



NATIONAL
RURAL HEALTH
RESOURCE CENTER

Flex Coordinator
Learning Collaborative 201
Week 6

The Big Picture - Results Matter

Shannon Calhoun

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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



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



Medicare is Changing: 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 current reimbursement** unless you engage in risk.



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 Care Initiative, which offers 2 pathways—Primary Care First and Direct Contracting—and five voluntary model options to test how to pay for primary care.



Commercial Payors are Changing

**Figure 2: LAN APM Measurement Effort Results:
Comparison between 2015, 2016, and 2017 Payments**



Figure 2 compares data from CY 2015, CY 2016, and CY 2017. In 2015, data was collected from 70 plans and 2 managed FFS Medicaid states, which represented 198.9 million lives or 67% of the U.S. covered population. In 2016, the data was collected from 78 plans, 3 managed FFS Medicaid states, and Medicare FFS. This represented 245.4 million lives or 84% of the U.S. covered population. In 2017, the data was collected from 61 plans, 3 states, and Medicare FFS, representing 226.3 million lives or 77% of the U.S. covered population.⁴

(https://revcycleintelligence.com/images/site/articles/_large/LAN_Chart_1%2C_Healthcare_Payments_by_Category.jpg)

Source: Health Care Payment Learning & Action Network (LAN)



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Demographic Changes

Influencing the framework:

- Baby Boomers entering retirement age,
- Millennials seeking healthcare through technology

A growing divide in consumer demand for delivery:

- Aging with complex chronic conditions require long term management of diseases
- Young measuring value through convenient access to primary care and wellness



Paradigm Shift

Merriam Webster's definition of a paradigm shift is

“an important change that happens when the usual way of thinking about or doing something is replaced by a new and different way.”



THE Paradigm Shift

We are in a discovery phase of THE Paradigm Shift in healthcare.

It is currently referred to as Transformation...to address both payment and delivery reform.

The shift is from reactive care to proactive care, from provider siloed to patient centered, and from transactional payments to outcome-based payments.

And there is opportunity to be successful!



Components of an Alternative Payment Model

- 1. Payments for Services.** The APM needs to pay healthcare providers in a way that reduces or eliminates any barriers in the current payment system that impede delivering high-value services to the eligible patients;
- 2. Accountability for Spending.** The APM needs a mechanism for assuring patients and payers that avoidable spending will decrease (if the goal of the APM is to achieve savings), or that spending will not increase (if the goal of the APM is to improve quality);
- 3. Accountability for Quality.** The APM also needs a mechanism for assuring that patients will receive equal or better quality of care and outcomes as they would with the kind of care they receive under the current payment system; and
- 4. Patient Eligibility.** The APM needs a mechanism for determining which patients will be eligible for the services supported by the APM



Current State of Healthcare

Maintaining the current state is
not sustainable.

The future of healthcare requires
change in both payment and
delivery.



Payment Reform: 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
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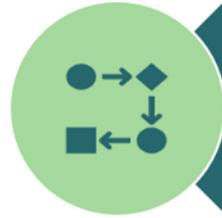


Alternative Payment Models

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.



Delivery Reform: Population Health Program Strategies



Workflow and Process



Prevention and Wellness



Coding, Documentation
and Reporting



Clinical Integration By Definition

“the means to facilitate the **coordination of patient care** across conditions, providers, settings, and time in order to achieve care that is safe, timely, effective, efficient, equitable, and patient-focused.”

-- The American Medical Association



What it is and isn't

Clinical integration tends to have many definitions and is not a firm set of principles or practices. It does not require a “closed” system of information, where one hospital or health care organization monitors and influences patient care within that system.

Clinical integration is a continuous process of alignment across the **care continuum** that supports the triple aim of health care:



Important!

It is important note that

CINs are a
legal
structure !

CINs are not a
payment model?



Two big problems

Low Volume

And

The Value Story



Tyranny of Small numbers

Rural providers' delivery and payment models are defined and are limited by the relatively small number of they patients serve. The effect of low volume, narrow margins, few options results in being ruled by the "tyranny of small numbers".

The unintended consequence is that in statistical terms rural providers are "outliers".



So why does this matter?

In the current state of health care reform-both payment and delivery reform--due to the spiraling increase in cost of care--the entities that pay provider's bills, or payors, are seeking to control cost. In doing so, they use data to determine their risks and ***the result is identifying and ultimately excluding outliers.***

The US Census Bureau reports that there are approximately 60 million people in rural American, and yet rural health is considered an outlier.



Thinking from a Payor Perspective

Managing the medical budget involves risk and risk analysis.

Risk analysis requires statistics.

And in statistics there are outliers.

Because of the tyranny of small numbers, **rural providers are outliers.**

Outliers are unimportant if they capture inaccurate information, and/or if they carry little weight in the analysis.

Outliers are really important if they carry a lot of weight, and/or if they give you important information that the more “normal” data don’t.



What
is the
Rural Option?



What are we thinking?

- We provide a service and we get paid, right?
- Has that changed?
- What service do we provide?
- How do we get paid?
- We are different!
- We are too small!
- We are exempt!
- That we are valuable because.....?



Become statistically important!



Opportunities in Coalitions, Collaborations and Networks

Volume	Infrastructure	Vehicle	Platform	Foundation
<ul style="list-style-type: none">• Patients• Data• Empirical Evidence of Value	<ul style="list-style-type: none">• Shared services• Shared Governance• Shared Cost	<ul style="list-style-type: none">• Participate in payment models• Shared services with different types of providers	<ul style="list-style-type: none">• Virtual integration• Collaboration	<ul style="list-style-type: none">• Act as an enterprise• Maintain financial autonomy



data

MUST

reflect your story

in order to demonstrate

value



Contact Information

Shannon S Calhoun

c.361.648.9799

shannonscalhoun@networkeffectus.com



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