Value-Based Payments for Rural Providers: The Rural ACO Experience.

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Who is the Consortium?

- The National Rural Accountable Care Consortium is a non-profit organization that supports rural healthcare transformation.
- Formed by rural providers to avoid being left behind.
- Awarded up to $31 million TCPI grant in 2015 to assist 525 rural health systems in preparing for value-based payments.
- The National Rural ACO which began operating the first ACO in 2014, operated 6 ACO’s in 2015, and organized 170 systems into 24 ACO’s for 2016.
- Services are provided by Caravan Health.
Green = ACOs
Blue = TCPI
Caravan Health

- 23 MSSP ACO’s
  - 6,000 health care providers
  - 55 PPS Hospitals
  - 92 Critical Access Hospitals
  - 168 Rural Health Clinics
  - 39 FQHC’s
  - 500,000 Medicare lives
- Practice Transformation Network (as of 4/20)
  - 5,000 health care providers
- 800 Independent Practices
- 82 CAHs
The Triple Aim

- Provide Better Care
- Lower Per Capita Cost
- Improve Financial Performance

Population Health
Per Capita Cost
Experience of Care
Per Capita Total Current Health Care Expenditures, U.S. and Selected Countries, 2010

- United States: $7,910
- United Kingdom: $5,270
- Switzerland: $5,270
- Luxembourg: $4,786
- Netherlands: $4,727
- New Zealand: $4,727
- Norway: $5,188
- Spain: $2,979
- Sweden: $3,561
- Austria: $3,162
- Belgium: $3,969
- Canada: $4,205
- Denmark: $4,300
- Finland: $3,093
- France: $3,835
- Germany: $4,187
- Iceland: $3,309
- Ireland: $3,589
- Italy: $2,852
- Luxembourg: $4,786
- Netherlands: $4,727
- New Zealand: $3,022
- Norway: $5,188
- Spain: $2,979
- Sweden: $3,561
- Switzerland: $5,270
- United Kingdom: $3,253
- United States: $7,910

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Projected Medicare Spending, 2013-2023

In billions:

- 2013: $586
- 2014: $597
- 2015: $615
- 2016: $671
- 2017: $695
- 2018: $722
- 2019: $794
- 2020: $849
- 2021: $911
- 2022: $1,018
- 2023: $1,064
Medicare Part A Trust Fund Balance at Beginning of the Year, as a Percentage of Annual Expenditures

In billions:

Medicare spending is expected to be $1,200 lower per beneficiary in 2014 than was projected in 2010, and $2,400 lower in 2019.

Secretary Burwell’s historic announcement:

“Our first goal is for 30% of all Medicare provider payments to be in alternative payment models that are tied to how well providers care for their patients, instead of how much care they provide – and to do it by 2016. Our goal would then be to get to 50% by 2018.

Our second goal is for virtually all Medicare fee-for-service payments to be tied to quality and value; at least 85% in 2016 and 90% in 2018.”
Payment Reform Roadmap

**GOAL 1:**
Medicare payments are tied to quality or value through alternative payment models (categories 3-4) by the end of 2016, and 50% by the end of 2018

30%

**GOAL 2:**
Medicare fee-for-service payments are tied to quality or value (categories 2-4) by the end of 2016, and 90% by the end of 2018

85%

**CURRENT STATE**

- **Category 1:** Fee-for-Service — No Link to Quality
- **Category 2:** Fee-for-Service — Link to Quality
- **Category 3:** APMs Built on Fee-for-Service Architecture
- **Category 4:** Population-Based Payment
MACRA: 2019 – 2025 (AKA “Doc Fix”)

- Increased federal deficit by $141 billion over next 10yrs.

Three key provisions:
1. Sustainable Growth Rate repeal and annual updates
2. Merit based payment system (MIPS)
3. Alternative Payment Models (APMs)

Score 1-100

July 2017 – CMS provides feedback on scores
July 2018 – CMS provides Claims data
Set benchmark in 2019
Below – Penalty
Above - Bonus

Certified PCMH highest potential score for the CPIA category
Evolution of Quality Measures

**Measures Individual Performance**

- **Facility Measures**
  - Meaningful Use
  - PCMH

- **Facility and Patient Measures**
  - PQRS
  - Readmission Rates
  - ACO Measures
  - Voluntary Bundles
  - Patient Satisfaction
  - MACRA - MIPS
  - MA Star Ratings

- **Patient Measures**
  - Value-Based Modifier
  - CCJR Bundles
  - More TBD

**Measures SYSTEM of Care**
Quality Score Tied to Payment

Adjustment Factor

By no later than December 2 each year, CMS will make available each eligible professionals’ adjustment factor for upcoming year

<table>
<thead>
<tr>
<th>Year</th>
<th>Penalty Cap</th>
<th>Bonus opportunity (subject to scaling factor)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2019</td>
<td>-4%</td>
<td>Up to +12%</td>
</tr>
<tr>
<td>2020</td>
<td>-5%</td>
<td>Up to +15%</td>
</tr>
<tr>
<td>2021</td>
<td>-7%</td>
<td>Up to +21%</td>
</tr>
<tr>
<td>2022</td>
<td>-9%</td>
<td>Up to +27%</td>
</tr>
</tbody>
</table>

Exceptional Performance Incentive Payment

If meet or beat stretch goal, also receive payment from annual $500 million incentive bonus pool (not to exceed 10 percent)
No MIPS if in a Qualified APM (e.g., ACO)
How Does Rural Score in Value Assessment?

• Cost
  • On a *risk-adjusted basis*, rural patients are more expensive (MedPAC)
  • Unit costs for CAH inpatient and outpatient procedures and provider-based RHC visits are typically higher than urban (1-3x) and have higher coinsurance.
  • Swing bed costs are four to eight times higher than skilled nursing home reimbursements.

• Quality
  • 2014 AHRQ study entitled “Rural Quality Is Sub-Par” indicates 25% lower quality scores in rural than in urban.
  • It also shows disparities between rural and urban life expectancy is widening – 0.4 years in 1970, now at 2.4 years.
  • NRACO cost and quality data is consistent with AHRQ and MedPAC findings.
Disparities in Quality of Care Between Rural and Urban

<table>
<thead>
<tr>
<th>Service</th>
<th>Better</th>
<th>Same</th>
<th>Worse</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Safety (n=19)</td>
<td>2</td>
<td>13</td>
<td>4</td>
</tr>
<tr>
<td>Person-Centered Care (n=16)</td>
<td>2</td>
<td>14</td>
<td>2</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>16</td>
<td>15</td>
<td>9</td>
</tr>
</tbody>
</table>

Key: n = number of measures.

Better = Population received better quality of care than reference group

Same = Population & reference group received about the same quality of care

Worse = Population received worse quality of care than reference group

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Potentially avoidable hospitalizations for all conditions per 100,000 population, by residence location, 2005-2012

Quality Varies but Problem Areas are the Same

Clinical Measure Values by ACO

<table>
<thead>
<tr>
<th>At-Risk</th>
<th>Care Coordination/Patient Safety</th>
<th>Preventive Health</th>
<th>Risk-standardized acute admission rate (RSAAR)</th>
</tr>
</thead>
<tbody>
<tr>
<td>CAD.</td>
<td>ACE-LV</td>
<td>DM-EVE</td>
<td>DM-HbA1c≥8</td>
</tr>
<tr>
<td>70%</td>
<td>33%</td>
<td>18%</td>
<td>85%</td>
</tr>
<tr>
<td>68%</td>
<td>31%</td>
<td>25%</td>
<td>91%</td>
</tr>
<tr>
<td>53%</td>
<td>40%</td>
<td>0.5%</td>
<td>40%</td>
</tr>
<tr>
<td>67%</td>
<td>36%</td>
<td>24%</td>
<td>100%</td>
</tr>
<tr>
<td>82%</td>
<td>35%</td>
<td>55%</td>
<td>99%</td>
</tr>
<tr>
<td>70%</td>
<td>29%</td>
<td>0.1%</td>
<td>100%</td>
</tr>
</tbody>
</table>
Rural Solutions - The NRACO Program

• Get the data to identify opportunities to improve quality and lower costs.
• Coordinate care for chronically ill to reduce costs and build market share.
• Provide 24-Hour Advice Nurse Hotline to reduce ED primary care.
• Redesign workflow at clinic to address care gaps.
• Annual Wellness Visits to promote prevention.
• Join forces with other independent providers to qualify for programs and spread costs (APMs – CINs, ACOs).
• Join forces with strong tertiary systems to provide best value for patients.
• Motivate the community to achieve better health.
Two-Thirds of Medicare Spending is for People with Five or More Chronic Conditions

- Three percent of Medicare expenditures involve individuals with one or less chronic conditions.
- Ninety-seven percent of Medicare expenditures involve individuals with two or more chronic conditions.

Source: Medicare Standard Analytic File, 2007
Focus Care Coordination on “Top 10%” Patients to Achieve Savings

Wellness Promotion

- Top 5%: $84,293
- 6-10%: $35,986
- 11-25%: $15,320
- 26-50%: $4,381
- 51-100%: $743

Care Coordination
What is an ACO?

• Providers agree to be accountable for the cost and quality of care of their primary care patients, helping them get the best care at the lowest cost, everywhere they go.

• If quality is good, and costs go down, providers can get up to 50% of the savings.

• If costs go up, there is no penalty. This is strictly a bonus program.

• All existing reimbursement stays the same.

• Participants receive powerful data and waivers that help them help their patients get better care at a lower cost.

• LIKELIHOOD OF EARNING SHARED SAVINGS IN FIRST THREE YEARS IS VERY LOW.
How Does “Shared Savings” Work?

ACO’s Baseline Spending per Patient - based on previous 3 years, for all ACO participants

$10,000

ACO’s Year 1 Spending per Patient

$9,500

Savings

$500

Shared Savings (50%)

$250

Quality Score Adjusted Shared Savings

$200

All existing reimbursement stays the same!

$10,000

$9,500

$500

$250

$200

ACO Programs

Savings

xQ

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Reporting on Quality

At-Risk Populations

Preventive Health

Patient and Caregiver Experience

Care Coordination and Patient Safety
Mandate to Improve Coding

- Value-based payments are based on allowed charges divided by HCC risk scores.
  - Cost/HCC score = adjusted cost
  - E.g., a beneficiary who had $10K in claims last year and an HCC score of 0.9 = $10,000 x .9 = $9,000 risk-adjusted cost used for value-based payments.
- HCC risk scores are calculated from all diagnoses listed on bills sent to CMS in the prior calendar year – no institutional memory.
- Rural typically under-codes because it does not generally affect our payments.
- This makes our higher costs look even worse.
- Most providers can increase their risk scores by at least 10%.
Results – A Tale of Six ACO’s
<table>
<thead>
<tr>
<th>Domain</th>
<th>Metric Name</th>
<th>2014</th>
<th>2015</th>
<th>Change</th>
</tr>
</thead>
<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>
</tr>
<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>
</tr>
<tr>
<td>At-Risk Population Coronary Artery Disease</td>
<td>CAD-Composite</td>
<td>11</td>
<td>7</td>
<td>63.64%</td>
</tr>
<tr>
<td>Care Coordination/Patient Safety</td>
<td>CARE-1 Medication Reconciliation**1</td>
<td>2</td>
<td>2</td>
<td>100.00%</td>
</tr>
<tr>
<td>Care Coordination/Patient Safety</td>
<td>CARE-2 Fall Screening</td>
<td>5</td>
<td>1</td>
<td>20.00%</td>
</tr>
<tr>
<td>At-Risk Population Depression</td>
<td>Depression remission 12 months</td>
<td>4</td>
<td>0</td>
<td>0.00%</td>
</tr>
<tr>
<td>At-Risk Population Diabetes</td>
<td>DM-7 Eye Exam</td>
<td>3</td>
<td>1</td>
<td>33.33%</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>
</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>
</tr>
<tr>
<td>At-Risk Population Diabetes</td>
<td>DM-15 Hemoglobin A1c Control</td>
<td>4</td>
<td>0</td>
<td>0.00%</td>
</tr>
<tr>
<td>At-Risk Population Diabetes</td>
<td>DM-16 Daily Aspirin or Antplatelet with IVD</td>
<td>1</td>
<td>1</td>
<td>100.00%</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>
</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>
</tr>
<tr>
<td>At-Risk Population Diabetes</td>
<td>DM-Composite</td>
<td>4</td>
<td>0</td>
<td>0.00%</td>
</tr>
<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>
</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>
</tr>
<tr>
<td>At-Risk Population Ischemic Vascular Disease</td>
<td>IVD-1 LDL-C Control**</td>
<td>9</td>
<td>4</td>
<td>44.44%</td>
</tr>
<tr>
<td>At-Risk Population Ischemic Vascular Disease</td>
<td>IVD-2 Use of Antithrombotic</td>
<td>9</td>
<td>9</td>
<td>100.00%</td>
</tr>
<tr>
<td>Preventative Health</td>
<td>PREV-05 Breast Screening</td>
<td>32</td>
<td>20</td>
<td>62.50%</td>
</tr>
<tr>
<td>Preventative Health</td>
<td>PREV-06 Colorectal Cancer Screening</td>
<td>36</td>
<td>18</td>
<td>50.00%</td>
</tr>
<tr>
<td>Preventative Health</td>
<td>PREV-07 Influenza Immunization</td>
<td>16</td>
<td>3</td>
<td>18.75%</td>
</tr>
<tr>
<td>Preventative Health</td>
<td>PREV-08 Pneumonia Vaccination</td>
<td>25</td>
<td>9</td>
<td>36.00%</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>
</tr>
<tr>
<td>Preventative Health</td>
<td>PREV-10 Tobacco Use Screening</td>
<td>20</td>
<td>20</td>
<td>100.00%</td>
</tr>
<tr>
<td>Preventative Health</td>
<td>PREV-11 High Blood Pressure Screening</td>
<td>36</td>
<td>26</td>
<td>72.22%</td>
</tr>
<tr>
<td>Preventative Health</td>
<td>PREV-12 Clinical Depression Screening</td>
<td>19</td>
<td>3</td>
<td>15.79%</td>
</tr>
</tbody>
</table>

| Grand Total                            |                                                          | 304  | 175  | 57.57%  |
|                                         |                                                          | 243  | 188  | 77.37%  |
|                                         |                                                          | 19.80% |
Emergency Department Discharges per 1000 Person-Years

Benchmark Years

- All MSSP ACOs
- National FFS

ALL NRACO


National Rural ACO

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30-Day Post-Discharge Provider Visits per 1000 Discharges

Benchmark Years

2012, 2013, 2014, Q1 2015, Q2 2015, Q3 2015, Q4 2015

All MSSP ACOs
National FFS

ALL NRACO

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30-Day Readmissions per 1000 Discharges

- All MSSP ACOs
- National FFS

Benchmark Years:
- 2012
- 2013
- 2014
- Q1 2015
- Q2 2015
- Q3 2015
- Q4 2015

ALL NRACO

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CMS computes total expenditures based on paid amounts from claims with dates of service within the 12 month period, allowing for at most a seven day claims run-out and using a completion factor to complete claims to 100 percent. Hospital inpatient, hospital outpatient, skilled nursing facility (SNF), Part B physician/supplier (carrier), home health, durable medical equipment (DME), and hospice claims are all used to compute total expenditures.
Practice Transformation Network Grant
What is a Practice Transformation Network (PTN)?

• The Practice Transformation Network (PTN) program is designed to help small and safety net providers transition from fee-for-service payment models to advanced payment models, and also to be able to succeed under the new guidelines for the Physician’s Quality Reporting System (PQRS) and the Value-Based Modifiers (VBM).

• This program is funding by the Transforming Clinical Practices Initiative (TCPI).
Set Up Your Billable Care Coordination Service

• Train, certify, and mentor your care coordinators
• Implement the necessary IT infrastructure
• Provide a federally-funded 24/7 nurse advice hotline

• Bill Medicare $42 PMPM
Redesign Your Practice to Manage Population Health

- Modify clinic workflow to address care gaps
- Provide data to identify cost-savings opportunities
- Report and improve ambulatory quality scores
- Measure patient satisfaction at the point of care (Tablet)
- Get paid quality bonuses
Qualify You for Patient-Centered Medical Home

- Develop physician-led care teams
- Facilitate coordinated, integrated care
- Promote culture of quality and safety
- Increase access to primary care

- Get paid PCMH bonuses
Increase Your Revenue to Preserve Your Future

• Increase local utilization
• Maximize additional population health payments
• Prevent value-based payment penalties
• Identify the right advanced payment models for your community
• Join a non-binding CIN to gain more revenue
Eligibility

- PHYSICIANS, PA’s and NP’s
- Rural PPS Hospitals
- Critical Access Hospitals (CAHs)
- RHCs, FQHCs
- Rural Fee-for-Service Clinics
- Urban rural network providers
- Not already part of any Medicare Shared Savings program (MSSP, CPCI, etc.)
Participation Requirements

• Participants must appoint or hire an in-house care coordinator (will bill Medicare for new services)

• Active participation in the program, including attendance at:
  • Training webinars
  • Regional workshops
  • Divisional workshops, and

(Travel for regional & divisional workshops is reimbursed through the grant)
Questions? Ready to Join?

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