Understanding and Facilitating Rural Health Transformation

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Plan for Today

- Health care ***value***
- Risk transfer
- CMS value-based initiatives (12 total)
  - Accountable Care Organizations (ACOs)
  - Comprehensive Primary Care Plus (CPC+)
  - Physician payment reform (MACRA)
- What this means for rural
- Rural Health Value project

Consider the Big Questions

- What is CMS trying to accomplish through value-based payment?
- What does value-based payment mean for rural hospitals?
- How might value-based payment lessen, or deepen, rural/urban disparities?
- How should rural hospitals and their communities respond to value-based payment?

2017 U.S. Health Care Landscape

- Federal health care ($1.1T) equals 1/3 of all federal spending
- Of 4,862 acute care hospitals, 37% are rural
- 50% of hospital reimbursement is linked to value performance
- 1,217 value-based contracts
- Uninsured rate is the lowest *ever*
- Uncompensated hospital care cost is the lowest in 26 years

Murphy, Brooke. 50 Things to know about the hospital industry | 2017. www.beckershospitalreview.com. January 25, 2017.

What's the Future?

- "We're likely heading toward regional integrated systems of health that provide both delivery and financing of health on an at-risk basis to populations."
- "But getting from where we are to there is a messy process."

Paul Keckley

The Politics of Health Care

- Divisive and acrimonious!
- Repeal, replace, tweak?
- Predictions?
- Politics may change the pace,
  but not the direction,
  of health care reform
- → **Value**

Triple Aim Equals Value

The health care value equation (2006)

$$\text{Value} = \frac{\text{Quality + Experience}}{\text{Cost}}$$

IHI Triple Aim, CMS Three Aims

Improved community health	Better patient care	Smarter spending

What is Value-Based Payment?

- **Payment** for one or more parts of the Three-Part Aim
  - Improved community health
  - Better patient care
  - Smarter spending
- Not payment for a "service;" that is, NOT fee-for-service
- Why is value-based payment important to rural hospitals and physicians?

EY Health Advisory Survey

Significant percent of surveyed organizations are prioritizing the following initiatives:

- Elevate the patient experience
- Transform the culture
- Advance with analytic insights
- Increase productivity
- Embrace the new way to pay

Ernst & Young. Value Driven Care. Are You Ready? Insights drawn from the EY Health Advisory Survey 2017.

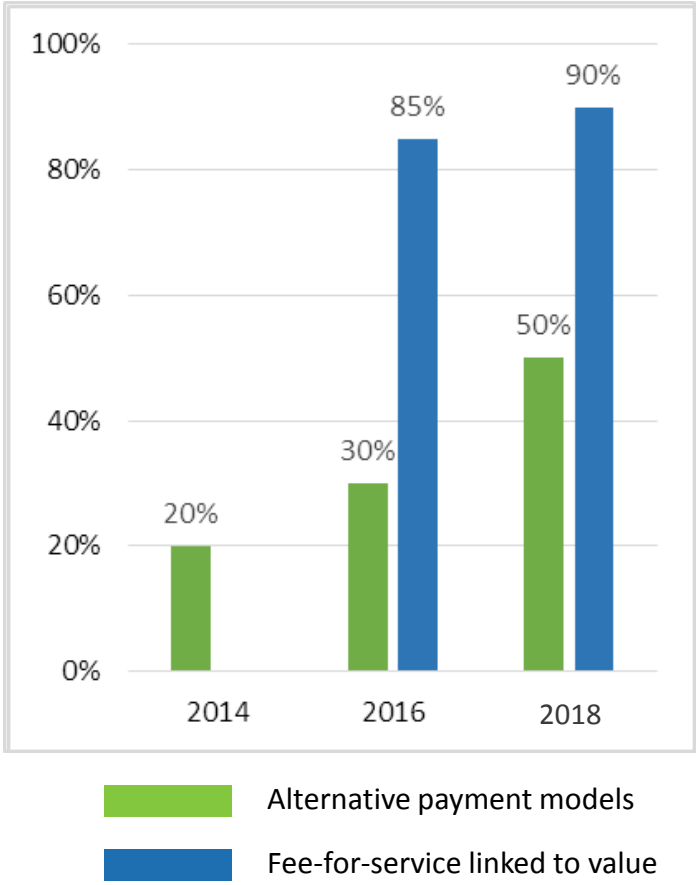
Form Follows Finance

- *How we are paid for health care determines how we deliver health care*
- CMS and other payers are reforming health care payment to reward **value**
- Fundamentally, payment reform involves **shifting financial risk** from payers to providers

CMS Payment Goals

- Alternative Payment Models
  - Shared savings program (ACOs)
  - Patient-centered medical homes
  - Bundled payments
- Remaining fee-for-service payment linked to quality/value
- Aggressive timeline favors:
  - Financial risk management experience
  - Population health care experience
  - And deep reserves for the transition
  - Yet, rural can compete in this new world, and some are already doing so

Percent of Medicare Payment Goals

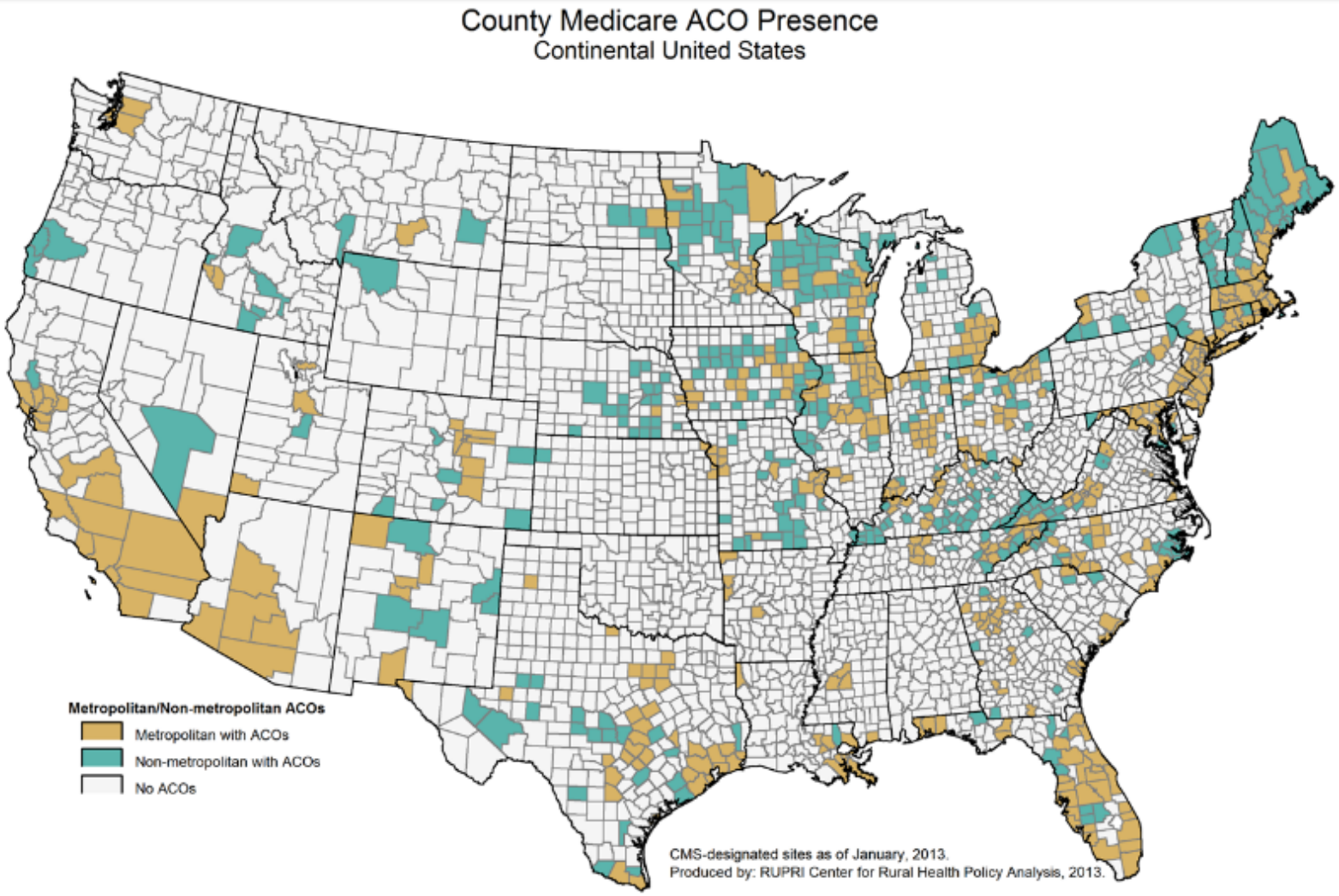


Accountable Care Organizations

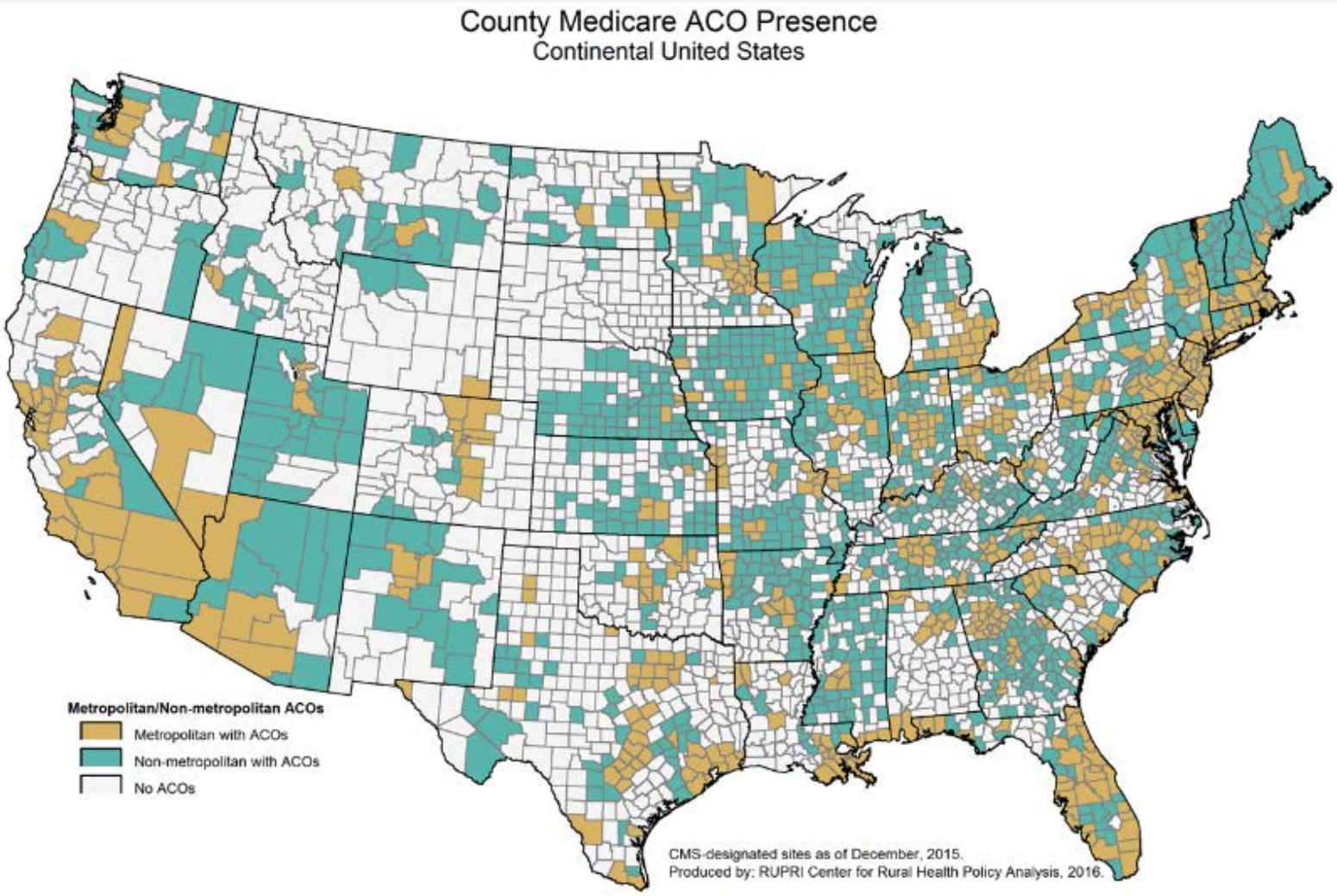
- Groups of providers (generally physicians and/or hospitals) that receive financial rewards to maintain or improve care quality for a group of patients while reducing the cost of care for those patients.
- ACOs in 2017
  - 923 public and private ACOs
  - 32 million patient enrollees
  - And growing!

David I. Auerbach, et al, Accountable Care Organization Formation Is Associated With Integrated Systems But Not High Medical Spending, *Health Affairs*, 32, no. 10 (2013):1781-1788.

2013 Medicare ACOs by County



2015 Medicare ACOs by County



ACO Penetration by State

Muhlestein, Saunders, and McClellan. Growth Of ACOs And Alternative Payment Models In 2017. Health Affairs Blog. June 28, 2017.

Early ACO Performance

- 31% received shared savings for 2015 performance (27% for 2014)
- Quality scores improved year 1 to 2, but no direct relationship to savings
- Physician-led and smaller ACOs seemed to perform better
- Greater 1st year spending reductions in independent primary care groups

Kocot and White (2016) "Medicare ACOs: Incremental Progress, But Performance Varies." *Health Affairs Blog* September 21. www.healthaffairs/blog

McWilliams et al (2016) Early Performance of Accountable Care Organizations in Medicare. *New England Journal of Medicine* April 13.

Rural ACO Performance Summary

- Financial
  - Savings associated with
    - Physician-based rural ACOs
    - Advanced Payment Program
  - No savings associated with ACO size/experience
- Quality
  - Rural ACOs performed better than urban (2014):
    - Care Coordination/Patient Safety
    - Preventive Health
    - At-Risk Population Domain scores
  - Urban ACOs performed better than rural (2014):
    - Patient/Caregiver Experience score
  - All ACOs improved quality from 2014 to 2015

Medicare ACO Updates

- Updates consistently support ACO ease-of-entry and expansion
- Except unrelenting demand for greater provider risk
  - Risk of financial loss if poor quality or patient satisfaction
- **Track 1+** is important to rural
  - Modest down-side risk
  - Prospective beneficiary assignment
  - 3-day requirement for SNF waiver
  - MACRA Alternative Payment Model eligibility

Summary of ACO Success Variables

- Physician engagement and leadership, including prior activity
- Collaboration across key providers, especially physicians and hospitals
- Sophisticated information systems
- Scale for investment or an initial outside source of capital
- Effective feedback loops to care providers

D'Aunno, Broffman, Sparer, and Kumar. (2016). Factors That Distinguish High-Performing Accountable Care Organizations in the Medicare Shared Savings Program. Health Serv Res. doi:10.1111/1475-6773.12642

Why Join an ACO

- Develop *experience*
  - (While starting small)
  - Population health management
  - Financial risk management
- Access *data*
  - All patient claims, regardless of where care is received
  - Cost per member
- Understand your *value*
  - How to influence cost/quality of care
  - How to optimize your future value

Comprehensive Primary Care Plus

- Largest primary care investment by CMMI to date
  - 2017 is first year of 5-year demo
- 2017: 2,866 practices, 13,090 physicians, 1.76 million patients
  - More joined in 2018 (Round 2)
- A *tripartite* payment system that includes: **Cap + P4P + FFS**
- Includes other payers!
- *"At CMS, we believe CPC+ is the future of primary care…"*

Changing payment to change care

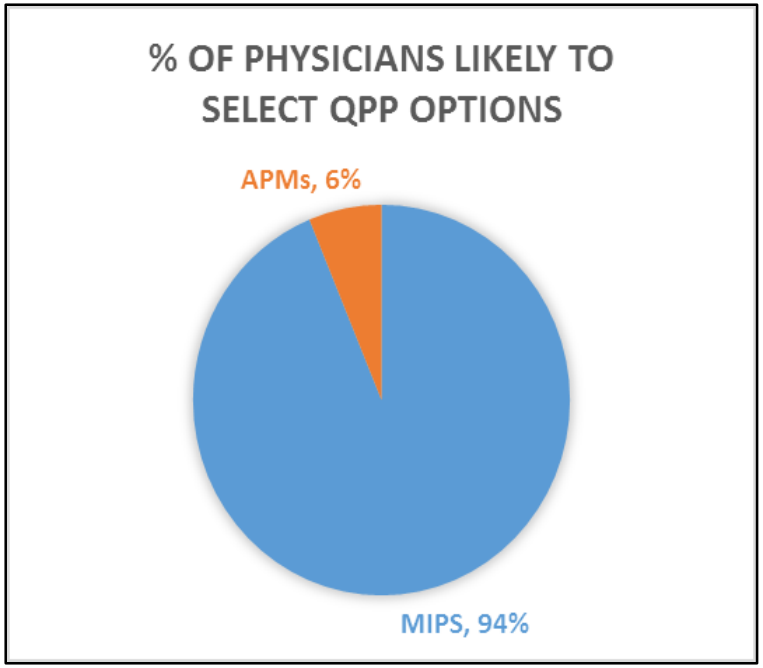
CPC+ Availability (So far!)

Medicare Access and CHIP Reauthorization Act

- Bipartisan law to replace the Sustainable Growth Rate (SGR)
  - MACRA is law – not a demonstration
- MACRA replaces
  - Physician Quality Reporting System
  - Value-Based Modifier
  - Meaningful Use
- MACRA Quality Payment Program
- **Pay increase opportunity**

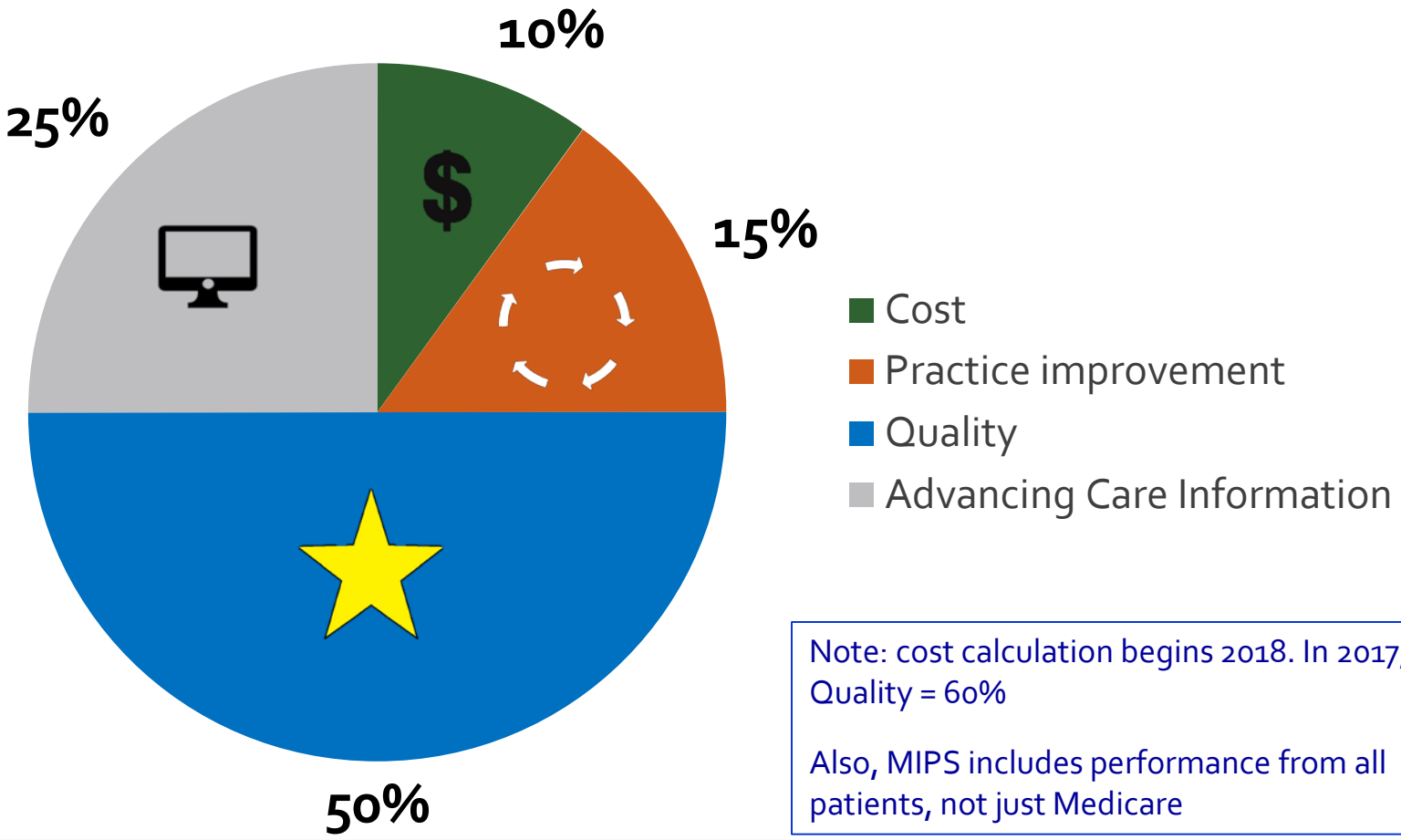
MACRA Quality Payment Program

- Two options
  - Merit-Based Incentive Payment System (**MIPS**), or
  - Advanced Alternative Payment Models (**APMs**)
- *Current* estimated distribution
  - MIPS: ~ 750,000 physicians
  - APMs: ~ 60,000 physicians
- Excluded physicians
  - < $30,000 per year Medicare billing,
  - < 100 Medicare patients per year, or
  - New to Medicare in 2017.



MIPS Bonus/Penalty Calculation

Merit-Based Incentive Payment System



Note: cost calculation begins 2018. In 2017, Quality = 60%

Also, MIPS includes performance from all patients, not just Medicare

Advanced Payment Model

- Must bear **financial risk** – risk for monetary gain or loss
- Payments based on quality comparable to MIPS
- Must use certified EHR
- Models that count as APMs
  - CPC+ (only medical home model now)
  - MSSP Tracks 2, 3 and Next Gen ACO
  - MSSP Track 1+

	2019	2020	2021	2022	2023	2024+
% Payment through APM	25%	25%	50%	50%	75%	75%
% Patients through APM	20%	20%	35%	35%	50%	50%

MACRA | Medicare Access and CHIP Reauthorization Act of 2015

Physician Payment Timeline

AMERICAN ACADEMY OF FAMILY PHYSICIANS

2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
Anticipated annual baseline payment updates-As provided by MACRA (Note: Updates are cumulative.)									
Jul-Dec +0.5	+0.5%[a]	+0.5%	+0.5%	+0.5%	0%	0%	0%	0%	0%
Current law: PQRS, MU, VBPM									
Penalty up to -3.5%	Penalty up to -6%	Penalty up to -9%	Penalty TBD						
Merit-Based Incentive Payment System (MIPS) Adjustments made on sliding scale based on performance in prior time period TBD									
Baseline payment adjustment[b]				(-/+) 4%	(-/+) 5%	(-/+) 7%	(-/+) 9%	(-/+) 9%[c]	(-/+) 9%[c]
Maximum payment adjustment for high performers				+12%	+15%	+21%	+27%	+27%[c]	+27%[c]
Exceptional performers may be eligible for an additional positive payment adjustment of up to 10%.[d]									
Alternative Payment Models (APMs) 5% annual bonus – Paid in lump sum Participants are exempt from MIPS.									

Legend

MU = Meaningful use
PQRS = Physician Quality Reporting System
VBPM = Value-Based Payment Modifier
RVU = Relative Value Unit

[a] The projected 0.5% update, established by MACRA, was negated due to other legislative provisions. As a result, the 2016 conversion factor will be $35.82 instead of $35.93, which is a net reduction of 11 cents per Relative Value Unit (RVU).

[b] Lowest quartile performers automatically receive the maximum negative payment adjustment.

[c] Payment adjustment listed for 2023 through 2024 is an assumption based on currently available information.

MIPS Maximum Bonus/Penalty

Advisory Board. Your Questions answered about the MACRA Final Rule. January 31, 2017.

MACRA *Proposed* Regulations

- Exclude < $90,000 or < 200 patients
  - Only 36% of clinicians eligible for MIPS
- New options for APM participation
  - ACO and CPC+ expansions
- Bonus for small practices
- Solo practitioner and/or small practices can form *virtual groups*
- Gradual implementation cost controls
- Summary: ***Regulatory flexibility***
  - Is that a good thing?

MIPS for Track 1 ACOs

- No down-side risk in Track 1
  - Almost all rural ACOs here now
- MACRA is budget neutral
  - Might ACOs tilt payment favorably?
- ACO quality scored as a **group**
  - Only primary care scored; specialists are carried along
  - ACOs already perform well
  - Advancing Care Info scored separately
  - Full credit for Practice Improvement
- Cost domain not included for ACOs
  - Other 3 domains weighted higher

New Physician Payment Reality

- Minimal FFS payment increase
  - 0.5% x 5 years, then 0% x 5 years
  - Actually payment decrease (inflation)
- Merit-Based Incentive Payment System
  - Eventually **-9%** to **+27%** adjustment in pay
  - Plus, up to **10%** Exceptional Performance Incentive Payment (budget neutral exclusion)
  - Up to **46%** payment differential between high and low performers in 2024!
- Or, 5% APM bonus
  - Excluded from MIPS performance reporting requirements

Preparing for Value-Based Payment

- Requires new organizational skills and resources
- Invest in value-based care capacity building (like R+D)
- *Discriminating* approaches
  - Environmental insights
  - Sophisticated projections
  - Thoughtful experiments
  - Learning continuously
- ***Balance*** optimizing operations and testing new ideas

The Enduring Shift to Value

- MACRA is bipartisan, and the law
- ACOs have expanded rapidly
- CMMI and the states – the new crucibles of innovation
- CPC+ is the "future of primary care"
- Commercial payers are engaged
  - **Aetna:** >45% payments linked to value
  - **UnitedHealth Group:** >45% linked to value-based care
  - **Anthem:** 58% in alternative payment models

What This Means and Portends

- Politics will change the *pace* of payment reform, not the *direction*
- Gradual devaluation of fee-for-service payment (RIP)
- Relentless shift of financial risk from payers to providers
- Three-Part Aim has financial teeth
- Favors provider experience and resources to weather change
- **Risk of rural exclusion**

Returning to Basics

- Think beyond “medical” care
- Consider *total* cost of care
- Employ care management to change utilization patterns
- Begin to think of revenue as a function of enrolled lives and shared risk
- Understand the end game: **better care, better health, lower cost**

Rural Health Value Project

- Project Goal
  - To facilitate rural provider and community transitions from volume-based to value-based health care and payment
- **Rural Health Value** resource examples
  - Value-Based Care Strategic Planning Tool
  - Physician Engagement Primer for Health Care Leaders
  - Demonstrating CAH Value: A Guide to Potential Partnerships
  - Critical Access Hospital Pro Forma for Shared Savings (ACO)
  - Engaging Your Board and Community in Value-Based Care Conversations
  - Profiles in Rural Health Care Innovation
- www.ruralhealthvalue.org

Resources

- Rural Health Value – www.ruralhealthvalue.org
  - Tools and resources to assist rural providers and communities transition from volume-based care to value-based care
- Rural Health Information Hub – www.ruralhealthinfo.org
  - Access to current and reliable resources and tools to help learn about rural health needs and work to address them
- National Rural Health Resource Center – www.ruralcenter.org
  - Technical assistance and knowledge resources in rural health
- Rural Health Research Gateway – www.ruralhealthresearch.org
  - Easy and timely access to research conducted by the Rural Health Research Centers