Crossing the Uncharted Seas of Transformation
How Innovative Rural Hospitals Will Survive & Thrive in the New World of Healthcare

Monica Bourgeau, MS
Executive Director
30 Hospital CFO’s In Charge

Stop = 0  
Slow Down = 0  
Keep Going = 30  
Best Year Ever = 6

They also:
• Reduced spending by 3%
• Improved access to care
• Increased local utilization
• Improved quality scores
• Decreased Outmigration

What, Me Worry?

NATIONAL RURAL ACCOUNTABLE CARE CONSORTIUM

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## The Shift to Value

<table>
<thead>
<tr>
<th>Volume</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pay Per Unit</td>
<td>Outcomes/Quality</td>
</tr>
<tr>
<td>Reactive</td>
<td>Proactive</td>
</tr>
<tr>
<td>Full Hospitals, Lots of Patients, Focus on Illness</td>
<td>Prevention, Wellness, Manage Health</td>
</tr>
<tr>
<td>Provider/Facility Focused</td>
<td>Patient Focused</td>
</tr>
<tr>
<td>Little Coordination</td>
<td>Clinical Integration</td>
</tr>
<tr>
<td>Payors Take All Risk</td>
<td>Providers Take Some Risk</td>
</tr>
<tr>
<td>Variance in Practices</td>
<td>Evidence Based Practices</td>
</tr>
</tbody>
</table>
New Payment Models – Provider Choices

MIPS

OR

CPC+

MSSP Tracks 2&3

Next Gen ACO

Merit-Based Incentive Payment System

Oncology Care Model

Comprehensive ESRD

Qualifying Advanced Payment Models (APMs)
Rural Providers & Value: One foot on the dock and one on the Boat
The Speed of Change is Increasing

In January of 2015, Secretary Burwell Announced goals for:

• 30% of all Medicare provider payments to be in alternative payment tied to value by 2016.
• 50% by 2018
• Virtually all Medicare fee-for-service payments to be tied to quality and value; at least 85% in 2016 and 90% in 2018.”
Challenges for Rural Hospitals

- 76 Rural Hospital Closures since 2010
- Many rural states did not expand Medicaid
- Stand alone health systems
- Serve declining populations
- Limited managed care and IT expertise
- Independent provider mentality (change resistant)
- “Sick” care not “health” care orientation
- Difficult to recruit and retain physicians
- Community boards - dedicated but may not know healthcare
- High turnover; CEO tenure averages less than 3 years
- Limited Financial & Human Resources
Current State in Rural: Disparities in Quality of Care Measures for Noncore Areas by 4 NQS Priorities and Access

<table>
<thead>
<tr>
<th>Category</th>
<th>Better</th>
<th>Same</th>
<th>Worse</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Safety (n=19)</td>
<td>4</td>
<td>13</td>
<td>2</td>
</tr>
<tr>
<td>Person-Centered Care (n=16)</td>
<td>2</td>
<td>14</td>
<td>1</td>
</tr>
<tr>
<td>Effective Treatment (n=44)</td>
<td>2</td>
<td>25</td>
<td>17</td>
</tr>
<tr>
<td>Healthy Living (n=27)</td>
<td>1</td>
<td>15</td>
<td>11</td>
</tr>
<tr>
<td>Access (n=25)</td>
<td>1</td>
<td>16</td>
<td>9</td>
</tr>
</tbody>
</table>

Key: n = number of measures.
Better = Population received better quality of care than reference group
Same = Population and reference group received about the same quality of care
Worse = Population received worse quality of care than reference group
Disparities in Life Expectancy Between Rural and Urban are Increasing Rapidly

- Due primarily to disparities for heart disease, diabetes, COPD, lung cancer, stroke, suicide and accidents.
- Rural providers are about 20% less likely to provide the standard of care for preventive care, diabetes, CHF, COPD.
- Less than ½ routinely perform Annual Wellness Visits, obesity counseling, smoking cessation, advanced care planning, etc.
How Does This Affect Rural?

- Objective data suggests we are not high value providers.
- Unless we change, market forces will drive patients to other providers.
- We have to find a way to participate in ambulatory quality programs, even though we don’t have to yet.
Rural Strengths

• Passionate about serving their community
• Fixed population served “cradle to grave”
• Increased local volume reduces per capita costs
• Local brand is typically strong
• Major economic driver
• Nimble
Changing the Delivery System

The movement from Volume to Value requires a change in the delivery system as well as in the payment model.
5 Actions Rural Providers Should be Taking Today

Prevention:
1. Set up a Care Coordination Programs
2. Perform Annual Wellness Visits on 50% of Patients (AWV)
   - Advanced Care Planning
   - Behavioral Counseling
   - Depression Screening
3. Provide Integrated Behavioral Health

Coding:
4. Improve Hierarchical condition coding (HCC)

Quality:
5. Improve Process & Pre-visit Planning
The Core of Transformation

- At risk patients with 2+ chronic conditions expecting to last for the following 12 months or until death of the patient
  - Nurse-driven model
  - 20 minutes per month
  - 24/7 access to care team with access to electronic care plan
- Bill approx. $42 per enrolled patient per month
- Full case load + ~200 patients = ~$100,000 revenue
- Shown to reduce costs by 20-60% (Commonwealth Fund)
Two-Thirds of Medicare Spending Is for People With Five or More Chronic Conditions

- Ninety-eight percent of Medicare expenditures involve individuals with multiple chronic conditions.

Source: Medicare Standard Analytic File, 2007
2. Perform Annual Wellness Visits (AWV)

Comprehensive review of patient’s medical history & Creates a plan for their health & wellness

- Establishes relationship with primary care provider (PCP) or team
- Improves scores on CMS quality measures (11 measures)
- Health Risk Assessment
2. Perform Annual Wellness Visits (AWV)

- PHQ-9 Depression Screening
- Mini Cog Exam (tests for Alzheimers)
- Fall Risk Screening
- Advanced Care Planning
- Public health screenings
- Identifies at-risk patients for referral to care coordination
## AWV – Optional Services

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>G0447</td>
<td>Behavioral Therapy, Obesity</td>
</tr>
<tr>
<td>G0437</td>
<td>Tobacco-Use Cessation Counseling Services</td>
</tr>
<tr>
<td>G0436</td>
<td>Tobacco-Use Cessation Counseling Services</td>
</tr>
<tr>
<td>G0444</td>
<td>Screening for Depression in Adults</td>
</tr>
<tr>
<td>3725F</td>
<td>Screening for Depression in Adults</td>
</tr>
<tr>
<td>G0328</td>
<td>Colorectal Screening</td>
</tr>
<tr>
<td>G0108</td>
<td>Diabetes Self-Management Training</td>
</tr>
<tr>
<td>1100F</td>
<td>Fall Risk Screening</td>
</tr>
<tr>
<td>4037F</td>
<td>Influenza Immunization</td>
</tr>
<tr>
<td>4040F</td>
<td>Pneumococcal Immunization</td>
</tr>
<tr>
<td>4050F</td>
<td>Hypertension</td>
</tr>
<tr>
<td>99498</td>
<td>Advanced Care Planning</td>
</tr>
</tbody>
</table>

Check with your MAC re: payments
2. For Patients, the AWV

- One hour per year extends life and reduces disabilities.
  - Increases compliance with preventive care
  - Detects emerging chronic conditions
  - Detects functional decline
  - Detects changes in family/social support
  - Detects depression and substance abuse
  - Detects vision and hearing loss
- Appropriate referrals and follow up reduces progression of diseases and improves outcomes
Case Study: Hattiesburg Clinic

• Started Slowly in 2012
• Nurse-Driven Model for AWV’s
• Supports 22+ Nurses in Multi-Site Clinic (8 AWVs + CCM)
• Physician Engagement – Steering Committee
• Patient Engagement & Education
• Improved Quality Scores & Patient Compliance
• Wellness & Prevention Focus
Case Study: Hattiesburg Clinic

Pro Forma
- RN Average Salary ($25/hr + benefits @ 25%): $65,000
- Nurse sees average 6 patients/245 working days
- Total visits/year potential: 1470
- Average AWV Reimbursement Per Visit $137.51

- $202,700 Potential Revenue/RN

Appropriate Revenue & Effective Outcomes for Patients

AMGA 2014
## Wellness Visits Drive Quality Up

<table>
<thead>
<tr>
<th></th>
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<tbody>
<tr>
<td>At-Risk Population Coronary Artery Disease</td>
<td>CAD-2 Lipid Control**</td>
<td>11</td>
<td>9</td>
<td>81.82%</td>
<td>7</td>
<td>3</td>
<td>42.86%</td>
<td>-28.57%</td>
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<tr>
<td>At-Risk Population Coronary Artery Disease</td>
<td>CAD-7 ACE or ARB with Diabetes or LVSD</td>
<td>7</td>
<td>5</td>
<td>71.43%</td>
<td>7</td>
<td>3</td>
<td>42.86%</td>
<td>-28.57%</td>
</tr>
<tr>
<td>At-Risk Population Coronary Artery Disease</td>
<td>CAD-Composite</td>
<td>11</td>
<td>7</td>
<td>63.64%</td>
<td>7</td>
<td>5</td>
<td>71.43%</td>
<td>70.91%</td>
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<tr>
<td>Care Coordination/Patient Safety</td>
<td>CARE-1 Medication Reconciliation**1</td>
<td>2</td>
<td>2</td>
<td>100.00%</td>
<td>7</td>
<td>5</td>
<td>71.43%</td>
<td>-28.57%</td>
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<tr>
<td>Care Coordination/Patient Safety</td>
<td>CARE-2 Fall Screening</td>
<td>5</td>
<td>1</td>
<td>20.00%</td>
<td>11</td>
<td>10</td>
<td>90.91%</td>
<td>70.91%</td>
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<tr>
<td>At-Risk Population Depression</td>
<td>Depression remission 12 months</td>
<td></td>
<td></td>
<td></td>
<td>4</td>
<td>0</td>
<td>0.00%</td>
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<tr>
<td>At-Risk Population Diabetes</td>
<td>DM-7 Eye Exam</td>
<td></td>
<td></td>
<td></td>
<td>3</td>
<td>1</td>
<td>33.33%</td>
<td></td>
</tr>
<tr>
<td>At-Risk Population Diabetes</td>
<td>DM-13 High Blood Pressure Control**2</td>
<td>4</td>
<td>2</td>
<td>50.00%</td>
<td>10</td>
<td>7</td>
<td>70.00%</td>
<td>-30.00%</td>
</tr>
<tr>
<td>At-Risk Population Diabetes</td>
<td>DM-14 LDL-C Control in Diabetes</td>
<td>4</td>
<td>2</td>
<td>50.00%</td>
<td>10</td>
<td>7</td>
<td>70.00%</td>
<td>-30.00%</td>
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<tr>
<td>At-Risk Population Diabetes</td>
<td>DM-15 Hemoglobin A1C Control</td>
<td>4</td>
<td>0</td>
<td>0.00%</td>
<td>12</td>
<td>10</td>
<td>83.33%</td>
<td>8.33%</td>
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<tr>
<td>At-Risk Population Diabetes</td>
<td>DM-16 Daily Aspirin or Antiplatelet with IVD</td>
<td>1</td>
<td>1</td>
<td>100.00%</td>
<td>10</td>
<td>7</td>
<td>70.00%</td>
<td>-30.00%</td>
</tr>
<tr>
<td>At-Risk Population Diabetes</td>
<td>DM-17 Tobacco Non-Use**2</td>
<td>4</td>
<td>3</td>
<td>75.00%</td>
<td>12</td>
<td>10</td>
<td>83.33%</td>
<td>8.33%</td>
</tr>
<tr>
<td>At-Risk Population Diabetes</td>
<td>DM-2 HA1c Poor Control**3 (lower score)</td>
<td>4</td>
<td>1</td>
<td>25.00%</td>
<td>4</td>
<td>2</td>
<td>50.00%</td>
<td>25.00%</td>
</tr>
<tr>
<td>At-Risk Population Diabetes</td>
<td>DM-Composite</td>
<td>4</td>
<td>0</td>
<td>0.00%</td>
<td>7</td>
<td>7</td>
<td>100.00%</td>
<td>20.00%</td>
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<tr>
<td>At-Risk Population Heart Failure</td>
<td>HF-6 Beta-Blocker Therapy for LVSD</td>
<td>5</td>
<td>4</td>
<td>80.00%</td>
<td>7</td>
<td>7</td>
<td>100.00%</td>
<td>20.00%</td>
</tr>
<tr>
<td>At-Risk Population Hypertension</td>
<td>HTN-2 Controlling High Blood Pressure</td>
<td>15</td>
<td>9</td>
<td>60.00%</td>
<td>9</td>
<td>9</td>
<td>100.00%</td>
<td>40.00%</td>
</tr>
<tr>
<td>At-Risk Population Ischemic Vascular Disease</td>
<td>VPD-1 LDL-C Control**</td>
<td>9</td>
<td>4</td>
<td>44.44%</td>
<td>9</td>
<td>4</td>
<td>44.44%</td>
<td></td>
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<tr>
<td>At-Risk Population Ischemic Vascular Disease</td>
<td>VPD-2 Use of Antithrombotic</td>
<td>9</td>
<td>9</td>
<td>100.00%</td>
<td>9</td>
<td>9</td>
<td>100.00%</td>
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<tr>
<td>Preventative Health</td>
<td>PREV-05 Breast Screening</td>
<td>32</td>
<td>20</td>
<td>62.50%</td>
<td>40</td>
<td>40</td>
<td>100.00%</td>
<td>37.50%</td>
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<tr>
<td>Preventative Health</td>
<td>PREV-06 Colorectal Cancer Screening</td>
<td>36</td>
<td>18</td>
<td>50.00%</td>
<td>23</td>
<td>19</td>
<td>82.61%</td>
<td>32.61%</td>
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<tr>
<td>Preventative Health</td>
<td>PREV-07 Influenza Immunization</td>
<td>16</td>
<td>3</td>
<td>18.75%</td>
<td>11</td>
<td>7</td>
<td>63.64%</td>
<td>44.89%</td>
</tr>
<tr>
<td>Preventative Health</td>
<td>PREV-09 Pneumonia Vaccination</td>
<td>25</td>
<td>9</td>
<td>36.00%</td>
<td>17</td>
<td>10</td>
<td>58.82%</td>
<td>22.82%</td>
</tr>
<tr>
<td>Preventative Health</td>
<td>PREV-09 Body Mass Index Screening</td>
<td>21</td>
<td>17</td>
<td>80.95%</td>
<td>23</td>
<td>17</td>
<td>73.91%</td>
<td>-7.04%</td>
</tr>
<tr>
<td>Preventative Health</td>
<td>PREV-10 Tobacco Use Screening</td>
<td>20</td>
<td>20</td>
<td>100.00%</td>
<td>16</td>
<td>12</td>
<td>75.00%</td>
<td>59.21%</td>
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<tr>
<td>Preventative Health</td>
<td>PREV-11 High Blood Pressure Screening</td>
<td>36</td>
<td>26</td>
<td>72.22%</td>
<td>39</td>
<td>29</td>
<td>74.36%</td>
<td>2.14%</td>
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<tr>
<td>Preventative Health</td>
<td>PREV-12 Clinical Depression Screening</td>
<td>19</td>
<td>3</td>
<td>15.79%</td>
<td>16</td>
<td>12</td>
<td>75.00%</td>
<td>59.21%</td>
</tr>
</tbody>
</table>

**Grand Total**: 304 eligible, 175 measure met, 57.57%, 243 eligible, 188 measure met, 77.37%, 19.80%
3. Establish Integrated Behavioral Health

• Nearly half of all Americans will experience a mental health issue in their lifetime (AHA)
• Training Care Coordinators in a Behavioral Health Treatment Modality or Having Social Workers or Counselors on site
• American Psychiatric Association – Training for Psychiatrists
• Psychiatric Collaborative Care Model (2017 Fee Schedule)
4. Improve Diagnosis Coding to Provide Accurate HCC Risk Scores

- Value-based payments are based on expected cost multiplied by Hierarchical Condition Codes (HCC) risk scores.

- HCC risk scores are calculated from all diagnoses listed on bills sent to CMS in the prior calendar year – no institutional memory.

- Providers will be penalized for falsely low scores.

- DOCUMENT ALL SIGNIFICANT CHRONIC CONDITIONS ON THE BILL FOR THIS VISIT. ASK PATIENT ABOUT EACH ONE AND DOCUMENT IN SOAP NOTE. PRIORITIZE IF NECESSARY.
5. Improve Internal Processes & Previsit Planning

• Process & Pre-Visit Planning
  • Workflow Redesign for Population Health
  • Access to Care
  • Same Day Appointments
  • Patient Satisfaction
5 Actions Rural Providers Should be Taking Today

Prevention:
1. Set Up a Care Coordination Program
2. Perform Annual Wellness Visits on 50% of Patients (AWV)
   • Advanced Care Planning
   • Behavioral Counseling
   • Depression Screening
3. Provide Integrated Behavioral Health

Coding:
4. Improve Hierarchical condition coding (HCC)

Quality:
5. Improve Process & Pre-visit Planning
Future of Rural Healthcare Transformation

- Optimize Cost and Quality (TCPI)
- Form Clinically Integrated Networks with Other Independents
- Form ACO’s – MSSP, Commercial and Medicaid
- Form Rural Provider-Based Medicare Advantage Plans
- Enter Commercial and Private Exchanges
Transforming Clinical Practices Initiative (TCPI) – Resources & Technical Assistance

• 140,000 Clinicians will Participate in 29 Practice Transformation Networks (PTNs)

• Designed to help clinicians achieve large-scale health transformation over the next 4 years

Source: Centers for Medicare & Medicaid Services
The NRACC Practice Transformation Network

Establish Your Value-Based Infrastructure at No Cost.

Coordinate Care

Manage Population Health

Get More Revenue

Qualify for PCMH

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Questions?
Billing for Population Health

Fee-for-Service (+$225-$300)
- Wellness Visit
- Depression Screen
- Advanced Care Plan
- Smoking Cessation
- Obesity Counseling
- Substance Abuse Intervention
- Immunizations
- + E&M visit if needed

RHC
- Can only bill All Inclusive Rate (AIR), but can add cost of staff to do work to cost report for reimbursement.
- Cannot bill for more than one visit.

FQHC (~+$60)
- Can bill for the Wellness Visit (but not for the follow up or add-ons) for 1.3416 times FQHC PPS rate (including regular visit).
- Cannot bill for separate visit
Psychiatric Collaborative Care Model

• Overcomes the lack of psychiatrists, particularly in rural areas.
• Doctors or care coordinators are trained to implement all programs with monthly consultation and review with a psychiatrist.
• More than 80 peer reviewed publications supporting effectiveness.
• New payment model will enable practices to set up program and be successful.