Value-based Purchasing, Performance Measures, and Minority Health

2017 NMQF Leadership Summit on Health Disparities

April 24, 2017
Medicare Quality Payment Program In a Nutshell

Law intended to align physician payment with value

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)
Or now the...

Quality Payment Program

- Merit-Based Incentive Payment System (MIPS)
- Advanced Alternative Payment Models (APMs)
This new MIPS “report card” will replace current Medicare reporting programs

There are currently multiple individual **quality and value** programs for Medicare physicians and practitioners:

- **Physician Quality Reporting Program (PQRS)**
- **Value-Based Payment Modifier (quality and cost of care)**
- **“Meaningful use” of EHRs**

**MACRA** streamlines those programs into **MIPS**:

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

How will Clinicians be Scored Under MIPS? – FINAL RULE FOR 2019

A single MIPS composite performance score will factor in performance in 4 weighted performance categories:

**Year 1 or 2019***

- Quality: 60%
- Advancing Care Information: 25%
- Clinical practice improvement activities: 15%
- Cost: 0%

* Based on reporting data in 2017

Getting cost down to 0% in the first year is a BIG WIN for physicians!
How Much Can MIPS Adjust Payments?

- Based on the MIPS composite performance score, physicians and practitioners will receive positive, negative, or neutral adjustments up to the percentages below.
- MIPS adjustments are budget neutral.

MAXIMUM Adjustments

<table>
<thead>
<tr>
<th>Year</th>
<th>Adjustments</th>
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<tbody>
<tr>
<td>2019</td>
<td>4%</td>
</tr>
<tr>
<td>2020</td>
<td>5%</td>
</tr>
<tr>
<td>2021</td>
<td>7%</td>
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<tr>
<td>2022 onward</td>
<td>9%</td>
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Adjustment to provider’s base rate of Medicare Part B payment

Those who score in top 25% are eligible for an additional annual performance adjustment of up to 10%, 2019-24 (NOT budget neutral)
Timing of QPP Implementation

Performance:
The first performance period opens January 1, 2017 and closes December 31, 2017. During 2017, record quality data and how you used technology to support your practice. If an Advanced APM fits your practice, then you can provide care during the year through that model.

Send in performance data:
To potentially earn a positive payment adjustment under MIPS, send in data about the care you provided and how your practice used technology in 2017 to MIPS by the deadline, March 31, 2018. In order to earn the 5% incentive payment for participating in an Advanced APM, just send quality data through your Advanced APM.

Feedback:
Medicare gives you feedback about your performance after you send your data.

Payment:
You may earn a positive MIPS payment adjustment beginning January 1, 2019 if you submit 2017 data by March 31, 2018. If you participate in an Advanced APM in 2017, then you may earn a 5% incentive payment in 2019.

Source: https://qpp.cms.gov/
Pick Your Pace – MACRA/QPP Final Rule for 2017 Reporting

Not participating in the Quality Payment Program:
If you don’t send in any 2017 data, then you receive a negative 4% payment adjustment.

Test:
If you submit a minimum amount of 2017 data to Medicare (for example, one quality measure or one improvement activity for any point in 2017), you can avoid a downward payment adjustment.

Partial:
If you submit 90 days of 2017 data to Medicare, you may earn a neutral or small positive payment adjustment.

Full:
If you submit a full year of 2017 data to Medicare, you may earn a moderate positive payment adjustment.

Participate in the Advanced APM path:
If you receive 25% of Medicare payments or see 20% of your Medicare patients through an Advanced APM in 2017, then you earn a 5% incentive payment in 2019.

Source: https://qpp.cms.gov/
MIPS Final Rule: Overview of Quality Performance Category

- **Most participants:** Report up to 6 quality measures, including an outcome measure, for a minimum of 90 days.
  
  * Three population measures automatically calculated from administrative claims, but only one* used for performance score.
  
  * **Groups using the web interface:** Report 15 quality measures for a full year.

- **Groups in certain APMs, such as Shared Savings Program Track 1 or the Oncology Care Model:** Report quality measures through your APM. You do not need to do anything additional for MIPS quality.

- CAHPS for MIPS reporting is voluntary (and credit is provided under Improvement Activities)

- **NOTE:** Key Change from Current Program (PQRS): reduced from 9 measures to up to 6 measures with no domain requirement

- **Year 1 Weight:** 60%

* All-cause readmissions – but only for groups with 16 or more clinicians with at least 200 attributed cases.
Fulfill the required (i.e., base) 5 measures for a minimum of 90 days:

- Security Risk Analysis
- e-Prescribing
- Provide Patient Access
- Send Summary of Care
- Request/Accept Summary of Care

Choose to submit up to 9 measures for a minimum of 90 days for additional credit.

For bonus credit, clinicians can:

- Report Public Health and Clinical Data Registry Reporting measures
- Use certified EHR technology to complete certain improvement activities in the improvement activities performance category

OR

Clinicians may not need to submit advancing care information if these measures do not apply to you.

Year 1 Weight: 25%
MIPS Final Rule: Clinical Practice Improvement Activities*

- **Most participants:** Attest that they completed **up to 4** improvement activities for a minimum of 90 days.
  - Groups with fewer than 15 participants or if you are in a rural or health professional shortage area: Attest completion of up to 2 activities for a minimum of 90 days.

- **Participants in certified patient-centered medical homes, comparable specialty practices, or an APM designated as a Medical Home Model:** Automatically earn full credit.

- **Participants in certain APMs, such as Shared Savings Program Track 1 or the Oncology Care Model:** Automatically receive points based on the requirements of participating in the APM.
  - Part of an advanced APM, but not a qualifying participant - full credit.
  - Other APMs will get half credit.

- **Year 1 Weight:** 15%

* Now simply called Improvement Activities
APMs are **new approaches to paying** for medical care through Medicare that incentivize quality and value.

**As defined by MACRA, APMs include:**

- **CMS Innovation Center model** (under section 1115A, other than a Health Care Innovation Award)
- **MSSP** (Medicare Shared Savings Program)
- **Demonstration** under the Health Care Quality Demonstration Program
- **Demonstration** required by federal law

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.

**Advanced APM Incentive Payment**

- Be excluded from MIPS
- Receive a 5% lump sum bonus

Bonus applies in payment years 2019-2024; then QPs receive higher fee schedule updates starting in 2026

- The “APM Incentive Payment” will be based on the estimated aggregate payments for professional services furnished the year prior to the payment year.
- E.g., the 2019 APM Incentive Payment will be based on 2018 services.

How will MACRA and other quality reporting programs affect clinicians treating minority populations?

Both P4P and public reporting may adversely affect the income of physicians practicing in minority communities—particularly poor minority communities—thereby potentially reducing both the number of physicians who work in such communities and their ability to invest in processes to improve quality. Physicians in these areas are doubly disadvantaged in trying to achieve high quality scores: First, their “payer mix” is likely to include a high proportion of uninsured and Medicaid patients, so there will be less revenue for them to invest in information systems, staff, and the development of organized processes to improve quality.

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Second, patients in these areas might be less likely to adhere to treatment recommendations. They might, for example, be less likely to obtain preventive care such as mammograms and Pap smears and less likely to return for follow-up of abnormal results, because of problems with transportation and child care and because of difficulty comprehending the recommendation. If compared directly to physicians in wealthier areas, physicians in poor minority communities might be less likely to receive P4P incentive pay and more likely to be listed in public report cards as poor-quality physicians.

Six ways to address potential adverse impact on health care disparities

1. Reward both absolute quality scores and improvement over time.
2. Use risk adjustment or stratified analyses.
3. Reward both overall quality and reduction in disparities.
4. Use a variety of methods to minimize the “teaching to the test” problem.
5. Only use P4P and public reporting when statistically reliable and valid measurement can be done.
6. Include attention to the effects of the P4P or public reporting program on disparities.

So when all is said and done, will MACRA really bring greater value in American healthcare?

It depends . . . on whether MACRA ultimately supports (and does not undermine) what physicians and patients alike value the most.
What is value?

*Value (N)*: Attributed or relative worth, merit, or usefulness, Random House College Dictionary

*Value (N)*: a fair return in goods, services, or money for something exchanged. 2: worth in money. 3: worth, usefulness, or importance in comparison with something else. 4: a principle or quality that is valuable or desirable  Merriam-Webster
“Achieving high value for patients must become the overarching goal of health care delivery, with value defined as the *health outcomes achieved per dollar spent.*” [Emphasis added]

Values and value: they are not the same

- (Values) N, plural. A person’s principles or standards of behavior; one’s judgment of what is important in life. [http://www.oxforddictionaries.com/us/definition/english/value](http://www.oxforddictionaries.com/us/definition/english/value)

- (Value) N. Attributed or relative worth, merit, or usefulness, Random House College Dictionary
Assessing value

Is it any wonder, then, that measuring value in healthcare is so disconcerting . . . because it means someone (payers) assessing a clinician’s worth, merit, usefulness, desirability, and importance compared . . . to something (or someone) else
Physicians’ values:

▪ Relationships with patients: *empathy, compassion, face-to-face time with them*

▪ Being able to *exercise clinical judgment*, based on training and skills, without constantly being second-guessed

▪ Being able to spend *time with their own families, work-life balance*

▪ Being allowed to be a *healer, not a hamster!*

This: Not this
Patients’ values:

- A physician who *cares* about them, who is *ethical, emphatic and compassionate*
- A physician who is *up-to-date* on the latest science and provides excellent, high quality care
- A physician who *spends time with them*
- A physician who *listens* to them
- A physician who clearly *explains* things to them
- A physician who *shares decision-making* with them
- A physician who *sees them on time and is available after hours*
- A physician who *always puts* their *interests first*
- And, being able to obtain healthcare at a *reasonable* and *affordable out of pocket cost*
What patients (and physicians!) don’t value!
Patients’ and physicians’ values need not be in conflict with value as defined by MACRA.

But could be, if MACRA undermines professionalism (such as by discouraging physicians from taking care of sicker and minority patients), increases health care disparities or adds to administrative burdens, taking time away from the patient-physician encounter.

But MACRA if designed correctly, could also help support professionalism, reduce administrative burdens, help clinicians improve care for minority populations, and help promote the patient-physician relationship.
So will MACRA *really* bring greater value to Medicare? *Here’s what will decide:*

1. Will CMS simplify quality reporting, reduce burdens on clinicians, make quality reporting and HIT more clinically relevant, and provide more opportunities for physician-led Alternative Payment Models?

2. Will it incorporate the 6 elements to minimize potential adverse consequences on minority populations?

3. Will *physicians* conclude that their roles in providing more effective and efficient care, are supported with *appropriate and adequate payment*, sufficient to *sustain their practices*, with appropriate valuation of your *cognitive skills*, *without adding administrative burdens* that offer no value?
So will MACRA really bring greater value to Medicare? Here’s what will decide:

3. Will patients conclude that patient autonomy, shared decision-making, engagement, and their experience with the care delivered are valued? While giving them the best possible outcomes at an affordable (out-of-pocket) cost?

4. Most importantly, will MACRA value the patient-physician relationship above all else?
If we are to truly find **value** in the **right** place, it all begins and ends with this:

“But, now I will tell you a secret – a mystery. Those who suffer need you to be something more than a doctor; they need you to be a healer. And, to become a healer, you must do something even more difficult than putting your white coat on. You must take your white coat off. You must recover, embrace, and treasure the memory of your shared, frail humanity – of the dignity in each and every soul. When you take off that white coat in the sacred presence of those for whom you will care – in the sacred presence of people just like you – when you take off that white coat, and, tower not over them, but join those you serve, you become a healer in a world of fear and fragmentation, an ‘aching’ world, as your Chaplain put it this morning, that has never needed healing more.”

We need to ensure MACRA (and other “value-based” payment programs) support the physician’s role as:

“a healer in a world of fear and fragmentation, an ‘aching’ world . . . that has never needed healing more.”  (Berwick)