Generating New Revenue in the New World of Value-Based Care

Spring 2019 A2HA Meeting

March 26, 2019

PYA

The $3.5 Trillion Question

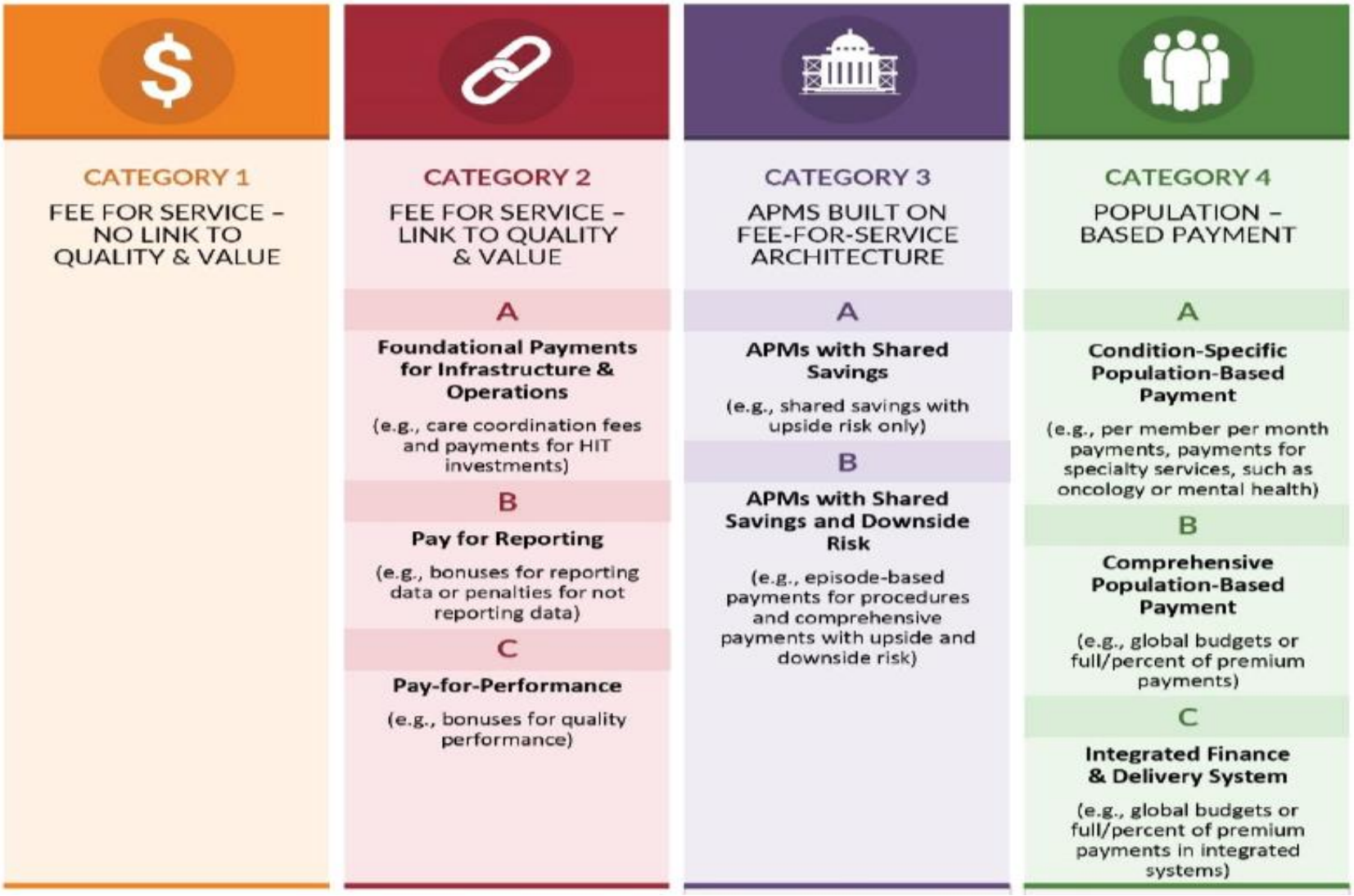
What happens when the buyer wants to buy *health* instead of *healthcare*?

Learning Objective

Balancing between the two canoes…

Develop infrastructure and competencies necessary for success under value-based payments while generating additional revenue under volume-based models

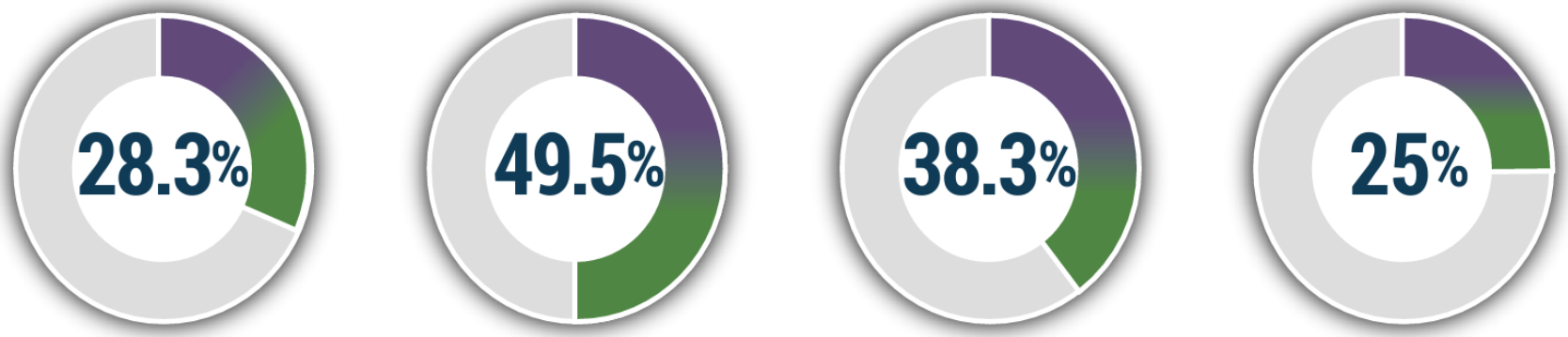
Alternative Payment Models



In **2017,**

34% of U.S. health care payments, representing approximately **226.3 million** Americans and **77%** of the covered population, flowed through Categories 3&4 models.

In each market, Categories 3&4 payments accounted for:



Representativeness of covered lives:
Commercial - 63%
Medicare Advantage - 70%
Medicare FFS - 100%
Medicaid - 50%

HCP LAN
Health Care Payment Learning & Action Network

What Do Payers Think about the Future of APM Adoption?

90% think APM activity will increase

9% think APM activity will stay the same

0% think APM activity will decrease

1% not sure or didn't answer

Categories Payers Feel Will Be Most Impacted

3B **48%**

3A **25%**

Will APM adoption result in...	Strongly Agree/ Agree	Strongly Disagree/ Disagree	Unsure
...better quality of care?	99%	0%	1%
...more affordable care?	89%	2%	9%
...improved care coordination?	97%	1%	2%
...more consolidation among health care providers?	59%	18%	23%
...higher unit prices?	6%	73%	21%

*Top 3 Barriers:

1. Willingness to take on financial risk
2. Ability to operationalize
3. Provider interest/readiness

Top 3 Facilitators:

1. Health plan interest/readiness
2. Purchaser interest/readiness
3. TIE: Provider interest/readiness and government influence

*Please see the Methodology and Results Report and the LAN Insights Report for more information.

New Part B Revenue

1. Annual Wellness Visits
2. Chronic Care Management
3. Transitional Care Management
4. Advance Care Planning
5. Care Plan Development
6. Internet Consultations
7. Virtual Check-Ins

Underlying Assumptions

Panel Assumptions

Patient Panel (per Physician)	2,000
Medicare Patients (Estimated Medicare Payer Mix)	26%
Total Medicare Patients	520
Number of Physicians (per Practice)	10
Total Medicare Patients (per Practice)	5,200
Medicare Advantage as Percent of All Medicare	36%
Percent of MA on Non-Capitated Plans	90%
Traditional Medicare Patients/MA on Non-Capitated	**3,521**

Key Considerations

Definition	Infrastructure	Beneficiary Benefits	Population Health Intersections	Gross Revenue Projections
Background and elements of service	Resources necessary to provide service	Impact on patient experience and overall health	Service's relationship to other PHM services	Practice's projected annual gross revenue from service

1. Annual Wellness Visits

- First-dollar coverage since 2011
  - "Welcome to Medicare"
  - Annual Wellness Visits
- Key elements
  - Administer health risk assessment, record patient's medical history, and review current medications and other care providers
  - Measure beneficiary's vital signs and assess cognitive function
  - Furnish personalized health advice, including written prevention plan of service
- Opportunity to furnish/arrange for other preventive services

1. Annual Wellness Visits

	Low	High
Number of Medicare Beneficiaries with AWV Coverage	3,253	3,253
Percent of Covered Beneficiaries Who Qualify for AWV	100%	100%
Number of AWV Eligible Patients	3,253	3,253
Percentage AWV Captured, Qualifying for Initial AWV	5%	8%
Number of Initial AWVs (CPT G0438)	163	260
National Payment for CPT G0438 (Initial)	$174.43	$174.43
Percentage AWV Captured, Qualifying for Subsequent AWV	65%	80%
Number of Subsequent AWVs (CPT G0439)	2,114	2,602
National Payment for CPT G0438 (Subsequent)	$118.21	$118.21
Annual AWV Revenue	**$278,328**	**$352,934**

2. Chronic Care Management

- Covered since 2015 for Medicare beneficiaries with 2 or more chronic conditions
- 20 minutes per calendar month of non-face-to-face care management services furnished by clinical staff under billing physician's general supervision
  - Complex CCM added in 2017 (60 minutes + 30 minute add-on)
- Specific billing rules (including patient consent, development of comprehensive care plan, medication reconciliation, use of EHR, coordination with other providers, 24/7 access to care)

2. Chronic Care Management

	Low	High
Number of Medicare beneficiaries w/ CCM coverage	3,253	3,253
Percent of Covered Beneficiaries Who Qualify for CCM	67%	67%
Number of CCM-Qualified Beneficiaries	2,169	2,169
Chronic Care Management		
CCM Beneficiaries (% of CCM-Qualified Beneficiaries)	50%	65%
CCM Beneficiaries	1,085	1,410
Avg. Number of Months Billed per Beneficiary	6	8
National Payment for CPT 99490	$42.17	$42.17
Complex CCM		
Complex CCM Beneficiaries (% of CCM-Qualified Beneficiaries)	30%	45%
Complex CCM Beneficiaries	651	976
Avg. Number of Months Billed per Beneficiary	1	1
National Payment for CPT 99487	$92.98	$92.98
Percent of Complex CCM with 30-Minute Add-On Code	15%	20%
Complex CCM with Add-On Code	98	195
National Payment for CPT 99489	$46.49	$46.49
Combined Annual CCM Revenue	**$339,613**	**$575,492**

CCM - Rural Health Clinics

	Low	High
Number of Medicare Beneficiaries with CCM Coverage	3,521	3,521
Percent of Covered Beneficiaries Who Qualify for CCM	67%	67%
Number of CCM-Qualified Beneficiaries	2,347	2,347
RHC CCM Beneficiaries (% of CCM-Qualified Beneficiaries)	50%	65%
RHC CCM Beneficiaries	1,174	1,526
Avg. Number of Months Billed per Beneficiary	6	8
National Payment for HCPCS G0511	$67.03	$67.03
CCM Subtotal	**$472,159**	**$818,302**

3. Care Plan Development

- Covered since 2017; billed once per beneficiary
- Physician's time and effort involved in care plan development that exceeds usual time and effort required for E/M service

3. Care Plan Development

	Low	High
Number of Medicare Beneficiaries with CCM Coverage	3,253	3,253
CPD Eligible Patients (All CCM Beneficiaries)	1,085	1,410
Annual Volume (Percent of Billed CCM Beneficiaries)	75%	90%
Annual Volume of CPD	814	1,269
National Payment for HCPCS G0506	$63.43	$63.43
One-Time Care Plan Development Revenue	**$51,632**	**$80,493**

4. Transitional Care Management

- Covered since 2013 for beneficiaries requiring moderate-to-high-complexity decision-making following discharge from Part A stay (hospital inpatient, SNF)
- Key elements
  - Initial contact with the beneficiary within 2 business days following discharge
  - face-to-face visit within 7 or 14 days (depending on level of service)
  - Medication reconciliation
  - Non-face-to-face care management services furnished for 30 days post-discharge (no specific time requirement)

4. Transitional Care Management

	Low	High
Number of Medicare Beneficiaries with TCM Coverage	3,253	3,253
Hospitalization Percentage (of Medicare Patients)	14.3%	14.3%
Number of Annual Hospitalizations per Hospitalized Beneficiary	1.37	1.37
Moderate to High Complexity of Decision Making (TCM Requirement)	67%	67%
Annual Volume of Qualifying Discharges	425	425
Estimated Percent of Eligible Contacted within 14 Days	50%	65%
Estimated TCM within 14 Days (CPT 99495)	213	276
National Payment for CPT 99495	$166.50	$166.50
Estimated Percent of Eligible Contacted within 7 Days	10%	15%
Estimated TCM within 7 Days (CPT 99496)	43	64
National Payment for CPT 99496	$234.97	$234.97
Annual TCM Revenue	**$45,568**	**$60,992**

5. Advance Care Planning

- Covered for all Medicare beneficiaries since 2016
- Physician must spend at least 30 minutes face-to-face with beneficiary (or family members/caregivers) discussing ACP, including reviewing and explaining advance directives (*e.g.*, healthcare proxies, durable powers of attorney for healthcare, living wills, medical orders for life-sustaining treatment).

5. Advance Care Planning

	Low	High
Number of Patients Receiving AWV	2,465	3,099
Advance Care Planning (Percent of AWV Volume)	15%	20%
Advance Care Planning Volume (CPT 99497)	370	620
National Payment for CPT 99497	$86.49	$86.49
ACP Additional 30 Minutes (Percent of ACP Volume)	5%	10%
ACP Volume (Additional 30 Minutes) (CPT 99498)	19	62
National Payment for CPT 99498	$76.04	$76.04
Annual ACP Revenue	**$33,446**	**$58,338**

6. Internet Consultations

- New in 2019 for treating physician – consultant interactions
- CPT® 99452 – Treating Physician
  - Interprofessional telephone/internet/electronic health record referral service(s) provided by a treating/requesting physician or qualified healthcare professional
- Additional Consultant Codes
  - Five codes ranging from minimum of 5 to minimum of 31 minutes; reimbursement from $18 - $73
  - Four codes require majority of time must be spent interacting with treating physician
  - All require written report

6. Internet Consultations

	Low	High
Number of Medicare Beneficiaries with IC Coverage	3,521	3,521
Internet Consultation Volume (Percent of Eligible)	5%	10%
Internet Consultation Volume	176	352
National Payment for CPT 99452	$37.48	$37.48
Annual Internet Consultation Revenue	**$6,598**	**$13,196**

7. Virtual Check-Ins

- New in 2019 to pay for patient communication unrelated to office visit
- HCPCS G2012 – Live Virtual Check-In
  - Brief communication technology-based service by physician or other qualified healthcare professional provided to established patient, not originating from related E/M service provided within previous 7 days nor leading to E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion.
- HCPCS G2010 – Store & Forward Images
  - Remote evaluation of recorded video and/or images submitted by the patient, including interpretation with follow-up with the patient within 24 business hours, not originating from related E/M service provided within previous 7 days nor leading to E/M service or procedure within next 24 hours or soonest available appointment.

7. Virtual Check-Ins

	Low	High
Number of Medicare Beneficiaries with Virtual Check-In Coverage	3,521	3,521
"Store and Forward" Volume (Percent of Eligible)	10%	12%
"Store and Forward" Volume	352	422
National Payment for HCPCS G2010	$12.61	$12.61
Live Virtual Check-In Volume (Percent of Eligible)	5%	10%
Live Virtual Check-In Volume	176	352
National Payment for HCPCS G2012	$14.78	$14.78
Annual Virtual Check-Ins Revenue	**$7,040**	**$10,524**

Revenue Summary

	Low End	High End
Annual Wellness Visit (AWV)	$301,282	$382,187
Chronic Care Management (CCM)	367,431	622,808
Care Plan Development (CPD)	55,882	87,089
Transitional Care Management (TCM)	49,104	65,996
Advance Care Planning	33,446	58,338
Virtual Check-Ins	7,040	10,524
Internet Consultations	6,598	13,196
Combined Potential Year One Gross Revenue Projections	**$820,783**	**$1,240,138**
Less 2% for Uncollected Beneficiary Co-Payments	**$804,368**	**$1,215,336**

Expenses and Net Revenue

	Low End	High End
Combined FFS Revenue	$804,368	$1,215,336
Operating Expenses		
Billing Cost (8% of New Revenue)	$65,663	$99,211
Health Coaches (x3) for Care Management Team	161,330	161,330
Nurse Practitioner (x3) for AWV Program	324,601	324,601
Analyst	96,000	96,000
Coding and Documentation Training and Review	10,000	30,000
Consulting Fees for Program Design and Development	35,000	75,000
Initial Operating Expense Subtotal	**$692,594**	**$786,142**
Net Revenue Projection	**$111,774**	**$429,194**

Remote Patient Monitoring

- New in 2019 to reimburse for remote monitoring of beneficiary's physiologic parameters
- CPT® 99453 ($19.46) – initial set-up and patient education
- CPT® 99454 ($64.15) – monthly monitoring fee
- CPT® 99457 ($51.54) – management services
  - 20 minutes or more of clinical staff/physician/other qualified healthcare professional time in a calendar month requiring interactive communication with the patient/caregiver during the month

Open Questions

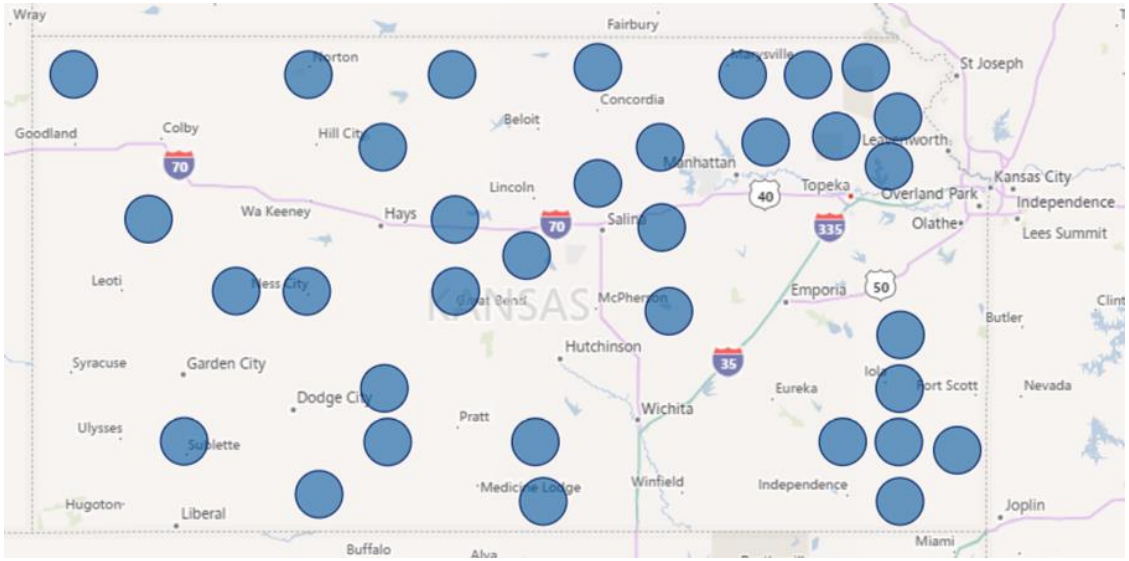
- Regulatory (CMS promises guidance forthcoming)
  - Qualifying technologies?
  - Simultaneous use of multiple technologies?
  - Medical necessity/documentation?
  - Exception monitoring?
  - Direct vs. general supervision of clinical staff?
- Practical
  - Most appropriate conditions for use of RPM?
  - Technology costs?
  - Patient acceptance?

Improving Hospital Revenue Through Continuum of Care Partnerships

Example – Returning Rural Patients to CAH Swing Beds

PYA

Kansas



285 SNFs
42 CAH Swing Beds

Methodology

Identify Swing Bed and SNF stays

Find prior inpatient admission for each Swing Bed or SNF stay – *Anchor Admission*

Include all Part A services (excluding RHC/FQHC) within 90 days of inpatient discharge - *Episode*

Compare Swing Bed and SNF episodes – *Total Cost of Care, ALOS, Readmission, Discharge Disposition*

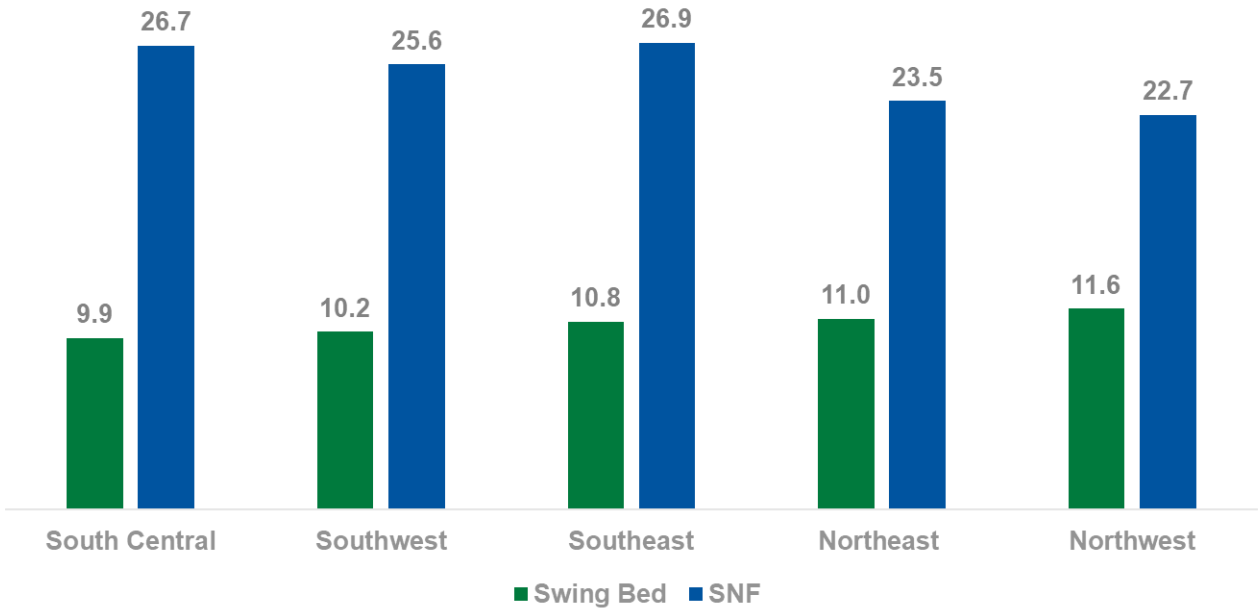
SNF Part B Expense

- Patient with severe headache requires CT scan
  - SNF: Excluded service under the SNF PPS consolidated billing requirements = add'l Part B expense
  - CAH Swing Bed: Must include on swing bed claim, regardless of reason for service, findings, or if add'l services were required
- Episode costs do not include similar SNF add'l Part B expense

Top 15 Diagnoses

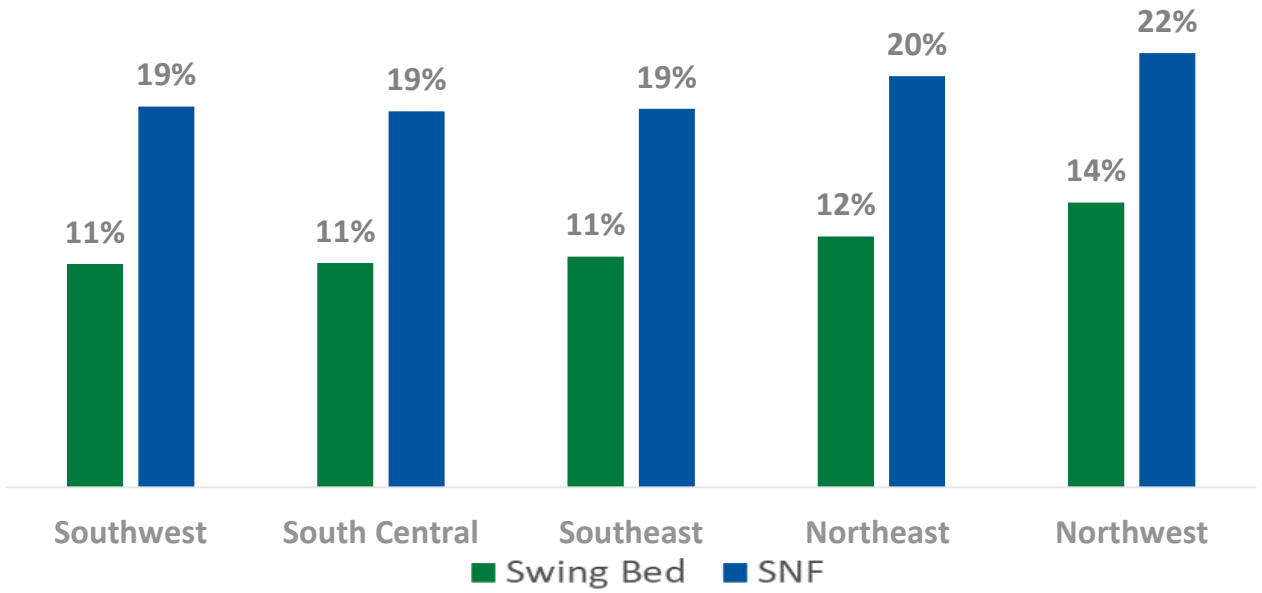
Swing Bed Admitting Diagnosis Code	Diagnosis Description	Episode Volume	Average IP Anchor LOS	Average Readmission LOS	Average Swing Bed LOS per Episode	Average Swing Bed LOS per Discharge	Average Other Post Acute Services	Average Swing Bed Total Cost of Care	Average SNF Total Cost of Care
V5789	Rehabilitation proc NEC	1,104	4.8	0.6	19.1	14.8	7.7	$29,846	$21,427
V571	Physical therapy NEC	402	4.5	0.8	17.2	14.7	8.2	$32,305	$18,670
486	Pneumonia, organism NOS	267	4.2	1.1	13.1	10.6	5.4	$21,326	$16,490
5990	Urin tract infection NOS	106	3.7	0.6	18.8	14.1	6.4	$21,497	$16,252
4280	CHF NOS	102	4.4	1.3	15.1	12.4	5.3	$26,871	$16,963
Z5189	Encounter for other specifie	100	4.1	0.0	28.8	12.1	1.1	$19,233	$17,116
49121	Obs chr bronc w(ac) exac	89	3.8	1.1	12.3	10.7	4.7	$20,377	$15,782
78079	Malaise and fatigue NEC	86	5.0	0.5	19.7	15.7	7.4	$27,690	$16,841
J189	Pneumonia, unspecified org	79	4.9	0.2	9.4	9.0	0.6	$12,906	$10,620
72887	Muscle weakness-general	66	4.6	0.8	11.7	11.7	12.5	$34,310	$20,239
Z471	Aftercare following joint rep	66	3.5	0.0	10.8	10.8	1.6	$18,763	$13,228
6826	Cellulitis of leg	53	4.3	0.5	16.6	13.4	8.4	$24,818	$15,761
R531	Weakness	52	6.2	0.1	12.3	12.3	1.5	$23,024	$11,596
V5481	Aftercare joint replace	35	5.2	0.0	12.3	12.0	9.1	$35,480	$19,569
N390	Urinary tract infection, site r	34	5.7	0.0	10.1	10.1	3.6	$16,283	$14,436

Regional Comparison – ALOS



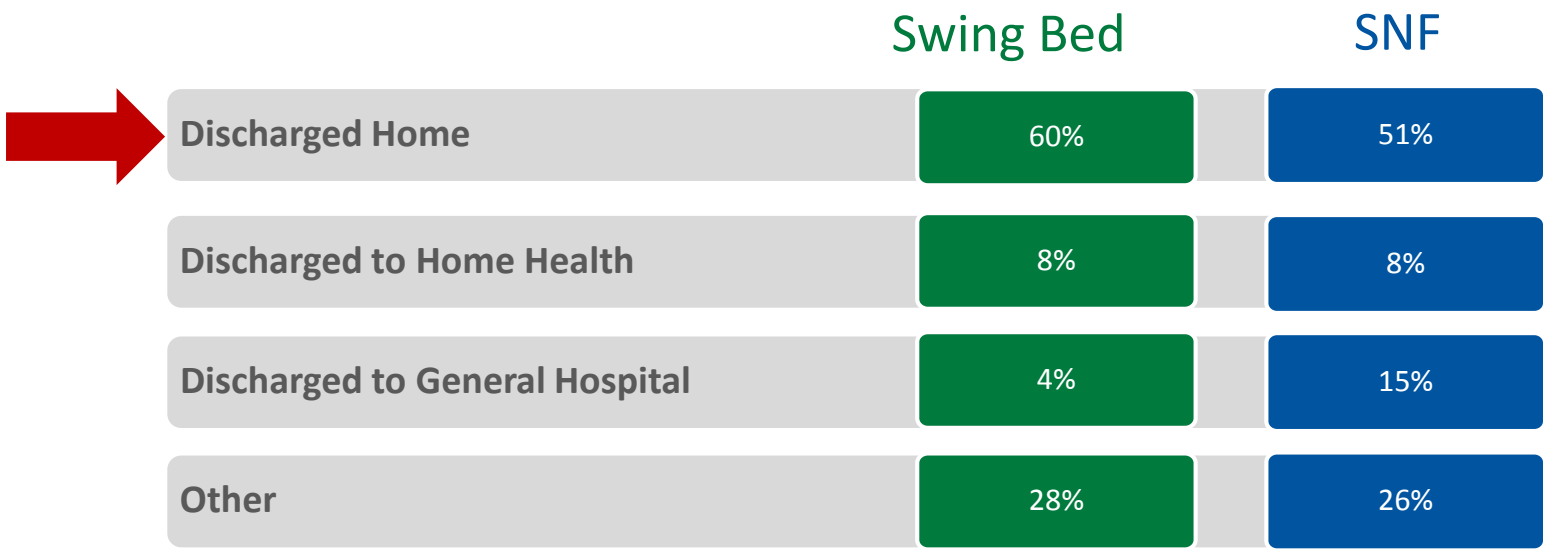
Swing Beds stays are ~***14 days less*** than SNF stays

Readmission Rate



Swing Beds have ~***7% lower readmission rates*** than SNFs

Discharge Disposition Comparison



Facility Comparison

			Regional Comparison - Swing Bed vs SNF		
Swing Bed Facility	Region	Episode Volume	Readmission Rate Variance	Average Total Cost of Care Variance	Average Swing Bed LOS per Admission Variance
Facility F	Southwest	127	-7.1%	-$5,064	-17.2
Facility H	Northeast	109	-13.1%	-$3,064	-12.4
Facility I	Northeast	109	-14.0%	-$5,255	-12.6
Facility J	Northwest	95	-7.9%	-$6,925	-15.2
Facility K	Northeast	93	-5.4%	-$105	-14.7
Facility O	Northeast	75	-5.8%	-$7,784	-17.8
Facility P	South Central	71	-11.7%	-$6,913	-17.3
Facility R	Northwest	64	-1.3%	-$2,047	-11.4
Facility X	Southeast	50	-10.8%	-$3,844	-19.9
Facility Z	South Central	44	-5.1%	-$3,690	-18.8
Facility AC	Northeast	41	-13.1%	-$2,940	-9.8
Facility AQ	Northeast	18	-9.4%	-$658	-12.4

Readmission Rates

86% of CAHs outperform SNF peers

Total Cost of Care

29% of CAHs outperform SNF peers

Average Length of Stay

98% of CAHs outperform SNF peers

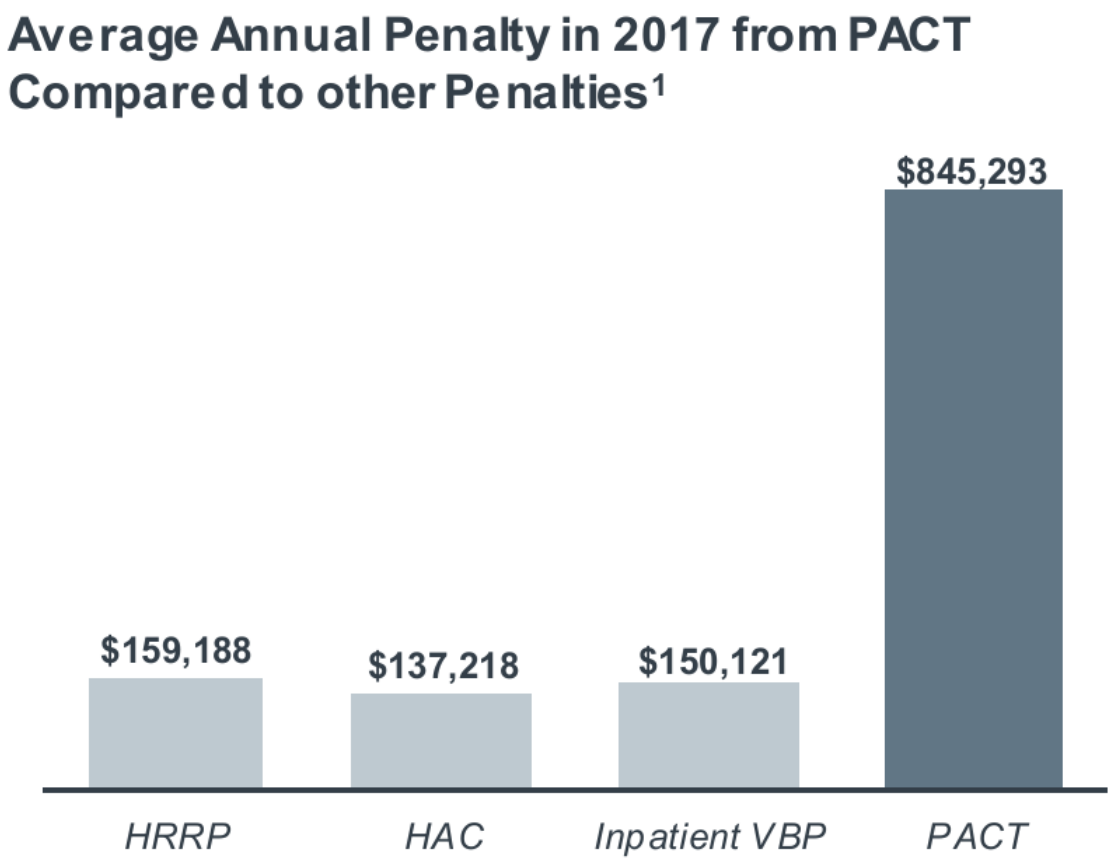
Swing Bed Value Equation

- Hospital readmission ✓
- Return to community ✓
- Average LOS ✓
  - Beneficiary out-of-pocket
- Process of care/teamwork ✓
  - Staffing levels
  - Lab and radiology
- Adverse events
  - Infections, falls, pressure ulcers, use of antipsychotic medications
- Patient experience of care/patient satisfaction
- Functional status
  - Need for assistance with ADLs (initial assessment vs. discharge)

Continuum of Care

- PPS hospitals' competing priorities
  - Reduce Medicare bed days beyond mean geometric LOS
  - Reduce readmissions
- Post-Acute Care Transfer Policy
  - When PPS hospital patient with LOS < geometric mean is transferred, hospital receives per-diem rate (for specified MS-DRGs)
    - Skilled nursing facilities
    - Inpatient rehab facilities and units
    - Long term care hospitals
    - Psychiatric hospitals and units
    - Children's and Cancer hospitals
    - Home with a home health plan of care that begins within 3 days
    - Hospice care (effective 10/1/18)
  - Transfer to swing bed *not* included

PACT's Impact on PPS Hospitals



1) The Advisory Board (2018)

Swing Bed → Transitional Care

- High quality post-acute care for challenging patient populations
  - Wound care, respiratory support, intravenous treatment, cardiac monitoring, pain management, complex tube feedings
- Benefits
  - Community hospital setting (vs. nursing home)
  - Closer to family and friends
  - Focus on successful return to home
  - Integration with referring acute care hospital

CAH/PPS Engagement

1. Self-assessment of performance
   - Claims data analysis
   - Documentation of adverse events
   - Patient satisfaction surveys
2. Self-assessment of capabilities
   - Available resources to provide transitional care
   - Willingness of local providers
   - Admission process
   - Transportation

Engagement, con't

3. Market analysis (potential opportunity)
   - SNFs (compare performance)
   - PPS hospitals (demonstrate savings)
4. Business plan
   - Necessary resource investment to pursue opportunities
5. Partner recruitment
   - Don't expect anyone to come knocking on your door
   - Make it easy

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