

The New Formula

Health Equity + Enhanced
Community Partnerships=
Improved Outcomes=
Better Payment

Today's Objectives

- Review of Health Equity Definitions
- Gain an Understanding of Health Equity in Minnesota
- Understand Link between Health Equity, Enhanced Community Partnerships and Health Outcomes
- Understand Connection between Health Outcomes & CMS Payment
 - MACRA
 - Rural & FQHC

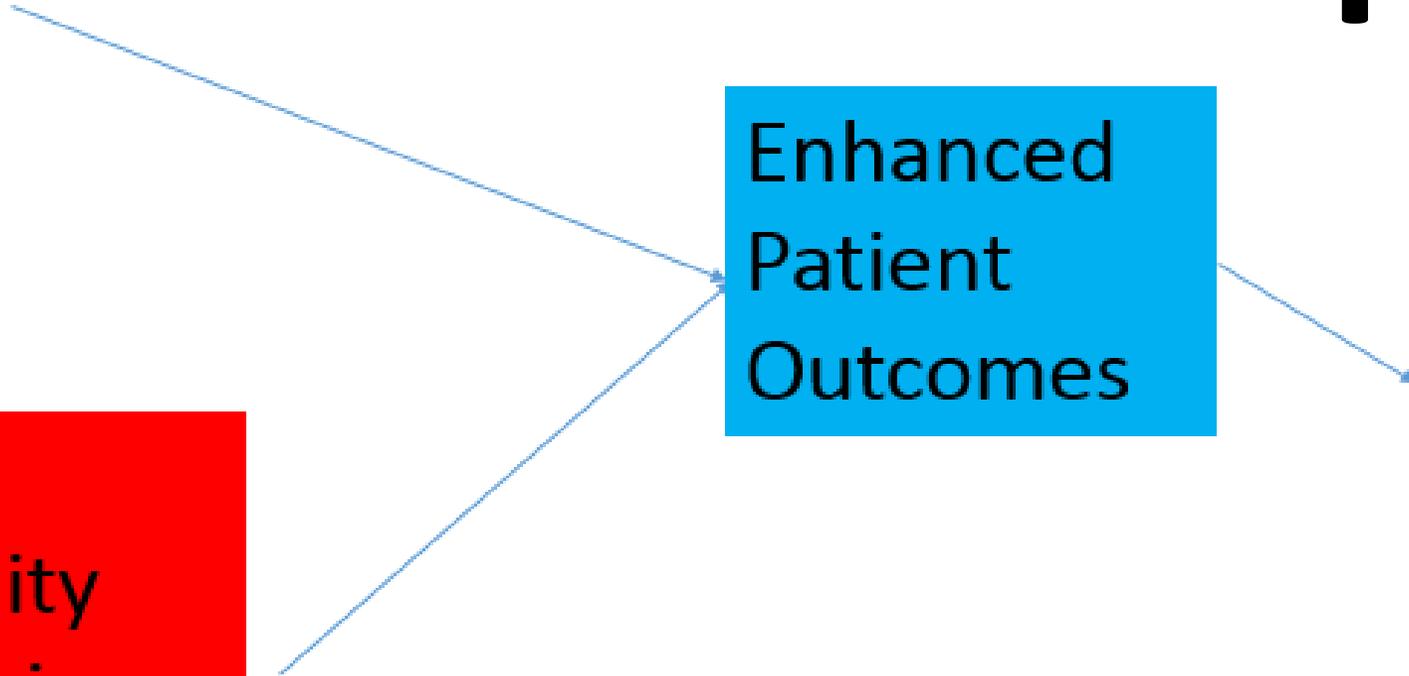
The Roadmap

Health
Equity

Stronger
Community
Partnerships

Enhanced
Patient
Outcomes

Better
Payment
Under the
New
Medicare
Model



Health Equity



Health Equity Highlights

- **Health Equity:** Achieving the conditions in which all people have the opportunity to attain their highest possible level of health.
- **Health Disparity:** A population based difference in health outcomes. Disparities are not necessarily inequities (e.g. elderly patients are more likely to experience complications from a surgery).
- **Health Inequity:** A health disparity based in inequitable, socially determined circumstances.

What Are You Personally Doing To Improve Health Equity?

- **Care Coordinator:** Is care coordination being done with health equity in mind? Are you developing community referrals based on your knowledge of health inequity within your clinic population?
- **Clinic Leader:** Are you creating policies within your organization to support health equity? Do you work with local public health to create community strategies to improve health equity?

What Are You Personally Doing To Improve Health Equity?

- **Local Public Health:** Do you know the health outcomes results for the clinics in your area? Are you working with clinics to improve their outcomes by reducing health inequity?
- **IT:** Are you creating reports that identify health disparities, based in inequities, for specific disease populations?

What Are You Personally Doing To Improve Health Equity?

- **QI:** Are you reviewing health inequity information and testing improvements to see if they make a difference in specific health outcomes?
- **Finance:** Do you review your health inequity information in order to determine if there are key partnerships you need to develop in order to move toward accountable care contracts?

Let's Hear From You

Have you used your race, language, ethnicity data to assist in improving outcomes?

Yes or No?



Health Equity in Minnesota



Minnesota Community Measurements (MNCM) 2014: Health Equity of Care Report

Minnesota ranks as one of the healthiest states in the nation, but its health inequities are among the worst.

Measures included in report:

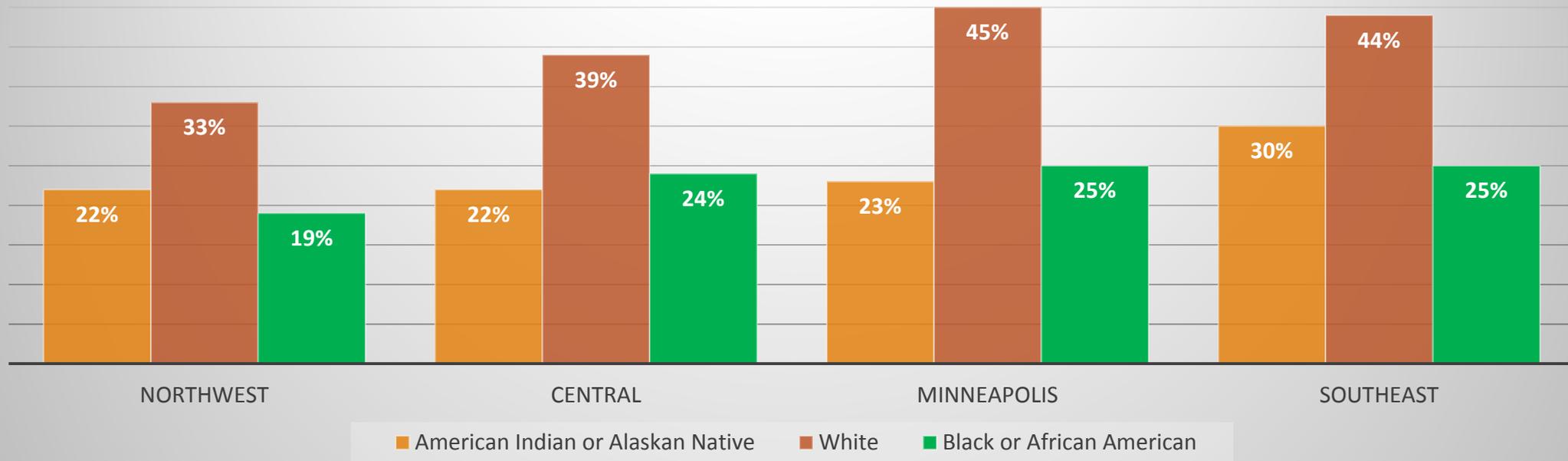
1. Optimal Diabetes Care
2. Optimal Vascular Care
3. Optimal Asthma Care- Adults
4. Optimal Asthma Care- Children
5. Colorectal Cancer Screening



Example of Findings

Rates of Optimal Diabetes Care by Region and Race

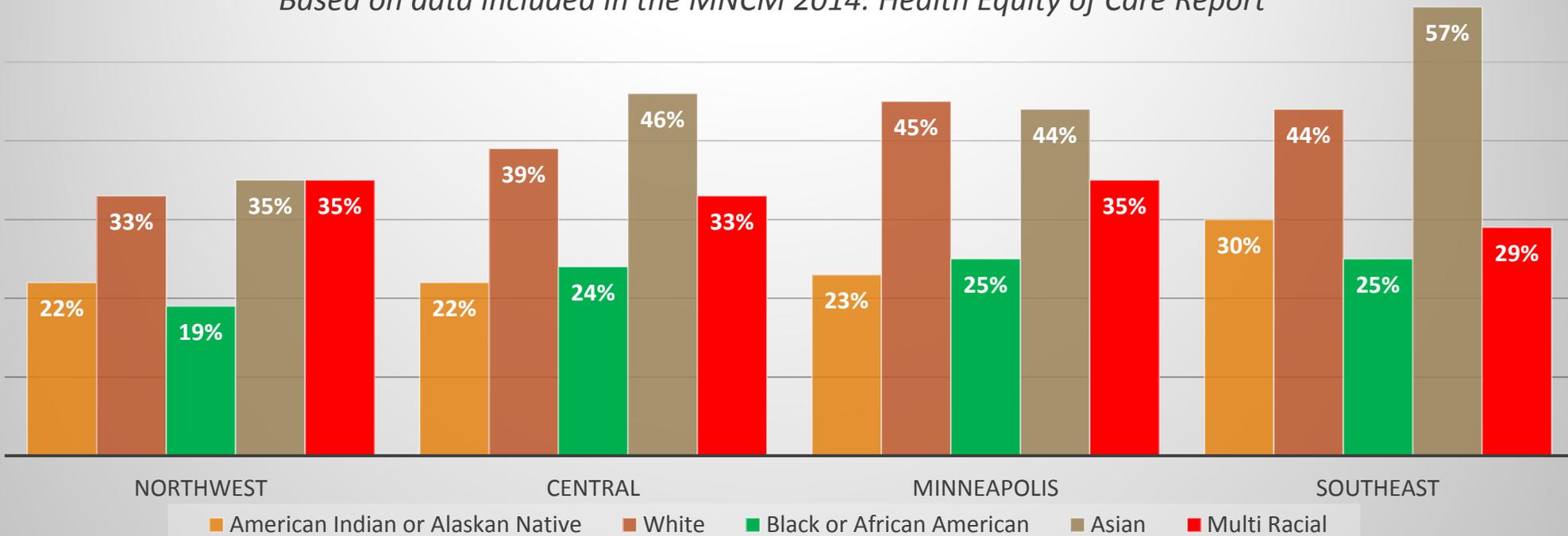
**Based on data included in the MNMCM 2014: Health Equity of Care Report*



Example Part II

Rates of Optimal Diabetes Care by Region and Race

**Based on data included in the MNMCM 2014: Health Equity of Care Report*



**Improved
Health Equity**



**Enhanced
Patient
Outcomes**

Advancing Health Equity in Minnesota- Report to the Legislature

Recommendations:

- Advance health equity through a **“health in all policies”** approach across all sectors
- Strengthen **community relationships** and partnerships to advance health equity
- Strengthen the **collection, analysis and use of data** to advance health equity

Health in All Policies



During 2011 and 2012, CentraCare Health in St. Cloud hired a consulting firm to conduct diversity related assessments of their organization.

Results of analysis led to:

1. The creation of a health equity work plan for the organization.
2. Multiple interpreter options for patients.
3. Providing staff with multilingual tools such as videos for patients on breast feeding, use of the ED, and patients rights.
4. The development of programs targeting specific patient populations. Ex: Veggie Rx.



Strengthening Community Relationships to Improve Outcomes

- A UCLA led community engagement initiative targeting those with depression in underserved communities of color.
- Leadership team included community agencies (e.g. mental health, faith-based, social services).
- Depression toolkits and provider resources developed by members of community engagement team.
- Use of tools were significantly more effective at improving mental health-related quality of life and increasing visits for depression care.

Collection, Analysis, and Use of Data

- Duke Univ. Med. Center Nurses called African American patients each month for a year to discuss cardiovascular disease risk management.
- Each call contained both standard and personally tailored components.
- Topics for discussion were selected based on an assessment of the patient's knowledge and stage of behavior change.
- Nurses provided periodic updates to providers.
- Self-reported medication adherence went from 2% to 22% & A1C's levels dropped.

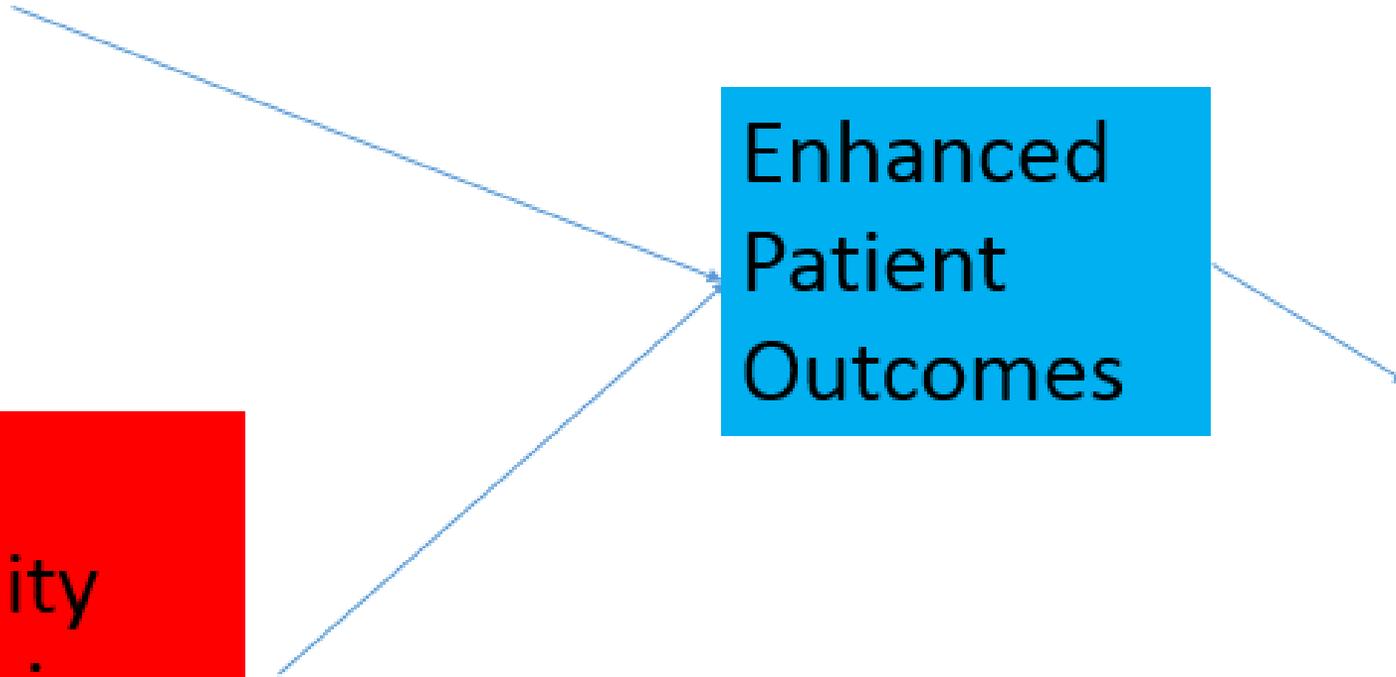
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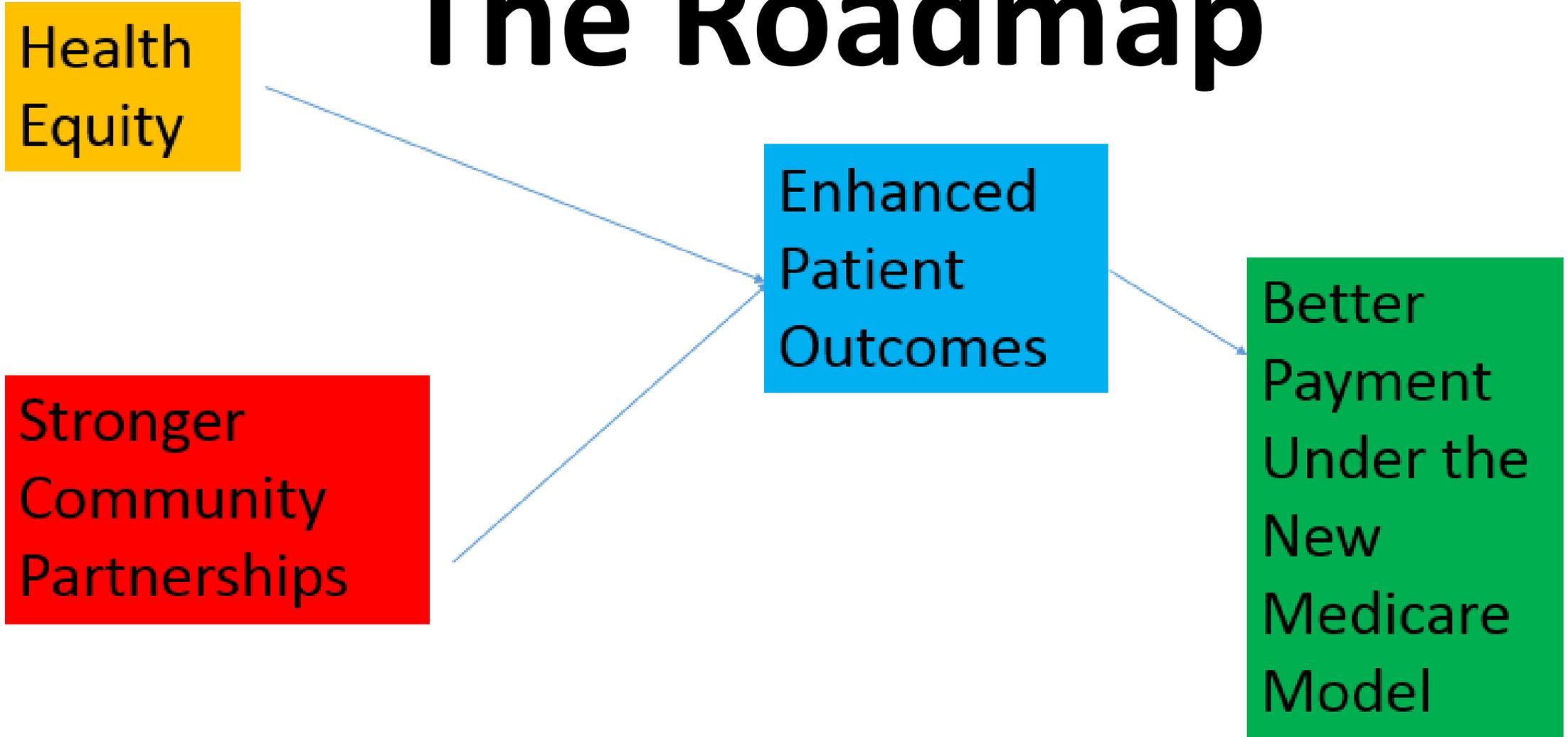
Examples of Clinic/Community Collaborations that Improved Health Outcomes

- ***Electronic Linkage System (eLinkS):*** Software facilitates referrals from physicians to community organizations focused on diet, exercise, smoking and alcohol consumption.
 - ***Outcome:*** 10% of patients referred to appropriate services vs. typical rate of 2-5%.
- ***Community Health Workers (CHWs):*** Hiring CHWs and employing them to promote the use of primary and follow-up care to prevent and manage HTN disease.
 - ***Outcome:*** Rates of “blood pressure control” rose from 18% to 34%.

Examples of Clinic/Community Collaborations that Improved Health Outcomes

- **Pharmacists:** Bring pharmacists into the health care team.
- ***Outcome:*** Increase from 32% to 48% of diabetic participants in Maryland P³ Program who met recommended blood glucose levels.

The Roadmap



Medicare in Transition



Health & Human Services Secretary Burwell has said that by the end of 2016, **30% of Medicare payments** will be directed at improved outcomes. The plan is to get to **50% of all payments based on quality outcomes** by 2018.*

* *"Mayo chief John Noseworthy talks about the future of health care"*, Minneapolis Star Tribune, January 30, 2016.

What is “MACRA”?

- The **Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)** is a bipartisan legislation signed into law on April 16, 2015. —

What does Title I of MACRA do?

- **Repeals** the Sustainable Growth Rate (SGR) Formula
- **Changes the way that Medicare** rewards clinicians for **value** over volume
- **Streamlines** multiple quality programs under the new **Merit-Based Incentive Payments System (MIPS)**
- Provides **bonus payments** for participation in **eligible alternative payment models (APMs)**

MIPS

The Merit-Based Incentive Payment System, MIPS, is a payment methodology that rewards providers for delivery of high quality health care.

Providers are given a Composite Performance Score based on four factors:

1. Quality
2. Resource Use
3. Clinical practice improvement activities
4. Meaningful use of certified EHR technology

It is this score that determines whether Medicare payment rates go up or down in a given year.

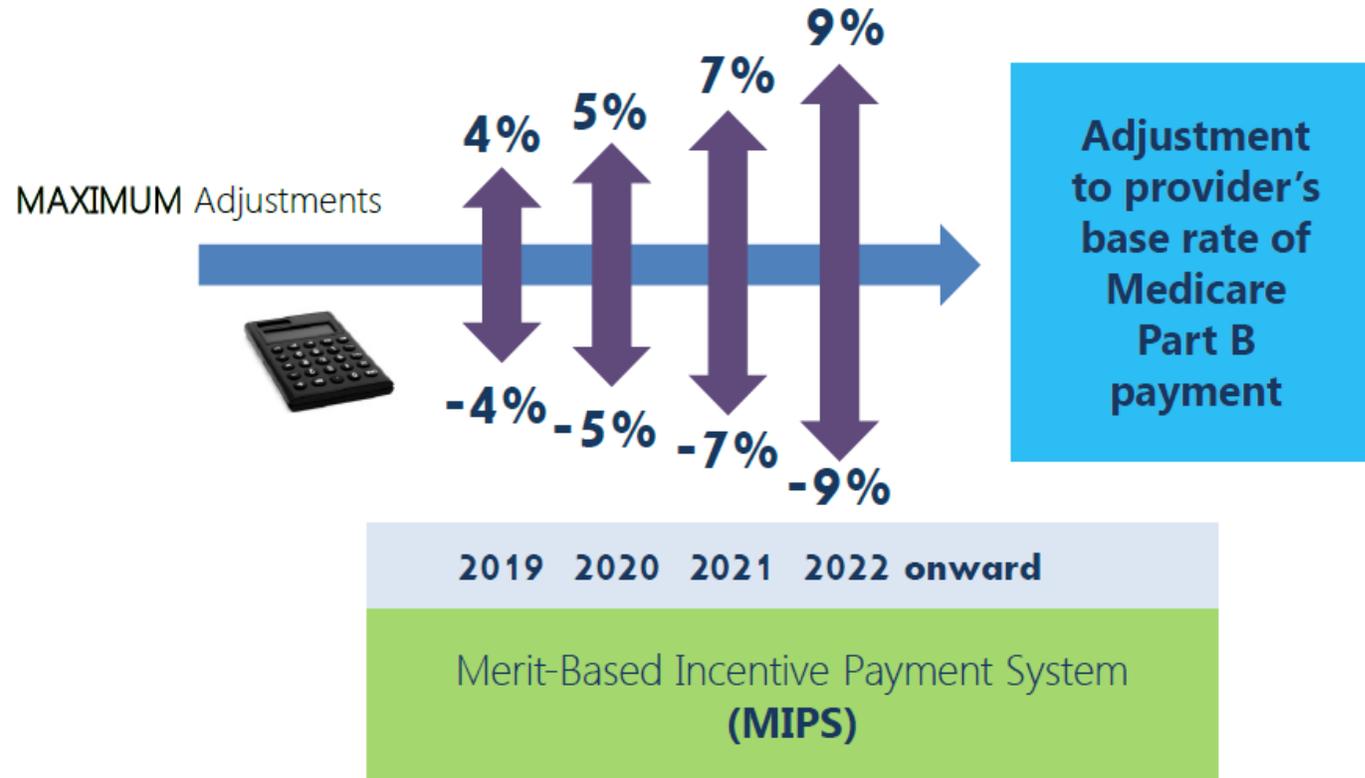
Alternative Payment Models (APMs)

New approaches to paying for medical care that reward quality and value.

- CMS has created an alternative to MIPS, referred to as an **eligible APM**.
- Eligible APMs must meet and maintain high standards of quality and cost efficiency.
- In return, they receive a guaranteed rate of reimbursement.
- No risk, but more limited rewards.

How much can MIPS adjust payments?

- Based on the MIPS **composite performance score**, physicians and practitioners will receive positive, negative, or neutral adjustments up to the percentages below.
- MIPS adjustments are **budget neutral**. A **scaling factor** may be applied to upward adjustments to make total upward and downward adjustments equal.



What Does This Mean For Clinics

100 Providers / 10 Clinics , \$100,000 Part B Charges Per Provider
Equals 10 million dollars

2019

- **MIPS Max Incentive is 4% or \$400,000**
- **MIPS Max Penalty is -4% or negative \$400,000**

2022

- **MIPS Max Incentive is 9% or \$900,000**
- **MIPS Max Penalty is -9% or negative \$900,000**

Rural Health Clinics

Two types of RHCs

Billing and payment are slightly different:

1. Independent RHCs bill RHC services to one of five regional fiscal intermediaries (transitioning to MAC). Medicare Independent RHC rate \$81.32 in 2016.

2. Provider-based RHCs bill RHC services to the FI/MAC of the host provider (usually a hospital). No cap on rate if < 50 beds.

➤ 4084 RHCs nationally, Minnesota (88)

855A Institutional Providers RHCs

RHCs are required to complete An evaluation of a clinic's total operation including the overall organization, administration, policies and procedures covering personnel, fiscal and patient care areas must be done at least annually.

Federally Qualified Health Center

Federally Qualified Health Center (FQHC) - umbrella term for a number of federally-supported safety-net programs.

The term also determines how the programs will be reimbursed by Medicaid. These programs include:

- Community/Migrant Health Centers
- Health Care for the Homeless
- Public Housing Health Centers
- School-based, School-linked Health Centers
- There are also FQHC 'Look-Alikes' (These meet all FQHC requirements but receive no grant)
- Minnesota Has 20 FQHCs, 1 FQHC Look-Alike and 63 sites of service MNACHC Web. Jan. 2016. <<http://mnachc.org/metro-map.html>>.

855A Institutional Providers FQHCs

- FQHCs are required to complete a Uniform Data System report yearly.
- In 2014 FQHCs spent \$152,751,940 on 174,688 patients for an average cost of \$874.43 per patient at 16 grantee sites.
- **2014 Health Center Program Grantee Profiles**
- **Health Center Program Grantee Data**

<http://bphc.hrsa.gov/uds/datacenter.aspx?q=d&year=2014&state=MN#glist>

Health Center Quality Improvement FY 2015 Grant Awards (August 2015)

- **Total Quality Improvement Awards to Minnesota:** 16 awards totaling \$898,528
 1. **EHR Reporter Awards:** 6 awards totaling \$90,000
 2. **Clinical Quality Improver Awards:** 13 awards totaling \$174,242
 3. **Health Center Quality Leader Awards:** 7 awards totaling \$209,534
 4. **National Quality Leader Awards:** 1 award totaling \$74,752
 5. **Access Enhancers Awards:** 5 awards totaling \$140,000
 6. **High Value Health Centers Awards:** 3 awards totaling \$210,000

FQHCs and RHCs

PQRS, EHR Incentive Payments

- In a recent MLN Matters article, CMS clarified that the PQRS penalties do not apply to those providers who ONLY provide Medicare Part B services at FQHCs or RHCs. However, if a provider provides Part B services at an FQHC or RHC and a non-FQHC/RHC setting, the PQRS penalties do apply.
- Eligible professionals that practice in **RHCs** and **FQHCs** are not eligible for Medicare incentives. They are eligible for Medicaid incentives if they have at least 30% patient volume attributable to “needy” patients.

FQHCs and RHCs Chronic Care Management Medicare

- The Centers for Medicare & Medicaid Services (CMS) recognizes care management as one of the critical components of primary care that contributes to better health and care for individuals, as well as reduced spending.
- In 2015, CMS began making separate payment under the Medicare Physician Fee Schedule (PFS) for chronic care management services using CPT Code 99490.
- This article is based on Change Request (CR) 9234, which provides instructions to MACs regarding payment for CCM services for dates of service on or after January 1, 2016, to RHCs billing under the RHC All-Inclusive Rate (AIR) and FQHCs billing under the FQHC Prospective Payment System (PPS).

Resources

MNCM: *2014 Health Equity of Care Report*

“Mayo chief John Noseworthy talks about the future of health care”, Minneapolis Star Tribune, January 30, 2016.

The Robert Wood Johnson Foundation, *Using Data to Reduce Disparities and Improve Quality: A Guide for Health Care Organizations*

http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2014/rwjf412417

Finding Answers: Disparities Research for Change.

http://www.solvingdisparities.org/sites/default/files/FA_2015GranteePortfolio_FIN.pdf

Advancing Health Equity in Minnesota- Report to the Legislature

Centers for Medicare & Medicaid Services. www.cms.gov

Resources

FQHCS & RURAL HEALTH

For information on RHCs and FQHCs contact
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HEALTH CARE HOMES

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payment contact Nurse Planners:

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