Fund Your Mission

Practical Steps to Move from Volume to Value



WINTERGREEN

Overview

The Rural Environment



Market

One in five Americans live in rural communities

Barriers

Highly fragmented provider community with various clinic designations

Entrenched need for autonomy and cultural resistance to change -- coupled with trust issues

Complex, arcane and fluid regulatory environment tied to optimal reimbursement

Opportunity

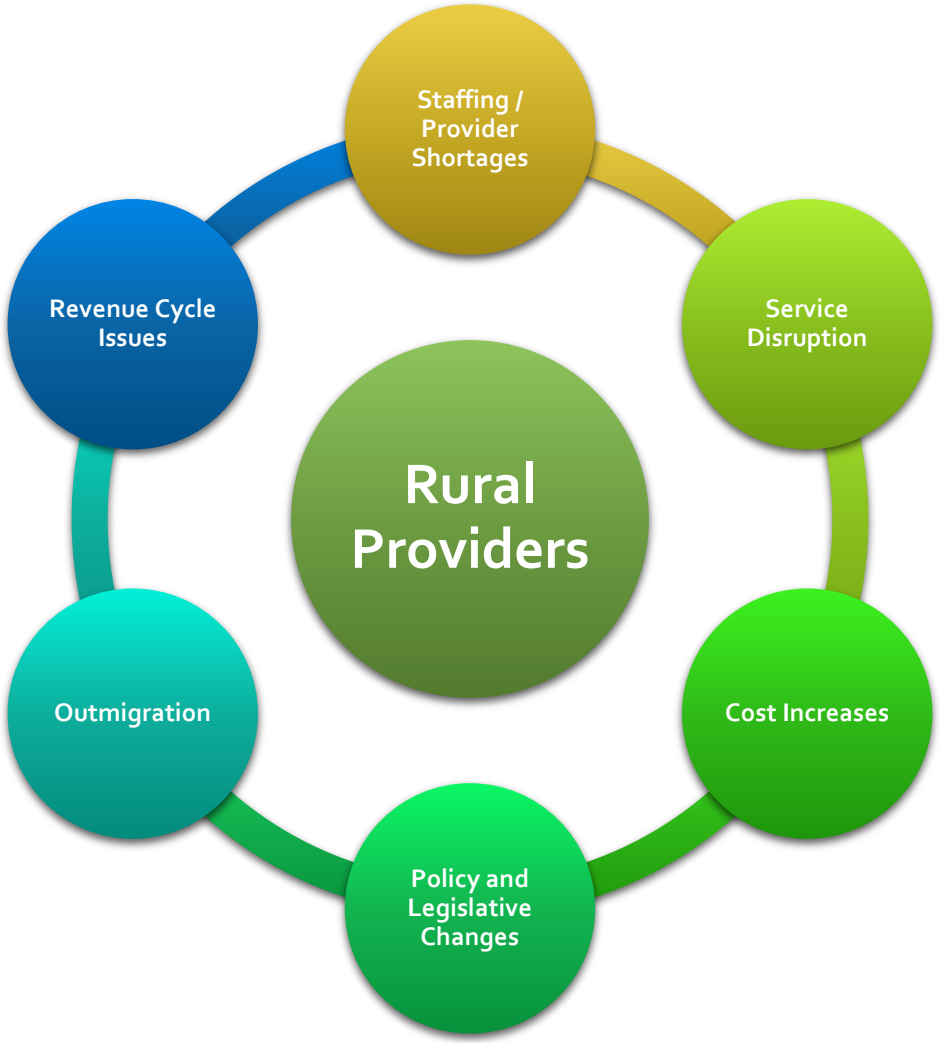
Organizations must take steps to improve their operational performance, service delivery, and financial position: specifically looking at the alignment and designation of each rural practice to improve performance

Rural markets are built on relationships that strengthen trust, honor legacy models and provide the type of innovation and expertise that is not present in the current, inefficient industry

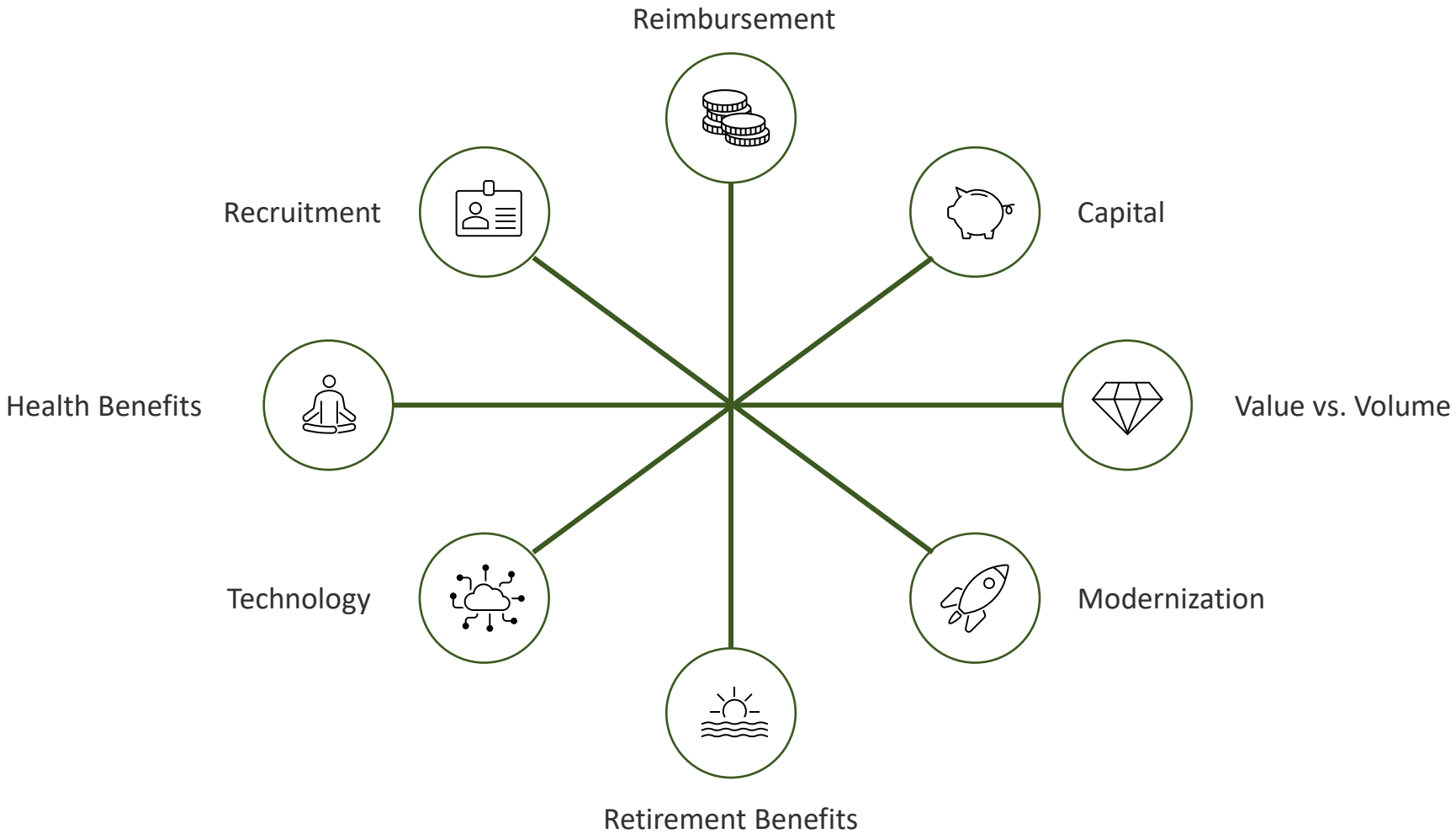
The Current Landscape

- Rural providers continue to experience cost increases, while having to address staffing shortages, outmigration, and significant policy/legislative changes

- The past few years have fundamentally changed how many patients receive healthcare services
  - Organizations must take a proactive approach to address these changes

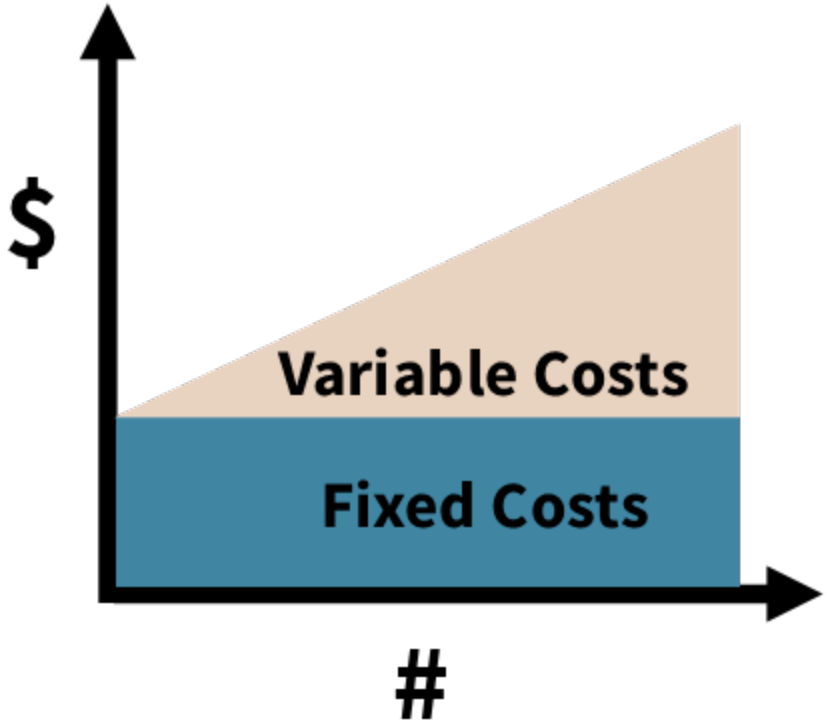


Interdependence of Major Drivers



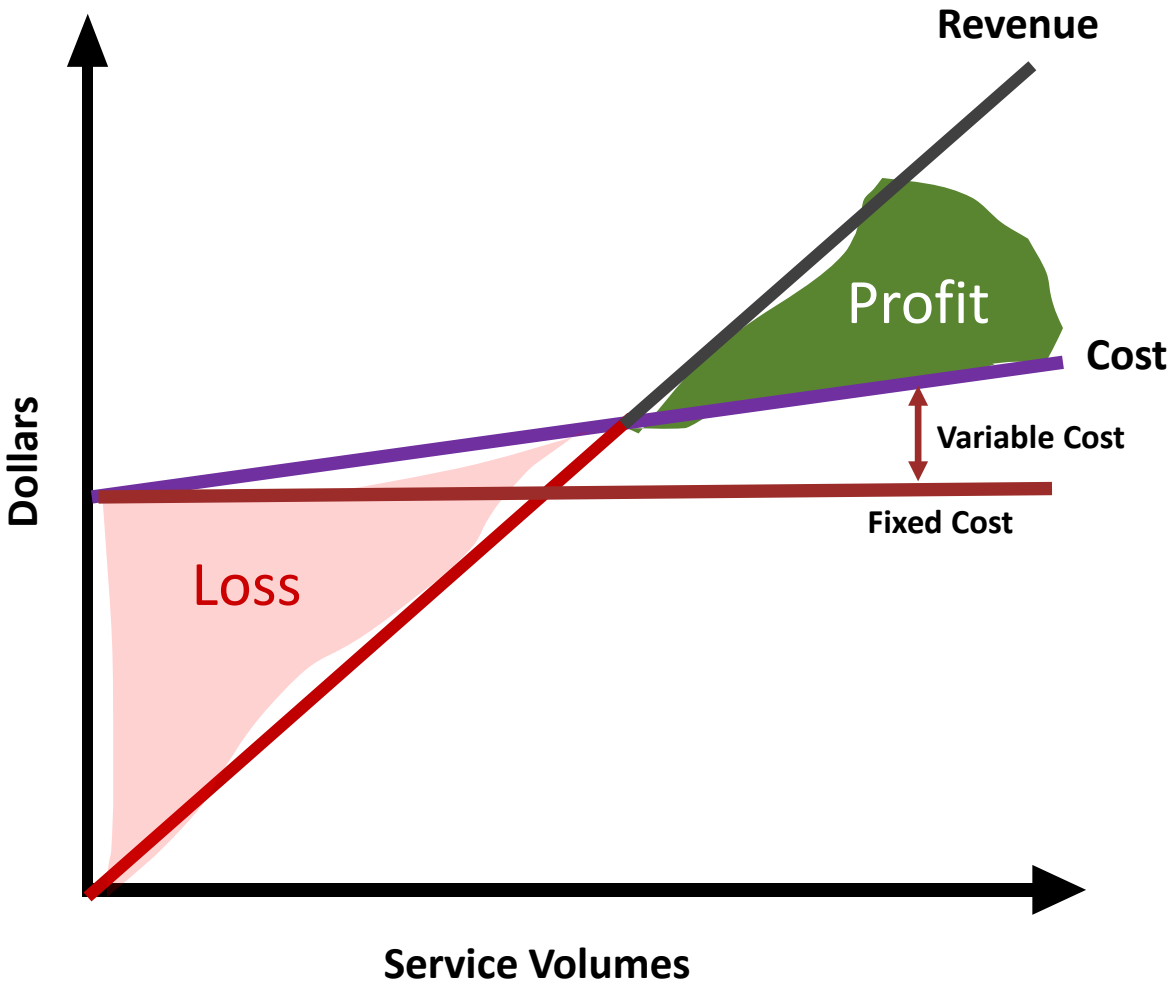
Understanding Your Cost Structure

- Fixed costs are those which exist irrespective of volume
  - Unit staffing, medical direction, medical equipment, par levels of supplies
- Variable costs are those which would be incurred with each additional CAH/RHC visit
  - Incremental medical supplies and pharmaceuticals
- In comparison to fixed costs, variable costs represent only a fraction of CAH/RHC costs
  - As volume grows, fixed costs are diluted faster than variable costs grow



Economic Philosophy

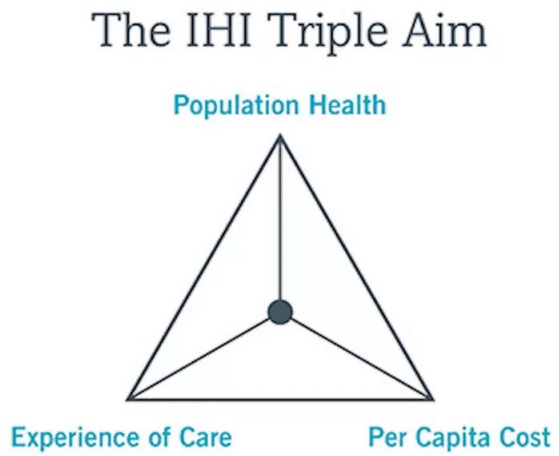
- The financial solvency of a CAH is dependent upon the realization that revenue (volume) and expenses both contribute to the financial position of an organization
  - Value is unlocked by marginal revenue gains that help dilute down a high fixed cost environment
  - Organizations need to understand the different and impact of contribution margin
  - Cost-based reimbursement will not generate profit and only cover the costs for those proportional services
  - CAHs need to break down the silos between quality and finance for improved outcomes



The IHI – Triple Aim

- The United States health care system is the costliest in the world and changes must occur to maintain the sustainability of services and care
  - The IHI Triple Aim framework, developed by the Institutes for Healthcare Improvement (IHI), describes an approach to optimizing health system performance

- IHI believes the United States must develop new designs that simultaneously pursue three dimensions: the Triple Aim
  - Improving the patient experience of care (including quality and satisfaction)
  - Improving the health of populations; and
  - Reducing the per capita cost of health care[1]
- Generally, in the United States health care environment, no one is accountable for all three dimensions of the IHI Triple Aim and thus lead to the following conceptual design:
  - Focus on individuals and families
  - Redesign of primary care services and structures
  - Population health management
  - Cost control platform
  - System integration and execution



[1] The IHI Triple Aim | IHI - Institute for Healthcare Improvement

Reimbursement Models

Payment Model – Fee-For-Service

- Under the fee-for-service payment methodology, providers receive payment for specific, individual services provided to a patient
  - The services provided and complexity of those services dictate the reimbursements received by the provider
  - The following table identifies several pros and cons associated with the fee-for-service reimbursement model

PROS	CONS
Encourages and incentivizes the delivery of care and maximizing patient visits	Does not incentivize providers to offer efficient and effective care
Offers great flexibility in the delivery of care	Limits care coordination and the management of specific conditions due to the lack of reimbursement for those services
Holds providers directly accountable for the services the provide	The system is complicated and patients often have difficulties management the system
Affords patients the opportunity to search out different providers of care	Can lead to unnecessary or more costly procedures due to the reimbursements received for those procedures

Payment Model – Value-Based Care

- Under a value-based payment model (often referred to as accountable care, population health, or at-risk contracting) organizations receive payments for specific objectives, such as reducing costs and improving quality, instead of directly providing care to patients

- The following are the 4 main types of value-based models:
  - Shared Risk: Requires organizations to keep costs at or below a certain target
  - Bundles: Rewards organizations to reduce costs associated with certain services within the bundle
  - Global Capitation: Focused on per member, per month (PM/PM) agreement where members share in short-term and long-term costs
  - Shared Savings: Incentivizes organizations to meet a target budget spend

Payment Model – Shared Risk

- Under the shared risk payment methodology, providers are penalized for failure to achieve a set cost structure for a specific patient population
  - The goal of the shared risk model is to force participants to achieve certain cost levels or face financial penalties for failure to achieve the set cost structure
  - The following table identifies several pros and cons associated with the shared risk reimbursement model

PROS	CONS
May provide cost-efficient and high-quality care to patients	Can create an unsustainable environment that could be outside the control of the provider
Providers have a vested interest in the costs of care for a patient population due to potential penalties	Creates environment where providers are less likely to refer patients out-of-network
Reduces unnecessary services received by a patient	May change the focus of providers from the delivery of care to the management of costs
Creates a focus on population health management	Administratively burdensome to collect, track, and manage the data necessary for the shared risk program

Payment Model - Bundles

- Under the bundled payment methodology, providers receive payment for the treatment of a specific condition that may involve multiple providers and settings
  - The intent of the bundled payment is to prevent unnecessary visits and costs for a specific condition
  - The following table identifies several pros and cons associated with the bundles reimbursement model

PROS	CONS
Improves care coordination between all providers involved within the bundle	Services within a bundle are not always clearly defined and can create confusion within the industry
Once approved, greater flexibility in the scheduling and delivery of care across the complete episode	Can limit access to care for certain patients or require patients to travel to other geographic areas
Effective management of the services within the bundle	Does not create specific incentives to reduce unnecessary episodes
Increases efficiencies from a billing perspective	High-risk patients may not receive care due to the potential exposure for a provider

Payment Model – Global Capitation

- Under the global capitation model, providers receive payments based on a pre-defined set of services for a specific patient population
  - Payments will vary based on the range of services, the number of patients served, a specific period that the services are provided, and other factors determined within the payment model
  - The following table identifies several pros and cons associated with the global capitation reimbursement model

PROS	CONS
Increases the direct alignment between the provider and the patient due to the associated risk held by the provider	Providers may delay care due to associated cost which is in excess of the payment within the capitated model
Increases the flexibility entities have in the provider payment model	Patients with higher per capita costs and certain pre-existing conditions may be excluded due to the associated cost
Providers have better leverage in a capitation model when negotiating with payers	The relative risk to the organization in a capitated model can be high if the organization is unable to provide the necessary services
Increased focus on preventative services and ways to reduce overall cost	

Payment Model – Shared Savings

- Under the shared savings payment methodology, providers receive incentives to meet certain quality and cost benchmarks for a specific population over a set period
  - The goal of the shared savings model is to give participants a financial incentive for improving patient outcomes and lowering the cost of care
  - The following table identifies several pros and cons associated with the shared savings reimbursement model

PROS	CONS
May provide cost-efficient and high-quality care to patients	Upfront costs associated with implementing systems and staff to support model
Providers are incentivized to reduce the cost of care to receive a portion of the shared savings	Creates environment where providers are less likely to refer patients out-of-network
Helps to diversify revenue streams and move providers away from solely relying on fee-for-service	Rewards high-cost providers that can manage expenses instead of providers that already provide value-based care
Creates a focus on population health management	Administratively burdensome to collect, track, and manage the data necessary for the shared savings program

Implementing Value-Based Care

Value-Based Care Success Factors

- Organizations that successfully transition from volume to value must implement and focus on specific elements for success
  - Culture and Leadership
    - Organizations and leadership must have a comprehensive understanding as to why an organization is going through the transition from volume to value and create specific incentives that target population health management and outcomes
  - Provider Strategy
    - Continued evaluation of provider complement and the creation of a high-performing network of providers that integrates primary, specialty, and behavioral health services within a geographic region or defined population
  - Operations, Technologies, and Partnerships
    - Continued evaluation and creation of innovative care delivery models that leverage technological solutions and partnerships to improve health outcomes

Value-Based Care Success Factors

- Risk-Based Contracting Expertise
  - Realizing the importance of and investing in risk-based contracting expertise so the organization can quickly assess risk of value-based contracts to mitigate unnecessary exposure
- Data Mining
  - Leveraging available data to drive the decision-making process and make directional changes when necessary
- Financial Literacy and Modeling
  - Understanding the financial impact of alternative models on reimbursement and net financial performance
    - The transition from fee-for-service to value-based payment models will fundamentally change the reimbursement model
  - Adequate cash reserves are also necessary to transition to alternative payment models

Operational Considerations

- **Clinically Integrated Networks**
  - Operational Functions
    - Team-based Care
    - Proactive Care
    - Clinical Guideline Use
    - Clinical Variation Reduction
    - Quality Improvement
    - Care Coordination
    - Data Sharing and Analysis
    - Clinical Accountability
    - Efficiency Improvement
    - Legal Protection
  - Organizational Components
    - Clinical Leadership
    - Performance Improvement
    - Information Technology
    - Legal and Contracting Options
    - Membership Criteria
    - Fund Flows

Operational Considerations

- **Internal Referral Process**
  - Structural integration and co-location (e.g. shared space)
  - Fully integrated (single organizational structure with employed staff)
  - Single medical record
  - Shared billing and scheduling systems
  - Shared risk

- **Integrated care initiatives should be:**
  - Patient centered (e.g., address the needs of the patient; is responsive to patient preferences, needs, and values; and ensures that patient values guide all clinical decisions);
  - Expand access to care, decrease burden of illness, optimize care;
  - Delivered in settings preferred by patients;
  - Evidence based;
  - Driven by clinical and care issues and functions not practice and administrative issues;
  - Focused not only on integrating care within practices/facilities but also across practices and care settings; and
  - Focused on both physical health and behavioral health settings

Care Management Services

- Medicare allows care management services that include transitional care management (TCM), chronic care management (CCM), principal care management (PCM), general behavioral health integration (BHI), and psychiatric collaborative care model (CoCM) services
  - **<u>Transitional Care Management Services (TCM)</u>**
    - Transitional Care Management (TCM) services address the hand-off period between the inpatient and community setting
      - After hospitalization or other inpatient stay, the patient may be dealing with a medical crisis, new diagnosis, or change in medication therapy that requires assistance post discharge
    - General TCM services include:
      - Contact the beneficiary or caregiver within two business days following a discharge
        - The contact may be via telephone, email, or a face-to-face visit
      - Conduct a follow-up visit within 7 or 14 days of discharge, depending on the complexity of medical decision making involved
        - The face-to-face visit is part of the TCM service and should not be reported separately
      - Medicine reconciliation and management must be furnished no later than the date of the face-to-face visit
      - Educate the beneficiary, family member, caregiver, and/or guardian
      - Establish or re-establish referrals with community providers and services, if necessary
      - Assist in scheduling follow-up visits with providers and services, if necessary

Care Management Services

- **Chronic Care Management (CCM)**
  - CCM is for members with two or more chronic conditions and includes the management of medications, appointments, and services managed by one healthcare provider
    - Providers can receive payment when at least 20 minutes of qualifying CCM services are provided during a calendar month
  - General CCM services include:
    - Management of care across providers
    - Coordination of your care between hospitals, pharmacies, and clinics
    - Management of medications taken
    - Providing round-the-clock access to emergency care
    - Education around conditions and medications
    - Management of community services such as transportation to appointments

Care Management Services

- **Principal Care Management (PCM)**
  - PCM is like Medicare's CCM with a few key differences
    - Under the new PCM codes, specialists may now be reimbursed for providing their patients with care management services that are more targeted within their own particular area of specialty
    - PCM services may be furnished to patients with a single high-risk or complex condition that is expected to last at least 3 months and may have led to a recent hospitalization, and/or placed the patient at significant risk of death and requires a minimum of 30 minutes of qualifying PCM services are furnished during a calendar month
  - General PCM services include:
    - A single complex chronic condition lasting at least 3 months, which is the focus of the care plan;
    - The condition is of sufficient severity to place patient at risk of hospitalization or have been the cause of a recent hospitalization;
    - The condition requires development or revision of disease-specific care plan;
    - The condition requires frequent adjustments in the medication regiment; and
    - The condition is unusually complex due to comorbidities

Care Management Services

- **General Behavioral Health Integration (BHI)**
  - BHI is a team-based, collaborative approach to care that focuses on integrative treatment of patients with primary care and mental or behavioral health conditions
    - RHCs can receive payment when at least 20 minutes of qualifying BHI services are provided during a calendar month
  - General BHI services include:
    - An initial assessment and ongoing monitoring using validated clinical rating scales;
    - Behavioral health care planning in relation to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose status changes;
    - Facilitating and coordinating treatment such as psychotherapy, pharmacotherapy, counseling and/or psychiatric consultation; and
    - Continuity of care with a designated member of the care team

Care Management Services

- **Psychiatric Collaborative Care Model (CoCM)**
  - Psychiatric CoCM is a specific model of care provided by a primary care team consisting of a primary care provider and a health care manager who work in collaboration with a psychiatric consultant to integrate primary health care services with care management support for patients receiving behavioral health treatment and includes the following:
    - Regular psychiatric inter-specialty consultations with primary care team
    - Regular review of treatment plan by primary care team
    - Specific requirements for the RHC providers, behavioral health care manager, and psychiatric provider
  - At least 70 minutes in the first calendar month, and at least 60 minutes in subsequent calendar months, of psychiatric CoCM services must have been furnished in order to bill for this service
    - Only services furnished by an RHC or FQHC practitioner or auxiliary personnel that are within the scope of service elements can be counted toward the minimum 60 minutes
      - Does not include administrative activities such as transcription or translation services
    - Psychiatric CoCM services furnished on or after January 1, 2019, are paid at the average of the national non-facility PFS payment rate for CPT codes 99492 and CPT code 99493 when psychiatric CoCM HCPCS code, G0512, is on an RHC claim, either alone or with other payable services

Patient Centered Medical Home (PCMH)

- Patient-centered medical home is a model of care where patients have a direct relationship with a provider who coordinates a cooperative team of healthcare, whether you're being seen at the doctor's office, if you become hospitalized or recuperating at home, through ongoing preventative care
  - Your medical team will be invested in your care

- Why become a PCMH as a value-based strategy
  - Medicare has moved to change how it structures payment from a quantity to a quality approach
    - Medicare will provide incentives for better processes and outcomes
  - Medicaid programs have made enhanced payments to providers who achieved certain distinctions or process measures

- Benefits of a PCMH strategy
  - Make primary care more accessible, comprehensive and coordinated.
  - Provides better support and communication
  - Creates stronger relationships with your providers
  - Improves patient outcomes
  - Lowers overall healthcare costs

[1] Patient-Centered Medical Home | Cleveland Clinic

Questions



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