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RESOURCE CENTER

Flex Coordinator
Learning Collaborative
Week 1

Healthcare Transformation
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

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Context

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

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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

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Webinar Series

1. Healthcare Transformation: Understanding Payment and Delivery Reform
2. Success in Transformation: How Population Health can grow Primary Care (the leader of healthcare transformation).
3. Delivery Reform for Payment Reform: Practice Transformation
4. How to demonstrate Value: Hierarchal Condition Category Coding.
5. Return on Investment to Value Based Care
6. The Big Picture-RESULTS MATTER

Webinar Prework

- Survey hospitals and ask if they are in any value based contracts or programs.
- Find 5 hospitals that agree to let you reach out to them weekly to gather information about their Value Based contracts/Services.

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Health Care Transformation: How did we get here?

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

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Industry and Market Trends

Percentage of GDP

20
15
10
5
0

2007 2012 2017 2022 2027 2032 2037 2042 2047 2052 2057 2062 2067 2072 2077 2082

$446B
$591B
$1.042 T

Effect of Excess Cost Growth
Interaction of Aging
and Excess Cost Growth
Effect of Aging of Population

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MACRA

1. Stopped the Doc Fix, aka SGR (the Sustainable Growth Rate)

2. Developed the Quality Payment Program, or QPP

3. QPP links payments to the quality of care provided through two pathways:

   - Merit-Based Incentive Payment System (MIPS)
   - Alternative Payment Models (APMs)

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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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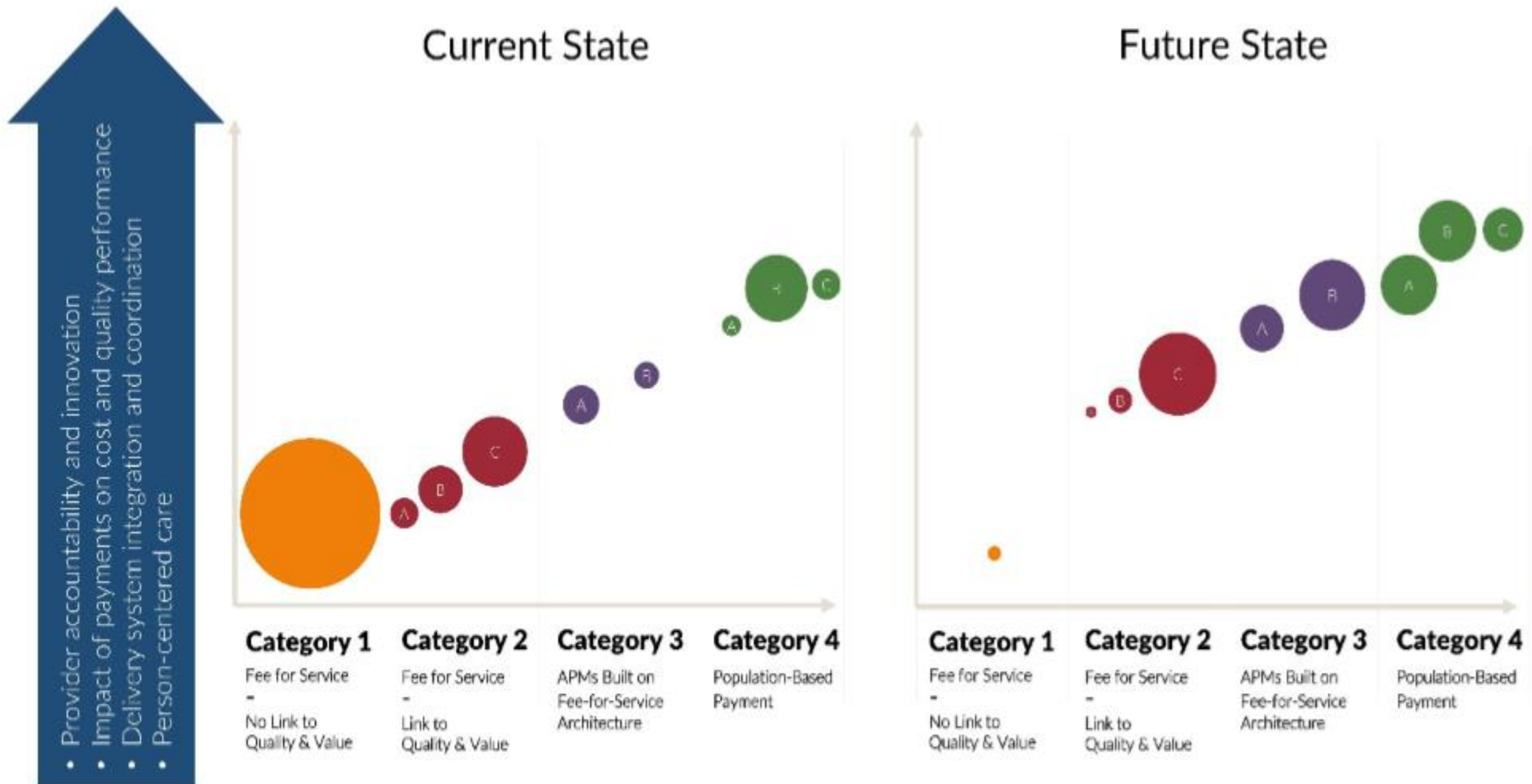
Foundations of Transformation

- Provider Accountability and Innovation
- Impact of Payments on Cost and Quality of Performance
- Delivery System Integration and Coordination
- Person Centered Care

Payment Reform Goals



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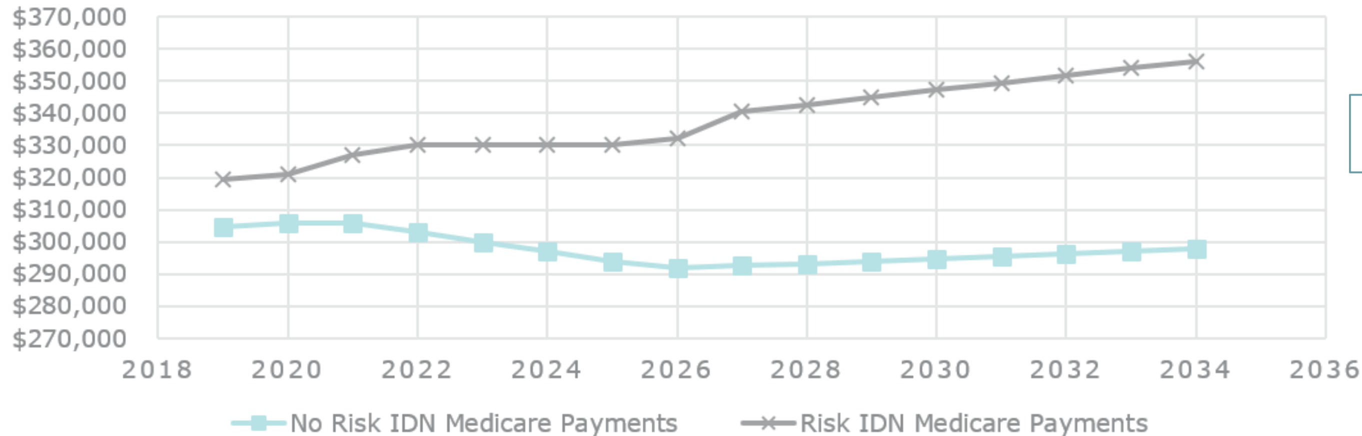
Physician Fee Schedule Increases Will Not Keep Pace With Inflation

	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



Risk Required

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

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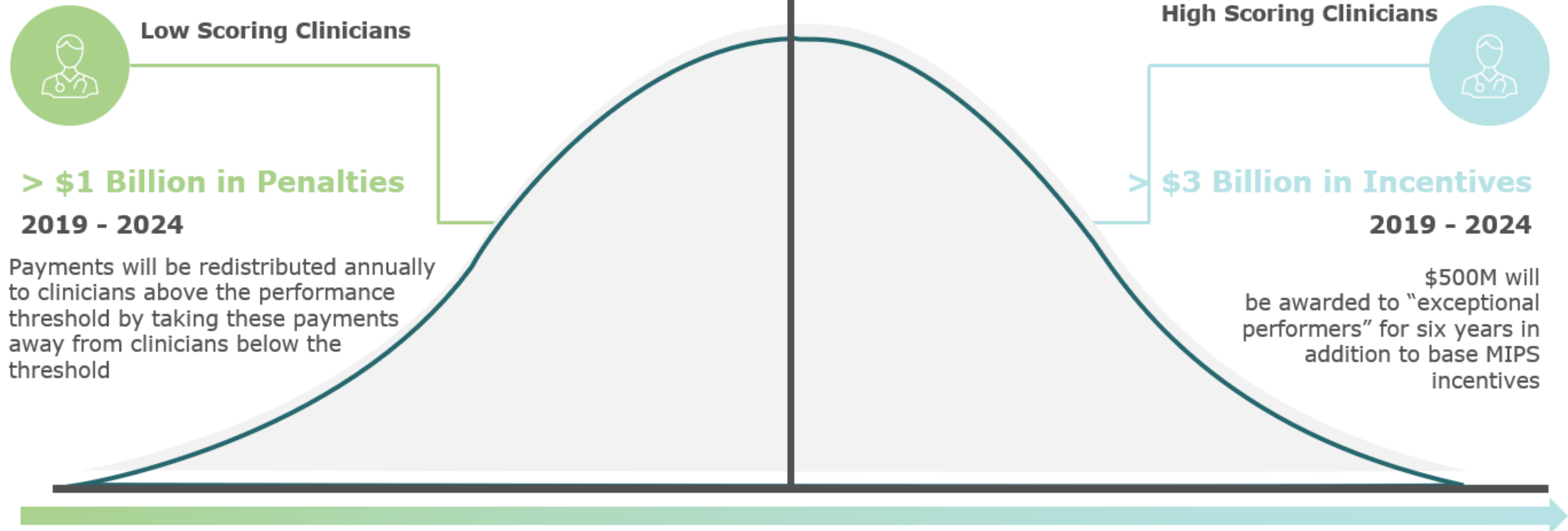
MIPS Scores Drives Payments

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



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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.

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.

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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.

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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

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#1 Reason Why Rural Providers Don't Engage

They are exempt.

Many rural providers are exempt from MIPS so are not engaging in value based initiatives. Transformation is happening even if you are exempt from reporting, so ***rural providers are falling behind.***

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#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.

The ***cost*** to build infrastructure is ***high*** and return on investment very low.

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#3 Reason Why Rural Providers Don't Engage

The program isn't designed for low volume.

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.***

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#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 with the disease state***.

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#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.

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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.

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Questions?

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