We Are Here Because of our Patients
We Are Here Because of our Community

• Our mission is to serve our community.
• Rural Health Systems are the economic engine of their community,
• The majority of our costs are subsidized by the government, often supplemented with local taxes.
• With sequestration, now 47 hospitals have closed in the past few years.
• The biggest threat to our survival is not yet well understood.
Value-Based Payments

• Secretary Burwell’s historic announcement

“Our first goal is for 30% of all Medicare provider payments to be in alternative payment models that are tied to how well providers care for their patients, instead of how much care they provide – and to do it by 2016. Our goal would then be to get to 50% by 2018.

Our second goal is for virtually all Medicare fee-for-service payments to be tied to quality and value; at least 85% in 2016 and 90% in 2018.”

Only 36 percent of the 1,201,363 professionals who were eligible to participate in 2012 participated in PQRS, so how is 85% going to happen?
How Will CMS Get 90%?

• 2015 PFS pays 4% bonus or 4% penalty in 2017 for top quartile performers on ACO-like quality measures and cost per beneficiary.

• 2016 “Doc Fix” pays 8% bonus or 4% penalty

• 2019 “Doc Fix” pays 24% bonus or 12% penalty
What Does That Mean to You?

• **If you could see what we see because we have the data....**

• Rural providers will typically have the highest UNIT costs (not cost per life) and will have lower quality scores because they do not participate in PQRS or other quality programs.

• Patients are getting 80% of their care outside of the rural health system, due to concerns about cost and quality.

• A cardiologist could risk losing ~$100K per year if his patients are high cost or if their quality scores are low, and much of this is out of his direct control – it depends on the health system they come from.

• Providers are going to steer their patients to high value partners. They will look on Physician Compare, Hospital Compare and other sources – where you aren’t listed! AND SO WILL YOUR PATIENTS!
And that Puts the Target on Your Back

We have to find a way to participate in these programs, even though we don’t have to. The greatest threat to the sustainability of rural healthcare systems are market forces that will force doctors and patients to choose high value providers and partners – and rural is rapidly being left behind.
National Rural Accountable Care Consortium

• Founded by rural hospital and FQHC leaders - Tim Putnam, Steve Barnett, Chris Baumgardner, David Ameen, Melanie Van Winkle, Jim Suver, Lee Barron, Alan McPhee, John Halfen and Drew Wickham

• Now includes 30 Rural Health Systems enrolled to date in 6 ACOs in 9 states with 65,000 attributed lives.

• Able to share lessons learned among consortium.

• Single data warehouse has given a new view to the rural reality.

• 2014 National Rural ACO Consortium members have reduced utilization in every category.

• Attributed lives increased by 18.5% in first nine months
NRACO Emergency Department Visits Per 1000 Attributed Beneficiaries

All ACOs Emergency Department Visits Per 1000 Beneficiaries

NRACO Benchmark

All ACOs FFS Benchmark
Bacterial Pneumonia Discharge Rates (Per 1000 Beneficiaries)

- NRACO Bacterial Pneumonia
- All ACOs Bacterial Pneumonia
- NRACO Benchmark
- All ACOs Benchmark


Discharge Rates:
- 2011: NRACO = 17.02, All ACOs = 9.77, Benchmark = 7.25
- 2012: NRACO = 13.20, All ACOs = 8.77
- 2013: NRACO = 8.00, All ACOs = 6.00
- 2014-Q1: NRACO = 10.00, All ACOs = 7.00
- 2014-Q2: NRACO = 9.00, All ACOs = 8.00
- 2014-Q3: NRACO = 7.00, All ACOs = 6.00

NRACO vs All ACOs Bacterial Pneumonia Discharge Rates
Chronic Obstructive Pulmonary Disease Discharge Rates
(Per 1000 Beneficiaries)

Discharge Rates

2011 2012 2013 2014-Q1 2014-Q2 2014-Q3
NRACO COPD All ACOs COPOD NRACO Benchmark All ACOs Benchmark

NRACO COPD
All ACOs COPOD NRACO Benchmark All ACOs Benchmark

2.51

9.03

8.57

12.40

9.89

2011
2012
2013
2014-Q1
2014-Q2
2014-Q3

NRACO COPD All ACOs COPOD NRACO Benchmark All ACOs Benchmark
Congestive Heart Failure Discharge Rates
(Per 1000 Beneficiaries)
NRACO 30-Day All-Cause Readmissions Per 1,000 Discharges
All ACOs 30-Day All-Cause Readmissions Per 1,000 Discharges
NRACO Benchmark
All ACOs Benchmark
Hospitalizations
(Per 1000 Person Years)

NRACO Hospitalizations Per 1000 Attributed Beneficiaries
All ACOs Hospitalizations Per 1000 Beneficiaries
Wellness Visits

Wellness Visits by Quarter

2013

Q1
Q2
Q3
Q4

2014

Q1
Q2
Q3
Q4

Show By PCP Visits

Contract Name
MSSP

Patient Status
(Multiple values)

Show By Visits
12 Months

Show:
Wellness Visits
Attributed Beneficiaries*

*Normalized for inactive beneficiaries throughout the year
35% Market Share for Attributed Lives
Likely 20% Market Share for Community

2013 and 2014 claims data, National Rural ACO
Payment Adjustments

• CMS currently does not count IME and DSH payments, but does count special rural payments.
• This creates a target on our back, driving volume away from us.
• Lower volume increases Medicare’s per capita costs.

| Impact of Volume on CAH Payments |
|-------------------------------|-----------------|-----------------|-----------------|-----------------|-----------------|
|                              | Baseline | Increase Days 50%, 90% Fixed Cost | Increase Days 50%, 50% Fixed Cost | Decrease Days 50%, 90% Fixed Cost | Decrease Days 50%, 50% Fixed Cost |
| Acute Days                   | 1,234    | 2,468                         | 2,468                         | 617                          | 617                          |
| Medicare Costs               | $3,711,245 | $4,321,370                  | $5,686,368                    | $3,286,683                   | $2,663,934                   |
| Cost/Day                     | $3,007.49 | $1,750.96                    | $2,304.04                     | $5,326.88                    | $4,317.56                    |
Rural Health Death Spiral

Higher Costs

Lower Volume

Hospital Closes

Service Reductions

Town Dies

Physicians Leave Town

Higher Costs

Lower Volume

Higher Costs

Higher Costs
Payment Adjustments

• We strongly recommend that for all MSSP and value-based payment calculations, all claims from safety net facilities are standardized to the corresponding PPS rates and all special payments are not included in the calculations. THIS DOES NOT CHANGE REIMBURSEMENT – JUST OUR APPEARANCE TO OTHERS. Example: CAH cost/day=National PPS average for VBM and MSSP calculations. Cost-based reimbursement stays the same.

• Rural providers MUST find a way to measure, report and improve quality and cost – and they have to be able to tell their story, because the “Compare” websites either don’t say anything or are very misleading due to low volumes.

• And that is why we are here today, because the MSSP can help.
What Can You Do?

• Talk to your representatives – please see handouts. Protect rural health by standardizing our payments to the PPS rates for the sake of calculations on

• Send a letter to Secretary Burwell.

• Get rural involved in the MSSP. You gotta be in it to win it!