MACRA is Coming: Reimbursement for Quality and the Shift to Population-Based Care

AMERICAN NEUROLOGICAL ASSOCIATION
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Disclosures

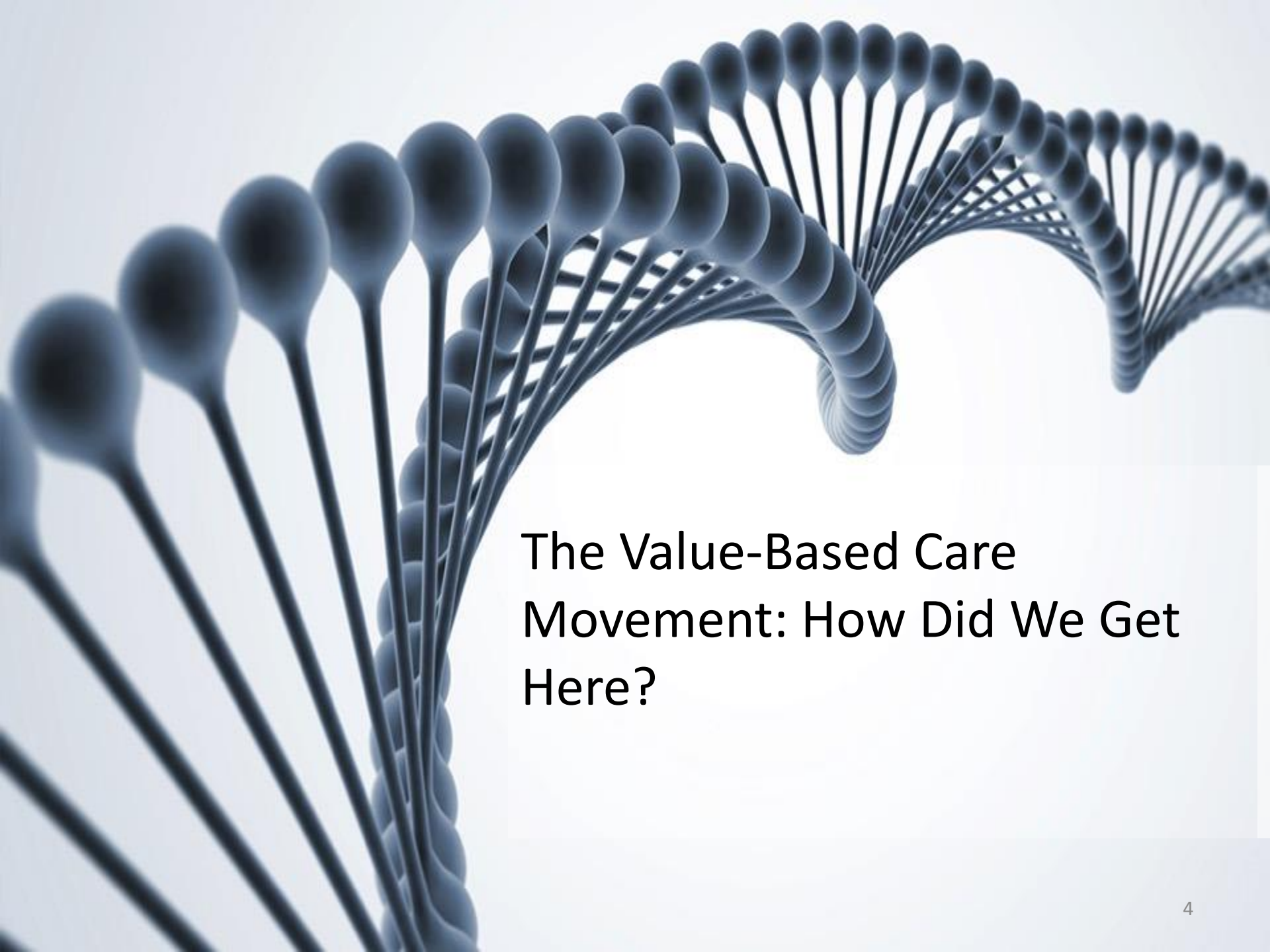
- Dr. Nuwer – No Health Care Policy conflicts.

  NIH NINDS and CDMRP research grants.
- Dr. Jones – None

Goals

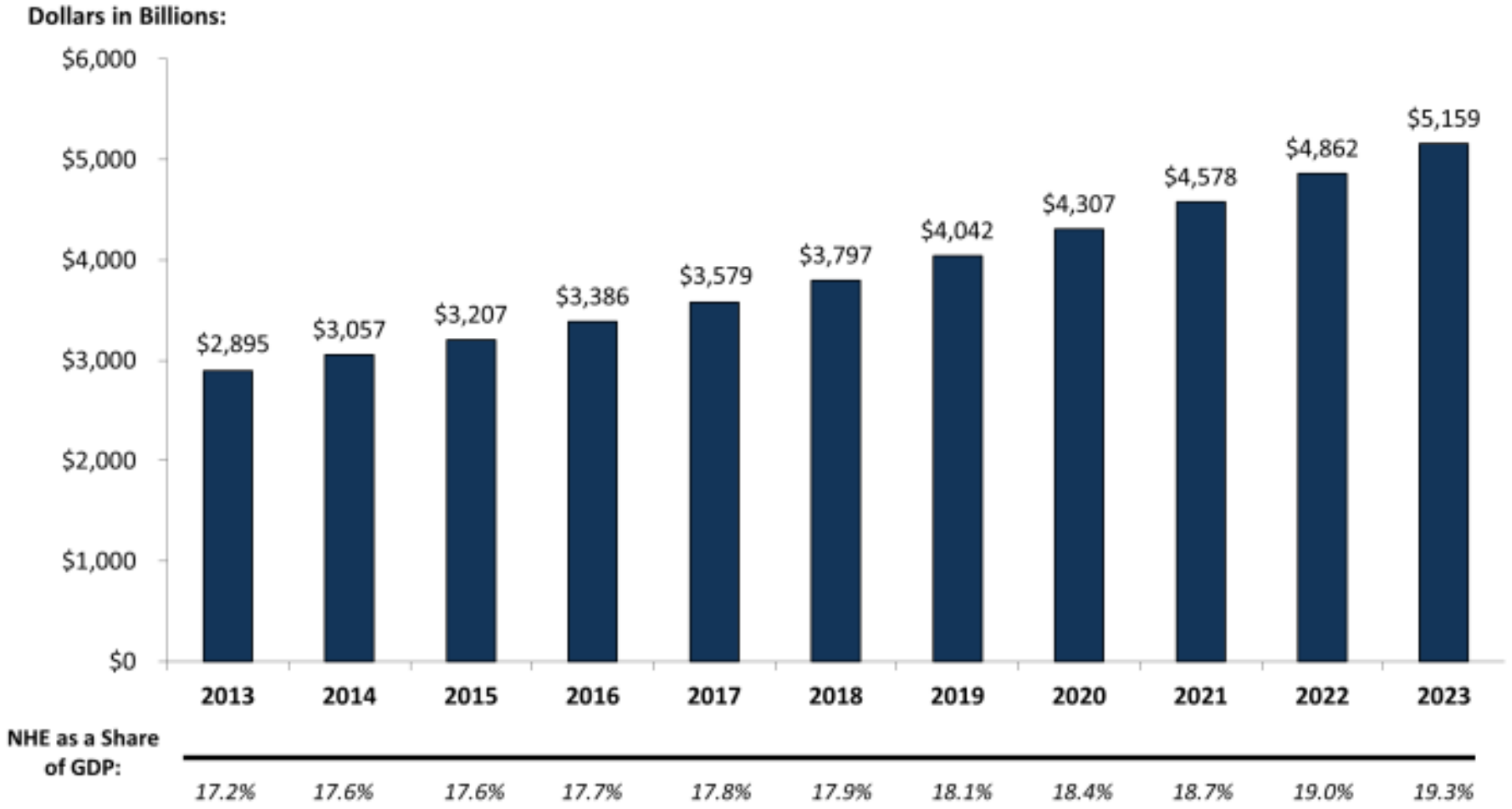
By the end of this talk you should be able to return to your departments and:

- Provide an overview of the factors driving the value-based care movement
- Discuss the essential elements of MACRA
- Develop a plan for participation in MACRA and related value-based payment models



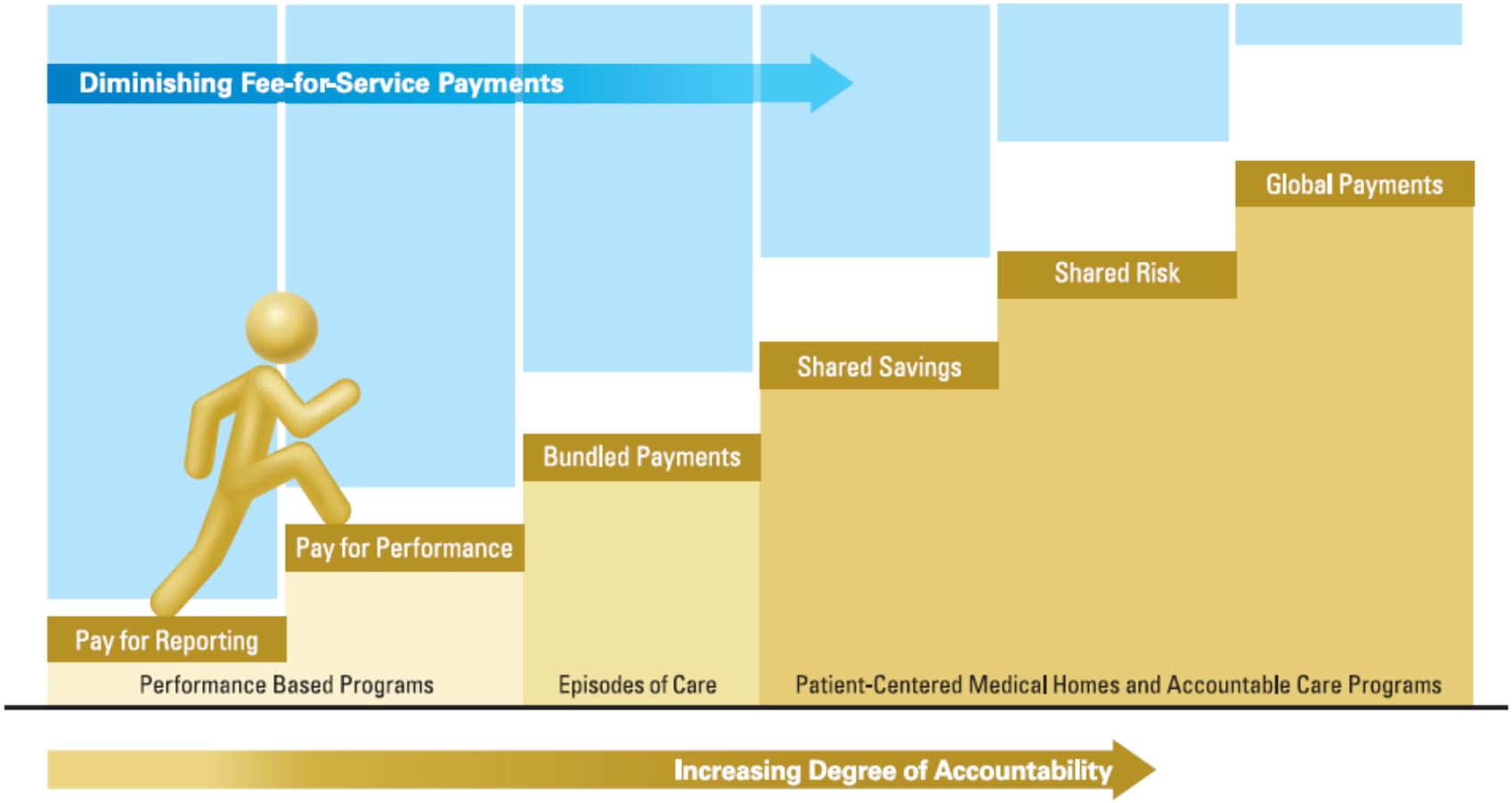
The Value-Based Care Movement: How Did We Get Here?

Background: Health Care Costs



Projections of National Health Care Expenditures and Share of GDP, 2013-2023, source Kaiser Family Foundation

Background: Health Care Costs

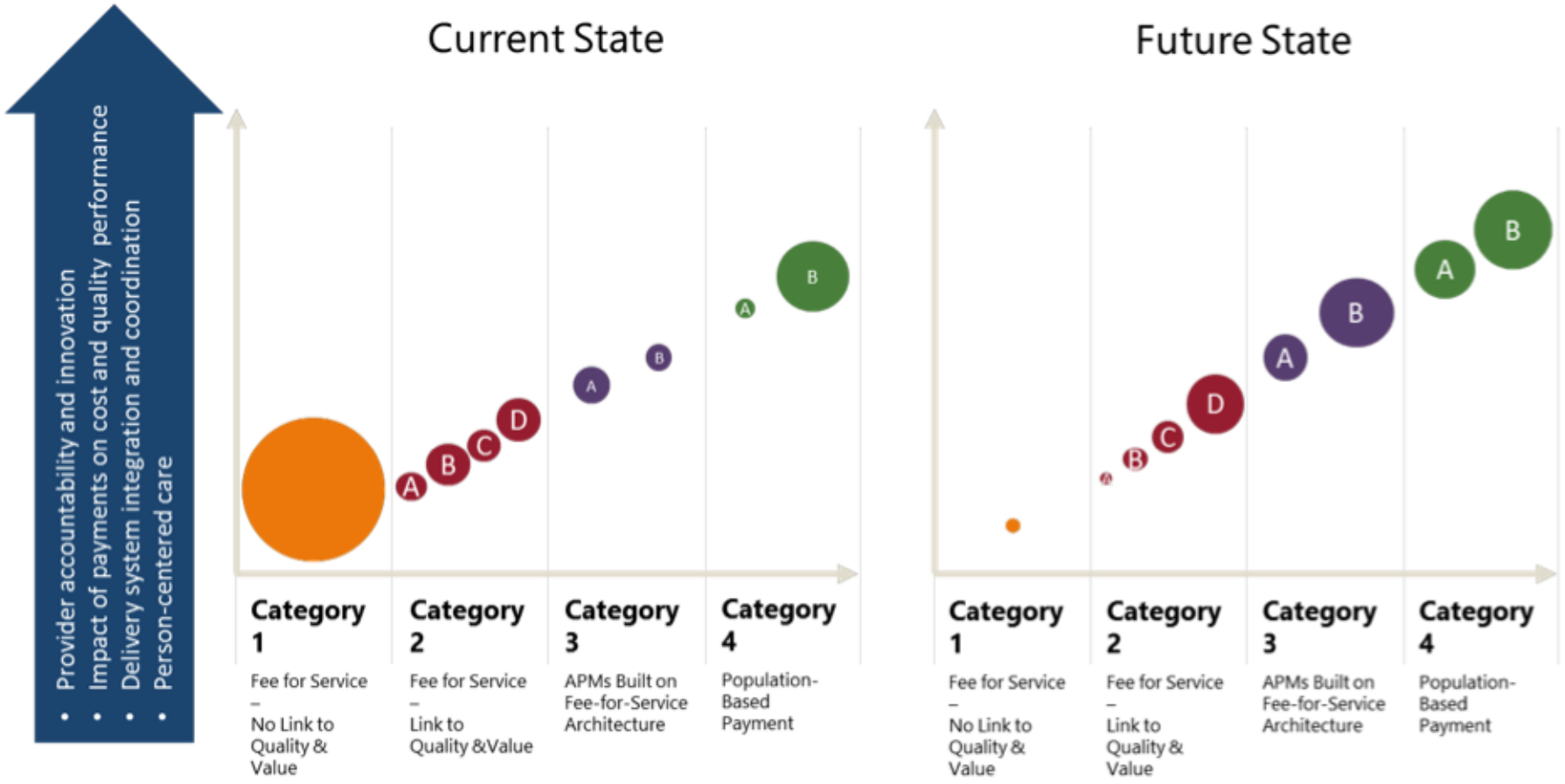


- Risk Transfer: Payer (insurer) → Provider
- Includes: Performance risk and actuarial risk

Background: Health Care Costs

Alternative Payment Model Framework Final White Paper. CMS Health Care Payment Learning and Action Network, January 2016

Background: Health Care Costs



Alternative Payment Model Framework Final White Paper. CMS Health Care Payment Learning and Action Network, January 2016

Background: What is MACRA?

- The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)
- Passed with wide bipartisan and bicameral support
  - House vote: 392-37
  - Senate vote: 92-8
- Signed into law April 2015
- First final rule released October 2016 governing 2017 implementation
- Final rule for 2018 coming soon

Background: What is MACRA?

- Permanent repeal of the SGR
- MACRA implements a completely new payment structure

Volume → Value = $\frac{\text{Quality + Safety + Service}}{\text{Total Cost Over Time}}$

- Rulemaking has been critical to implementation

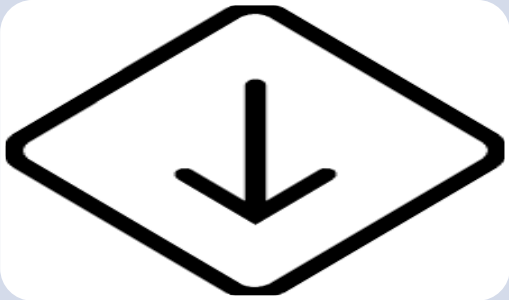
Background: MACRA → QPP

Merit-Based Incentive Payment System (MIPS)

- Default pathway
- Essentially a heavily modified form of fee-for-service

MACRA: MIPS Exclusions

First year of Medicare Part B Participation



Below low volume threshold:

<$30,000 Medicare allowable charges,

OR

Fewer than 100 Medicare patients

Qualifying participant in an approved Advanced Alternative Payment Model (APM)

MACRA: MIPS Exclusions

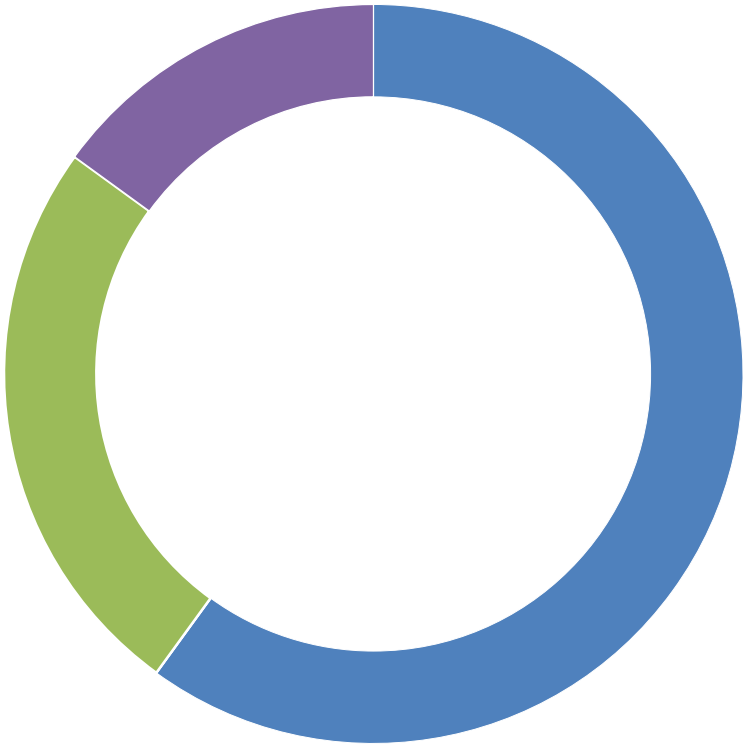
MIPS exclusion impact on neurology:

- CMS estimates that of 17,378 eligible neurologists, a total of 24.9% will be exempt from the MIPS program in 2019 (based on 2017 performance). Here is a breakdown of estimated neurology exclusions:
  - Excluded due to low volume threshold: 18.5% (3,215)
  - Excluded due to being a qualified APM participant (QP): 1.6% (275)
  - Excluded due to being newly enrolled in Medicare: 4.8% (842)

MACRA: MIPS Categories

- Quality
- Cost
- Advancing Care Information (formerly known as Meaningful Use of Electronic Health Records)
- Improvement Activities

MACRA: MIPS Categories



- Quality (60%)
  - *Decreases to 30% in 2019
- Cost (0%)
  - *Increases to 30% in 2019
- Advancing Care Information (25%)
- Improvement Activities (15%)

MACRA: MIPS Categories

- Quality (60% for 2017, will drop to 30% by 2019)
  - Will closely resemble PQRS
    - Requires reporting 6 quality measures
    - In 2017, reporting just 1 measure will help avoid penalty
  - Measures can be selected from multiple domains:
    - Clinical care
    - Safety
    - Care coordination
    - Patient and caregiver experience
    - Population health and prevention
    - Affordable care

MACRA: MIPS Categories

- Quality (60% for 2017, will drop to 30% by 2019)
  - Certain measure types have been given priority for inclusion:
    - Outcomes
    - Patient experience (such as patient reported outcomes or PROs)
    - Care coordination
    - Appropriate resource use

MACRA: MIPS Categories

- Cost (0% for 2017, up to 30% in 2019)
  - This will be similar to the Value-based Payment Modifier (VBPM)
  - No reporting is necessary
    - Resource use (cost) data are collected automatically by CMS from submitted claims
  - Most current methods of risk adjustment and patient attribution will be carried forward

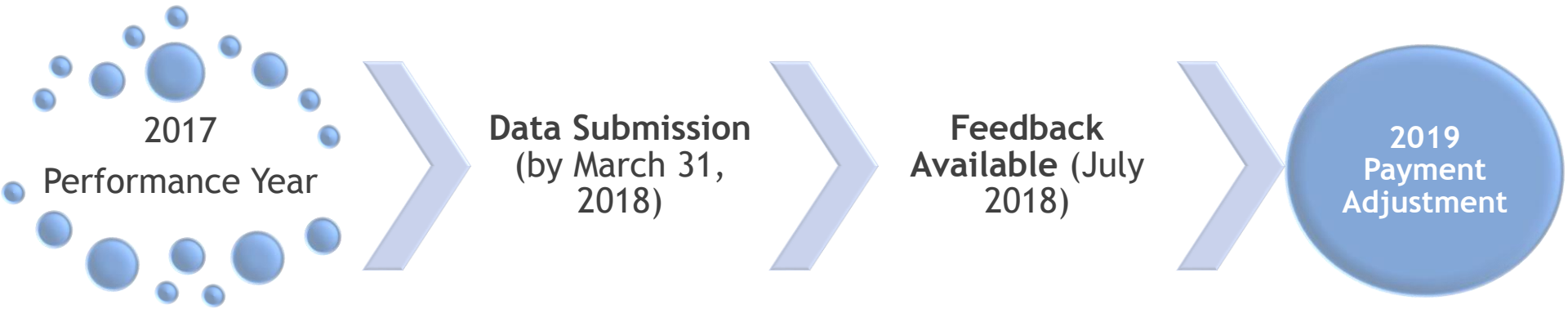
MACRA: MIPS Categories

- Advancing Care Information (ACI, formerly Meaningful Use or MU) (25%)
  - Will generally align with existing MU requirements
  - Inconsistencies between current programs (e.g., PQRS and MU) will be eliminated
  - Final rule calls for reporting a combination of Base and Performance ACI measures
  - Approved measures (in the Quality category) will automatically satisfy the MU quality measure reporting requirements

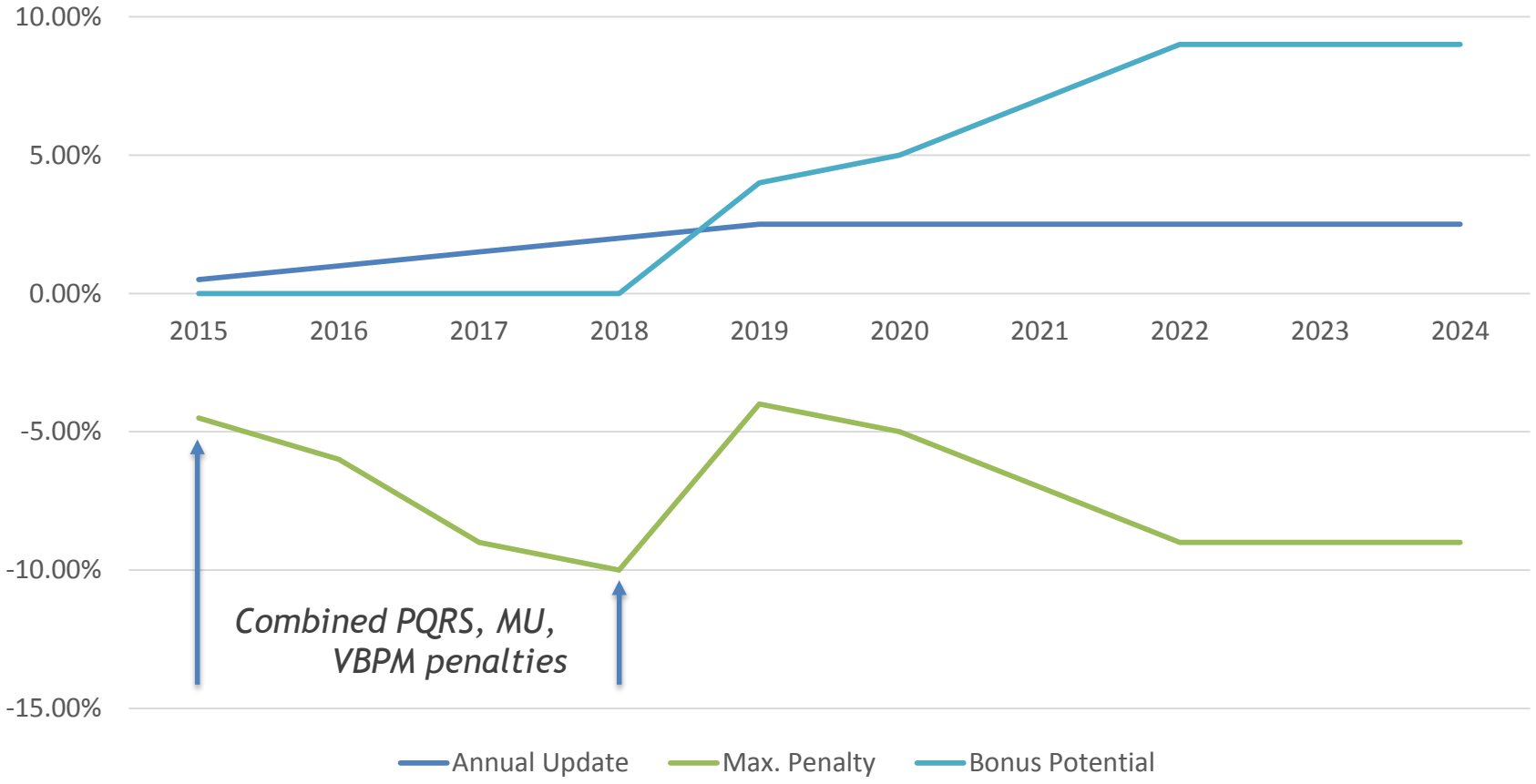
MACRA: MIPS Categories

- Improvement Activities (15%)
  - This is new for CMS, but will feel similar to practice improvement activities in other parts of our practice
  - QCDR (such as the Axon Registry) participation will positively impact score
  - The final rule for 2017 calls for participants to report:
    - 2 “high-weighted” activities, or
    - 4 “medium-weighted” activities

MACRA: MIPS Timeline



MACRA: MIPS Risk Corridor



MACRA: MIPS Reporting

Quality	• Claims • QCDR or Qualified Registry • EHR • Administration claims for population health (no submission required) • Groups only (25+): CMS web interface; CMS approved survey vendor for CAHPS and MIPS
Cost	• Administrative claims (no separate submission required))
Advancing Care Information (MU)	• Attestation • QCDR or Qualified Registry • EHR • Groups only (25+): CMS web interface
Improvement Activities	• Attestation • QCDR or Qualified Registry • EHR • Groups only (25+): CMS web interface; administrative claims (no separate submission required)

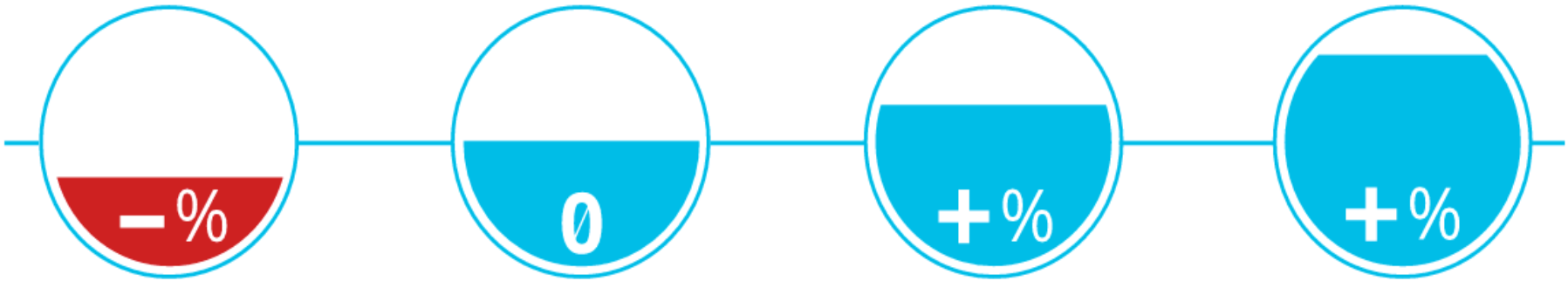
MACRA: MIPS Implementation

- In its final rule, CMS identified 2017 as a "transition year," with several reporting options and outcomes:
  - Full-year reporting begins on January 1, 2017
  - Partial year reporting for a reduced number of days
  - A "test" option under which physicians can report minimal amounts of data
- Softer implementation will likely continue, though unclear to what extent

MACRA: MIPS Implementation

Pick Your Pace in MIPS

If you choose the MIPS path of the Quality Payment Program, you have three options.



Not participating in the Quality Payment Program:

If you don't send in any 2017 data, then you receive a negative 4% payment adjustment.

Test:

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

Partial:

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

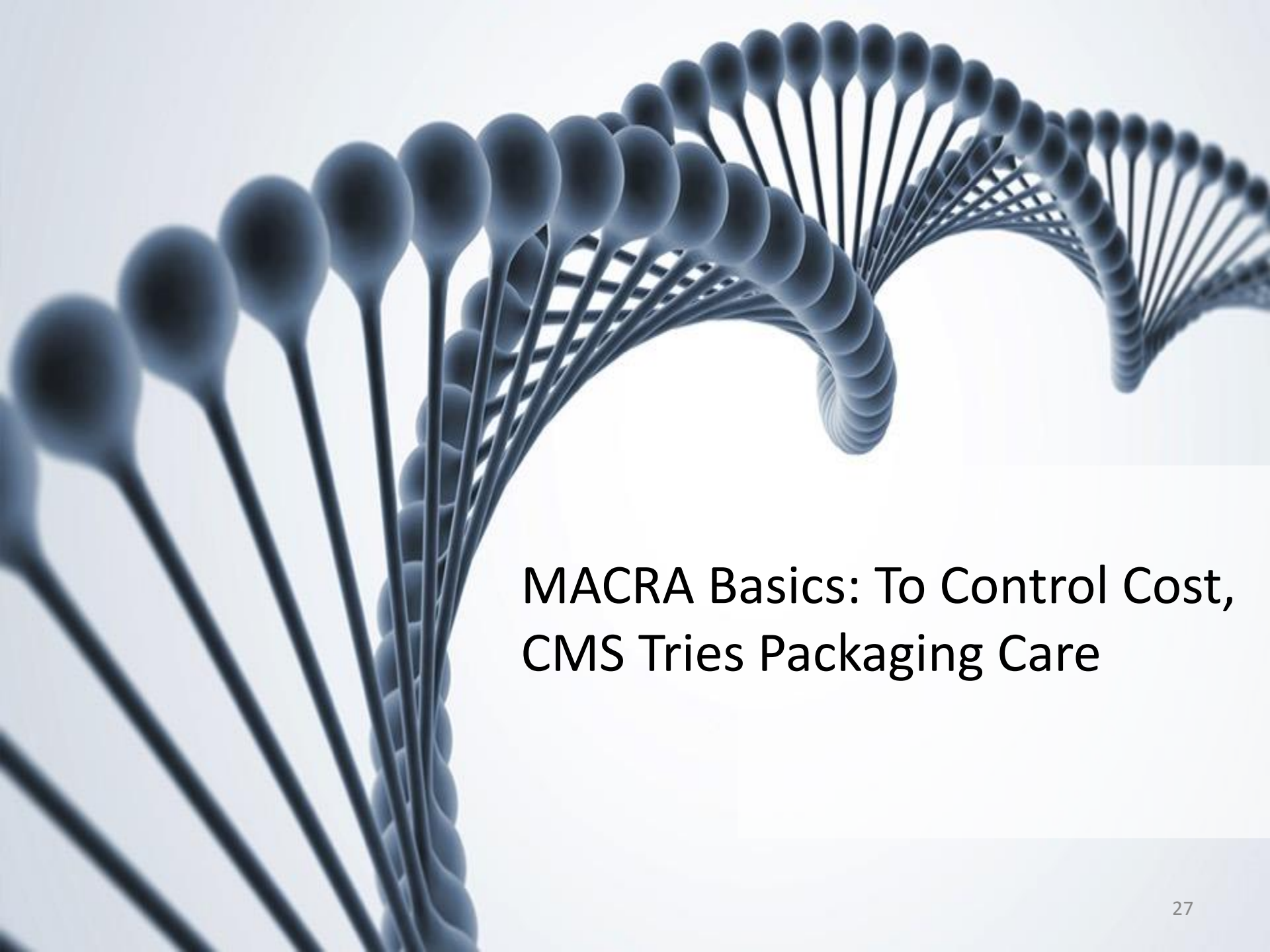
Full:

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

Top

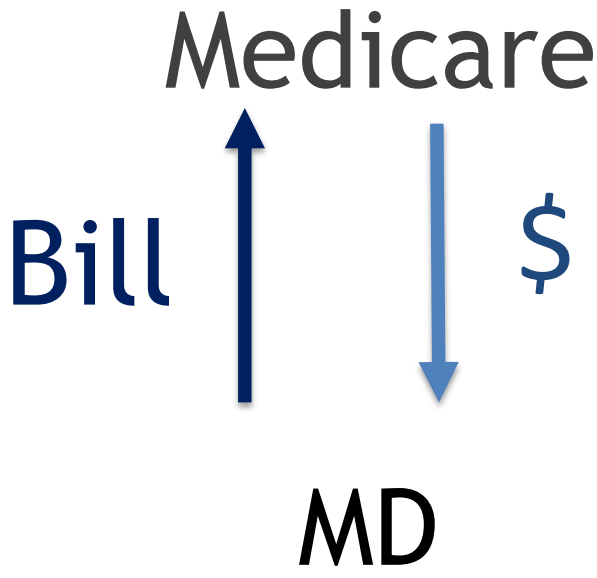
MACRA: AAPM Pathway

Advanced Alternative Payment Models (AAPMs)

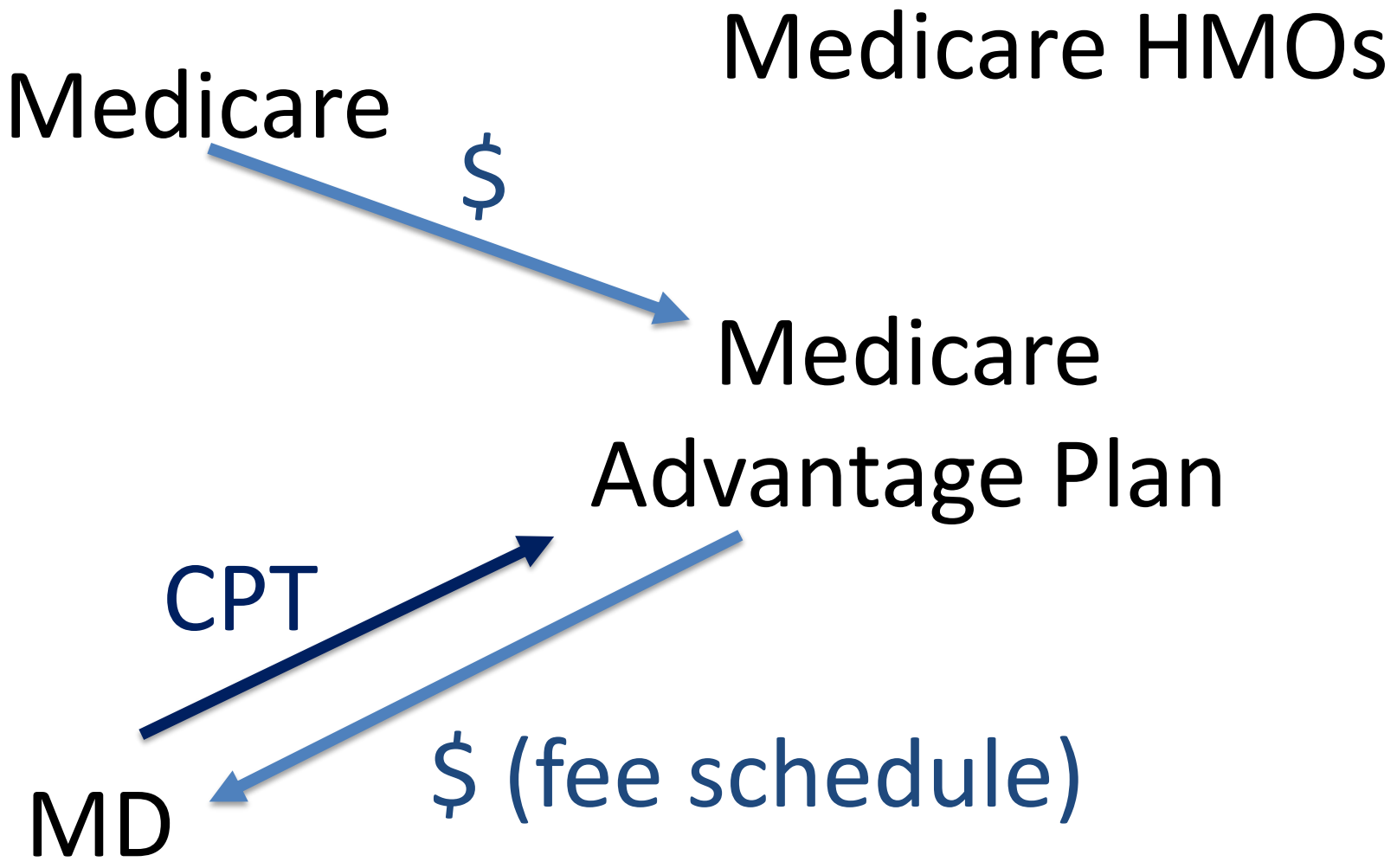


MACRA Basics: To Control Cost, CMS Tries Packaging Care

1960's Medicare design



- Medicare paid physician "usual, customary, reasonable"
- Patients paid the balance


Medicare HMOs
Medicare
$
Medicare
Advantage Plan
CPT
$ (fee schedule)
MD

HMO Acuity Adjustment

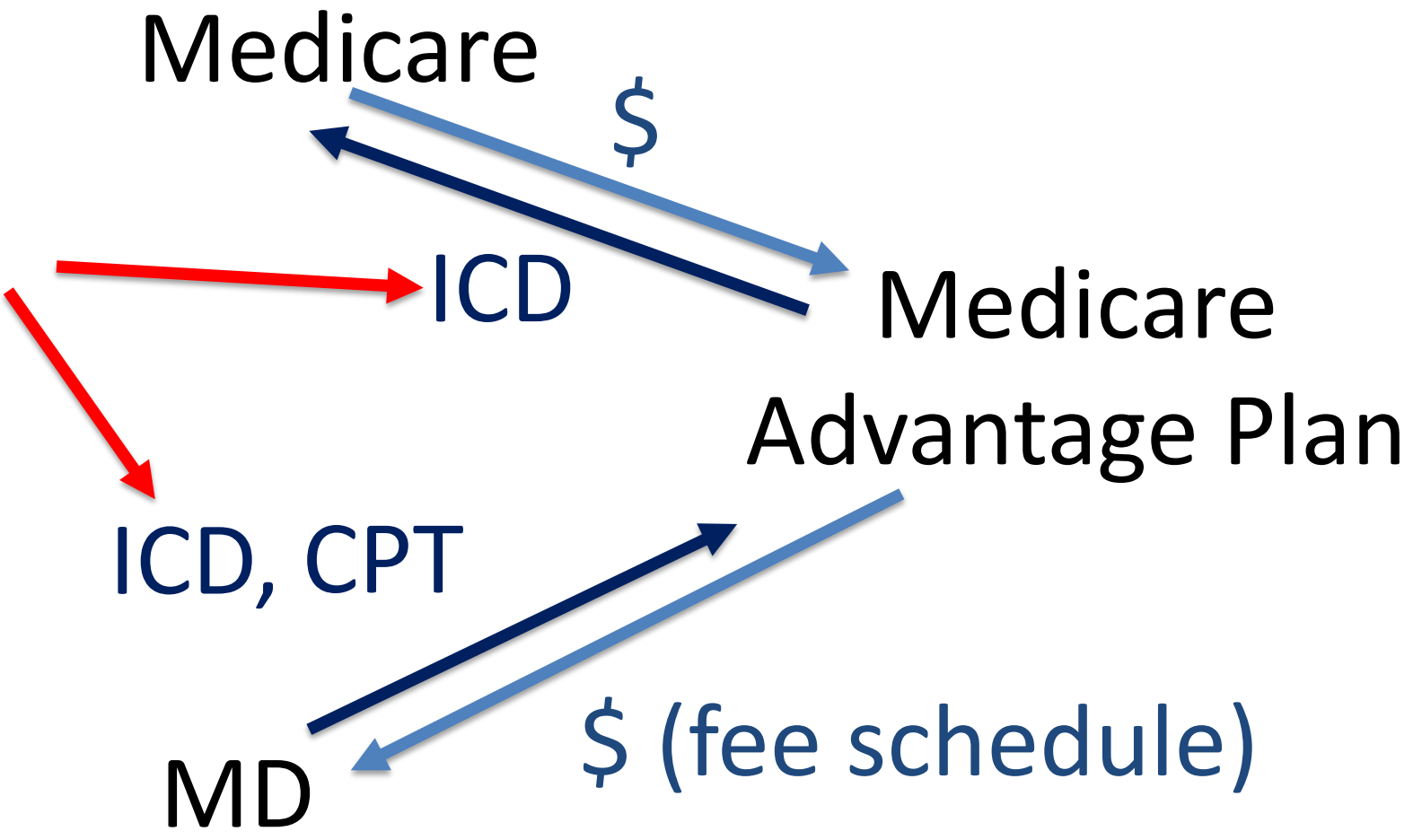
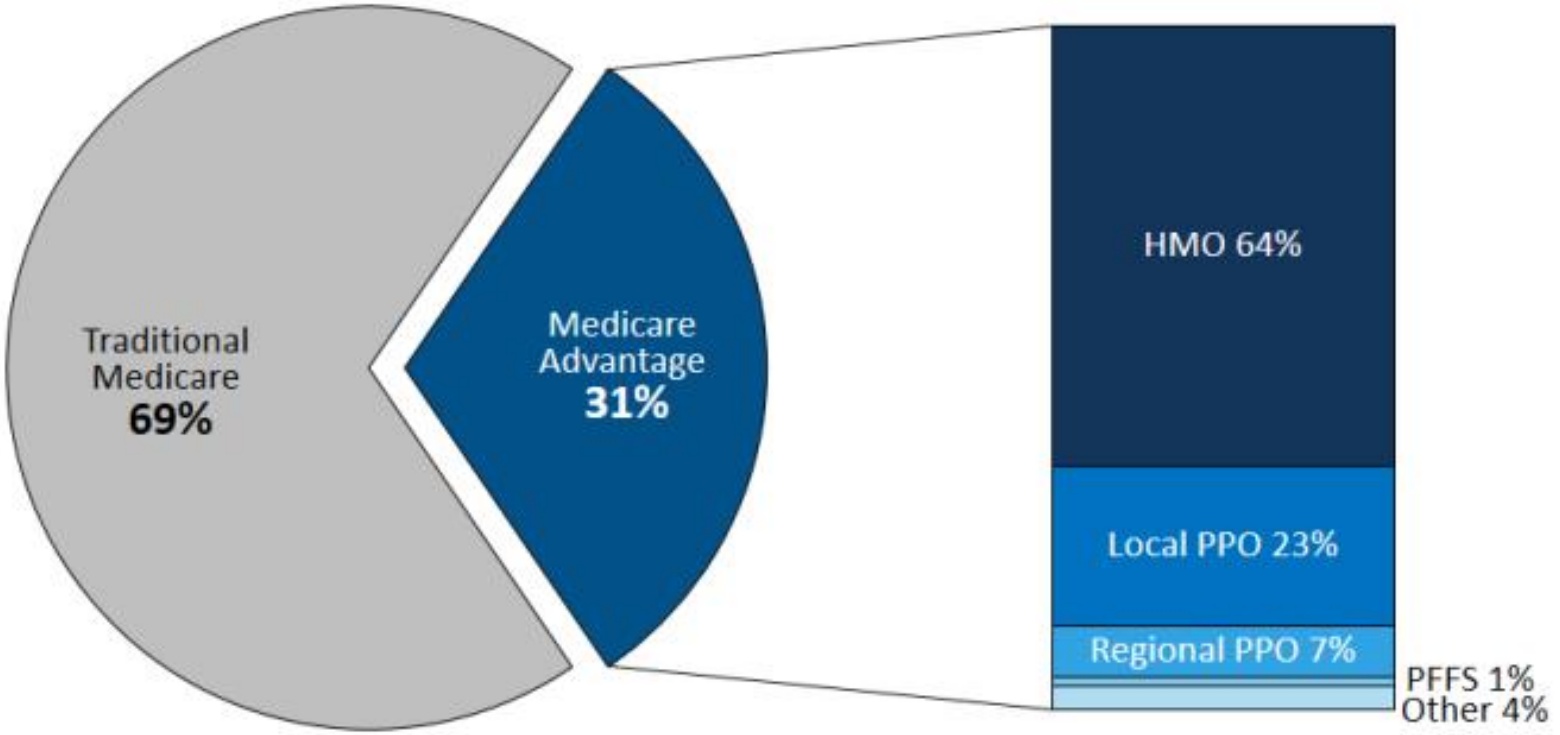


Figure 3

Distribution of Enrollment in Medicare Private Plans, by Plan Type, 2016



Total Medicare Advantage Enrollment, 2016 = 17.6 Million

NOTE: PFFS is Private Fee-for-Service plans, PPOs are preferred provider organizations, and HMOs are Health Maintenance Organizations. Other includes MSAs, cost plans, and demonstration plans. Includes enrollees in Special Needs Plans as well as other Medicare Advantage plans. Excludes beneficiaries with unknown county addresses and in territories other than Puerto Rico.
SOURCE: Authors' analysis of the Centers for Medicare and Medicaid Services (CMS) Medicare Advantage enrollment files, 2016.

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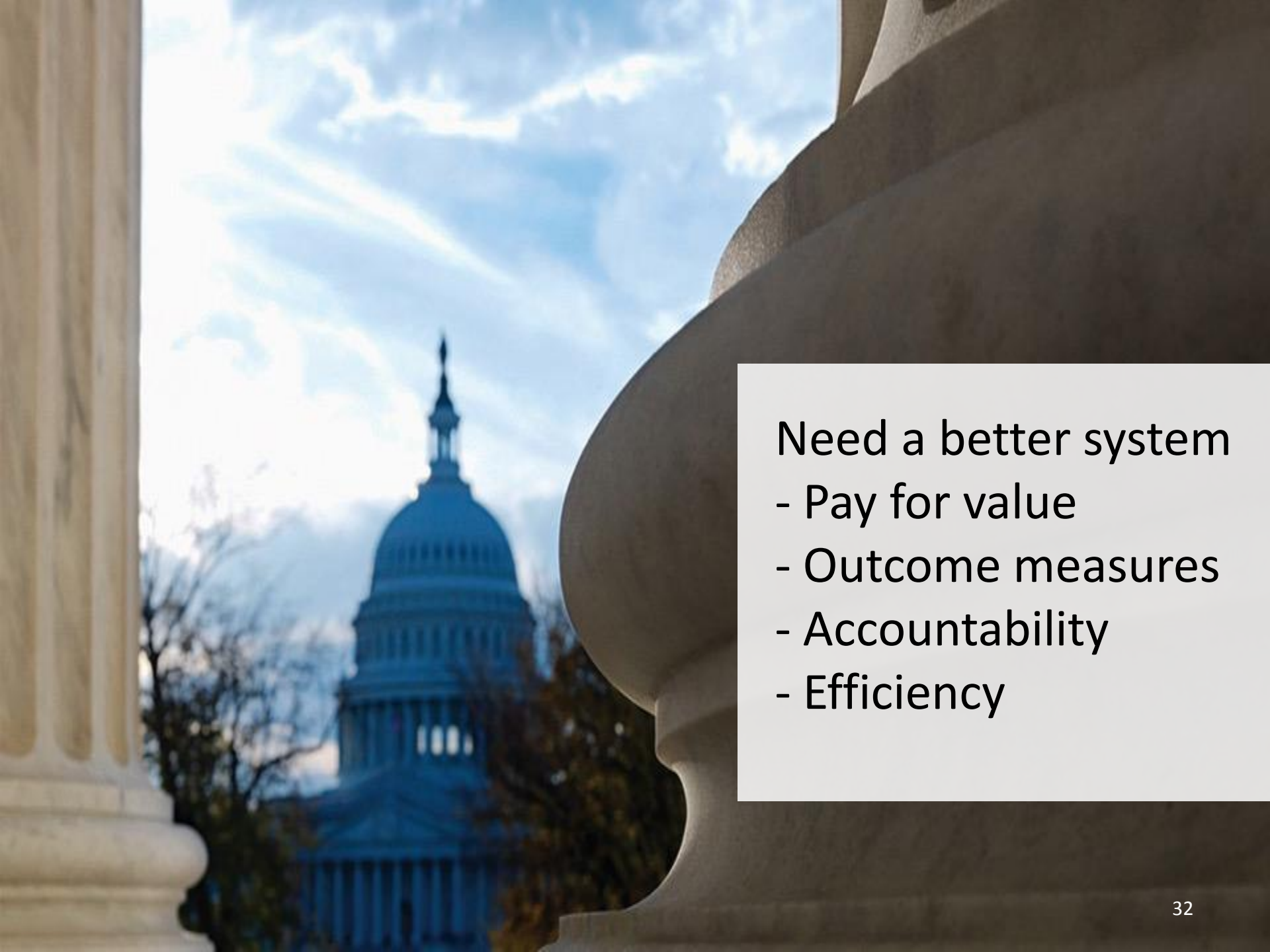
Figure 3: Distribution of Enrollment in Medicare Private Plans, by Plan Type, 2016



Need a better system
- Pay for value
- Outcome measures
- Accountability
- Efficiency

MACRA's Quality Payment Programs (QPP): Advanced Alternative Payment Model (APM)

Alternative Payment Model Options

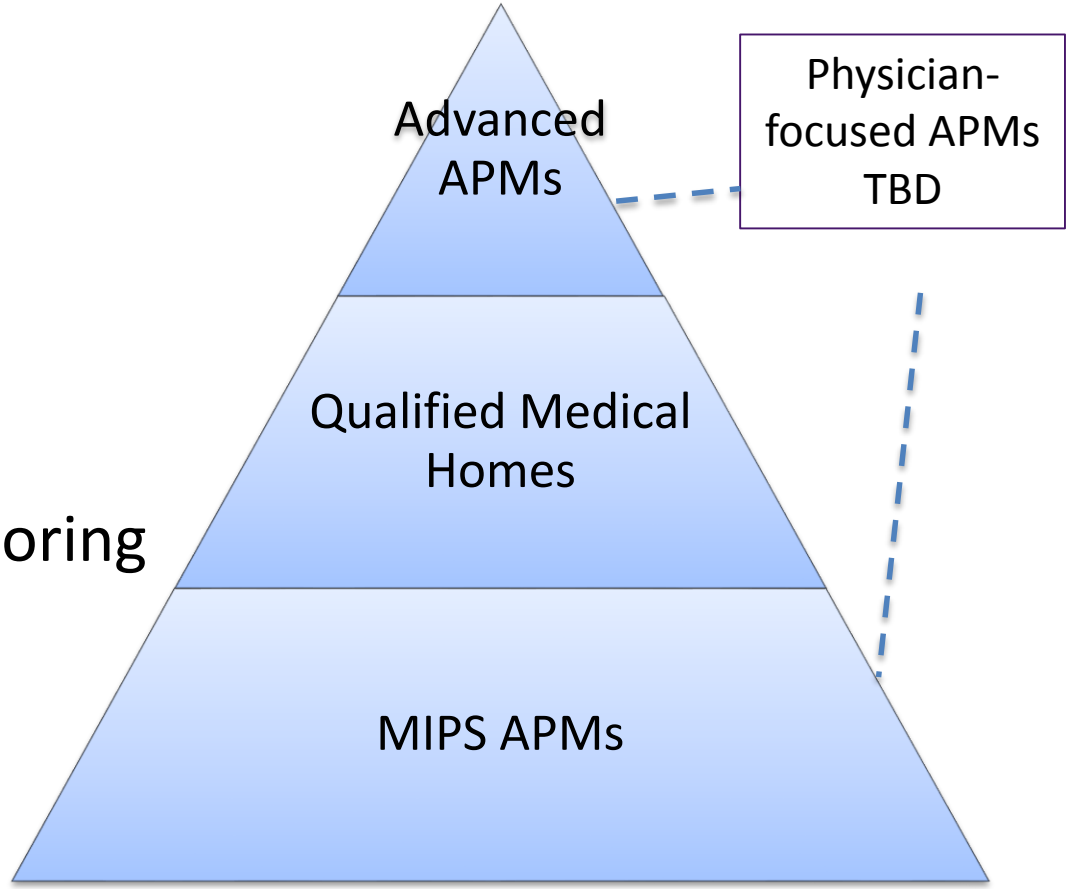
- **Advanced APMs**

  greater risks and rewards
- **Qualified Medical Homes**

  different risk structure
- **MIPS APMs**

  receive favorable MIPS scoring
- **Physician-focused APMs**

  under development

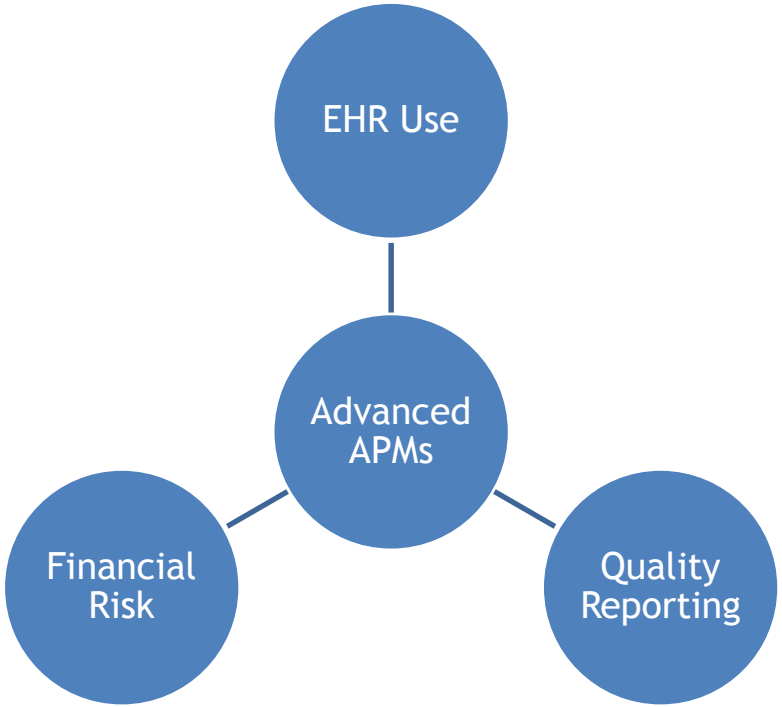


Advanced Alternative Payment Model

APMs pay to incentivize quality and value in health care.

Elements of an **Advanced** APM:

- **EHR,** certified
- **Quality** measures like MIPS
- **Risk** for annual financial loss



Advanced APM Participants:

- No MIPS bonuses or penalties
- Annual 5% bonus
- Higher fee schedule payments
- Must meet a participation threshold percentage

Types of Advanced APMs:

Comprehensive ESRD Care Model

(13 ESCOs)

Comprehensive Primary Care Plus

(14 states/regions)

Medicare Shared Savings Track 2

(6 ACOs, 1% of total)

Medicare Shared Savings Track 3

(16 ACOs, 4% of total)

Next Generation ACO Model

(currently 18)

Oncology Care Model Track 2

(A portion of 196 practices will qualify)

ACO Track 1+

Voluntary bundled payment models

Comprehensive Care for Joint Replacement Payment Model (CEHRT Track)

Advancing care coordination through episode payment models Track 1 (CEHRT)

Vermont Medicare ACO Initiative (all payer ACO model)

APM Requirements & Payments

	Qualified Advanced APM	Partially Qualified Advanced APM	MIPS APM participant
Patient and revenue thresholds required	≥25% revenues or ≥20% patients in 2019, rising to 75% or 50%	≥20% revenues or ≥10% patients in 2019, rising to 50% and 35%	None
Eligible for APM bonus, higher updates	Yes	No	No
Must participate in MIPS	No	Optional	Yes
MIPS scoring and adjustments	N/A	Favorable scoring	Favorable scoring

Advanced APMs: Issues to Address

- Too few qualified Advanced and other APMs
  - Particularly for specialists
- Timeline for developing new models is long
  - Transition bonus payments expires after 2024
- Risk requirements are unrealistic
- Risk requirements are complicated

Quality Measures

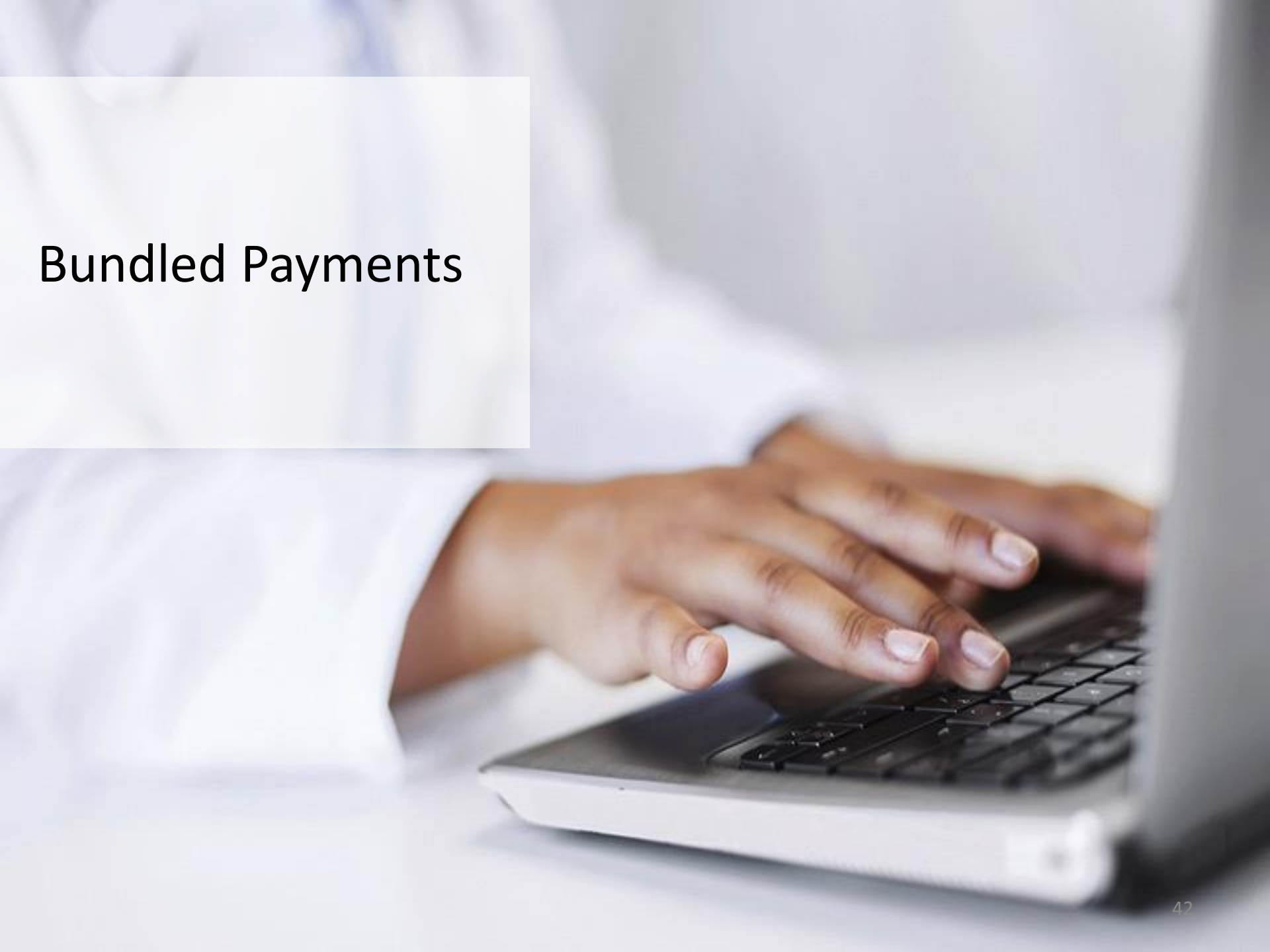
Quality Measurements

- Many are available in Neurology
- Many are available for general health care
- Numbers required annually have varied
- Measures depend on literature support

Quality Measure examples:

- ALS Patient Care Preferences
- Evaluate Risk of Opioid Misuse
- Headache Disorders Quality of Life Assessment
- Parkinson's Treatment Options Review
- Counseling for Childbearing Potential for Epilepsy
- Dementia: Cognitive Assessment
- Tobacco Use Screening & Cessation Intervention

Bundled Payments



One Way to APM: Bundled Payments

Concept

- Defined episode of care

Example:

- Joint replacement surgery

Questions/Issues

- Who receives the payment?
- Who decides how to distribute the funds?
- Who realizes the savings?

Bundled Payments for Episodes of Care

- Goal is to cover 50% of Medicare costs.
- Already in use:
  - 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 benign prostatic hyperplasia; Hip replacement or repair;
  - Knee arthroplasty.

Bundled Payment in Neurology?

- Acute conditions or episodes
  - Stroke?
  - Traumatic injury?
- Chronic conditions
  - MS?
  - ALS?
  - Epilepsy?
- Episode durations might be 3 months or longer

Headache Bundles: An Example

- **Category 1:** Initial Diagnosis and Treatment for Headache, Undiagnosed, Difficult to Diagnose or Poorly Controlled.
  - **One-time payment**
  - 3-month period
- **Category 2:** Continued Care Difficult-to-Manage Headaches
  - **Monthly bundled payment**
  - One month
- **Category 3:** Continued Care for Well-Controlled Headaches
  - **Add-on service**
  - Indefinitely, as-needed

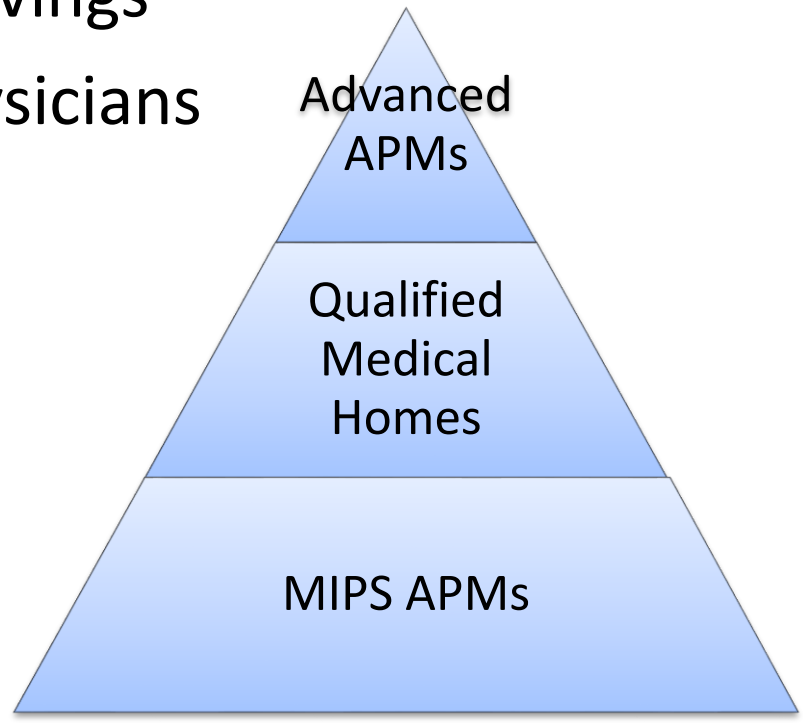
Medicare Shared Savings Program (MSSP) as an Advanced APM

Medicare Shared Savings Program: MSSP Track 1+

Track 1 = no risk = Not an Advanced APM

Track 1+ = Least risk of the MSSP Advanced APMs

- 5% bonus plus any MSSP savings
- Primary Care only vs All Physicians
- Hospital, SNFs included



Magnitude of Shared Losses

	Track 1	Track 1+	Track 2	Track 3	Next Gen
Loss Sharing Rate	N/A	30%	40-60%	40-75%	80-85% Option = 100%
Loss Sharing Limit (% of benchmark)	N/A	4%	Year 1 = 5.0% Year 2 = 7.5% Year 3 = 10.0%	15%	15%
Buffer: Minimum Loss Rate (No shared losses until buffer met)	N/A	Choice between 0-2.0%	Choice between 0-2.0%	Choice between 0-2.0%	None. First dollar over benchmark

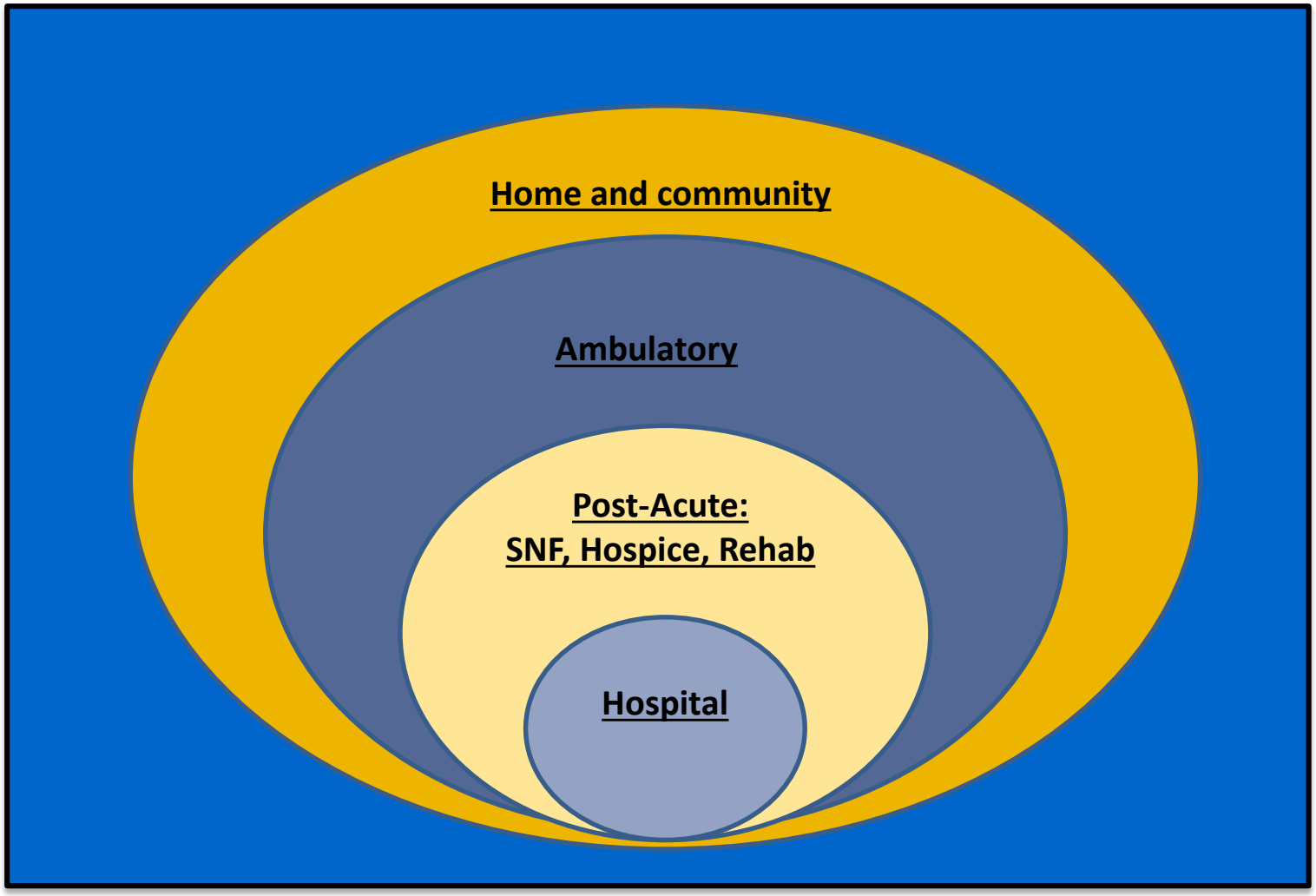
MSSP Track 1+

Track Metrics, Take Action on items such as:

- Ambulatory Care Sensitive (ASC) Discharges
  - admissions that should have been avoided
- Advanced Imaging (CT and MRI)
- Hospital Discharges
- 30-Day Readmissions
- ED visits

Population Health

Contractual accountability and risk managing of patient health: quality, cost and patient experience

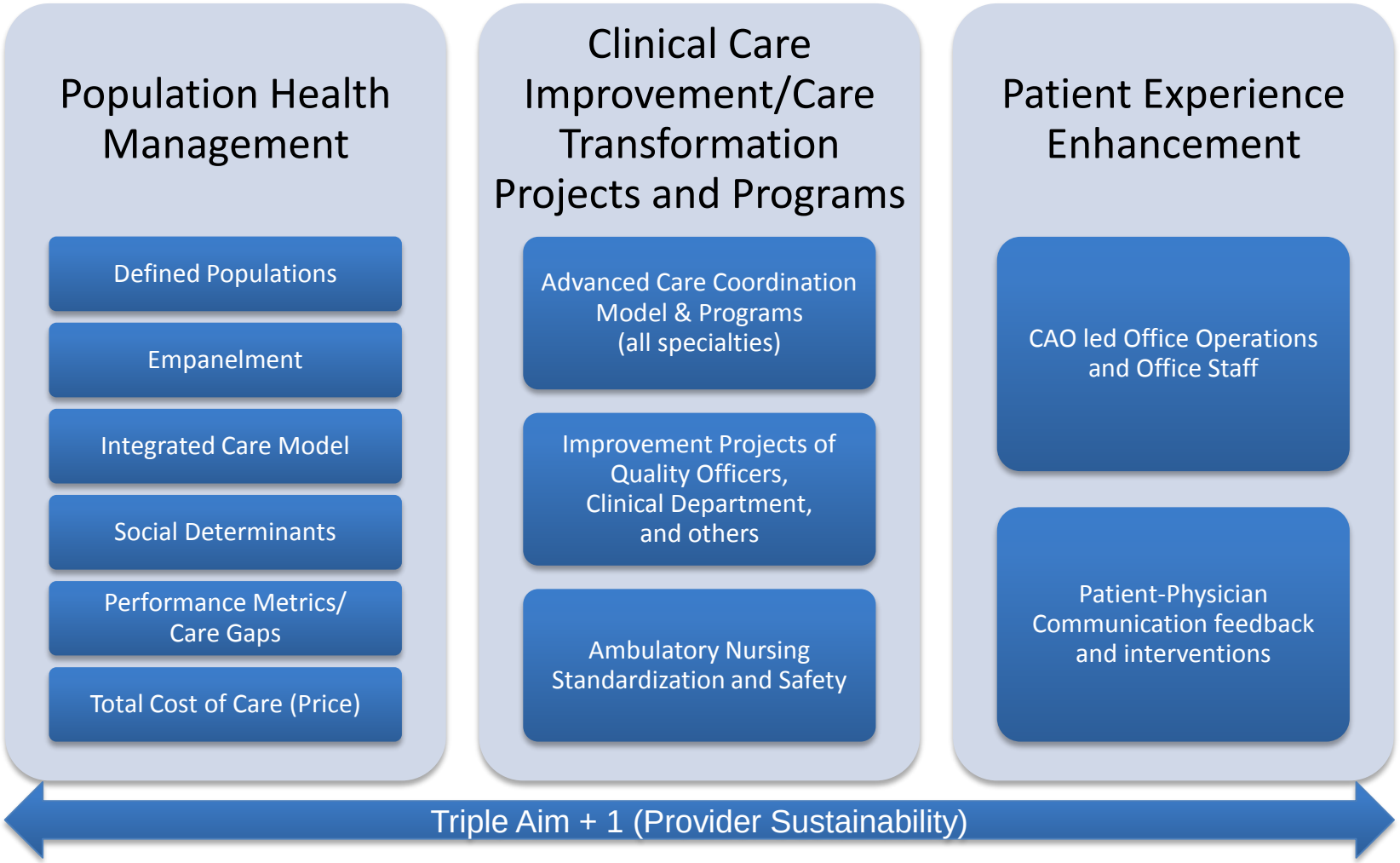


What Physicians Can Do to Prepare

Population Health

- Innovative care models
- Coordinate Care across all settings
  - home, SNF, clinic, and hospitals
- Aggregate and manage risk in large populations
- Opportunity to expand service lines
- Task Forces: identify gaps, phone and electronic communications, determine timeframes, sort priorities, straighten workflows, automate processes, work at top of license

Collaborative Efforts across the Health System

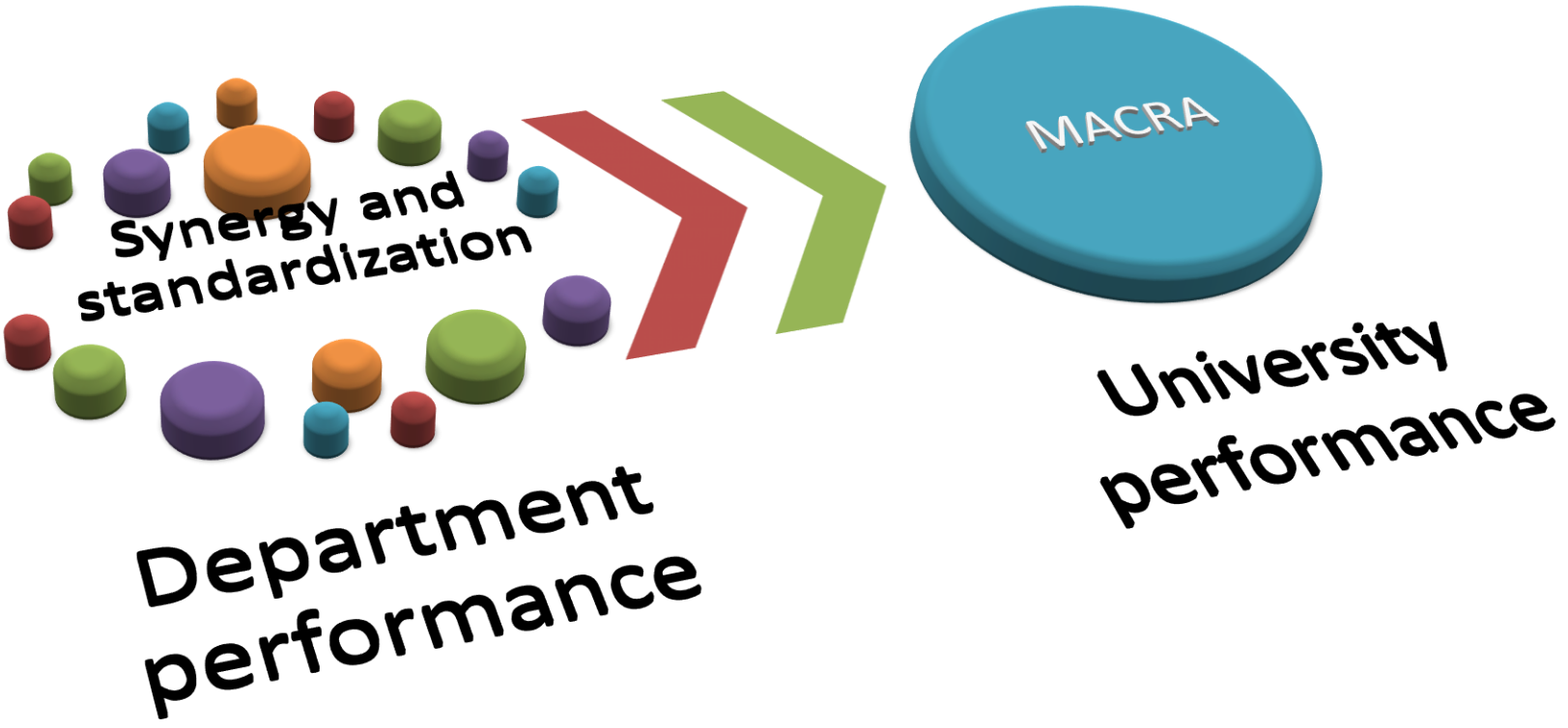


Population Health Care Coordination

Task Forces reach across all domains

- Ambulatory clinics
- Inpatient advisory
- SNF
- Quality
- Education
- Research
- Revenue
- IT
- Strategic

Central leadership guides cohesive and coordinated performance



Centralization vs. Academic Mission

To realize savings, APMs:

- depend on standardization and centralization
  - not typical of academic institutions.
- control patient access and referrals
- need large primary care programs

Universities traditionally:

- depend on flexibility and individuality
- dominated by specialists who order expensive tests, hospital charges

Transition will complicate the academic triple mission of patient care, education, and research.

Working Together

- APMs are resource intensive
- Systems need organization, cost management, align clinical performance, coordinate patient care.
- Difficult for physicians to remain independent.
- Heightened pressure for faculty to work effectively with community practitioners.

Achieving Success Together in Population Health

Health system physicians and administration work together:

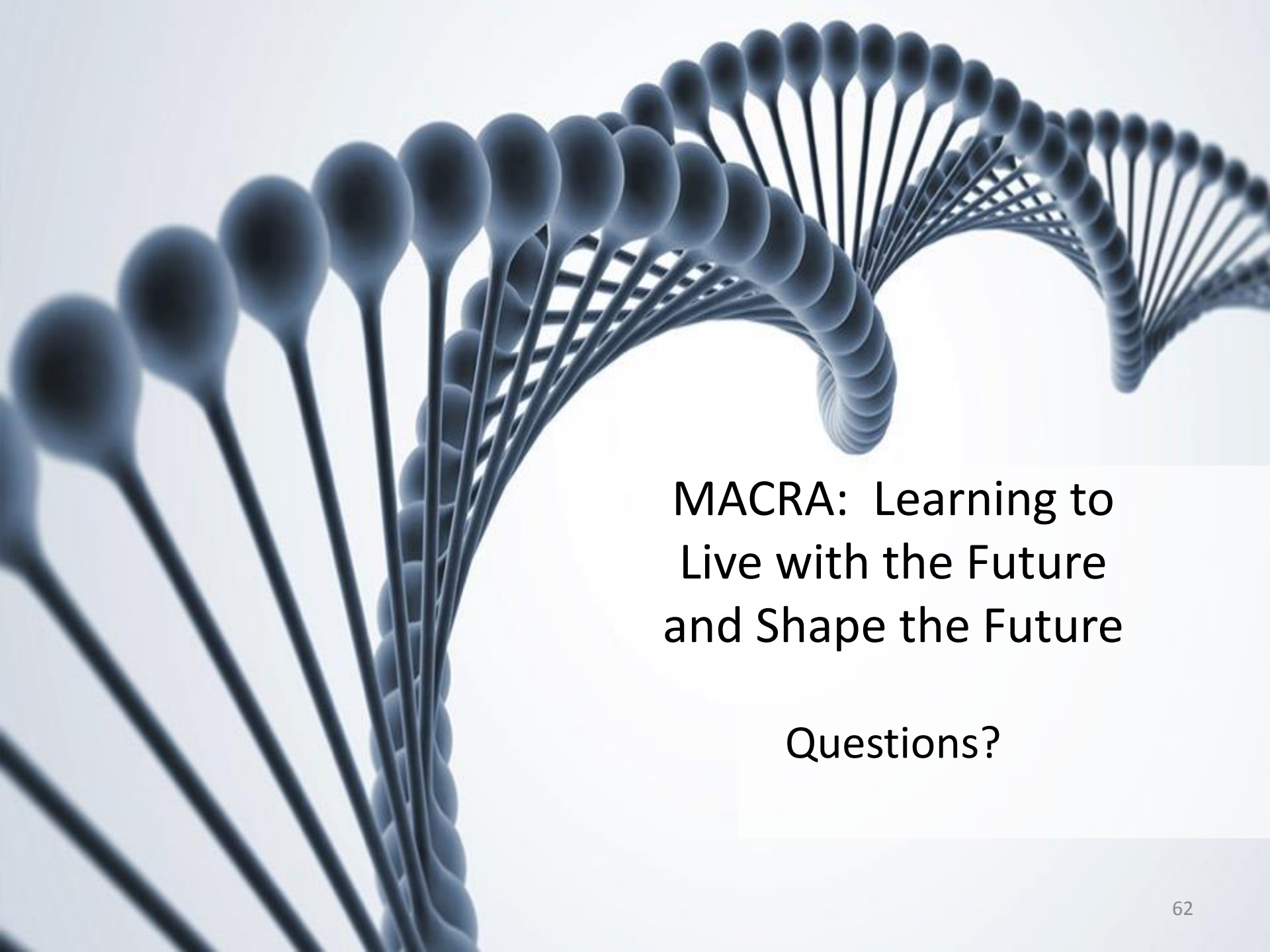
- Develop dashboards, task forces, and specific action items
- Ensure evolution of care redesign within all specialties
- Enhance performance on quality metrics
- Close "care gaps"
- Optimize resource use
  - Admissions/readmissions/ED
  - Laboratory and imaging
  - High-cost drugs
- Enhance diagnostic coding
- Maintain and enhance patient experience
- Optimize EHR
- Identify high-risk patients, use team-based care coordination

Focus Areas

Clinical Priorities	Analytic Infrastructure	Quality Thresholds
Admissions/Readmissions	Risk Stratification	Care Gaps
Bed Days	Report Optimization & Dashboards	
High Cost Condition Management	Software Tools	
High Cost Pharmaceuticals	Clinical Data Integration	
Site of Care (e.g. ASC)		
Patient Engagement		
ED appropriate use		

Work in your Department with APMs

- Appoint Department physician, manager champions
  - Department-specific clinical, analytic, quality goals
  - Find care gaps
  - Support workflow and process changes
- Work with system population health teams on analytics, care transformation and care management.
- Optimize EHR platform to support population health management.
- Participate in Bundle development
- Champions may play roles in developing the future



MACRA: Learning to Live with the Future and Shape the Future

Questions?