Governor's Council on Health Care Innovation and Reform

November 16, 2016

Agenda

9:30 – 10:15 am	Welcome and Introductions
10:15 – 10:35 am	Ground Rules and Discussion
10:35 – 11:35 am	MACRA Update – Edith Stowe, Manatt Health
11:35 – 11:50 am	*Break*
11:50 – 12:50 pm	CPC+ Update – Edith Stowe, Manatt Health
12:50-1:05 pm	Collaborative Care Codes – Anne Shields, UW
1:05-1:15 pm	Health Information Exchange Update – Jean Branscum, MMA
1:15-1:30 pm	Other Updates and Public Comment

Delivery Model Principles

As the Council considers and evaluates delivery models, it should assess the extent to which each model supports a set of core principles:

Patient-centered

Data-driven and measurable

Empowers providers

Collaborative

Replicable for different conditions

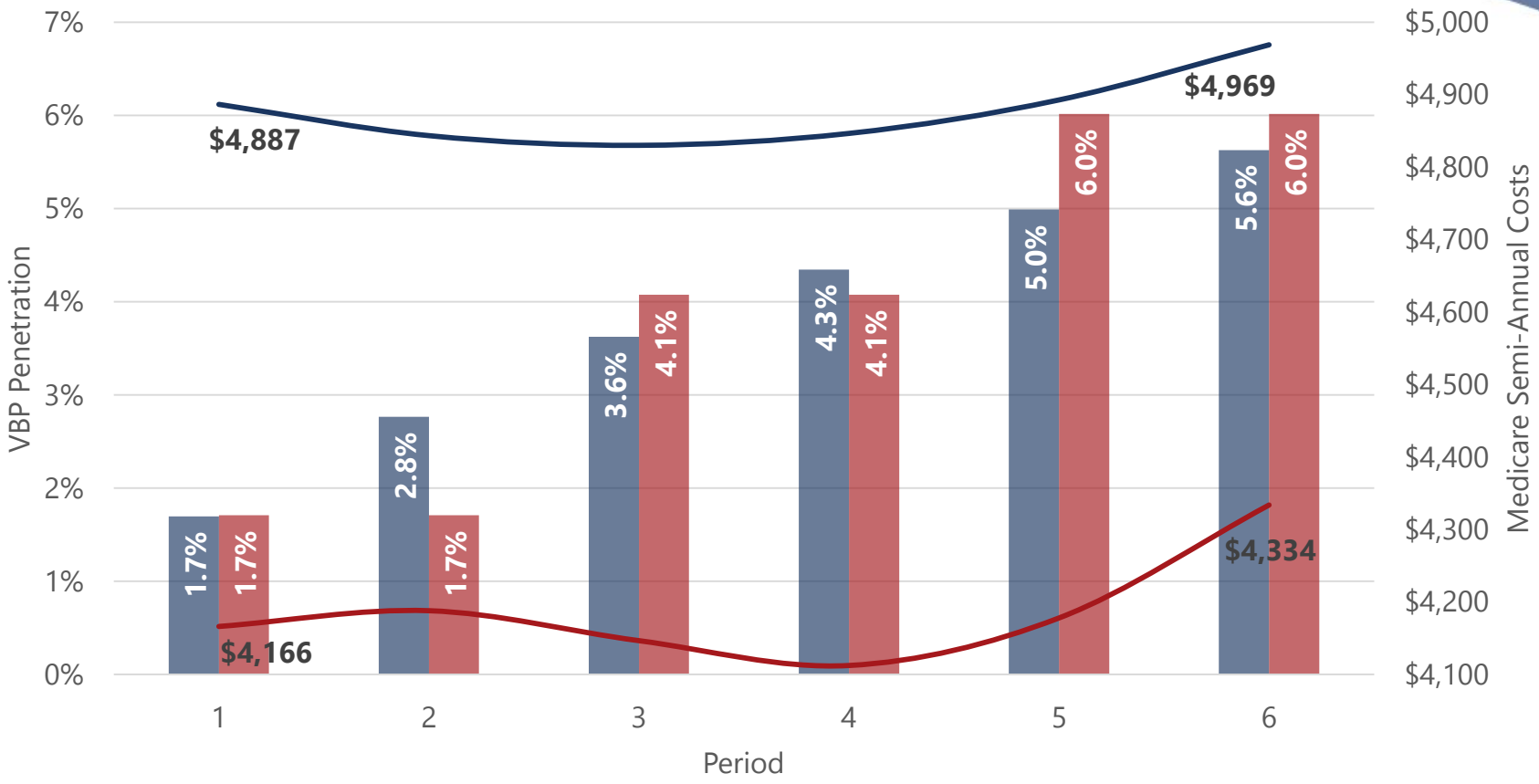
Scalable

Sustainable and tied to payment reform

Multi-payer

Billings – VBP Penetration and Medicare Cost Growth – 2012 through 2014

LEAVITT PARTNERS



National

Billings CBSA

Billings VBP growth is nearly identical to what our analysis would predict
Billings Medicare Costs are lower than average, but growth is as predicted

Update on the Medicare Access and CHIP Reauthorization ACT (MACRA)

Edith Coakley Stowe, Manatt Health

November 16, 2016

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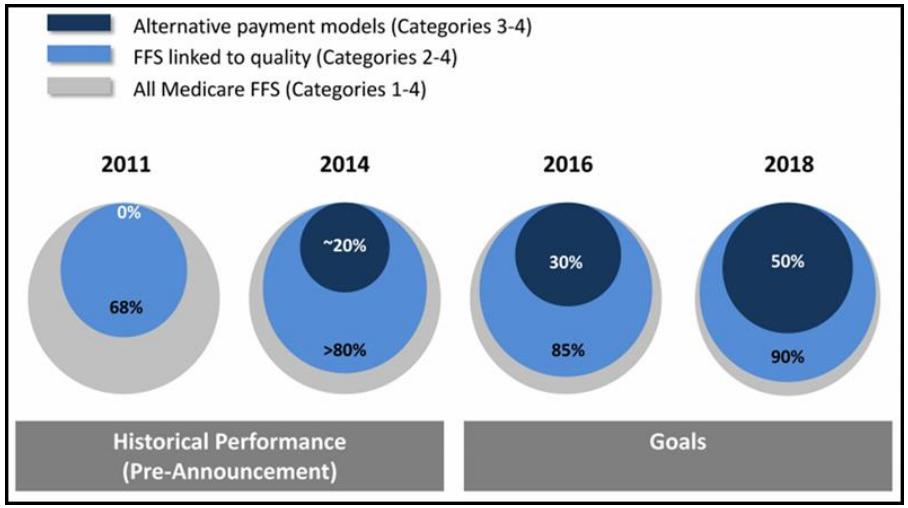
MACRA – Recap

- In April 2015, Congress enacted MACRA. Just before the law was passed, HHS had announced goals for the spread of Medicare "Alternative Payment Models" (APMs) over time (*right*).
- **MACRA combines SGR repeal with a new framework that ties rate increases to markers of value, while also creating new incentives for providers to participate in APMs.**
- The law goes into effect in January 2017. Final rulemaking was issued on October 14, 2016.
- **MACRA is expected to remain in place under the new Administration.**



MACRA Framework - Recap

Every year, most* providers who serve Medicare FFS patients will be reimbursed in one of two possible tracks.
CMS is calling this framework the "Quality Payment Program."

Merit-Based Incentive Payment System (MIPS)
Most providers
Adjusts all Part B fee-for-service payments up or down based on new reporting program that integrates elements of PQRS, Meaningful Use and Value-Based Modifier.

"Advanced Alternative Payment Models" (A-APMs)
Some providers
Providers who participate in certain APMs that CMS designates **Advanced APMs** will be MIPS-exempt and will receive an annual 5% bonus.

* Certain exceptions apply, including low volume/revenue providers and providers new to Medicare.

Initial Scale and Scope (Performance Year 2017)

In the final rule, CMS expanded exclusions for low-volume Medicare providers.

Those who bring in $30,000 or less per year in Part B allowed charges, *and/or have* no more than 100 Medicare fee-for-service patients will be exempt for 2017.

Clinicians billing Medicare Part B program
1-1.4m clinicians

Excluded clinicians:
Approx. 670,000 clinicians

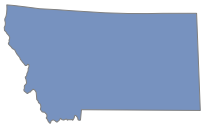
"Advanced Alternative Payment Models" (A-APMs)
70 - 120,000 clinicians

$333-571m *incentive payments*

Merit-Based Incentive Payment System (MIPS)
592 - 642,000 clinicians

$699m *total upward MIPS adjustments*

$199m *total downward MIPS adjustments*



Source: HHS Regulatory Impact Analysis (RIA) within Final Rule

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Recap: MACRA Implementation Timeline

Payment Year											
2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026-

Universal annual payment updates (was SGR)

0.5% annual payment update

MIPS

PQRS P4R

MU penalties

Value Modifier

All Part B FFS payments modified by a % determined by MIPS score

- +/- 4%
- +/- 5%
- +/- 7%
- +/- 9%

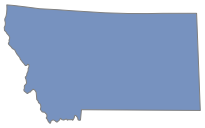
MIPS exceptional performance adjustment ($500m/year fund)

0.25% update

Advanced Alternative Payment Models

Advanced APM Participants exempt from MIPS and receive annual 5% bonus

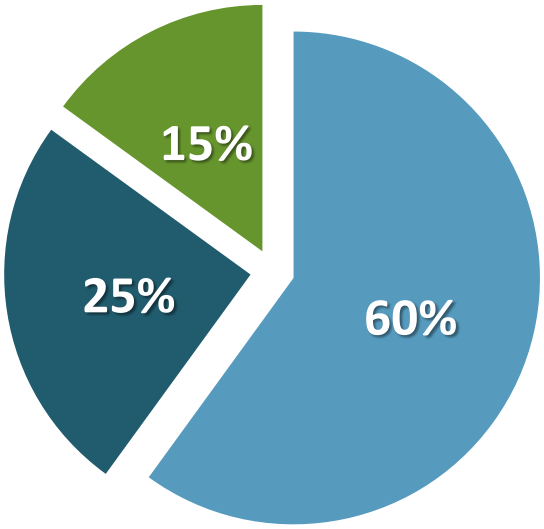
0.75% update



MIPS: Scoring

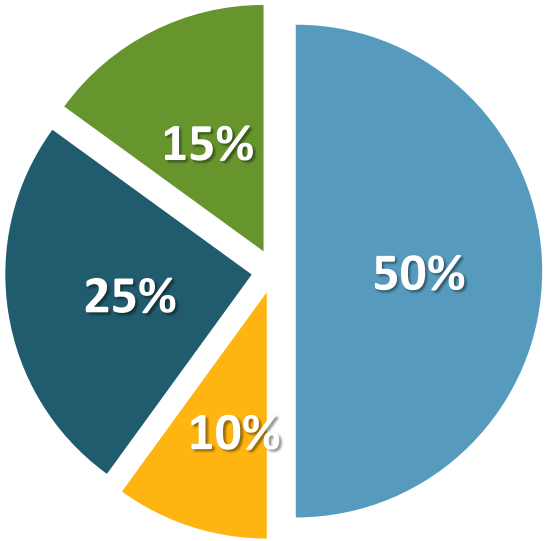
Each year, each "Eligible Clinician" or group will receive an upward, downward or neutral payment adjustment based on a "MIPS Final Score" reflecting four categories

Payment Year 2019

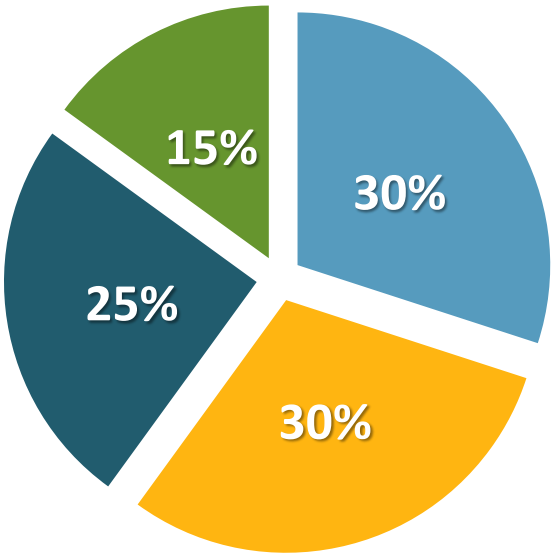


Note: Cost is not included in the final score in payment year 2019.

Payment Year 2020



Payment Year 2021+



Quality

Cost

Advancing Care Information

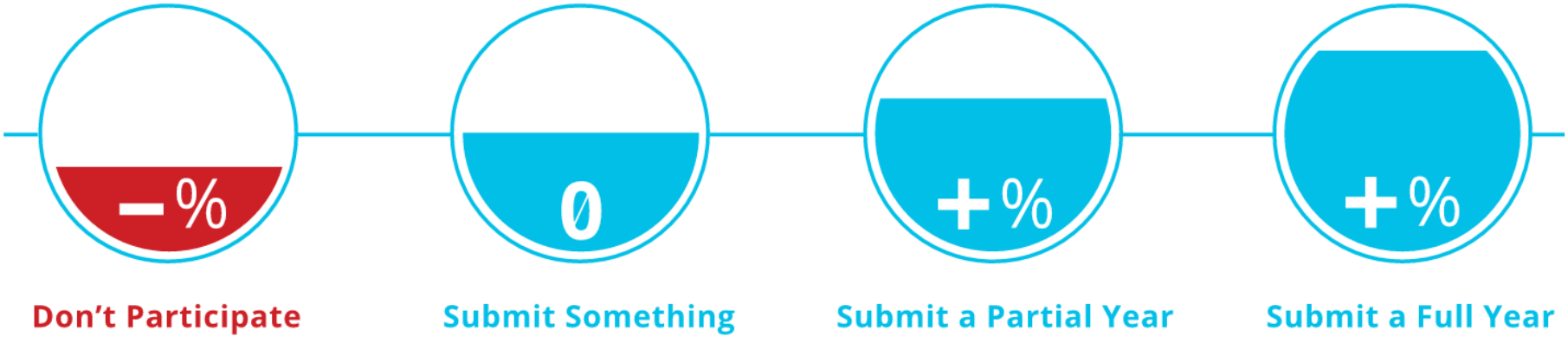
Improvement Activities

2017 MIPS Reporting Options ("Pick Your Pace")

After intense feedback from providers during the summer of 2016, CMS is now casting performance year 2017 as a "transition year"

Pick Your Pace in MIPS

If you choose the MIPS path of the Quality Payment Program, you have three options.



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.

Source: https://qpp.cms.gov/

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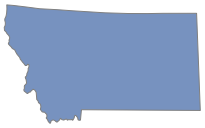
Quality Performance Category (60% in 2017)

The Quality Performance category is equivalent to PQRS, with some changes

- ECs are generally required to report **6** measures, with at least one **outcome measure**.*
- **Approximately 270 measures from which to choose.**
  - Generally same as PQRS measures; 18 new measures
  - Specialty and subspecialty measure sets provided for optional use
- **Choice of Reporting Methods:**
  - **Individuals:** qualified registry, EHR, QCDR, claims
  - **Groups:** qualified registry, EHR, QCDR, CMS Web Interface
- **Performance on each measure determined by comparison to deciles of national performance in baseline period.**
  - Bonus point opportunities for reporting additional outcome/high priority measures; CAHPS; and "end to end electronic reporting."

* If available; otherwise another "high priority" measure (appropriate use, patient safety, efficiency, patient experience, care coordination).



Cost Performance Category (2018+)

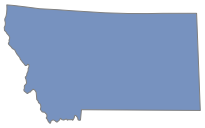
The Cost Category builds on the cost component of the Value Modifier program

- Every EC will have an attributed population created by CMS using claims data. CMS will calculate two measures:

  1. **Total per capita costs for all attributed beneficiaries** (Part A & B spending during performance period)
  2. **Medicare spending per beneficiary during ten distinct episodes** * (Part A & B spending during episode that spans from three days prior to an inpatient hospital admission through 30 days after discharge)

- Like quality category, performance based on historical deciles
- MACRA requires CMS to bring Part D spending into the score, but this integration will likely be delayed by several years

* Examples include: mastectomy; aortic/mitral value surgery; coronary artery bypass graft.



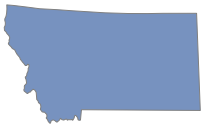
Advancing Care Information Performance Category (25% in 2017)

MACRA sunsets the Medicare EHR Incentive Program ("Meaningful Use"), incorporating much of its design into Advancing Care Information (ACI)

- Providers must report on **5 measures**:
  1. Perform a Security Risk Analysis
  2. E-Prescribing
  3. Provide Patients Electronic Access to Their Data
  4. Send a Summary of Care Record using Health Information Exchange
  5. Request/Accept a Summary of Care Record

- Scoring incorporates **base score** + **performance score**. Points are available for reporting additional measures, reporting to public health agencies/CDRs, and/or using EHR for practice improvements

- By **2018**, all providers will need to have adopted 2015 Edition Certified Electronic Health Record Technology (CEHRT)



Improvement Activities Performance Category (15% in 2017)

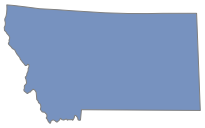
IA = "An activity that relevant eligible clinician organizations and other relevant stakeholders identify as improving clinical practice or care delivery, and that the Secretary determines, when effectively executed, is likely to result in improved outcomes"

Improvement Activity Subcategories:

Expanded Practice Access (4)	Emergency Response and Preparedness (2)	Achieving Health Equity (5)
Care Coordination (14)	Population Management (16)	Integrated Behavioral and Mental Health (8)
Patient Safety and Practice Assessment (21)	Beneficiary Engagement (23)	Participating in APM

Bonuses

- PCMH certification earns the maximum score
- Participation in a CMS survey on improvement brings the maximum score
- Participation in an APM achieves 50% of the score
- ECs in rural areas/HPSAs receive preferential scoring



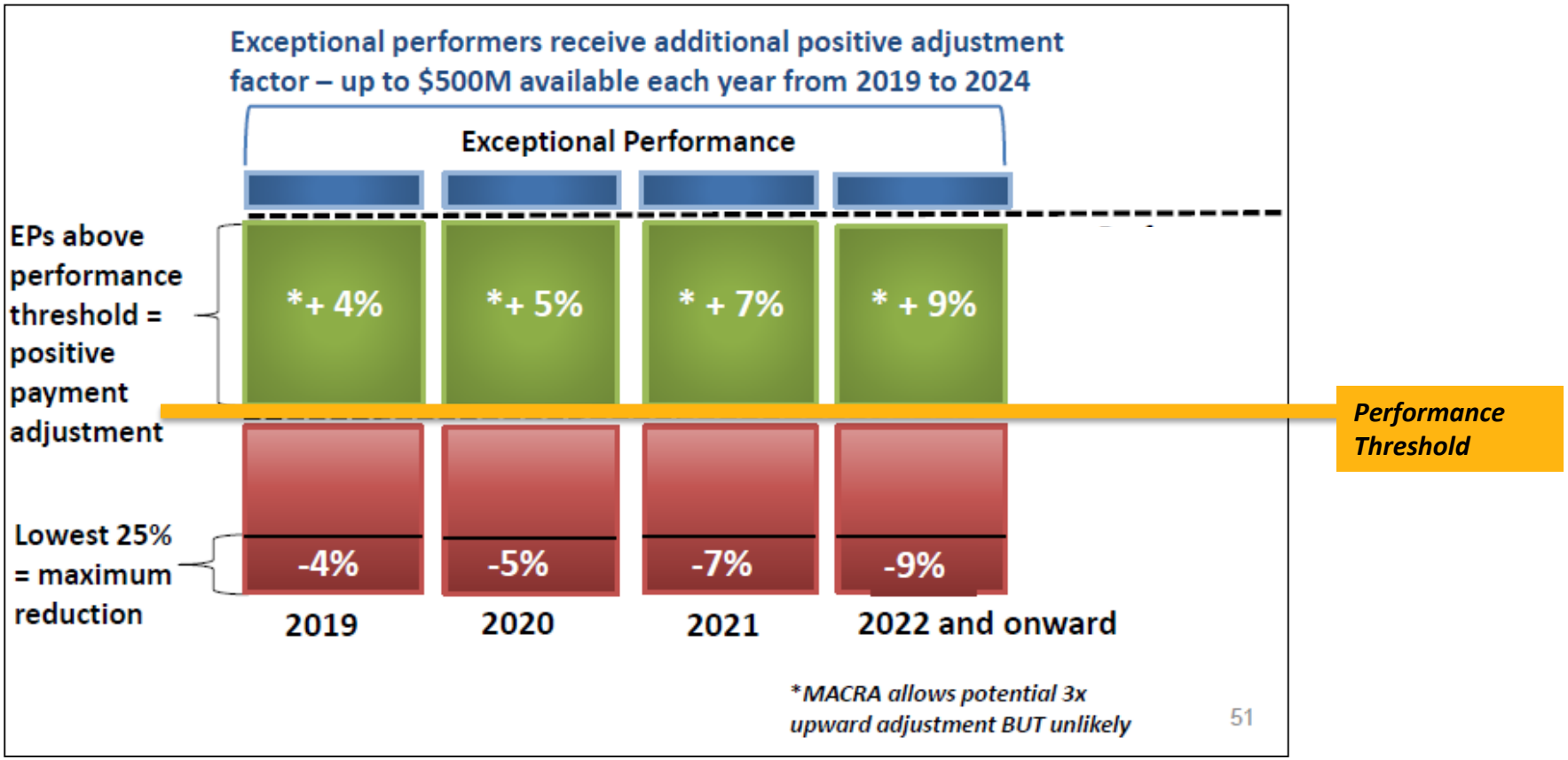
MIPS Scoring Methodology

An EC or group's scores from each category are aggregated into a single MIPS Final Score out of 100

Note: Performance will be reported on the CMS Physician Compare site

Payment Adjustment based on MIPS Final Score

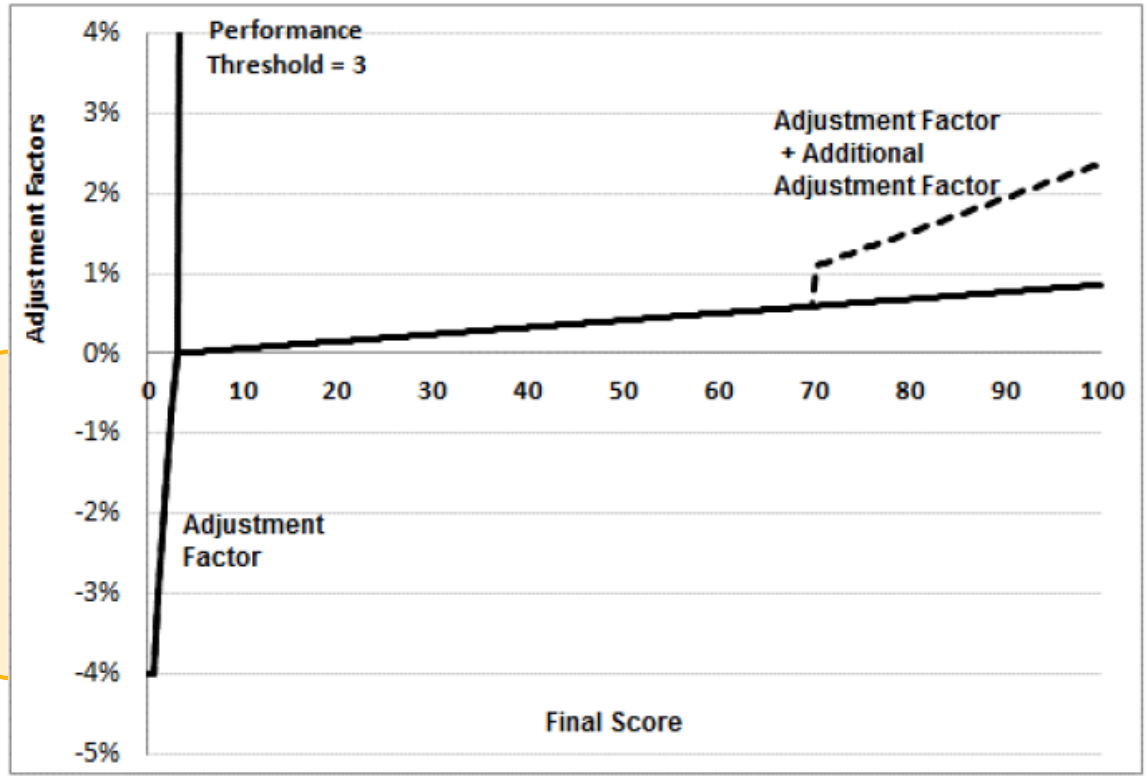
Each final score will then be compared against a "threshold CPS" to determine the % payment adjustment. MIPS is budget neutral.



Effect of "Pick Your Pace" in 2017

Only a small number of MIPS Eligible Clinicians will receive negative payment adjustments in payment year 2019. The majority of MIPS Eligible Clinicians will receive small positive adjustments.

CMS estimates that about 10% of providers will not participate and will therefore receive negative payment adjustments.



CMS estimates that 90% of providers will receive positive payment adjustments. However, these will be insignificant if below the threshold score for "exceptional performance" funding.

Source: Final Rule. Distribution is described as "illustrative only."

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"Advanced Alternative Payment Models" Track

Alternative Payment Models

Description

- ✓ CMS Innovation Center models (under s. 3021, other than a Health Care Innovation Award)
- ✓ MSSP (Medicare Shared Savings Program)
- ✓ Demonstration under Health Care Quality Demonstration Program
- ✓ Demonstration required by federal law
- ✓ Physician Focused Payment Models (special process)

Examples

2019 "non-advanced" APMs:

- MSSP Track 1
- Oncology Care Model (1-sided)

Advanced Alternative Payment Models

Description

- ✓ Require use of CEHRT
- ✓ Quality requirements "comparable to MIPS"
- ✓ "Financial risk for monetary losses, of a more than nominal amount," OR medical home model expanded under Innovation Center authority

2017 Advanced APMs*

- MSSP Tracks 2/3
- CPC+
- Compehensive ESRD Care Model (CEC)
- Next Gen ACO
- Oncology Care Model (2 sided)

2018 Advanced APMs*

2017 Advanced APMS, plus

- MSSP Track 1+ (new)
- Voluntary Bundled Payment
- CJR
- Cardiac Care
- Vermont Medicare ACO

*CMS anticipates additional models will qualify as Advanced APMs in the future, and will also reopen applications to previously closed programs, such as CPC+ and CJR in 2018.

Payment Consequences for APM and A-APM Participation

Participants Alternative Payment Models

Subject to MIPS, but special "APM scoring standards" apply:

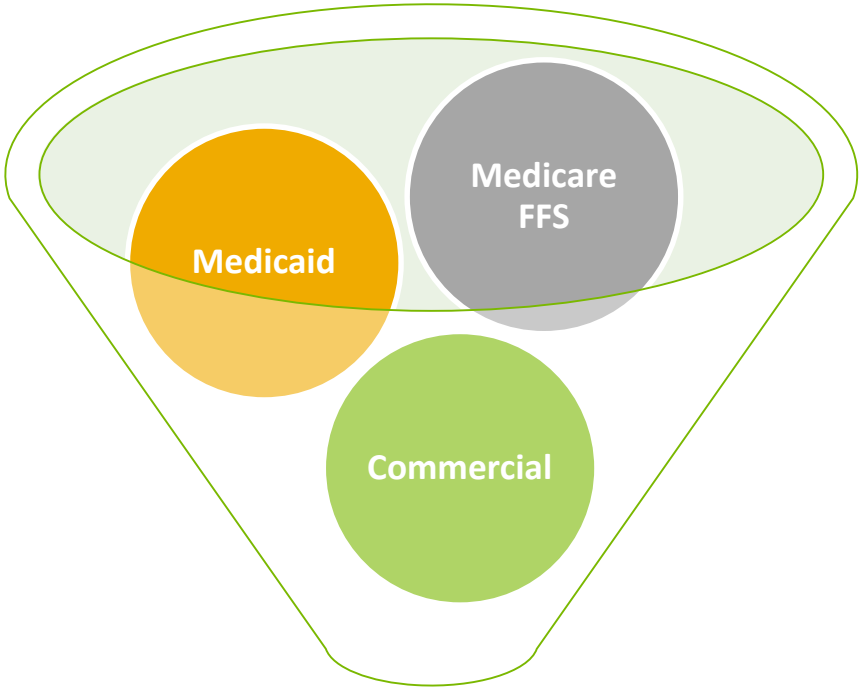
- Cost category is waived
- More weight for IA category, and favorable scoring within that category
- MIPS unit must match the unit participating in the model

Participants in *Advanced* Alternative Payment Models

If participants meet "QP thresholds" (% of revenue through AAPM and/or % of total patient count through AAPM), ECs are designated as **"Qualifying Participants"** for the performance year in question.

Qualifying Participants are MIPS exempt and receive a 5% bonus based on the previous year's Part B revenues.

The "All-Payer Combination Option" Starting in 2019



QP status: 5% bonus and MIPS exemption

Starting in 2019, participants in Medicare Advanced APMs who would otherwise not meet QP thresholds will be able to **combine their participation in Medicare and non-Medicare Advanced APMs**

Take-Homes for Montana

MACRA (aka Quality Payment Program) will start in January as scheduled, but CMS has lowered the bar for the first year. The practical effect of MACRA on payments will ramp up over several years.

- **MIPS:**
  - MIPS is coming into force on schedule, but with a "transitional" year in 2017 which will shield most providers from negative adjustments initially.
  - 2017 is an opportunity to plan strategy for 2018 onwards.
  - The low-volume threshold for 2017 has been raised, which may exclude a significant number of Montana providers in the coming year.
- **Advanced APMs:**
  - The 5% bonus for A-APM participation is a sweetener for entering A-APMs, but does not necessarily mean the participants "win" in the models themselves.
  - The Obama administration signaled plans to increase the range of A-APM options for 2018. It is too early to know whether the Trump administration will continue those plans.

Comprehensive Primary Care Plus (CPC+): *Updates for Montana*

Edith Coakley Stowe, payer facilitator for Montana CPC+

Manatt Health

November 16, 2016

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Today's Presentation

CPC+ Recap

Multi-payer Alignment in Montana

Next Steps for Montana CPC+

CPC+ Recap

CPC+ Recap

CPC+ aims to improve health and reduce costs though transformed primary care, supported by multi-payer payment reform, data transparency and aligned quality measurement. Montana has been selected to participate, starting in January 2017.

5
Years

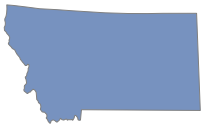
Beginning January 2017, progress monitored quarterly

2
Program Tracks

Based on practices' readiness for transformation

Up to 2,500
Practices Per Track

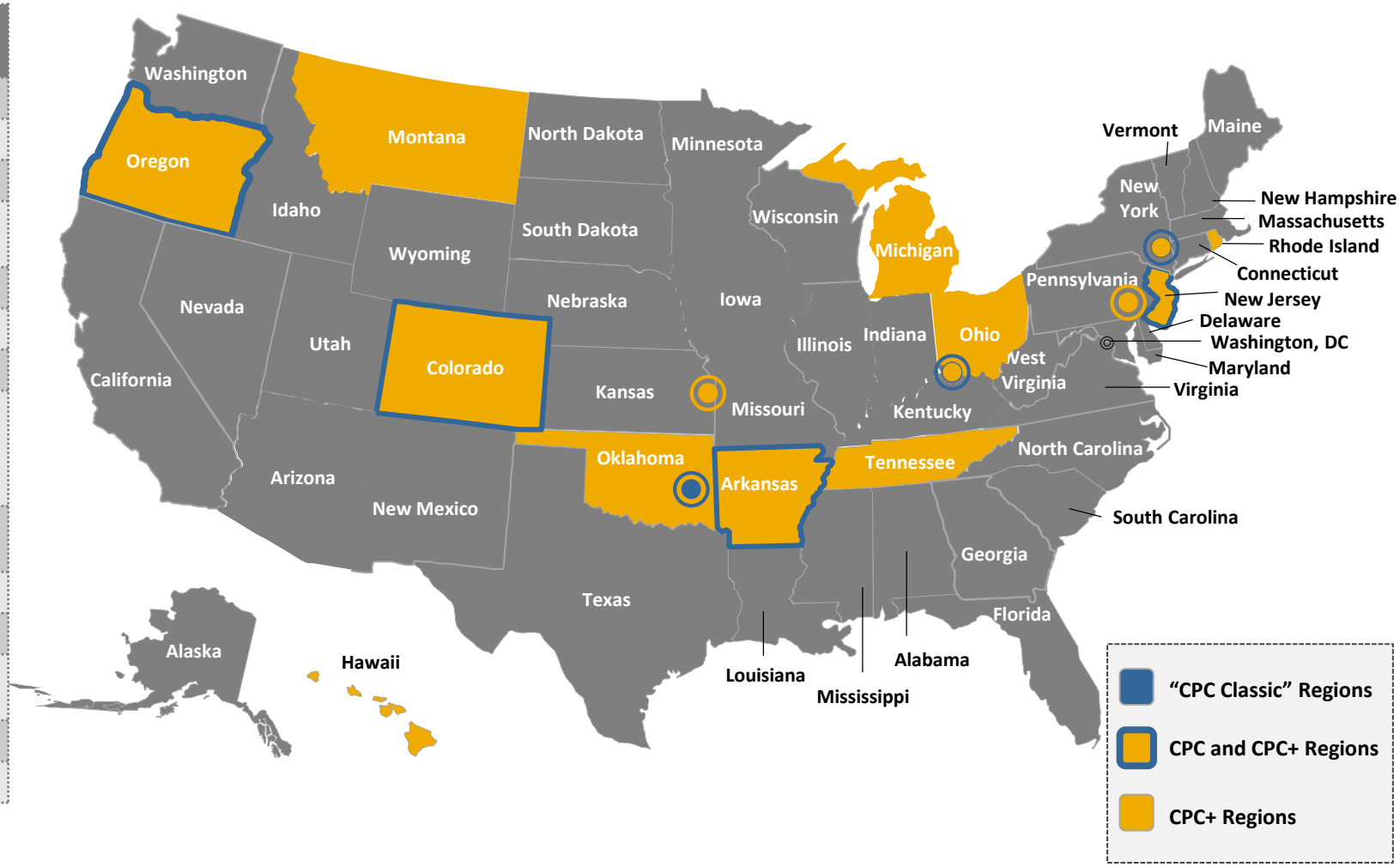
Dependent upon interest and eligibility

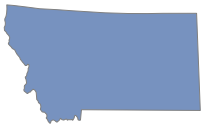


Source: Centers for Medicare & Medicaid Innovation: https://innovation.cms.gov/files/x/cpcplus-practiceslidepres.pdf

CPC+ Regions and Payers

CPC+ Region	# of Payers
AR	6
CO	5
HI	1
Greater Kansas City	1
MI	2
MT	3
NJ	3
North Hudson-Capital Region	3
OH & Northern KY	12
OK	5
OR	15
Greater Philadelphia	2
RI	3
TN	4





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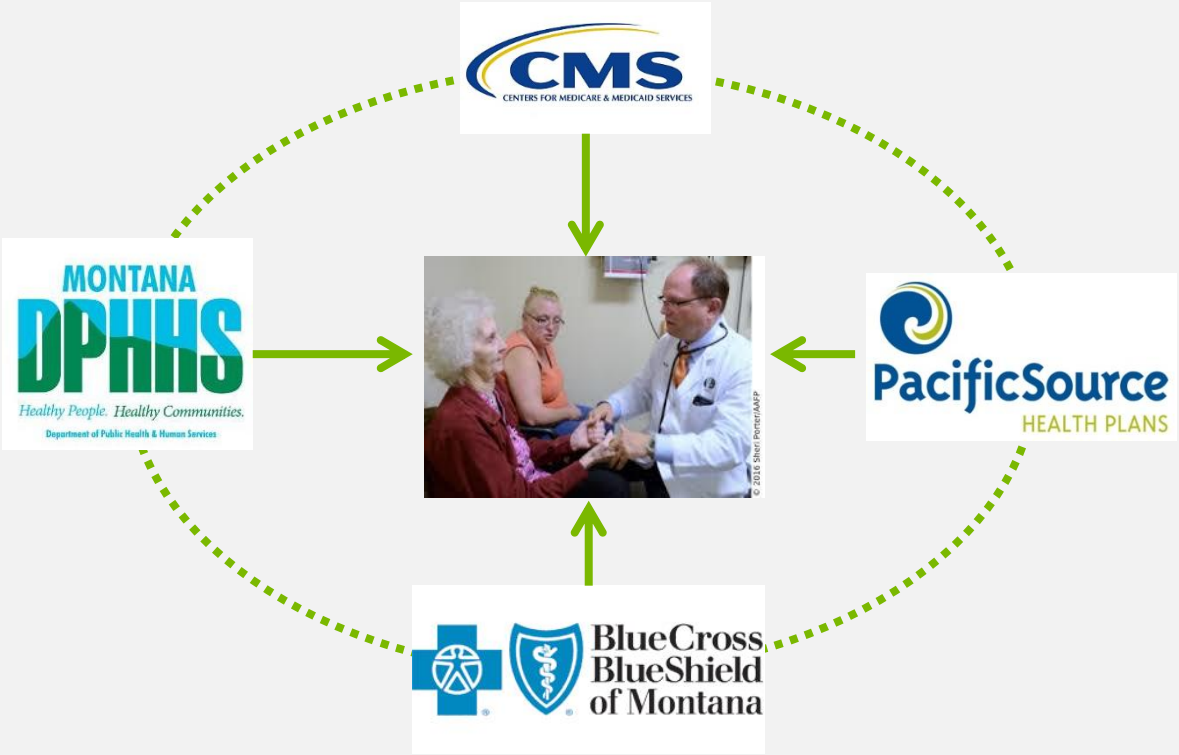
CPC+ in Montana

In Montana, DPHHS, Blue Cross/Blue Shield and Pacific Source are participating in CPC+ alongside CMS



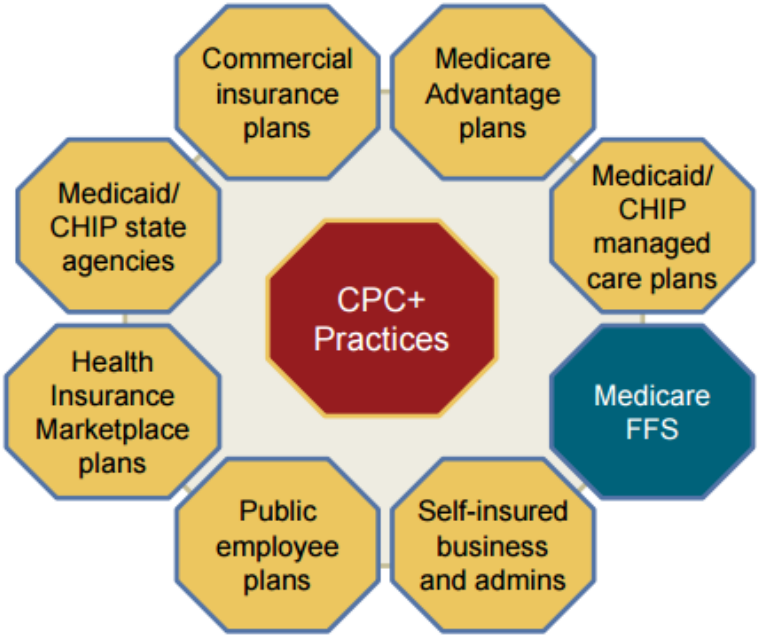
Participating payers have signed Memoranda of Understanding, undertaking to:

- Pay practices non-visit-based care management fees and quality payments;
- Share cost and quality information with practices
- Align on quality metrics

Source: Centers for Medicare & Medicaid Innovation: https://innovation.cms.gov/files/x/cpcplus-practiceslidepres.pdf

Partner Payers Aligned With But Not Identical to Medicare

Payers Invited to Partner

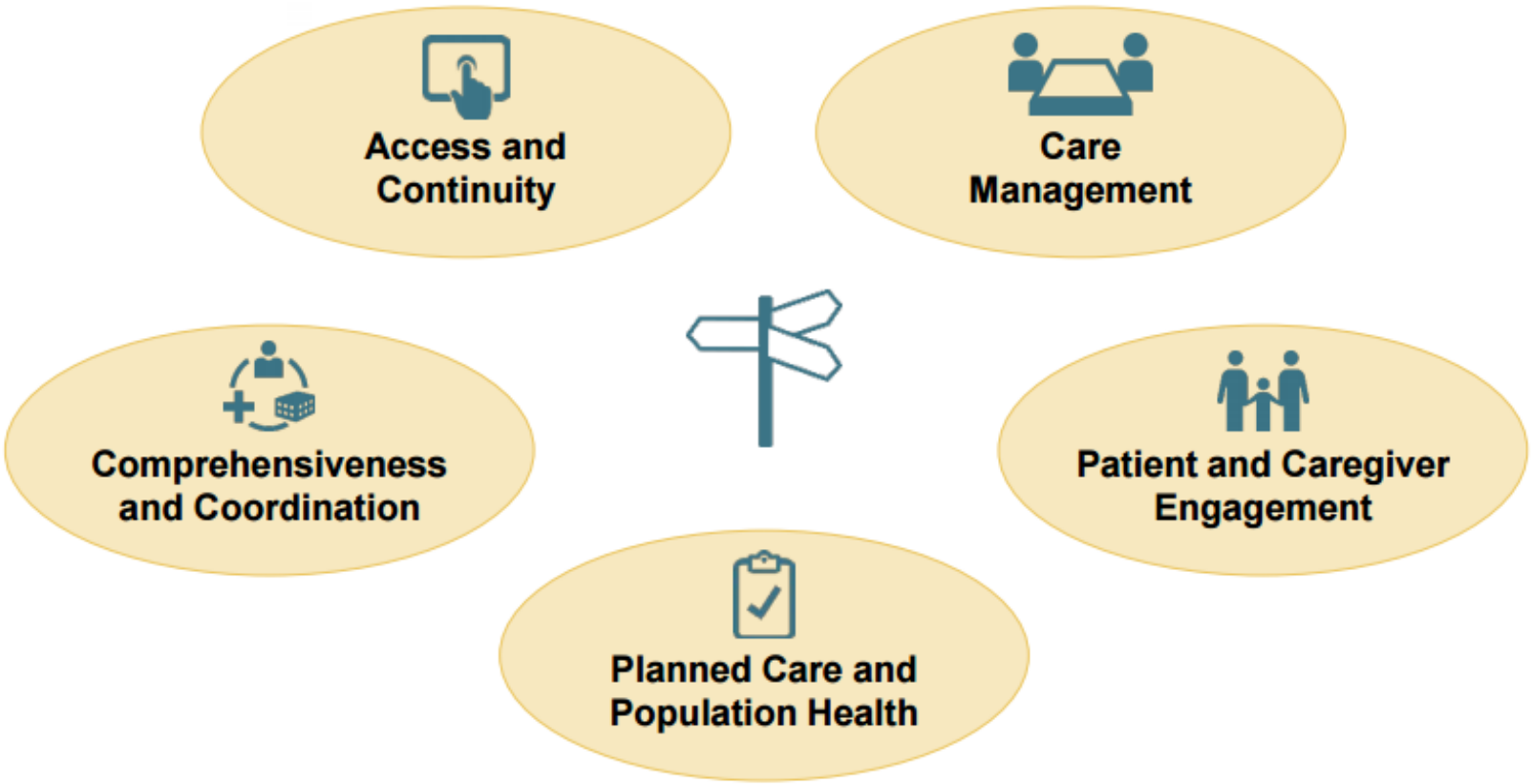


Required Payer Alignment

- Enhanced, non-FFS support
- Change in cash flow mechanism from fee-for-service to at a least a partial alternative payment methodology for Track 2 practices
- Performance-based incentive
- Aligned quality and patient experience measures with Medicare FFS and other payers in the region
- Practice- and member-level cost and utilization data at regular intervals

Source: Centers for Medicare & Medicaid Innovation: https://innovation.cms.gov/files/x/cpcplus-practiceslidepres.pdf

Five Functions of CPC+ Care Delivery Transformation



Source: Centers for Medicare & Medicaid Innovation: https://innovation.cms.gov/files/x/cpcplus-practiceslidepres.pdf

CPC+ Track Requirements

Track 2 capabilities are inclusive of and build upon Track 1 capabilities

	Requirements for Track 1	Requirements for Track 2
Access and Continuity	Empanelment 24/7 patient access Assigned care teams	Alternative to traditional office visits, e.g., e-visits, phone visits, group visits, home visits, alternate location visits, and/or expanded hours.
Care Management	Risk stratified patient population Short-term and targeted, proactive, relationship-based care management ED visit and hospital follow-up	Two-step risk stratification process for all empanelled patients Care plans for high-risk chronic disease patients

Source: Centers for Medicare & Medicaid Innovation: https://innovation.cms.gov/files/x/cpcplus-practiceslidepres.pdf

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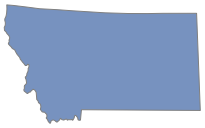
CPC+ Track Requirements (Continued)

Track 2 capabilities are inclusive of and build upon Track 1 capabilities

	Requirements for Track 1	Requirements for Track 2
Comprehensiveness and Coordination	Identification of high volume/cost specialists Improved timeliness of notification and information transfer from EDs and hospitals	Behavioral health integration Psychosocial needs assessment and inventory of resources and supports to meet psychosocial needs Collaborative care agreements Development of practice capability to meet needs of high-risk populations
Patient and Caregiver Engagement	At least annual Patient and Family Advisory Council Assessment of practice capabilities to support patient self-management	At least biannual Patient and Family Advisory Council Patient self-management support for at least three high-risk conditions
Planned Care and Population Health	At least quarterly review of payer utilization reports and practice eCQM data to inform improvement strategy	At least weekly care team review of all population health data

Source: Centers for Medicare & Medicaid Innovation: https://innovation.cms.gov/files/x/cpcplus-practiceslidepres.pdf

Multi-Payer Alignment in Montana



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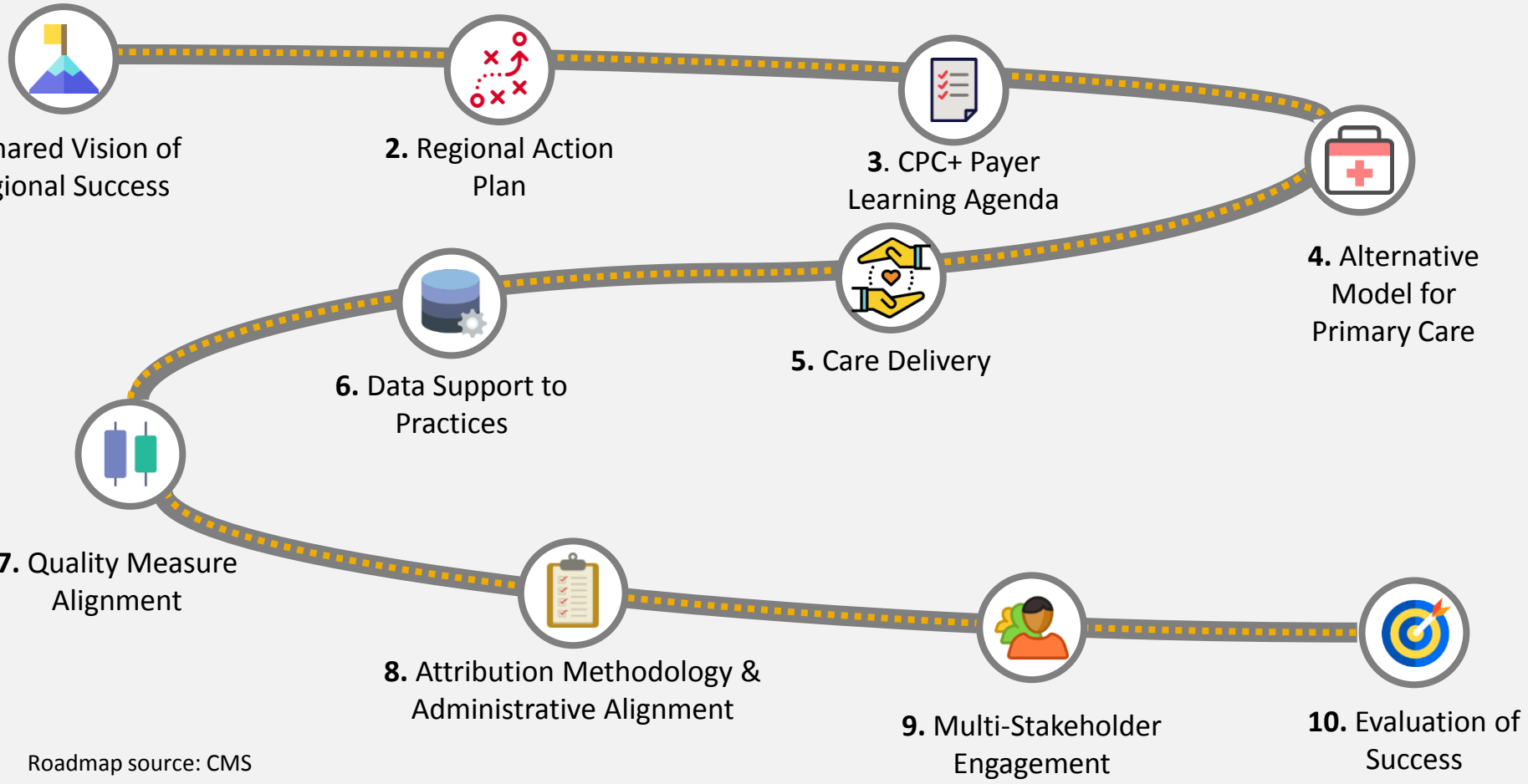
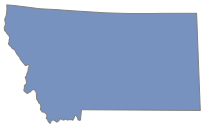
CPC+ Payer Partner Collaboration Roadmap

Montana payers have begun discussions of how they will align their approaches for success in CPC+



Roadmap source: CMS

Next Steps for Montana CPC+



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Next Steps

November: Practice Selection. Approximately 70 Montana practices have applied for CPC+. CMS will announce the list of successful practices by about 11/25.

December: Onboarding and Preparation. CMS onboarding steps with practices. Payer contract amendments with practices.

January 2017: Kick-off. *Montana can expect:*

- National and regional learning offerings for CPC+ practices
- Implementation of payment models by CMS and other participating payers
- Implementation and refinement of payer/practice data sharing strategies
- Aligned quality strategies between payers
- "Advanced Alternative Payment Model" MACRA status for CPC+ practices
- *Mid-year:* opportunity for further payer and practice applications for a 2018 start

Collaborative Care Codes

Anne Shields, University of Washington AIMS Center

AIMS CENTER
W UNIVERSITY of WASHINGTON
Psychiatry & Behavioral Sciences

Medicare Benefit for Collaborative Care

and Other Integrated Behavioral Health Strategies

CMS Final Rule for January 1, 2017

Anne Shields, RN, MHA, Associate Director
University of Washington AIMS Center
Advancing Integrated Mental Health Solutions

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Four New "Incident to" Codes for Integrated Behavioral Health

Collaborative Care Model (CoCM)

G0502 CoCM: First 70 min / mon

G0503 CoCM: First 60 min subsequent mo

G0504 CoCM: Additional 30 min, any mo

Other Integrated Behavioral Health Services

G0507 Care Management for BH, 20 min

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CoCM Payment Code Structure

Each G code bundles payment to primary care for the work of the collaborative care team:

- **Primary care provider**
- **Behavioral health care manager**
- **Psychiatric consultant (psych ARNP or psychiatrist)**

CMS requires use of a registry to track visits and patient outcomes

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Thank you!

Questions and Discussion

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Health Information Exchange Update

Jean Branscum, MMA

Other Updates & Public Comment