Medicare Quality & Payment Reform Initiatives 2016-2019

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Introductions

The Lake Superior Quality Innovation Network (Lake Superior QIN) is comprised of three quality improvement organizations:

- Stratis Health in Minnesota
- MetaStar in Wisconsin
- MPRO in Michigan

Objectives

- Discuss how the current Medicare quality and value programs will be replaced by the Merit Based Incentive Program (MIPS) in 2017
- Learn about alternative payment models (APMs)
- Decide which strategy aligns best with your organizational goals
Medicare Incentive Programs 2015-2018

1. EHR Incentive Program (Meaningful Use)
2. Physician Quality Reporting System (PQRS)
3. Value-Based Modifier (VBM) Program

Meaningful Use

- Stage 2 modifications final for 2015-2017
- 2015 changed from full year to 90 days
- Stage 2 final rule came out with less than 90 days
- Hardship exemptions
- Meaningful Use Stage 3 Final Rule out this spring

PQRS Reporting

- A quality reporting system that uses negative payment adjustments to promote reporting of quality information by individual eligible professionals (EPs) and group practices
- Applies to Medicare Part B Physician Fee Schedule (MPFS) services for beneficiaries
- Includes Accountable Care Organizations (ACOs), Medicare Shared Savings Programs (MSSPs), and Comprehensive Primary Care Practice Sites (CPCPs)
What You Need to Report

Nine clinical quality measures across three National Quality Strategy (NQS) domains

- Patient Safety
- Person & Caringer Centered Experience & Outcome
- Communication & Care Coordination
- Effective Clinical Care
- Community/Population Health
- Efficiency & Cost Reduction

Value-Based Modifier Program

- VBM assesses both quality of care and cost of care under the Medicare Physician Fee Schedule
- VBM includes cost measures, quality measures, and PQRS measures
- Phase-in of VBM began in 2015-2017
  - Phase 1: In 2015 groups of 100+ PQRS EPs (data 2013)
  - Phase 2: In 2016 groups of 10-99 PQRS EPs (data 2014)
  - Phase 3: In 2017 ALL physicians and physician groups (data 2015)

Payment Calculation

- Based on cost and quality data
- Quality Resource and Use Reports (QRURs)
- Quality tiering determines the type of adjustment (upward, downward, neutral)
- Includes ALL cost measures (except Part D outpatient prescription costs)
Quality Measures for VBM

- 30-day all cause hospital admissions
- Hospital admissions for ambulatory care sensitive conditions-acute care
- Hospital admissions for ambulatory care sensitive conditions-chronic care

Cost Measures for VBM

- Total per capita costs for all attributed beneficiaries
- Total per capita costs for beneficiaries with specific chronic conditions:
  - Chronic obstructive pulmonary disease/asthma
  - Coronary artery disease
  - Diabetes
  - Heart failure
- Medicare spending per beneficiary

What’s At Risk Now?

<table>
<thead>
<tr>
<th>Year</th>
<th>VBM</th>
<th>PQRS</th>
<th>MU</th>
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<tbody>
<tr>
<td>2016</td>
<td>-2%</td>
<td>-2%</td>
<td>-2%</td>
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<tr>
<td>2017</td>
<td>-3%</td>
<td>-2%</td>
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<tr>
<td>2018</td>
<td>-4%</td>
<td>-2%</td>
<td>-2%</td>
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Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)

- Signed into law on April 16, 2015
- Repeals the Sustainable Growth Rate (SGR) formula
- Rewards providers for providing better care vs more care
- Two paths to choose from: Merit Based Incentive Program (MIPS) or Alternative Payment Model (APM)


Two Goals for Medicare Fee for Service

- GOAL 1: 30%
  - Medicare fee for service payments tied to quality of care for patients age 66, and 55% at the end of 2016
- GOAL 2: 85%
  - Medicare fee for service payments tied to quality of care for patients age 66 and 95% at the end of 2020


Merit-Based Incentive Program (MIPS)

- Created from MACRA
- Proposed to begin on January 1, 2017
- Combines existing programs into one
- Links fee for service payments to quality and value
- Composite performance score (0-100)

Quality

- Formerly known as PQRS
- Accounts for 50% scoring
- Minimum of six measures and should include:
  - One cross-cutting measure (face to face with one Medicare beneficiary)
  - One outcome measure (if possible)

Resource Use

- Formerly known as VBM program
- Accounts for 10% scoring
- Claims data only
- Continue two measures from VBM:
  - Per capita costs for all attributed Medicare beneficiaries
  - Medicare spending per beneficiary
Clinical Practice Improvement Activities

- Accounts for 25% scoring
- Minimum number of activities
- Some reportable...some not
- 90+ activities to choose from

Examples include:
- Expanded practice access
- Population management
- Care coordination
- Beneficiary engagement
- Patient safety and practice assessment
- Participation in an Alternative Payment Model (APM)


Advancing Care Information

- Formerly known as Meaningful Use
- Accounts for 25% scoring
- Gets rid of “all or nothing” reporting
- Base score: provide numerator/denominator or yes/no for six objectives and their measures
Advancing Care Information

Measures include:
- Protect patient information (Y/N)
- Patient electronic access (N/D)
- Coordination of care through patient engagement (N/D)
- E-Prescribing (N/D)
- Health Information Exchange (N/D)
- Public Health Clinical Data Registry Reporting (Y/N)

Other Considerations

- Eligible Clinicians (ECs):
  - can report as an individual, group, or as an alternative payment model entity group
  - should know in advance what they need to do to perform well in MIPS
  - can request targeted review of MIPS calculation
- Public reporting of MIPS will be made available on Physician Compare

MIPS Payment Adjustment

Adjustment to provider’s base rate of Medicare Part B payment

Exemptions from MIPS

- First year of Medicare participation for ECs
- Below low volume threshold
  - $\leq 100$ Medicare patients
  - $\leq 10,000$ Medicare FFS revenue
- Participants in APM who qualify for a bonus payment
- MIPS does not apply to hospitals or facilities


Proposed/Final Rule for MIPS

- Proposed rule was made available on April 27, 2016
- 90-day comment period ends June 27, 2016
  - https://www.regulations.gov/#!docketDetail.rpp=100;so=DESC;sb=docId;po=0;D=CMS-2016-006
- Final rule will be published later this fall

Alternative Payment Models

- APMs are a new way to compensate providers for care and services rendered to Medicare beneficiaries
- Promotes value and quality over volume by moving away from the traditional Medicare FFS structure
- Goal of APMs is to reduce spending while improving patient care

Alternative Payment Models

APMs

| ACOs | Bundled Care Models | PCMH |

MIPS and APM Timeline

• 2016 is the last year that MU, PQRS, and VBM are reported on as stand alone programs

• Performance period is two years behind reporting period

• **2017 is the first performance period for MIPS for 2019 evaluation**

Choosing Between MIPS or APMs?

Questions that you need to ask before choosing:

• Have you implemented certified electronic health record technology (CEHRT)?

• Do you qualify to participate in MIPS or an APM?

• How strong has your quality reporting been for MU, PQRS, and VBM?
Choosing Between MIPS or APMs?

- Do you have time to invest in acquiring or maintaining PCMH accreditation? Is it a CMS approved program?
- Are you willing to face a certain level of risk when participating in an ACO model?
- Have you submitted your ACO application before the required deadline?

Getting Started

Educate your organization about value-based care
Continue your work with MU
Improve your PQRS reporting
Use Quality Resource Use Reports (QRURs)
Focus on improving cost and quality
Stay informed and continuously review your progress

Resources

CMS MACRA/MIPS Website
https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS.html

CMS PQRS Website

CMS Value-Based Modifier (VBM) Website
https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ValueBasedPayment/VBM.html

Medicare and Medicaid EHR Incentive Programs
https://www.cms.gov/Medicare/Inpatient-Hospital-Quality-Incentive-Programs

Agency for Healthcare Research and Quality (AHRQ) Care Coordination
Working with Lake Superior QIN

Free assistance for providers, including:

- Real-time assistance
- Access to timely educational opportunities
- Guidance on best practice interventions and patient engagement strategies
- Process improvement and workflow optimization
- Help with increasing use of certified electronic health record technology (CEHRT)
- Timely feedback and coaching

Excellence in Operations & Quality Improvement

Questions?

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