Continued Evolution of Transformation in Healthcare Delivery and Finance: Rural and Primary Care Implications

Presentation to the Primary Care National Conference
Omaha, NE
March 24, 2017

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Form Follows Finance

- No margin, no mission
- Imperative to meet personal and organization needs; without that no access to services
- So have to succeed in maximizing revenue within the frameworks set by payers

What payers?

- Third party insurers
- Large employers
- Medicare
- Medicaid
- Direct from patients/consumers

Payment through contracts and/or fixed payment

- Insurance contracts one at a time
- Medicare use of payment schedules and new payment design
- Medicare also uses private contracts (Medicare Advantage)
- Medicaid moving away from administrative price setting to purchasing models, which means contracts (MCOs in IA and NE)
- Pricing and marketing to consumers

Theme across payers: performance based contracts and fees

- Evidence based belief that there is a “sweet spot” combining measures of quality and financial performance
- For insurers a means of showing value to large employers, groups, and individuals
- For Medicare achieving the 2015 goal to reach 90% of fee-for-service payment with value component by 2018
- In Medicaid programs holding MCOs and ACOs accountable
- Consumer expectations and data to support

Specific manifestations

- Performance based enhancements to existing payment schedules
- Accountable Care Organizations
- Medicare and CHIP Reauthorization Act of 2015 and performance-based payment adjustment
- New payment models: bundled payment, global budgets, per capita payment

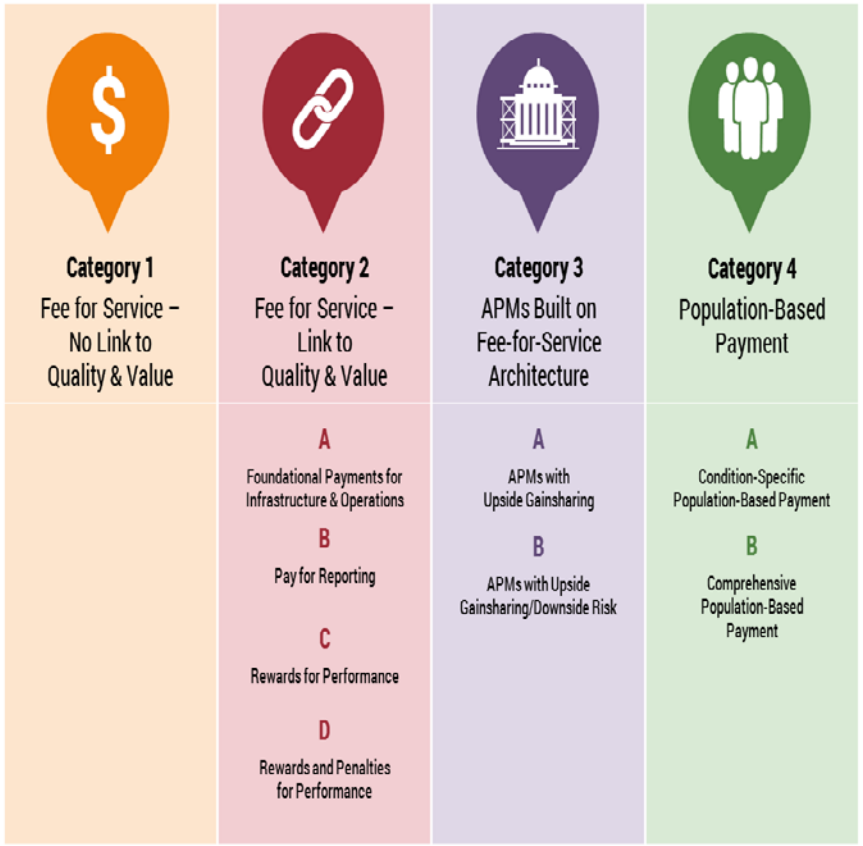
Evolution of Medicare Payment Through Four Categories

- 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

Source of this and following slides: CMS Fact Sheets available from cms.gov/newsroom

Evolution of Medicare Payment Through Four Categories

Figure 1. APM Framework (At-A-Glance)



Building blocks to achieve healthy populations

- Patient-centered medical homes; person-centered health homes: per member per month payments
- Chronic care management: new payment codes such as 99490 in Medicare
- Comprehensive primary care initiative

Accountable Care Organizations Have Come to Rural America

- Data extracted from Centers for Medicare & Medicaid Services public information for years 2012 – 2015, plus "first look" at 2016
- Non-metropolitan presence (defined as participating provider) in each cycle
- Non-metropolitan presence in three models: Pioneer demonstration, Advanced Payment demonstration/Medicare Shared Savings Program, ACO Investment Model, Next Generation demonstration
- Increased rural presence across time

By the Numbers …

- ACOs operate in 72.% of metropolitan counties, 39.7% of non-metropolitan counties
- 7.6 million beneficiaries now receiving care through ACOs
- Rural sites in all four census regions

By the numbers …

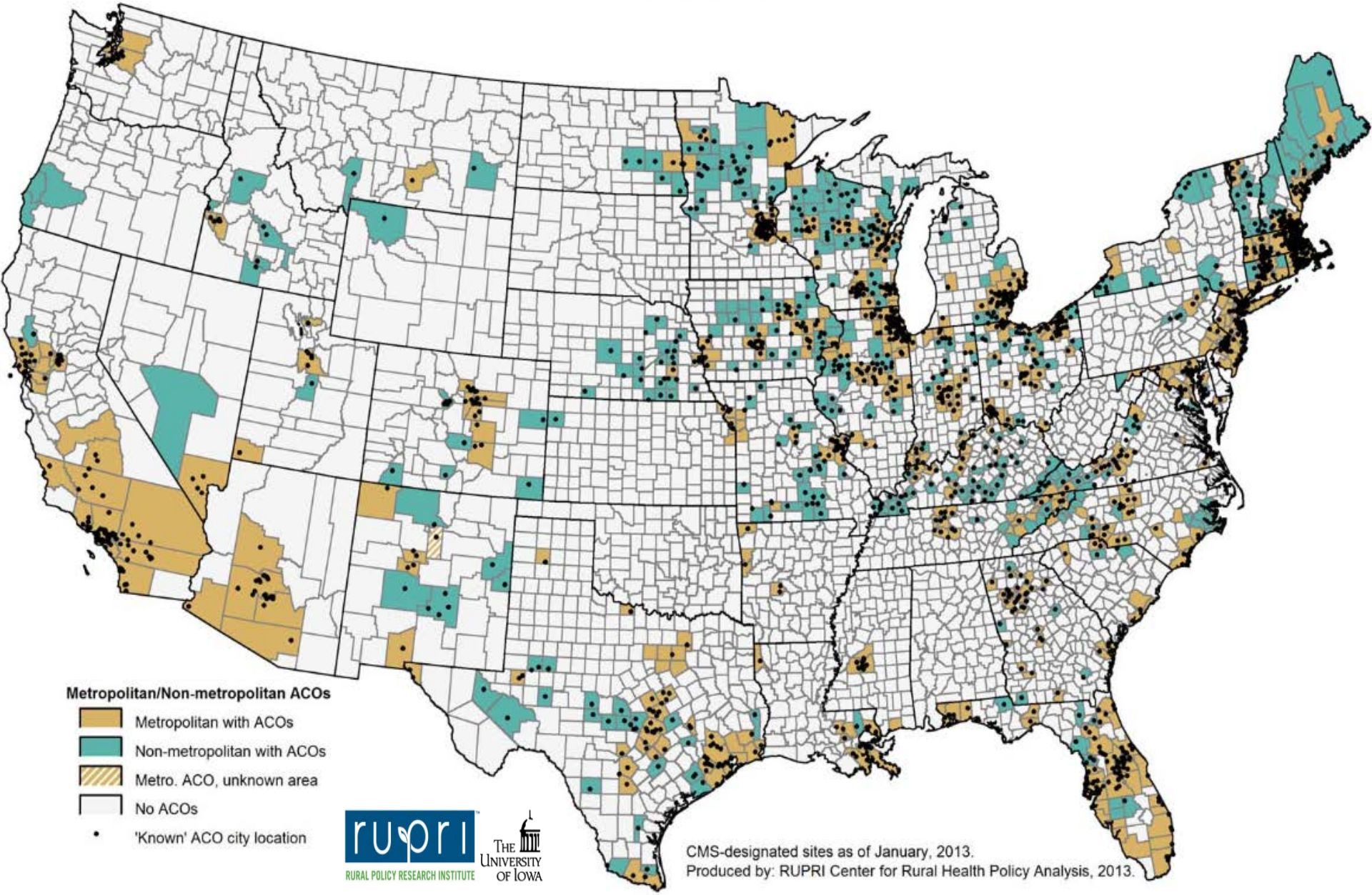
- Approximately half of Medicare ACOs have rural presence, although for 18% (76) that is between 1 and 24 percent of counties included
- 7 (1.7%) are 100% non-metropolitan
- 23 (5.4%) are 75-99% non-metropolitan
- 104 (24.6%) are 25-74% non-metropolitan
- At least 37 of the 101 new ACOs in 2016 have a rural presence, many of those exclusively rural

Data are as of the end of 2015

And Now the Visuals

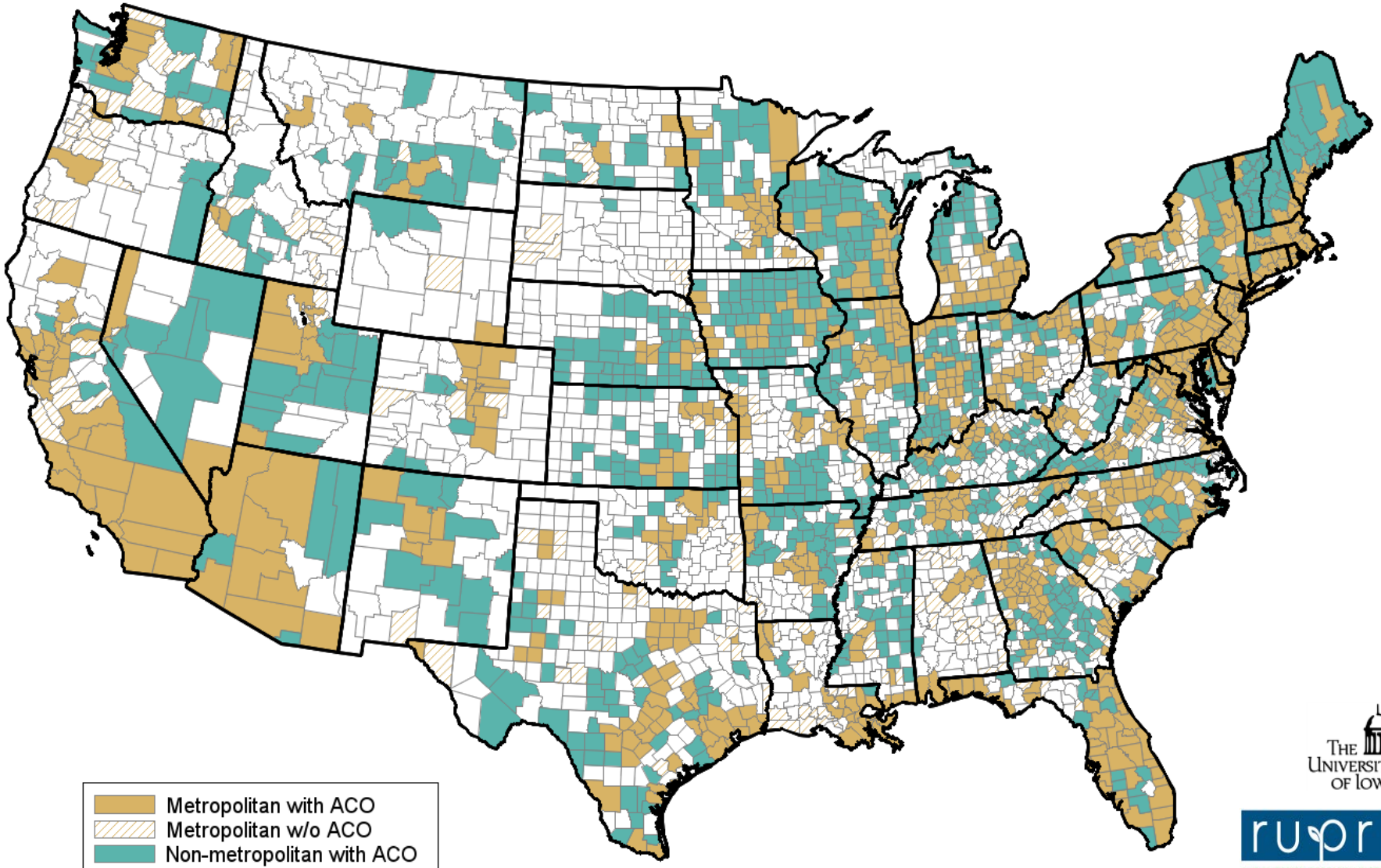
- 2013 national map
- 2015 national map

County Medicare ACO Presence
Continental United States



County Medicare ACO Presence

Continental United States



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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.

Innovations in ACOs

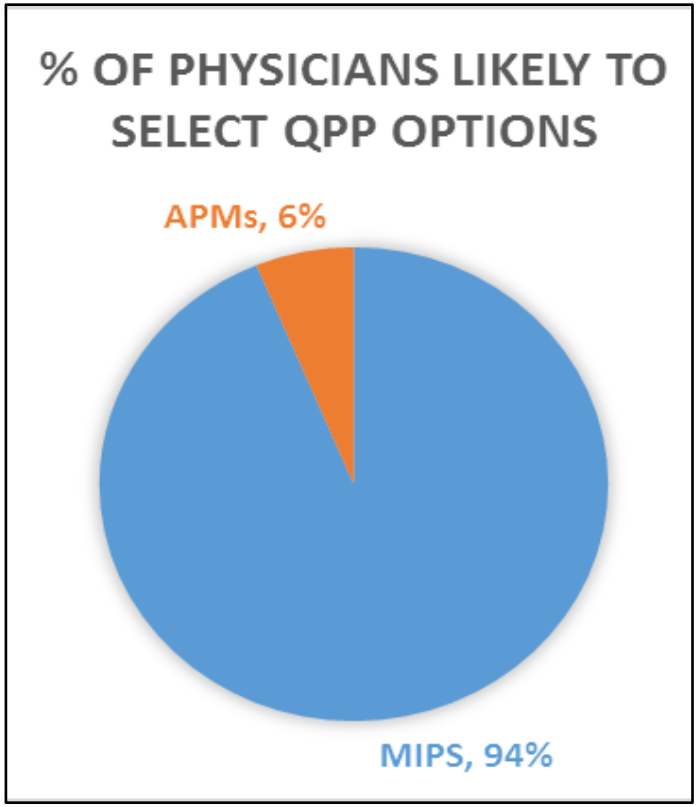
- Care management to meet the quality of care targets and achieve savings
- Signing multiple ACO contracts (Medicare, Medicaid, commercial, with large employers)
- Accepting financial risk: Tracks 2 and 3; Next Generation
- Addressing social determinants of health
- Qualifying as advanced alternative payment models

Medicare Access and CHIP Reauthorization Act

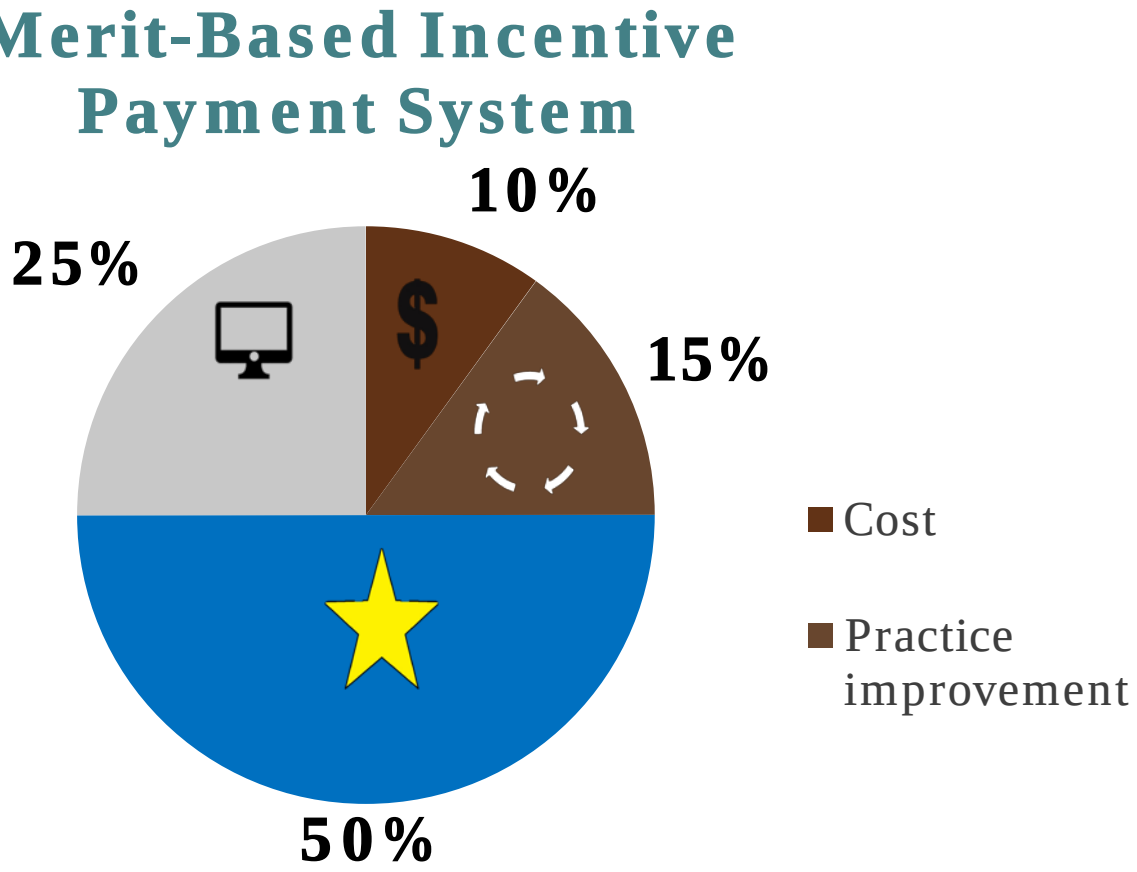
- Bipartisan law to replace the Sustainable Growth Rate (SGR)
  - MACRA is law, but regulations are *proposed* (962 pages!)
- MACRA replaces
  - Physician Quality Reporting System
  - Value-Based Modifier
  - Meaningful Use
- MACRA Quality Payment Program
  - Merit-Based Incentive Payment System, or
  - Advanced Alternative Payment Models
- **Pay increase opportunity**

MACRA Quality Payment Program

- Two options – physicians may select either
  - Merit-Based Incentive Payment System (MIPS), or
  - Advanced Alternative Payment Models (APMs)
- Distribution
  - MIPS – ~ 750,000 physicians
  - APMs – ~ 60,000 physicians
- Budget neutral
  - There will be physician **winners** and **losers**!



MIPS Payment Distribution



MIPS Category Details

- Quality (50%)
  - Replaces PQRS
  - > 200 measures to pick from
  - Physicians select 6 measures
  - 1 cross-cutting and 1 outcome
  - CMS calculates 2-3 population measures
- Advancing Care Information (25%)
  - Replaces Meaningful Use
  - Not all-or-nothing like Meaningful Use
  - Scoring
    - 6 base score categories
    - 3 performance score categories
    - Public health registry bonus

MIPS Category Details

- Cost (10%)
  - Replaces value-based modifier
  - No reporting; based on claims
  - 40-episode specific measures
- Clinical Practice Improvement Activities (15%)
  - 90 options within 9 categories
    - Expanded access, population management, health equity, patient safety, patient engagement, emergency preparedness, care coordination, APM participation, integrated behavioral health

Advanced Payment Model

- Must bear **financial risk**
- Payments based on quality comparable to MIPS
- Must use certified EHR
- Unique financial risk standards for Medical homes
- Models that count as APMs
  - CPC+
  - MSSP Tracks 2 and 3
  - Next Generation ACO Model

	2019	2020	2021	2022	2023	2024+
% Payment through APM	25%	25%	50%	50%	75%	75%
% Patients through APM	20%	20%	35%	35%	50%	50%

MACRA | Medicare Access and CHIP Reauthorization Act of 2015

Physician Payment Timeline

AMERICAN ACADEMY OF FAMILY PHYSICIANS

2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
Anticipated annual baseline payment updates-As provided by MACRA (Note: Updates are cumulative.)									
Jul-Dec +0.5	+0.5%[a]	+0.5%	+0.5%	+0.5%	0%	0%	0%	0%	0%
Current law: PQRS, MU, VBPM									
Penalty up to -3.5%	Penalty up to -6%	Penalty up to -9%	Penalty TBD						
Merit-Based Incentive Payment System (MIPS) Adjustments made on sliding scale based on performance in prior time period TBD									
Baseline payment adjustment[b]				(-/+) 4%	(-/+) 5%	(-/+) 7%	(-/+) 9%	(-/+) 9%[c]	(-/+) 9%[c]
Maximum payment adjustment for high performers				+12%	+15%	+21%	+27%	+27%[c]	+27%[c]
Exceptional performers may be eligible for an additional positive payment adjustment of up to 10%.[d]									
Alternative Payment Models (APMs) 5% annual bonus – Paid in lump sum Participants are exempt from MIPS.									

Legend

MU = Meaningful use
PQRS = Physician Quality Reporting System
VBPM = Value-Based Payment Modifier
RVU = Relative Value Unit

[a] The projected 0.5% update, established by MACRA, was negated due to other legislative provisions. As a result, the 2016 conversion factor will be $35.82 instead of $35.93, which is a net reduction of 11 cents per Relative Value Unit (RVU).
[b] Lowest quartile performers automatically receive the maximum negative payment adjustment.
[c] Payment adjustment listed for 2023 through 2024 is an assumption based on currently available information.
[d] Exceptional performance criteria has not been defined.

December 2015

New Physician Payment Reality

- Minimal FFS payment increase
  - 0.5% x 5 years, then 0% x 5 years
  - Actually payment decrease (inflation)
- **Merit-Based Incentive Payment System**
  - Eventually **-9% to +27%** adjustment in pay
    - Based on quality, resource use, meaningful use, and clinical practice improvement activities
  - Up to **36%** differential per year!
  - Plus, up to **10%** Exceptional Performance Incentive Payment (budget neutral exclusion)
- **Or, 5% APM bonus**
  - Excluded from MIPS and meaningful use

MACRA Rural Issues

Solo and small practices will get hit hardest under the new incentive payment system

Practice size	Eligible clinicians	Percentage likely to be penalized	Percentage likely to get bonus
Solo	102,788	87%	12.9%
2-9	123,695	69.9%	29.8%
10-24	81,207	59.4%	40.3%
25-99	147,976	44.9%	54.5%
100 or more	305,676	18.3%	81.3%
Overall	761,342	45.5%	54.1%

Source: Modern Healthcare, April 30, 2016. Adapted from CMS data reported in Federal Register 5/9/2016.

Questions about ACOs and MACRA

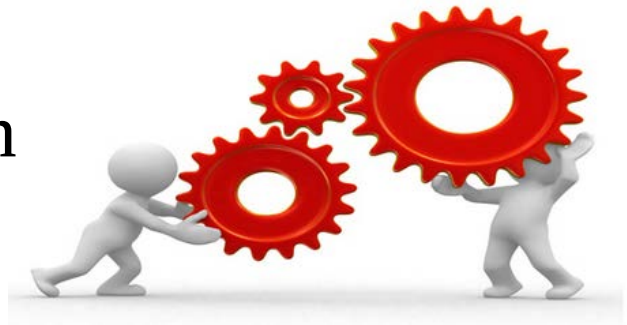
- How will my clinic be affected?
- What can I do help the clinic prosper financially?
- How will these organizational and financial changes help us achieve goals related to population health?

Other payment models

- Global budgeting in Maryland and Pennsylvania
- Bundled payment models
- Per capita payment models (similar to managed care)

Exciting possibilities for redesign

- Investments in practice redesign
- Investments in population health
- Enhanced roles for clinicians in improving individual and population health



Challenges

- How to design team-based care
- The role of physician assistants

For further information

The RUPRI Center for Rural Health Policy Analysis
http://cph.uiowa.edu/rupri

The RUPRI Health Panel
http://www.rupri.org

Rural Telehealth Research Center
http://ruraltelehealth.org/

The Rural Health Value Program
http://www.ruralhealthvalue.org

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