Payment Reform To Drive High Value Care

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Objectives

• Gain an appreciation for the forces of healthcare transformation & the goal to deliver high value care:
  
  Better outcomes at Lower costs

• Understand payment reform initiatives where the intent is to align payment with delivering high value care.

• Utilize ACP resources (such as position papers and online resources) to help meet these opportunities
Two separate but related imperatives are Driving Reform

**PUBLIC IMPERATIVE**

- Government facing fiscal challenges
  - Quality & safety reform efforts
  - Affordable Care Act
  - Alternative Payment Models
  - Provider Payment Reform

**PRIVATE IMPERATIVE**

- Employers/Employees Facing Escalating Costs
  - Age of consumer technology
  - Move to defined contribution
  - High deductible health plans
  - Consumerism
“More than at any other time in history, mankind (healthcare) is at a crossroads. One path leads to despair and utter hopelessness, the other to total extinction. Let’s hope we have the wisdom to choose correctly.”

- Woody Allen
Deliver better care (best health outcomes) at lower costs
Vision to action: The 3 Interconnected Revolutions...

1. PATIENT
2. VOLUME
3. EPISODE

1. PERSON
2. VALUE
3. POPULATION
BIG IDEA: The voice of the person receiving healthcare

TRAVEL

BANKING

HEALTHCARE
86% of patients conduct health-related search before scheduling an appointment.¹

More than 33% of Americans use social media to research health conditions.¹

41% say social media impacts their choice of healthcare providers.¹

¹. Medcitynews.com/2014/03/healthcare-are-dr-google-2014-digital-patient-journey
DIGITALLY CONNECTED...

2 OF 3
FIND PORTALS A CONVENIENT WAY TO COMMUNICATE WITH DOCTORS.³

82%
AMERICANS AGES 18-34 WHO HAVE A DOCTOR PREFER CONSULTATION VIA MOBILE DEVICE.¹

84%
PATIENTS BELIEVE THEY SHOULD HAVE FULL ACCESS TO MEDICAL RECORDS ONLINE.³


...provide quality patient care....based on an examination of what patients want and need from a healthcare delivery system.
Vision to action: The 3 Interconnected Revolutions...

1 PATIENT
2 VOLUME
3 EPISODE

PERSON
VALUE
POPULATION
BIG IDEA: Patient level MEASUREMENT
• Historical paradigm: quality assurance
• New archetype: measure & move the mean
We manage what we measure...

IOM Quality Domains

- TIMELY
- EQUITABLE
- EFFICIENT
- PATIENT-CENTERED
- EFFECTIVE
- SAFE
Value, a Ratio...

\[ \text{VALUE} = \frac{\text{QUALITY} + \text{SERVICE}}{\text{COST}} \]
Developing and implementing performance measures linked to quality improvement and accountability

A first step is to decrease or eliminate care that provides no benefit and may even be harmful. A second step is to provide medical interventions that provide good value: medical benefits that are commensurate with their costs.
Vision to action: The 3 Interconnected Revolutions...

1. PATIENT
2. VOLUME
3. EPISODE

PERSON

VALUE

POPULATION
BIG IDEA: LONGLITUDINAL Care TEAMS
Integrating to Advance Health...

- Patient/Family/Society
- Acuity/Complexity & Cost per unit service
- Healthcare Delivery

- Mobile Centric
  - Wellness & Patient Activation Model
- Ambulatory Centric
  - Chronic Care Model
- Inpatient Centric
  - Acute Care Model
Teams need to be organized around the patients value stream...
encourage positive dialogue among all of the health care professions involved in patient care—in the hope of advancing team-based care models that are organized for the benefit and best interests of patients.

Key attributes include...integrated comprehensive care with smooth information transfer across a team of providers...
FRAMEWORK FOR HIGH VALUE CARE...

VISION

PATIENT

MEASURE

TEAM
Value: You improve what you measure.

Physicians Police Thyself
Medical Licensure
Peer review
M&M Conferences

Subjective, implicit, focus on outliers

1992
2003

System & Provider Attributable Performance

Objective & explicit metrics → move the mean
National Surveys (e.g. Leapfrog, AHA, etc.)

Clinical Disease Registry

MISC.

HEDIS

Clinical Disease Registry

National Surveys (e.g. Leapfrog, AHA, etc.)

MIPS

MU-EP

VBM

PQRS

IQR

MU-EH

HAC

HRRP

VBP

HOSPITAL Inpatient prospective payment

HOSPITAL Outpatient prospective payment

PROVIDER Payment System

Payer & Organization Driven

Other

§§§ Payment Adjustment §§§
Explosion of Metrics...

TIMELY

EQUITABLE

EFFICIENT

PATIENT-CENTERED

EFFECTIVE

SAFE

IOM Quality Domains

Unit of Measurement Matters...

- Hospital Quality
- Hospital Quality + Service
- Clinical Condition Quality
- Clinical Condition Value
- Physician Value
- Individual Patient Value
CMS Value Programs Tied to $$$...

- **HOSPITAL QUALITY REPORTING**: 2% of APU
- **VALUE-BASED PURCHASING**: 2% BASE DRG PMTS
- **READMISSIONS REDUCTION PROGRAM**: 3% BASE DRG PMTS
- **HOSPITAL-ACQUIRED CONDITIONS**: 1% TOTAL PMTS
- **MEANINGFUL USE**: 5%
- **PHYSICIAN QUALITY**: 2% PMTS
- **Value Based Modifier (VBM)**
New Core Quality Measure Sets...

- CMS & AHIP announcement Feb 16, 2016
- Multi-payer alignment on core measures primarily for physician quality programs
- Measures in 7 sets:
  - Primary care/PCMH/ACOs
  - Cardiology
  - Gastroenterology
  - HIV & Hepatitis C
  - Medical Oncology
  - OB GYN
  - Orthopedics

## Primary Care/ACO/PCMH measures...

<table>
<thead>
<tr>
<th>NQF #</th>
<th>Measure</th>
<th>Measure Steward</th>
<th>PCMH</th>
<th>ACO</th>
<th>Consensus Agreement / Notes</th>
</tr>
</thead>
</table>
| 0018  | Controlling High Blood Pressure              | NCQA            | ✓    | ✓   | Consensus to include either #0018 or "N/A - Controlling High Blood Pressure" HEDIS measure in the core set if data needed for either measure is available through EHR or provider self-report with audit.  

*Note:* Both blood pressure control measures are included in the core set with the choice being an "either/or" due to controversy regarding the 2014 JAMA paper sometimes referred to as “JNC 8”, which recommends relaxing systolic blood pressure (SBP) targets to 150 mmHg for patients aged 60 and older without diabetes mellitus or chronic kidney disease (CKD).  

Revised ACC/AHA hypertension guidelines are expected to be released later this year. Until these revised guidelines are available, a number of organizations continue to recognize the 2004 Joint National Committee (JNC 7) hypertension guidelines, which recommend a SBP target of 140 mmHg, as the national standard. Given the changing nature of these guidelines, the Collaborative will revisit this measure topic when the revised guidelines are available to determine which blood pressure control measure aligns with the updated evidence base.  

*Note:* #0018 is specified for physician-level use. |

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Cardiovascular care  
Diabetes  
Care continuity  
Prevention/wellness  
Behavioral health  
Utilization  
Service
MACRA: Title I Background

- Medicare Access and CHIP Reauthorization Act (MACRA) signed into law April 16, 2015
- Permanently Repeals the Sustainable Growth Rate (SGR) formula
  - Enacted under the Balanced Budget Act of 1997
  - Used to set annual updates to Medicare payments under the Physician Fee Schedule (PFS)
  - Linked to Medicare annual payment adjustments for physician services to the Gross Domestic Product growth
- Averted the 21 percent reduction to Medicare in 2015
MACRA Bottom Line

• Aligns & adds value programs (MU, VBM, PQRS) and pushes towards new payment models

Defines how Medicare will begin paying PROVIDERS beginning January 1 2019

• Proposed rule will come out soon & final rule in the fall with implementation thereafter
Today’s Goal...

You don’t have to see the whole staircase, just take the first step.
Can’t I think about this later?

No – to stay ahead of the game, preparation begins now!
MACRA

MIPS

+/- 9% to participate in merit-based incentive pay (=pay for value).

APM’s

5% upside to engage in qualified alternate payment model.

* Attribution may change— for example to the NPI number (This is TBD by CMS)
Implications...

Cost & Quality Performance
(TIN based reporting)
Who Does MIPS Apply To?

• Eligible Professionals (EPs):
  • Starting in 2019
    • Physician
    • Physician assistant (PA)
    • Nurse practitioner (NP)
    • Clinical nurse specialist
    • CRNA
  • Starting 2021, this category can be expanded
Overview of MIPS

New Consolidated Pay-for-Performance Program

- Physician Quality Reporting (PQRS)
- Meaningful Use (Eligible Providers)
- Value Based Modifier (Cost-of-Care)

Merit-Based Incentive Payment System (MIPS)**

** Plus NEW category of “Clinical Practice Improvement”
**MIPS: Clinical Practice Improvement Activities**

The Secretary is required to specify clinical practice improvement activities. Subcategories of activities are also specified in the statute, which are:

<table>
<thead>
<tr>
<th>Expanded Practice Access</th>
<th>Population Management</th>
<th>Care Coordination</th>
<th>Beneficiary Engagement</th>
<th>Patient Safety &amp; Practice Assessment</th>
<th>Participation in an APM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Same day appointments for urgent needs</td>
<td>Monitoring health conditions &amp; providing timely intervention</td>
<td>Timely exchange of clinical information</td>
<td>Establishing care for complex patients</td>
<td>Use of clinical or surgical checklists</td>
<td>At a minimum receive ½ CPIA score for APM participation</td>
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<tr>
<td>After hours clinician advice</td>
<td>Participation in a QCDR</td>
<td>Use of remote monitoring and Telehealth</td>
<td>Patient self management &amp; training</td>
<td>Practice assessments related to maintain certification</td>
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*EP in a practice certified as a patient-centered medical home, or comparable specialty practice, will receive the highest CPIA score.*
*These are payment years—performance years are 2 years prior.*
APMs

- Provides incentives and pathway for physicians to develop and participate in new models of healthcare delivery and payment
- Medicare Eligible APMs must use CEHRT and are defined as:
  - Those that involve risk of financial losses and a quality measure component (e.g., the Medicare Shared Savings Program)
  - A model under the CMMI
  - A demonstration under section 1866C of the SSA
    - The Health Care Quality Demonstration Program that examines the extent to which financial incentives promote improvements in care
  - A demonstration required by federal law
APMs (cont’d)

• Provides 5 percent incentive payments from 2019 to 2023 for those who join new models

• Participants need to receive at least 25 percent of their Medicare revenue through an APM in 2019 to 2020.
  – Threshold increases over time
  – Incentivizes participation in private-payer APMs

• EPs will only be subject to the quality reporting requirements for their APM
  – Exempt from the new MIPS quality program
Figure 2: The Work Group’s Goals

CURRENT STATE

FUTURE STATE

CMS Payment Reform Timeline

<table>
<thead>
<tr>
<th>Year</th>
<th>Incentives (%)</th>
<th>Penalties (%)</th>
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<tbody>
<tr>
<td>2016</td>
<td>55%</td>
<td>30%</td>
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<tr>
<td>2018</td>
<td>40%</td>
<td>50%</td>
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Limited v. comprehensive population-based payments

‘D’ = incentives & penalties

Bundles ACO’s PCMHs (?)
https://hcp-lan.org/groups/apm-fpt/apm-framework/
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<td><strong>Fee Schedule Updates</strong></td>
<td>0.5</td>
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<td>0.0</td>
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<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.75 QAPMCF*</td>
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<td>0.25 N-QAPMCF**</td>
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**MIPS**

- **Quality**
- **Resource Use**
- **Clinical Practice Improvement Activities** 4%, 5%, 7%, 9% (MIPS Payment Adjustment +/-)
- **Meaningful Use of Certified EHR Technology**
- **PQRS, Value Modifier, EHR Incentives**

**Certain APMs**

- **Qualifying APM Participant**
  - Medicare Payment Threshold
  - Excluded from MIPS

- **5% Incentive Payment**
  - Excluded from MIPS

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*Qualifying APM conversion factor
**Non-qualifying APM conversion factor
ACP Is Here to Help!
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http://healthsciences.utah.edu/value-university/index.php