MACRA Playbook

Oregon MACRA Playbook Conference: Implementing Value-Based Payment and Improving Care in a New Environment

Elizabeth Mitchell, President & CEO
Network for Regional Healthcare Improvement

June 22, 2017

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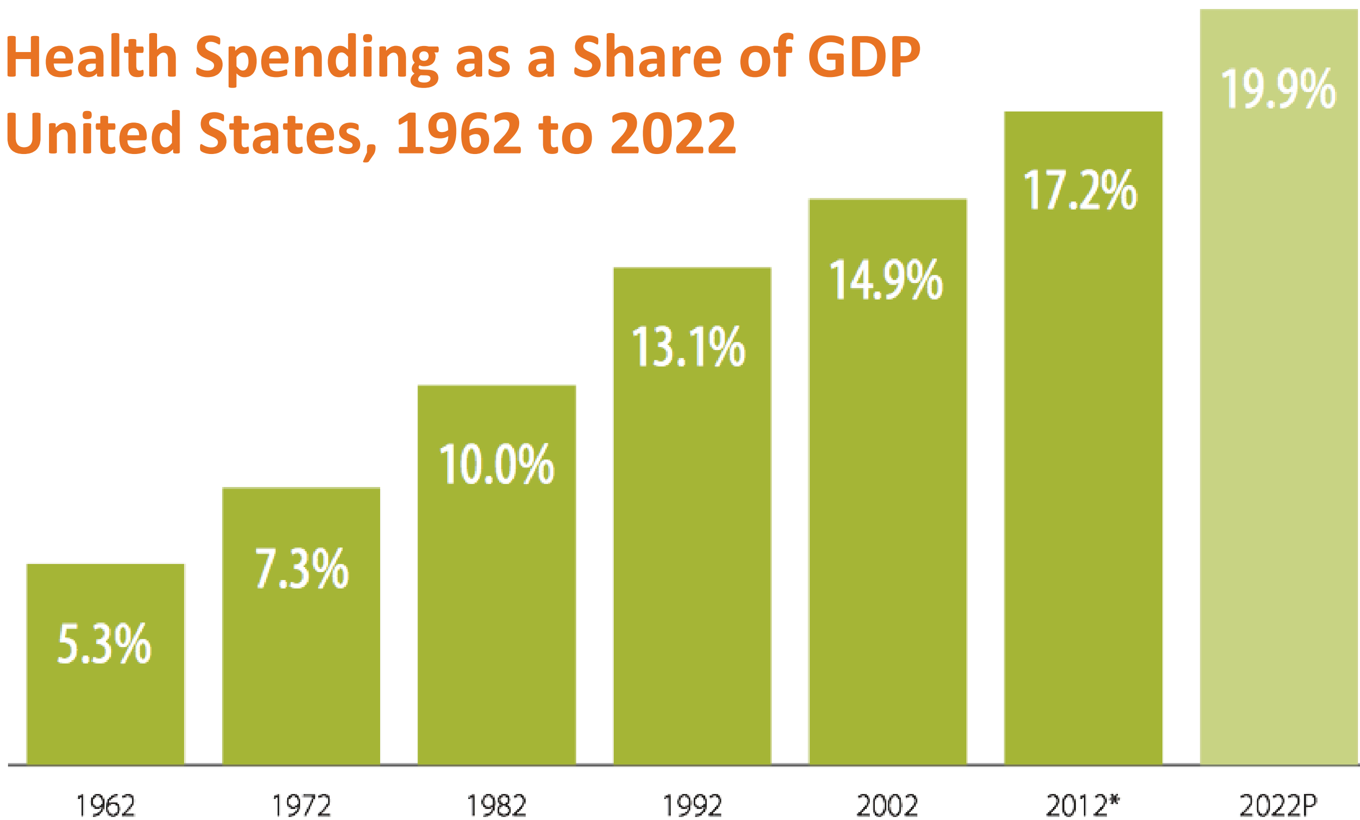
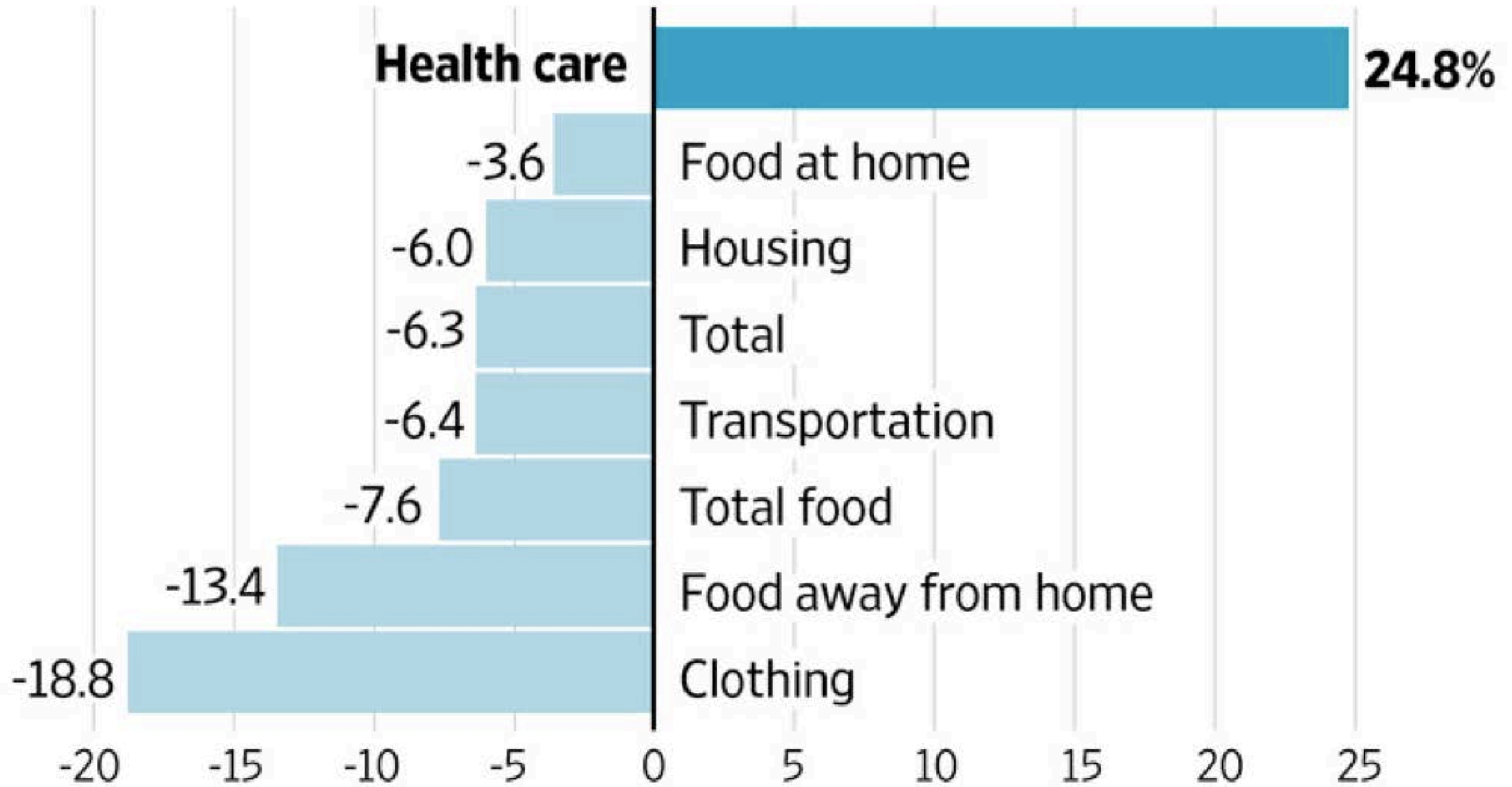
We have a problem

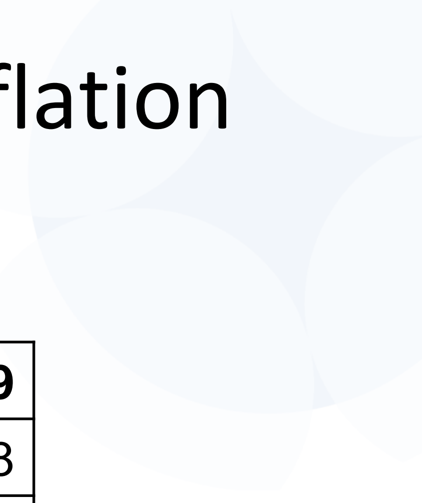


Percent change in middle-income households' spending on basic needs (2007-2014)



Source: Brookings Institution, Wall Street Journal

If food prices had risen at medical inflation rates since the 1930s



	2009
1 dozen eggs	$85.08
1 pound apples	$12.97
1 pound sugar	$14.53
1 roll toilet paper	$25.67
1 dozen oranges	$114.47
1 pound butter	$108.29
1 pound bananas	$17.02
1 pound bacon	$129.94
1 pound beef shoulder	$46.22
1 pound coffee	$68.08
10 Item Total	**$622.27**

Source: American Institute for Preventive medicine

The move to value payment

THE WALL STREET JOURNAL.

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http://www.wsj.com/articles/medicare-to-rework-billions-in-payments-1422293419

U.S. NEWS

Medicare to Rework Billio Payments

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By LOUIS
Updated

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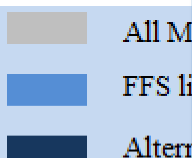

Target percentage of Medicare FFS

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All Medicare FFS

BECKER'S Hospital CFO

BECKER'S HOSPITAL REVIEW 6th Annual Meeting

153 Health Syste Executive Speake

Abo

transformation to value-based care.

The New York Times

POLITICS

Congress Approves Bill to Avert Medicare Pay Cut for Doctors

By REUTERS MARCH 31, 2014, 7:09 P.M. E.D.T.

WASHINGTON — The U.S. Senate gave final congressional approval on Monday to legislation to avert a pay cut for doctors who participate in the Medicare insurance program for the elderly and disabled.

By a vote of 64-35, the Democratic-led Senate sent the measure, approved last week by the Republican-led House of Representatives, to President Barack Obama to sign into law.

MACRA is part of a broader push towards value and quality

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

Medicare Fee-for-Service

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

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

STAKEHOLDERS:

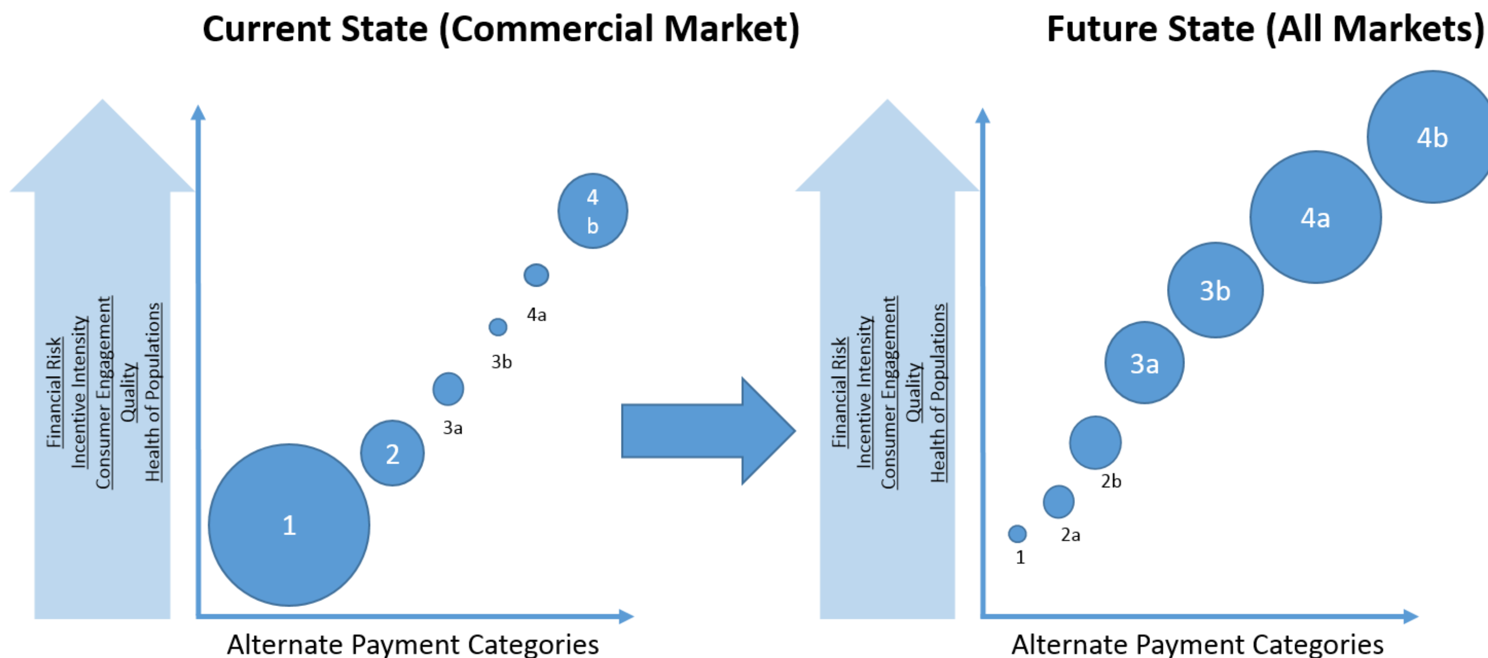
Consumers | Businesses
Payers | Providers
State Partners

Set **internal goals** for HHS

Invite **private sector payers** to match or exceeed HHS goals

Over time, the desire is to influence a shift in payment models to Categories 3 and 4

Conceptual diagram of the desired shift in payment model application given the current state of the commercial market*



Note:

- Size of "bubble" indicates overall investment in each category of APM
- Over time, APMs will move up the Y-axis and there will be more investment in the higher categories

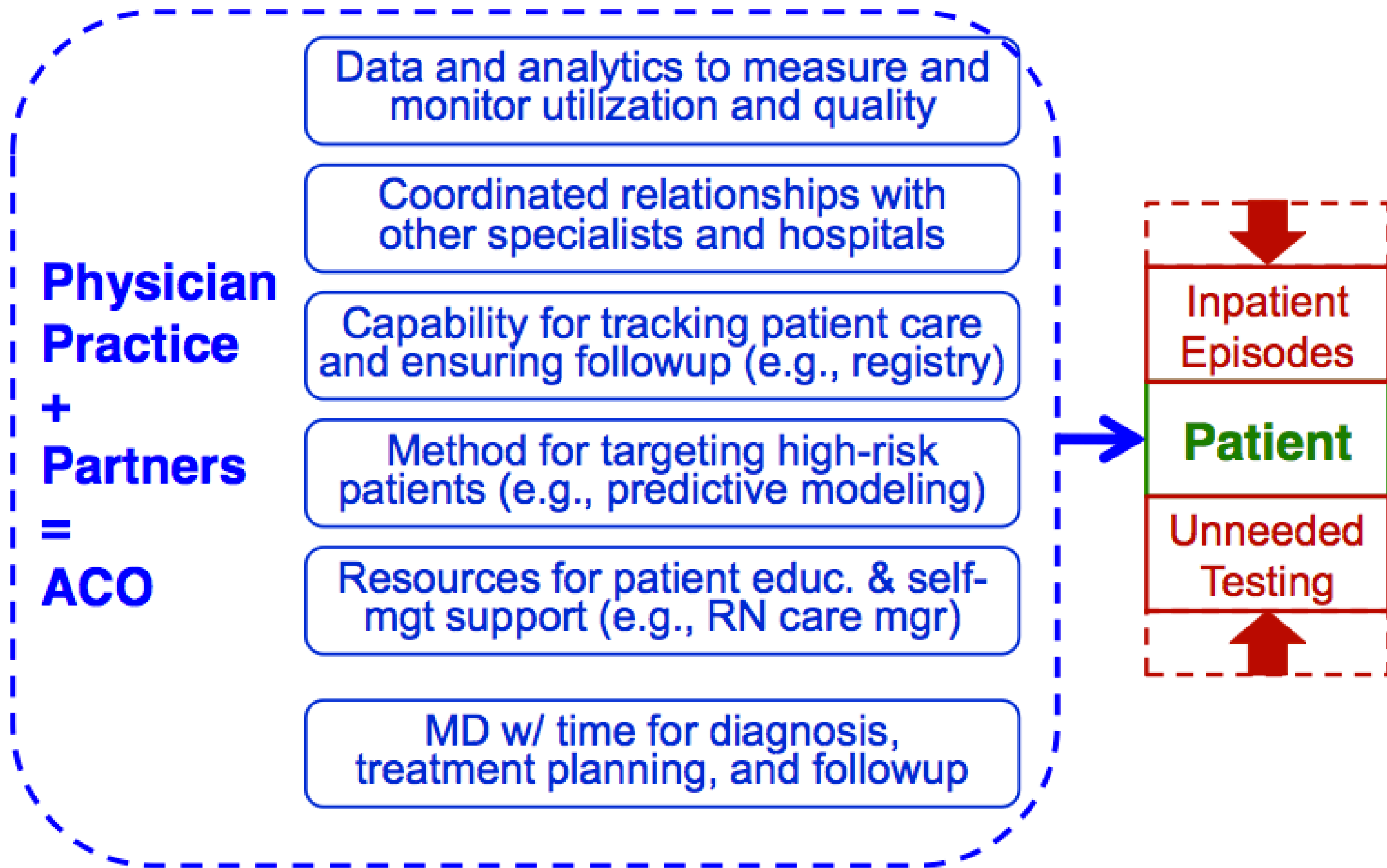
HCP LAN
Health Care Payment Learning & Action Network

**Source: CPR 2014 National Scorecard on Payment Reform, based on the National commercial market using 2013 data.*

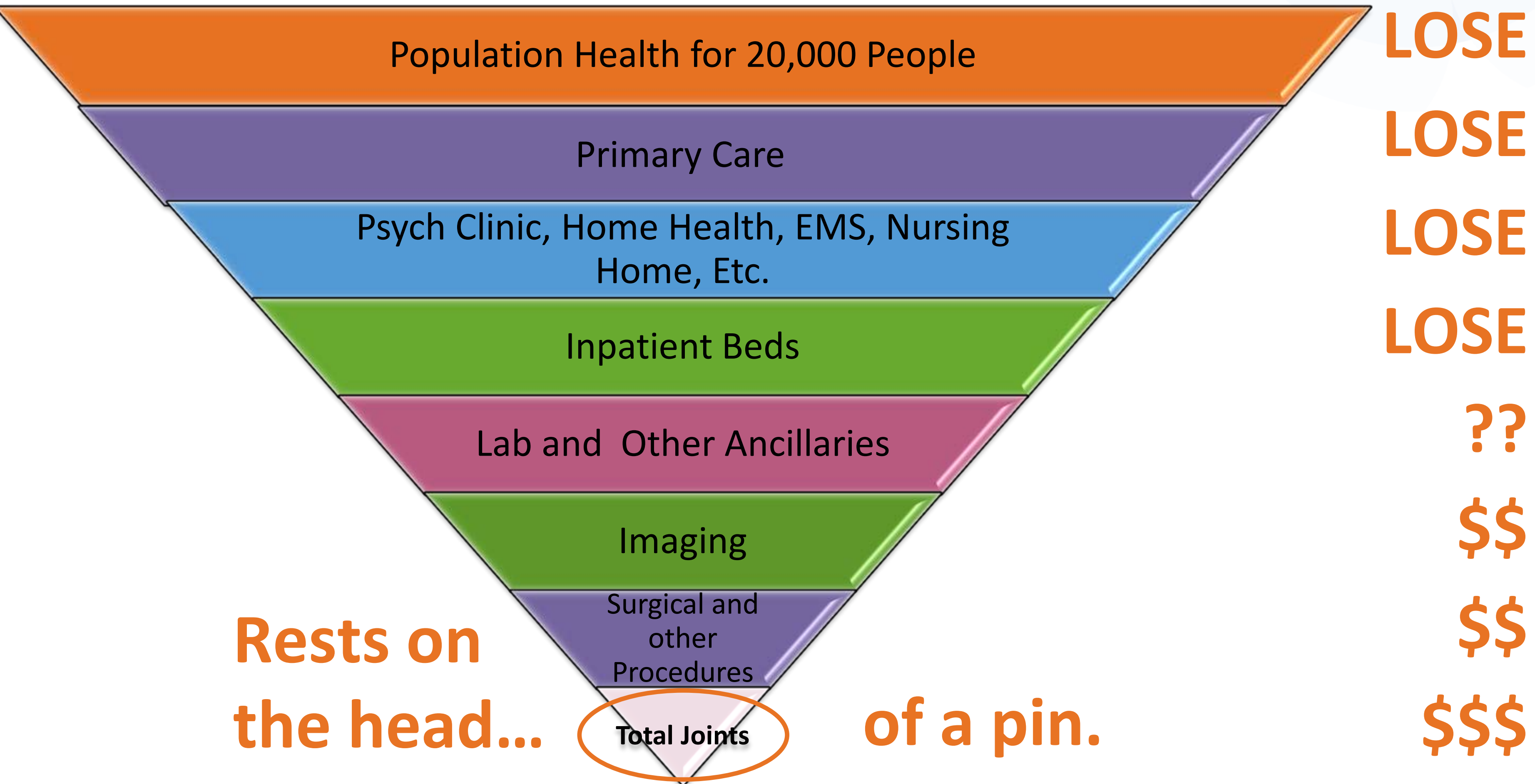
From FFS to PBP: some changes required

- New measures – quality and cost
- New shared data infrastructure
- New incentives
- Transparency
- Alignment across payers
- New care models
- New community partners
- New relationships

Goal: Give MDs the Capacity to Deliver "Accountable Care"



Dr. Steele: The way YOU pay is a major part of the problem!



You get what you pay for

Employers Want:

- Informed Employees
- Improved Outcomes
- Care Coordination
- Prevention
- Functional Status
- Return to Work

Employers Pay For:

- Tests
- Visits
- Procedures
- Prescriptions
- Errors & Complications

Payment reforms should support care changes

- It's not about "risk" or "incentives," it's about giving healthcare providers the *ability/flexibility* to improve outcomes and reduce costs in a way that is financially feasible

- Desired changes in care should drive payment reforms that support them, not the other way around

- Principal Tools:
  - Episode-of-Care Payment
  - Risk-Adjusted Global Payment

How will providers be scored under MIPS?

A single MIPS **composite performance score** will incorporate performance in **4 weighted performance categories**:

Quality

Resource use

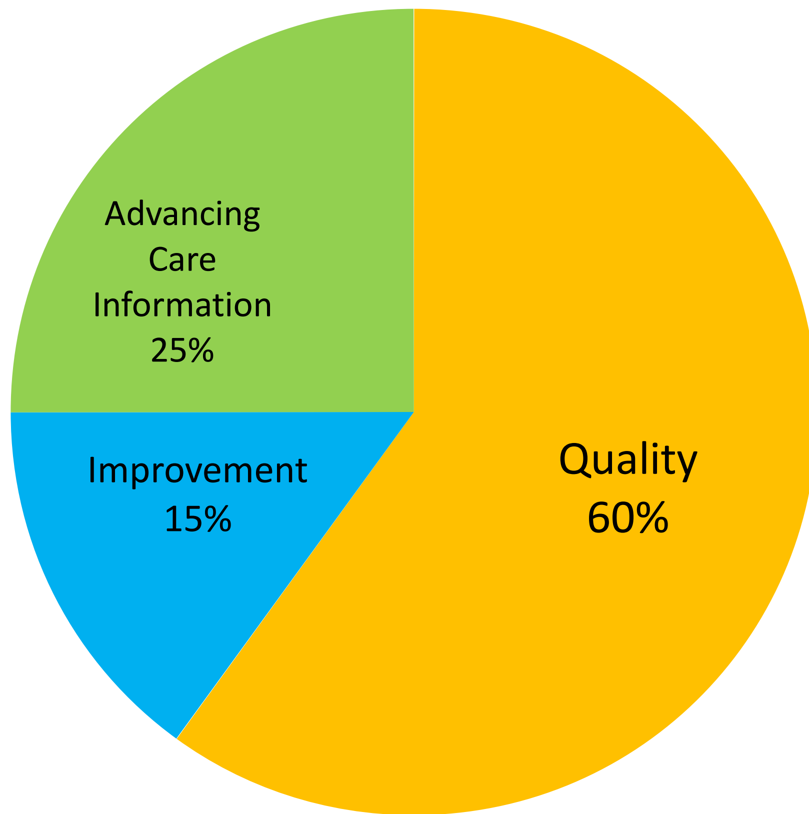
2

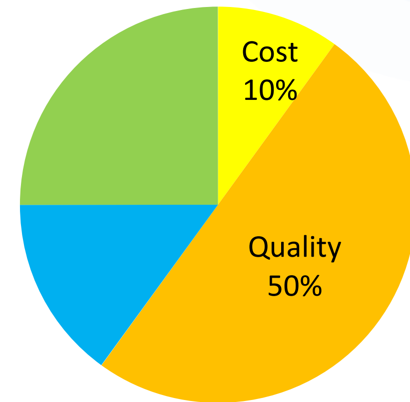
Clinical practice improvement activities

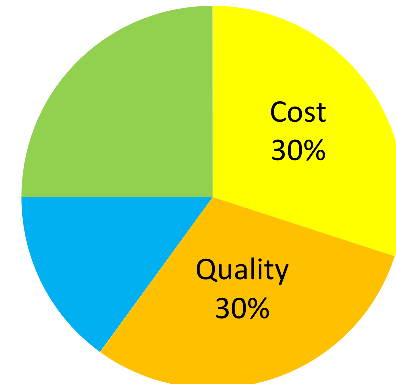
Meaningful use of certified EHR technology

MIPS Composite Performance Score

Cost performance category will be weighted at 0% for transition year, but weight will increase in future years

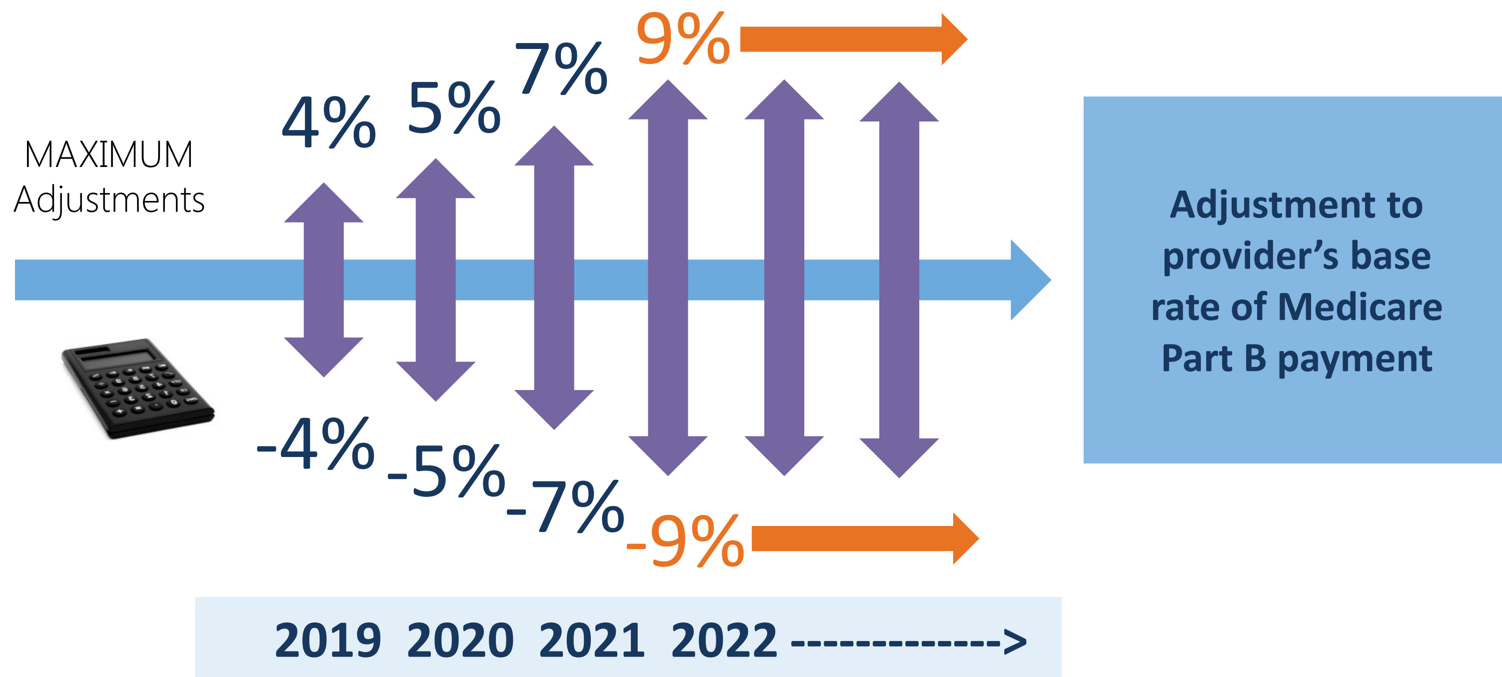






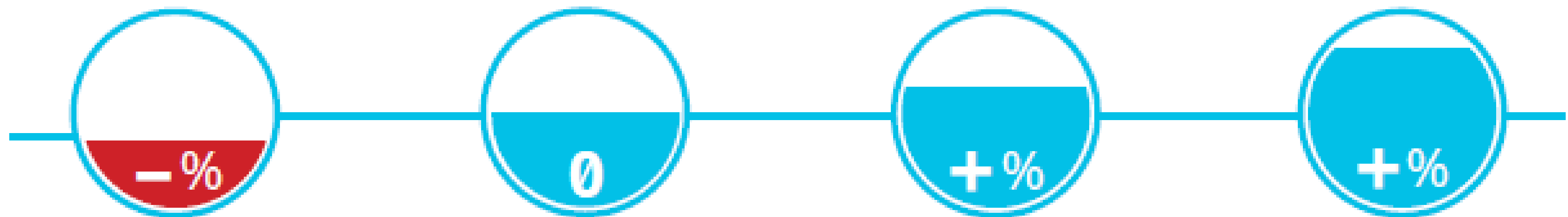
Merit-Based Incentive Payment System (MIPS)

- Based on the MIPS **composite performance score**, providers will receive positive, negative, or neutral adjustments up to the percentages below.
- MIPS adjustments are **budget neutral**.



“Pick-your-Pace” in MIPS for 2017

Pick your pace in MIPS: If you choose the MIPS track of the Quality Payment Program, you have three options.



Don’t Participate

Not participating in the Quality Payment Program: If you don’t send in any 2017 data, then you receive a negative 4% payment adjustment.

Submit Something

Test: If you submit a minimum amount of 2017 data to Medicare (for example, one quality measure or one improvement activity), you can avoid a downward payment adjustment.

Submit a Partial Year

Partial: If you submit 90 days of 2017 data to Medicare, you may earn a neutral or small positive payment adjustment.

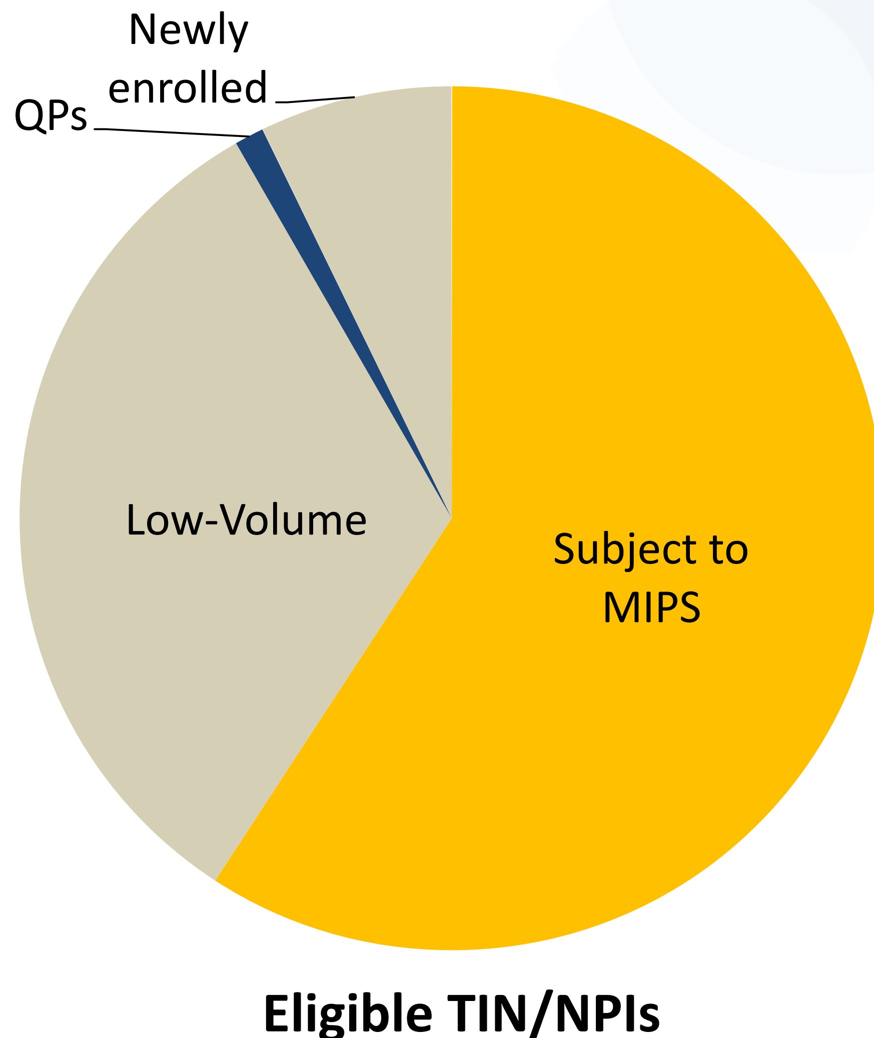
Submit a Full Year

Full: If you submit a full year of 2017 data to Medicare, you may earn a moderate positive payment adjustment.

Source: Quality Payment Program Fact Sheet (Oct. 14, 2016)

MIPS is expected to apply to roughly 60% of all clinicians in the first year

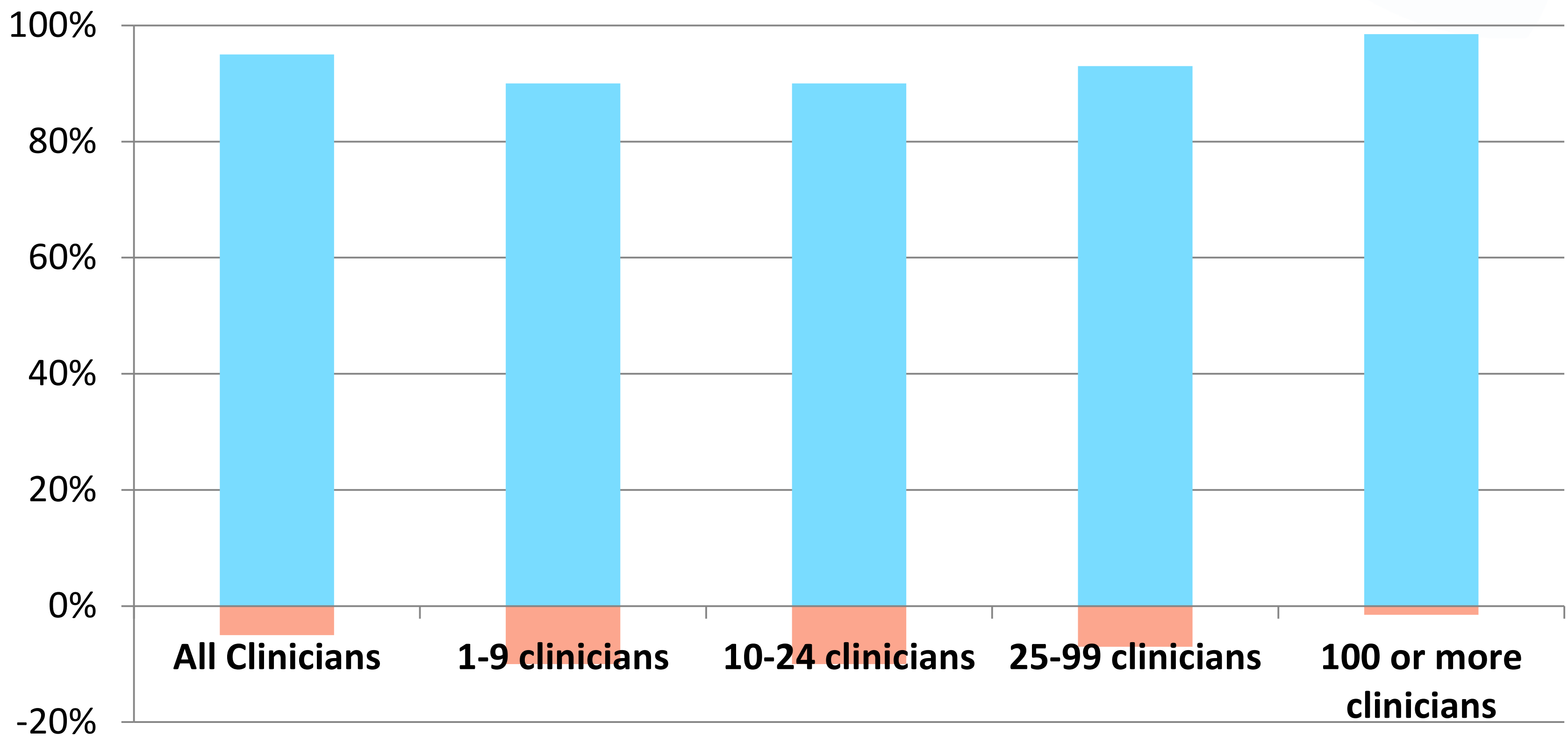
"Low volume" excluded clinicians are those with Medicare billings less than or equal to $30,000 or with 100 or fewer Medicare Part B-enrolled patients



Eligible TIN/NPIs

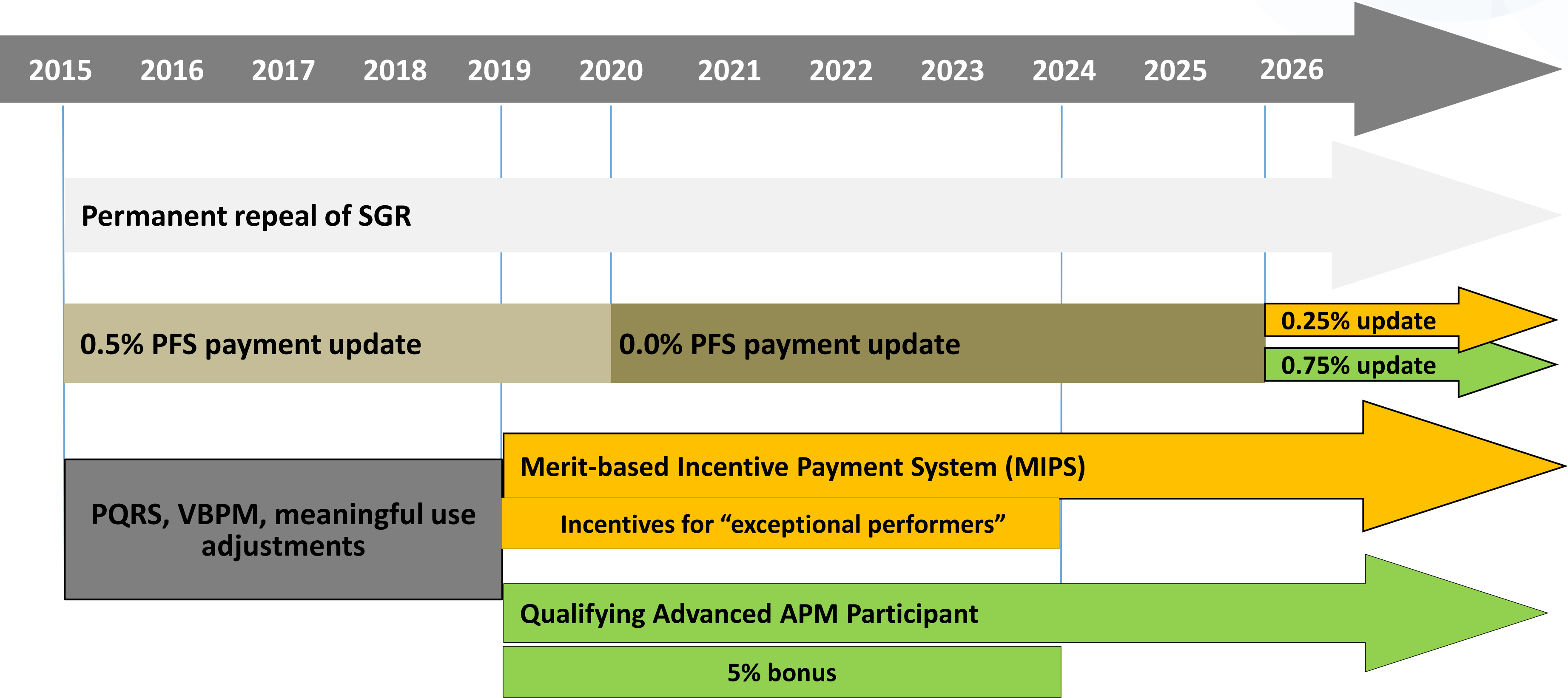
Source: Final Rule, Total Exclusions by Reason and Practice Size (Table 59)

Transition year policies, combined with new "low-volume" threshold, expected to lessen the impact on smaller, solo practices

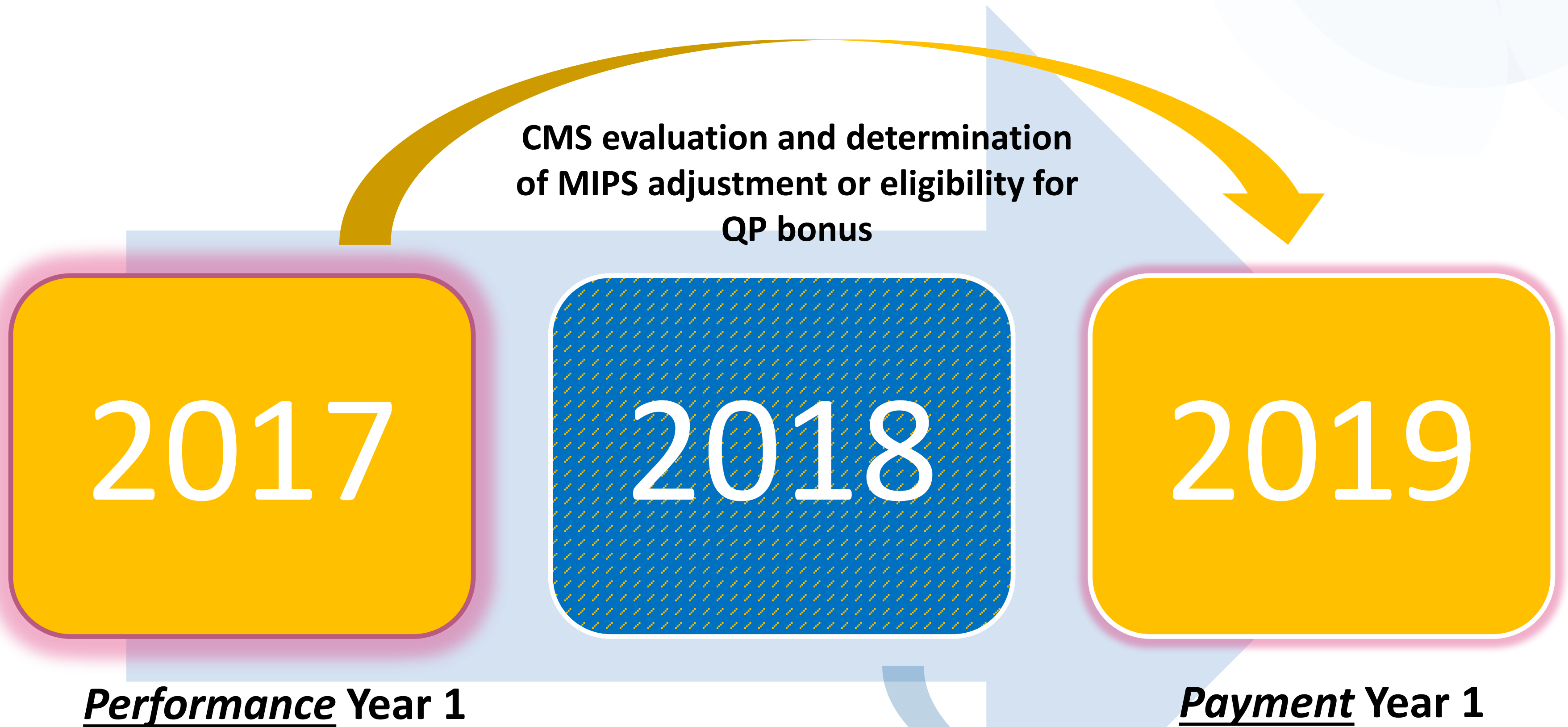


Source: MIPS Final Rule Estimated Impact on Total Allowed Charges by Practice Size, assuming 90% participation (Table 62)

The Quality Payment Program payment pathways



Performance Period and Payment Year



Alternative Payment Models (APMs)

APMs are **new approaches to paying** for medical care through Medicare that **incentivize quality and value.**

According to MACRA law, 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

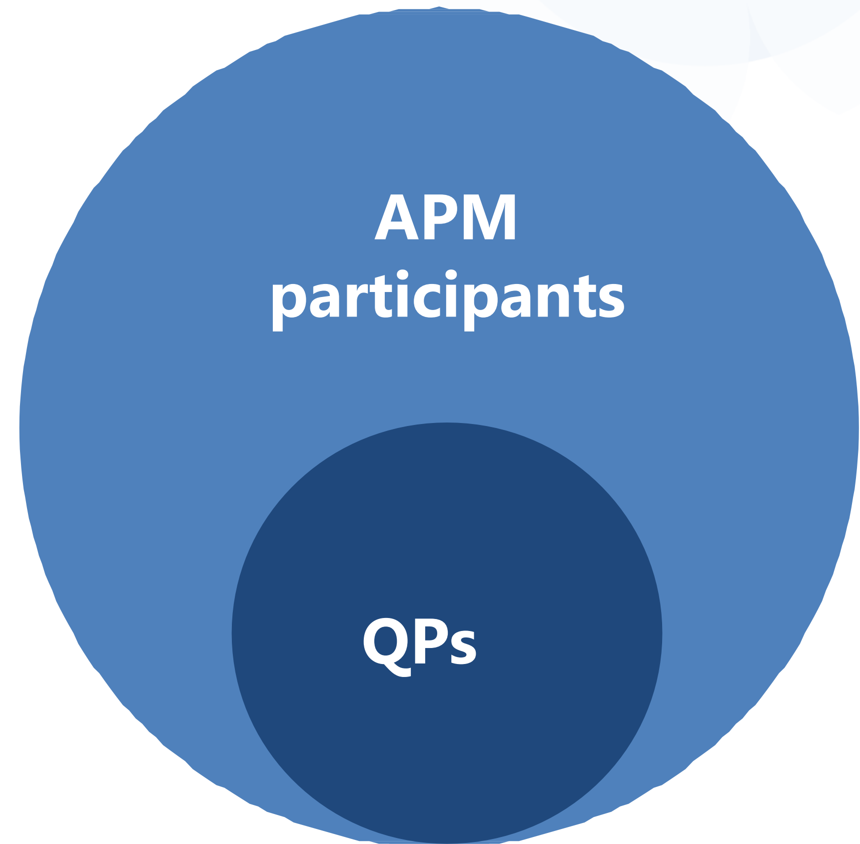
- MACRA **does not change how any particular APM pays for medical care and rewards value**
- APM **participants may receive favorable scoring under certain MIPS** performance categories
- Only **some** of these APMs will be **advanced** APMs.

How does MACRA provide additional rewards for participation in APMs?

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

Providers who participate in **the most advanced** APMs may be determined to be **qualifying APM participants ("QPs")**. As a result, QPs:

1. Are **not subject** to MIPS
2. Receive 5% lump sum **bonus payments** for years 2019-2024
3. Receive a **higher fee schedule update** for 2026 and onward



CMS will post a list of 2017 Advanced APMs by January 1, and says it will expand on that list for 2018

APMs	Advanced APM for 2017?
Next Generation ACOs **re-opening for new participants for 2018*	Yes
MSSP ACOs Track 1	No
MSSP ACOs Tracks 2 & 3	Yes
Comprehensive Primary Care Plus **re-opening for new practices and payers for 2018*	Yes
Oncology Care Model 1-sided risk	No
Oncology Care Model 2-sided risk **now available for 2017*	Yes
Comprehensive ESRD Care Model	Yes

New **2018 Advanced APMs** expected to include: ACO Track 1+, a new voluntary bundled payment model, CJR (CEHRT track), and Advancing Care Coordination through Episode Payment Models Track 1

Which APMs are "Advanced APMs"?

MACRA APMs:

- CMMI Model
- MSSP ACO
- Model developed through other federal demonstration authorities

...where physicians

Use certified EHR

And

Are paid based on quality measures "comparable" to MIPS

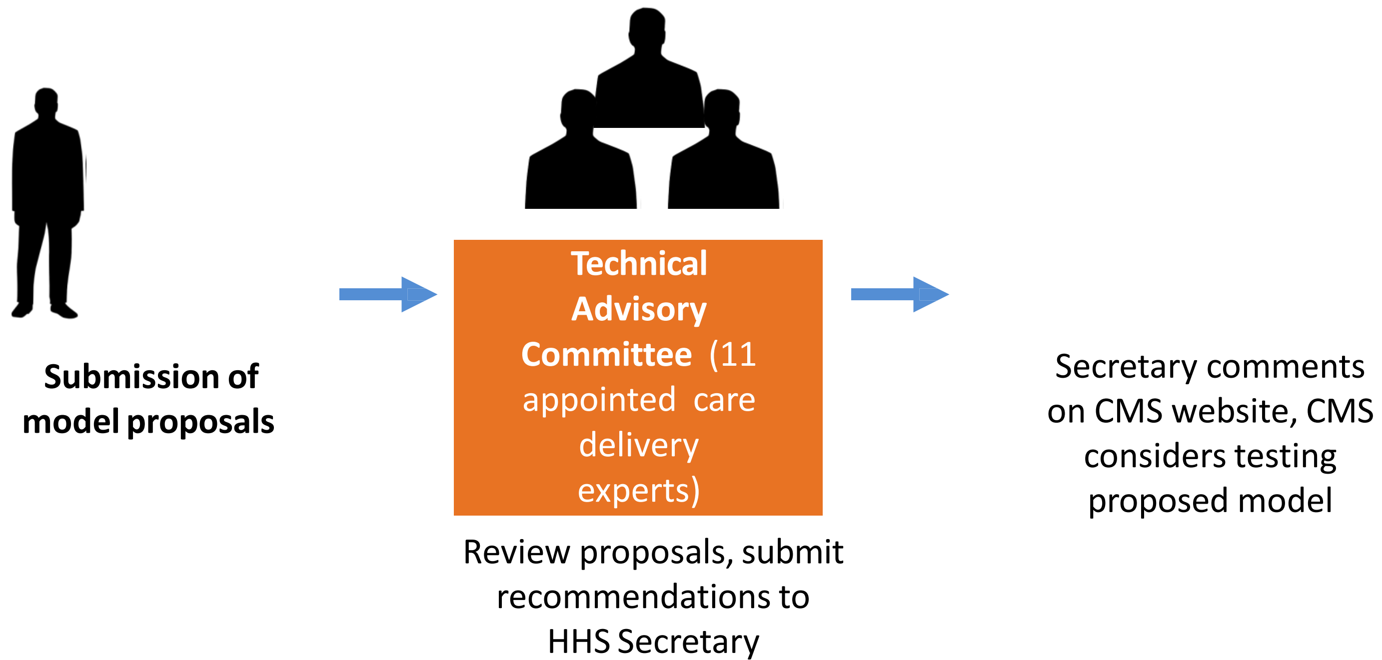
...and the entity

Bears more than nominal financial risk for losses

Or

Is a Medical Home Model expanded by CMMI

Independent PFPM Technical Advisory Committee



What are physician-focused payment models?

As defined in the MACRA Final Rule, released October 14, 2016, a physician-focused payment model is an Alternative Payment Model:

(1) In which Medicare is a payer;

(2) In which eligible clinicians that are eligible professionals as defined in section 1848(k)(3)(B) of the Act are participants and play a core role in implementing the APM's payment methodology, and

(3) Which targets the quality and costs of services that eligible professionals participating in the Alternative Payment Model provide, order, or can significantly influence.

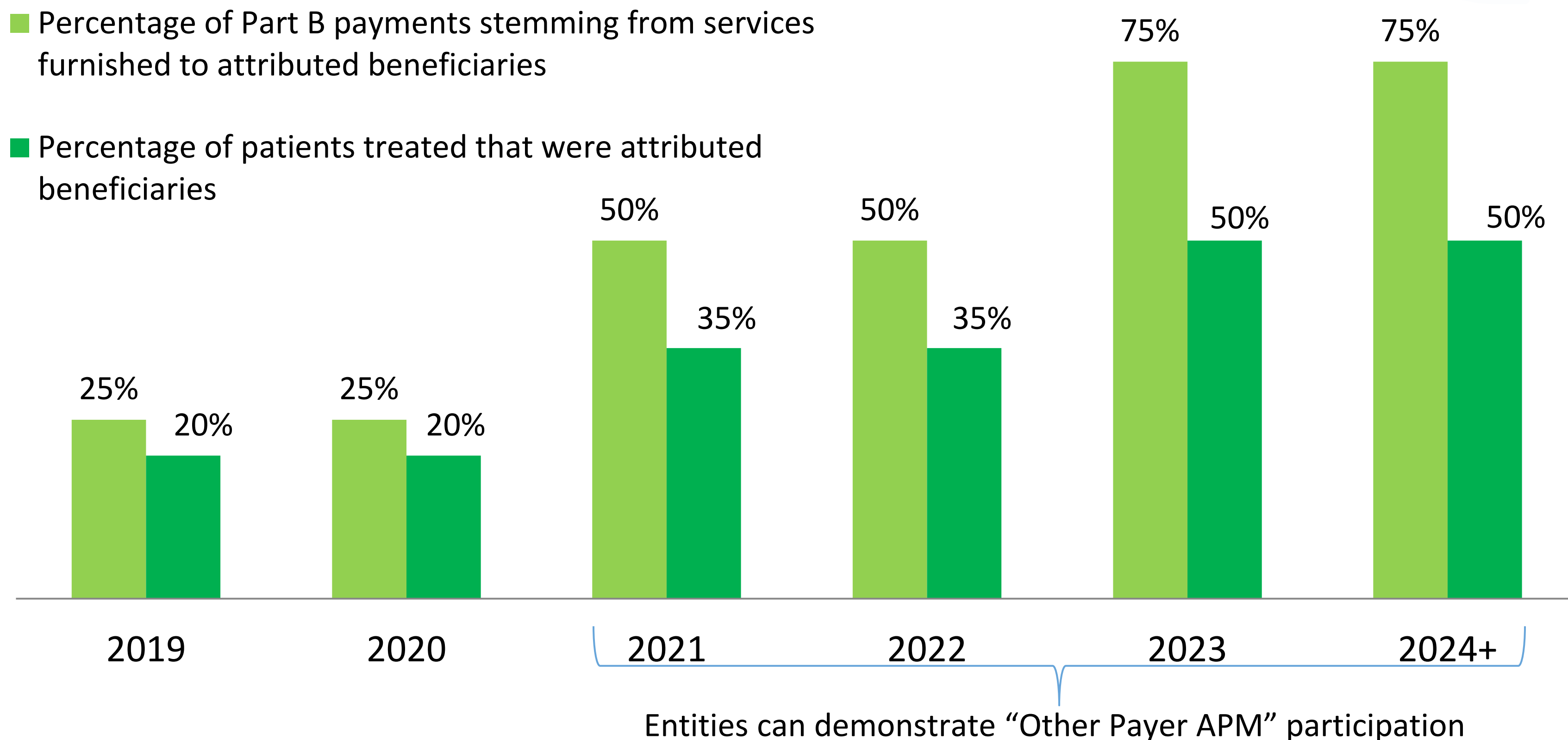
Criteria for evaluating models

- Scope of proposed payment model (high priority)
- Promoting quality and value (high priority)
- Flexibility for practitioners
- Payment methodology (high priority)
- Evaluation goals
- Integration and care coordination
- Patient choice
- Patient safety
- Health information technology

To earn the APM Incentive Payment, Advanced APM participants must collectively meet participation thresholds

"QP thresholds in the first years . . . are highly attainable by Advanced APM participants."

-CMS Final Rule

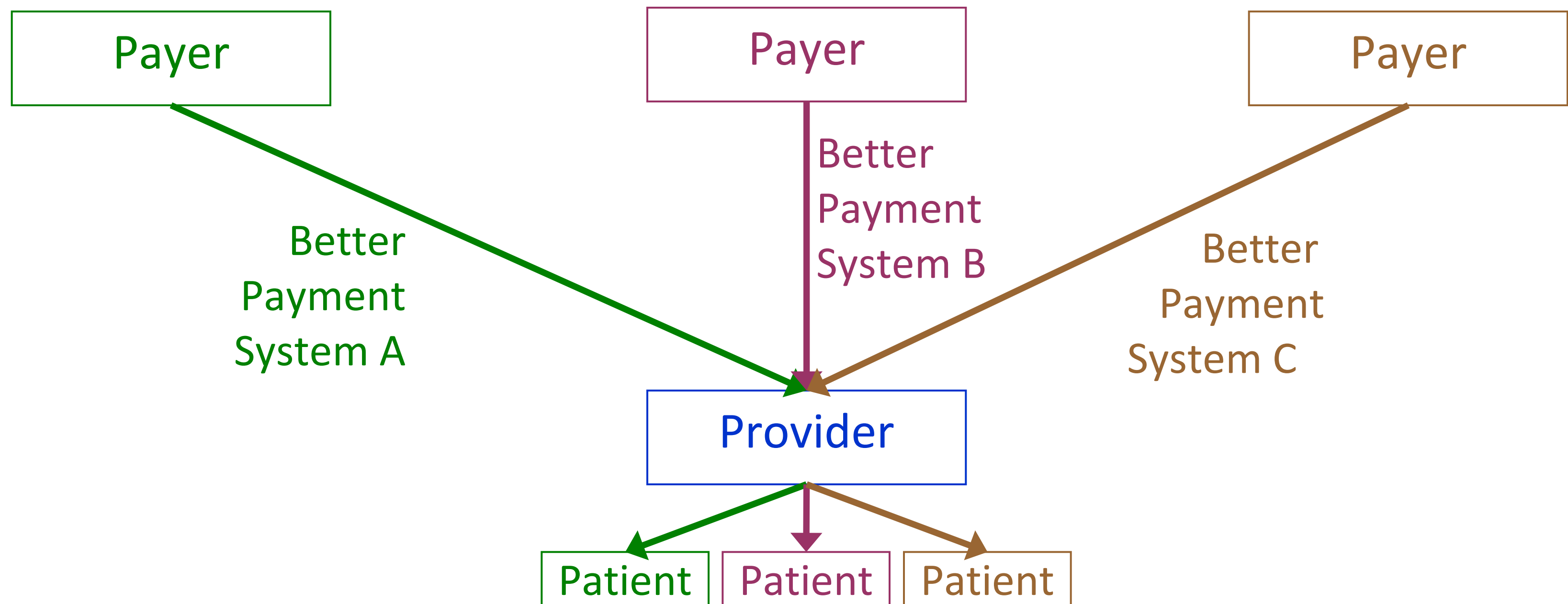


Success will require multi-payer solutions

- Common incentives
- Common measures
- Shared data
- All payer measurement
  - Quality
  - Outcomes
  - Total Cost of Care

Payers need to *align* to allow focus on better care

Even if every payer's system is better than it was,
if they're all different, providers will spend too much time
and money on administration rather than care improvement



CMS Urges Health Plans to Ease Physician Reporting Burden

Slavitt lauds potential of Medicare Advantage

by Shannon Firth

Washington Correspondent, MedPage Today

October 25, 2016

> *"All the ways that health plans, in many respects, use to differentiate themselves, that annoyed the crap out of doctors -- just stop,"*
>
> \- Andy Slavitt, Acting Administrator, CMS

United States Government Accountability Office

Report to Congressional Committees

October 2016

HEALTH CARE QUALITY

HHS Should Set Priorities and Comprehensively Plan Its Efforts to Better Align Health Quality Measures

GAO-17-5

Source: GAO inpterpretation of Centers for Medicine & Medicaid Services measure for controlling high blood pressure GAO-17-5

What GAO Found

- 5% of measures used by commercial plans were common
- Physician practices spend 785+ hours per physician per year on quality measurement
- Average annual cost of quality measurement per physician is $40,000+

Factors Driving Misalignment of Health Care Quality Measures

Factor	Description
Dispersed decision-making	Among public and private payers and other stakeholders, each entity independently decides which quality measures it will use and which specifications should apply to those measures.
Variation in data collection and reporting systems	Payers may choose different measures, modify existing measures, or leave details about measure specifications up to providers in order to accommodate differences in data that providers collect and the systems they use to collect these data.
Few meaningful measures	Although hundreds of quality measures have been developed, relatively few are measures that payers, providers, and other stakeholders agree to adopt, because few are viewed as leading to meaningful improvements in quality.

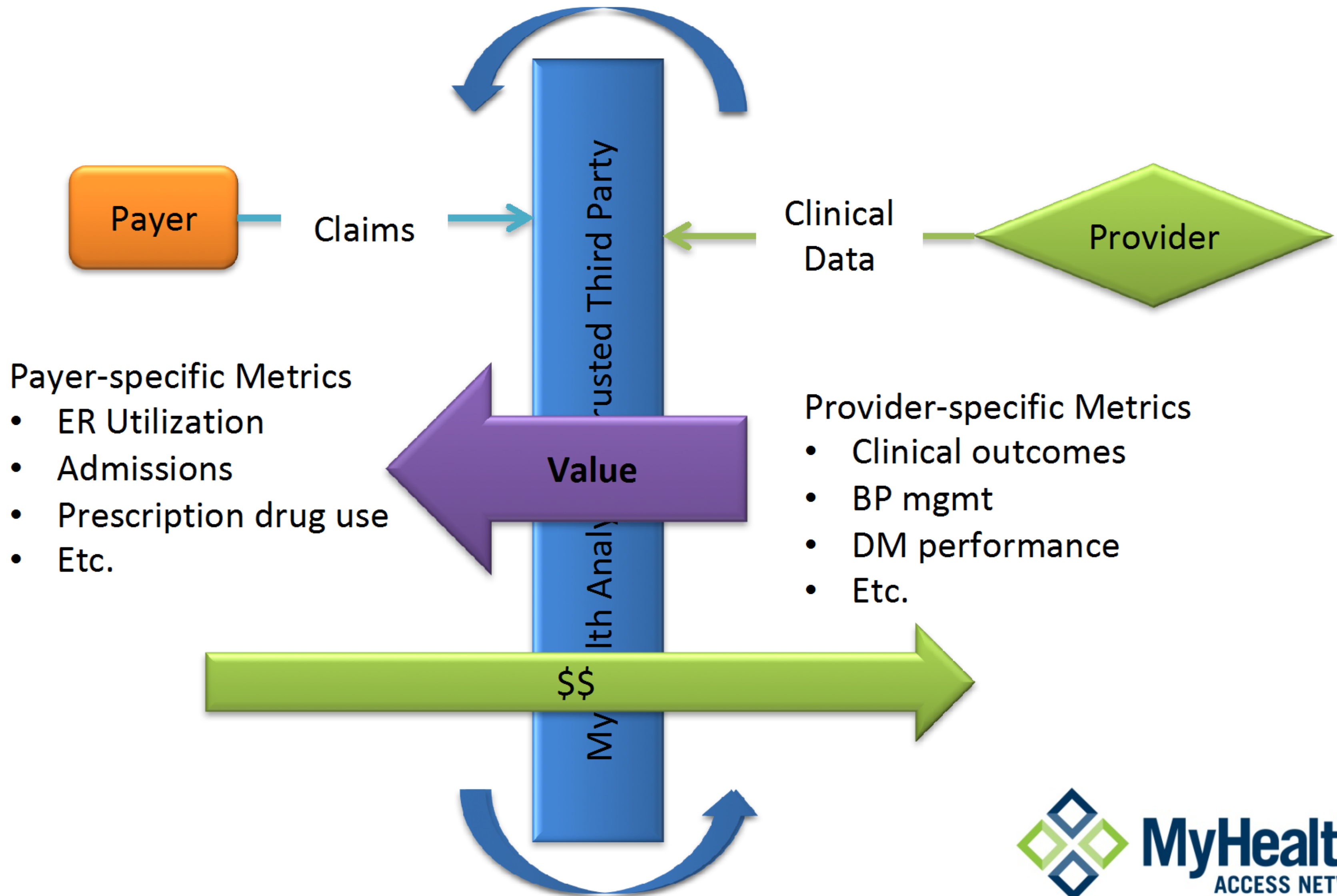
Source: GAO interviews with Department of Health and Human Services officials and experts. | GAO-17-5

Looking for healthcare data

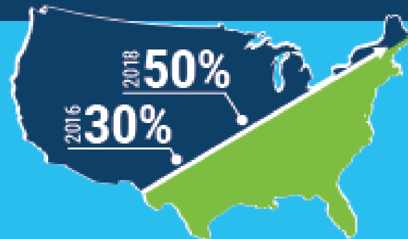
Greatest opportunities for data collaboratives to support APMs

- We need **public and private data combined** to transform healthcare- **follow the people**
- Providers need the ability to **“see” entire population** during multiple regional and national transformation efforts – health plans and providers cannot do this on their own, no matter how large
- **Quality improvement activities on the ground** at practice level – sense making – all providers and stakeholders need this information together to change care and outcomes
- **Standardize methodology and metrics** – stop the madness!

Pay for Value: Trusted 3rd Party

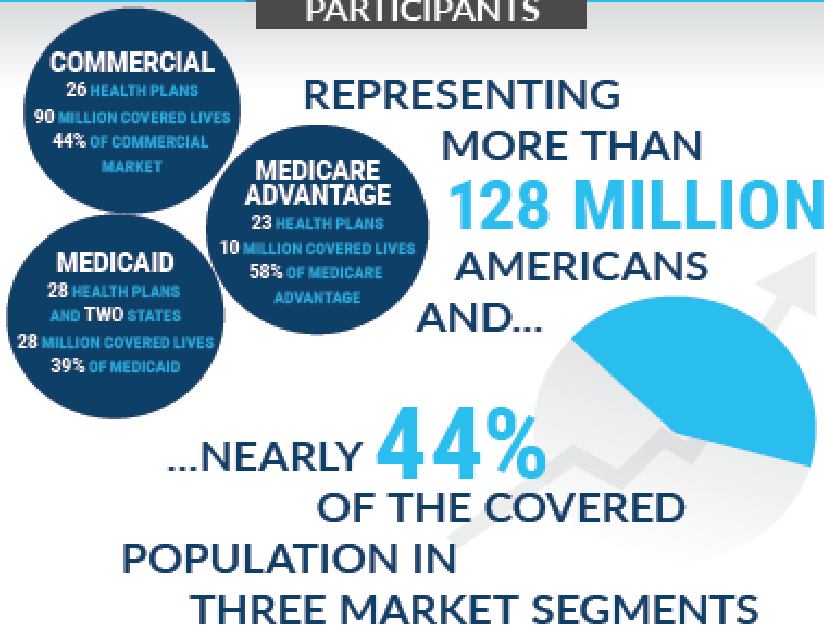


APM MEASUREMENT

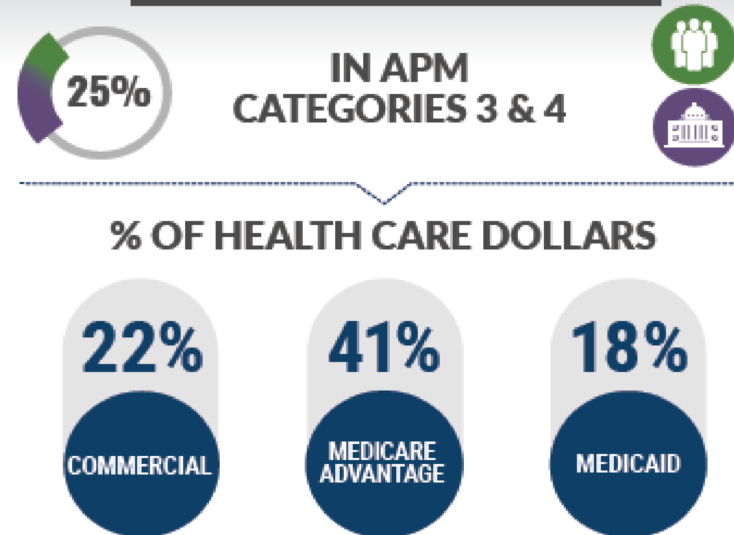


Public and private health plans voluntarily participated in a national effort to measure the use of alternative payment models (APMs) as well as progress towards the LAN's goals of tying 30% of U.S. health care payments to APMs by 2016 and 50% by 2018.

PARTICIPANTS



2016 RESULTS

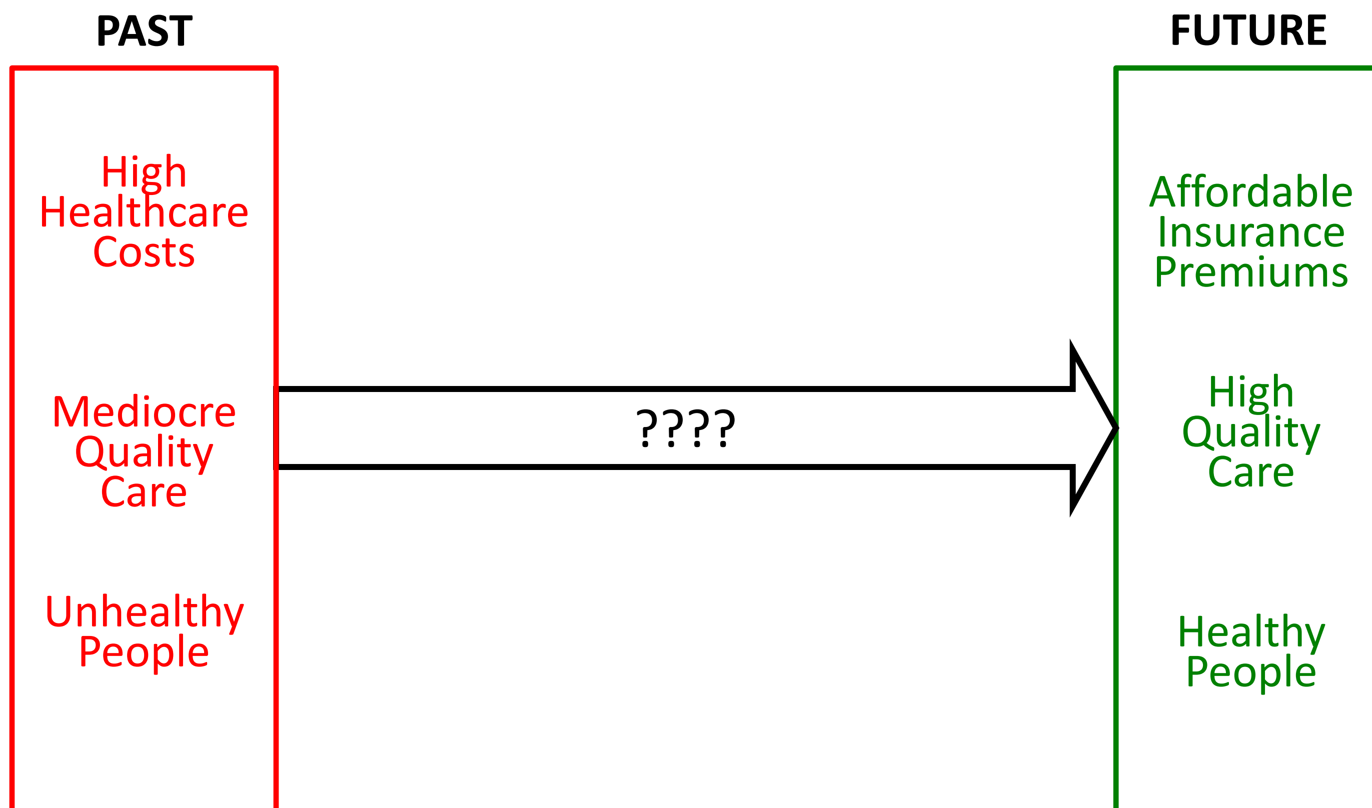


*Data from January 1, 2016 was collected over an 8-week period and aggregated to produce results based on the LAN's APM Framework.

The U.S. Department of Health and Human Services (HHS) announced in March 2016 an estimated 30% of traditional Medicare payments are tied to APMs that reward the quality of care over quantity of services provided. These results are separate from the results shown above.

* The results are based on contracts in effect on January 1, 2016 and represent estimated spending from January – December 2016.

Are We Making Progress on the Road to Higher-Value Healthcare?



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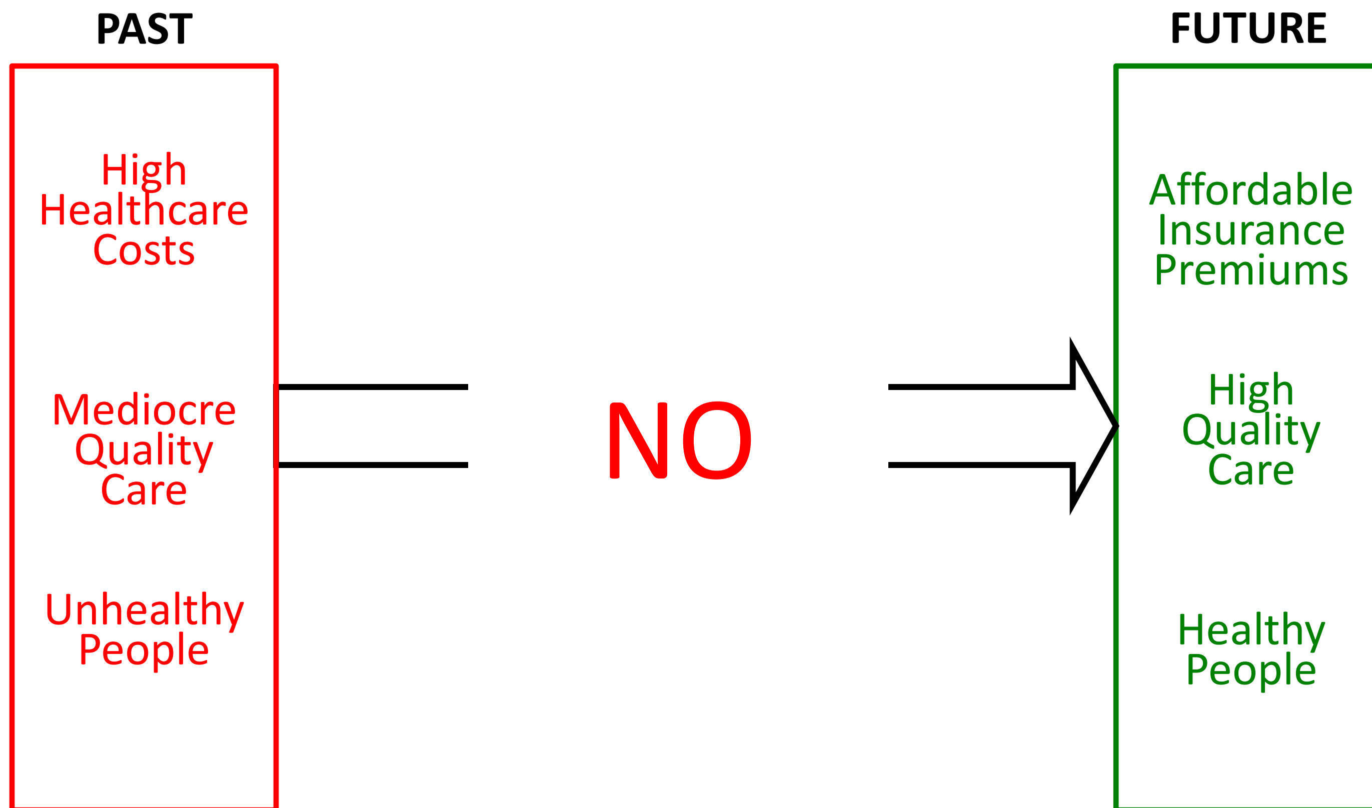
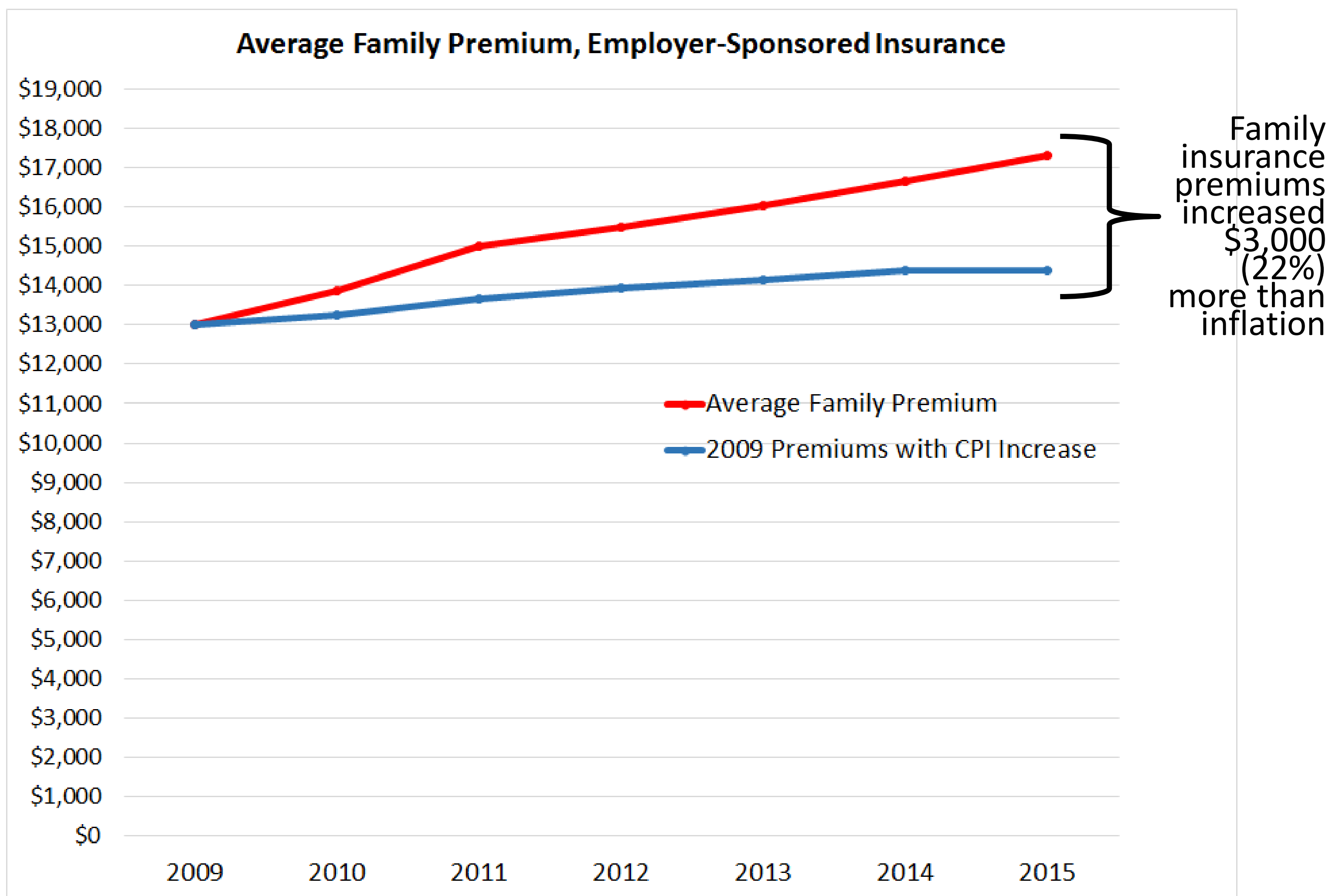
Are We Making Progress on the Road to Higher-Value Healthcare?



Health Care is NOT More Affordable



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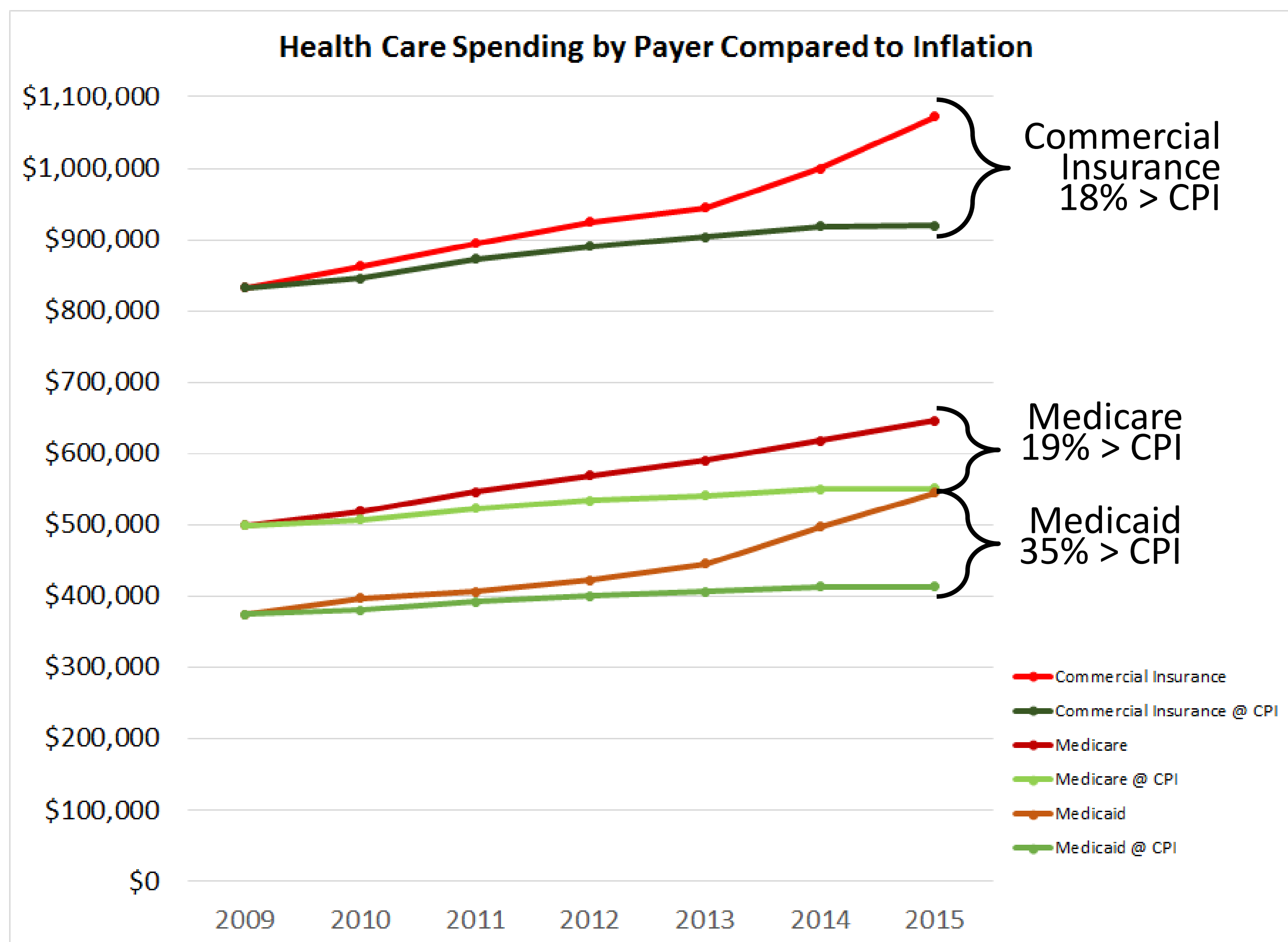
Spending is Growing Rapidly Regardless of Payer



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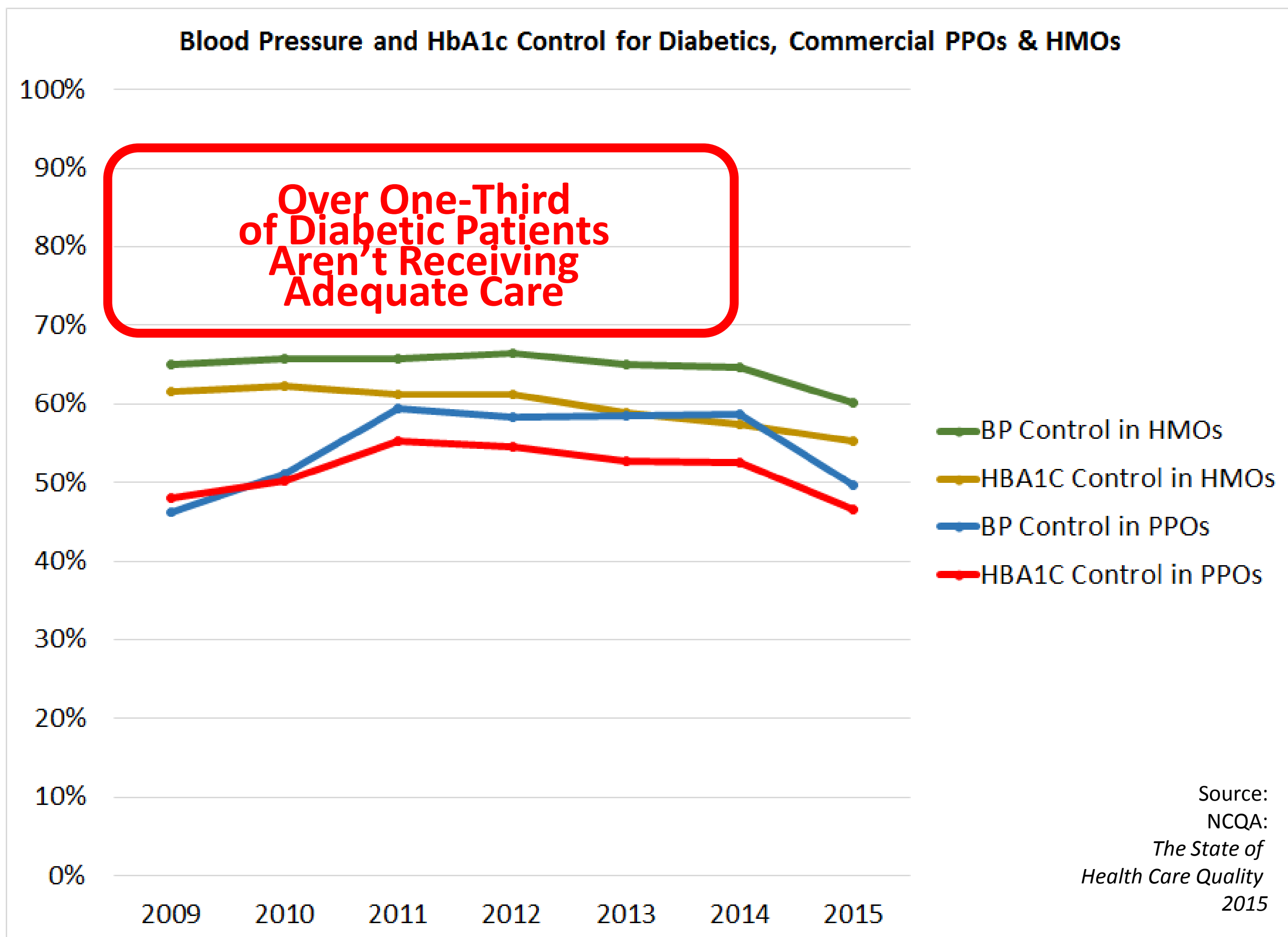
Quality Has NOT Improved



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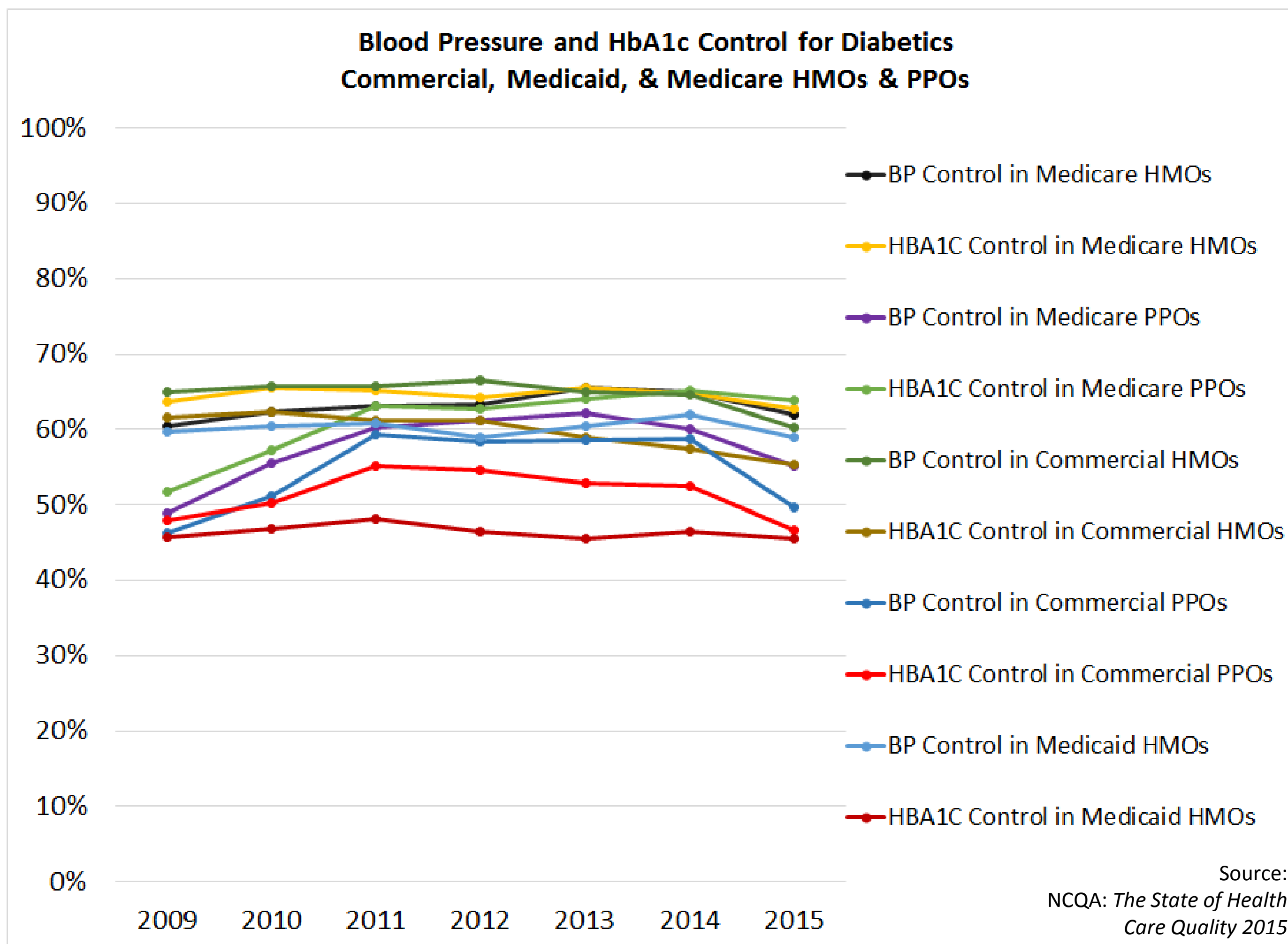
Quality Is Poor & Stagnant Regardless of Payer



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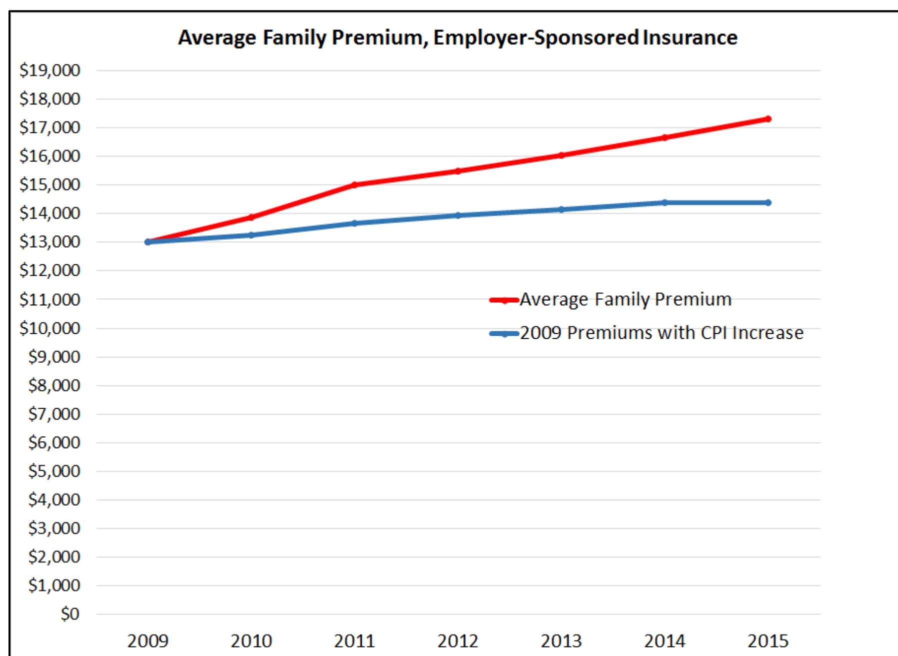
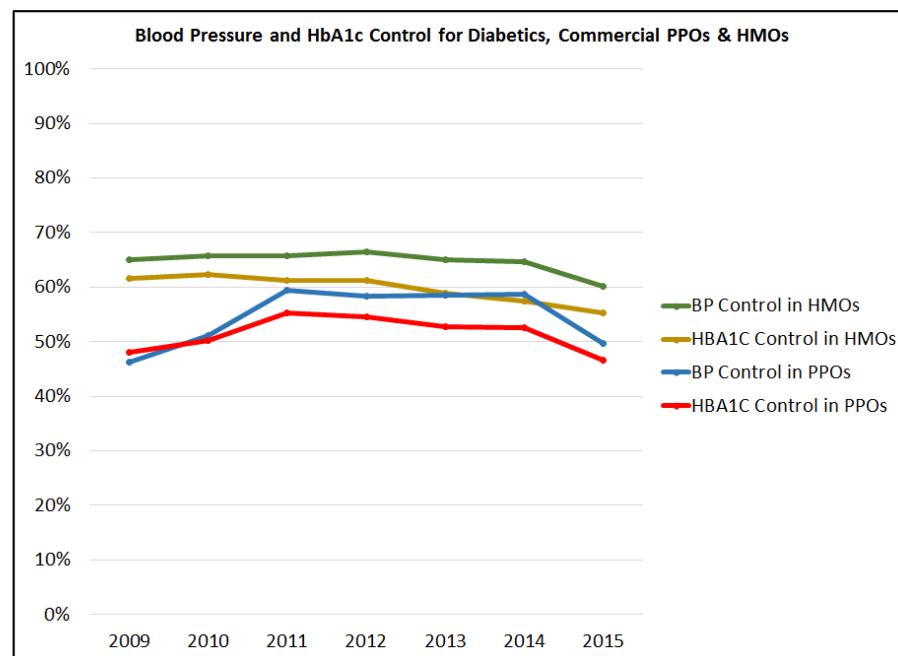
"Value" is *Lower* Today Than 6 Years Ago





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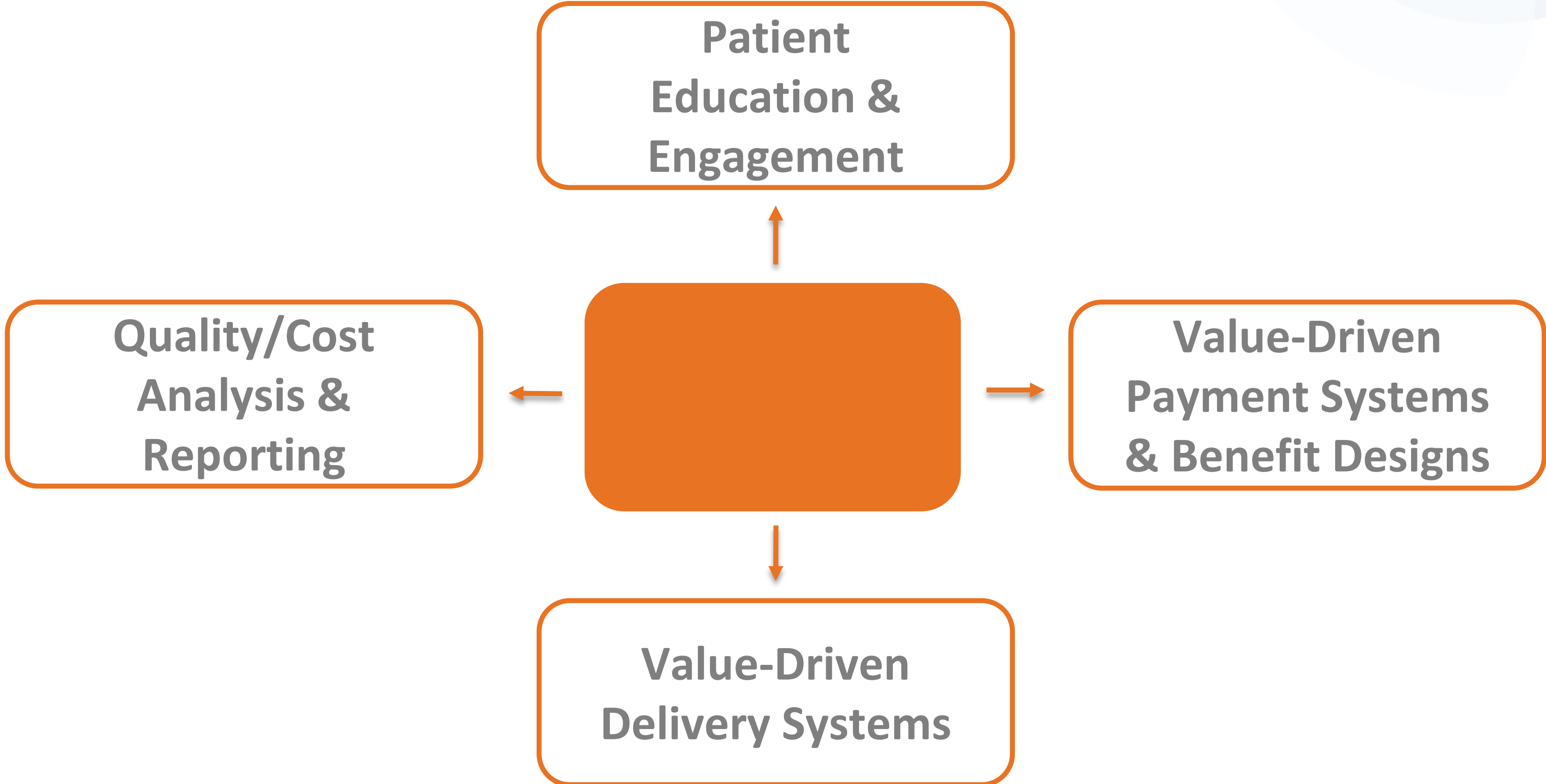
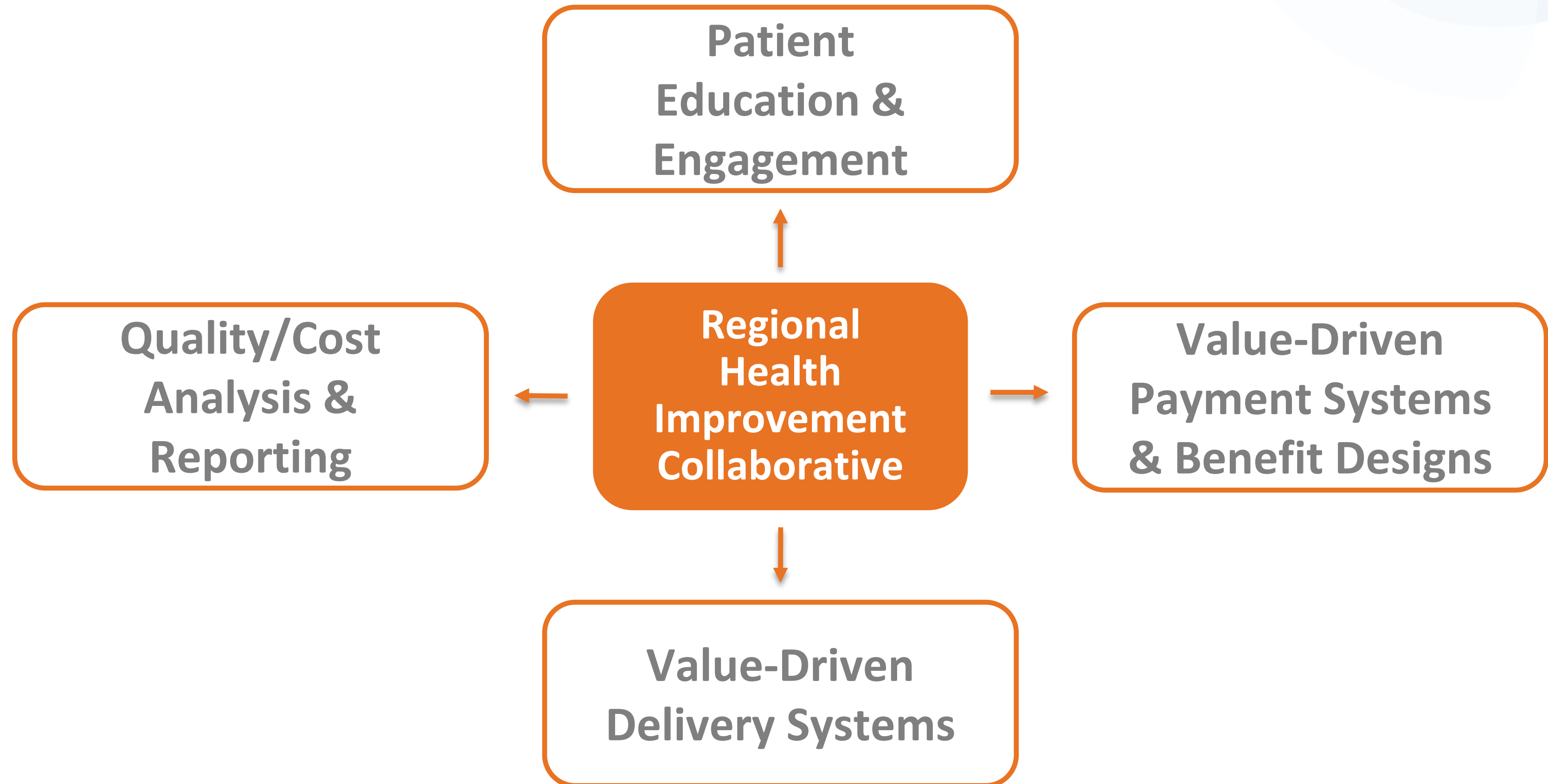
Who aligns on behalf of the community?



The role of Regional Health Improvement Collaboratives



Alone:

Providers:

- Can change care but not payment
- Don’t control patient incentives for utilization
- Don’t have needed data

Employers:

- Can change payment but not care
- Don’t make care decisions

Plans:

- Only influence a portion of providers’ patients
- Don’t have multipayer population data

Patients:

- Have limited information or influence

State Governments:

- Limited time horizon
- Political environment and regulatory role

CMS support of health care Delivery System Reform will result in better care, smarter spending, and healthier people

Historical state → Evolving future state

Public and Private sectors

Historical state

Key characteristics

- Producer-centered
- Incentives for volume
- Unsustainable
- Fragmented Care

Systems and Policies

- Fee-For-Service Payment Systems

Evolving future state

Key characteristics

- Patient-centered
- Incentives for outcomes
- Sustainable
- Coordinated care

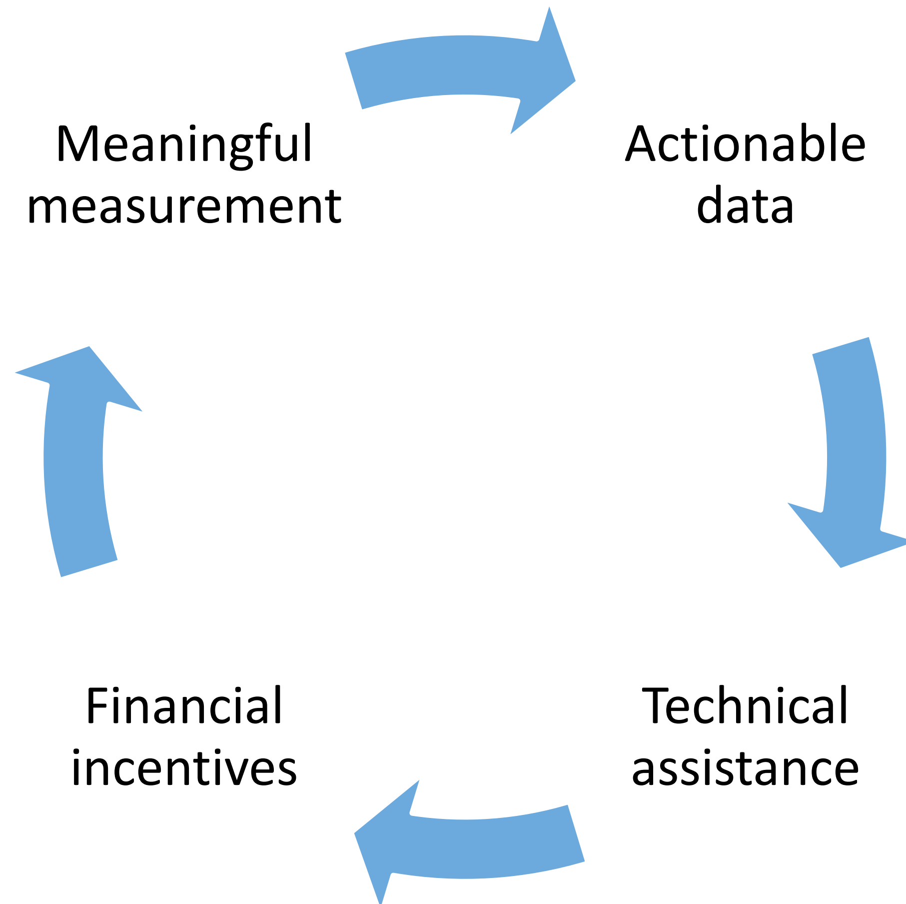
Systems and Policies

- Value-based purchasing
- Accountable Care Organizations
- Episode-based payments
- Medical Homes
- Quality/cost transparency

MACRA: implications for employers

- Accelerates the move toward **APMs** system-wide
  - Your health plans and providers are likely to be more receptive to bundled payments, PCMH, ACOs
    - (Although this will be a somewhat chaotic in the next few years as physicians and health systems figure this out. Lots of clutter and confusion right now.)
  - Medicare APM models are not ideal (e.g., patient attribution vs. choice in ACOs). Employers should push for more advanced models.
- Opportunity to drive development of **better performance measures**: clinical outcomes, PROs, patient experience, TCC

Sustainable reforms will require stakeholder buy-in



CHQPR

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Moving to Accountable Care

- There is no one-size-fits-all solution to healthcare transformation; each region will need to actually make it happen in its own unique environment. The best federal policy will support regional innovation.
- Payment reform is necessary, but not sufficient. Delivery system reform, changes in benefit design, and effective quality measurement are also essential. Everything needs to focus on improving *outcomes.*
- Physicians need to take the lead by agreeing to take accountability for reducing costs without rationing, creating organizational structures that enable them to do so, and demanding the payment changes needed to support them.

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MACRA is a policy framework

You will define community success.

What are the key plays to advance high value care:

- Employers:
- Providers:
- Plans:
- Patients:
- Partners:

NRHI Membership

Aligning Forces for Quality – Southcentral Pennsylvania
Better Health Partnership
California Quality Collaborative
Center for Improving Value in Healthcare
Community First, Inc.
Finger Lakes Health Systems Agency
Great Detroit Area Health Council
Health Insight - Nevada
Health Insight - New Mexico
Health Insight – Utah
Healthcare Collaborative of Greater Columbus
Institute for Clinical Systems Improvement
Integrated Healthcare Association
Iowa Healthcare Collaborative
Kansas City Quality Improvement Collaborative
Kentuckiana Health Collaborative
Louisiana Health Care Quality Forum
Maine Health
Management Coalition
Maine Quality Counts
Massachusetts Health Quality Partners
Michigan Center for Clinical Systems Improvement
Midwest Health Initiative
Minnesota Community Measurement
Mountain-Pacific Quality Health Foundation
MyHealth Access Network
New Jersey Health Care Quality Institute
North Coast Health Information Network
Oregon Health Care Quality Corporation
Pacific Business Group on Health
Pittsburgh Regional Health Initiative
The Health Care Improvement Foundation
The Health Collaborative
Washington Health Alliance
Wisconsin Collaborative for Healthcare Quality
Wisconsin Health Information Organization

Thank You

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