



NATIONAL
RURAL HEALTH
RESOURCE CENTER

Flex Coordinator
Learning Collaborative 201
Week 1

Understanding Payment and Delivery Reform

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The Center's Purpose

The National Rural Health Resource Center (The Center) is a nonprofit organization dedicated to sustaining and improving health care in rural communities. As the nation's leading technical assistance and knowledge center in rural health, The Center focuses on five core areas:

- Transition to Value and Population Health
- Collaboration and Partnership
- Performance Improvement
- Health Information Technology
- Workforce



Context

- What to expect over the course of the webinar series
 - Understanding components of healthcare transformation
 - How transformation affects CAHs and RHCs
 - Tools and resources for providers to engage in transformation

Today's Agenda

- Preview of the webinar series
- Drivers of healthcare transformation
- Foundation elements of healthcare transformation
- Overview of value-based payment methodology
- Impact on rural health



Webinar Series

1. CMS is leading healthcare Transformation

- Understanding Payment and Delivery Reform

2. The Paradigm Shift

- Transformation from Volume to Value

3. Accountable Care Organizations and other pay for value programs

- Opportunities, Barriers for Rural providers

4. Clinically Integrated Networks

- Opportunities, Barriers for Rural Providers

5. How to win with the Tyranny of Small Number

- Collaborations, Coalitions and Networks

6. The Big Picture—Results Matter

Demonstrate worth, value and quality



Healthcare Transformation



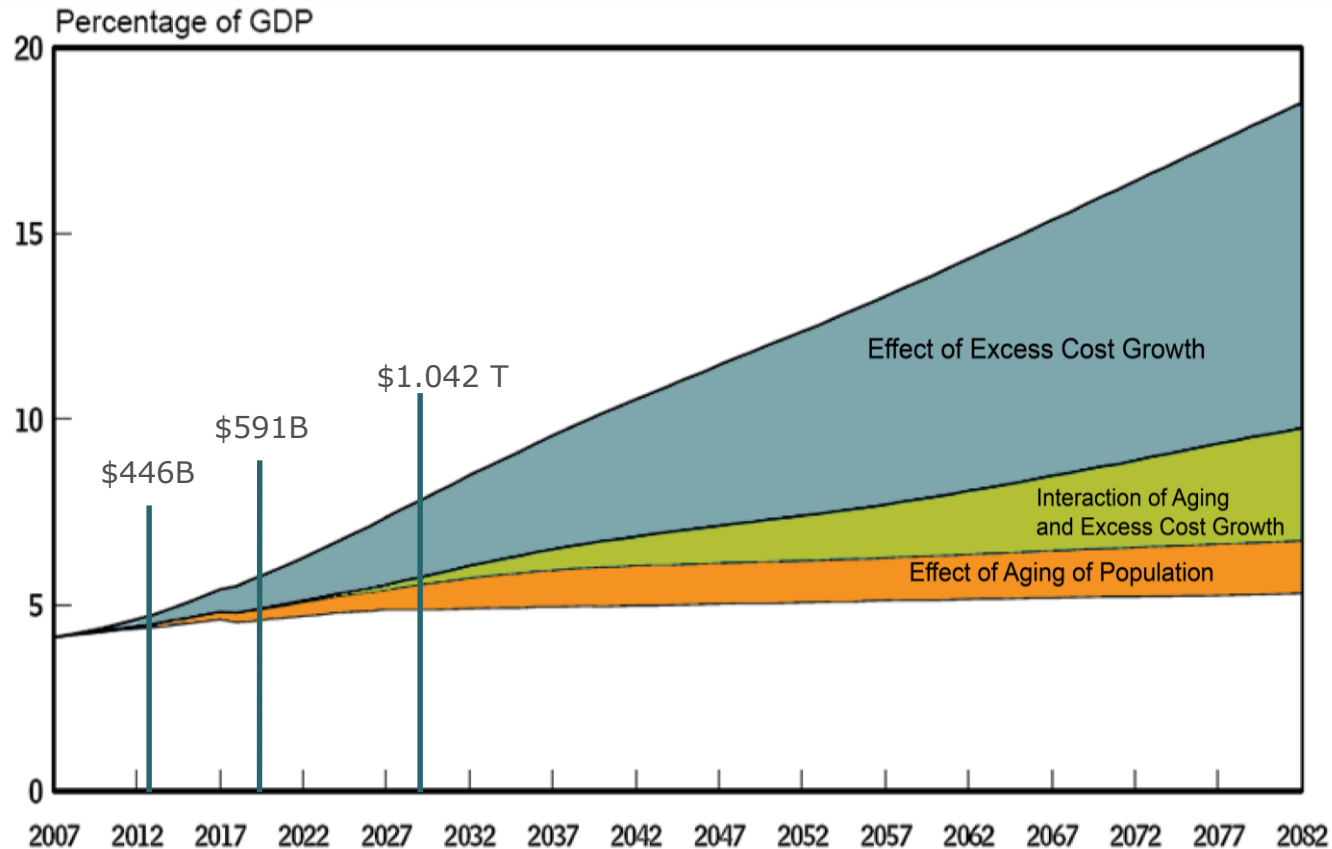
How did we get here?

- Medicare is leading the charge:
 - Entrance of Baby Boomers
 - Bending the Cost Curve
 - Total Spend



Industry Trends

Projected Federal Spending on Medicare and Medicaid



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Foundations of Transformation

Payment and Delivery

Provider
Accountability
and
Innovation

Reduce
barriers to
value
driven care

Impact of
Payments on
Cost and
Quality of
Performance

Re-align
incentives

Delivery
System
Integration
and
Coordination

Increase
competition

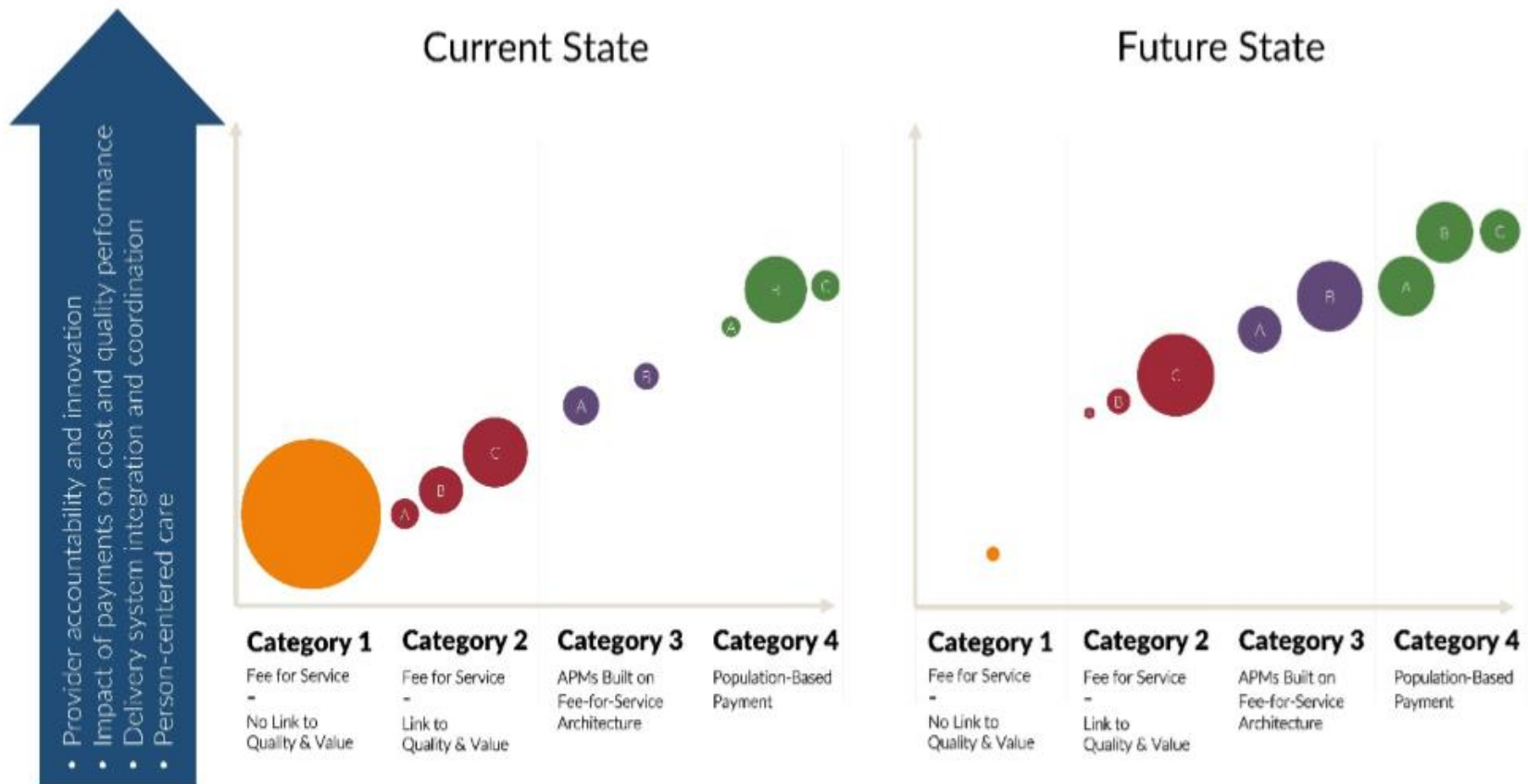
Person
Centered Care

Empower
Patients

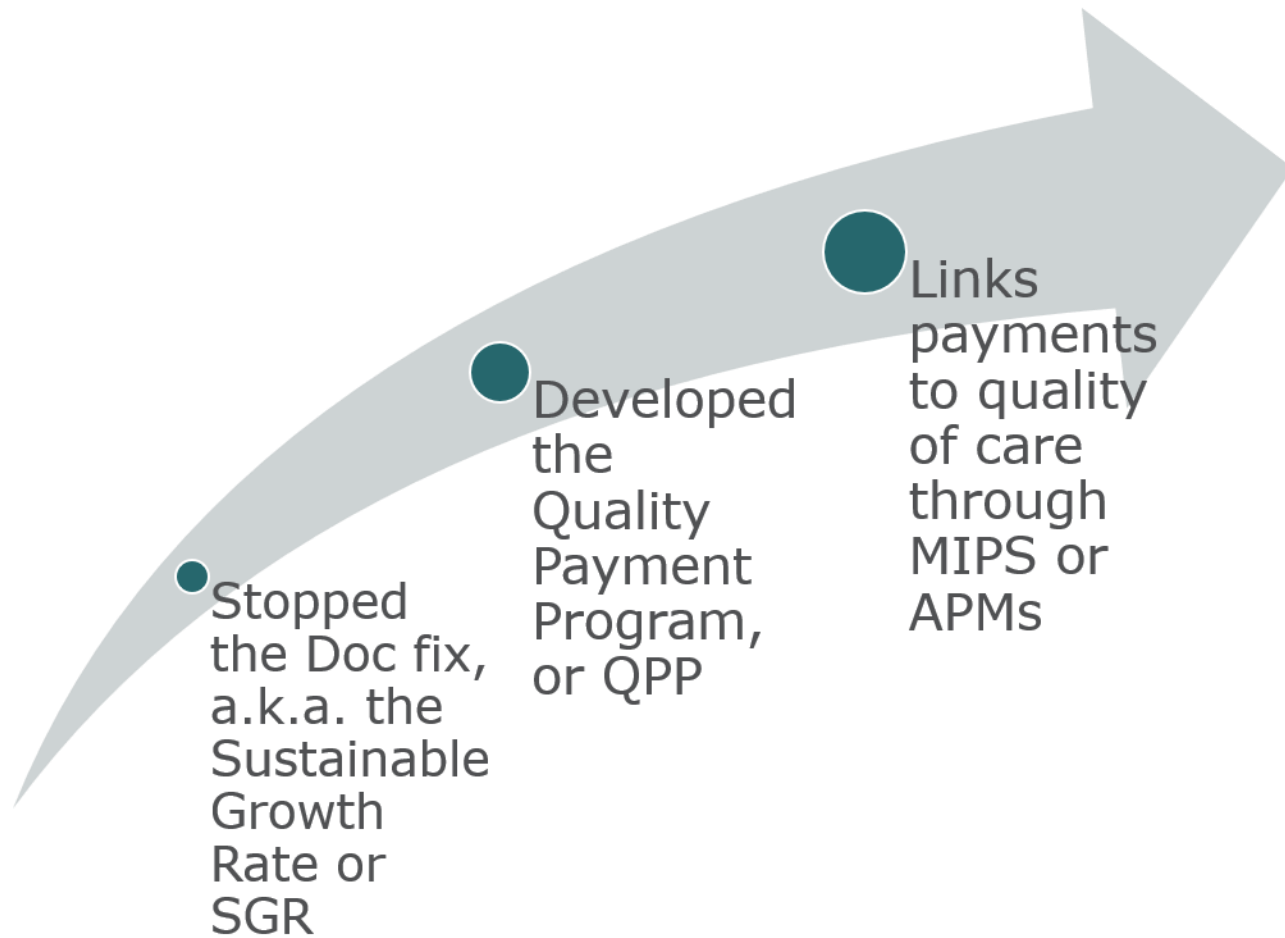


Payment Reform Goals

Figure 3: Payment Reform Goals



MACRA: Medicare Access and CHIP Reauthorization Act



Quality Payment Program Objectives

- To **improve** beneficiary **population health**
- To **improve** the **care** received by Medicare beneficiaries
- To **lower costs** to the Medicare program through improvement of care and health
- To advance the use of healthcare information between allied providers and patients
- To educate, engage and empower **patients as members** of their **care team**
- To maximize QPP participation with a flexible and transparent design, and easy to use program tools
- To maximize QPP participation through education, outreach and support tailored to the needs of practices, especially those that are small, rural and in underserved areas
- To **expand Alternative Payment Model participation**
- To provide accurate, timely, and actionable performance data to clinicians, patients and other stakeholders
- To **continuously improve QPP**, based on participant feedback and collaboration

MIPS VS APMS



Alternative Payment Models

An ***Alternative Payment Model*** (APM) is a payment approach that gives *added incentive payments* to provide *high-quality* and *cost-efficient* care. APMs can apply to a specific clinical condition, a care episode, or a population.



Types of APMS

- APMS-
 - MIPS-APMs
 - Advanced APMs
 - All-Payer/Other Payer options
- MIPS eligible clinicians participating in an APM are also subject to MIPS.
 - MIPS APMs have [MIPS eligible clinicians](#) participating in the APM on their CMS-approved participation list.
 - An Advanced APM is a track of the Quality Payment Program that offers a 5 percent incentive for achieving threshold levels of payments or patients through Advanced APMs. If you achieve these thresholds, you are excluded from the MIPS reporting requirements and payment adjustment.



Example of APM

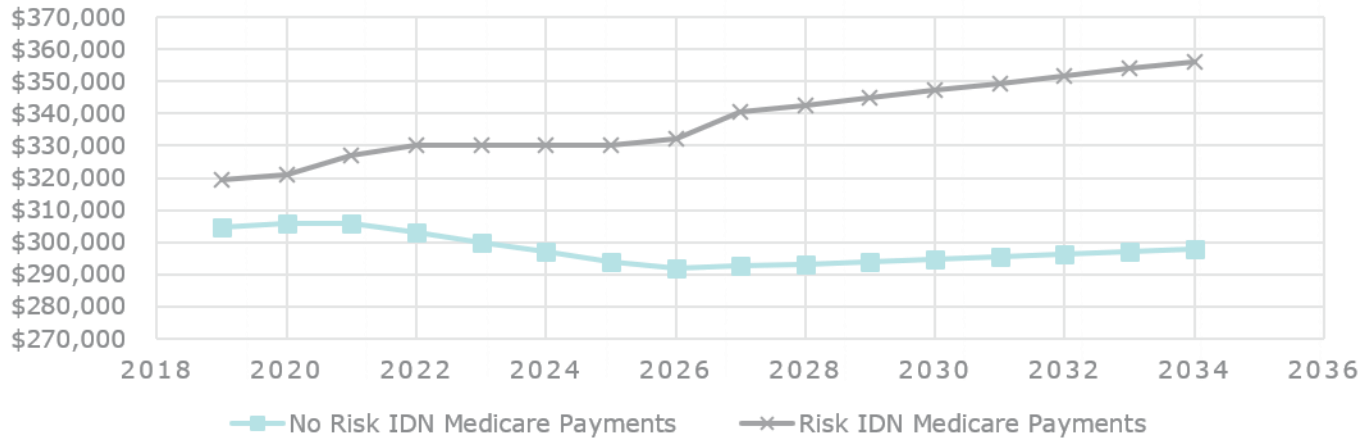
- Medicare Shared Savings ACO (MSSP)
 - Formation
 - # of lives
 - Providers in to be measured and have opportunity for incentive payment
 - Establish average total spend (benchmark)
 - Measure quality and review total spend annually
 - Claims data and legal protections



Physician Fee Schedule Increases Will Not Keep Pace With Inflation

2015 and earlier	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026 and later
Fee Schedule Updates	0.5 %	0.5 %	0.5 %	0.5 %	0	0	0	0	0	0	0.75% QAPM 0.25% Non-QAPM

**MEDICARE PAYMENT PER PCP/SPECIALIST TRIAD
RISK VS. NO RISK**



↑
Risk Required

Medicare payments include fee schedule reimbursement, MIPS adjustments and shared savings.

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MIPS Scores Drives Payments

Shifting Payments to High-Performing Providers

Provider in MIPS (including MIPS APMs) are placed on a curve and their reimbursement adjusted based on relative performance



Low Scoring Clinicians

**> \$1 Billion in Penalties
2019 - 2024**

Payments will be redistributed annually to clinicians above the performance threshold by taking these payments away from clinicians below the threshold

High Scoring Clinicians



**> \$3 Billion in Incentives
2019 - 2024**

\$500M will be awarded to "exceptional" performers for six years in addition to base MIPS incentives

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2017 MIPS vs. MIPS-APM Scores

	Actual 2017 MIPS Scores	With 2022 Cost Scoring
	Average	Average
Small Non-APM Practice	43	28
Rural Non-APM Practice	63	48
All Non-APM Participants	66	51
All APM Participants	88	88
Caravan Health APM Participants	92	92

Source: <https://www.cms.gov/blog/quality-payment-program-qpp-year-1-performance-results>

The very best, top-performing practices will get average MIPS scores and little or no upward adjustment if they are not in an ACO.

- ACO quality scores are better due to having claims data to find missing results, six weeks to polish data and only reporting on a sample of attributed patients. ACO average quality score is 91%.
- Cost was not counted in 2017 MIPS reporting. In 2019 the weight on cost will be between 15%, going to 30% by 2022. We estimate that APM participants will have an average 29 point advantage over all other providers in 2019 and a 41 point advantage in 2022.

Medicare's Next Move: An Overhaul to ACOs

ACOs, a type of an Alternative Payment Model (APM), are groups of healthcare providers that take responsibility for the total cost and quality of care for their patients, and in exchange they can receive a portion of the savings they achieve. To ensure the ACO program delivers the most value, Pathways to Success is designed to advance five goals: **Accountability, Competition, Engagement, Integrity, and Quality.**



Changes

Accountability and Competition: The final rule reduces the amount of time that an ACO can remain in the program without taking accountability for healthcare spending from six years to two years for new ACOs and three years for new “low revenue” (physician-led) ACOs, including some rural ACOs. The rule also strengthens incentives by providing higher shared savings rates as ACOs transition and accept greater levels of risk.

Quality: To increase flexibility for ACOs taking on risk, Pathways to Success expands access to high-quality telehealth services that are convenient for patients, including telehealth services provided at a patient’s place of residence.

Beneficiary Engagement: Pathways to Success promotes beneficiary engagement and improved health outcomes by allowing ACOs to offer new incentive payments to beneficiaries for taking steps to achieve good health, such as obtaining primary care services and necessary follow-up care. In addition, this rule requires ACOs to provide beneficiaries with a written explanation in person or via email or patient portal of what it means to be in an ACO to put patients in the driver seat.

Integrity: This rule establishes rigorous benchmarks by incorporating factors from regional Medicare spending to establish an ACO’s benchmark during all agreement periods, providing a more accurate point of comparison for evaluating ACO performance. In addition, ACOs that terminate their participation will be accountable for prorated shared losses.



Seema Verma's Rural Offerings

1. QPP provides support for small, underserved, and rural practices...helping them actively participate in the program.
2. Advancing new telehealth payment policies across the board to cover more services.
3. Working with the FCC to accelerate the expansion of broadband capabilities to support telehealth technology in rural communities.
4. Due to differences in Medicare wage index, issued a proposed rule to increase reimbursement to rural hospitals that would allow them to improve quality, attract more talent, and expand patient access.
5. Expanding value-based payment arrangements that cater to the unique needs of rural communities and recently announced the new CMS Primary Cares Initiative, which offers 2 pathways—Primary Care First and Direct Contracting—and five voluntary model options to test how to pay for primary care.



The Bird's Eye View

To maintain sustainability, regardless of your size, volume or location, Medicare **has the intention to bend the cost curve and purchase high quality services.**

To achieve this goal, Medicare **seeks to change the system** in delivery and payment.

Inherent in these efforts is a requirement for providers to **engage in risk.**

The system is built to award providers taking risk and the result is that those not taking risk are **significantly disadvantaged** in succeeding in transformation.

There is **currently no way to increase reimbursement** unless you engage in risk.



What is the *Rural Option?*



#1 Reason Why Rural Providers Don't Engage

They are exempt.

Many rural providers are exempt from required participation in MIPS so they are not engaging in value-based initiatives.

Transformation is happening even if you are exempt from reporting, so **rural providers are falling behind.**

#2 Reason Why Rural Providers Don't Engage

They don't have enough volume.

They **don't meet the patient volume requirements** for some APMs. Participation could require collaboration outside of their community or system, and the **cost** to build infrastructure is **high** and return on investment very low.



#3 Reason Why Rural Providers Don't Engage

The program isn't designed for silos of the care continuum.

Focus is on total spend by payor on a patient.

Since rural patients go to specialists or other providers out of the rural system or community, it is **difficult to determine and manage the total spend.**



#4 Reason Why Rural Providers Don't Engage

Current Rural programs don't incentivize detailed documentation.

RHCs that get paid an All Inclusive Rate haven't historically documented more than four conditions, which doesn't show the severity of the disease state. The result is that through claims analysis the rural providers billing amount does **not align the amount of resources needs for the reported the disease state.**

#5 Reason Why Rural Providers Don't Engage

Medicare payment models are moving to downside risk.

Medicare's intention is to move away from Fee For Service payments to Fee For Value payments. All future programs favor those accepting risk but **downside risk may not be approved** by rural boards.

Transformation Effect on Rural

There is **no other option to receive an increase** in payment other than value-based payments.

Not reporting data shows up in Physician Compare with no quality score and **perceived** as a negative score and provider is of **low quality**, which will divert patients away from rural providers.

Contact Information

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Resources

- <https://www.cms.gov/newsroom/press-releases/cms-finalizes-pathways-success-overhaul-medicares-national-aco-program>
- <https://www.cms.gov/newsroom/press-releases/remarks-administrator-seema-verma-national-rural-health-association-annual-conference>

