Rural Health Clinic Technical Assistance Webinar

This webinar is brought to you by the National Association of Rural Health Clinics and is supported by cooperative agreement UG6RH28684 from the Federal Office of Rural Health Policy, Health Resources and Services Administration (HRSA). It is intended to serve as a technical assistance resource based on the experience and expertise of independent consultants and guest speakers.

Value-Based Care Is Here, and RHCs Are Joining the Transition

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Rural Health Value (RHV)

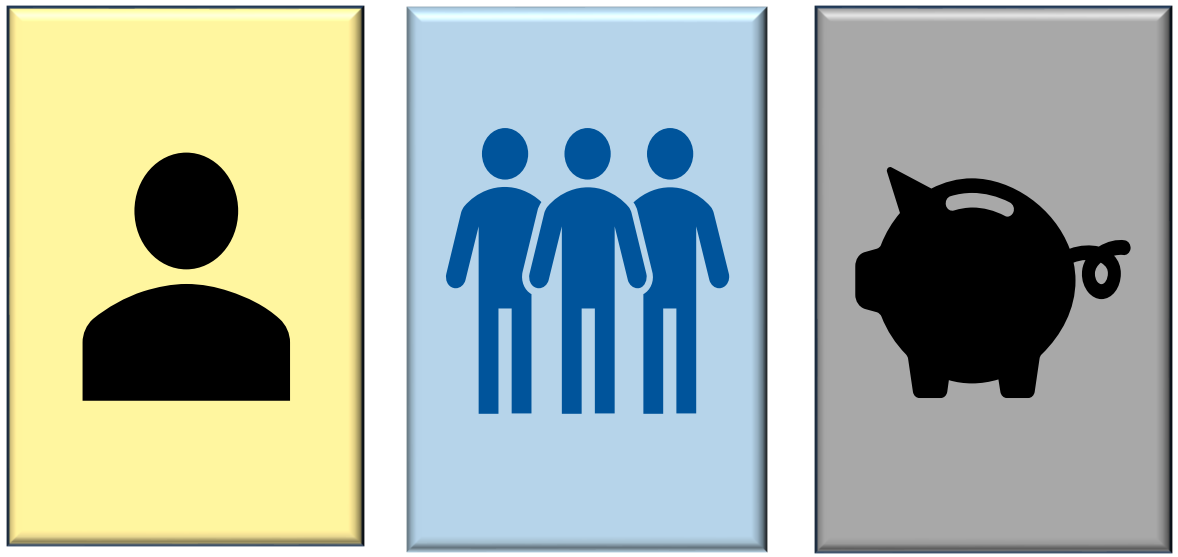
To facilitate rural provider and community transitions from volume-based to value-based health care and payment.

Rural Health Value's charge

- Develop tools and resources
- Interpret health policy
- Disseminate best practices
- Provide direct technical assistance
- Share rural stakeholder experiences

www.ruralhealthvalue.org

Triple Aim and Why It's Important



Better Care | **Improved Health** | **Smarter Spending**

What most people expect of the healthcare system!

Shouldn't we be paid for what our patients and communities deserve?

Let's also consider the *Quadruple* Aim.

Triple Aim Leads to *Value*

$$\text{Value} = \frac{\text{Quality + Experience}}{\text{Cost}}$$

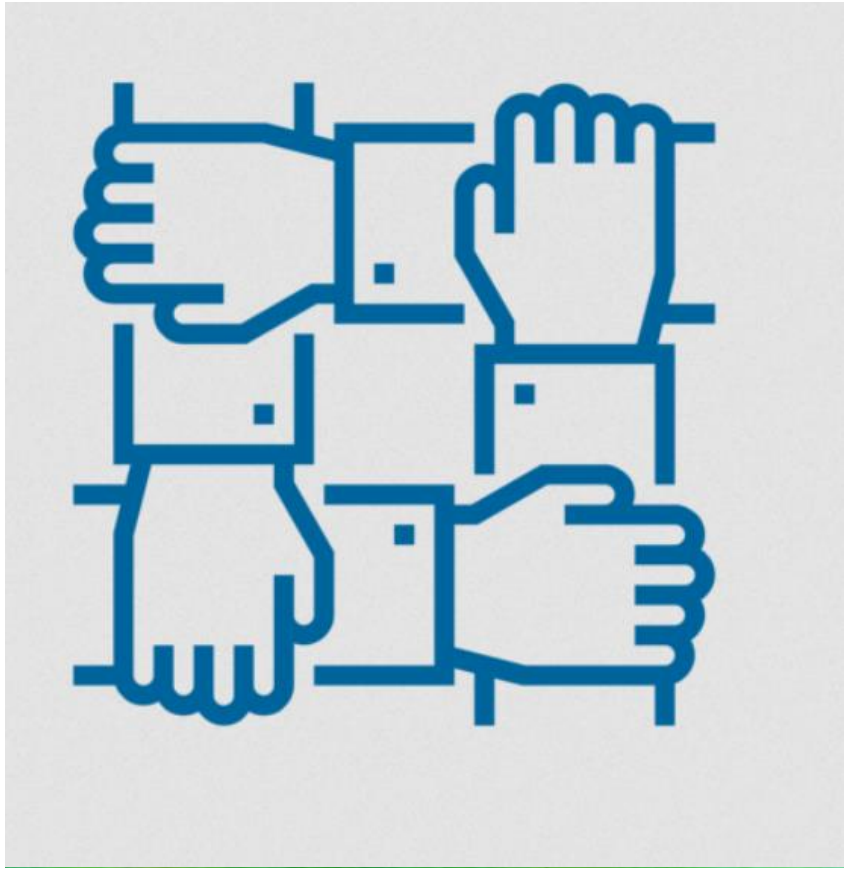
From Now Until When

Today: fee-for-service predominates

- Pays for each unit of service
- Rewards industriousness and efficiency
- Contributes to high-cost health care
- Worsens professional satisfaction

Future: **value-based care**

- Requires team-based care
- Rewards better care and efficiency
- Increases healthcare quality
- Reduces healthcare costs (?)
- Improves professional satisfaction



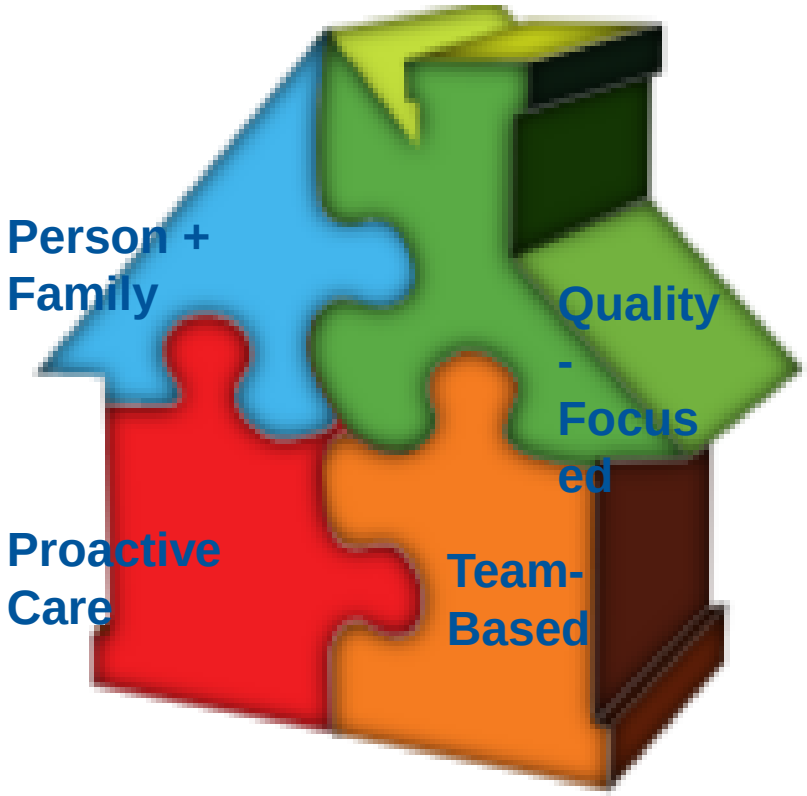
Value-Based *Care*

Value-based care prioritizes high-quality, person-centered, and efficient care.

Value-based care does NOT prioritize the volume of services provided.

Robust primary care practices are an essential ingredient (as in person-centered health homes).

Like you deliver in RHCs!



Form Follows Finance

How we *deliver* care depends on how we are *paid* for care.
Healthcare reform is changing both payment and delivery.
Payment supplies fuel for the Volume → **Value** transition.

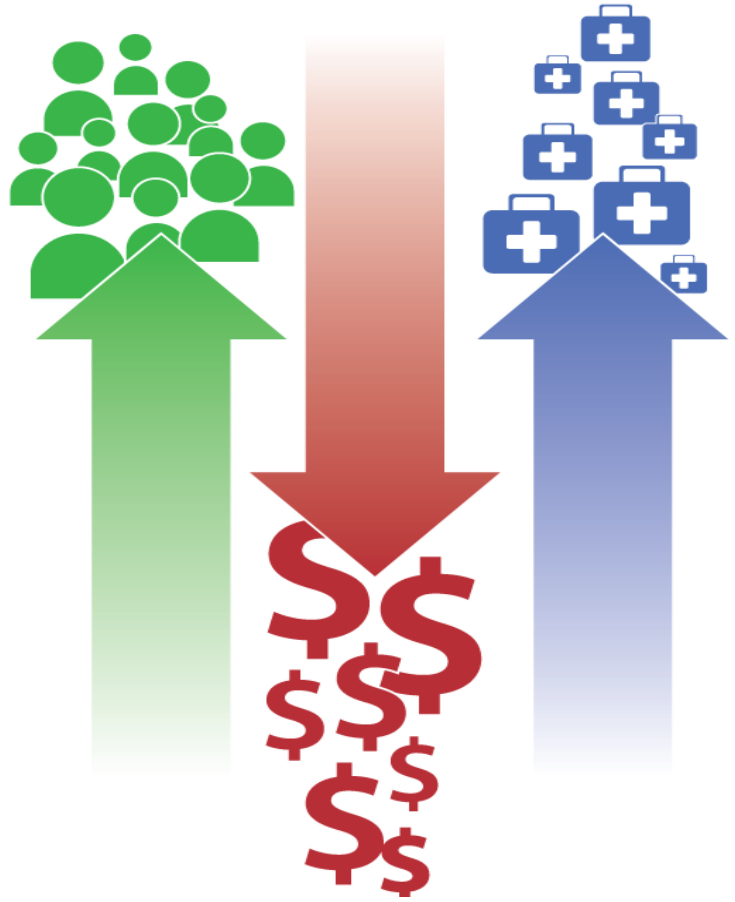
Value-Based *Payment*

Payment for one or more parts of the Triple Aim

- Better patient care
- Improved community health
- Smarter spending

Not payment for a “service,” that is, NOT fee-for-service. RHCs’ AIR is a fee for a service.

To *receive* value-based payment, we must *deliver* value-based care



Why discussing payment, not care?

Career as a rural family doc, yet…

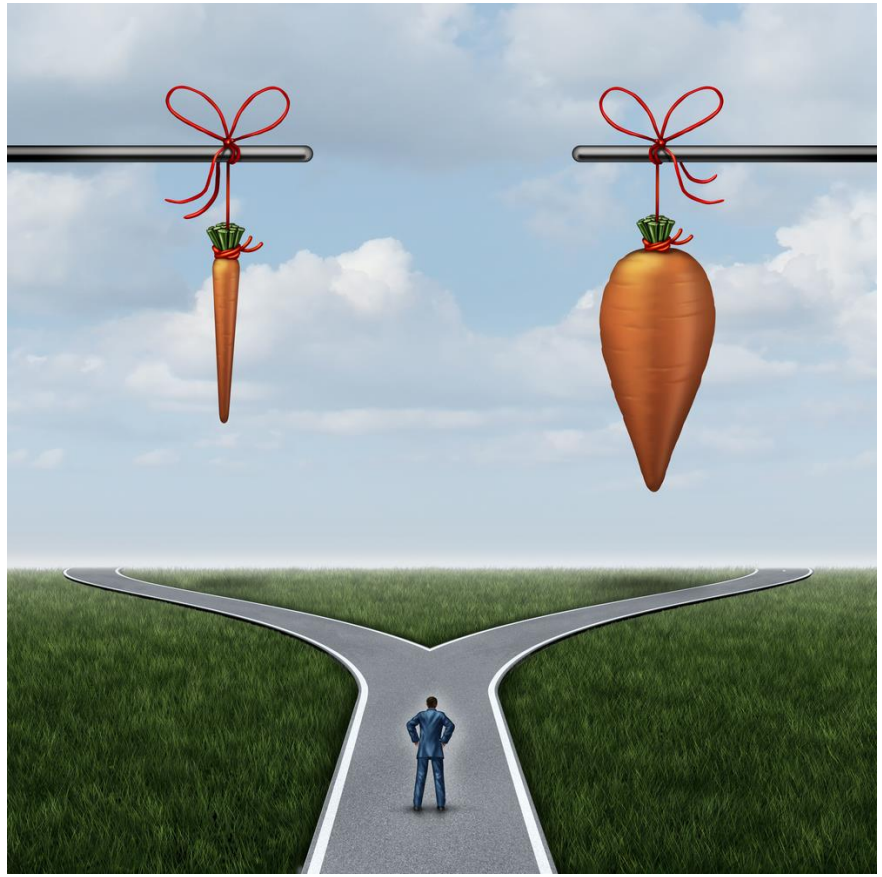
Money is a medium of exchange.

Incentives drive behavior.

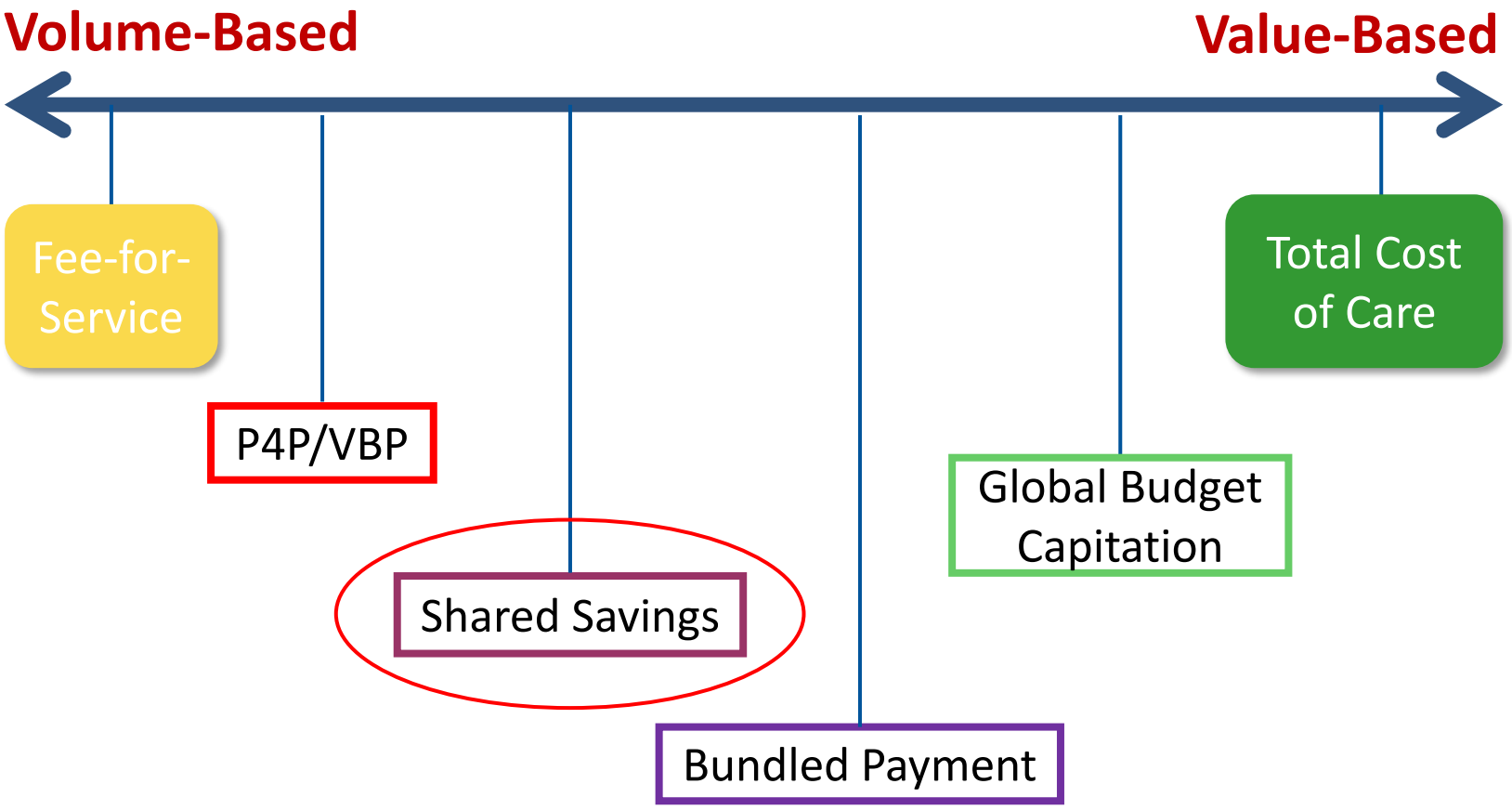
Not all incentives are financial, but finance remains important.

Let’s incentivize the Triple Aim.

Make it easy to do the *right* thing.



Payment Continuum



Accountable Care Organizations (ACOs)

ACOs are also known as **shared savings** organizations**.**

Groups of providers (generally physicians and/or hospitals) that receive financial rewards for improving the quality of care for a group of patients while reducing the cost of care for those patients.

Value-Based Payment by the Numbers

Multiple rural value-based payment models and programs, e.g.,

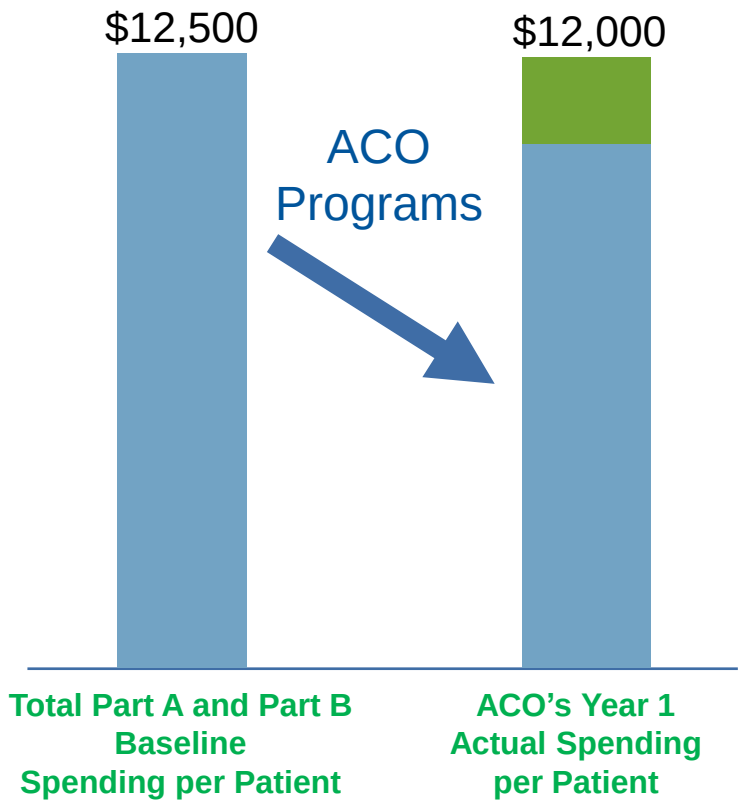
- Primary care capitation
- Rural hospital global budgets

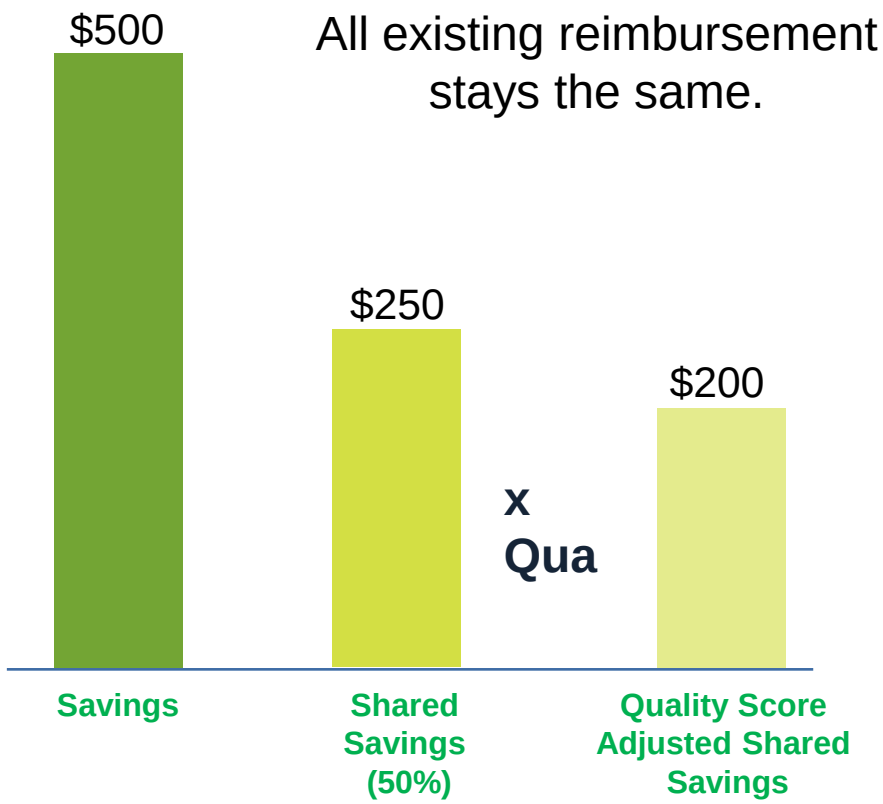
But ACOs are by far the most prevalent.

- **938 ACOs** – 10 percent of the population
- **438 Medicare ACOs** (Shared Savings Program) – greater than 11 million beneficiaries

CMS states that all providers should be “accountable” by 2030.

ACO Financing (Medicare Example)





Accountable Care Organization Goal

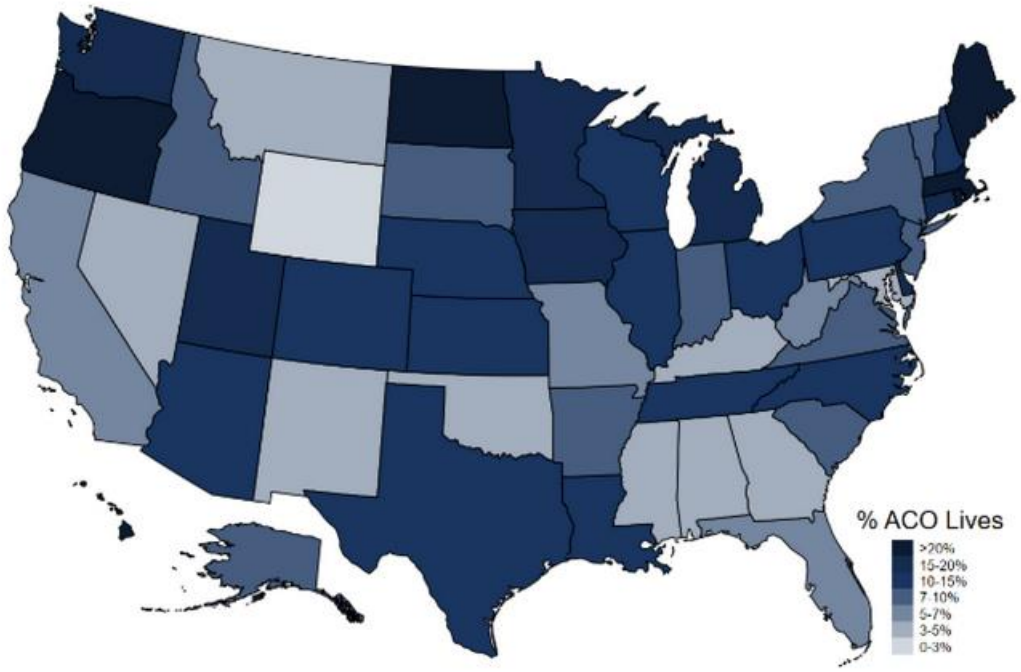
To receive a **share** of cost savings

Requires

- *Outpatient* care performance
- Primary care visit attribution
- Population health management
- Financial risk management
- *Robust* primary care

Still fee-for-service however

Significant rural participation



Source: "All-Payer Spread Of ACOs And Value-Based Payment Models In 2021: The Crossroads And Future Of Value-Based Care", Health Affairs Blog, June 17, 2021.

ACO Aggregators

National – for example

- Signify Health
- Aledade

Regional – for example,

- Illinois Rural Community Care Organization
- Prairie Health Ventures

ACO aggregator investment cost, saving distribution, and performance metrics may differ from Medicare!

What Volume-to-Value Portends

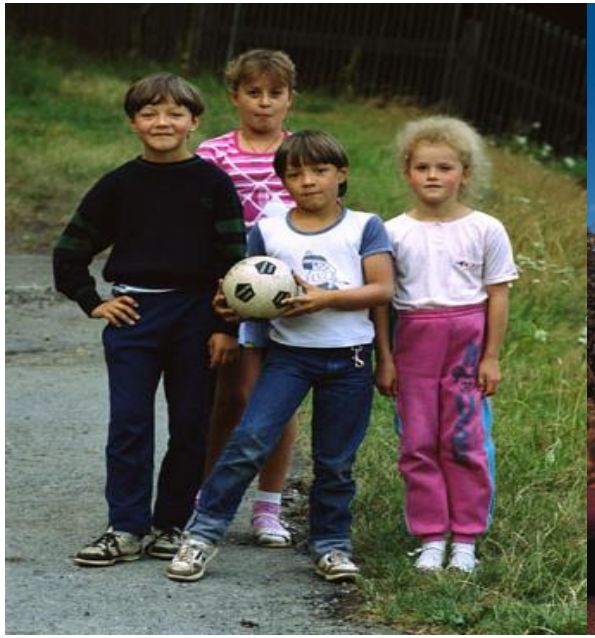
Gradual devaluation of fee-for-service.

Payment for delivering better care, improved health, and smarter spending.

Requiring, *and rewarding*, strong primary care participation as in RHCs!

An opportunity to better deliver your healthcare mission as healers.

Healthy RHCs and Rural Communities



MEDICARE SHARED SAVINGS PROGRAM

RHCs & the Medicare Shared Savings Program

What You Need to Know

March 7, 2023

Doug Jacobs, MD, MPH
Chief Transformation Officer
Center for Medicare

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Agenda

- Shared Savings Program Overview
- Shared Savings Program 2024 Changes

Shared Savings Program Overview

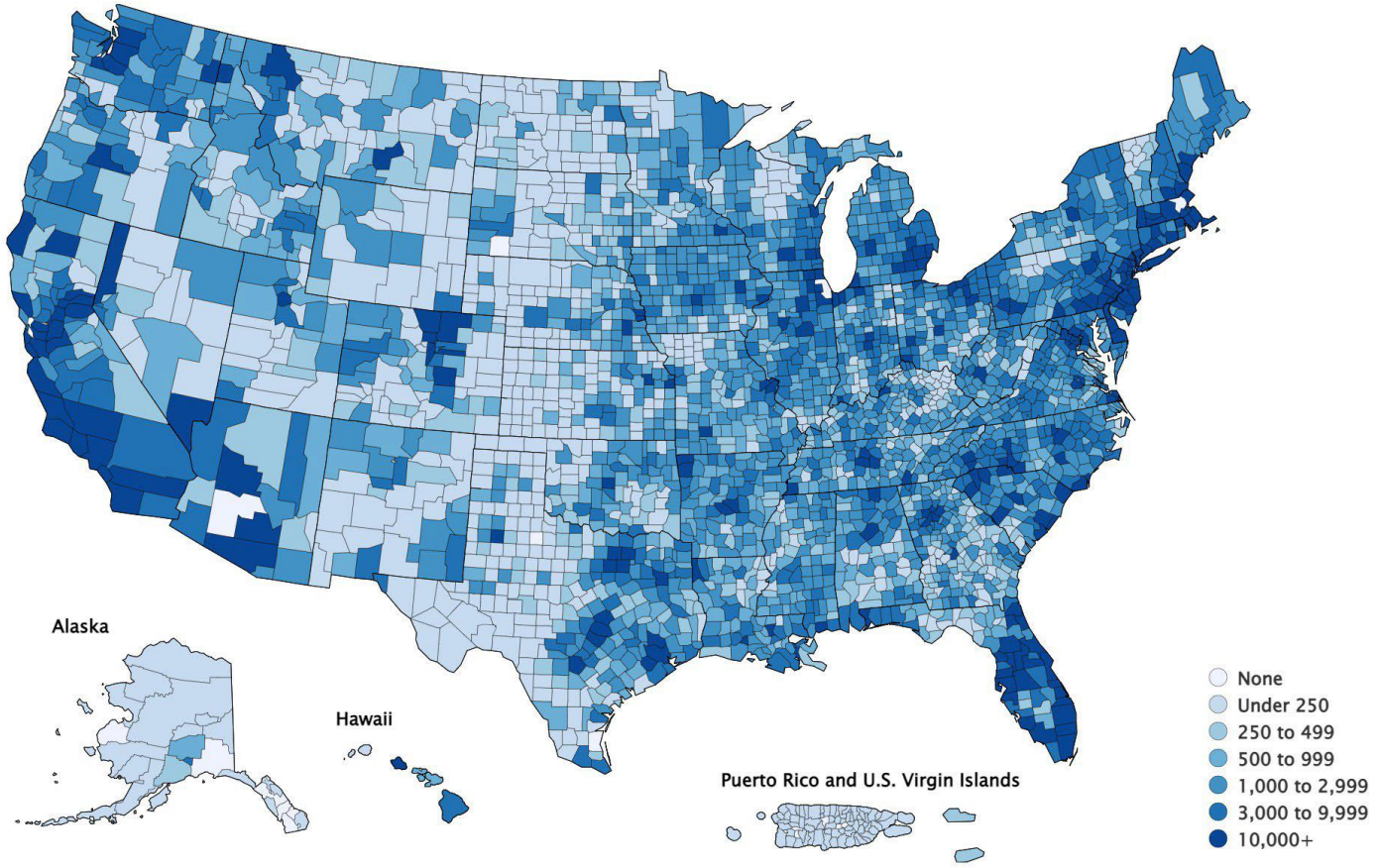
Medicare Shared Savings Program

- The Shared Savings Program is a voluntary program that encourages groups of doctors, hospitals, and other health care providers to come together as an Accountable Care Origination (ACO) to give coordinated, high-quality care to their Medicare beneficiaries.
- It is an alternative payment model that:
  - Promotes accountability for a patient population.
  - Coordinates items and services for Medicare FFS beneficiaries.
  - Encourages investment in high quality and efficient services.
- An ACO does not limit which doctors beneficiaries can see or require preapproval to see a doctor. Beneficiaries retain all Traditional Medicare benefits and can go to any doctor who accepts Medicare.

Medicare Shared Savings Program

- Providers of services and suppliers that participate in an Accountable Care Organization (ACO) continue to receive traditional Medicare FFS payments under Parts A and B.
- ACOs that successfully meet quality and savings requirements share a percentage of the savings with Medicare.
  - ACOs under some risk tracks may also be required to repay Medicare for shared losses.
- ACOs report the Alternative Payment Model Performance Pathway which measures quality performance using preventive care and chronic disease measures, admission and readmission outcome measures, and patient experience of care
- ACOs, their participating providers, and their performance results are publicly reported and available on Data.CMS.gov

SSP ACO Beneficiary Population – As of January 1, 2023



SSP Participation Statistics

Performance Year	ACOs	Assigned Beneficiaries	Total Earned Shared Savings	Average Overall Quality Score
2023	456	10.9 million	TBD	TBD
2022	483	11.0 million	TBD	TBD
2021	477	10.7 million	$2.0 billion	91%
2020	517	11.2 million	$2.3 billion	97%
2019	487	10.4 million	$1.5 billion	92%
2018	561	10.5 million	$983 million	93%
2017	480	9.0 million	$799 million	92%
2016	433	7.7 million	$700 million	95%
2015	404	7.3 million	$645 million	91%
2014	338	4.9 million	$341 million	83%
2012 / 2013	220	3.2 million	$315 million	95%

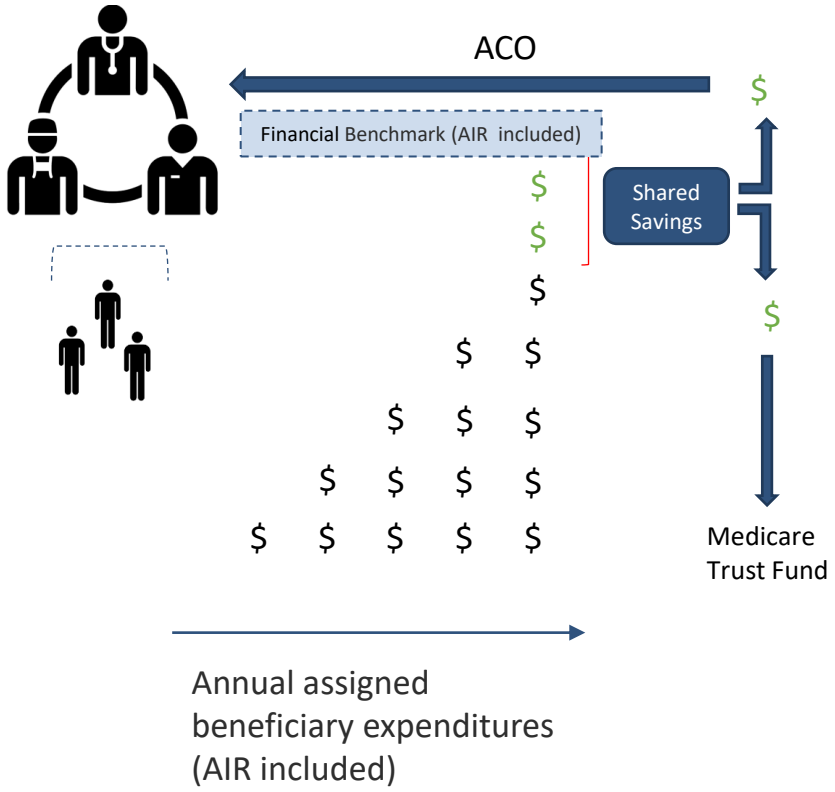
FQHC/RHC Participation in SSP

Performance Year	2013	2014	2015	2016	2017	2018	2019	2019A	2020	2021	2022	2023
FQHC/RHC	455	811	1,213	1,665	2,263	2,689	3,482	3,682	4,042	4,527	5,351	6,649
Federally Qualified Health Center	339	640	857	1,075	1,541	1,761	2,277	2,358	2,629	3,130	3,708	4,409
Rural Health Clinic - Free Standing	91	107	142	200	218	232	281	315	336	323	352	666
Rural Health Clinic - Provider Based	25	64	214	390	504	696	924	1,009	1,077	1,074	1,291	1,574

Assignment Methodology

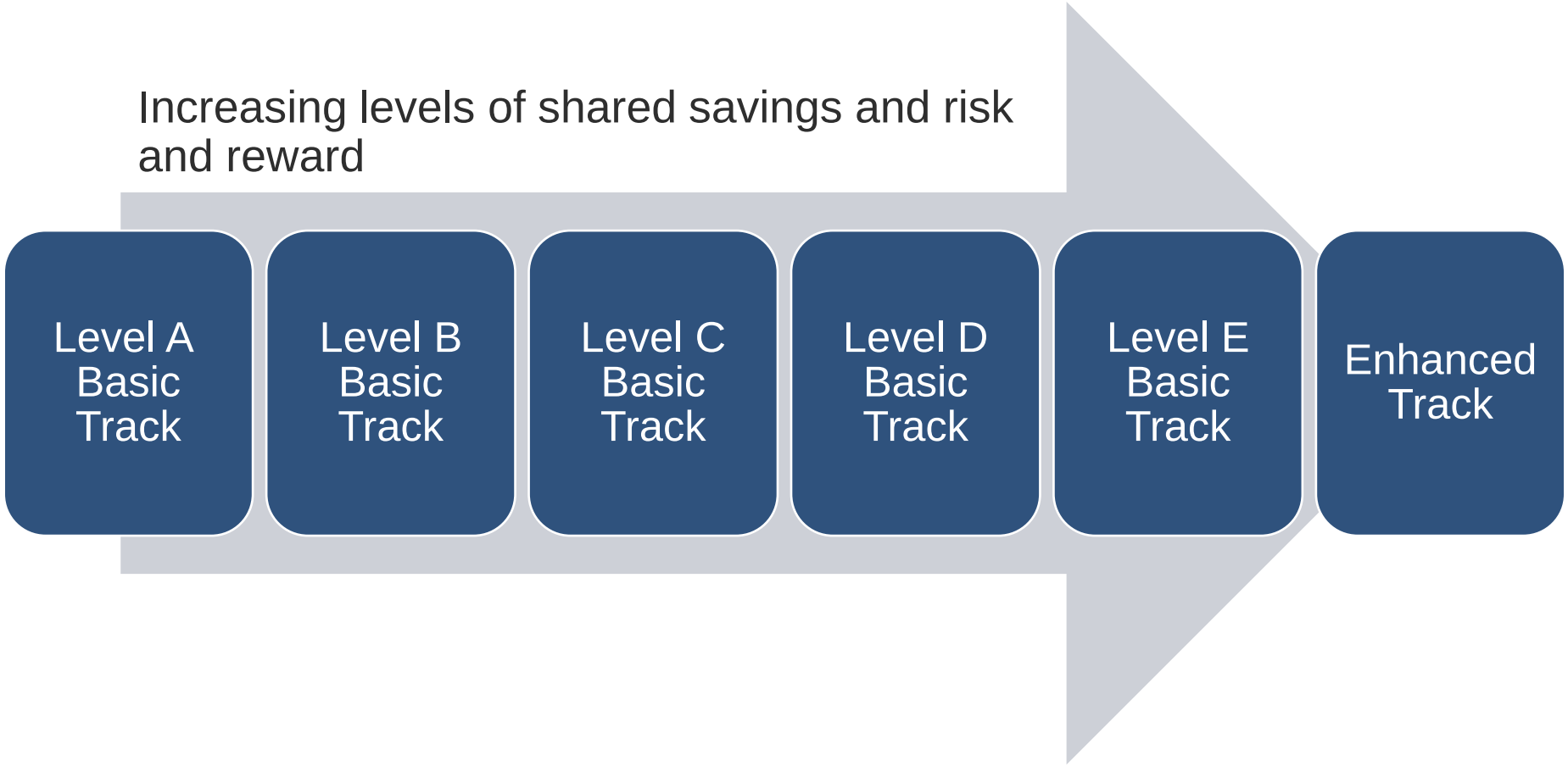
- In performing claims-based assignment, CMS determines whether allowed charges for a beneficiary's primary care services in an ACO are greater than allowed charges for the beneficiary's primary care services in any other ACO, or other individual practitioners, or groups of practitioners identified by Medicare-enrolled billing TINs or CMS Certification Numbers (CCNs) that are not participating in the Shared Savings Program.
- Beneficiary assignment includes services provided in FQHCs and RHCs. For performance years starting on January 1, 2019, and subsequent performance years, CMS treats a service reported on an FQHC/RHC claim as a primary care service performed by a primary care physician. If a beneficiary is eligible for assignment to an ACO, then CMS uses all claims for services furnished by all FQHC/RHC practitioners submitted by the FQHC/RHC to determine whether the beneficiary received a plurality of his or her primary care services from the ACO.

Earning Shared Savings



- There are multiple options of what "level" for the ACOs to participate at.
- The "level" determines the relative percentage of shared savings split between the ACO and Medicare, and for some levels there are also "shared risk" between ACO and Medicare.

Participation Levels



Shared Savings Program 2024 Changes

CY 2023 PFS

- On November 1, 2022, the Centers for Medicare & Medicaid Services (CMS) issued the Calendar Year (CY) 2023 Physician Fee Schedule (PFS) final rule that includes changes to the Medicare Shared Savings Program (Shared Savings Program) to advance CMS' overall value-based care strategy of growth, alignment, and equity.
- We encourage you to review the final rule available through the Federal Register.
- CMS fact sheet summarizes the major changes to the Medicare Shared Savings Program. (The final rule includes changes to the regulations not reviewed in this presentation.)
- More information on how to apply and the application cycle for a January 1, 2024 start date will be available through the Shared Savings Program's website in the Spring 2023.
- Questions? Contact SharedSavingsProgram@cms.hhs.gov

Goals of CY 2023 PFS

- Increase the percentage of people with Medicare in accountable care arrangements
- Encourage participation of new ACOs
- Encourage long-term participation
- Promote health equity
- Support providers seeing rural or underserved beneficiaries

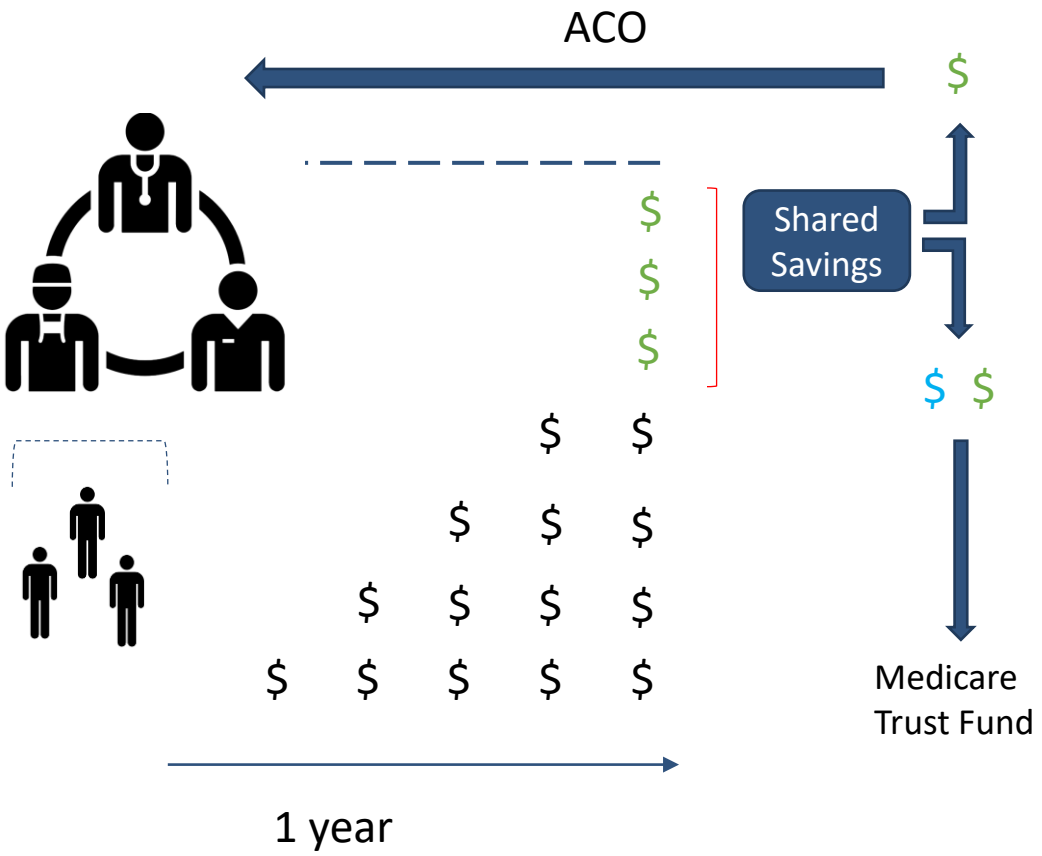
Advance Investment Payments

- Beginning January 1, 2024 - New payment option for new, low revenue ACOs joining the BASIC track
- Intended to encourage health care providers in rural and underserved areas to join together as ACOs.
- AIP offers ACOs advance shared savings payments to build the infrastructure needed to succeed in the program and promote equity by holistically addressing beneficiary needs, including social needs.
- Must use AIPs to improve health care provider infrastructure, increase staffing, or provide accountable care for underserved beneficiaries, which may include addressing social determinants of health.

Advance Investment Payments

- One-time upfront fixed payment of $250,000
- Additional quarterly payments
  - Up to 2 years (amount based on assigned beneficiaries' attributes, including Area Deprivation Index (ADI) score, Medicare Part D low-income subsidy (LIS), and dual eligible status)
  - Up to $45 per beneficiary per month
- 10,000 beneficiary cap for quarterly payments
- AIP funds will be recouped from earned shared savings in an ACO's current and subsequent agreement period, if a balance persists.

Advance Investment Payments



AIP $

- Hire community health worker
- Partnership with local community-based organization to address food insecurity

After the advanced investment payments are recouped by Medicare, the ACO earns its full amount of shared savings in subsequent years.

Longer Transition to Risk

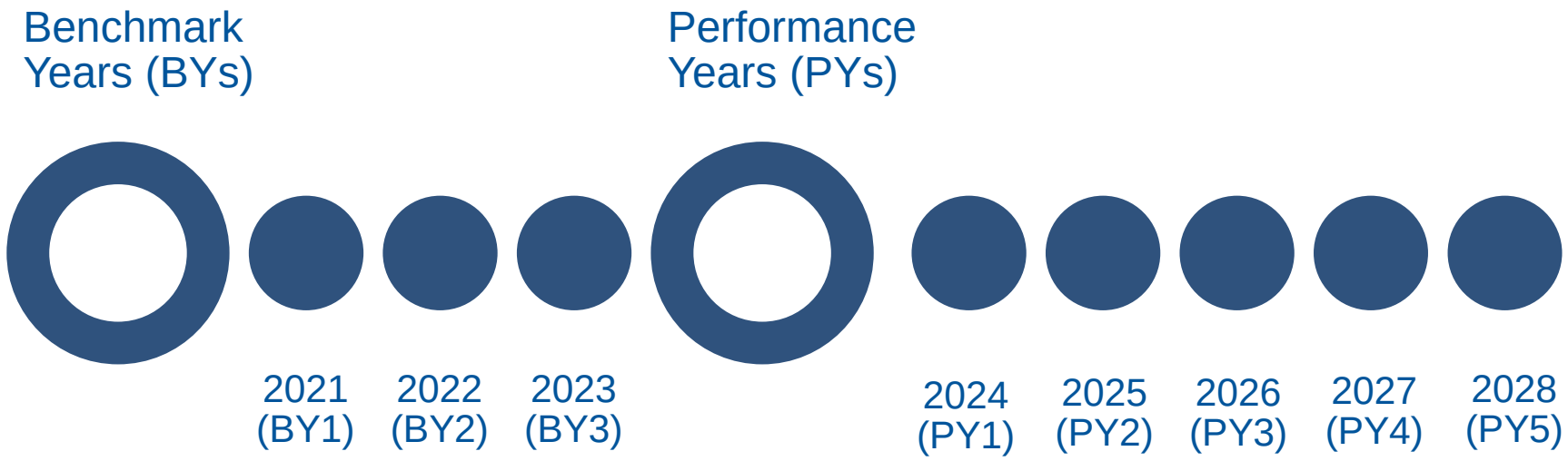
- For agreement periods beginning on January 1, 2024, ACOs that are inexperienced with performance-based risk will be allowed to participate in one 5-year agreement under a one-sided shared savings model.
- For agreement periods beginning on January 1, 2024, and in subsequent years, participation in the ENHANCED track will be optional.

Strengthening Financial Incentives for Participation

- Provisions applicable for agreement periods beginning on January 1, 2024, and in subsequent years, ensure a robust benchmarking methodology that will reduce the effect of ACO performance on ACO historical benchmarks and increase options for ACOs caring for high-risk populations.
  - Modify the methodology for updating the historical benchmark to use a three-way blend of one-third a prospectively projected administrative growth factor which will be a variant of the United States Per Capita Cost, and two-thirds the existing national-regional blend.
    - ✓ The Accountable Care Prospective Trend (or ACPT) will be calculated as one or more annualized growth rates for per capita spending for a 5-year period projected near the start of the ACO's agreement period and will be risk adjusted and expressed as a flat dollar amount.
  - Incorporate a prior savings adjustment in historical benchmarks for renewing and re-entering ACOs, to account for savings generated by the ACO in the performance years corresponding to the benchmark years for the ACO's new agreement period.
  - Modify the negative regional adjustment to limit its impact for ACOs serving beneficiaries with high risk scores and dually eligible for Medicare and Medicaid.
  - Improved the risk adjustment methodology by accounting for all changes in demographic risk scores for the ACO's assigned beneficiary population between BY3 and the performance year prior to applying the 3 percent cap on prospective HCC risk scores, and apply the cap in aggregate across the four Medicare enrollment types.

Overview of Financial Model

Example: ACO with January 1, 2024 Agreement Period Start Date



ACO Expenditure Calculations

- ACO per capita expenditures are a key element of the program's financial model
- CMS uses the same methodology to calculate total per capita Medicare Parts A and B fee-for-service expenditures for benchmark years and performance years
- RHC AIR payments are included in Shared Savings Program benchmark, performance year calculations, and national-regional trend and update factor calculations. Including AIR payments in both benchmark and performance year calculations allows for symmetry when financial comparisons are made. Changes in AIR payments that occur between the benchmark and performance year are reflected and accounted for in changes in the national-regional update factors.
- For additional information please reference the Medicare Shared Savings Program, Shared Savings and Losses and Assignment Methodology Specifications

Overview of Financial Model

Historical Benchmark

- Determined during the start of the Performance Year
- Based on 3 years of historical data
- Account for changes in assigned beneficiary health status between each of the 3 benchmark years using risk adjustment. Trend forward expenditures for each benchmark year using a blend of national and regional growth rates.

Financial Reconciliation

- Performed after the end of each Performance Year
- Compares ACO assigned beneficiary Performance Year expenditures to the updated benchmark to determine savings or losses
- Starting with agreement periods on or after January 1, 2024, the benchmark is updated during financial reconciliation using a three-way blend, which uses national and regional growth rates and the Accountable Care Prospective Trend (ACPT). The benchmark is risk adjusted to account for changes in assigned beneficiary health status between the benchmark and performance year.

Quality Performance Standard – Policies to Promote Health Equity & All Payer Quality Measure Reporting

- ACOs that meet or exceed the Shared Savings Program quality performance threshold will earn the maximum sharing rate for their track. If an ACO does not meet the quality performance threshold to earn the maximum sharing rate, CMS will use the ACO's quality performance score to determine shared savings rate and earned performance payment.
- ACOs must report the APM Performance Pathway annually which assesses ACOs quality performance on the CAHPS for MIPs patient experience survey, two claims based outcome measures focused on readmissions and admissions for patients multiple chronic conditions; and either 3 all payer/patient eCQM/MIPS CQM measures or 10 CMS Web Interface measures (2024 last year for Web Interface reporting)
- Beginning with performance year 2023, implement a health equity adjustment of up to 10 bonus points to an ACO's quality performance category score when reporting all-payer measures based on (1) high quality measure performance and (2) providing care for a higher proportion of underserved beneficiaries (based on ADI score; or enrollment in LIS or dual eligibility for Medicare and Medicaid).
  - This policy will only positively impact ACOs and not penalize them, and represents one of the first that promotes equity in a value-based care program, while simultaneously avoiding the pitfalls of other pay-for-equity type approaches.

Quality Reporting

- In order to meet the quality reporting requirements under the Shared Savings Program, ACOs must meet the requirements described below. Either:
  - Report the 10 CMS Web Interface measures and administer the CAHPS for MIPS Survey. CMS will automatically calculate and score the ACO on the 2 administrative claims-based measures included in the APP. OR
  - Report the 3 eCQMs/MIPS CQMs and administer the CAHPS for MIPS Survey. CMS will automatically calculate and score the ACO on the 2 administrative claims-based measures included in the APP.
- When an ACO aggregates its data for submission to CMS, if that ACO has an ACO participant TIN that is a Rural Health Center (RHC), the ACO's submission should include data from that ACO participant TIN as applicable based on the measure specifications and eligible and matched patients.
- MIPS payment adjustments do not apply to facility payments to RHCs. Clinicians providing items and services in RHCs will not be required to participate in MIPS or be subject to MIPS payment adjustments, including the APM Incentive Payment for clinicians attaining Qualified Provider (QP) status through their participation in an Advanced APM (including SSP ACOs).. However, if the clinicians practicing in RHCs bill services under the PFS and attain QP status, the APM Incentive payment may apply to those PFS services.

SSP and AIP Timeline

- **May 18, 2023 –** Phase 1 of the application for the Medicare Shared Savings Program opens
- **June 15, 2023** – Phase 1 of the application due to CMS
- **October 19, 2023** – Phase 2 of the application opens, which includes the AIP application
- **October 30, 2023** – Phase 2 of application due to CMS
- Additional SSP/AIP application information will be posted in early 2023 on the Application Types & Timeline webpage

Questions?