Critical Access Hospital and
Rural Health Clinic Conference

Focusing on the Quadruple Aim

Preparing Now for What's to Come: Concepts for Understanding the Financial Impact of Value-Based Care

September 14, 2017

WIPFLi LLP
CPAs and Consultants
HEALTH CARE PRACTICE

AGENDA

- Reimbursement Opportunities – Moving From FFS to Value-Based Care
- Should We Join an ACO?
- Creating a Value Model for Population Health Management
- Financial "Check Up" as You Prepare for the Future

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Reimbursement Opportunities

Moving From FFS to Value-Based Care

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Reimbursement Opportunities Under Value-Based Care

- Quality Improvement Programs
- Transitional Care Management
- Chronic Care Management
- Per Member, Per Month Fees to Manage Patient Care
- Others

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Quality Reporting

Quality Reporting

- Electronic Health Records (EHRs)
- Quality Payment Programs:
  - MIPS
  - APMs

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Quality Reporting

	Part A Cost	Part B Cost	Part B MFFS	Total
Example CAH Net Reimbursement (2010)	$5,000,000	$10,000,000	$2,000,000	$17,000,000
Sequestration (2% net reimbursement)	(100,000)	(200,000)	(40,000)	(340,000)
Bad Debt (reduced from 100% to 65%)	(52,500)	(105,000)	-	(157,500)
Meaningful Use (1% IP and 1+MFFS)	(50,000)	-	(20,000)	(70,000)
PQRS (2% MFFS)	-	-	(40,000)	(40,000)
VBM (2% to 4% MFFS)	-	-	(80,000)	(80,000)
Sample CAH (2017)	4,797,500	9,695,000	1,820,000	16,312,500
Total Reduction in Reimbursement	$ (202,500)	$ (305,000)	$ (180,000)	$ (687,500)

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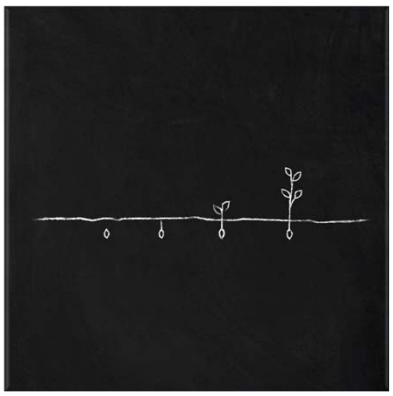

EHRs

EHRs Update 2016

- Modified Stage 2 or Stage 3 reporting in 2017.
- For all new and returning participants, the EHR reporting period is a minimum of any continuous 90 days between January 1 and December 31, 2017.
- For the 2017 EHR reporting period, the attestation deadline is February 28, 2018.

EHRs Update 2016

Beginning on a voluntary basis in 2017 and required beginning in 2018, all Eligible Hospitals will attest to Stage 3 objectives and measures.

What About Eligible Professionals?

- Must submit a 2017 Meaningful Use attestation unless:
  - The eligible professional (EP) is transitioning to Merit-Based Incentive Program System (MIPS) and has never previously attested as a meaningful user may avoid 2018 penalties.
  - The EP attested previously and can show they were not able to in 2016 for reasons beyond their control.

Quality Payment Programs

Quality Payment Programs

Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)

- During November of 2016, CMS issued the final rule for MACRA.
- MACRA replaces the Sustainable Growth Rate formula by paying clinicians for the value and quality of care they provide through a single framework called the "Quality Payment Program," which has two paths:
  - MIPS
  - Alternative Payment Models (APMs)

Quality Payment Programs

MIPS

- Features of PQRS, the Value Modifier, and the EHR Meaningful Use program are included in MIPS.
- The score is used to determine and apply a MIPS payment adjustment factor for 2019 going forward.
- Adjustment can be positive, negative, or zero.
- Applies to individual EPs, groups of EPs, or virtual groups: 2019 and 2020 (first two years):
  - Physicians, PAs
  - Certified Registered Nurse Anesthetists
  - NPs, Clinical Nurse Specialists
  - Groups that include such professionals

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Quality Payment Programs

MIPS (Continued)

- Performance Categories:
  - Quality measures (60% the first year)
  - Advancing care information (25% first year)
  - Replaces meaningful use component
  - Improvement activities (15% of score):
    - Subcategories (include better off-hours access, care coordination)
    - Patient safety, beneficiary engagement
    - Others as determined by secretary
  - Cost (starting in second year)

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Accountable Care Organizations (ACOs)

Advanced APMs (ACOs)

ACOs

- ACO quality reporting fulfills MIPS reporting requirements.
- ACO participants must report as a group and not individually.
- EPs must continue to attest for MU individually for the 2017 program year unless there is a qualified hardship.
- Reporting occurs January through March 2018 for the 2017 program year.

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Advanced APMs (ACOs)

Alignment With MIPS

Satisfactorily reporting all quality measures through the ACO qualifies MIPS EPs who are ACO providers/suppliers who have assigned billing to an ACO participant:

- Advanced APM may potentially earn a 5% incentive payment.
- Avoid the 2019 quality reporting payment adjustments (up to a 4% reduction).

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Other Reimbursement Opportunities Moving From FFS to Value-Based Care

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Reimbursement Opportunities Under Value-Based Care

Transitional Care Management (CPT 99495 and 99496)

- This allows providers to bill for their efforts in helping to transition patients from an inpatient setting to a community setting (home, assisted living, etc.).
- Primary care physician takes on the role of coordinator in a patient's post-acute care setting even when that care is delivered out of the office (helps to ensure appropriate follow-up and avoid unnecessary readmissions).
- Rules are in place related to communication with the patient or caregiver within 2 business days of discharge. In addition, the provider must engage in medical decision making and conduct an in-person visit within 7 or 14 days of discharge, depending on the complexity of the patient's condition.
- Reimbursement rates of $165 (moderate complexity) to $233 (high complexity). These would be Rural Health Clinic (RHC) billable visits.

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Reimbursement Opportunities Under Value-Based Care

Chronic Care Management (CPT 99490)

- This allows providers to bill for incremental time spent managing patients with chronic diseases.
- The provider must dedicate 20 minutes per month managing patients with multiple chronic diseases (excluding in-person visits).
- CMS estimates nearly 66% of Medicare beneficiaries are eligible to receive these services.
- Reimbursement is $41 per month, per beneficiary.
- Estimates suggest a FFS clinic could achieve reimbursement of over $85,000 annually (based on assumptions of patient volumes, etc.). Service could be done in an RHC; however, reimbursement would be at fee for service rates.

Source: November 2016 HFM article "Building a Fee For Service Bridge to Population Health."

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Reimbursement Opportunities Under Value-Based Care

Welcome to Medicare Visits and Medicare Annual Wellness Visits

- These services could be done in a RHC setting and be counted as a cost-based RHC encounter.
- Since these services are preventative in nature, no deductible or coinsurance would apply (no patient out of pockets).
- If a Welcome to Medicare Visit is done the same day as an encounter for a medical condition, two visits could be counted and billed to Medicare.

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Reimbursement Opportunities Under Value-Based Care

Per Member, Per Month Fees to Manage Patient Care

- Some insurers are willing to pay a per member, per month amount to health systems that are building clinically integrated networks if they can demonstrate that they are building systems to better coordinate care and manage patients throughout the continuum (using care managers and others).
- We find many small rural health systems provide some or all of these additional services without additional reimbursement.
- Consider building this into your insurance contracting strategy.

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Should We Join an ACO?

Should We Join an ACO? - Factors to Consider

- Opportunity to work collaboratively with other providers.
- Opportunity to learn about population health through the ability to:
  - See data at the global level (cost per member).
  - Understand your system's value (numbers of lives managed, etc.).
  - Understand how you can influence cost/quality of care.
  - Understand how to optimize your value in the future.
- Opportunity to start "small" with limited risk - Ability to allow incentives to drive innovation/change within your organization.
- Capital requirements - What type of capital outlay would be required?
- Other resource requirements - Administrative, technology, clinical resources competing with other organizational initiatives in a scarce resource environment.

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Creating a Value Model for Population Health Management

Creating a Value Model for Population Health

- Basic value equation for value-based care from the view of the health care provider system:
  - Loss of fee-for-service volume/revenue
    Minus
  - Incremental cost reduction from lower fee-for-service volumes
    Minus
  - Direct program costs
    Plus
  - Shared savings revenue potential
- Longer term - Is there value in increasing capacity and ability to manage more patients?

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Creating a Value Model for Population Health

- Shared savings revenue potential:
  - Quality bonus potential (process measures and/or outcome measures)
  - Cost-reduction bonus potential (Did your ACO reduce overall acuity-adjusted cost for a given population?)
  - Per member, per month fee for "care management"
  - Other

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Creating a Value Model for Population Health

From the View of the ACO

	Before Initiative			After Initiative		
	Utilization per 1000	Average Cost per Unit (Reimbursement Rate)	Cost per Member per Month (PMPM)	Utilization per 1000	Average Cost per Unit (Reimbursement Rate)	Cost per Member per Month (PMPM)
Low Cost Services						
Office visit (PC)	6,000	100	0.23	6,400	100	0.25
Pharmacy	1,000	200	0.16	1,200	200	0.19
Lab	60	50	0.06	70	50	0.07
Preventative Care	100	120	0.01	200	120	0.02
Total PMPM			0.46			0.53
Total costs - What are we paying for the service?			5,000,000			5,731,884
High Cost Services						
Inpatient acute	200	10,000	0.72	60	100	0.22
ED visits	300	800	0.05	210	200	0.04
High end imaging	100	1,000	0.08	50	50	0.04
Total PMPM			0.85			0.29
Total costs - What are we paying for the service?			9,202,899			3,144,928
Total increase in low cost services			(731,884)			
Total decrease in high cost services			6,057,971			
Net total cost savings			5,326,087			
Program Costs			(3,000,000)			Infrastructure and administrative functions payout of bonuses, etc.
Net impact (ROI)			2,326,087			
			1.78			

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Creating a Value Model for Population Health

From the View of the Health Care Provider

	Before Initiative			After Initiative		
	Utilization per 1000	Average Incremental Cost per Unit	Reimbursement Rate	Utilization per 1000	Cost Impact	Reimbursement Impact
Low Cost Services						
Office visit (PC)	6,000	50	135	6,400	20,000	54,000
Pharmacy	1,000	100	300	1,200	20,000	60,000
Lab	60	10	100	70	100	1,000
Preventative Care	100	60	150	200	6,000	15,000
Reimbursement Impact					46,100	130,000
High Cost Services						
Inpatient acute	200	5,000	8,000	60	(700,000)	(1,120,000)
ED visits	300	250	500	210	(22,500)	(45,000)
High end imaging	100	250	1,500	50	(12,500)	(75,000)
Reimbursement Impact					(735,000)	(1,240,000)

Total reimbursement impact of low cost services	130,000	
Total reimbursement impact of high cost services	(1,240,000)	
Change in reimbursement (reduction)	(1,110,000)	
Total increase in variable costs for low cost services	(46,100)	
Total decrease in variable costs for high cost services	735,000	
Change in variable costs (savings)	688,900	
Impact before infrastructure costs/benefits	(421,100)	
Program Costs for the health care provider	(500,000)	Care redesign/technology etc.
ACO shared savings	1,000,000	Based on quality/cost and other metrics
Net impact at the health provider level	78,900	

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Creating a Value Model for Population Health

What made the most impact on CAHs as they work on population health?

- Nurse advice line
- Use of some population health management tool
- Care Manager position
- Take advantage of Medicare annual wellness visits
- Take advantage of Medicare chronic care management reimbursement
- Manage patients through total care management programs

Source: Caravan Health

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Creating a Value Model for Population Health - In-Depth View

A more in-depth model template was developed by The Rural Health Value Network (www.ruralhealthvalue.org). You can access this free Microsoft Excel tool from their website.

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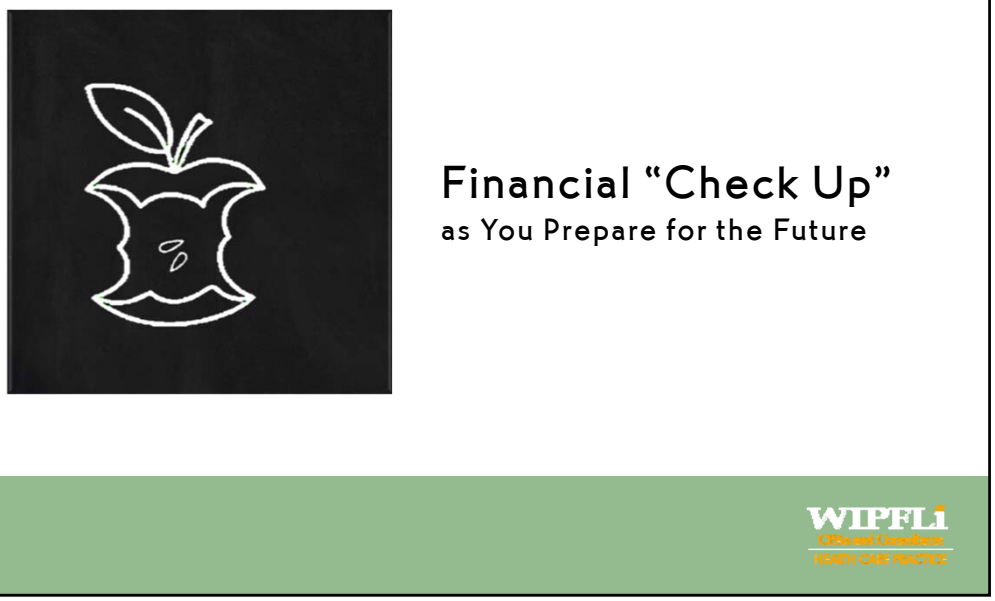
General Discussion

Where is your organization on the continuum of population health?

- Are you currently capturing reimbursement to help with the transition?
- What is happening in your market along the continuum of population health?
- Are you part of an ACO? Are you investigating this opportunity?
- Have you redesigned your organization's care to prepare for the new health care value proposition and the Quadruple Aim?



Financial "Check Up"

Focus on Operational Efficiency

- Improve revenue cycle processes –
  Can you improve revenue by 2% to 4%?
  - Front-end eligibility
  - Documentation, coding, and billing
  - Underpayment of claims
  - Denial of claims
  - Contract management
  - Pricing strategies
- Review your organization's expense structure:
  - Staffing
  - Supplies and implants
  - Contracted services

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Financial "Check Up"

Focus on Operational Efficiency (Continued)

- Review your physician clinic operations:
  - Locations
  - Certification (RHC, provider-based clinic, etc.)
  - Patient volumes (new and established)
  - Revenue cycle processes
  - Staffing and scheduling
  - Referral patterns (to your facility and elsewhere)
- Review your 340B Drug Pricing Program:
  - Are your processes compliant with current regulations?
  - Are you optimizing the value of this program within your community?

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Financial "Check Up"

Focus on Operational Efficiency (Continued)

- Understand where your inpatient and outpatient volumes are coming from:
  - By type of service
  - By referral source
  - By payor
  - From emergency
- Understand your current-state quality metrics:
  - Are you reporting Medicare Beneficiary Quality Improvement Program measures?
  - What image does your organization project on the Internet (CMS HospitalCompare and other sites)?

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Financial "Check Up"

Focus on Operational Efficiency (Continued)

- Explore buying services vs. making services:
  - Infrastructure (IT, facilities, etc.)
  - Ancillary services provided to patients
  - Department/program oversight functions
  - Sharing of scarce physician resources with other area facilities
  - Staffing when volume is variable, etc.
- Explore relationships that can assist with support functions:
  - Joint ventures with other health systems
  - Relationships with other local community resources, etc.

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In Summary

- Make sure your operations are as efficient and as effective as possible under current-state conditions.
- Understand the value of building a highly functioning primary care network operating under a team-based model to properly address the transition toward population health and the Quadruple Aim.
- Build relationships with other health care providers (upstream) within your market and with the community (for community-based services) while positioning yourself as the "cornerstone" of the community with respect to the population's health care needs.

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Questions?
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Thank you!
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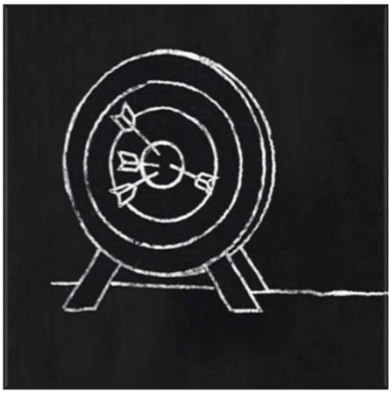

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