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Better Patient Care
Better Bottom Line

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Today's Presentation

GOAL: Generate enthusiasm for APMs!

- Objective 1: Understand the rapid transition of rural providers from fee-for-service to fee-for-value and key programing necessary for a successful, sustainable value based model.
- Objective 2: Recognize challenges and develop strategies for mitigating barriers when transitioning to value-based payments.

Key Takeaways

- Rural providers are rapidly moving into Medicare ACOs/CPC+ in order to improve quality and financial performance,
- Rural providers can be successful in value based programs.
- Dakota hospitals are finding success through value based programs.

About Caravan Health

Accountable Care Organizations – 23

Hospitals – 164

Doctors – 6,000

Quality Scores – 97%

Shared Savings – 257% of National Average

Application Success Rate - 100%

Value Based Programs Enabled by Caravan Health

AIM ACOs | MACRA | CPC+ | Commercial ACOs

What is an Accountable Care Organization (ACO)?

•Providers agree to be accountable for the cost and quality of care of their primary care patients.

•Must have 5,000 "covered lives" attributed for eligibility.

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

•This provides an opportunity for you to learn to effectively manage population health while avoiding unnecessary penalties.

•It also provides great advantages for MIPS reporting.

•**REIMBURSEMENT DOES NOT CHANGE!**

Who Is Attributed?

- 92% of patients are attributed to Primary Care Providers.
- Based on most allowed charges for primary care in the past 12 months.
- Average PCP has 150-200 lives attributed.
- NPs and PAs will get attribution beginning in 2019.

How is Savings Calculated?

- Based on patients who would have been attributed over the last three years.
- Four benchmarks are calculated for Aged, Disabled, Duals and ESRD.
- Benchmarks are weighted 60% in prior year, 30% two years back and 10% three years back, adjusted for historic medical trend.
- Every year your benchmarks for each category is adjusted for medical trend and your total benchmark is calculated for patient mix.
- HCC scores are not counted after the program starts, but matter for setting your benchmark.
- Average is about $10,000.

Benefits of ACO

Improve the Health of your Friends, Families and Neighbors

- Provide coordinated, proactive care for your community.
- Use claims data to predict and prevent disease progression.
- Help your patients achieve their personal health goals.
- Engage your community in its health and well-being.

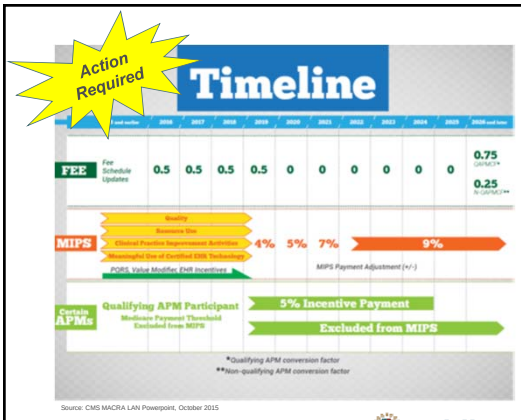
Why Should I Join an ACO?

Improve your Financial Performance to Stay Independent and Sustainable

- Protect your employed and community physicians from MACRA penalties.
- Implement new wellness services that generate $500 to $1,000 annually per Medicare patient.
- Increase life-saving, preventative services such as mammograms and colonoscopies.
- Keep health care local and prevent out-migration.
- Maximize your MACRA bonuses and quality scores with the least amount of effort.
- Earn additional financial incentives for improving quality and lowering costs.

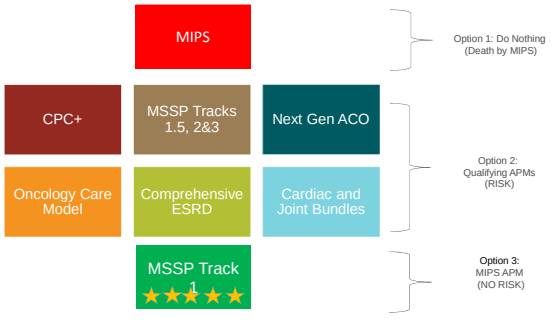
Why Not Wait Another Year?

- Don't fall behind – half of all providers will be in value-based payment programs in 2018.
- The majority of MACRA bonuses will go to ACO participants because of special scoring.
- 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.
- "Repeal and Replace" does not affect value-based payments – they are here to stay.
- Today, you still get fee-for-service with no down-side risk. Risk will increase over time and you must prepare.
- If you join now, funds are available to lessen your upfront and ongoing costs.



Source: CMS MACRA LAN Powerpoint, October 2015

Quality Payment Program

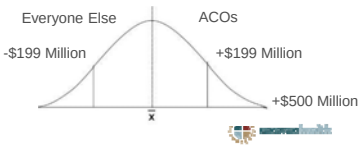


I'm Rural, So I'm Exempt, Right?

- RHCs and FQHCs are exempt from the Quality Payment Program (QPP), except RHC/FQHC Part B billing.
- Providers that work in rural hospitals **are not exempt** from the QPP.
- Your hospital-based specialists' scores will be compared to high performing ACO Primary Care Providers.
- After the transition period, you should expect your hospital-based clinicians to pay the penalty.
- Use the MACRA Calculator to estimate the impact.
- If your providers are not employed, will you lose access to them or have to make them whole?
- How will your community feel about your Physician Compare scores being in the bottom half, or missing?

Who Wins and Who Loses?

- **Program takes $199 million from the bottom 50% and gives to the top 50%.**
- **For five years, the top 10% get another $500 million.**
- **Everyone who takes risk is out of the pool.**
- **In 2018, ~40% of QPP providers will be in Track 1 ACOs.**
- **Track 1 ACO participants get special scoring:**
  - Quality scores will average 92%.
  - Automatic 100% for Clinical Practice Improvement Activities.
  - Exempt from Resource Utilization Category.
  - Those that do well on Advancing Care Information will be in the top 10%.



ACO's Will Perform Better Because of Cost Exemption

	PRACTICE SCORE	2018 MIPS WEIGHT	2018 MIPS SCORE	2018 MIPS-ACO WEIGHT	2018 MIPS-ACO SCORE	2019 MIPS WEIGHT	2019 MIPS SCORE	2019 MIPS-ACO WEIGHT	2019 MIPS-ACO SCORE
QUALITY	100%	50%	50	50%	50	30%	30	50%	50
CPIA	100%	15%	15	20%	20	15%	15	20%	20
COST	50%	10%	5	0%	0	30%	15	0%	0
ACI	100%	25%	25	30%	30	25%	25	30%	30
TOTAL			95		100		85		100

- Cost must weigh 30% by 2019
- If you have average cost you will lose 15 points
- If you have high cost you will lose 30 points
- Top 10% will be dominated by ACO participants
- Top 10% can earn exceptional performance bonus worth up to 3 times penalty
- Average penalty/bonus in 2019 will be from $5K-$20K per physician

The Caravan Health ACO Model

- If needed, we will join you to other communities to make up your ACO cohort but each of you acts as your own ACO.
- You have attributed lives that you are accountable for cost and quality.
- Each individual community needs to work toward improving care while reducing per capita cost.
- Your local governance is provided within quarterly ACO Steering Committee meetings.
- Your ACO governance is provided within the quarterly ACO Board Meeting (each community has a representative on the ACO Board).
- **The key to success is to implement the tools and tactics provided to you by Caravan Health, and to do the work!**

The Caravan Health ACO Program

- Practice, community and ACO-level **governance and support**
- **Practice Improvement** Coach, Program Manager, IT and Analytics Staff, Financial and Management Consultant, CMO
- **Quarterly workshops** for practice managers and care coordinators
- **Population health software** uses claims for risk stratification, HCC coding, and true patient history
- **24-Hour Advice Nurse hotline**
- More comprehensive **Annual Wellness Visits**
- **Chronic care management** and **behavioral health** integration
- **Quality** reporting and improvement (meets MIPS requirements)
- **Compliance/legal**
- **Patient satisfaction** program

Types of Educational Programs

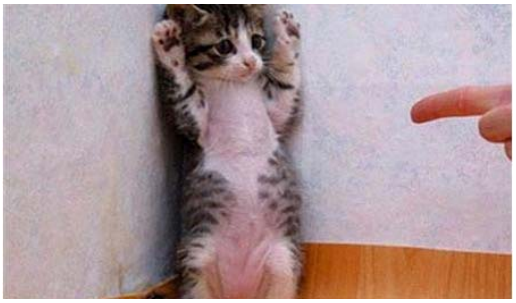
Webinars
- Pertinent initiatives to build your population health program
- Instructional for use of tools and resources available to you
- Recorded, posted on Swank LMS

Quarterly Workshops
- April, July and October
- Face-to-face education
- AWV, CCM and Health Coach Training
- PDSA activity

Care Coordinator Training and Support
- Cohort Calls
- Coach 1:1 Calls w/CC's
- CC Resource Toolkit
- Clinical Health Coach Training for CC's

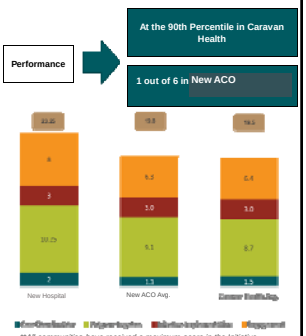
Practice Improvement
- Individual work plan
- PDSA cycles
- Monthly coaching calls

Accountability



New Hospital Pre-Launch – May 6, 2016 Scorecard

Category	Metric	Current Status	Score
Care Coordination	Care Coordinator Hired by 4/1/16	Completed	1
	CC registered for ICCC Health Coaching Course by 4/15/16	Completed	1
	Course Status as of 4/30/16	Registered	NA
		Care Coordination Points	2
		Total Points Possible	2
		Care Coordination Score	100%
Program Logistics	MSSP Application Responsiveness	Completed	1
	Attended PreLaunch Webinar Series	Completed	1
	Financial Consultant Questionnaire Completed by 10/10/15	Completed	1
	Financial Consultant Selected by 11/15/15	Completed	1
	Ilusionative Survey Completed by 1/1/16	Completed	1
	Demographics File submitted by 1/1/16	Completed	1
	Ilusionative Go/live Date or have existing 24/7 coverage	03/01/2016	1
	Pt Satisfaction Questionnaire Completed by 1/1/16	Completed	1
	IT Systems Questionnaire Completed by 11/1/15	Completed	1
	Received Lightbeam User List	Completed	1
	Dat File Status as of 5/5/16	Development	0.25
		Program Logistics Points	10.25
		Total Points Possible	11
		Program Logistics Score	93%
Initiative Implementation	Viewed Jan. TCM Billing Webinar	Completed	1
	Viewed Feb. CCM Billing Webinar	Completed	1
	Viewed March AWV/Prev Wellness Webinar	Completed	1
		Initiative Implementation Points	3
		Total Points Possible	3
		Initiative Implementation Score	100%
Engagement	Viewed Jan. Marketing Training Webinar	Completed	1
	Attended Annual Mtg in DC (Extra Credit)	Completed	1
	CEO or Proxy Attended Q1 ACO Board Meeting	Completed	1
	Hosted Launch Meeting	Completed	1
	Viewed EBM AWV Webinar for Physicians	Completed	1
	Viewed April Patient Satisfaction Webinar or have existing tool	Complete	1
	Viewed May Lightbeam User Group Call (Extra Credit)	Completed	1
	Attended April Quality Improvement Workshop	Completed	1
		Engagement Points	8
		Total Points Possible	6
		Total Extra Credit Points Possible	2
		Engagement Score	133%
Total Points			21.25
Total Extra Credit Points			2
Total Possible Points			22
Total Score			106.6%



***All communities have received a maximum score in the Initiative Implementation category for viewing webinars in Q1 due to a late release of Swank, Caravan Health's Learning Management System used to track attendance.*

How Do You Lower Cost and Improve Quality?

- Annual Wellness Visits
- Chronic Care Management
- Transitional Care Management
- Behavioral Health Integration
- Cognitive Assessments
- Patient Satisfaction
- Claims data insights
- Billing for these services will create a sustainable population health program.
- RHCs and FQHCs have special challenges.
- **IT'S ALL ABOUT THE POPULATION HEALTH NURSE!**

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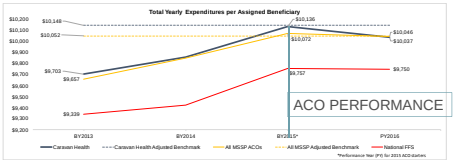
Results

2016 ACO Preliminary Results

ACO	Projected Savings and Losses	Projected Shared Savings	Beneficiaries	Savings Per Beneficiary	Shared Savings Per Beneficiary
A2876	$10,670,487	$5,335,243	12,122	$880	$440
A2860	$7,348,727	$3,674,363	13,018	$565	$282
A2861	$5,247,899	$2,623,949	10,893	$482	$241
A2856	$4,086,807	$2,043,404	10,012	$408	$204
A2880	$3,668,965	$1,834,482	15,303	$240	$120
A2869	$3,018,470	$1,509,235	9,405	$321	$160
A2864	$2,273,492	$1,136,746	5,271	$431	$216
A2866	$2,217,864	$0	13,233	$167.60	
A2858	$1,612,997	$0	9,578	$168.41	
A2872	$1,453,786	$0	14,544	$99.96	
A2895	$1,422,349	$0	8,315	$171.03	
A2852	$1,077,165	$0	6,157	$174.95	
A2862	$696,171	$0	13,180	$52.03	
A2871	$693,927	$0	11,478	$60.46	
A2867	-$769,525	$0	10,989	-$70.03	
A2892	-$1,078,800	$0	8,182	-$131.85	
A2881	-$1,126,201	$0	19,621	-$57.40	
A2890	-$1,144,699	$0	4,912	-$233.04	
A2882	-$1,428,235	$0	6,905	-$206.84	
A2862	-$2,251,442	$0	6,584	-$348.03	
A2879	-$3,288,365	$0	18,340	-$179.30	
A2893	-$3,331,775	$0	11,062	-$301.19	
A2622	-$3,536,579	$0	9,053	-$390.65	
Totals	**$27,493,284**	**$18,157,423**	**248,357**		
Average Savings	**$1,195,360**				
Savings per Beneficiary				**$110.70**	
Shared Savings per Beneficiary					**$ 238.84**
Average Shared Savings		**$2,593,918**			

How Did We Compare to Others?



Program	Adjusted Benchmark vs 2016 (%)	Inpatient 2015 vs 2016 (%)	SNF 2015 vs 2016 (%)	ED 2015 vs 2016 (%)
Caravan Health	-1.1%	-0.1%	-10.7%	-6.9%
All ACOs in MSSP	-0.1%	0.1%	-13.7%	-6.6%
National FFS		1.0%	-8.0%	-6.4%

2016 Impact on Financial Performance - Mag/Evergreen

	Rural Hospitals Total				2016 MSSP Results	
	2015	2016	% Change	Difference	% Change	Difference
Gross IP Revenue	**$ 376,843,601**	**$ 389,878,287**	**3.5%**	**$ 13,034,686**	**-17.7%**	**$ (7,403,986)**
IP Acute Discharges	17,105	16,919	-1.1%	(186)		
IP Acute Days	18,111	17,330	-4.3%	(781)		
Gross OP Revenue	**$ 681,440,146**	**$ 752,828,401**	**10.5%**	**$ 71,388,255**		
OP Visits	312,427	348,619	11.6%	36,192.00		
ED Visits	94,160	90,479	-3.9%	(3,681.00)	-13.2%	
Clinic Visits	250,338	259,335	3.6%	8,997.00		
Net Patient Revenue	**$ 423,477,195**	**$ 453,319,677**	**7.0%**	**$ 29,842,482**	**-8.4%**	**$ (10,922,710)**

Seven Rural Hospitals

- 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.

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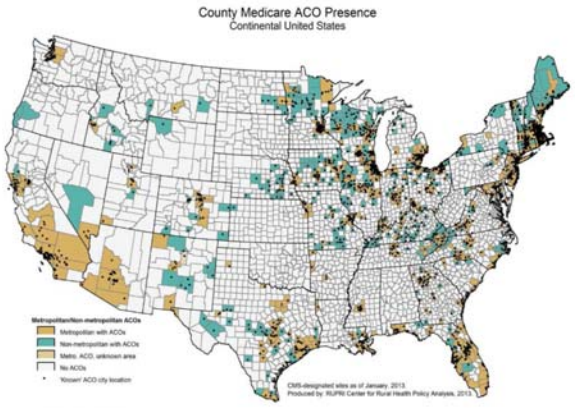
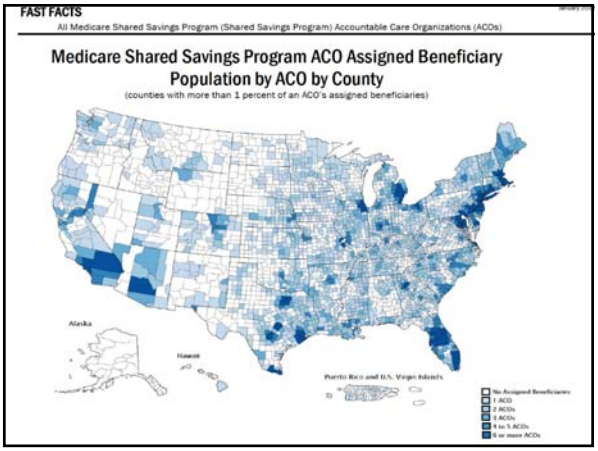
Accountable Care Organization (ACO)??





High Sierras Northern Plains ACO

- Started January 1, 2016
- North Dakota and California providers
- One sided risk Medicare Shared Savings (MSSP)
- Received CMS AIM Funding
  - ACO Investment Model (AIM)
  - 45 ACOs approved, 23 with Caravan Health
  - Prepay Shared Savings
  - Encouraged rural participation in the ACO model
- Board of Directors that manage the ACO
- ACO Champions that lead the ACO work

High Sierras Northern Plains ACO

- North Dakota Participants
  - First Care Health Center — Park River
  - Heart of America Medical Center — Rugby
  - McKenzie County Healthcare Systems — Watford City
  - Sakakawea Medical Center/CCCHC — Beulah/Hazen
  - Southwest Healthcare Services — Bowman
- California Participants
  - Barton Health, Mammoth Hospital, Ridgecrest Regional Hospital, Truckee Tahoe Medical Group
- New Participant – Arizona
  - Gila Health Resources

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Silos of Care and Reimbursement

How did SMC & CCCHC step off the curb to collaborate?

- Collaborating since 2011
- Shared CEO – engaged leadership
- Integrated Governance
- Committed staff
- Strong Medical Director leadership
- Patient Centered Medical Neighborhood
- Common goal of patient/family centered care
- Realized that by working together we are greater than the sum of our parts!!

Our Transformation to a Value-Based Model of Care Delivery

- Collaborative Community Health Needs Assessment
- Development of a Collaborative Community Health Improvement Plan
- Transition from a Patient-Centered Medical Home to a Patient-Centered Medical Neighborhood Model of Care Delivery
  - Population Health Committee
  - Comprehensive Care Coordination
  - Data – population management software / claims analysis

Comprehensive Care Coordination

- Primary Care RN Care Coordinators
  - Pre-visiting planning – AWVs, LTC, Consults/Referrals
  - Visiting Specialists (psych, cards, ortho, OB/GYN)
  - Pharmacy – medication management
- RN Community Care Coordinator and CHW
- Behavioral Health Care Coordinator
  - MAT – Suboxone; BH Integration with Primary Care
- Public Health Nurse
- Hospital RN Care Coordinator
  - Transitions of Care back to Primary Care
  - ER Discharge and Follow-up through Care Coordination
  - Home Health

Comprehensive Care Coordination

- Population Health Management
  - Pop Health Committee – innovative projects focused on improving the health of our community
    - Mammo Marathon, FluFIT, Healthy Halloween Bash, Kid's Day
- Development of a Community "Transitions of Care" Policy
  - Protocols for each organization
    - Transitional Care Management
    - Chronic Care Management
- Coordination of care for high utilizers of ER or inpatient
- Challenges / Barriers to Care
  - Transportation, Community and Home Based services
- Using Data to Drive Change

Questions?

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Thank You

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