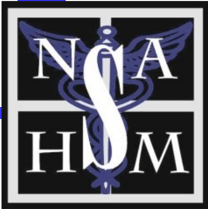


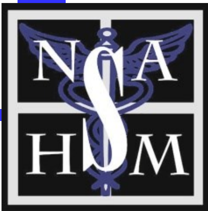
Trading Volume for Value:

The transition away from Fee-for-Service Medicare payments

Charles A. James, Jr.

President and CEO

North American Healthcare Management Services

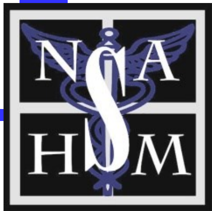


CMS Announcement

On January 26, 2015, CMS announced their road map for the transition payment for value in a News Release titled:

"Better Care. Smarter Spending. Healthier People: Paying Providers for Value, Not Volume." 1.26.2015.

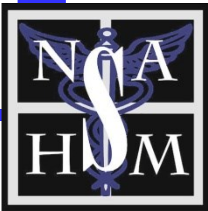
http://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-01-26-3.html



Per CMS:

"When it comes to improving the way providers are paid, we want to reward value and care coordination – rather than volume and care duplication. In partnership with the private sector, the Department of Health and Human Services (HHS) is testing and expanding new health care payment models that can improve health care quality and reduce its cost."

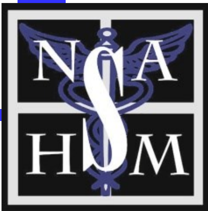
CMS 2015 Fact Sheet: "Better Care. Smarter Spending. Healthier People: Paying Providers for Value, Not Volume." 1.26.2015



CMS Framework

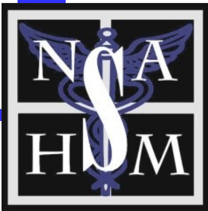
“HHS has adopted a framework that categorizes health care payment according to how providers receive payment to provide care.[1]

- category 1—fee-for-service with no link of payment to quality
- category 2—fee-for-service with a link of payment to quality
- category 3—alternative payment models built on fee-for-service architecture
- category 4—population-based payment”



The ACA

"…thanks to reforms under the Affordable Care Act and other changes, by 2014, an estimated 20 percent of Medicare reimbursements had shifted to categories 3 and 4, directly linking provider reimbursement to the health and well-being of their patients."



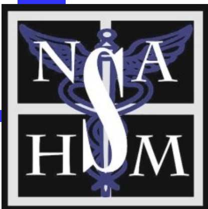
Roadmap

"Moving from category 1 to category 4 involves two shifts: (1) increasing accountability for both quality and total cost of care and (2) a greater focus on population health management as opposed to payment for specific services."

CMS 2015 Fact Sheet: "Better Care. Smarter Spending. Healthier People: Paying Providers for Value, Not Volume." 1.26.2015.

Goals

Overall, HHS seeks to have 85 percent of Medicare fee-for-service payments in value-based purchasing categories 2 through 4 by 2016 and 90 percent by 2018.



Payment Model Targets

Target percentage of Medicare FFS payments linked to quality and alternative payment models in 2016 and 2018

- All Medicare FFS (Categories 1-4)
- FFS linked to quality (Categories 2-4)
- Alternative payment models (Categories 3-4)

2016

30%

85%

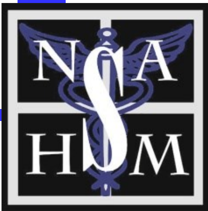
All Medicare FFS

2018

50%

90%

All Medicare FFS



Three Areas of Focus

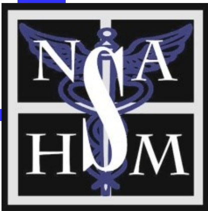
1. Improving the way providers are paid,
2. Improving and innovating in care delivery,
3. Sharing information more broadly…while maintaining privacy.

Alternative Payment Models

"Alternative payment models such as Bundled Payments or Accountable Care Organizations generally make doctors and hospitals attentive to the total costs of treating a patient at a high level of quality, giving clinicians the opportunity to focus on quality, patient-centered care."

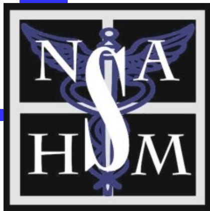
Provider Payments - ACOs

- Medicare Shared Savings Programs
- Advanced Payment ACO Model
- Pioneer ACO Model



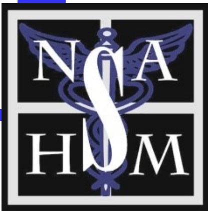
Medicare Shared Savings Program

Congress created the Shared Savings Program to facilitate coordination and cooperation among providers to improve the quality of care for Medicare Fee-For-Service (FFS) beneficiaries and reduce unnecessary costs. Eligible providers, hospitals, and suppliers may participate in the Shared Savings Program by creating or participating in an Accountable Care Organization (ACO).



What is a Shared Savings program?

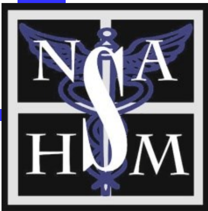
The Shared Savings Program ACOs are groups of doctors and other health care providers who voluntarily work together with Medicare to give high quality service to Medicare Fee-for-Service beneficiaries. An ACO is not a Medicare Advantage plan or an HMO.



SSP Description

According the CMS Provider Taxonomy Framework, “some payment is linked to the effective management of a population or an episode of care. Payments still triggered by delivery of services, but opportunities for shared savings or 2-sided risk.”

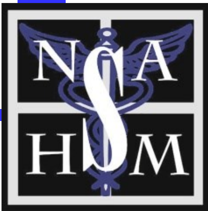
CMS 2015 Fact Sheet: “Better Care. Smarter Spending. Healthier People: Paying Providers for Value, Not Volume.” 1.26.2015.



Bundled Payments

"Under the Bundled Payments for Care Improvement initiative, organizations will enter into payment arrangements that include financial and performance accountability for episodes of care. These models may lead to higher quality, more coordinated care at a lower cost to Medicare."

Bundled Payments for Care Improvement (BPCI) Initiative: General Information. http://innovation.cms.gov/initiatives/bundled-payments/index.html



Four Bundled Payment Models

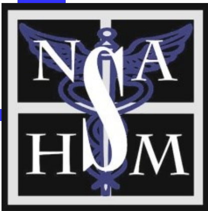
The Bundled Payments initiative is comprised of four broadly defined models of care, which link payments for multiple services beneficiaries receive during an episode of care.

Model 1: Retrospective Acute Care Hospital Stay Only

Model 2: Retrospective Acute Care Hospital Stay plus Post-Acute Care

Model 3: Retrospective Post-Acute Care Only

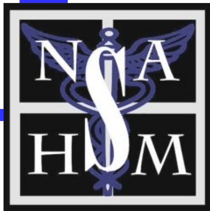
Model 4: Acute Care Hospital Stay Only



Community Based Organizations

Community-based organizations (CBOs) will use care transition services to effectively manage Medicare patients' transitions and improve their quality of care. Up to $300 million in total funding is available for 2011 through 2015. The CBOs will be paid an all-inclusive rate per eligible discharge based on the cost of care transition services provided at the patient level and of implementing systemic changes at the hospital level. CBOs will only be paid once per eligible discharge in a 180-day period for any given beneficiary. Community-based Care Transitions Program.

http://innovation.cms.gov/initiatives/CCTP/



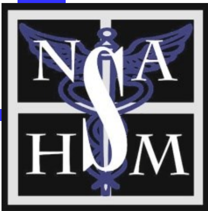
Care Delivery

"Better care coordination can also mean giving patients more quality time with their doctor; expanding the ways patients are able communicate with the team of clinicians taking care of them; or engaging patients and families more deeply in decision-making."

CMS 2015 Fact Sheet: "Better Care. Smarter Spending. Healthier People: Paying Providers for Value, Not Volume." 1.26.2015

Information Sharing

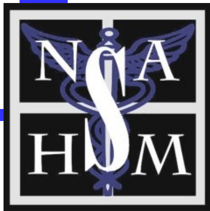
Interoperability



Interoperability fosters:

- Sharing information broadly with patients and other providers;
- Reducing duplication of treatment;
- Automated health alerts;
- Increased preventive screening;
- Access to data!

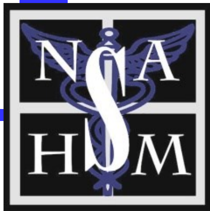
CMS 2015 Fact Sheet: "Better Care. Smarter Spending. Healthier People: Paying Providers for Value, Not Volume." 1.26.2015



Health Care Payment Learning and Action Network

The Learning and Action Network will accelerate the transition to more advanced payment models by fostering collaboration between HHS, private payers, large employers, providers, consumers, and state and federal partners.

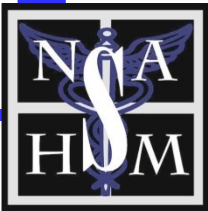
CMS 2015 Fact Sheet: "Better Care. Smarter Spending. Healthier People: Paying Providers for Value, Not Volume." 1.26.2015.



Learning and Action Network partners will:

- Serve as a convening body to facilitate joint implementation and expansion of new models of payment and care delivery
- Identify areas of agreement around movement toward alternative payment models and define how best to report on these new payment models
- Collaborate to generate evidence, share approaches, and remove barriers
- Develop common approaches to core issues such as beneficiary attribution, financial models, benchmarking, and risk adjustment
- Create implementation guides for payers and purchasers.

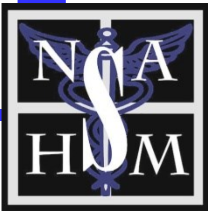
CMS 2015 Fact Sheet: "Better Care. Smarter Spending. Healthier People: Paying Providers for Value, Not Volume." 1.26.2015.



Medicare Provider Payment Modernization Act - HR 1470

"This section repeals the SGR to provide long-term stability to the Medicare physician fee schedule. It provides stable updates for five years and ensures no changes are made to the current payment system for four years."

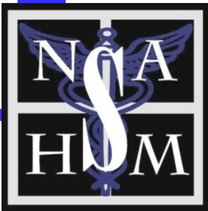
Taken from HR1470 summary by the House Committees on Energy & Commerce and Ways & Means.



Not Just an SGR Fix

"In 2019, it establishes a streamlined and improved incentive payment program that will focus the fee-for-service system on providing value and quality. The incentive payment program, referred to as the Merit-Based Incentive Payment System (MIPS)."

Taken from HR1470 summary by the House Committees on Energy & Commerce and Ways & Means.

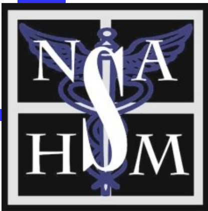


Timeframe

"Professionals will receive an annual update of 0.5 percent in each of the years 2015 through 2019.

The rates in 2019 will be maintained through 2025, while providing professionals with the opportunity to receive additional payment adjustments through the MIPS."

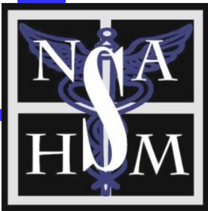
Taken from HR1470 summary by the House Committees on Energy & Commerce and Ways & Means.



Merit-Based Incentive Payment System (MIPS)

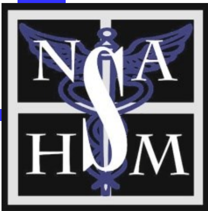
"…consolidates the three existing incentive programs, continuing the focus on quality, resource use, and meaningful electronic health record (EHR) use with which professionals are familiar, but in a cohesive program that avoids redundancies."

Taken from HR1470 summary by the House Committees on Energy & Commerce and Ways & Means.



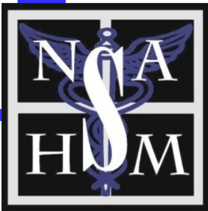
SGR Fix

"**Professionals** who receive a significant share of their revenues through an APM(s) that involves risk of financial losses and a quality measurement component **will receive a five percent bonus each year from 2019-2024**. A patient-centered medical home APM will be exempted from the downside financial risk requirement if proven to work in the Medicare population.“ NRHA Action Alert 3.19.2015



MIPS Eligible Professionals

- Doctors of medicine or osteopathy
- Doctors of dental surgery/medicine
- Doctors of podiatric medicine, optometry, chiropractors
- Physician Assistants, Nurse Practitioners, Clinical Nurse Specialists, and Certified Registered Nurse Anesthetists



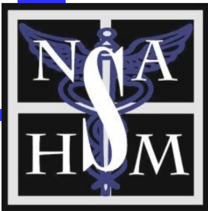
Current Incentive Programs

The MIPS streamlines and improves on the current incentive programs:

- Physician Quality Reporting System (PQRS)
- Value-Based Modifier (VBM)
- Meaningful use of EHRs (EHR MU)

Performance Measures

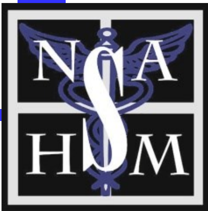
- Quality - PQRS, VBM, EHR MU measures
- Resource Use – Allocating costs; assigning 2-sided risk
- Meaningful Use – MU3



Physician Quality Reporting System

“The Physician Quality Reporting System (PQRS) is a quality reporting program that encourages individual eligible professionals (EPs) and group practices to report information on the quality of care to Medicare. PQRS gives participating EPs and group practices the opportunity to assess the quality of care they provide to their patients, helping to ensure that patients get the right care at the right time.”

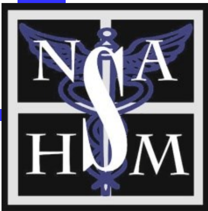
CMS- About PQRS



Incentive/Negative Adjustment

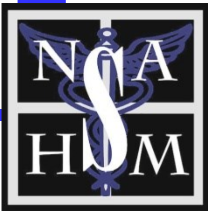
The 2015 PQRS incentive amount is .5%.

The negative payment adjustment for ALL eligible professionals is 2.0% of the Medicare Physician Fee Schedule.



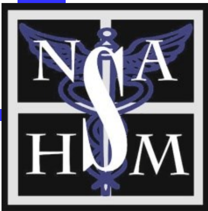
Two Reporting Methods

- Claim submissions with Qualified Data Codes (QDC) on the appropriate MPFS claim.
- Registry reporting via EHR (Direct), qualified PQRS registry, or qualified clinical data registry.



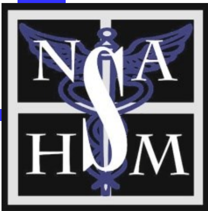
Reporting Periods

- The deadline to avoid the 2015 penalty was in 2013.
- In order to avoid the penalty for 2016:
  - Claim-based reporting entities was closed on 12.31.2014.
  - the registry reporting deadline was 2.28.2014.



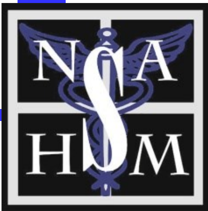
2015 Reporting Deadlines

Deadline	What closes	Resources
June 30, 2015	Last day to register through the PV-PQRS Registration System to participate in 2015 PQRS via GPRO	PQRS GPRO Criteria PQRS GPRO Web Interface
December 31, 2015	Reporting for the 2015 PQRS program year ends for both group practices and individuals (Note: 2015 program year data will determine the 2017 payment adjustment)	Analysis and Payments Payment Adjustment Information



2016 Deadlines

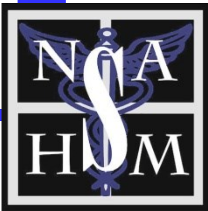
Deadline	What closes	Resources
February 26, 2016	Last day that 2015 claims will be processed to be counted for PQRS reporting to determine the 2017 payment adjustment	• 2015 resources to be posted to PQRS website
March 31, 2016	Last day for QCDRs (QCDR XML only) and registries to submit 2015 data	



RHCs and FQHCs

Question:

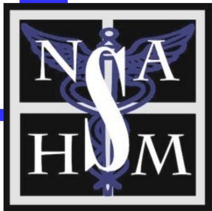
I’m an Eligible Professional (EP) and I furnish professional Medicare Part B services at an RHC/FQHC and also furnish services at a non-RHC/FQHC setting. Are the non-RHC/FQHC services eligible for the 2015 PQRS incentive payment or for the PQRS negative payment adjustment?



Answer:

Yes. for an EP who furnishes professional Medicare Part B services at an RHC/FQHC and also furnishes services at a non-RHC/FQHC setting, the non-RHC/FQHC services may be eligible for the PQRS incentive payment or the negative payment adjustment.

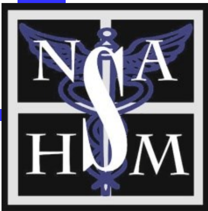
MLN Matters® Number: SE1508



Why is the Negative Adjustment on RHC claims?

The PQRS program applies a negative payment adjustment to practices with EPs, identified on claims by their individual National Provider Identifier (NPI) and Tax Identification Number (TIN), or group practices participating via the Group Practice Reporting Option (GPRO) (referred to as PQRS group practices) who do not satisfactorily report data on quality measures for covered Medicare Physician Fee Schedule services furnished to Medicare Part B Fee-For-Service beneficiaries.

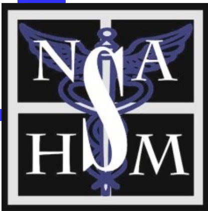
MLN Matters® Number: SE1508



Essential Community Providers

"A QHP issuer must have a sufficient number and geographic distribution of essential community providers, where available, to ensure reasonable and timely access to a broad range of such providers for low-income, medically underserved individuals in the QHP's service area, in accordance with the Exchange's network adequacy standards".

45 CFR 156.235 - Essential community providers



MU3

"Stage 3 of meaningful use is expected to be the final stage and would incorporate portions of the prior stages into its requirements. In addition, following a proposed optional year in 2017, beginning in 2018 all providers would report on the same definition of meaningful use at the Stage 3 level regardless of their prior participation, moving all participants in the EHR Incentive Programs to a single stage of meaningful use in 2018."

Electronic Health Record Incentive Program—Stage 3 Proposed rule

MU3 – Reduction in complexity?

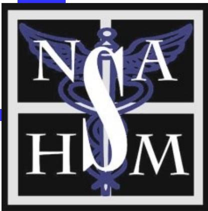
- Moving from 20 measures to eight.
- Single reporting periods.
- Many objectives retained from Stage 2.

Interoperability

“All of them are about the "movement of information to support the improvement of healthcare“

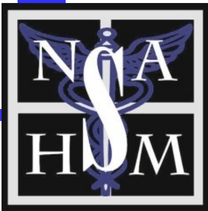
Elisabeth Myers

CMS eHealth Initiatives



Incentives for RHC/FQHC

- RHCs and FQHCs - as an entity - are only eligible for the Medicaid.
- Individual providers could attest for Medicare OR Medicaid.
  - Medicare – fee schedule only.
  - Medicaid > 30%.



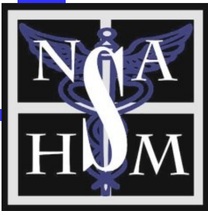
PQRS Incentives for RHC/FQHC

- RHC claims are NOT subject to PQRS negative payments – individual RHC providers ARE!

Payment for Quality

All providers are going to be in the quality reporting business.

Now is the time to prepare.



Sources

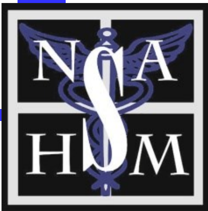
CMS 2015 Fact Sheet: “Better Care. Smarter Spending. Healthier People: Paying Providers for Value, Not Volume.” 1.26.2015

PQRS – Physician Quality Reporting System

http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/

HR 1470. SGR Repeal and Medicare Provider Payment Modernization Act Summary. Prepared by the House Committees on Energy & Commerce and Ways & Means.

http://energycommerce.house.gov/sites/republicans.energycommerce.house.gov/files/114/Analysis/20150319SGRSectionbySection.pdf



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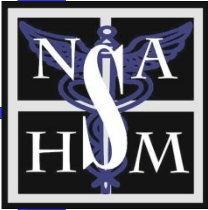
Meaningful Use Stage 3. Proposed Rule. www.cms.gov/Regulations-and Guidance/Legislation/EHRIncentivePrograms/Downloads/Stage3_Rule.pdf

Milliard, Mike. "CMS lays out vision for Stage 3 Meaningful Use". (Healthcare IT News: www.healthcareitnews.com/news/cms-lays-out-vision-stage-3-meaningful-use?single-page=true) April 13, 2015

Presentation Link

http://northamericanhms.com/blog/



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