“Coming of Age” in the Value-Based Payment Era”

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Case Presentation: Dr. Dark

Dr. Dark runs an independent two physician family practice in the suburban Northeast. Over the past few years, he has become disillusioned with the “turmoil” in the healthcare system, including declining revenue and new burdensome initiatives like meaningful use requiring “more work for less pay.” He is very worried about his ability to sustain the practice in the future and is concerned about the implications of MACRA/MIPS. He also wonders whether it is valuable for his practice to continue to participate in PPRNet and its research projects.
Agenda

• Discuss the many definitions of “value”
• Highlight valuable PPRNet activities
• Provide an overview of upcoming financial incentive programs
• Discuss the shared value these programs have for PPRNet and our members
What is “value”?

Full Definition of **value**

1. A fair return or equivalent in goods, services, or money for something exchanged

2. The monetary worth of something: **Market Price**

3. Relative worth, utility, or importance: *a good value at the price* < the value of base stealing in baseball* < had nothing of value to say*

4. A numerical quantity that is assigned or is determined by calculation or measurement: *let x take on positive values* < a value for the age of the earth*

5. The relative duration of a musical note

6. **a**: Relative lightness or darkness of a color: **Luminosity**
   **b**: The relation of one part in a picture to another with respect to lightness and darkness

7. Something (as a principle or quality) intrinsically valuable or desirable: *sought material values instead of human value* — W. H. Jones
How is value defined in healthcare?

\[
Value = \frac{Quality^*}{Payment^†}
\]

* A composite of patient outcomes, safety, and experiences
† The cost to all purchasers of purchasing care

The health outcomes achieved per dollar spent
HHS Goals:

- 85% of all Medicare fee-for-service payments tied to quality or value by 2016 and 90% by 2018
- 30% of Medicare payments tied to quality or value through alternative payment models by the end of 2016 and 50% by the end of 2018

3 strategies:

- Incentives
- Improving the way care is delivered (attention to population health, coordination among providers)
- Accelerating the availability of information to guide decision making
FOR IMMEDIATE RELEASE
March 3, 2016

HHS reaches goal of tying 30 percent of Medicare payments to quality ahead of schedule

A major milestone in the effort to improve quality and pay providers for what works

Thanks to tools provided by the Affordable Care Act, an estimated 30 percent of Medicare payments are now tied to alternative payment models that reward the quality of care over quantity of services provided to beneficiaries, HHS announced today. Today’s announcement means that over 10 million Medicare patients are getting improved quality of care by having more time with their doctors and better coordinated care – nearly a year ahead of schedule.

The Affordable Care Act established tools such as the Medicare Shared Savings Program and the Center for Medicare and Medicaid Innovation, which tests a number of alternative payment models for achieving better care, smarter spending and healthier people. Alternative payment models are ways for Medicare to reimburse providers based on the health of the patient and quality of care rather than the number of services provided. Examples include accountable care organizations (ACOs), advanced primary care medical homes, and new models that bundle payments for episodes of care.

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What constitutes “value” for PPRNet members?

• Providing excellent care for patients
• Autonomy
• Financial security
• Work-life balance
• Practice satisfaction
• Camaraderie with colleagues
What constitutes “value” for the PPRNet research team?

- Maintaining PPRNet member practices to participate in our activities
- Achieving funding
- Publishing and recognition of our study findings
- Disseminating our findings to improve healthcare
- Camaraderie with colleagues and PPRNet members
- Work-life balance
Finding shared values...

“Valuable” PPRNet activities
- Clinical quality measure reports
- PPRNet research projects
- Continuing Education
- Qualified Clinical Data Registry
- Specialized registry for MU/Advancing Care Information
- Alignment/assistance with federal incentive programs
PPRNET CLINICAL QUALITY MEASURE (CQM) REPORTS
PPRNet CQM Reports

• Over 60 CQMs
• Practice, provider and patient level performance
What “value” do PPRNet CQM reports provide for PPRNet members?

• Continuously updated to reflect new evidence and guidelines
• Longitudinal performance and patient registry presenting “actionable” information
• Benchmarks, medians and provider-level report provide comparisons with others
• PPRNet practice improvement model designed to help practices use CQM reports to improve quality
What “value” do PPRNet CQM reports provide for the PPRNet research team?

• Opportunity to measure improvement during quality improvement projects

• Opportunity to develop and test new and innovative CQMs
PPRNET RESEARCH PROJECTS
Ongoing or Upcoming PPRNet Research Projects

- Enhancing Quality and Access to Lifestyle Counseling and Health Behavior Change
- Reducing ADEs from Anticoagulants, Diabetes Agents and Opioids in Primary Care (MS TRIP 3)
- Reducing Overuse in Primary Care through Safe and Effective Health Information Technology” (HIT-OVERUSE)
- A Virtual Learning Collaborative for Alcohol Screening, Brief Intervention and Treatment in Primary Care (ALC-TRIP)
- Translating CKD Research into Primary Care Practice
- Learning From Primary Care EHR Exemplars About Health Information Technology Safety
What “value” do PPRNet research projects provide for PPRNet members?

• Opportunity for practices to work with research team members on-site and remotely with practices to help improve care

• Assist practices with promoting team care, improving use of HIT tools, prioritizing performance and engaging patients

• Practices contribute to our mission to identify strategies to improve health care in member practices and elsewhere
What “value” do PPRNet research projects provide for the PPRNet research team?

- Research funding is our holy grail
- Research funding (and publications) are our academic currency
- Research funding sustains our network
CONTINUING EDUCATION
PPRNet Continuing Education

- Annual network meetings
- CE cruises (Bahamas 2015, Alaska 2016, spring 2017?)
- Performance in Practice CE module
- Part IV ABFM credit
What “value” does PPRNet CE provide for PPRNet members?

- Helps members stay current with new evidence and guidelines
- Provides training in QI
- Helps members maintain board certification for participating in PPRNet activities
- Opportunity for members to network with colleagues
- CE events are fun!
What “value” does PPRNet CE provide for the PPRNet research team?

• Means of disseminating results of our research projects (one of our major goals)

• May attract new members to PPRNet to participate in other PPRNet activities

• Provides nominal revenue stream for other PPRNet activities

• CE events are fun!
QUALIFIED CLINICAL DATA REGISTRY
Qualified Clinical Data Registry (QCDR)

“A CMS-approved entity that has self-nominated and completed a qualification process that collects clinical data for the purpose of patient and disease tracking to foster improvement in the quality of care delivered to patients.”

- Participation satisfies PQRS reporting requirement
- Data submitted not limited Medicare beneficiaries
- CQMs not limited to PQRS measures
- By participating in 2016, providers will avoid a -2 to 4% Medicare payment adjustment and be eligible to receive up to a +4% adjustment through the value-based modifier
- Prominently featured in MACRA legislation
PPRNet-QCDR

- Successfully submitted data on behalf of over 60 providers in 2015
- Approved for both individual and group practices for the 2016 reporting year
- 30 PPRNet CQMs posted on PPRNet website

http://academicdepartments.musc.edu/PPRNet/QCDR/QCDR
PPRNet QCDR Participation Requirements

• Sign updated BAA and provide written consent from each provider to authorize PPRNet to submit data to CMS
• Provide tax documentation and Medicare claim form to verify TIN/NPI
• If submitting as a group, provide GPRO registration.
• Extract and send data to PPRNet at least 4 times in 2016
• Participate in an audit in January 2017 to verify accuracy of data
Register for the PPRNet-QCDR

• Complete online registration form by October 31, 2016 (https://redcap.musc.edu/surveys/?s=7WKFX8DYWM)

• Electronically send additional documentation to pprnet@musc.edu

• Reporting fee is $200/provider, waived for practices participating in 2 or more ongoing projects (MS TRIP 3, HIT OVERUSE, ALC TRIP, CKD-TRIP)
What “value” does the PPRNet-QCDR provide to the PPRNet research team?

• Opportunity to highlight PPRNet’s innovative CQMs

• Encourages seasoned and new practices to continue to participate in PPRNet research activities
What “value” does the PPRNet-QCDR provide for PPRNet members?

• Provides regular feedback on high priority CQM to PPRNet practices

• Reduces reporting burden for PPRNet members

• Provides potential for PPRNet members to receive financial incentives for the work they are already doing
SPECIALIZED REGISTRY FOR MEANINGFUL USE
Participation in PPRNet can serve to meet the MU public health reporting objective, Option 3 – Specialized Registry Reporting

PPRNet can serve to meet the public health reporting objective for the Medicare and Medicaid Electronic Health Record (EHR) Incentive Program for Eligible Professionals, under Measure Option 3 – Specialized Registry Reporting. PPRNet receives electronic data generated from certified EHRs through a secure data upload on our web portal and uses the data to improve population health outcomes through quality reporting and quality improvement activities. Eligible Professionals that elect to use PPRNet to meet this objective must be actively engaged with PPRNet. Active engagement for a provider means that he/she is a PPRNet member in good standing or joined PPRNet within 60 days of the start of the EHR reporting period, have submitted clinical summary/transition of care documents data in CCDA format for appropriate testing and validation, and are regularly submitting data extracts from the EHR to PPRNet (production data).
What “value” does this provide for PPRNet practices and the PPRNet research team?

• Encourages practices to participate in PPRNet

• Enables practices to “get credit” for their “meaningful use” of EHRs
MACRA
“Before I begin, one of the acronyms I’m going to use is completely made up. See if you can figure out which one.”
Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)

• Signed into law April 14, 2015

• Eliminates the flawed sustainable growth rate formula (and 21% payment cut)

• Transitions Medicare payment away from fee for service to payment for value

• Proposed rule issued, final rule expected Fall 2016; delay of start a possibility

• $20 million annually to assist small practices and practices servicing underserved areas
Track 1: MIPS

Consolidation of several current performance programs into new Merit-Based Incentive Payment System by 2019 (MIPS):

• Quality Reporting (formerly known as PQRS-Physician Quality Reporting System)
• Advancing care information (formerly known as Meaningful Use)
• Clinical practice improvement activities
• Resource use (claims-based)
# PROPOSED RULE

## MIPS: Performance Category Scoring

<table>
<thead>
<tr>
<th>Summary of MIPS Performance Categories</th>
<th>Maximum Possible Points per Performance Category</th>
<th>Percentage of Overall MIPS Score (Performance Year 1-2017)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Quality:</strong> Clinicians choose six measures to report to CMS that best reflect their practice. One of these measures must be an outcome measure or a high-value measure and one must be a crosscutting measure. Clinicians also can choose to report a specialty measure set.</td>
<td>80 to 90 points depending on group size</td>
<td>50 percent</td>
</tr>
<tr>
<td><strong>Advancing Care Information:</strong> Clinicians will report key measures of interoperability and information exchange. Clinicians are rewarded for their performance on measures that matter most to them.</td>
<td>100 points</td>
<td>25 percent</td>
</tr>
<tr>
<td><strong>Clinical Practice Improvement Activities:</strong> Clinicians can choose the activities best suited for their practice; the rule proposes over 90 activities from which to choose. Clinicians participating in medical homes earn ‘full credit’ in this category, and those participating in Advanced APMs will earn at least half credit.</td>
<td>60 points</td>
<td>15 percent</td>
</tr>
<tr>
<td><strong>Cost:</strong> CMS will calculate these measures based on claims and availability of sufficient volume. Clinicians do not need to report anything.</td>
<td>Average score of all cost measures that can be attributed</td>
<td>10 percent</td>
</tr>
</tbody>
</table>
MIPS Financial Adjustments

*Potential for 3X adjustment

2019 2020 2021 2022 onward

Merit-Based Incentive Payment System (MIPS)
MIPS: Scaling Factor Example

Dr. Joy Smith, who receives the +4% adjustment for MIPS, could receive up to +12% in 2019. For exceptional performance she could earn an additional adjustment factor of up to +10%.

Note: This scaling process will only apply to positive adjustments, not negative ones.
Track 2- Alternative Payment Models (APM)

- Advanced APMs include any model under the Center for Medicare and Medicaid Innovation Center, Medicare Shared Savings Program, Next Generation ACO, CPC+ and other demonstration programs.
- Must bear more than nominal financial risk.
- Physicians in advanced APMs will receive annual bonuses capped at 5% each year (in addition to FFS) if they can show they receive substantial revenue through APM.
What “value” does PPRNet membership provide in the MACRA era?

- QCDRs are featured prominently in MACRA legislation and in the proposed rule
- QCDRs will be able to do individual and group reporting for the MIPS Quality Performing Category
- PPRNet is considered a “specialized registry” for the MIPS Advancing Care Information Category
- Participation in PPRNet QCDR can satisfy the MIPS Clinical Practice Improvement activities Category
- Payment in an advanced APM must be based on quality measures (likely similar to PPRNet CQMs)
What “value” does MACRA provide for PPRNet members?

- Allows physicians to earn higher positive payment adjustments with less potential penalties.
- Reduces the reporting burden for physicians
- Supports the PCMH model (PCMHs receive highest CPIA score)
- Incentivizes participation in advanced alternative payment models such as CPC +
COMPREHENSIVE PRIMARY CARE PLUS (CPC+) INITIATIVE
Comprehensive Primary Care Plus (CPC+)

- CMS Innovation Center national advanced primary care medical home five-year model beginning January 2017
- Aims to strengthen primary care through a regionally-based multi-payer payment reform and care delivery transformation (payment AND care delivery model)
- Up to 5000 practices in up to 14 regions
- Follow up to CPC initiative (500 practices, 38 payers, 7 regions)
- Brings together CMS, commercial insurance plans and state Medicaid agencies
- Non-visit based care management fees paid per patient (Medicare and other payers)
- Features bonus prepaid bonus incentives “at risk” based on quality/utilization measures
CPC+ Regions Announced 8/1

Where is CPC+ offered?

Payers are partnering together in 14 regions to provide aligned financial support to practices.

Arkansas  New Jersey
Colorado  Ohio
Hawaii  Oklahoma
Michigan  Oregon
Montana  Rhode Island
North Hudson/Capital District (NY)  Tennessee
Greater Kansas City (KS)  Greater Philadelphia (PA)
What do CPC+ Practices have to do?

Use defined, stepwise requirements to guide them through care delivery changes to provide 5 primary care functions:

1. Access and continuity
2. Risk-stratified care management
3. Planned care for chronic conditions/preventive care
4. Patient/caregiver engagement
5. Comprehensiveness/coordination of care
Track 2 is for more advanced practices expected to provide enhanced services for patients with complex needs (including identifying psychosocial needs and resources), along with HIT vendors support

* Prospectively paid risk adjusted fee to provide practices with financial resources to hire staff/implement processes

** Up-front payment of expected E&M claims, independent of claims, makes practices “incentive neutral” to mode of care delivery, allowing non-face-to-face visits, longer office visits, etc.

*** Medicare incentive payment= prepaid upfront, practices keep $$ if quality and utilization performance thresholds met
More about CPC+

- Participating practices offered learning opportunities (in-person and web-based), online collaboration tools, web-based portals to facilitate practice sharing.
- Practices require to annually report eCQMs (via certified EHR technology) and CAHPS surveys (administered by CMS).
- Performance feedback provided at the practice-level quarterly by CMS.
CPC+ and MACRA

- CPC+ considered an Advanced APM
- Physicians participating in CPC+ would be exempt from MIPS payment adjustments and qualify for a 5% Medicare Part B incentive payment

What will payment look like for a CPC+ practice under MACRA?
- Risk-adjusted prospective payment $15-$27/month per beneficiary
- At-risk incentive payments of $2.50-$4.00/month per beneficiary
- 5% bonus on Medicare FFS payments (Advanced APMs)
CPC+ Next steps

Practices within the 14 regions can apply until mid-September 2016

https://innovation.cms.gov/initiatives/comprehensive-primary-care-plus
What “value” does PPRNet membership provide for CPC+ Practices?

• PPRNet CQMs similar to CPC+ CQMs, longitudinal performance on PPRNet CQM reports should help practice improve quality
• Practice delivery design strategies encouraged by CPC+ are similar to PPRNet improvement strategies
• Participation in PPRNet research and CME meetings can help practices improve care delivery (and achieve incentives)
What “value” does CPC+ provide for PPRNet practices?

• Incentivizes what many of you have already been doing (performance review, care delivery redesign, participation in learning collaborative)
• Track 2 facilitates non-traditional models of care
• Reduces potential reporting “burden” of MIPS
• Prioritizes improved quality of care for your patients
MILLION HEARTS CARDIOVASCULAR DISEASE RISK REDUCTION MODEL
• Randomized-controlled design, 5 year model test
• Intended to test scalable models of care delivery that reduce cardiovascular risk
• 516 practices/organizations nationwide selected (intervention/control groups)
• Goal is to promote CVD prevention and improved CVD outcomes through risk assessment and risk management
• Focus on primary prevention of CVD among Medicare Part B beneficiaries
Million Hearts Design

- Risk stratification based on ACC/AHA ASCVD risk calculator of all Medicare eligible patients
- Risk modification using shared decision making to reduce ASCVD risk scores
- Incentives in intervention practices include one time $10/patient for risk assessment and additional incentive in years 2-5 based on % risk reduction (up to $10 per high risk patient per month)
- Potential for intervention practices to earn >$34,000
- Control groups receive a one-time $20 per-patient payment and must submit data in every year of the project
What “value” does PPRNet membership provide for Million Hearts Practices?

• PPRNet already calculates ACC/AHA ASCVD risk for your patients (using baseline lipid levels)
• If helpful, we could recalculate risk over time for Million Hearts practices
2.5 Concordance with ACC/AHA Cholesterol Guidelines for ASCVD Risk Reduction

Practice_ID=200208

Subgroup Sizes: Min n = 745  Max n = 859

June 30, 2016
What “value” does Million Hearts provide for PPRNet practices?

- Opportunity to focus on improving cardiovascular risk for your patients
- Potential financial incentives for population-level risk management (which many of you are already doing!)
In summary

The future!
Coming Soon

• The future of primary care relies on quality measurement and value-based payment

• There are many imminent programs intended to support and improve primary care by rewarding high value care

• While fee-for-service medicine still exists, MACRA, CPC+, and Million Hearts all provide additional financial incentives to primary care practices
• PPRNet’s approach to practice-based improvement is mirrored in many of these programs (i.e. delivery redesign, performance review, population management, learning collaborative)

• The PPRNet research team will continue to do research to test innovative clinical quality (and value) measures and care delivery redesign strategies
Continuing to find shared values in the futures

The PPRNet research team will continue to align our activities with financial incentive programs to ensure a “win win” situation for all!

- High value care
- Research projects
- Financial incentives
- Reduced reporting burden
- MIPS
- QCDR
- Innovative CQMs
- Continuing education

And Our Patients Win!

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And returning to our case of Dr. Dark...

- Upcoming federal programs should be “valuable” for Dr. Dark’s practice, entail less burden, help sustain the practice, and support the provision of high quality primary care.
- Participation in PPRNet activities including research projects will also be valuable for the practice and align with theses upcoming federal programs.
Questions?