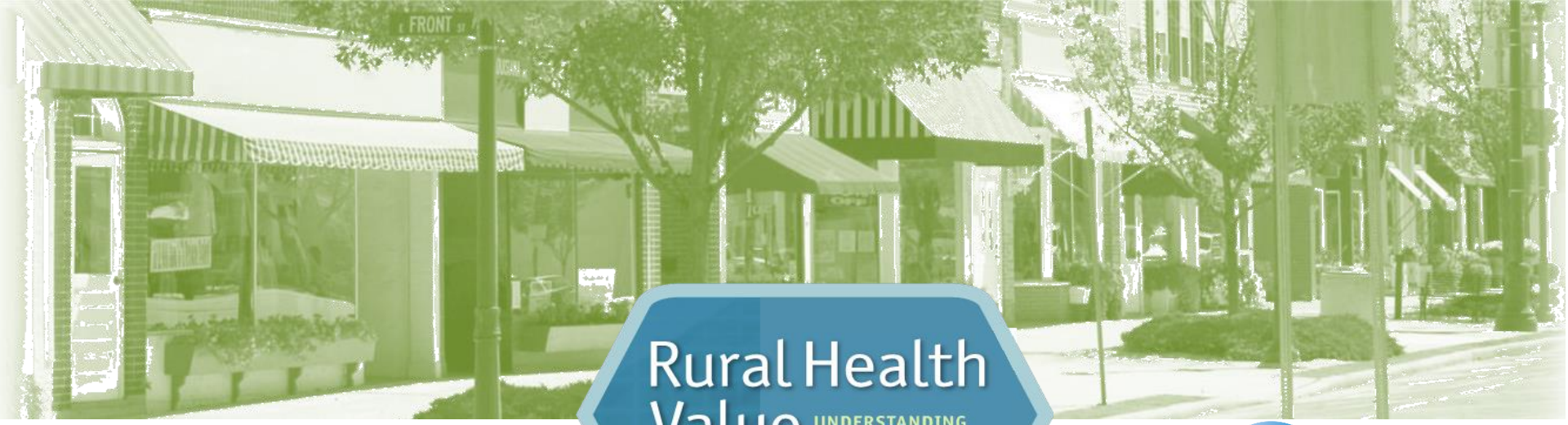

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Center for Rural Health Policy Analysis

Rural Health Value
UNDERSTANDING AND FACILITATING RURAL HEALTH TRANSFORMATION.

StratisHealth

Rural Models in Value-based Care and Payment

Flex Program Reverse Site Visit

Rockville, MD

July 20, 2016

Overview

- New payment models for *Better Care, Smarter Spending, Healthier People*
- Strategies from Rural Innovators
- Rural Health Value resources

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Rural Health Value

Vision: To build a knowledge base through research, practice, and collaboration that helps create high performance rural health systems

- 3-year HRSA FORHP Cooperative agreement
- Partners
  - RUPRI Center for Rural Health Policy Analysis and Stratis Health
  - Support from Stroudwater Associates, WIPFLI, and Premier
- Activity
  - Resource development and compilation, technical assistance, research

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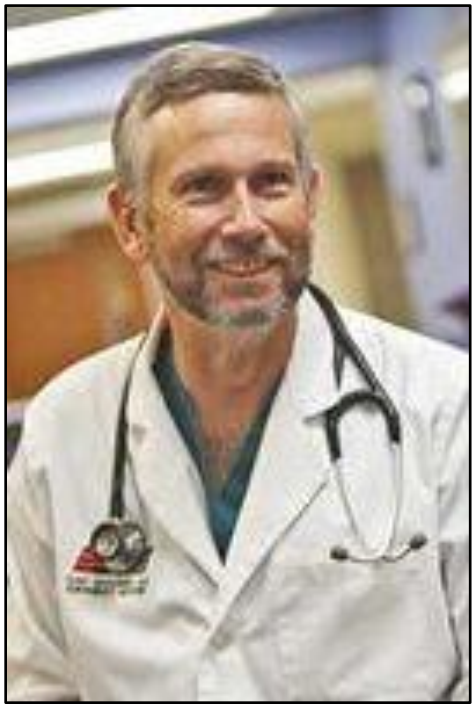
My Muses

Keith Muller, PhD



Clint MacKinney, MD, MS

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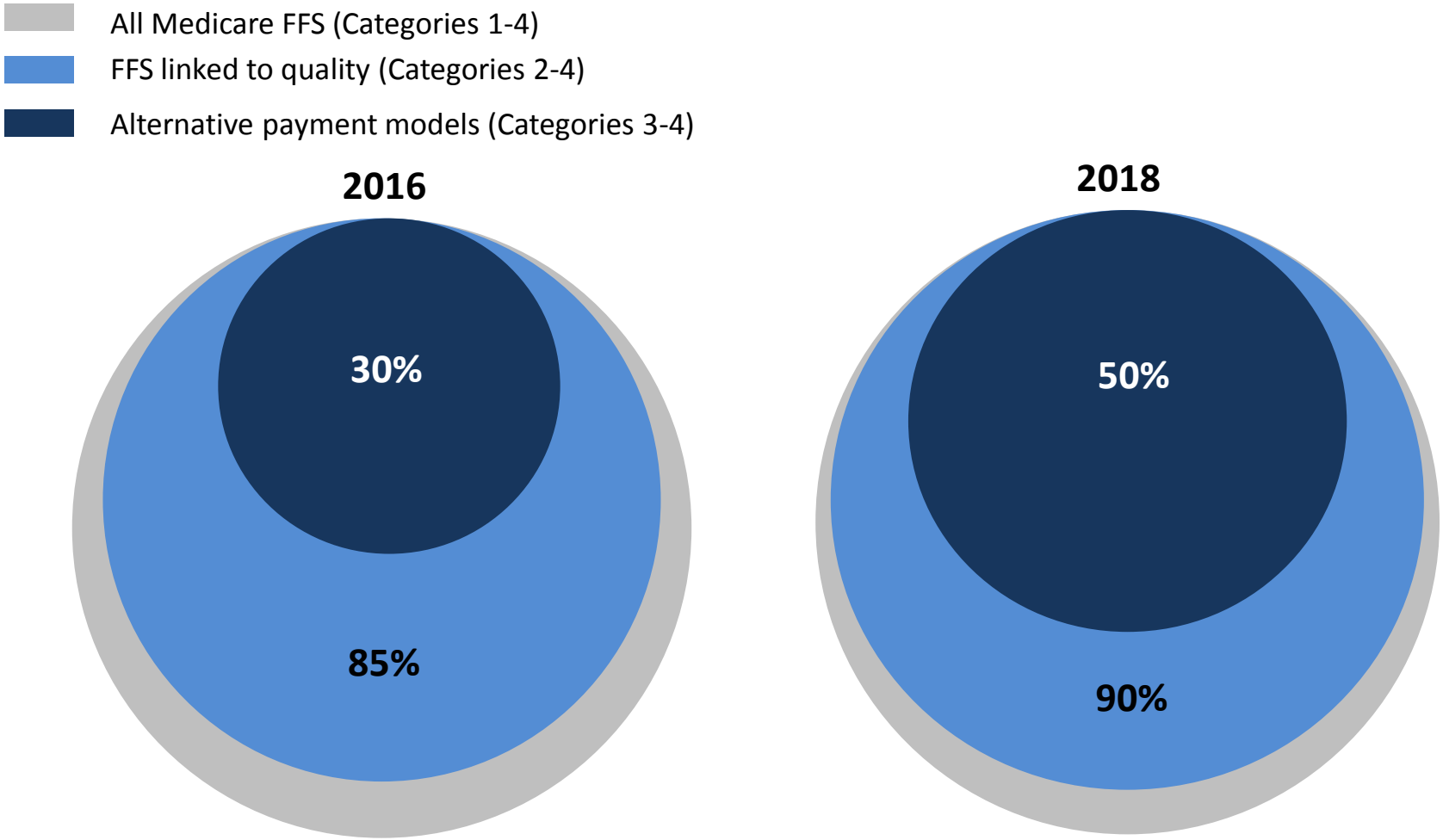
Target percentage of Medicare FFS payments linked to quality and alternative payment models in 2016 and 2018



Source of this and following slides: CMS Fact Sheets available from cms.gov/newsroom. Better Care. Smarter Spending. Healthier People: Paying Providers for Value, Not Volume. January 2015

Evolution of Medicare Payment Through Four Categories

- Fee-for-service with no link to quality
- Fee-for-service with link to quality
- Alternative payment models built on fee-for-service architecture
- Population-based payment

CMS Slogan: Better Care, Smarter Spending, Healthier People

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Payment Taxonomy Framework

	Category 1: Fee for Service—No Link to Quality	Category 2: Fee for Service—Link to Quality	Category 3: Alternative Payment Models Built on Fee-for-Service Architecture	Category 4: Population-Based Payment
Description	Payments are based on volume of services and not linked to quality or efficiency	At least a portion of payments vary based on the quality or efficiency of health care delivery	Some payment is linked to the effective management of a population or an episode of care. Payments still triggered by delivery of services, but opportunities for shared savings or 2-sided risk	Payment is not directly triggered by service delivery so volume is not linked to payment. Clinicians and organizations are paid and responsible for the care of a beneficiary for a long period (e.g. ≥1 yr)
Medicare FFS	• Limited in Medicare fee-for-service • Majority of Medicare payments now are linked to quality	• Hospital value-based purchasing • Physician Value-Based Modifier • Readmissions/ Hospital Acquired Condition Reduction Program	• Accountable care organizations • Medical homes • Bundled payments • Comprehensive primary care initiative • Comprehensive ESRD • Medicare-Medicaid Financial Alignment Initiative Fee-For-Service Model	• Eligible Pioneer accountable care organizations in years 3-5

CMS Slogan: Better Care, Smarter Spending, Healthier People

- **Medical Home Models:**
  - Comprehensive Primary Care Initiative (ending 2016)
  - Multi-payer Advanced Primary Care Initiative (extended through 2016)
  - Federally-Qualified Health Center Advanced Primary Care Practice (ended 2014)
- **Medicare Care Choices:** 141 Hospice providers. Beneficiaries can access hospice services with concurrent curative care (palliative care)
- **Transforming Clinical Practice Initiative:** designed to support 150,000 clinician practices over next 4 years in comprehensive quality improvement strategies through Practice Transformation Networks (PTNs) and Support and Alignment Networks (SANs)

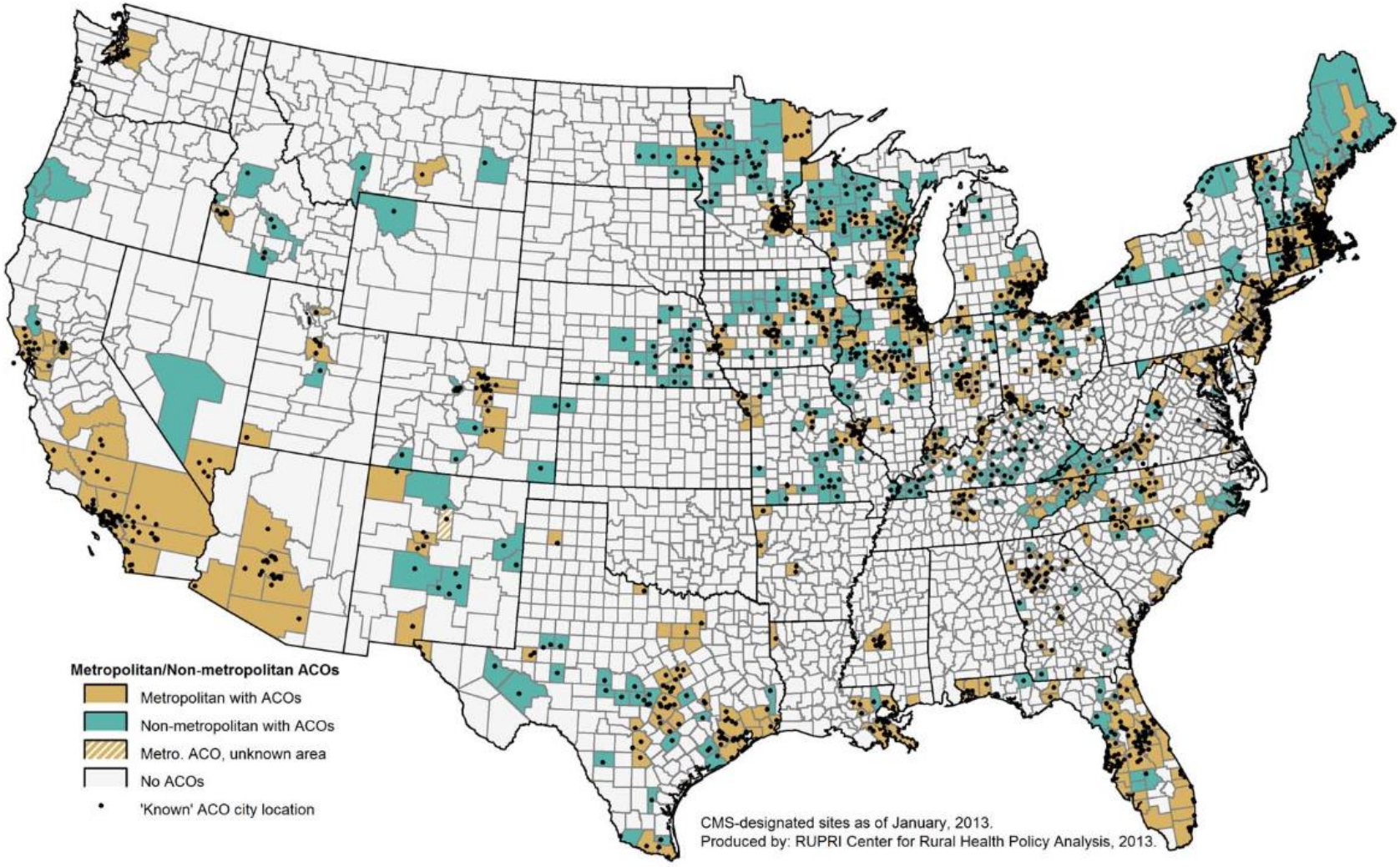
http://www.healthcarecommunities.org/CommunityNews/TCPI/PTNMap.aspx

CMS Slogan: Better Care, Smarter Spending, Healthier People

- **Pay for Value with Incentives:** Hospital-based Value Based Purchasing, Hospital Readmissions Reduction, Hospital-Acquired Condition reduction program, Home Health VBP (9 states)
- **New payment models:** Accountable Care Organizations, Bundled Payments for Care Improvement, Health Care Innovation Awards

Resource on payment models: http://kff.org/report-section/payment-and-delivery-system-reform-in-medicare-a-primer-executive-summary/

County Medicare ACO Presence
Continental United States



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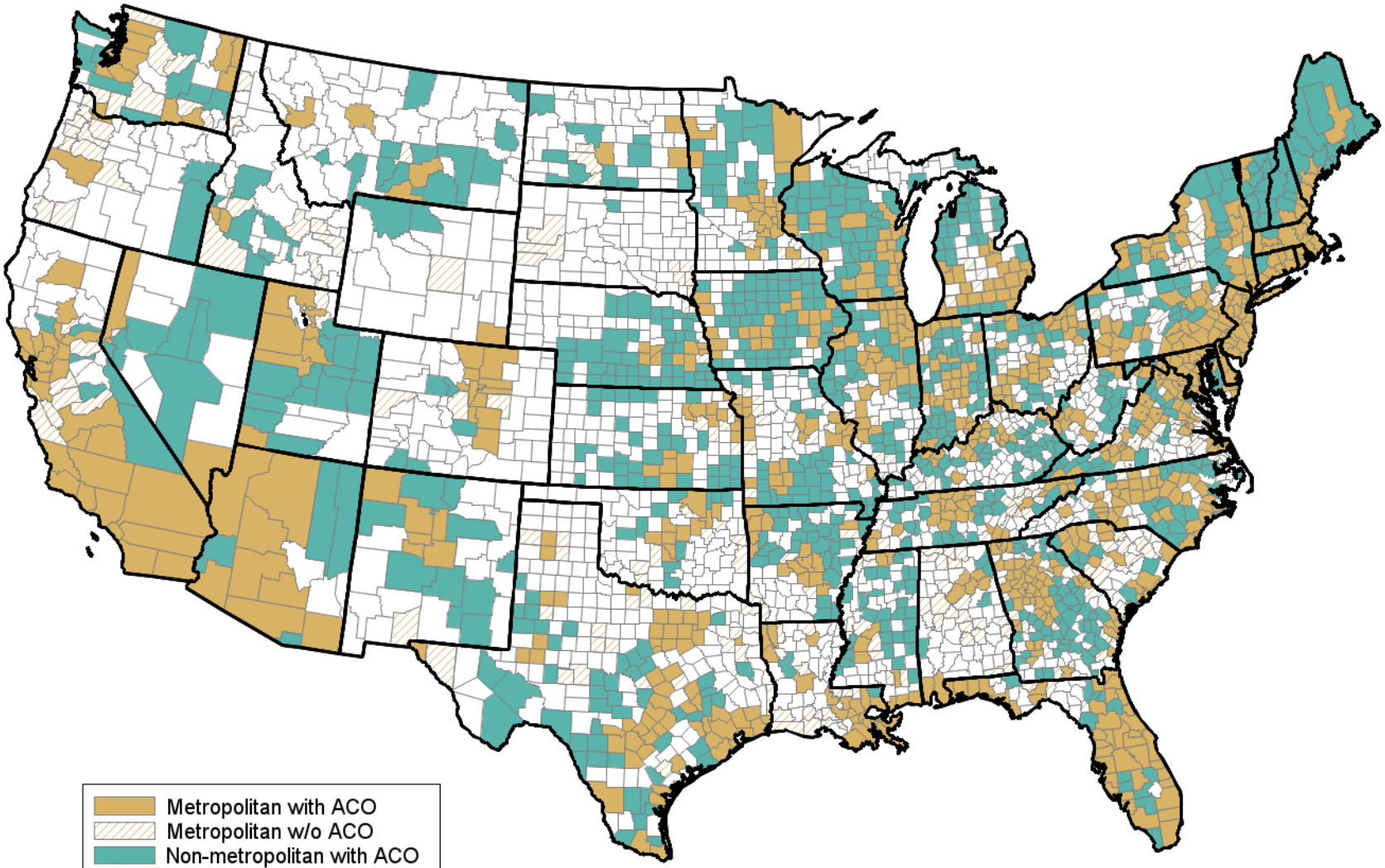
County Medicare ACO Presence

Continental United States



Counties have an 'ACO presence' when they contain the practice site of at least one participating provider.
Includes all active CMS ACOs as of August, 2015.
Produced by: RUPRI Center for Rural Health Policy Analysis, 2016.

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CMS Slogan: Better Care, Smarter Spending, Healthier People

- Partnership for Patients focused on reducing hospital acquired conditions and preventing avoidable hospital readmissions
  - Hospital Engagement Network (HEN) to Hospital Innovation and Improvement Network (HIIN)
- Million Hearts Initiative focused on preventing heart attacks and stroke
- Medicare Diabetes Prevention Program (preventive service model under development)

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And it just keeps coming…

- Medicare Access and CHIP Reauthorization Act (MACRA) Quality Payment Program (QPP):
  - Medicare Incentive Payment System (MIPS) - Alignment of programs to measure quality of physician care, and pay accordingly
  - Advance Payment Models (APMs): Incentive for providers to increase financial risk sharing
- Comprehensive Primary Care Plus initiative: Up to 20 regions including up to 5,000 practices, more than 20,000 doctors and clinicians
- Regional Multi-Payer Prospective Budgets – CMS Request for Information (RFI)

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CMS Models Only Part of the Story

- Growth in Medicare Advantage
  - *Rural* enrollment in 2016: 2.2 million (21.8%)
- State Medicaid Program Redesign
  - Managed Care
  - ACO-type payment structures
- Commercial/Private Insurance
  - Increasing costs/patient risk-sharing
  - Narrow networks

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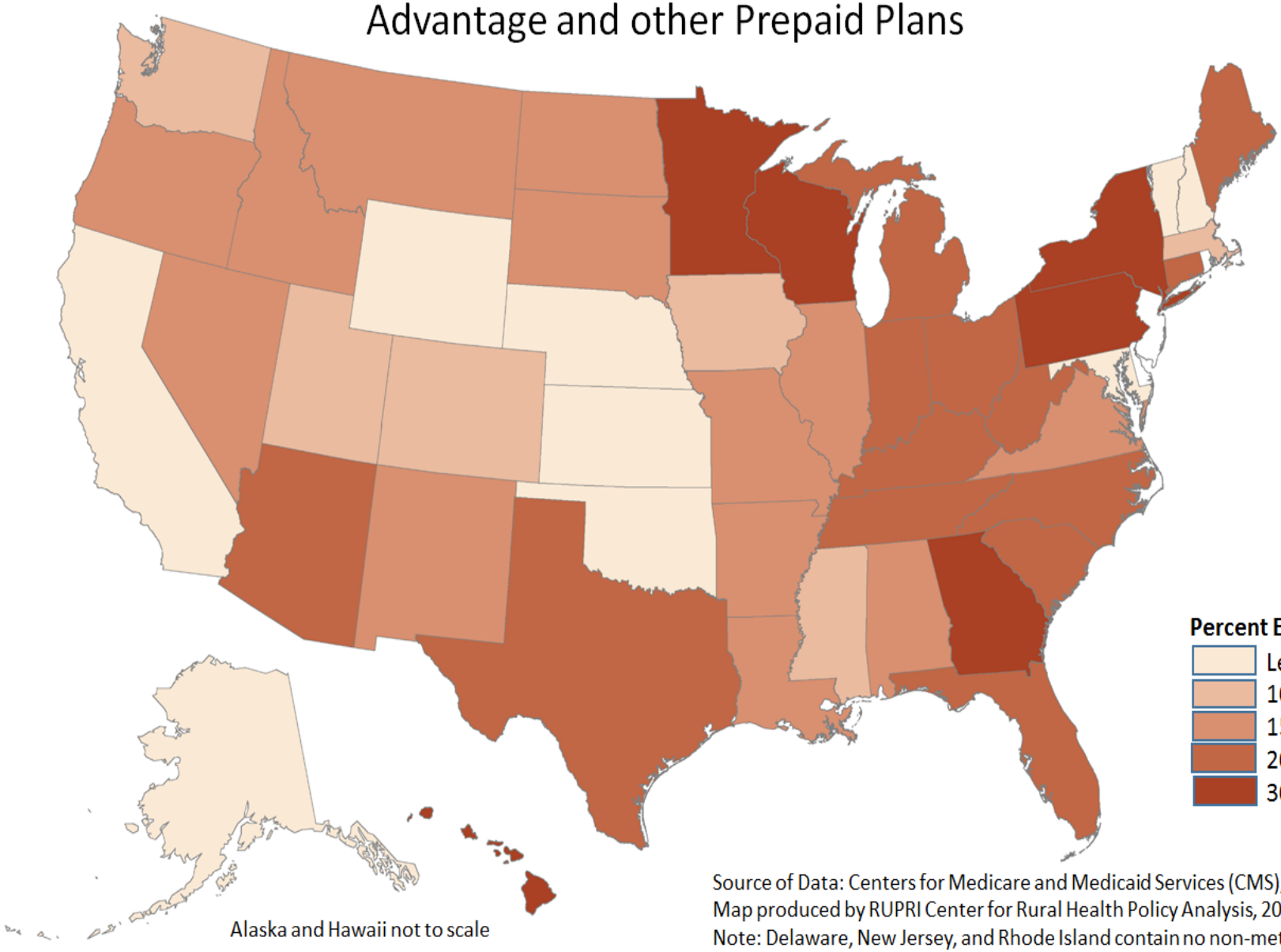
Percent of Eligible Rural Beneficiaries Enrolled in Medicare Advantage and other Prepaid Plans



Alaska and Hawaii not to scale

Source of Data: Centers for Medicare and Medicaid Services (CMS), as of March 2016.
Map produced by RUPRI Center for Rural Health Policy Analysis, 2016.
Note: Delaware, New Jersey, and Rhode Island contain no non-metropolitan counties.

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Keeping the End in Mind

Characteristics of a High Performance Rural Health Care System:

- **Affordable**: to patients, payers, community
- **Accessible**: local access to essential services, connected to all services across the continuum
- **High quality**: do what we do at top of ability to perform, and measure
- **Community based**: focus on needs of the community, which vary based on community characteristics
- **Patient-centered**: meeting needs, and engaging consumers in their care

http://www.rupri.org/wp-content/uploads/2014/09/The-High-Performance-Rural-Health-Care-System-of-the-Future.pdf

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Strategies to Support Innovation: Lessons From the Field

- Reflect a climate of necessity
- Identify resources and funds to test and initiate change
- Find and use the innovators in your community—the people who make it happen
- Encourage creativity, with a focus on meeting individual patient needs

Resource: Rural Health Value - Innovation in Rural Health Care: Contemporary Efforts to Transform into High Performance Systems

www.RuralHealthValue.org

- Physician Engagement - A Primer for Healthcare Leaders
- Engaging Your Board and Community in Value-Based Care Conversations
- Critical Access Hospital Financial Pro Forma
- Value-Based Care Assessment Tool
- Comprehensive Primary Care Plus – A Rural Commentary
- Rural Innovation Profiles

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www.RuralHealthValue.org

Upcoming Tools & Resources

- Guide to Value-Based Initiatives for Rural Providers
- Shared Savings Contract Pro Forma
- CAH Guide: Demonstrating Value to Payers and Partners

Be a leadership voice for rural health care value.
A positive attitude is infectious!

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StratisHealth

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www.ruralhealthvalue.org

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