The Value Modifier & Medicare Access and CHIP Reauthorization Act (MACRA)

New Medicare Value-Based Physician Payment is Closer Than You May Think!

February 11, 2016
Housekeeping

1. **Using the control panel** - Use the control panel on the right side of your screen to minimize and expand this panel by clicking on the arrow in the upper right corner.

2. **Ask Questions** - You can submit questions using the Question section located near the bottom of the control panel. We will take time to answer as many questions as we can during Q&A at the end of the presentation. If your question was not answered, we will respond to you individually after the event.

3. **After the webinar** - We want your feedback! Please take the short survey at the completion of the webinar. Also, all registrants will receive a copy of the presentation, and the recording for on-demand replay.
AGENDA

• Demystify new Medicare payment incentives:
  – Value-Based Payment Modifier (VM)
  – Medicare Access & CHIP Reauthorization Act (MACRA)

• Main Messages:
  – New Law: Physician payment under Medicare PFS (Physician Fee Schedule) is changing significantly for PCPs and specialists
  – Physician engagement with PCMH and quality improvement is essential
  – IBM Watson Health continues to help providers to maximize CMS performance and payment

• Next Steps
Value-based Payment Modifier (VM)
Introduction: the Value Modifier

• One of the current annual payment adjustments, but will be folded into MACRA

• Payment adjustments to the Medicare Physician Fee Schedule (MPFS) are made based upon:
  – Quality of care
  – Cost of care

• Assessment by measures

• Quality-Tiering: the process by which quality and cost determine the direction and the degree of the payment adjustment

• The adjustment made is called the Value Modifier
Value-based Payment Modifier (VM)

Multiple Quality Measures
Multiple Quality Domains

Quality Composite
2015

+ Cost Composite
2015

Quality-Tiering

Value Modifier
2017
VM Quality Composite: Measures

- Three **sources** for potential quality measures:
  - Physician Quality Reporting System (PQRS)
  - Three Claims-Based Outcome Measures
  - Consumer Assessment of Health Providers and Systems (CAHPS)
VM Quality Composite: PQRS Reporting

• In regards to the Value Modifier, PQRS Reporting will cause an immediate categorization for all groups “based on whether and how groups and solo practitioners participate in the PQRS in 2015.” – CMS

• **Category 1:**
  – Satisfactory PQRS Reporters

• **Category 2:**
  – Non-Satisfactory PQRS Reporters

**The First VM Hurdle**

**Note:** An automatic downward Value Modifier adjustment can occur in addition to a downward PQRS payment. This could mean multiple payment penalties annually from the VM, PQRS, and Meaningful Use.
VM Quality Composite: 3 Claims-Based Outcome Measures

1. 30-Day All-Cause Hospital Readmissions

2. Preventable Hospitalizations for Acute Conditions
   - Bacterial Pneumonia
   - Urinary Tract Infection
   - Dehydration

3. Preventable Hospitalizations for Chronic Conditions
   - Short-Term Complications from Diabetes
   - Long-Term Complications from Diabetes
   - Uncontrolled Diabetes
   - Lower Extremity Amputation among Patients with Diabetes
   - Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults
   - Heart Failure
VM Quality Composite: CAHPS

- Consumer Assessment of Health Providers and Systems (CAHPS)
- Patient Experience Surveys
- Pertain to healthcare/hospital systems, insurance programs, clinicians groups, etc.
- Some groups will be required, and some groups may elect, to have CAHPS data as a quality measure

Source #2, #7, #9 Appendix G
Value-based Payment Modifier (VM)

Quality Composite + Cost Composite

Quality-Tiering

Value Modifier
VM Cost Composite: Review

“Low”, “Average”, or “High” Quality Composite 2015 + “Low”, “Average”, or “High” Cost Composite 2015

Quality-Tiering

Value Modifier 2017
Quality-Tiering:
The process by which both the Quality Composite and the Cost Composite are utilized to determine a group’s or individual’s Value Modifier.

2017 Value Modifier for groups with 2-9 EPs as well as solo practitioners

<table>
<thead>
<tr>
<th>Cost/Quality</th>
<th>Low Quality</th>
<th>Average Quality</th>
<th>High Quality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low Cost</td>
<td>+0.0%</td>
<td>+1.0x*</td>
<td>+2.0x*</td>
</tr>
<tr>
<td>Average Cost</td>
<td>+0.0%</td>
<td>+0.0%</td>
<td>+1.0x*</td>
</tr>
<tr>
<td>High Cost</td>
<td>+0.0%</td>
<td>+0.0%</td>
<td>+0.0%</td>
</tr>
</tbody>
</table>

Source #3
Quality-Tiering: The process by which both the Quality Composite and the Cost Composite are utilized to determine a group’s Value Modifier.

<table>
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</thead>
<tbody>
<tr>
<td>Low Cost</td>
<td>+0.0%</td>
<td>+2.0x*</td>
<td>+4.0x*</td>
</tr>
<tr>
<td>Average Cost</td>
<td>-2.0%</td>
<td>+0.0%</td>
<td>+2.0x*</td>
</tr>
<tr>
<td>High Cost</td>
<td>-4.0%</td>
<td>-2.0%</td>
<td>+0.0%</td>
</tr>
</tbody>
</table>

Source #3
Quality-Tiering: This table applies only to groups or solo practitioners that are non-physician EPs only.

- **2018 Value Modifier for groups of non-physician EPs, applied to PAs, NPs, CNSs, & CRNAs**

<table>
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<td>+0.0%</td>
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<td>+1.0x*</td>
</tr>
<tr>
<td>High Cost</td>
<td>+0.0%</td>
<td>+0.0%</td>
<td>+0.0%</td>
</tr>
</tbody>
</table>

Source #21
**Quality-Tiering:**
This table applies only to groups that have at least one physician, and also to solo physician providers.

- **2018 Value Modifier for groups of 2-9 EPs, applied to physicians, PAs, NPs, CNSs, & CRNAs**

<table>
<thead>
<tr>
<th>Cost/Quality</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Low Cost</td>
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<td>+1.0x*</td>
<td>+2.0x*</td>
</tr>
<tr>
<td>Average Cost</td>
<td>-1.0%</td>
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<td>+1.0x*</td>
</tr>
<tr>
<td>High Cost</td>
<td>-2.0%</td>
<td>-1.0%</td>
<td>+0.0%</td>
</tr>
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</table>

*Source #21*
Quality-Tiering: 2018 Value Modifier for groups of 10+ EPs, applied to physicians, PAs, NPs, CNSs, & CRNAs

<table>
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<th>Cost/Quality</th>
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Source #21
Value Modifier: Take Aways

- Will continue to affect Medicare PFS payments in 2016, 2017, 2018
- 2019: PQRS, Value Modifier and Meaningful Use will be incorporated into MACRA

- IBM Watson Health:
  - Insight measures support some PQRS measures
  - Enables real-time assessment of quality performance
    - Actionable data
  - Allows for tracking of patients with chronic conditions
    - Better care, improved results
    - Implications for cost measures (preventable admissions)
Medicare Access & CHIP Reauthorization Act of 2015 (MACRA)
Introduction: MACRA

Medicare Access & CHIP Reauthorization Act of 2015 (MACRA)

- The future of payment adjustment systems, affecting 2019 payments
- MACRA will retire, or “sunset”, SGR & current incentive programs, and replace them with the following two new systems:
  - Merit-Based Incentive Payment System (MIPS)
    - Eligible Professionals paid under MPFS
  - Alternative Payment Models (APMs)
    - Must meet APM criteria
- Will incorporate and modify existing measures
- Will create new quality measures
MACRA: Replacing the SGR

Source #15
Merit-Based Incentive Payment System (MIPS)

• New, quality-driven incentive system for physicians reimbursed under Medicare PFS, who are not in an APM

• Will incorporate existing programs within a new entity (MIPS):
  – Physician Quality Reporting System (PQRS)
  – Value-based Payment Modifier (VM)
  – Meaningful Use of certified EHR technology (MU)

• Projected to affect the **2019 payment period using 2017 data**

• Will utilize **four performance categories**:
  – 1. Quality
  – 2. Resource Use
  – 3. Clinical Practice Improvement Activities
  – 4. Meaningful Use of certified EHR technology
Alternative Payment Models (APMs)

- Establishes incentive payments for Medicare PFS providers (“Eligible Providers”) participating in different health care payment models, such as:
  - Accountable Care Organizations
  - Patient Centered Medical Homes
  - Bundled Payment Models
- “Lump-sum” incentive projected for 2019 - 2024
  - May change to higher annual payments beginning in 2026
- Categories:
  - Category 1: Fee-for-Service, no link to quality
  - Category 2: Fee-for-Service, link to quality
  - Category 3: APMs built upon Fee-for-Service Architecture
  - Category 4: Population-Based Payment

Source #16
Measure Development Plan (MDP)

• December 18, 2015: “CMS Quality Measure Development Plan DRAFT” was made available

• Draft plan for the development of **quality measures**
  – Finalized: 5/1/2016, with annual updates

• Purpose:
  – Framework for future **measure development**
  – **Prioritizes** measure development for specialty providers
  – Builds upon existing quality measures
  – Requires public reporting on the Physician Compare website

• Measures will pertain to both MIPS and APMs
DRAFT Measure Development Plan (MDP)

• Priority focus for MIPS measures:
  – Outcome measures
  – Specialty-specific measures

• High-priority domains
  1. Person and Caregiver-Centered Experience and Outcomes
     – Focus on Patient Reported Outcome Measures (PROM)
  2. Communication and Care Coordination
     – Including treatment with other providers
  3. Appropriate Use and Resource Use (implicit cost measures)

Source #16
Measure Development Timeline

- **Jan. 2016**: Draft MDP Published for Comment
- **Mar. 2016**: Comment period ends
- **May 2016**: Final MDP published
- **May 2017**: Annual Update to MDP
- **May 2018**: Annual Update to MDP
- **Jan. 2019**: MIPS Payment Adjustment Begins

- **June 2016**: Call for measures ends
- **Nov. 2016**: Final Rule no later than Nov. 1, 2016
- **June 2017**: Call for measures ends
- **Nov. 2017**: Final Rule no later than Nov. 1, 2017
- **June 2018**: Call for measures ends
- **Nov. 2018**: Final Rule no later than Nov. 1, 2018

Source #15
DRAFT Measure Development Plan (MDP)

• Public comments regarding Draft Measure Development Plan can be submitted Jan 1, 2016 – March 1, 2016:
  – On-line Submission Tool:
    – https://www.surveymonkey.com/r/26NYQRB
  – MDP Dedicated Email Box:
    – MACRA-MDP@hsag.com
  – U.S. Postal Mail:
    Attn: Eric Gilbertson, CMS MACRA Team
    Health Services Advisory Group, Inc.
    3133 East Camelback Road, Suite 240
    Phoenix, AZ 85016-4545
MACRA Review

- PQRS
- VM
- Meaningful Use
- ACO
- SSP
- PCMH
- MIPS
- APMs

Source #15
So What?

- **Significant** changes in current quality-incentivized programs coming
- Upcoming period of rapid, new measure development that will:
  - Follow trajectory of patients and populations with chronic conditions across care continuums
  - Emphasize outcomes (patient-reported, global & population-based)
  - Utilize patient experience, care coordination, appropriate use
  - Promote multiple levels of accountability
  - Apply to multiple types of healthcare providers
  - Use EHR generated data as well as clinical data registries
  - Account for variety of payment models, align with private sector reporting, multi-payer applicability
  - Stratify results by demographics for disparity screening
  - Utilize CMS Physician Compare

Source #15
Implications for Providers

• New Law: Physician payment under Medicare PFS is changing
  – VM 2017 payments, which were based on 2015 measure data (over!)
  – VM 2018 payments, with 2016 measures
  – MACRA payments starting in 2019
    – Measures/details TBD
    – Only drafts currently available

• IBM Watson Health positioned to support the new payment incentives
  – Measures (quality and resource use)
  – Clinical practice improvement activities (PCMH)
Next Steps
Next Steps

• Ongoing updates
  – Blog postings
  – Webinars

• 2016 TIMELINE
  – March 1, 2016: Comment Period ends for MDP Draft
  – May 1, 2016: MDP finalized and available
  – November 1, 2016: Final Rule on MIPS measures available
Questions
THANK YOU!

The recording and handouts will be sent to you via email within 2 business days
Sources


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Sources

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