NATIONAL RURAL
ACCOUNTABLE CARE CONSORTIUM

Challenges and Opportunities -- Managing Rural Population Health

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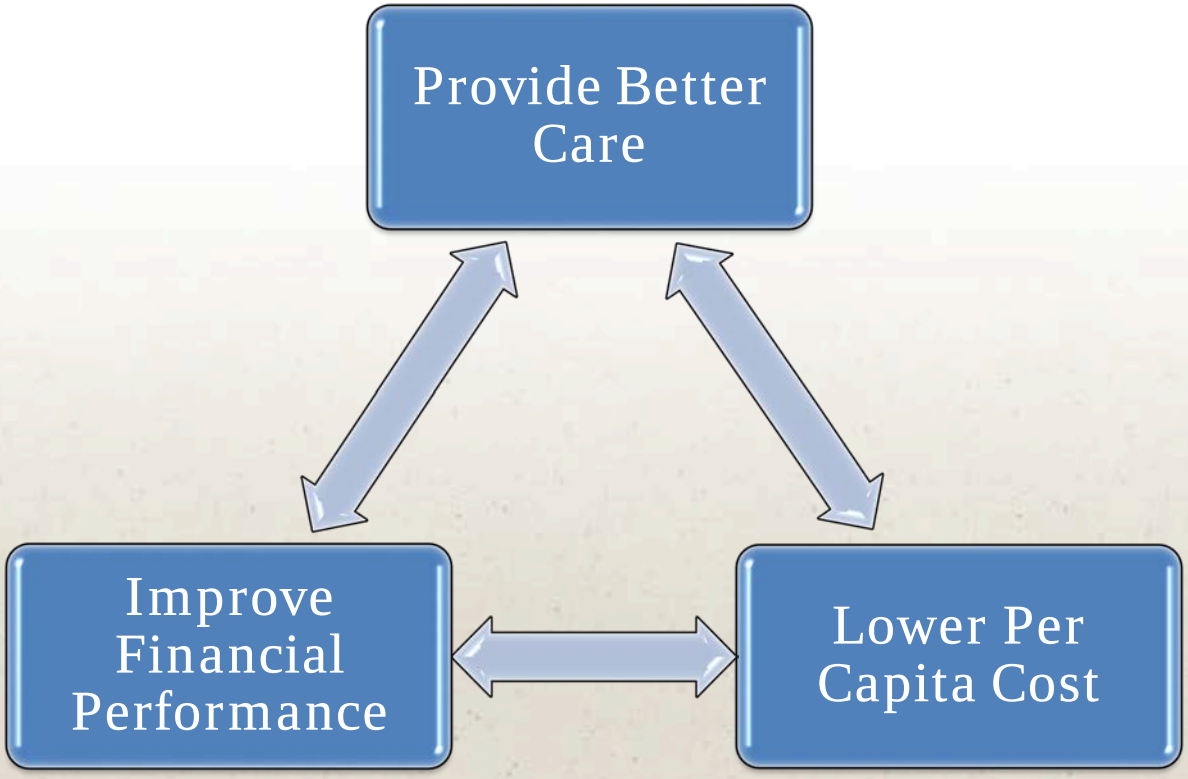
Who is the Consortium?

- Formed by rural providers in 2012 to avoid being left behind
- Followed IPA model – aggregating independent providers employed by independent hospitals
- Began operating first ACO in 2014
- Operated 6 ACO's in 2015 – formed 501c3
- Awarded $31 million TCPI grant in 2015 to assist 525 rural health systems to get ready for value-based payments
- Organized 170 rural health systems into 24 ACO's for 2016 performance year under AIM – 223,000 Medicare Beneficiaries
- Our goal is to enroll 25% of rural providers in APM's by 2018

Our Triple Aim



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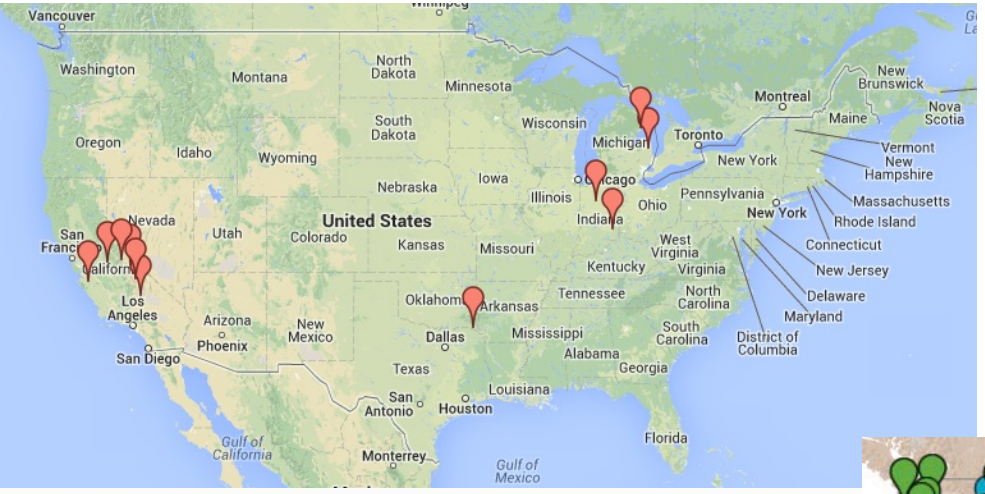
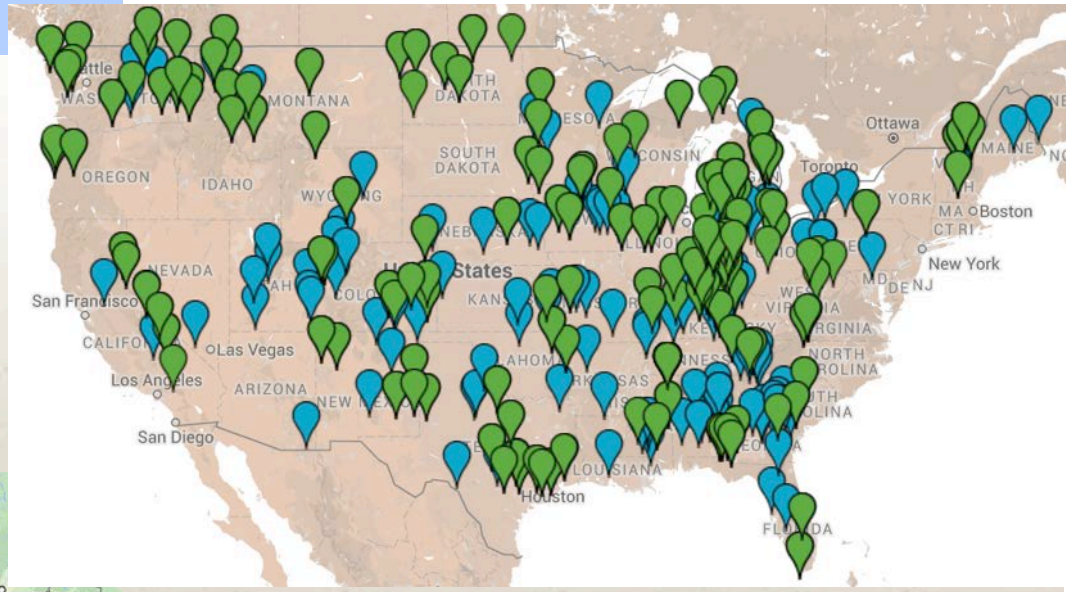


2014

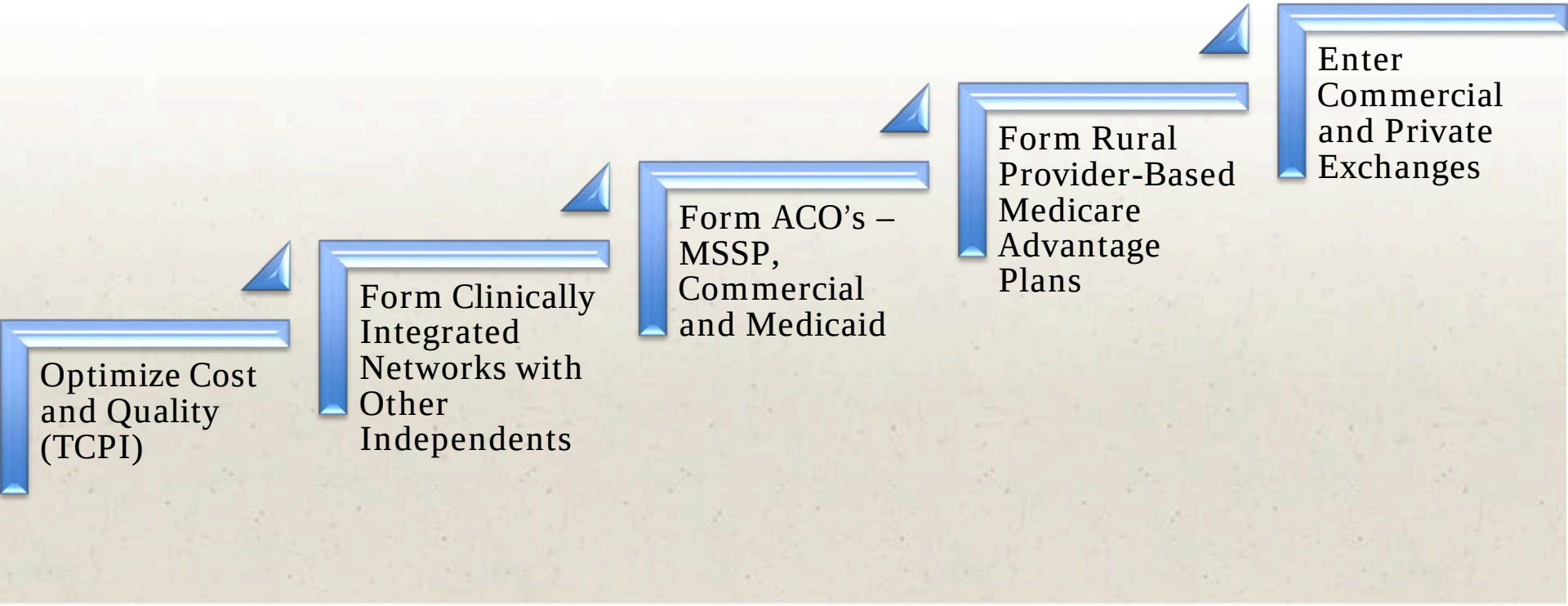
2015

Green = ACO,s
Blue = TCPI



2016

Rural Strategic Plan for Transformation



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A Snapshot of Rural Health Providers

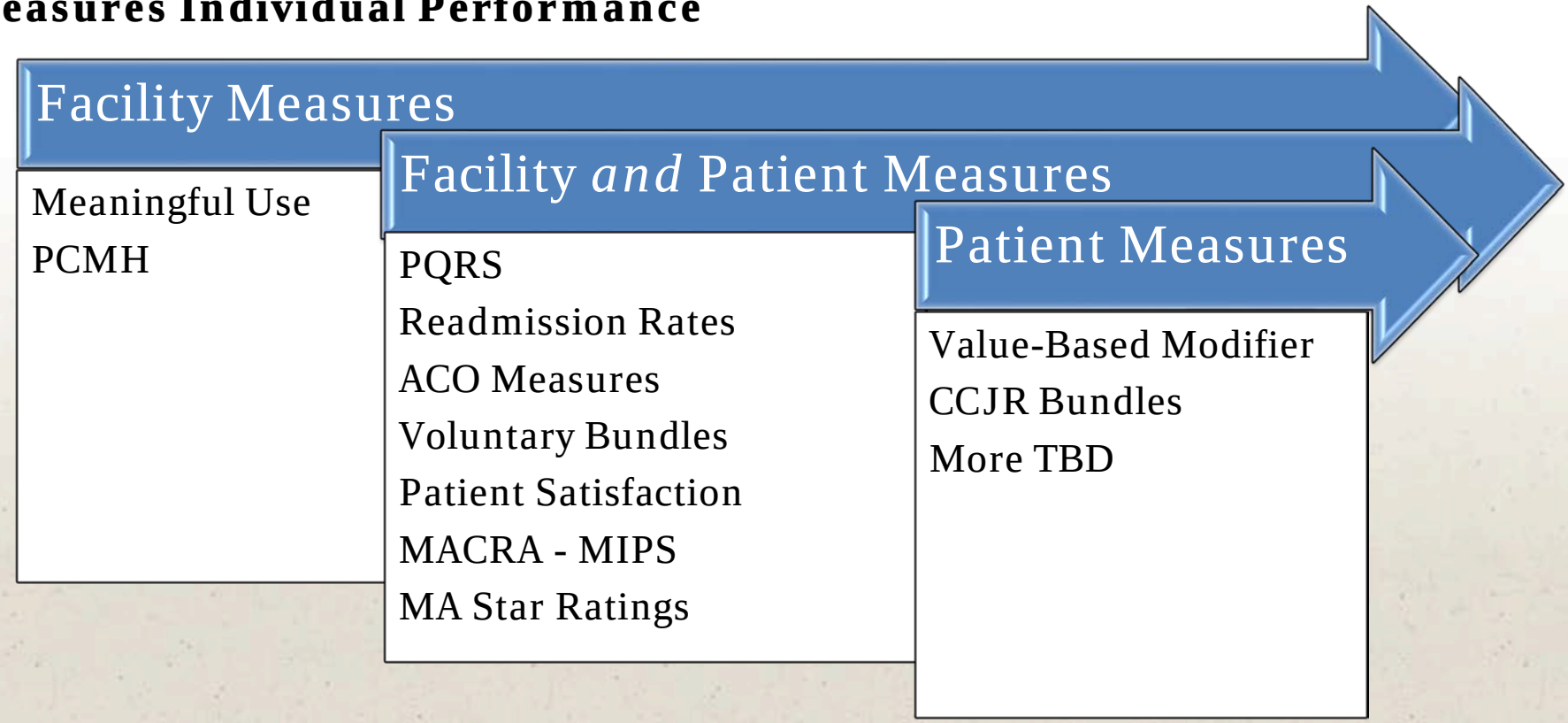
- Approximately 60 million people live in rural America
  - Peer reviewed data says they are sicker than urban
  - HCC data does not agree (MedPAC, June 2012, NRACO data)
- ~ 2000 rural health hospitals anchor the majority of rural physicians
  - Few and rapidly disappearing independent clinicians
- Most rural hospitals are now “health systems” with inpatient, outpatient, swing bed and primary care services
  - More than half also have home health, hospice or SNF
  - Mission statement is universally to serve their community
  - 75% of business is outpatients
- Most rural providers are exempt from reporting Medicare quality data, including 1,308 CAHs and 5,000 RHCs and rural FQHCs

Special Payment Systems Preserve Access

- ~4000 Rural Health Clinics – Cost-based, all inclusive rate billed under Part A
  - Physician owned capped at `$80/visit vs 2013 FFS average $107
  - Hospital-based clinics bill cost ($100-$300/visit)
- ~1000 Rural FQHCs ~ $165/visit
- RHCs and FQHCs not eligible providers for PQRS or Medicare Meaningful Use payments
- Critical Access Hospital Clinics – Fee Schedule +15%
- CAHs paid 101% of reasonable costs x Medicare share less sequestration
- Generally FP, NP, PA, OB, GS, IM with a few cardiologists

Evolution of Quality Measures

Measures Individual Performance



Measures SYSTEM of Care

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Estimated Penalties for Low Cost/Quality Scores

	PQRS	MA	MIPS
Loss	8%	5-15%	36%
PER PT	$128	$500-$1500	$576
PER 1000	$128,000	$500K - $1.5M	$576,000

- MA assumes $10,000 per beneficiary premium, 5 Star bonus
- PQRS assumes $10,000 per beneficiary cost, 16% MD services, 8% swing
- MIPS assumes $10,000 per beneficiary cost, 16% MD services, 36% swing

That Puts the Target on Our Back

- Objective data suggests we are not high value providers.
- We have to find a way to participate in ambulatory quality programs, even though we don't have to yet, and to advocate for different payment standardizations.

The greatest threat to the sustainability of rural healthcare systems are market forces that will force doctors and patients to choose high value providers and partners – and rural providers will be left behind if they don't work on these measures.

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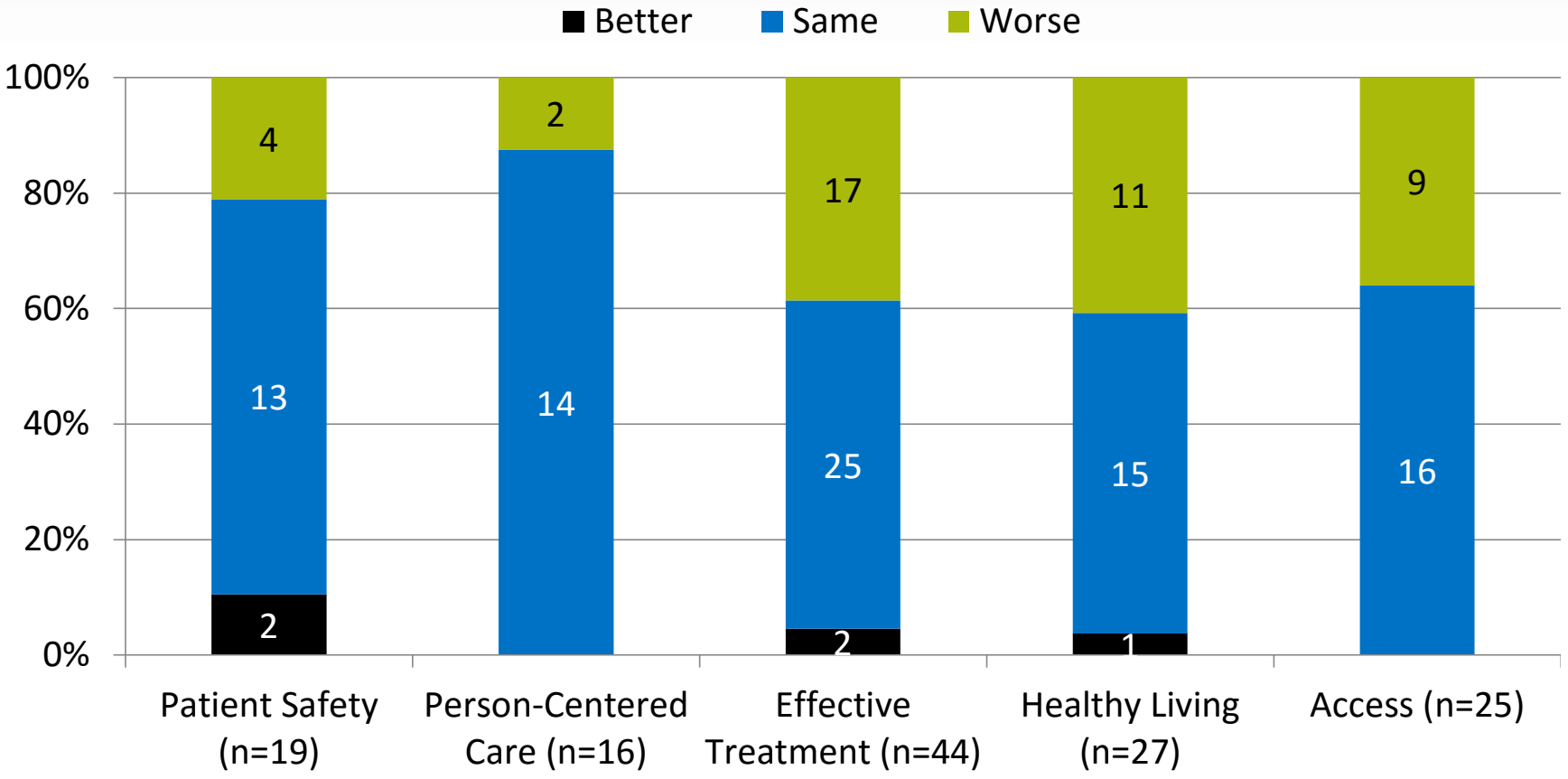
How Does Rural Score in Value Assessment?

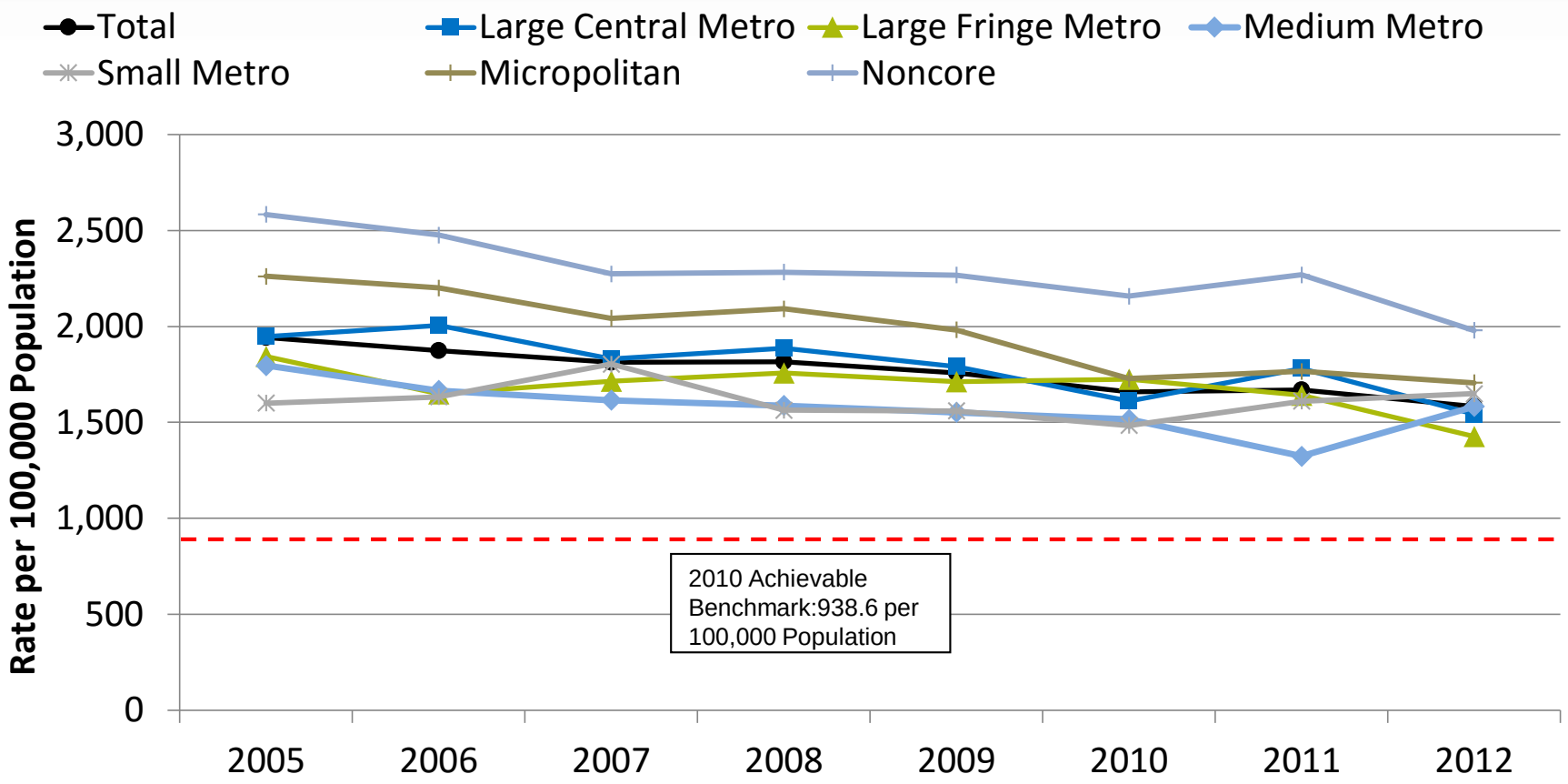
- Cost
  - In 2013 rural patients were 3.7% less than urban for total spend (Medicare Statistical Supplement) – which is not transparent to urban providers or patients
  - Unit costs for CAH inpatient and swing beds, outpatient procedures and provider-based RHC visits are typically higher than urban (1-3x)
- Quality
  - Rural hospitals have high HCAHPS scores but limited experience with CG-CAHPS.
  - AHRQ study indicates lower ambulatory quality scores in rural – not a volume or talent issue, a process issue

Disparities in quality of care measures for noncore areas by 4 NQS priorities and Access



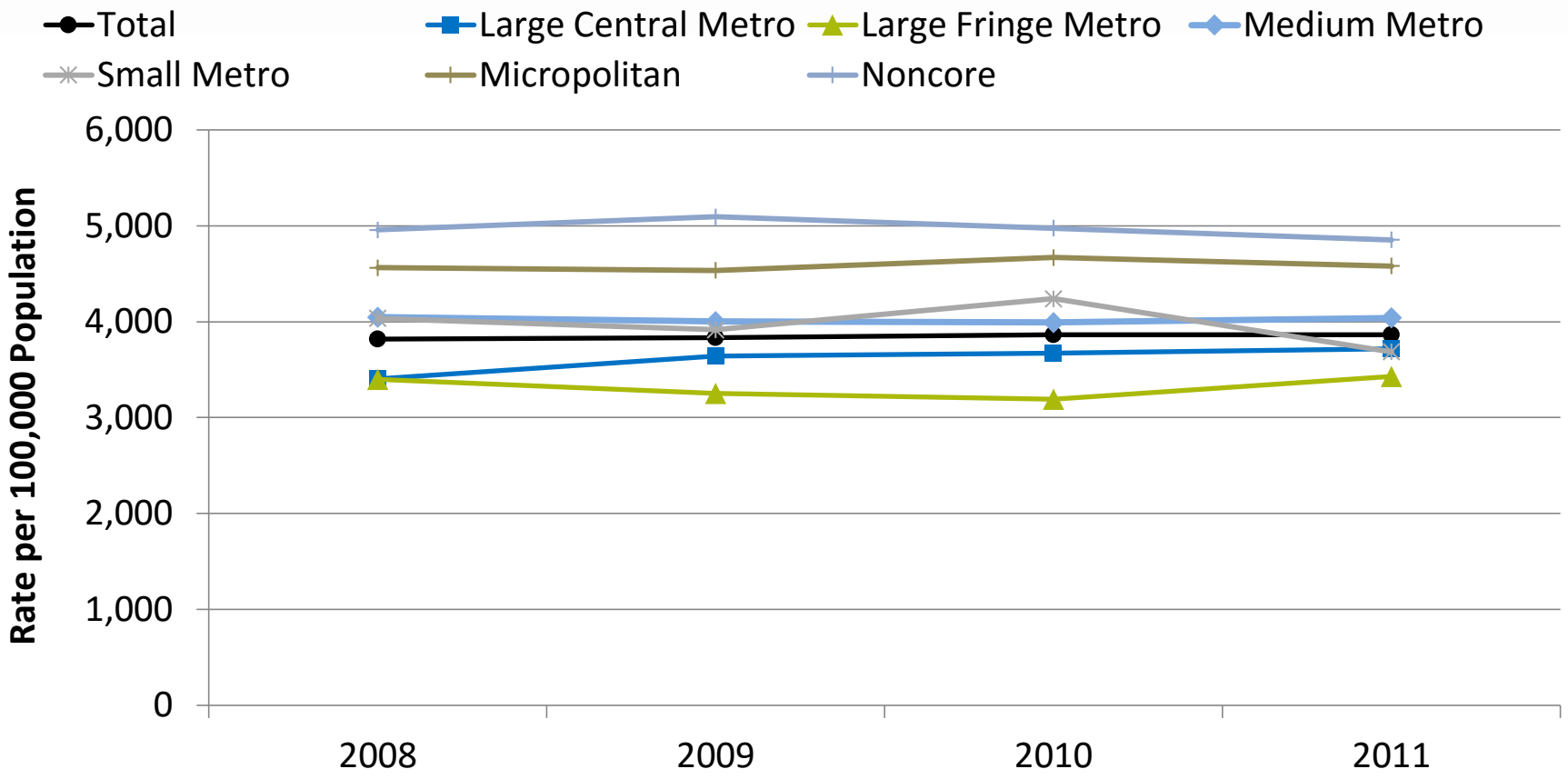
Key: n = number of measures.
Better = Population received better quality of care than reference group
Same = Population and reference group received about the same quality of care
Worse = Population received worse quality of care than reference group

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.

All emergency department visits per 100,000 population, adults age 18 and over, by residence location, 2008-2011



Source: Agency for Healthcare Research and Quality (AHRQ), Healthcare Cost and Utilization Project, 2008-2011 Nationwide Emergency Department Sample and AHRQ Quality Indicators, version 4.4.

Challenges

- Stand alone health systems – two thirds are local governmental facilities with no affiliations
- Little to no growth potential – declining populations
- Need to remain financially viable to support community health
- Very limited managed care and IT expertise
- Independent provider mentality – live free or die.
- “Sick” care not “health” care orientation
- Very difficult to recruit and retain physicians
- 70% Medicare and Medicaid with negative margins
- Although hospital is only 25% of revenue, it gets 90% of attention
- CEO turnover is typically < 3 years
- Community board is dedicated but not educated and experienced in healthcare
- Many rural states did not expand Medicaid – and their hospitals are closing

Strengths

- Integrated delivery networks can provide 70% of needed services
- Passionate about serving their community
- Deep relationships with their population
- Nimble – able to change quickly when they know what to do
- Fixed population served “cradle to grave”
- Excess capacity can be leveraged to work on population health
- Increased local volume reduces per capita costs dramatically when cost-based reimbursed
- Local brand is typically very strong – most beloved institution in town and major economic driver.

Rural Solutions

- 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
- Require Annual Wellness Visits to promote prevention
- Revisit billing practices and Physician compensation
- Join forces with other independent providers to qualify for programs and spread costs (CINs)
- Join forces with strong tertiary systems to provide best value for patients
- Enroll in ACOs to get data and advance down payment continuum

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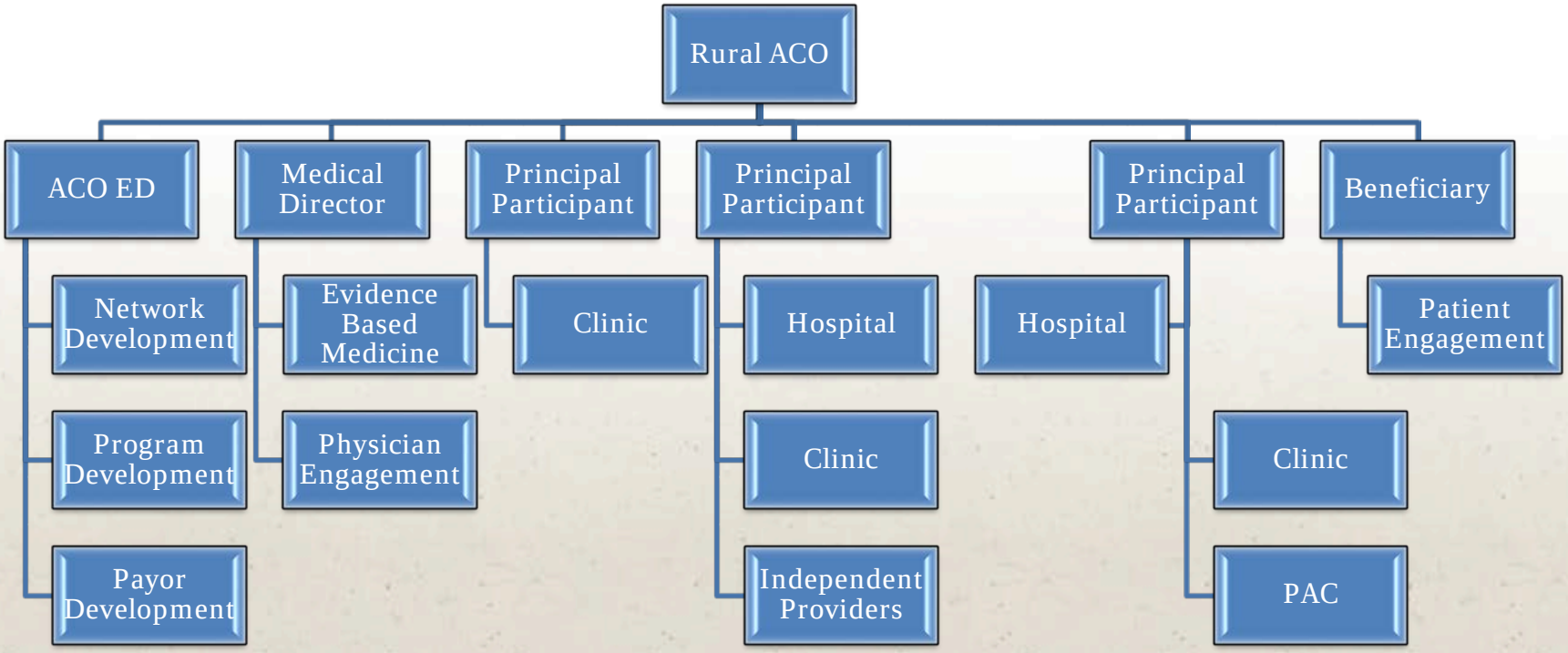
Governance

- Rural faces same issues as faced by independent small practices
  - Must join with unaffiliated providers to achieve minimum number of lives
- Our model
  - Equal voice for each member regardless of number of lives
  - Payments split based on individual performance
  - Each member is a mini-ACO
- Mutual Accountability
  - Need to identify non-performers early and ACT!
  - We use AWVs, CCM billing, attendance as early proxy

Unaffiliated Governance Model - ACOs



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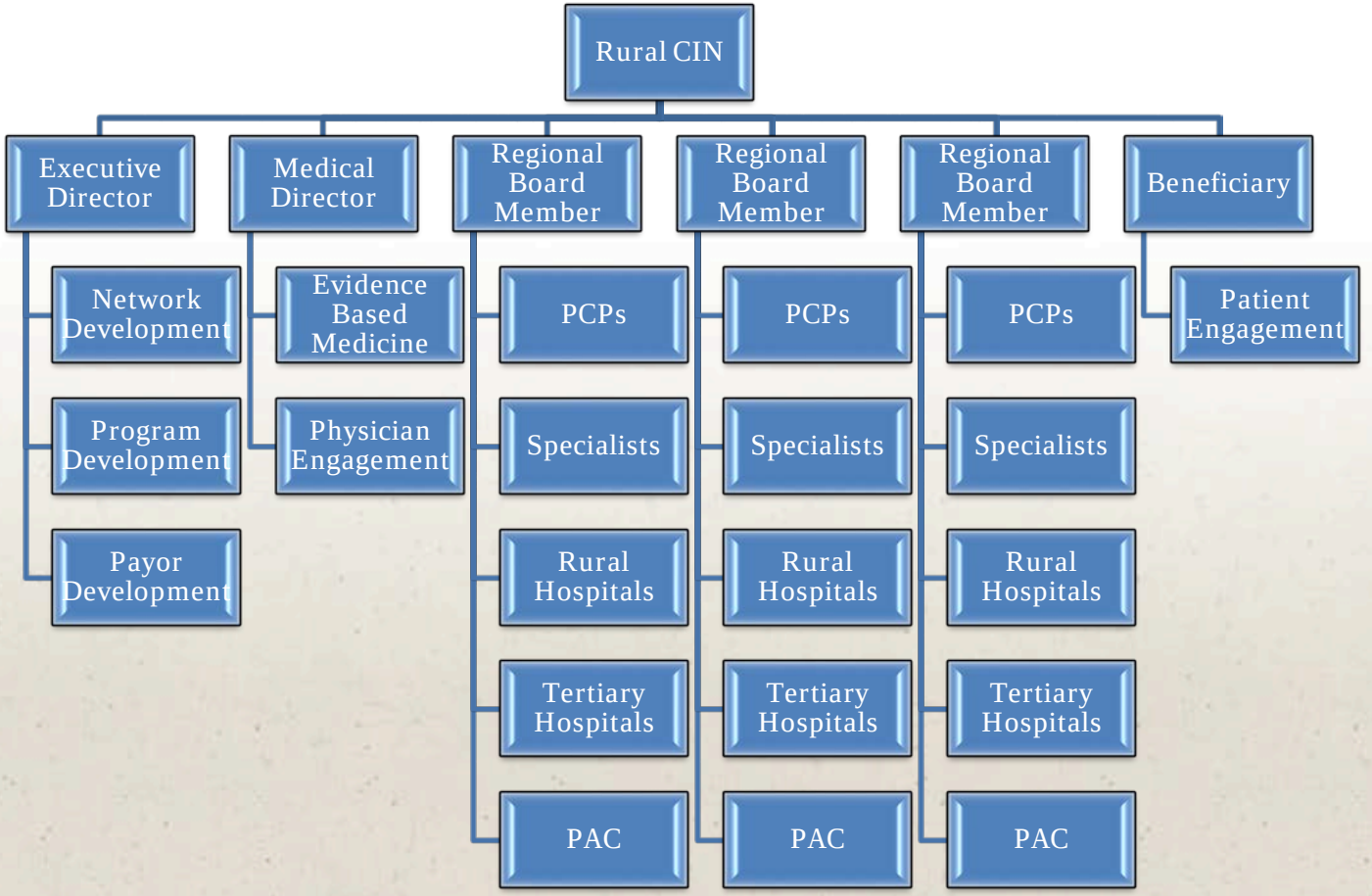
Unaffiliated Governance Model - CINs



Participation at Meetings & Events

	Monthly Workgroup	Steering Committee	Monthly Cohort Calls	Quarterly Regional Workshop	Biannual Division Meeting
NRACO Staff		FC, CCP Coach	CCP Coach	CCP Coach, ACO Ex Dir, SMEs	CMO, ACO Ex Dir, SMEs
ACO Champion	X	X		X	
Care Coordinator	X	X	X	X	
CEO				X	X
Physician Lead	X	X			X
Others as relevant	X	X		X	

Accountability – 1st Year

Member Responsibilities/ Success Metric	DUE DATE	Time Estimate	Who
Financial Consultant Questionnaire	Oct 12th	<15 Minutes	CEO/CFO
IT Systems Questionnaire	Nov 1st	<15 Minutes	IT
Financial Consultant Selected	Nov 15th	2-3 hr	CEO/CFO
Nurse Advice Hotline Survey	Dec 1st	<15 Minutes	ACO Champion
Attend Pre-Launch Webinars	Dec 10th	14 x 1hr	Various
MSSP Application Responsiveness	Jan 1st	0-1 hr	CEO
Patient Satisfaction Questionnaire	Jan 1st	<15 Minutes	ACO Champion
Demographics file submitted	Jan 1st	1-10 hr	IT
Attend Feb ACO Board Meeting by phone	Feb 29th	2 hr	CEO
Attend Feb National Meeting (extra credit)	Feb 29th	2-4 days	CEO & Physician Leader
Care Coordinator hired	April 1st	10-12 hr	HR & Supervisor
Host Launch Meeting	April 1st	1 day	ACO Champion
Attend first Regional Workshop	April 30th	1 day	CC, ACO Champion, Practice Manager(s)
Attend May Division Meeting	May 31st	1 day	CEO & Physician Leader
Bill for AWV, CCM, TCM	June 1st	0-5 days	Practice Manager(s) & CC

Lingering Issues with Virtual ACO's

- First 3 years everyone is learning and shared savings are unlikely
- If low performers are ejected, what happens to them and their patients?
- Presumably can use first cycle performance to aggregate similar players for cycle 2 – but goes against a regional approach.
- Using claims data to distribute shared savings is only a proxy – impossible thus far to replicate CMS calculations
- What percentage of shared savings should be distributed based on quality vs. cost savings?
- How are highest quality performers recognized?
- How predictive is past performance on future performance?
- Given these complexities few (if any) are preparing to take risk.

Lessons Learned From ACO Data

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2015 NRACO Communities

- Six ACOs with 29 Rural Health Systems enrolled ranging from $5 million to $700 million in annual revenue
- 62,360 Medicare Beneficiaries in 9 states (Indiana, Iowa, Illinois, California, Washington, Oregon, Texas, Missouri, Michigan)

NRACO (2014 starters) 11,063	NWRACO 6,962	SHOACO 16,523	ARACO 10,288	Reid ACO 8,347	NRACO II 9,177
Margaret Mary	Mason General	Hancock	Matagorda	Reid	Virginia Gay
Logansport	Summit Pacific	Henry	Chambers		Iowa Specialty
Alcona	Peace Harbor	Johnson	El Campo		Fayette
McKenzie		Hendricks	Brazosport		Morris
John C Freemont		Witham	TTMG		Ridgecrest
Mammoth			Connally		
S Inyo			Coryell		
			Missouri Delta		

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2015 NRACO Communities

- Additional Community Characteristics:
  - 45% (13) Critical Access Hospitals
  - 45% (13) have Rural Health Clinics
  - 10% (3) have Federally Qualifies Health Centers
  - Fun fact - 12 different EHRs & 1 on paper

Current NRACO Service Delivery Model

Quarterly	Monthly	Ongoing
ACO Board Meetings; CMS Expenditure & Utilization Reports	Community-level Steering Committee meetings	1:1 Care Coordination coaching
Evidence Based Medicine (EBM) initiative training for clinicians	Data: Community-level Claims Data Reports on Part A, B & D; Patient Satisfaction Survey Results	Lightbeam training via NRACO user group webinars
Workflow redesign and implementation training on EBM topic for ambulatory practice staff	Peer Community: Care Coordination Cohort calls per ACO	Preparing for Quality Measure Reporting – IT interface & QM education
	Care Coordination Newsletter	Ad-hoc webinars and support

Progress - Care Coordination

- Every community successfully hired an R.N. Care Coordinator
- Many have built good referral processes with their primary care partners through Transition of Care program implementation
- Chronic Care Management caseloads are growing
  - As of June 2015, NRACO communities are providing Chronic Care Management and/or Transitional Care Management to **over 4,000 high-risk, chronically ill patients**
  - In aggregate, 6.5% of total attributed Medicare beneficiaries receiving integrated and coordinated care
  - *Remember - Top 5% of Medicare patients account for 50% of Medicare spend!*

Progress – EBM Initiatives

Educated and trained clinicians and practice staff in four areas:

1. Chronic Care Management
2. Transitional Care Management
3. Prevention and Wellness/Annual Wellness Visits (AWVs)
4. Post Acute Care

- Highlights:
  - AWV: As of Sept. 2015, **72% (21) of communities regularly performing Medicare Wellness Visits**; 8 others actively working on finalizing workflow and documentation capture.
  - PAC: Many holding scheduled meetings with Community PAC facility partners and performing “warm hand-off’s” at discharge to PAC facilities

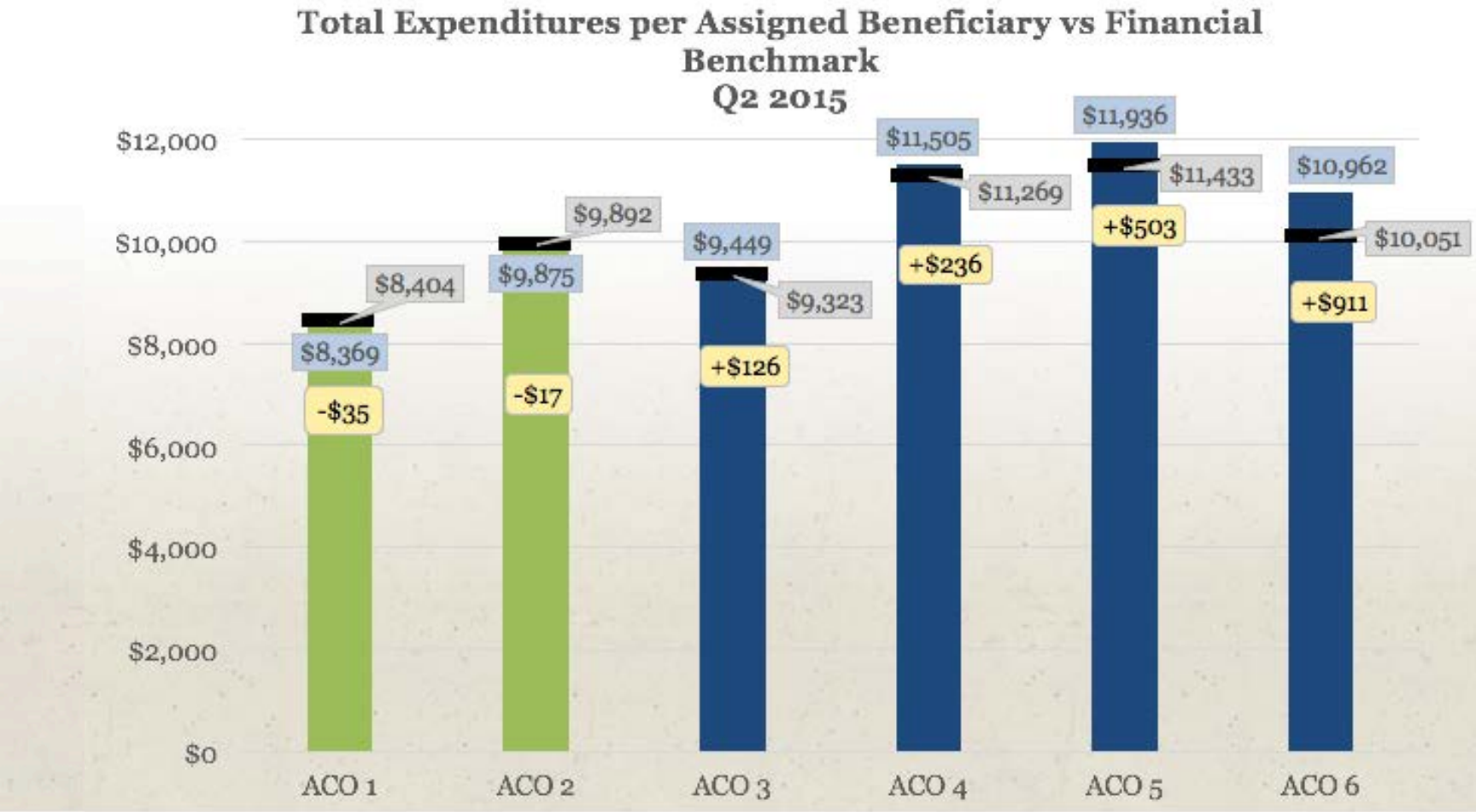
Progress – Lightbeam Interface

Clinical data file transfer from community EHR to Lightbeam for 2015 Quality Measure Reporting and Population Health Analytics

Interface Status	Communities
Complete	5
In QA	15
Ready for Backload	2
In Process (writing queries, submitting test files)	4
Not Started	2
Will not Interface	2

- **Expecting 25 to be complete prior to quality reporting**

Progress - Overall Cost



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Expenditure and Utilization Opportunities

1. **Long Term Hospital Expenditures** – Half (3/6) of ACOs are above MSSP average.
2. **Skilled Nursing Facility Expenditures and Utilization** – 40-50% higher

SNF	Rural	MSSP
Discharges/1000	93	62
Days/1000	2250	1596
$/Bene/yr	$1177	$730

3. **Bacterial Pneumonia Rate** – All 6 ACOs have higher rates than the MSSP average: 20-50%.
4. **Emergency Department Visits** – All 6 rural ACOs had higher ED visit rates this quarter compared to the MSSP: 9-20%
5. **Primary Care Services** – 5/6 ACOs provide fewer visits with PCP than the MSSP average this quarter. RHC average is 3 vs 4.8 FFS.

Summary

- Year of ACO implementation is for adjustment and learning
- Moving rural to a population health orientation. Using data to identify high risk/high cost patients and quality gaps
- Making a difference for patients.

- For more information:

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