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 programming 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.

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**About Caravan Health**

Accountable Care Organizations - 23
Hospitals - 814
Doctors - 6,000
Quality Scores - 97%
Shared Savings - 25% of National Average
Application Success Rate - 100%

**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!**

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**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.

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**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.

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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.

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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.

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Quality Payment Program

- MIPS
- CPC+
- MSSP Tracks 1, 2 & 3
- Next Gen ACO
- Oncology Care Model
- Comprehensive ESRD
- Cardiac and Joint Bundles
- MSSP Track

Option 1: Do Nothing (Death by MIPS)

Option 2: Qualifying APMs (RISK)

Option 3: MIPS APM (NO RISK)

I’m Rural, So I’m Exempt, Right?

- RHGs 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

- 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
  - Tools and Test Drive
  - Advanced education
  - Any time: Care Coordinator Training

- Care Coordinator Training and Support
  - School Cells
  - Coach 1:1 Calls
  - CCM Resource Toolkit

- Practice Improvement Individual Work Plan
  - PDSA cycles
  - Monthly coaching calls

Accountability
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.
- RHOs and FQHCs have special challenges.
- IT'S ALL ABOUT THE POPULATION HEALTH NURSE!

2016 ACO Preliminary Results

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<th>ACO Projected Savings and Losses</th>
<th>Projected Shared Savings</th>
<th>Beneficiaries</th>
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2016 Impact on Financial Performance - Mag/Evergreen

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<th>Rural Hospitals Total</th>
<th>2016 MSSP Results</th>
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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.
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 Participants

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

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-visit planning – AWVs, LTC, Consults/Referrals
  • Visiting Specialists (psych, card, 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

• 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?

Thank You
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