Taking Value-Based Care from Discussion to Doing: Using Real Life Examples from an MD

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Dr. Krause completed his family medicine residency at the University of California (UC) Davis Medical Center. His primary clinical settings are family medicine, urgent care, and ski injury medicine. During the winter, he manages ski trauma at the Northstar and Squaw Valley ski areas, and he is also a physician for the U.S. Ski Team at World Cup events in the United States and Europe. He is an assistant professor for the UC Davis School of Medicine at the director of Rural-PRIME medical education at Tahoe Forest Hospital. In addition, he directs a winter injury clerkship that trains 10 sports medicine fellows in sports injury medicine. Dr. Krause’s special interests include rural medicine, medical education, and the transition to value-based payments through alternative payment models. He is the Chief Medical Officer for Caravan Health’s accountable care organizations (ACOs), the largest network of ACOs in rural America. He believes that the transition from a fee-for-service system to value-based medicine is the biggest shift in physician reimbursement in our generation. By closely following the direction of the Centers for Medicare & Medicaid Services (CMS) and other payers, family physicians can remain viable and succeed in the new and quickly changing payment systems of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), ACOs, Comprehensive Primary Care Plus (CPC+), and other models.

Learning Objectives

1. Describe how to leverage Medicare’s Annual Wellness Visits (AWV) to enhance preventive care for Medicare beneficiaries.
2. Recognize how AWV can improve quality scores, patient care, and attribution.
3. Assess why and how HCC and Risk Adjustment Factor scores can positively affect your practice’s quality and cost comparisons.
4. Summarize the basic components of Care Coordination to support your community’s patients and providers.

Audience Engagement System

Step 1: Step 2: Step 3
What Does “Value-Based Care” Mean To CMS?

- **Value**: Quality/Cost adjusted for Risk
- **How is “Quality” defined by CMS?**
- **How is “Cost” defined by CMS?**
- **How do you compare patients of variable health to each other?** (“Risk adjustment”)
- **Why does CMS want to move to Value-Based Care?**
  - To improve the Quality and decrease the Cost of healthcare in the US and make us competitive with other countries

Accountable Care Experience

- Family doctor, Lake Tahoe region of California
- Part of an Accountable Care Organization (ACO) for almost 3 years
- Track 1 MSSP ACO
- Rewards quality and efficiency, “risk-free” for 3-6 yrs
- Grouped with 10 other small health systems to report as an ACO
- It is a MIPS-Alternative Payment Model (MIPS-APM) under the Quality Payment Program, which gives a scoring advantage over regular MIPS

The ACO Virtual Groupings Model

- Join other communities to make up the ACO cohort
- The ACO has attributed lives & is accountable for their cost and quality
- Each individual community works toward improving care while reducing per capita cost
- Local governance: Quarterly ACO Steering Committee meetings
- ACO governance: Quarterly ACO Board Meeting
- The key to success is to implement the public health tools and ACO recommended tactics to augment good patient care!

Alphabet Soup: A Guide

- **MACRA**: Medicare Access and CHIP Reauthorization Act. Legislation passed in 2015 with bipartisan support (not ACA)
- **QPP**: Quality Payment Program. New Medicare payment program for clinician reimbursement rates effective CY2019. Reporting that affects these payments is NOW!
- **MIPS**: Merit-based Incentive Payment System. A track within the Quality Payment Program
- **Medicare ACO**: Accountable Care Organization. Groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high quality care to their Medicare patients
- **MIPS-APM**: MIPS-Alternative Payment Model. A specialized option in the QPP for Track 1 risk-free ACOs.

AES POLL QUESTION

What does QPP stand for
A. Quality Performance Program
B. Quality Program Performance
C. Queried Payment Program
D. Quality Payment Program

Strategies that have worked for Accountable Care:

![Care Coordination](image)
Key Population Health Terms

- **AWV**: Annual Wellness Visit: Preventive care provided to Medicare beneficiaries
- **CCM**: Chronic Care Management: Addresses care of those with chronic diseases
- **TCM**: Transitional Care Management: Addresses transitions of care between settings
- **HCC**: Hierarchical Category Conditions: Conditions that predict healthcare costs in the future year
- **RAF**: Risk Adjustment Factor: A summary of HCCs and OREC per health system or ACO

**Annual Wellness Visits**
1st of 3 Keys to Success in a Value-based World

Reasoning Behind AWVs

- Establish patient relationships with PCP team
- Promotes preventive care & public health screenings
- Meets 11 quality measures for CMS
- Identifies high risk patients for Care Coordination
- Documents comorbidities for risk adjustment
- Attributions of patients if in an ACO
- Provides new RVUs & revenue stream for clinicians
  - Initial AWV = $173.70. Subsequent AWV = $117.71. Welcome to MCR = $168.68
  - Advanced Care Planning, Depression Screening and possibly E&M Coding can be added to the visit

Wellness Visits Makes A Quality Difference

AES POLL QUESTION
What does Medicare AWV stand for?
A. Medicare Annual Wellness Version
B. Medicare Annual Wellness Visit
C. Medicare Arrival Well Visit
D. Medicare Welcome Visit

Patient Attribution In An ACO
1. >50%: Prevention visits
   a. Heavily Weighted on AWVs
2. >20%: E&M Coding by Primary Care providers
3. <5%: Billing from visits to other providers
4. <10%: Other billing
   a. Ancillary services: PT, audiology, etc.
   b. Diagnostic imaging, labs, etc.
What We Did To Succeed With AWVs

- Educated physicians of importance of AWVs and the systematic process of delivering them efficiently
- MA in charge of the AWVs
  - Process Champion & got feedback on how to set providers up for success
- Added additional services to the visit, which elevated revenue & boosted buy-in from providers

AES POLL QUESTION

What is the best thing clinicians can do to ensure their Medicare patients are attributed to them?
A. Ensure all Medicare patients have Medicare Annual Wellness Visits.
B. Limit patient access to specialists.
C. Purchase an electronic medical record.
D. Coordinate care with specialists.

CMS Risk Adjustment Overview

- CMS risk adjusted reimbursement methodology traditionally applied to Medicare Advantage Plans
- Now risk adjustment is extending to Value-based payment models and other commercial payers – (bundles, ACO’s, CPC+, QPP/MIPS, etc.)
- Method used to adjust contract bidding and payment based on enrollee:
  1. Demographic characteristics
  2. Health status (based on diagnoses coded)

What Are HCCs?

Hierarchical Category Conditions: Categories of Medical Conditions that are associated with a group of diagnosis codes
- You only get credit for the highest code within each HCC Family
  - Example: Diabetes with Retinopathy outranks Diabetes without Complication (Higher value)
- HCC codes from different families are additive.
  - Example: Heart Failure and Diabetes with Retinopathy codes are added towards the Risk Adjustment Factor (RAF)
- Diagnoses that are costly to manage are found in the model.
  - Most chronic diseases are listed.

Coding For Medicare Wellness Visits And Related Services

<table>
<thead>
<tr>
<th>Service</th>
<th>Billing Code</th>
<th>Average National Medicare Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial AWV</td>
<td>G0402</td>
<td>$168.68</td>
</tr>
<tr>
<td>Subsequent AWV</td>
<td>G0438</td>
<td>$173.70</td>
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<tr>
<td>Advanced Care Planning</td>
<td>99497</td>
<td>$82.90</td>
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<td>Depression Screening</td>
<td>G0444</td>
<td>$18.30</td>
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<td>Cognitive Assessment</td>
<td>G0505</td>
<td>$238.30</td>
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<td>Smoking Cessation 3-10 min</td>
<td>99406</td>
<td>$14.71</td>
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<tr>
<td>Smoking Cessation &gt;10 min</td>
<td>99407</td>
<td>$28.35</td>
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</tbody>
</table>

*Coding specifics come from AAFP and confirmed by CMS

Risk Adjustment Factors

2nd of 3 Keys to Success in a Value-based World
CMS Calculates the RAF

- From CMS: Risk adjustment predicts (or explains) the future healthcare expenditures of individuals based on demographics and disease data.
- CMS assigns a RAF (Risk Adjustment Factor) to every patient annually based on the following:
  - Age
  - Gender
  - OREC
  - HCC Codes

\[ \text{OREC} \times \text{HCC} = \text{RAF} \]

Why Do We Care About RAF Scores?

- Medicare Shared Savings Program (ACOs):
  - Sets Financial Benchmark
  - If HCC Scores Drop, RAF Decreases
  - Benchmark Will Reset Lower, putting Shared Savings at risk.
- Being in a MSSP Track 1 ACO protects physician payments under MACRA/MIPS, starting in 2019
  - Additional Positive Payment Adjustments are paid out as a percentage add-on to each claim if MIPS-APM scores are high.
  - 75% of those earning positive adjustments will also get the additional adjustment.
- Value Based Payment Models Use Risk Adjustment:
  - Prepares you for other models like CPC+, Bundled Payments, Risk-bearing ACOs
  - Future payment models will also likely be risk adjusted

What We Did to Succeed in Improving Our RAF Scores

- Educated providers about the importance of risk adjustment to future Value-based payments
- Trained MA on HCC coding and RAF scores
- Had MA pend diagnoses of HCC value at AWVs
- Used ACO’s data repository to find potentially missing HCC codes and reintroduce them to providers at the AWV
  - Example: History of coding for amputation, but not yet coded in this calendar year? That’s an opportunity to increase the RAF.

Care Coordinator

- Registered Nurse hired for population health
- Bill for Chronic Care Management (CCM)
- Bill for Transitional Care Management (TCM)
- Build trusting relationships with complex patients & help them to navigate the healthcare system (close gaps in care delivery)
- Partner with community clinicians to provide care & AWVs
- Provide behavioral health services
- Assist with documentation and quality reporting

Implement a Care Coordinator Model

- Promotes patient self-management
- Health coaching strategies
- Partnership with patient and family on their health
- Engagement with relevant community resources
- Facilitates care management team approach with clinicians
- Support patients with chronic diseases
What We Did To Succeed In Care Coordination

- Educated providers about the importance of ACO membership and having Care Coordination
- Hired an experienced Med-Surg RN in partnership with our local hospital
- Used ACO waiver to avoid Stark laws and enabled paying for the RN at outpatient rather than inpatient rates
- Trained the RN via ACO funding to manage chronic disease along with MDs
- Billed for CCM and TCM, which paid for RN’s work

Coding for Care Coordination and Related Services

<table>
<thead>
<tr>
<th>Service</th>
<th>Billing Code</th>
<th>Average National Medicare Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chronic Care Management</td>
<td>99490</td>
<td>$42.71</td>
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<tr>
<td>Complex Chronic Care Management</td>
<td>99487</td>
<td>$93.67</td>
</tr>
<tr>
<td>CCM each additional 30 min</td>
<td>99489</td>
<td>$47.01</td>
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<tr>
<td>Transitional Care Management</td>
<td></td>
<td></td>
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<tr>
<td>Mod</td>
<td>99495</td>
<td>$165.45</td>
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<tr>
<td>High</td>
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<td>$233.99</td>
</tr>
</tbody>
</table>

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What Will Value-based Payment Models Mean For Family Physicians?

My Experience in an ACO

- 7-physician independent primary care medical group
- Part of a MSSP Track 1 ACO for 2.5 years
- Improved revenue from AWVs & associated billing (>250/visit)
- Increased resources (full-time MA & part-time Care Coordinator) to assist providers with CCM, TCM & AWVs
- RNs & MAs do the majority of the AWV set-up for providers
- Purchased another office devoted mostly to AWVs & preventive care.
- ACO participation and improvement in our quality scores puts us at the 90th percentile of MIPS-APM, which should set us up for incentive payments
- We have improved patient care and we feel more prepared for whatever Value-based payment model comes next.

Track 1 ACO Benefits to Providers

- Potential for Shared Savings without risk
- Simplification of MIPS reporting
- Exemption from IA reporting and cost component of MIPS
- Decreased risk of MIPS negative payment adjustments for providers and colleagues
- Potential increased revenue from exceptional performance bonuses
- Increased revenue via added services and more RVUs
- More support staff to assist with the most challenging patients
- Improved reputation via Physician Compare stats online
- Transition to Value-based care models

ACO Membership: Benefits to Patients

- Complete claims data on all patients
- Care Coordinator improves PCP communication
- Improved preventive care through AWVs
- Team-based care improves patient satisfaction & success
- Support of patients with chronic diseases
  - Care Coordination for CCM & TCM
  - Advanced Care Planning, Psychosocial Assessments, Behavioral Health Support & Dementia Care Planning
Recommendations/Steps to Take
1. Streamline your delivery of AWVs
2. Get educated about HCCs and pay attention to your RAF scores
3. Consider hiring a Care Coordinator
4. Prepare for MACRA/MIPS and transition to Value-based Care
5. Consider an ACO or other Value-based Model

Questions

THANK YOU!
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