RURAL ACOS
CAN WORK AND LEAD THE WAY

Rural Health Care Leadership Conference
February 5-8, 2017
Agenda – Rural ACO

- Illinois Rural Community Care Organization (IRCCO)/Statewide Rural ACO
- IRCCO – Infrastructure and Development
- 3-Year Journey – Changing the Conversation
- AIM Investment Funds Impact
- Return on Investment – Value Impact
- Lessons Learned as an ACO
- Moving Forward 2017
Illinois Critical Access Hospital Network

- **ICAHN** is a not-for-profit 501(c)3 corporation established in 2003 for the purposes of **sharing resources, education, promoting efficiency** and **best practice** and improving health care services for member critical access hospitals and their **rural communities**. ICAHN, with 55 member hospitals, is an independent network governed by a nine-member board of directors.

- **Members = 32 Independent; 23 Systems**
  - 8 providing OB Services
  - 11 Long Term Care
  - 1 Inpatient Psych Unit
  - Incubator for rural programs and services
  - Statewide rural network
  - **Illinois Rural Community Care Organization**
    - Rural ACO/Medicare Shared Savings Program 2015 /Sole Member LLC
IRCCO Implementation Plan 2015

• **Building Infrastructure - $210,000/ 2015**
  - Governance
  - ICAHN Management / care navigator program
  - MSSP – CMS Reports and Data Management
  - Participant involvement/monthly meetings/SP
  - Chief Medical Office – outreach and physician engagement
  - Newsletter; training and education
  - ACO IT Platform for data claims assignment and dashboards (eCW)

• **Building the Service – “Customer Service, Primary Care and Local Access”**
  - Patient Centered Medical Home standard
  - Care Coordination Program – each participant
  - Medicare Well Visit Program
  - Reducing variability – evidenced based chronic care standards for rural
  - Primary care – management of patient group
  - Quality reporting/PQRS/CAHPS

• **Implementation/Marketing - Credibility**
  - IRCCO Logo – ACO Abstract
  - Added participants for 2016
  - Outreach

• **Evaluation**
  - No Shared Savings 2015
Our Journey – “On the Bus”

- 2014 - ACO Concept/IRCCO established as LLC sole member of ICAHN
- 2015 – MSSP; ACO Concepts
  - PCMH, Care Coordination, Data Management, AIM Application

- 2016 – Processes – IRCCO Management Team
  - Transfer coordination; medication management; readmissions; MWV; primary care post hospitalization; referral management

- 2017 – Outcomes – ACO Participants
  - A1C < 7; hypertension lower; Stroke readiness; ED Utilization; Post Acute care decreased LOS – home management; advanced care/best practices
  - Test “the water” with commercial ACOs

- 2018 – Building towards sustainability
  - Improved Utilization; Cost Savings; Quality, Outcomes
  - Preparation for Risk Sharing
Most Important!!

- We have changed the Conversation…
Medical Staff Engagement - Critical

- Chief Medical Officer / Family Practice
- Inclusion in Governance/Decision-making
- Medical Provider Workgroups (chronic care)
- Physician Meetings
- Importance of Culture Change
- Consideration work flow/schedule
- Standards and Data
- Patient Outcomes

Dr. Gregg Davis
# IRCCO Population Health Strategies

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<th>Early Onset Chronic Disease</th>
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<td>Medicare Well Visits</td>
<td>Provider Benchmarks</td>
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<td>Specialty care vetting</td>
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<td>Healthy Eating</td>
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<td>• Self-management skill-building</td>
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<td>Exercise Programs</td>
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<td>• Medication abuse</td>
<td>• ADTs</td>
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<td>Building relationship with patients</td>
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AIM Funding 2016 – Difference!

- Allows IRCCO to “Ramp Up”
- Funds for
  - Regional Care Managers (2)
  - Chief Medical Officer/paid position (part time)
  - Clinical Informatics Specialist
  - Chronic Care Manager Specialist/Trainer
  - Provider Training and Compliance Support
  - Build IT Infrastructure – connectivity and care management/ care plan tool “Roundingwell”
ACO IT Support – What do I need?

- eClinicalWorks – Platform to manage claims and build dashboards
- ADTs (Admission Discharge Transfers) Alerts – support through Central Illinois Health Information Exchange (HIE)
- Care Management Module – Roundingwell
- PQRS provider monitoring
- CAREFUL….what do you really need and can pay for?
To Change the Culture/Value

- Change must come from within the hospital and practice setting
- Move from volume to value
IRCCO Care Coordination Program

Care Management Model

Regional Approach

Individual or Team Based Approach
Expectations of the Regional Care Managers /IRCCO

- Connect with assigned hospitals (8-14)
- Host weekly individual calls with each member
- Host monthly regional calls and/or regional boutique meetings
- Ensure all members are on track for success
- Provide ongoing resources and assistance in all facets of care coordination
- Assist with PCMH and office workflow
- IRCCO Care Coordination Playbook
Goal: Reduce Beneficiary Cost 5%

- $10,600 average cost per beneficiary (2015 adjusted)

Strategies on how do we reduce 5%
- Breaking down the $10,600 using dashboards
  - ED Utilization – target more than 4 visits per year; CHF and COPD
  - Primary Care – target more than 4 visits per year
  - Hospitals (participant and tertiary care)
  - Well visits
  - Utilization
  - Skilled Care/post hospitalizations (coming soon)
  - Medications - Benchmark of 90% generic utilization
  - Too many procedures (coming soon)
  - Patient engagement (coming soon)
IRCCO’s ED UTILIZATION COUNT ANALYSIS, (NYU) ALGORITHM,
57% AVOIDABLE VISITS = SAVINGS AVAILABLE
15 Months / $49 million
Hospital Concerns

Why Change?

- If the goal is to reduce Medicare beneficiary spend and IRCCO is able to do so, what about the hospital or practice’s bottom line?
- What is my return on investment (ROI)?
- Summer 2016 challenge
Value of Primary Care – Change ROI...always the patient
PRIMARY CARE COMPETITIVE ADVANTAGE

- High touch – Low tech care focus
- Our patients are our neighbors
- Rural support system
- Primary care focus
- Opportunity to grow your market share
- Financial Return on Investment
  - Reduced Revenue from lost volume is replaced 6:1 by value driven revenue
PRIMARY CARE REVENUES

- Medicare Well Visits
- Care Gap Closures
- Transitional Care Management (TCM)
- Chronic Care Management (CCM)
- Better Utilization of Services
  - Specialty Referral Management/next step
# ANNUAL REVENUE PROJECTIONS

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<th>YEAR ONE</th>
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<td>MWV</td>
<td>$787,644</td>
<td>$2,297,295</td>
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<td><strong>UTILIZATION REDUCTION DOLLARS</strong></td>
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<td>$474,000</td>
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<td><strong>UR = $15.7% REDUCTION ASSUMPTION</strong></td>
<td>2%</td>
<td>3%</td>
<td>4%</td>
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<td>CCM</td>
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<td>TCM</td>
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<td><strong>CARE GAP CLOSURE</strong></td>
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<td><strong>TOTALS</strong></td>
<td><strong>$4,496,491</strong></td>
<td><strong>$11,386,197</strong></td>
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### Impact of Volume to Value Transition

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<th>REDUCED IN NETWORK ER $ + REDUCED IN NETWORK HOSPITALIZATION $ = $74,790,507 MAX LOST REVENUE FROM 100% VOLUME REDUCTION</th>
<th>YEAR #1 2% REDUCTION IN VOLUME</th>
<th>YEAR #2 3% REDUCTION IN VOLUME</th>
<th>YEAR #3 5% REDUCTION IN VOLUME</th>
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<td>RMETED FROM VOLUME REDUCTION</td>
<td>$1,495,810</td>
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<td>TOTAL REVENUE GAIN FROM VALUE</td>
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<td>TOTAL NET REVENUE GAIN</td>
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<td>MARKET SHARE GAIN</td>
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<td>QUALITY OF CARE IMPROVED</td>
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<td>POSITIONING FOR COMMERCIAL MARKET’S TRANSITION TO VALUE</td>
<td>POSITIVE</td>
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Dr. Davis’s Primary Care Practice

- **My Practice Data - IRCCO Chief Medical Officer**
  - 1700 ACTIVE PATIENTS OF ALL TYPES
  - 2000 MEDICARE VISITS PER YEAR
  - 459 INDIVIDUAL MEDICARE PATIENTS
  - 78 MEDICARE ADMISSION ANNUALLY

- AN ADOPTION RATE OF YEAR ONE - 25%, YEAR TWO - 35%, YEAR 3 - 50%

- ROLL OUT – PROVIDERS PER YEAR: YEAR 1- 48: YEAR 2- 100; YEAR 3- 148
- AVERAGE MWV PAYMENT OF $143

- 66% OF MEDICARE PATIENT HAVE 2 CHRONIC CONDITIONS AND QUALIFY FOR CCM AT $40.39/MONTH PAYMENT

- 78 ANNUAL ADMISSIONS WITH 66% QUALIFIED FOR TCM AT $200/VISIT
- 20% OF MEDICARE PATIENTS HAVE GAP CLOSURES AT $800/MONTH
Focus 2016 – Value of Primary Care

- Care Coordination…implemented
- Coding!!!
- Revenues – primary care
  - Medicare Well Visits
  - Chronic Care Management
  - Transitional Care Management
  - Gap Closure /prevention screening
- Increase primary care – loyalty
- Transfer process evaluation
IRCCO -18 months Evaluation...Still Further Work

- Committed – *local primary care based*
- Organized Statewide ACO – group decisions; ready for commercial…*slowly moving towards risk*
- Claims Management – eClinicalworks and IRCCO staff
  - Target areas identified both clinical and financial improvements
  - Defined per facility
  - Process Improvement
  - Understanding data
  - Impact of Coding….needs improvement
- Care Coordination Program – Results…seeing change
- Quality Reporting – improving and should hit CMS thresholds
- Practitioner and Participant Involvement - needs improvement
- Website – patient education, wellness initiatives
- Special programs – well visits, BCBS medical homes, chronic care management, referral tracking, community inventory, patient involvement – *new health coaching program spring 2017*
Pivotal Lesson Learned

- Hospital staffs and provider involved are committed and making great strides
- Those not involved, minimal change
- 2017 Goal – every ACO participant involved
  - ED Utilization
  - Post Acute Care Utilization
  - 30 Day Readmissions
  - Medicare Well Visits – Gaps in Care
  - Cost of Care Reduction
  - Market share Expansion
POTENTIAL CAUSES OF ACO FAILURE

- Lack of engagement by CEO’s, providers and hospitals - #1 Challenge/IRCCO

- Care coordinators assigned to duties not related to care coordination (most common cause of failure in ACO’s)

- Incomplete or inaccurate coding of diseases (HCC)
  “Tell the complete story every visit”
Other Lessons Learned

- IRCCO allows rural hospitals and providers to move to value...there is a ROI
- Change is not easy - manage practice workflow and provide ongoing support
- Learn to manage our patients – different strategies
- Must provide value – together rural is better
- Care coordination – initial key to success
  - Example: One Medicare patient visited ED 150 times in 18 months
# Our New Dashboard

## Latest Quarter Attribution, Claims
1/1/2016 - 11/27/2016

<table>
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<tr>
<th>Disease Specific Expenditures</th>
<th>COPD</th>
<th>Stroke</th>
<th>Heart Failure</th>
<th>Diabetes</th>
<th>HTN</th>
<th>IRCCO</th>
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<th>Carlinville</th>
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<th>Fayette County</th>
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<th>Gregg</th>
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IRCCO Governing Board
Moving Forward 2017

- Achieve financial sustainability as an ACO
- Develop new revenue streams
- Implement dashboards boards for individual participants and use them to build accountability
- Increase provider buy in and establish accountability and ultimately performance
- Need to achieve meaningful progress
- Create an educational video explain ACO for hospital staff...buy in important!
CMO Outreach to Hospitals and Providers

- Individual participant meetings – present data
  - CMO, Regional Care Manager, Hospital CEO, Providers (ex. Group PMPM $800 – Hospital PMPM $850….discussion on making change)
  - Risk adjust comparison

- Opportunities to improve
  - Using data to make changes

- Rural relevant care

- Managing specialty referral
Challenges – Still Ahead

- Independent hospitals and practices – staying committed/all volunteer
- 15 Disparate EMRs
- Full commitment – needing the ROI for care coordination
- Chronic care management program
- Understanding and using data
- Coding…not telling the full story
- Reducing care variance
IRCCO 2017

- Illinois Statewide Rural ACO
- 24 Critical Access and Rural Hospitals; 35 rural health clinics
- 15 Independent physician practices
- >250 Medical providers providing care for > 30,000 Medicare Beneficiaries
- Medicare Shared Savings Program Year 3; AIM Investment Funds 2016
- BCBSIL ACO 2017-2018
- www.iruralhealth.org
What is Unique about IRCCO?

- Statewide rural ACO
- Democratic management – providers have feedback; hospitals build change/programs locally
- IRCCO is in this for the long haul
- Programs and processes developed for rural providers
- Able to leverage numbers and resources
- Seeing the difference for Illinois rural communities
Supporting the Health Care Stool

- Our focus must be on all legs of the stool – Secure Primary Care
  - Medicare/traditional/MSSP
  - Commercial/ BCBS and others (self-funded included)
  - Medicare Advantage/ UnitedHealthcare/state employees
  - Medicaid – managed care organizations
Blue Cross Blue Shield Illinois

- Begin receiving claims – learning process 2017
- Will move to BCBS ACO in 2018
- >11,000 beneficiaries/IRCCCO
- Opportunity….BCBSIL interested in building a partnership
  - IRCCO begins a variety of independent rural facilities together as one/common practices
NEW: Coaching Program for Self-funded Employee Insurances 2017

- Evaluating health coaching program for high risk employees (hospital or local business community)
- Risk analysis – plans of care
- Wellness with ROI on prevention
- Revenue stream for IRCCO and Hospital and Medical Providers (identification of new patients)
Decisions to Make 2017

- Will IRCCO continue the 4th year as Track 1
- Move to ACO 1+ or bear risk
- Distribution of shared savings – will original MSSP plan need to change?
- Add more participants or not?
- What about participants who cost the ACO?
- Preparing for sustainability/ 2019 payback AIM
- Are we reducing “spend per person” and creating a positive ROI/increase in market share?
Rural ACOs can Lead the Way

Questions/Comments

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[www.iruralhealth.org](http://www.iruralhealth.org)