

Primary
Care



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COMMON PRACTICE

Alphabet Soup of Value-Based Payment

Do you ever feel like this when you go to a meeting about practice change?

The speaker starts the meeting off with something like this: "Good day to all of you, grateful you could be here at the first joint meeting of the CIN and ACO. We will be discussing the great work being done by the PCC around NCQA and PQRS quality measures that will be reported out through MIPS and MACRA, as MU has been transformed into these programs. As we move into the APM due to the end of the SGR, we will be working through the PCC of the CIN to begin a PCMH with PCMN and PCSP components. This clinical transformation will give us the greatest opportunity to succeed in our effort to raise our HCC scores, which impact payment and M&M scores as we continue our journey into this world of value through our effort to improve our contracts with payers through the APM."

What?!? Most of you feel the acronym confusion! It has become really tough to understand all the language that is currently used to describe the transformation from volume to value payment. Here are a few definitions that may help you understand these terms:

ACO: Accountable Care Organization-Groups of doctors, hospitals and other health care providers who voluntarily come together to achieve the aim of value by providing coordinated, high-quality care to a population of Medicare patients. Value is defined as giving quality care while trying to contain excessive utilization. It requires us to give patients the right care through open access while avoiding care without proven benefit. The ACO draws our focus to the high-risk, high-cost patient. Many ACOs try to dissuade providers from using newly developed treatment options that may be less effective or have only marginally higher effectiveness versus time-honored and cheaper alternative choices. Cost-containing measures include generic utilization of pharmacy benefit and working with patients through conversation and population health to reduce ER utilization and hospital readmission.

CIN: Clinically Integrated Network-A collection of health care providers that enter into contracts with payers. The goal is to provide high quality care with reduction in excessive utilization due to integration. It is very similar to an ACO in concept and design. Most ACOs are contracts with

Medicare, but a CIN could have similar contracts with private payers, employers or government agencies. Once the CIN can demonstrate a value proposition, payers and large employers are approached to support the network and other incentives that are based on achieving defined results.

PCMH: Patient Centered Medical Home-A model of delivering and organizing care in a way that is comprehensive, patient-centered, and coordinated from an office-based clinic perspective. It focuses on quality, safety and access. This focus is on the whole person undergirds what the CIN and ACO world of value-based care is trying to obtain. It includes a system of care teams centered around the patient, who has unlimited access to providers. Because of the patient-care team relationship, comprehensive, coordinated care emerges, which brings value to the patient. These clinics are certified by NCQA and other agencies.

MACRA: The Medicare Access and CHIP Reauthorization Act replaced the SGR or sustainable growth rate, which changed the way in which Medicare reimburses providers.

QPP: The Quality Payment Program laid out under MACRA includes two tracks, APM (Advanced Payment Model) or MIPS.

MIPS: The Merit-based Incentive Payment System is one of the two tracks of the Quality Payment Program. It repackages parts of the Physician Quality Reporting System (PQRS) and Meaningful Use. The MIPS score is based on four measures: quality, cost, advancing care information and clinical practice improvement activities.

NCQA: The National Committee for Quality Assurance is a private, not-for-profit organization dedicated to improving health care quality by evaluating and reporting on the quality of managed care and other health care organizations in the United States. In addition to developing HEDIS® (Healthcare Effectiveness Data and Information Set) and maintaining and updating a database of HEDIS® results (known as Quality Compass®), NCQA uses an extensive process to accredit health plans (including preferred provider organizations) and other organizations. NCQA also has a certification program for physician organizations, disease management programs and other entities. In partnership with other organizations, NCQA runs several programs that identify and recognize physician practices that provide high-quality care in specific areas, such as diabetes, back pain and cardiovascular care, as well those that use systematic, patient-centered, coordinated care management processes.

HCC: Hierarchical Condition Category has drawn attention primarily from the growth of Medicare Advantage plans where payments are based on the Medicare beneficiaries' health status as expressed by the HCC. Nearly one-third of Medicare beneficiaries are members of these plans. The term "risk adjustment" describes what HCCs do. HCCs predict the health care resource consumption of individuals. HCC scores are used to adjust payments to a health plan based on the level of risk the beneficiary presents to a plan. Providers, by accurately and specifically coding, can

better align the HCC score to the level of sickness (i.e. riskiness) of the patient. HCCs adjust payments so that there is a higher reimbursement for sicker individuals.

Please use this guide to help you through the alphabet soup of value-based payment.

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