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

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

→ Value
The health care value equation (2006)

Value = 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?
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

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
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

- 2014: 20%
- 2016: 30%
- 2018: 50%
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!

2013 Medicare ACOs by County

County Medicare ACO Presence
Continental United States

Metropolitan/Non-metropolitan ACOs
- Metropolitan with ACOs
- Non-metropolitan with ACOs
- No ACOs

CMS-designated sites as of January, 2013.
Produced by: RUPRI Center for Rural Health Policy Analysis, 2013.

Rural Health Value
Understanding and facilitating rural health transformation.
2015 Medicare ACOs by County

County Medicare ACO Presence
Continental United States

METROPOLITAN/NON-METROPOLITAN ACOs
- METROPOLITAN WITH ACOs
- NON-METROPOLITAN WITH ACOs
- NO ACOs

CMS-designated sites as of December, 2015.
Produced by: RUPRI Center for Rural Health Policy Analysis, 2015.

Rural Health Value
UNDERSTANDING AND FACILITATING RURAL HEALTH TRANSFORMATION
ACO Penetration by State

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

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
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

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
MIPS Bonus/Penalty Calculation

Merit-Based Incentive Payment System

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

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+

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<th>2019</th>
<th>2020</th>
<th>2021</th>
<th>2022</th>
<th>2023</th>
<th>2024+</th>
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<td>% Payment through APM</td>
<td>25%</td>
<td>25%</td>
<td>50%</td>
<td>50%</td>
<td>75%</td>
<td>75%</td>
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<tr>
<td>% Patients through APM</td>
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<td>35%</td>
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### Physician Payment Timeline

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### Current law: PQRS, MU, VBPM

- Penalty up to -3.5%
- Penalty up to -6%
- Penalty up to -9%
- Penalty TBD

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### Merit-Based Incentive Payment System (MIPS)

Adjustments made on sliding scale based on performance in prior time period TBD.

<table>
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<th>Year</th>
<th>Baseline payment adjustment</th>
<th>Maximum payment adjustment for high performers</th>
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<tr>
<td>2015</td>
<td>(-/+ ) 4%</td>
<td>+12%</td>
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<tr>
<td>2016</td>
<td>(-/+ ) 5%</td>
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<td>(-/+ ) 7%</td>
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<td>2018</td>
<td>(-/+ ) 9%</td>
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<tr>
<td>2019</td>
<td>(-/+ ) 9%&lt;sup&gt;c&lt;/sup&gt;</td>
<td>+27%</td>
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</tr>
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### Alternative Payment Models (APMs)

5% annual bonus – Paid in lump sum. Participants are exempt from MIPS.

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### Legend

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

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<sup>a</sup>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).

<sup>b</sup>Lowest quartile performers automatically receive the maximum negative payment adjustment.

<sup>c</sup>Payment adjustment listed for 2023 through 2024 is an assumption based on currently available information.
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
- 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
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**
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
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](http://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](http://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](http://www.ruralcenter.org)
  - Technical assistance and knowledge resources in rural health

- Rural Health Research Gateway – [www.ruralhealthresearch.org](http://www.ruralhealthresearch.org)
  - Easy and timely access to research conducted by the Rural Health Research Centers