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NATIONAL RURAL ACCOUNTABLE CARE CONSORTIUM
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INTRODUCTION TO POPULATION HEALTH

Kathy Whitmire, Vice President

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Learning Objectives

1. Provide an overall framework for population health
2. Allow clinics to understand why population health is important even in a fee-for-service delivery model
3. Provide a brief overview of incentive programs, payment structure, and the concept of MACRA and MIPS

SO . . . What is Population Health?

- It is a term that is widely used in healthcare, but not universally understood.
- Some definitions of population health emphasize outcomes.
- Others focus on measurement.
- Still others emphasize accountability.

So what does population health truly mean? Who is responsible? What impact does it have on our current health care environment?

SO . . . What is Population Health?

"Effectively taking responsibility for the health care of populations of patients to ensure high-quality, efficient health care at the lowest possible cost for the population."

- HIGH QUALITY – LOW COST

Key Pillars of Population Health

Business Model	Payment Models	Clinical Integration	Technology
Business vision, population definition, policies, modeling, financials, contracts, procedures, market analysis, and value proposition	Risk, incentives, payment management, shared savings	Workflows, role changes, people, care coaches, wellness program development, heath risk assessment process, population engagement	Integration and interoperability including HIE, patient portal, analytics, coaching tools and health risk assessment

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Population Health Vision

Patient centered, integrated care delivery model based on:

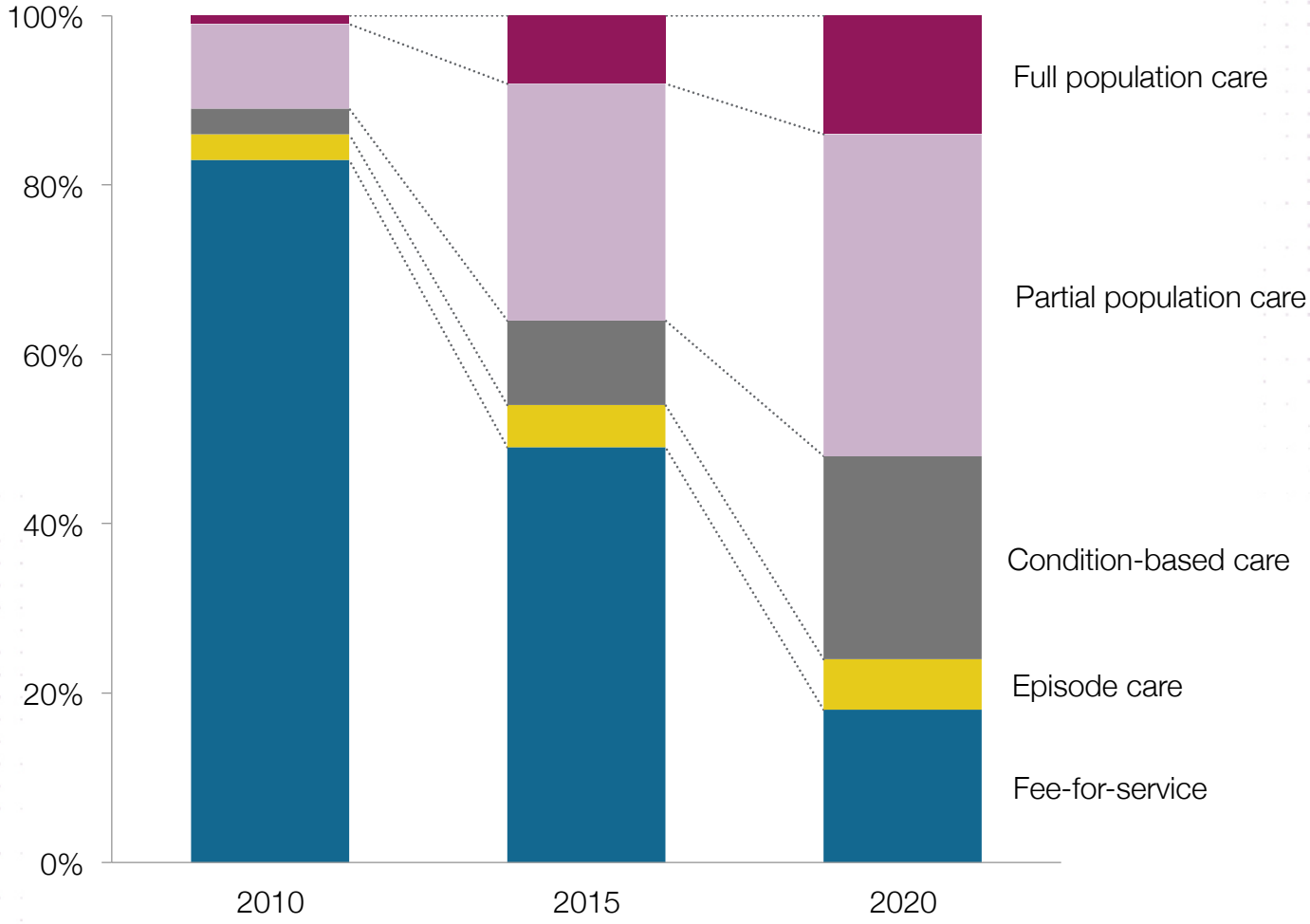
- Aligned incentives
- Coordinated, collaborative processes
- Evidence-based prevention and disease management protocols
- Seamless sharing of information

Supported by **wellness and care coordination** programs that focus on:

- Patient engagement
- Community integration
- Prevention and health promotion

Driven by analytics to support quality outcomes and value-based accountable reimbursement

The Changing Market



Source: *"The View from Healthcare's Front Lines: An Oliver Wyman CEO Survey"*

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Benefits of Population Health Program

Effective population health management benefits patients, physicians, health care organizations, the entire health care system, and the nation at large. Here's how:

- **Patients receive better coordinated care – and enjoy better health – because they are reminded of procedures needed to manage their condition or disease.** They also save their portion of the cost for more expensive procedures not required because of timely care.
- **Physicians are better informed and their patients are more engaged, resulting in better outcomes in care.** Physicians also more easily satisfy quality measures that focus on engaging patients and providing timely, appropriate, coordinated care.
- **Health care organizations are more profitable – whatever their payment model(s) – because gaps in care are filled, patient volume increases** and the cost of delivering care can be more accurately quantified.
- **The health care system benefits from increased preventative care, which helps avoid more expensive procedures** and leads to higher quality, more efficient, coordinated care across health care organizations.
- **The nation benefits from reduced health care costs, better management of diseases, and a generally healthier population**.

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SO . . . How does this all of this affect you in a Rural Health Clinic?

1) Do you offer Chronic Care Management (CCM) services in your RHC?

2) Do you do Annual Wellness Visits (AWV)?

- These services are new billable Medicare Population Health Services

SO . . . How does this all of this affect you in a Rural Health Clinic?

1) Do you report quality? patient satisfaction?

2) Do you follow up on your patients after discharge from the hospital or observation?

If the answers are yes, then you are in the population health world!

MACRA Overview

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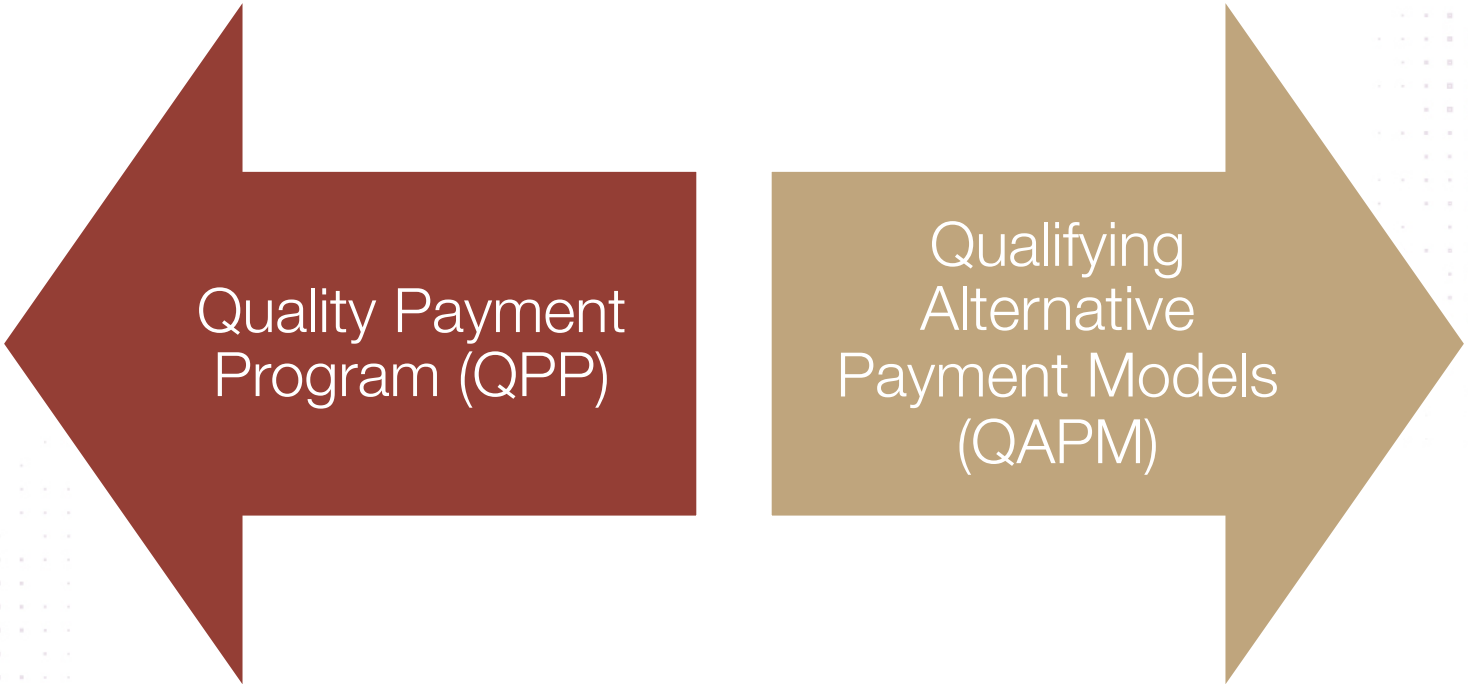
Providers Choose Between Two Tracks



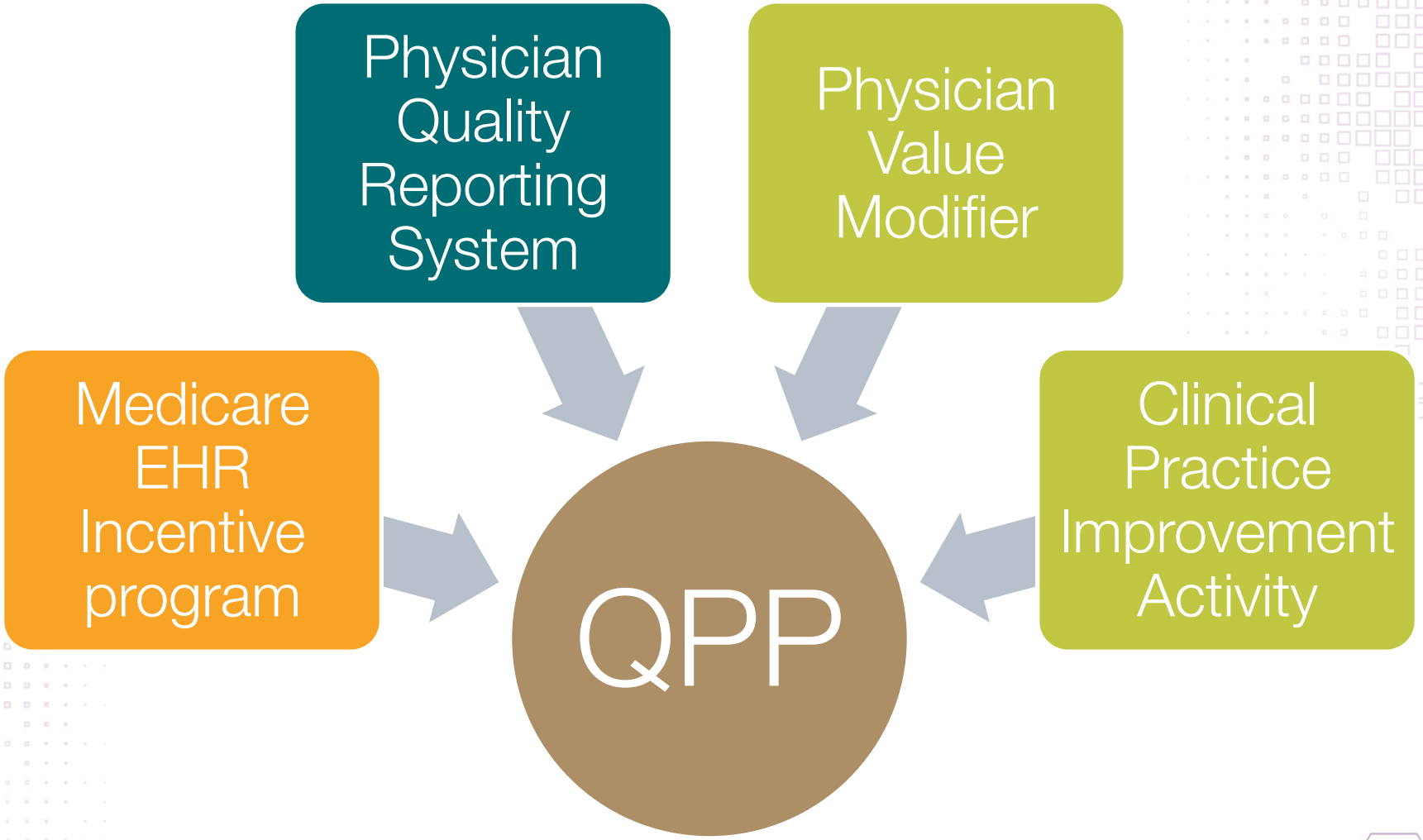
2017: Three Options for the QPP

"Pick Your Pace"

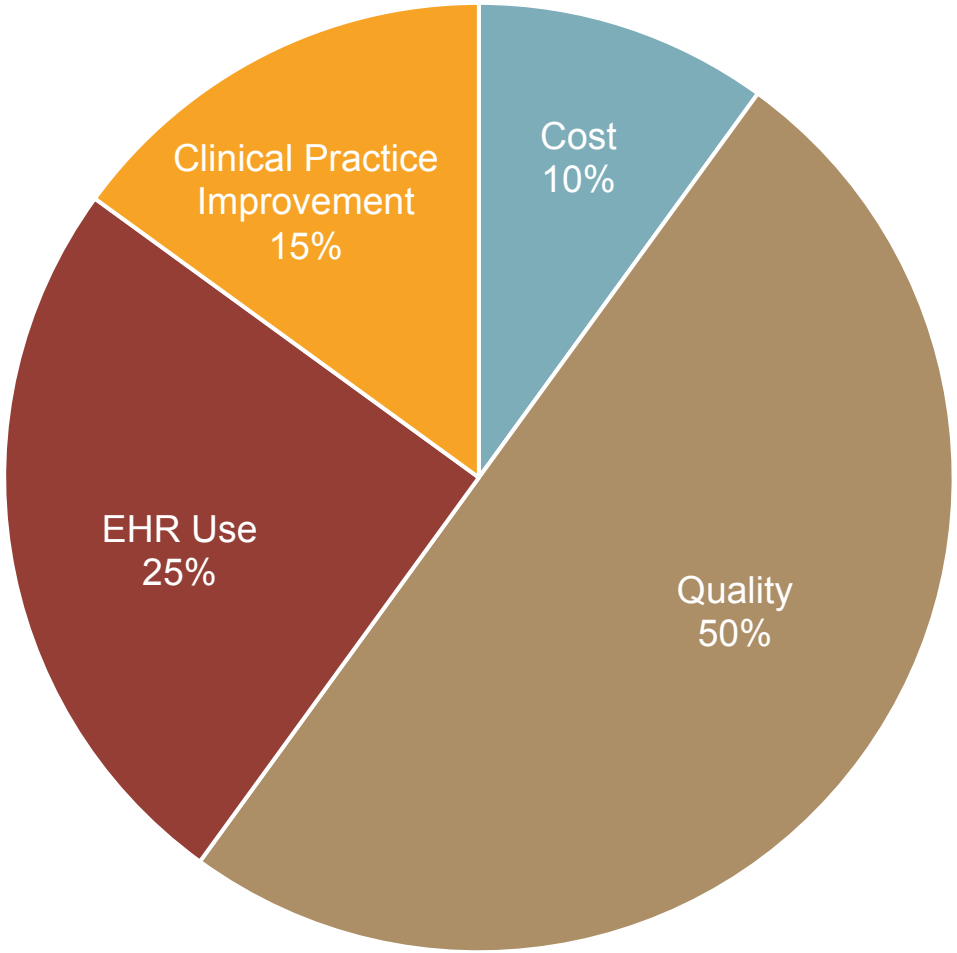
Offering three options to report under MIPS for the first performance period:

1. **Test the Quality Payment Program.** Report on some of the required MIPS data. Physicians using this option will not be eligible to receive a performance bonus, but will not be subject to a penalty.
2. **Participate for part of the calendar year.** Report all of the required MIPS data for 90 days. Physicians using this option will be eligible to receive a smaller bonus.
3. **Participate for the full calendar year.** Report all of the required MIPS data for the full year. Physicians using this option will be eligible to receive the full bonus depending on their performance score.

Quality Payment Program: Consolidates 3 Programs into 1 and Adds 1 More

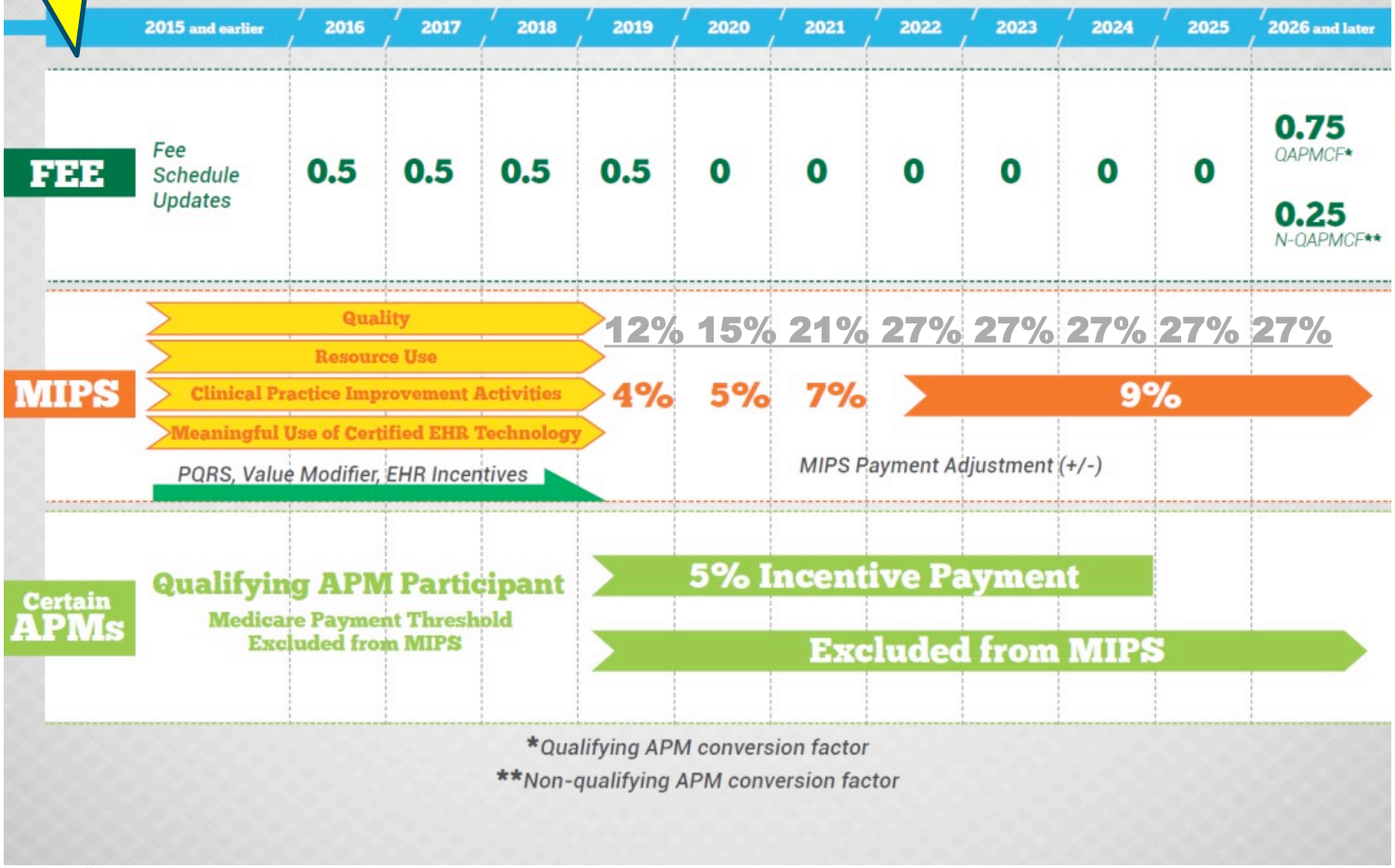


QPP Scoring Has 3 Domains in 2017
4 Domains in 2018



Action Required

MIPS Timeline



Alternative Payment Models

QPP APMs
Qualifying APMs

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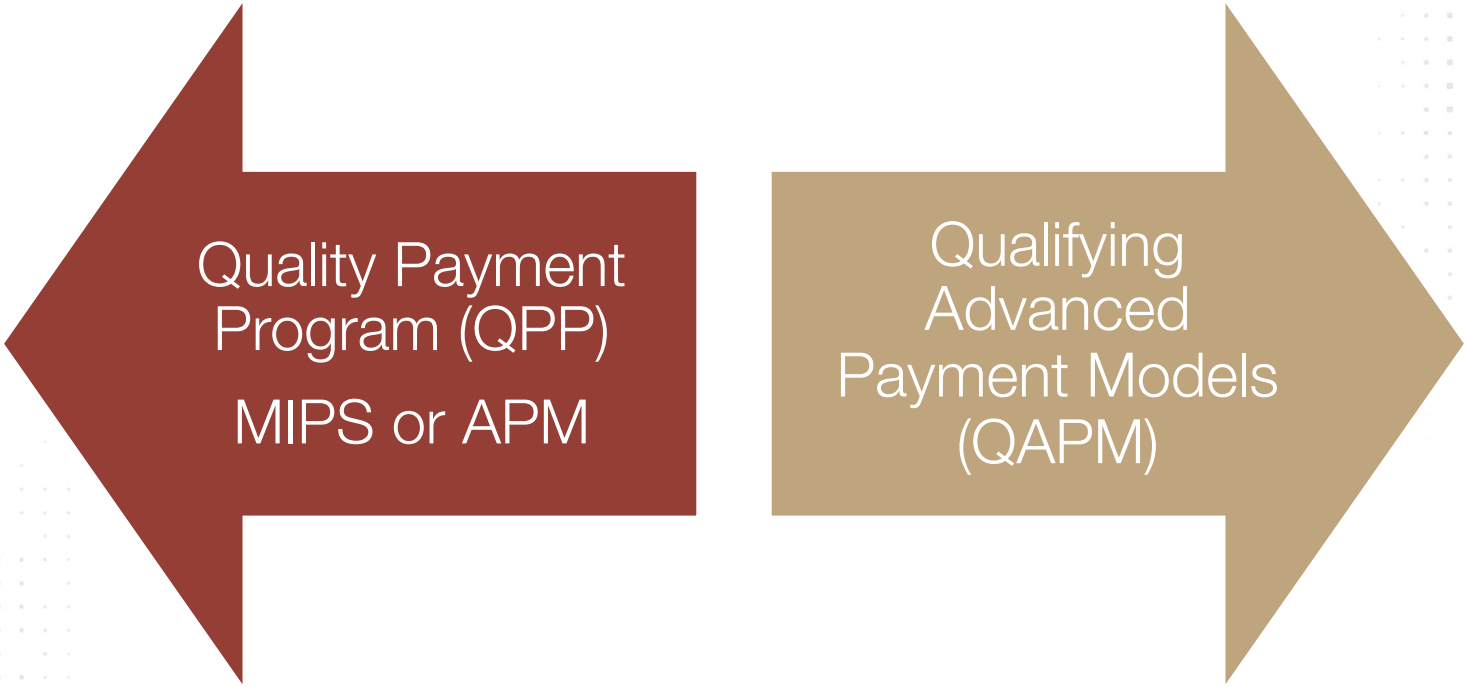
Providers Choose Between Two Tracks
MACRA
Medicare Access and CHIP Reauthorization Act



What is an APM / ACO?

APM – Alternative Payment Model

New approaches to paying for medical care of Medicare patients that incentives quality and value.

ACO - ACOs are groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high quality care to their Medicare patients. The goal is to ensure that patients, especially the chronically ill, get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors. *Some ACOs participating in CMS programs will qualify as APMs or Advanced APMs if they meet the criteria.*

What is an MSSP ACO?
Medicare Shared Savings Program

- Providers agree to be accountable for the cost and quality of care of their Medicare primary care patients

- Must have 5,000 “covered lives” attributed for eligibility

- In most ACO’s, 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. Patient attribution data is being gathered in 2017 performance year.

QAPMs or QPP APMs – Which is Right for You?

Requires Risk

10% loss = $100,000 Repayment

5% Max Bonus

Does Not Require Risk

27% Max Bonus

4-9% Max Penalties

QPP Alternative Payment Models

- QPP APMs = Medicare Shared Savings Program, Track 1
- **ACO Participation Improves QPP performance.**
- **All providers billing under ACO TIN's will get the ACO quality score unless they choose to report both.**
- QPP APMs are exempt from the Resource Utilization metric.
- All Participants must submit data individually for Clinical Practice Improvement and Advancing Healthcare Information.
  - If you are compliant with our program, or if you are PCMH, you get a perfect score for Clinical Practice Improvement.
  - You automatically get 50% credit for Clinical Practice Improvement in an ACO.
- **Most ACO Participants will not be penalized and can earn high bonuses if they pay attention to EHR issues.**

Qualifying Advanced APMs

- Participants in "Qualifying Advanced APMs" will **be exempt from QPP and will receive up to a 5% incentive payment, plus higher updates on their fee schedule rates in out years.**
- Requirements:
  - Financial Risk: Total risk, marginal risk, and minimum loss rate
  - Quality Measures: At least one must be an outcome measure
  - Require EHR Use: 50% in Year 1, 75% in Year 2

  OR
  - CMMI Medical Home Model -Comprehensive Primary Care Plus – CPC+

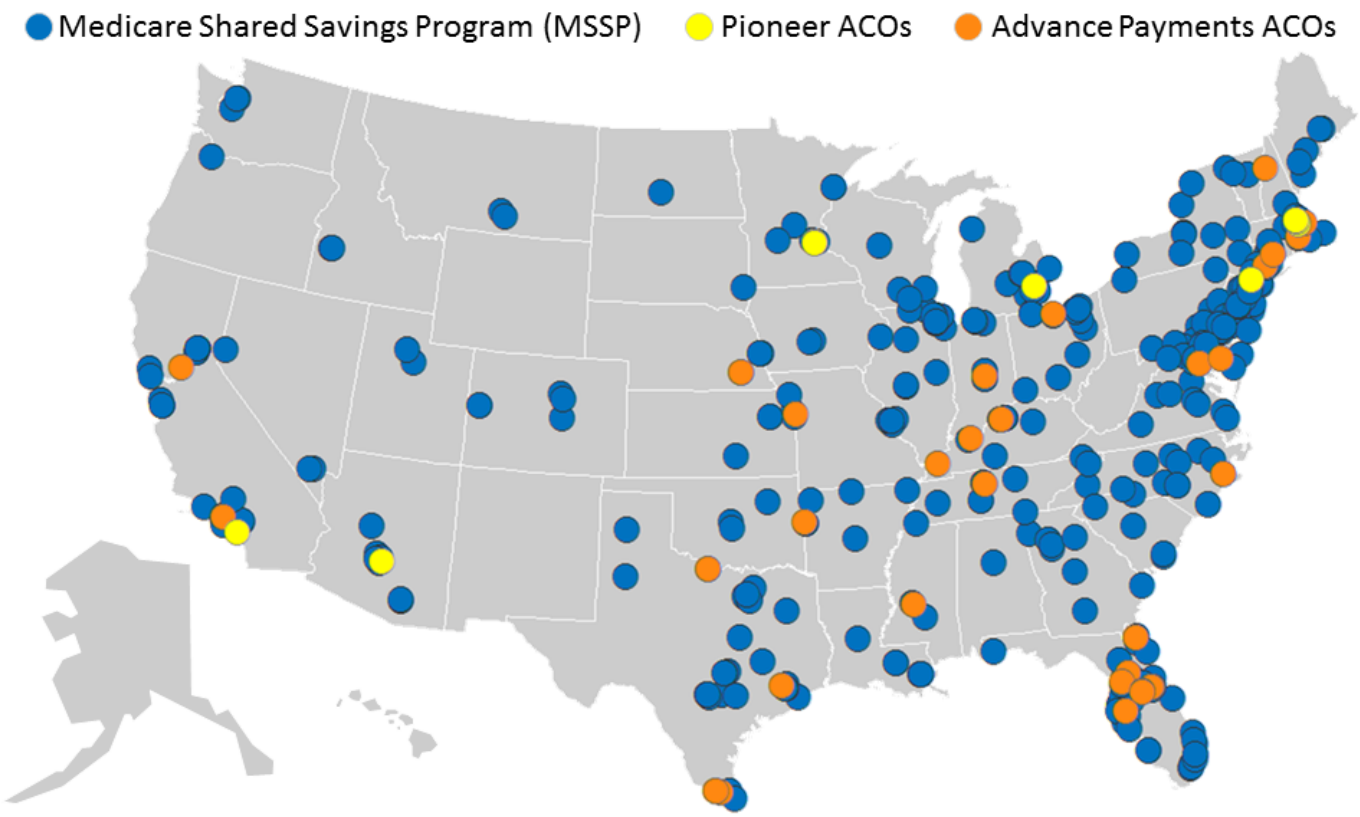
2017 Qualifying Advanced APMS

CPC+	MSSP Tracks 2&3	Next Gen ACO
Oncology Care Model	Comprehensive ESRD	Cardiac and Joint Bundles

Where Are ACO's Forming?

Figure 2

Accountable Care Organization (ACO) Models



SOURCE: Map data downloaded October 7, 2016 from CMS: https://innovation.cms.gov/initiatives/map/index.html and https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/ACOs-in-Your-State.html. Participant counts in this dataset are updated periodically. See Table 3 for official counts in most recently-available CMS documents and webpages.

THE HENRY J. KAISER FAMILY FOUNDATION

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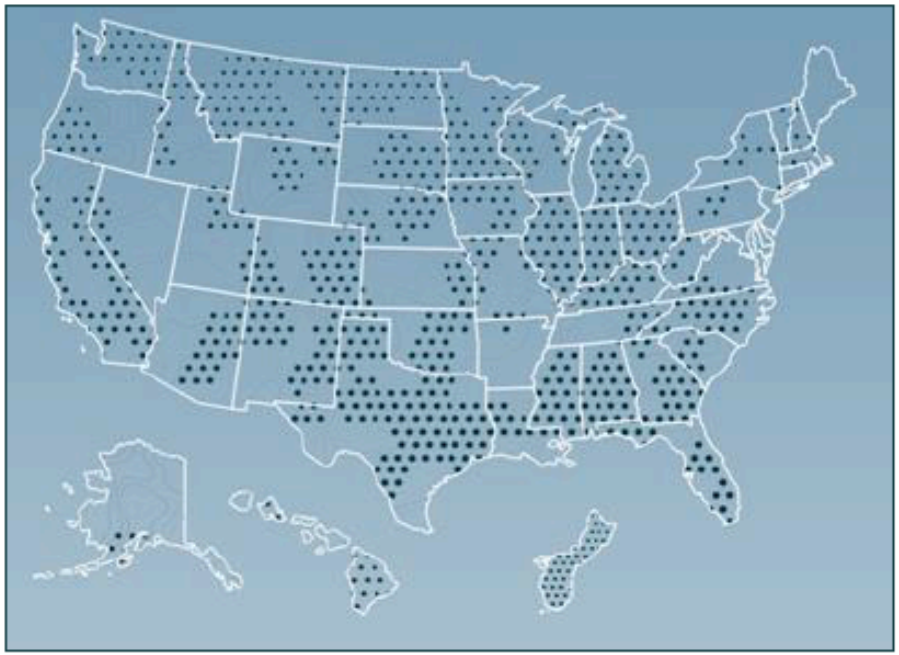
Caravan Health Foot Print

- *278 Community Hospitals*
- *411 Physician Practice Organizations*
- *Over 6,000 Clinicians*
- *500,000 Patient Lives*
- *23 ACOs*
- *73 CPC+ Organizations*
- *2.5x Shared Savings Above National Average*



Value Based Programs Enabled by Caravan Health

AIM ACOs	MACRA	CPC+	Commercial ACOs

Why Should I Join an 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 thru CPSI

2016 Year One Preliminary ACO Results

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2016 Impact on Financial Performance – Magnolia Evergreen ACO

Metric	Rural Hospital 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		
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**	**7.0%**	**$ 29,842,482**	**-8.4%**	**$ (10,922,710)**

- Seven Rural Hospitals
- Local hospital Revenue went up 7% in spite of saving 8.4% per beneficiary.
- Local hospital revenue went up $30 million in spite of saving Medicare $11 million
- Inpatient revenue increased $13 million in spite of saving Medicare $7 million

2016– Magnolia Evergreen ACO Participants

- Anderson Physician Alliance, Inc
- Columbia County Hospital District
- Coulee Medical Center
- Kings Daughters Medical Center
- Meridian Medical Associates, PA
- Neshoba County General Hospital
- Sunnyside Community Hospital Association
- Tri-State Memorial Hospital

- CONGRATULATIONS!!!!!

What about MIPS ?

Merit-based Incentive Payment System

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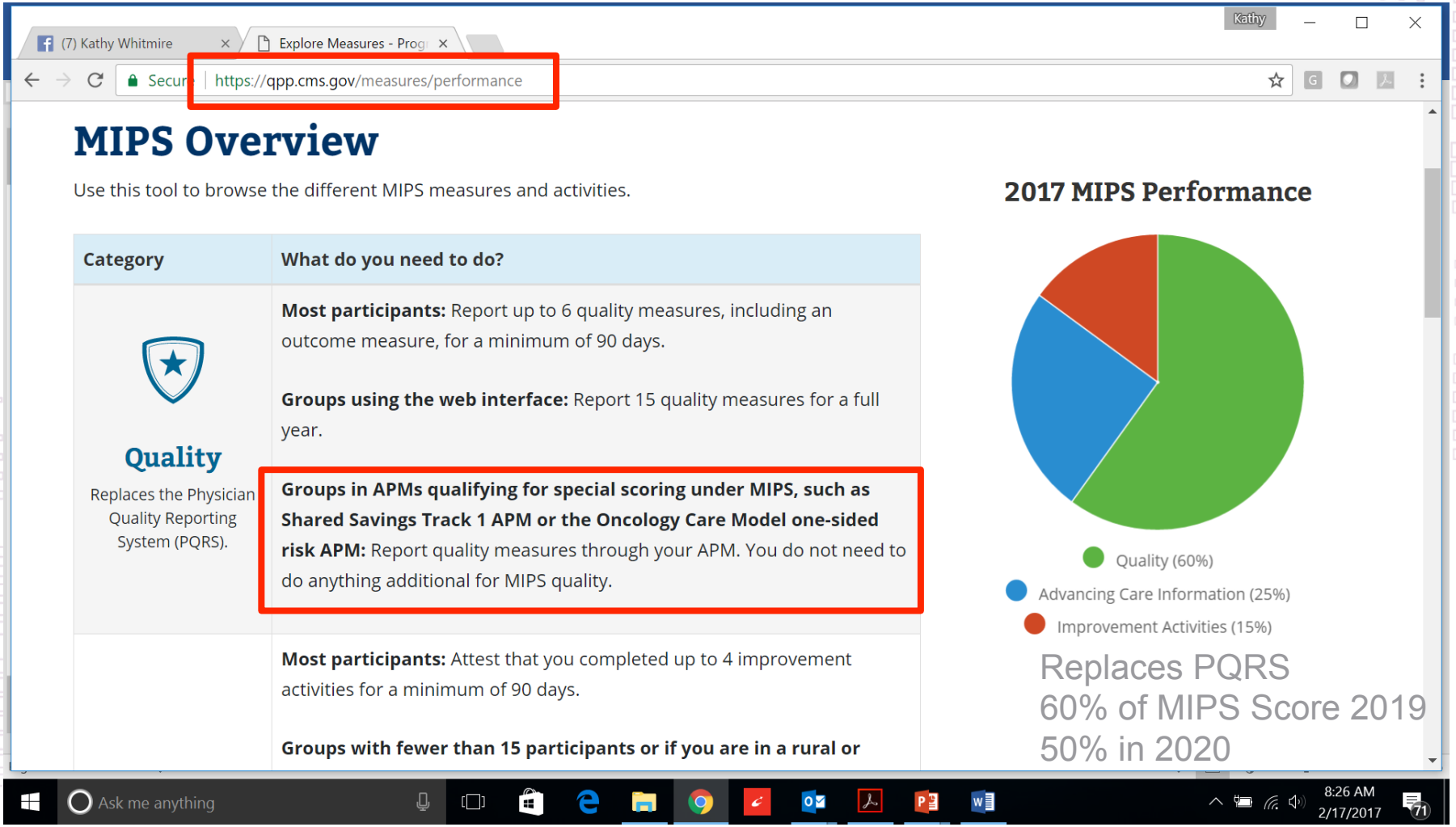
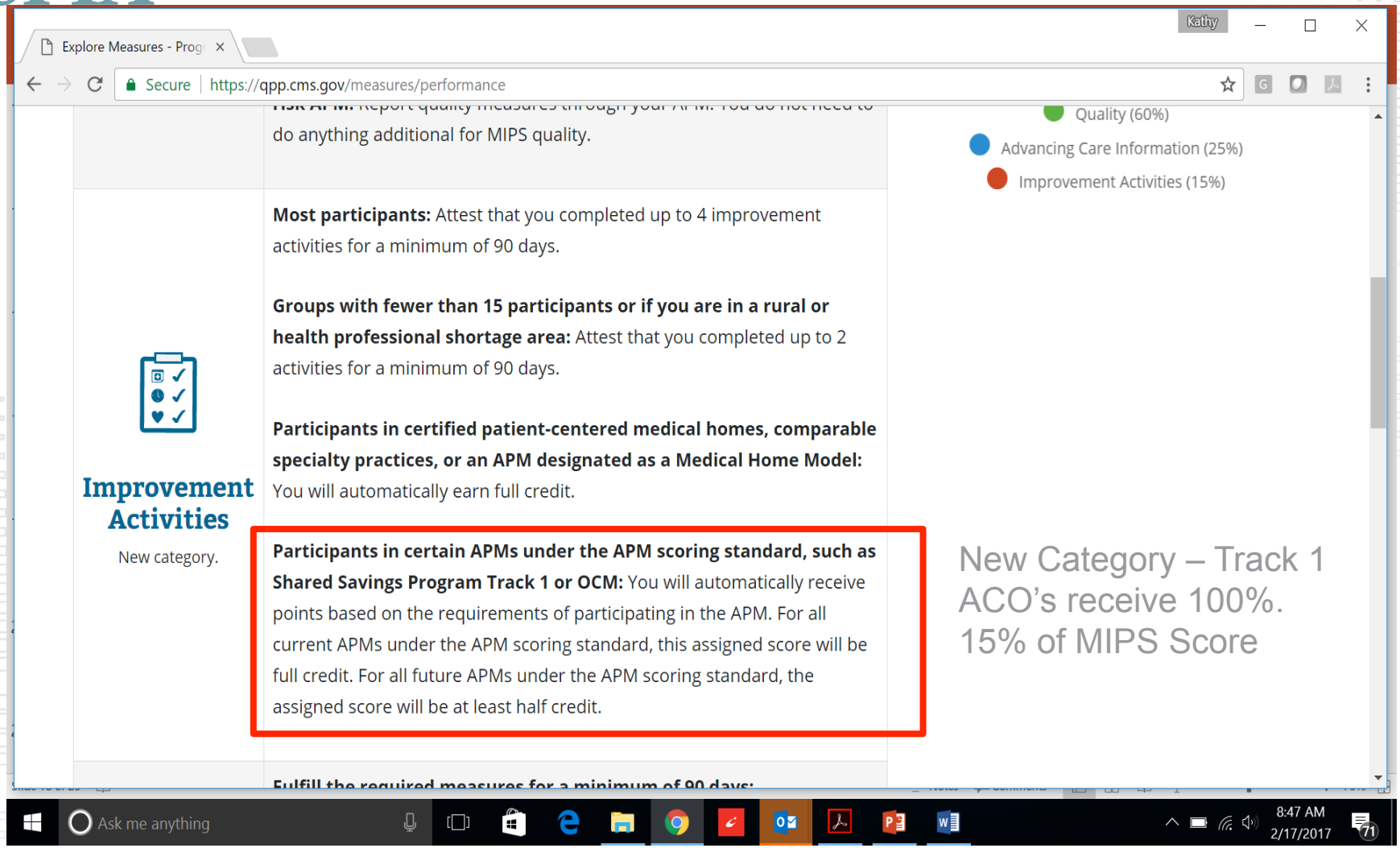
Quality

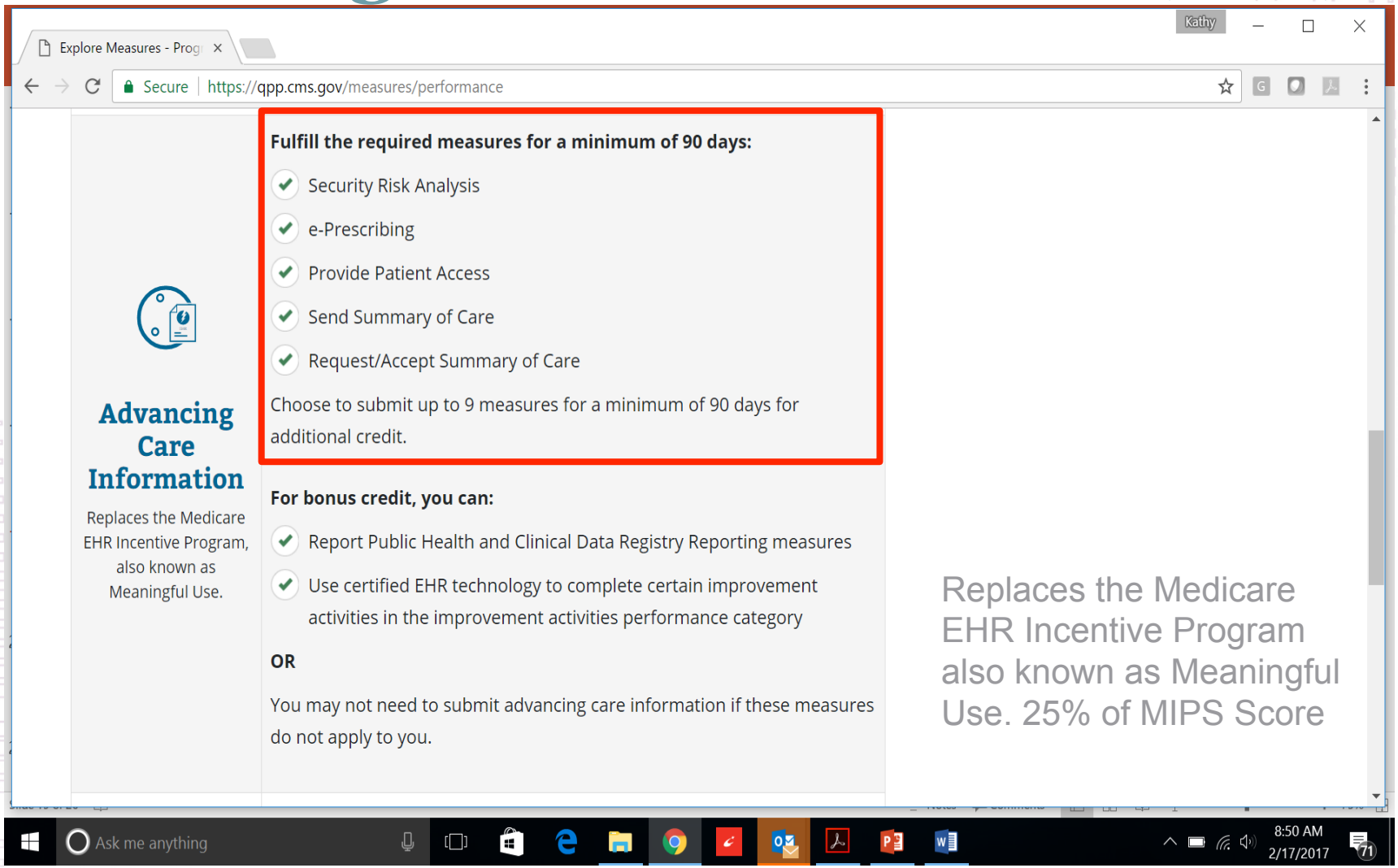

(7) Kathy Whitmire
Explore Measures - Prog
Kathy
https://qpp.cms.gov/measures/performance
MIPS Overview
Use this tool to browse the different MIPS measures and activities.
Category
What do you need to do?
Quality
Replaces the Physician Quality Reporting System (PQRS).
Most participants: Report up to 6 quality measures, including an outcome measure, for a minimum of 90 days.
Groups using the web interface: Report 15 quality measures for a full year.
Groups in APMs qualifying for special scoring under MIPS, such as Shared Savings Track 1 APM or the Oncology Care Model one-sided risk APM: Report quality measures through your APM. You do not need to do anything additional for MIPS quality.
Most participants: Attest that you completed up to 4 improvement activities for a minimum of 90 days.
Groups with fewer than 15 participants or if you are in a rural or
2017 MIPS Performance
Quality (60%)
Advancing Care Information (25%)
Improvement Activities (15%)
Replaces PQRS
60% of MIPS Score 2019
50% in 2020
Ask me anything
8:26 AM
2/17/2017

Clinical Practice Improvement Activities - CPIA



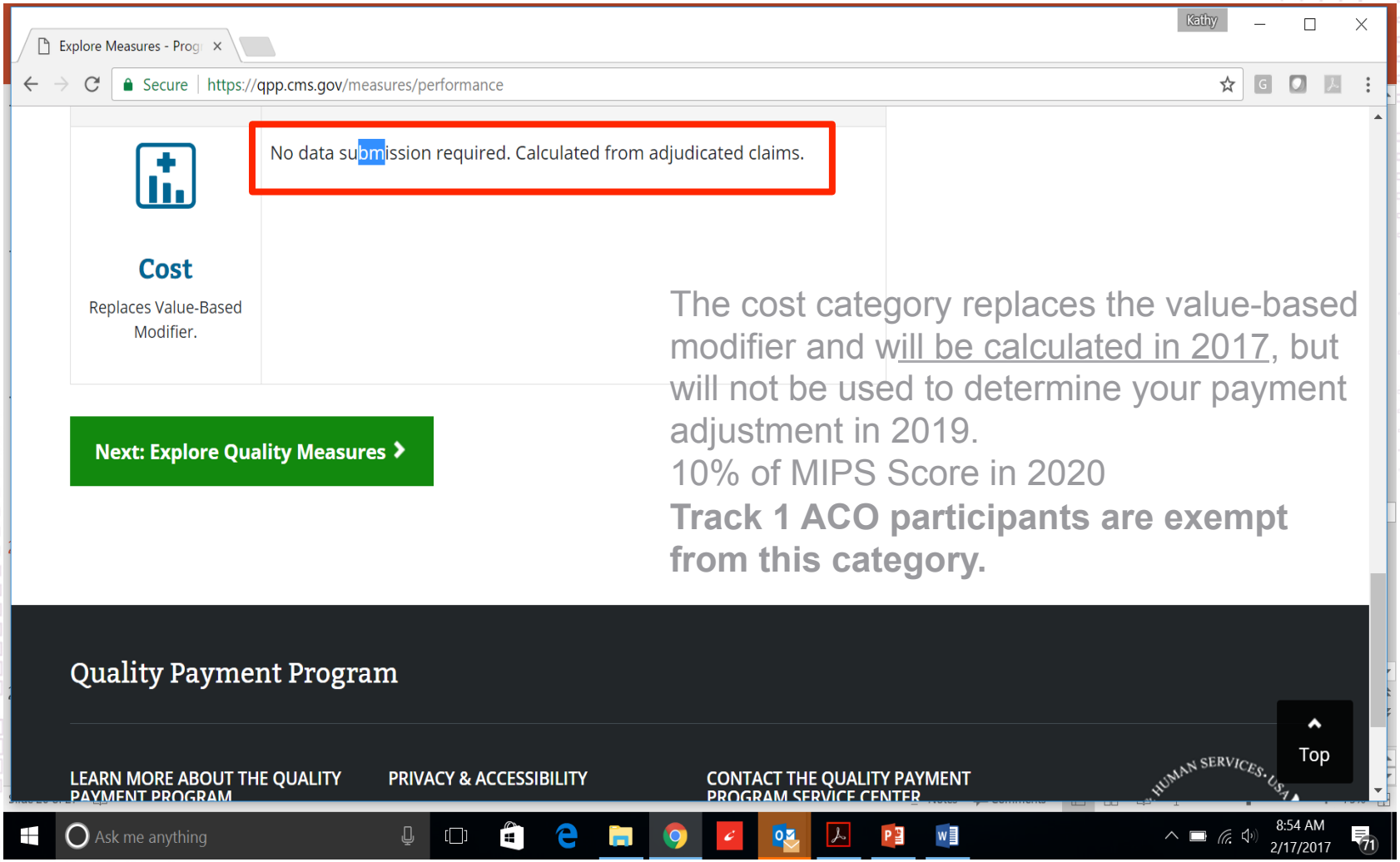
New Category – Track 1 ACO's receive 100%. 15% of MIPS Score

Advancing Care Information (ACI)



Replaces the Medicare EHR Incentive Program also known as Meaningful Use. 25% of MIPS Score

COST / RESOURCE USE - QRUR



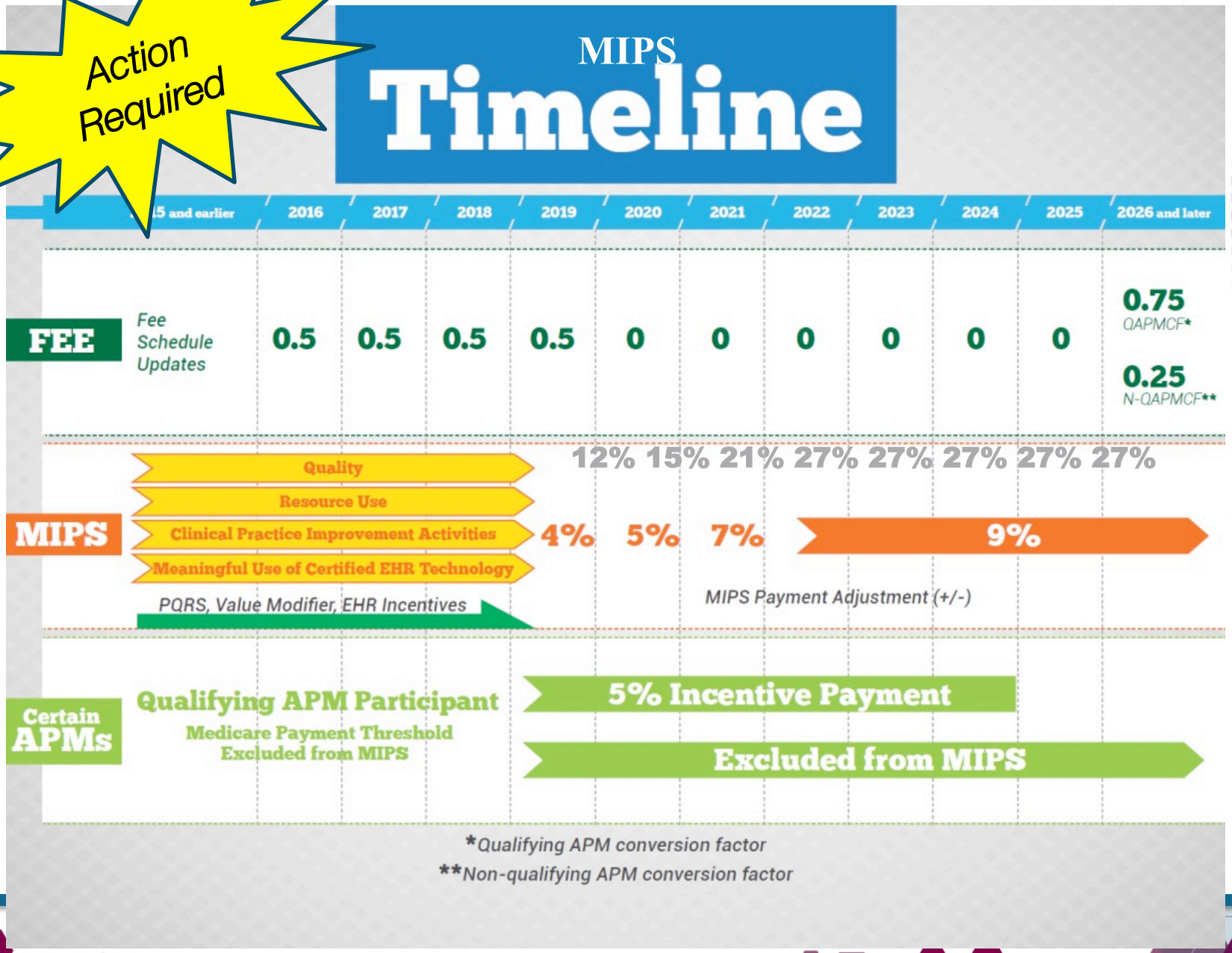
The cost category replaces the value-based modifier and will be calculated in 2017, but will not be used to determine your payment adjustment in 2019.

10% of MIPS Score in 2020

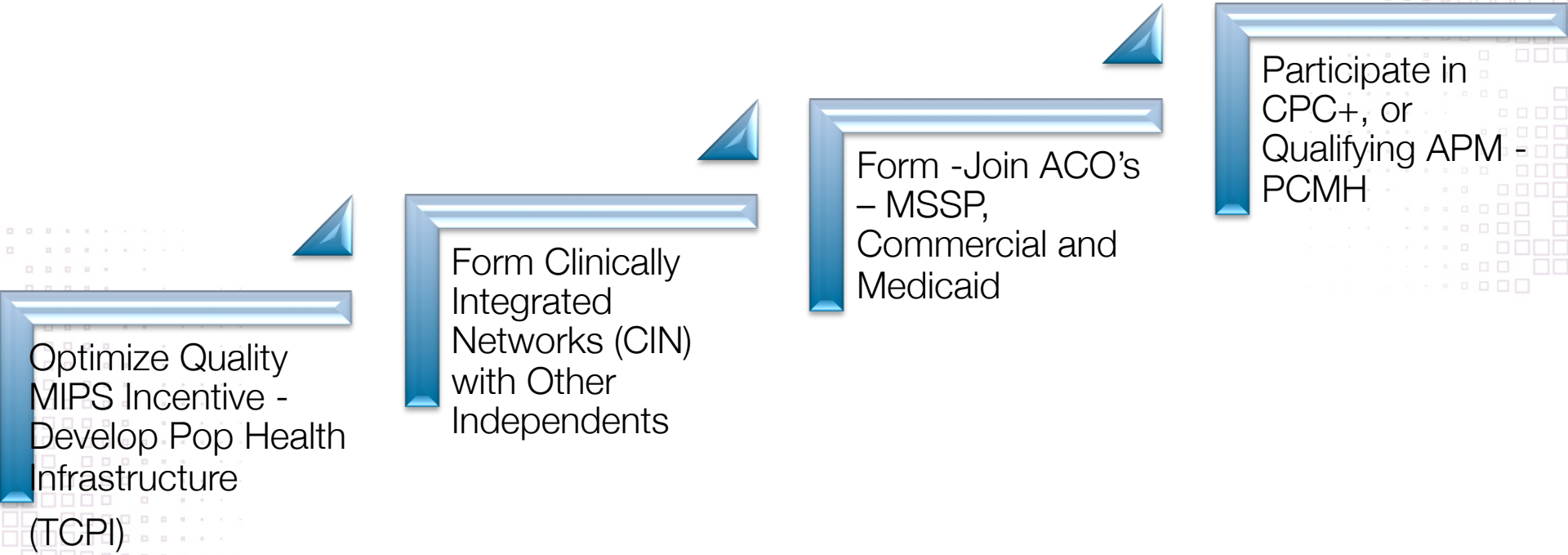
Track 1 ACO participants are exempt from this category.

Action Required

MIPS Timeline



In Summary, TCPI is the First Step of a Strategic Plan for Practice Transformation



ACRONYM CONTEST:

- ACO
- APM
- AWV
- CCM
- CPIA
- MACRA
- MIPS
- MSSP
- QPP
- PCMH

Questions? – Next Steps

JOIN TCPI
Go to www.nationalruralaco.com
Click on **Apply Now** to get ready for the future.

COMPLETE A Non-binding Letter of Intent (LOI)
http://caravanhealth.com/apply/

OR CONTACT:

Kathy Whitmire, RVP Southeast
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THANK YOU!

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Questions?

Thank You!

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