Mini-Summit XIII:

Making Value-Based Payment Work for Small and Rural Physician Practices and Hospitals

The National ACO, Bundled Payment and MACRA Summit
Washington, DC 6/7/18

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Learning Objectives

- Discuss where Heartland Physicians ACO found savings opportunities in our ACO made up of rural, independent practices and hospital, even with initial average spending that was already at the low end nationally
- Explore what the resources were available through the ACO program we instituted that enabled us to do what these practices wouldn't be able to do otherwise
- Discuss the limitations of the ACO program that prevented us from doing what we would have liked to do
- Detail what things we feel are needed to support higher-value care for small providers and rural communities.

I greatly enjoy healthcare consulting, ACO development and management, and health policy work. However, as I work in these worlds, this is where my heart will always be...

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OVERVIEW

- MSSP Track 1 ACO, 2016 start date
- 91 clinicians across 7 practices, from solo to large multispecialty group to CAH associated practice
- 6173 attributed lives in 2016
- Achieved $2.3 million in savings in 2016, which equates to $374.18 savings per beneficiary or ~4.3% savings
- Distributive model –
  - independent practices connected for MSSP/VBP work
  - organized and supported by MedLink Advantage, an ACO management and consulting company that I lead as CEO
- Our new ACO startup was funded by the ACO Investment Model (AIM) program to lessen the upfront investment needed by individual practices

Our Overall Approach to Success in Value-Based Healthcare

We believe that the degree of ACO success we will achieve is in large part determined by the degree to which we understand and actively manage these three factors using a thoughtful, balanced, physician-led approach.

- Quality – Improve
- Cost – Lower
- Risk – Manage

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Where We Found Savings

- As we analyzed our initial claims data, the usual suspects quickly emerged as high cost buckets that we thought we could impact:
  - ER visits
  - Admissions/Readmissions
  - SNF
  - Small group of high cost patients drove more than 50% of the costs
- Each practice was provided with actionable data
  - Each category presented by practice, physician and patient
  - Filterable and sortable to be able to move quickly from big picture trends down to patient level data for interventions
  - Prioritized our initial approach by both overall spend and anticipated ability to have meaningful interventions
    - Started with a focus on ER and SNF initially, then quickly moved to address admission/readmissions and spotlight highest-cost patients

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Where We Found Savings

- ER - in 2016, our ER data showed:
  - $1.9 million in spend (~5% decrease in spend over 2015)
  - 109 beneficiaries (7%) had >5 visits and accounted for 26% of costs
  - After working throughout 2016, we saw a >5% decrease in ER utilization, which is challenging in a rural environment with less urgent care options
  - This was complemented by a 6.4% increase in primary care visits
- SNF - Our initial SNF data showed significantly higher overall usage compared to national trends, in admissions, cost and LOS
  - Significant room for management improvement – overall most practices had fairly loose oversight of SNF care in non-CAH facilities
  - Able to decrease overall SNF admissions by 5.5%
  - Able to decrease average LOS by >10%

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Where We Found Savings

- Readmissions - as we began to look at improving care around readmissions,
  - We focused on close follow-up (TCM visits in 48 hours or less) for patients who were hospitalized.
  - We saw a 5.6% decrease in all-cause readmissions
  - This was accompanied by a 6.6% increase in post-discharge provider visits, which also added some additional, appropriate FFS revenue with the use of TCM codes
- We have also supported practices in the development or improvement of their disease registries for improved CDM using a combination of claims data and practice support for PCMH best practice transformation to develop this capability in practices
  - We saw a $465,000 savings in care of our diabetic cohort (continuously assigned patients) over one year
  - We saw a $1.2 million decrease in spend from 2016 to 2017 in our COPD cohort (continuously assigned patients

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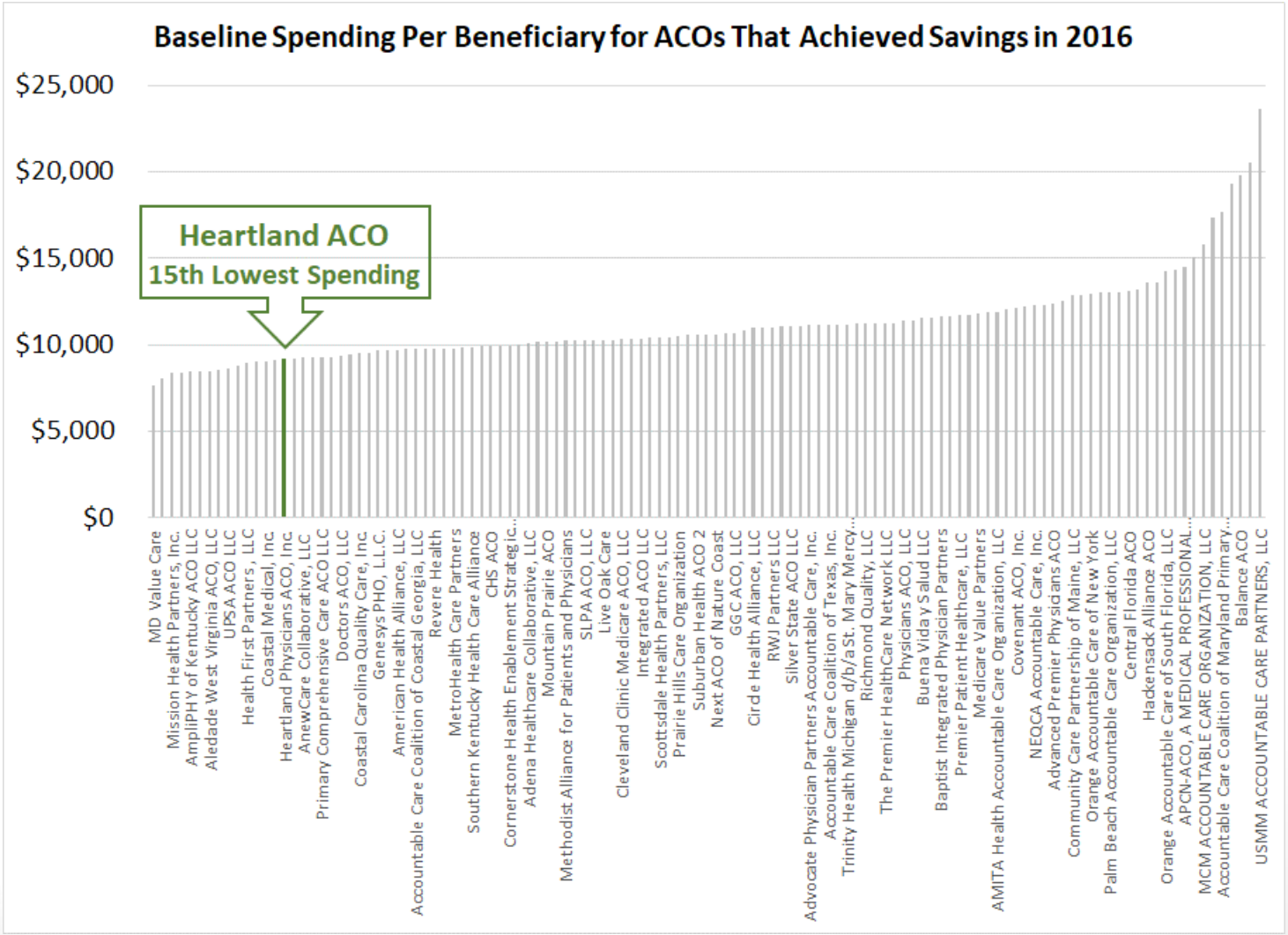
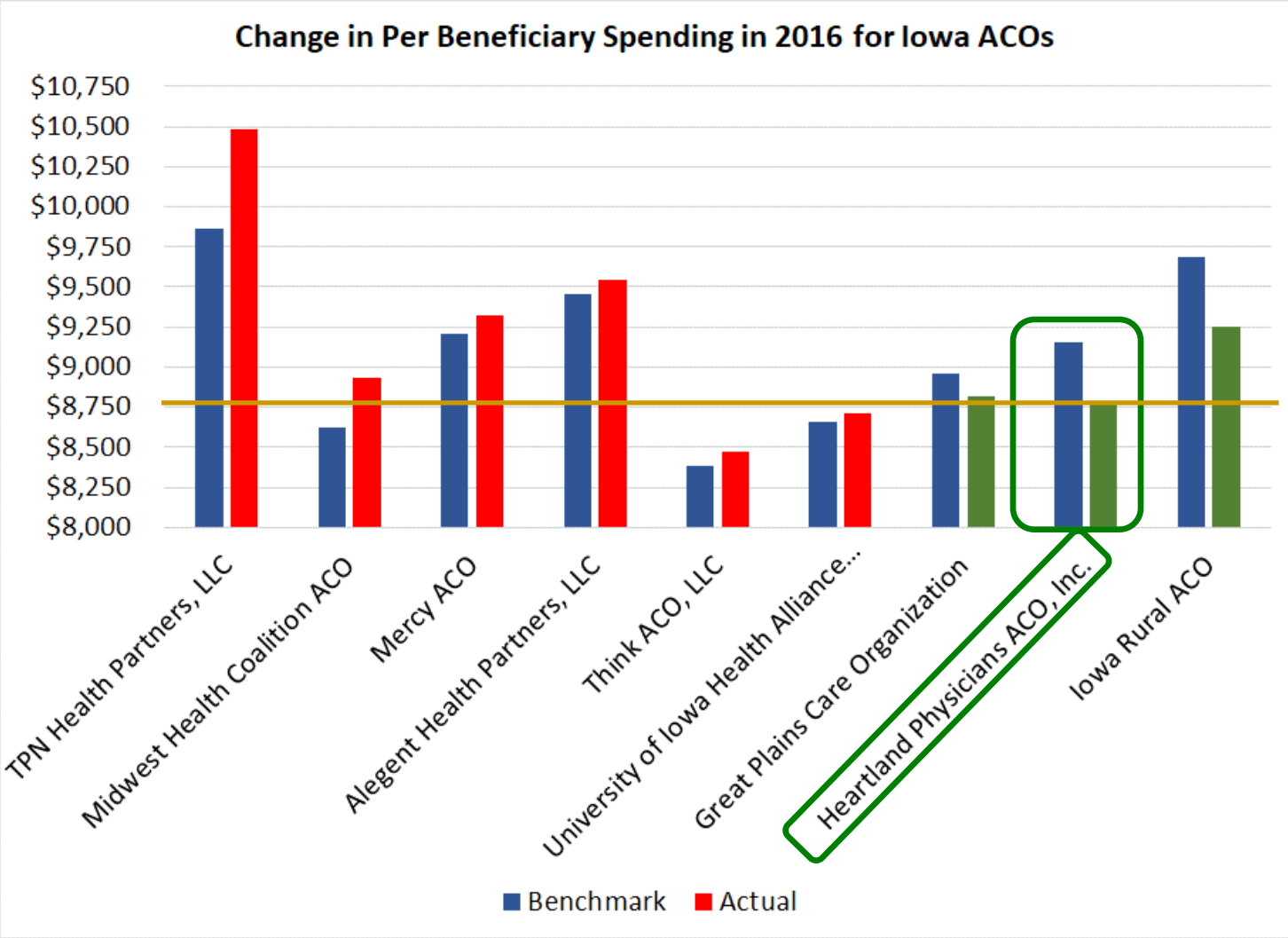
Where We Found Savings

- Chronic Care Management (CCM) program
  - Our largest practice has implemented a CCM program for a small subset of their most challenging, complex patients (identified by claims data analysis)
  - Over the first year, this practice has been able to decrease the total spend on this subset of high-cost patients by nearly 20%
- Risk Adjustment – While not directly affecting the absolute dollars spent on patient care, HCC coding/Risk Adjustment can obviously have a significant impact on the shared savings of an ACO
  - Educated practice medical staffs and billers coders through a combination of in-person educational presentations at the practice level (important – physician to physician education needed!)
  - Taught fundamentals of HCC coding, risk adjustment in VBP, and how these differ from coding for a FFS office visit

Heartland Generated Savings From a Low Starting Point



Heartland Spending is Lower Than Most Other Iowa ACOs



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What ACO Resources Helped

- MedLink Advantage management services – allowed meaningful, scalable, coordinated services to this group of independent practices.
  - Data – cost data analyzed and presented to practices in actionable format
    - Provided as Tableau reports – ER, SNF, admit/readmit, total COC, etc.
  - Practice Support of Medical Home changes – **how** to use the data to impact change at a practice level
    - Best practices around delivery system transformation nationally
    - What is working in our ACO practices
    - Monthly scheduled and prn calls with each practice
  - Care Coordination support **at the practice level**
    - Educate and help develop care coordinators
    - Provide actionable data and intervention programs

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What ACO Resources Helped

- MedLink Advantage management services
  - Education of practice leaders and teams has been key
    - Annual conference
    - Learning Collaboratives twice a year for practice teams to learn/share
    - Webinars
    - In-practice live education for medical staffs/teams
  - Board support
    - Inform decision making on resource spend and drive understanding of and case for practice-level change
  - Care Coordination organization and support
    - Some practices had Care Coordination/CDM, but significantly ramped up and organized as part of ACO work
    - Some direct AIM $ directed to care coordination
  - Risk adjustment education and support
  - GRPO Quality reporting organization and support

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What were the limitations of the ACO program preventing more success?

- MSSP ACO program elements that were especially disadvantageous for smaller/rural ACOs:
  - Benchmarking/Attribution – while always challenging, Heartland lost 27% of its preliminary attribution prior to the first day of performance due to a large employer moving it's retirees to an MA plan on January 1 of our first performance year. This group was significantly healthier than the remainder of our ACO beneficiaries and had a $1200 PMPY lower spend in benchmark year 3.
  - Therefore our benchmark included this group that we were not able to care for during our performance years, significantly affecting ACO savings performance. Will affect all three years.
  - Demographic Reversion – Based on actuarial review, we suffered a significantly negative financial impact from the demographic reversion process - we were estimated to have a 2.88% decrease in our 2016 updated benchmark versus if we had been fully risk adjusted

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What were the limitations of the ACO program preventing more success?

- Lack of upfront funding for things we know would make a difference (more details shortly)
  - Care Coordination/CDM – made good strides in each practice, but not enough funding for the manpower to do it fully and well
  - Population Health IT platform – Aggregate and use data more effectively
  - Robust enough payment to appropriately cover the increased staffing needs to do the VBP work – clinicians/staff/etc.
  - Community resource coordination/Health Coaching to address SDH

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What were the limitations of the ACO program preventing more success?

- Data challenges – CCLF files are a good source of claims data information, however
  - We have 7 different EHRs – challenges in pulling/collating quality data across platforms
  - Difficulty obtaining ADT feeds for real-time information about ER visits, admissions, transfers, etc.
- Inability to access any other complementary VBP programs in rural Iowa – BCPI, CPC+, etc.
- No alignment across payers in Iowa – BCBS, Medicaid MCOs
  - Quality metrics – all different
  - Cost data availability – poor except for CMS
  - Risk adjustment methodology and use in ACO contracting - differs

What Does a Successful ACO Start to Look Like…

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What is needed to support high-value care in small practices/rural communities

- How is this transition to VBP different in small independent practices, Critical Access Hospitals, etc. in rural communities?
  - Most are operating on very small margins
  - Little influence to negotiate with payers or even stay ahead of the rapidly-changing payment system
  - Usually no significant financial reserves/funding streams that are often available to larger practices and healthcare systems/hospitals
  - On the positive side, most have very close relationships with patients/families and relatively close ties to their communities
  - However, they also feel the demand of providing a wide range and full scope of services with ever-increasing financial and regulatory pressures

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What is needed to support high-value care in small practices/rural communities

- How is this transition to VBP different in small independent practices, Critical Access Hospitals, etc. in rural communities?
  - Over the past 10-20 years, most have streamlined, downsized, and/or changed the composition of their outpatient clinic staff (usually with increasingly less training/experience) due to persistent financial constraints and shrinking margins. Case study – Myrtue Medical Center
    - When I started practice in rural Iowa 19 years ago**, every** physician had a personal nursing staff of 2 fulltime RNs (approximately 24 total) – most were mid-career or later nurses with many years/decades of experience of complex patient care in ER/inpatient care/surgery/etc., many as department supervisors
    - Now, the same practice, with the same number of physicians, even more patients to care for, with increasingly complex needs, and a system that demands much more with regards to quality, documentation, process, etc. operates with mostly CMA, 6 LPNs and 2 RNs. (Many of these RNs now travel 40-60 miles one way for employment)
    - While I'm not advocating that we can or should go back to such a staffing model, but we certainly are seeing the acute need for well-trained, experienced nursing and other staff to meet needs of well-delivered VBP care.

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What is needed to support high-value care in small practices/rural communities

- Upfront funding for management/organization, delivery system transformation and immediate increase in care coordination and community alignment coordination needs.
- Would use to fund:
  - ACO/VBP Management and coordinationservices
    - Many of the asks of ACOs and other VBP arrangements are difficult if not impossible for small/rural practices to do individually
    - Given the need for collaboration/coordination between many practices, effective management service organization (MSO) services are crucial.
    - Offers ability to learn from and collaborate with similar practices
    - Can leverage the advantages of larger overall entities in purchasing, contracting, etc.

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What is needed to support high-value care in small practices/rural communities

- Upfront funding would be used for:
  - Tiered proactive patient intervention at the practice level
    - Health Coaching – interventions by lower education level resources such as CMA/CAN or even non-clinical staff – determine and begin to address SDH/prevention needs
    - Care Management/Chronic Disease Management – higher level interventions with defined populations (Diabetic/CHF/COPD patients, frequent ER utilizers, TCM patients, etc.)
    - Complex Case Management – highest level (RN?) interventions with smaller number of patients with complex needs/high cost
  - Community Resource Specialist –
    - CHW or nurse who can direct and coordinate patient referrals to wide variety of community resources available in most places but often poorly used. Ability for referrals from physicians, nurses, health coaches, etc.
    - The personal, local face of community connections like Aunt Bertha

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What is needed to support high-value care in small practices/rural communities

- Upfront Funding would be used for:
  - Population Health IT platform – Aggregate and use data more effectively
    - Ability to organize care coordination work effectively
    - Ability to make daily visits more effective in closing care gaps, prevention, risk adjustment, etc.
    - Ability to augment EHR functionality – disease/cost registries, etc.
    - Ability to pull, analyze and report quality data across multiple EHRs in real time
    - Ability to provide cost data like we are already, but over the same platform
    - Ability to analyze risk adjustment/coding of individuals and populations
  - Quality Improvement training/projects at the practice level
    - Heartland has partnered with Interstate Postgraduate Medical Association (IPMA) to provide QI training and support, which also provided 30 hours CME credit for Physicians, 30 hours CEU for nurses, etc. – great engagement!!
  - Leadership training
    - Significant need for physician leaders to develop new and expanded skill sets in order to function well under and lead through change in VBP

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What is needed to support high-value care in small practices/rural communities

- Believing in these fundamentals, we are putting together an **Alternative Payment Model** proposal around these principles, focused on maximum healthcare value creation in rural America – world-class healthcare at lower cost
- Our APM will include elements such as:
  - Upfront payment to practices to support the integration of the people and resources detailed on the previous slides
  - Ability for bundled payment methodology to be leveraged in CAH settings to improve care and lower cost
  - Accountability for both improving quality and lowering costs
  - However no assumption of downside risk by the practices as this is not appropriate or desirable in the small practice/rural setting

While it may occasionally be tempting to feel like this when discussing ACOs, bundled payments, and MACRA… **Don't give in!**

Instead, remember this important underlying theme that we instill in our ACO practices:

Change is an ongoing process, not an event.

Questions Encouraged

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