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

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Regional Vice President

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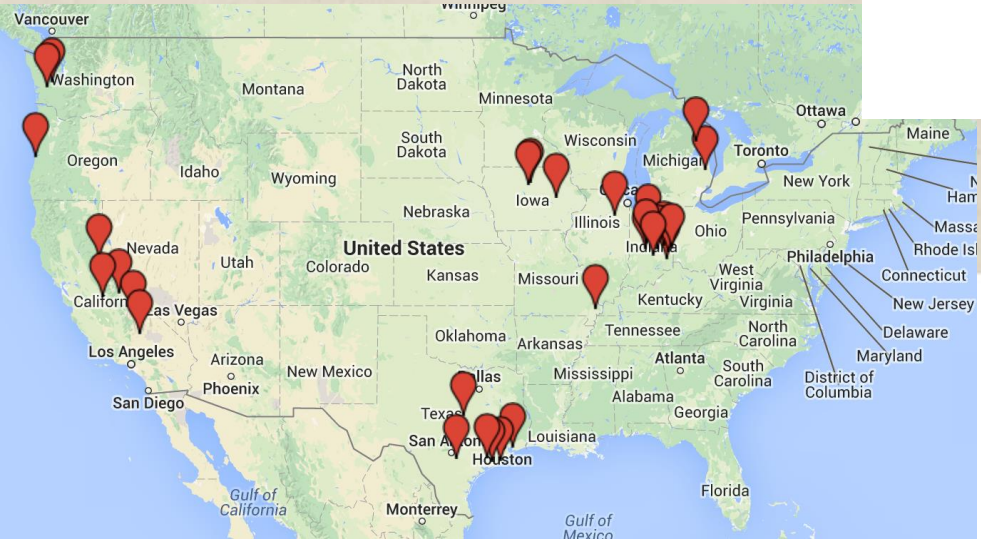
Who is the Consortium?

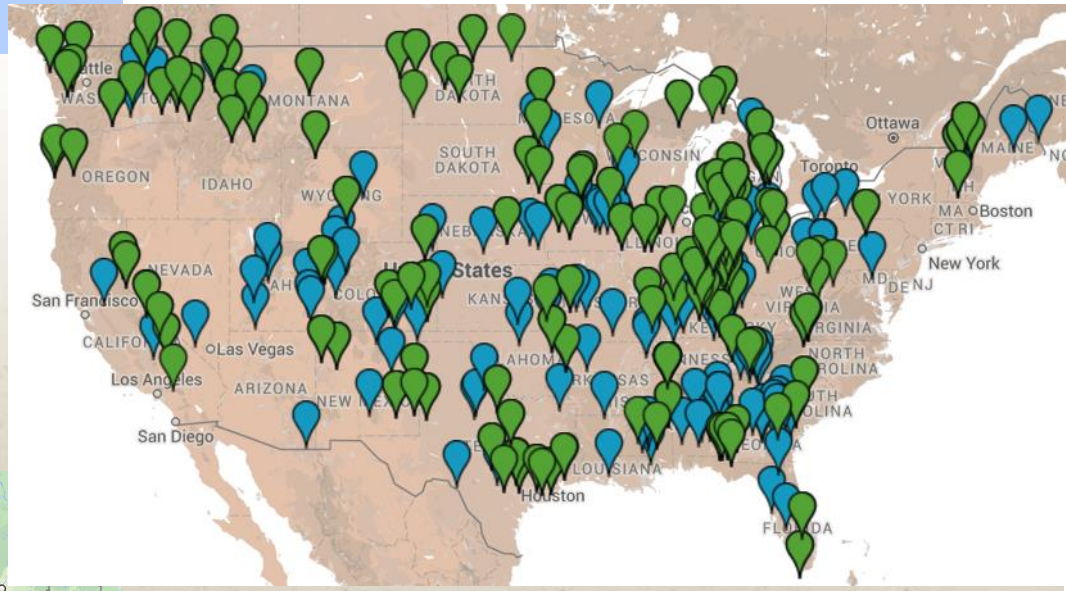
- The National Rural Accountable Care Consortium is a non-profit organization that supports rural healthcare transformation.
- Formed by rural providers to avoid being left behind.
- Awarded up to $31 million TCPI grant in 2015 to assist 525 rural health systems in preparing for value-based payments.
- 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.

2014

2015



Green = ACO,s
Blue = TCPI



2016

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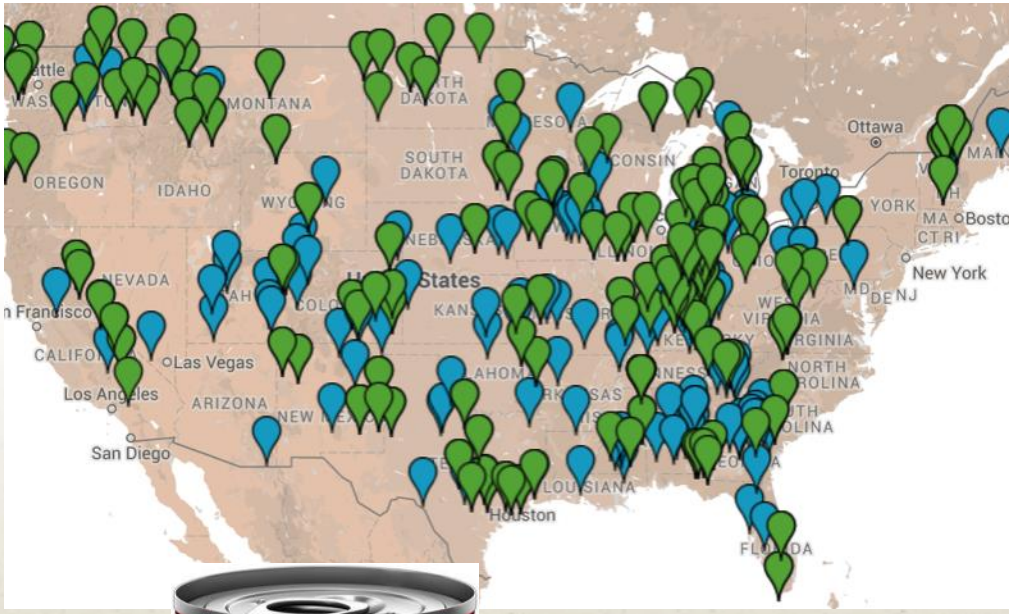
Caravan Health

- **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



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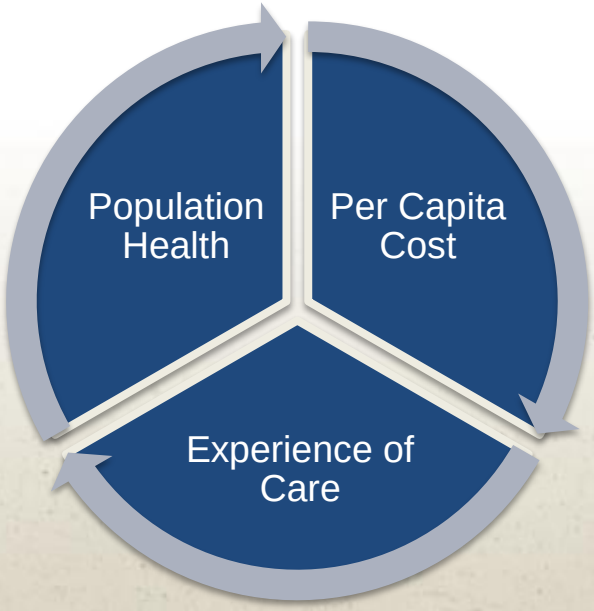
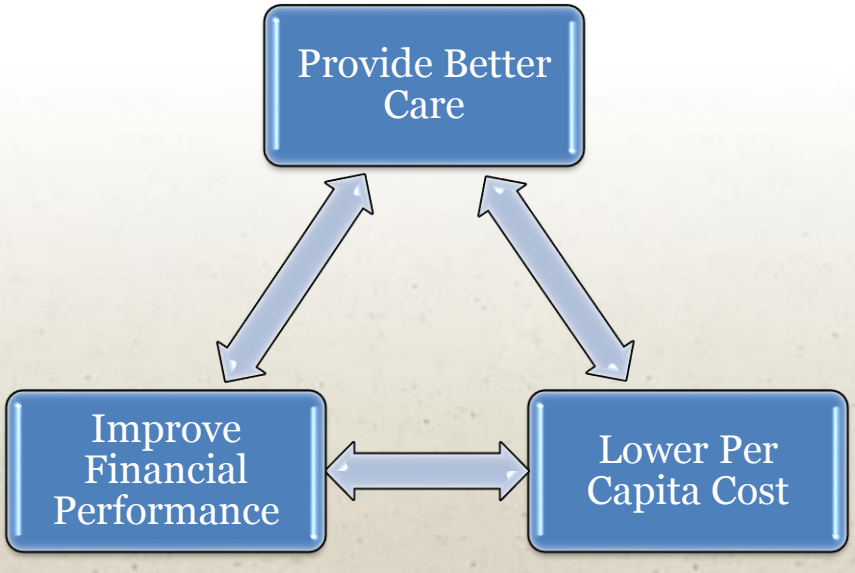
The Triple Aim





Per Capita Total Current Health Care Expenditures, U.S. and Selected Countries, 2010

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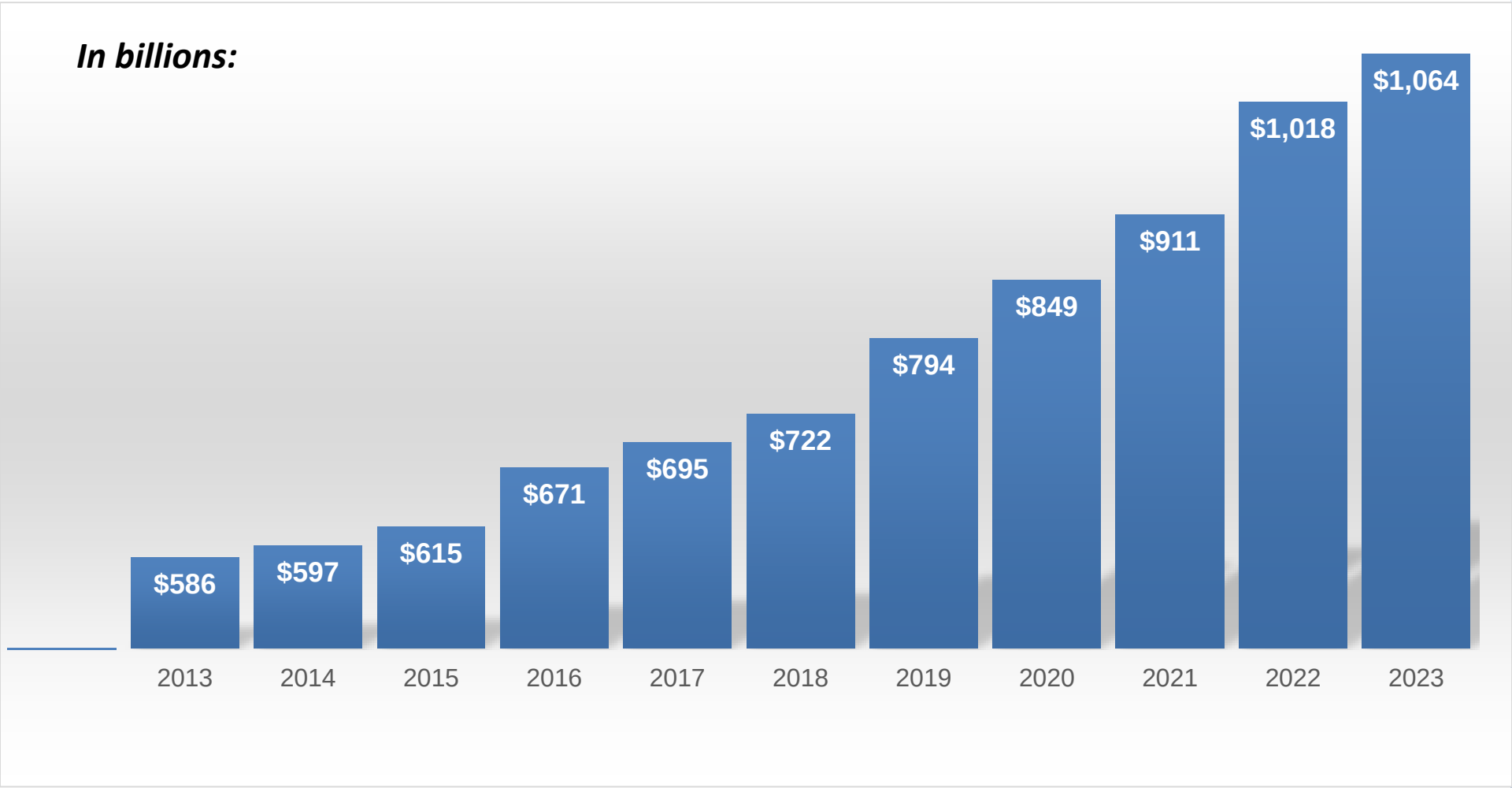
Projected Medicare Spending, 2013-2023



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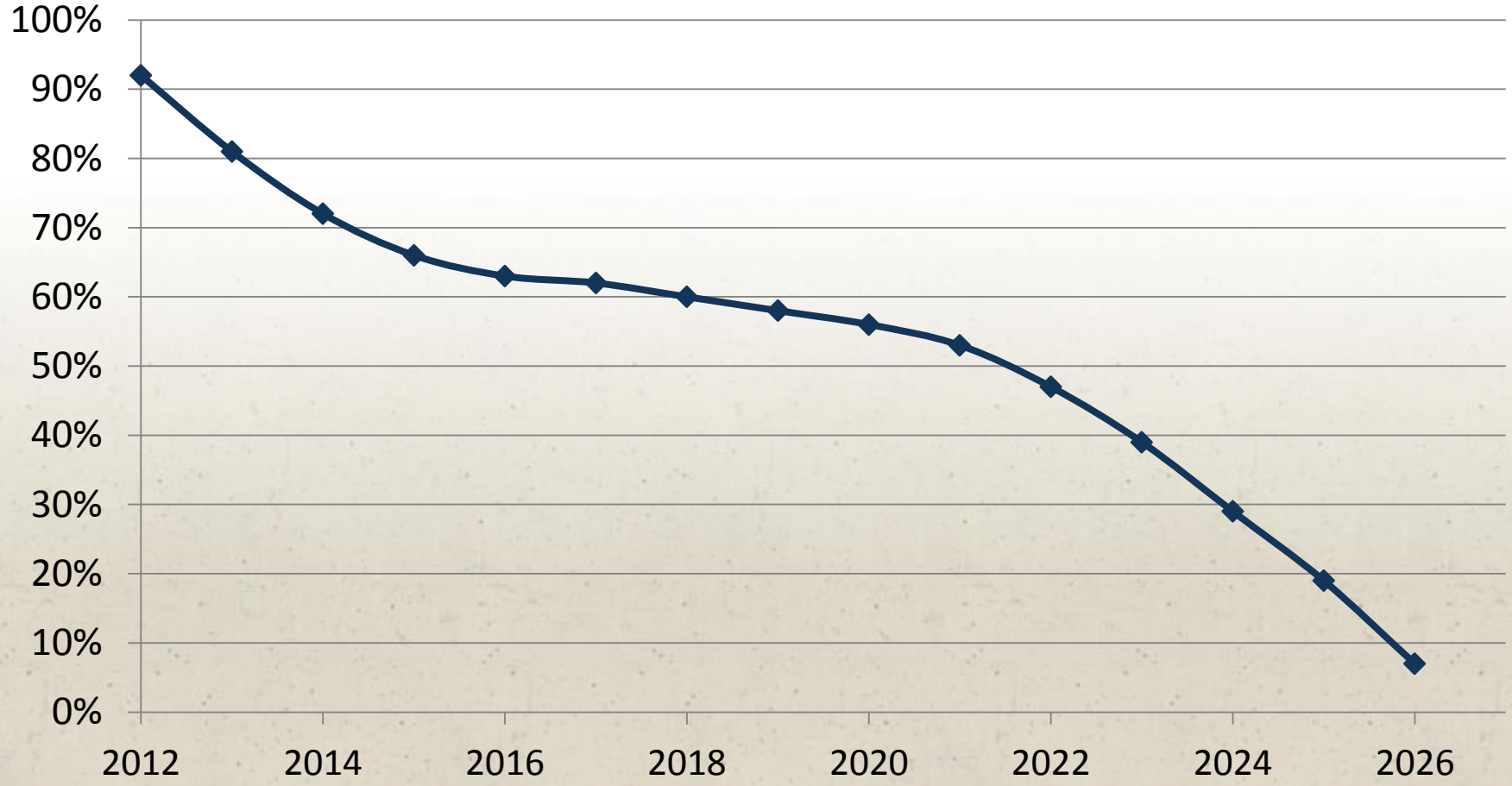
Medicare Part A Trust Fund Balance at Beginning of the Year, as a Percentage of Annual Expenditures

In billions:



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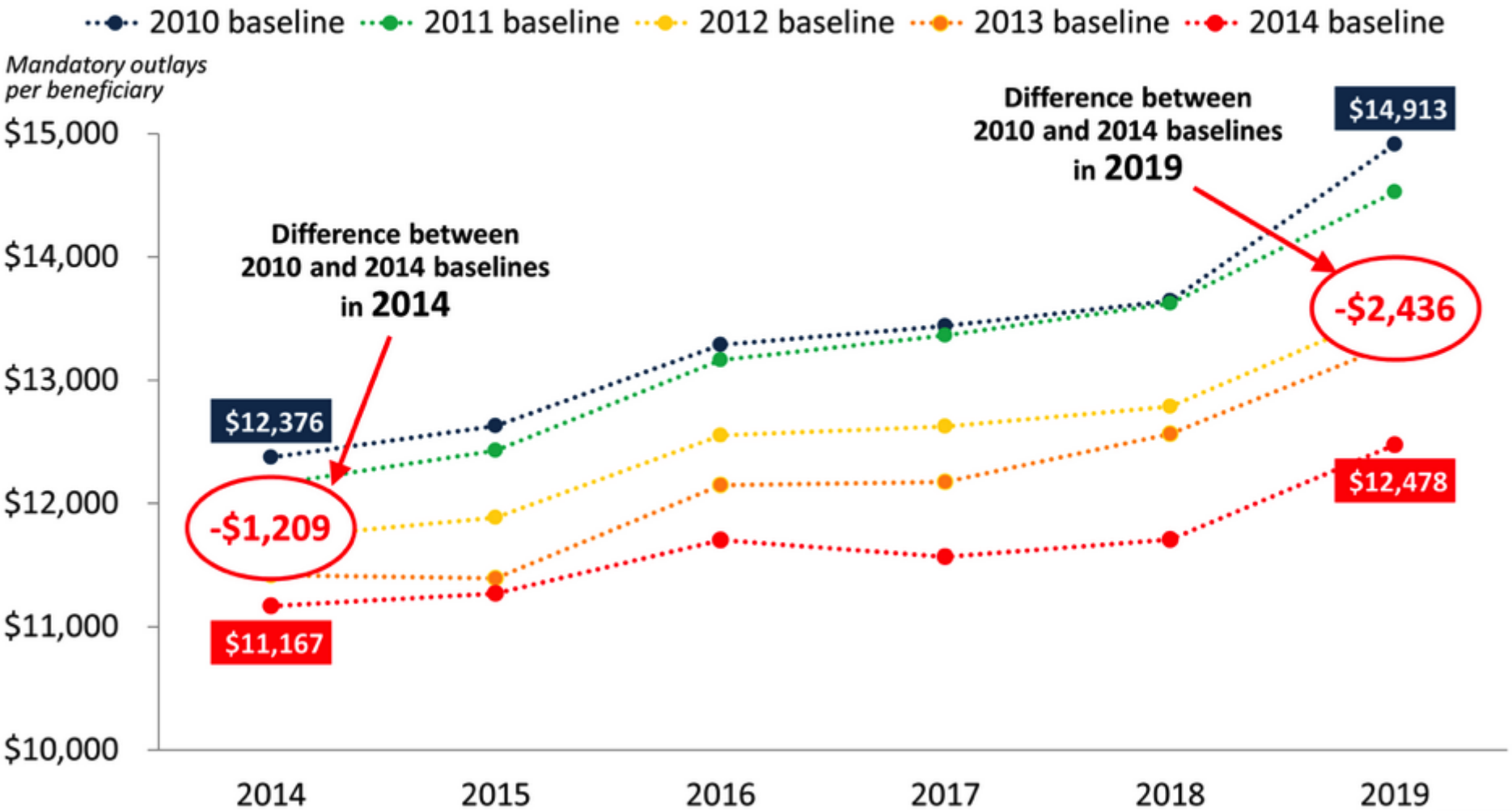
Medicare spending is expected to be $1,200 lower per beneficiary in 2014 than was projected in 2010, and $2,400 lower in 2019



SOURCE: Kaiser Family Foundation analysis of mandatory Medicare outlays and Medicare enrollment data from CBO Medicare baseline projections, 2010-2014; 2014 estimates based on August 2014 baseline.

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Legislative

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%

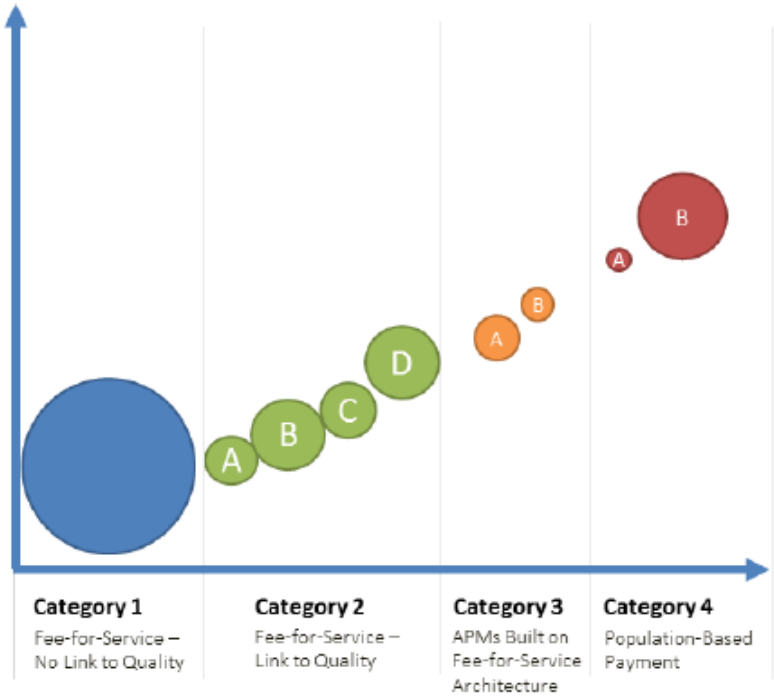
GOAL 2:

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

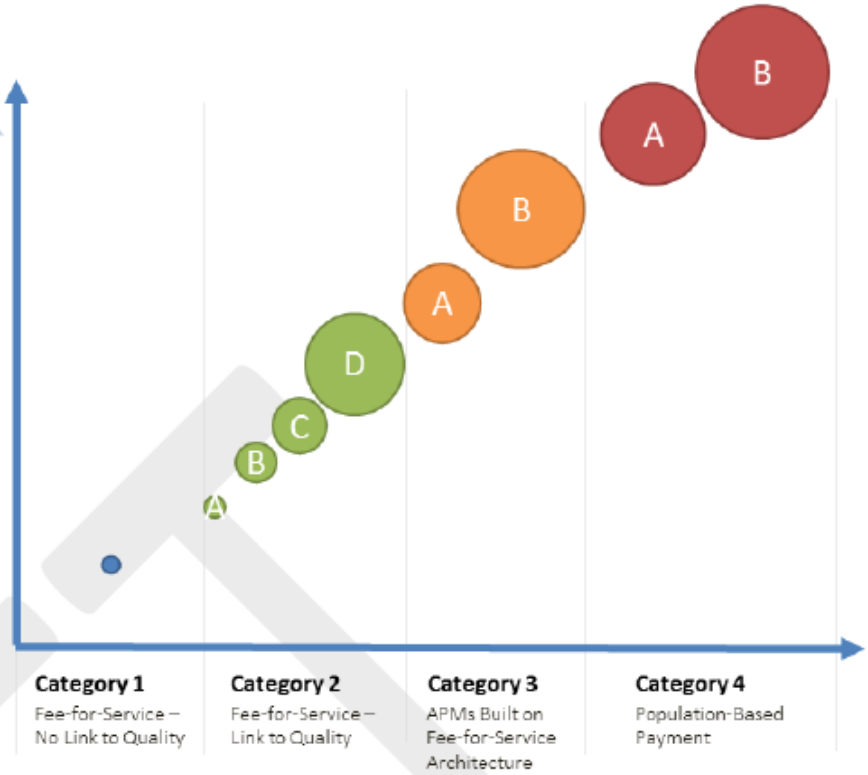
85%

HCP LAN
Health Care Payment Learning & Action Network

CURRENT STATE



- Provider risk and innovation
- Impact of payments on cost and quality performance
- Delivery system integration and coordination
- Patient-centric care



MACRA: 2019 – 2025 (AKA "Doc Fix")

- **Medicare and CHIP Reauthorization Act of 2015.**
- **Increased federal deficit by $141 billion over next 10yrs.**

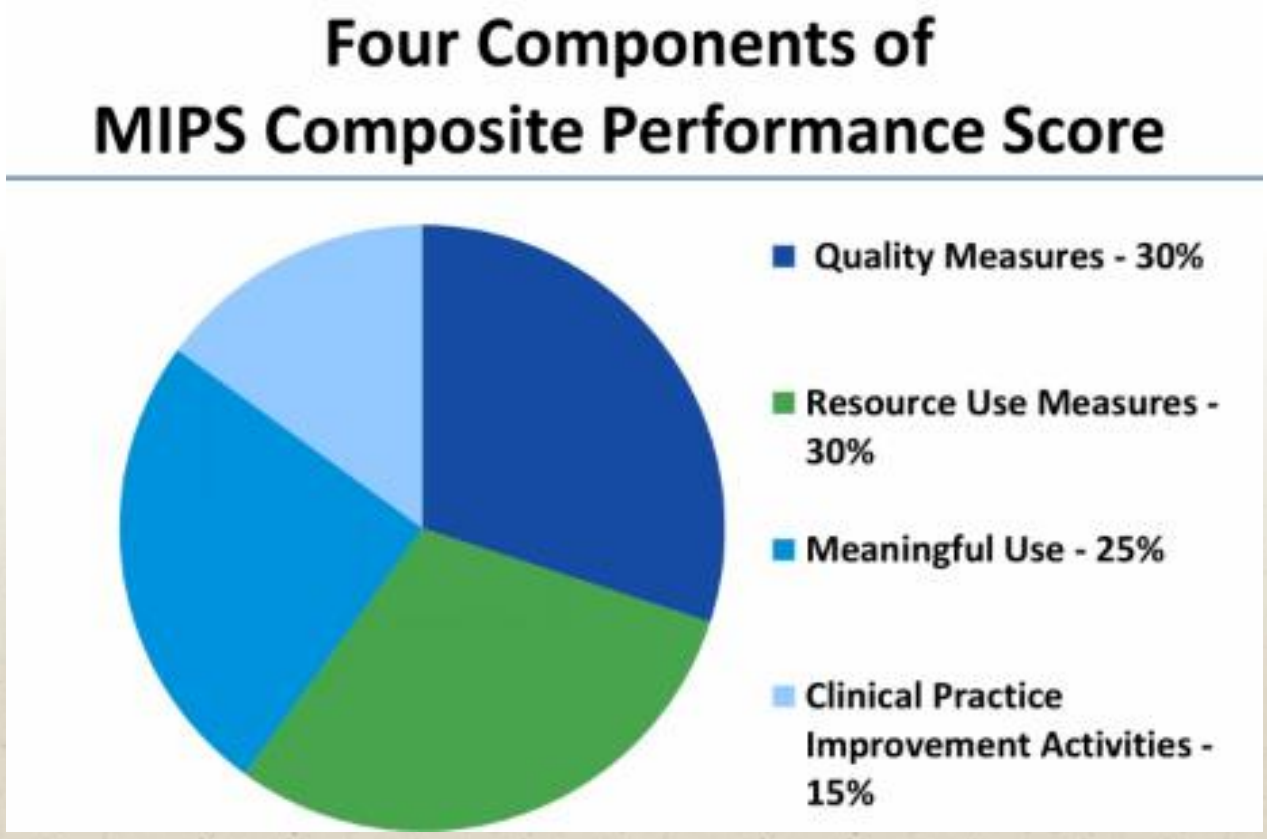
Three key provisions:

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

Annual Updates

2015	0.5 percent update effective June 1 - versus 21 percent cut scheduled for April 1
2016 – 2019	0.5 percent annual updates
2020 - 2025	No updates
2026+	0.75 percent annual updates for providers in alternative payment models 0.25 percent annual updates for everyone else

Measurement year 2017-2018. Benchmark set in 2019.



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

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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

Year	Penalty Cap	Bonus opportunity (subject to scaling factor)
2019	-4%	Up to +12%
2020	-5%	Up to +15%
2021	-7%	Up to +21%
2022	-9%	Up to +27%

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)

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No MIPS if in a Qualified APM (e.g.,ACO)

Alternative Payment Models

Professional who receives significant share of revenues thru qualifying APM	• 5% annual bonus between 2019 and 2024 (paid as lump sum) • Additional 0.5% annual update beginning in 2026 • Excluded from MIPS assessment and most MU requirements
Definition of "Qualifying APM"	• Involves risk of financial loss + quality measure component • CMS to develop specific criteria for multiple models

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.

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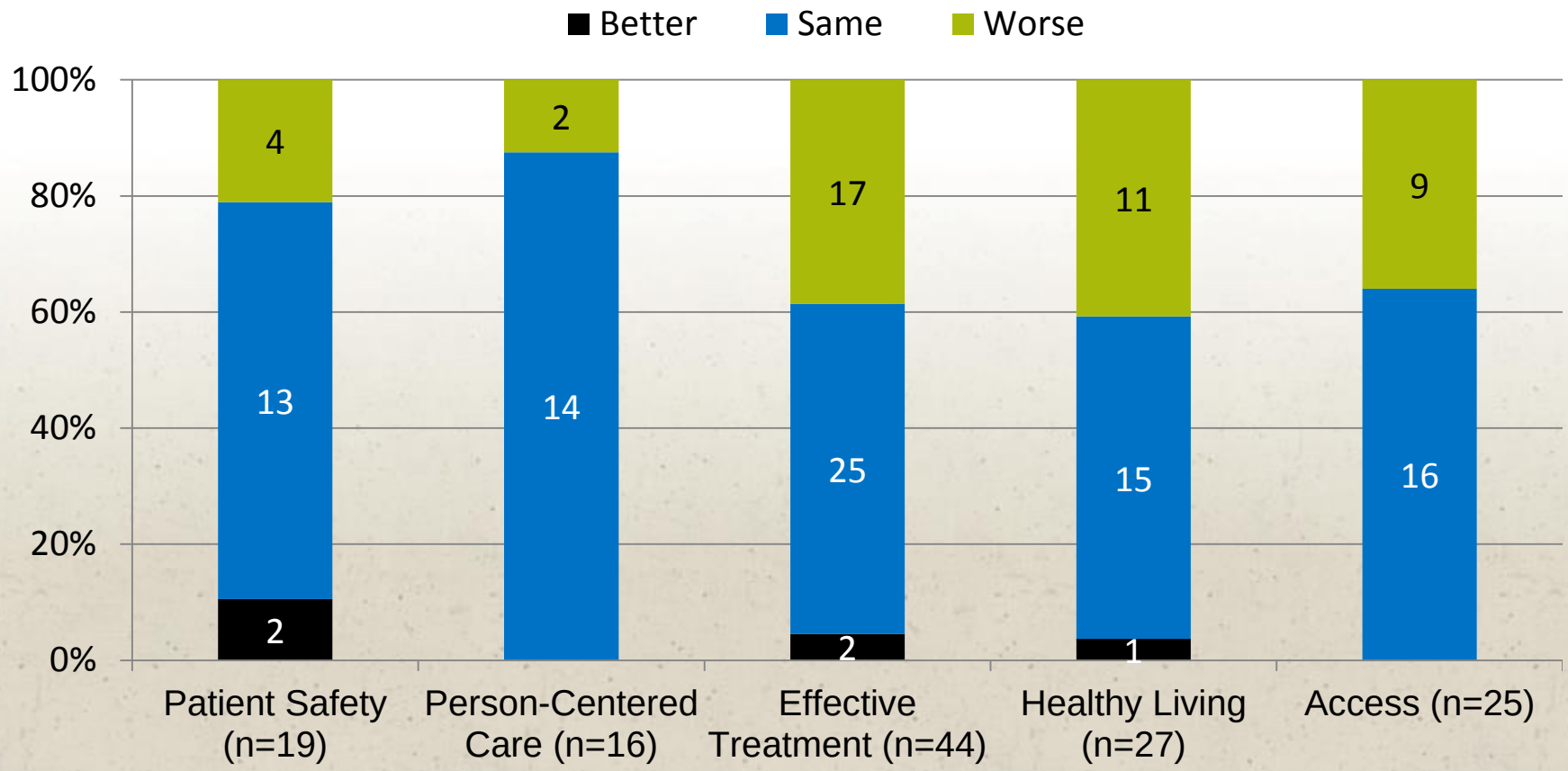
Disparities in Quality of Care Between Rural and Urban



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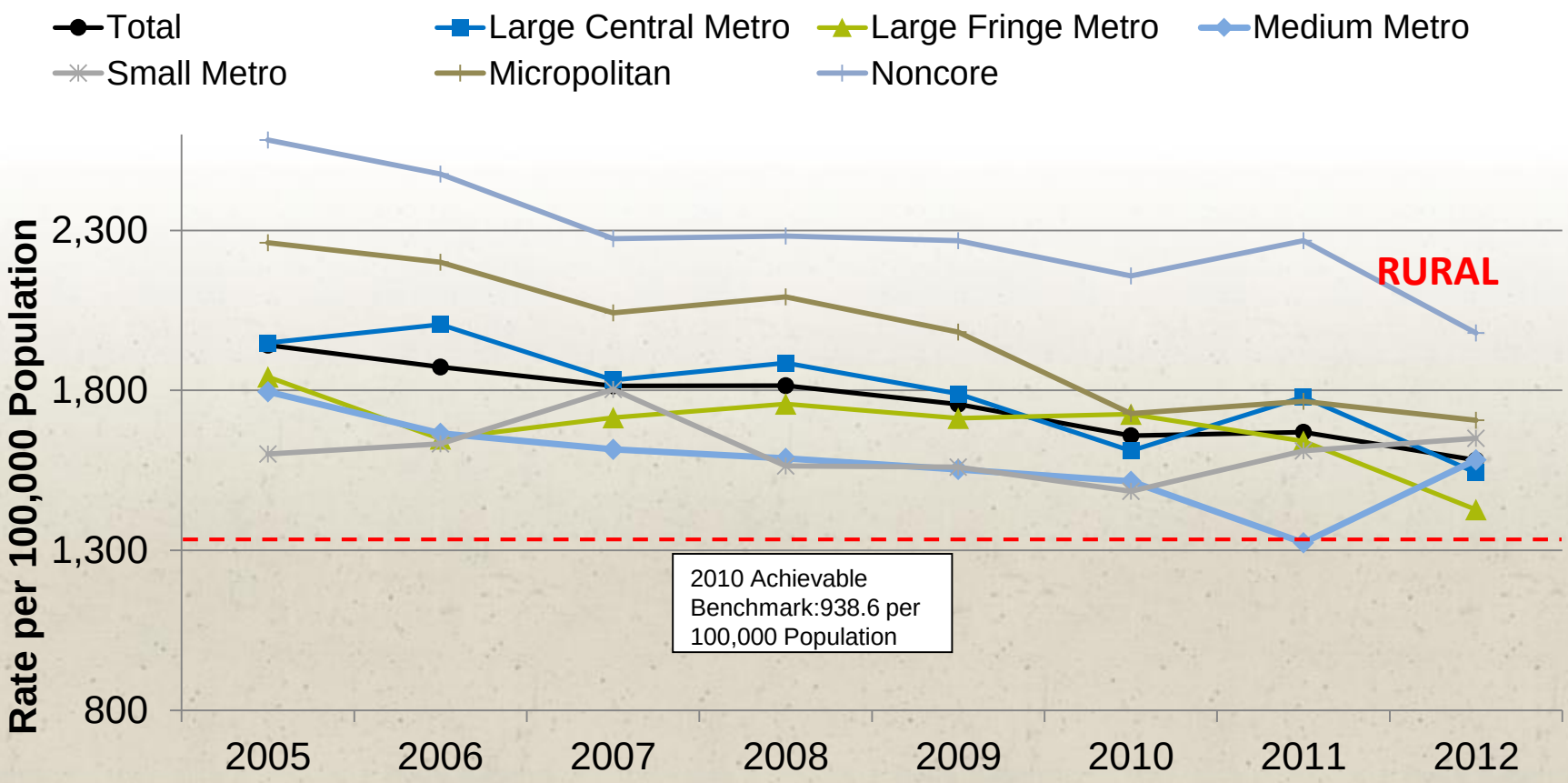
Potentially avoidable hospitalizations for all conditions per 100,000 population, by residence location, 2005-2012



Source: Agency for Healthcare Research and Quality (AHRQ), Healthcare Cost and Utilization Project, 2005-2011 Nationwide Inpatient Sample and 2012 State Inpatient Databases quality analysis file and AHRQ Quality Indicators, version 4.4.

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Quality Varies but Problem Areas are the Same

Clinical Measure Values by ACO

ACO Measures Program-2015																							
At-Risk							Care Coordination/Patient Safety					Preventive Health								Risk-standardized acute admission rate (RSAAR)			
CAD-ACE-LV	DM-EYE	DM-Hb A1C>9	HF-BB-LVSD	HTN-BP	IVD-ASA	ASCA-CHF	ASCA-COPD	F	MEDS	RSACR	AWS	BP2Y	CCS	DS	II	MMS	PV	T	RSAAR-CHF	RSAAR-DM	RSAAR-MCC	RSAAR-SNF
70.%	33.%	18.%	85.%	14.%	38.%	32.%	52.%	5.3%	11.%	70%	13.%	21.%	26.%	2.5%	35.%	50.%	20.%	26.%	16.%	58.%	62.%	100%
68.%	31.%	25.%	91.%	40.%	32.%	36.%	53.%	9.2%	21.%	79.%	18.%	44.%	17.%	2.4%	42.%	49.%	44.%	57.%	26.%	61.%	72.%	100%
53.%	40.%	0.5%		40.%	18.%	44.%	66.%	2.4%	5.6%	87.%	21.%	36.%	18.%	0.1%	38.%	61.%	22.%	38.%	41.%	75.%	75.%	66.%
67.%	36.%	24.%	100%	11.%	37.%	22.%	46.%	4.3%	7.7%	84.%	14.%	17.%	45.%	0.6%	36.%	65.%	33.%	41.%	34.%	69.%	73.%	71.%
82.%	36.%	55.%	99.%	69.%	63.%	34.%	52.%	91.%	106%	82.%	39.%	74.%	63.%	0.4%	53.%	64.%	77.%	94.%	0	51.%	53.%	80%
70.%	29.%	9.1%	100%	33.%	32.%	28.%	56.%	2.9%	6.2%	85.%	10.%	35.%	26.%	0.5%	44.%	61.%	44.%	40.%	6.9%	66.%	62.%	92.%

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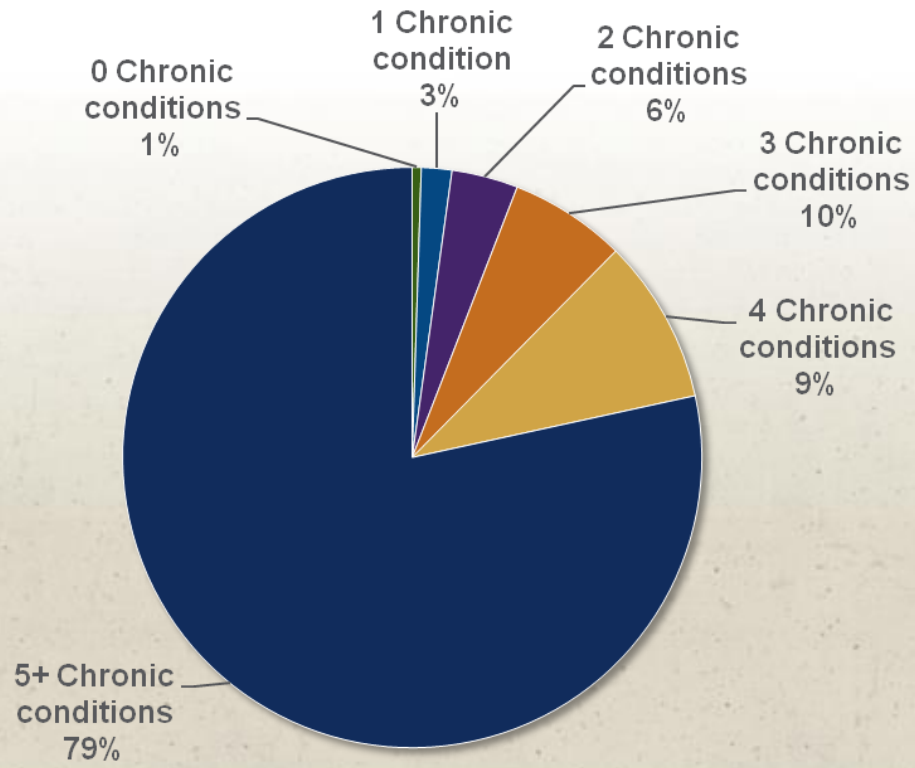
Rural Solutions - The NRACO Program

- 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.

Percentage of Medicare Expenditures



Source: Medicare Standard Analytic File, 2007

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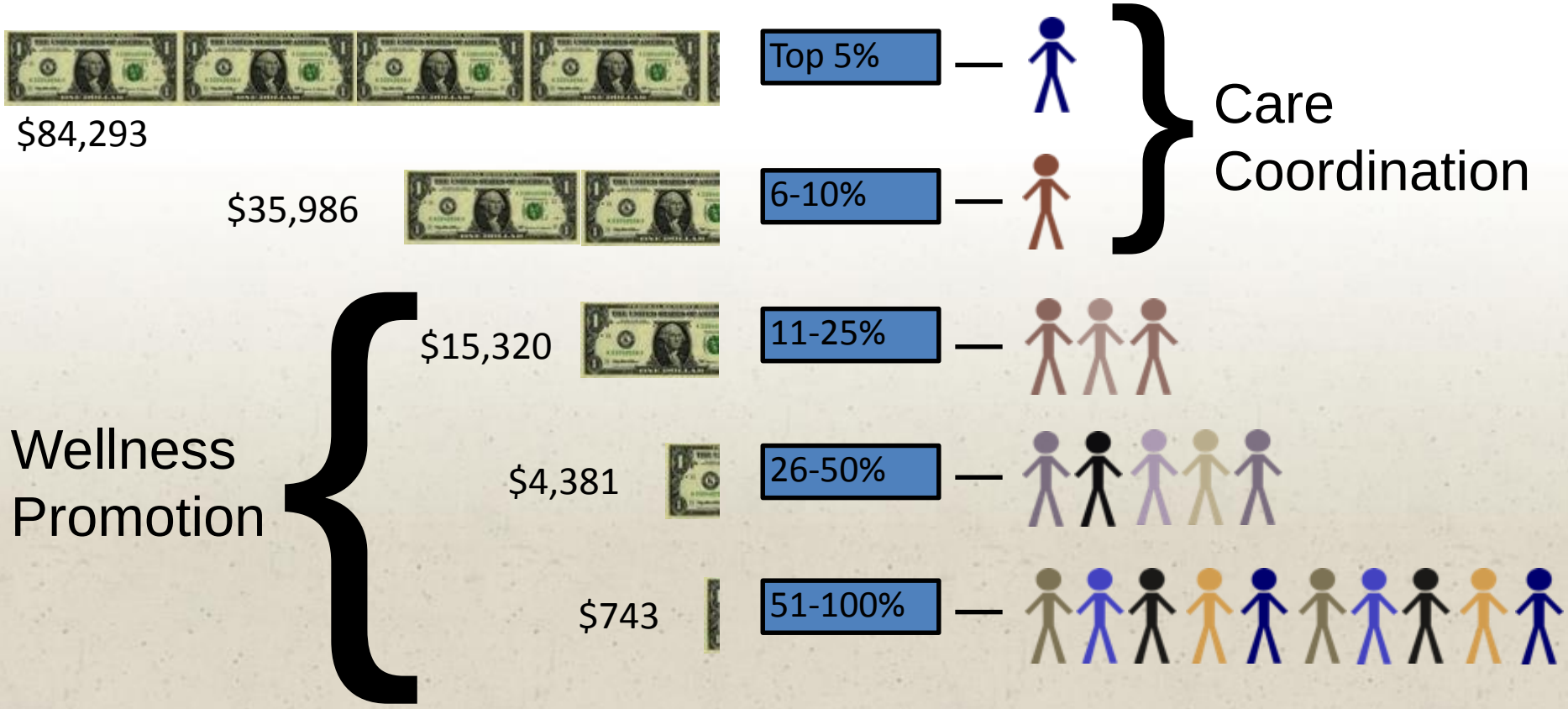
Focus Care Coordination on "Top 10%" Patients to Achieve Savings



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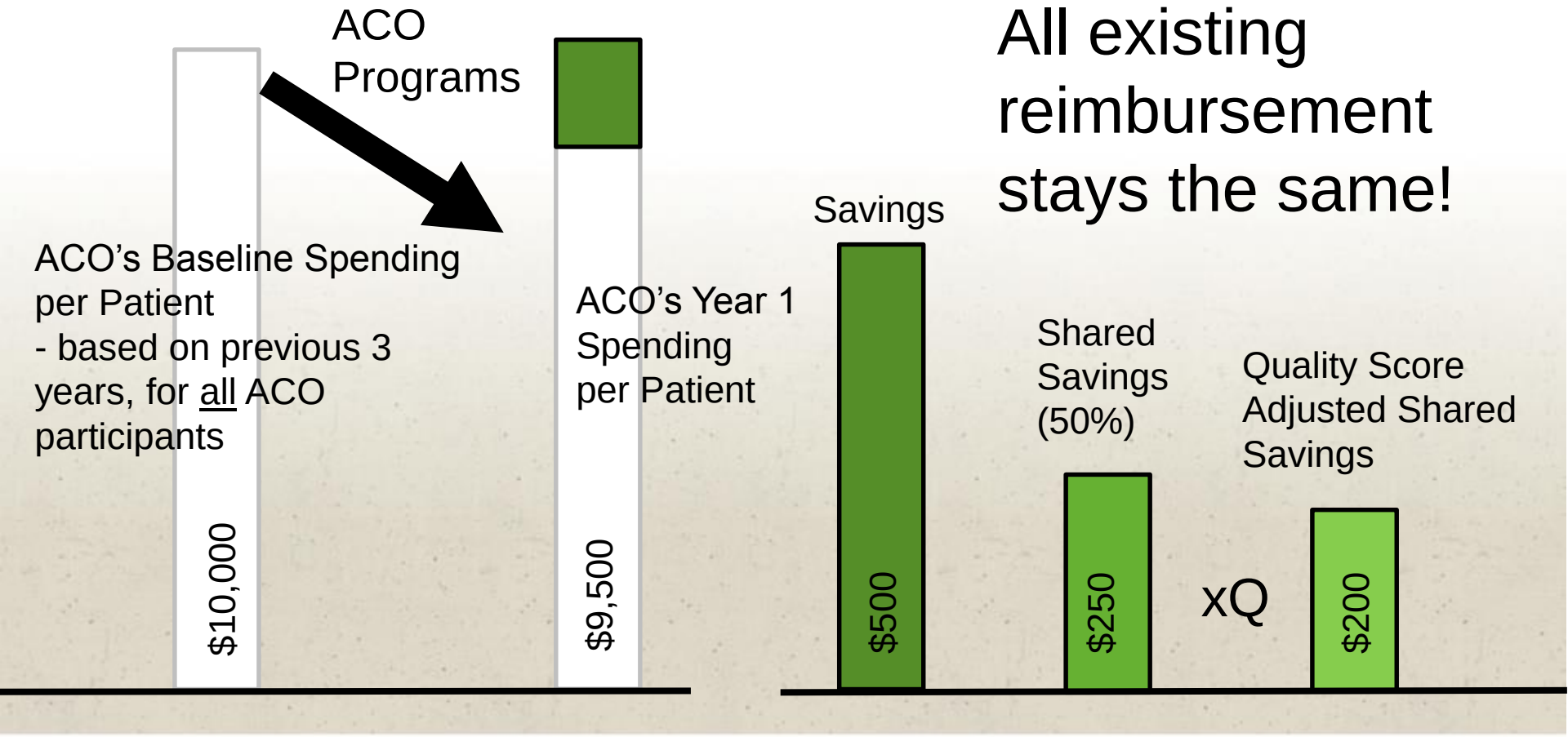
What is an ACO?

- 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?



All existing reimbursement stays the same!

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Reporting on Quality

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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

		2014			2015			
Domain	Metric Name	Eligible	Measure Met	Performance	Eligible	Measure Met	Performance	Change
At-Risk Population Coronary Artery Disease	CAD-2 Lipid Control**	11	9	81.82%				
At-Risk Population Coronary Artery Disease	CAD-7 ACE or ARB with Diabetes or LVSD	7	5	71.43%	7	3	42.86%	-28.57%
At-Risk Population Coronary Artery Disease	CAD-Composite	11	7	63.64%				
Care Coordination/Patient Safety	CARE-1 Medication Reconciliation**1	2	2	100.00%	7	5	71.43%	-28.57%
Care Coordination/Patient Safety	CARE-2 Fall Screening	5	1	20.00%	11	10	90.91%	70.91%
At-Risk Population Depression	Depression remission 12 months				4	0	0.00%	
At-Risk Population Diabetes	DM-7 Eye Exam				3	1	33.33%	
At-Risk Population Diabetes	DM-13 High Blood Pressure Control**2	4	2	50.00%				
At-Risk Population Diabetes	DM-14 LDL-C Control in Diabetes	4	2	50.00%				
At-Risk Population Diabetes	DM-15 Hemoglobin A1c Control	4	0	0.00%				
At-Risk Population Diabetes	DM-16 Daily Aspirin or Antiplatelet with IVD	1	1	100.00%	10	7	70.00%	-30.00%
At-Risk Population Diabetes	DM-17 Tobacco Non-Use**2	4	3	75.00%	12	10	83.33%	8.33%
At-Risk Population Diabetes	DM-2 HA1c Poor Control**3 (lower score)	4	1	25.00%	4	2	50.00%	25.00%
At-Risk Population Diabetes	DM-Composite	4	0	0.00%				
At-Risk Population Heart Failure	HF-6 Beta-Blocker Therapy for LVSD	5	4	80.00%	7	7	100.00%	20.00%
At-Risk Population Hypertension	HTN-2 Controlling High Blood Pressure	15	9	60.00%	9	9	100.00%	40.00%
At-Risk Population Ischemic Vascular Disease	IVD-1 LDL-C Control**	9	4	44.44%				
At-Risk Population Ischemic Vascular Disease	IVD-2 Use of Antithrombotic	9	9	100.00%				
Preventative Health	PREV-05 Breast Screening	32	20	62.50%	40	40	100.00%	37.50%
Preventative Health	PREV-06 Colorectal Cancer Screening	36	18	50.00%	23	19	82.61%	32.61%
Preventative Health	PREV-07 Influenza Immunization	16	3	18.75%	11	7	63.64%	44.89%
Preventative Health	PREV-08 Pneumonia Vaccination	25	9	36.00%	17	10	58.82%	22.82%
Preventative Health	PREV-09 Body Mass Index Screening	21	17	80.95%	23	17	73.91%	-7.04%
Preventative Health	PREV-10 Tobacco Use Screening	20	20	100.00%				
Preventative Health	PREV-11 High Blood Pressure Screening	36	26	72.22%	39	29	74.36%	2.14%
Preventative Health	PREV-12 Clinical Depression Screening	19	3	15.79%	16	12	75.00%	59.21%
Grand Total		**304**	**175**	**57.57%**	**243**	**188**	**77.37%**	**19.80%**

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Total Expenditures per Assigned Beneficiary

$13,000
$12,000
$11,000
$10,000
$9,000
$8,000
$7,000
$6,000

$11,058
$10,570
$10,033
$9,726
$9,768
$9,273
$9,027
$8,028
$11,556
$11,531
$10,232
$9,854
$9,785
$9,406
$8,295
ALL NRACO
$11,905
$11,178
$10,830
$10,170
$9,982
$9,627
$9,591
$9,582
$7,898

All MSSP ACOs
National FFS

2012
2013
2014
Q1 2015
Q2 2015
Q3 2015
Q4 2015

Benchmark Years to PY Quarters

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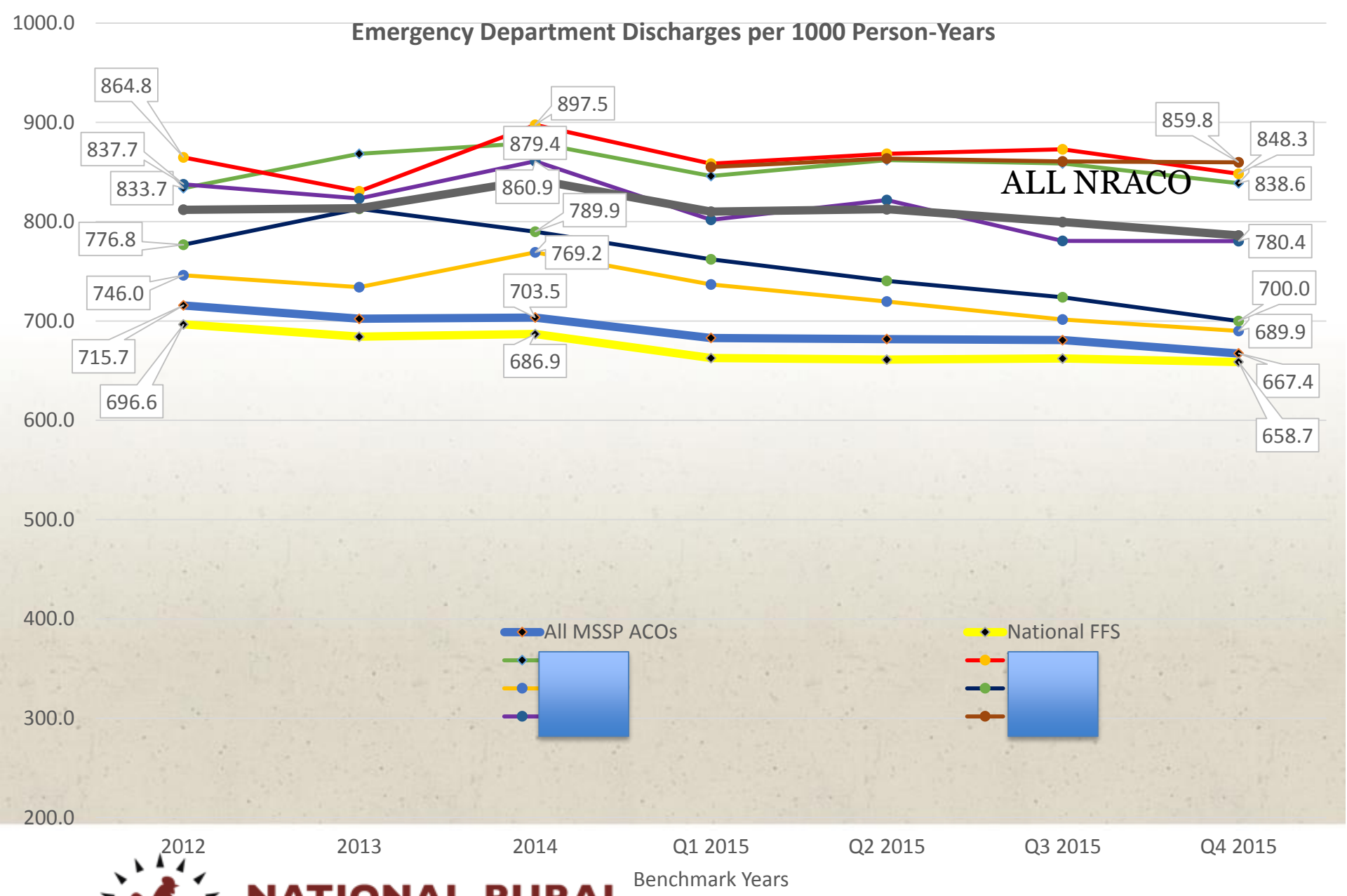

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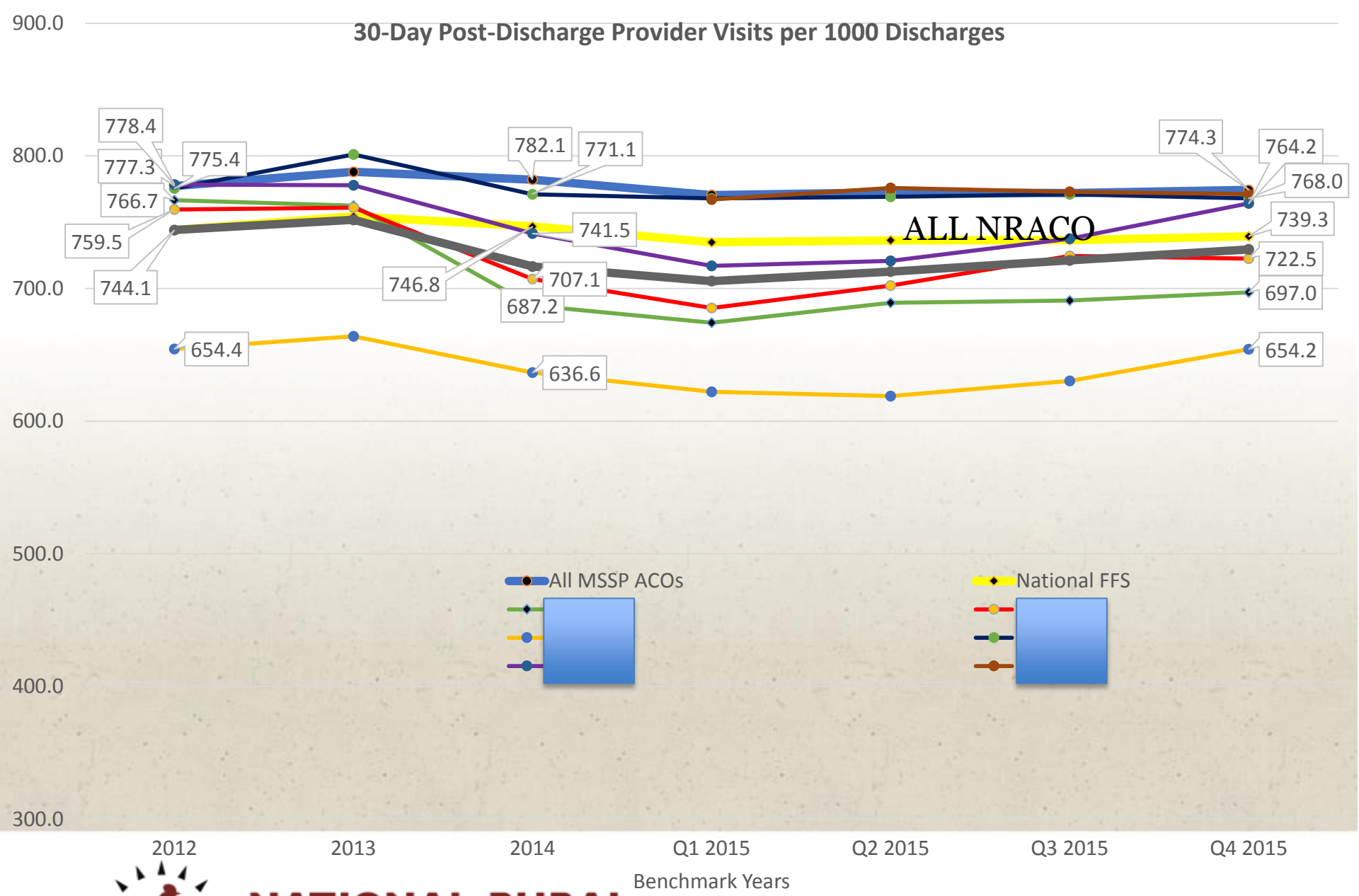

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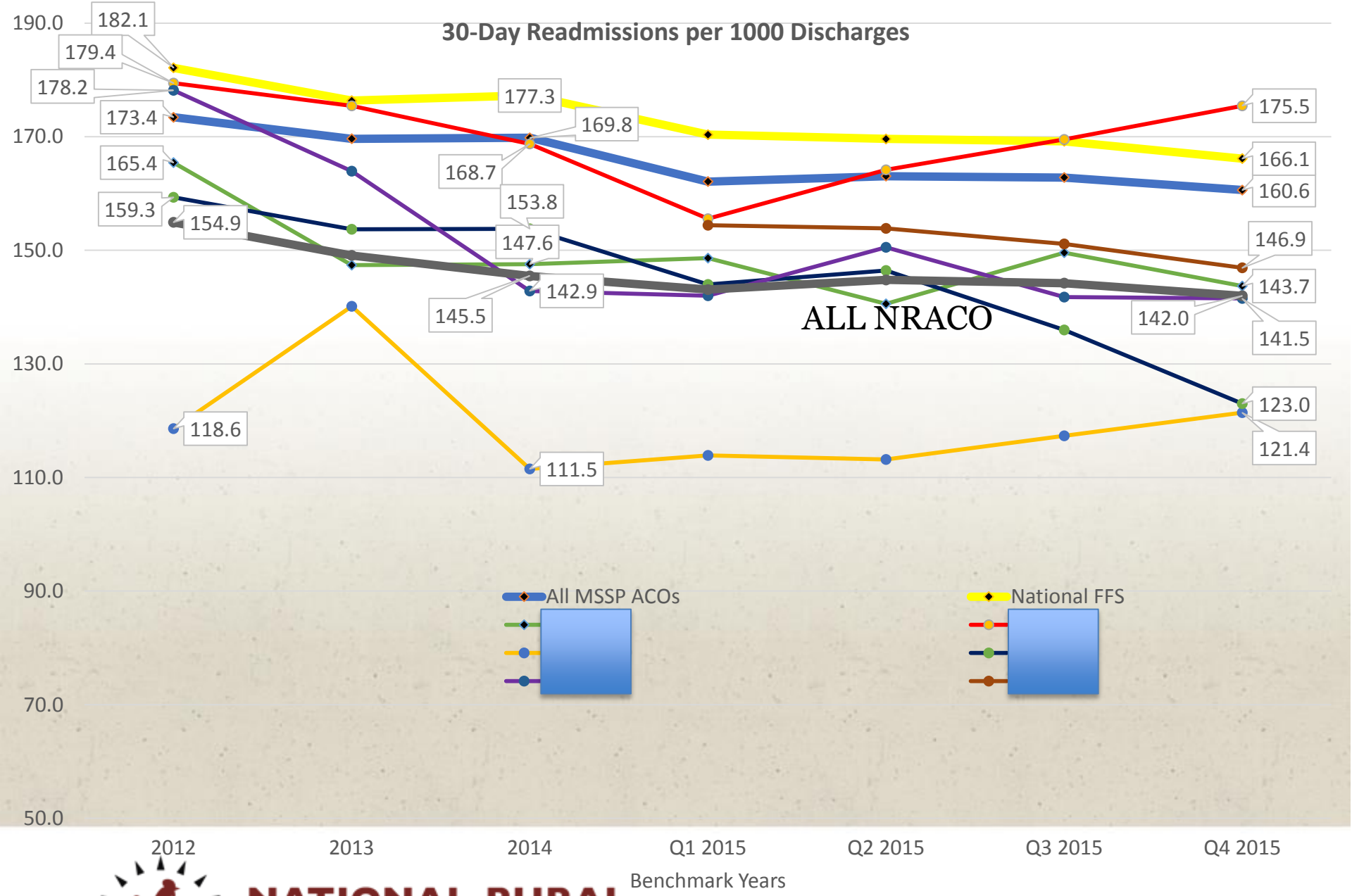

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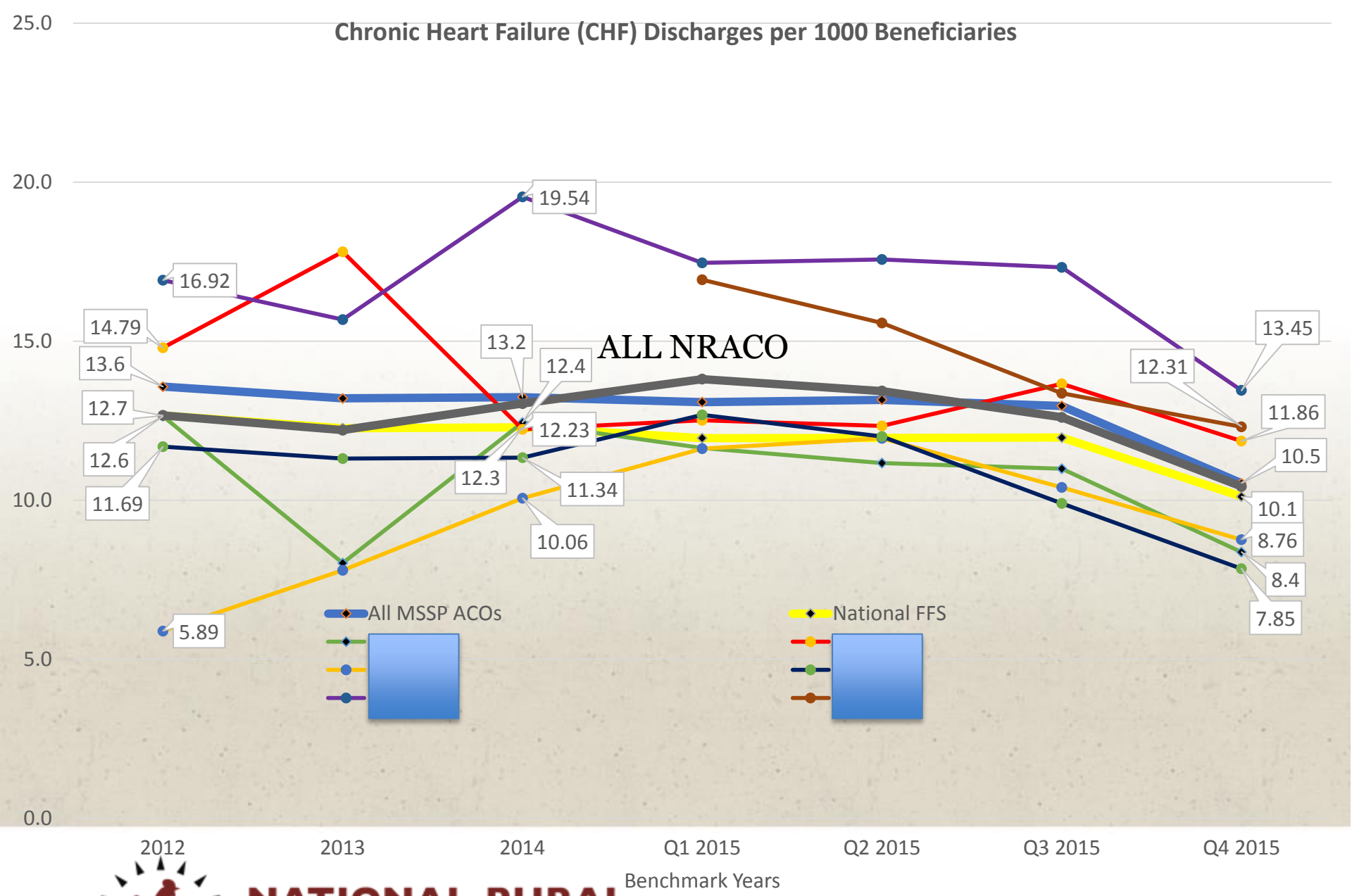

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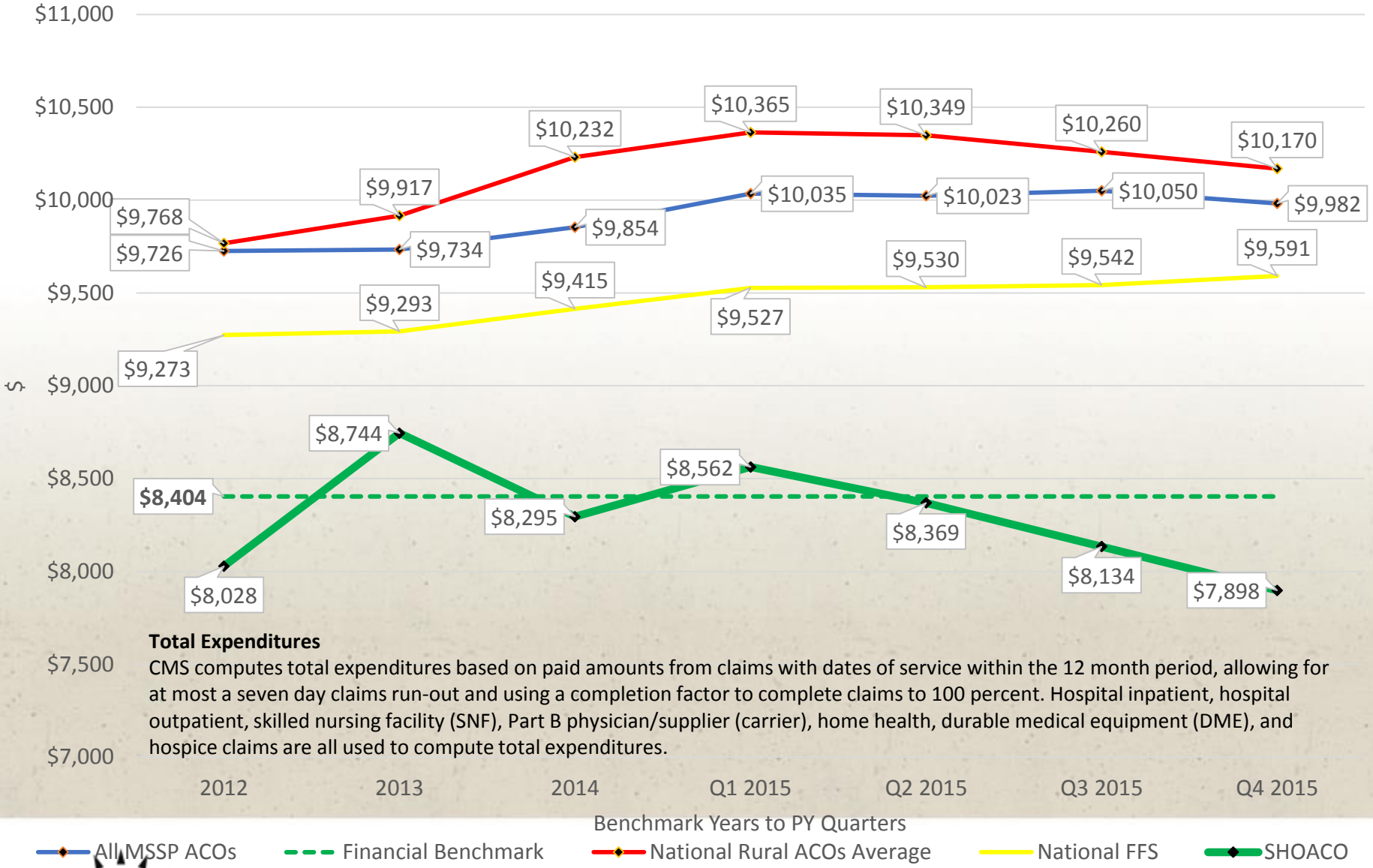
Total Expenditures per Assigned Beneficiary



Total Expenditures

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

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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

NATIONAL RURAL
ACCOUNTABLE CARE CONSORTIUM

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?

Go to www.nationalruralaco.com

Click on Apply Now

OR contact:

info@nationalruralaco.com

OR go to our webinar:

May 25th, 12 PM Pacific

www.readytalk.com, 5004777

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