Session 107AB
Better Together: Population Health and the Future of Rural Healthcare

Presented by:
Eric Shell
Warren K. West, FACHE
Better Together: Population Health and the Future of Rural Healthcare

Disclosure of Relevant Financial Relationships

The following faculty of this continuing education activity has no relevant financial relationships with commercial interests to disclose:

- Eric K. Shell, CPA, MBA
- Warren K. West, FACHE
Presenters

• Eric K. Shell, CPA, MBA
  – Director, Stroudwater Associates
• Warren K. West, FACHE
  – CEO, Littleton Regional Healthcare and North Country Healthcare

Learning Objectives

• At the close of this presentation, attendees will understand the process, risks, challenges, and benefits of creating an interdependent rural hospital network through the real-life experience of a critical access hospital CEO and a nationally recognized rural healthcare expert.
Agenda

• In this presentation, Eric K. Shell, Director at Stroudwater Associates, and Warren West, CEO of Littleton (NH) Regional Healthcare and North Country Healthcare, will use the case study of a successful NH rural hospital network to explore the future of rural care as the healthcare industry transitions from a fee-for-service model to compensation based on value and quality.

Market Overview

• High-deductible health plans
  • Non-healthcare CEO quote:
    • “We just renewed our High Deductible Plan going into our third year, and guess what.....5% reduction in premium!! Needless to say everyone is thrilled. Not sure what the average HSA balance is, but I think it is high. Doing what it is supposed to do, turning health care patients into consumers.”
  • Underinsurance
  • State budget deficits
  • Recovery Audit Contractors (RAC)
  • Reduced re-admissions
  • Accelerating shift to outpatient care
  • MACRA (SGR Fix)
  • Comprehensive Pay Model
  • New payment models
  • Bipartisan Budget Act of 2015
Growth of High Deductible Plans

Reduced Readmission Rates

CMS: 2,610 PPS hospitals to receive penalties in 2015

Source: Centers for Medicare and Medicaid Services, Offices of Enterprise Management
MACRA – Rate Changes Summary

Implementing the Medicare Access and CHIP Reauthorization Act’s (MACRA) physician payment reforms, 2016-22

<table>
<thead>
<tr>
<th>Year</th>
<th>Fee updates</th>
<th>MIPs (Merit Based Incentive Payment System)</th>
<th>AMRs (Alternative Payment Models)</th>
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<tr>
<td>2016</td>
<td>0.5%</td>
<td>Increase in some specialties, decrease in others</td>
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<td>2017</td>
<td>0.5%</td>
<td>Increase in some specialties, decrease in others</td>
<td></td>
</tr>
<tr>
<td>2018</td>
<td>0.5%</td>
<td>Increase in some specialties, decrease in others</td>
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<tr>
<td>2019</td>
<td>0%</td>
<td>Increase in some specialties, decrease in others</td>
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<td>0%</td>
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</tr>
<tr>
<td>2022</td>
<td>0%</td>
<td>Increase in some specialties, decrease in others</td>
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</tbody>
</table>


Market Overview – Healthcare Reform

- Coverage Expansion
  - By 1/1/14, expand Medicaid to all non-Medicare eligible individuals under age 65 with incomes up to 133% FPL based on modified AGI
    - Currently, Medicaid covers only 45% of poor (≤ 100% FPL)
    - 16 million new Medicaid beneficiaries; mostly "traditional" patients
    - FMAP for newly eligible: 100% in 2014-16; 95% in 2017; 94% in 2018; 93% in 2019; 90% in 2020+
    - Establishment of state-based Health Insurance Exchanges
    - Subsidies for health insurance coverage
    - Individual and employer mandate

- Provider Implications
  - Insurance coverage will be extended to 32 million additional Americans by 2019
    - Expansion of Medicaid is major vehicle for extending coverage
    - May release pent-up demand and strain system capacity
    - Traditionally underserved areas and populations will have increased provider competition
    - Have insurance, will travel!
President-elect Trump’s Stand on Health Insurance Coverage and Costs 11/9/16

- The Congressional Budget Office (CBO) estimated repeal of the ACA would increase the federal deficit by $137 – $353 billion over 10 years (2016-2025)
- Since enactment, the uninsured rate has fallen to 8.6% and an estimated 20 million Americans have gained coverage, while 27 million remain uninsured
- Donald Trump supports complete repeal of the ACA, including the individual mandate to have coverage. In lieu of requiring insurers to provide coverage to everyone regardless of health status, he would work with states to create high risk pools for individuals who have not maintained continuous coverage
- In place of refundable premium tax credits, Trump would provide a tax deduction for the purchase of individual health insurance. He would promote competition between health plans by allowing insurers to sell plans across state lines.
- He would promote the use of Health Savings Accounts (HSA), and specifically would allow tax-free transfer of HSAs to all heirs.
- Trump would also require price transparency from all hospitals, doctors, clinics and other providers so that consumers can see and shop for the best prices for health care procedures and other services.

Source: Kaiser Family Foundation [Link]

Market Overview – Healthcare Reform

- Medicare and Medicaid Payment Policies
  - Medicare Update Factor Reductions
  - Annual updates will be reduced to reflect projected gains in productivity
  - Medicare and Medicaid Disproportionate Share Hospital (DSH) Payment Reductions
  - Medicare Hospital Wage Index
  - Independent Payment Advisory Board (IPAB)
    - Charged with figuring out how to reduce Medicare spending to targets with goal of $13B savings between 2014 and 2020

Summary Impact

<table>
<thead>
<tr>
<th>ACA Payment Changes for Medicare and Medicaid</th>
<th>Reduction through 2022</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payment Reductions</td>
<td>$7.9 Billion</td>
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<tr>
<td>Medicaid DSH Payments</td>
<td>$10.2 Billion</td>
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<tr>
<td>Medicaid DSH payments</td>
<td>$500 Million</td>
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<td>EHR Meaningful Use Incentive Payments</td>
<td>$5.5 Billion</td>
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<tr>
<td>I&amp;I Payment Reductions</td>
<td>1.1%</td>
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<tr>
<td>Readmission Penalties</td>
<td>Increase from 1% to 2%</td>
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<tr>
<td>Hospital Acquired Infections</td>
<td>1% penalty beginning in 2015</td>
</tr>
<tr>
<td>OHS Payments</td>
<td>1.25% reduction beginning in 2015 to fund value-based purchasing</td>
</tr>
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</table>
Market Overview – Healthcare Reform

- Medicare and Medicaid Payment Policies (continued)
- Provider Implications
  - Payment changes will increase pressure on hospital margins and increase competition for patient volume
  - “Do more with less and then less with less”
  - Medicaid pays less than other insurers and will be forced to cut payments further
Market Overview – Healthcare Reform

• Medicare and Medicaid Delivery System Reforms
  • Expansion of Medicare and Medicaid Quality Reporting Programs
  • Medicare and Medicaid Healthcare-Acquired Conditions (HAC) Payment Policy
    • By Oct. 2014, the 25% of hospitals with the highest HAC rates will get a 1% overall payment penalty
  • Medicare Readmission Payment Policy
    • Hospitals with above expected risk-adjusted readmission rates will get reduced Medicare payments
  • Value-based purchasing
    • Medicare will reduce DRG payments to create a pool of funds to pay for the VBPP
      • 1% reduction in FFY 2013, grows to 2% by FFY 2017
  • Bundled Payment Initiative
  • Accountable Care Organizations
    • Each ACO assigned at least 5,000 Medicare beneficiaries
    • Providers continue to receive usual fee-for-service payments
    • Compare expected and actual spend for specified time period
    • If ACO meets specified quality performance standards AND reduces costs, ACO receives portion of savings

http://www.cms.gov/Medicare/Medicare‐Fee‐for‐Service‐Payment/sharedsavingsprogram/News.html

2017 CONGRESS ON HEALTHCARE LEADERSHIP
ACO Growth 2010-2014

*Includes ACOs with both government and commercial contracts. Source: Leavitt Partners, 2015.

ACO Growth 2010-2013

Arlington’s Privia Health lands $400M to begin national expansion
Sep 16, 2014, 7:50am EDT

Arlington-based Privia Health LLC is getting a $400 million infusion to expand nationally, the company announced Tuesday morning. An investor group led by an affiliate of Goldman Sachs & Co. is funding the expansion.

Privia, which markets itself as a platform for physicians to stay in private practice while becoming part of a larger network, will grow from Greater Washington to New York, Georgia, Florida and Texas — all areas with a significant numbers of independent physicians and strong potential health plan partners.

“This is giving us the rocket fuel to expand,” said Jeff Butler, Privia’s founder and CEO. He and Privia President Dave Rothenberg will continue to lead the company.
2015 Medicare ACO Quality and Financial Results (9/8/2016)

- The CMS 2015 quality and financial performance results for Medicare ACOs show that ACOs continue to improve the quality of care for Medicare beneficiaries, while generating financial savings.
- Over 400 Medicare ACOs generated over $466 million in total program savings in 2015.
  - Of these, 125 qualified for shared savings payments.
- Pioneer ACOs decreased in number by nearly a third, but still generated over $37m in savings.
  - Six of the eight Pioneer ACOs that generated savings earned shared savings.
  - Of the four that generated losses, one owed shared losses.
  - The mean quality score among Pioneer ACOs increased to 92.26 percent in PY4 from 87.2 percent in PY3.
  - Nine of the 12 Pioneer ACOs had overall quality scores above 90 percent for PY4.
- MSSP ACOs generated over $429m in savings.
  - 83 MSSP ACOs had health care costs lower than their benchmark, but did not qualify for shared savings, as they did not meet the minimum savings.
  - An increasing proportion of ACOs have generated savings above their minimum savings rate each year.
  - ACOs with more experience in the program were more likely to generate savings above their MSR.
  - 45% of ACOs participating in the Advance Payment model or ACO Investment Model generated savings above their MSR.
  - Shared Savings Program ACOs that reported quality in both 2014 and 2015 improved on 84 percent of the quality measures that were reported in both years.


Fee-For-Service Financial Model

- **Assumptions**
  - **Utilization**
    - Inpatient and Outpatient
      - Impact of ACA
      - Impact of Blue Cross steerage initiatives
  - **Revenue**
    - Third party price increases
    - Cost based Medicare revenue
    - DSH payments (Zeroed out in 2014)
    - Bad debt % of patient service revenue (75% reduction in 2014)
      - Impact of ACA
    - Meaningful use incentive payments
    - Other operating revenue
    - Non-operating gains and
  - **Expenses**
    - Salaries, wages and benefits
    - Productivity
    - Supplies and other

When operating income becomes negative in 2016, cash reserves start to decline.

- Operational improvement and shared service economies of scale are insufficient to combat declining utilization.
- Can’t cut your way to sustainability.

Market Overview – Healthcare Reform

- Medicare and Medicaid Delivery System Reforms (continued)
  - Provider Implications
    - Hospitals are taking the lead in forming Accountable Care Organizations with physician groups that will share in Medicare savings.
    - Value-based purchasing program will shift payments from low performing hospitals to high performing hospitals.
    - Acute care hospitals with higher than expected risk-adjusted readmission rates and HAC will receive reduced Medicare payments for every discharge.
    - Physician payments will be modified based on performance against quality and cost indicators.
    - There are significant opportunities for demonstration project funding.
Challenges Affecting Rural Hospitals

- Factors that will have a significant impact on rural hospitals over the next 5-10 years
  - Difficulty with recruitment of providers and aging of current medical staff
  - Struggle to pay market rates
  - Increasing competition from other hospitals and physician providers for limited revenue opportunities
  - Small hospital governance members without sophisticated understanding of small hospital strategies, finances, and operations
  - Consumer perception that "bigger is better"
  - Severe limitations on access to capital for necessary investments in infrastructure and provider recruitment
    - Facilities historically built around IP model of care
    - Increased burden of remaining current on onslaught of regulatory changes
    - Regulatory friction/overload
    - Payment systems transitioning from volume-based to value-based
    - Increased emphasis of quality as payment and market differentiator
  - Reduced payments that are "real this time"
    - 3rd party steerage (surgery, lab, and imaging), RAC audits

We Have Moved into a New Environment!

- Subset of most recent challenges
  - Payment systems transitioning from volume-based to value-based
  - Increased emphasis as quality as payment and market differentiator
  - Reduced payments that are "real this time"
  - New environmental challenges are the TRIPLE AIM!!!
  - Market competition on economic driver of healthcare: PATIENT VALUE
Future Hospital Financial Value Equation

- Definitions
  - Patient Value
    \[
    \text{Patient Value} = \frac{\text{Quality}}{\text{Cost}} \times \text{Population}
    \]
  - Accountable Care:
    - A mechanism for providers to monetize the value derived from increasing quality and reducing costs
      - Accountable care includes many models such as bundled payments, value-based payment program, provider self-insured health plans, Medicare-defined ACO, capitated provider sponsored healthcare, etc.
    - Different “this time”
      - Providers monetize value
      - Government “all in” (????)
      - New information systems to manage costs and quality
      - Agreed-upon evidence-based protocols
      - Going back is not an option

Future Hospital Financial Value Equation

- ACO Relationship to Small and Rural Hospitals
  - Revenue stream of future tied to primary care physicians (PCP) and their patients
  - Small and rural hospitals bring value/negotiating power to affiliation relationships as they are typically PCP-based
    - Smaller community hospitals and rural hospitals have value through alignment with revenue drivers (PCPs) rather than cost drivers, but must position themselves for new market:
      - Align with PCPs in local service area
      - Develop a position of strength by becoming highly efficient
      - Demonstrate high quality through monitoring and actively pursuing quality goals
Future Hospital Financial Value Equation

- Economics
  - As payment systems transition away from volume-based payment, the current economic model of increasing volume to reduce unit costs and generate profit is no longer relevant
  - New economic models based on patient value must be developed by hospitals, but not before the payment systems have converted
  - Economic model: FFS Rev and Exp VS. Budget Based Payment Rev and Exp

The Challenge: Crossing the Shaky Bridge
The Premise

Finance

Macro-economic Payment System
• Government Payers
  • Changing from F-F-S to PBPS
• Private Payers
  • Follow Government payers
  • Steerage to lower cost providers

Provider Imperatives
• F-F-S
  • Management of price, utilization, and costs
• PBPS
  • Management of care for defined population
  • Providers assume insurance risk

Function

Provider organization
• Evolution from
  • Independent organizations competing with each other for market share based on volume to
  • Aligned organizations competing with other aligned organizations for covered lives based on quality and value

Form

Network and care management organization
• New competencies required
  • Network development
  • Care management
  • Risk contracting
  • Risk management

Payment Transition – CMMI (Dr. Rajkumar 3/2016)
Implementation Framework – What Is It?

Our Region

North Country Hospitals & FQHCs
NCH Profile FY2016

- Gross Revenue: $360,428,577
- Total Operating Revenue: $207,891,377
- Number of Employees: 1,300
- Employed Physicians: 106
- Physician Visits: 145,602
- Emergency Department Visits: 29,507
- Outpatient Surgeries: 6,564
- Inpatient Surgeries: 993
- Discharges: 4,077
- Births: 421
Realization of Future Healthcare Environment

1. Small independent hospitals are dinosaurs. “If we do not adapt to the new environment, we will become extinct.”
2. Bigger is better – “Scale Matters”

Three Parallel Endeavors

1. The formation of a new parent organization overseeing the activities of four Critical Access Hospitals
2. The formation of a Community Care Organization overseeing the continuum of care in the North Country (population health/risk based contracting) owned and operated by four hospitals and three FQHCs
3. Participation in AIM ACO, a three-year forward funded Medicare Innovation Program with Shared Savings, working with NRACO (Caravan Health) and six hospitals and three FQHCs in New Hampshire
What Healthcare Challenges Do We Face in the North Country?

- ACA changing entire healthcare landscape
- State Disproportionate Share payments at risk
- We have lost much of our large industry:
  - Access to private health insurance is declining
  - More privately insured have high-deductible plans
- Our regional population is the most economically challenged and sickest in the state
What Do We Propose To Do To Meet These Challenges?

• Finalized an affiliation among AVH, Littleton Regional, UCVH and Weeks Hospitals
  – Will retain each hospital and its core services in its home community
  – Will maintain our status as a critical access hospital
• Why?
  – We all share the same mission and values
  – We want to maintain our identity within a larger health system
  – We’re stronger together

Goal

• Develop a new, highly sophisticated healthcare system
  • Branded “North Country”
  • Economic engine of four communities and beyond
  • 1,300+ employees
  • Gross revenue of $360 million
  • Provide access and services previously unimaginable
A North Country Solution

• Creates a four-hospital family
  – The first four-hospital system to come together without a tertiary hospital involved
• An affiliation, not a merger
• Each hospital maintains its own identity
• Each hospital exchanges some individual autonomy for the ability to jointly develop a highly coordinated healthcare network that serves the North Country region

Affiliation Agreement
Article 1, Statement of Common Purpose

• Integration and collaboration to improve quality and reduce costs
• Create a truly regional health care system with greater coordination of care, implementation of best practices, elimination of inefficiencies, collaborative regional planning, and enhance regional access and improve quality and reduce cost
Who We Are Now!

Develop a centralized, clinically and operationally integrated healthcare system

• One system with many delivery sites
• One organization with One Team
• One set of standards for:
  – The Patient Experience
  – The Workforce Experience

Bylaws Article IV – Major Operational Matters

• Corporation Annual Operating Budget*
  – Two-thirds vote – Parent and Hospital vote initiated by System CEO
• Corporation Annual Capital Budget*
  – Two-thirds vote – Parent and Hospital vote initiated by System CEO
• Hospital Operating and Capital Budgets*
  – Two-thirds vote – Hospital and Parent vote initiated by System CEO and Hospital President
• Deviation from Approved Hospital Capital Budget*
  – Two-thirds vote – Hospital and Parent vote initiated by System CEO and Hospital President
• Adoption of Compensation and Benefit Programs*
  – During the first two years – two-thirds vote – Hospital and parent vote initiated by System CEO and Hospital President
  – In subsequent years – majority vote
• Approval of Information Technology Systems*
  – During the first two years – two-thirds vote – Hospital and parent vote initiated by System CEO and Hospital President
  – In subsequent years – majority vote
• Approval of Financial Accounting Systems and Auditors*
  – During the first two years – two-thirds vote – Hospital and parent vote initiated by System CEO and Hospital President
  – In subsequent years – majority vote
• Addition, Elimination or Material Alteration of a Clinical Service*
  – During the first two years – Two-thirds vote – Hospital and Parent Vote initiated by System CEO and Hospital President
  – In subsequent years – majority vote – Hospital and Parent Vote Initiated by System CEO and Hospital President
• Affiliation Committees to Address Integration and Operational Synergies*
  – Majority vote – Hospital and Parent Vote Initiated by System CEG and Hospital President

* Negative votes on Major Operational Matters may be overturned by the Parent with a vote of at least 75% of the Parent Board Directors at which a quorum is present, if the vote occurs within 90 days after the negative vote of a Hospital Board.
Key Functions of Hospital Board

- Quality oversight
- Medical staff credentialing
- Medical staff relationships
- Institutional financial management
- Accreditation
- Corporate compliance
- Facility planning (with parent)
- Strategic planning (with parent)
- Approval and monitoring of operating and capital budgets
- Participate in the formation and development of North Country Healthcare
- Shared oversight of the performance of the Hospital President

Organization Chart: North Country Healthcare

- Home Health Board
- AVH Board
- LRH Board
- UCVH Board
- WMC Board

Corporate Report
Operations Report

System CEO
System CFO

- Medical Staff
- Hospital President
- Hospital CFO

Parent Board

- Home Health
- Synergy Planning
- System Integration
- Business Integration
- IT Integration
- Contract Negotiations
- CCO
- Lobbying

Parent Affiliate

December 2016

2017 CONGRESS ON
HEALTHCARE LEADERSHIP
What We Are Doing!!

• Take advantage of synergies around
  • Administrative function
  • Group purchasing organization
  • Patient financial services
  • Other back office functions
• Explore clinical services redistribution
• Work together to reduce system “leakage”
• Expand medical specialty services in network
• Create centers of excellence (high quality; high volume)

Projected Impact Shared Savings

<table>
<thead>
<tr>
<th>Factor</th>
<th>Impact on Operating Income Increase (Decrease) – in thousands</th>
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<tr>
<td></td>
<td>FY 2016*</td>
</tr>
<tr>
<td>1 Facilities/Utilities</td>
<td>$ 200</td>
</tr>
<tr>
<td>2 Revenue Cycle</td>
<td>--</td>
</tr>
<tr>
<td>3 Laboratory</td>
<td>200</td>
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<tr>
<td>4 Supply Chain</td>
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<td>5 Third-Party Contracts</td>
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<tr>
<td>6 Pharmacy</td>
<td>--</td>
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<tr>
<td>7 Human Resources</td>
<td>--</td>
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<tr>
<td>8 Home Health</td>
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<td>9 Insurance Consolidation</td>
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<td>10 Staffing</td>
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<tr>
<td>11 UCVH</td>
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<tr>
<td>12 Education</td>
<td>75</td>
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<tr>
<td>Total Net</td>
<td>$ 2,575</td>
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* actual numbers
Launching the North Country Community Care Organization (CCO)

What Is The North Country Community Care Organization (CCO) Entity?

A legal entity-created as a Limited Liability Corporation (LLC), designed to engage in and perform under accountable care contracts with commercial health insurance companies and government payers
As a Distinct Entity, the CCO Has: A CCO Mission…

The Community Care Organization (CCO) will create a clinically integrated network to:
• Improve the population health of the region
• Achieve the Triple Aim of high quality care delivery that achieves cost effectiveness with enhanced patient experience
• Enter into total cost of care risk sharing contracts with payors that align economic incentives of all CCO members

…A CCO Vision…

Through open communication and collaborative efforts among North Country health care providers, the CCO will support its member organizations’ work to decrease care variation, improve health outcomes, and reduce unnecessary resource use.

Through these efforts, the CCO will strive to achieve a risk adjusted population total cost equal to, or better than, the statewide average while concurrently improving measurable health quality metrics.
...And CCO Values

The CCO and its Member Organizations commit to the following values in guiding activity:

• **Primary Care** will play a prominent role in CCO efforts and the clinical improvement work pursued

• The creation of an organized and integrated "medical neighborhood" where all clinical stakeholders work collectively toward total population health goals will be supported

• All CCO stakeholders offer important and unique perspectives to shape the actions of the CCO

• The CCO will be data driven in its decision making and selection of clinical improvement efforts

• The CCO will share successful efforts of one member organization with other members

Why Do We Need CCO?

Basic Rationale

• Together create lives & spend aggregation appropriate for payment reform – ability to “play”
  – 20% Bonus ↑ Anthem EPHC; Benevera Equity Qualification

• Create vehicle for FQHCs & CAHs/specialists to collectively engage in & manage total cost of care contracts
  – Ensure aligned economic incentives
  – Support community-wide care management coordination
  – Models attribute lives by primary care; most costs hosp./specialty

• Ensure collective voice to shape product design that impacts patients and keeps appropriate care in North Country
  – E.g., patient steerage; site of service incentives
Aggregate Lives: Qualification for Benevera Equity

- Benevera Model for Provider Equity
  - 1,500 Members to qualify for equity
  - 3,000 Members for additional earnings potential
- Current estimated HPHC lives
  - Littleton only – 620
  - UCVH/Indian Stream – 890
  - Coos/AVH – 1,750
  - Weeks – 650
  - Ammonoosuc – 420 (another 250 with Cottage)
- Total combined – 4,330

Together Qualify for Equity & Enhanced Earnings

How Will NCCCO Be Governed?

- Initial members are FQHCs and hospitals
- Manager Board created with member representatives
- Other “key constituents” added to Board of Managers (e.g., NCHC Executive Director)
- “Block Voting” created to ensure “balance” between FQHCs and hospitals
What Are CCO Member Commitments?

- Agree to be represented by CCO in Payer Risk Contract discussions:
  - CCO has “first shot” at Payer Risk Sharing contract arrangement
  - Participant decides whether to “play or pass” based on CCO arranged terms
  - If Participant “passes”, not included until CCO contract renewal
- Participate in clinical improvement and quality initiatives
- Support provision of data for population health management and analytic purposes
- Meet any established credentialing requirements
- Adhere to any CCO established protocols or performance standards (e.g., “Choosing Wisely”)
How Will The CCO Contracting Function?

CCHQ Performance Sharing with Members: Initial Guiding Principles

- **Economic Performance Sharing**
  - Cover CCO costs first
  - Bulk of shared savings after CCO cost coverage flows to CCO members (i.e., minimal retained earnings)
  - Economic distribution method set in advance for each year
  - Consider CCO member sustainability in establishing distribution method
  - Strive to align distribution method to actions needed for overall CCO success (e.g., behavioral health support)
What Activities Will the CCO Undertake?

• Establish payer “risk share” contracts that:
  – Create a performance payment opportunity for members
  – Focus on shared savings bonuses initially with existing individual FFS payments remaining
  – Focus on commercial payers initially (AIM ACO)

• Coordinate key functions needed to manage total cost of care
  – Care coordination & care management
  – Data analytics
  – Clinical improvement initiatives

Initial Distribution Plan

• The CCO receives its shared surplus based on its performance and the contractually-agreed-upon split with the payer
• The CCO allocates a portion of its surplus amount to fund any uncovered CCO overhead—to reduce owner capital call
• The remaining amount is split between two pools: a primary care pool and a paid services pool
• The primary care pool is allocated among CCO members based on proportion of attributed covered lives
• The paid services pool is allocated among CCO members based on proportion of total CCO member services rendered
• The total distribution received by a CCO member is the sum of the primary care pool and paid services pool allocations
NCCCO Establishment Next Steps

- Member Boards vote to participate/become NCCCO “owner”
- Final NCCCO governance set based on committed members
- Submit request to NH Attorney General for antitrust approval following NCCCO formation
- “Incorporate” the NCCCO entity—file necessary paperwork
- Consider public announcement
- Establish NCCCO contracting committee (from Board of Managers)
- Initiate commercial payer discussions for risk sharing contract in 2017

AIM ACO Project

Advanced Investment Model
ACO

caravanhealth
AIM ACO Project

- 11,000 attributed lives
- 2.5 million forward funding (over three years)
- Shared savings model (50/50 after payback)
- Working with Caravan Health (national organization)

Rural Solutions - The Caravan Health Program

- Get the data to identify opportunities to improve quality and lower costs
- Coordinate care for chronically ill to reduce costs and build market share
- Provide 24-Hour Advice Nurse Hotline to reduce ED primary care
- Redesign workflow at clinic to address care gap
- Annual Wellness Visits to promote prevention
- Join forces with other independent providers to qualify for programs and spread costs (CINs)
- Join forces with strong tertiary systems to provide best value for patients
- Motivate the community to achieve better health
Primary Care Practice “A Common Vision”

- Patient Outreach/Non-established Patients
- Referral to CC
- Timely PCP Encounters for High Risk Patients
- Build Capacity/Efficiency
- Proactive Approach to Chronic Disease Management
- Avoid Readmissions
- Build Attribution/Reduce Cost
- Improve Quality

Ultimate Goal

A regional Clinically Integrated Network with hospitals and FQHCs
Three Common Stages of Evolution to CIN

AGGREGATION
- Mostly defensive
- Transactional, one-off deals
- Disparate offices/systems
- No consolidation of offices
- Pure productivity-based comp.
- No organization or code of conduct
- Escalating investment

CONSOLIDATION
- Consolidation of locations
- Common name
- Central, shared governance
- Hierarchy w/performance evaluation
- Standard offices/systems
- Single blended comp. plan
- Budget discipline
- Referral management
- Investment is stabilized

INTEGRATION
- Standard clinical work
- Common culture/vision
- Shared incentives
- Team-based care
- Commitment to redesign for better quality and efficiency
- Investment yields return

“I do my part seeing patients. In return, the system needs to support me and my income. Finding the resources to do so is their problem.”

“My role is to see patients and support system initiatives so the system has enough resources to support me and my income.”

“I am the system, my income depends on the collective performance of me and my colleagues.”

Conclusions

- For decades, rural hospitals have dealt with many challenges including low volumes, declining populations, difficulties with provider recruitment, limited capital constraining necessary investments, etc.
  - The current environment driven by healthcare reform and market realities now offers a new set of challenges. Many rural healthcare providers have not yet considered either the magnitude of the changes or the required strategies to appropriately address the changes
- Core set of new challenges represents the Triple Aim being played on in the market
- Locally delivered healthcare (including rural and small community hospitals) has high value in the emerging delivery system
- “Shaky Bridge” crossing will required planned, proactive approach
  - Finance will lead function and form
  - Maintain alignment between delivery system models and payment systems building flexibility into the delivery system model for the changing payment system
Conclusions (continued)

• Opportunities for rural hospitals
  – Proactively improve operational efficiency
  – Align with primary care providers
  – Develop scale
  – Create infrastructure for population health management
  – Proactively transition payment model

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Bibliography/References

- The majority of slides used in this presentation feature original work. Data sources also include the following:
  - 2012 KCMU/Urban Institute Medicaid Physician Fee Survey
  - Caravan Health
  - Centers for Medicare and Medicaid Services (CMS)
  - CMS Innovation Center (CMMI)
  - Harvard Business Review: Redefining Competition in Health Care, Michael E. Porter and Elizabeth Olmsted Teisberg
  - Kaiser Family Foundation
  - Kaufman Strategic Advisors
  - Leavitt Partners
  - Washington Business Journal