Current Medicare Fee-for-Service Pay-for-Performance Initiatives for Hospital and Physician Services

July 13, 2015
Agenda

- Broad Overview of Payment Policy Direction
  - Current State
  - Future State

- Current mandatory Medicare Pay-for-Performance Programs
  - Hospital/Inpatient
  - Physician/Clinical

- Future state: Recently enacted Medicare Access and CHIP Reauthorization Act (MACRA)
Fee-for-Service still dominates public programs

Various Initiatives aim to reduce cost; incentivize quality and efficiency
- Pay for quality reporting
- Patient-Centered Medical Homes
- Bundled/Global Payments (surgical packages, etc.)
- Value-based modifiers
- Accountable Care Organizations
- Advanced Primary Care Demonstration
- Payer-specific and managed care contracts
- Penalties: Readmissions and Healthcare Acquired illness/injuries

Providers/Hospitals may feel stuck between two different “worlds” of payment: Fee-for-service & global payment
Basic spectrum of service payment

- Fee-For-Service
- Bundling
- Value-based payment modifiers
- ACO’s & Patient Centered Medical Homes
- Partial Capitation
- Fully capitated payment system
January 2015 – Secretary Burwell issues announcement of goals to tie Medicare fee-for-service payment to value

Alternative Payment Models – ACO’s, bundled payments
- 30% by the end of 2016
- 50% by the end of 2018.

Fee-for-Service pay for performance programs, such as Value-based purchasing and readmissions reduction
- 85% by 2016
- 90% by 2018
Medicare Hospital Performance Initiatives

Value-Based Purchasing Program, Readmissions Reduction, and Healthcare Acquired Conditions
Pay-for-Performance programs generally follow an existing reporting infrastructure.

Measures are reported or abstracted, then assessed per program scoring methodology:
- CMS Hospital Inpatient Quality Reporting Program Measures
- CMS Hospital Outpatient Quality Reporting Measures
- Inpatient Psychiatric Facility Quality Reporting Program Measures

At this point, none of the Medicare hospital-based quality programs include specific measures related to diabetes and/or depression (yet).
Hospital Readmissions Reduction (HRR) and Hospital-Acquired Conditions (HAC) Programs
Section 3025 of the Affordable Care Act

Penalty Program Only- no reward for strong performance

Payment reduction based on “higher than expected” readmissions

Commenced on October 1, 2012

Currently in third year of implementation

- Total hospitals penalized FY 2015 (78%); 433 more than FY 2014

- Hospitals nationally penalized the maximum 3%

- Average penalty assessed
Conditions used in HRR

<table>
<thead>
<tr>
<th>FY Year</th>
<th>Maximum Payment Penalty</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013</td>
<td>1%</td>
</tr>
<tr>
<td>2014</td>
<td>2%</td>
</tr>
<tr>
<td>2015 and beyond</td>
<td>3%</td>
</tr>
</tbody>
</table>
# Hospital-Acquired Conditions (HAC) Program Background

## Since 2008
- Medicare has not typically reimbursed for avoidable complications not present on admission (POA)

## Section 3008
- Affordable Care Act authorized the HAC reduction program
- Penalty only – no reward for strong performance
- Top quartile always penalized, regardless of distributive performance

## Exemptions
- Critical Access Hospitals (CAH) and specialty hospitals (Cancer centers, long-term, etc.)

## Penalties
- FY 2015 (first year), 721 hospitals penalized for a total $373 million
- 1% statutory cap on penalties

## Rulemaking Update
- Details on FY 2016 IPPS Proposed Rule Implementation starts on page 24509
**Domain 1**
PSI-90 AHRQ Pt Safety Composite
- PSI-3: pressure Ulcer
- PSI-6: iatrogenic pneumothorax
- PSI-7: central venous catheter-related blood stream infection rate
- PSI08: hip fracture
- PSI-12: perioperative PE/DVT rate
- PSI-13: sepsis rate
- PSI-14: wound dehiscence rate
- PSI-15: accidental puncture

**Domain 2**
CDC Measures – chart abstracted
- CLABSI: Central Line Bloodstream infections
- CAUTI’s: Catheter Urinary Tract Infections
- SSI: Colon & Abdominal Hysterectomy
- **NEW!**: MRSA- Methicillin-Resistant Staphylococcus aureus
- **NEW!**: C Diff – Clostridium difficile

**FY 2017 HAC Domain Weights**
- **Domain 1**: 15%
- **Domain 2**: 85%
CMS authority to expand list of “applicable conditions” in Readmissions program and HAC

- FY 2015 added 2 new conditions - chronic obstructive pulmonary disorder and total hip and knee replacement
- FY 2017 CMS finalized adding coronary artery bypass graft
- FY 2017, proposes to expand measure cohort for 30-Day Pneumonia Readmission Measure

More hospitals are being penalized by readmissions (78% in FY 2015), but average penalties remain below 1%

Results publicly posted on Hospital Compare – we’re seeing more and more Medicare data being publicly posted
Hospital Value-Based Purchasing Program
- Existing value-based initiative for hospitals
- One of several “value” programs created by the Affordable Care Act
  - Goal to pay for better value of care
  - Builds on existing Hospital Inpatient Quality Reporting (IQR) infrastructure
  - Applies to payments for hospital discharges occurring on or after Oct. 1, 2012
- Budget-neutral incentive payments
  - Amounts withheld redistributed to hospitals by performance rates
  - Statutory ceiling on payment withheld at 2% by FY 2017
- Hospitals are scored by either their achievement or improvement
  - Achievement – Performance compared to all other hospitals in baseline period
  - Improvement – Current performance compared to own baseline period
### FY 2016 (Oct. 2015)

- DRG withhold 1.75%
- $1.5 billion available for redistribution
- Efficiency increases to 25% weighting
- Removes 5 process measures; adds outcomes

### FY 2017 (Oct. 2016)

- DRG withhold reaches 2% statutory ceiling
- Performance measure domains modified
- Increased emphasis on quality outcomes
- Removes 6 more process measures
FY 2016 Measures & Domain Weights

Clinical Process of Care

<table>
<thead>
<tr>
<th>AMI 7a</th>
<th>Fibrinolytic agent received w/in 30' of hospital arrival</th>
</tr>
</thead>
<tbody>
<tr>
<td>PN 8</td>
<td>Initial antibiotic selection for CAP immunocompetent pt</td>
</tr>
<tr>
<td>SCIP 2</td>
<td>Received prophylactic Abx consistent with recommendations</td>
</tr>
<tr>
<td>SCIP 3</td>
<td>Prophylactic Abx discontinued w/in 24 hrs of surgery end time or 48 hrs for cardiac surgery</td>
</tr>
<tr>
<td>SCIP 9</td>
<td>Postoperative Urinary Catheter Removal on Post Operative Day 1 or 2</td>
</tr>
<tr>
<td>SCIP-Card 2</td>
<td>Pre-admission beta-blocker and perioperative period beta blocker</td>
</tr>
<tr>
<td>SCIP VTE2</td>
<td>Received VTE prophylaxis within 24 hrs prior to or after surgery</td>
</tr>
<tr>
<td>Removed! IMM-2</td>
<td>Influenza Immunization</td>
</tr>
<tr>
<td>Removed! AMI 8a PCI</td>
<td>Received w/in 90' of hospital arrival</td>
</tr>
<tr>
<td>Removed! HF 1</td>
<td>Discharge instructions was removed from FY2016 measures</td>
</tr>
<tr>
<td>Removed! PN 3b</td>
<td>Blood culture before 1st antibiotic received in hospital</td>
</tr>
<tr>
<td>Removed! SCIP 1 Abx</td>
<td>w/in 1 hr before incision or w/in 2 hrs if Vancomycin/Quinolone is used</td>
</tr>
<tr>
<td>Removed! SCIP 4</td>
<td>Controlled 6 AM postoperative serum glucose – cardiac surgery</td>
</tr>
</tbody>
</table>

Patient Experience

| Communication with nurses |
| Communication with doctors |
| Responsiveness of hospital staff |
| Pain management |
| Communication about medications |
| Cleanliness and quietness |
| Discharge information |
| Overall rating of hospital |

Outcomes

| AHRO PSI composite |
| CLABSI |
| **New! CAUTI** |
| **New! SSI Colon**‡ |
| SSI Abdominal Hysterectomy‡ |
| 30-day mortality, AMI |
| 30-day mortality, heart failure |
| 30-day mortality, pneumonia |

Efficiency

- 1.75% DRG withhold

FY 2016 performance scores expected this summer
Budget neutral, re-distribution program by withholding hospital payments; capped at 2% withhold in FY 2017 and beyond

Incentives -- payment linked to the better of total performance score
- Achievement (national benchmark)
- Improvement (self benchmark)

Implementation Points of Emphasis
- Utilizes Hospital IQR program as foundation, measures are usually reported first before inclusion in VBP
- FY 2017 additional movement away from process-based measures towards outcomes; eliminates 6 process measures.
- FY 2018 follows suit, proposing to eliminate process domain completely and seeking input on measures of efficiency for the FY 2018 IQR program
- No direct measures specific to depression or diabetes yet (but may be relevant/related to other diagnoses).
Pay for Performance in Clinical Services
Medicare Physician Value-Based Payment Modifier & the
Merit-Incentive Payment System
What is the Medicare Physician VBPM?

- Section 3007 of the Affordable Care Act (ACA)
- Based on existing physician fee schedule, payment adjustments based on the quality and cost of care
- Considered a payment “at-risk” program; differs from the hospital value-based purchasing program as an up-front withholding and redistribution
- Like the hospital VBP, the physician value modifier is budget neutral – some physicians and groups are paid more, some will be paid less, but total program spending remains the same
- Performance is categorized based on standard deviation(s)
- Gradual implementation, but by **2017 ALL** Medicare providers will be subject to the value modifier in some way
PQRS and Physician Feedback Program form the Foundation of the Value Modifier
• Commenced as voluntary quality reporting program for physicians since 2007
• Provides incentives and imposes penalties based on satisfactory quality reporting
• Failure to satisfactorily report under PQRS will result in maximum penalty under VBPM, which will be applied on top of the separate PQRS penalty

What is PQRS?
**COST/Efficiency**

- Total per capita costs measure (annual payment standardized and risk-adjusted Part A and Part B costs)
- Total per capita costs for beneficiaries with four chronic conditions: COPD, Heart Failure, Coronary Artery Disease, Diabetes
- Medicare Spending Per Beneficiary measure (added CY 2016)

**Quality**

(150+ to choose from)

- All Cause Readmission
- Composite of Acute Prevention Quality Indicators: (bacterial pneumonia, urinary tract infection, dehydration)
- Composite of Chronic Prevention Quality Indicators: (chronic obstructive pulmonary disease, heart failure, diabetes)
- Consumer Assessment of Healthcare Providers and Systems (CAHPS)
Measure specifics can be found using the [2015 PQRS Measures Groups Specifications Manual](#) and more info on PQRS [here](#).
2016 Value-Based Payment Modifier

Groups with 10+ EPs

PQRS Reporters
Avoid the 2016 PQRS payment adjustment by satisfactorily submitting data on quality measures

Non-PQRS Reporters
Fail to avoid the 2016 PQRS payment adjustment

Groups with 10-99 EPs
Upward, or no adjustment based on quality tiering

Groups with 100+ EPs
Upward, neutral or downward adjustment based on quality tiering

-2.0% adjustment
2017 Value-Based Payment Modifier: Mandatory Quality Tiering

All eligible professionals

PQRS Reporters
Avoid the 2017 PQRS payment adjustment by satisfactorily submitting data on quality measures

Groups with 2-9 and solo practitioners
- Upward, or no adjustment based on quality tiering

Groups with 10+ EPs
- Upward, neutral or downward adjustment based on quality tiering

Non-PQRS Reporters
Fail to avoid the 2017 PQRS payment adjustment

Groups with 10+ EPs
- -4% adjustment

Groups with 2-9 and solo practitioners
- -2% adjustment
## Quality Tiering - Performance is categorized

### 2016

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

### 2017

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

x* represents an undefined bonus factor
Future State
Overview of Payment System Reforms in the Medicare Access and CHIP Reauthorization Act of 2015 (H.R. 2)
Timeline of Medicare physician payment reforms

Permanent repeal of SGR


0.5% PFS payment update  0.0% PFS payment update  0.25% update

PQRS, VBPM Meaningful Use adjustments  Track 1: MIPS adjustments  0.75% update

Track 2: 5% bonus for qualifying APM
TRACK 1

MIPS: COMING IN 2019

PAYING FOR “VALUE” IN FFS
Eligible professionals will be measured in 4 performance categories, and receive a composite score ranging from 0-100.

- **EHR Meaningful Use**: 25%
- **Quality**: 30%
- **Clinical Practice Improvement**: 15%
- **Resource Use**: 30%

*Weightings for 2021 and beyond*
Positive adjustments applied on a linear sliding scale, capped* at:

- 4% for 2019
- 5% for 2020
- 7% for 2021
- 9% for 2022 and beyond

Negative adjustments applied on a linear sliding scale, capped at:

- -4% for 2019
- -5% for 2020
- -7% for 2021
- -9% for 2022 and beyond

*Highest performers get extra adjustment of up to additional 10% through 2024
TRACK 2

INCENTIVIZING ALTERNATIVE PAYMENT MODELS (APM)
1. Participation in an “eligible alternative payment entity”

- CMMI Model
- MSSP ACO
- Health Care Quality Demo under 1866C
- Demo required by federal law

Requires use of certified EHR

Payment based on quality measures

And

Bears financial risk for losses

And

Medical home expanded under CMMI

OR

Eligible Alternative Payment Entity
To qualify, a minimum percentage of payments must be attributable to Part B services furnished through the eligible alternative payment entity.

As an alternative, Secretary is granted authority to use patient counts in lieu of payments, subject to same thresholds.

<table>
<thead>
<tr>
<th>Thresholds</th>
<th>2019-2020</th>
<th>2021-2022</th>
</tr>
</thead>
<tbody>
<tr>
<td>25% Medicare Part B payments</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Option 1: Medicare threshold</td>
<td></td>
<td></td>
</tr>
<tr>
<td>50% Medicare Part B payments</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Option 2: All-Payer threshold</td>
<td></td>
<td></td>
</tr>
<tr>
<td>50% all-payer, including 25% Medicare Part B payments</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
CONCLUSION
Medicare will continue trend of tying payment to value,
- focus still remains on adjustments to fee-for-service chassis

Separation remains on hospital and physician/clinical mandatory performance programs

Some consistency across programs exists
- Mixture of pay for reporting, penalty and performance programs in current state
- Statutory caps on payment risk for all initiatives
- Several programs use measure composites classified into “domains”, weighted, and then scored

What’s next
- Over the next 2-3 years, providers and systems will need to decide on whether to focus on MIPS or develop a Track 2 APM as result of new law
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Appendix
CMS collects data on eligible hospital discharges and readmissions within reporting period.

CMS generates an “expected” risk adjusted readmission rate based on case mix and average national data.

Adjusted actual discharge rates (predicted) are compared to “expected” rates.

Specific penalties (if applicable) determined by amount of aggregate DRG payment received for readmissions (page 24496).

Excess ratios >1.0 subject to some level of penalty.

Ratios <1.0 are not.

Hierarchical logistical regression determines “Excess Readmission Ratio”.

Hospital Readmissions Reduction Program – How the program works
<table>
<thead>
<tr>
<th>Measures</th>
<th>Number eligible discharges</th>
<th>Number of Readmissions</th>
<th>Predicted (actual) Readmission Rate</th>
<th>Expected Readmission Rate</th>
<th>Excess Readmission Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>AMI – Heart Attack</td>
<td>325</td>
<td>71</td>
<td>22.3%</td>
<td>19%</td>
<td>1.17</td>
</tr>
<tr>
<td>COPD – Lung Disease</td>
<td>185</td>
<td>24</td>
<td>13.1%</td>
<td>15%</td>
<td>0.87</td>
</tr>
<tr>
<td>HF – Heart Failure</td>
<td>341</td>
<td>94</td>
<td>27.5%</td>
<td>24.3%</td>
<td>1.13</td>
</tr>
<tr>
<td>PN - Pneumonia</td>
<td>195</td>
<td>21</td>
<td>11%</td>
<td>17%</td>
<td>0.65</td>
</tr>
<tr>
<td>THA/TKA – Hip/Knee</td>
<td>564</td>
<td>17</td>
<td>3.2%</td>
<td>5.1%</td>
<td>0.62</td>
</tr>
</tbody>
</table>

This hospital would receive some level of penalty across all inpatient discharges, but not greater than 3%
Eligible hospitals & CMS collect & report data

CMS places measures into weighted categories (domains)

Scores (ranging 1-10) for each measure by deciles based on national ranking

Domain scores are added for a total HAC score (lower scores are better)

Measure points are multiplied by the weight of the domain

Total HAC scores are compared to national ranking

HAC scores at or above the 25 percentile are penalized 1% DRG

HAC Program – How the program works
FY 2016 HAC Program (finalized)

**Domain 1**
PSI-90 AHRQ Pt Safety Composite
*Performance period:* July 1, 2012—June 30, 2014
- PSI-3: pressure Ulcer
- PSI-6: iatrogenic pneumothorax
- PSI-7: central venous catheter-related bloodstream infection rate
- PSI08: hip fracture
- PSI-12: perioperative PE/DVT rate
- PSI-13: sepsis rate
- PSI-14: wound dehiscence rate
- PSI-15: accidental puncture

**Domain 2**
CDC Measures
- CLABSI: Central Line Bloodstream infections (expanded from ICU’s only to all hospital units)
- CAUTI’s: Catheter Urinary Tract Infections (expanded from ICU’s only to all hospital units)
- NEW!: SSI: Colon & Abdominal Hysterectomy

**FY 2016 HAC Domain Weight**
- **Domain 1:** 25%
- **Domain 2:** 75%
## HAC Scoring Sample

<table>
<thead>
<tr>
<th>Domain</th>
<th>Measure Result</th>
<th>Performance Decile</th>
<th>Points based on decile</th>
<th>Domain Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domain 1 Score</td>
<td>0.8732</td>
<td>6&lt;sup&gt;th&lt;/sup&gt;</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>Domain 2 Score</td>
<td></td>
<td></td>
<td></td>
<td>5</td>
</tr>
<tr>
<td>CLABSI</td>
<td>0.535</td>
<td>4&lt;sup&gt;th&lt;/sup&gt;</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>CAUTI</td>
<td>1.20</td>
<td>6&lt;sup&gt;th&lt;/sup&gt;</td>
<td>6</td>
<td></td>
</tr>
</tbody>
</table>

### Domain 1 and Domain 2 Scores

<table>
<thead>
<tr>
<th>Domain 1 Score</th>
<th>Weight of Domain 1</th>
<th>Domain 1 weighted score</th>
<th>Domain 2 Score</th>
<th>Weight of Domain 2</th>
<th>Domain 2 weighted score</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.0</td>
<td>0.35</td>
<td>2.1</td>
<td>5.0</td>
<td>0.65</td>
<td>3.25</td>
</tr>
</tbody>
</table>

**Your hospital’s total HAC Score** (2.1+3.25)

<table>
<thead>
<tr>
<th>FY 2015 payment reduction threshold (75&lt;sup&gt;th&lt;/sup&gt; percentile)</th>
<th>Subject to payment reduction?</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.35</td>
<td>7.0</td>
</tr>
<tr>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>
Both are penalty programs only

HAC program
- Risk-adjusted and assessed against a national benchmark- SIRs (standardized infection rates)
- Points are scored based on decile categories (30%=3 points)
- Lower scores are better
- Will always have a 1% penalty assessed to lowest performing quartile (aka highest quartile in points scored)

MRR program
- Assessed against the average rate of hospitals with similar case mixes (similar to HAC)
- Risk-adjusted
- Lower scores are better
- Penalty for excessive readmissions varies from minimal to up to 3%
### Hospital VBP Financing

<table>
<thead>
<tr>
<th>Year</th>
<th>Hospital DRG Withhold Amount Subject to re-distribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY 2013</td>
<td>1.00%</td>
</tr>
<tr>
<td>FY 2014</td>
<td>1.25%</td>
</tr>
<tr>
<td>FY 2015</td>
<td>1.50%</td>
</tr>
<tr>
<td>FY 2016</td>
<td>1.75%</td>
</tr>
<tr>
<td>FY 2017</td>
<td>2.00%</td>
</tr>
<tr>
<td>FY 2018 and beyond</td>
<td>2.00%</td>
</tr>
</tbody>
</table>

- Budget Neutral (Per Statute)
- DRG withholds simultaneously align with VBP Adjustment Factors (each Fiscal Year)
- $1.4 billion set aside for re-distribution in FY 2015
Eligible hospitals report quality measures via Inpatient Quality Reporting (IQR)

CMS places measures into weighted categories (domains)

CMS generates improvement and achievement scores within each domain against baseline

TPS translated to % using linear exchange function

Total performance score (TPS) created

Hospitals receive the higher of either the sum of achievement or improvement scores

Percent converted to a VBP Payment Adjustment Factor

Hospitals receive TPS and Adjustment Factors at least 60 days prior to FY implementation

Withhold + Adjustment factors applied to DRG payments in Fiscal Year
**Achievement Points**
- At or above benchmark = 10 points
- Between threshold and benchmark = 1-9
- Below threshold = 0

**Improvement Points**
- At or above benchmark = 9
- Rate less than or equal to baseline = 0
- Between baseline and benchmark = 0-9

**Achievement vs. Improvement**
What’s the difference?
Outcomes based

2.0% DRG withhold

Clinical Process of Care
- AMI 7a Fibrinolytic agent received w/in 30’ of hospital arrival
- IMM-2 Influenza immunization
- NEW! PC-01 Early elective delivery prior to 39 weeks
- REMOVED! PN 6 Initial antibiotic selection for CAP immunocompetent pt
- REMOVED! SCIP 2 Received prophylactic Abx consistent with recommendations
- REMOVED! SCIP 3 Prophylactic Abx discontinued within 24 of surgery end time
- REMOVED! SCIP 9 Postoperative Urinary Catheter Removal on Post Operative Day 1 or 2
- REMOVED! SCIP-Card 2 Pre-admission beta blocker and perioperative period beta blocker
- REMOVED! SCIP VTE2 Received VTE prophylaxis within 24 hours prior to or after surgery

Patient Experience & Care Coordination
- Communication with nurses
- Communication w/ physicians
- Responsiveness of staff
- Pain management
- Communication about medications
- Cleanliness and quietness
- Discharge information
- Overall rating

Clinical Outcomes
- AMI 30-Day mortality rate
- HF 30-day mortality rate
- PN 30-day mortality rate

Efficiency & Cost Reduction
- MSPB – Medicare spending per beneficiary
- CLABSI – blood infection
- Surg. Site infection
- NEW! C.diff clostridium difficile infection
- NEW! MRSA methicillin-resistant staph

Safety NEW!
- Catheter-associated urinary tract infection
- PSI-90 AHRQ Pt Safety Composite

Outcomes
- Process 5%
- Outcomes 25%
- Efficiency & Cost Reduction 25%
- Safety 20%
- Patient Experience 25%

FY 2017 Measures & Domain Weights
Currently in performance periods for all measures. Payment adjustment effective for discharges from October 1, 2016 to September 30, 2017. Baseline periods generally 1-3 years prior.
### Example FY 2015 performance score calculation breakdown

<table>
<thead>
<tr>
<th>Domain</th>
<th>Unweighted Improvement Score</th>
<th>Unweighted Achievement Score</th>
<th>Unweighted Score</th>
<th>Weighting</th>
<th>Weighted Domain Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Process of Care</td>
<td>68.3</td>
<td>62.1</td>
<td>68.3</td>
<td>20%</td>
<td>13.66</td>
</tr>
<tr>
<td>Patient Experience of Care</td>
<td>52.7</td>
<td>39.2</td>
<td>52.7</td>
<td>30%</td>
<td>15.81</td>
</tr>
<tr>
<td>Outcome Domain</td>
<td>61.0</td>
<td>63.5</td>
<td>63.5</td>
<td>30%</td>
<td>19.05</td>
</tr>
<tr>
<td>Efficiency</td>
<td>21.2</td>
<td>34.5</td>
<td>34.5</td>
<td>20%</td>
<td>6.9</td>
</tr>
<tr>
<td><strong>Total Performance Score (TPS)</strong></td>
<td><strong>55.4</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>National TPS</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td><strong>41.7</strong></td>
</tr>
</tbody>
</table>

- **Base Operating DRG Percent Payment Amount Reduction**: 1.5%
- **Net Change in Base Operating DRG Payment Amount (Linear Exchange)**: +0.574%
- **Value-Based Incentive Payment Adjustment Factor**: 1.00574

1.00 is the “break even” point of the withhold
Upcoming FY payments for DRG’s would increase by over $\frac{1}{2}$ of 1%.
Example: $10,000$ surgery would be reimbursed $10,057$ for the fiscal year.
### Clinical Outcomes of Care

<table>
<thead>
<tr>
<th>AMI 30-Day Mortality Rate</th>
<th>CAUTI – urinary catheter infect.</th>
</tr>
</thead>
<tbody>
<tr>
<td>HF 30-Day Mortality Rate</td>
<td>PSI-90 AHRQ Pt Safety Composite</td>
</tr>
<tr>
<td>Influenza immunization</td>
<td>CLABSII – blood infection</td>
</tr>
<tr>
<td>PC-01 Early elective delivery prior to 39 weeks</td>
<td>Surg. Site infection</td>
</tr>
</tbody>
</table>

### Safety

- CAUTI – urinary catheter infect.
- PSI-90 AHRQ Pt Safety Composite
- CLABSII – blood infection
- Surg. Site infection
- C.diff - Clostridium difficile infection
- MRSA Methicillin-Resistant staph
- PC-01 elective delivery prior to 39 weeks

### Patient Experience & Care Coordination

- Communication with nurses
- Communication with physicians
- Responsiveness of staff
- Pain management
- Communication about medications
- Cleanliness and quietness
- Discharge information
- Overall rating

### NEW! 3-Item Care Transition Measure (CTM–3)

- Patient and Family preferences in care received
- Clear understanding of patient responsibility for managing health post-discharge
- Understand purpose of medications

### Efficiency & Cost Reduction

- MSPB – Medicare spending per beneficiary

---

Refer to the FY 2016 Proposed Rule, pages 24506 – 24507 for performance thresholds and benchmarks for all measures.
Although a first step, CMS seems to be setting direction with additional efficiency measures

- Conditional approval by Measure Application Partnership (MAP) but not yet NQF endorsed (measures submitted)
- Linked to hospital services and high variation
- Numerous references to the general approach and alignment with the MSPB measure
- First finalized in the Hospital Inpatient Quality Reporting (IQR) program

### FY 2018 IQR Proposed Cost Measures

<table>
<thead>
<tr>
<th>Medical</th>
<th>Surgical</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kidney/Urinary Tract Infection</td>
<td>Hip replacement/revision</td>
</tr>
<tr>
<td>Cellulitis</td>
<td>Knee replacement/revision</td>
</tr>
<tr>
<td>Gastrointestinal hemorrhage</td>
<td>Lumbar spine fusion/refusion</td>
</tr>
</tbody>
</table>

Additional details on proposed efficiency/payment measures are on pages 24568 through 24574 of the proposed rule.
MRR, HAC, and VBP in context

Max potential cumulative negative impact combined VBP, MRR & HAC

-7 -6 -5 -4 -3 -2 -1 0 1 2 3

2015 2016 2017 2018 2019

VBP (+) VBP (-) HAC MRR IQR
Physician Value-Based Payment Modifier Implementation Timeline

Performance Year 1
- 2013

Payment Adjustment Year 1
- 2014
- Performance Year 3
- 2015

Payment Adjustment Year 2
- 2016

Payment Adjustment Year 3
- 2017

Performance Year 2
- 2015

Basic Overview of VBPM Scoring Methodology

Step 1: CMS will calculate a standardized score for each cost and quality measure.

Step 2: Standardized score is classified into a domain.

Step 3: Domain scores are equally weighted and developed into quality or cost composites.

Step 4: Quality and cost composites are classified into low, median or high tiers compared to mean composite.

Step 5: Modifier is calculated based on tier placement.
PERFORMANCE HIGHLIGHTS

YOUR QUALITY COMPOSITE SCORE: AVERAGE

Average Range

\[-0.13\]

Standard Deviations from National Mean

YOUR COST COMPOSITE SCORE: AVERAGE

Average Range

Standard Deviations from National Mean (Negative Scores Are Better)
Quality Tiering Sample

YOUR QUALITY TIERING PERFORMANCE: AVERAGE QUALITY, AVERAGE COST

Best performers

Lowest performers
Based on 2012 performance, electing the quality tiering approach would result in a payment adjustment of +0.0%.

Payment adjustments for each level of performance are shown below:

<table>
<thead>
<tr>
<th></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>+2.0x%</td>
<td>+3.0x%</td>
</tr>
<tr>
<td>Average Cost</td>
<td>-0.5%</td>
<td>+0.0%</td>
<td>+2.0x%</td>
</tr>
<tr>
<td>High Cost</td>
<td>-1.0%</td>
<td>-0.5%</td>
<td>+0.0%</td>
</tr>
</tbody>
</table>

Note: x refers to a payment adjustment factor yet to be determined due to budget neutrality requirements.
Groups with 100+ EPs

PQRS Reporters
Avoid the 2015 PQRS payment adjustment by satisfactorily submitting data on quality measures

- No VBPM adjustment
- Elect optional quality-tiering
- Upward, neutral or downward adjustment

Non-PQRS Reporters
Fail to avoid the 2015 PQRS payment adjustment

- -1.0% VBPM
Groups that elect quality tiering will be eligible for an upward, neutral or downward adjustment in 2015.

<table>
<thead>
<tr>
<th>Quality/Cost</th>
<th>Low cost</th>
<th>Average Cost</th>
<th>High Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>High Quality</td>
<td>+2.0x*</td>
<td>+1.0x*</td>
<td>+0.0%</td>
</tr>
<tr>
<td>Average Quality</td>
<td>+1.0x*</td>
<td>+0.0%</td>
<td>-0.5%</td>
</tr>
<tr>
<td>Low Quality</td>
<td>+0.0%</td>
<td>-0.5%</td>
<td>-1.0%</td>
</tr>
</tbody>
</table>

* Additional +1.0x for groups that care for high-risk patients (top 25%)
### Quality/Cost

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

- Quality composite score based on quality data submitted by ACO during performance period and applied to all TINs participating in ACO
- Cost composite score will not be calculated and all TINs participating in ACO will be considered “average cost”
- Additional +1.0x for groups that care for high-risk patients
- TINs with 2-9 EPs and solo practitioners held harmless for negative adjustments in 2017
Groups and solo practitioners in these models will be classified as “average cost” and “average quality”.

Modifier will apply to all physicians billing under a group’s TIN.

<table>
<thead>
<tr>
<th>Quality/Cost</th>
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<tr>
<td>High Quality</td>
<td>+4.0x*</td>
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<td>Low Quality</td>
<td>+0.0%</td>
<td>-2.0%</td>
<td>-4.0%</td>
</tr>
</tbody>
</table>
The Physician Value Modifier in Context

- **2015**
  - Value Modifier Penalty: -1.50%
  - EHR Penalty: -1%

- **2016**
  - Value Modifier Penalty: -2%
  - EHR Penalty: -2%

- **2017**
  - Value Modifier Penalty: -3%
  - EHR Penalty: -4%

- **Value Modifier Penalty (Max)**
- **EHR Penalty**
- **Reporting**
Overview of H.R. 2 (Public Law 114-10)

- Permanently repeals SGR and provides schedule of fixed payment updates
- Creates new Merit-Based Incentive Payment System (MIPS)
- Incentivizes movement to alternative payment models
H.R. 2 marks the end of an era

- **12** Years that the SGR formula has threatened substantial cuts to physician pay
- **17** Short-term legislative “doc fixes”
- **$150 billion** Amount spent on short-term fixes
Debate over “pay-fors” ended with agreement to *partially* offset new spending.

- **$214 billion in new spending**
  - CHIP
  - Extenders
  - SGR Repeal and Payment Reforms

- **$70 billion in offsets**
  - IPPS
  - Post Acute
  - Premiums
  - Other
  - Not offset
2019 - two new payment systems emerge

<table>
<thead>
<tr>
<th>Track 1: FFS and Merit-Based Incentive Program</th>
<th>Track 2: Participation in Qualifying Alternative Payment Models</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Assessment on measures of quality, resource use, clinical practice improvement, and EHR meaningful use</td>
<td>• 5% bonus between 2019-2024</td>
</tr>
<tr>
<td>• Payment adjustment increases over time:</td>
<td>• For professionals who receive a “significant share” of payments through an alternative payment entity that is risk-bearing or is a Medicare–recognized medical home</td>
</tr>
<tr>
<td>✓ 2019= +/-4%</td>
<td>• Must have quality component and use EHR</td>
</tr>
<tr>
<td>✓ 2020= +/-5%</td>
<td>• “Significant share” determined by % of revenue in APMs</td>
</tr>
<tr>
<td>✓ 2021= +/-7%</td>
<td>• Excluded from MIPS</td>
</tr>
<tr>
<td>✓ 2022 and beyond = +/-9%</td>
<td>• 0.75% update 2026 and beyond</td>
</tr>
<tr>
<td>• Excludes “partial” qualifying APMs and low-volume practices</td>
<td></td>
</tr>
<tr>
<td>• 0.25% update 2026 and beyond</td>
<td></td>
</tr>
</tbody>
</table>
Measures largely based on existing programs, but opportunities exist for stakeholder engagement and program formalization

**Quality**

Process for stakeholder input on operational plan for quality measure development

**Resource Use**

Process for stakeholder input on development of episode and patient condition groups, attribution methodology, and measures
Statute specifies performance subcategories, but measures undefined in the new law:

- Expanded practice access
- Population management
- Care coordination
- Beneficiary engagement
- Patient safety and practice assessment
- Participation in an alternative payment model

Statute directs CMS to seek stakeholder input in defining activities and criteria for assessing performance (request for information and rulemaking)
To qualify, an eligible professional must do 2 things:

- Qualifying APM participants will receive 5% bonus from 2019-2024
1. Participate in an “eligible alternative payment entity”

2. Earn a significant share of Part B revenue through that entity
New Technical Advisory Committee (TAC) will recommend new “Physician-focused” APMs

1. RFI on APM Criteria
2. Notice & Comment rulemaking on APM criteria (2016)
3. Stakeholder submission of models to TAC
4. TAC review of models and recommendation
5. CMS review and response
Pulling it all together: Performance-based payment under old and new regimes