THE CHANGING HEALTHCARE LANDSCAPE:
AN EVOLUTION TO VALUE

Richard Bikowski MD
Professor, Family and Community Medicine. EVMS
Chief Quality Officer, EVMS MG

Driving Forces in Healthcare Reform

Why Not the Best? Results from the National Scorecard on U.S. Health System Performance, 2011
October 18, 2011
Authors: The Commonwealth Fund Commission on a High Performance Health System

US Score Last Three Measures:
2006 - 67/100
2008 - 65/100
2011 - 64/100

Cost of Healthcare U.S.
$3.0 Trillion in 2014 (17.5% of GDP)
$9,523 per person each year

National Health Expenditures 2014 Highlights, CMS
IOM “Crossing the Quality Chasm” 2001

A Call for Transformation

- Health information technology
- Care delivery system redesign
- Evidenced based care
- Prepare the workforce
- Reimbursement: “align payment with quality”

Delivery System Redesign

Chronic Care Model


Chronic Care Model:
http://www.improvingchroniccare.org/

1. Community
   Resources and Policies

2. Health System
   Organization of Health Care

3. Self-Management Support

4. Delivery System Design

5. Decision Support

6. Clinical Information Systems

Functional and Clinical Outcomes

Quality Evolution

American Academy of Family Physicians (AAFP)
American Academy of Pediatrics (AAP)
American College of Physicians (ACP)
American Osteopathic Association (AOA)

Joint Principles of the Patient-Centered Medical Home
March 2007

Introduction

The Patient-Centered Medical Home (PCMH) is an approach to providing comprehensive primary care for children, youth and adults. The PCMH is a healthcare setting that facilitates partnerships between individual patients, and their personal physicians, and when appropriate, the patient's family.

The AAFP, ACP, AAP, and AOA, representing approximately 335,000 physicians, have developed the following joint principles to describe the characteristics of the PCMH:

Principles

Personal relationship - each patient has an ongoing relationship with a personal physician/trial to provide first contact, continuous and comprehensive care.

Physician directed medical practice - the personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.

Whole person orientation - the personal physician is responsible for providing care for all the patient's health care needs and taking responsibility for appropriately referring care to other qualified professionals. This includes care for all ages.

PCMH 2014 Content and Scoring

(6 standards/27 elements)

<table>
<thead>
<tr>
<th>Standards</th>
<th>Pts</th>
</tr>
</thead>
<tbody>
<tr>
<td>1: Enhance Access and Continuity</td>
<td></td>
</tr>
<tr>
<td>A. <strong>Patient-Centered Appointment Access</strong></td>
<td>4.5</td>
</tr>
<tr>
<td>B. AAFP Access to Clinical Advice</td>
<td>3.5</td>
</tr>
<tr>
<td>C. Electronic Access</td>
<td>2</td>
</tr>
<tr>
<td>2: Team-Based Care</td>
<td></td>
</tr>
<tr>
<td>A. Continuity</td>
<td>3</td>
</tr>
<tr>
<td>B. Medical Home Responsibilities</td>
<td>2.5</td>
</tr>
<tr>
<td>C. Culturally and Linguistically Appropriate Services (CLAS)</td>
<td>2.5</td>
</tr>
<tr>
<td>D. <strong>The Primary Team</strong></td>
<td>4</td>
</tr>
<tr>
<td>3: Population Health Management</td>
<td></td>
</tr>
<tr>
<td>A. Patient Information</td>
<td>3</td>
</tr>
<tr>
<td>B. Clinical Data</td>
<td>4</td>
</tr>
<tr>
<td>C. Comprehensive Health Assessment</td>
<td>4</td>
</tr>
<tr>
<td>D. <strong>Use Data for Population Management</strong></td>
<td>5</td>
</tr>
<tr>
<td>E. Implement Evidence-based Decision-Support</td>
<td>4</td>
</tr>
<tr>
<td>4: Plan and Manage Care</td>
<td></td>
</tr>
<tr>
<td>A. Identify Patients for Care Management</td>
<td>4</td>
</tr>
<tr>
<td>B. <strong>Care Planning and Self-Care Support</strong></td>
<td>3</td>
</tr>
<tr>
<td>C. Medication Management</td>
<td>4</td>
</tr>
<tr>
<td>D. Use Electronic Referring</td>
<td>3</td>
</tr>
<tr>
<td>E. Support Self-Care and Shared Decision Making</td>
<td>20</td>
</tr>
<tr>
<td>5: Track and Coordinate Care</td>
<td></td>
</tr>
<tr>
<td>A. <strong>Patient Tracking and Follow-Up</strong></td>
<td>6</td>
</tr>
<tr>
<td>B. <strong>Referral Tracking and Follow-Up</strong></td>
<td>6</td>
</tr>
<tr>
<td>C. Coordinate Care Transitions</td>
<td>18</td>
</tr>
<tr>
<td>6: Measure and Improve Performance</td>
<td></td>
</tr>
<tr>
<td>A. <strong>Measure Clinical Quality Performance</strong></td>
<td>4</td>
</tr>
<tr>
<td>B. Measure Resource Use and Care Coordination</td>
<td>4</td>
</tr>
<tr>
<td>C. Measure Patient Experience</td>
<td>3</td>
</tr>
<tr>
<td>D. <strong>Implement Continuous Quality Improvement</strong></td>
<td>4</td>
</tr>
<tr>
<td>E. <strong>Demonstrate Continuous Quality Improvement</strong></td>
<td>3</td>
</tr>
<tr>
<td>F. Report Performance</td>
<td>0</td>
</tr>
<tr>
<td>G. Use Certified EHR Technology</td>
<td>20</td>
</tr>
</tbody>
</table>

*Must Pass Elements

Scoring Levels:
- Level 1: 35-59 points
- Level 2: 60-84 points
- Level 3: 85-100 points

09/13/2016
“The Bad”

Quality, care management, PCMH
Encounters, volume, FFS

“Better, Smarter, Healthier”
Sylvia Burwell, Secretary HHS
January 26, 2015

MACRA is part of a broader push towards value and quality

In January 2015, the Department of Health and Human Services announced new goals for value-based payments and APMs in Medicare

Medicare Fee-for-Service

GOAL 1:
Medicare payments are tied to quality and value through alternative payment models (APM) by (30%) by the end of 2016, and 50% by the end of 2018.

GOAL 2:
Medicare fee-for-service payments are tied to quality or value (categories 1-4) by the end of 2016, and 50% by the end of 2018.

Stakeholders:
- Consumers
- Businesses
- Payers
- Providers
- States

Set measurable goals for success
Incentivize private sector payers to match or exceed HHS goals
Medicare Reporting Prior to MACRA

Currently there are multiple quality and value reporting programs for Medicare clinicians:

- Physician Quality Reporting Program (PQRS)
- Value-Based Payment Modifier (VM)
- Medicare Electronic Health Records (EHR) Incentive Program

REPORT MEASURES  QUALITY + COST  Use CEHRT

PASS/FAIL  All or Nothing

Value Based Modifier

The scatter plot below displays your TIN's quality and cost performance ("You" diamond), relative to that of your peers.

Your TIN's Performance: Average Quality, Average Cost

Higher Quality

Lower Cost

The scatter plot below displays your TIN's quality and cost performance ("You" diamond), relative to that of your peers.
EVMS MG 2013

**PERFORMANCE HIGHLIGHTS**

**Year Quality Composite Score: Low**

<table>
<thead>
<tr>
<th>Low Quality &amp; Low Cost</th>
<th>Low Quality &amp; High Cost</th>
<th>High Quality &amp; Low Cost</th>
<th>High Quality &amp; High Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.25</td>
<td>0.3</td>
<td>0.5</td>
<td>0.75</td>
</tr>
</tbody>
</table>

**Year Cost Composite Score: Average**

<table>
<thead>
<tr>
<th>Average</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.45</td>
<td>0.12</td>
</tr>
</tbody>
</table>

**Year Performance: Low Quality, Average Cost**

MACRA:
Medicare Access and CHIP Reauthorization Act of 2015

INTRODUCING THE QUALITY PAYMENT PROGRAM

*Proposed Rule May 8, 2016*

*Final Rule November, 2016*
Quality Payment Program

CMS Quality Payment Program

1st Performance Year

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Fee Schedule</td>
<td>+0.5% each year</td>
<td>No change</td>
<td>+0.25% or 0.75%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>~90% of providers</td>
<td>MIPS</td>
<td>~10% of providers</td>
<td>QPP in Advanced APM</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Max Adjustment (+/-)</td>
<td>4</td>
<td>5</td>
<td>7</td>
<td>9</td>
<td>9</td>
<td>9</td>
<td>9</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

MACRA: Medicare Access and CHIP Reauthorization Act of 2015
Merit-based Incentive Payment System (MIPS 2017/2019)

<table>
<thead>
<tr>
<th>50%</th>
<th>10%</th>
<th>15%</th>
<th>25%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality</td>
<td>Resource use</td>
<td>Clinical practice improvement activities</td>
<td>Advancing care information</td>
</tr>
</tbody>
</table>

MIPS Composite Performance Score (CPS)

0-100 Points

Top 25%

-4% +4%(X) + HP Bonus

FIGURE A: Illustrative Example of MIPS Adjustment Factors Based on Composite Performance Scores (CPS)
Quality Measures

- 6 “PQRS measures”… (CAHPS counts as 1, Bonus points)
- 90% of all payer patients (registry, EHR methods)
- Claims: **Avoidable acute admissions** (UTI, Pneumonia, Dehydration)
- Claims: **Avoidable chronic admissions** (CHF, DM, COPD)
- Claims: 30 day all cause re-admission rate
### Hypertension PQRS (MAP)

#### BP Control HTN MAP Cohort

<table>
<thead>
<tr>
<th>Date</th>
<th>Value</th>
<th>Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aug-15</td>
<td>65.0%</td>
<td></td>
</tr>
<tr>
<td>Sep-15</td>
<td>66.0%</td>
<td></td>
</tr>
<tr>
<td>Oct-15</td>
<td>67.0%</td>
<td></td>
</tr>
<tr>
<td>Nov-15</td>
<td>68.0%</td>
<td></td>
</tr>
<tr>
<td>Dec-15</td>
<td>69.0%</td>
<td></td>
</tr>
<tr>
<td>Jan-16</td>
<td>70.0%</td>
<td></td>
</tr>
<tr>
<td>Feb-16</td>
<td>71.0%</td>
<td></td>
</tr>
<tr>
<td>Mar-16</td>
<td>72.0%</td>
<td></td>
</tr>
<tr>
<td>Apr-16</td>
<td>73.0%</td>
<td></td>
</tr>
<tr>
<td>May-16</td>
<td>74.0%</td>
<td></td>
</tr>
<tr>
<td>Jun-16</td>
<td>75.0%</td>
<td></td>
</tr>
</tbody>
</table>

#### Axis Label

- **BP Control HTN MAP Cohort**
- **Goal**

**Start**
CMS Core Measures

Base score 50 points: Yes/ No

Performance score: Future Emphasis: Data Sharing

100 point maximum

Portal
Care Transitions
Referrals
Electronic SOC
(CCDA)
CPIA (60 point maximum)

- PCMH: 60 points
- High priority activity (20 points)
- Medium priority activity (10 points)
- MOC Part 4 can count

CPIA Categories (60 point maximum)

- Expanded Practice Access (4)
- Beneficiary Engagement (24)
- Achieving Health Equity (5)
- Population Management (16)
- Patient Safety and Practice Assessment (21)
- Emergency Preparedness and Response (2)
- Care Coordination (14)
- Participation in an APM, including a PCMH
- Integrated Behavioral and Mental Health (8)

Access
Manage TOCs
Referral process
Care management
MOC Part 4
Cost of Care

• Total per capita cost
• Medical spending per beneficiary (MSPB) for attributed patients
• Episodes of care:
  Examples:
  Admission CHF
  Total Hip replacement
  URI
  Colonoscopy

Key to understand:
TCOC (opportunities/drivers)
Episodes of care (BCPI)

Cost of Care – Know your QRUR

<table>
<thead>
<tr>
<th>Performance Category</th>
<th>Cost Measure</th>
<th>Your TIN’s Eligible Cases or Episodes</th>
<th>Your TIN’s Per Capita or Per Episode Costs</th>
<th>Benchmark</th>
<th>Reference Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Per Capita Costs for All Attributed Beneficiaries</td>
<td>Per Capita Costs for All Attributed Beneficiaries</td>
<td>4,056</td>
<td>$14,818</td>
<td>$12,214</td>
<td>$8,120 - 16,308</td>
</tr>
<tr>
<td>Diabetes</td>
<td>Medicare Spending per beneficiary</td>
<td>1,325</td>
<td>$19,812</td>
<td>$20,298</td>
<td>$19,656 - 21,541</td>
</tr>
<tr>
<td>Diabetes</td>
<td>$20,298</td>
<td>1,445</td>
<td>$18,084</td>
<td>$11,747 - 23,420</td>
<td></td>
</tr>
<tr>
<td>Per Capita Costs for Beneficiaries with Specific Conditions</td>
<td>Chronic Obstructive Pulmonary Disease (COPD)</td>
<td>515</td>
<td>$32,234</td>
<td>$29,862</td>
<td>$18,845 - 39,190</td>
</tr>
<tr>
<td>Coronary Artery Disease (CAD)</td>
<td>1,027</td>
<td>$26,713</td>
<td>$21,592</td>
<td>$14,007 - 25,178</td>
<td></td>
</tr>
<tr>
<td>Heart Failure</td>
<td></td>
<td>719</td>
<td>$35,558</td>
<td>$33,411</td>
<td>$21,749 - 46,074</td>
</tr>
</tbody>
</table>

Note: The lower limit of the reference range for a measure is defined as one standard deviation below the measure’s benchmark, and the upper limit is one standard deviation above the measure’s benchmark. The reference range is shown for informational purposes only and is not used to determine whether a measure is included in the Cost Composite Score for the Value Modifier. If dashes (–) appear in this table, this indicates that per capita or per episode costs could not be calculated for your TIN because there were no eligible cases or episodes for that measure.
Summary: Quality Payment Program

- Expect MACRA implementation to proceed
  - Upcoming Presidential elections estimated to have limited impact
    - MACRA passed House 392-37; passed Senate 92-8
- Assess your performance under current programs
  - How did your group perform in PQRS and MU? Have you downloaded your 2014 or mid-year 2015 Quality and Resource Use Report?
- Engage in ongoing learning about MACRA & MIPS
- Pick the “right” quality measures
- Share Quality Data with Practices and Providers

Summary: Quality Payment Program

- Transitions of care (*hospital and ED, referrals, summary of care and direct messaging*)
- Care management
- Build a portal population and use it
- Practice performance improvement (*access, referrals, transitions, MOC*)
- Total cost of care, episodes of care, opportunities
- Keep “advanced” APM models in view (*2019/2021 all payer*)
Remember, It’s Currently “Proposed”

Payment Model Evolution

Fee for Service  Quality Incentive Care Management  Quality Shared Savings  At Risk “Comprehensive care+ episode payments”

Fee for Service  Fee for Service  Fee for Service  Fee for Service
Advanced APMs meet certain criteria.

As defined by MACRA, Advanced APMs must meet the following criteria:

- The APM requires participants to use certified EHR technology.
- The APM bases payment on quality measures comparable to those in the MIPS quality performance category.
- The APM either: (1) requires APM Entities to bear more than nominal financial risk for monetary losses; OR (2) is a Medical Home Model expanded under CMMI authority.

Value Based “One Sided Risk” Shared Savings

- **5000 primary care patients**
- **$70,920,000 Total Patient Costs ($1,182 PMPM)**
- **$4,920,000 (7%) “Shared Savings”**
- **$66,000,000 Total Patient Costs ($1,100 PMPM)**

P4P: percent of shared savings dependent on quality score (up to 50% of savings)

$0 up to $2,460,000
“Two Sided Risk” Shared Savings

5000 primary care patients

At Risk for Increased Spending (4% Max)

$70,920,000 (2016)
Total Patient Costs ($1,182 PMPM)

$4,920,000 (7%)
“Overspend/Loss”

$66,000,000 (2017)
Total Patient Costs ($1,100 PMPM)

$4,920,000 (7%)
“50% Shared Savings”

50% Shared Savings

At Risk for Increased Spending (4% Max)

“Two Sided Risk” Shared Savings

Comprehensive Primary Care Plus

CMS launches largest-ever multi-payer initiative to improve primary care in America

CPC+ Participating Regions & Provisional Payer Partners

North Hudson-Capital Region
Greater Philadelphia Region
Ohio & Northern Kentucky Region
Greater Kansas City Region

Region spans the entire state
Region comprises contiguous counties
Medicare Will Partner with Aligned Public and Private Payers

- CMS is soliciting interested payer partners: April 15 – June 1, 2016

Three Payment Innovations Support Practice Transformation

<table>
<thead>
<tr>
<th></th>
<th>Care Management Fee (PBPM)</th>
<th>Performance-Based Incentive Payment</th>
<th>Underlying Payment Structure</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Track 1</strong></td>
<td>$15 average</td>
<td>$2.50 opportunity</td>
<td>Standard FFS</td>
</tr>
<tr>
<td><strong>Track 2</strong></td>
<td>$28 average; including $100 to support patients with complex needs</td>
<td>$4.00 opportunity</td>
<td>Reduced FFS with prospective &quot;Comprehensive Primary Care Payment&quot; (CPCP)</td>
</tr>
</tbody>
</table>
Resources


https://www.acponline.org/practice-resources/business-resources/payment/medicare/macra