Merit Health

MACRA > TCPI > CIN: Connecting the dots
Friday December 16, 2016

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Caravan Health / NRACC
Current Market Issues

• Many factors hitting physicians at same time:
  • Downward slope of FFS reimbursement.
  • Payor consolidation.
  • Narrow network deployment.
  • Push toward electronic medical record/health information exchange.
  • MACRA/MIPS- Complicated program; $’s at risk.

• Lack of resources for independent practices to address:
  • Standalone for managed care agreements.
  • Usually no in-house IT resource.
  • Less physician admin time available due to keeping up FFS revenue.
Positioning Your Practice

• Fee for service payment methods are **blurring** and morphing into new payment models.

• Increasing **focus on accountability** for total cost of care, while maintaining quality.

• **Growing emphasis on care coordination**, health IT and patient satisfaction.

• Practices with a sophisticated understanding of **financial and clinical analytics** will be best positioned for evolving payment models.

• **Stay ahead of the curve** and thoughtfully consider if certain voluntary incentive programs are right for your practice.

• **Be aware of the changing landscape** by engaging with educational resources.
What can you do now?

• Satisfy Meaningful Use Stage 2 (Will suffice for ACI metrics)

• If possible, report Quality & ACI (Formerly MU) for the entire performance year 2017
  • This qualifies providers for an estimated ≈+2.4% Medicare bonus in 2019

• Ensure your EHR is certified by the ONC of HIT
  • Instill Quality Assurance to ensure data flows appropriately
  • Consider using a qualified clinical data registry to extract/submit quality

• Consider plausible Clinical Practice Improvement Activities

• Remember, NPs, PAs, CRNAs, & Clinical Nurse Specialists are Eligible Clinicians

• Prepare to Model APM eligibility

• Consider participation in a “Transformation Network” to assist in preparation. CMS grant funded/free to the practice.
What is Clinical Integration?

In 1996, the DOJ and the FTC defined CI as an active and ongoing program to evaluate and modify practice patterns by the CI network’s physician participants and create a high degree of interdependence and cooperation among the physicians to control costs and ensure quality.

Generally, the FTC considers a program or network to be clinically integrated if it performs the following:

1. Establish mechanisms to monitor and control utilization of healthcare services that are designed to control costs and ensure quality of care.
2. Selectively chooses CI network physicians who are likely to further these efficiency objectives.
3. Utilizes investment of significant capital, both monetary and human, in the necessary infrastructure and capability to realize the claimed efficiencies.
Benefits of Clinical Integration

1. Autonomy within collaboration, in a legal entity.
2. Proactive approach to FFV changes in the market.
3. Technology infrastructure that provides the ability to measure and report on quality outcomes and cost savings as a group.
4. Improves communication and subsequent transition of care, coordination of chronic disease management, and population health management.
5. Legally and strategically gives you more flexibility and authority to speak with one single voice.
6. Reduction in network “leakage.”
TCPI benefits towards Clinical Integration

1. Immediate implementation and support of key CIN infrastructure outlined below.
2. No cost to attain analytics platform. Revenue impact immediately via HCC module.
3. Care coordination efforts.
4. Comprehensive training and educational opportunities.
5. 3 year grant to help form CIN collaborative framework and infrastructure.
6. Opportunity to partner and collaborate with national organization and peers.
TCPI / CIN Crosswalk

<table>
<thead>
<tr>
<th>Req #</th>
<th>CIN Requirements (Legal &amp; Operational)</th>
<th>Provided by TCPI</th>
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<tbody>
<tr>
<td>1</td>
<td>IT Connectivity</td>
<td>x</td>
</tr>
<tr>
<td>2</td>
<td>Data analytics and sharing</td>
<td>x</td>
</tr>
<tr>
<td>3</td>
<td>Patient engagement</td>
<td>x</td>
</tr>
<tr>
<td>4</td>
<td>Care coordination</td>
<td>x</td>
</tr>
<tr>
<td>5</td>
<td>Engagement by legal counsel</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Clinical workgroups / initiatives</td>
<td></td>
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<tr>
<td>7</td>
<td>Shared-risk arrangements</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Governance structure</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Accountability mechanisms</td>
<td></td>
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<tr>
<td>10</td>
<td>Physician engagement</td>
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</tbody>
</table>

**Caravan Health Services:**
1. Care Coordination: Clinical Health Coach training and education for Care Coordinators.
2. Population Health Data Analytics: Lightbeam Solutions software.
3. 24/7 Nurse Advice Line.
4. Patient Satisfaction Surveys via tablets.
5. Education via online webinars and workshops.
TCPI Training & Obligations

1. Agree to Opt In

2. Complete surveys & webinars
   a. Caravan educational / learning portals
   b. CCM Billing webinar
   c. Lightbeam specifications
   d. Nurse Advice Line Questionnaire & webinar
   e. Patient Satisfaction Survey Questionnaire & Survey Tool / Tablet webinar

3. Clinical Health Coach training

4. Schedule baseline practice assessment
MACRA AND PHYSICIAN REIMBURSEMENT

Physician Education
December 16, 2016
Presentation

- CMS Goals
- Merit Incentive Based Payment System
- Advanced Alternative Payment Models
- Importance of Clinical Integration Models
- Next Steps
Quality Payment Program

(1) support care improvement by focusing on better outcomes for patients, decreased provider burden, and preservation of independent clinical practice;

(2) promote adoption of alternative payment models that align incentives across healthcare stakeholders; and

(3) advance existing efforts of Delivery System Reform, including ensuring a smooth transition to a new system that promotes high-quality, efficient care through unification of CMS legacy programs.
Two Payment Models = QPP

**Merit-based Incentive Payment System (MIPS)**

- Providers are scored on 3 and then 4 metrics to create a Composite Score
- Providers Reimbursement will go up or down depending upon performance when compared with peers

**Advanced Alternative Payment Model**

- Must be a Qualified Provider
- Bonus Payment of 5%; and
- Not subject to MIPS
MIPS

Eligible Providers

- Physicians
- Nurse Practitioners
- Clinical Nurse Specialists
- Certified Registered Nurse Anesthetists
- Groups of these providers
- $100M in Technical Assistance for small and rural groups

Excluded Providers

- New Physician enrolled in part B in last year
- Low Volume < $30K for Medicare/ <100 Medicare Patients
- Participate in Advanced APM
- Projected to Exclude 32.5% of Practitioners
MIPS

*MMS* - *Merit-Based Incentive Payment Model*

Increase in Reimbursement based upon the Composite Performance Score (CPS)

- Quality (60%)
- Resource Use (10%) — *Removed in Year 1 in the Final Rule*
- Clinical Practice Improvement Activities (15%)
- Advancing Care Information (meaningful use) (25%)
EVALUATION PERIOD IS CALENDAR YEAR 2 YEARS PRIOR

(i.e. 2017 performance impacts $199Million for 2019)

2019 1\textsuperscript{st} Payment Period (-4\% to +4\%)
2020 2\textsuperscript{nd} Payment Period (-5\% to +5\%)
2021 3\textsuperscript{rd} Payment Period (-7\% to +7\%)
2022 4\textsuperscript{th} Payment Period (-9\% to +9\%)
Quality

Selection of 6 measures
▪ 1 cross-cutting measure and 1 outcome measure, or another high priority measure if outcome is unavailable
▪ Select from individual measures or a specialty measure set
▪ Population measures automatically calculated

Key Changes from (PQRS):
Reduced from 9 measures to 6 measures • Emphasis on outcome measurement
• Year 1 Weight: 60%
Quality Domains

- Clinical Care
- Safety
- Care Coordination
- Patient and Caregiver Experience
- Population Health and Prevention
Clinical Practice Improvement

CPIA = Care coordination, beneficiary engagement, population management, and health equity

• Large Practice –
  • Reduced to 4 Medium and 2 High priority Measures

• Small Practice
  • Reduced to 2 Medium and 1 High Priority measure

• One CPIA may also count for Advancing Care Information Bonus
Advancing Care Information

- Reduced from 11 to 5 measures
- Bonus for Public Registry Reporting/Clinical Data Registries
- Patient Electronic Access
- Electronic Care Coordination
- Health Information Exchange

- Bonus points for reporting to public health or clinical data registries
## Performance Standards 2017

<table>
<thead>
<tr>
<th>Performance Category</th>
<th>Proposed Performance Standard</th>
<th>Final Performance Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advancing Care Information</td>
<td>Based on participation (base score) and performance (performance score). Base score: Achieved by meeting the Protect Patient Health Information objective and reporting the numerator (of at least one) and denominator or yes/no statement as applicable (only a yes statement would qualify for credit under the base score) for each required measure. Performance score: decile scale for additional achievement on measures above the base score requirements, plus 1 bonus point.</td>
<td>Based on participation (base score) and performance (performance score). Base score: Achieved by meeting the Protect Patient Health Information objective and reporting the numerator (of at least one) and denominator or yes/no statement as applicable (only a yes statement would qualify for credit under the base score) for each required measure. Performance score: Between zero and 10 or 20 percent per measure (as designated by CMS) based upon measure reporting rate, plus up to 15 percent bonus score.</td>
</tr>
</tbody>
</table>
Data Submission

1. Qualified clinical data registries (QCDRs)
   - 50 % of the MIPS eligible clinician or group’s patients that meet the measure’s denominator criteria, regardless of payer

2. Health IT vendors, and

3. CMS-approved survey vendors will have the ability to act as intermediaries on behalf of MIPS eligible clinicians for submission of data to CMS
   - Sample of the Medicare Part B patients CMS provides

4. Claims Data
   - Report on at least 50 % of the Medicare Part B patients seen during the performance period
MIPS + APM or Advanced APM

- MIPS providers are also eligible for exceptional performance increase up to 27%
- MIPS providers that are in an APM may receive an increase in reimbursement of 0.5% in addition until 2020

Advanced APM = 5% Bonus
MACRA

Alternative Payment Models ("APM")

1. CMS Innovation Center model
2. MSSP (Medicare Shared Savings Program)
3. Demonstration under the Health Care Quality Demonstration Program
4. Demonstration required by federal law
   • FINAL RULE ACO 1+
Advanced APMs

Qualifying Providers must:
1. Use a Certified Electronic Health Record
2. Perform under the Quality metrics used for MIPS
3. Financial Risk (similar to ACO) or Medical Home Model
Alternative Payment Models

- Final Rule creates a Physician-Focused Payment Model Technical Advisory Committee (PTAC) to provide recommendations on
- Physician Focused Payment Models ("PFPM")
Qualifying Provider

- CMS will calculate a percentage “Threshold Score” for each Advanced APM Entity using two methods (payment amount and patient count).
- Methods are based on Medicare Part B professional services and beneficiaries attributed to Advanced APM Entities.
- The Threshold Score for each method is compared to the corresponding QP threshold table.
QPP Projections

2017—70,000 to 120,000

2018—125,000 to 250,000

$333 Million to $571 Million incentive payments in 2019
### Potential of the Other Payer Combination Option

- The Other Payer Combination Option are poised to drive increased participation in risk-bearing coordinated care models across all payers, not just Medicare.

<table>
<thead>
<tr>
<th>Year</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>2021</td>
<td>Beginning in 2021, health care professionals can also qualify for APM Incentive Payments through Other Payer Advanced APM thresholds. In order to qualify in 2021 and 2022, Qualifying APM Participants (QPs) must receive at least 50% of the sum of payments by Medicare and other payers through Advanced APMs and Other Payer Advanced APMs.</td>
</tr>
<tr>
<td>2022</td>
<td>For 2023 and subsequent years, QPs must receive at least 75% of payments through Advanced APMs and Other Payer Advanced APMs.</td>
</tr>
</tbody>
</table>

Under an Other Payer Advanced APMs, at least 25% of Medicare payments for covered professional services must be through Advanced APMs.

Source: Public Law 114-10 (April 16, 2015)
PICK YOUR PACE

- Don’t Participate
  - Negative 4%

- Submit Something
  - Submit 1 Quality 1 Improvement Activity

- Submit a Partial Year
  - Submit at least 90 Days

- Submit a Full Year
  - Submit for full Year
Final Rule Changes

1. Creation of Transition year and Learning Development Period
2. Adjustment of MIPS Low volume Threshold
3. Established Advanced APM Risk Standard
4. Simplified Advancing Care Information
5. Established Medical Home Models for coordination of care
CLINICAL INTEGRATION MODELS
To effectively implement CI, the network should understand the relevance and the possible options for each of the seven components discussed here:
Patient in the Center of Integrated Care

# Build Core Capabilities

<table>
<thead>
<tr>
<th>Provider Alignment</th>
<th>Care Delivery</th>
<th>Information Technology</th>
<th>Data Mgmt./Analytics</th>
<th>Payment Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Governance</td>
<td>• Prevention and wellness initiatives</td>
<td>• Patient registry</td>
<td>• Patient/condition identification</td>
<td>• Patient attribution</td>
</tr>
<tr>
<td>• Organizational structure</td>
<td>• Evidence-based protocols</td>
<td>• Electronic medical record</td>
<td>• Clinical outcomes</td>
<td>• Incentive distribution/ funds flow</td>
</tr>
<tr>
<td>• Foundational primary care</td>
<td>• Care transition initiatives</td>
<td>• Computerized physician order entry (CPOE)</td>
<td>• Quality reporting</td>
<td></td>
</tr>
<tr>
<td>• Primary care/ specialist communication</td>
<td>• Patient health tools</td>
<td>• Case management workflow tools</td>
<td>• Utilization reporting</td>
<td></td>
</tr>
<tr>
<td>• Network development and management</td>
<td>• Health management support</td>
<td>• Decision support</td>
<td>• Movement toward data standardization</td>
<td></td>
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<tr>
<td>• Contracting</td>
<td></td>
<td>• Provider portal</td>
<td></td>
<td></td>
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<tr>
<td>• Clinical collaboration forums</td>
<td></td>
<td>• Billing/claims</td>
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<tr>
<td></td>
<td></td>
<td>• Contracting</td>
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<tr>
<td></td>
<td></td>
<td>• Health information exchanges</td>
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</tbody>
</table>

Source: Kaufman, Hall & Associates, Inc.
HIT Leadership Summit
December 7th, 2016

3 Key Areas of Focus for Healthcare Delivery Systems

1. Physician workflows
2. Evaluate and Integrate the Ecosystem
3. MACRA is the Spark to push the value based initiatives
Next Steps

- Pull Qualitynet Reports
  - Evaluate Quality Score and Cost Score
- Evaluate Clinical Practice Improvement Activity options (Table H)
- Educate Physicians and Staff
- Pick Your Pace
For more information, contact:

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Establish Your Value-Based Infrastructure at No Cost.
Population Health

TCPI Program Elements that Drive Success

**Prevention:**
- Annual Wellness Visits
- Chronic Care Management
- Advanced Care Planning
- Behavioral Counseling
- Depression Screening
- Mental Health Support
- 24/7 Access

**Coding:**
- HCC 101

**Quality:**
- Process
- Pre-visit Planning
- Patient Satisfaction
Fee for Service Practices and RHC’s:

- Annual Wellness Visits
- Chronic Care Management
- Advanced Care Planning
- Behavioral Counseling
- Depression Screening

New Value-Based Payment Models:

- Medicare Incentive Payment System – MIPS
- Medicare Shared Savings Program - MSSP
- NextGen ACO Shared Savings Program
- Mandatory Bundled Payments
  - CCJR in 2016 and Heart Procedures in 2017
- Comprehensive Primary Care Plus – CPC+ (in 14 states)
- Million Hearts
(MIPS) Performance Categories:

- **Quality measures** (60% of Score)
- **Resource Use measures** (0% of Year 1 Score)
  - Will grow to count for 30% in 2021
- **Clinical Improvement Activities** (15% of Score)
  - Sub-Categories-Includes Better Off-Hours Access, Care Coordination
  - Patient Safety, Beneficiary Engagement
  - Others as Determined by Secretary
- **Meaningful Use of EHRs** (25% of Score)
Under MIPS The Merit-Based Incentive Payment System (MIPS) physicians, PAs and NPs billing Medicare using the Physician Fee Schedule will required to report various measures which will be used to determine end-of-year payment adjustments. Although RHCs are exempt from the reporting requirements, CMS has provided RHC eligible clinicians the opportunity to “voluntarily report on applicable measures and activities for MIPS.” RHC clinicians opting to voluntarily report will have no bearing on RHC payments
At-Risk Populations

Preventive Health

Patient and Caregiver Experience

Care Coordination and Patient Safety

Reporting on Quality Under MIPS
MIPS: Clinical Improvement Activities

**Expanded Practice Access**
- Same day appointments for urgent needs
- After hours clinician advice

**Population Management**
- Monitoring health conditions & providing timely intervention
- Participation in a qualified clinical data registry

**Care Coordination**
- Timely communication of test results
- Timely exchange of clinical information with patients AND providers
- Use of remote monitoring
- Use of telehealth

**Beneficiary Engagement**
- Establishing care plans for complex patients
- Beneficiary self-management assessment & training
- Employing shared decision making

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/Timeline.PDF
(MIPS) TIMELINE:

• CMS will propose the initial policies for the MIPS in CY2017 PFS Rule Making -proposed rule published around June 2016

• **Performance Period begins Jan 1, 2017.** CMS must make available timely (“such as quarterly”) confidential feedback reports to each MIPS EP starting **July 1, 2017**

• **Beginning July 1, 2018,** CMS must make available to each MIPS EP information about items and services furnished to the EP’s patients by other providers and suppliers for which payment is made under Medicare

• Information about the performance of MIPS EPs must be made available on Physician Compare
MACRA: MIPS Implementation

[Image of a timeline showing MIPS implementation over different years with various percentages and thresholds.]

- **FEE** Schedule Updates: 0.5, 0.5, 0.5, 0.5, 0, 0, 0, 0, 0, 0.75, 0.25
- **MIPS** Quality: 4%, 5%, 7%, 9%
- **APMs** Incentive Payment: 5%

[Notes: Qualifying APM conversion factor, Non-qualifying APM conversion factor]

Evolution of Value-Driven Measures

Measures Individual Performance

Facility Measures
- Meaningful Use
- PCMH

Facility and Patient Measures
- PQRS
- Readmission Rates
- ACO Measures
- Voluntary Bundles
- Patient Satisfaction
- MACRA - MIPS
- MA Star Ratings

Patient Measures
- Value-Based Modifier
- CCJR Bundles
- More TBD

Measures SYSTEM of Care
What is a Practice Transformation Network (PTN)?

• The Practice Transformation Network (PTN) program is designed to help small and safety net providers transition from fee-for-service payment models to advanced payment models, and also to be able to succeed under the new guidelines for the Physician’s Quality Reporting System (PQRS) and the Value-Based Modifiers (VBM).

• This program is funded by the Transforming Clinical Practices Initiative (TCPI).
Step One: Set up your Care Coordination Program

EDUCATION: Attend Care Coordination Webinar
ACTION: Designate a Care Coordinator

- Certify your coordinators with the Clinical Health Coach (CHC) Training program offered by the Iowa Chronic Care Consortium.
  - A 26 hours on-line and self-paced program.
- Participate in hands-on Regional Workshops held quarterly.
Step Two: Develop Your Billable Chronic Care Management (CCM) Service

EDUCATION: Attend Chronic Care Management Webinar
ACTION: Download Consent Form and Support Materials

- Train and Certify your Care Coordinators as Clinical Health Coaches (CHC)
- Implement the necessary IT infrastructure for access to Care plans in Lightbeam
- Provide a federally-funded 24/7 nurse advice hotline
- Bill Medicare $42 PMPM
Step Three: NurseWise/Evolve

**EDUCATION:** Attend 24hr Nurse Advice Hotline Webinar

**ACTION:** Complete Nursewise Survey on PTN website

- 24-hour telephonic access to medical advice for Medicare patients.
- Necessary for your billable care coordination program’s after-hours coverage.
Step Four: Point-of-Service Patient Satisfaction Survey Tool and Tablet

**EDUCATION:** Attend webinar about survey tool and tablet.

**ACTION:** Complete Survey posted on PTN webpage.

- Each practice is eligible to receive single use tablet for patients to complete satisfaction survey & receive feedback.
- Tablets will be deployed within 60 days of enrollment.
Step 5: Preparing to become a Patient-Centered Medical Home (PCMH)

**ACTION:** Complete Practice Baseline Assessment

**EDUCATION:** Attend webinar about PCMH.

**ACTION:** Complete Plan-Do-Study-Act activities.

- Assessment is aligned with PCMH goals and track’s your practice performance.
- Conducted by NRACC Quality Specialist or your state’s QIO/QIN with your leadership.
- Lays the foundation to apply for certification as a PCMH. PCMH elements are built into quarterly training workshops in a Plan, Do, Study, Act (PDSA) format.
Step 6: Practice Workflow Redesign

EDUCATION / ACTION:
Schedule staff to attend one Regional Workshop per quarter.

• Your practice will receive easy-to-implement workflow tools.
• We will work together to create custom implementation plan – tailored to your practice’s needs and challenges
• Regional Workshop will be held in Savannah on October 18th and in Atlanta on October 21st.
OUTCOMES: Redesign Your Practice to Better Manage Population Health

- Modify clinic workflow to address care gaps
- Provide data to identify cost-savings opportunities
- Report and improve ambulatory quality scores
- Measure patient satisfaction at the point of care (Tablet)
- Get paid quality bonuses
OUTCOMES: Improved Billing and New/Increased Revenue Streams

Action for Success: Actively participate in program activities – PDSAs, Workflows, Trainings, and Workshops.

• Program activities designed to reduce cost and improve quality.
• Maximize additional population health payments
• Prevent value-based payment penalties
• Improve financial stability of local health systems.
In Summary, TCPI is the First Step of a Strategic Plan for Practice Transformation

- Optimize Quality MIPS Incentive - DevelopPop Health Infrastructure (TCPI)
- Form Clinically Integrated Networks (CIN) with Other Independents
- Form - Join ACO’s – MSSP, Commercial and Medicaid
- Participate in Qualifying APM – PCMH, Bundled Payments
TCPI Participation Requirements

• Participants must appoint or hire an in-house care coordinator (will bill Medicare for new services)
• Active participation in the program, including attendance at:
  • Training webinars
  • Regional workshops
  • Divisional workshops, and

(Travel for regional & divisional workshops is reimbursed through the grant)
Questions? – Next Steps

Go to www.nationalruralaco.com
Click on **Apply Now** to get ready for the future.

OR CONTACT:

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THANK YOU!