Strategies for Managing Payment Uncertainty as a Critical Access Hospital

Lynn Barr, CEO and Founder, Caravan Health
Eric Shell, Director, Stroudwater Associates

About Caravan Health

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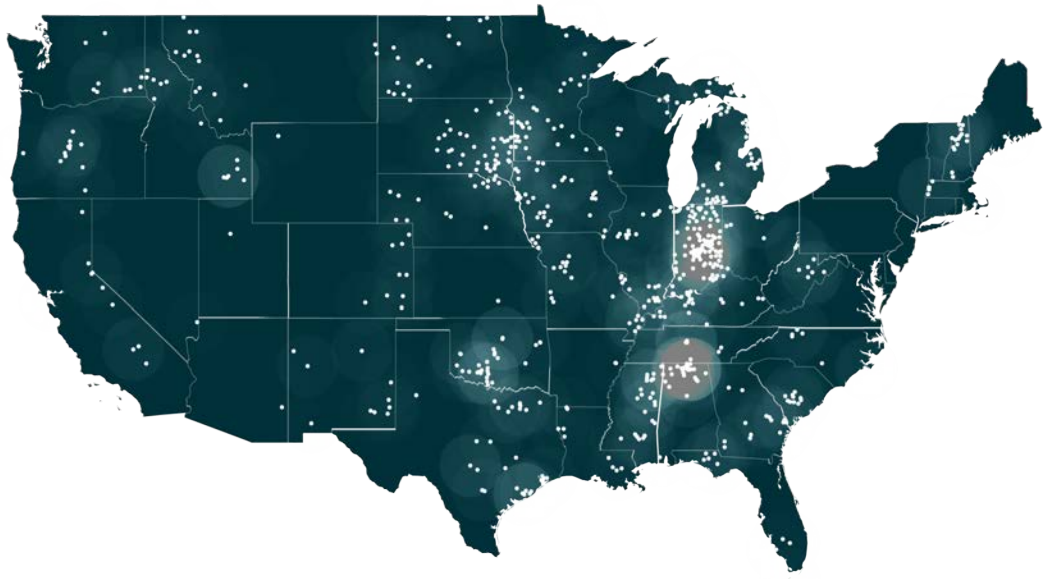
Helping Providers Navigate the Challenges of Value-Based Payments

Practice Transformation	Data and Analytics	Network Development	Accountability and Performance Improvement

- **Founded by Rural Providers**
- **17 Accountable Care Organizations ranging from 5,000 to 230,000 attributed lives**
- **CMS Practice Transformation Network**
- **>250 health systems**
- **>14,000 clinicians**
- **>500,000 attributed Medicare lives**



Leading the Way in Rural Health Care

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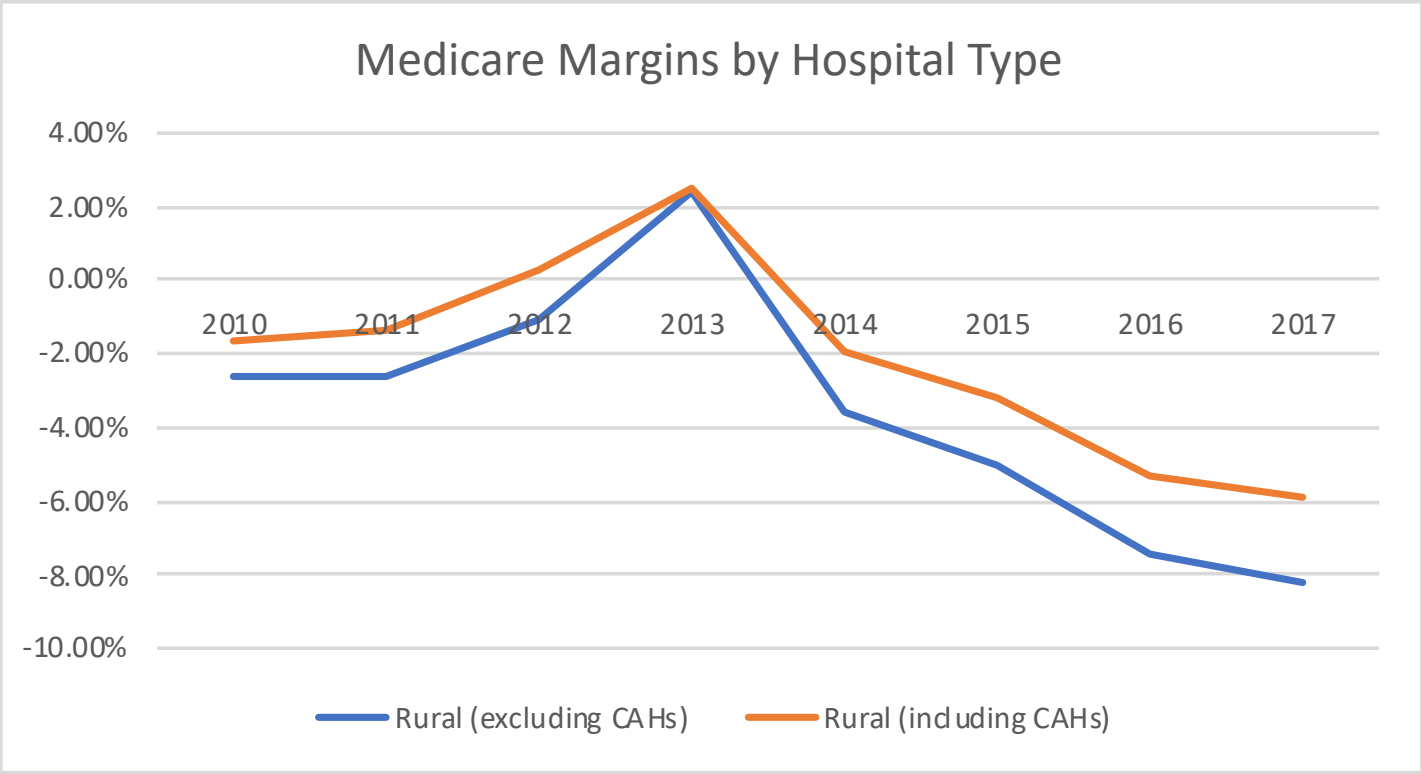
- Caravan is a pioneer in accountable care for rural hospitals
- Our work with rural providers led to the creation of collaborative ACOs – larger ACOs made up of unrelated health systems
- Caravan sponsored many of the small rural ACOs in the highly successful ACO Investment Model (AIM)
- CAHs, like all providers in Medicare, will benefit from experience with value-based payment

About Stroudwater

- Founded in 1985, Stroudwater is a national boutique consulting firm that designs solutions for healthcare leaders' most pressing challenges
- We employ thought leadership and focused analytics in a collaborative process that engages our clients and enables their transformation as the healthcare industry shifts toward population health and payment for value
- We have corporate offices in Tennessee, Maine, and Atlanta, and are proud to have friends and clients in all 50 states
- Our team includes clinicians, corporate officers, investment bankers, financial analysts, academics, practice management experts, quality improvement specialists, and other leaders
- Deep expertise in rural hospital strategies, finances, and operations

Carbon Monoxide – Medicare Margins



Source: MedPac Report to Congress, March 15, 2019

- Why?
  - Decreased patient volume
  - Reduced FFS payment relative to costs

Hospitals Targeted in Federal Cost-Cutting Push (3/6/19)

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- Led by Sen. Lamar Alexander (R-Tenn.), a bipartisan group including the Brookings Institution and the American Enterprise Institute submitted a set of healthcare cost-cutting recommendations that target hospitals
- Recommendations in the letter include:
  - **Targeting merger-and-acquisition (M&A) activity**
    - Specifically, increased for antitrust enforcement by the Federal Trade Commission and the Department of Justice's Antitrust Division against both provider and health plan M&A
  - **Eliminating any willing provider rules governing network participation**
  - **Requiring participation in all-payer claims databases**
  - **Repealing certificate of need laws**
  - **Requiring contracts to eliminate surprise bills**
  - ***Expanding site-neutral payments***
  - **Expanding bundled payments**
  - ***Narrowing 340B***

"There's just no getting around the fact that hospitals make up a huge chunk of healthcare spending in the United States…So, if you want to save any substantial amount of money, it's going to be hard to do that without having any effects on the hospitals."

Benedic Ippolito, an author of the joint letter and an economist at AEI

Source: hfma.org Healthcare Business News, *Hospitals Targeted in Federal Cost-Saving Ideas, Rich Daly,* 3/6/19, https://www.hfma.org/Content.aspx?id=63470

MedPAC March 2019 Report to Congress

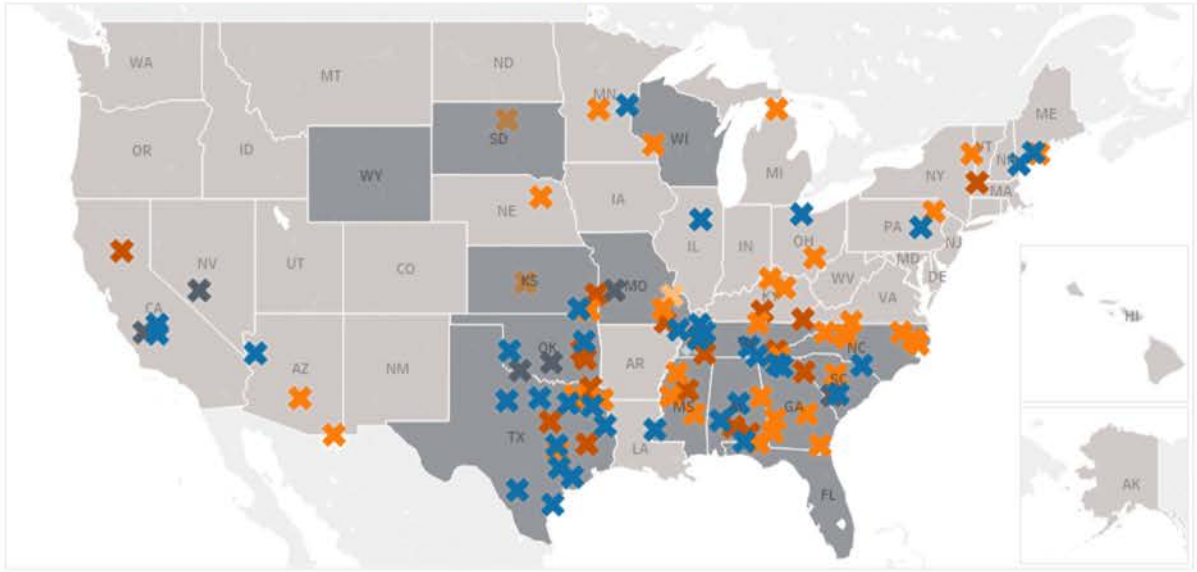
- Background
  - In 2017, hospitals aggregate Medicare margin was -9.9%
    - Medicare margin for efficient providers was -2%
  - 2019 aggregate Medicare margin is projected to decline to -11%
  - Payment policy goal is to improve program's value to beneficiaries and taxpayers
    - Will require knowledge about costs and health outcomes of services
    - Looking for opportunities that provide incentives for high-quality care
  - ***"In the longer term, pressure on providers may cause them to increase their participation in alternative payment models"***
  - During FY 2017, inpatient payments increased by 2.2% and outpatient payments increased by 8.1%
- For 2020, the commission recommends that the Congress update Medicare IP and OP payment rates by 2%
  - Difference between 2% update and update amount specified in law (2.8%) to be used to increase payments to the new Hospital Value incentive Program (HVIP)
  - HVIP will eliminate penalties in current quality programs resulting in .5% increase
  - After net effect of new HVIP, update amount expected to be 3.3%

Source: MedPAC Report to the Congress: Medicare and the Health Care Delivery System, March 15, 2019
http://www.medpac.gov/docs/default-source/reports/mar19_medpacreporttocongress_sec.pdf?sfvrsn=0

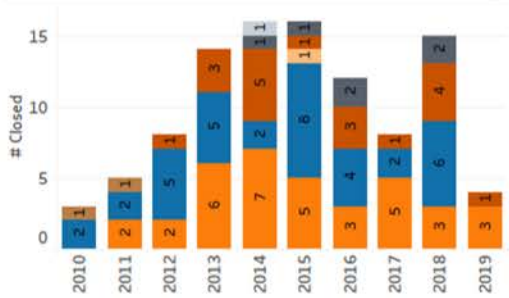
Hospital Closures

101 Closed Rural Hospitals

There have been 101 Rural Hospital closures since 2010 and 143 since 2005. These counts do not include those that have closed and re-opened.



Closure Year	Hospital Name
2019	Georgiana Medical Center-AL
	Cumberland River Hospital-TN
	Washington County Hospital-NC
	Oswego Community Hospital-KS
2018	Mercy Hospital Fort Scott-KS
	Fairfield Memorial Hospital-SC
	Little River Healthcare Cameron Hospital-TX
	Little River Healthcare Rockdale Hospital-TX
	Adventist Health Feather River-CA



StateAbv	# Closed
TX	17
TN	10
GA	7
AL	6
NC	6
OK	6
MO	5
MS	5
CA	4
KS	4
KY	4
SC	4
AZ	3
ME	3
MN	2
OH	2
PA	2
VA	2
FL	1
IL	1
MA	1
MI	1
NE	1
NV	1
NY	1
SD	1
WI	1

Closure Year	Critical Access Hospital	Prospective Payment System	Medicare Dependent Hospital	Sole Community Hospital	Re-based Sole Community Hospital	Disproportionate Share Hospital	Rural Referral Center	Total
2010		2			1			3
2011	2	2			1			5
2012	2	5	1					8
2013	6	5	3					14
2014	7	2	5	1		1		16
2015	5	8	1	1			1	16
2016	3	4	3	2				12
2017	5	2	1					8
2018	3	6	4	2				15
2019	3		1					4
Total	36	36	19	6	2	1	1	101

Medicare Payment Type
- Prospective Payment System
- Critical Access Hospital
- Medicare Dependent Hospital
- Sole Community Hospital
- Re-based Sole Community Hospital
- Disproportionate Share Hospital
- Rural Referral Center

Current Status of Medicaid Expansion Decision
- Adopted the Medicaid Expansion
- Not Adopting the Medicaid Expansion at this Time

Updated:3/12/2019

Sources: The North Carolina Rural Health Research Program (NC RHRP) at the Cecil G. Sheps Center for Health Services Research & kff.org

Design:@GreggLathrop

Source: NC Rural Health Research Program at the Cecil G. Sheps Center for Health Services and Research and KFF.org

CMMI Direction: Blow Up Fee for Service

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- If there was any doubt about administration's desire to push healthcare towards a value-based system, Center for Medicare & Medicaid Innovation (CMMI) Director Adam Boehler makes things clear:

"I'll tell you a lot of what I do in my role running CMMI as senior adviser to Secretary Azar is to ***blow up fee for service…*** *That's one of our prime goals—is to get rid of fee for service."*

- However, getting rid of fee for service is easier said than done given the industry's current reliance on the existing infrastructure.

34%
of healthcare payments tied to an APM in 2017

10.5%
of Medicare payments in traditional legacy arrangements not linked to quality

>50%
of Medicare FFS payments with some level of pay-for-performance

Source: FierceHealthcare, *CMMI's Adam Boehler wants to 'blow up' fee for service,* Evan Sweeney, 11/29/18
https://www.fiercehealthcare.com/payer/cmmi-s-adam-boehler-wants-to-blow-up-fee-for-service

The Challenge: Crossing the Shaky Bridge

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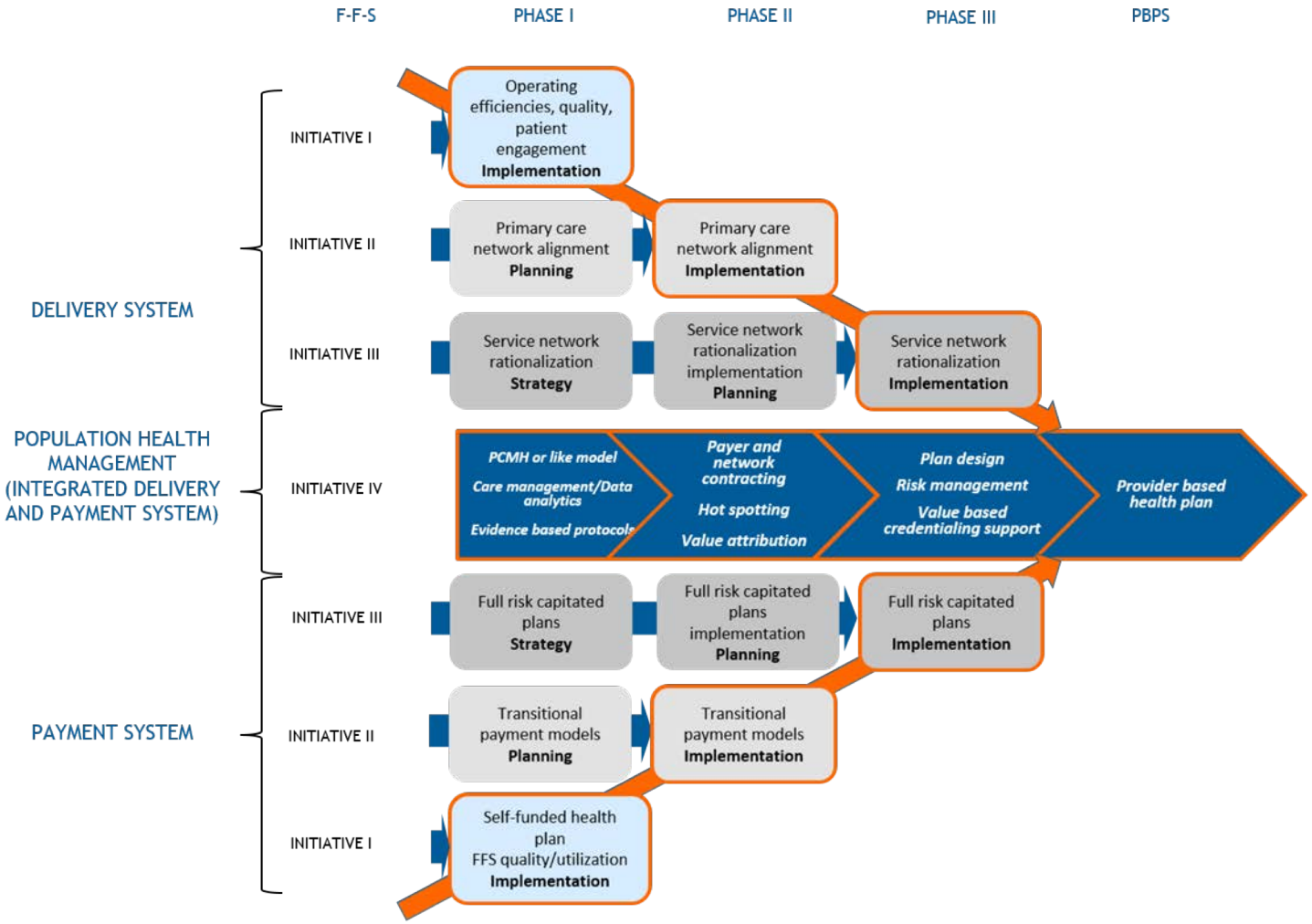
Fee for Service Payment System

Population Based Payment System

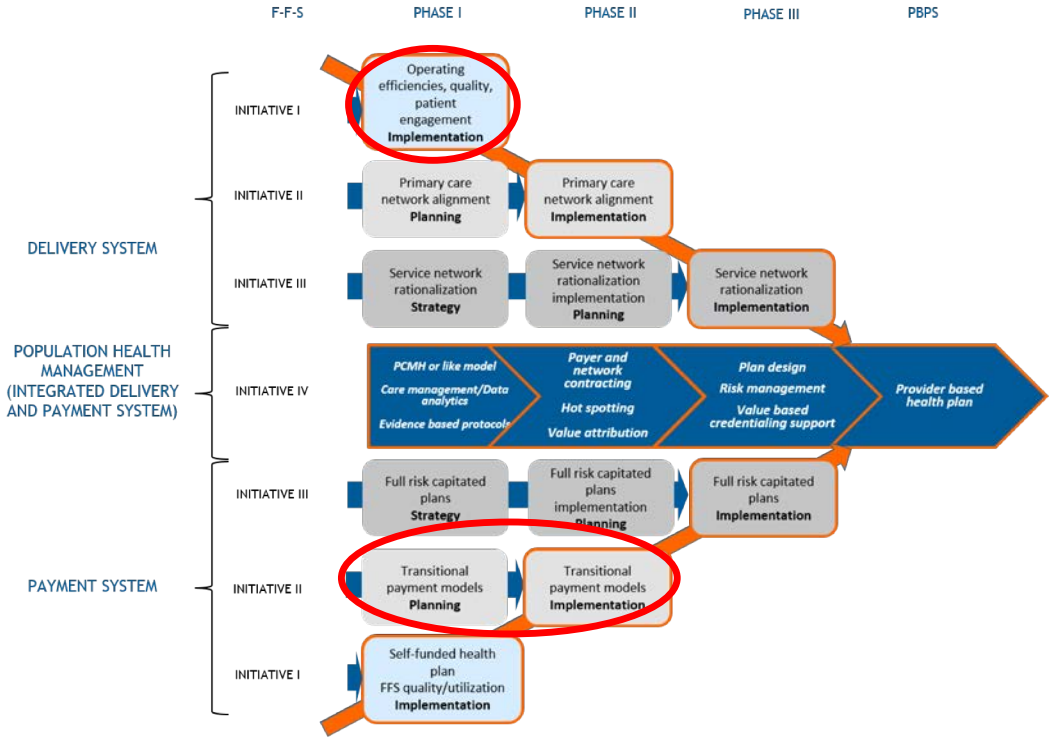
2014 2016 2018 2020 2022 2024 2026

Population Health Strategy

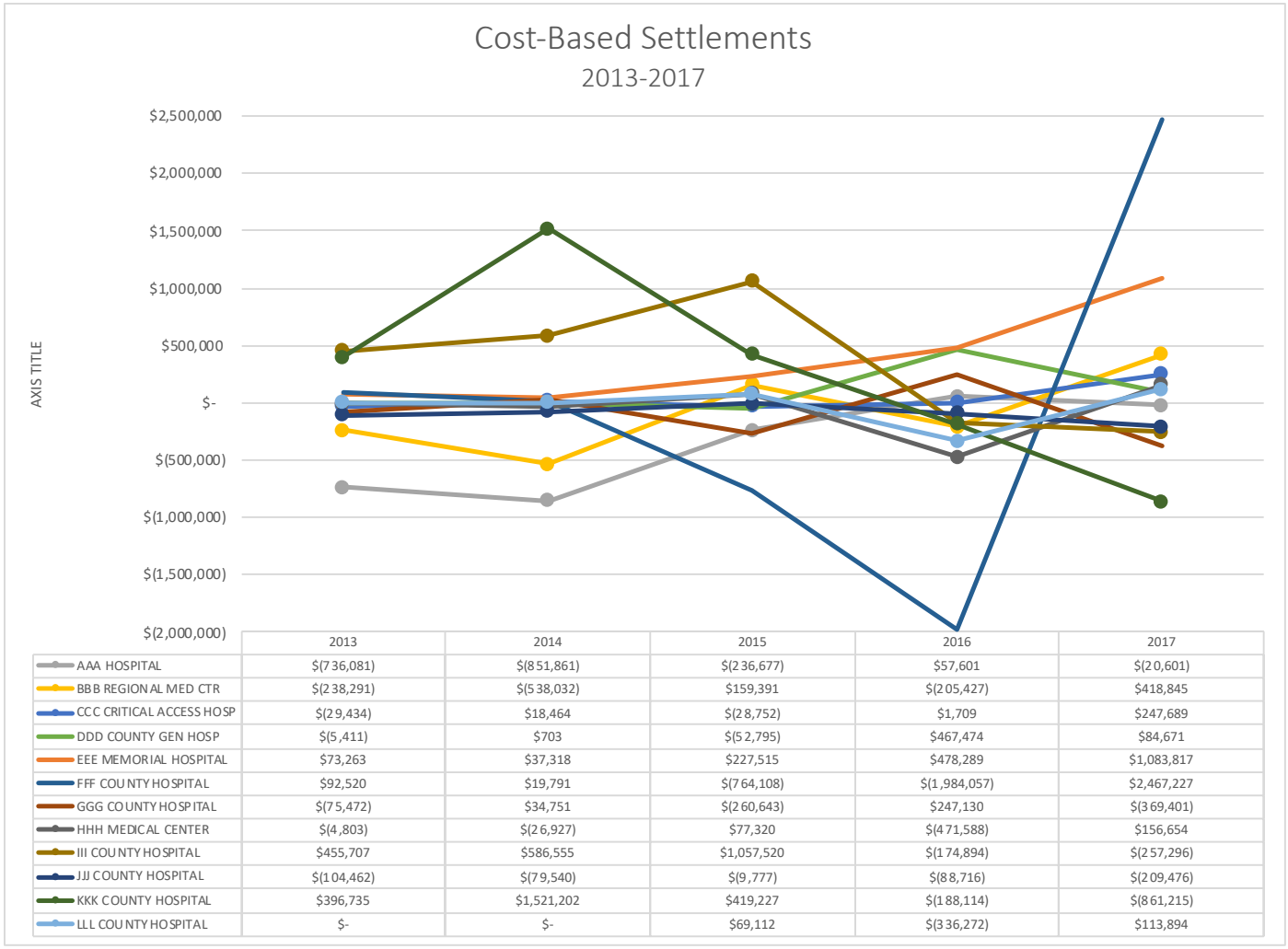


Future Imperatives

- Improve Operational Efficiencies
  - Accurate financial reporting through transition
- Transition Payment
  - Risk of remaining in FFS will eventually exceed the risk of alternative payment systems
  - Imperative to reliably forecast fee-for value income (residual claim on health)



Overview of CAH Settlements - Sample



	2013	2014	2015	2016	2017
AAA HOSPITAL	$(736,081)	$(851,861)	$(236,677)	$57,601	$(20,601)
BBB REGIONAL MED CTR	$(238,291)	$(538,032)	$159,391	$(205,427)	$418,845
CCC CRITICAL ACCESS HOSP	$(29,434)	$18,464	$(28,752)	$1,709	$247,689
DDD COUNTY GEN HOSP	$(5,411)	$703	$(52,795)	$467,474	$84,671
EEE MEMORIAL HOSPITAL	$73,263	$37,318	$227,515	$478,289	$1,083,817
FFF COUNTY HOSPITAL	$92,520	$19,791	$(764,108)	$(1,984,057)	$2,467,227
GGG COUNTY HOSPITAL	$(75,472)	$34,751	$(260,643)	$247,130	$(369,401)
HHH MEDICAL CENTER	$(4,803)	$(26,927)	$77,320	$(471,588)	$156,654
III COUNTY HOSPITAL	$455,707	$586,555	$1,057,520	$(174,894)	$(257,296)
JJJ COUNTY HOSPITAL	$(104,462)	$(79,540)	$(9,777)	$(88,716)	$(209,476)
KKK COUNTY HOSPITAL	$396,735	$1,521,202	$419,227	$(188,114)	$(861,215)
LLL COUNTY HOSPITAL	$-	$-	$69,112	$(336,272)	$113,894

- Significant variance in CAH Cost Report Settlements

Why do Settlements Occur?

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CAH Interim Payments and Revenue Recognition

	Prior Year	Scenerio 1 15% Volume Decrease		Scenerio 2 15% Volume Increase		Scenerio 3 15% Expense Increase	Scenerio 4 15% Expense Decrease
Medicare Acute Costs	$ 2,500,000	$ 2,500,000	*	$ 2,625,000	**	$ 2,875,000	$ 2,125,000
Medicare Acute Days	2,000	1,700		2,300		2,000	2,000
Cost Per Day	$ 1,250.00	$ 1,470.59		$ 1,141.30		$ 1,437.50	$ 1,062.50
Interim Rate		$ 1,250.00		$ 1,250.00		$ 1,470.59	$ 1,141.30
Difference		$ 220.59		$ (108.70)		$ (33.09)	$ (78.80)
Settlement		$ 375,000		$ (250,000)		$ (66,176)	$ (157,609)

* Assumes 0% costs increase due to higher nursing and benefits offset by a lower ancillary cost allocation

** Assumes 5% increase in costs related to higher nursing and benefits as well as additional ancillary costs

- Primary Reasons:
  - Increases and decreases in patient volume
  - Increases and decreases in expenses
  - Chargemaster changes
- Without changes in interim rates

What's the Problem (In an FFS environment)?

- Inaccurate Financial Statements (*Assumes that interim cost report modeling is not performed)*
  - Misinformed operating decisions
    - Spending "phantom" cash
      - Pending negative settlement
    - Delays in positive ROI investments
      - Pending positive settlement
  - Loss in confidence from board in senior management financial reporting
- Payment inaccuracies *(primarily related to positive settlements)*
  - Medicare – delayed receipt of cash
  - Medicare Advantage – Lost revenue and cash flow opportunity
    - Direct result of most MA plans without year end settlements

What's the Problem (In a value-based/ACO environment)?

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- Issue:
  - CAH cost report settlements are not included in ACO budget or "spend"
    - Also not included in bundled payments
  - Cost report settlements can distort gain share opportunity

CAH Settlement Impact on ACO Financial Reporting

Budgeted Cost Per Medicare Beneficiary	$	10,000
Beneficiaries Attributed to CAH		1,000
CAH Attributed Budget	$	10,000,000
% of Medicare Budget at CAH		35%
Portion of Medicare Budget provided by CAH	$	3,500,000
Assumed Savings Per Patient	$	300
Total Assumed Savings	$	300,000

	Paid Correctly	10% Under Payment	10% Over Payment
Settlement	$ -	$ 350,000	$ (350,000)
Assumed ACO Savings	$ 300,000	$ 300,000	$ 300,000
Net Cost Report/ACO Settlement Impact	$ 300,000	$ 650,000	$ (50,000)

What's the Problem (In a value-based/ACO environment)?

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- Setting ACO Budgets
  - Cost report settlements are not included in prior period budgets
    - "Cost" of positive settlements not included in budget leading to understatement of budget for future years

- Annual Gainsharing/Downside Risk
  - Cost report settlements are not included in current year spend
    - For negative settlement periods, CAH will own back $ on cost report as well as have the inflated cost charged against ACO spend

CAH Strategies

- Perform Interim Cost Reports/Cost-Based Revenue Models
  - "Book" expected settlement to general ledger
    - If volume changes are in excess of expense changes, update cost report
    - If material changes to chargemaster, update cost report
  - Benefits:
    - Insures accurate financial reporting and operational decision making

- If material rate differences, file new rates with MACs
  - ***Assumes MACs will adjust rates on an interim basis***
  - Benefits:
    - Matches cash flow to revenue
    - Ensures MA plans pay accurately during the year
    - Medicare ACO budget is developed with accurate CAH spend
    - Medicare ACO gainshare/risk is appropriate

- Begin thinking Chargemaster as Cost Master for value based payers

CAH Strategies – Cost Master

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XXX Area Hospital
FY17 As-is Financial Performance

	Cost-Based	Fee-for-Service	Global Budget	Total
Revenue				
Patient Revenue	$ 27,256,656	$ 11,917,634	$ -	$ 39,174,290
PMPM (Capitation)	-	-	-	-
Contractual Allowances	(7,752,513)	(8,346,364)	-	(16,098,877)
Net Patient Revenue	19,504,143	3,571,270	-	23,075,413
Expenses				
Direct	9,753,084	3,528,125	-	13,281,209
Indirect	9,751,059	3,527,392	-	13,278,451
Total Expenses	19,504,143	7,055,517	-	26,559,660
Patient Services Profit (Loss)	$ -	$ (3,484,247)	$ -	$ (3,484,247)

- Allocates costs to payers based on Medicare cost report allocation methodology
  - Benefits
    - Allows CAH to evaluate profitability by payer category

Why Take Risk?

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<u>ACO participants taking risk will get 5% lump sum payments</u> that are not counted in shared savings and are exempt from MIPS reporting – making your clinicians happier and more attractive to others in value-based payments.

CMS is steadily increasing incentives for risk-takers

- ✓ Reduce risk corridor to 0.5% or lower
- ✓ Direct admissions to SNFs
- ✓ Telehealth to patient homes as a billable visit
- ✓ Exempt from MIPS and Meaningful Use
- ✓ 0.5% higher annual increases in Part B starting in 2026 that will accumulate over time to the clinicians NPI.

It will be difficult to recruit physicians if you do not take risk. **Beginning in 2026, <u>every year</u> a clinician does not take risk, their lifetime Medicare earning potential decreases by 0.5%.**

Transitioning from Volume to Value

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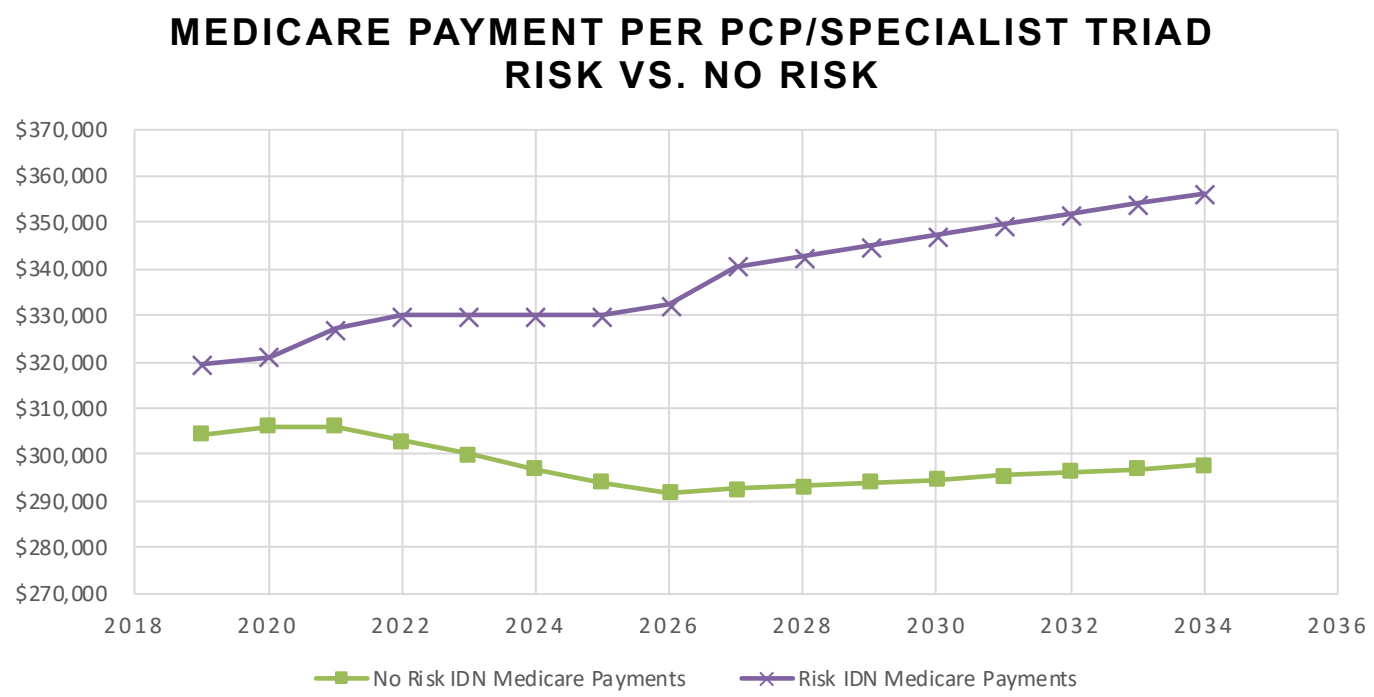
2015 and earlier	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026 and later
Fee Schedule Updates	0.5 %	0.5 %	0.5 %	0.5 %	0	0	0	0	0	0	0.75% QAPM 0.25% Non-QAPM



Risk Required

Medicare payments include fee schedule reimbursement, MIPS adjustments and shared savings.

Unpredictable Results are Unsustainable

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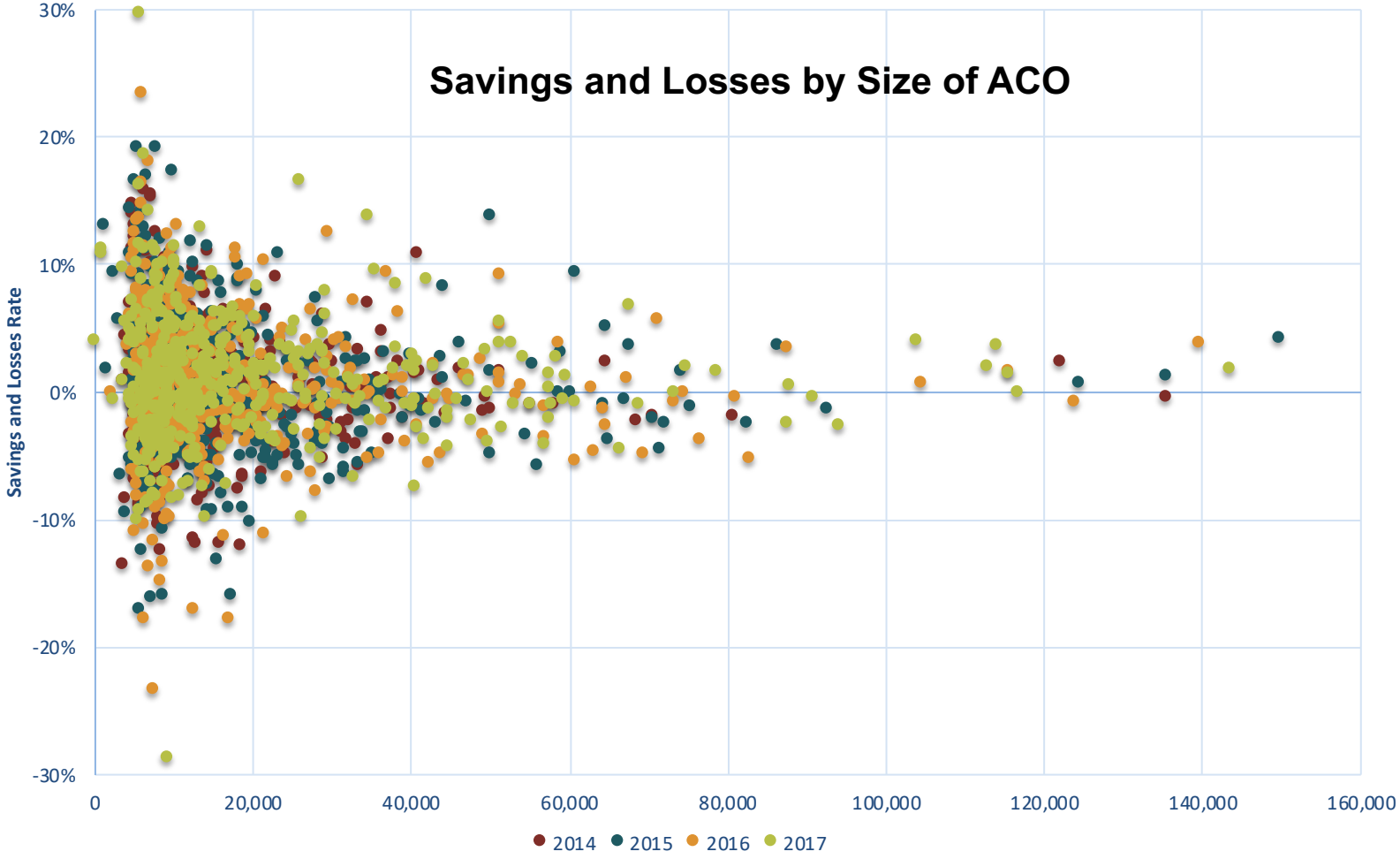
Most ACOs experience savings and loss variation plus or minus 10%



How Do You Consistently Win in the MSSP?

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Managing your patients better than fee-for-service

- ✓ Wellness
- ✓ Prevention
- ✓ Chronic Care Management
- ✓ Behavioral/Mental Health Support
- ✓ Post-Acute Care

Accurately coding chronic conditions every year

Having enough lives to reduce statistical variation

Your path to... … Shared Savings

How Do You Take the Risk Out of Risk?

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Caravan Health will cover all losses after the first 1% per patient. Clients must participate in a collaborative ACO and follow the Caravan Health methodology to qualify.

Caravan charges no additional fees but receives an additional 10% of shared savings.

Client

Principal Participants must provide 1% of spend per patient, to be held in escrow or through a letter of credit.

If losses are incurred, this amount is used to cover up to the first 1% of loss. Otherwise, funds are returned at the end of the performance period.

Caravan's historic ACO performance predicts that neither party is likely to write a check to Medicare yet get all of the MIPS advantages and earn shared savings.

Summary

- Continued pressure on current FFS payment system will place premium on short-term operational efficiencies as well as a strategy to transition to alternative payment systems
  - To be successful across the “bridge”, CAHs must have accurate financial information to optimize decision making and maximize cash flow

- Current CAH cost report settlement process can negatively impact both effective decision making and matching cash to reality, as well as skew ACO budgets and gainsharing

- CAH must reduce uncertainty of financial statement accuracy, cash flow, and ACO budgets by maintaining updated cost-based rate information and amounts

- We must pool providers and their attributed lives to create reliable value-based income streams and avoid actuarial risk.

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Thank You

www.CaravanHealth.com

lbarr@caravanhealth.com 916.542.4582

www.StroudwaterAssociates.com

eshell@stroudwater.com 207.221.8252

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