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Avera.org

March 2, 2017

Physician-Focused Payment Model Technical Advisory Committee
C/o U.S. DHHS Asst. Secretary for Planning and Evaluation Office of Health Policy
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Washington, D.C. 20201
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Letter of Intent – Avera Health, Intensive Care Management in Skilled Nursing Facilities Alternative Payment Model (ICM SNF APM)

Dear Committee Members,

On behalf of Avera Health, I would like to express intent to submit a Physician-Focused Payment Model for PTAC review on April 30, 2017.

Payment Model Overview: Residents in SNFs have complex care needs and their access to care is often delayed and fragmented. As a result, they experience higher readmission rates and avoidable transfers as compared to other patients. The Intensive Care Management in Skilled Nursing Facilities Alternative Payment Model (ICM SNF APM) leverages a board-certified geriatrician's expertise across geography, population, and clinical teams using an interactive telecommunications system (42 CFR 410.78) for encounters. The model requires participating organizations to provide a comprehensive multidisciplinary geriatric program which includes: geriatrician-led intensive care management team, transitional care support, immediate 24/7 access to a provider for urgent/acute care diagnosis and treatment, mentoring for nurses and assistants, quality and performance improvement. This Alternative Payment Model (APM) would achieve elder care cost reductions and improve quality of care. The model is based on the Avera Virtual Care Center Centers for Medicare and Medicaid Innovation (CMMI) Round 2 Health Care Innovation Award (HCIA) in 2014.

The geriatrician-led clinical team would deliver care for residents in SNFs and would receive a Per Beneficiary Per Month (PBPM) reimbursement adjusted by the beneficiaries' skilled or unskilled status. Care would be available in person or via telemedicine (42 CFR 410.78), and the APM would be available to all SNFs in urban or rural settings. To manage risks, newly participating providers would be paid a percentage of the monthly care management fee during the first 12 months of participation. Annual reporting would qualify the provider to receive up to 100% of the PBPM fee based on population health quality targets like measurable reduction in hospital admissions, hospital readmission, and use of emergency services. The model would suspend a co-payment by beneficiaries and not require beneficiary consent to participate beyond existing standard consent to treat.

The proposed model meets requirements defined in the MACRA final rule for a physician-focused payment model as an Advanced Payment Model. The payment model would impact Medicare beneficiaries as the target population. Clinicians involved in the model are

eligible professionals as defined in section 1848(k)(3)(B) of the Social Security Act. The clinicians and providers in the model are essential to implementation of the model. The model requires meeting targets which improve quality of care and reduce the costs which eligible professionals participating in the model provide, order, and influence.

Goals of the Model: The goals of the program include: 12% reduction in cost of care for Medicare beneficiaries, measurable staff and resident satisfaction, and improved longitudinal population health management. Through October 2015, the Avera HCIA program achieved an estimated $281 per beneficiary per month (PBPM) savings to Medicare while achieving greater than 98% satisfaction from staff and 99% from patients.

The model has three performance drivers for providers: 1) Build the assessment capability and skillset of Skilled Nursing Facility (SNF) teams through bedside mentoring, training and performance improvement; 2) Provide SNF residents with easy, early, and routine access to goal-directed longitudinal care; and 3) Proactively monitor and intervene in care transitions and improve chronic disease management.

Expected Participants: The ICM SNF APM participants are Medicare beneficiaries admitted to select SNFs including dual-eligible beneficiaries. SNF residents typically have multiple medical and behavioral comorbidities requiring close observation. Currently, Avera is providing care to more than 5,000 SNF residents each year across more than 65 facilities in both rural and urban areas. Avera's participating providers include a board-certified geriatrician leading a 24/7/365 intensive multidisciplinary team, including: 4 physicians, 10 certified nurse practitioners, a pharmacist, a behavioral health specialist, and a social worker, to improve access to person-centered urgent/acute care based on the biopsychosocial model. This model would be available to the some 7,500 board certified geriatricians practicing in the US as well as other qualifying providers participating on their care teams.

Implementation Strategy: Avera Health, a provider organization, headquartered in Sioux Falls, SD, is submitting this proposal along with its nationally-recognized telehealth service, Avera eCare. Avera Health is a vertically integrated Catholic health ministry with over 330 locations in South Dakota, Minnesota, Iowa, Nebraska, and North Dakota. The Avera Medical Group includes more than1700 employed and affiliated providers. Avera eCare is a comprehensive suite of telehealth services including eICU CARE, ePharmacy, eLong Term Care, eEmergency, eConsult, and more which provide cost-effective, quality care to over 330 health care facilities in 13 states.

Timeline: Avera eCare expects to submit a full physician-focused payment model proposal to PTAC by April 30, 2017. As the proposed payment model describes the work already being completed by Avera HCIA, Avera eCare would be ready to implement the payment model as soon as it is approved, and would expand to additional SNFs over time.

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