Alternative Payment Models: Business and Physician Perspectives (Part 1)
Preparing for the New Rural Hospital Business Models

May 3, 2017

ICAHN Illinois Critical Access Hospital Network

Illinois Rural Community Care Organization
Agenda

• Background – ICAHN and Rural ACO
• Critical Access Hospital Program
• Healthcare Challenges
• Moving from Volume to Value
• Alternative Payment Models - Rural ACO Experience
• Finding the ROI
• Readiness and Taking the Next Step
Illinois Critical Access Hospital Network

**ICAHN** is a not-for-profit 501(c)3 corporation established in 2003 for the purposes of sharing resources, education, promoting efficiency and best practice and improving health care services for member critical access hospitals and their rural communities. ICAHN, with 55 member hospitals, is an independent network governed by a nine-member board of directors.

- **Members = 38 Independent; 17 Systems**
  - 8 providing OB Services
  - 11 Long Term Care
  - 1 Inpatient Psych Unit
  - Incubator for rural programs and services
  - Statewide rural network
- **Illinois Rural Community Care Organization 2014**
  - Rural ACO/Medicare Shared Savings Program 2015 /Sole Member LLC
CAH Program - Today

• Medicare CAH Program – 20 years old
• Payment Program – cost based
• Swing bed program – pros and cons
• Medicare Advantage program growing
• Focus on health and wellness
• Vast majority CAHs own medical practices and clinics
• Hospitalist program
What are CAH CEO Concerns – 2017 Impacting the Business Models

• # 1 – Physician recruitment and retention
• # 2 – RN Shortage
• # 3 – Leakage...keeping patients locally
• # 4 – Specialty services – access and return
• #5 – Medicaid and state insurance timeliness – no cash flow!
• #6 – Payment system reform...will CAHs lose?
• #7 – Swing Bed program
• #8 – Life safety upgrades/regulations
• #9 – Leadership development
• #10 – Managing the culture change!

Tracy Bauer, CEO
Impact on Healthcare Environment

- Healthcare costs
- Affordable Care Act...replace?
- Commercial Carriers moving to value
- Medicaid Managed Care
- Global Payments – Bundling
- Rural Hospital Closures – 80 since 2010
- Competition/outreach

**Most Significant:** MACRA – Merit Incentive-based Program System (MIPS) and Value Based Care
Population Health Management

Understanding how to reduce overall healthcare costs for your local community....Princeton, IL
Moving from Volume To Value Based Care

• Healthcare Reform
  – Triple Aim
  – Primary Care Driven
  – Clinically Integrated Networks
  – Transitional Care and High Costs
  – Coordinated Care Program – Navigator Programs
  – Quality Reporting and Data Based Decisions
  – Consumer – the new patient
  – Market Share – fast growing systems
  – Changing Reimbursement System
  – Accountable Care Organizations
Moving to Value...

• Delivery System Reform... *how will this impact hospitals and practitioners? SGR gone!!*

• **Quality Payment Program (QPP) – 2017 Baseline**
  – Merit Incentive-based Payment System (MIPS)
    • 10% payment swing (+) or (-)
  – Advanced Alternative Payment Models (APMs)
    • 5% Payment incentive (+)
MIPS – What are the Details?

• **Four** performance areas for practitioners
  – Quality
  – Advancing Care Information
  – Improvement Activities
  – Cost

• Practitioners scores carries year to year

• All practitioners – (4) activities for 90 days
  – Small practices 2 activities/90 days
2017 Breakdown – MIPS
New Physician Payment System

• How will it be calculated?
• % Physician Fee Schedule - 2017
  – Advancing Care Information – 25%
  – Quality – 60%
  – Improvement Activities
  – Cost
Advanced Alternative Payment Models – 5% +

• All about risk...

  – Comprehensive ESRD Care – 2 Sided Risk
  – Comprehensive Primary Care Plus (CPC+)
  – Next Generation ACO model
  – Shared Savings Program – Track 1 + (Best Rural Option)
  – Shared Savings Program – Track 2
  – Shared Savings Program – Track 3
  – Oncology Care Model – 2 Sided Risk
  – Comprehensive Care for Joint Replacement (Track 1-CEHRT)
Accountable Care Organizations

- Accountable Care Organizations (ACOs) are groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high quality care to their Medicare patients.

- The goal of coordinated care is to ensure that patients, especially the chronically ill, get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors.

- When an ACO succeeds both in delivering high-quality care and spending health care dollars more wisely, it will **share in the savings** it achieves for the Medicare program. *Centers for Medicare & Medicaid Services*

- *Shared Savings Models – Track 1, 1+, 2 and 3 and Next Generation ACO*
- *Various levels of risks and options*
What Does MACRA Mean for CAHs?

• Physicians and advanced practice practitioners admit to the hospitals, order care services and order medication, tests and treatment.

• Practitioner has overall responsibility for the patient
  – Changes in care
  – Utilization of services

• Primary care based
  – Good News!
MACRA Impact on Medical Providers

“WHY?...order patterns change”

• Pre-MACRA Baseline – revenues grow both physician and hospital

• Low incentives – little financial risk; physicians revenues decline and hospital revenue increases

• Medium incentives – More physician risk (Patient Centered Medical Homes, ACO Track 2); physicians revenues begin to show increase and hospital revenues decrease

• High incentives – Advanced APMs and high risk; physician revenues increase and hospital revenues substantially decrease
Sense of Urgency – Impact MACRA
Loss of Revenue begins 2019

Financial Management

RAND study: MACRA could cause $250B drop in hospital Medicare revenue by 2030

Written by Emily Rappleye (Twitter | Google+) | April 20, 2017 | Print | Email
Business Options for CAHs

Prepare for VBP - Population

- Very difficult alone – Lose revenues in time
- Become part of a system
- Become part of an ACO as an independent
- Partner with a resource hospital
- Do nothing...pass you by
What Did CAHs in Illinois Do?

Our Journey – Driving the Bus

• 2014 - ACO Concept/IRCCO established as LLC sole member of ICAHN

• 2015 – 3-year Contract MSSP with No Downside Risk; Learn ACO Concepts
  – PCMH, Care Coordination, Data Management, AIM Application

• 2016 – Improve Processes – IRCCO Management Team
  – Transfer coordination; medication management; readmissions; MWV; primary care post hospitalization; referral management

• 2017 – Define Outcomes – ACO Participants
  – A1C < 7; hypertension lower; Stroke readiness; ED Utilization; Post Acute care decreased LOS – home management; advanced care/best practices
  – Test “the water” with commercial ACOs

• 2018 – Building towards sustainability
  – Improved Utilization; Cost Savings; Quality, Outcomes
  – Preparation for Risk Sharing
IRCCO CAHs - Learn from Medicare Shared Savings – no downside risk now

• Why participate in Medicare Shared Savings Program?
  – Understand our claims and where patients receive their care; utilization of services
  – Build care coordination and moves towards clinical integration, at least, locally
  – Real carrot is implementing processes with all payors
How Did IRCCO Begin?
Target - Reduce Individual Beneficiary Cost

• **$10,600 average cost per beneficiary (2016 adjusted)**
• Strategies on how do we reduce 5%...then 10%
  – Breaking down the $10,600 using dashboards
    • ED Utilization – target more than 4 visits per year; CHF and COPD
    • Primary Care – target more than 4 visits per year
    • Hospitals (participant and tertiary care)
    • Well visits
    • Utilization
    • Skilled Care/post hospitalizations (coming soon)
    • Medications - Benchmark of 90% generic utilization
    • Downstream spend
    • Care coordination
Next: Change the Culture/Value

- Change must come from within the hospital and practice setting
- Move from volume to value
Caution: Hospital Concerns - Why Change?

• If the goal is reduce Medicare beneficiary spend and your hospital is able to do so, what will be my bottom line?
• What is my return on investment (ROI)?
Solution: Finding the ROI

Lower beneficiary Costs...Increase Business

• Increase primary care market share
  – Care Coordination
  – Better Utilization of Services
  – Wellness and Prevention
  – Gap Closures
  – Provide Value and Quality
  – Keep Patients Locally

• Practitioner – Hospital Team Approach
  – Physician and hospital partnership/alignment
Most Importantly - Securing Your Primary Care

• **Target All Payors**....how will you manage these beneficiaries
  – Medicare
  – Commercial
    • Employer Based
    • Self-funded
  – Medicare Advantage
  – Medicaid
### How will you Manage Population Health?

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Challenges: Making the Decision to Take Risk

- Unstable political climate and payment system
- Slow move to value-based purchasing
- Rural health clinics not subject to MIPS incentive or penalty
- Participant financial reserves - limitation with many
- Hospitals need to plan for revenues/losses associated with ACO
- Inconsistent performance among participants
  - No sense of urgency for some
- Uncharted waters – no history
- Variable risk tolerance and able to manage processes
Bottom Line to Be Successful...
MACRA and VBP Care: Top 6

- Foremost - Quality and Patient Centered Care
- Understanding and Managing Data
- Practitioner and Hospital Alignment
- Care Coordination among Settings
- Control Your Costs - Risk
- Primary Care – manage downstream spend
I: Healthcare is Local – Your Own Provider

• Better manage care and build patient loyalty
• Patient Centered Care
Best Practice Performance

• Changing the conversation
  – Practitioner performance
  – Culture Change
  – Monitor benchmarks per site
  – Care Coordination all settings

• Achieve shared savings

• New conversation...understanding competency for providers

• Measure and promote best practice and performance
II: Managing and Understanding Data

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<td>69.60</td>
<td>10.70</td>
<td>9.93</td>
<td>19.31</td>
<td>40.18</td>
<td>5.92</td>
<td>7.51</td>
<td>6.35</td>
<td>42.63</td>
<td>1.80</td>
<td>2.03</td>
<td>1.07</td>
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*Incomplete data-2017 starter

<table>
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<tr>
<th>Quarter 3 Historical Benchmark Per Member</th>
<th>$10,529.00</th>
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<tr>
<td>PMM Benchmark</td>
<td>$877.42</td>
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<tr>
<td>10% Reduced PMM &quot;TARGET&quot;</td>
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<td>5% Reduced PMM</td>
<td>$789.69 - $839.55</td>
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<td>No Reduction of PMM</td>
<td>$833.55</td>
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<td>Metric Description Key:</td>
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<td>PMM/WithoutPartD</td>
<td>Total Costs Per Member Per Month Without Part D claims (Part D excluded in Shared Savings Calculation)</td>
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<tr>
<td>Risk - Utilizing Patients</td>
<td>Average Patient Risk Score for All Patients</td>
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<tr>
<td>Hospital PMM</td>
<td>Hospital Admit (CBS or INPT) Costs Per Member Per Month</td>
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</tbody>
</table>
Analytics

4% Percent of companies that can perform predictive analytics about their workforce
7-15% Percent healthcare costs are rising on average per year
70% Percent of all healthcare costs caused by unhealthy behavior

Data analytics and visualization allows you to develop a strategy to manage and control costs

- Strategic benefit design and risk assessment tools
- Price transparency increases personal accountability
III: Practitioner and Hospital Alignment

• Managing the patient through all settings
• Support for primary care – value to the medical provider
• Work flow support
• Resource allocation
• Compensation
• Involvement in care coordination
IV: Care Coordination

Healthcare wrapped around the patient

Result: Higher Quality, Higher Service, Lower Costs (Triple Aim)
Care Coordination Costs

- Team Approach Versus Individual/staff
- Meeting Time
- Documentation – Software program
- Chronic Care Management Training
- Resource Inventory

- Value – Patient Care Experience Improved!
V: Control Your Costs

- Why are post acute hospitalization costs higher? / Asking questions and measuring

<table>
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<tr>
<th>Category</th>
<th>1Q 15</th>
<th>2Q 15</th>
<th>3Q 15</th>
<th>4Q 15</th>
<th>1Q 16</th>
<th>All ACOs 1Q 16</th>
<th>2Q 16</th>
<th>All ACOs 2Q 16</th>
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<th>All ACOs 3Q 16</th>
<th>4Q 16</th>
<th>All ACOs 4Q 16</th>
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<tbody>
<tr>
<td>Total # Beneficiaries</td>
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<td>Assigned Beneficiaries</td>
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<tr>
<td>% Beneficiaries Assigned</td>
<td>70%</td>
<td>69%</td>
<td>72%</td>
<td>73%</td>
<td>84%</td>
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<td>Total Expenditure per Beneficiary</td>
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<td>Mean # PCP Visits/12 months</td>
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<td>4.26</td>
<td>4.26</td>
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<td>Assigned Beneficiaries w/o HCC data/incomplete diagnoses</td>
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<td>No HCCs per 10,000 beneficiaries</td>
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<td>ED Visits</td>
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<td># of ED Admissions leading to Hospitalization</td>
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<td>84</td>
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<td>30 Day Readmission per 1000 discharges</td>
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<td>30 Day Post Discharge PCP Visit per 1000 discharges</td>
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<td>772</td>
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<td>Skilled Nursing Days</td>
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<td>Skilled Nursing Costs per Beneficiary</td>
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<td>Hospital Inpatient Costs per Beneficiary</td>
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<tr>
<td>Hospital Outpatient Costs per Beneficiary</td>
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<td>3245</td>
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<td>Part B Physician/Supplier (Carrier) Cost per Beneficiary</td>
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<td>2153</td>
<td>2157</td>
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</table>
VI: Value of Primary Care

• Care Coordination
• Huddles
• Coding!!!
• Revenues – primary care
  – Medicare Well Visits
  – Chronic Care Management
  – Transitional Care Management
  – Gap Closure /prevention screening
• Increase primary care – loyalty
• Transfer process evaluation
Primary Care Revenues

• Medicare Well Visits
• Transitional Care Management
• Advanced Care Planning
• Chronic Care Management
• Coaching Programs – Prevention
• Gap Closure
Illinois Rural Community Care Organization

- Illinois Statewide Rural ACO
- 24 Critical Access and Rural Hospitals; 35 rural health clinics
- 15 Independent physician practices
- >250 Medical providers providing care for > 30,000 Medicare Beneficiaries
- Medicare Shared Savings Program Year 3; AIM Investment Funds 2016
- BCBSIL ACO 2017-2018
IRCCO  Moving Forward 2017

• MSSP – 3 months into 3rd year
• “Inch Worm Effect”
  – Finances – fee for service – VBS
  – Hospital and physician practices
  – 2017 – Inch Worm moving faster!!!
• Will ACOs go away?....
  – Impact of MACRA – physician payment system and advanced payment models
  – Continued growth of Medicare advantage, integrated networks, reducing costs
  – Will transform – evolving model
  – 480 MSSPs; > 900 ACOs overall
What Should My Hospital Do?

• Assess your hospital situation  
  – Primary Care  
  – Readiness for change and transformation  
• Find good resources – long term change comes within  
• Inventory your financial reserves  
• Set goals and learn from others  
• Evaluate options – Change the Conversation!
Financially Moving to Value

• Still in a volume world and will continue to be paid for services rendered; Billing and coding the same
• Budget line item for shared savings – participation and or risk
• Care coordination and rebuilding primary care will have expenses dependent on goals and service area
• Practitioner incentive as appropriate
Rural Can Lead...

- Primary Care Based
- Care is Local
- Change Quickly
- Community Focused
- Know Patients Well
- Share Resources
- Value is our patients!
Thank you

• Questions

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