Healthcare Delivery System Transformation: Are You Ready?
Medical Staff Leadership Forum

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No financial conflict of interest to disclose.
Objectives

• Discuss the Centers for Medicare & Medicaid Services (CMS) healthcare delivery system transformation strategies.

• Describe the impact of Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) on physicians’ payment.

• Leverage the available technical assistance to prepare for healthcare delivery transformation.
Nearly 25 percent of the nation’s Medicare beneficiaries

HSAG is the Medicare Quality Improvement Network-Quality Improvement Organization (QIN-QIO) for Arizona, California, Florida, Ohio, and the U.S. Virgin Islands.
Healthcare Transformation

Healthcare Transformation Is Underway
CMS Quality Strategy: Concurrently Pursue Three Aims

**Better Care**
Improve overall quality by making healthcare more patient-centered, reliable, accessible, and safe.

**Healthier People**
Improve population health by supporting proven interventions to address behavioral, social, and environmental determinants of health, in addition to delivering higher-quality care.

**Smarter Spending**
Reduce the cost of quality healthcare for individuals, families, employers, and government.

Source: The Centers for Medicare & Medicaid Services
CMS Quality Strategy Goals

1. Make care safer by reducing harm caused in the delivery of care.
2. Strengthen person & family engagement as partners in their care.
3. Promote effective communication & coordination of care.
5. Work with communities to promote best practices of healthy living.
6. Foster Learning Organizations

Eliminate Racial & Ethnic Disparities
Enable Local Innovations
Strengthen Infrastructure & Data Systems
CMS Support of Healthcare Delivery System Reform

**Historical State**
- Key Characteristics
  - Producer-centered
  - Incentives for volume
  - Unsustainable
  - Fragmented care
  - Systems and Policies
    - Fee-for-Service (FFS) payment systems

**Evolving Future State**
- Key Characteristics
  - Patient-centered
  - Incentives for outcomes
  - Sustainable
  - Coordinated care
- Systems and Policies
  - Value-based purchasing (VBP)
  - Accountable Care Organizations (ACOs)
  - Episode-based payments
  - Medical homes
  - Quality/cost transparency

Result: Better care, smarter spending, and healthier people

Source: The Centers for Medicare & Medicaid Services
# Framework of Payment to Clinicians

<table>
<thead>
<tr>
<th>Category 1: FFS, no link to value</th>
<th>Category 2: FFS, link to quality</th>
<th>Category 3: Alternative payment models (APMs) built on FFS architecture</th>
<th>Category 4: Population-based payment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Description</strong></td>
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<tr>
<td>• Payments are based on volume of services and not linked to quality or efficiency</td>
<td>• A portion of payments vary based on the quality or efficiency of healthcare delivery</td>
<td>• Some payments are linked to the effective management of a population or an episode of care</td>
<td>• Payment is not directly triggered by service delivery, so volume is not linked to payment</td>
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<td></td>
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<td>• Payments still triggered by delivery of services, but opportunities for shared savings or two-sided risk</td>
<td>• Clinicians/organizations are paid and responsible for the care of a beneficiary for a long period (e.g., ≥1 year)</td>
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<tr>
<td><strong>Medicare FFS examples</strong></td>
<td></td>
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<tr>
<td>• Limited in Medicare FFS</td>
<td>• HVBP</td>
<td>• ACOs</td>
<td>• Eligible Pioneer ACOs in 3 to 5 years</td>
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<tr>
<td>• Majority of Medicare payments are now linked to quality</td>
<td>• Physician Value Modifier</td>
<td>• Medical homes</td>
<td>• Maryland hospitals</td>
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<td></td>
<td>• Readmissions/Hospital-Acquired Condition Reduction Program</td>
<td>• Bundled payments</td>
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<td>• Comprehensive Primary Care initiative</td>
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<td>• Comprehensive End-Stage Renal Disease (ESRD)</td>
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<td>• Medicare-Medicaid Financial Alignment Initiative</td>
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<td>FFS Model</td>
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CMS Goals by 2016 and 2018

Historical Performance

- 2011: 68% FFS linked to quality, 32% All Medicare FFS
- 2014: 85% FFS linked to quality, 15% APMs

Goals

- 2016: 85% FFS linked to quality, 15% APMs
- 2018: 90% FFS linked to quality, 10% APMs

Source: The Centers for Medicare & Medicaid Services
### Goal 1: APMs Where Providers Are Accountable for Both Cost and Quality

CMS will continue to test new models and will consider expanding existing models.

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

Source: The Centers for Medicare & Medicaid Services
Goal 2: More Linkage of FFS Payments to Quality or Value

**Hospitals, percentage of FFS payment at risk**

- **Readmissions Reduction Program**: 6.75% at risk in 2014, 8% in 2015, 8% in 2016.
- **HVBP (Hospital Value-Based Purchasing)**: 2% at risk in 2014, 3% in 2015, 3% in 2016.
- **IQR/MU (Inpatient Quality Reporting/meaningful Use)**: 1.75% at risk in 2014, 2% in 2015, 2% in 2016.
- **HAC (Hospital-Acquired Conditions)**: 2% at risk in 2014, 1% in 2015, 1% in 2016.

**Physician/clinician, percentage of FFS payment at risk**

- **Physician VBM (Value-Based Modifier)**: 6% at risk in 2014, 9% in 2015, 9% in 2016.
- **EHR MU (Electronic Health Record Meaningful Use)**: 2% at risk in 2014, 4% in 2015, 4% in 2016.
- **PQRS (Physician Quality Reporting System)**: 2% at risk in 2014, 2% in 2015, 2% in 2016.

Source: The Centers for Medicare & Medicaid Services
What Is MACRA?

What Does MACRA Do?

• **Repeals** the Sustainable Growth Rate (SGR) Formula

• **Changes the way that Medicare pays clinicians** and establishes a new framework to reward clinicians for value over volume

• **Streamlines** multiple quality reporting programs into one new system: the Merit-Based Incentive Payment System (MIPS)

• **Provides** bonus payments for participation in eligible Alternative Payment Models (APMs)
The SGR

Each year, Congress passed temporary “doc fixes” to avert cuts (no fix in 2015 would have meant a 21% cut in Medicare payments to clinicians).

MACRA replaces the SGR with a more predictable payment method that incentivizes value.
Currently, there are multiple quality and value reporting programs for Medicare clinicians:

- PQRS
- Value-Based Payment Modifier
- Medicare EHR Incentive Program

Source: The Centers for Medicare & Medicaid Services
MACRA streamlines these programs into the Quality Payment Program.

- PQR
- Value-Based Payment Modifier
- Medicare EHR Incentive Program

Quality Payment Program

MIPS or APMs

Source: The Centers for Medicare & Medicaid Services
Proposed Rule, Released April 27, 2016

- Major provisions of MIPS
- Proposed models that qualify as Advanced APMs
- Timelines and reporting requirements

Source: The Centers for Medicare & Medicaid Services
Which Clinicians Does MACRA Affect—Will It Affect Me?

Short answer: MACRA affects clinicians who participate in Medicare Part B.
MACRA Affects Medicare Part B Clinicians

Affected clinicians are called “eligible professionals” (EPs) and will participate in MIPS. The types of Medicare Part B healthcare clinicians affected by MIPS may expand in the first three years of implementation.

**Years 1 and 2**
- Physicians, physician assistants (PAs), nurse practitioners (NPs), clinical nurse specialists, nurse anesthetists

**Years 3+**
- Secretary may broaden EP group to include others, such as
  - Physical or occupational therapists,
  - Speech-language pathologists,
  - Audiologists,
  - Nurse midwives,
  - Clinical social workers,
  - Clinical psychologists,
  - Dietitians/nutritional professionals

Source: The Centers for Medicare & Medicaid Services
How Will MACRA Affect Medicare Clinicians?
MACRA Changes How Medicare Pays Clinicians

The current system:

1. Services provided
2. Medicare Fee Schedule
3. Adjustments
4. Final payment to clinician

- PQRS
- VBM Modifier
- Medicare EHR Incentive Program

Source: The Centers for Medicare & Medicaid Services
The system after MACRA:

- Services provided
- Medicare Fee Schedule
- The Quality Payment Program
- Final payment to clinician
- Adjustments
- MIPS or APMs

Source: The Centers for Medicare & Medicaid Services
One Path to Quality

MIPS
MIPS: First Step to a Fresh Start

✓ MIPS is a new program
  • Streamlines 3 currently independent programs to work as one and to ease clinician burden.
  • Adds a fourth component to promote ongoing improvement and innovation to clinical activities.

✓ MIPS provides clinicians the flexibility to choose the activities and measures that are most meaningful to their practice to demonstrate performance.

Quality  Resource use  Clinical practice improvement activities  Advancing care information

Source: The Centers for Medicare & Medicaid Services
Proposed Rule
MIPS: Eligible Clinicians

• Eligible clinicians can participate in MIPS as an:
  
  **Individual**
  
  Or
  
  **Group**

  A group, as defined by taxpayer identification number (TIN), would be assessed as a group practice across all four MIPS performance categories.

Note: “Virtual groups” will not be implemented in Year 1 of MIPS.

Source: The Centers for Medicare & Medicaid Services
What Will be Involved in MIPS?

The MIPS composite performance score has four weighted categories:

- Quality
- Resource use
- Clinical practice improvement activities
- Advancing Care Information

Clinicians will be reimbursed under Medicare Part B based on this Performance Score.
Year 1 Performance Category Weights for MIPS

- Clinical Practice Improvement Activities: 15%
- Advancing Care Information: 25%
- Cost: 10%
- Quality: 50%

Source: The Centers for Medicare & Medicaid Services
What Will Determine My MIPS Score?

The MIPS composite performance score will factor in four weighted categories:

- Quality
- Resource use
- Clinical practice improvement activities
- Advancing Care Information

Proposed quality measures are available in the proposed rule. Quality measures will be published in an annual list.

*Clinicians will be able to choose the measures on which they’ll be evaluated.*

Source: The Centers for Medicare & Medicaid Services
Proposed Rule
MIPS: Quality Performance Category

✔ Selection of six measures.
✔ One cross-cutting measure and one outcome measure, or another high priority measure is outcome is unavailable.
✔ Select from individual measures or a specialty measure set.
✔ Population measures automatically calculated.
✔ Key changes from current program (PQRS):
  – Reduced from 9 measures to 6 measures with no domain requirement;
  – Emphasis on outcome measurement;
  – Year 1 weight: 50%

Source: The Centers for Medicare & Medicaid Services
What Will Determine My MIPS Score?

Resource Use

The MIPS composite performance **score** will factor in four weighted categories:

- **Quality**
- **Resource Use**
- **Clinical practice improvement activities**
- **Advancing care information**

*Will compare resources used to treat similar care episodes and clinical condition groups across practices*

*Can be risk-adjusted to reflect external factors*

Source: The Centers for Medicare & Medicaid Services
Summary:
✓ Assessment under all available resource use measures, as applicable to the clinician;
✓ CMS calculates based on claims so there are no reporting requirements for clinicians;
✓ Key changes from the current program (VBM):
  ✓ Adding 40+ episode specific measures to address specialty concerns
  ✓ Year 1 Weight: 10%

Source: The Centers for Medicare & Medicaid Services
What Will Determine My MIPS Score?
Clinical Practice Improvement Activities

The MIPS composite performance score will factor in four weighted categories:

- Quality
- Resource use
- Clinical practice improvement activities
- Advancing care information

Examples include care coordination, shared decision making, safety checklists, expanding practice access

Source: The Centers for Medicare & Medicaid Services
Proposed Rule: MIPS: Advancing Care Information Performance Category

All MIPS-Eligible Clinicians

Participating as an...

Individual

Or

Group

Those Not Eligible

Include: nurse practitioners (NPs), physician assistants (PAs), hospitals, facilities, and Medicaid
CMS proposes six objectives and their measures that would require reporting for the base score:

- **Protect Patient Health Information** (yes required)
- **Electronic Prescribing** (numerator/denominator)
- **Patient Electronic Access** (numerator/denominator)
- **Coordination of Care Through Patient Engagement** (numerator/denominator)
- **Health Information Exchange** (numerator/denominator)
- **Public Health and Clinical Data Registry Reporting** (yes required)
Summary:

✅ Scoring based on key measures of health IT interoperability and information exchange.

✅ Flexible scoring for all measures to promote care coordination for better patient outcomes.

✅ Key changes from current program (EHR Incentive):
  - Dropped "all or nothing" threshold for measurement
  - Removed redundant measures to alleviate reporting burden
  - Eliminated clinical provider order entry and clinical decision support objectives
  - Reduced the number of required public health registries to which clinicians must report
  - Year 1 weight: 25 percent
How Much Can MIPS Adjust Payments?

Based on a composite performance score, clinicians will receive +/- or neutral adjustments up to the percentages below.

Adjusted Medicare Part B payment to clinician

The potential maximum adjustment % will increase each year from 2019 to 2022

MIPS

Source: The Centers for Medicare & Medicaid Services
Proposed Rule

MIPS Performance Period

- All MIPS performance categories are aligned to a performance period of one full calendar year.
- Goes into effect in the first year (2017 performance year, 2019 payment year).

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MIPS Performance Period (Begins 2017)
Who Will Not Participate in MIPS?

There are **three groups** of clinicians who will NOT be subject to MIPS:

1. **FIRST year of Medicare Part B participation**
2. **Below low patient volume threshold**
3. **Certain participants in ADVANCED APMs**

**Note:** MIPS **does not** apply to hospitals or facilities.

Medicare billing charges less than or equal to $10,000 and provides for 100 or fewer Medicare patients in one year.
Another Path to Quality

APMs
What Is a Medicare APM?

- APMs are new approaches to paying for medical care through Medicare that incentivize quality and value.
- As defined by MACRA, APMs include:
  - **CMS Innovation Center model** (under section 1115A, other than a Health Care Innovation Award).
  - **MSSP** (Medicare Shared Savings Program).
  - **Demonstration** under the Health Care Quality Demonstration Program.
  - **Demonstration** required by federal law.

Source: The Centers for Medicare & Medicaid Services
Advanced APMs Must Meet Certain Criteria

As defined by MACRA, Advanced APMs must meet the following criteria:

- The APM requires participants to use certified EHR technology.
- The APM bases payment on quality measures comparable to those in MIPS.
- The APM either:
  1. Requires APM entities to bear more than nominal financial risk for monetary losses, OR
  2. Is a Medical Home Model expanded under CMMI* authority.

*Center for Medicare & Medicaid Innovation (CMMI)
Medical Home Models:

✓ Have a unique financial risk criterion for becoming an Advanced APM.

✓ Enable participants (who are not excluded from MIPS) to receive the maximum score in the MIPS CPIA* category.

A Medical Home Model is an APM that has the following features:

✓ Participants include primary care practices or multi-specialty practices that include primary care physicians and practitioners and offer primary care services.

✓ Empanelment of each patient to a primary care clinician; and

✓ At least four of the following:
  • Planned coordination of chronic and preventive care.
  • Patient access and continuity of care.
  • Risk-stratified care management.
  • Coordination of care across the medical neighborhood.
  • Patient and caregiver management.
  • Shared decision making.
  • Payment arrangement in addition to, or substituting for, fee-for-service payments.

* Clinical Practice Improvement Activity

Source: The Centers for Medicare & Medicaid Services
Nominal Amount Standard

• The amount of risk under an Advanced APM must at least meet the following components:
  ✓ Total risk of at least 4 percent of expected expenditures
  ✓ Marginal risk of at least 30 percent
  ✓ Minimum loss ration (MLR) of no more than 4 percent
Based on the proposed criteria, which current APMs will be Advanced APMs in 2017?

- **Shared Savings Program (Tracks 2 and 3)**
- **Next Generation ACO Model**
- **Comprehensive ESRD Care (CEC) (large dialysis organization arrangement)**
- **Comprehensive Primary Care Plus (CPC+)**
- **Oncology care Model (OCM) (two-sided risk track available in 2018)**
Note: MACRA does NOT change how any particular APM rewards value. Instead, it creates extra incentives for APM participation.
Review: The Proposed Quality Payment Program for Medicare Part B

MIPS or APMs

Source: The Centers for Medicare & Medicaid Services
Review: Participation in the Quality Payment Program

Potential financial rewards

<table>
<thead>
<tr>
<th>Not in APM</th>
<th>In APM</th>
<th>In Advanced APM</th>
</tr>
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<tbody>
<tr>
<td>MIPS adjustments</td>
<td>MIPS adjustments +</td>
<td>APM-specific rewards +</td>
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<tr>
<td></td>
<td>APM-specific rewards</td>
<td>5% lump sum bonus</td>
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</table>

If you are a qualifying APM participant (QP)
How Do I Become a Qualifying APM Participant (QP)?

Eligible APM → QP

You must have a **certain %** of your patients or payments through an **eligible APM**.

QPs will:

- **Be excluded from MIPS.**
- **Receive a 5% lump sum bonus.**

Bonus applies in 2019–2024; will then receive higher fee schedule update starting in 2026.

Source: The Centers for Medicare & Medicaid Services
What If I’m In An Advanced APM, But Don’t Quite Met the Threshold to Be a QP?

- If you meet a **slightly reduced threshold** (% of patients or payments in an advanced APM), you are considered a “**partially qualified professional**” (partial QP) and can:

  - Opt out of MIPS
  - Participate in MIPS

  - **No payment adjustment**
  - Receive **favorable weights** in MIPS

Example: 20% in 2019 (Criteria defined in law)

Source: The Centers for Medicare & Medicaid Services
What About Private Payer or Medicare APMs?

• Can they help me qualify to be a QP?

Yes, starting in **2021**, participation in **some** of these APMs with other non-Medicare payers can **count toward** criteria to be a QP.

If the APMs meet criteria similar to those for eligible APMs run by CMS:

- Certified EHR use
- Quality Measures
- Financial Risk

“Combination all-payer and Medicare threshold option”

Source: The Centers for Medicare & Medicaid Services
Most Practitioners Will Be Subject to MIPS

Not in APM

In non-eligible APM

In eligible APM, but not a QP

QP in eligible APM

Source: The Centers for Medicare & Medicaid Services

Note: Figure not to scale.
When Will These MACRA Provisions Take Effect?
MIPS Adjustments and APM Incentive Payment Will Begin in 2019

Source: The Centers for Medicare & Medicaid Services
## Proposed Rule
### MIPS Timeline

<table>
<thead>
<tr>
<th>2017</th>
<th>2018</th>
<th>July</th>
<th>2019</th>
<th>2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Performance period (Jan-Dec)</td>
<td>Reporting and data collection</td>
<td>Second feedback report (July)</td>
<td>Targeted review based on 2017 MIPS performance</td>
<td>MIPS adjustments in effect</td>
</tr>
<tr>
<td>First feedback report (July)</td>
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</table>

Source: The Centers for Medicare & Medicaid Services
## Proposed Rule: QP Determination and APM Incentive Payment Timeline

<table>
<thead>
<tr>
<th>Year</th>
<th>QP Performance Period</th>
<th>Incentive Payment Base Period</th>
<th>Payment Year</th>
</tr>
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<tbody>
<tr>
<td>2017</td>
<td>QP Status based on Advanced APM participation here.</td>
<td>Add up payments for a QP’s services here.</td>
<td>+5% lump sum payment made here. (and excluded from MIPS adjustments)</td>
</tr>
<tr>
<td>2018</td>
<td>Incentive Payment Base Period</td>
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<tr>
<td>2019</td>
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<td>Payment Year</td>
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<tr>
<td>2020</td>
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</table>

Repeat the cycle each year ...

Source: The Centers for Medicare & Medicaid Services
Take-Away Points

1. MACRA changes the way Medicare pays clinicians and offers financial incentives for providing high-value care.
2. The Quality payment Program includes two pathways to value: participation in MIPS, or in an Advanced APM.
3. Medicare Part B clinicians will participate in the MIPS program unless they are in their first year of Part B participation, have a low volume of patients, or participate in an Advanced APM.
4. Payment adjustments and bonuses will begin in 2019.

Source: The Centers for Medicare & Medicaid Services
What Should I Do to Prepare For MACRA?

• Look for future educational activities.
• Review fact sheets and the proposed rule on these changes released April 27 and provide comments on the proposal (until June 26). http://go.cms.gov/QualityPaymentProgram
• Final rule is targeted for early fall 2016.
• Consider collaborating with one of the TCPI* Practice Transformation Networks or Support and Alignment Networks.

*Transforming Clinical Practice Initiative (TCPI)
References and Further Reading

• MACRA: Medicare Access and CHIP Reauthorization Act of 2015

• Quality Payment Program
  http://go.cms.gov/QualityPaymentProgram

• Contact information for the Transforming Clinical Practice Initiative
  http://www.healthcarecommunities.org/CommunityNews/TCPI.aspx

• CMS Innovation Center
  https://innovation.cms.gov/

• CMS Quality Measures Development Plan

Source: The Centers for Medicare & Medicaid Services
Questions?

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