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New York Rural Hospitals Can Thrive Under the Quality Payment Program

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About Caravan Health

The healthcare industry is moving from Fee-for-Service to **Value-based Payments.**

CMS is driving this change through **highly-complex programs.**

Providers need **expert help** to qualify, participate, and succeed.

Part 1: MACRA and Rural Hospitals

- Understand how MACRA impacts rural patients and providers.

Part 2: Population Health Solutions

- Learn about strategies for rural hospitals to help patients, improve income and prepare for a value-based future.

Part 3: Calculate the Impact

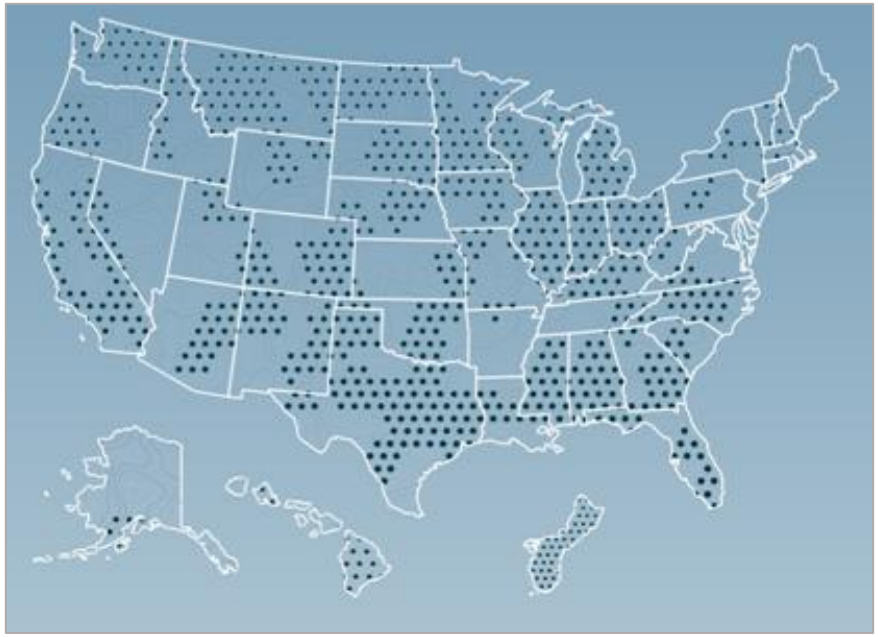
- Use a calculator to estimate the impact of the QPP on eligible part B payments.

About Caravan Health

Helping Providers Navigate the Challenges of Value-Based Payments

Medicare ACOs	MACRA	CPC+	Commercial ACOs

- Founded in 2013
- 38 Accountable Care Organizations (250+ hospitals)
- >14,000 Providers
- >1,000,000 Patient Lives
- Results (cms.data.gov)
  - 95%- 97% Quality Scores
  - 6.5x National Average of Shared Savings



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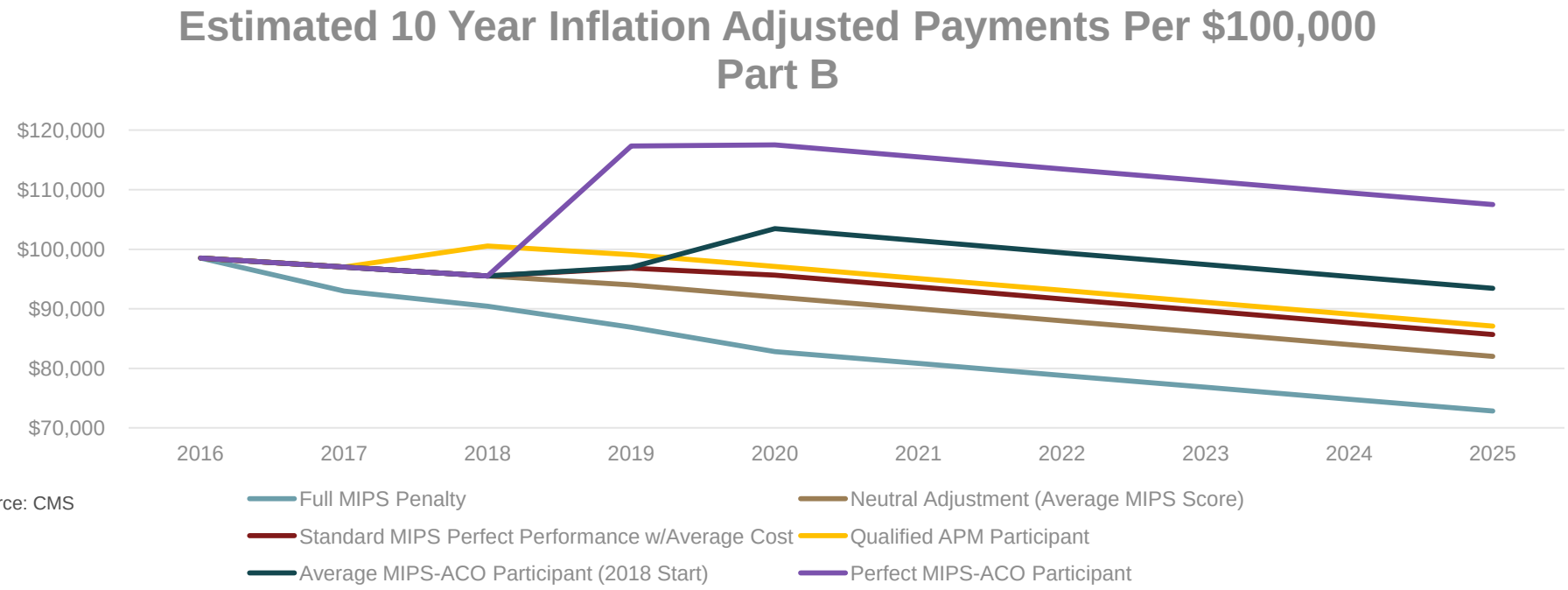
MACRA Quality Payment Program

Physician Fee Schedule Increases Will Not Keep Pace With Inflation

2015 and earlier		2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026 and later
Fee	Fee Schedule Updates	**0.5**	**0.5**	**0.5**	**0.5**	**0**	**0**	**0**	**0**	**0**	**0**	**0.75** QAPMCF* **0.25** N-QAPMCF*



Source: CMS

MACRA: Medicare Access and CHIP Reauthorization Act

Passed with bipartisan support; signed into law in April 2015.

Repealed the Sustainable Growth Rate Formula which linked Medicare annual payment adjustment for physician services to GDP growth.

Established the Quality Payment Program (QPP). Clinicians who participate in Medicare Part B choose how to participate based on practice size, specialty, location, or patient population.

Qualifying Advanced Alternative Payment Models (QAPMs)

- Incentives for taking risk, but also may pay large penalties; MIPS exempt
- Requires quality reporting and >50% EMR adoption
- Limited to 5% upward adjustment
- Example: Track 2 or 3 ACO

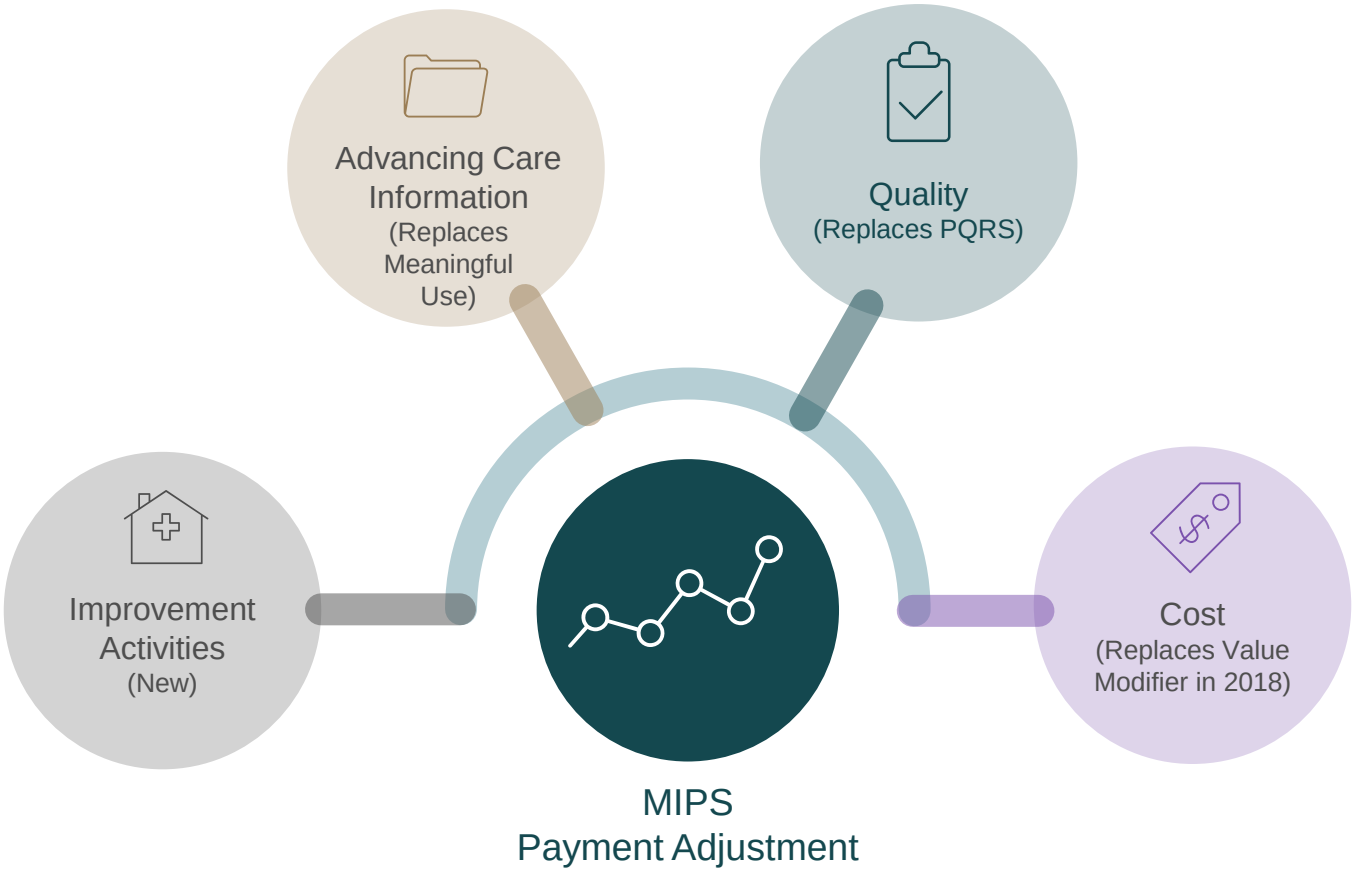
Merit-based Incentive Payment System (MIPS)

- Most complex MIPS reporting
- Lowest scoring MIPS option
- Potential for up to 9% adjustment, not likely to exceed 5%

MIPS-APM

- Least complex MIPS reporting
- Highest scoring MIPS option
- Potential shared savings with no downside risk
- Potential for up to 37% adjustment, not likely to exceed 20%
- Example: Track 1 ACO

MIPS Scoring



MIPS Scores Drives Payments

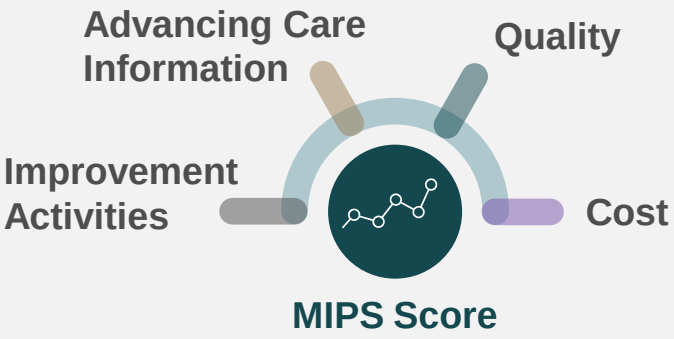
MIPS places the final score of each clinician on a curve, and adjusts Part B payments based on their precise location as compared to others.

- Dollars shift from the bottom 50% to the top 50%
- The top performers get another $500 million for five years
- In 2018, 30%- 40% of QPP participants will be in Track 1 ACOs who earn higher MIPS scores due to special scoring

MIPS-APM Participants Score Higher

MIPS

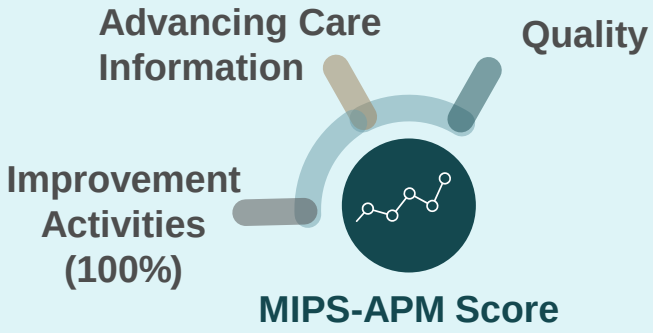
- MACRA LAW: Cost must be 30% of MIPS score by 2019 – average cost will mean maximum score is 85 points



MIPS-APM

One MIPS score for *all* providers

- Exempt from Cost
- Automatic 100% for CPIA
- Weighted Average ACI score – Stage 2 MU > 85 points
- ACO Quality Scores Average 91%



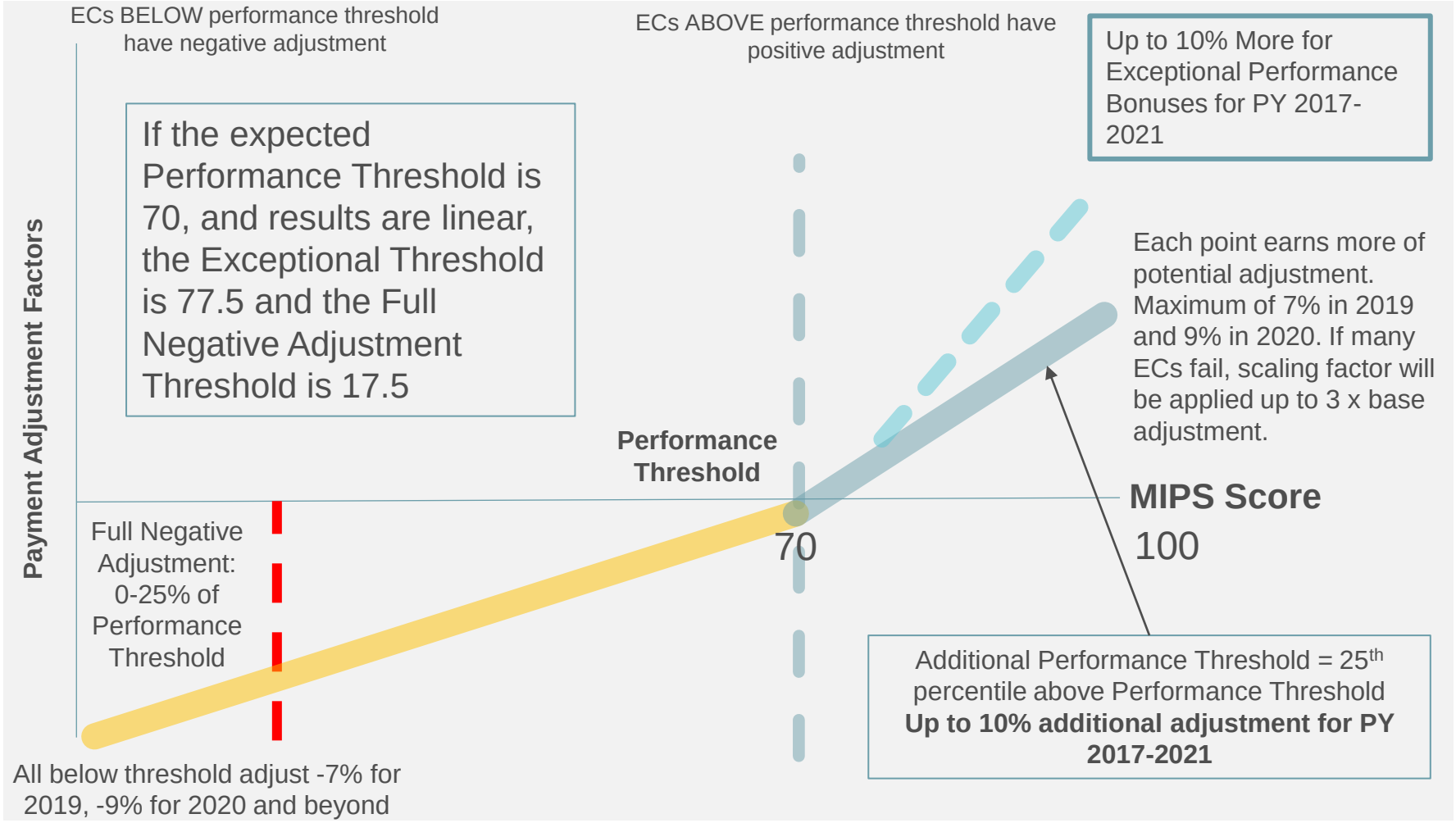
ACO Participation Improves MIPS Score

	Practice Score – No ACO	2019 MIPS Weight	2019 MIPS Score	Same Practice but in ACO	2019 MIPS–APM Weight	2019 MIPS–APM Score
Quality	85%	30%	25.5	91%	50%	45.5
Improvement Activities	100%	15%	15	100%	20%	20
COST	50%	30%	15	50%	0%	0
Advancing Care Info.	90%	25%	22.5	90%	30%	27
Total			**78**			**92.5**

The very best, top-performing practices will get average MIPS scores and little or no upward adjustment if they are not in an ACO.

- ACO quality scores are better due to having claims data to find missing results, six weeks to polish data and only reporting on a sample of attributed patients. ACO average quality score is 91%.
- In 2019 cost will weigh 30%. ACO participants will have an average 15 point advantage.

Every Point Adjusts Income (In 2 Years)



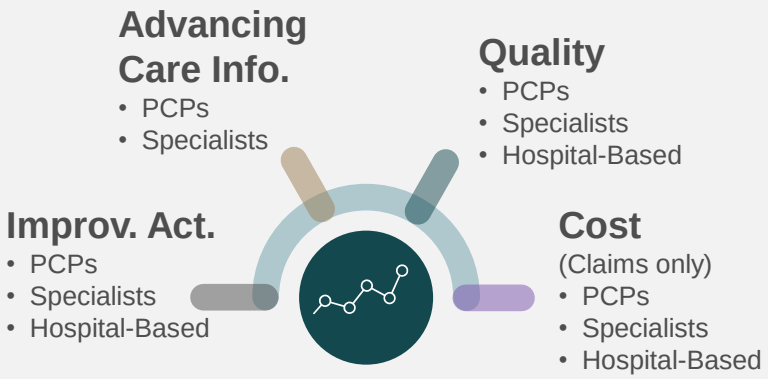
Perfect MIPS-APM Score is Best Result

MIPS Strategy *For Participant with $100,000 in 2015 Billing*	Estimated 10 Year Inflation Adjusted Total Revenue	Estimated Inflation Adjusted Change in Revenue by 2025	Physician Compare Grade after 2018
Pay Penalty	$835,745	26% Down	F
Average MIPS (or Exempt)	$907,000	18% Down	C (or Listed as Exempt)
Perfect MIPS Average Cost	$931,874	14% Down	B
Qualified APM	$947,725	12.9% Down	APM Score
Average MIPS-APM	$978,610	6.6% Down	A
Perfect MIPS-APM	$1,083,345	7.5% Up	A

MIPS-APM Participants Report Less

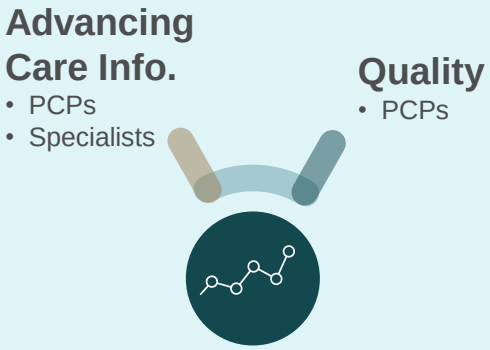
MIPS

- All eligible clinicians report all categories except Advancing Care Information (which exempts hospital-based physicians)
- Cost is claims-based and does not require reporting



MIPS-APM

- All TINs report ACI except TINs that only include hospital-based physicians
- Only PCPs (and specialists that act like PCPs) report quality on a subset of patients attributed to ACO for primary care



ACOs Enable and Fully Qualify Clinically Integrated Networks

The Hospital as the ACO Convener

Why?

- Organize your clinicians around your mission of community care
- Improve the income and reputation of your community clinicians
- Protect your referral network from joining a competing ACO that is free and shares savings to providers
  - **Aledade:**
    Charges cost + 40% shared savings
  - **Collaborative Health Systems:**
    Charges cost + 50% of shared savings
  - Competitors?
- Allows YOUR exempt providers to be listed on Physician compare with very high scores.
- Population Health is a surprisingly good business model for hospitals

How?

- Utilize waivers of Stark, Anti-Kickback Stature, Patient Inducement, and Anti-trust
- Hospital forms ACO and loans costs to ACO
- Physicians participate at no cost
- If shared savings, loans are repaid, hospital keeps 20% plus their share of savings, independents get the rest
- If no shared savings, loan is forgiven

Benefits of Track 1 MIPS-APM

Clinical and Community

- Provide coordinated, proactive care for your community
- Engage patients with important wellness visits and preventative care services like mammograms and colonoscopies
- Receive claims data from CMS and use it to predict and prevent disease progression
- Strengthen local providers' reputation and income
- Sustain a strong local health care system, preventing out-migration

Financial Performance

- Sustain existing fee-for-service reimbursement and avoid unnecessary downside risk
- Grow wellness revenues by $500 to $1,000 annually per Medicare patient
- Maximize MACRA bonuses and quality scores with the least amount of effort
- Protect employed and community physicians from MACRA penalties
- Earn additional financial incentives for improving quality and lowering costs
- Receive infrastructure and support to succeed under value-based reimbursement models

Practice Score Card: The Key to Success

Practice ABC

Category	Metric	Status	Points	Points Possible
Leading Indicators	RN Care Coordinator in place	✓	6	6
	Physician Leader in place	✓	6	6
	Lightbeam Interface Status as of X/X/XXXX date	In Dev.	4	6
Care Coordination	# Active Medicare AWV Cases - Claims + EHR Interface Data Q1 2017	300		
	% of patients with AWV - full credit for over 50%	41.0%	4	6
	# Active Medicare CCM Cases - Self Reported Q1 2017	140		
	% of patients in CCM - full credit for over 10%	17.0%	6	6
	# Active Medicare TCM Cases - Self Reported Q1 2017	170		
	% of patients in TCM - full credit for over 10%	8.0%	4	6
Key Billing Indicators	Billing AWV	✓	4	4
	Billing CCM	✓	4	4
	Billing TCM	✓	4	4
	Billing Advance Care Planning (ACP)	X	0	4
Outcomes	Patient Satisfaction Tablet Utilization Rate	27.0%	6	6
	Quality score	100.0%	6	6
	Total Cost - full credit for reduction beyond statistical threshold	-3.2%	6	6
	ED utilization - full credit for reduction beyond statistical threshold	-2.5%	2	2
	SNF utilization - full credit for reduction beyond statistical threshold	3.0%	0	2
	IP utilization - full credit for reduction beyond statistical threshold	-1.0%	2	2
Staff Engagement	Representative at Board Meeting	✓	4	4
	ACO Champion at Road Map Call	✓	2	2
	Practice Manager at Road Map Call	✓	2	2
	Care Coordinator at Road Map Call	✓	2	2
	Attend QIW	✓	4	4
	Attend Care Coordinator Cohort Calls	✓	4	4
Physician Lead	Attend Quarterly Steering Committee Meeting	✓	3	3
	Attend Cohort Calls	✓	3	3
TOTAL SCORE			**88**	**100**

ACO BOARD SCORECARD ADDITIONS/ADJUSTMENTS

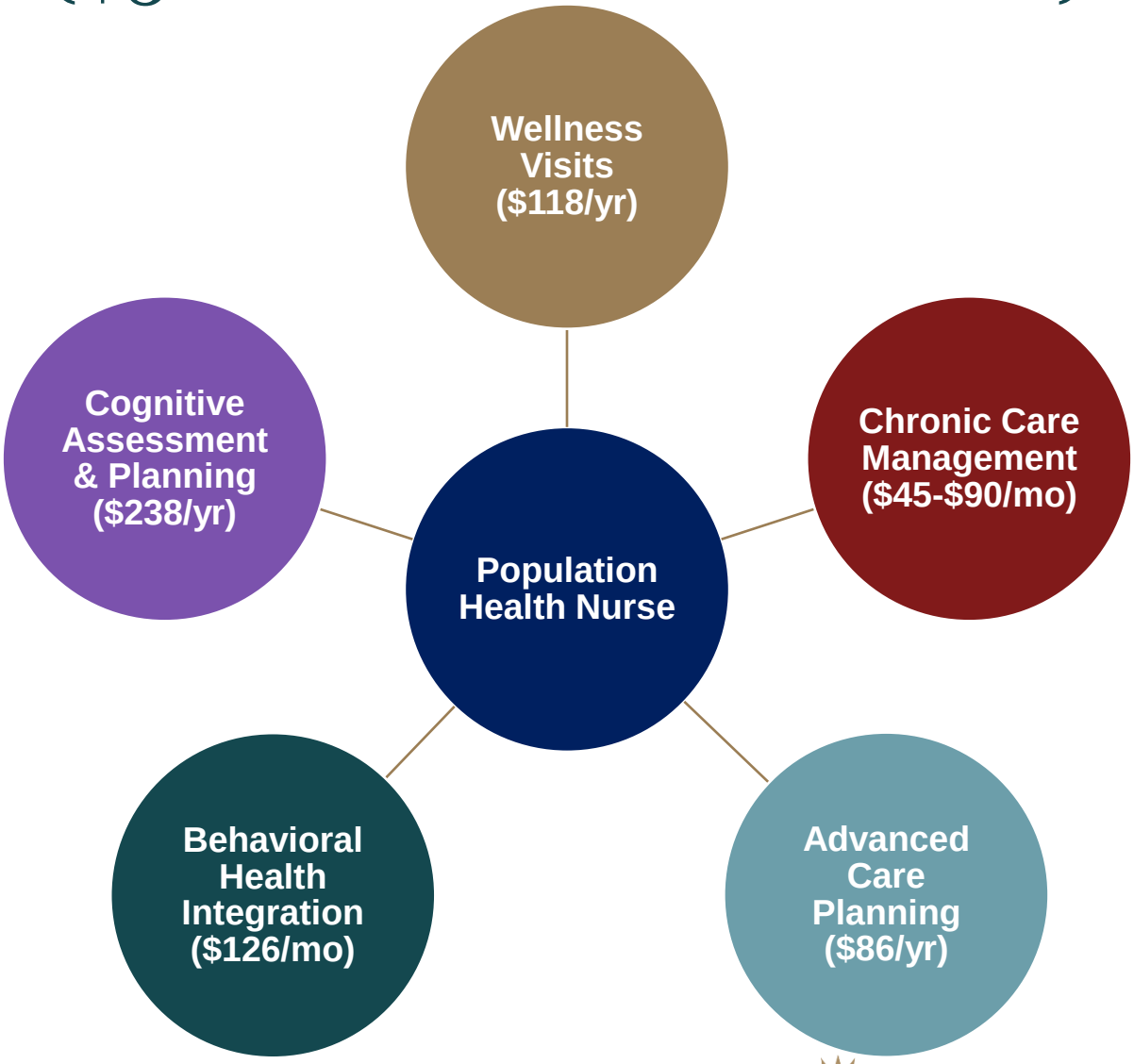
ACO Medical Director	Attend EBM Webinars	X	0	2
	Attend Cohort Calls	✓	2	2
	Attend Physician Leader Cohort Calls	✓	2	2

New Revenue Streams Fund Participation

- Nurse-led Care Coordination
- Wellness & Prevention Program
- Behavioral & Mental Health
- Quality Bonuses Under MACRA
- Shared Savings

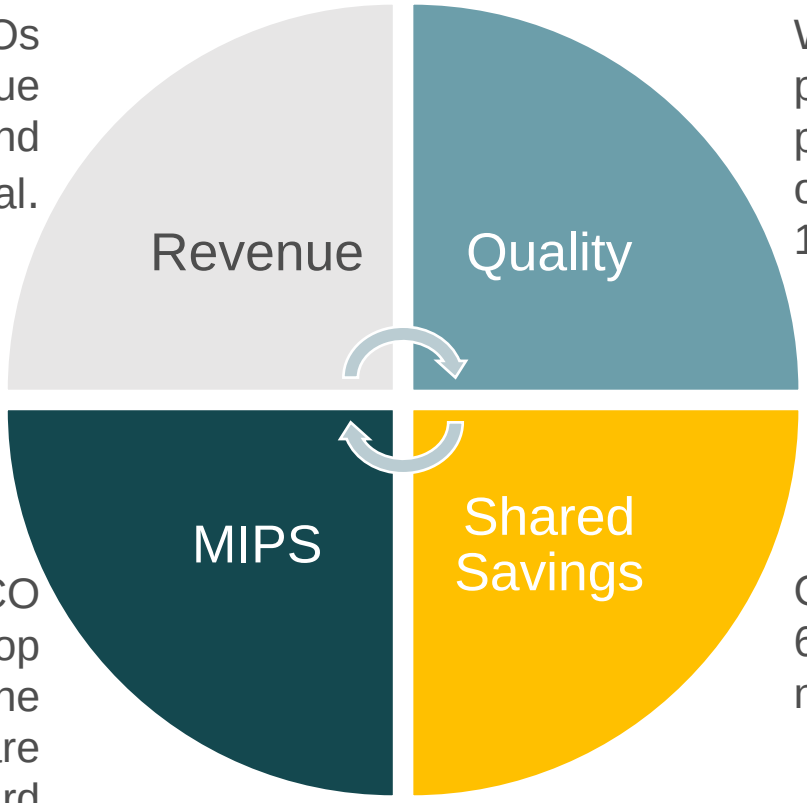
- ✓ Improved Outcomes
- ✓ New Fee-for-Service Revenue
- ✓ Incentive Revenue
- ✓ Increased Quality Scores
- ✓ Reduced Per Capita Spend
- ✓ Increased Market Share

Driving Change Using Fee For Service ($500+ Per Patient Per Year)



Our Experience in Rural Population Health

Rural ACOs increased net revenue between $1.5M and up to $29M per hospital.



Within one year of ACO participation, rural practices increased their overall quality score by 15%.

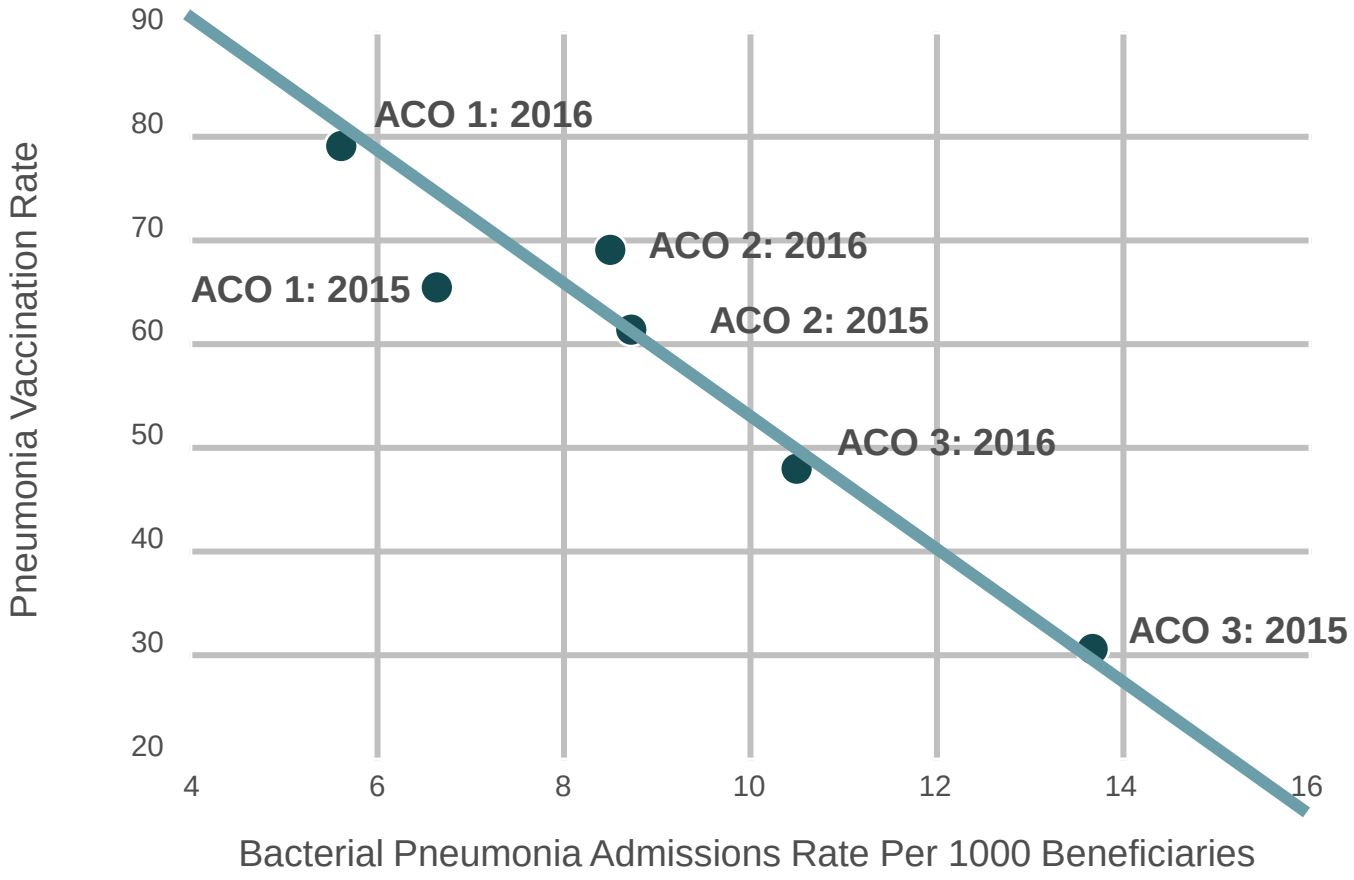
All of our rural ACO participants are in the top 13% of all providers in the country under MIPS and are expected to get an upward adjustment of Part B payments in 2019.

Our rural ACOs saved 6.5x more than the national average.

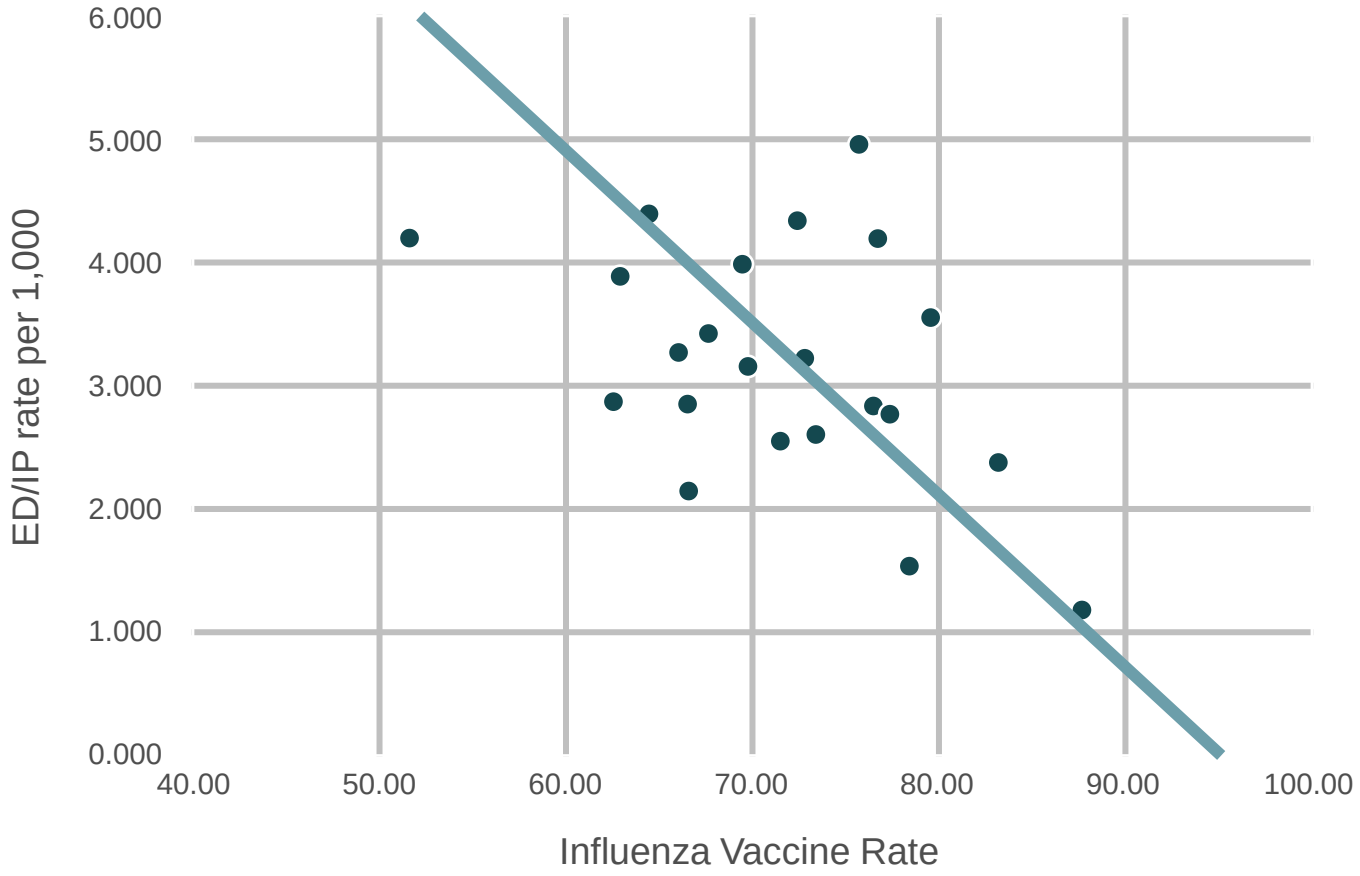
Wellness Visits Improve Quality Scores

Measure	2015 Communities 2015 Measure Rate	2015 Communities 2016 Measure Rate	Measure Rate % Change from 2015 to 2016
Influenza Immunization	48%	71%	48.2%
Screening for Future Fall Risk	42%	60%	43.3%
Screening for High Blood Pressure and Follow-up	62%	82%	30.6%
Screening for Clinical Depression and Follow-up	35%	43%	22.7%
Pneumonia Vaccination Status for Older Adults	58%	68%	17.6%
Documentation of Current Medications in the Medical Record	78%	86%	10.6%
ACE Inhibitor or Angiotensin Receptor Blocker Therapy	77%	83%	6.8%
Colorectal Cancer Screening	55%	59%	6.0%
Hemoglobin A1c Control	79%	83%	5.9%
Tobacco Use: Screening and Cessation Intervention	87%	92%	5.2%
Beta-Blocker Therapy for LVSD	91%	93%	2.9%
Use of Aspirin or Another Antithrombotic for IVD	87%	89%	2.0%
Controlling High Blood Pressure	68%	69%	1.7%

Increased Pneumococcal Vaccines: Decreased Pneumonia Admissions



Increased Flu Shots: Reduced ED and Inpatient Admissions



Utilization Rates - % Change 2016 vs. 2015

Hospitals Thrive in ACOs

- Formed in 2016, the Magnolia-Evergreen ACO includes seven rural Critical Access and PPS hospitals.
  - Four hospitals in Washington
  - Three hospitals in Mississippi
  - One large independent primary care practice in Mississippi
- All independent and unaffiliated; joined together to create 5000 attributed Medicare lives.

Tri-State Memorial
Washington

- 25-bed Critical Access Hospital
- 12 primary care providers
- 16 specialty providers

Neshoba County
Mississippi

- 48 acute beds
- 160-bed Skilled Nursing Facility
- 2 rural health clinics with 10 doctors and 7 nurse practitioners

Inflation and Demographics Adjusted Benchmark (2015)	Adjusted Benchmark (2016)	Adjusted Benchmark 2015 vs 2016	Total IP Cost PPPY (2015)	Total IP Cost PPPY (2016)	IP Cost 2015 vs 2016
$10,692	**$9791**	-$901 (-8.4%)	**$3443**	**$2832**	**-17.7%**
Total SNF Cost PPPY (2015)	Total SNF Cost PPPY (2016)	Total SNF Cost 2015 vs 2016	ER Visits per Thousand Beneficiaries (2015)	ER Visits per Thousand Beneficiaries (2016)	ER Visits per Thousand Beneficiaries 2015 vs 2016
$1157	**$896**	**-22.6%**	**941**	**817**	**-13.2%**
		Projected Savings/Losses	**-$10,992,709.74**		

Case Study: Magnolia-Evergreen 2016 Impact on Financial Performance

- Local hospital revenue went up 7% while saving 8.4% per beneficiary
- Net patient revenue went up $30 million while saving Medicare $11 million
- Inpatient revenue increased $13 million while saving Medicare $7 million

Rural Hospitals Total					Estimated 2016 MSSP Results	
	2015	2016	Change	Difference	Change	Difference
Gross Inpatient Revenue	**$376,843,601**	**$389,878,287**	**3.5%**	**$13,034,686**	**-17.7%**	**($7,403,986)**
IP Discharges	17,105	16,919	-1.1%	(186)		
IP Acute Days	18,111	17,330	-4.3%	(781)		
Gross Outpatient Revenue	**$681,440,146**	**$752,828,401**	**10.5%**	**$71,388,255**		
OP Visits	312,427	348,619	11.6%	36,192		
ED Visits	94,160	90,479	-3.9%	(3,681)	-13.2%	
Clinic Visits	250,338	259,335	3.6%	8,997		
Net Patient Revenue	**$423,477,195**	**$453,319,677**	**7%**	**$29,842,482**	**-8.4%**	**($10,992,710)**

In Summary

Value-based Payment is Here to Stay

In 2018, more than half of all providers will participate in these programs.

Now is the Time to Take Action

Today, providers can earn value-based incentives while receiving fee-for-service payment without downside risk. Resources and support are available to lessen your upfront and ongoing costs.

Avoid Penalties

Hospital-based physicians are not excluded from MACRA and most are expected to penalized if not part of either a large organization or an ACO.

Strengthen Provider Reputation

Quality data will be displayed on Physician Compare starting in 2018.

Maximize Value-based Reimbursement

Get >10% upward adjustment of Part B payments. As a Track 1 ACO, earn Exceptional Performance bonuses through MIPS-APM special scoring that boosts score by at least 15 points.

Use the Population Health Calculator

- http://caravanhealth.com/macra/ to download the MACRA Calculator

- Enter number of clinicians by specialty

- Example- Community Hospital in rural New York
  - Population- 33,000
  - Rural PPS Hospital
  - Approximately 71 providers in the community

- Potential MACRA Bonus: $2 - $4 million

Start Now!

- Join a CMS funded Practice Transformation Network
- Funded through the Transforming Clinical Practice Initiatives
- NRACO has PTN members from across the U.S. and is still enrolling
- Go to:

http://www.nationalruralaco.com/begin-process-portal.shtml

- PTNs serve as a training ground for APMs

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Thank You

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Attend the Accountable Care Symposium!

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