Value-Based Care Strategic Planning Tool

Small Rural Hospital Transition
HELP Webinar
February 4, 2016

NATIONAL RURAL HEALTH RESOURCE CENTER

RUPRI RURAL POLICY RESEARCH INSTITUTE

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THE UNIVERSITY OF IOWA

Rural Health Value Project

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

- Partners
  - Second 3-year FORHP Cooperative Agreement
  - RUPRI Center and Stratis Health
  - Support from Stroudwater Associates, WIPFLI, and Premier
- Activities
  - **Tool & Resource** development, compilation, and dissemination
  - Technical assistance
  - Research

Four Converging Forces

- Price reduction threats and volume reduction pressures
- Expanding insurance coverage, but narrower networks
- Increasing quality of care measures and accountabilities
- Widespread healthcare provider affiliations

Triple Aim© Equals Value

The healthcare value equation (2006)

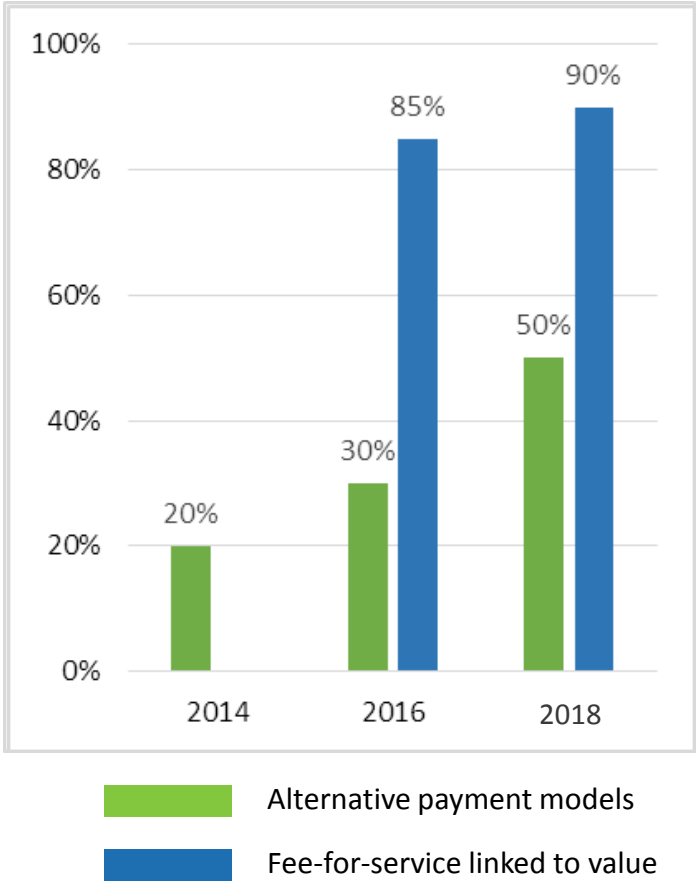
$$\text{Value} = \frac{\text{Quality + Experience}}{\text{Cost}}$$

- And healthcare payment is changing to reward **value**

CMS Payment Goals

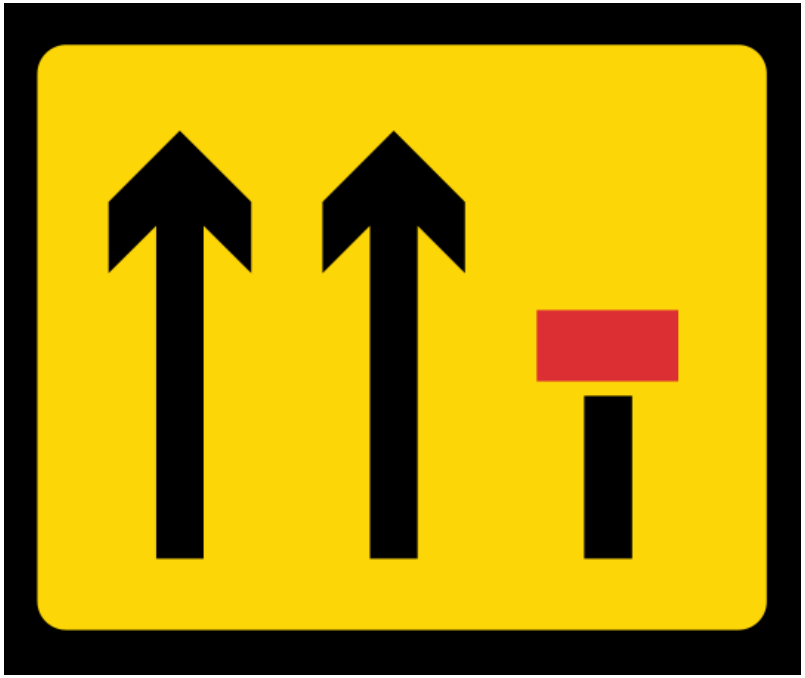
- Alternative Payment Models
  - Shared savings program (ACOs)
  - Patient-centered medical homes
  - Bundled payments
- Remaining fee-for-service payment linked to quality/value
- Aggressive timeline favors:
  - Financial risk mgmt. experience
  - Population health mgmt. experience
  - and deep pockets
  - Yet, rural can compete in this new world

Percent of Medicare Payment Goals



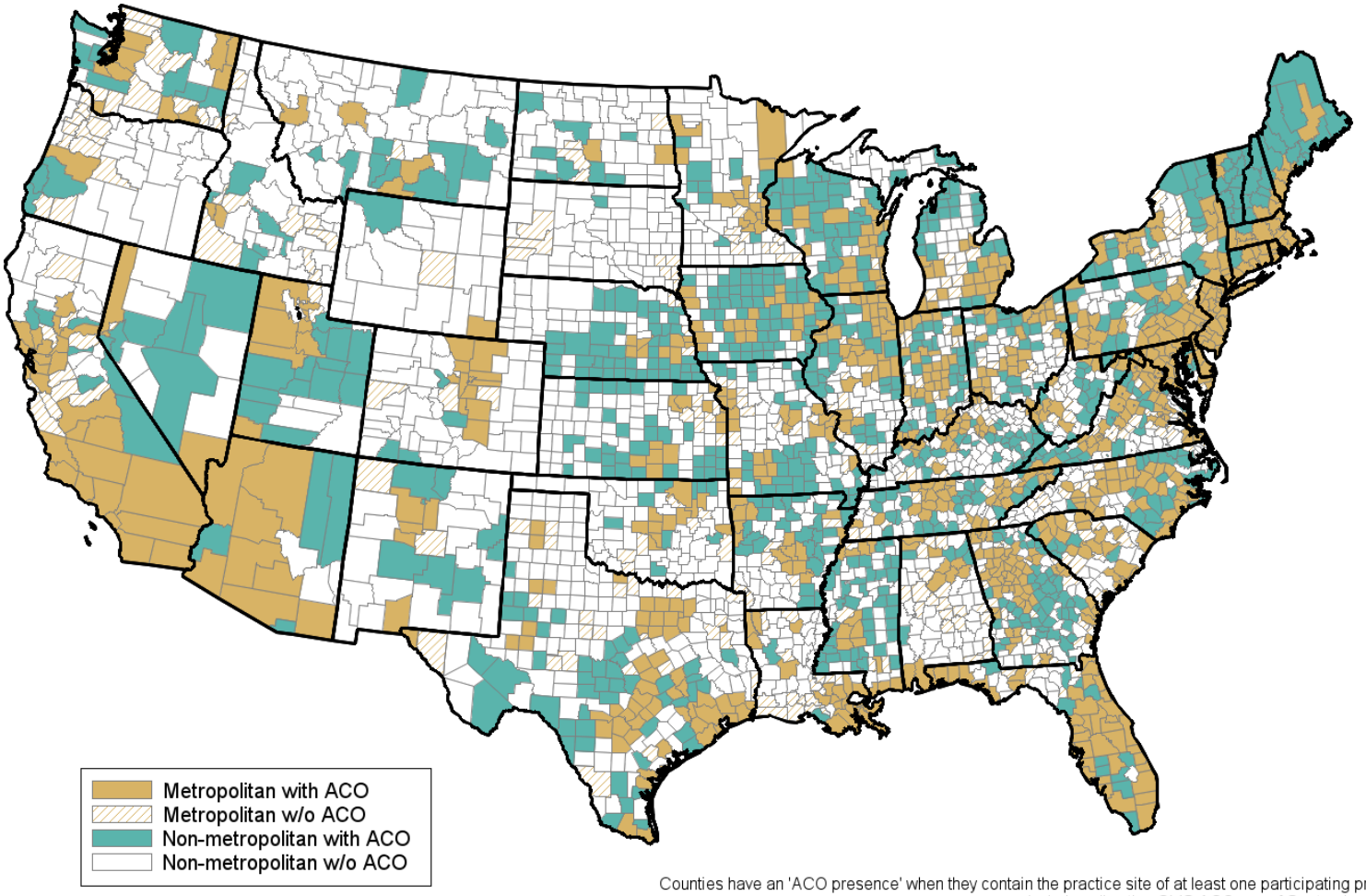
Accountable Care

- Accountable care
  - *Monetizing the value derived from increasing quality and reducing costs*
- Different "this time"
  - Providers monetize value
  - New information systems to manage costs and quality
  - Evidence-based protocols
  - No going back
- APMs pay for **value**
  - That is, value-based payment
  - Fee-for-service and cost-based reimbursement pay for volume



ACOs **Bundled** **FFS**

Medicare ACO County Presence



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

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Value-Based Payment Expansion

- 700+ public and private ACOs
  - 20+ million patients
  - 400+ Medicare ACOs
  - Medicare ACOs in 49 states and DC
- 40% of 2014 commercial payments linked to **value** (11% in 2013)[1]
  - Commitment to 75% by 2020[2]
- Value-based payment has legs!
  - Maybe not ACOs…
  - ACOs are *pointing the way* to replace FFS
  - Accountable care *communities*?

[1]2014 commercial, in-network payments. http://www.catalyzepaymentreform.org/images/documents/nationalscorecard2014.pdf
[2]Healthcare Transformation Task Force – a national consortium of providers, payers, purchasers, and patients. http://www.hcttf.org/

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
    - Based on quality, resource use, meaningful use, and clinical practice improvement activities
  - Exceptional Performance Incentive Payment
  - Up to **36%+** differential per year!
- **Or, 5% APM bonus**
  - Excluded from MIPS and most meaningful use
  - Physician risk level requirement TBD

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.
[d] Exceptional performance criteria has not been defined.

December 2015

Value-Based Care

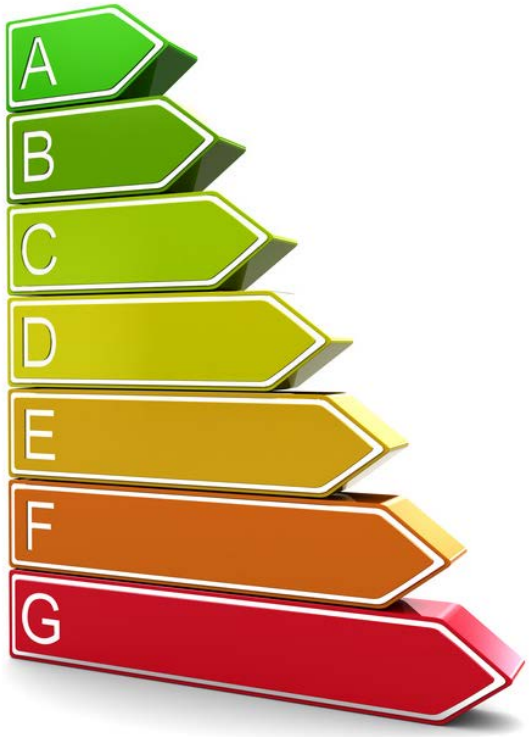
- Value-based care (VBC)
  - Health care that improves clinical quality, increases community health, and uses resources wisely
- Value-based care *capacity*
  - Resources, processes, policies, infrastructure, etc. required to deliver VBC
- VBC Tool
  - The online tool developed by the Rural Health Value Team to assess VBC readiness

VBC Tool Purpose

- Assist rural healthcare organizations develop *value-based care* capacity
- Educate leaders, directors, stakeholders
- Prioritize action as part of strategic planning
- Identify tools and resources to benefit rural healthcare people, places, and providers

VBC Tool Design

- An online assessment tool
- Designed to assess 121 value-based care *capacities* grouped in eight *categories*
  - Governance and Leadership
  - Care Management
  - Clinical Care
  - Community Health
  - Patient and Family Engagement
  - Performance Improvement
  - Health Information Technology
  - Financial Risk Management



VBC Tool Capacities

- Value-based care *capacities* are healthcare organization resources, processes, infrastructure (etc.) to deliver value-based care

- VBC Tool Capacity Examples
  - HCO assesses and identifies patients at high risk for poor outcomes or high resource utilization, and assigns care managers to them.
  - For non-urgent clinic visits, pre-visit planning occurs for complex patients.
  - HCO strategic planning incorporates measurable population health goals that reflect health needs of the community.

VBC Tool Assessments

- Possible *responses* for each value-based care capacity
  1. Fully developed and deployed
  2. Developed, incompletely deployed
  3. In development
  4. In discussion
  5. Not applicable
  6. Not considered

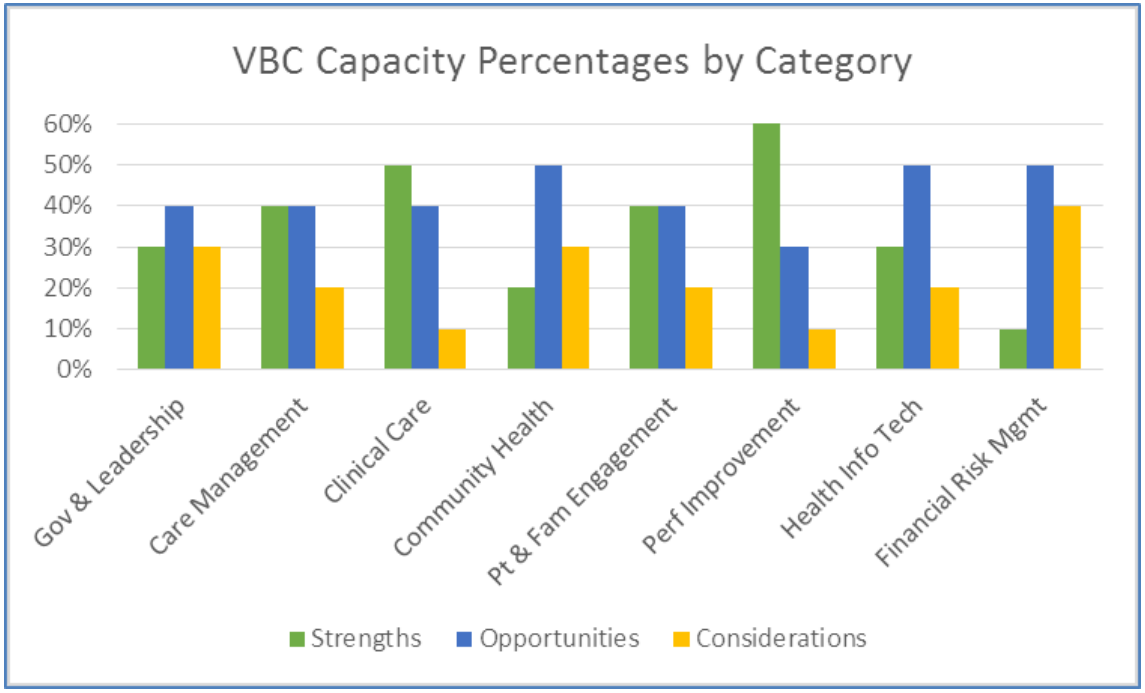
VBC Tool - How To Complete

- Assemble leadership team in a meeting room with internet access and screen
- Complete the VBC tool together, as a team
- We anticipate about 1½ to 2 hours to complete

- An important part of strategic planning!
- Access the VBC Tool at www.ruralhealthvalue.org, then click the link "The Value-Based Care Assessment Tool"

The VBC Readiness Report

- Summary
- Strengths
- Opportunities
- Considerations
- Next Steps



- We anticipate that the VBC Readiness Report will be prepared and emailed to you within two weeks of VBC Tool completion

Strengths

1. **Fully developed and deployed, or**
2. **Developed, incompletely deployed**

- Measure progress and **celebrate** fully developed and deployed value-based care capacities.
- Maintain momentum of fully developed, incompletely deployed value-based care capacities.

Opportunities

3. In development

- Consider <u>prioritizing</u> these value-based care capacities for action.
- Only reasonable effort and/or resources may be required to fully develop and deploy the capacity.
- Concentrate **leadership attention** here!

Considerations

4. **In discussion,**
5. **Not applicable,**
6. **Not considered, or**

- **Assessment left blank**

- May be very <u>good reasons</u> for less leadership attention!
- Yet, these capacities will remain <u>important</u> to the delivery of value-based care.
- Periodically **consider** these value-based care capacities.

Next Steps

1. Review Value-Based Care Tool results with governing body and leadership team.
2. List opportunities to develop value-based care capacities.
3. List opportunities to deploy already developed value-based care capacities.
4. Prioritize value-based care development opportunities based on:
   a. Leadership commitment to *strategic* value-based care capacity development
   b. Resources (staff time and financing) available for value-based care capacity development
   c. Organizational interest in value-based care capacity development
5. Design, implement, and manage action plans to develop and deploy individual value-based care capacities.
6. Design action plans that include:
   a. Measureable objectives
   b. Single person accountabilities
   c. Resource commitment
   d. Timelines/due dates
7. Remain involved with strategic action plans to facilitate progress, allocate resources, and demonstrate commitment.

VBC Tool Caveats

- The VBC Tool is not designed for inter-hospital comparisons
  - However, we plan a comparison report if a sufficient number of VBC Tools completed
- The VBC Tool has not been validated
  - VBC Tool results may not predict contract negotiation success, organizational profitability, managerial effectiveness, etc.
- However, the VBC Tool can:
  - Assist rural healthcare organizations develop *value-based care* capacity
  - Educate leaders, directors, stakeholders
  - Prioritize action as part of strategic planning

Rural Health Value Project

- Check out www.RuralHealthValue.org
  - Tools and resources
  - Profiles in innovation
  - Guide to value-based rural grants
  - White papers and pertinent articles
  - Presentations and more!
- New Tools & Resources
  - Value-Based Care Strategic Planning Tool
  - CAH FFS/CBR Financial Pro Forma
  - Physician engagement resources
  - Shared Savings Contract Pro Forma (spring 2016)
  - And more to come!