Value-Based Payment: Coming to Rural America

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Plan for Today

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- 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

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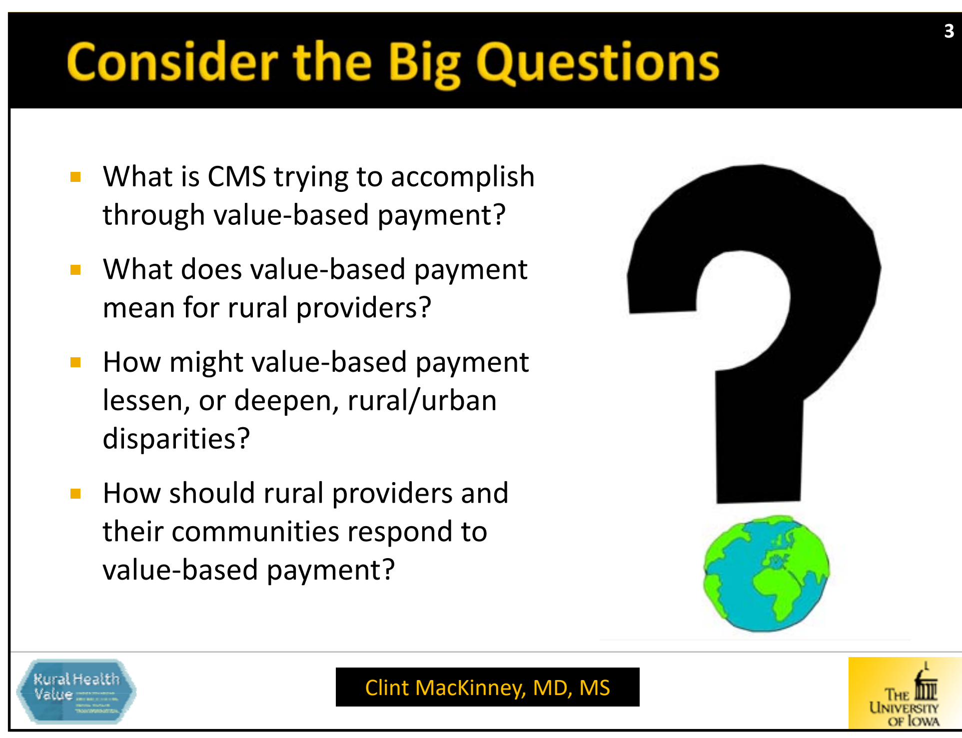
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Consider the Big Questions
What is CMS trying to accomplish through value-based payment?
What does value-based payment mean for rural providers?
How might value-based payment lessen, or deepen, rural/urban disparities?
How should rural providers and their communities respond to value-based payment?
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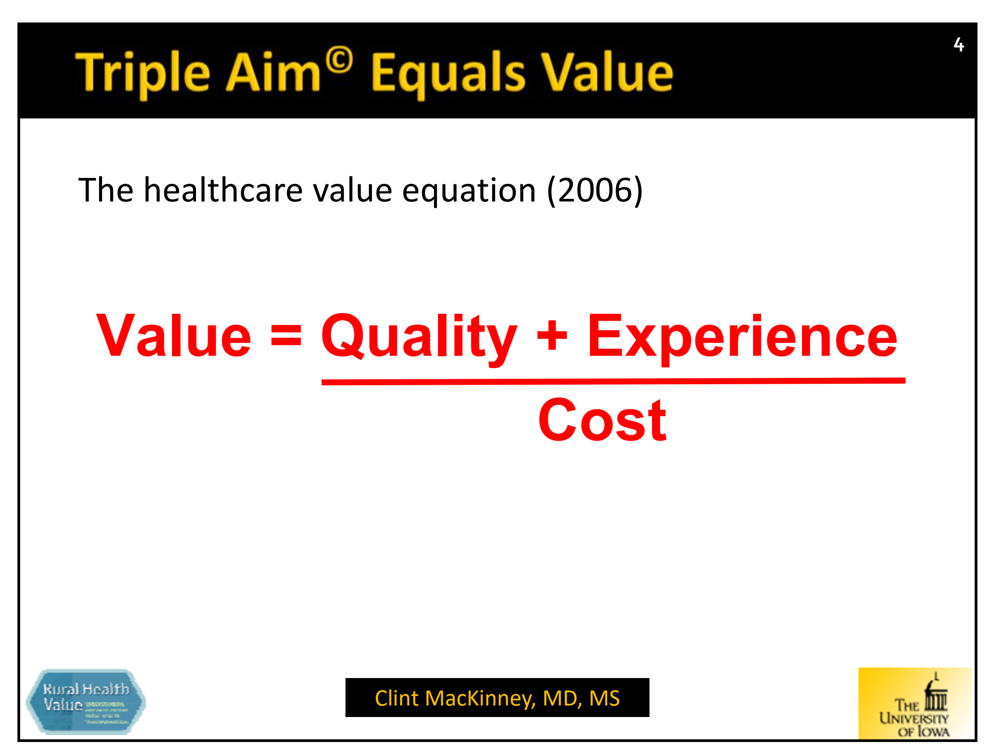
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Triple Aim© Equals Value
The healthcare value equation (2006)
Value = Quality + Experience
Cost
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Form Follows Finance

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- *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

FOLLOW THE MONEY

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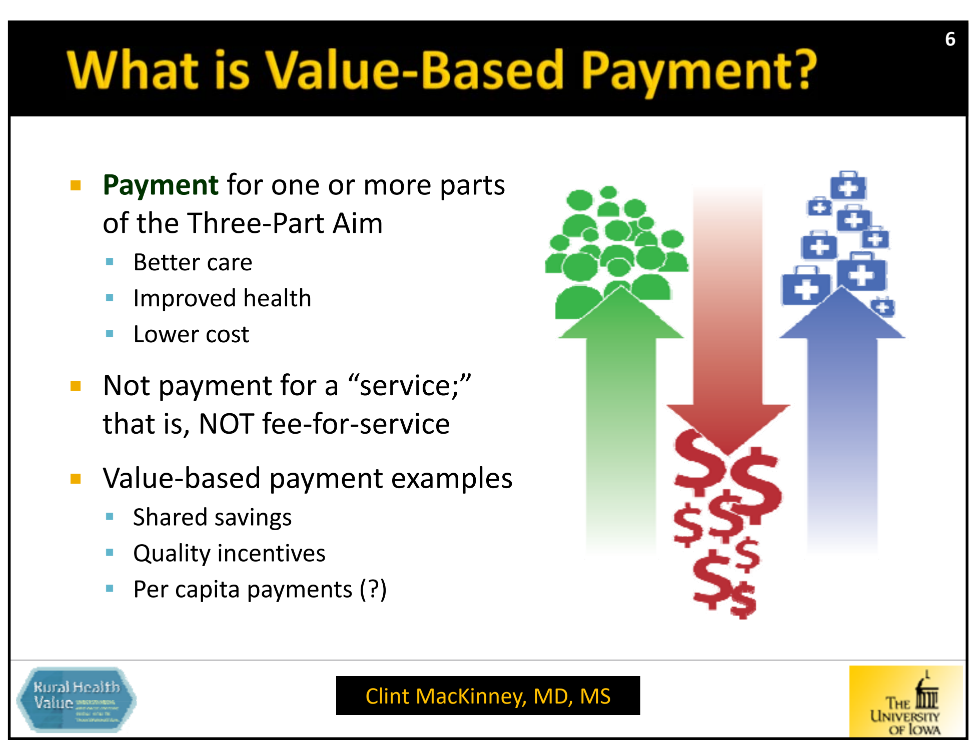

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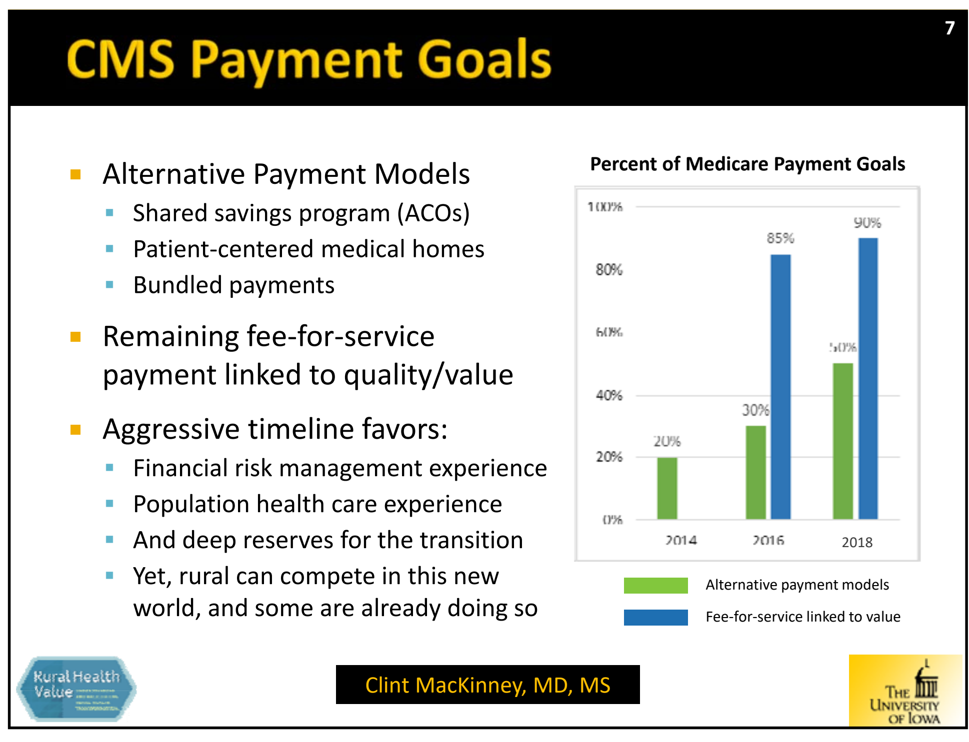

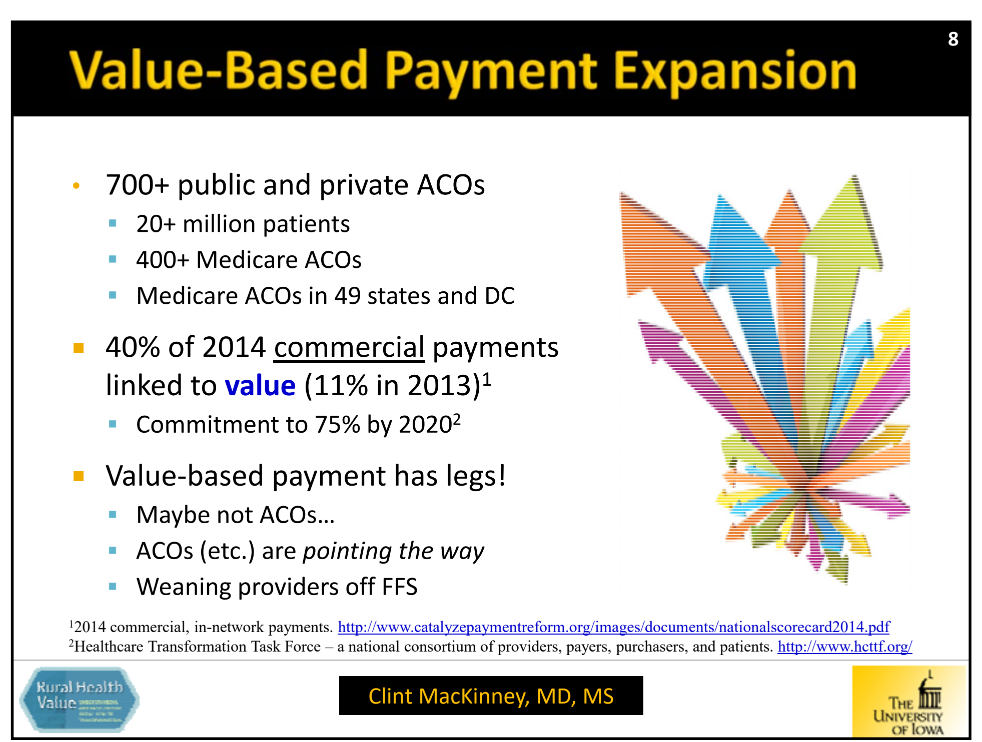

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Accountable Care Organizations

- 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.*

- 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.

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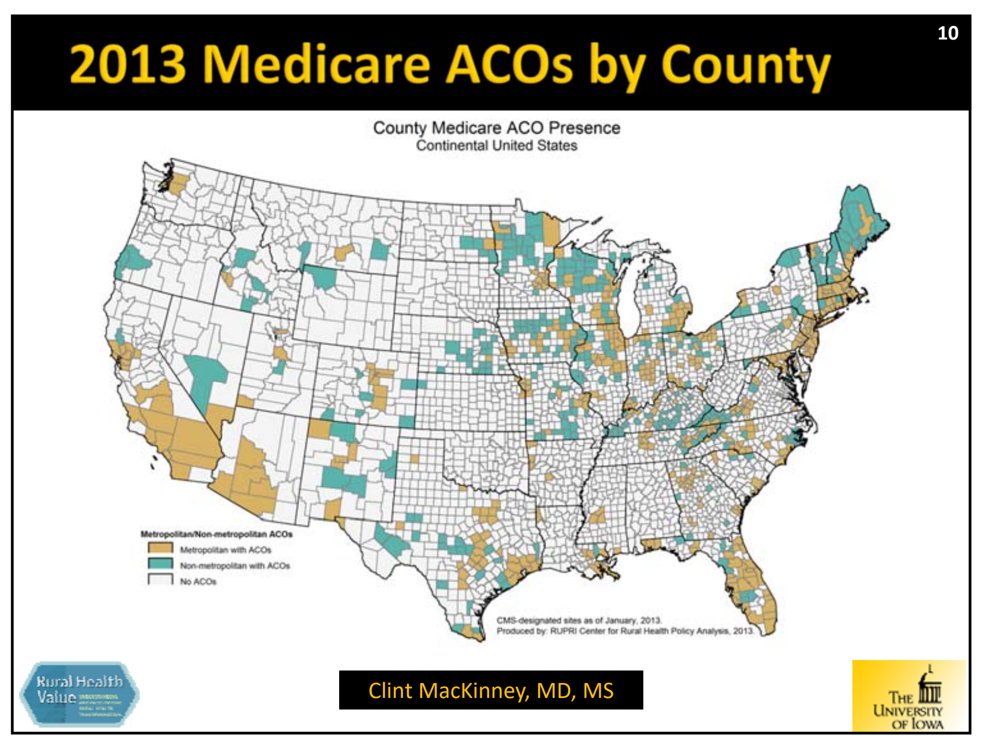
2013 Medicare ACOs by County



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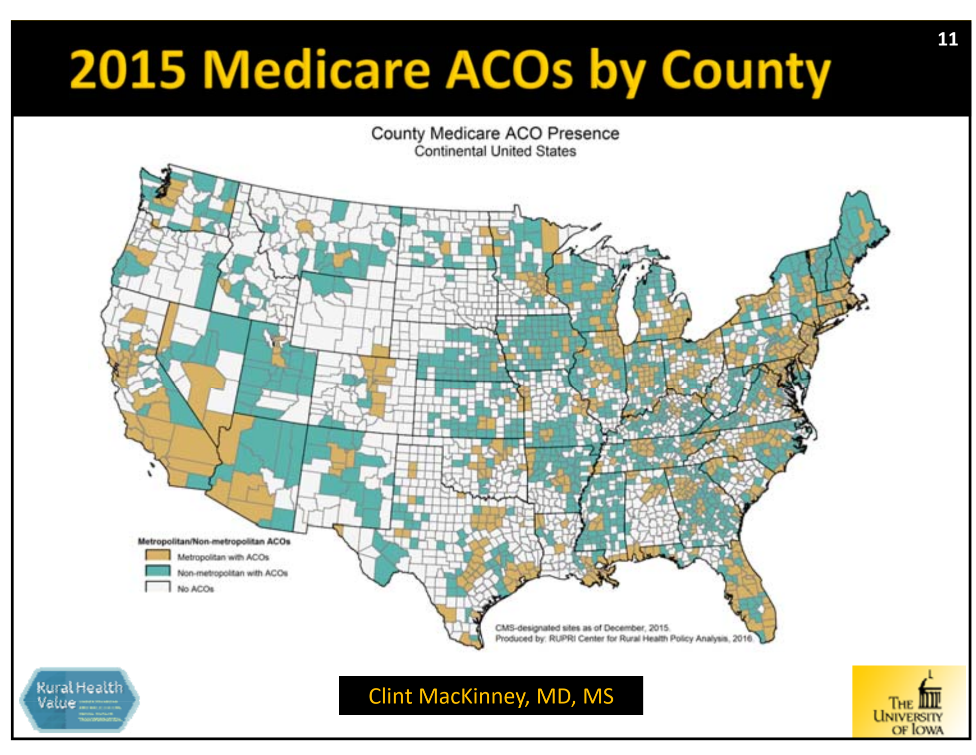

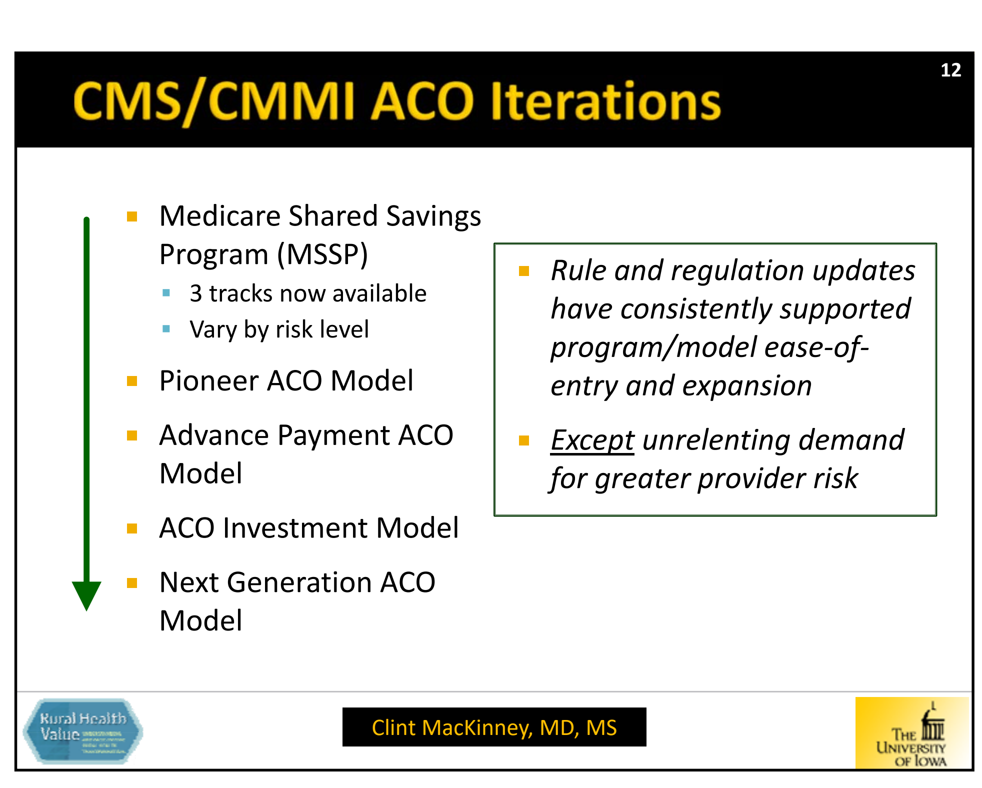

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Comprehensive Primary Care Plus

- 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!**

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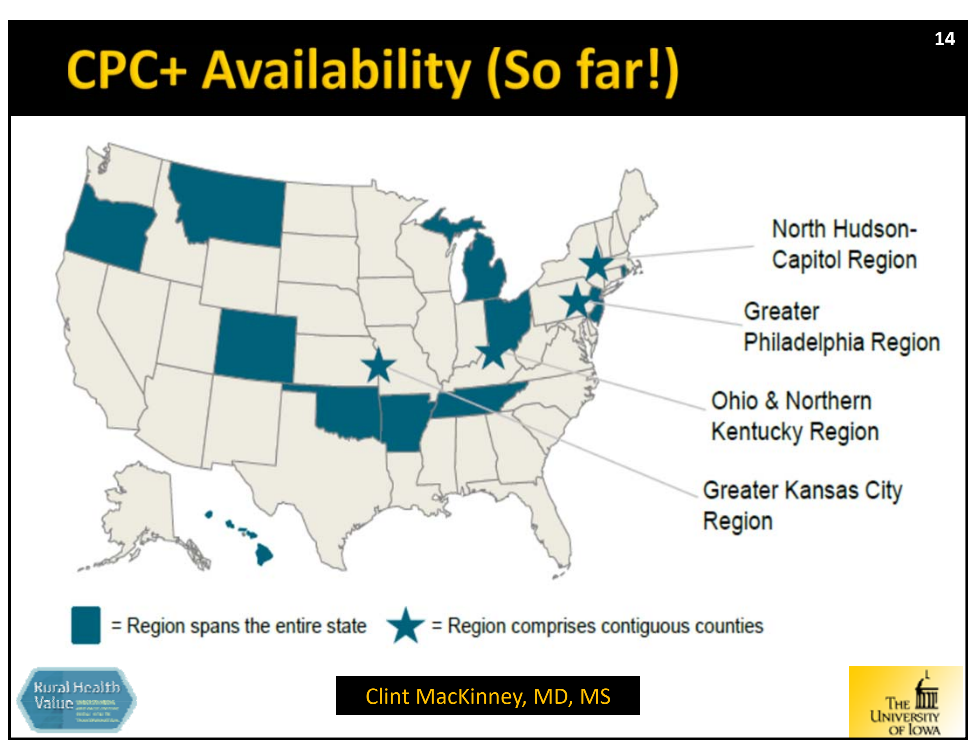
CPC+ Availability (So far!)



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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.**

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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**

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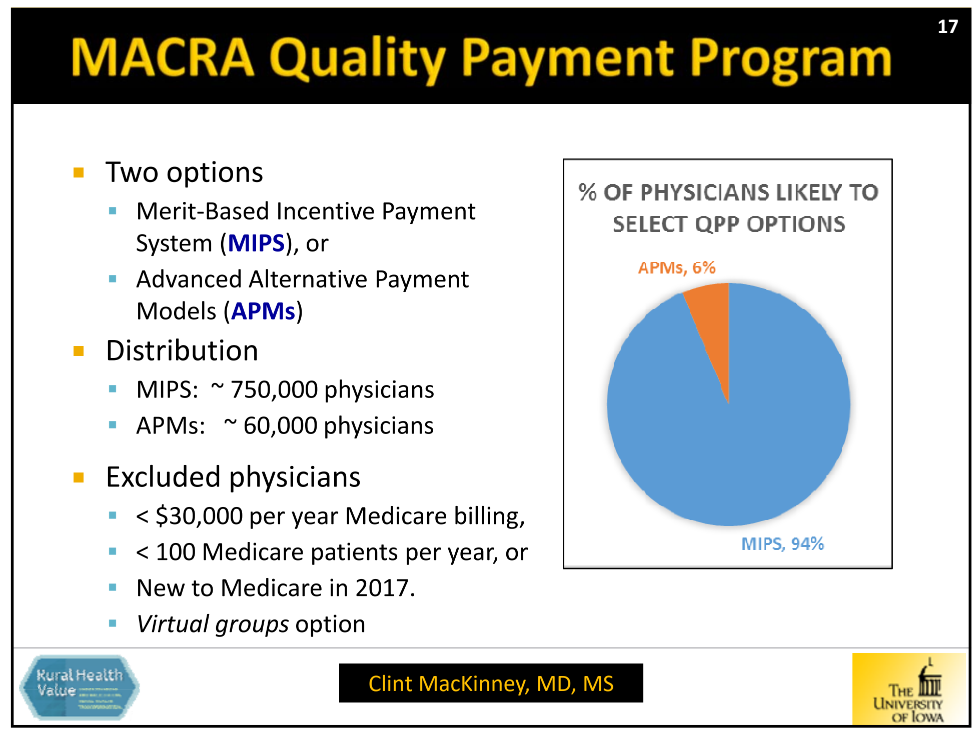

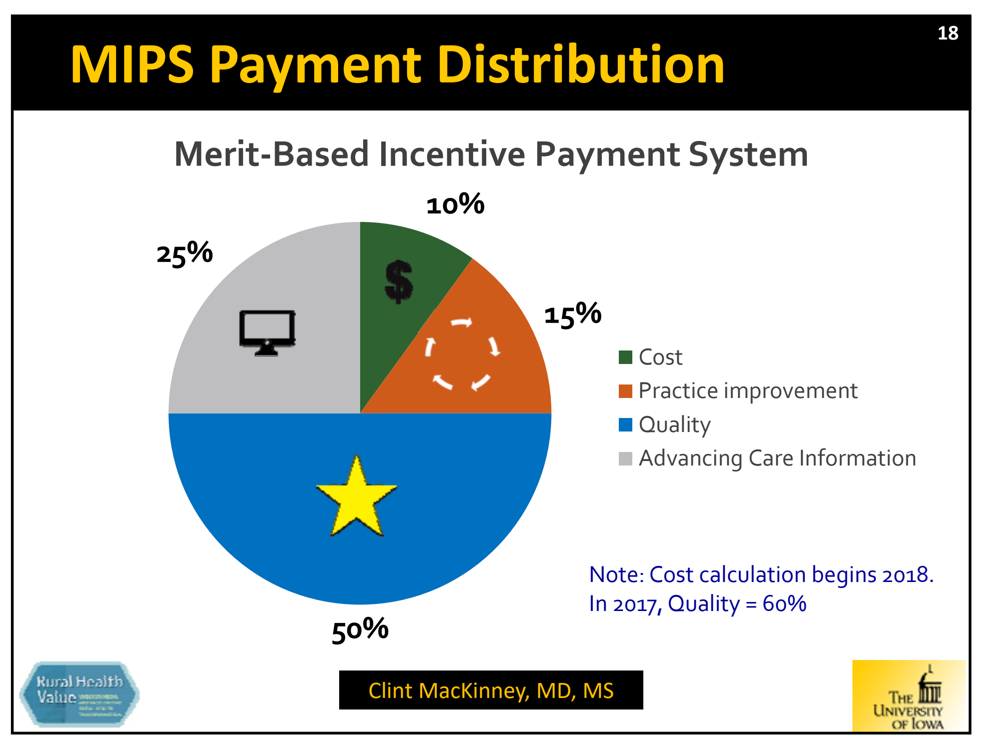

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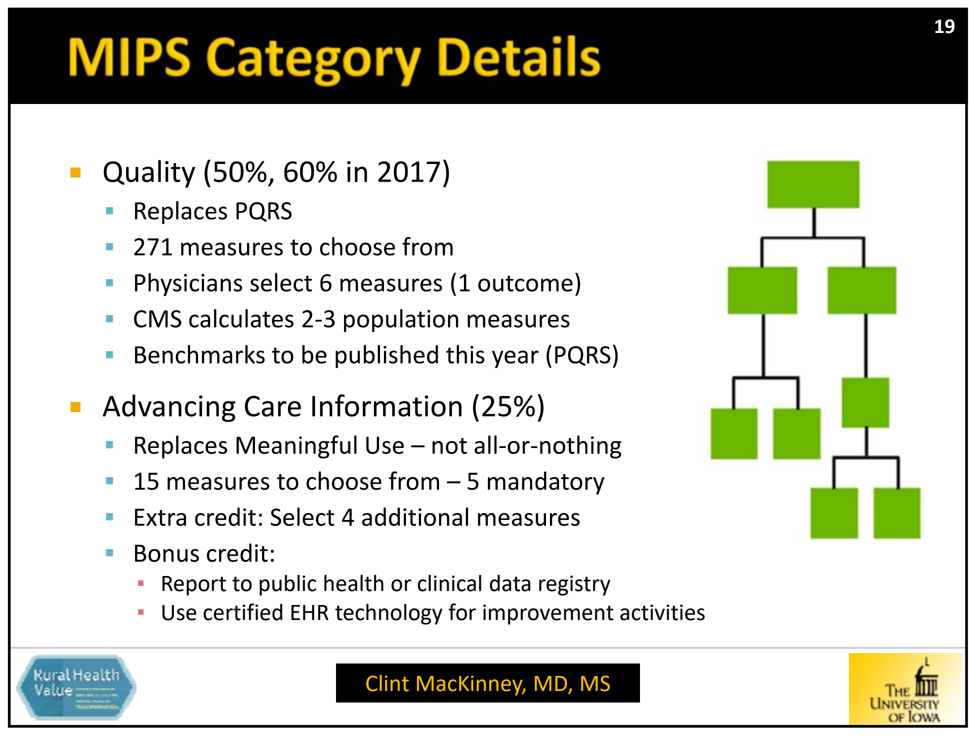

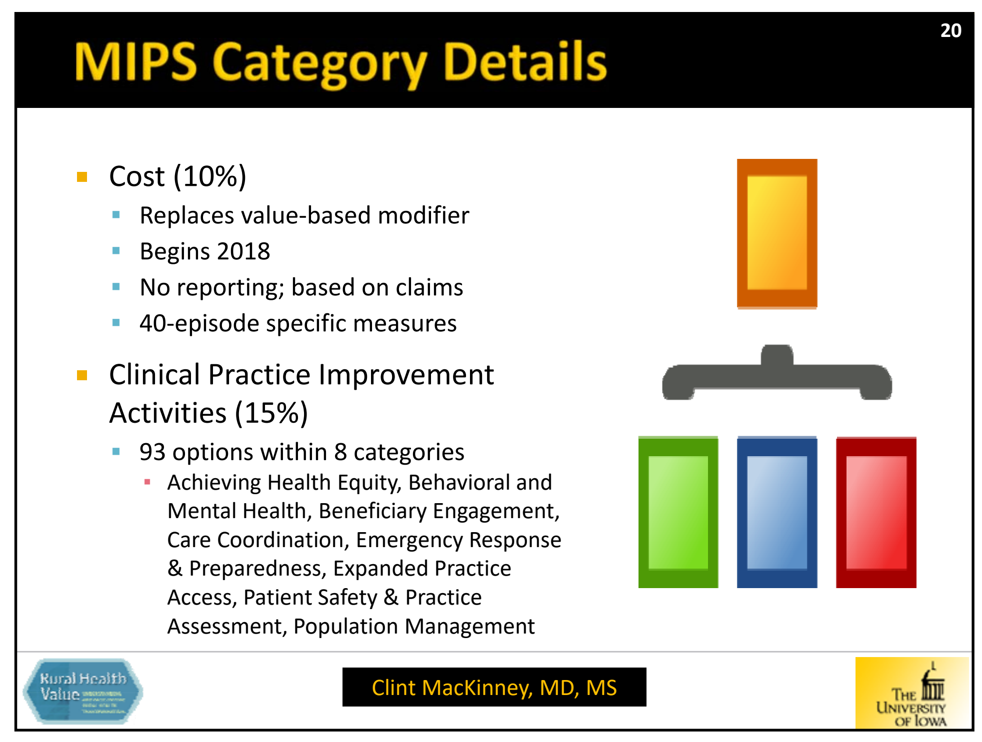

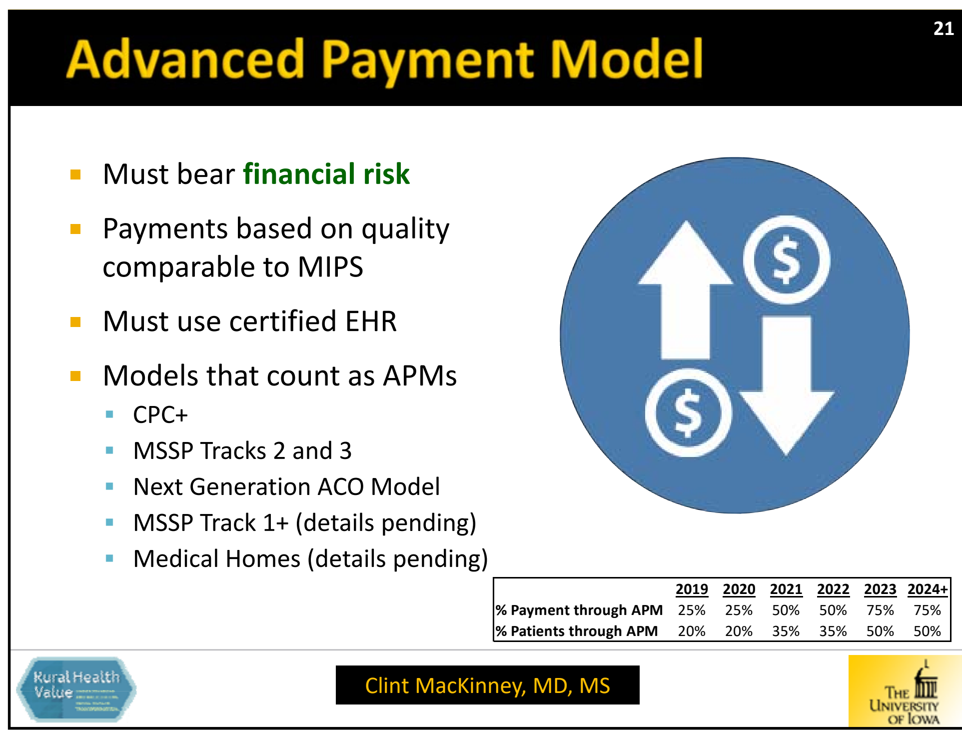

	2019	2020	2021	2022	2023	2024+
% Payment through APM	25%	25%	50%	50%	75%	75%
% Patients through APM	20%	20%	35%	35%	50%	50%

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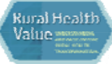
Medical Home Model

- 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



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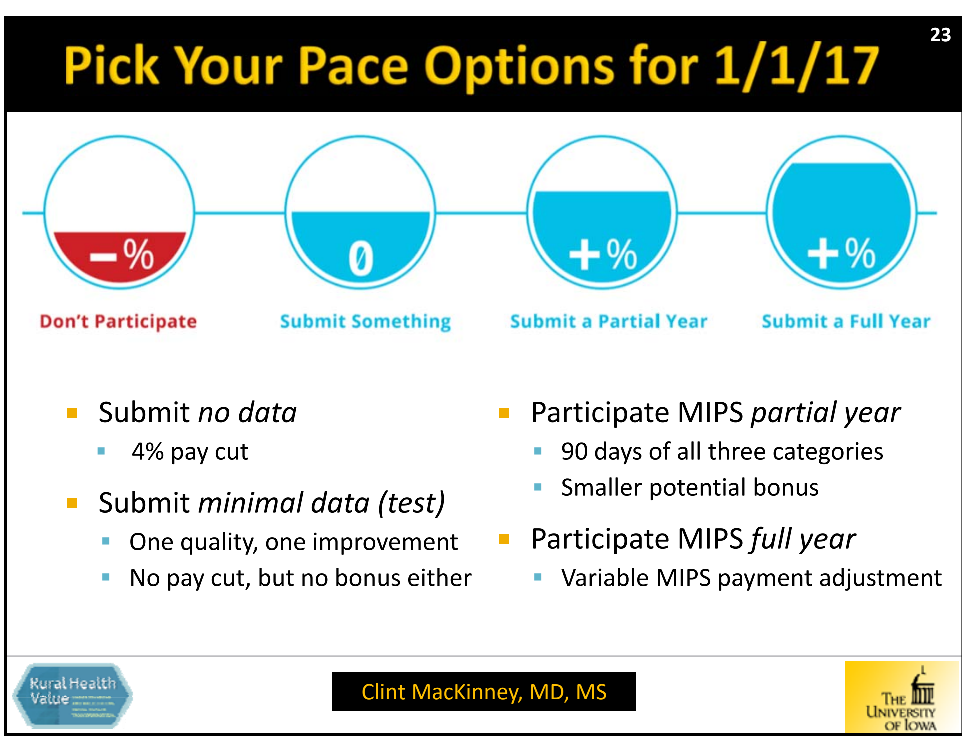

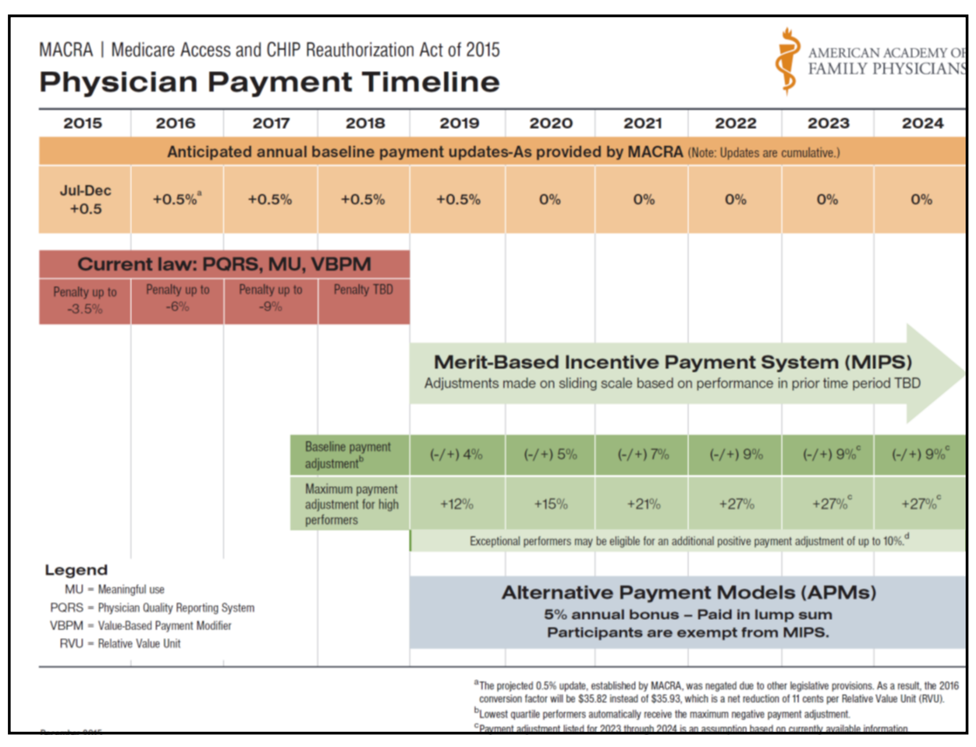

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New Physician Payment Reality

- 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

SGR

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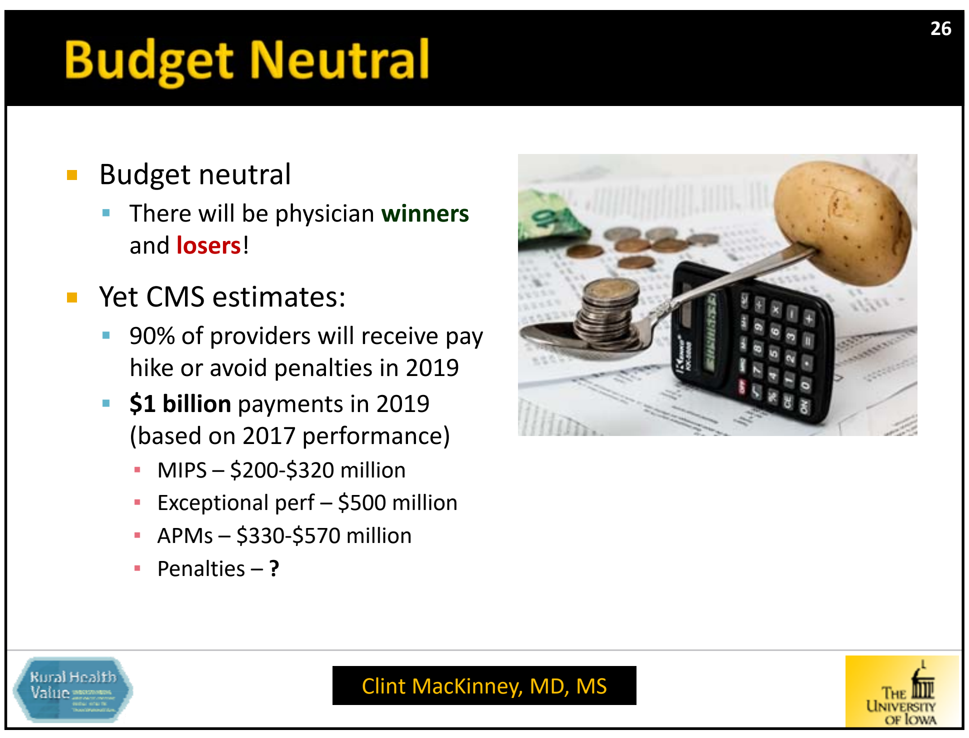

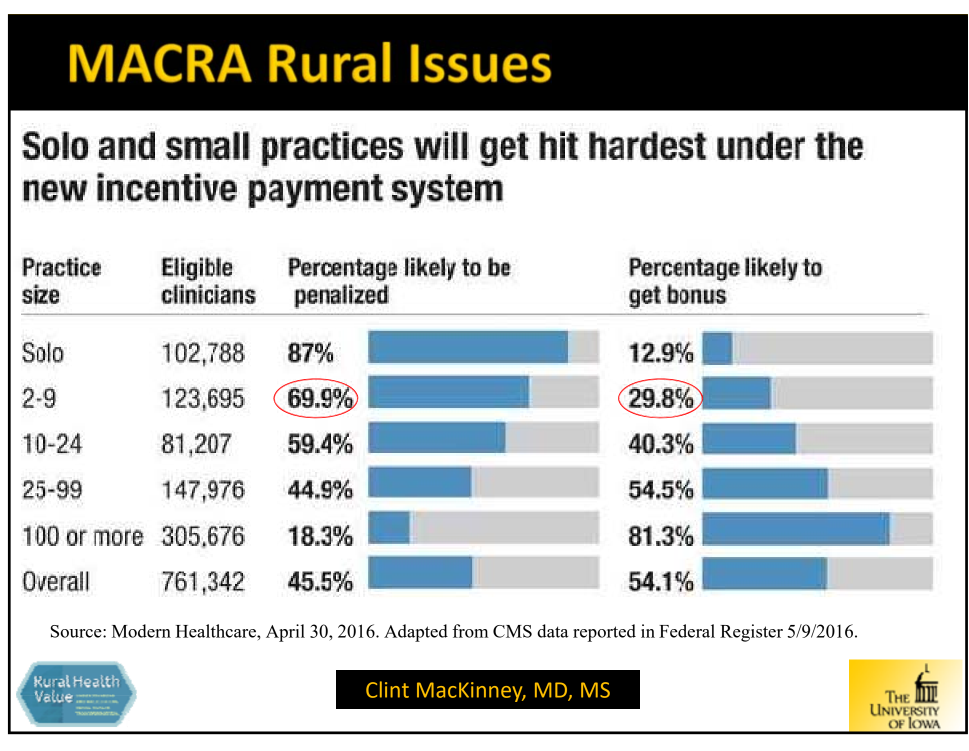
MACRA Rural Issues
Solo and small practices will get hit hardest under the new incentive payment system
Practice size
Eligible clinicians
Percentage likely to be penalized
Percentage likely to get bonus
Solo 102,788 87% 12.9%
2-9 123,695 69.9% 29.8%
10-24 81,207 59.4% 40.3%
25-99 147,976 44.9% 54.5%
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.
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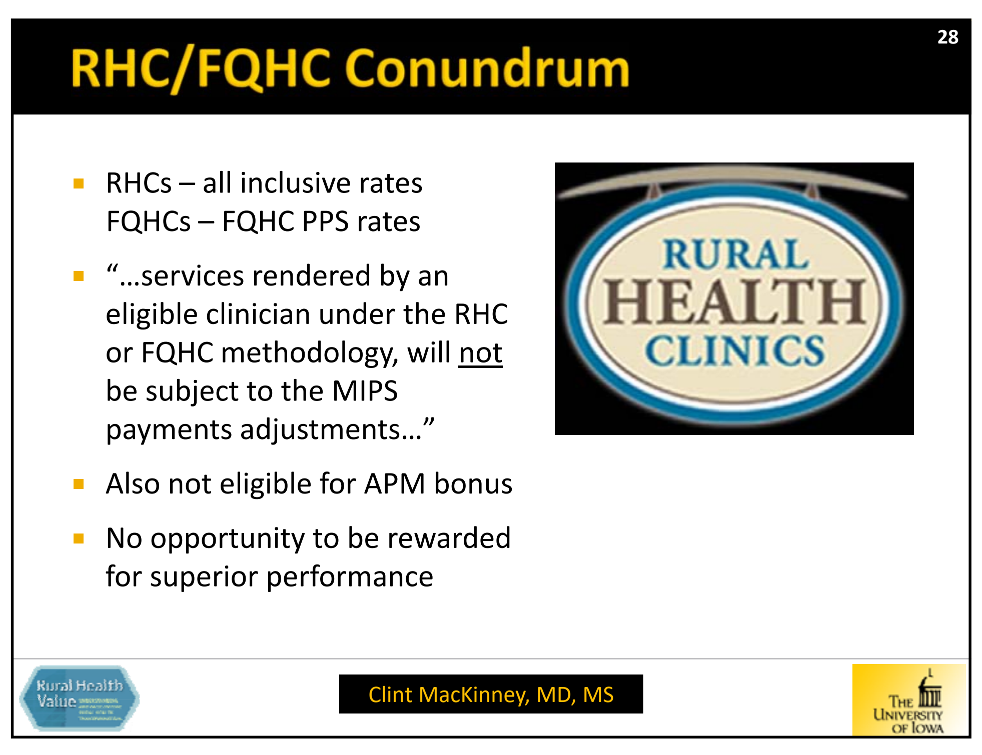
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RHC/FQHC Conundrum
RHCs – all inclusive rates
FQHCs – FQHC PPS rates
"…services rendered by an eligible clinician under the RHC or FQHC methodology, will not be subject to the MIPS payments adjustments…"
Also not eligible for APM bonus
No opportunity to be rewarded for superior performance
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