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RHCs & the Medicare Shared Savings Program - What You Need to Know Webinar

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SPEAKERS

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Dr. Clint MacKinney, Co-Principal Investigator at Rural Health Value

Moderators

Nathan Baugh, Executive Director @NARHC

Sarah Hohman, Director of Government Affairs @ NARHC

Sarah Hohman 00:07

Hello everyone, thank you so much for joining us today we will give everyone just a minute or two to hop on and then we will start the formal presentation. Hello everyone, thank you so much for joining us. My name is Sarah Holman. I'm the director of government affairs for the National Association of rural health clinics and together with Nathan bond, Marcus executive director will be moderating today's webinar. Today's topic is Rh C's and the Medicare Shared Savings Program. Before we get the first question, I just want to let folks know that as soon as we start the presentation, I'm going to send the link to slides and where you can find the recording tomorrow in the chat, so just bear with me for a second. This webinar series is sponsored by hearses Federal Office of Rural Health Policy or Fr. HB and done in conjunction with us here at narc. We're supported by a cooperative agreement as you can see on your screen through the Federal Office of Rural Health Policy that allows us to bring you these webinars free of charge. We ask that you help us spread the word about these free webinars by encouraging anyone who may benefit from this free technical assistance and RHC specific information to sign up to receive our emails about about these offerings. You can submit questions through the q&a feature of zoom. In today's presentation, we ask that as much as possible you hold your questions until we get to the q&a section. In the event that your question is is answered by one of our speakers today during the presentation. As with all webinars, we're at the mercy of good bandwidth for all parties. And as we know, connectivity can go up and down. If you have any audio or visual freezes, please feel free to leave the webinar hop right back in. But if all else fails, like I said, this will be posted tomorrow, the recording on our website, and I will put the link to those slides in the chat in just a minute. And with that, I'm pleased to introduce today's speakers. Dr. Doug Jacobs is the chief transformation officer at the Center for Medicare within CMS. And Dr. Clint McKinney is a co Principal Investigator at Rural Health value. Thank you both for being here and for your time. And I will now turn it over to you to begin today's formal presentation.

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Dr. Clint MacKinney 04:09

Great. Well, thank you very much. Let me kind of get everything arranged here. And we will get started just a second. There, I think we're set up does that all look good to somebody who can say yes, on the on the call.

Sarah Hohman 04:33

Yeah, that looks good. If you can just click got it on your on that one screen. It's blocking a little bit of your presentation from there we go. There we go. Yep. All

Dr. Clint MacKinney 04:44

right. Perfect. Thank you very much. And welcome, everyone. I'm Clinton McKenney from rural health value. And I've been asked to start this off by Sarah and Lindsey by talking just a little bit about some basics level setting I think around value based care you and the role that rural health clinics can play in this transition that we're going through right now. So let me tell you first a little bit about rural health value. This is a team that is comprised of folks from the University of Iowa Rubery, in particular at University of Iowa and Stratis. Health Stratos is the QIO for Minnesota. And we form together a team or have a team that's been funded by Fr HP over the past decade. To facilitate this volume to value transformation in rural places, or rural providers and rural communities. I listed some of our charges there, we've been developing tools and resources to aid in this transition, we comment about policy, we try to identify best practices around value in rural health care, we also have been writing technical assistance. And if you're interested in some of the work that we've been doing, you can look at our webpage there at row health value.org. Now I like starting off conversations about value and value based care with the triple aim. Admittedly, it really appeals to me, I think if you sat down with a friend of yours, or a family member over a beer or a glass of wine, and you talk about healthcare, they're going to say that, you know, if I enter the healthcare system, I expect to be made better. And I expect to be treated with compassion, and with empathy during the time when I might be frightened, or confused.

Sarah Hohman 06:29

Hey, Clint, I hate to interrupt you for just a second. But um, can you stop sharing and try to reshare we see like your presenter mode right now.

Nathan Baugh 06:38

Yeah, it should be you hit the three dots.

Dr. Clint MacKinney 06:41

Let me thanks very much for telling me the three dots.

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Nathan Baugh 06:44

They're like bottom right. Should be in presenter mode. There we go. Or hide Presenter View. Better? Yes, that's perfect.

Dr. Clint MacKinney 07:00

Okay, good. Yeah, no, thank you very much for telling me. So, um, I was talking about the triple aim. And that people, I think most of us kind of expect that from the health care system, that we're made better that we improve the health of our community members, and our family members. And that also, we work hard for our tax dollars and work hard for the money we spend on insurance premiums. So we should be paid we should be, have our money used wisely. And then from a healthcare provider, or healthcare organization perspective, kind of keep asking, shouldn't we be paid for what our patients and communities deserve. And lastly, especially after the tragedies, both for our for our nation, and for our health care providers around the COVID pandemic, we should be considering the Quadruple Aim, which speaks to the satisfaction that professionals should get from the work that they spend. So that leads directly into something that I started talking about back in the early 2000s 2006. Specifically, and I was asked to speak about why the government was messing with my health care and as a group of a group of hospitals and physicians. And I kind of came up with the idea that that really, I think payers and the government are messing in health care, because we're not delivering on the value we're not we all know we're capable of, we know our quality could be better, we know that the patient experience could be better. And we know that we're by far the most costly healthcare system in the country in the world. And then, a few short years later, Don Berwick and his colleagues came out with the triple aim, which was very affirming for me, because it spoke to exactly what I've been thinking but probably not articulating quite as well as they did. So where are we really today? Today, we're in a fee for service world or fee for service predominated world in health care, which fee for service pays for each unit of service, whether that unit of service is a CAT scan, or an office visit, or a lab test or a hospitalization, that's fee for service, it's paying for a unit of service. Now it's not all bad. It rewards industriousness, it can reward efficiency. But I'm also argue that it contributes to the high cost of health care and, and I also don't think that it really helps professional satisfaction. I don't hear anyone that's really saying, I really like being asked to see 25 or 30 patients in my office every day. So the alternative or the future that I think is coming is value based care, which requires these requires team based care. It tends to reward better care and efficiency, like fee for service rewards efficiency. I think getting it can increase quality. We're going to talk in a little bit about ACOs. And there's really good evidence that participation in ACO increases quality. The the jury's still out and whether it reduces costs. Early early evidence suggests that it does or at least at least somewhat But I also think there's great opportunity to improve professional satisfaction in value based care. So what is this? When I talk about value based care? What am I actually talking about? Well, it's it's healthcare that prioritizes, high quality, person centered and efficient care, it does not prioritize a volume of services provided. And that's kind of the key differential. It's always a little odd when something's defined by what it's not. But often, value based care is defined as not being fee for service or not being defined by a volume of services. It absolutely requires robust primary care, that's an essential ingredient in value based care, as in what we call the person centered health home, previously known as patient centered medical homes. And this is the kind of care that are delivered in RH C's. So our C's are very well positioned to participate in a very real way in value based care. Now, as I talked

about value based care, I have to kind of shift pretty quickly to financing and to payment. And it seems like even though I want to talk about what care is delivered, when I'm talking to healthcare policymakers, or I'm talking to hospital CEOs, or CFOs, I need to shift gears and talk about finance. And whether we kind of like it or not, how we deliver care depends, at least in good part on how we're paid for care. And healthcare reform is starting to change both the payment and the delivery of health care. And it's this payment that's providing the fuel for our volume to value transition. If it weren't there, it ain't going to happen. And only until we start to see the payment shifting, are we starting to see the care shifting from a volume based perspective to a value based perspective. So what is value based payment, as opposed to value based care? Well, it's payment for one or more parts of the triple aim, better patient care, improve community health, and smarter spending. Again, it's not a payment for a service, it's not fee for service. But to be able to receive a Value Based Payment did deliver value based care. And that's kind of key. Now, again, I commented that it pains me a little bit to be able to have to discuss payment, not just the care, because I'm even though all of you on the call really don't know this, my career has been as a rural family physician, and I spent 40 years in healthcare, and I'm very honored to come from that heritage, but are beginning to learn that money is a is a currency or a medium of exchange. And I've become somewhat interested in behavioral economics and behavioral economics. And in fact, economics in particular, I guess, is really all about incentives, and incentives drive drive behaviors. Now, of course, of course, we all on this, on this meeting, understand that not all fun, incentives are financial. But that doesn't make finance unimportant. So my argument around supporting value based care and value based payments, let's incentivize the triple aim, make it easy to do the right thing. Now, we can think of payment as a continuum from a volume based over on the left side of your screen, which includes fee for service to pure value based on the right side of the screen, which would be kind of total cost of care. Now there's lots of iterations permutations between there. And that's where we're kind of experimenting. Now with With few exceptions, we're kind of still on the left side of this continuum. And what I like to do, as an example, around value based care, I like to talk about shared savings plans if I could. Now sharing savings plans are probably best known as accountable care organizations, or ACOs. So they are the the the engine, the organization that is involved in shared savings plans. Now what that is, is a group of providers, a group of healthcare organizations, and it's generally physicians and hospitals, but not necessarily exclusively, so that receive financial rewards for improving the quality of care for a group of patients, while reducing the cost of care for those patients. That's kind of the key. So you've got two priorities. Here, we have improving quality, and reducing costs. Those are two priorities. When these two, these organizations come together to form a new organization called an accountable care organization. Now, we're probably most familiar with accountable care organizations in the Medicare program called the Medicare Shared Savings Program. But that's certainly not the only ACOs in the country. In fact, here's some value based payment by the by the numbers, we've got lots of models and programs going on. And just as an aside, when we talk about models, we're talking about time limited demonstrations. And when we're talking about programs, we're talking about programs that are ensconced in law, so they're actually they're not time limited, they're in their law. So some of the models are included. Primary Care capitation some of you may be familiar with a primary care first model. Also another model that's being tested right now as rural hospital global budgets that's going on in Pennsylvania right now. But ACOs, or shared savings plan programs or systems are by far the most prevalent. Right now there's 938 ACO is operating in the country, enrolling about 10% of the population, which is really significant. And if we look just at Medicare 438, Medicare ACOs, called a Shared Savings Program, with with greater than 11 million beneficiaries right now. And it's important to kind of pay

attention to what CMS and Medicare are doing. They're not testing the old way of delivering care and paying and paying providers, they're testing new ways, often value based ways. And they're saying now in our last strategy, or as last strategy refreshed from CMMI, that all providers should be accountable to quality and, and cost by 2030. So so that's a significant stake in the sand. And we need to pay attention to what one of our most important payers is doing, and that's Medicare, and also Medicaid. Now, I want to talk a little bit more about how ACOs work, and I'm going to use the Medicare Shared Savings Plan as as an example. Now, what happens in the Medicare Shared Savings Program is Medicare CMS calculates a budget for an individual beneficiary, and they calculate both Part A and Part B. Part D is not included in the Medicare Shared Savings Program, but they calculate a budget for that for an individual beneficiary. That's predicated on past past expenses, trended forward with medical economic indices and, and other factors. So once we know we have a budget for an individual enrollee, obviously that particular budget will be rolled up to all the enrollees, beneficiaries that we have in our ACO, let's just say that's 1000, or something like that. So we'd have a budget of 1 million plus that we are working with. And that with that said at the beginning of the year, then through the year through the year, we apply what I called here in this slide ACO programs, they're programs designed or policies designed to reduce costs, while improving quality, they might be care coordination, they might be managing referrals to so they go to high quality specialists, it might be reducing, reducing duplication of services or testing, it may be ensuring that patients actually are able to attend their appointments, making sure that there's good follow up after they're in the hospitals, there isn't medication errors. So we we apply those kinds of processes to improve quality, and hopefully reduce cost. And then we'd look at how much actually Part A and Part B spent on our patients over the year. And all this year, you're still doing all your coding, you're still doing all your claims, you're doing everything like you had done previously. But at the end, all the costs from part A and part B are tallied up whether or not they incur in your clinic, whether they occur in the hospital, or whether they occur in Florida or Texas or wherever your snowbirds from Wisconsin and Minnesota are going it's all totaled up and then we get another number. And in this particular example, CMS calculates that our enrollees only spent 12,000 per beneficiary. So you see that there is a $500 differential so So CMS just saved $500 on our particular ACO enrollee. So now we're going to get to share in those savings. So if if you provide perfect quality, perfect quality, and these are outpatient measures, I won't go into details about that. But if you provide perfect quality, Medicare sharing around 50% of that safety, so you will actually get a check sometime after the year for that $250 For each one of your each one your patients. Now, if your quality isn't quite perfect, there will be a decrease in that down to let's in this particular example $200. So you still you get a check for $200, kind of at the end of that time. So you can see, as a friend of mine once said, The house always wins. Medicare wins on this. But nonetheless, you're being rewarded for providing quality and reducing costs to Medicare. That's how the ACO financing works. So our goal as an ACO is to receive a share of those cost savings. What's it require first outpatient care performance again, that's why it's important that we're talking today primarily as rural health clinics. Outpatient Care performance is key. Primary care visit, attribution is key. So we need to have our patients attributed to us. By seeing them with by our primary care providers, we need to be able to understand how we manage the health of our population, we need to understand financial risk. And I keep saying again and repeating myself robust primary care as what's be seen in a person centered health home or patient centered medical home. It's still fee for service, though, that's key here. So we're not really to pure value based care or simply sharing and savings that we've generated. Unless you think this is something that's only happening in big cities. Not true, as you can see on this, on this map, there's significant rural participation. Now, part of the reason why they're significant rural participation is

through ACO aggregators. These are generally national or maybe regional in scope, that pull together healthcare providers into an ACO or multiple ACOs. To do a couple of things. They tend to aggregate investment costs, savings, distribution, performance metrics, they kind of do all that for you. But those may differ from Medicare. They also provide an economy of scale that often individual clinics or individual local health systems can't provide. I give a couple examples here in a national scale. signifie health is quite prominent, especially in a rural space. Alidade works with primary care clinics, regional Illinois, rural community care organization run by Pat scowl in Illinois, and Prairie health ventures and in Midwestern states, Nebraska, Iowa. So these are these are examples of aggregators, where we're pulling together different providers to actually serve as as an ACO. Now, let me kind of do a little bit of kind of looking to the future with you as we wrap up, I think that we're going to see a gradual devaluation of fee service fee for service. We already see people in policy talking about wanting to increase sequestration. We've heard about that. So for those of you who work in in critical access hospitals, you know, that we're not really getting 100% cost based reimbursement plus 1%, we're actually getting cost based reimbursement minus 1%. And that's only for allowable charges. Because of cost based reimbursement, we can see changes to our Ayar overtime. Well, I think most people aren't predicting dramatic increases in revenue from either the government payers or from the commercial payers. We're going to see increasing payment change to delivering better care, improved health and smarter spending, that's value based care, we're seeing a shift that way it's going to the shift is going to require and reward, strong primary care participation. And I think it's also going to provide something a little bit less tangible. But I think just as important, all of us, I think many of us went into health care as a calling. We feel a duty to our patients and our communities. And we've been fighting even though we may not know it, we've been fighting a payment system that doesn't reward the activity that we know as important. That's our health care mission as healers. We're healers on this on this call. And here's an opportunity for us to start thinking about more liberally unshackled to think about how we can start delivering on our mission without kind of the fetters, of the fetters of, of financial constraints. And here's the reason why. I think what we're shooting for here with the movement from fee for service to value based care is healthy, our ACS and rural communities where we were places where our kids can go grow up and and be well educated, where our workers are productive, and our elder citizens can retire with a safety and security. Thank you very much. And Sara, turn it back over to you.

Sarah Hohman 24:04

Thank you so much, Dr. McKinney. And I will immediately pan over to Dr. Jacobs.

Dr. Doug Jacobs 24:12

Great. Thank you so much. Thank you so much, Sarah. And thank you so much Dr. McKinney really appreciated the presentation. And so now we're going to dive a little bit deeper into the Medicare Shared Savings Program. And just as just as a quick reminder, I'm I'm I work at the Center for Medicare, which is part of the Center for Medicare and Medicaid Services, CMS. My backgrounds and I'm actually an internal medicine physician and primary care doctor and I still see patients. So I certainly get the perspective and especially the value that our agencies bring to the delivery of primary care, particularly the delivery of primary care in rural areas. So it's really an honor to be with you all today. Um, all right, so let's let's dive in. Just a quick disclaimer before we start the what I'm going to be showing you, if you

want additional details, to really check out the regulations online, which which go into a lot of depth, but this is for education purposes. Excellent. So we're gonna start with just a little bit of a deeper dive into the Shared Savings Program and what it means. And I think Dr. McKinney does a good job of describing how the payment mechanisms work. I'll provide a little bit more detail there. But we're really excited about a lot of the changes that that we finalize now starting in 2024. And so we're gonna dive a little bit deeper there. Some of the slides are somewhat detailed in their descriptions, headsets so that you all have a reference. But I'll try to make make things understandable and support as much as I can on this webinar. Next slide. Alright, so first, the Shared Savings Program Overview. The Shared Savings Program is a program. So as Dr. McKinney said it's in legislation. It exists in perpetuity. And it's a voluntary program that encourages groups of doctors, hospitals and other health care providers to come together as ACOs. It's an alternative payment model that's a type of value is sometimes a value based care model is is oftentimes referred to as an alternative payment model as an alternative to fee for service that promote accountability for the patient population for total cost and quality of care allows for better coordination of items and services for those traditional Medicare beneficiaries, and encourages investment in high quality and efficient services. Important to note that an ACO doesn't limit what doctors beneficiaries can see, doesn't require pre approval to see certain certain doctors or other clinicians. And so beneficiaries retain all their traditional Medicare benefits. Next slide. And as Dr. McKinney mentioned, the accountable care organization continues to receive traditional Medicare fee for service payments with that retrospective reconciliation at the end of the year. So and we'll go over how that works. Again, the ACO is that successfully meet those quality and savings targets sharing the percentage of savings with Medicare. And that depending on the level that the ACO is participating in, they also might be required to share in some losses or risk. And we'll we'll go over exactly what that means. ACOs report via quality performance pathway called the alternative payment model performance pathway. I know that's, that's somewhat of a mouthful. But that's basically to see is the ACO providing high quality care, and if so they can share in their full amount of shared savings. And all data on ACOs is publicly reported every year that we get that data on data.cms.gov. So I wanted to start with a map here also. This is to say that ACOs, and people who see providers are a part of ACOs. It exists all over our country. We and including in rural areas. Part of our goal going forward by 2030, as Dr. McKinney said is to get 100% of traditional Medicare beneficiaries in an accountable care relationship with their provider. And so that means some of the rural areas that aren't participating as ACOs are trying to institute new policies to really drive participation, and also in other underserved areas as well. Next slide. And all that data that's public and online. We just want to call out a few things here. So we have the performance data, most recently from 2021. We've seen high quality, performance results over time, and higher quality performance over time and physician groups that aren't participating as ACOs. We've also seen the relative amount of shared savings grow over time too. That means both Medicare and ACOs are having an increased amount of shared savings. We've seen the total amount of assigned beneficiaries to ACOs relatively plateau over the past five or so years. And so part of the proposals that we're going to talk about today that we finalized, that's really trying to grow enrollment in ACS and this was particularly talked about So what that means for Rh C's looks like. And so we wanted to especially call out how RHC participation has changed over time. We've seen first that that FQHCs have have definitely increased their participation with 4409 in 2023, up from 3708, but also, the rural health clinics, we've seen in 2022, we had 352, freestanding, our ACS participates. Now, that went up to 666 in 2023. And then provider based our ACS, we've seen in 2022, there's 1291, and strong growth in 2023, to 1574. So we're really encouraged by this increase in both FQHC and RHC participation as accountable care organizations. And

we think that this is really a success to build on top of, and we'll be talking about some of this proposal soon. Okay, excellent. Okay, so now, you might be thinking to yourself, well, this is all fine and good. But we want to know exactly why as it is, we should think about participating, or what does this all mean, for our ACs? So, first one is start with the assignment methodology. And the assignment methodology is how we figure out in Medicare, whether a patient is assigned to a specific clinic as their primary source of care. And so the way we do this is we look at the total plurality of an individual's primary care services. And as the question where are they getting the majority of those primary care services. And what we've done over time is that for FQHCs, and our HCS, we say that any claim that comes from an FQHC or RHC counts as a primary care service performed by a primary care, clinician, and so so that that basically counts in the assignment to RH C's as part of an ACO. And the reason why that's also important is that when a person is assigned to the RHC, as part of the ACO, that means that they're they then become accountable for the total cost and quality of that person. And, and that that goes into the benchmark calculation as well. Next slide. Okay, so how does this model work? And so this is gonna look similar to what Dr. McKinney showed, it's a little bit more operational. So the the ACO takes is a group of providers that are coming together, and they're taking care of this population. And every year, we set what we call this financial benchmark. And the financial benchmark is basically the total expected cost to take care of that population. And over time, the ACO continues to build Medicare, the claims just just like before, and that included in that on both the financial benchmark calculation and also the builds claims, and includes the all inclusive rate. And then at the end of the year, we look at that difference. It's actually Kenny shows something very similar. And that's the Shared Savings pool. And so you might be asking yourself, okay, well, how much of that shared savings pool goes to me if I become an ACO compared to Medicare, on and basically a couple of things. One is, if you, you have to provide high quality care, so we've measured quality, and the second piece is ACOs have the option to participate at different levels. And so what level the ACO participates at, will determine the relative percentage of shared savings they would get, but also if they would be responsible for shared losses. If those if the total cost of the care for the population retreating goes, it goes above that benchmark. And that's exactly what this is. Okay. Next, next slide. So, we wanted to call out what this means to participate at different levels. Starting at the left side, basically, from ABCDE to the enhanced tracks, you get to higher levels of both risk and reward. So some downside risk starts in Level C, but then the downside risk becomes more but also the potential for shared savings increases as well. levels A through levels e are called the basic track. And the enhanced track is a higher level of risk after that. And so when ACOs join, they can decide to join at any level of participation. Okay, next slide. Okay, so now we're getting into some of the changes that we finalized. And many of these changes are starting 20 in the in 2024. This is from the calendar year 2023, Physician Fee Schedule rule. This is a rule that Medicare comes out with every single year. And it really provides updates for our payment programs. And this last year's rule, finalized for this year includes many changes to the Medicare Shared Savings Program. So we encourage you to take a look at the rule online, it's linked to in the slides. But we also have a fact sheet on the changes in the Medicare Shared Savings Program, in particular that are good to dive into if you want some additional detail. This is also just to call out before I go into these changes that more information on how to apply for this for January 1 2024 Start date will become available on the Shared Savings Program website in spring of this year. And we also have a email inbox that we're providing for you here as well. In case you have any questions, don't hesitate to reach out and ask us questions, especially if we can't get to everything today. Okay, so the goals of some of these changes were to increase the percentage of people in Medicare, that that are going to the provider that is in an accountable care arrangement. That's part of that overarching goal to

get everyone in traditional Medicare in an accountable care related arrangement by 2030. But we also want to encourage participation of new ACOs. And also encourage those ACOs that have already joined the program that they stay in the program to and continue to provide high quality and cost effective care. We also are thinking about how we can promote health equity as part of the Accountable Care Organization model. And we'll get into some how some of the changes might do that. And especially important, particularly important for the conversation today is that we want to better support providers seeing both rural communities and other underserved communities as well. Excellent. Okay, so the first change that we're excited about to talk to you all, is what we're calling advanced investment payments. And so this is an option for new low revenue ACOs. Joining the basic tracks, remember, basic track was level eight through Level II. And what we mean by low revenue is it typically means smaller ACOs tend to be provider based. But also if they include rural hospitals, those oftentimes qualify as low revenue ACOs. So the idea here is to encourage healthcare providers in rural and underserved areas to join as ACOs. And so these the advanced investment payments are these advanced payments, that ACOs would get on and these new ACOs will be able to invest in, in building infrastructure that that the ACO needs to better perform on this, this idea of accountable holistic care, and that includes addressing the social needs of people with Medicare. So there are three buckets that eligible ACOs could use these advanced investment payments for. The first is provider infrastructures. So for example, maybe the ACO wants to invest in one of those new data systems to better connect the health clinic with local community based organizations and figured out when the patient actually goes to see that food bank. Number Number two, increased staffing. We've we've heard a lot of the staffing challenges our country. So an ACO could use these these funds to hire new community health workers, new behavioral health clinicians, new care coordinators. So increased staffing was in seventh bucket. And also this idea of providing Accountable Care for underserved beneficiaries, which can include addressing social determinants of health. And so this is one of the first times that we're saying that payments are eligible to address social needs, in particular, within the traditional miniature programs. Next slide. Okay, so what do these payments look like? Well, there are one time upfront payments of $250,000, that the new ACOs will get upon signing. And then additional quarterly payments up to two years. ACOs are treating underserved populations, which we're measuring as part of the area deprivation index, which is a measure of neighborhood level deprivation and rural areas tend to have higher levels of area deprivation index scores. We're also measuring in for those individuals who have are receiving low income subsidies for Medicare Part D, and also dual eligibility status. So ACOs that are serving these populations. And we think that the populations that are he served, we'll we'll certainly qualify as underserved. In many, many cases, the ACO can get up to $45 per beneficiary per month to create some of the health care transformation to succeed and accountable care. There'll be a 10,000 beneficiary cap for these quarterly payments. And then advanced investment payments would be recouped from the Earn shared savings at the end of the current and subsequent repayment period. And that's only if the ACO is actually achieving shared savings. I know that was a lot to take in. So let me demonstrate on the diagram that I use for for what this will actually mean and look like. Next slide. Okay, so remember, we had our ACO is treating a population, and over time that they're continuing to build Medicare. So the difference here is that we're seeing upfront C, and we're demonstrating it, but with the blue dollar sign, the ACO can create these investments, maybe hire a community health worker, maybe a partnership with a local community based organization to address food insecurity. So at the end of the year, say they make $3 signs or the Shared Savings pool is $3. Signs. And so how does that your savings then get split up? So with the advance investment payment, what we're saying is that, okay, Medicare first recoup set blue dollar signs. And then the remainder is split

between Medicare and the ACO just like it was before. So you can kind of think of the advance investment payments as this interest free loan. And were you paid back to, to Medicare at the end of an agreement at the end of the end of the year, if only if and only if you're achieving shared savings. And so that's that's how the advanced investment payments are working. So this, this will occur for one agreement period or a second agreement period, if there's still a balance with these advanced investment payments. Okay, next slide. And actually, before I get to this, I just wanted to also say that the advanced investment payments, were specifically being responsive to providers in rural and other underserved areas that have told us that they need some upfront ability to make these investments so that they succeed can succeed in value based care. So we're pretty excited about that. All right, sorry, I just want to make that last point before I move on to then see the next change. So the second change is we've also heard from stakeholders that there is this reticence to adopt downside risk. And that oftentimes, providers need more time in an upside only risk model, before they transition and are comfortable transitioning to downside risk. So starting January 1 2024, ACOs, that are inexperienced with performance ratio based risk, will be allowed to participate in a one five year agreement under one sided shared savings model only. And then for beginning January 1 2024. And in subsequent years, on participation in the enhanced track that remember that the highest level of shared savings and shared risks will be optional for ACOs. So we're trying to be responsive to those ACOs especially that are treating rural and under other underserved areas that folks just need more time is an upside only model. Next slide. Okay, I know there's a lot of text on the slide. And part of that so that you can look look at them later. But we wanted to go over some of the ways that we're strengthening financial incentives to participate in the model more broadly as well. A lot of this has to do with that benchmark the number on the model that I showed earlier. There's that financial benchmark which that expected cost of to take care of that population that is assigned to the ACO. So I'm starting here in January 1 2024. And then in subsequent years, we have a bevy of policies that were really trying to drive participation by ACOs calm to make it more financially advantageous to participate. So that both ACO and Medicare can succeed and in providing high quality and cost effective care. So okay, so the first, this is the second bullet here. One of the things that we've done is we've modified the methodology for, for calculating this benchmark. And it used to be that it was all based on historical benchmarks. And what we've done this year is that we've taken a third of the benchmark, and made it more of a project projection going forward. And we think that over time, this will make it more more enticing for more providers to participate and succeed. And another thing that we've done too, you might have heard that a problem that has been in the program historically, are the problem from a product providers perspective, as they've told it to us, is something called the ratchet effect, which is where, because this benchmark is based on a historical look at the past three years of of the total cost of care of spending. providers that are successful in lowering that total cost of care, have described to us that it didn't get penalized going forward. Because there are five overall financial benchmarks, calculations lower. And so the way that we've addressed this, in this, this rule, that we're incorporating what we're calling a prior savings adjustment in the historical benchmarks. So if the ACO succeeded in creating savings in previous years, we're accounting for that in the benchmark calculation. We're also modifying the basically, because we the way that we calculate this historic benchmark, it incorporates both the the ACOs. The regional spending, and, and the National spending overall, what happens is when an ACO is comparing their own spending, to the region's spending ratios that are less efficient, there's less of an incentive to participate. So we're basically modifying this negative regional adjustment to make it that even less efficient ACOs perhaps serving more complex populations can also participate and succeed in the model. We've lastly, we've done we've

created some changes to improve the risk adjustment methodology in the Shared Savings Program, looking at the way that we've applied certain risk adjustment caps, the the end effect of that is that ACOs that are treating more high risk populations, like dual eligibles, and stage renal disease patients, that they their overall risk or caps would would be a little bit higher with these changes. And so I wanted to demonstrate this to you. Just Just a quick visual demonstration. Do you mind going to the next slide on this one? Perfect. So we mentioned that in ACO signs and agreement with Medicare for five years, and sometimes that's, that's called the performance here. So you can see here if an ACO signs signs up with with CMS starting in January 1 2024. They would be with us from 2020 420-520-2627 and 28. And the way that we calculate those benchmarks is that we have the three year look back. So those three years have sometimes referred to as benchmark years. And and that that is what I was talking about on the previous slide, in terms of the overall formation of of the financial benchmark. Next slide. Okay, so how do these expenditure calculations work? And we look at ACO per capita expenditures that are a key element of the program's financial model. So CMS uses the same methodology to calculate total per capita Medicare Parts A and Part B. expenditures for benchmark years and performance. Here's specifically for our HCS the air payments are included in the Shared Savings Program benchmark calculations in the performance your calculations, and in this national regional trends and update factor calculations so on. And so including both the air payments in both the benchmarks and performance your calculations allows for some symmetry when financial comparisons are made. And so changes in air payments that occurred between the benchmark and performance here are also reflected and accounted for and changes when we look at the national and regional update factors in the benchmarks. So we have additional information on this that we've linked in the slides, if you want to dive into that deeper. Okay, so just just to reiterate, so we have this historical benchmark that is calculated, and it's based on those three years of historical data. And it accounts for those those changes in the sign beneficiary health status. And then we trend forward for that year, using a blend of the national regional growth rates and at the end of the year, then we perform that look back. And, and so we're starting next year, we're incorporating some of those changes that we described, including that that new projection called the accountable care perspective trend, or a CPT. Next slide. Okay, the last few slides focus on the quality performance, how do we calculate quality. And so ACOs in general, just a reminder that ACOs that provide high quality care will be eligible to receive their full shared savings amount, and performing high performing and giving higher quality care, you can achieve more shared savings, so called issue ACOs should care about their both their quality score and what's happening with the overall total cost of care, just like Dr. McKinney said. And so specifically some of the changes that we've made in this year for starting 2023, and will continue in 2024, related to what we're calling the health equity adjustment. So ACOs that are treating high percentage of individuals who are residing in areas with high area deprivation index index indices, high amount of dually eligible patients, or high amount of patients that are receiving low income subsidies for Medicare Part D, are eligible for these extra bonus reward points to their quality score is they're also providing high quality care to that population. So this will only positively impact ACOs, because it's only a reward factor. And this, this represents one of the first policies in a value based care arrangement that will explicitly promote equity, while simultaneously avoiding pitfalls of other pay for equity type approaches, we're not risk adjusting away disparities. We're not sitting lower standards to treat underserved populations, we're saying, Hey, if you treat an underserved population, and a rural population being one of them's that you're eligible for this, this health equity adjustment. Okay, next slide. And particular some things to note for for RHC. So RFCs, if you join as an ACO, you'll need to report certain quality measures that ACOs are responsible for, for reporting. Those,

those quality measures are what we judged in determining the relative amount of shared savings that the RSP as part of an ACO we get. And when I also I also wanted to mention that for RSUs, in general, they aren't eligible for receiving the MIPS payment adjustment either up or down. But they would be eligible for receiving all of these shared savings, of course. So I think that that that's the main point that I wanted to make here. And the slide has other additional information in case you want to reference it. Next slide. Okay, so some dates to look out for starting May 18. That's when phase one of the application for the Medicare Shared Savings Program begins. We'll be including information related to the advanced investment payments that people can review as part of that June 15. That's phase one of the applications due to CMS October 19. That's when phase two of the application opens. October 30, is when phase two the application is due. And then that would be for starting in January 1 of 2024. So keep an eye on our web page. We're going to be posting additional information as they described about the advanced investment payments. Excellent. So I know we went over a lot. Hopefully we have some time for questions. We really appreciate the opportunity to talk with you all today. And excited for the discussion. Thank you so much.

Nathan Baugh 55:10

Excellent. Thank you Dr. Jacobs and Dr. McKinney. So now I'll go ahead and enter your questions into the q&a box, folks. And we'll try to get through as many as we can. I believe we have this scheduled to 415. Eastern. That's right, sir. Yep, that's right. So we'll have a hard stop at 415. Dr. McKinney Dr. Jacobs. I assume that's okay with you guys.

Dr. Clint MacKinney 55:35

Yes. Yep. All right. So

Nathan Baugh 55:41

I'm going to break my rule here, even though I asked for folks to hold questions. And ask one from Alicia, Alicia here. And Rec design decides to join an ACO is there a contract? And if so, for how many years?

Dr. Doug Jacobs 55:59

Yep. So I can take that. So, yes, there's a there's an agreement. And it would be for five years. So when I when I showed that slide, with all the performance years, there's there's five performance years involved in that, at the end of five years an ACO can decide to sign another agreement with with Medicare, which is, which is another five years ACOs can also decide to early renew with us as well.

Nathan Baugh 56:29

And to be clear, that's the Medicare Shared Savings Program. ACOs. Right. Dr. Jacobs?

Dr. Doug Jacobs 56:35

Oh, correct. Yes. Sorry. And everything that I went over today is related to the Medicare Shared Savings Program. ACOs. Yeah, that's a good term. Thank you.

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Nathan Baugh 56:44

Yeah. And we have some questions about some of the other models, not the programs. So let's just, we'll be careful to try to distinguish between the two, as we go through here. Um, next question I want to ask is from John. He asks, Can independent REC is owned by a nurse practitioner with the MPs providing a majority of primary care participate in ACO? Like, if they're a heavy in P practice, does that impact their ability to participate in let's say, Medicare shared savings?

Dr. Doug Jacobs 57:25

I don't believe so. I don't believe it's a problem. But maybe we have some other program experts on on the line. I just want to make sure I'm not missing anything. Joe or Lucy, do you have any any thoughts on this one in particular?

Josef Otto 57:45

Maybe I can start and then others can jump in if they have additional information. But from I would agree that there isn't a limitation on ra T's that have particular ownership, be known by a nurse practitioner in being able to participate in the program. And then I would also just like to highlight that nurse practitioners, pas, clinical nurse specialists are also using our assignment methodology. So those beneficiaries that they would see would be assignable to the ACO. And as as Dr. Jacobs included, in one of the slides, it talks about assignment methodology specifically for RHC. And really how every service provided in an RFP is used for our assignment methodology. And let me just see if others have additional information they'd like to add. And again, that relates to the Medicare Shared Savings Program.

Timothy Jackson 58:45

I don't have anything else that that I was, was right on.

Nathan Baugh 58:49

Great. Just on that assignment methodology, when all RHC services are considered primary care for the purposes of attribution that I would assume that would include, like, even if the RHC is doing, for example, behavioral health, for purposes of MSSP accounts for attribution?

Josef Otto 59:17

I believe? That's correct. Yeah. It's all services provided by the FDA. Trc. Great and just for, and I would recommend that people that are more interested in learning about our assignment methodology do go to or what we call our specifications, and there's a hyperlink in the slide about our financial methodology that talks about how we assign beneficiaries ACOs and specifically to our keys.

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Nathan Baugh 59:49

Excellent. Um, next question. Would you mind covering some of the differences between Medicare Shared Savings Program and the other one that people have hurdle which is ACO reach, what would be the distinction or the main differences. So,

Dr. Doug Jacobs 1:00:11

there's a number of differences between the ACO reach and the Medicare Shared Savings Program. One is the level of risk and reward in ACO reach is certainly higher. That's something to pay attention to. There are other aspects of of ACO reach that are different include including some of the way that that risk adjustment is done in calculator over time. There's other changes that are that are different in some of the benchmark calculations. Some of the and some of there's some other requirements related to health equity. I think if you're if you're considering both of them, definitely take a more detailed look at the some of the information online because that's going to be a more detailed determination as to whether or not you want to participate in one, one or the other. The ACL REACH program is run by our colleagues at the Center for Medicare and Medicaid Innovation, sometimes, sometimes just referred to as the Innovation Center. And they we've also come out with now a an ACO strategy, where we talk about how in the future, we're gonna work with the Innovation Center also to test new models on the Medicare Shared Savings Program as well, kind of on top of the Medicare Shared Savings Program to see if we can improve quality or reduce cost. And so it's it's part of our aligned way of thinking about driving participation in ACO is going forward. Because in that that way, if some of these new models would have improvements in quality or reduction in overall costs, we could incorporate them into the Medicare Shared Savings Program writ large. And in part, some of the changes that I talked about today, the advanced investment payments that actually grew out of an innovation center model are referred to as the ACO investment model. So anyway, it's just some additional color on on our ACO strategy going forward. There are two.

Nathan Baugh 1:02:24

Excellent, thank you. Next question from Brooke has actually two questions. First, she's wondering if that she says, Will there be a pandemic clause in the ACO contract? I'm interpreting that to mean, you know, in the base years, I might the pandemic impact that. And then she follows up and says that this model shows a lot of accountability on physicians, but no account be accountability for patients. Is there a way that the patients will be held accountable? Have you guys seen that and MSSP like a way to have the patience or kind of have patients be involved in accountability for their own health?

Dr. Doug Jacobs 1:03:10

Maybe we can start with the some of the pandemic policies. Joe, do you have any thoughts there? On the pandemic? Or came I see you on as well?

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Josef Otto 1:03:23

Yeah, I can get started. So we rely on a couple of things, and maybe to point out and so the first one, the point that would be we have an extreme and uncontrollable circumstances policy that has been in effect for several years, even prior to the pandemic. And for ACOs that are in two sided, you know, tracks. So that would be like the enhanced track level CD and he the basic track, that in any years that the COVID-19 public health emergency impacted performance, that would be for 2020 2021 2022 and at least part of 2023, then ACOs that are in that two sided model would have their shared losses, either totally reduced, or in 2023. Were potentially would be part of the year we'd have it reduced by the portion of months that they were impacted by the Ph. D. that extreme and uncontrollable circumstances policy applies to not only the Ph. D. But other disasters that could occur such as a hurricane could also reduce the potential losses that NACA would would have. Oh, the other thing that I would point out in our policies are related to the COVID-19 public health emergency we looked at how expenditures could be potentially impacted with providers within Accountable Care Organizations caring for many beneficiaries that may have COVID-19. So what we did Find through rulemaking is what we call a COVID-19 episode of care. So we would remove costs associated with that COVID-19 inpatient admission for the time that the patient was admitted, you know, every month that they were admitted. And then the month after they were discharged and remove those expenditures from the our expenditure calculations. And then moving forward when we're looking back in historical benchmark years. When we're calculating that historical benchmark, we would continue to remove those COVID-19 expenditures as long as that COVID As long as that episode of care occurred during the public health emergency. So those were are two things. There's other information online through COVID-19. Net FAQs, but those are the two I'd like to point out related to kind of our finance calculation, but I'm not sure Tim or others wanted to point out other things.

Timothy Jackson 1:05:58

Yeah, thanks, Joe. Yeah, very briefly. On the quality side, you know, we know that the impacts are different for different providers and different populations. And we recognize that, you know, not everybody is impacted the same extent. So to ensure there's relief available for the clinicians under that extreme and uncontrollable circumstances that Joe just referenced, we set what is effectively a quality floor so that they are not adversely impacted by things or circumstances out of their control, that they can't be accounted for, that may impact their quality performance, and lower them but below what they would have expected to otherwise. So what that really means we provide a little bit of protection, recognizing that, you know, patients and circumstances can challenge their performance in we want to make sure that as an ACO is serving his community and serving his patients, that they are not concerned that if the quality dips for any number of reasons, within that PHP that they have, they have the ability to focus on what they can affect. And we are trying to provide that relief saying this job reference, thanks so much.

Dr. Doug Jacobs 1:07:15

And I'll maybe just say briefly, on the patient accountability piece, I don't really think there's a mechanism in that shared savings program to, for example, penalized patients that aren't doing well with their care or something like that. I just more broadly, though, I think successful clinicians oftentimes

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engage patients in their care or figure out ways to engage patients in their care. And that can oftentimes be more challenging for patients with less resources or in communities with issues related to social determinants of health. And so part of what we're trying to do with some of these advanced investment payments, and allowing more supports for underserved beneficiaries, is it's really figured out that to unlock some of the potential that providers could have in partnership with other community based organizations or other entities to lower those barriers for patients to actually be engaged in their care. For example, maybe particularly in rural areas, transportation can oftentimes be an issue. Those payments can be used to address some of those barriers as well.

Nathan Baugh 1:08:22

Excellent, thank you. I'm going to skip around, I'm going to try to find some easier questions here. First, is, can a rural hospital with three RFCs be in an ACO by itself? And can you be in more than one Medicare Shared Savings Program at a time?

Dr. Doug Jacobs 1:08:45

He read that one more time, sorry,

Nathan Baugh 1:08:47

can a rural hospital with three RFCs being an ACO by itself? Does that sound like a reasonable size of an ACO? And then can you could you be in more than one Medicare Shared Savings Program at one time?

Dr. Doug Jacobs 1:09:05

So you can't be any more than what I can share? Oh, go ahead, Lucy. Sure.

Lucy Bertocci 1:09:10

I didn't take this one. And that's helpful. So So on the first question, rural hospital was three RTS, can it be an ACO by itself? And so the answer, and that sort of depends on whether all of those folks together meet the eligibility requirement. And for this one, in particular, they would need to meet the eligibility requirement to have 5000 assigned beneficiaries. So it sort of depends on how large are the entities are and how many beneficiaries they're seeing. On the second question, can you be in more than one? Like Shared Savings Program ACO? The answer to that one is no, you're also not able to be in like the ACO program that we run the shared savings program versus any of them run through the Innovation Center. No, you can only be in one ACO there as well, because we use we use the the claims history to figure out where beneficiaries should be assigned. And so they're required to be exclusive to a single ACO. Got it? Thank

Nathan Baugh 1:10:16

you. Next question from IV. I'm going to translate this a little bit or add some color here. She asked how a Medicare annual wellness exam should be paid in the ACO. And if we see non ACO patients, are we in

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the we are in the ACO? How do we get paid from from Medicare? So is there such a concept as an ACO, patient and a non ACO patient, if I've decided to participate in an ACO?

Timothy Jackson 1:10:51

I can also take this one. Go ahead. And so So basically all of these continue to be paid through fee for service participating in the program doesn't change any of the billing that happens sort of on the day to day basis. So you continue to get paid by Medicare for those patients.

Nathan Baugh 1:11:18

They hadn't checked real quick, sorry, for us, it wouldn't, we wouldn't be paid fee for service, we would be paid Ayar paid normally. Okay,

Timothy Jackson 1:11:27

that makes sense. Yeah, you continue to get paid normally. And this is true whether or not the beneficiary is assigned to an ACO or not you, you continue to be paid normally for all those beneficiaries. And then the Shared Savings determination comes in after the end of the performance year, but nothing sort of changes day to day in those operations.

Nathan Baugh 1:11:52

So is sorry, is there such a thing as like an ACL, if I've joined an ACL? Do I have non ACL patients and ACL patients,

Timothy Jackson 1:12:02

you might there may be there may be beneficiaries that you see that are not aligned to the ACO sort of depends on where else they're receiving care from. So it's certainly possible that once you join an ACO that you'll have, probably the majority of your beneficiaries will be be assigned to the ACO, but you may have some patients who are not, particularly if they're receiving a lot of their care from from other providers.

Dr. Clint MacKinney 1:12:34

This is Clint, I might add to that, that Medicare Advantage patients are not included in the ACO. So so take a look at your Medicare Advantage penetration in your area as well too, because they'll be excluded from this program. Okay,

Nathan Baugh 1:12:48

thank you. Dr. McKinney. Last question is about notification. Johnny Perkins says, I know we have to notify our Medicare beneficiaries when participating in an ACO. Recently, the regulations changed to notify flying them two times during our five year contract period, initially, and then following 180 days

after our initial contact. Are there specific questions we should ask when after we send our initial letter? I've not been able to find guidance. So maybe we could go ahead. Dr. Jacob. Sorry. No.

Dr. Doug Jacobs 1:13:31

This is an area where we recently made some changes as the question indicated. Lucy, did you want to fill in on this one too?

Timothy Jackson 1:13:40

Just Just to note that, I'm pretty sure there's guidance coming out pretty soon on this. We've received a lot of similar questions in terms of the specific change that we made for this year to scale back the number of notifications, and we're putting out guidance that should help answer these questions.

Dr. Doug Jacobs 1:14:00

And the stem of the question is right, though there's a initial, there's an initial contact, and then 180 days afterwards, like a follow up contact is to assess comprehension. But more information forthcoming there.

Nathan Baugh 1:14:16

Well, with that 415 On my, my clock here, so. So we'll turn it over to you to close it out. And also thank Dr. McKinney and Dr. Jacobs for participating. But sir, I'll let you do the honors.

Sarah Hohman 1:14:32

Thank you. Thank you, everyone for for sticking with us. And especially thank you to our our speakers and our additional panelists who jumped in for the questions as well. Also, thank you to Fr HP for sponsoring the Archie technical assistance webinar series. I put this information in the chat as well. We'd really encourage you to submit some additional ideas for webinar top Facts and presentation topics. You can email Nathan or I, our contact information is the chat is in the chat. Additionally, if there were questions that we weren't able to get to, given our time constraints, don't hesitate to reach out to to either of us. For CRTP, folks, the CEU code can be found at the completion of the webinar. When you complete a survey, you'll then get the code. As always, when we schedule our next webinar, we will send that out via email. So make sure you're signed up for our listserv and getting those emails. Thank you again for your participation and to our speakers. And that concludes today's presentation. Thanks, everyone.