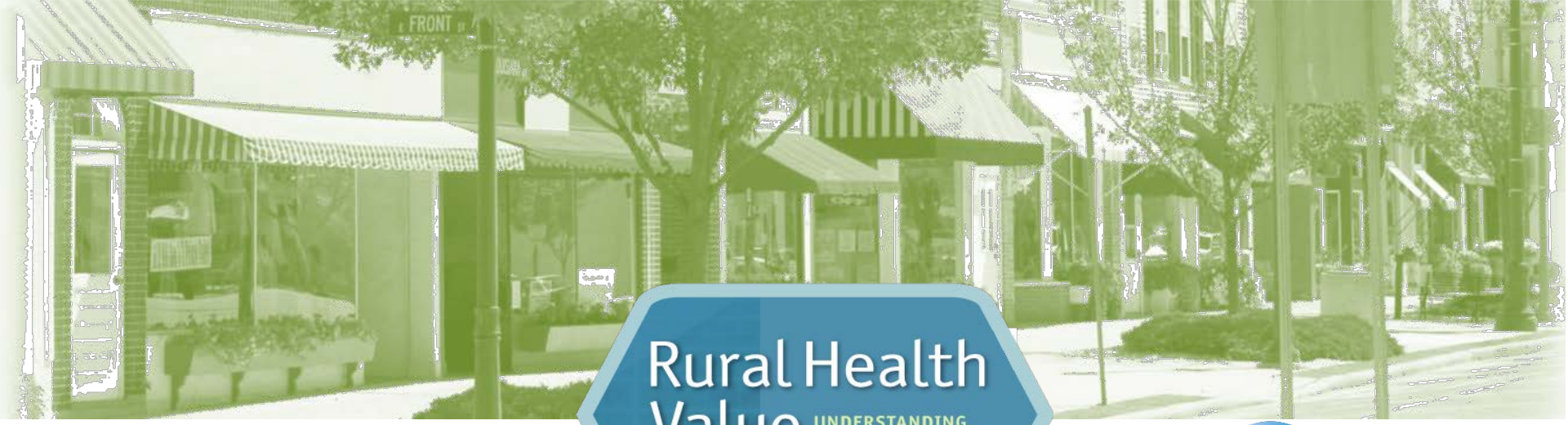

RUPRI
RURAL POLICY RESEARCH INSTITUTE
Center for Rural Health Policy Analysis

Rural Health Value
UNDERSTANDING AND FACILITATING RURAL HEALTH TRANSFORMATION.

StratisHealth

Building Capacity for Value

Oregon CAH Quality and MBQIP Workshop
May 1, 2018

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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Overview

- What is Health Care Value
- Value-based payment models
- Model for Transformation
- Tools and Resources

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Evolving view of value…

$$\text{Value} = \frac{\text{Quality} + \text{Experience}}{\text{Cost}}$$

Seminal article: The Triple Aim: Care, health, and cost. Institute for Healthcare Improvement, published in 2008.

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Depends on your point of view…

https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-01-26.html

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Focus on value is not diminishing…

"There is no turning back to an unsustainable system that pays for procedures rather than value. In fact, the only option is to charge forward — for HHS to take bolder action, and for providers and payers to join with us."

Alex M. Azar II, Secretary of HHS,
March 5, 2018
(Remarks to the Federation of American Hospitals)

Source: https://www.hhs.gov/about/leadership/secretary/speeches/2018-speeches/remarks-on-value-based-transformation-to-the-federation-of-american-hospitals.html

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The Value Conundrum

You can always count on Americans to do the right thing – after they've tried everything else.

-Winston Churchill

- Fee-for-service
- Capitation
- Market
  - **What about paying for value?**
  - **And why is this important?**

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Form Follows Finance

- How we deliver care depends on how we are paid for care.
- Health care reform is changing both payment and delivery.
- Fundamentally, reform involves transfer of financial risk from payers to providers.

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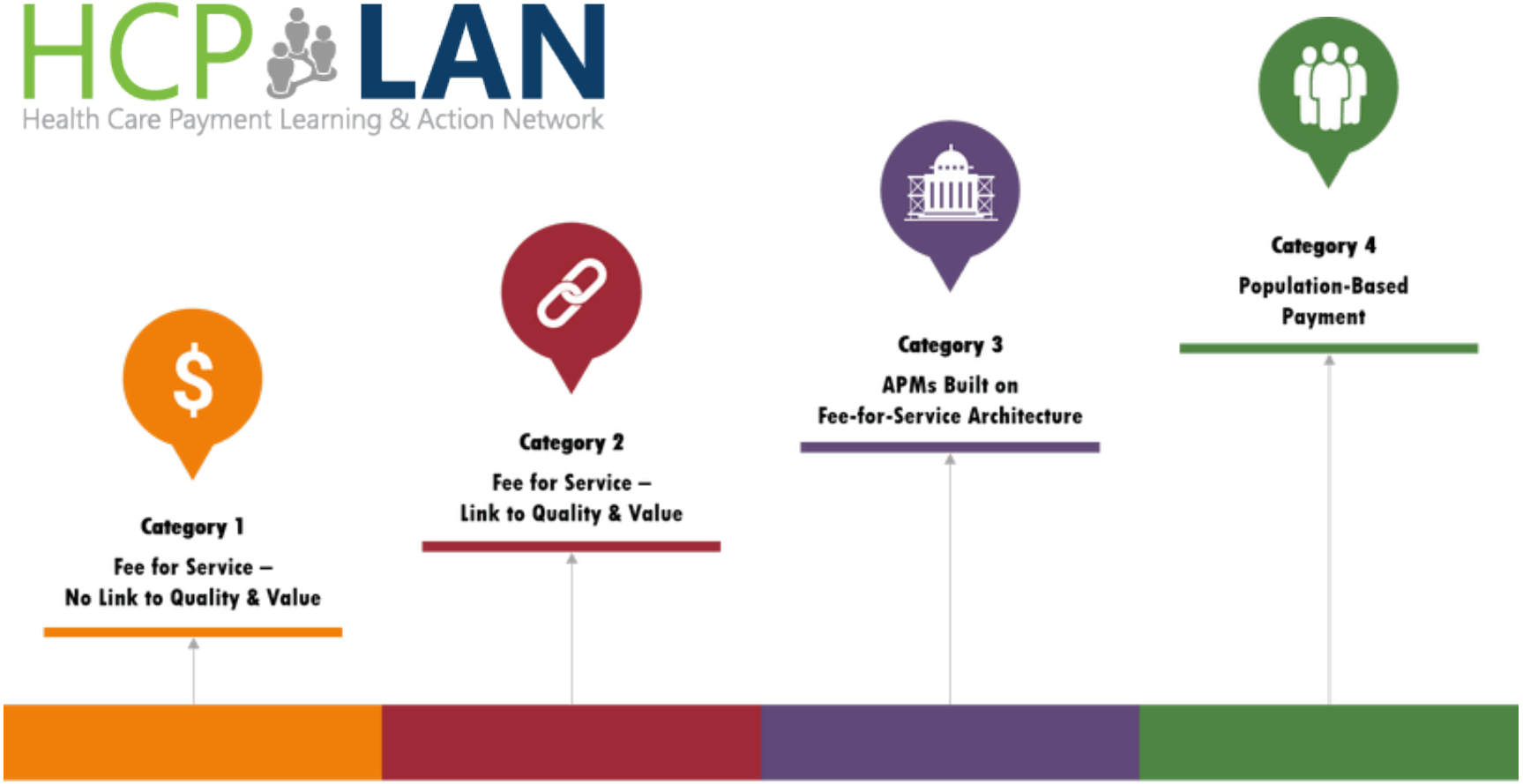
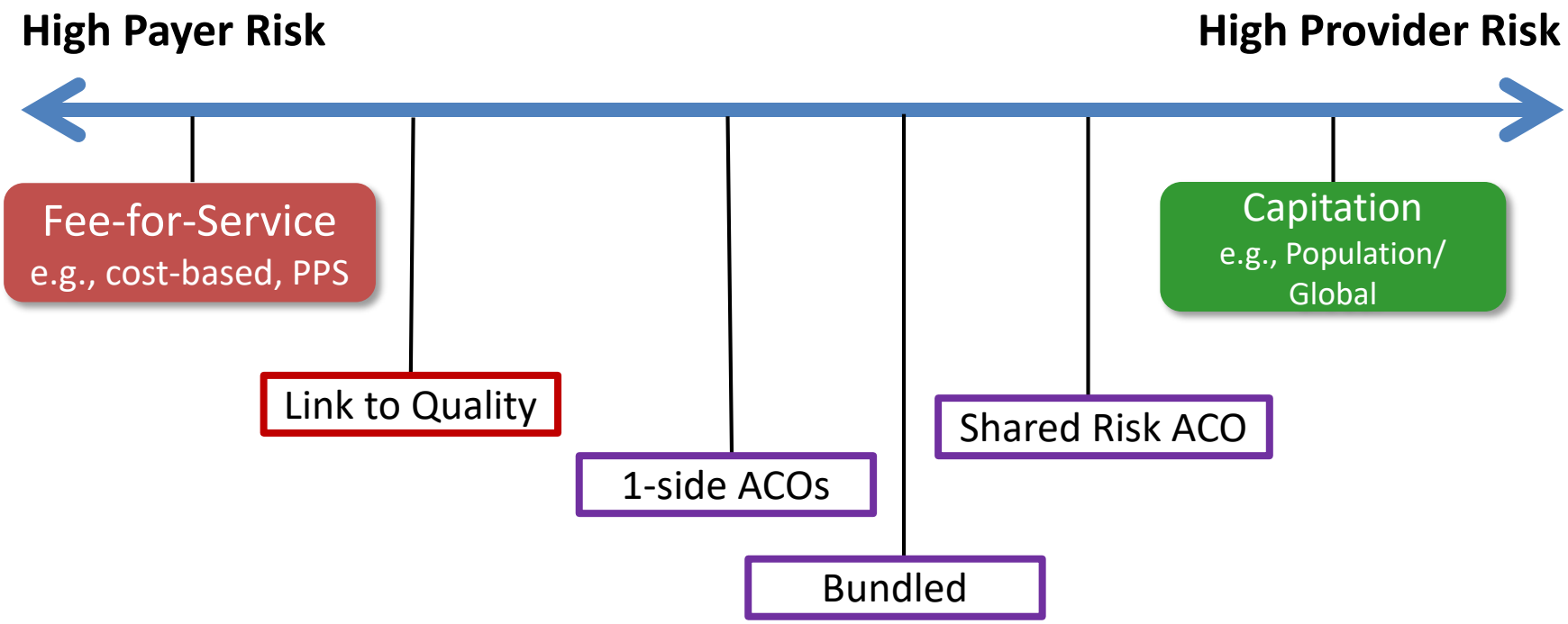
Value-based Payment Taxonomy

HCP LAN
Health Care Payment Learning & Action Network



https://hcp-lan.org/groups/apm-framework-refresh-white-paper/

Payment Risk Continuum



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CMS Drive to Value-based Payment

- Medicare Shared Savings Program (Accountable Care Organizations)
- Hospital Value-Based Payment Program
- Quality Payment Program (as a result of MACRA, the Medicare Access and CHIP Reauthorization Act)
  - MIPS (Merit-based Incentive Payment System)
  - Advanced Alternative Payment Models
- And more…

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Accountable Care Organizations

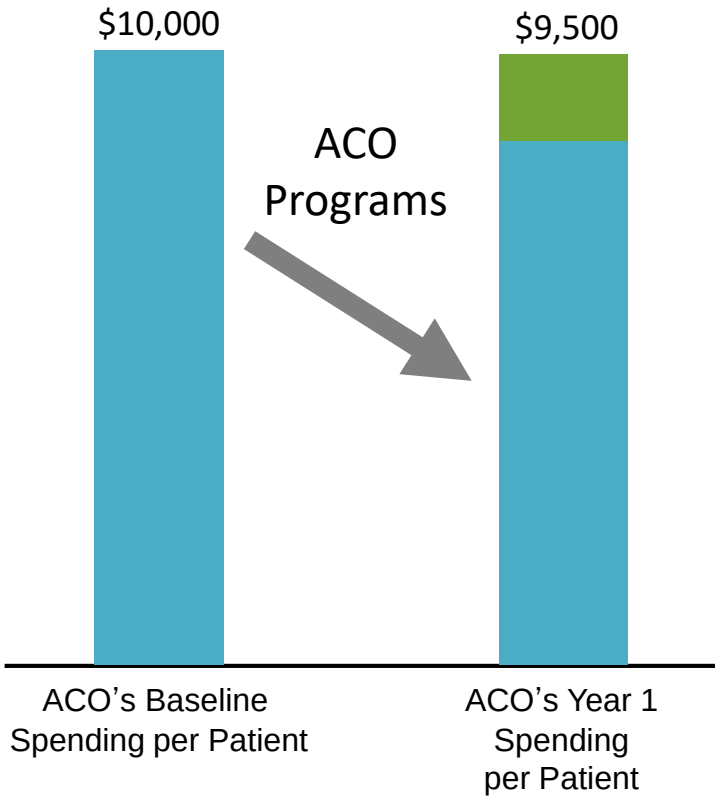
*Groups of providers (generally physicians and/or hospitals) that receive financial rewards to maintain or improve care quality for a group of patients while reducing the cost of care for those patients.**

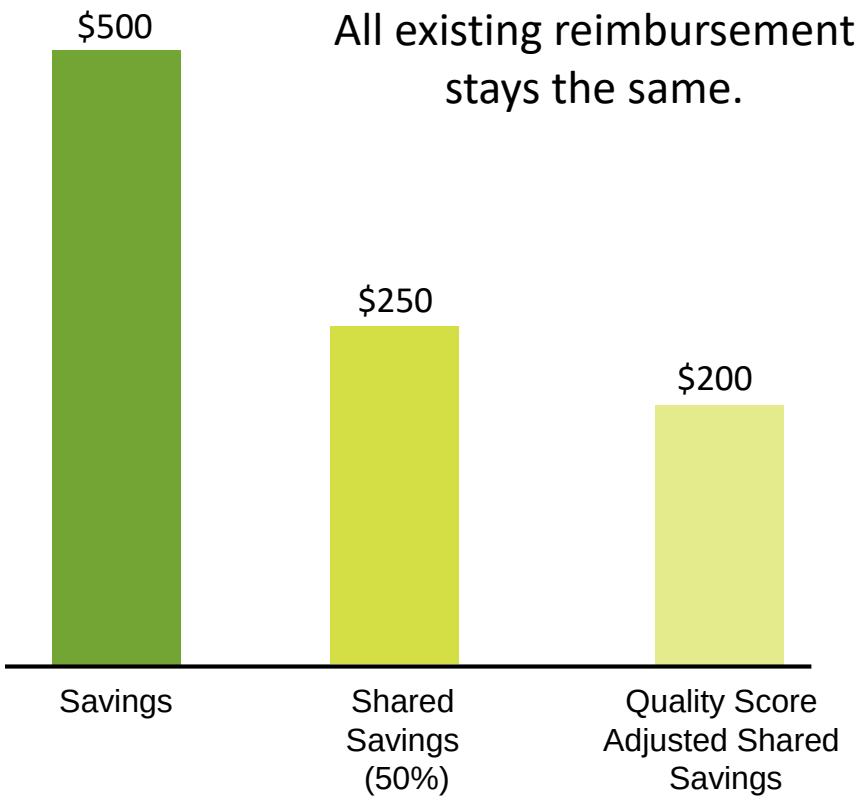
How Medicare ACOs (called Medicare Shared Savings Programs) work:

- Beneficiaries attributed to ACO based on where they receive primary care
- Medicare pays fee-for-service (not capitation)
- CMS shares 50% of difference between estimated and actual cost
- But shared savings percent will be reduced if suboptimal quality

*Source: David I. Auerbach, et al, Accountable Care Organization Formation Is Associated With Integrated Systems But Not High Medical Spending, *Health Affairs*, 32, no. 10 (2013):1781-1788.

ACO Financing





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Presence of ACOs

- Rapid growth of Medicare ACO/Shared Savings
  - August 2012: 220
  - January 2015: 393
  - January 2016: 433
  - January 2018: 561
- Both hospital and physician led
- Critical access hospitals: 421 participating
- Only 13% of non-metro counties have NO Medicare FFS beneficiaries in an ACO
- 22% of non-metro counties have more than 30% of Medicare FFS attributed to and ACO
- In Oregon, 150% increase in the number of non-metro counties with more than 5% of Medicare FFS beneficiaries attributed to an ACO between 2014 and 2016 (17.4% to 43.5%)

Sources: CMS - Medicare Shared Savings Program Fast Facts , RUPRI Center for Health Policy: Medicare Accountable Care Organization Growth in Rural America, 2014–2016

2015 Medicare Shared Savings Program (MSSP) Results

- 400 ACOs = **$466 million** savings
- ACOs improved on 84% of Quality Improvement measures from Year 1 to Year 2
- 125 ACOs qualified for shared savings
- Rural ACOs outperformed urban ACOs on several financial and quality metrics

Source: https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-08-25.html

5 Recommendations For ACO Success

1. Set up care coordination programs
2. Perform annual wellness visits
3. Provide behavioral health support
4. Improve Hierarchical Conditioning Coding (HCC)
5. Improve quality processes/pre-visit planning

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CMS Hospital Value-Based Purchasing (VBP) Program

- 2% withhold, which can be "clawed back" based on performance scores (high performance or improvement)
- 2017 performance domains
  - Experience of Care/Care Coordination (25%)
  - Safety (20%)
  - Clinical Care (30%)
    - Clinical Care – Outcomes (25%)
    - Clinical Care – Process (5%)
  - Efficiency/Cost Reduction (25%)
- VBP is for PPS hospitals only

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BCBS of MI: Rural Hospital P4P

- 2018-2019 Program:
  - Hospital-wide patient safety assessment survey at least once every two years
  - Determines up to 6 percent of a rural hospital's payment rate for the following year. Participation is mandatory.
  - Four program areas:
    - HCAHPS
    - Clinical Quality Indicators
    - Population Health Management
    - Quality Initiatives
- Most CAHs have received the full incentive payment since the program launched

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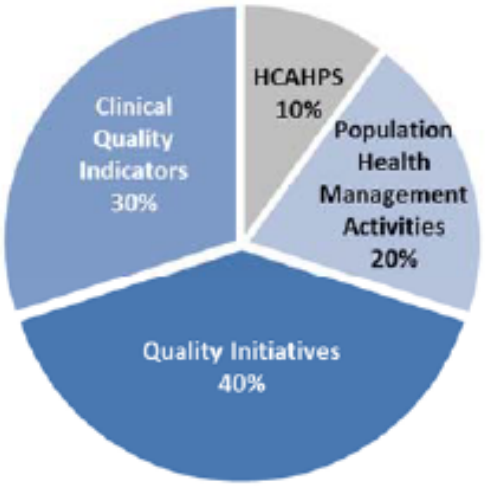
2018-2019 Pay-for-Performance Program structure

Critical Access Hospitals (CAH)

- CMS Outpatient Measures:
  - OP – 5a
- CMS Influenza Measures:
  - OP – 27
  - IMM – 2
- EDTC Composite Measure



Health of the Community:

1. HCAHPS
2. Population Health Management Activities:

- Population Health Champion
- Admit, Discharge, Transfer (ADT) Notification Service

- MICAH Quality Network Participation
- MHA Hospital Improvement Innovation Network (HIIN)

Scoring:

- Performance against benchmark
- Attestation of activities
- Participation in QI initiatives with MICAH and HIIN

Source: https://www.bcbsm.com/providers/value-partnerships/hospital-pay-for-performance.html

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Quality Payment Program (QPP)

- Medicare's new approach to paying physicians and other clinicians as a result of MACRA (Medicare Access and CHIP Reauthorization Act)
- Two tracks:
  - Merit-based Incentive Payment System (MIPS)
    - Eventually **-9%** to **+27%** adjustment in pay
    - Consolidates three existing programs (PQRS, VBM, MU) and adds a new category (improvement activities)
  - Advanced Alternative Payment Models (APMs)
    - **5%** APM bonus
    - Excluded from MIPS performance reporting requirements
- Most physicians/clinicians will initially be paid under the MIPS track
  - Baseline data 2017
  - First bonus/penalty 2019

www.qpp.cms.org

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Quality Payment Program cont.

- MIPs categories:

- Complex program with numerous variables
- Technical Assistance:
  - QIN-QIOs (15 or more clinicians)
  - SURS (Small, underserved, rural – less than 15)
  - PTNs (Practice Transformation Networks)

For more information: www.qpp.cms.org

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Wide variety of models being tested…

- **Comprehensive Primary Care Plus Initiative (CPC+):** focused on primary care redesign, regional and multi-payer
- **Million Hearts Initiative** focused on preventing heart attacks and stroke
- **Accountable Health Communities** focused on enhanced clinical-community linkages to addressing health-related social needs
- **Medicare Care Choices:** 141 Hospice providers. Beneficiaries can access hospice services with concurrent curative care (palliative care)
- **Medicare Diabetes Prevention Program** Wellness coaching program addressing lifestyle factors for individuals at risk of diabetes.

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Resources

- **Rural Health Value:**
  Catalog of Value-Based Initiatives for Rural Providers
  https://cph.uiowa.edu/ruralhealthvalue/InD/Briefs/

- **Kaiser Family Foundation:** Payment and Delivery System Reform in Medicare: A Primer on Medical Homes, Accountable Care Organizations, and Bundled Payment
  http://kff.org/report-section/payment-and-delivery-system-reform-in-medicare-a-primer-executive-summary/

- **Brookings Institute:** The Beginners Guide to New Health Care Payment Models
  https://www.brookings.edu/blog/health360/2014/07/23/the-beginners-guide-to-new-health-care-payment-models/

CMS Models Are Only Part of the Story

- Growth in Medicare Advantage
  - *Non-metro* enrollment in 2017: about 2.4 million nationally (23%)
  - In Oregon varies by county from 3% to 33% in non-metro counties
- State Medicaid Program Redesign
  - Managed Care
  - ACO-type payment structures (CCO's)
- Commercial/Private Insurance
  - Increasing costs/patient risk-sharing
  - Narrow networks

Value-based payment is here to stay!

(but acronyms and programs likely to change)

Medicare Advantage Data: https://www.public-health.uiowa.edu/rupri/maupdates/nstablesmaps.html

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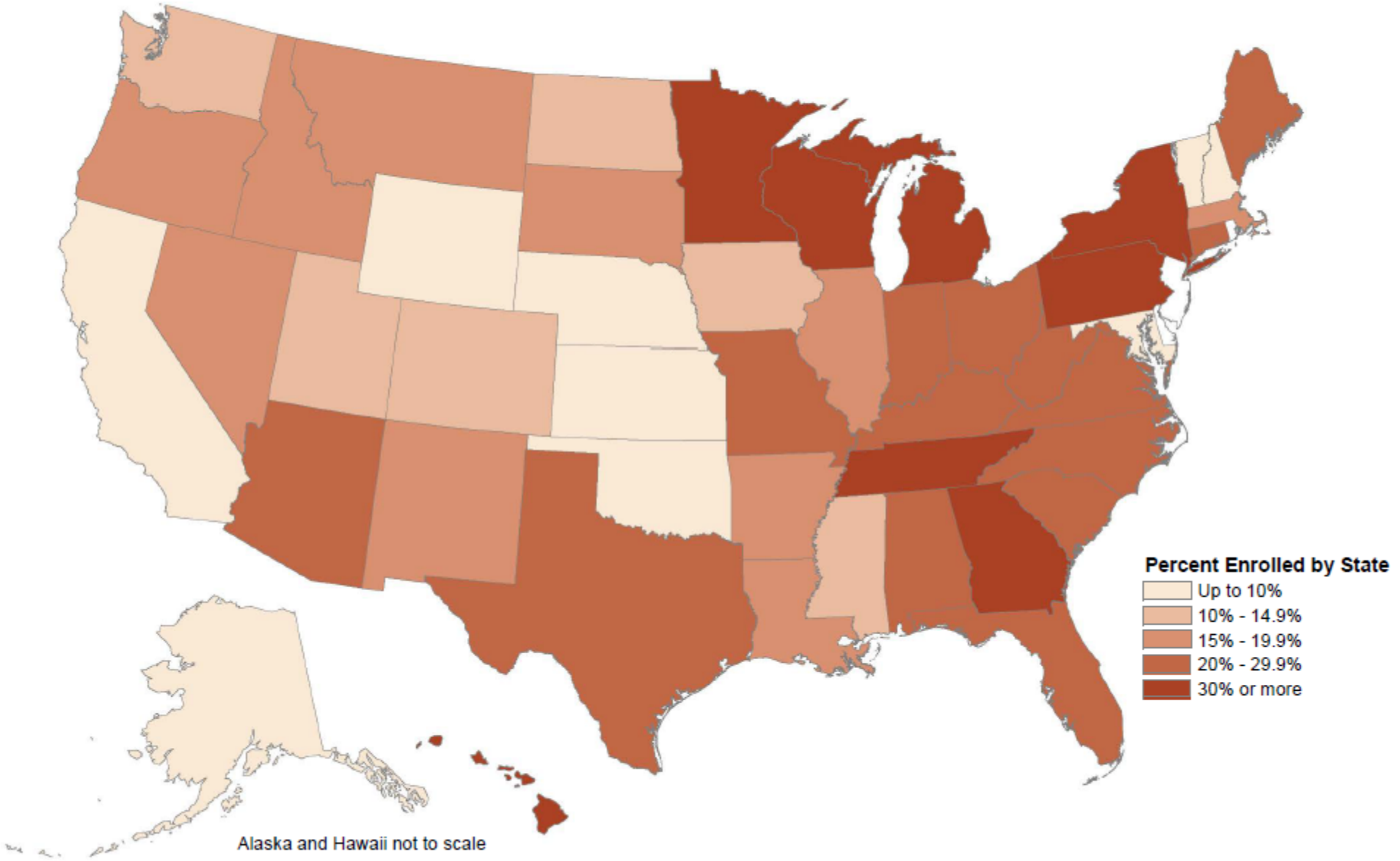
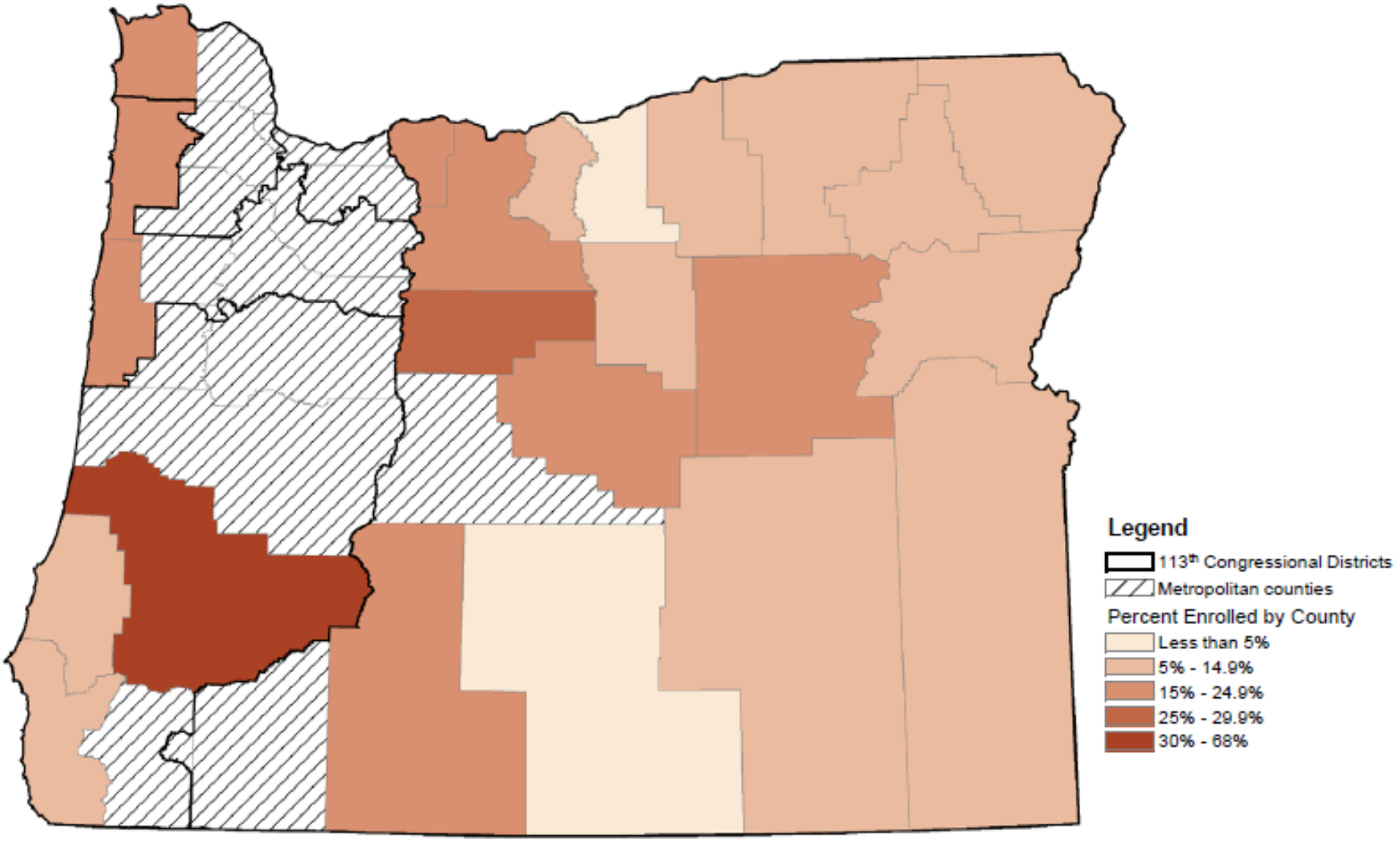
Percent of Eligible Non-Metropolitan Beneficiaries Enrolled in Medicare Advantage by State, March 2017



Source of data: Centers for Medicare and Medicaid Services (CMS) data, as of March 2017
Produced by: RUPRI Center for Rural Health Policy Analysis, 2017

Note: Delaware, New Jersey, and Rhode Island contain no non-metropolitan counties

Percent of Eligible Medicare Non-Metropolitan Beneficiaries Enrolled in Medicare Advantage and other Prepaid Plans: Oregon, March 2017



Source of data: Centers for Medicare and Medicaid Services (CMS) data, as of March 2017.

Produced by: RUPRI Center for Rural Health Policy Analysis, 2017

What is coming…

- Updated HHS priorities:
  - Consumer driven interoperable IT
  - Reducing provider burden
  - Flexibility for innovative models (particularly at a state level)
  - Transparency across the system
- Global budget demonstrations (MD, PA, others)
- Exploration and testing of new rural models (ex. Outpatient Community Hospital)

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How does a rural health system move to value?

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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Model for Transforming Care

Stratis Health developed the framework to assist organizations with visioning and planning for value.

The framework can help health care leaders:

- Understand the full scope of actions required to succeed under value-based models.
- Understand organizational gaps and needs, set priorities, and allocate resources.
- Identify the essential components to assist with defining a vision for their organization in a delivery system reformed world.

TRANSFORMING CARE | Alternative Payment Models and Delivery System Reform

ACTIONS TO BUILD THE FOUNDATION

- Provide Visionary Leadership and Promote a Learning Culture
- Embed Strong Organizational Change Skills Supported by Quality Improvement Methods
- Redesign Care to Consistently Use Evidence-Based or Best Practices
- Establish an Enabling IT Platform With Interoperable EHR and Effective HIE

ACTIONS TO BUILD RELATIONSHIPS, MANAGE POPULATIONS AND ADD VALUE

Address Health Equity and Social Determinants

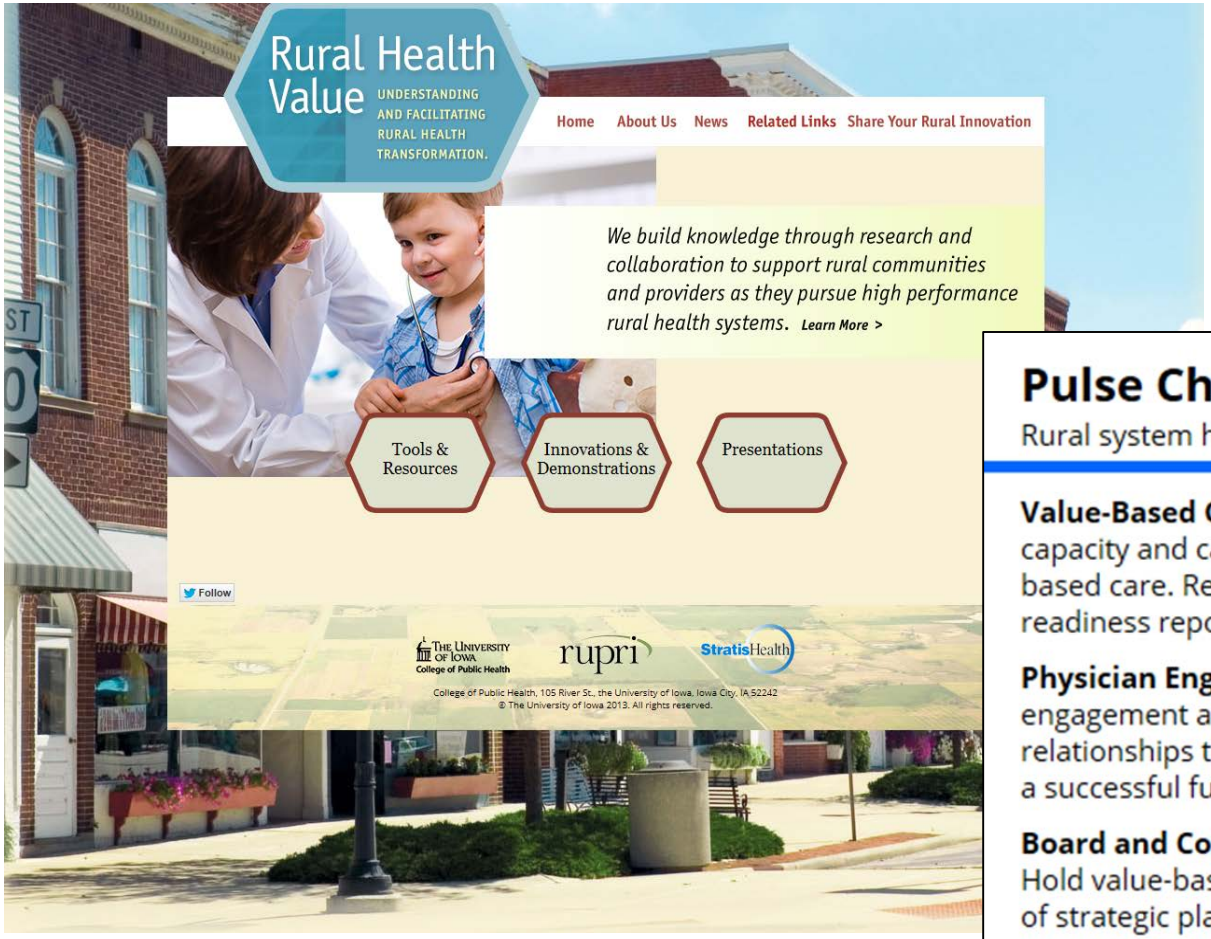
OUTCOMES

- Better Care
- Better Health
- Lower Cost

Sources: The Strategy That Will Fix Health Care, Michael E. Porter and Thomas H. Lee, Harvard Business Review, October 2013. The Chronic Care Model, Edward H. Wagner.

Tools and Resources

www.ruralhealthvalue.org



Pulse Check

Rural system high performance

Value-Based Care Assessment - Assess capacity and capabilities to deliver value-based care. Receive an eight category readiness report.

Physician Engagement - Score current engagement and build effective relationships to create a shared vision for a successful future.

Board and Community Engagement - Hold value-based care discussions as part of strategic planning and performance measurement.

Social Determinants of Health - Learn and encourage rural leaders/care teams to address issues to improve their community's health.

Discussion

- How do you see the shift from volume to value happening at rural hospitals in Oregon?
- What are your payers and providers saying about value?
- How is your organization planning for or implementing value-driven care?
- What would help you on your journey to value?

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