

VALUE PAYMENT: A NEW REIMBURSEMENT SYSTEM USING QUALITY AS CURRENCY

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Healthcare Quality/ Value Challenge

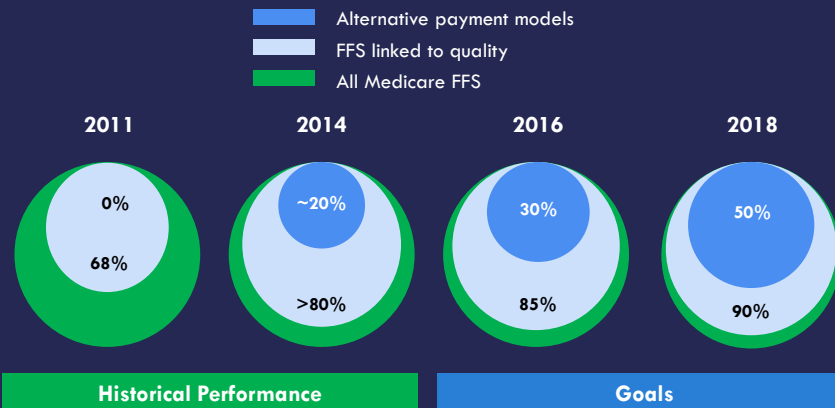
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Value-Based Programs

- Supports the IHI Triple Aim:
 1. Better care for individuals
 2. Better health for populations
 3. Lower cost

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Moving from Rewarding Volume to Value



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Agenda

CMS Provider Programs:

- ❑ Physician Quality Reporting System
- ❑ Value Modifier Program
- ❑ Meaningful Use
- ❑ Alternative Payment Models
- ❑ Merit-based Incentive Payment System

CMS Post-Acute Care Programs:

- ❑ IRU Quality Reporting Program
- ❑ SNF Quality Reporting Program
- ❑ Skilled Nursing Facility Value-Based Purchasing
- ❑ HHA Quality Reporting Program
- ❑ Home Health Value-Based Purchasing Model
- ❑ Hospice Quality Reporting Program

CMS Hospital Programs:

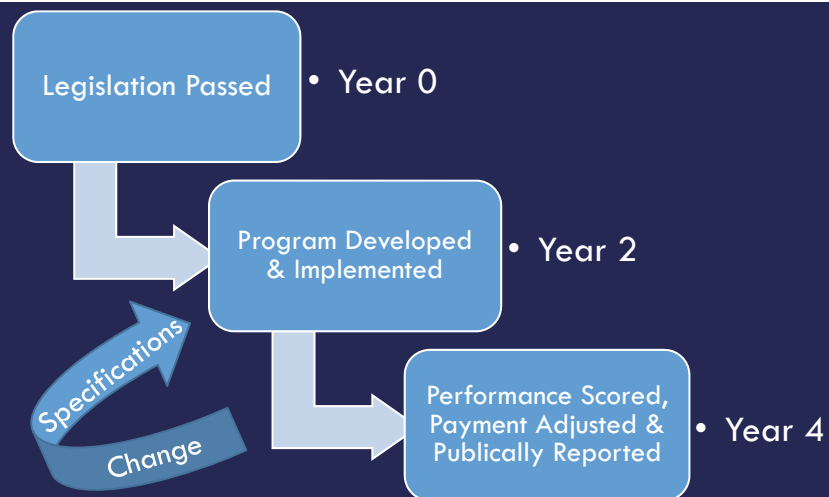
- ❑ Inpatient Quality Reporting Program
- ❑ Outpatient Quality Reporting Program
- ❑ Hospital Value-Based Purchasing Program
- ❑ Hospital-Acquired Condition Reduction Program
- ❑ Readmissions Reduction Program
- ❑ Meaningful Use

Other Payor Programs:

- ❑ PA Medicaid Preventable Admissions Program
- ❑ Medicare Part C & D
- ❑ Commercial Insurance Incentives/ Penalties



Building a Foundation



Hospital Reimbursement

Acute Care Hospitals
Critical Access Hospitals

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Hospital Inpatient Quality Reporting (IQR) Program

- Legislation: Medicare Prescription Drug, Improvement and Modernization Act of 2003 and Section 5001(a) of Public Law 109-171 of the Deficit Reduction Act of 2005
- Penalty for failure to report: **25% reduction** of the Inpatient Prospective Payment System Annual Payment Update

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IQR Measures

- ❑ Patient and Family Experience of Care (HCAHPS)
- ❑ Clinical Process of Care Measures
- ❑ Electronic Clinical Quality Measures
- ❑ Healthcare-Associated Infection
- ❑ Healthcare Personnel Influenza Vaccination Rate
- ❑ 30 Day Mortality
- ❑ 30 Day Readmission
- ❑ Patient Safety Indicators (PSI-90)
- ❑ Total Hip and Total Knee Replacement Complications
- ❑ Death Among Surgical Patients with Serious Treatable Complications
- ❑ Medicare Spending per Beneficiary
- ❑ Payment per 30 day Episode of Care
- ❑ Excess Days in Acute Hospital (new for FY2018)

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Hospital Outpatient Quality Reporting (OQR) Program

- ❑ Modeled after Hospital Inpatient Quality Reporting Program, Hospital OQR Program
- ❑ Effective for payments beginning in calendar year 2009
- ❑ Penalty for failure to report: **2% reduction** in the Outpatient Prospective Payment System Annual Payment Update

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Hospital Value-Based Purchasing (VBP) Program

- Legislation: Section 1886(o) of the Social Security Act, as added by Section 3001(a) of the Patient Protection and Affordable Care Act (ACA) of 2010
- **Program intent:** Promote better clinical outcomes for hospital patients, improve the patient experience of care during hospital stays, and encourage hospitals to improve the quality and safety of care that all patients receive by:
 - Eliminating or reducing the occurrence of adverse events
 - Adopting evidence-based care standards and protocols that result in the best outcomes for the most patients
 - Re-engineering hospital processes that improve patients' experience of care
- **Redistribution of 2.00%** from participating hospitals' DRG payments in FY 2017 and forward

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FY2018&19 Domain Weights & Measures

Earning Hospital VBP Points

- For each measure, the hospital receives the greater of:
 - Achievement compared to national benchmarks (0-10 points)
 - OR
 - Improvement from the baseline period (0-9 points)
- AND
- Patient and Caregiver Experience includes a Consistency Score
 - Based on a hospital's lowest HCAHPS dimension score during the performance period relative to the other hospitals' scores from the baseline period

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Hospital VBP Program Evaluation

- Bonuses & penalties received by most participating hospitals amounted to less than 0.5%

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Hospital-Acquired Condition Reduction Program (HACRP)

- Legislation: Section 1886(p) of the Social Security Act, as added under section 3008(a) of the Affordable Care Act
- Scoring:
 - Healthcare Acquired Infections 85%
 - Patient Safety Indicator 15%
- **Reduces payments by 1%** to hospitals that rank in the worst-performing quartile of all hospitals with respect to risk-adjusted HAC quality measures

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HACRP vs HAC Program

Important Note: HAC Reduction Program is separate and distinct from the Deficit Reduction Act of 2005: Hospital-Acquired Conditions (Present on Admission Indicator) program

- Hospital-Acquired Conditions (Present on Admission Indicator) program withholds payment for conditions *NOT* present on admission meeting the following criteria:
 - A. High cost or high volume or both
 - B. Result in the assignment to a diagnostic-related group (DRG) that has a higher payment when present as a secondary diagnosis, and
 - C. Could reasonably have been prevented through the application of evidence-based guidelines

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HAC Reduction Program Evaluation

- Financial impact = Saves Medicare approximately \$364 million for FY 2016
 - 758 of 3,308 hospitals penalized in FY 2016
 - 724 hospitals penalized in FY 2015

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Change in Rates for Hospital-Acquired Conditions, 2010–13

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Readmissions Reduction Program

- Legislation: section 1886(q) of the Social Security Act, as added by section 3025 of the Affordable Care Act, as amended by section 10309 of the Affordable Care Act
- 30 day risk-standardized all-cause readmission
- CMS reduces payments to hospitals with excess readmissions by up to **3%** for all inpatient admissions

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Readmission Reduction Program Evolution

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Readmission Reduction Program Evaluation

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Hospital Meaningful Use

- American Recovery and Reinvestment Act of 2009 (ARRA) mandated payment adjustments for those that are not meaningful users of Certified Electronic Health Record (EHR) Technology beginning on October 1, 2014
- All eligible hospitals are required to attest to a single set of 9 objectives and measures
- Reporting period: full calendar year

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Post-Acute Care Reimbursement

Inpatient Rehabilitation
Skilled Nursing Facility
Home Health and Hospice

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Inpatient Rehabilitation Unit/Facility Quality Reporting Program

- Legislation: Section 3004(a) of the Affordable Care Act of 2010
- Measures: infections, readmissions, pressure ulcers
- Penalty for failure to report: **2% reduction** of the annual payment update

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Skilled Nursing Facility Quality Reporting Program

- Legislation: IMPACT Act of 2014
- Measures: Falls, pressure ulcer, functional assessment
- Penalty for failure to submit all data necessary on at least 80% of the MDS assessments: **reduce payment rates by 2 percentage points**
- Data submission started 10/1/16, Penalties start FY 2018

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Skilled Nursing Facility Value-Based Purchasing Program (SNFVBP)

- Legislation: Section 215 of the 2014 Protecting Access to Medicare Act (PAMA)
- Skilled Nursing Facility 30-Day All-Cause Readmission Measure
- **Redistribution of 2%** withheld from SNFs in reimbursement from CMS starting in 2018

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Home Health Quality Reporting Program

- Legislation: Section 1895(b)(3)(B)(v)(II) of the Social Security Act
- Began reporting data for 2007
- Quality Assessments Only metric
 - Start of Care/Resumption of Care matched with End of Care Performance standards:
 - 2015-2016 = 70%
 - 2016-2017 = 80%
 - 2017-2018 = 90%
 - Home Health Care Consumer Assessment of Healthcare Providers and Systems Survey (HH CAHPS)
- Penalty for failure to report or meet compliance threshold: **2% reduction**

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Home Health Value-Based Purchasing (HHVBP) Model

- Legislation: Section 1115A of the Social Security Act
- On January 1, 2016, model implemented in all Medicare-certified HHAs in the following states: Arizona, Florida, Iowa, Maryland, Massachusetts, Nebraska, North Carolina, Tennessee, and Washington
- HHAs compete for payment adjustments to their current reimbursements based on quality performance
- Overall economic impact for CY 2018 through 2022 is estimated at \$380 million

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Hospice Quality Reporting Program

- Legislation: Section 3004 of the Affordable Care Act (ACA)
- Measures:
 - Hospice Item Set
 - Hospice CAHPS
- Compliance threshold:
 - FY2018 – 70% submitted within 30 days
 - FY2019 – 80% submitted within 30 days
 - FY2020 and beyond – 90% submitted within 30 days
- Penalty for failure to report and meet compliance threshold: **2% reduction** in annual payment update

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Changes to PAC Quality Reporting Programs

- IMPACT ACT = Improving Medicare Post-Acute Care Transformation Act of 2014
- Programs:
 - Long-Term Care Hospitals
 - Inpatient Rehabilitation Facilities (IRF-PAI)
 - Skilled Nursing Facilities (MDS)
 - Home Health Agencies (OASIS)
- Reporting measures:
 - Admission and Discharge Assessments
 - Quality measures
 - Resource utilization measures
- Finalized Changes beginning with 10/1/16 & are additive

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Provider Reimbursement

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Provider Meaningful Use

- Legislation: American Recovery and Reinvestment Act of 2009 (ARRA) mandated payment adjustments for those that are not meaningful users of Certified Electronic Health Record (EHR) Technology beginning on October 1, 2014
- Failure to attest in 2016 **payment reduction = (-)4% in 2018**
- 171,000 Eligible Providers penalized in 2017

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Physician Quality Reporting System (PQRS)

- Legislation: Tax Relief and Healthcare Act of 2006
- Reporting criteria: report on 9 or more measures covering at least 3 domains, and 1 cross-cutting measure for at least 50% of patients
- PQRS Reporting options include group reporting or individual reporting where at least 50% of the EPs in the group meet the reporting criteria
- Failure to report penalty:
 - 2015 & 2016 PQRS - **negative 2.0%** of MPFS in 2017 & 2018

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Physician Value Modifier (VM) Program

- Legislation: Section 3007 of the 2010 Patient Protection and Affordable Care Act
- Failure to report PQRS = automatic VM adjustment
 - **(-)2%** for groups of 1-9 Eligible Providers
 - **(-)4%** for groups of 10+ Eligible Providers
- Budget neutral scoring:

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Physician VM Program Measures

- Quality measurement component:
 - Physician Quality Reporting System (PQRS)
 - Composite measure of hospital admissions for ambulatory care-sensitive conditions
 - Acute conditions
 - Chronic conditions
 - 30-day all-cause hospital readmissions
- Cost measurement component:
 - Total per capita costs measure
 - Total per capita costs for beneficiaries with chronic conditions
 - Medicare Spending Per Beneficiary

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Physician VM Program Evaluation

- 13,813 physician groups participated
 - 5,418 groups failed to meet PQRS reporting requirements & received automatic reduction
 - 59 groups received downward adjustment based on quality & cost performance
 - 8,208 groups remain neutral
 - 128 groups received upward adjustment based on quality & cost performance

CY 2018 will be the final payment adjustment period under the Value Modifier

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Quality Payment Program (QPP)

- Legislation: Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)
- Changes the way Medicare rewards clinicians to value over volume
 - 1) Streamlines multiple quality reporting programs into the new Merit-based Incentive Payment System (MIPS)
 - 1) Provides incentive payments for participation in Advanced Alternative Payment Models (APM)
- Repeals Sustainable Growth Rate
- Final rule October 14, 2016
- 2017 performance = 2019 payment

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MACRA Eligible Clinicians

Years 1 and 2

- Physicians
- PAs and NPs
- CRNAs
- Clinical nurse specialists

Possible Expansion in years 3+

- PTs, OTs, SLPs
- Nurse midwives
- Clinical Social Workers and Psychologists
- Dieticians
- Audiologists

Excluded: 1st year of Medicare Participation
 Low-volume \leq \$30,000 in Medicare charges, \leq 100 Medicare pts 9/1 -8/31

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Non-Patient Facing Clinicians

- Non-patient facing threshold is <100 patient facing encounters in a designated period
- Group is non-patient facing if > 75% of NPIs billing under the group's TIN during a performance period are labeled as non-patient facing
- Special reporting requirements for non-patient facing clinicians

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Alternative Payment Models (APMs)

- Qualifying advanced APM participants = must be on an APM Participation List on at least one of the snapshot dates (March 31, June 30 or August 31) of the performance period
 - Lump sum **5% bonus** for years 2019-2024
 - Higher fee schedule update for 2026 forward
- Non-qualifying APM participants
 - Subject to MIPS and receive favorable scoring for clinical practice improvement activities
 - Eligible for APM-specific rewards

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CMS 2015 ACO Quality & Financial Performance Results

- ACOs meeting quality and cost benchmarks receive 50% of the savings
- To keep a larger share of the savings (up to 60 %), ACOs can choose to participate in a “two-sided risk” model, whereby they must repay a share of losses if health care spending for attributed patients exceeds the budget target
- The 2015 results revealed that:
 - 400+ ACOs
 - 125 MSSP ACOs outperformed their benchmark
 - \$429 million in shared savings payments

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Current Advanced APM Qualifiers

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APM Participation

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Long Term Advantage of APMs

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Merit-based Incentive Payment System

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MIPS Performance Category: Quality

- Components:
 - Selection of 6 of 271 measures (PQRS was 9)
 - Individual measures or specialty set with 1 outcome measure
 - Choose your measures from qpp.cms.gov
 - CAHPS counts as 1 of 6 measures for groups
 - Readmissions (for groups of 16+ with 200+ cases)
- Reporting:
 - For >3 points, must report 50% of >20 eligible patients
 - Threshold increases to 60% of eligible patients in 2018
 - Readmissions calculated by claims by CMS

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MIPS Performance Category: Quality

- Scoring:
 - 3 points if measure can not be scored against benchmark
 - 3-10 points if measure can be reliably scored against benchmark
 - To establish benchmark, need at least 20 reporters with performance >0% on 20+ patients each reporting >50% of eligible cases
- Bonus points awarded for:
 - 1 bonus point for using CEHRT to submit measures to registries or CMS
 - 1 bonus point for each additional high priority measure
 - 2 bonus points for each additional outcome and patient experience measure
- Weight in 2017 = 60%, report 1 to avoid penalty

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MIPS Performance Category: Quality

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MIPS Performance Category: Cost

- Components:
 - Medicare spending per beneficiary (min # patients is 35)
 - Total per capita cost (min # patients is 20)
 - Episode payment (10 episode specific measures in comparison)
- CMS calculates score based on claims – no reporting required
- Average score of all cost measures that can be attributed to eligible clinician
- Weight in 2017 = 0%

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Cost: Episode Payment

- Cataract/lens surgery
- Mastectomy
- Aortic/mitral valve surgery
- Coronary artery bypass graft
- Repair of hip/ femur fracture or dislocation
- Cholecystectomy and common duct exploration
- Colonoscopy and biopsy
- Transurethral resection of the prostate for BPH
- Hip replacement or repair
- Knee arthroplasty

MIPS Performance Category: Advancing Care Information

- ❑ Must use certified 2014 or 2015 edition EHRs to report Objectives and Measures
- ❑ Must attest that to support information exchange and prevent information blocking
- ❑ Weight in 2017 = 25%, Report 5 required Objectives and Measures for a continuous 90-day period in 2017 to avoid a penalty
- ❑ Scoring is more complex in future years

MIPS Performance Category: Advancing Care Information

- ❑ Failure to use a certified EHR = zero score

ACI Base Score



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ACI Performance Score



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ACI Bonus Points

- 5% bonus potential for reporting (via Yes/No statement) to one or more additional public health and clinical data registries:
 - Syndromic surveillance
 - Electronic case (in 2018)
 - Public health registry
 - Clinical data registry
- 10% bonus potential for reporting certain Improvement Activities (IAs) using CEHRT

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Special Categories of Eligible Clinicians

- CMS automatically reweighs ACI performance category to 0 for:
 - Clinicians who lack of face-to-face patient interaction
 - Hospital-Based clinicians who furnishes 75% or more of services in hospital or ED
- May apply for ACI performance category score weighted to 0 & 25% assigned to Quality category for the following reasons:
 - Insufficient internet connectivity
 - Extreme and uncontrollable circumstances
 - Lack of control over the availability of CEHRT

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MIPS Performance Category: Improvement Activity

- Perform CPIA for continuous 90-day period
- 93 activities in 9 categories to choose from at qpp.cms.gov
- Groups >15, Report up to 4 activities/year for 40 points
 - High activities (20 points) + Medium activities (10points)
- Patient Centered Medical Home = 40 points
- MIPS APM (does not qualify as advanced) = 20+ points
- Only 2 activities required for groups ≤ 15 , rural and HPSA practices, non-patient facing specialists
- Weight in 2017 = 15%, report 1 to avoid penalty

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IA Categories

- Expanded practice access = weekend hours, telehealth
- Beneficiary engagement = patient portal, group visits
- Achieving health equity = see new medicaid patients
- Population management = registries, feedback reports
- Patient safety and practice assessment = maintenance of certification
- Emergency preparedness and response = disaster relief
- Care coordination = transitional care management
- Integrated behavioral and mental health = depression screening

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Reporting as Group or Individual

	INDIVIDUAL	GROUP
QUALITY	<ul style="list-style-type: none"> • Qualified Clinical Data Registry • Qualified Registry • EHR • Claims 	<ul style="list-style-type: none"> • Qualified Clinical Data Registry • Qualified Registry • EHR • Claims • CMS Web Interface • CAHPS
COST	<ul style="list-style-type: none"> • Claims 	<ul style="list-style-type: none"> • Claims
ADVANCING CARE INFORMATION	<ul style="list-style-type: none"> • Attestation • Qualified Clinical Data Registry • Qualified Registry • EHR 	<ul style="list-style-type: none"> • Qualified Clinical Data Registry • Qualified Registry • EHR • CMS Web Interface
IMPROVEMENT ACTIVITIES	<ul style="list-style-type: none"> • Attestation • Qualified Clinical Data Registry • Qualified Registry • EHR 	<ul style="list-style-type: none"> • Attestation • Qualified Clinical Data Registry • Qualified Registry • EHR

Evolution of MIPS Scoring Weights

MIPS Scoring

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MACRA Timeline & Payment Adjustments

- Budget neutral program

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MIPS Differential per Visit

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MIPS Differential per Provider

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Pick Your Pace: 2017 Transitional Performance Reporting Options

- MIPS Testing**
 - Report some data at any point in CY 2017 to demonstrate capability
 - 1 quality measure, or 1 IA, or 4/5 required ACl measures
 - No negative adjustment in 2019
- Partial MIPS reporting**
 - Submit partial MIPS data for at least 90 consecutive days
 - 1+ quality measure, or 1+ IA, or 4/5 required ACl measures
 - No negative adjustment/potential for positive adjustment (< 4%) in 2019
- Full MIPS reporting**
 - Meet all reporting requirements for at least 90 consecutive days
 - No negative adjustment/Maximum chance for positive 2019 adjustment (< 4%)
- Advanced APM participation**
 - No MIPS reporting requirements
 - Eligible for 5% advanced APM participation incentive in 2019



Beyond Medicare FFS

- Medicare Part C & D
- Commercial Insurance
- Medicaid



Medicare Part C & D

- Affordable Care Act established CMS' Star Ratings as the basis of Quality Bonus Payments to MA plans
- Domains:
 - Staying Healthy: Screenings, tests and vaccines
 - Managing chronic conditions
 - Member experience with plan
 - Member complaints and changes in plan's performance
 - Plan customer service
 - Drug safety and accuracy of drug pricing
- 5-star plans
 - Market year-round
 - Beneficiaries can join plans at any time via a special enrollment period
- Medicare Plan Finder online enrollment disabled for consistently Low Performing Plans

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Commercial Insurance

- Health Care Transformation Task Force
 - Value-based coalition formed by payers, patients, providers, and purchasers
 - Includes Aetna, Blue Cross, Health Care Services Corporation, Ascension Health, and Trinity Health
- Goal for 75% of their respective businesses would be operating under value-based payments by 2020

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Pennsylvania Department of Human Services

- Legislation: CMS final Medicaid managed care regulations (Mega Reg) published May 6, 2016
- Total amount allocated for the State Fiscal Year 2016-17 Quality Initiative is \$25 million
- Target funds to be expended through value based arrangements:
 - CY2017 – 7.5%
 - CY2018 – 15%
 - CY2019 – 30%

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PA DHS Hospital Quality Incentive Program Measure & Scoring

- Quality measure: Potentially Preventable **Admissions**
- Scoring:
 - Incremental improvement from CY 2015 to CY 2016
 - Benchmark achievement by meeting or exceeding 25th or 50th percentile
 - Hospitals can qualify for both improvement and benchmark incentives
- Impact: **Incentive, not penalty**
- Outcomes of similar program:
 - Texas Medicaid – 18% reduction in PPA expenditures

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Quality of Care & Financial Risk

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Transparency of Scoring

- CMS efforts to increase transparency
 - APM participation “snapshots” 3 times per year
 - Claims lookback so clinicians know if they meet MIPS criteria for special exceptions: (Non-patient facing, hospital-based, small practices)
- But scoring calculation will be a “black box” for most clinicians
 - Difficult to replicate CMS calculations (don’t try this at home)
- Access and review feedback reports and Quality and Resource Use Reports (QRURs)
- If you believe that the negative payment adjustment is being applied in error, you can submit an informal review request via a web-based tool on the CMS Website within 60 days of the release date of the feedback reports
- CMS will investigate the merits of your informal review request and issue a decision within 90 days of receipt
- No further opportunity to appeal beyond the informal review

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Public Reporting

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Burden of Reporting for Systems

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Burden of Reporting for Physicians

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