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CMMI Value-based Health Care Models and ACOs

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DRCHSD Summit, September 29, 2021

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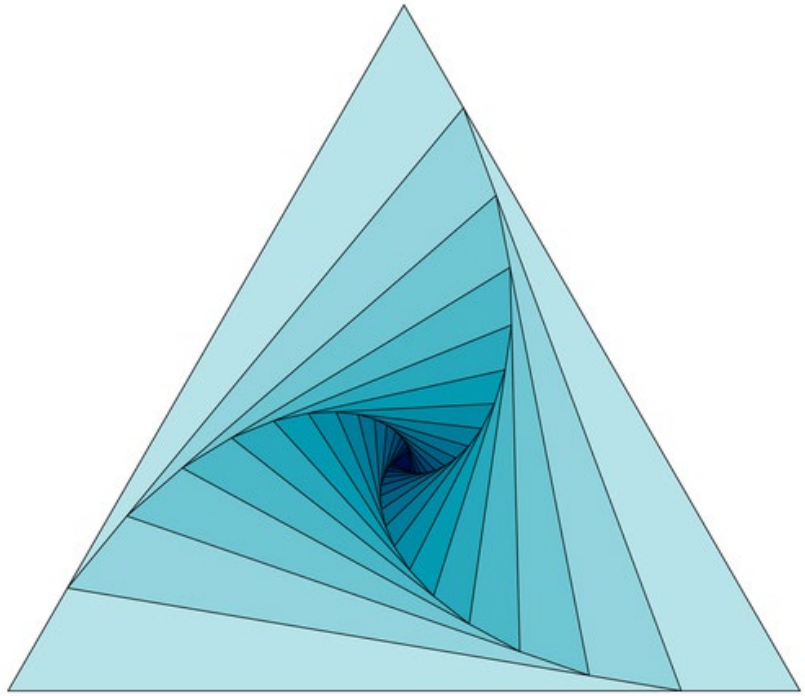
Compelling Questions

- Aren't population health and value-based care just new terms for managed care, and didn't we try that already?
- Does it mean we'll have to change?
- Does my hospital have any energy left after COVID?
- What is RISK?
- Isn't operating a rural hospital already risky enough?
- Isn't my hospital too small to move into value-based care?
- If we don't do anything, is there a chance this will all go away?

The Need to Demonstrate Value



Triple Aim

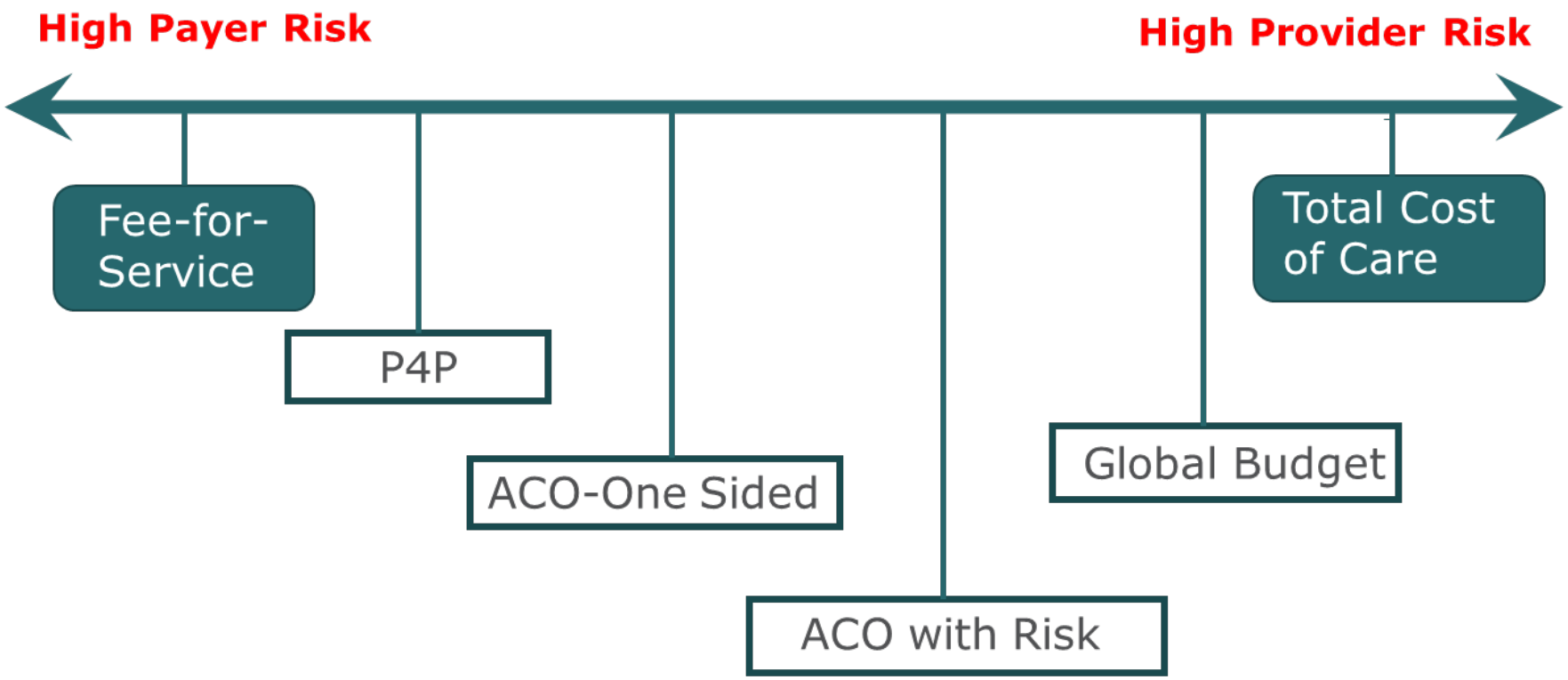
- ✓ Better Care
- ✓ Better Health
- ✓ Lower Cost

Better Care + Smarter Spending = Healthier People

Hospital Financial Value Equation

$$\text{Value Payment} = \frac{\text{Quality}}{\text{Cost}} \times \text{Population}$$

Value-Based Continuum



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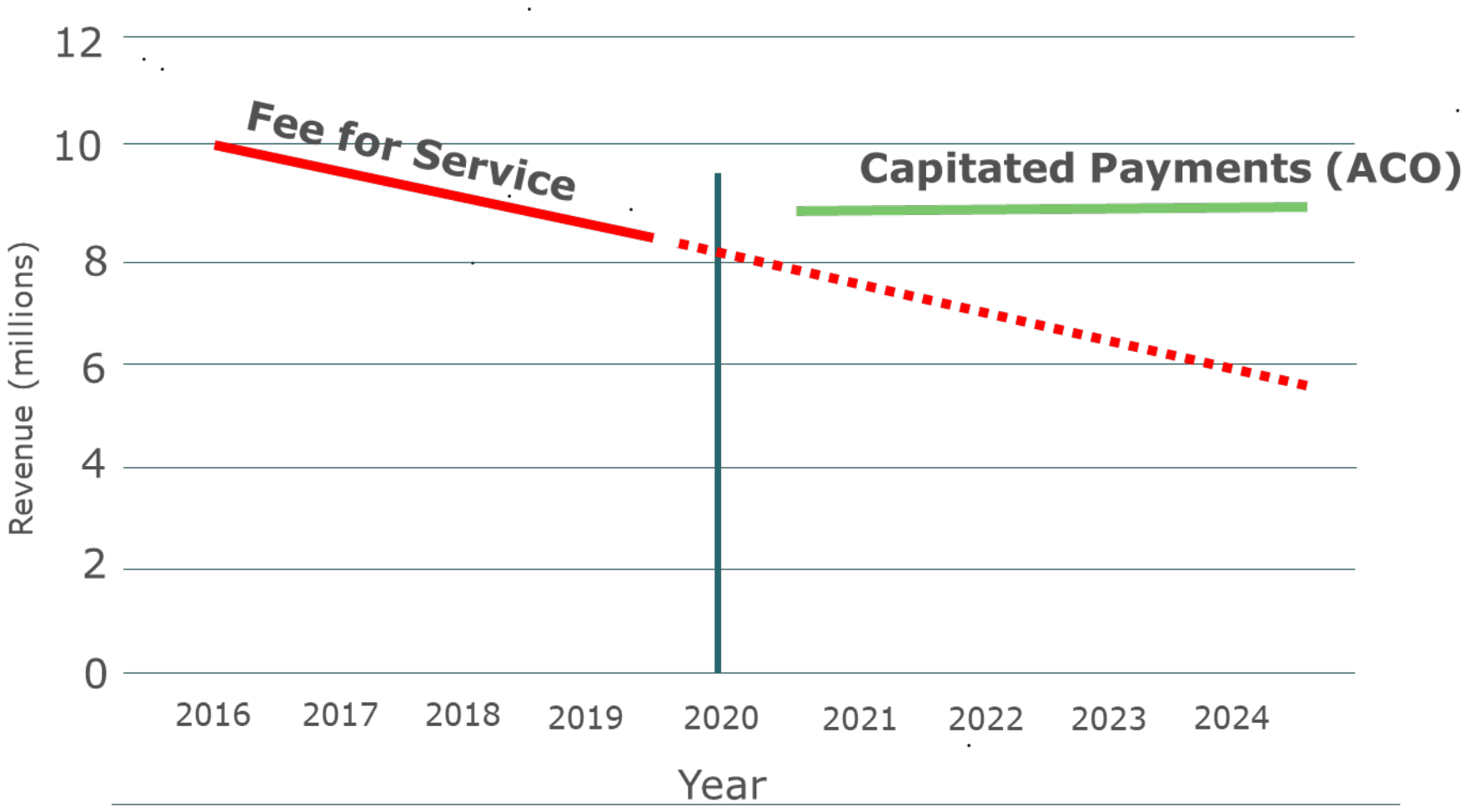
Historic Trend vs Value Payment



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New CMS CHART Models

- CHART Aims:
  - Increase hospital financial stability
  - Remove regulatory barriers
  - Enhance access

1) Community Transformation Tract—AL, TX,WA,SD

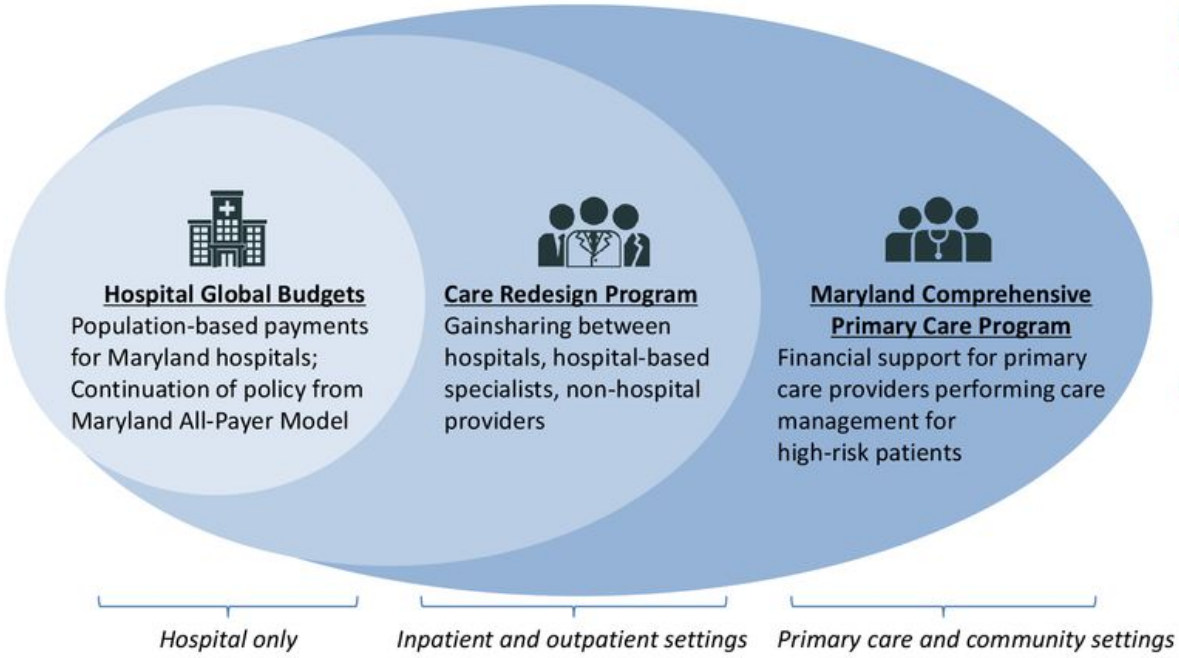
* Organize communities
* Develop transformation plans
* Change to capitated payments
* Include all payers
* Semi-monthly payments to hospitals

Maryland Total Cost Model

Maryland Total Cost of Care Model

New Model in Maryland Covering Full Continuum of Care

Components of Maryland Total Cost of Care Model



Benefits of TCOC Model

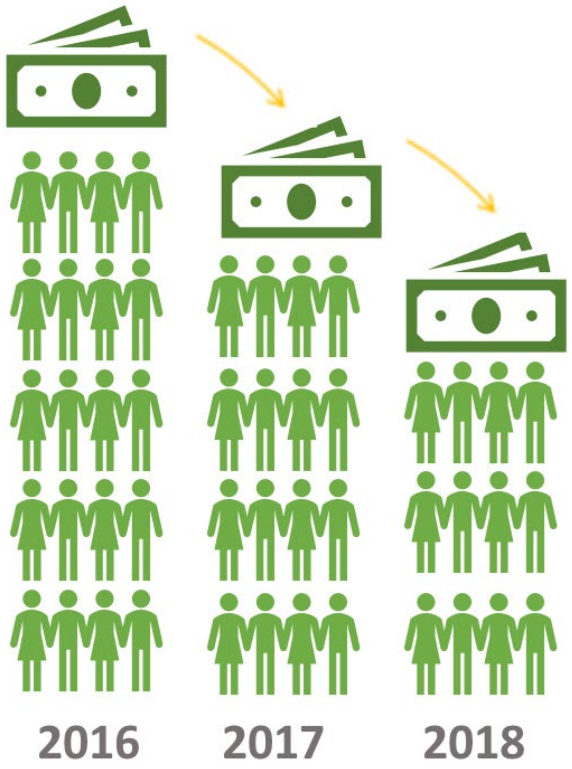
- ✓ Adds new providers and settings into care transformation effort
- ✓ Links disparate providers to create more patient-centered care
- ✓ Aligns incentives across providers to reduce hospitalizations and total cost of care

Performance Period begins January 1, 2019 and continues through 2026

Pennsylvania Rural Health Model

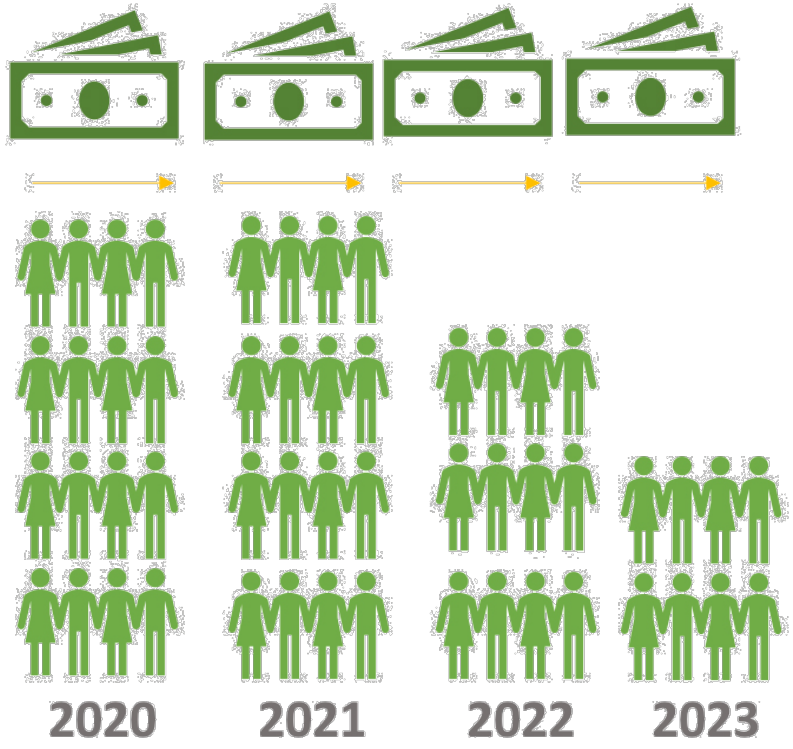
Fee for Service

Hospital is paid for the # of healthcare resources consumed by the community, but as the community is getting smaller, so is revenue.



Global Budget

Hospital is paid the same amount of money as historic NPR regardless of how many resources are consumed by the community.



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Pennsylvania Rural Health Model (continued)

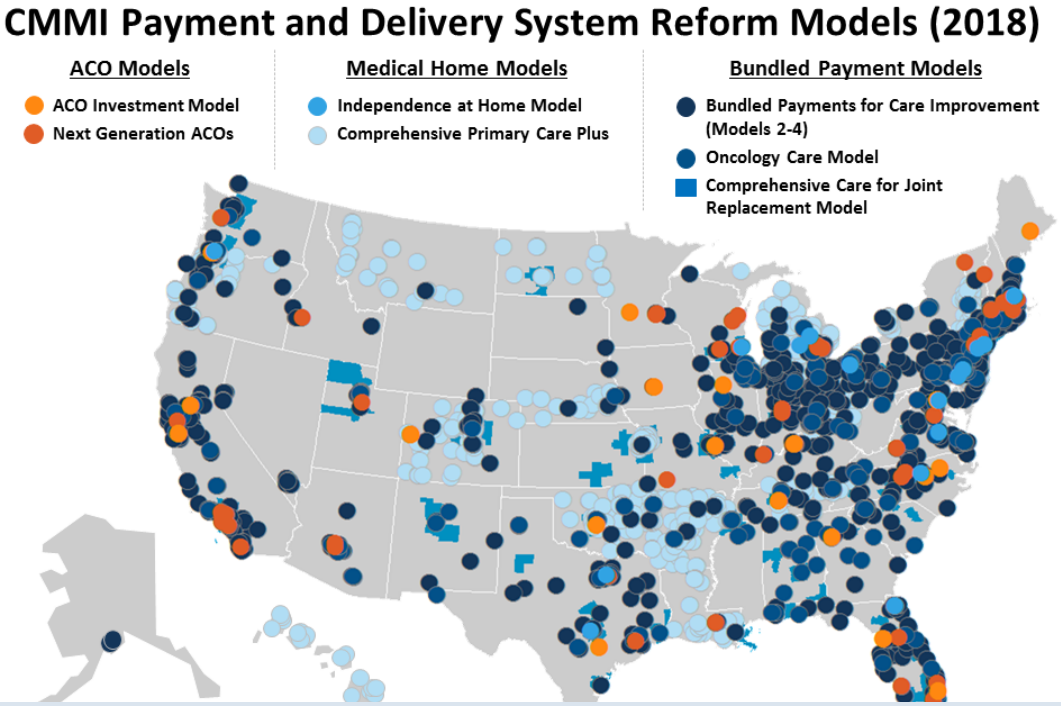
- Goal: Improve quality and address community health needs in 54 rural hospitals in six years
- Hospital global budgets: for all outpatient and inpatient services
- Hospitals will redesign patient care across the service delivery continuum
- All payers will pay the same in monthly payments

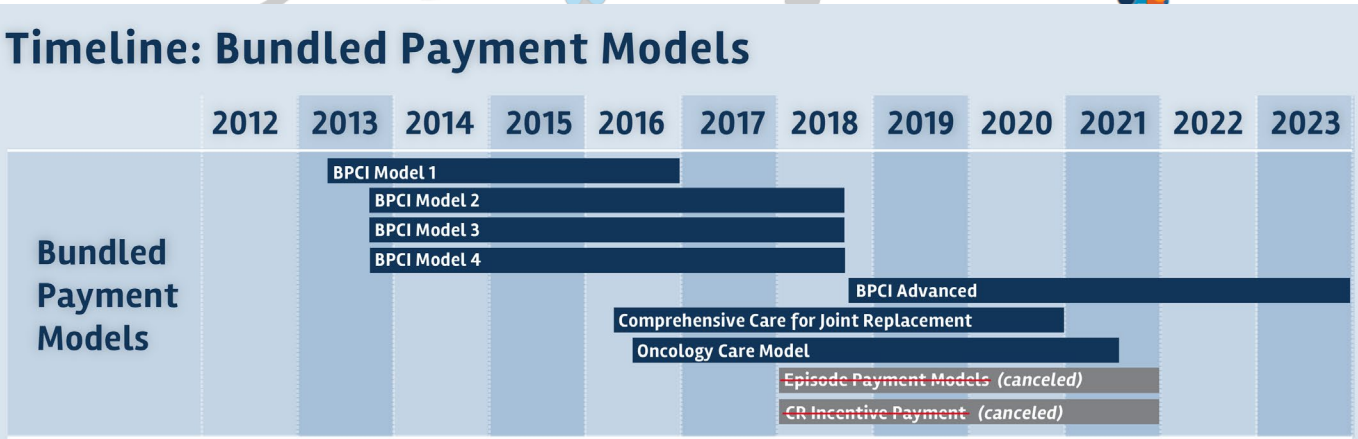
New CMS CHART Models (continued)

2) ACO Transformation Tract

* Based on previous AIM model (2016)
* Up to 20 ACOs receive funding
* Up front $200,000 & $36 per person
* $8 PBPM advanced payments
* Maximum of 10,000 beneficiaries
* Delayed one year—until 2022

Bundled Payment for Care Improvement





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Accountable Care Organizations (ACO's)

- A mechanism to monetize value by increasing quality and reducing cost
- A group of health care providers that takes responsibility for the cost and quality of care for a group of patients or individuals

Update on ACO's Presence

- Growth of Medicare ACO/Shared Savings
  - August 2012: 220
  - January 2015: 404
  - January 2016: 433 (41 new in rural)
  - January 2018: 649
  - January 2020: 558
  - January 2021: 477
- Both hospital and physician led
- Rural hospitals are outperforming urban

Source: CMS - Medicare Shared Savings Program Fast Facts

Rural ACO Advantages

- Current funding available through CHART for strategic investments & advanced payments
- Rural health is primary care based
- Rural health is more community based, enabling partnerships with other providers and other segments of the community
- Rural health care delivery systems can change more rapidly than urban systems

Rural ACOs: What We've Learned

1. Develop care coordination programs
2. Pay attention to post-acute care
3. Provide behavioral health support
4. Improve HCC (Hierarchical Conditioning Coding)
5. Expand clinic hours, implement pre-visit planning and focus on prevention quality processes and metrics

Rural ACOs: What We've Learned (continued)

6. Reduce out-migration & increase outpatient volume

7. Increase use of telehealth & technology

8. Engage and enlist physicians as partners

9. Manage, analyze and act on patient information

10. Manage downstream costs of patient care

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Rural ACO: Our Learning Experience

ICAHN
Illinois Critical Access Hospital Network

Illinois Rural Community Care Organization

Pat Schou, FACHE

Executive Director

DRCHSD Summit, September 29, 2021

Started Our Conversation

Future for Rural Health

- No turning back….
- Value based care – foundation
- **Pay for performance payment models**
- Quality the Center
- Healthy People 2020
- Global Budgets, CMS Direct Contracting,
- MSSP new generation…all have risk
- IRCCO discussions with CMS/CMMI with other ACOs
- Commercial ACOs, Medicare Advantage, MMAI, MCOs

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Healthcare Today… Change or not?

- How we care for patients has not changed
- It is how we *manage the care* of the patient that has changed
- Are rural facilities ready? If so, what resources are needed to be ready? Options?

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Illinois Rural Community Care LLC

- Established by ICAHN Board May 2014 as LLC – parent ICAHN (will manage); Separate IRCCO Board
- Reason – Prepare for Population Health and Value Based Care/share resources and best practices for success
- Purpose of developing an accountable care organization to leverage numbers
- Approved as a Medicare Shared Savings Program (MSSP) Track 1 2015 – 2017; Renewed as MSSP Track 1 2018-2020; renewal 2021 under Pathways to Success
- Approved for Blue Cross Blue Shield ACO Program January 2018 through 2020; discussions with other carriers

What does IRCCO look like today?

Approved Medicare Shared Savings Program 2015- current

- 44,000 Traditional Medicare Patients
- Learned from MSSP – care coordination
- Population Health management

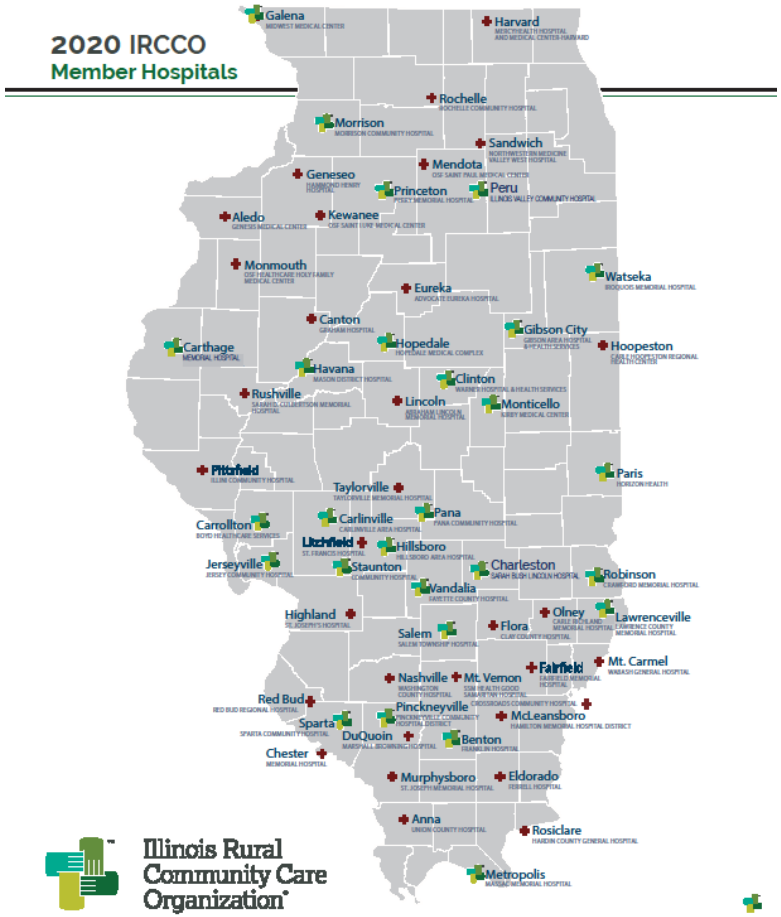
Approved Illinois Blue Cross Blue Shield Shared Savings Program 2017-current

- 40,000 BCBS Beneficiaries
- FY 2019 Earned $2.4 million shared savings

27 CAHs and small rural hospital members

➢ Credible rural ACO nationally

- >500 Medical Providers



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IRCCO 2014 – 2021: Evolution of the ACO

IRCCO Journey

- 2014 - ACO Concept/IRCCO established
- 2015 – MSSP; ACO Concepts
  - Care Coordination, Understand Data, Quality Reporting
- 2016 – Processes
  - Transfer coordination; medication management; readmissions; MWV; primary care post hospitalization; referral management
- 2017 – Outcomes/ Added BCBS
  - A1C < 7; hypertension lower; ED utilization; Skilled Care challenges for CMS
- 2018 – Building towards sustainability; MSSP Renewal 3 years; BCBS
- 2019 – BCBS Shared Savings; Hospital Referrals; Coding; ACO hospital team
- 2020 – COVID…identify Medicare Advantage Partner
- 2021 – Signed CHS/Centene; Apply for MSSP and take risk; other options

Framework: Getting Everyone on the Same Page

How Does IRCCO Work?

Payer claims – tell the story
Acclivity Dashboard

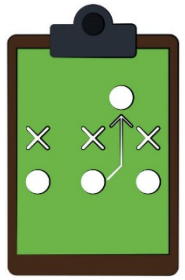
Quality and Performance Management

IRCCO Team and Hospital ACO Team
IRCCO Playbook Tool

Strategies

- Annual Well Visit – Codes/Prevention
- Care Coordination
- Emergency Department Utilization
- Specialty Referral Tracking
- Post Acute Care Management
- HCC Code Management

IRCCO Playbook for Success



IRCCO CARE COORDINATION MANAGEMENT

	Quarter 4			Quarter 1			Quarter 2			Quarter 3		
Metric Measured	October	November	December	January	February	March	April	May	June	July	August	September
MWV												
Post DC Calls												
TOC Follow Up												
ER PCP Alignment												
ER Telephone Follow Up												
Referral Tracking												
Referral Completion Process												
At end if we want to add one more	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!

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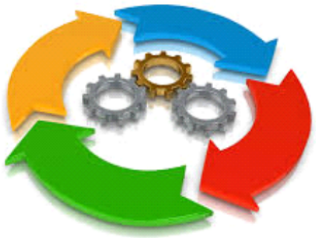
IRCCO Teams Measure Progress

Timely Workbook updates show engagement and give us the ability to monitor processes that contribute to meeting IRCCO goals.



Updated 5/2021

Hospital *Updated on 5/19/2021*	Most recent Workbook updates
Salem Township Hospital	5/17/2021
Pinckneyville Community Hospital	5/17/2021
Horizon Health	5/14/2021
Warner Hospital & Health Services	5/14/2021
Lawrence County Memorial	
Mason District Hospital	5/13/2021
Crawford Memorial Hospital	5/13/2021
Fayette County Hospital	5/13/2021
Sparta Community Hospital	5/11/2021
Pana Community Hospital	5/11/2021
Kirby Medical Center	5/10/2021
Thomas H. Boyd Memorial Hospital	5/10/2021
Franklin Hospital	5/7/2021
Iroquois Memorial Hospital	5/6/2021
Community Hospital of Staunton	4/27/2021
Memorial Hospital	4/20/2021
Carlinville Area Hospital	4/19/2021
IVCH-St. Margaret's Health	4/15/2021
Jersey Community Hospital	4/15/2021
Gibson Area Hospital	4/1/2021
Midwest Medical Center	3/30/2021
Sarah Bush Lincoln Health Center	3/24/2021
Perry Memorial Hospital	2/15/2021
Massac Memorial Hospital	7/1/2020

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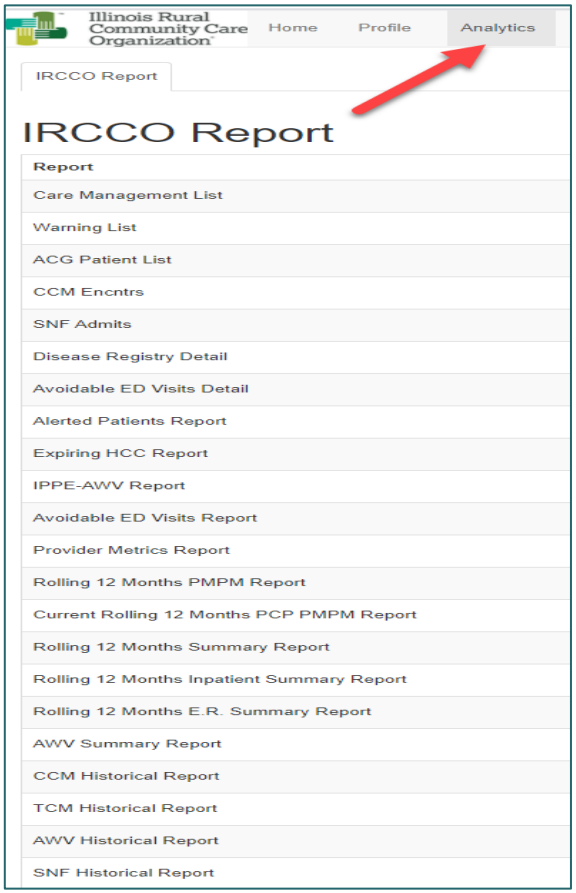
Acclivity: CMS Claims Data Analytics



- Training recording, Acclivity resources for each report, Appendix, and Patient Profile resources all shared, and access given to members last week.

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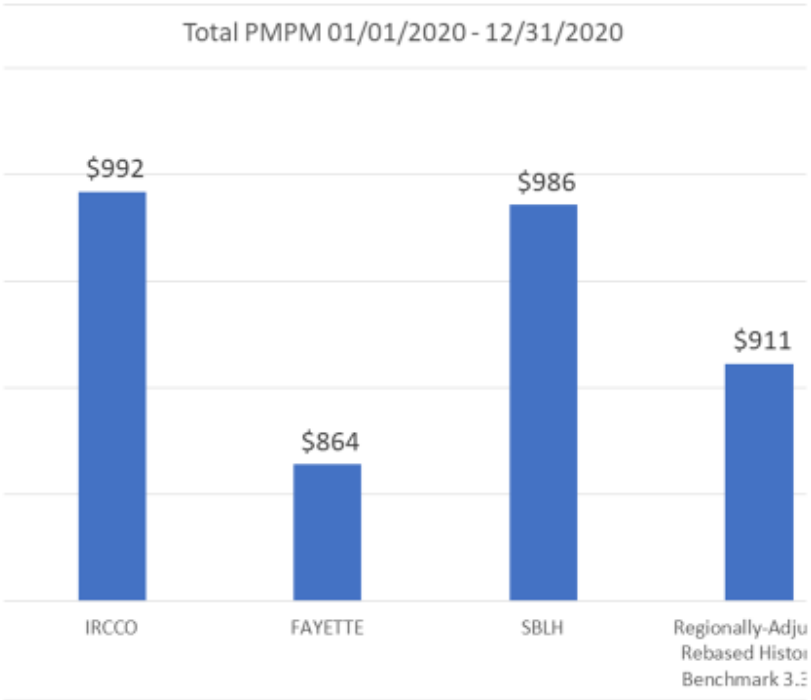
Measuring Hospital Performance



SBH Fayette County Comparison

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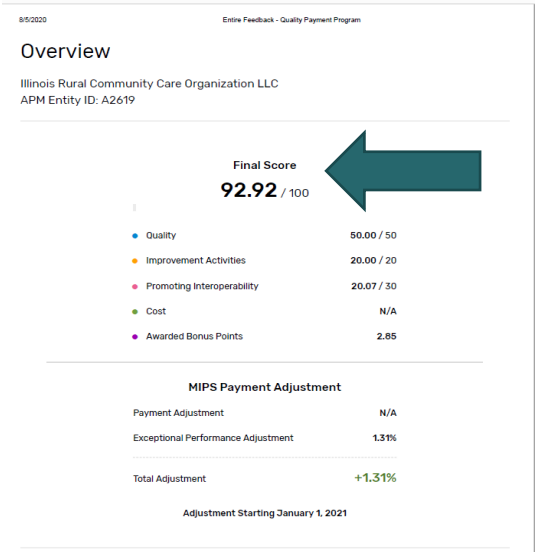
Improved Quality Scores - GPRO

Measure	2015	2018	2019	2019 Numerator	2019 Denominator
Care-2: Screening for Future Fall Risk	22.20%	79.73%	87.93%	489	560
DM-2: Diabetes HbA1c Poor Control (>9%) - Inverse Measure	25.63%	18.26%	15.20%	90	592
HTN-2: Controlling High Blood Pressure	67.86%	73.10%	75.22%	434	577
PREV-5: Breast Cancer Screening	54.52%	65.40%	62.04%	371	598
PREV-6: Colorectal Cancer Screening	32.79%	56.98%	63.31%	383	605
PREV-7: Influenza Immunization	52.71%	67.56%	72.94%	380	521
PREV-10: Tobacco Screening and Cessation Intervention	*86.38%	55.56%	75.71%	53	70
PREV-12: Screening for Depression and Follow-up Plan	13.35%	57.27%	68.66%	401	584
PREV-13: Statin Therapy for Prevention and Treatment of CVD	NA	81.97%	82.61%	456	552
MH-1: Depression Remission at Twelve Months	NA	9.38%	17.31%	9	52

*Tobacco Screening and Cessation Measure, as of 2018 GPRO, no longer considers the screening component in the score. Beginning in 2018, only identified tobacco users were included in the denominator and those who received tobacco cessation intervention were included in the numerator.



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Education and Meetings: ACOs Are "Work"

Meeting Type	Hosted by	Topics	Frequency and location	Audience
Participant Meetings	Executive Director	Overall updates and progress in all facets of IRCCO	Monthly via Zoom	Open to all ACO staff at all sites
Boutique Meetings	Regional Managers	Each region meets to discuss updates, needs, share best practices, networking etc.	2-3 times per year in person in north/south simultaneously	At least one representative from hospital and one from clinic from each site but all ACO team members invited
Mini-Boutique Meetings	Regional Managers	Best practices in key IRCCO intiatives presented by local staff	4 per year via Zoom	Open to all ACO staff at all sites
Care Navigator Meetings	Regional Managers	Care Coordination efforts, PCMH foundation, best pratices, guest speakers, networking, etc	1 per year, in person, middle of the state	At least one Care Coordinator from each site bot other staff and providers invited
ACO Team Meetings	Regional Managers	Discussion of Workbook metrics, actions plans, project updates, quality outcomes, workflow and PI	At least quarterly, usually monthly, and ad hoc as requested, mix of Zoom and on-site	Each site's desginated ACO team, including CEO
Provider Council Meetings	Chief Medical Officer	IRCCO Business updates, ideas for tackling clinical issues, seek feedback from providers on ACO in general	Every other month via Zoom	One IRCCO provider from each site
Quality Guidance Meeting	Data Coordinator	Abstraction education, updates on metric or process changes, dealines, etc.	Yearly and ad hoc via Zoom	At least one staff member from each site responsible for quality data reporting, but open to all ACO staff
Identified needs for Education	Regional Managers,CMO, Data Coordinator, Dir. Of Informatics/HIM	Have included Well visits, transitions of care, ACO 101, HCC coding, provider contracts, data abstraction, project direction, many more	Ad hoc Zoom and on-site	Specified audiences but open to all

Blue Cross Blue Shield Data

Illinois Rural Community Care Organization

September 2021 BCBS– Race, Ethnicity, Language Report

Blood Pressure – Race

Blood Pressure, <140/90 & ≥140/90

Race	BP <140/90	Percentage	BP ≥140/90	Percentage
American Indian or Alaska Native	0	0.00%	0	0.00%
Asian	3	0.14%	1	0.18%
Black or African American	21	0.95%	5	0.89%
Native Hawaiian or other Pacific Islander	1	0.05%	0	0.00%
White	2173	97.79%	549	98.04%
Unknown/Declined to Answer	24	1.08%	5	0.89%
Total	**2222**	**100%**	**560**	**100%**

Challenges
IRCCO Rural ACOs

- Older and sicker population (cardiovascular disease, diabetes, obesity)
- All independents – learn to work together
- No admission, discharge and transfer HIE/ no common EMR
- Lack of skilled nursing care management/local facilities
- Care coordination/inconsistency
- Rural health clinic billing
- Re-think patient management/education

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What IRCCO has learned – Population Health

- Rural skilled care patients – care is not well coordinated
- Importance of wellness – few gap care programs in place
  - Rural patients are generally sicker and more chronic diseases
- Can lower A1C and BP – learning disease registries
- Rural providers have been behind – but can compete and excel
- Patient engagement still difficult/not organized well enough yet
- Seeing success with care coordination and improving some outcomes
  - Beneficiaries can be reluctant to pay "co-pay"/poorer population
- Rural people want to stay locally

Why are you still in IRCCO? Asked the hospitals…

- Learn about value-based care
- IRCCO provides a blueprint
- Allow independents to work together
- Leverage numbers for better options
- Learn from each other
- Save and share resources
- Keep our rural communities viable/care locally

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Moving Forward Strategic Plan to Stay Viable

Continue Traditional Medicare /Shared Savings Program

- Move to risk and identify financial support
- Increase dollars for providers to improve outcomes and scores
- Evaluate advanced Medicare programs
- Direct Contracting – 2023/2024

Add Medicare Advantage product option that is rural friendly – *New…find a partner*

Continue Blue Cross Blue Shield ACO Participation

Years 2023 and 2024 – explore other payment options - MCOs

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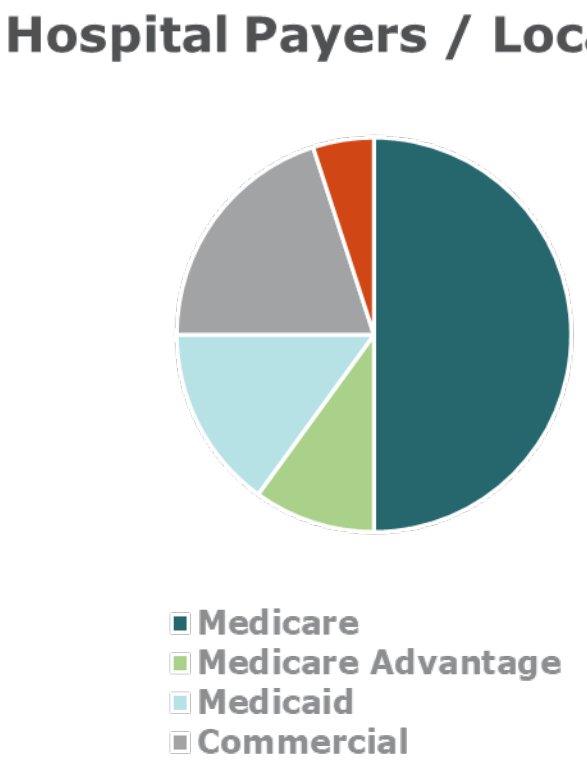
Rural Hospitals
Strategies to Stay Viable



- **Rural hospitals need to think about payment strategies for each of their payers.**
- **How can rural compete?**
- **Contracts**
- **ACOs can leverage**

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IRCCO…Why Partner?

- Needed a national financial partner $$$
- Rural hospitals do not have financial capital
- Payment programs require risk taking/lack financial experience
- Medicare Advantage – ACO takes financial risk
- Medicare Shared Savings – ACO must take on financial risk after 2022
- Payers want "skin in the game"
    - What can hospitals afford?
- Powerful as a statewide group of rural facilities
- So, what does risk mean? Hospital and Partner pay back
    - Do not meet financial performance
    - Do not meet quality goals

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Remember: IT'S NOT All ABOUT REIMBURSEMENT

- Improving Patient Care
- Reduce avoidable readmissions & ER visits
- Reduce errors & omissions post discharge
- Avoid unnecessary complications
- Impact on "Shared Savings"
- Improve patient satisfaction
- Improve survey results
- Increase **MARKET SHARE /Local Services**

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IRCCO Team and Resources

Cost of Operations - $750,000/year

- ACO IT Dashboard/claims
- Staff
  - Chief Medical Office
  - 2 Regional Managers
  - Data Coordinator
  - Clinical Informatics/HIM
  - Finance
  - Executive Director
- Professional Insurance
- Management Fees/Office Management








IRCCO - Healthcare Future

- Provides an opportunity for rural hospitals to compete and take advantage of revenue payment programs
- Allows for negotiating options/avoids capitation
- Hospitals and their boards and providers – be a decisionmaker
- Partner with national organizations for financial support as an owner
- Limits financial risk and moves to value-based care
- Future is pay for performance (VBC)

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The Challenge: Crossing the Shaky Bridge

Source: http://www.flickr.com/photos/67759198@N00/2974261334/sizes/o/in/photostream/

The Destination…

A health system that links health care with community stakeholders to create a network of organizations working together to improve population health

The Right Track

"Even if you're on the right track,
you'll get run over if you just sit there."
(Will Rogers)

Panelists:

Courtney Phillips
CEO, South Sunflower County Hospital

Jason Schrumpf
CEO, Missouri Delta Medical Center

Ryan Kelly
CEO, Horizon Professional Services

Larry Spour
CEO, Marshall Browning Hospital

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Panel Discussion

1. Briefly tell us about your organization and your value-based initiative.

2. What was the most challenging aspect of your initiative?

3. How did you engage your medical providers?

4. What is one of the most important lessons learned from participating in the initiative?

5. Would you participate in your value-based initiative again if you had the choice?

Contact Information

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