Thriving in a Value Based Payment World

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President Elect ACP
Disclosure of Financial Relationships
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Has no relationships with any entity producing, marketing, re-selling, or distributing health care goods or services consumed by, or used by patients.

No other conflict of interests.
Objectives/Knowledge Gaps

- The 21st century office and the transformation to quality based payment
- Physician Quality Reporting System (PQRS), EHR Incentive Program (MU), Value Based Payment (VBP)
- Medicare Access and CHIP Reauthorization Act of 2015
- Alternative Payment Models
Objective
Help to make Decisions

- Accept Health Insurance
- If participate in Health Insurance
  - A. Fee for Service
  - B. Patient Centered Medical Home (PCMH)
  - C. Alternative Payment Models
Principles and Framework
Three Overarching Themes

- High Value Care
- Lowering Health Care Spending
- Triple Aim of Care
High Value Care

- Avoid unnecessary testing
- Use the ER and hospital care judiciously
- Improve outcomes with disease prevention and health promotion
- Prescribe medications safely and cost effectively
- Accurate diagnosis and treatment
All of the following factors will attenuate rising health care costs except:

A. Negotiated drug pricing
B. Reduction in volume of tests, procedures and hospital admission
C. Reduction in the price of health services
D. Payment for better care management.
Change in U.S. Health Spending Per Capita

Average annual growth rate of health spending per capita for 1970s – 1990s; Annual change in actual health spending 2000-2013 and projected health spending 2014-2024

Which of the following is not a “Triple Aim of Care” per Centers for Medicare Services (CMS)

A. better patient experience
B. Improved quality
C. Lower Costs
D. Improved payment for primary care

A. 25%  B. 25%  C. 25%  D. 25%
Triple Aim of Health Care

- Better patient experience,
- High quality care/public health
- Lower costs/bending the cost curve
CMS recently announced goals to include which one of the following:

A. 90% payments tied to quality by 2020
B. 85% payments tied to quality by 2018
C. 85% payments tied to quality by 2016
D. 60% of payments tied to quality by 2016
CMS Goals

- 85% of fee for service payments tied to quality/value by 2016 and 90% by 2018
- 30% of payments tied to quality or value through alternative payment models by 2016 and 50% by 2018.
- The alternative payment models are Merit Based Incentive Program (MIPS), Accountable Care Organizations (ACOs) and bundled payments.
How many in the audience have established

A. Office work flow diagrams
B. Mission/Vision statements
C. Team huddles
D. Participate in PQRS/MU/VBP programs
E. Plan to participate in Alternative Payment Models

Select all that apply
The New Paradigm

20th Century Office

- Paper Record
- Front desk
- Intake
- Physician
- Billing

21st Century Office

- Electronic Health Record
- Physician/RNP/PA/CNM/Pharmacy/Behavioral Health
- Front Desk
- Intake
- Clinical nurse Manager
- Clinical data entry
- IT specialist/data analysis/submission
- Billing CPT/ICD 10/high deductibles/co-payments
Practice Mission/Goals

- Chronic Disease Management
- Acute Disease \( \text{Dx/Rx} \)
- Quality Care/Low Cost/Patient experience
- Prevention
Office Team Culture

- Establish a vision and mission statement
- Promote continuous learning, engaging patients and good communication
- Evaluate your office team culture and brainstorm about changes/improvements
- Consider team huddles and debriefs on a daily or weekly basis
- Individual development will help build a stronger team
- Engage patients with focus surveys and advisory councils.
Team Leaders
Physicians/Practice Managers

- Establish a commitment to measuring quality and improving care
- Identify key team leaders in each department of the office
- Adequate hardware and software support for EHR.
- State of science interoperability
- Accountability and management of reporting deadlines
- Adequate external funding for a significant time period
Documenting High Value Care (HVC)

Structured Clinical Data Sets

Clinical Input

External data /Lab/imaging

Data Entry/Non-structured Data

Intake

Value Based Reporting
MU/PQRS
Health Plan
Public Health

IT/EHR
Which one of the following topics may be reviewed in pre-visit planning?

A. medication reconciliation
B. smoking and substance counseling
C. collation of laboratory data
D. Review of new diagnoses, procedures or operations
E. Specific patient concerns
F. All of the above
Office Work Flow

**Pre Visit Planning**
Medication accuracy/patient concerns/new history/labs/diet/smoking counseling

**Visit**
Flow sheets/Active Problem lists/screening alerts/immunizations/labs/chronic problems/Transitions in care

**Real Time/Post visit data entry/planning**
Patient portal/referral tracking/appointments/collection/visit data entry/coding/lab/procedure tracking
Front Desk Functions

Check in:
   a. Demographic data entry into fields
   b. Patient Portal enrollment

Check out:
   a. Referral tracking and laboratory/tests data entry
   b. Appointment scheduling
   c. Real time Patient care summary
Intake Functions

- Vital signs/BMI
- Medication review
- Active complaints
- New diagnoses/recent procedures/operations
- Depression Screen
- Fall Risk Screen
Clinicians

- Narrative
- Review of Transition in Care/Summary Document
- Clinical Decision Support /smoking counseling/depression counseling/Nutritional counseling
- Immunization status review
- Problem/medication lists
- Screening for disease prevention (colonoscopy/mammography etc)
- ROS/Physical Exam templates/customize to visit
- Assessment/Plan using ICD 10 diagnostic codes and CPT level of care
- Prescriptions/Referrals/Procedures
Scribes!

- Narrative
- Templates/Exam/ROS
- Family and Social History
- Assessment and Plan
- Vitals/BMI
- Counseling/Transition in care
- PHQ 2 score/Fall risk score
- Medication changes
Sample Encounter form

PHQ-2: Over the last two weeks, how often have you been bothered by any of the following problems:
1. Little interest or pleasure in doing things:
   - Not at all
   - Some days
   - More than half the days
   - Nearly every day
2. Feeling down, depressed or hopeless
   - Not at all
   - Some days
   - More than half the days
   - Nearly every day

Fall Risk (64+):
1. Have you fallen 2 or more times in the last 12 months? Yes  No
2. Have you fallen once with injury in the last 12 months  Yes  No

New Drug Allergies: (since last visit, list drug/reaction)

Weight________ Height________ B/P_____/____ R  L  Cuff: Reg  Lg  P_____

R____T____ Pain____ Pulse Ox____ Pulse Ox with exercise____ LO2____ RA_______ LMP_____
- Smokes now? Yes  No  If yes, how much?
- If yes, ready to set quit date in next 6 months Yes  No
- Ever smoked? Yes  No  If yes, when did you quit?

<table>
<thead>
<tr>
<th>PCP to address</th>
<th>Order</th>
<th>Decline</th>
<th>Nursing</th>
<th>Last Done</th>
<th>Next Due</th>
<th>Referrals</th>
</tr>
</thead>
</table>

Health Maintenance
- Mammogram
- Bone Density
- Colonoscopy
- Annual Eye Exam
- Sexual Hx- 18-24 yo female (ANNUAL ONLY)
- Chlamydia Screen- 18-24 yo female (check labs)

Immunizations
- Influenza
- Pneumovax
- Shingles (Zostavax)
- Gardasil/HPV
- Td or Tdap

Labs
- A1c
- Lipids
- Urine Microalbumin
- Bun/Creat (HTN)
- Tobacco Cessation Counseling

Other Past Hx: (Dx:)
- Dietary Counseling (V65.8)
Susie Sick  
Patient #: 555  
DOB: 05/05/1955 (60 years)  
Visit Date: Wednesday, August 5, 2015

Email:

**Allergies:** Do you have any **new medication allergies** since your last visit?

Yes  No

Medication:  
Reaction:  

**Is this your first office visit after a:**

- Hospitalization  
- ER Visit  
- Urgent Care/Walk In Visit  
- Rehab or Nursing Home Discharge

**Medications**

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<tr>
<th>Medication</th>
<th>Dosage</th>
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<tr>
<td>Amlodipine Besylate</td>
<td>1 Tablet daily</td>
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<td>Avandia</td>
<td>1 Tablet daily</td>
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<tr>
<td>Benazepril HCl</td>
<td>1 Tablet QD</td>
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<tr>
<td>Cardizem CD</td>
<td>1 Tab Three times daily as needed</td>
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<tr>
<td>Alprazolam</td>
<td>1 Tab TID pm</td>
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<tr>
<td>Lisinopril</td>
<td>1 Tablet daily</td>
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<td>Ativan</td>
<td>1 Tablet daily</td>
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<td>Atenolol</td>
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<tr>
<td>Prednisone</td>
<td>1 Tablet daily</td>
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<tr>
<td>Prilosec OTC</td>
<td>1 specific dose unknown daily</td>
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<tr>
<td>Nystatin-Triamcinolone</td>
<td>1 Powder at bedtime</td>
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<tr>
<td>Simvastatin</td>
<td>1 (one) Strip two times daily</td>
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<td>Precision Xtra Blood Glucose</td>
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<tr>
<td>Lantus</td>
<td>1 Tablet daily</td>
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<td>Lantus SoloStar</td>
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<td>Robitussin Peak Cold Multi-Sym</td>
<td>1 Tablet monthly</td>
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<td>Azor</td>
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<td>Calcium Carbonate-Vitamin D</td>
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<td>Celexa</td>
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<td>Advair Diskus</td>
<td>1 Puff(s) two times daily, as needed</td>
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<td>Fosamax</td>
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### Past History

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#### Occupation:

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#### Living Situation:

- [ ] |

#### Sexual Orientation:

- Heterosexual  Homosexual  Bisexual

- Condom: Y N

### Immunizations:

- Refuses Flu
- Refuses Pneumovax

### Health Maint:

- Done  Due

- Colonoscopy
- Mammogram
- Dexa
## Physical Exam

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### Assessment:
(Plus Blue Sheet)

- ...
- ...
- ...

### PCMH Care Plans (Required)

<table>
<thead>
<tr>
<th>Goal</th>
<th>Patient Engagement</th>
<th>Barriers</th>
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<tbody>
<tr>
<td>DM A1C Goal</td>
<td>Met</td>
<td>Diet Adherence</td>
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<tr>
<td>HTN BP Goal</td>
<td>Met</td>
<td>Diet Adherence</td>
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<tr>
<td>Smoking Goal</td>
<td>QUIT</td>
<td>Not Ready</td>
</tr>
<tr>
<td>Weight Gain</td>
<td>Lose, Gain</td>
<td>Diet Adherence</td>
</tr>
</tbody>
</table>

### Smoking Cessation Counseling
End of life counseling

### Nutrition Counseling

### MU 2 required:

- Transition into Care: Yes, No
- Review summary of care: Yes, Not provided
Clinical Nurse Managers

- Program Reporting
- Registries
- ED follow up
- Hospital discharge follow up
- Chronic care management
- Identifying sickest and potentially unstable patients
Quality Reporting of Data Sets

- IT/Program Manager critical to managing data set and expert in the following:
  - EHR functions and reporting
  - Performance measures
  - Program requirements
  - Reporting to programs
  - Software and hardware requirements and interface with IT expert
Quality Reporting Programs through 2018

- Physician Quality Reporting System (PQRS), (participation rate 15% to 51% from 2007 to 2013)
- EHR Incentive Program (Meaningful Use)
- Value Based Payment (VBP)
National Quality Strategy Domains for PQRS and MU

- PQRS and MU reporting options require nine measures over at least three domains:
  - Patient safety
  - Person and Caregiver Experience
  - Communication and Care Coordination
  - Effective Clinical Care
  - Community/Population Health
  - Efficiency and Cost Reduction
Measures Selection

- Clinical Conditions
- Types of care (Chronic, acute, preventive)
- Setting of care (ER, office, other)
- Aligning with other Quality Programs
EHR Incentive Program (Meaningful Use)

- **Stage 1**
  - 13 Core Measures
  - 9 Menu Measures
  - Clinical Quality Measures- detailed information available from CMS regarding 2013 or 2014 standards
Meaningful Use

- Stage 2
- 17 Core Measures
- 3 Menu Measures
- Clinical Quality Measures: must meet 9 measures from three of the defined health domains
- ACP asking for revision of MU-2 to harmonize with new Alternative Payment models.
MU ATTESTATION RATES

- Attested to stage 2 (years 1 and 2)
- Attested to stage 1 (years 1 and 2)
- New Participants
- EP's successfully attested 2014

0 50,000 100,000 150,000 200,000 250,000
MU-2 Revised/Final Rule

- All providers now attest to a single set of objectives/Measures
- For EP there are 10 objectives including one public health reporting objective
- Patient Electronic Access/messaging changed from 5% threshold to one patient during measurement period
- Reporting period is calendar year and a 90 day period.
MU-3

- MU-3 is optional in 2017 and required in 2018
- 8 objectives and 60% of measures require interoperability (up for 33%)
- Public health reporting with choice of measures
- CQM aligned with CMS quality reporting program
- Applicable program interfaces, increasing access for patient to health records.
MU-3
Not Ready for Prime Time

- Modification needed for group reporting, risk adjustment and not applicable to Alternative Payment Models (APM)
- Proposed quality measures are process and not outcomes based.
- Measures should be scope of practice and specialty specific.
- Public health registries should be bidirectional.
- Registries should accept one document format and not be duplicative.
- Security risk issues around encrypted PHI
- Clinical Decision Support (CDS) usability and relevance.
Value Based Payment Modifier Program – Finalized for 2015

- Groups with 2 or more eligible professionals AND solo EPs in 2015
  - Successful PQRS Reporters
    - Groups of 10 or more EPs: Upward, no, or downward adjustment based on quality tiering
    - Groups of 2-9 EPs and Solo: Upward or no adjustment based on quality tiering
  - Non-PQRS Reporters: -4.0% or -2.0% (downward adjustment in addition to -2% for PQRS requirement)
- Mandatory quality-tiering: Groups of 2-9 and solo practices would be held harmless from downward adjustments under quality-tiering

<table>
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<tr>
<th>Quality/cost</th>
<th>Low cost</th>
<th>Average cost</th>
<th>High cost</th>
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<tr>
<td>High quality</td>
<td>+4.0x*</td>
<td>+2.0x*</td>
<td>+0.0%</td>
</tr>
<tr>
<td>Medium quality</td>
<td>+2.0x*</td>
<td>+0.0%</td>
<td>-2.0%</td>
</tr>
<tr>
<td>Low quality</td>
<td>+0.0%</td>
<td>-2.0%</td>
<td>-4.0%</td>
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</tbody>
</table>
MACRA establishes the following except:

A. SGR is permanently repealed
B. Positive updates of .5% per year through 2019
C. 0.75% increase for APM and 0.25% for non APM annually
D. FFS is phased out by 2026 and APM becomes mandatory
Medicare Access and CHIP Reauthorization Act of 2015-H.R. 2

- The SGR is permanently repealed.
- Positive payment update of 0.5 percent for 4.5 years through 2019
- In 2026 and beyond, physicians in Advanced Practice Models (APM’s) qualify for a 0.75% update, all others 0.25% yearly update.
- Fee for service is retained and APM and other programs are voluntary.
MACRA creates alternative payment models of Merit Based Incentive Program and Accountable Care Organization. A provider may participate in either or both programs.

A. True
B. False
MACRA: Starting in 2019*, physicians will choose from one of two paths: MIPS or APMs?

* This decision will likely need to be made sooner than 2019 (probably in 2017) in order to fully prepare.
MIPS requires all the following except:

A. performance measurements
B. resource use
C. Meaningful use
D. use of clinical registries
E. MOC participation
Two pathways: MIPS versus APMs

- MIPS adjusts traditional fee-for-service payments upward or downward based on new reporting program (starting in 2019), replacing PQRS, Meaningful Use, and Value-Based Modifier

- Measurement categories:
  - Clinical quality (30%)
  - Meaningful use (25%)
  - Resource Use (30%)
  - Practice improvement (15%)

- 5% annual bonus FFS payments for physicians who get substantial revenue from alternative payment models that
  - Involve upside and downside financial risk, e.g. ACOs or bundled payments
  - OR
  - PCMHs, if shown to improve quality w/o increasing costs, or lower costs w/o decreasing quality
MIPS Performance Category Weights

Each of the four MIPS performance categories is weighted to determine physician performance:

- Clinical improvements: 15%
- Quality: 30%
- Resource use: 30%
- Meaningful use: 25%
Each eligible professional will:

- Receive a composite score of 0-100 based primarily on performance in the 4 measurement categories.
- Only be assessed on measures and categories that apply to them; scoring weights may be adjusted as necessary to account for their ability to successfully report on each category or activity.
- Will receive credit for improvement from one year to the next.

So, this really is each EP determining their own individual conversion factor!
Physicians with the highest MIPS composite scores could earn additional “exceptional performance” payments

- Funded by “new” money (not budget-neutral): $500 million allocated each year from 2019 through 2024.
  - Additional “exceptional performance” adjustment cannot exceed 10% in any year.
- Exceptional threshold:
  - Score equal to the 25\textsuperscript{th} percentile of the range of possible composite scores higher than the performance threshold, or
  - Score equal to actual composite scores for MIPS-eligible professionals with scores at or higher than performance threshold.
APM payment structure

- APMs will be supported by their own payment rules, in addition to the 5% annual APM-only incentive payments in 2019-24. For example:
  - Comprehensive Primary Care Initiative (PCMHs): 500 practices in 7 markets are now getting $20 per Medicare patient per month (risk adjusted) plus FFS, with opportunity for shared savings.
  - ACOs: opportunity to share in savings; the greater the risk, the greater the potential savings.
ACO’s in the United States

- 2013: 258
- 2014: 522
- 2015: 585

- 56 million people or 15% of the population.
ACO FINANCIAL PERFORMANCE

- Exceeded cost projections (157)
- Saved Money (196)
- Savings Only (89)
- Savings and Payment (92)

Total (353)
Savings and Payout
In the Negative
Percentage of ACP’s that generated savings

- 2012: 35%
- 2013: 25%
- 2014: 20%
Under MACRA, what’s the range of possible FFS updates and incentive payments per year? (Physicians can participate in either MIPS or APM, not both)

<table>
<thead>
<tr>
<th>Date</th>
<th>Baseline</th>
<th>MIPS (incentive adjustments), without exceptional performance adjustment*</th>
<th>Baseline, plus/minus MIPS, without exceptional performance adjustment*</th>
<th>MIPS maximum, with exceptional performance adjustment*</th>
<th>APM (FFS bonus only, does not include incentives from own APM pay structure)</th>
</tr>
</thead>
<tbody>
<tr>
<td>4-1-2015</td>
<td>0% instead of 21% SGR cut</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>7-1-2015 thru 12-31-2018</td>
<td>0.5%</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>2019</td>
<td>0.5%</td>
<td>+/ - 4.0%**</td>
<td>= -3.5% to +4.5%**</td>
<td>14.5%</td>
<td>FFS bonus: +5%</td>
</tr>
<tr>
<td>2020</td>
<td>0%</td>
<td>+/ - 5.0%**</td>
<td>= -5.0% to +5.0%**</td>
<td>15%</td>
<td>FFS bonus: +5%</td>
</tr>
<tr>
<td>2021</td>
<td>0%</td>
<td>+/ - 7.0%**</td>
<td>= -7.0% to +7.0%**</td>
<td>17%</td>
<td>FFS bonus: +5%</td>
</tr>
<tr>
<td>2022, 2023 and 2024</td>
<td>0%</td>
<td>+/ - 9.0%**</td>
<td>= -9.0% to +9.0%**</td>
<td>19%</td>
<td>FFS bonus: +5%</td>
</tr>
<tr>
<td>2025</td>
<td>0%</td>
<td>+/ - 9.0%**</td>
<td>= -9.0% to plus 9.0%**</td>
<td>N/A</td>
<td>0%</td>
</tr>
<tr>
<td>2026 and subsequent years</td>
<td>0.25% (for non-APM physicians only)</td>
<td>+/ - 9.0%**</td>
<td>= -8.75% to plus 9.25% **</td>
<td>N/A</td>
<td>0.75%</td>
</tr>
</tbody>
</table>

*Exceptional performance adjustment for those with the highest composite scores, limited to additional adjustment of 10% per year.

**HHS can increase the maximum MIPS positive adjustment (not counting the exceptional performance adjustment) to no more than 3x maximum MIPS incentive adjustment for that calendar year, if there are sufficient funds available. HHS cannot increase the maximum negative MIPS adjustment by more than the amount specified.
All of the following are features of MACRA except:

<p>| | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>20%</td>
<td>A.</td>
<td>Top 25% of MIPS performers eligible for 500 million dollars between 2019 and 2024</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20%</td>
<td>B.</td>
<td>The Relative Value Scale resets Evaluation and Management codes for primary care.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20%</td>
<td>C.</td>
<td>Secretary may establish MOC as one option for Clinical Quality Improvement, but not mandatory</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20%</td>
<td>D.</td>
<td>$20 million for technical assistance to small practices</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20%</td>
<td>E.</td>
<td>$15 million per year for measure development (5 years).</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
MACRA other features

- Top 25% of MIPS performers eligible for 500 million dollars between 2019 and 2024
- The Secretary may establish MOC as one option for Clinical Quality Improvement, but not mandatory
- $20 million for technical assistance to small practices
- $15 million per year for measure development (5 years).
What else does the MACRA legislation do?

**Strong incentives for PCMHs**

- Certified PCMHs and PCMH specialty practices will get highest possible scores for clinical practice improvement under MIPS (15% of total).
- As noted earlier, PCMHs can potentially qualify as an APM without having to take financial risk.
Do you think the increased use of PCMH is having a positive, negative or no impact on the quality of medical care delivered to patients?

A. Positive
B. Negative
C. No impact

33% 33% 33%
Exhibit 1. Providers’ Views Are Mixed on Impact of Medical Homes, with Those Working in Medical Homes More Positive

Do you think the increased use of medical homes is having a positive, negative, or no impact on primary care providers’ ability to provide quality care to their patients?

### Physicians

<table>
<thead>
<tr>
<th></th>
<th>Not sure</th>
<th>Negative</th>
<th>No impact</th>
<th>Positive</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>27%</td>
<td>14%</td>
<td>26%</td>
<td>33%</td>
</tr>
<tr>
<td>Among those in PCMH/APCP</td>
<td>15%</td>
<td>17%</td>
<td>24%</td>
<td>43%</td>
</tr>
<tr>
<td>Among those not in PCMH/APCP</td>
<td>31%</td>
<td>13%</td>
<td>27%</td>
<td>28%</td>
</tr>
</tbody>
</table>

### Nurse practitioners/Physician assistants

<table>
<thead>
<tr>
<th></th>
<th>Not sure</th>
<th>Negative</th>
<th>No impact</th>
<th>Positive</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>32%</td>
<td>8%</td>
<td>19%</td>
<td>40%</td>
</tr>
<tr>
<td>Among those in PCMH/APCP</td>
<td>15%</td>
<td>11%</td>
<td>10%</td>
<td>63%</td>
</tr>
<tr>
<td>Among those not in PCMH/APCP</td>
<td>38%</td>
<td>7%</td>
<td>22%</td>
<td>31%</td>
</tr>
</tbody>
</table>

Note: PCMH = patient-centered medical home; APCP = advanced primary care practice.
Source: The Commonwealth Fund/Kaiser Family Foundation 2015 National Survey of Primary Care Providers.
Do you think the increased use of ACO’s is having a positive, negative or no impact on the quality of medical care delivered to patients?

A. Positive
B. Negative
C. No impact

33% 33% 33%
Exhibit 2. Views on the Impact of Accountable Care Organizations Are Mixed, with Many Providers Unsure

Do you think the increased use of accountable care organizations (ACOs) is having a positive, negative, or no impact on primary care providers’ ability to provide quality care to their patients?

<table>
<thead>
<tr>
<th></th>
<th>Not sure</th>
<th>Negative</th>
<th>No impact</th>
<th>Positive</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Physicians</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All</td>
<td>38%</td>
<td>26%</td>
<td>21%</td>
<td>14%</td>
</tr>
<tr>
<td>Among those in ACOs</td>
<td>25%</td>
<td>24%</td>
<td>20%</td>
<td>30%</td>
</tr>
<tr>
<td>Among those not in ACOs</td>
<td>43%</td>
<td>27%</td>
<td>21%</td>
<td>7%</td>
</tr>
<tr>
<td><strong>Nurse practitioners/Physician assistants</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All</td>
<td>52%</td>
<td>16%</td>
<td>14%</td>
<td>17%</td>
</tr>
</tbody>
</table>

Note: The number of NPs/PAs in ACOs is too small to analyze.
Source: The Commonwealth Fund/Kaiser Family Foundation 2015 National Survey of Primary Care Providers.
Do you think the increased use of quality metrics to assess provider performance is having a positive, negative or no impact on primary care providers ability to provide quality care to patients?

A. Positive  
B. Negative  
C. No impact
### Exhibit 3. Providers Are Largely Negative About Increased Use of Quality Metrics to Assess Provider Performance

Do you think the increased use of quality metrics to assess provider performance is having a positive, negative, or no impact on primary care providers’ ability to provide quality care to their patients?

#### Physicians

<table>
<thead>
<tr>
<th></th>
<th>Not sure</th>
<th>Negative</th>
<th>No impact</th>
<th>Positive</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>10%</td>
<td>50%</td>
<td>17%</td>
<td>22%</td>
</tr>
<tr>
<td>Among those receiving incentive payments based on quality of care</td>
<td>6%</td>
<td>50%</td>
<td>15%</td>
<td>28%</td>
</tr>
<tr>
<td>Among those not receiving such incentive payments</td>
<td>13%</td>
<td>50%</td>
<td>18%</td>
<td>17%</td>
</tr>
</tbody>
</table>

#### Nurse practitioners/Physician assistants

<table>
<thead>
<tr>
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<th>Positive</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>22%</td>
<td>38%</td>
<td>12%</td>
<td>27%</td>
</tr>
<tr>
<td>Among those receiving incentive payments based on quality of care</td>
<td>14%</td>
<td>41%</td>
<td>10%</td>
<td>35%</td>
</tr>
<tr>
<td>Among those not receiving such incentive payments</td>
<td>25%</td>
<td>36%</td>
<td>13%</td>
<td>25%</td>
</tr>
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</table>

Source: The Commonwealth Fund/Kaiser Family Foundation 2015 National Survey of Primary Care Providers.
The Evolution of Payment Models

Pure Fee for Service

Fee for Service with PCMH oversight and clinical management payment (dollars per member per month)/Transitions in care/Chronic Care Management/Annual Wellness Visit

Value Based Payment/PQRS/MU (quality and cost measures)

APM (ACO or PCMH) or MIPS (your choice)

Next Iteration?
Take Home Messages

- Commitment to quality and cost through incentive programs
- Identifying team leaders
- Office work flow
- Data entry SCREIBES!
- Registries
- Program Reporting
- MIPS or ACO/PCMH/Bundled Payment, your choice.
Triple Aim of Health Care

- Better patient experience,
- High quality care/public health
- Lower costs/bending the cost curve
Change in U.S. Health Spending Per Capita

Average annual growth rate of health spending per capita for 1970s-1990s;
Annual change in actual health spending 2000-2013 and projected health spending 2014-2024

Objective
Help to make Decisions

- Accept Health Insurance
- If participate in Health Insurance
  - A. Fee for Service
  - B. PCMH
  - C. MIPS
  - D. ACO/Bundled Payments
Stay or Go?
Thank you for your attention

Questions?
Evaluation

- Please take < 90 seconds to evaluate this session.
- Time permitting, speaker will take questions following evaluation.
- Responses are not displayed and are important in maintaining high quality education.
The overall performance of the speaker:

1. Poor
2. Fair
3. Average
4. Good
5. Excellent
How well were the learning objectives met?

1. Poor
2. Fair
3. Average
4. Good
5. Excellent
Did speaker present a balanced view of therapeutic options?

1. Yes
2. No
3. N/A
How useful will this session be in your practice?

1. Poor
2. Fair
3. Average
4. Good
5. Excellent
As a result of this program, do you intend to change your patient care?

1. Yes
2. No
Thank you!
ICD-10

Physician practices must be fully compliant with ICD-10 coding no later than October 1, 2015.

ACP resources:

- ICD-10 webpage revamped and regularly updated: http://www.acponline.org/running_practice/payment_coding/coding/icd10.htm
  - Includes links to ACP and trusted external resources (including CMS)
EHR Incentive Program
(aka Meaningful Use)

- ACP Meaningful Use webpage:
  http://www.acponline.org/running_practice/technology/index.html#meaningful-use
  • Important Meaningful Use dates are included in the Timeline

- ACP offers American EHR Partners:
  http://www.americanehr.com/Home.aspx
  • Offers the resources and tools physicians need to effectively implement and use Electronic Health Records (EHRs)
The VBP program is intended to provide comparative performance information to physicians as part of Medicare’s efforts to improve the quality and efficiency of medical care.

- ACP’s VBP webpage is regularly updated: http://www.acponline.org/running_practice/payment_coding/medicare/vbp_program.htm

  - Includes program year summary, recorded presentations, links to articles, and links to CMS and other external resources
  - Important deadline and dates to be aware of are included in the Timeline
Physician Quality Reporting System (PQRS)

- ACP PQRS website: http://www.acponline.org/running_practice/payment_coding/pqrs/

- ACP offers the PQRSWizard (https://acp.pqriwizard.com/default.aspx) a fast, convenient, and cost-effective online tool to help collect and report quality measure data for the Centers for Medicare & Medicaid Services (CMS) PQRS incentive payment program
Physician Quality Reporting System (PQRS)

- ACP PQRS website: http://www.acponline.org/running_practice/payment_coding/pqrs/
- ACP offers the PQRSWizard (https://acp.pqriwiz.com/default.aspx) a fast, convenient, and cost-effective online tool to help collect and report quality measure data for the Centers for Medicare & Medicaid Services (CMS) PQRS incentive payment program.
Physician and Practice Timeline

The Timeline provides an at-a-glance summary of upcoming important dates related to a variety of regulatory, payment, educational, and delivery system changes and requirements. The Timeline includes dates for programs such as:

- Physician and Quality Reporting System (PQRS)
- Value-Based Payment (VBP) Modifier
- Meaningful Use
- ICD-10
- Sunshine Act
- Maintenance of Certification (MOC)