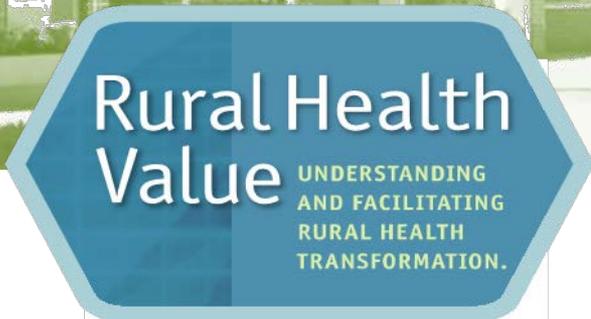




Center for Rural Health Policy Analysis



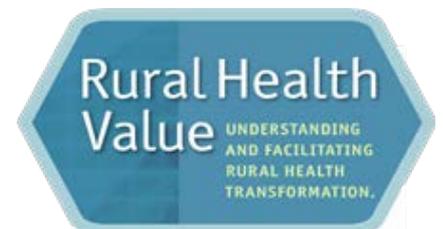
Rural Models in Value-based Care and Payment

**Flex Program Workshop
Duluth, MN**

October 18, 2016

Overview

- New payment models for *Better Care, Smarter Spending, Healthier People*
- Strategies from Rural Innovators
- Rural Health Value resources



Rural Health Value

Vision: To build a knowledge base through research, practice, and collaboration that helps create high performance rural health systems

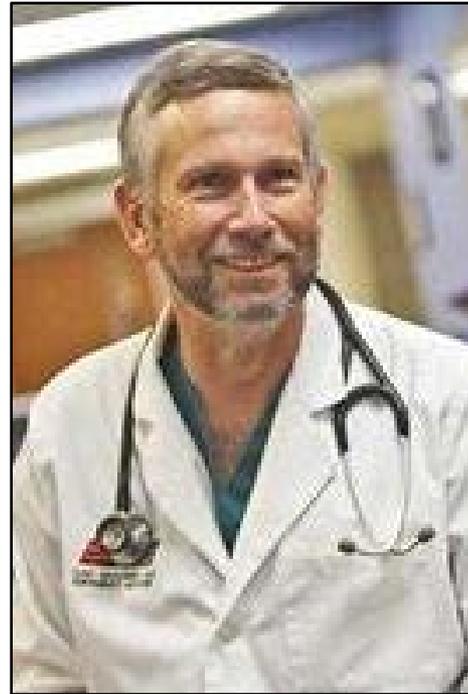
- 3-year HRSA FORHP Cooperative agreement
- Partners
 - RUPRI Center for Rural Health Policy Analysis and Strategic Health
 - Support from Stroudwater Associates, WIPFLI, and Premier
- Activity
 - Resource development and compilation, technical assistance, research



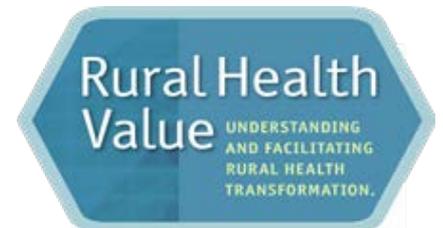
My Muses



Keith Muller, PhD

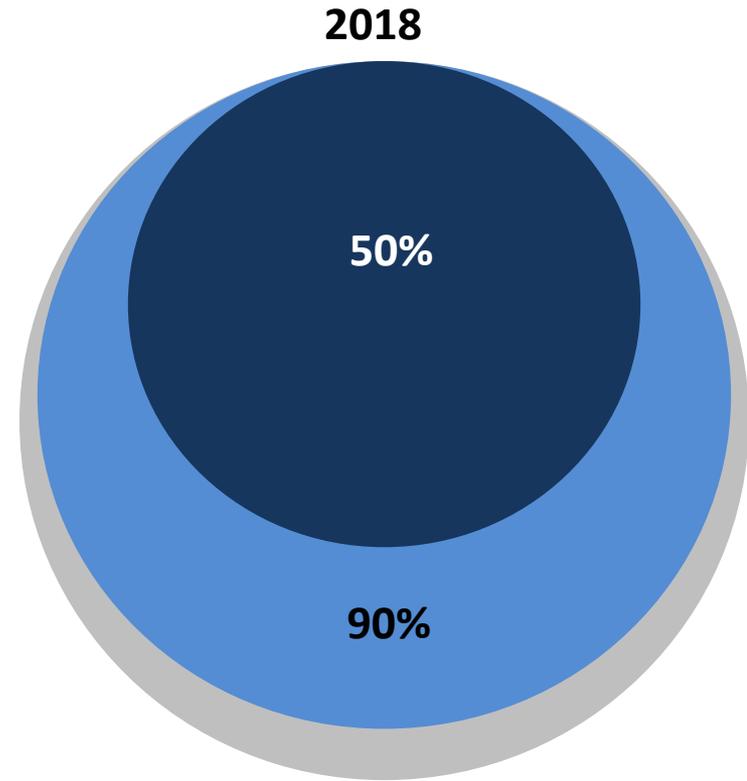
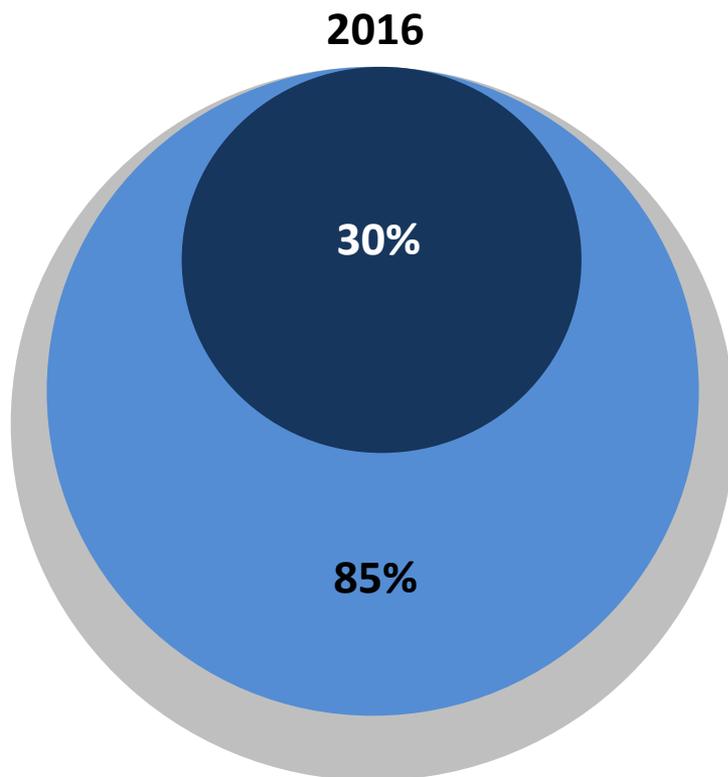


Clint MacKinney, MD, MS



Target percentage of Medicare FFS payments linked to quality and alternative payment models in 2016 and 2018

- All Medicare FFS (Categories 1-4)
- FFS linked to quality (Categories 2-4)
- Alternative payment models (Categories 3-4)



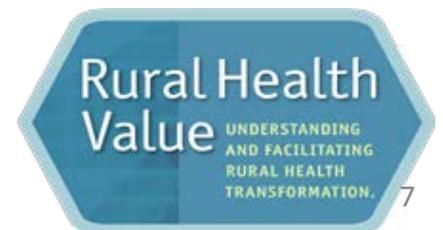
Payment Taxonomy Framework

	Category 1:	Category 2:	Category 3:	Category 4:
	Fee for Service— No Link to Quality	Fee for Service—Link to Quality	Alternative Payment Models Built on Fee- for-Service Architecture	Population-Based Payment
Description	Payments are based on volume of services and not linked to quality or efficiency	At least a portion of payments vary based on the quality or efficiency of health care delivery	Some payment is linked to the effective management of a population or an episode of care. Payments still triggered by delivery of services, but opportunities for shared savings or 2-sided risk	Payment is not directly triggered by service delivery so volume is not linked to payment. Clinicians and organizations are paid and responsible for the care of a beneficiary for a long period (e.g. ≥ 1 yr)
Medicare FFS	<ul style="list-style-type: none"> Limited in Medicare fee-for-service Majority of Medicare payments now are linked to quality 	<ul style="list-style-type: none"> Hospital value-based purchasing Physician Value-Based Modifier Readmissions/Hospital Acquired Condition Reduction Program 	<ul style="list-style-type: none"> Accountable care organizations Medical homes Bundled payments Comprehensive primary care initiative Comprehensive ESRD Medicare-Medicaid Financial Alignment Initiative Fee-For-Service Model 	<ul style="list-style-type: none"> Eligible Pioneer accountable care organizations in years 3-5

Evolution of Medicare Payment Through Four Categories

- Fee-for-service with no link to quality
- Fee-for-service with link to quality
- Alternative payment models built on fee-for-service architecture
- Population-based payment

CMS Slogan: Better Care, Smarter Spending, Healthier People



CMS Slogan: **Better Care, Smarter Spending, Healthier People**

- **Medical Home Models:**
 - Comprehensive Primary Care Initiative (ending 2016)
 - Multi-payer Advanced Primary Care Initiative (extended through 2016)
 - Federally-Qualified Health Center Advanced Primary Care Practice (ended 2014)
- **Medicare Care Choices:** 141 Hospice providers. Beneficiaries can access hospice services with concurrent curative care (palliative care)
- **Transforming Clinical Practice Initiative:** designed to support 150,000 clinician practices over next 4 years in comprehensive quality improvement strategies through Practice Transformation Networks (PTNs) and Support and Alignment Networks (SANs)



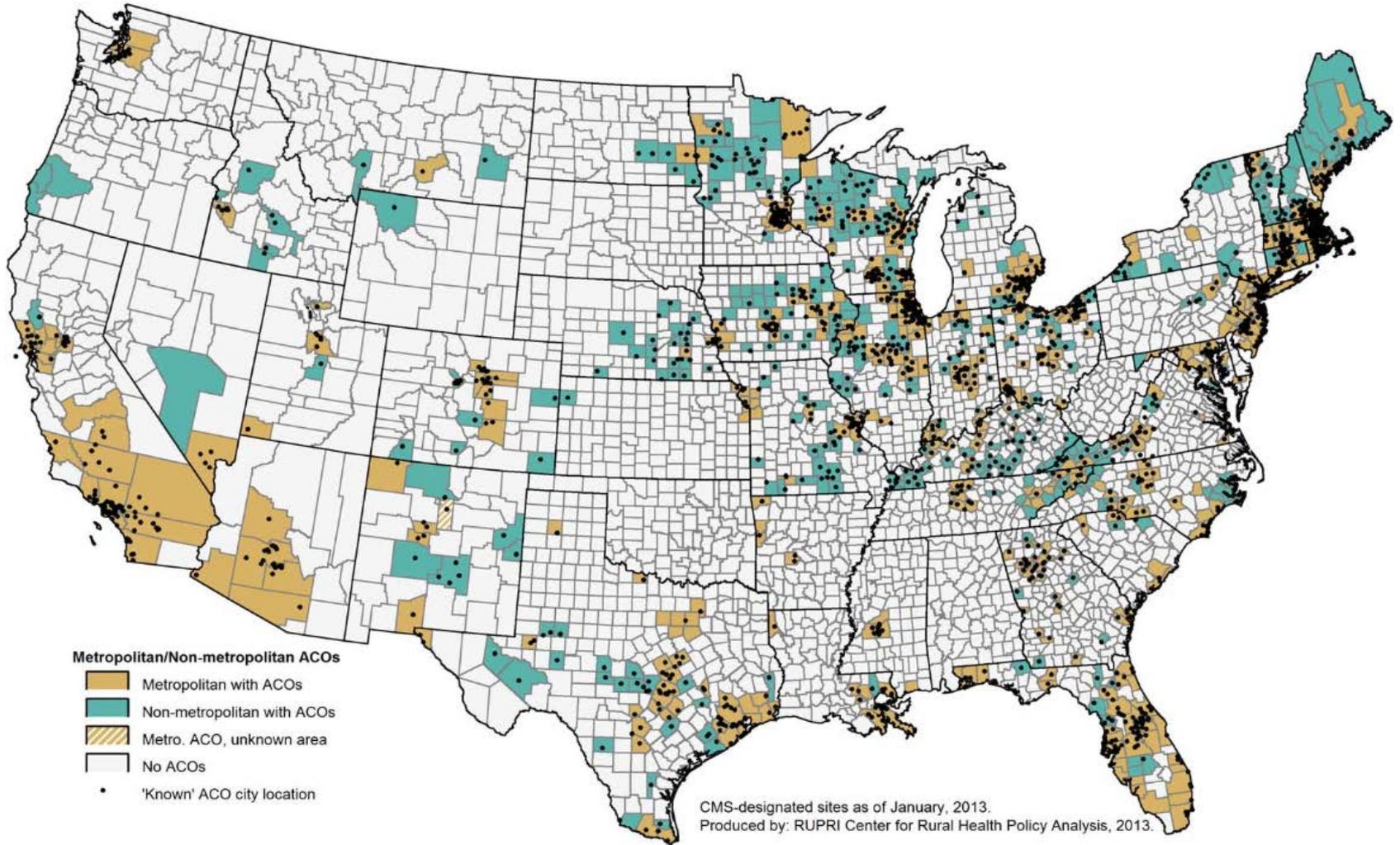
CMS Slogan: Better Care, Smarter Spending, Healthier People

- **Pay for Value with Incentives:** Hospital-based Value Based Purchasing (VBP), Hospital Readmissions Reduction, Hospital-Acquired Condition Reduction program, Home Health VBP (9 states)
- **New payment models:** Accountable Care Organizations, Bundled Payments for Care Improvement
 - [Frontier Community Health Integration Project \(FCHIP\)](#)

Resource on payment models: <http://kff.org/report-section/payment-and-delivery-system-reform-in-medicare-a-primer-executive-summary/>

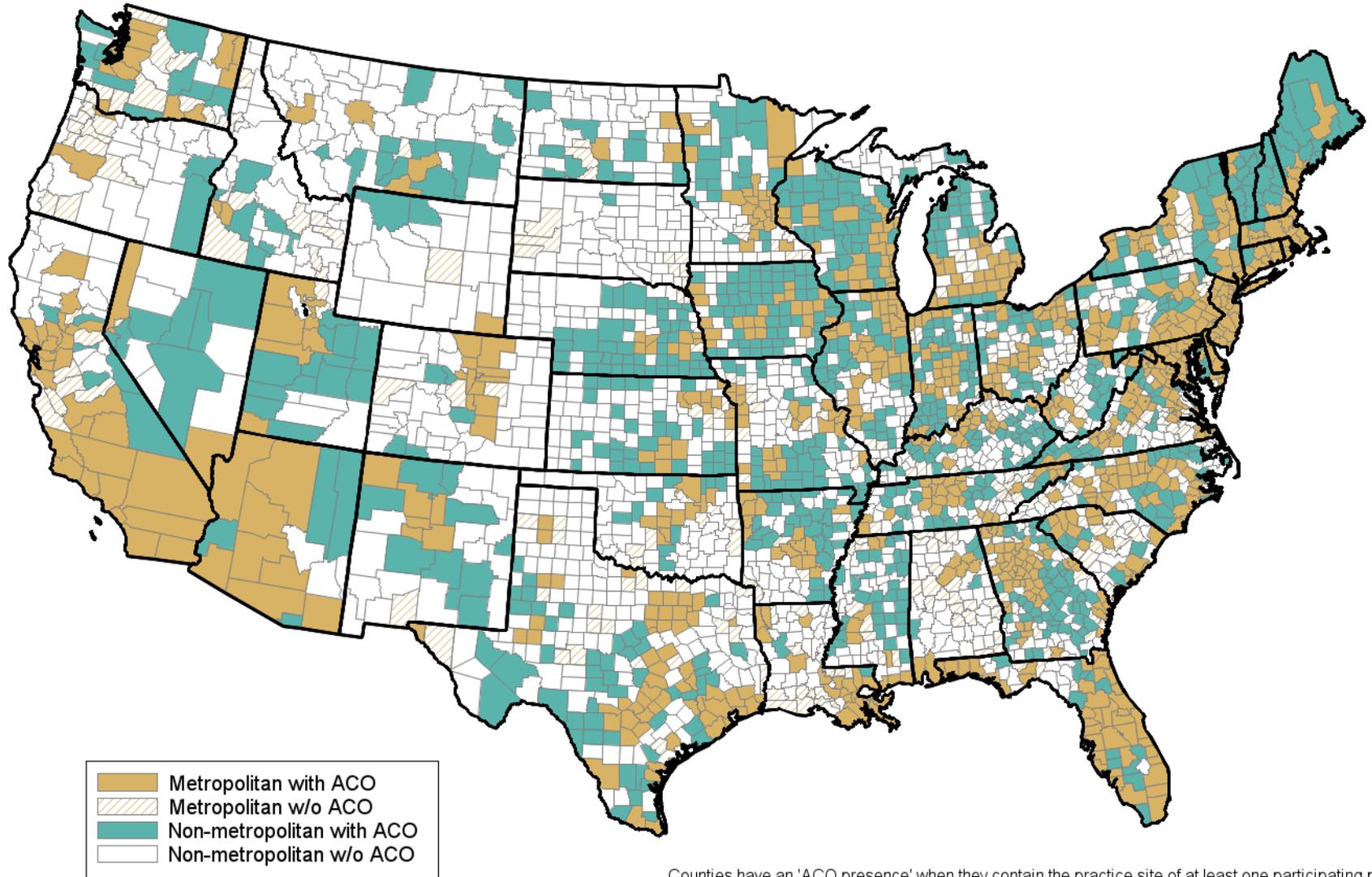


County Medicare ACO Presence Continental United States



County Medicare ACO Presence

Continental United States



Counties have an 'ACO presence' when they contain the practice site of at least one participating provider.
Includes all active CMS ACOs as of August, 2015.
Produced by: RUPRI Center for Rural Health Policy Analysis, 2016.

CMS Slogan: Better Care, Smarter Spending, **Healthier People**

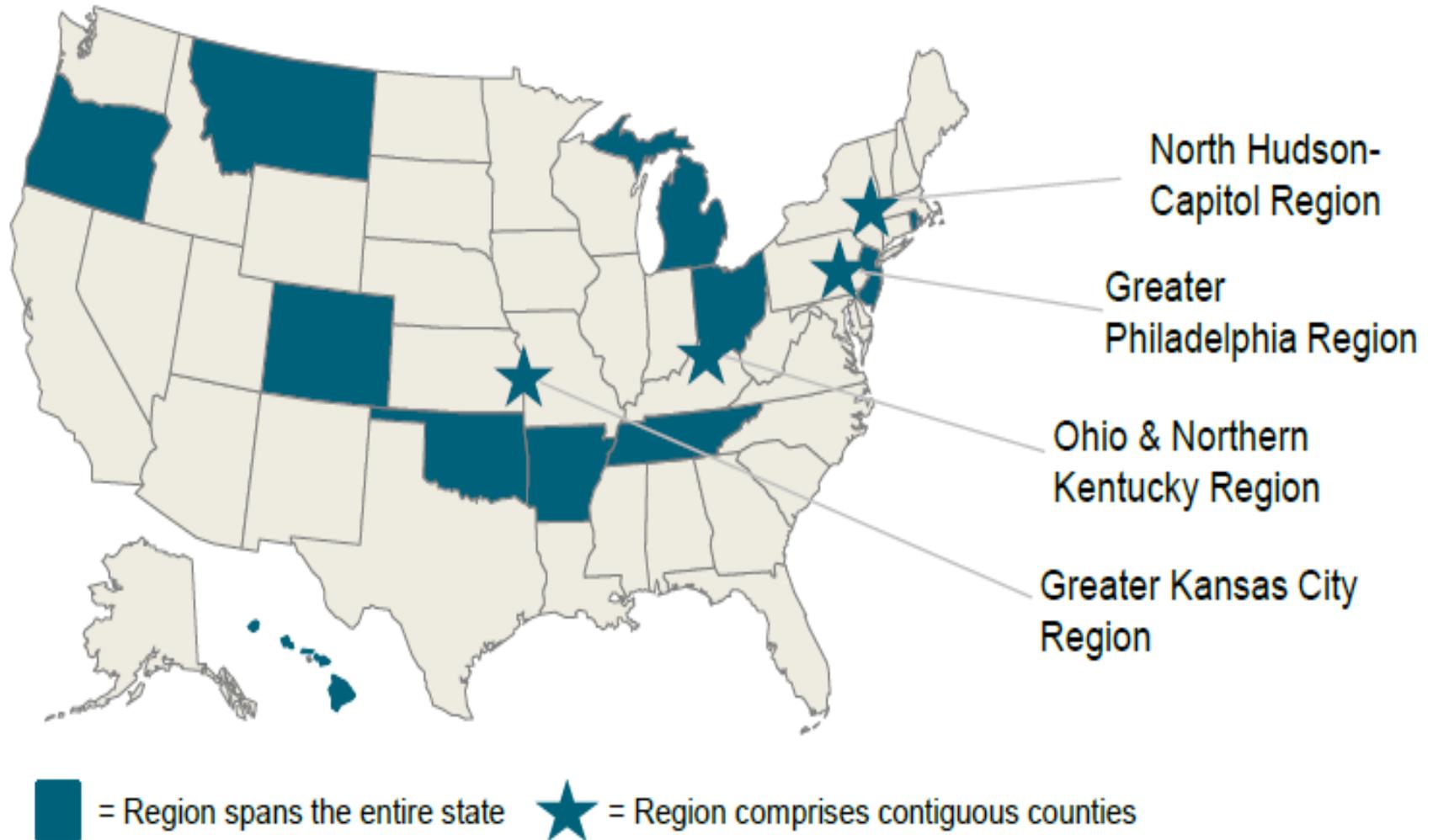
- **Million Hearts Initiative** focused on preventing heart attacks and stroke
- **Accountable Health Communities** focused on enhanced clinical-community linkages to addressing health-related social needs
- **Medicare Diabetes Prevention Program** (preventive service model under development)

And it just keeps coming...

- Medicare Access and CHIP Reauthorization Act (MACRA) Quality Payment Program (QPP):
 - Medicare Incentive Payment System (MIPS) - Alignment of programs to measure quality of physician care, and pay accordingly
 - Advance Payment Models (APMs): Incentive for providers to increase financial risk sharing
- Comprehensive Primary Care Plus Initiative (CPC+):
 - 14 regions including up to 5,000 practices, more than 20,000 doctors and clinicians (participants announced late 2016)
 - Multi-payer participation required
 - “(At CMS), we see CPC+ as the future of primary care in the US...”⁽¹⁾
- Regional Multi-Payer Prospective Budgets – CMS Request for Information (RFI)

⁽¹⁾<https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2016-Press-releases-items/2016-08-01.html>

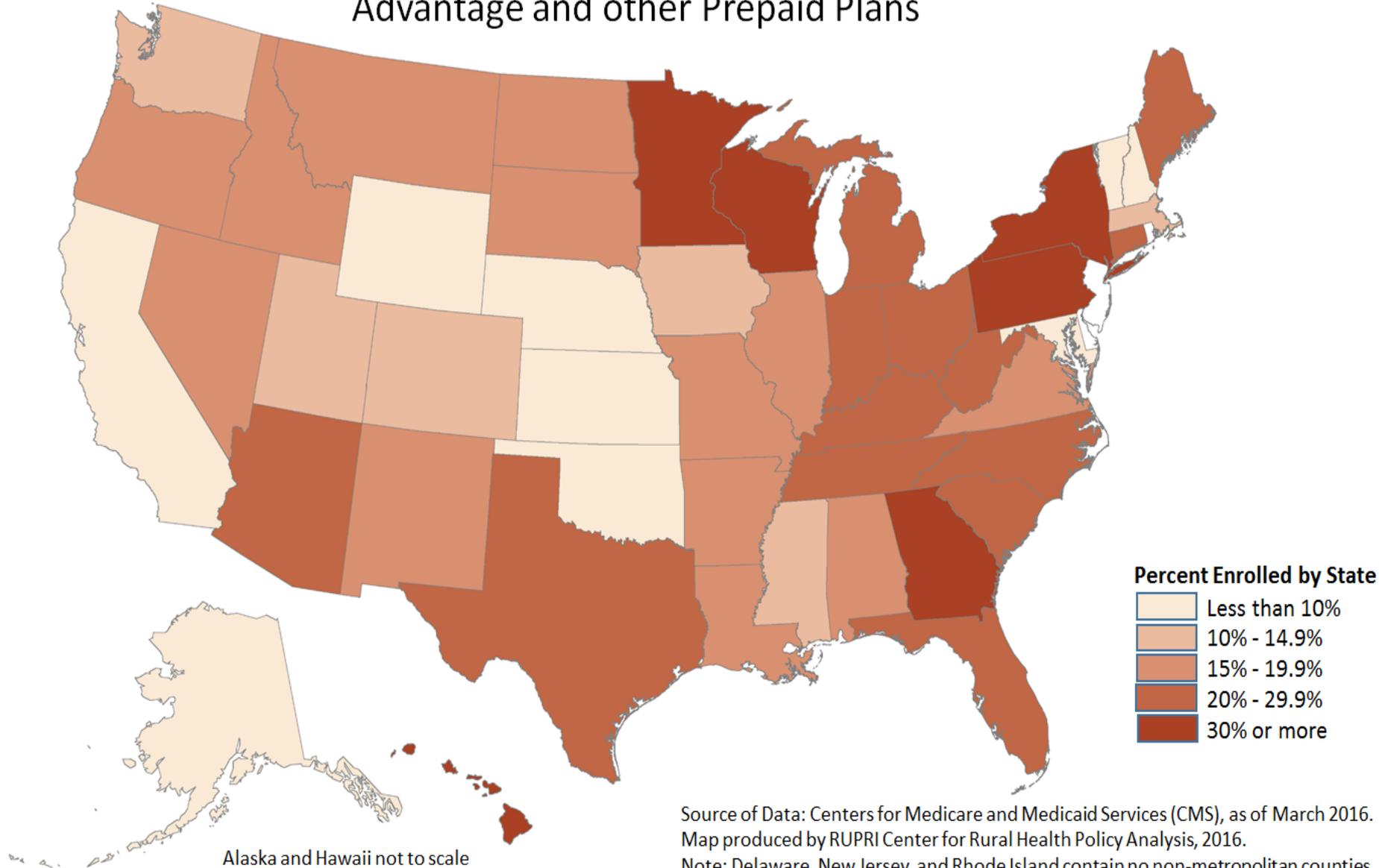
CPC+ Eligible Regions



CMS Models Only Part of the Story

- Growth in Medicare Advantage
 - *Rural* enrollment in 2016: 2.2 million (21.8%)
- State Medicaid Program Redesign
 - Managed Care
 - ACO-type payment structures
- Commercial/Private Insurance
 - Increasing costs/patient risk-sharing
 - Narrow networks

Percent of Eligible Rural Beneficiaries Enrolled in Medicare Advantage and other Prepaid Plans

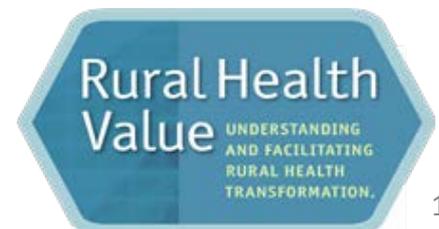


Keeping the End in Mind

Characteristics of a High Performance Rural Health Care System:

- **Affordable**: to patients, payers, community
- **Accessible**: local access to essential services, connected to all services across the continuum
- **High quality**: do what we do at top of ability to perform, and measure
- **Community based**: focus on needs of the community, which vary based on community characteristics
- **Patient-centered**: meeting needs, and engaging consumers in their care

<http://www.rupri.org/wp-content/uploads/2014/09/The-High-Performance-Rural-Health-Care-System-of-the-Future.pdf>

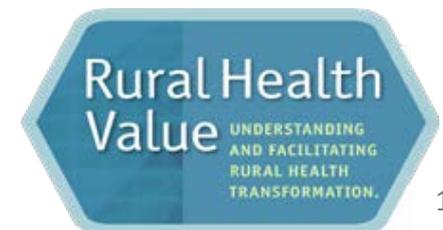




Strategies to Support Innovation: Lessons From the Field

- Reflect a climate of necessity
- Identify resources and funds to test and initiate change
- Find and use the innovators in your community—the people who make it happen
- Encourage creativity, with a focus on meeting individual patient needs

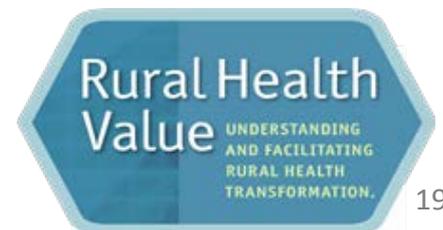
Resource: Rural Health Value - [Innovation in Rural Health Care: Contemporary Efforts to Transform into High Performance Systems](#)





www.RuralHealthValue.org

- [Physician Engagement - A Primer for Healthcare Leaders](#)
- [Engaging Your Board and Community in Value-Based Care Conversations](#)
- [Critical Access Hospital Financial Pro Forma](#)
- [Value-Based Care Assessment Tool](#)
- [Understanding the Social Determinants of Health: A Self-Guided Learning Module for Rural Health Care Teams](#)
- [Using Data to Understand Your Community](#)
- [Rural Innovation Profiles](#)

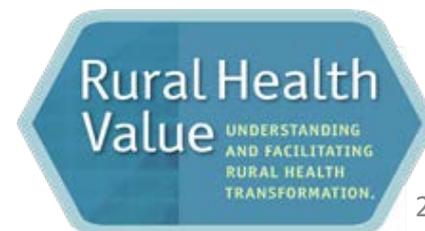


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Upcoming Tools & Resources

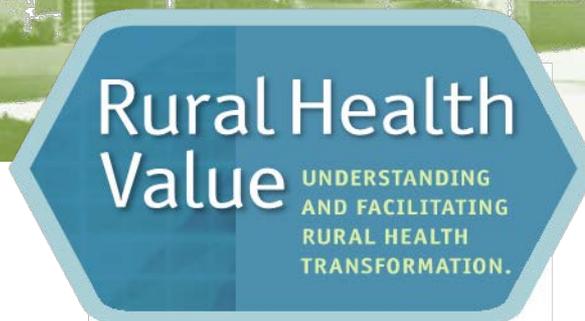
- Guide to Value-Based Initiatives for Rural Providers
- Shared Savings Contract Pro Forma
- CAH Guide: Demonstrating Value to Payers and Partners

*Be a leadership voice for rural health care value.
A positive attitude is infectious!*





Center for Rural Health Policy Analysis



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www.ruralhealthvalue.org

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