

An Overview of Value-Based Payment Models

Trudi Matthews,
Senior Policy Advisor, External Affairs, UKHC &
Managing Director, Kentucky Regional Extension Center

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Kentucky REC & the Great Lakes PTN

CMS established the **Transforming Clinical Practices Initiative (TCPI)** to help clinicians achieve large-scale health transformations through collaborative and peer-based learning networks

- Great Lakes PTN is one of **29 Practice Transformation Networks (PTNs)**
- GLPTN works with 10 **Support and Alignment Networks (SANs)**

GLPTN State Level Leadership:

- Indiana University (primary grant recipient)
- **University of Kentucky (Kentucky)**
- Purdue Healthcare Advisors (Indiana)
- Northwestern University (Illinois)
- Altarum Institute (Michigan)



NORTHWESTERN
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Kentucky Regional Extension Center Overview

UK's Kentucky REC is a trusted advisor and partner to healthcare organizations, supplying expert guidance to maximize quality, outcomes and financial performance

Kentucky REC Description



To date, the Kentucky REC's activities include:

- Helping bring over \$100 million incentive dollars to providers throughout the Commonwealth
- Assisting more than 3,400 individual providers across Kentucky, including primary care providers and specialists
- Helping more than 95% of the Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) within Kentucky
- Working with more than 1/3 of all Kentucky hospitals
- Supporting dozens of practices and multiple health systems with meaningful use, practice transformation and preparation for value based payment

REC Service Lines

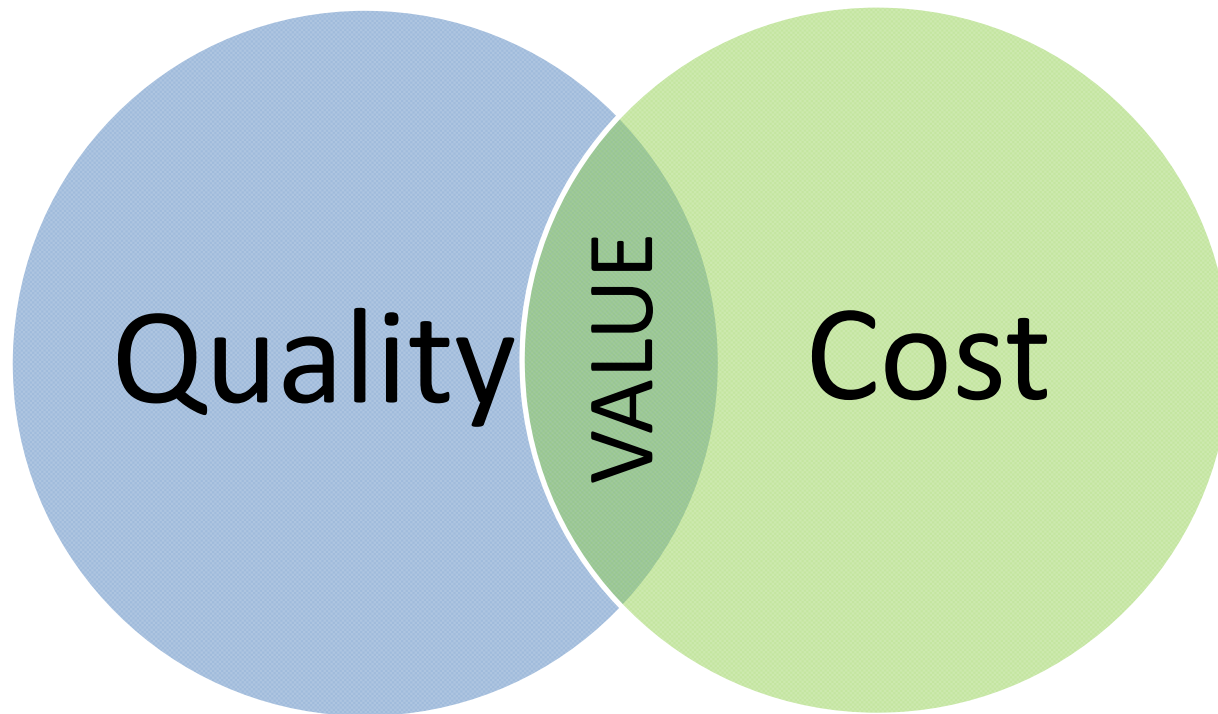
Physician Services

1. Meaningful Use
2. Privacy & Security Consulting
3. Patient Centered Medical Home (PCMH) Consulting
4. Value Based Payment & MACRA Preparation Support
5. Kentucky Medical Professions Placement Services (KMPPS)

Hospital Services

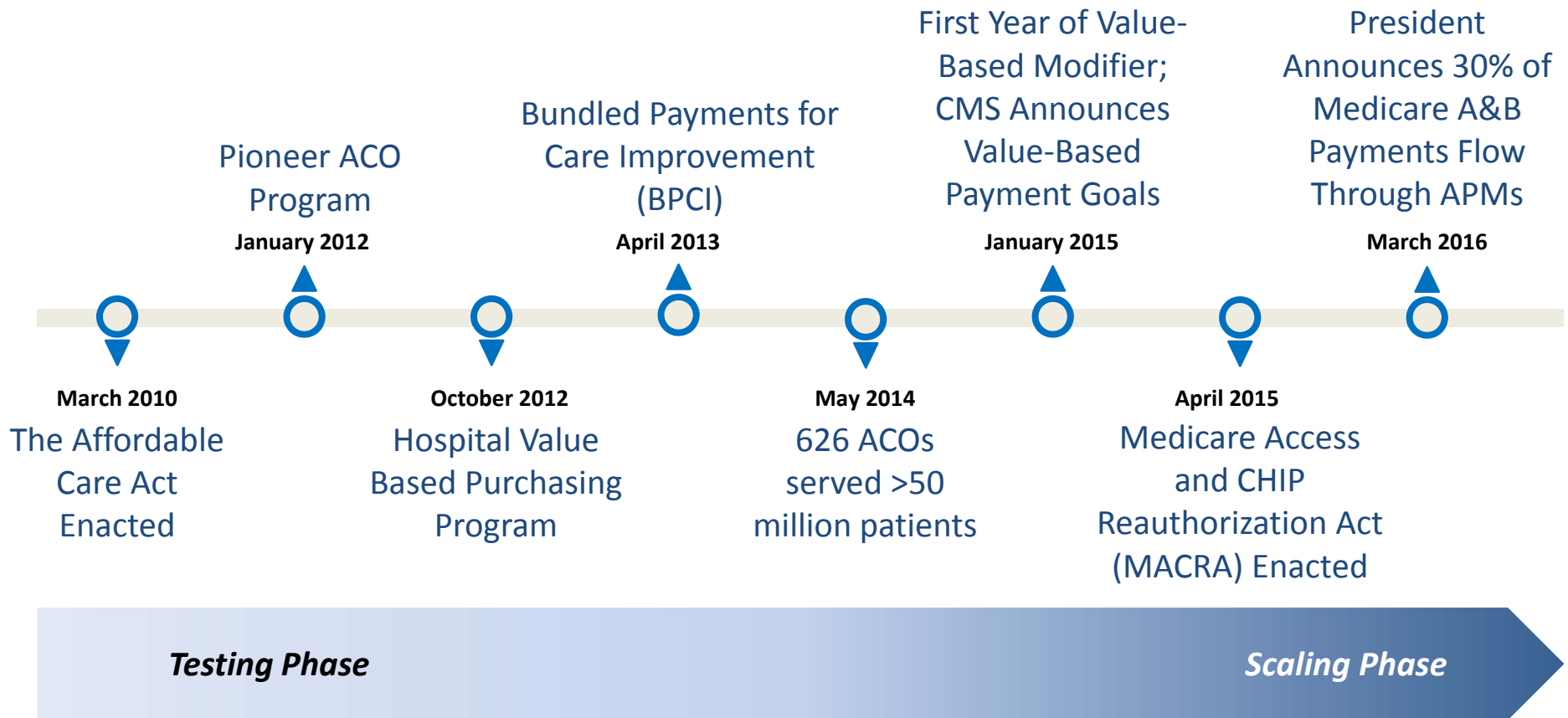
1. Meaningful Use
2. HIPAA Security Assessment
3. Electronic Quality Reporting Support

What is Value Based Payment?



Volume to Value Based Shift

Recent legislative and marketplace developments suggest that the transition from volume to value-based payment is accelerating from a “testing” phase to a “scaling” phase



2015: CMS Accelerates Shift to Value-Based Payment

In January 2015, the Department of Health and Human Services announced **new goals** for **value-based payment** and **APMs in Medicare**

Medicare Fee-for-Service

GOAL 1:

Medicare payments are tied to quality or value through alternative payment models (categories 3-4) by the end of 2016, and 50% by the end of 2018

30% 

GOAL 2:

Medicare fee-for-service payments are tied to quality or value (categories 2-4) by the end of 2016, and 90% by the end of 2018

85% 



STAKEHOLDERS:

Consumers | Businesses
Payers | Providers
State Partners



Set internal goals for HHS



Invite private sector payers to match or exceed HHS goals

Commercial Insurers Accelerate VBP

“Our industry is in the midst of a profound shift from fee-for-service, or volume-based care, to value-based care. Aetna has successfully built more than 72 ACO relationships with providers, growing from very small numbers in 2011 to more than 2 billion dollars in revenue today. ...**We plan to maintain 75 percent of our medical spending in value-based contracts by 2020.**”

- *Charles Kennedy, MD, chief population officer for Healthagen, Aetna*



Source: [Health Care Learning & Action Network](#)

April 2016 - Medicaid Managed Care Regulations

Among other provisions, State Medicaid Agencies may require an MCO to:

- *Implement **value based purchasing models for provider reimbursement***
- *Participate in multi-payer delivery system reform or performance improvement*

Phase out of supplemental payments – with option to move payments into value-based payment models

Overview of the MACRA Proposed Rule

April 2016 MACRA Proposed Rule: New Medicare Part B Payment Program



MIPS

Merit-based Incentive
Payment System

APM

Alternative Payment
Models

Eligible Clinicians (ECs)



ECs for 2019 and 2020: Physicians, PAs, NPs, CNS, CRNA

After 2020, CMS may expand to other clinicians in Medicare FFS:

PT, OT, NMW, CSW, Clinical Psychologists, Dieticians and Nutrition professionals

Not covered by MACRA:

1) Hospital/Part A payments; 2) FQHCs/RHCs and 3) Medicaid Providers

Exclusions:

- 1st year ECs
- Under 10K + 100 patients
- “Non-patient facing” provider
- Advanced APM Qualifying Provider

MACRA Near Term Dates

**October/November 2016:
Expected Release of Final Rule**

**Jan – Dec 2017:
1st Performance Period for MACRA**

**March 31, 2018:
Reporting Deadline for First Year**

**Jan – Dec 2019:
1st Payment Year for MACRA**

2017 Reporting Options

Option 1:
Test Only

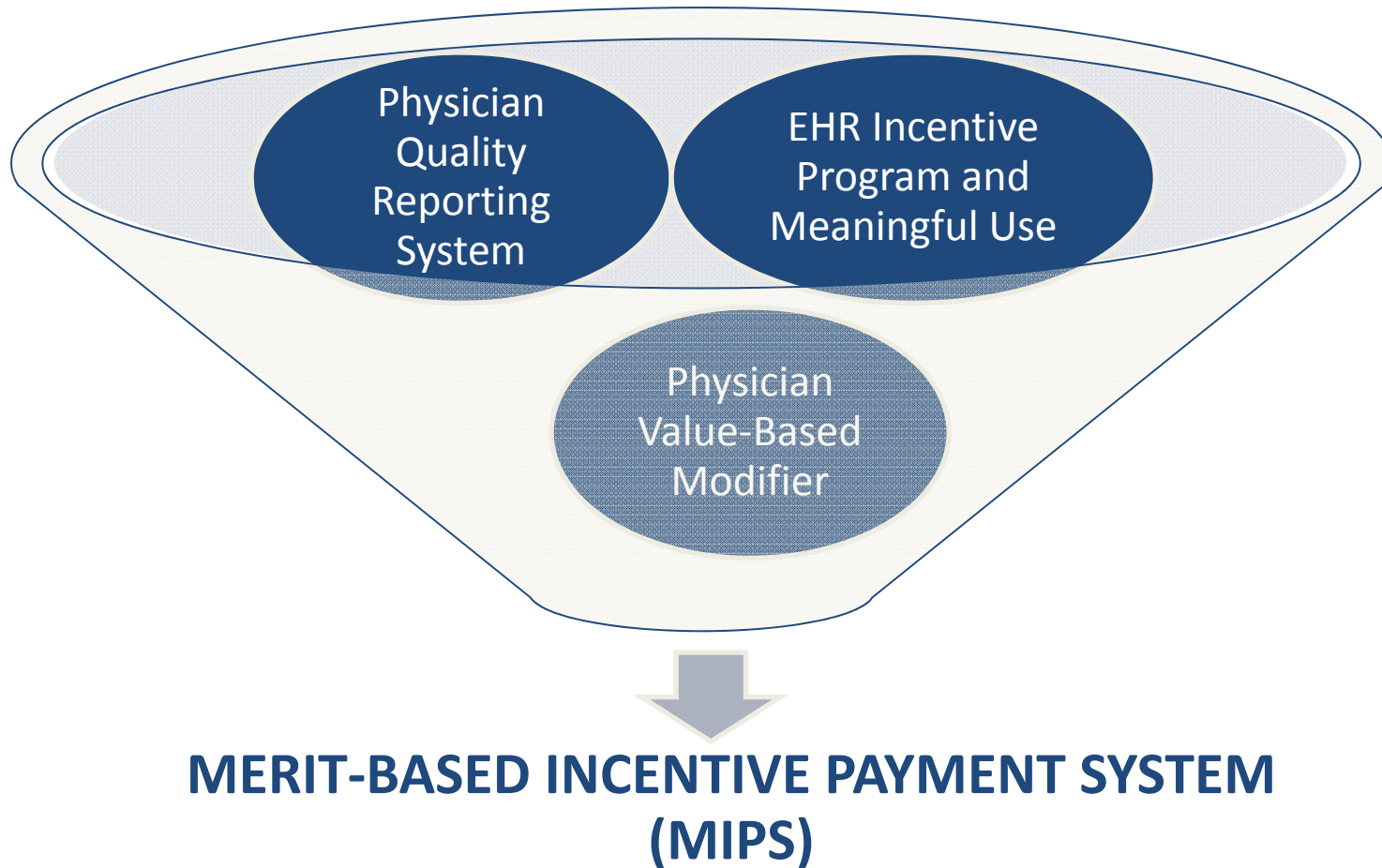
Option 2:
Partial Year

QPP

Option 3:
Full Year





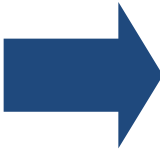
Option 4:
Advanced APM

Consolidation of Programs

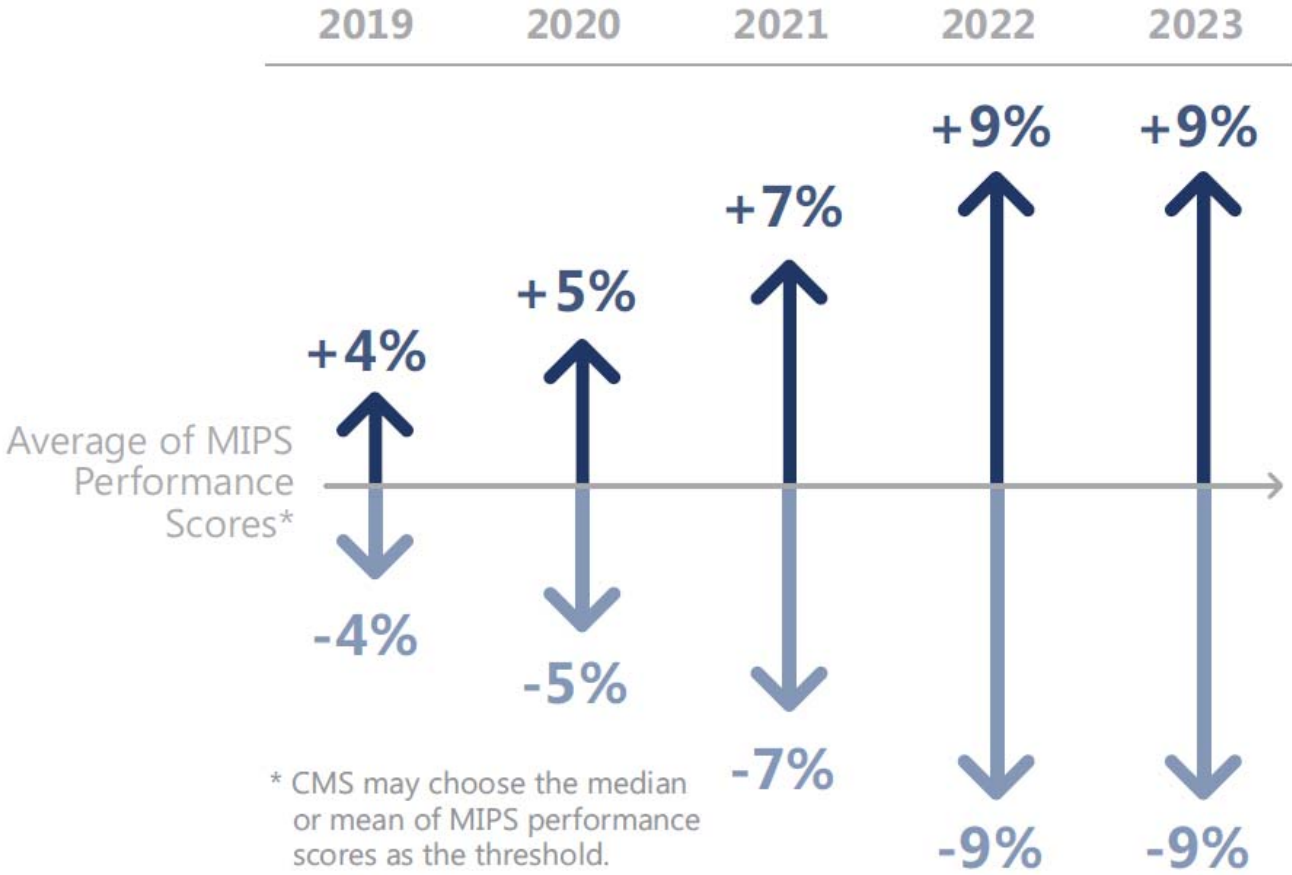


How will MIPS measure performance?

Providers will receive a **MIPS composite performance score** based on 4 weighted performance categories:

	 Quality	 Resource use	 Clinical practice improvement activities	 Advancing Care Information	 MIPS Composite Performance Score
CY19	50%	10%	15%	25%	
CY20	45%	15%	15%	25%	
CY21	30%	30%	15%	25%	

Maximum MIPS Payment Adjustments



Source: Leavitt Partners - MACRA: Quality Incentives, Provider Considerations, and the Path Forward

What's the big deal about APMs?

Stated intention of CMS that more and more of its \$ will be spent in APMs over time

5% Annual Participation Bonus for Advanced APM participants from 2019-2025

Favorable scoring under MIPS for all APM participants

Annual update after 2025 is 0.75% for APM entities versus 0.25% for MIPS entities

Advanced Alternative Payment Models

Advanced APM participants are eligible for 5% bonus payment.

But, only some APMs are risk-bearing Medicare payment models that qualify for this bonus payment.

In new
NPRMs,
Advanced
APMs
include:

- ✓ Next Generation ACO Model
- ✓ Medicare Shared Savings Program – Tracks 2 & 3
- ✓ Comprehensive Primary Care Plus (CPC+)
- ✓ Comprehensive ESRD Care Model
- ✓ Oncology Care Model Two-Sided Risk Arrangement (available in 2018)
- ✓ Cardiac CJR Episode Payment Model

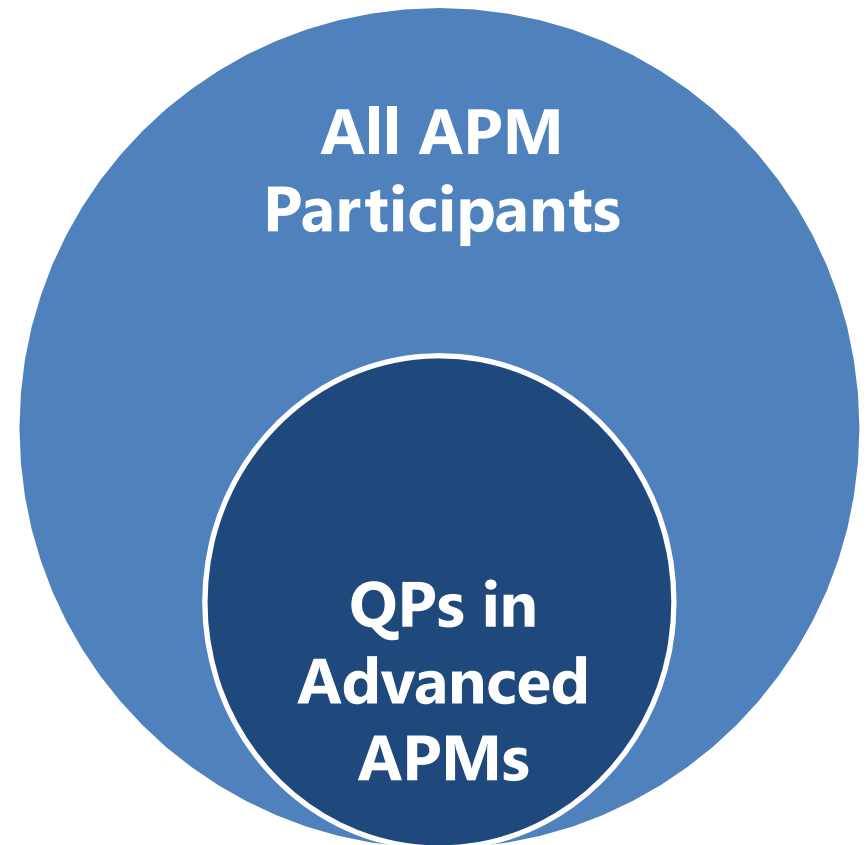
- MACRA does not change how any particular APM rewards value.
- APM participants who are not “Qualifying Providers” (QPs) will receive **favorable** scoring under MIPS.

Not Every APM Will Qualify for 5% APM Bonus

Most physicians and practitioners who participate in APMs will be subject to MIPS and will receive *favorable scoring* under the MIPS clinical practice improvement activities performance category.

Only providers in Advanced APMs will be deemed qualifying APM participants (“QPs”):

1. Report APM quality measures
2. Use of Certified EHR
3. Meet Advanced APM criteria (risk-bearing or medical home model)
4. Must meet APM thresholds for payment and patient volumes



Physician Compare

Medicare.gov | Physician Compare

The Official U.S. Government Site for Medicare

About Physician Compare

About Physician Compare

❖ Information available on Physician Compare

About the data

Resources

Help

Information available on Physician Compare

On Physician Compare, you can find:

- ◆ Addresses where the professional sees patients (always confirm the address when you make an appointment; some professionals work at more than one location)
- ◆ Primary and secondary specialties
- ◆ Medicare assignment status
- ◆ American Board of Medical Specialties (ABMS) board certification
- ◆ Whether the individual or group participates in select Centers for Medicare and Medicaid Services (CMS) quality programs
- ◆ Gender
- ◆ Medical school education and residency information
- ◆ Groups that individuals work with (individual profile) or individuals who work with the group (group profile)
- ◆ Hospital affiliation

The information on Physician Compare comes primarily from the Provider, Enrollment, Chain, and Ownership System (PECOS). PECOS data is checked against Medicare claims data.

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Coming Soon – Your MACRA performance score!

Impact of MACRA on Medicare Providers



Financial & Strategy Implications

- MACRA moves Medicare payment from one size fits all to a meritocracy
- Market share will shift from low performers to high performers over time
- Delay means disaster; exponential leaps in value will be needed to catch up with those that perform better as thresholds increase over time



Reputational Status

Publicly available scores on quality and value that compare organizations/professionals will affect:

- Health plan negotiations
- Talent recruitment
- Consumer choice

**Overview of the Mandatory
Cardiac CJR Episode Payment
Proposed Rule**

3 Main Components of Proposed Rule

1. Expansion of Current Comprehensive Joint Replacement (CJR) Bundle to include Hip/Femur Fractures (SHFFT) episodes

2. Mandatory Cardiac Bundled/Episode-based Payment Program

3. Cardiac Rehab Incentive Program

Proposed Rule - Cardiac Bundled Payment

98 MSAs in the US will be randomly selected

- Roughly 1 in 3 chance
- 284 eligible MSAs based certain criteria: 75 AMIs per year, more than 75 non-BPCI AMIs per year, and at least 50% of non-BPCI AMIs per year

90 day Retrospective Bundled Payment

Includes CABG, AMI (with PCI) as episodes

- CABG: MS-DRGs 231-236
- AMI: MS-DRGs 280-282; 246-251

Proposed Rule - Cardiac Bundled Payment

1st Performance Period: July 1, 2017 – Dec. 31, 2017;
CY thereafter – Jan-Dec

- No downside risk in first 9 months
- Graduated limits on risk thereafter: 5%, 10%, 20%
- Bonuses for higher quality

Participants could qualify for **Advanced Alternative Payment Model**

- eligible for 5% bonus under MACRA

Test Cardiac Rehab Incentive Program in 90 markets:

- 45 with Cardiac bundles, 45 without

Kentucky MSAs Eligible for the Cardiac Model

Ashland –
Huntington,
WV

Clarksville, TN
– Fort
Campbell, KY

Elizabethtown

Evansville

Lexington

Louisville

Owensboro

Northern Ky
(Cincinnati)

Quality Measures & Reporting

AMI Measures	CABG Measures	4 Ratings
<p>MORT–30–AMI: Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Acute Myocardial Infarction (AMI) Hospitalization (NQF #0230).</p>	<p>MORT–30–CABG: Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Coronary Artery Bypass Graft Surgery (NQF #2558)</p>	<p>Excellent</p>
<p>AMI Excess Days: Excess Days in Acute Care after Hospitalization for Acute Myocardial Infarction (acute care days include emergency department, observation, and inpatient readmission days)</p>	<p>HCAHPS Survey (NQF #0166), HLMR scores like CJR</p>	<p>Good</p>
<p>HCAHPS Survey (NQF #0166), linear mean roll-up (HLMR) scores like CJR</p>		<p>Acceptable</p>
<p><i>Proposed: AMI mortality measure using hybrid claims & clinical data</i></p>		<p>Below Acceptable</p>

How can clinicians and staff prepare?

"People's lives can be absolutely transformed by being nudged along a slightly altered route."

- Dr. Ben Fletcher

Some clinicians
think MACRA means...



- Stop seeing sick, non-compliant patients
- Start accepting only patients who are healthy
- But successful VBP/APM leaders understand the 5-50 Rule.

5% of patients are responsible for 50% of costs.

Immediate Actions to Consider

- Engage leadership, clinicians & staff
- Consider medical home model/recognition
- Dominate your quality data
- Regular review of QRUR & other payer feedback
- Review compensation models



Focus on Common Elements on the Payment Innovation Journey



Thank you!

Questions?

