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!!*

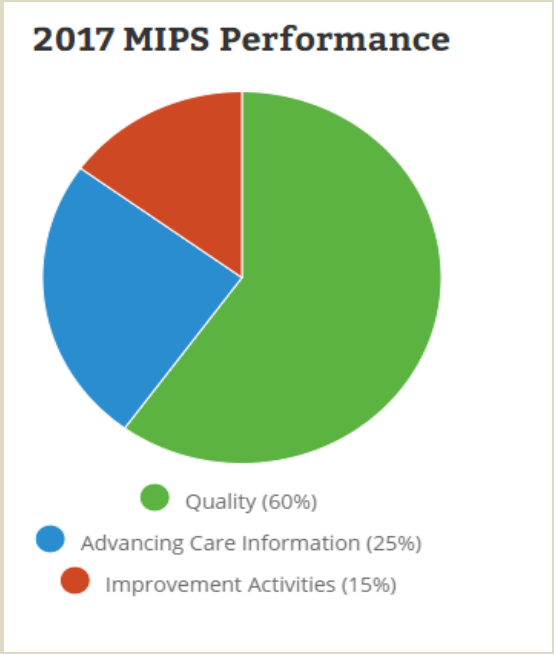
- **Quality Payment Program (QPP) – 2017 Baseline**
  - Merit Incentive-based Payment System (MIPS)
    - 10% payment swing (+) or (-)
  - Advanced Alternative Payment Models (APMs)
    - 5% Payment incentive (+)

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

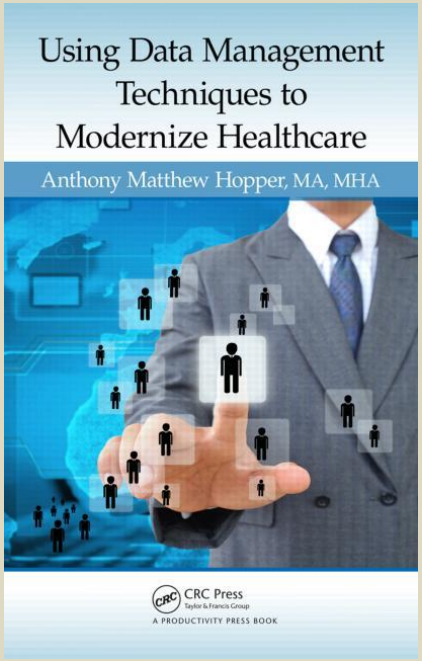
Financial Management

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

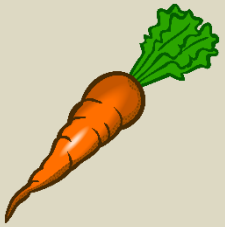


What Did CAHs in Illinois Do?
Our Journey – Driving the Bus

- 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

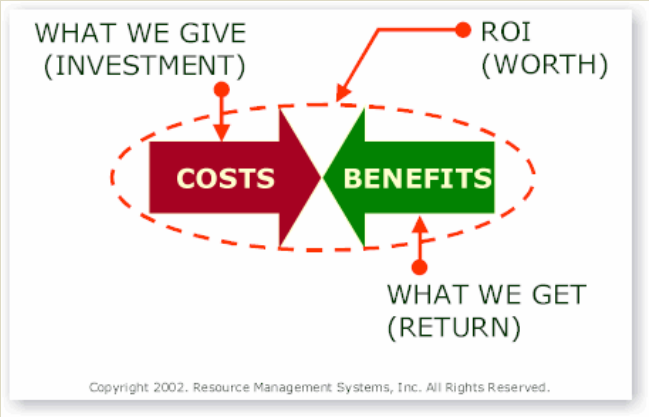
Next: Change the Culture/Value

- 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

Walmart
Save money. Live better.

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?

Healthy Patients	Early Onset Chronic Disease	Full Onset Chronic Disease	Complex
Medicare Well Visits Screenings Immunizations Healthy Eating Exercise Programs Newsletter Patient Education Building relationship with patients	Provider Benchmarks • Diabetes • Hypertension • Cholesterol • Mental Health positive screen • Medication abuse • Traumatic injury • Arthritis Cardiac Rehab Physical Therapy Group counseling Support Groups Primary care monitoring	• Chronic Care Management Program • Health Coach • Community Care Worker Program • Self-management skill-building • Specialty care referral monitoring • ADTs All beneficiaries should be in a care coordination program	Specialty care vetting • Outcomes • Cost • Relationship primary care • Support for family Care coordination tracking/ADTs

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

IRCCO Claims Data

Claims 1/1/2016 - 12/31/2016	IRCCO	Ascano	Carlinville	Community	Crawford	Fayette	Gibson	Gregg Davis	Gregory Delost	Hillsboro	IVCH	Iroquois*	Joel Leifheit	Ketan Patel	Kirby
PMPMWithoutPartD	$845.00	$811.00	$1,090.00	$741.00	$781.00	$992.00	$820.00	$755.00	$752.00	$1,391.00	$812.00	$62.00	$987.00	$716.00	$970.0
Risk - Utilizing Patients	1.84	1.86	1.9	1.6	1.69	2.18	1.71	2.02	1.46	2.2	1.93	0.54	2.41	1.46	1.8
Hospital PMPM	$271	$248	$330	$232	$259	$300	$258	$227	$268	$438	$301		$385	$219	$24
Non ER Hospital PMPM	$198	$224	$242	$173	$219	$245	$188	$201	$224	$325	$170		$198	$202	$17
ER Hospital Admits PMPM	$73	$24	$88	$59	$40	$55	$70	$26	$43	$114	$131		$187	$17	$7
ER Visits (No Admit) PMPM	$39	$42	$63	$46	$41	$50	$32	$30	$34	$65	$26		$25	$32	$6
Hospital Outpatient PMPM	$203	$247	$220	$177	$227	$203	$236	$181	$148	$176	$160	$32	$112	$130	$25
SNF PMPM	$105	$65	$202	$73	$76	$97	$90	$111	$99	$463	$87		$151	$120	$17
HHA PMPM	$22	$7	$38	$20	$18	$52	$9	$15	$4	$28	$28		$34	$9	$1
Hospice PMPM	$14	$9	$21	$13	$6	$13	$24	$24	$16		$7		$6	$13	$2
Part B PMPM	$171	$183	$190	$161	$128	$250	$155	$158	$173	$184	$186	$26	$259	$178	$16
Hospital Admits/1000	326.27	305.68	392.07	257.64	321.38	375.82	257.25	256.01	276.76	508.2	335.35	0	404.58	229.81	293.1
Non ER Hospital Admits/1000	223.99	267.47	294.05	212.34	266.7	310.4	154.89	225.44	205.19	349.39	139.59	0	152.95	196.64	202.5
ER Hospital Admits/1000	102.28	38.21	98.02	45.3	54.68	65.43	102.35	30.57	71.58	158.81	195.77	0	251.63	33.17	90.8
ER (No Admit) Visits/1000	739.61	840.63	809.71	775.74	773.99	1014.87	633.26	550.23	529.67	889.34	573.16	0	468.73	585.2	948.1
SNF Admits/1000	262	99.35	277	172.7	212.63	196.28	306.51	202.51	152.7	667.01	297.09	0	414.45	251.14	335.6
HHA Admits/1000	118.84	45.85	185.38	110.42	104.49	398.65	45.98	68.78	28.63	158.81	132.35	0	177.62	42.65	73.8
Hospice Admits/1000	60.31	30.57	78.84	59.45	31.59	57.82	87.57	91.7	90.66	0	34.47	0	34.54	56.86	94.6
Hospital Outpatient Admits/1000	9816.46	8520.89	10999.21	7850.86	11405.72	9610.09	10954.28	8096.76	8226.58	9242.83	9334.69	4573.77	7173.96	4525.2	11918.4
Part B Visits/1000	18005.71	23919.64	19415.88	18878.3	12640.22	27051.59	16541.98	20809.32	20890.94	23472.34	22164.2	5081.97	23307.97	19148	14163.1
LOS - Non ER Hospital	4.65	3.54	4.75	4.85	5.01	4.84	32703.57	3.92	3.49	4.27	5.24		6.71	4.55	4.1
LOS - ER Hospital	4.62	4.4	4.5	5.81	5.08	6.51	4.42	6	5.67	4.2	3.94		4.65	3.43	5.4
LOS - SNF	18.99	14.46	15.31	19.66	19.98	12.55	5.06	19.28	11.78	14.52	18.08		16	24.8	19.6
LOS - HHA	30.03	9.33	35.53	27.03	29.6	28.94	21	38.44	17	17	38.76		38.17	29.06	17
MWV %	87.52%	69.60%	10.70%	9.93%	19.31%	40.18%	5.92%	7.51%	50.00%	6.35%	42.63%	1.86%	86.14%	2.03%	10.67

*Incomplete data-2017 starter

Quarter 3 Historical Benchmark Annual Per Member		**$10,529.00**
PMPM Benchmark		**$877.42**
10% Reduced PMPM *TARGET*	< or = to $789.68	$789.68
5% Reduced PMPM	$789.69 -$ 833.55	$833.55
No Reduction of PMPM	>$833.55	>$833.55

Metric Description Key:	
PMPMWithoutPartD	Total Costs Per Member Per Month Without Part D claims (Part D excluded in Shared Savings Calculation)
Risk - Utilizing Patients	Average Patient Risk Score for All Patients
Hospital PMPM	Hospital Admit (OBS or INPT) Costs Per Member Per Month

Sheet1

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

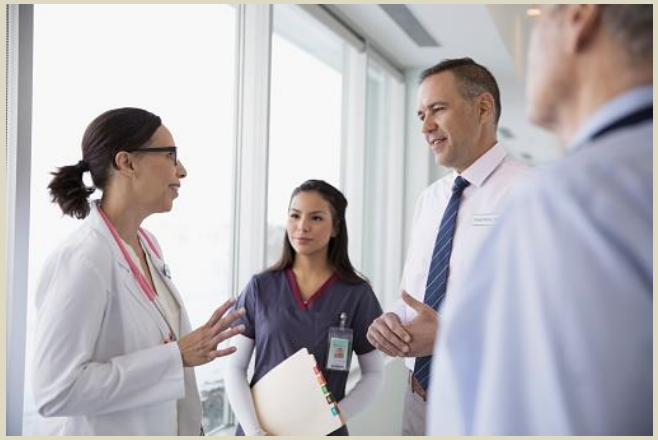
- **Value – Patient Care Experience Improved!**

V: Control Your Costs

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

IRCCO Benchmark Data Comparison												
Category	1Q 15	2Q 15	3Q 15	4Q 15	1Q 16	All ACOs 1Q 16	2Q 16	All ACOs 2Q 16	3Q 16	All ACOs 3Q 16	4Q 16	All ACOs 4Q 16
Total # Beneficiaries	19,866	19.592	19,444	19,139	25,431		24,640					
Assigned Beneficiaries	13,996	13,786	13,821	13,888	21,484		20,426					
% Beneficiaries Assigned	70%	69%	72%	73%	84%		83%					
Total Expenditure per Beneficiary	**$10,920**	**$10,995**	**$10,974**	**$10,941**	**$11,125**	**$10,124**	**$11,159**	**$10,100**				
Mean # PCP Visits/12 months	4.17	4.26	4.26	4.15	4.22	4.27	4.20	4.29				
Assigned Beneficiaries w/o HCC data/incomplete diagnoses	1308	1,476	1,603	1794	1,908		2,092					
No HCCs per 10,000 beneficiaries	4,312	4,247	4,215	4203	3,152	2,732	3,270	2,810				
ED Visits	892	895	910	900	923	686	910	690				
# of ED Admissions leading to Hospitalization	87	87	87	84	108	206	105	203				
30 Day Readmission per 1000 discharges	168	160	160	163	161	160	153	160				
30 Day Post Discharge PCP Visit per 1000 dicharges	636	636	772	629	624	775	663	776				
Skilled Nursing Days	2,956	3,100	3,004	2,788	2,773	1,569	2,732	1,494				
Skilled Nursing Costs per Beneficiary	$ 1,562	$ 1,621	$ 1,636	$ 1,587	$1,525	$721	$1,568	$703				
Hospital Inpatient Costs per Beneficiary	3441	3444	3406	3400	$3,404	$3,209	$3,425	$3,246				
Hospital Outpatient Costs per Beneficiary	3229	3245	3217	3202	$2,584	$1,997	$3,291	$2,027				
Part B Physician/Supplier (Carrier) Cost per Beneficiary	2157	2153	2157	2190	$2,282	$3,266	$2,237	$3,268				

VI: Value of Primary Care



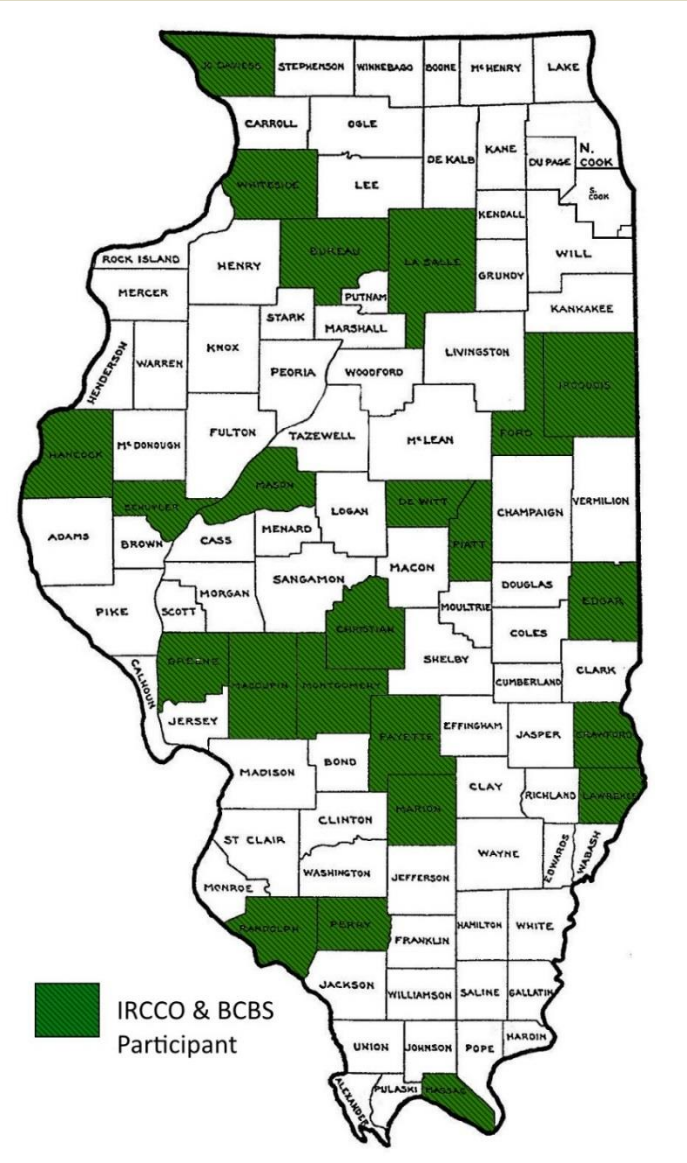
- Care Coordination
- Huddles
- Coding!!!
- Revenues – primary care
  - Medicare Well Visits
  - Chronic Care Management
  - Transitional Care Management
  - Gap Closure /prevention screening
- Increase primary care – loyalty
- Transfer process evaluation

Primary Care Revenues

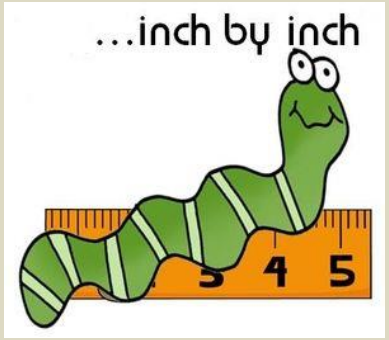
- Medicare Well Visits
- Transitional Care Management
- Advanced Care Planning
- Chronic Care Management
- Coaching Programs – Prevention
- Gap Closure

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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