The Role of Networks in the Transition Toward Value and Population Health

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Rural Health Innovations (RHI), LLC, is a subsidiary of the National Rural Health Resource Center (The Center), a non-profit organization. Together, RHI and The Center are the nation’s leading technical assistance and knowledge centers in rural health. In partnership with The Center, RHI connects rural health organizations with innovations that enhance the health of rural communities.
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
Current Health System Results

- High cost
- Low quality
- High chronic illness
- Low access
It’s Changing!

Triple Aim
• Better Health
• Better Care
• Lower Cost

• Better Care
• Smarter Spending
• Healthier People
Alternative Payment Models are Taking Shape

Target percentage of payments in ‘FFS linked to quality’ and ‘alternative payment models’ by 2016 and 2018

- Alternative payment models (Categories 3-4)
- FFS linked to quality (Categories 2-4)
- All Medicare FFS (Categories 1-4)

2011  
0%  ~70%

2014  
~20% >80%

2016  
30%  85%

2018  
50%  90%

Historical Performance | Goals

Alternative Payment Models and Sustainability, Advance Interoperable HIE Program Senior Leader Call, February 24, 2016, John Rancourt, Deputy Director, Office of Care Transformation,
HHS/CMS will achieve Goal 1 through alternative payment models where providers are accountable for both cost and quality

<table>
<thead>
<tr>
<th>Major APM Categories</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accountable Care Organizations</td>
<td>Medicare Shared Savings Program ACO*</td>
<td>Pioneer ACO*</td>
<td>Comprehensive ESRD Care Model</td>
<td>Next Generation ACO</td>
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<tr>
<td>Bundled Payments</td>
<td>Bundled Payment for Care Improvement*</td>
<td></td>
<td>Comprehensive Care for Joint Replacement</td>
<td>Oncology Care</td>
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<tr>
<td>Advanced Primary Care</td>
<td>Comprehensive Primary Care*</td>
<td>Multi-payer Advanced Primary Care Practice*</td>
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<tr>
<td>Other Models</td>
<td>Maryland All-Payer Hospital Payments*</td>
<td>ESRD Prospective Payment System*</td>
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</table>

CMS will continue to test new models and will identify opportunities to expand existing models

* MSSP started in 2012, Pioneer started in 2012, BPCI started in 2013, CPC started in 2012, MAPCP started in 2011, Maryland All-Payer started in 2014 ESRD PPS started in 2011

Alternative Payment Models and Sustainability, Advance Interoperable HIE Program Senior Leader Call, February 24, 2016, John Rancourt, Deputy Director, Office of Care Transformation,
Accountable Care Organizations (ACO’s)

Accountable Care Organizations:
- A mechanism to monetize value by increasing quality and reducing cost
- A group of health care providers that takes responsibility for the cost and quality of care for a group of patients or individuals
Update on ACO’s Presence

- **Rapid growth**
  - August 2012: 154
  - January 2015: 747
  - January 2016: 1,000+ (41 new in rural)

- Both hospital and physician led

- Medicare and private insurance models
In August 2015, CMS issued 2014 quality and financial performance results showing that Medicare Accountable Care Organizations (ACOs) continue to improve the quality of care for Medicare beneficiaries, while generating financial savings, suggesting that **ACOs are delivering higher quality care to more and more Medicare beneficiaries each year.**

Adapted from Stroudwater
Medicare ACO 2014 Results

- **Pioneer ACOs generated total model savings of $120 million** during Performance Year 3, an increase of 24% from Performance Year 2 ($96 million).

- **Total model savings per ACO increased** from $2.7 million per ACO in Performance Year 1 to $6.0 million per ACO in Performance Year 3.

- The mean **quality score among Pioneer ACOs increased** to 87.2 percent in Performance Year 3, compared to 85.2 percent in Performance Year 2 and 71.8 percent in Performance Year 1.

- The organizations showed **improvements in 28 of 33 quality measures** and experienced average improvements of 3.6% across all quality measures compared to Performance Year 2.

- Ninety-two Shared Savings Program ACOs **held spending $806 million below their targets** and earned performance payments of more than $341 million as their share of program savings.

- Shared Savings Program ACOs that reported in both 2013 and 2014 **improved on 27 of 33 quality measures**.

Adapted from Stroudwater
What is Health?

"Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."

The conditions and circumstances in which people are born, grow, live, work, and age. These circumstances are shaped by a set of forces beyond the control of the individual: economics and the distribution of money, power, social policies, and politics at the global, national, state, and local levels.

WHO and CDC (adapted)
Population Health has Many Determinants

- Health Behaviors (30%)
  - Tobacco Use
  - Diet & Exercise
  - Alcohol & Drug Use
  - Sexual Activity

- Clinical Care (20%)
  - Access to Care
  - Quality of Care

- Social & Economic Factors (40%)
  - Education
  - Employment
  - Income
  - Family & Social Support
  - Community Safety

- Physical Environment (10%)
  - Air & Water Quality
  - Housing & Transit

Rural Health Value, “Understanding the Social Determinants of Health: A Self-Guided Learning Module for Rural Health Care Teams.”, RUPRI, Stratus Health
Tip of the Societal Disparities Iceberg

Disparities in Health

- Social exclusion
- Poverty
- Poor housing
- Drug abuse
- Unemployment
- Racism
- Liquor stores
- Violent neighborhoods
- School suspensions
- Bad schools
- Food deserts
- Red lining
- Crime
- Incarceration
- Injuries
- Substance Use
- Lack of wealth
- Environmental contamination
- Immobility
- Disrupted families
- Suicide
- Segregation
- Blight
- Lack of hope

From Assistant Commissioner, MN Dept of Health, Jeanne Ayers speech to the MN Community Health Workers Alliance Meeting, May 23, 2016
Population Health has Many Partners

- Hospitals
- Clinics
- Mental Health
- Schools
- Government
- Businesses
- Long-Term Care
- Housing
- Public Health
- Faith-based Organizations

Rural Health Innovations
National Rural Health Resource Center
Conversation Question

• Where do you see evidence or demonstration of your network programs addressing population health and social determinants of health?
Networks’ Role in Health Reform

- Rural leadership
- Health information technology (HIT)
- Quality reporting
- Patient and community engagement
- Workforce shortages
- Value-based models
MACRA: Modernizing Payment for Quality

Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)

First step of implementation is a proposed rule:

- On April 27, 2016, the DHHS issued a proposal to align and modernize how Medicare payments
- Quality Payment Program ties payments to the cost and quality of patient care
- Impacts hundreds of thousands of doctors and other clinicians

Source: CMS Press Office press release 4/27/16
Proposed Rule: Quality Payment Program

Implementing the Medicare Access and CHIP Reauthorization Act's (MACRA's) physician payment reforms, 2016-22

<table>
<thead>
<tr>
<th>Year</th>
<th>Fee updates</th>
<th>MIPS and APMs begin operating</th>
<th>Annual fee updates as of 2026</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016</td>
<td>0.5%</td>
<td></td>
<td>0.25% MIPS APMs</td>
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<tr>
<td>2017</td>
<td>0.5%</td>
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<tr>
<td>2018</td>
<td>0.5%</td>
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<tr>
<td>2019</td>
<td>0.5%</td>
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<tr>
<td>2020</td>
<td>0%</td>
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<tr>
<td>2021</td>
<td>0%</td>
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<tr>
<td>2022</td>
<td>0%</td>
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**MIPS Maximum Bonus or Penalty (+/-)**
- 2016: +4% (-4%)
- 2017: +5% (-5%)
- 2018: +7%
- 2019: +7% (-9% continues after 2022)

**APMs Across-the-Board Bonus**
- 2016: 5%
- 2017: 5%
- 2018: 5%
- 2019: 5%

**Additional Funding**
- $15 million available every year for measure development
- $20 million available every year for technical assistance to small practices
- Up to $500 million authorized every year for MIPS bonuses of up to 10% for exceptional performance (2019-24)

Most Medicare clinicians will participate in the Quality Payment Program through MIPS

<table>
<thead>
<tr>
<th>Performance Category</th>
<th>% of Score in Years 1 - 5</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality</td>
<td>50% → 30%</td>
<td>Clinicians choose to report six measures from a range of options that accommodate differences among specialties and practices</td>
</tr>
<tr>
<td>Advancing Care Information</td>
<td>25% → 25%</td>
<td>Clinicians choose to report customizable measures that reflect how they use technology in their day-to-day practice</td>
</tr>
<tr>
<td>Clinical Practice Improvement Activities</td>
<td>15% → 15%</td>
<td>Rewards clinical practice improvements, such as activities focused on care coordination, beneficiary engagement, and patient safety</td>
</tr>
<tr>
<td>Cost</td>
<td>10% → 30%</td>
<td>Score based on Medicare claims using 40 episode-specific measures, meaning no reporting requirements for clinicians</td>
</tr>
</tbody>
</table>
What infrastructures may be needed to make the connections between the social determinants of health and the new financial payment models?
Networks make these payment models work

- Create infrastructure
- Build trust and collaboration
- Share and analyze information
- Creating collective volume
- Creating economies of scale
How Networks Can Help

- Convene
- Facilitate
- Educate
- Manage change
- Manage care
Delivery system must respond at a similar pace to changing payment models in order to maintain financial viability.

Getting too far ahead or lagging behind will be hazardous to their health.
Payment System Path

**POPULATION HEALTH MANAGEMENT (INTEGRATED DELIVERY AND PAYMENT SYSTEM)**

**INITIATIVE IV**
- PCMHR or like model
- Care management/Data analytics
- Evidence based protocols
- Value attribution

**PHASE I**
- F-F-S

**PHASE II**
- Payer and network contracting
- Hot spotting

**PHASE III**
- Plan design
- Risk management
- Value based credentialing support

**PBPS**
- Provider based health plan

**PAYMENT SYSTEM**

**INITIATIVE III**
- Full risk capitated plans
- Strategy

**INITIATIVE II**
- Transitional payment models
- Planning

**INITIATIVE I**
- Self-funded health plan
- FFS quality/utilization

Implementation
Rural Reasons for Optimism

- Revenue stream of the future tied to primary care providers
- Lower beneficiary costs in rural
- Critical access hospitals (CAHs), rural health clinics (RHCs), and federally qualified health centers (FQHCs) have reimbursement advantages in the old payment system
- Rural can change more quickly
- Rural is more community-based
What Rural Providers Can Do Now

• Determine where health providers are now in preparation for value --readiness

• Develop strategies to bridge the gap between current and future payment systems

• Work together in networks to maximize efficiency, shared volume and needed resources
The Challenge:
Crossing the Shaky Bridge

Source: http://www.flickr.com/photos/67759198@N00/2974261334/sizes/o/in/photostream/
Leadership

• Educate & Align Key Leaders:
  – Boards
  – Providers
  – CEO/CFO/CNO/Managers
• Develop a compelling strategic plan to achieve value
Collaboration/Partnerships

• Partner with:
  – Primary care providers
  – Other/community services
  – Businesses
  – Payers?
• Join Networks/Systems
• Engage Community and Patients
A Collaborative Effort
Maximize Finances/Quality

- Maximize Financial and Quality Performance
  - Optimize revenue cycle management and cost accounting
  - Improve customer satisfaction and quality
  - Develop LEAN processes
Care Management

- Develop care coordination capabilities
- Redesign care processes
- Focus on high cost patients
- Focus on chronic illness management
Information Management

- Develop access to shared patient databases
- Gain access to in-depth data analysis
- Use information to improve value of services
- Use information to improve patient outcomes
Technology

• Develop effective:
  – Telehealth applications
  – Websites and social media
  – Handheld technology applications
  – Educational technology
Workforce Preparation

• Help staff understand the “why” of change
• Develop a culture of continuous improvement
• Teach staff new value-based and population health skills and knowledge
• Maximize teamwork and customer focused services
Population Health Management

- Develop new wellness and disease prevention services
- Engage and enlist partnerships with patients and their families
- Lead/join initiatives to address community health needs and issues
A health system that links health care with community stakeholders to create a network of organizations working together to improve population health
“Even if you’re on the right track, you’ll get run over if you just sit there.”
-Will Rogers
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Get to know us better:
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