What’s CMS Up To These Days?

HIMSS/MoHIMA Symposium

September 14, 2016

VBR Framework

PYA

FEE-FOR-SERVICE (FFS) PAYMENTS	ADJUSTED FFS PAYMENTS	APMs INCORPORATING FFS PAYMENTS	POPULATION-BASED APMs
A Traditional FFS	**A** Pay For Reporting	**A** Total Cost of Care Shared Savings	**A** Condition-Specific Population-Based Payments
B Infrastructure Incentives	**B** Pay For Performance	**B** Total Cost of Care Shared Risk	**B** Primary Care Population-Based Payments
C Care Management Payments	**C** Pay/Penalty For Performance	**C** Retrospective Bundled Payments	**C** Comprehensive Population-Based Payments
		D Prospective Bundled Payments	

Medicare Transition To Value-Based Reimbursement

By 12/31 2016

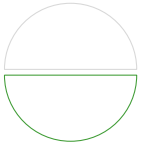
85% of Medicare fee-for-service payments tied to scores on quality and efficiency measures.

30% of traditional Medicare payments through APMs

03/03/2016 - Mission Accomplished

By 12/31 2018

90% of Medicare fee-for-service payments tied to scores on quality and efficiency measures.



50% of traditional Medicare payments through APMs

CMMI Initiatives

- CPCI/CPC+
- Comprehensive ESRD Care
- State Innovation Models
- Health Care Innovation Awards
- Bundled Payment For Health Improvement
- Pioneer/AIM/NextGen ACO models
- Oncology Care Model
- Transforming Clinical Practice Initiative
- Accountable Health Communities

Center for Medicare Initiatives

- Meaningful Use
- Medicare Shared Savings Program
- Hospital payment adjustments: RRP, VBP, and HACRP
- MPFS payment adjustments: PQRS and VBP
- MPFS payments for care management
- Comprehensive Care for Joint Replacement
  - Expand to include fractures
- Episode Payment Model
  - 98 TBA MSAa
  - Heart attack & CABG

MACRA

- Repealed Sustainable Growth Rate
- Established annual increases to MPFS conversion factor
- Directed CMS to implement Merit-Based Incentive Payment System
  - Sunsets current MPFS adjustments (PQRS, MU, VBP)
  - Replaces with individual physician/non-physician practitioner adjustments to MPFS payments based on composite performance score (1-100)

Timeline

DATE	EVENT
11.01.16	Publication of MIPS Final Rule
01.01.17	MPFS adjustments for PQRS(-2%)/MU(-3%)/VBP(+/-4%) based on 2015 performance
01.01.17	First MIPS performance period commences *
01.01.18	MPFS adjustments for PQRS/MU/VBP based on 2016 performance (reported in Q1 2017)
01.01.18	Second MIPS performance period commences
01.01.19	MPFS adjustments for MIPS (-4/+12) based on 2017 performance *
01.01.19	Third MIPS performance period commences

2017 Pick Your Pace

1. Submit “some” data, avoid penalty (no bonus)
2. Opt for partial year participation
3. Opt for standard MIPS
4. Qualify for Advanced APM

All details TBA…

Physician Awareness

- Deloitte 2016 Survey of US Physicians
  - 50% of non-pediatrician physicians had never heard of MACRA
  - 32% recognized the name, but not familiar with details
  - 21% of self-employed physicians reported some level of familiarity
  - 9% of employed physicians reported the same

MIPS Eligible Clinicians

Years 1 and 2	Years 3+
	
Physicians (MD/DO & DMD/DDS), PAs, NPs, CNSs, CRNA	Physical or occupational therapists, speech-language pathologists, audiologists, nurse midwives, clinical social workers, clinical psychologists, dieticians/nutritional professionals

MIPS-Exempt

- First year of Medicare Part B participation
- Below low volume threshold
  - Medicare billed charges of $10,000 or less and
  - Provide care for 100 or fewer Medicare beneficiaries
- Qualifying Participants (QPs) in Advanced APMs

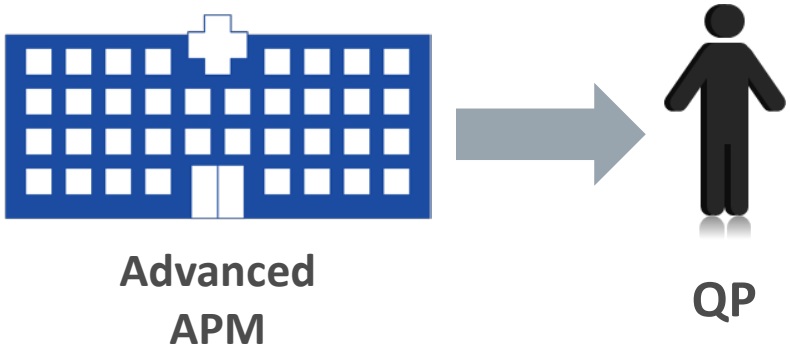
Part B Only

- MIPS **does not** apply to Part A providers
  - Hospitals, CAHs, RHCs, FQHCs
- MIPS **does** apply to hospital/CAH-employed practitioners billing under Part B
  - Does not impact hospital's/CAH's facility charge

Advanced APMs

- Medicare Shared Savings Program
  - Tracks 2 & 3 only
- Next Generation ACO Model
- Comprehensive ESRD Care
- Comprehensive Primary Care Plus (CPC+)
  - Unless MSSP or 50+ MECs
- Oncology Care Model (OCM)
  - Two-sided risk track only (available in 2018)

QPs and Partial QPs



Minimum % of patients/payments through Advanced APM

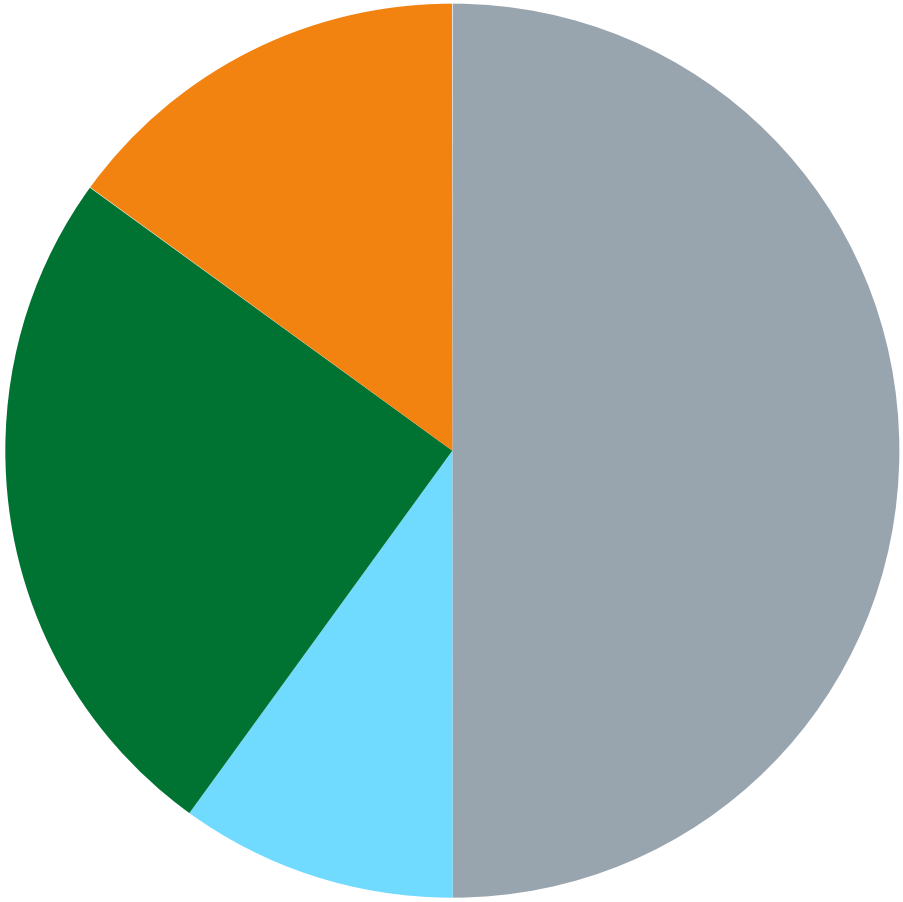
Lower % for medical home APMs (CPC+)

QPs will:

- Be excluded from MIPS
- Receive 5% lump sum bonus

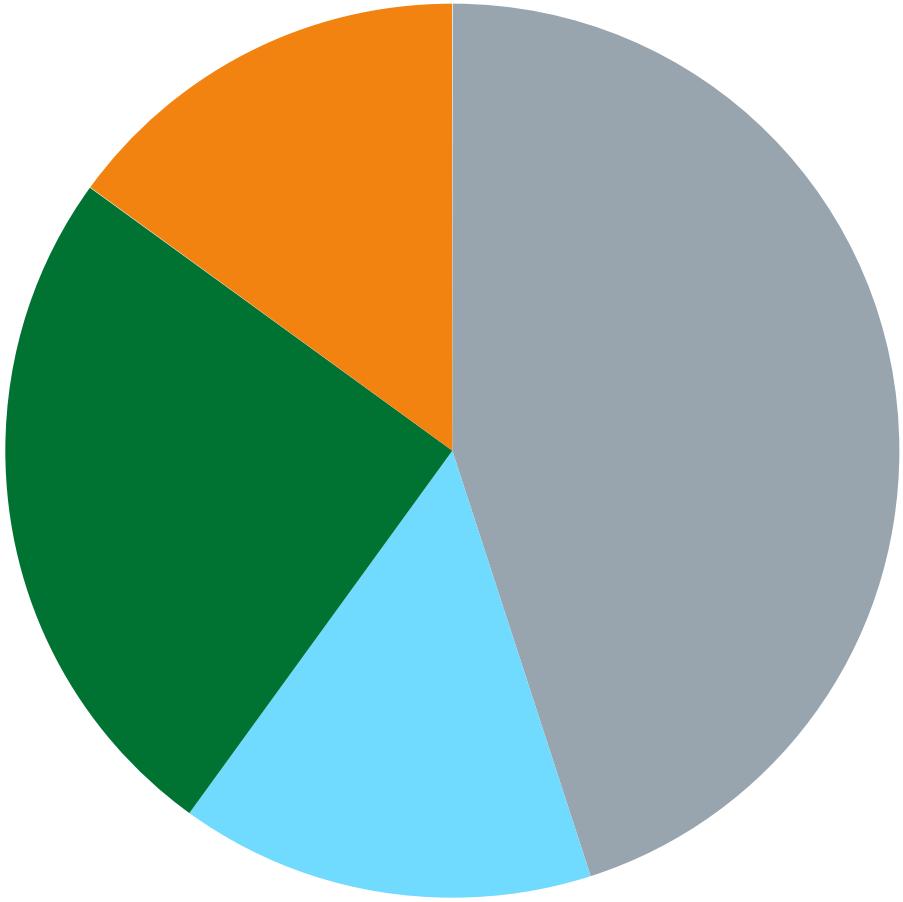
Partial QPs (lower thresholds) not eligible for bonus, but can opt out of MIPS payment adjustments

2017 CPS Components



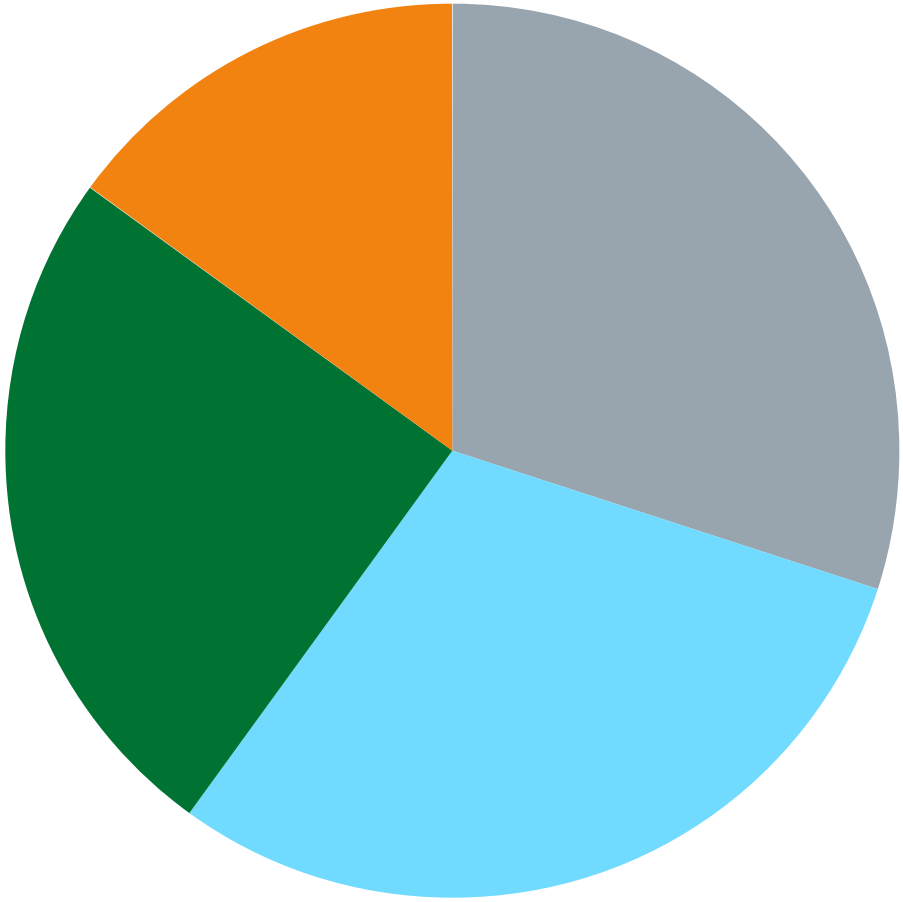
- Quality - 50%
- Resource Use - 10%
- Advancing Care Information - 25%
- Clinical Practice Improvement Activities - 15%

2018 CPS Components



- Quality - 45%
- Resource Use - 15%
- Advancing Care Information - 25%
- Clinical Practice Improvement Activities - 15%

2019 CPS Components



- Quality - 30%
- Resource Use - 30%
- Advancing Care Information - 25%
- Clinical Practice Improvement Activities - 15%

Participation Election

Individual

OR

Group

- Each NPI who has reassigned to group's TIN assessed as a group across all four MIPS performance categories.
- Each NPI/TIN receives same composite performance score

Hedging Bets

- If group (TIN) reports, clinician (NPI) may also report individually for the same performance year
  - In adjustment year, CMS will assign the higher CPS (group or individual) to NPI's services billed under that TIN.
- If NPI bills under multiple TINs during performance year, CPS for that NPI/TIN will apply in adjustment year

Musical Chairs

- Scenario #1: NPI bills under TIN A in performance year, bills under TIN B in adjustment year
  - NPI's payments based on TIN A CPS (group or individual)
  - CPS follows the NPI, as opposed to NPI being subject to new TIN's CPS
- Scenario #2: NPI bills under TIN A and TIN B in performance year, bills under TIN C in adjustment year
  - CMS calculates weighted average CPS based on percentage of allowed charges between TIN A and TIN B

Quality Component

Report on 6 measures

vs. PQRS - 9 measures with domain requirements

Select from individual measures (300+) or specialty measure sets (includes 23 specialties)

1 cross-cutting measure

except for providers with 25 or fewer patient-facing encounters

1 outcome measure

or add'l high priority measure if no available outcome measure

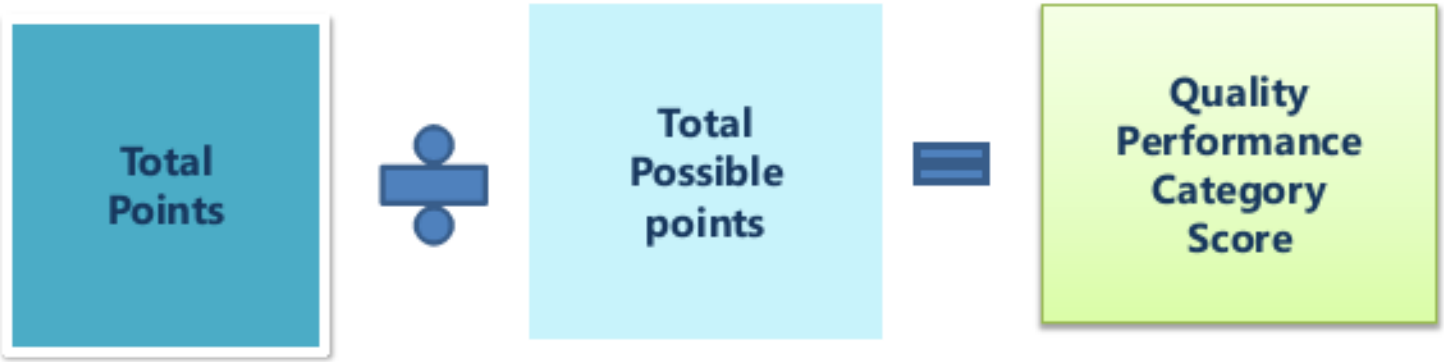
Population measures calculated from claims data

Cross-Cutting Measures

1. Advance Care Plan (!)
2. Documentation of Current Medications (!)
3. Tobacco Screening and Cessation Intervention
4. Controlling High Blood Pressure (!)
5. Screening for High Blood Pressure
6. Receipt of Specialist Report(!)
7. Adolescent Tobacco Use
8. Screening for Unhealthy Alcohol use
9. BMI Screening and Follow-up Plan
10. CAHPS Patient Satisfaction Survey(!)

(!) = High Priority Measure

Quality Score Calculation



Quality Score Calculation

- Measures to points
  - For each measure, CMS establishes deciles based on national performance in baseline period
  - Compare score to decile breaks and assign corresponding points
    - Partial points assigned based on percentile distribution
  - Assign zero points for unreported measures
- Up to 10% in bonus points
  - 1 extra point for each measure reported using CHERT for end-to-end electronic reporting – up to 5%
  - 2 points for add'l outcome/patient experience measure; 1 point for other high priority measures – up to 5%

Point Assignment Based on Deciles

DECILE	Decile 1	Decile 2	Decile 3	Decile 4	Decile 5	Decile 6	Decile 7	Decile 8	Decile 9	Decile 10
Possible POINTS	1.0-1.9	2.0-2.9	3.0-3.9	4.0-4.9	5.0-5.9	6.0-6.9	7.0-7.9	8.0-8.9	9.0-9.9	10

0% 7% 16% 23% 36% 41% 62% 69% 79% 85% 100%

Example of decile breaks for a specific quality measure

Eligible clinician with 19% performance rate would get approximately 3.3 points (based on distribution within the decile).

Eligible clinician with 95% performance rate would get 10 points.

Measure	Measure Type	Number of Cases	Points Based on Performance	Total Possible Points (10 x Weight)	Quality Bonus Points For High Priority	Quality Bonus Points for EHR
Measure 1	Outcome Measure using CEHRT	20	4.1	10	0 (required)	1
Measure 2	Process using CEHRT	21	9.3	10	N/A	1
Measure 3	Process using CEHRT	22	10	10	N/A	1
Measure 4	Process	50	10	10	N/A	N/A
Measure 5	High Priority- Patient Safety	43	8.5	10	1	N/A
Measure 6 (Missing)	Cross-Cutting	N/A	0	10	N/A	N/A
Acute Composite	Admin. Claims	10	Not scored: below minimum sample size	N/A	N/A	N/A
Chronic Composite	Admin. Claims	20	6.3	10	N/A	N/A
All-Cause Hospital Readmission	Admin. Claims	N/A	N/A	N/A	N/A	N/A
Total Points	All Measures	N/A	48.2	70	1	3

Resource Use Component

- Utilize two current VM Program measures
  - Total per capita cost for all attributed beneficiaries
  - Medicare spending per beneficiary
- Replace VM Program's four condition-specific measures with episode-based efficiency measures
  - 41 proposed clinical condition/treatment episodes

[A] RU	[B] Type of Measure	Number of Cases	Performance	[D] Measure Perf. Threshold	[E] Points Based on Decile	[H] Total Possible Points (10 points x [F])
M1	MSPB	20	15,000	13,000	4.0	10
M2	Total Per Capita	21	12,000	10,000	4.2	10
M3	Episode 1	22	15,000	18,000	5.8	10
M4	Episode 2	10	11,000	9,000	Below Case Threshold	N/A
M5	Episode 3	0	N/A	N/A	No Attributed Cases	N/A
M36	Episode 4	45	7,000	10,000	8.3	10
TOTAL					22.3	40

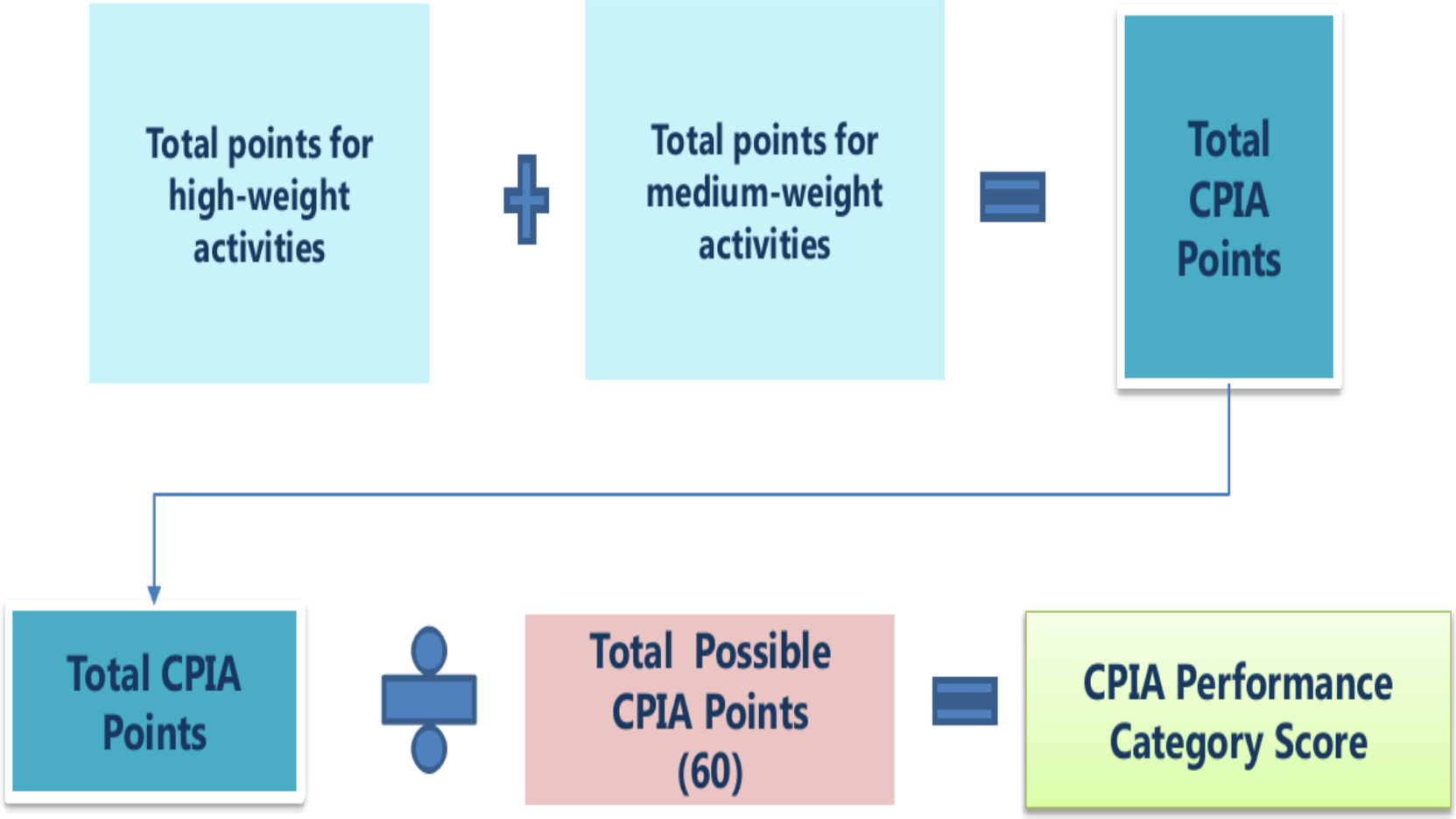
Patient Relationship Categories and Codes

- MACRA-mandated tools to compare relative resource use among practices
- Begin including codes on claims no later than 01/01/2018
- CMS proposes three categories (codes to follow)
  - Continuing care relationship
  - Acute care relationship
  - Care furnished pursuant to order from other practitioner

CPIA Component

- Minimum selection of one CPIA activity (from 90+ proposed activities) with additional credit for more activities
- Full credit for patient-centered medical home
- Minimum half credit for APM participation

CPIA Component Scoring



ACI Component

- F/K/A meaningful use
- Scoring based on key measures of health IT interoperability and information exchange.
- Flexible scoring for all measures to promote care coordination for better patient outcomes.
- Key changes from meaningful use
  - Dropped “all or nothing” threshold for measurement
  - Removed redundant measures to alleviate reporting burden
  - Eliminated Clinical Provider Order Entry and Clinical Decision Support objectives
  - Reduced the number of required public health registries to which clinicians must report

Base Score (50 points)

Protect Patient Health Information (yes required)

Electronic Prescribing (numerator/denominator)

Patient Electronic Access (numerator/denominator)

Coordination of Care Through Patient Engagement (numerator/denominator)

Health Information Exchange (numerator/denominator)

Public Health and Clinical Data Registry Reporting (yes required)

Performance Score (80 points)

Patient Electronic Access

Coordination of Care Through Patient Engagement

Health Information Exchange

Composite Score

Bonus Point relates to reporting to public heath registries

APM Scoring Standard

- Applies to participants in MIPS APMs (other than QPs)
  - Advanced APMs
  - Track 1 MSSP ACO
  - Oncology Care Model (one-sided model)
- Avoid multiple reporting requirements
- Applies to all NPIs participating in APM as of last day of performance period
- NPI's APM CPS trumps all other CPS (group or individual)

Applying the APM Scoring Standard

- Component weighting
  - 50% quality
  - 30% advancing care information
  - 20% clinical practice improvement activities
- Quality component score based on APM performance measures
- For ACI and CPIA components, each ACO participant (TIN) reports as group.
  - CMS calculates APM's scores for these components based on the weighted mean average of TINs' scores
  - Weighting based on # of clinicians billing under each TIN

Performance Threshold

Mean or median of composite performance score for all MIPS-eligible clinicians for period prior to performance period

Score below threshold = penalty

Score above threshold = bonus

Adjustment Factor

By no later than December 2 each year, CMS will make available each clinician's (TIN/NPI) adjustment factor for upcoming year

Year	Penalty Cap	Bonus opportunity (subject to scaling factor)
2019	-4%	Up to +12%
2020	-5%	Up to +15%
2021	-7%	Up to +21%
2022	-9%	Up to +27%

Exceptional Performance Incentive Payment

If meet or beat stretch goal, also receive payment from annual $500 million incentive bonus pool (not to exceed 10 percent)

Reputational Impact

- Each clinician's composite and component scores published on Physician Compare website
- MIPS-based decision-making
  - Individual patients
  - Provider networks
  - Medical staff credentialing
  - Professional liability insurance
  - Others?

Thank You!

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- 20+ years as healthcare transactional and regulatory attorney
- Consulting practice focused on value transformation
- Believer in “simple”