

Value-Based Payment: Coming to Rural America

Fall Providers & Partners Conference
PrimeWest Health
November 1, 2016



A. Clinton MacKinney, MD, MS
Clinical Associate Professor and Deputy Director
RUPRI Center for Rural Health Policy Analysis
University of Iowa | College of Public Health
clint-mackinney@uiowa.edu



Plan for Today

2

- Describe three new CMS/CMMI payment models
 - Next Generation ACO
 - Comprehensive Primary Care Plus (CPC+)
 - Quality Payment Program (MACRA)
- And, as CMS goes, so go other payers!
- Rural implications



Clint MacKinney, MD, MS



Consider the Big Questions

3

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



Clint MacKinney, MD, MS



Triple Aim[®] Equals Value

4

The healthcare value equation (2006)

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



Clint MacKinney, MD, MS



Form Follows Finance

5

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



Clint MacKinney, MD, MS



What is Value-Based Payment?

6

- **Payment** for one or more parts of the Three-Part Aim
 - Better care
 - Improved health
 - Lower cost
- Not payment for a “service;” that is, NOT fee-for-service
- Value-based payment examples
 - Shared savings
 - Quality incentives
 - Per capita payments (?)



Clint MacKinney, MD, MS

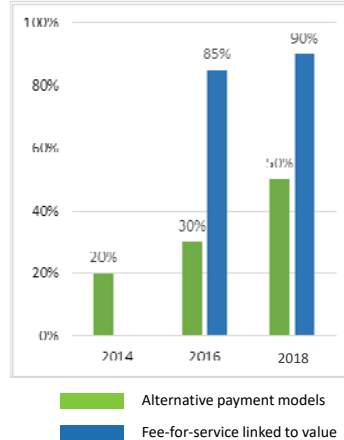


CMS Payment Goals

7

- 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



Clint MacKinney, MD, MS



Value-Based Payment Expansion

8

- 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 2020²
- Value-based payment has legs!
 - Maybe not ACOs...
 - ACOs (etc.) are *pointing the way*
 - Weaning providers off FFS



¹2014 commercial, in-network payments. <http://www.catalyzepaymentreform.org/images/documents/nationalscorecard2014.pdf>

²Healthcare Transformation Task Force – a national consortium of providers, payers, purchasers, and patients. <http://www.hcttf.org/>



Clint MacKinney, MD, MS



Accountable Care Organizations

9

- 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.*
- How Medicare ACOs work
 - Beneficiaries attributed to ACO based on where they receive primary care
 - Medicare pays us fee-for-service (not capitation!)
 - CMS shares 50% of difference between estimated and actual cost
 - But shared savings percent will be reduced if suboptimal quality



*Source: 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.



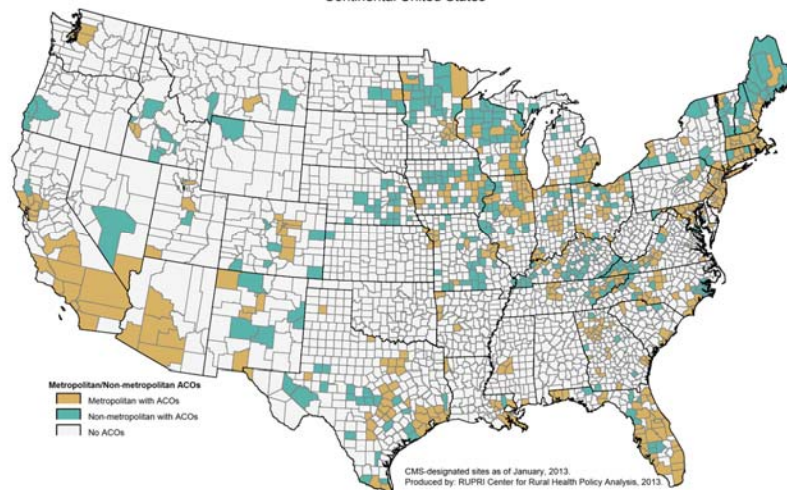
Clint MacKinney, MD, MS



2013 Medicare ACOs by County

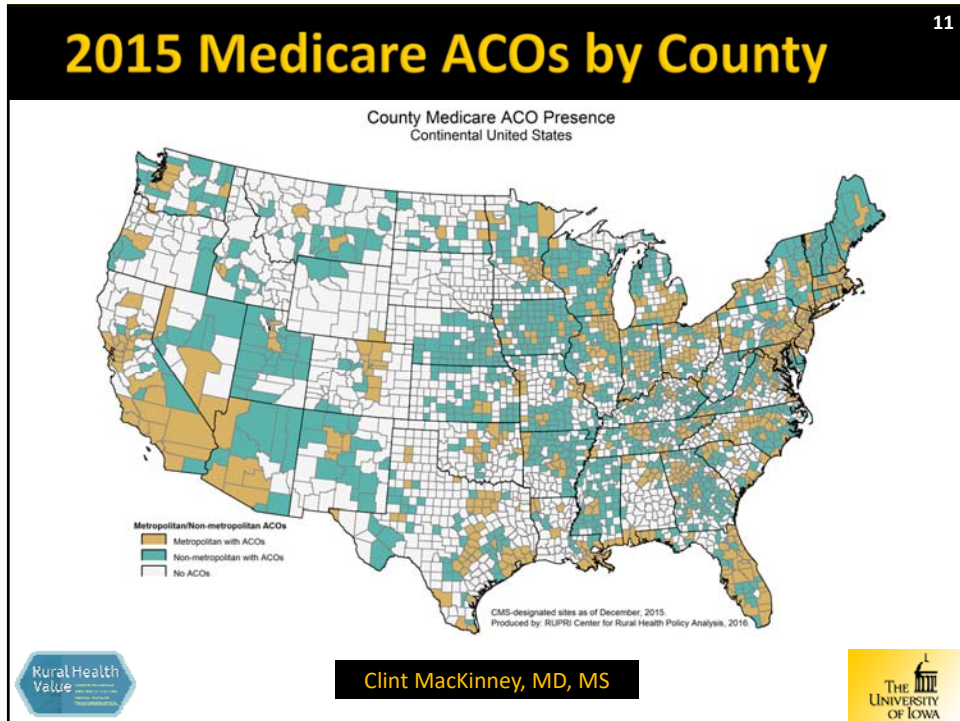
10

County Medicare ACO Presence
Continental United States



Clint MacKinney, MD, MS





12

CMS/CMMI ACO Iterations

- Medicare Shared Savings Program (MSSP)
 - 3 tracks now available
 - Vary by risk level
- Pioneer ACO Model
- Advance Payment ACO Model
- ACO Investment Model
- Next Generation ACO Model

Rule and regulation updates have consistently supported program/model ease-of-entry and expansion

Except unrelenting demand for greater provider risk

Rural Health Value

Clint MacKinney, MD, MS

THE UNIVERSITY OF IOWA

Comprehensive Primary Care Plus

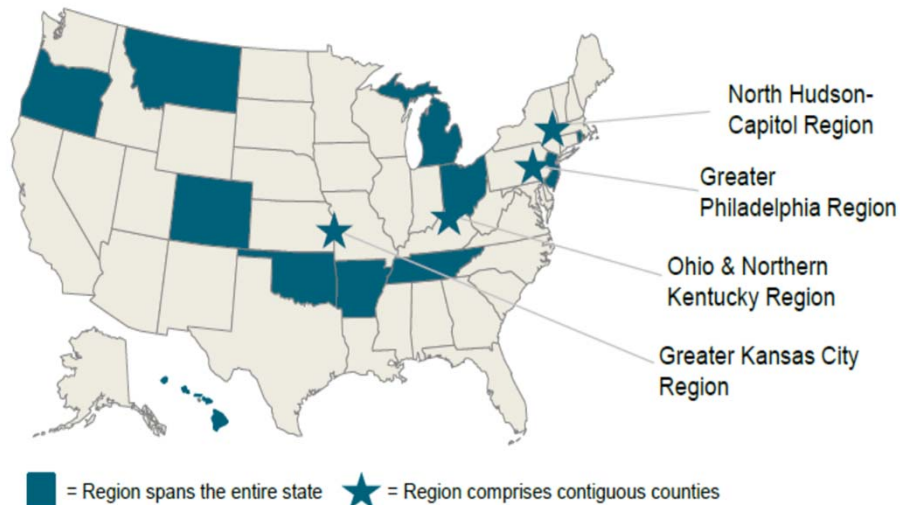
- Largest Center for Medicare and Medicaid Innovation (CMMI) investment in primary care to date
- Up to 5,000 practices, 20,000 physicians, 25 million patients
- Supports 5 primary care functions
 - Access and Continuity
 - Care Management
 - Comprehensiveness and Coordination
 - Patient and Caregiver Engagement
 - Planned Care and Population Health
- Includes other payers!



Clint MacKinney, MD, MS



CPC+ Availability (So far!)



Clint MacKinney, MD, MS




15


CPC+ Tracks and Payment

Track	Care Management Fees (PBPM)	Performance-Based Incentive Payments	Visit and Non-Visit Payments
1	\$15	Utilization, Quality, and Experience	CMF + FFS
2	\$28 (\$100 for complex)	Utilization, Quality, and Experience	CMF + ↓FFS + ↑CPCP

- A *tripartite* payment system
 - FFS + P4P + Cap
- “At CMS, we believe CPC+ is the future of primary care...”
- **Changing payment to change care.**




Clint MacKinney, MD, MS




16


Medicare Access and CHIP Reauthorization Act

- Bipartisan law to replace the Sustainable Growth Rate (SGR)
 - MACRA is law – not a demonstration
 - Regulations (2,204 pages!) were released on October 14, 2016
- MACRA replaces
 - Physician Quality Reporting System
 - Value-Based Modifier
 - Meaningful Use
- MACRA Quality Payment Program
- **Pay increase opportunity**





Clint MacKinney, MD, MS



17

MACRA Quality Payment Program

- Two options
 - Merit-Based Incentive Payment System (**MIPS**), or
 - Advanced Alternative Payment Models (**APMs**)
- 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.
 - *Virtual groups* option

% OF PHYSICIANS LIKELY TO SELECT QPP OPTIONS

Option	Percentage
MIPS	94%
APMs	6%

Clint MacKinney, MD, MS

18

MIPS Payment Distribution

Merit-Based Incentive Payment System

Category	Percentage
Quality	50%
Advancing Care Information	25%
Practice improvement	15%
Cost	10%

■ Cost
 ■ Practice improvement
 ■ Quality
 ■ Advancing Care Information

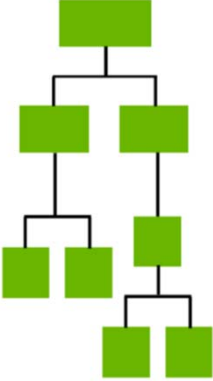
Note: Cost calculation begins 2018.
 In 2017, Quality = 60%

Clint MacKinney, MD, MS

19

MIPS Category Details

- **Quality (50%, 60% in 2017)**
 - Replaces PQRS
 - 271 measures to choose from
 - Physicians select 6 measures (1 outcome)
 - CMS calculates 2-3 population measures
 - Benchmarks to be published this year (PQRS)
- **Advancing Care Information (25%)**
 - Replaces Meaningful Use – not all-or-nothing
 - 15 measures to choose from – 5 mandatory
 - Extra credit: Select 4 additional measures
 - Bonus credit:
 - Report to public health or clinical data registry
 - Use certified EHR technology for improvement activities



Rural Health Value

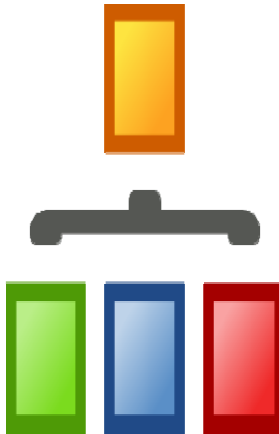
Clint MacKinney, MD, MS

THE UNIVERSITY OF IOWA

20

MIPS Category Details

- **Cost (10%)**
 - Replaces value-based modifier
 - Begins 2018
 - No reporting; based on claims
 - 40-episode specific measures
- **Clinical Practice Improvement Activities (15%)**
 - 93 options within 8 categories
 - Achieving Health Equity, Behavioral and Mental Health, Beneficiary Engagement, Care Coordination, Emergency Response & Preparedness, Expanded Practice Access, Patient Safety & Practice Assessment, Population Management



Rural Health Value

Clint MacKinney, MD, MS

THE UNIVERSITY OF IOWA

Advanced Payment Model

- Must bear **financial risk**
- Payments based on quality comparable to MIPS
- Must use certified EHR
- Models that count as APMs
 - CPC+
 - MSSP Tracks 2 and 3
 - Next Generation ACO Model
 - MSSP Track 1+ (details pending)
 - Medical Homes (details pending)



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



Clint MacKinney, MD, MS



Medical Home Model

- Medical Home Model must have the following elements:
 - Include **primary care practices** or multispecialty practices that include primary care physicians and practitioners and offer primary care services.
 - **Empanelment** of each patient to a primary clinician.
- Medical Home Model must have at least four of the following elements:
 - Planned coordination of **chronic and preventive care**.
 - Patient access and **continuity of care**.
 - Risk-stratified **care management**.
 - **Coordination of care** across the medical neighborhood.
 - Patient and caregiver **engagement**.
 - **Shared decision-making**.
 - Payment arrangements in addition to, or substituting for, FFS payments (e.g., **shared savings** or population-based payments).
- **Details still in development**



Clint MacKinney, MD, MS



23

Pick Your Pace Options for 1/1/17

Don't Participate

- Submit *no data*
 - 4% pay cut
- Submit *minimal data (test)*
 - One quality, one improvement
 - No pay cut, but no bonus either

Submit a Partial Year

- Participate MIPS *partial year*
 - 90 days of all three categories
 - Smaller potential bonus
- Participate MIPS *full year*
 - Variable MIPS payment adjustment

Submit a Full Year

Clint MacKinney, MD, MS

MACRA | Medicare Access and CHIP Reauthorization Act of 2015

AMERICAN ACADEMY OF FAMILY PHYSICIANS

Physician Payment Timeline

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

^aThe 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).

^bLowest quartile performers automatically receive the maximum negative payment adjustment.

^cPayment adjustment listed for 2023 through 2024 is an assumption based on currently available information.

New Physician Payment Reality

25

- 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



Clint MacKinney, MD, MS



Budget Neutral

26

- Budget neutral
 - There will be physician **winner**s and **loser**s!
- Yet CMS estimates:
 - 90% of providers will receive pay hike or avoid penalties in 2019
 - **\$1 billion** payments in 2019 (based on 2017 performance)
 - MIPS – \$200-\$320 million
 - Exceptional perf – \$500 million
 - APMs – \$330-\$570 million
 - Penalties – ?



Clint MacKinney, MD, MS



MACRA Rural Issues

Solo and small practices will get hit hardest under the new incentive payment system

Practice size	Eligible clinicians	Percentage likely to be penalized	Percentage likely to get bonus
Solo	102,788	87%	12.9%
2-9	123,695	69.9%	29.8%
10-24	81,207	59.4%	40.3%
25-99	147,976	44.9%	54.5%
100 or more	305,676	18.3%	81.3%
Overall	761,342	45.5%	54.1%

Source: Modern Healthcare, April 30, 2016. Adapted from CMS data reported in Federal Register 5/9/2016.



Clint MacKinney, MD, MS



RHC/FQHC Conundrum

28

- RHCs – all inclusive rates
 FQHCs – FQHC PPS rates
- “...services rendered by an eligible clinician under the RHC or FQHC methodology, will not be subject to the MIPS payments adjustments...”
- Also not eligible for APM bonus
- No opportunity to be rewarded for superior performance



Clint MacKinney, MD, MS



Payment Reform Is Here

29

- Quality Payment Program is momentous
 - Complex and thus ripe for gaming
 - But a profound *philosophical* shift that will change behavior
- Tripartite physician payment is the future
 - Modeled by the CPC+ demo
 - FFS + P4P + Cap
- Are rural providers ready?
 - Learn more: <https://qpp.cms.gov/>



Clint MacKinney, MD, MS



What This Means and Portends

30

- Gradual devaluation of fee-for-service payment (RIP)
- Relentless shifting of risk from payers to providers
- Financial teeth behind the Three-Part Aim
- Favors provider experience and resources (integration)
- RHC/FQHC conundrum
- **Risk of rural non-inclusion**



Clint MacKinney, MD, MS

