Understanding and Facilitating Rural Health Transformation

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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

- 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
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)

\[
\text{Value} = \frac{\text{Quality} + \text{Experience}}{\text{Cost}}
\]
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
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

[Bar graph showing percent of Medicare Payment Goals from 2014 to 2018]
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.
2015 Medicare ACOs by County

County Medicare ACO Presence
Continental United States

CMS-designated sites as of December, 2015.
Produced by: RUPRI Center for Rural Health Policy Analysis, 2016.
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


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

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...”
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
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

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

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></th>
<th>2019</th>
<th>2020</th>
<th>2021</th>
<th>2022</th>
<th>2023</th>
<th>2024+</th>
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<tr>
<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>
<td>20%</td>
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<td>35%</td>
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# Physician Payment Timeline

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<tr>
<td>Jul-Dec</td>
<td>+0.5(^a)</td>
<td>+0.5%</td>
<td>+0.5%</td>
<td>+0.5%</td>
<td>0%</td>
<td>0%</td>
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**Anticipated annual baseline payment updates-As provided by MACRA**  
(Note: Updates are cumulative.)

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<td>Current law: PQRS, MU, VBPM</td>
<td>Penalty up to -3.5%</td>
<td>Penalty up to -6%</td>
<td>Penalty up to -9%</td>
<td>Penalty TBD</td>
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**Merit-Based Incentive Payment System (MIPS)**  
Adjustments made on sliding scale based on performance in prior time period TBD

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<tr>
<td>Baseline payment adjustment (\text{b})</td>
<td>(-/+ 4%)</td>
<td>(-/+ 5%)</td>
<td>(-/+ 7%)</td>
<td>(-/+ 9%)</td>
<td>(-/+ 9(^c))</td>
<td>(-/+ 9(^c))</td>
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<tr>
<td>Maximum payment adjustment for high performers</td>
<td>+12%</td>
<td>+15%</td>
<td>+21%</td>
<td>+27%</td>
<td>+27%</td>
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*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.

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\(^a\)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

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
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 \textit{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](http://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