medicare Part B allowable amounts during the index (inpatient) hospitalization
- Must have 35 or more cases assigned
- Calculates the total Medicare Part A and B costs from 3 days prior to the inpatient admission to 30 days after, and calculates a residual compared to expected costs
- Provides some risk adjustment
- Modified HCC, age, enrollment status, ESRD status, comorbidity interactions, recent long-term care use, and MS-DRG
- Excludes outlier episodes (above 99th percentile)

Current Cost Measures: Total Per Capita Costs

- Total Per Capital Costs for All Attributed Beneficiaries
- Applies if assigned 20 or more "primary care beneficiaries" by Medicare
- Primary care beneficiaries are assigned to primary care clinicians' (GP, FP, IM, Geriatrics, NP, PA and CNS) TIN/NPI if they billed the plurality of primary care services
- POS 31 billing is excluded
- Calculates the sum of Medicare Part A & B costs for each beneficiary, compared to an expected result
- Provides some risk adjustment
- HCC risk score and ESRD status
- Excludes outlier episodes (above 99th percentile)

MIPS

What we Know From Value Based Payment Modifier

- Quality – no measures designed for PALTC population.
  - >98% of groups successfully reporting PQRS were 'average quality'
  - At least 1 AMDA Group did achieve High quality!
- Weighted Quality and Cost Equally
  - Primary Care Beneficiaries included PAC (POS 31) and LTC (POS 32)
  - 2012-2016 Attribution was possible in both settings
  - 2017 forward under MIPS eliminated POS 31 Attribution (big win – Thanks AMDA)
  - PAC – Cost owner is the MSPB and TPCC* owner
  - LTC – Cost owner is the TPCC owner (you!)
    - Unfortunately, you likely inherit the prior admission and POS 31 costs
  - Your costs will greatly exceed a primary care beneficiary in the ambulatory environment

VBM – Scored on Standard Deviations

Example of Cost Attribution in VBM from QRUR

VBP Risk Adjusted Cost History

Higher values are worse scores!
VBM – Scored on Standard Deviations

What's Risk Adjustment

- Risk Adjustment. A statistical process that takes into account the underlying health status and health spending of the enrollees in an insurance plan when looking at their health care outcomes or health care costs. ([www.healthcare.gov](http://www.healthcare.gov))
- Combination of Age, Sex, Income (i.e. Medicaid), Diagnoses – Combine to form a Risk Score (a/k/a – HCC)
- All PALTC Groups treat High Risk Patients (average >75th percentile)
- ORR reports' 2015 & 2016 Risk Percentile
  - 90th, 92nd, 93rd, 90th, 90th, 88th, 90th
- High Risk score - Earns 5 bonus points for MIPS in 2018

Future opportunities for MIPS cost measures

- Specialty adjustment for TPCC measure
  - Pursue a LTPAC CMS specialty designation, similar to the newly approved “Hospitalist” specialty
  - List as a new CMS specialty code
  - Submit professional services claims under the new specialty code
  - Be compared to your peers, as opposed to ambulatory primary care
- Episode based cost measures
  - CMS is creating "Episode-based Cost Measures"
  - Eight are in trials
  - More are being developed
  - Proactive participation and development of measures appropriate for LTPAC
  - Proactive restriction of measures that are not considering the unique LTPAC population

Quality Measure Limitations in PALTC

- Measures were designed and published for an ambulatory care practice
- Submission requirements
  - Must have at least 20 denominator eligible cases
  - Must submit at least 6 measures (or all applicable measures within a specialty set)
- Future status will likely require submission via registries to be successful
  - Increases the number of measures available for reporting

- Technically 51 (of 275) unique MIPS quality measures may be reported if billing HCPCS codes between 99304 and 99318, and 99490 (CCM)
- 17 are reportable via claims based reporting
  - Limited impact/focus
    - Diseases: Diabetes, Glaucoma, Macular Degeneration, Otitis Externa, Atrial Fibrillation and Primary Headache
    - Population Health: Influenza, Plan of Care, Falls, Elder Maltreatment Screening and High Blood Pressure screening
- 51 are reportable via registry reporting
  - Adds: Heart Failure, Coronary Artery Disease, Adult Kidney Disease, Sleep Apnea, Dementia, Parkinson’s Disease, Sinusitis, Ischemic Vascular Disease

ETHAN BACHRACH, MD, MBI
Future opportunities for MIPS quality measures

- Respond to the “Annual Call for Measures” and drive for LTPAC appropriate quality measures
- Measures must be submitted to CMS
- Reviewed and selected measures are added to the Measures under Consideration (MUC) list for public comment
- Selected measures are reviewed by the Measure Application Partnership (MAP) formed by the National Quality Forum (NQF)
- Measures must be submitted to an applicable, specialty-appropriate peer reviewed journal
- Be compared to LTPAC clinicians/patients versus measures designed for an ambulatory care population

Appendices

TPCC: Primary care codes (beneficiaries)

<table>
<thead>
<tr>
<th>TPCC Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>G0053</td>
<td>New patient, office or other outpatient visit</td>
</tr>
<tr>
<td>G0054</td>
<td>Established patient, office, or other outpatient visit</td>
</tr>
<tr>
<td>G0050</td>
<td>New patient, hospital visit</td>
</tr>
<tr>
<td>G0051</td>
<td>Established patient, hospital visit</td>
</tr>
<tr>
<td>G0490</td>
<td>Preventive care management</td>
</tr>
<tr>
<td>G0491</td>
<td>Adult immunizations and screening visit(s)</td>
</tr>
<tr>
<td>G0493</td>
<td>Annual wellness visit, initial</td>
</tr>
<tr>
<td>G0491</td>
<td>Annual wellness visit, subsequent</td>
</tr>
<tr>
<td>G0495</td>
<td>Hospital outpatient clinic visit (Eating Teaching Amendment hospitals only)</td>
</tr>
</tbody>
</table>

Notes: Services billed with HCPCS code G0491-G0495 that are performed in a skilled nursing facility place of service code 31 will not be considered as primary care services.

MIPS Claims Based Quality Measures: LTPAC

<table>
<thead>
<tr>
<th>Measure Name</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Diabetes: Hemoglobin A1c (HbA1c) Poor Control (&gt;9%)</td>
<td></td>
</tr>
<tr>
<td>12 Primary Open Angle Glaucoma (POAG): Optic Nerve Evaluation</td>
<td></td>
</tr>
<tr>
<td>14 Age‐Related Macular Degeneration (AMD): Dilated Macular Examination</td>
<td></td>
</tr>
<tr>
<td>19 Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care</td>
<td></td>
</tr>
<tr>
<td>47 Care Plan: Prevention and Management of Depression by a Health Care Professional</td>
<td></td>
</tr>
<tr>
<td>93 Acute Otitis Externa (AOE): Systemic Antimicrobial Therapy – Avoidance of Inappropriate Use</td>
<td></td>
</tr>
<tr>
<td>110 Preventive Care and Screening: Influenza Immunization</td>
<td></td>
</tr>
<tr>
<td>141 Primary Open Angle Glaucoma (POAG): Reduction of Intraocular Pressure (IOP) by 15% OR Documentation of a Plan of Care</td>
<td></td>
</tr>
<tr>
<td>154 Falls: Risk Assessment</td>
<td></td>
</tr>
<tr>
<td>155 Falls: Plan of Care</td>
<td></td>
</tr>
<tr>
<td>181 Elder Maltreatment Screen and Follow‐Up Plan</td>
<td></td>
</tr>
<tr>
<td>317 Preventive Care and Screening: Screening for High Blood Pressure and Follow‐Up Documented</td>
<td></td>
</tr>
<tr>
<td>326 Atrial Fibrillation and Atrial Flutter: Chronic Anticoagulation Therapy</td>
<td></td>
</tr>
<tr>
<td>419 Overuse Of Neuroimaging For Patients With Primary Headache And A Normal Neurological Examination</td>
<td></td>
</tr>
<tr>
<td>435 Quality of Life Assessment For Patients With Primary Headache Disorders</td>
<td></td>
</tr>
</tbody>
</table>

CMS Episode-based Cost Measures

- The following eight episode based cost measures are under development and testing
  - Elective Outpatient Percutaneous Coronary Intervention (PCI)
  - Knee Arthroplasty
  - Revascularization for Lower Extremity Chronic Critical Limb Ischemia
  - Routine Cataract Removal with Intraocular Lens (IOL) Implantation
  - Screening/Surveillance Colonoscopy
  - Intracranial Hemorrhage or Cerebral Infarction
  - Simple Pneumonia with Hospitalization
  - ST-Elevation Myocardial Infarction (STEMI) with PCI

Long Term Care ACO’s

What is Working? What is Not?

Jason Feuerman, SVP, Strategic Development and Managed Care President
Genesis Physician Services
Special Needs Plan for Long Term Care Providers

How the MSSP ACO Solution Compares to an Institutional

- Tailwinds support opportunity for rapid industry-wide expansion of successful value-based care management models developed for the SNF industry by largest provider.
- Healthcare industry movement from fee-for-service to value-based care models creating momentum.
- SNF physicians have few opportunities and little established infrastructure or resources to participate directly in shared savings programs.
- Genesis HealthCare ACO employed the MSSP platform to create a highly efficient managed care model for the long-term care population, leveraging key characteristics benefits.
- Aligned incentives between SNF providers and their attending physicians to achieve the Triple Aim: improved quality of care, more efficient delivery, better patient outcomes and greater cost efficiency.
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Genesis HealthCare Delivery Platform – Transformation to Value-Based Care

- 425 Facilities across 27 states
- ~200+ Clinical specialty units
- ~100+ Employed/Contracted medical professionals
- ~30,000 Dedicated locations
- ~1,700+ Rehabilitation locations across ~45 states
- ~300,000 Residents cared for each year

Advantages of LTC ACOs vs Community-Based ACOs

- Assigned beneficiaries are residents of LTC facilities and are easily identifiable.
- LTC facilities are obligated to ensure needed services and resources are provided to residents.
- LTC facilities manage SNF utilization and potentially avoidable hospital admissions (#2 and #1 cost drivers, respectively).
- Maintaining a steady and predictable benchmark is possible due to the homogeneous nature of the beneficiary served (geography becomes the primary driver of volatility with respect to the benchmark).
- Targeted benchmark is more than three (3) times that of a community-based ACO providing meaningful opportunity for cost improvement.

How the MSSP ACO Solution Compares to an Institutional

Special Needs Plan for Long Term Care Providers

Advantages of Pursuing the MSSP Program

- The Medicare Shared Savings Program (MSSP) represents the most efficient and effective way for nursing facility providers to participate directly in Medicare savings for their long-term care residents.
- Despite the challenges of a newly designed model, there are many advantages to pursuing the MSSP ACO versus other provider risk programs.

- Genesis Healthcare ACO employed the MSSP platform to create a highly efficient managed care model for the long-term care population, leveraging key characteristics benefits.
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How the Medicare Shared Savings Program Works

- You need to have a physician entity to bill on behalf of physicians serving long term care residents - GPO.
- The physician entity(s) is placed into the MSSP program.
- Medicare fee for service beneficiaries are assigned to providers based on which primary care provider billed the most during a calendar year (i.e., plurality of visits).
- There is a minimum of 5,000 beneficiaries that have to be attributed to qualify.
- The Post Acute ACO (MSSP) focuses solely on long-term care residents.
- Benchmark cost targets are generated each year based on the previous year’s beneficiary attribution and are trended and risk adjusted accordingly.
- If the MSSP ACO produces actual Medicare spend BELOW the by the minimum savings rate defined by CMS, the ACO will share in up to 50 percent based on achieving certain quality metrics.
- Genesis has committed to sharing net savings with participating physicians and facilities. This creates a fully aligned and collaborative approach to improving quality, patient care and healthcare efficiencies.

Key Differentiators

- Managing an LTC population “in place”
- Greater control over pharmacy, costs savings by virtue of managing care in the SNF.
- Demonstrated success in episodic payment model.
- 200+ participating SNF physicians/practitioners/affiliates.
- Provides a large, homogenous, assigned population with high benchmark.
- Longstanding experience in a unique setting.
- MSSP Program has significant advantages.
- MSSP has no regulatory capital requirements, member acquisition costs, or downside medical loss risk (Track 1).

Opportunities

- Limited overhead
- NO regulatory capital required
- Limited overhead contracts are high
- Very limited
- Significant operational control
- Full operational control
- Full contractual

Limitations & Enrollment Requirements

- Participation is optional (Track 1)
- Adapts to various Tracks offering greater upside using simpler reporting and lower minimum savings rate.
- Full risk
- Performs Medicare payments calculated
- Full risk
- Services and resources are provided to residents.
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How Does Risk Adjustment Work in the MSSP

Medicare’s Risk Adjustment methodology is the basis for Medicare Advantage payment rates and a factor in a MSSP ACO’s target development.

The purpose is to more accurately predict health costs/expenditures of members by adjusting payments based on demographics (i.e. age and gender) as well as health status.

Risk-adjustment data is pulled from diagnosis data reported from claims data and medical record documentation from physician offices, hospital inpatient and hospital outpatient factors.

The diagnosis information used for final rates and factors is one year in arrears. For example, 2016 documented diagnosis will drive 2017 final Medicare Advantage rates and ACO risk score factors.

The diagnosis codes are entered into a Hierarchical Condition Category (HCC) Model.

Quality Obligations Under the MSSP

- **Performance Year 1**
  - ACO satisfies the quality performance standard when we completely and accurately report quality data on all measures and achieve performance benchmarks.

- **Performance Year 2 & Subsequent Performance Years**
  - ACO must continue to completely and accurately report quality data on all measures and achieve performance benchmarks.
  - Quality performance benchmarks are phased-in for performance measures.
    - Performance period 2 (2017), 25 of the 33 measures will be based on actual performance, with the other eight continuing to be on a pay-for-reporting basis.
    - Performance period 3 (2018), 32 measures will be based on actual performance and one measure—the health status/functional status survey-based measure—will continue to be on a pay-for-reporting basis.

CMS and the MSSP – The Challenges

- Patient Attribution Methodology
- National Trend Factor
- Application of National Trend Factor
- Timely and reliable reports
**Institutional Special Needs Programs**

**How do I-SNPs work?**

Cathy Lipton, MD, CMD

Regional Medical Director

Optum

**The Challenge**

**Patient care is reactive and driven by poorly informed patients and their families**

1. Health care providers delivering care in nursing facilities, reimbursed within a fee-for-service methodology, do not have sufficient time to have meaningful advance care planning discussions with patients and their families.

2. Patients and families are poorly educated about the status and prognosis of their multiple chronic and acute illnesses.

3. Many decisions about diagnosis and treatment result in burdensome (unhelpful and expensive) events.

4. End of life is often unnecessarily traumatic and painful for patients and families.

**Medical costs for long-term care residents of nursing homes is inefficient**

1. Health care providers have limited on-site availability to assess and manage acute changes in condition:
   - Higher than necessary transfer rates to emergency care settings
   - Limited ability to treat frail older adults in the safest setting, their residence the nursing home

2. High emergency transfers result in frequent unnecessary hospitalizations attended by nurses and physicians unfamiliar with these medically complex patients with multiple advanced illnesses.

**The Solution**

**OptumCare Model**

- Optum’s ISNP model (formerly known as Evercare) supports the United Healthcare (UHC) Nursing Home Plan and is designed to improve the quality of nursing home care

- As part of the Optum Care clinical model, nurse practitioners are provided to partner with primary care physicians and nursing home staff to coordinate treat-in-place care

  - The Medicare three-day qualifying stay is waived allowing skilled care in the nursing home

  - Emergency department and hospitalizations visits are avoided by generating skilled events and other professional services onsite within participating facilities in contrast to Medicare fee-for-service care

  - Financially, UHC Nursing Home Plan is paid on a PMPM basis from Medicare (CMS) and the contracted nursing homes and all other providers submit claims (that would otherwise be submitted to CMS) to the UHC Nursing Home Plan for payment

  - Additional nursing home revenue occurs from performance pay and other sources

  - Designed to maintain or increase revenue for the participating nursing homes

**Speaker Disclosures**

Cathy Lipton, MD, CMD at Optum and has no other financial relationship(s) to disclose.
What is Medicare Advantage?

Medicare is a federally-regulated health insurance program, which consists of four parts:

- **Part A**
  - In-patient (IP) hospital, IP skilled nursing facility care, critical access hospitals, home health, and hospice
- **Part B**
  - Provider services, office visits, screenings, therapies, preventive services, out-patient hospital, emergency care, ambulance, medical/surgical supplies and durable medical equipment
- **Part C - Medicare Advantage (MA)**
  - Includes Part A and B
  - Additional services – may include extra dental, vision, hearing and preventive services and some optional supplement services (examples gym memberships and transportation)
- **Part D – Pharmacy benefits**
  - Can be offered alone (via Prescription Drug Plan) or as part of an MA plan
  - Includes plans with varying out-of-pocket requirements

ISNP Overview

- ISNP program is a specialized Medicare Advantage plan managed by Optum Complex Care Management (CCM). The ISNP program provides clinical services for members in the long term care setting that have enrolled in the United Healthcare Nursing Home Plan.
- The goals of the program are to improve the overall quality of care, decrease the need for transitions between levels of care and to support the member in developing a plan of care consistent with their overall goals of care.
- The care team for the ISNP program is led by the Advanced Practice Clinician (APC) with support from an RN.
- The APC partners with the member’s primary care physician, the member and/or family/authorized representative, and nursing home staff to provide primary/preventive care and personalized care coordination.

Enrollment Process

- Enrollment is voluntary
- Enrollment is limited to facilities with ISNP contracts
  - SNF’s maintain the right to accept or deny admission to their facility
- Enrollment may take place at any time during the month but the benefits do not go into effect until the 1st day of the following month
  - If a member dis-enrolls, their benefits are good through the end of the month
- CMS regulations require consent to contact prior to the Optum Sales Team making contact with the member or family
  - Facility and APC’s can obtain the consent form
- Optum works closely with the SNF and APC to engage new members/families:
  - CMS approved letters, family-rights, displays, materials available
  - Facility does not sell, but educates families on the ISNP option
  - Provide responsible parties information upon request

Program Overview

- Once a member is enrolled in the UHC Nursing Home Plan, their plan benefits become effective on the 1st day of the following month
- Optum APC’s are available Monday-Friday 8am-5pm
- Optum On-Call Team is available nightly from 5pm-8am and 24/7 on holidays and weekends
- Within the first 30 days of enrollment the Optum APC will:
  - Complete a comprehensive geriatric assessment on each member
  - Develop and communicate a problem list & plan for each member
  - Identify “high risk” patients (falls, confusion, frequent hospitalizations)
  - Develop a contingency plan for high risk conditions
  - Communicate with resident’s primary care physician
  - Reach out to responsible party to establish lines of communication
  - Review goals of care and advance directives
Our Model of Care

Implement a world class care model that anticipates and adapts to progressive illness with demonstrable outcomes including:

• Improved quality of life
• Reduction of disease and symptom burden
• Informed decision making
• Care focused on appropriate goals

Ongoing Management

• Overall care coordination between the interdisciplinary care team
• Bi-Annual Comprehensive Visits
• Minimum of monthly NP visits
• Acute care management
  • Initiation of skilled services for changes in condition
  • Part A skilled time management
  • Part B Care Coordination
• HEDIS Measures
• Annual Medication Reviews
• Monthly family/RP communication
• Monthly PCP communication
• Ongoing Advanced Care Planning

UnitedHealthCare vs. Original Medicare and Medicaid

<table>
<thead>
<tr>
<th>2017 Key Benefits</th>
<th>UnitedHealthcare Nursing Home Plan</th>
<th>Medicare</th>
<th>Medicaid</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse Practitioner / CarePlus Institutional Clinical Nurse</td>
<td>X</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Skilled Nursing / Part A Benefit (without 3 day hospital stay)</td>
<td>X</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>No limits or funds for therapy / wounds</td>
<td>X</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Preventative Dental Benefit $250/year</td>
<td>X</td>
<td>-</td>
<td>Limited</td>
</tr>
<tr>
<td>Routine Podiatry (2 visits per year)</td>
<td>X</td>
<td>-</td>
<td>Limited</td>
</tr>
<tr>
<td>Eye Exam and Eyewear ($100 credit every year)</td>
<td>X</td>
<td>-</td>
<td>Limited</td>
</tr>
<tr>
<td>Hearing exam</td>
<td>X</td>
<td>-</td>
<td>Limited</td>
</tr>
<tr>
<td>Non-emergency Transportation (12 one-way)</td>
<td>X</td>
<td>-</td>
<td>Limited</td>
</tr>
<tr>
<td>OCN Care Catalog – New 2018</td>
<td>X</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

Advantages for the Skilled Nursing Facility (SNF)

• Optum clinician is the first call for nursing staff, subject to applicable CMS rules and regulations
• Skilled benefit without 3 day qualifying hospitalization – eliminates need for out of pocket expense for bed hold, if applicable
• Facilitate communication among care team members
• Documentation supports state survey process and corrective action plans
• Additional Part B payments for accu-checks, enteral feeding and therapy screens
• Provide education and in-service for facility staff
• Improved census stability due to treat in-place model of care; increased skilled census through all-payer contract
• Treat in place helps avoid unnecessary transfers
• Optum clinicians supplement physician visits

Outcomes

Proven results1,2

45% reduction in hospitalizations
50% reduction in emergency room visits
97% of family members satisfied and would recommend it to others
93% of nursing home directors say expectations are exceeded
92% of nursing home directors would recommend the plan to other nursing homes

How do ISNPs Get Funded?

• CMS provides a per member per month (PMPM) payment to the Health Plan
• This payment factors in fixed factors (age, sex, special status) and Risk Adjustment, or RAF, factors based on the diagnostic coding and documentation of acute and chronic conditions
• In addition to this PMPM, there are additional quality bonuses earned for ISNPs that achieve 4 or 5 Stars; these bonus payments must be put back into member benefits
• The Health Plan is then at full financial risk for the ISNP membership
• Using the PMPM payment, the ISNP must cover everything within Medicare guidelines (Parts A, B, and D), the cost of the plan’s infrastructure, and any “enhanced” benefits – over and above traditional Medicare – that will improve the health and well being of the plan’s membership
How Does Risk Adjustment Impact a Health Plan?

The payment a health plan receives for a member in an MA plan is based on the predicted health status and fixed demographic characteristics of a typical member.

Of course, not all members of an MA plan’s health care needs are typical. Each member’s needs are unique and based on many factors.

Among other factors, the CMS payment model takes into account reported acute and chronic medical conditions to determine the additional payment a health plan receives to care for an MA patient through a calculation called risk adjustment.

What is Risk Adjustment Factor (RAF)?

CMS requires health plans to report ICD-10 diagnosis codes related to each MA member. Certain chronic medical conditions, like heart disease or diabetes, are grouped into Hierarchical Condition Category (HCCs) codes. These HCCs are added, along with the fixed factors, by CMS to create a RAF score for each member.

RAF is the CMS payment methodology that allows for:

- Fair and accurate payments to MA health plans
- Payments made based on a member’s health status, which results in a higher payment for members who are sicker and require more complex care

How has RAF’s Importance Changed?

Prior to 2003
100% of health plan payments were based on demographics like gender, age, zip code.

Since 2007
100% of payments are based on RAF. RAF places significant weight on the accuracy and specificity of documentation.

2003
RAF payments began
CMS began adjusting health plan payments based on the documented chronic medical conditions of MA members. Initially, 10% of payments are affected, with gradual increases over the next four years.

Since 2007
100% of payments are based on RAF. RAF places significant weight on the accuracy and specificity of documentation.

Background of STAR Ratings

The concept was first designed in 2007.
The intent was to assist in member plan selection, not for pay for performance.

ACA introduced pay for performance
And implemented that with 2012 STARs payments

CMS felt it was a reliable, consistent system
Provided easy comparisons for consumers
Assessed outcomes and improvement with weighted scales

Business Implications for revenue and enrollment
High ratings mean we will be rewarded with more funding from CMS, in the form of quality bonus payments and rebates. The additional funding must be used to fund member benefits, such as lower out-of-pocket costs or more resources to help support their health care needs.

Over 40 measures are included in the final ratings

STAR’s Measure Sources

Claim and medical record chart data
HEDIS – Healthcare Effectiveness Data and Information Set from the National Committee on Quality Assurance (NCQA), updated July of each year
Member survey focusing on service experience and access to care
CAHPS – Consumer Assessment of Healthcare Providers and Systems (HEDIS) from AHRQ
Member survey focusing on members’ perception of health status
HOS – Health Outcomes Survey from CMS panel
Pharmacy measures
PDE – Prescription Drug Event from PQI & Acumen
Members’ complaints, appeals and grievances – Service metrics (Health Plan Operations) from the plan

Star Ratings are not on a typical one-year cycle, where how we perform this year impacts next year. Instead, the annual Star Ratings reflect plan performance from two years prior, with bonus payments issued three years after.

2019 Plan STAR Ratings will be published by CMS in October 2018. A new ratings measurement year started on January 1, 2018, which will be reflected in 2020 Plan STAR Ratings.
Taking Lessons Learned to the Post Acute SNF Population

- “Transitions to SNF” or “TTS” program:
  - Reduce skilled length of stay
  - Reduce unnecessary readmissions to the hospital
  - Improve coding accuracy and completeness
  - Close STAR/HEDIS gaps
  - Improve discharge planning
  - Presently a case-rate relationship
- Optum APCs assigned to cases upon admission:
  - Initial visit/touch within 24 hours
  - Emphasis on early discharge planning
  - Monitoring for changes in condition
  - Care coordination/collaboration including PCP, family, SNF
  - Smooth transition back to community providers

Advanced Bundled Payments (BPCI Advanced)
What is the relevance in the PALTC Medicine Specialty?

Matt Gray
Vice President, Risk Based Programs
TeamHealth

Learning Objectives

By the end of the session, participants will be able to:

- Compare New and Current Bundled Payment Models
- Understand the key differences between the current BPCI program and BPCI Advanced
- Determine the relevance to PALTC clinicians
• On January 9, 2018, CMS announced the launch of a new voluntary episode payment model called BPCI Advanced.
• BPCI Advanced is built on the foundation of the current BPCI program, which began in April 2013 and is scheduled to run through September 30, 2018.
• The Model Performance Period of BPCI Advanced will start on October 1, 2018 and run through December 31, 2023.

How Does BPCI Advanced Compare to Current Bundled Payment Models?

• The focus was to build upon the successes of the current BPCI initiative while incorporating a few new features...
  - Risk-adjusted prospective pricing
  - Qualifying as an advanced APM
  - Incentives tied to Quality
• Model pricing was designed to recognize rather than penalize historical efficiency achievements, including those of current BPCI Awardees.
• Significant shifts in patient-mix in some Model 3 clinical episodes (bundles) that could not be adequately captured in claims data for risk adjustment.

Why is there no version of BPCI Advanced that initiates with the post-acute period (Model 3)?

• The focus was to build upon the successes of the current BPCI initiative while incorporating a few new features...
• Risk-adjusted prospective pricing
• Qualifying as an advanced APM
• Incentives tied to Quality
• Model pricing was designed to recognize rather than penalize historical efficiency achievements, including those of current BPCI Awardees.
• Significant shifts in patient-mix in some Model 3 clinical episodes (bundles) that could not be adequately captured in claims data for risk adjustment.
What are the 29 Inpatient Clinical Episodes (Bundles) Included in BPCI Advanced?

- Disorders of the liver excluding malignancy, cirrhosis, alcoholic hepatitis (New episode added to BPCI Advanced)
- Acute myocardial infarction
- Back & neck except spinal fusion
- Cardiac arrhythmia
- Cardiac defibrillator
- Cardiac valve
- Cellulitis
- Cervical spinal fusion
- COPD, bronchitis, asthma
- Combined anterior posterior spinal fusion
- Congestive heart failure
- Coronary artery bypass graft
- Double joint replacement of the lower extremity
- Fractures of the femur and hip or pelvis
- Gastrointestinal hemorrhage
- Gastrointestinal obstruction
- Hip & femur procedures except major joint
- Lower extremity/lumbar procedure except hip, foot, forearm
- Major bowel procedure
- Major joint replacement of the lower extremity
- Major joint replacement of the upper extremity
- Pacemaker
- Percutaneous coronary intervention
- Renal failure
- Sepsis
- Simple pneumonitis and respiratory infections
- Spinal fusion (non-cervical)
- Stroke
- Urinary tract infection

What are the 3 Outpatient Clinical Episodes (Bundles) included in BPCI Advanced?

- Percutaneous Coronary Intervention (PCI)
- Cardiac Defibrillator
- Back & Neck except Spinal Fusion

BPCI Advanced Qualifies as an Advanced APM

- Convener and Non-Convener Participants bear financial risk of more than a normal amount
- Participants must attest to their use of CEHRT
- Payments for covered professional services will be linked to Quality Measures comparable to MIPS Quality Measures

CMS has selected 7 quality measures for the BPCI Advanced Model

1. All-cause Hospital Readmission Measure (NQF #1793)
2. Advanced Care Plan (NQF #0326)
3. Perioperative Care: Selection of Prophylactic Antibiotic: First or Second Generation Cephalosporin (NQF #0269)
4. Hospital-Level Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) (NQF #1550)
5. Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Coronary Artery Bypass Graft Surgery (NQF #0258)
6. Excess Days in Acute Care after Hospitalization for Acute Myocardial Infarction (NQF #2881)
7. AHRQ Patient Safety Indicators (PSI 90)

Some ACO Beneficiaries will be able to Trigger Clinical Episodes in BPCI Advanced

Beneficiaries assigned to Track 1, Track 2 and Track 1+ will be able to trigger Clinical Episodes but CMS may recoup a portion of the BPCI Advanced discount amount.

Summarizing the Key changes in BPCI Advanced

- No Model 3: EIs must be ACHs or PGPs
- Decreased the number of clinical episodes (bundles) from 48 to 32 (29 Inpatient and 3 Outpatient)
- Payments will be linked to Quality Measures including All Cause Readmissions and Advanced Care Planning
- Some ACO Beneficiaries will be able to trigger BPCI Advanced episodes
**What is the relevance of BPCI Advanced in the PALTC Medicine Specialty?**

- The majority of the duration of a 90 day episode falls outside of the inpatient stay
- Can participate as a Convener Participant or as a Participating Practitioner
- Achievement of Quality Measures will factor heavily into the financial opportunities (NPRA sharing)
- PALTC clinicians that can contribute to successful Quality Improvement and Active Care Coordination programs will be preferred partners for Participants

**Speaker Disclosures**

Kerry Weiner, MD, MPH, is the Chief Strategy Officer at Care Connect Healthcare. He has no other financial relationship(s) to disclose.

**AAPM: All-Payer Combination Option**

- **AAPMs**: Qualify for 5% incentive payment; avoid MIPS reporting.
- **QP Threshold**: 25% billing or 20% beneficiaries.
- **Goal**: Increase Qualified Provider Options.

**All-Payer Combination Option Overview**

Two pathways to allow clinicians to become QPs.

- **Medicare Option**: Achieve QP status exclusively based on participation in Advanced APMs within Medicare fee-for-service.
- **All-Payer Combination Option**: Achieve QP status based on a combination of participation in Advanced APMs within Medicare fee-for-service AND Other Payer Advanced APMs.

**All-Payer Combination Option Begins 2019**

- Other Payer Advanced APMs are non-Medicare payment arrangements with criteria similar to Advanced APMs.
- Other Payer Advanced APMs include:
  - Title XIX (Medicaid)
  - Medicare Health Plans (Including Medicare Advantage)
  - CMS Multi-Payer Models
  - Other commercial and private payers
All-Payer Combination Option

Physician-Focused Payment Model Technical Advisory Committee (PTAC)

• Comment and recommend to HHS promising proposals submitted by stakeholders.
• 22 Models under consideration
• 3 proposals recommended for limited testing
  • ACS - Brandeis AAPM
  • Project Sonar
  • Oncology Bundle Using CAN- Guided Care
• 3 PAC relevant models deemed “promising”.

Advanced APMs

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PTAC: Three PAC Proposed Models

• Am Academy of Hospice & Palliative Care Medicine
  • Patient and Caregiver Support for Serious Illness (PACSSI).
• Coalition to Transform Advanced Care
  • Advanced Care Model
• Avera Health
  • Intensive Care Management in SNF

New APMS for PALTC

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Comparing PTAC Models

<table>
<thead>
<tr>
<th>ACM</th>
<th>FHCRC</th>
<th>CMS NF</th>
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<tbody>
<tr>
<td>Beneficiaries</td>
<td>Palliative, 3 yr. PCA, Palliative, 3 yr. PCA, All residents</td>
<td>Palliative, 1 yr. PCA, Palliative, 1 yr. PCA, All residents</td>
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<tr>
<td>NH/HC use</td>
<td>HF</td>
<td>HF</td>
</tr>
<tr>
<td>Coverage Period</td>
<td>1 yr.</td>
<td>Until DC, hospice</td>
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<tr>
<td>Accountable Party</td>
<td>PCT</td>
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<tr>
<td>Pt. Distribution</td>
<td>Sign-up</td>
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<tr>
<td>Quality Metrics</td>
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<td>Incentive</td>
<td>$ and 2 sided</td>
<td>$ and 2 sided</td>
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<tr>
<td>Pt. access to providers</td>
<td>Flex + flexibility</td>
<td>Flex + flexibility</td>
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Perfect PALTC Advanced APM

- Based on Place of Service 32?
- Inclusive of Dual Eligibles
- Appropriate QMs: ACDs, Influenza, Pneumococcal, Zoster Vaccines, Care Plan Reviews, Medication Reviews, Readmissions ??
- QM Reporting Incorporated into Clinician Workflow
- Your Ideas?

Discussion

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Thank You!