THE ALPHABET SOUP OF MEDICAL PAYMENTS: WHAT IS MACRA, VBP AND MORE!

Lisa Scheppers MD FACP
Margo Ferguson MT MSOM
THE REASON FOR CHANGE

“What if we don’t change at all ... and something magical just happens?”
VOLUME TO VALUE

Fee-for-service | PAYMENT | Bundled, Shared
--- | --- | ---
Patient | FOCUS | Population
Treat | INCENTIVE | Prevent
Affordable Care Act (ACA) March 2010

- The law had 3 goals
  - Make affordable health insurance available to more people
  - Expand the Medicaid program
  - Support innovative medical care delivery methods

- The U.S. Department of Health and Human Services (HHS) announced 3/3/16 that it had reached its goal of tying 30% of Medicare payments to alternative payment models (APM).*
  - By the end of 2018, HHS predicts about 50% Medicare payments will be going to APMs.
  - New physician payment methodology in 2019
  - Private payers moving in the same direction at a similar pace

*Medical Economics, May 10, 2016
HHS Outlines Value-Based Payment Goals
— By 2016, 85% of payments will be based on value, not volume.

CMS Sets Goals and Timeline for Shifting Reimbursements from Volume to Value

HHS announces historic changes to Medicare

Feds step up changes to hospital payments
Title I – Quality, Affordable Health Care for All Americans
Title II – Role of Public Programs
Title III – Improving the Quality and Efficiency of Health Care
  ▪ Linking payment to Quality Outcomes Under the Medicare Program
  ▪ National Strategy to Improve Health Care Quality
  ▪ Encouraging Development of New Patient Care Models
Title IV: Prevention of Chronic Disease and Improving Public Health
  ▪ Modernizing Disease Prevention
  ▪ Increasing Access to Clinical Preventive Services
  ▪ Creating Healthier Communities
Title V Health Care Workforce
  ▪ Increasing the Supply of the Health Care Workforce
Title VI – Transparency and Program Integrity
Title VII – Improving Access to Innovative Medical Therapies
Title VIII – Class Act
Title IX – Revenue Provisions
Title X – Strengthening Quality, Affordable Health Care for All Americans
MEASURING QUALITY METRICS

- From one patient to the population view
- Data to Analytics
- Outcomes measurements
  - Length of Stay
  - Morbidity and Mortality
  - Medication adherence
  - Infection rates
  - Readmission data
  - Cost
  - Patient satisfaction
MOVING TO PERFORMANCE BASED PAYMENTS

Value-based Payment (VBP) Models

- Fee-for-Service
- Performance-based Incentives
- Performance-Based Contracts (PBC)
- Bundled/Episode Payments
- Centers of Excellence
- Accountable Care Programs
- Shared Savings
- Shared Risk
- Capitation + PBC

Degree of Care Provider Integration and Accountability

Arizona Health Care Cost Containment System
FY 2018 Pay for Performance - Hospital

6% of DRG Payments at risk in FY 2018 Performance

Hospital Compare

IQR (Inpatient Quality Reporting)
25% reduction of market basket update for not reporting

Measures must be publicly reported for at least 1 year before proposing for VBP

VBW 2% of base DRG
- Reward for good performance/penalties for poor performance
- Credit for improvement
- Readmission measures cannot be in VBP; HAC measures eligible for VBP

Readmissions 3% of base DRG
- Penalties for excess readmissions
- No credit for improvement
- Up to 3% of base DRG at risk

HAC 1% of total payment
- Automatic penalty for one quarter of hospitals deemed as having “worst” performance
- No credit for improvement
- HAC measures are in VBP too

Readmission and HAC measures do not need to be publicly reported or included in IQR in advance, but they typically are

Measures must be publicly reported for at least 1 year before proposing for VBP
OUTCOME BASED PAYMENT-HOSPITAL

FY 2018 Hospital Value-Based Purchasing

**Safety (25% of Total Performance Score)**
- **Baseline period**: 7/2010-6/2012
- **Performance period**: 7/2014-6/2016

<table>
<thead>
<tr>
<th>Measure ID</th>
<th>Description</th>
<th>Threshold</th>
<th>Benchmark</th>
</tr>
</thead>
<tbody>
<tr>
<td>CAUTI</td>
<td>Catheter-Associated Urinary Tract Infection</td>
<td>0.906</td>
<td>0.000</td>
</tr>
<tr>
<td>CLABSI</td>
<td>Central Line-Associated Blood Stream Infection</td>
<td>0.399</td>
<td>0.000</td>
</tr>
<tr>
<td>C. difficile</td>
<td>Clostridium difficile Infection</td>
<td>0.734</td>
<td>0.002</td>
</tr>
<tr>
<td>MRSA</td>
<td>Methicillin-Resistant Staphylococcus aureus Bacteremia / MO LabID</td>
<td>0.787</td>
<td>0.000</td>
</tr>
<tr>
<td>SSI</td>
<td>Surgical Site Infection</td>
<td>0.824</td>
<td>0.000</td>
</tr>
<tr>
<td>PSI-90</td>
<td>Complications/patient safety for selected indicators (composite)</td>
<td>0.677321</td>
<td>0.397051</td>
</tr>
<tr>
<td>PC-01</td>
<td>Elective Delivery Prior to 39 Completed Weeks Gestation</td>
<td>0.020408</td>
<td>0.000</td>
</tr>
</tbody>
</table>

Infections are SRs. PSI-90 is a score and PC-01 is a rate. Lower is better for all measures.

**Patient Experience of Care (25% of Total Performance Score)**
- **Baseline period**: CY 2014
- **Performance period**: CY 2016

<table>
<thead>
<tr>
<th>Measure ID</th>
<th>Description</th>
<th>Floor (%)</th>
<th>Threshold (%)</th>
<th>Benchmark (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communication with Nurses</td>
<td>56.27</td>
<td>78.52</td>
<td>86.68</td>
<td></td>
</tr>
<tr>
<td>Communication with Doctors</td>
<td>57.39</td>
<td>80.44</td>
<td>88.51</td>
<td></td>
</tr>
<tr>
<td>Responsiveness of Hospital Staff</td>
<td>36.40</td>
<td>65.08</td>
<td>80.35</td>
<td></td>
</tr>
<tr>
<td>Pain Management</td>
<td>62.19</td>
<td>70.20</td>
<td>78.46</td>
<td></td>
</tr>
<tr>
<td>Communication about Medicines</td>
<td>43.43</td>
<td>63.27</td>
<td>73.66</td>
<td></td>
</tr>
<tr>
<td>Hospital Cleanliness and Quietness</td>
<td>40.05</td>
<td>65.00</td>
<td>79.00</td>
<td></td>
</tr>
<tr>
<td>Discharge Information</td>
<td>62.56</td>
<td>86.60</td>
<td>91.63</td>
<td></td>
</tr>
<tr>
<td>Care Transition</td>
<td>25.21</td>
<td>51.45</td>
<td>62.44</td>
<td></td>
</tr>
<tr>
<td>Overall Rating of Hospital</td>
<td>37.67</td>
<td>70.23</td>
<td>84.58</td>
<td></td>
</tr>
</tbody>
</table>

Higher is better for all scores.

**Clinical Care (25% of Total Performance Score)**
- **Baseline period**: 10/2009-6/2012
- **Performance period**: 10/2013-6/2016

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<tr>
<th>Measure ID</th>
<th>Description</th>
<th>Threshold (%)</th>
<th>Benchmark (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>MORT30-AMI</td>
<td>Acute Myocardial Infarction (AMI) 30-day mortality rate</td>
<td>86.1458</td>
<td>92.1569</td>
</tr>
<tr>
<td>MORT30-HF</td>
<td>Heart Failure (HF) 30-day mortality rate</td>
<td>88.1794</td>
<td>90.3986</td>
</tr>
<tr>
<td>MORT30-FN</td>
<td>Pneumonia (PN) 30-day mortality rate</td>
<td>88.2986</td>
<td>90.8124</td>
</tr>
</tbody>
</table>

Measures expressed as survival rates (higher is better).

**Efficiency (25% of Total Performance Score)**
- **Baseline period**: CY 2014
- **Performance period**: CY 2016

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<tr>
<th>Measure ID</th>
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<th>Threshold</th>
<th>Benchmark</th>
</tr>
</thead>
<tbody>
<tr>
<td>MSPB-1</td>
<td>Medicare Spending per Beneficiary</td>
<td>Median MSPB ratio for all hospitals during performance period</td>
<td>Mean of the lowest decile MSPB ratios for all hospitals during performance period</td>
</tr>
</tbody>
</table>

Lower is better for all scores.

Adapted by Qualis Health from materials provided by Stratis Health and prepared under contract with the Centers for Medicare & Medicaid Services (CMS), and agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. E/WA-C1-GH-1858-08-15.

Qualis
Shaping the future of quality reporting – Physician Payment

Current
- Meaningful use
- Value-based payment modifier
- PQRS

MIPS
- Advancing care information (ACI)
- Resource use (aka Cost)
- Quality
- Clinical practice improvement activities

New

Meaningful use - Value-based payment modifier - PQRS

Cost - Quality
MACRA

Quality reporting: Then and now

PQRS, VBPM, MU

- Max cumulative penalties of up to 9% in 2018
- Scores evaluated on all-or-nothing basis
- No budget neutrality requirements; only VBPM features upside risk
- 3 separate programs

MIPS

- Max penalty of 4% in 2019
- Scores must be evaluated on a “sliding scale”
- Program must be budget neutral and feature dual-sided risk*
- 1 program with 4 performance categories...

* Does not include extra “exceptional performance” bonuses in 2019-2024
NEUTRAL BUDGET PROGRAM

2018  2019  2020  2021  2022  2023+

-4%   +4%*  +5%*  +7%*  +9%*  +9%*

-5%   -7%   -9%   -9%   -9%   -9%
Alternative Payments Models (APMs)

- CMS Innovation Center model
  - ACO, PCMH, Bundled Payments
- Medicare Shared Savings Program
- Demonstration under the Health Care Quality Demonstration Program
- Demonstration required by federal law
ADVANCED ALTERNATIVE PAYMENT MODELS (ADVANCED APMS)

- APMs rewards plus 5% incentive
- Medical Home Model
  - PCPs
  - Empanelment of each patient
  - 4 more elements
    - Coordination of chronic an preventive care
    - Patient access and continuity of care
    - Coordination across the medical neighborhood
    - Patient and caregiver engagement
    - Shared decision-making
    - Payment arrangements in addition to or substituting for fee-for-service
- At least 50% of clinicians must use EHR
- Must report at the group Tax ID Number
- Must bear a more than nominal amount of financial risk
- (8% of part A and part B revenues)
"He thinks he can defray the cost of his office visit by checking his own reflexes."
Trial to 800 hospital 4/2016 in 67 metropolitan statistical areas (MSAs)
- Denver, Boulder, Lincoln
- Single payment for 90 day period
- Hip and Knee Replacement
- Was to expand to include fracture
  - delayed until October 2017

Currently Hospitals are denying coverage to participants based on risk
CARDIAC BUNDLED PAYMENTS

- 98 geographic MSA, 1120 hospitals
  - Boulder, Denver, Fort Collins, Grand Junction, Pueblo, Lincoln, Omaha

1. Quality-first model (high standard of quality if cost is lower)

2. Composite Quality Score
   a) 30 day all cause Risk Standardized Mortality rate following AMI
   b) Excess days in Acute care after hospitalization for AMI
   c) HCAHPS

3. Avoid expensive and harmful events

4. Improve care coordination
   a) CMS provide hospitals with relevant spending and utilization data
   b) Waiving certain Medicare requirements to encourage flexibility in the delivery of care
   c) Facilitating the sharing of best practices between participant hospitals

- Delayed until 2018
  - Additional review
  - Adequate time to undertake notice and comment on rule making
  - Participants have a clear understanding of the rules

- Coronary Artery Bypass Graft (CABG) Model very similar
CHALLENGES

- Patient compliance
- Patient behaviors
- High risk patients
- Data reporting/analytics to predict high-risk population
- Lack of coordinated communication
- Culture change of care
- Alignment for hospital and physician payment models to support Population Health strategies
KEYS TO SUCCESS

- Proactively manage patient risk
- Engage patients across the episode
- Partner with specialist with a high standard of care
- Eliminate common barriers to protocol adherence
- Predict discharge disposition before surgery
<table>
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<tr>
<th>CARE MANAGEMENT CHALLENGES</th>
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<tr>
<td><strong>1)</strong> Limited resources with growing number of patients</td>
</tr>
<tr>
<td><strong>2)</strong> Traditional Primary care model insufficient to meet demand</td>
</tr>
<tr>
<td><strong>3)</strong> In-person visits alone fail to engage patients in self management</td>
</tr>
</tbody>
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- Risky patients comprise over 50% of typical patient population
- Number of patients with chronic disease projected to skyrocket
- Shortage of PCPs predicted to worsen in future
- Medical Home investments expensive and time intensive
- Much of patient care takes place outside of the purview of the hospital
- Patients lack sufficient information and tools to successfully self-manage care
“They tried adding healthy snacks to the office vending machines, but all that rotting fruit made the candy bars taste bad.”
Cleveland Clinic CEO – Toby Cosgrove

“We have an increasingly aging population, and we have more things we can do for people.”

“We are never going to control the cost of health care if we don’t decrease the things that are driving up the cost, which are chronic diseases - obesity, smoking, lack of exercise.”
KEYS TO SUCCESS

Non-clinical home care services

Pharmacists

Meals on wheels

Health coaches

CHF, COPD, Lives Alone, Depression, Unable to drive

Transportation Services

Social workers

Care managers

Housing assistance

Depression Screening
Aria Health – Preventative Screening Guidelines for chronic disease management with tracking

Bassett Medical Center – IBM Watson program for patient acceptance and focusing on non-compliant patients

Baystate Health- analytic platforms for connectivity, coordination and transparency. Emphasis on chronic medical and behavioral health conditions.

Lee Memorial Health System – align community leaders promoting healthy lifestyles, primary care alternatives to the ED, chronic disease prevention, public engagement, healthcare workforce shortage

Montefiore Health System – “Shop Healthy” campaign

St. Joseph Hoag Health Wellness – lifestyle management and health and wellness programs with yoga, sleep improvement, personalized weight management, nutrition coaching.
FUTURE