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PAYMENT REFORM & QUALITY REPORTING: WHAT RHCs NEED TO KNOW

Presented by:
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June 6, 2018

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AGENDA

- Why is payment reform being pursued?
- Review existing payment reform models
- Review key data elements required for success
- Strategies for success in alternative payment models
- Questions

PAYMENT REFORM – WHY?

- CMS goal of 50% of Medicare payments made under Alternative Payment Models (APMs) by end of 2018
- HHS Strategic Plan FY 2018 – 2022
  - Reform, strengthen & modernize health care system
  - Protect health of Americans
  - Strengthen economic & social well-being of Americans
  - Foster sound, sustained advances in the sciences
  - Promote effective & efficient management & stewardship
- RHC facilities largely excluded…for now
  - Existing models largely used as “testing” opportunities
  - APMs likely to be extended to RHCs once CMS has more information

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EXISTING PAYMENT REFORM MODELS: BUNDLED PAYMENT FOR CARE IMPROVEMENT ADVANCED (BPCI ADVANCED)

- Voluntary model for physician practices & acute care hospitals
- Participants can choose episodes of participation
- Shifts emphasis from individual services towards coordinated clinical episodes (90 days)
- Establishes an accountable party

EXISTING PAYMENT REFORM MODELS: BUNDLED PAYMENT FOR CARE IMPROVEMENT ADVANCED (BPCI ADVANCED)

- Episodes assessed on quality & cost of care
  - High quality + high cost = Fail
  - Low quality + low cost = Fail
  - Low quality + high cost = Fail
  - High quality + low cost = SUCCESS!
- Benchmark pricing based on:
  - Patient case mix
  - Peer group trends
  - Historic efficiency
- Semi-annual reconciliation including two “true-ups”

EXISTING PAYMENT REFORM MODELS: BUNDLED PAYMENT FOR CARE IMPROVEMENT ADVANCED (BPCI ADVANCED)

- Considerations for participation in model
  - Clear opportunities for improvement within the model?
  - Can we assume financial risk?
  - What access to data do we have?
  - Does it make sense to work with a Convener?
  - Would we qualify for incentive payments under Quality Payment Program?

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EXISTING PAYMENT REFORM MODELS: QUALITY PAYMENT PROGRAM (QPP)

- Mandatory model for physicians began 2017
- Consolidated Medicare quality reporting programs (PQRS, Value-Based Modifier & Meaningful Use)
- Established path for alternative payment models
- Increased & consolidated financial impacts
- Ranks peers nationally & reports scores publicly

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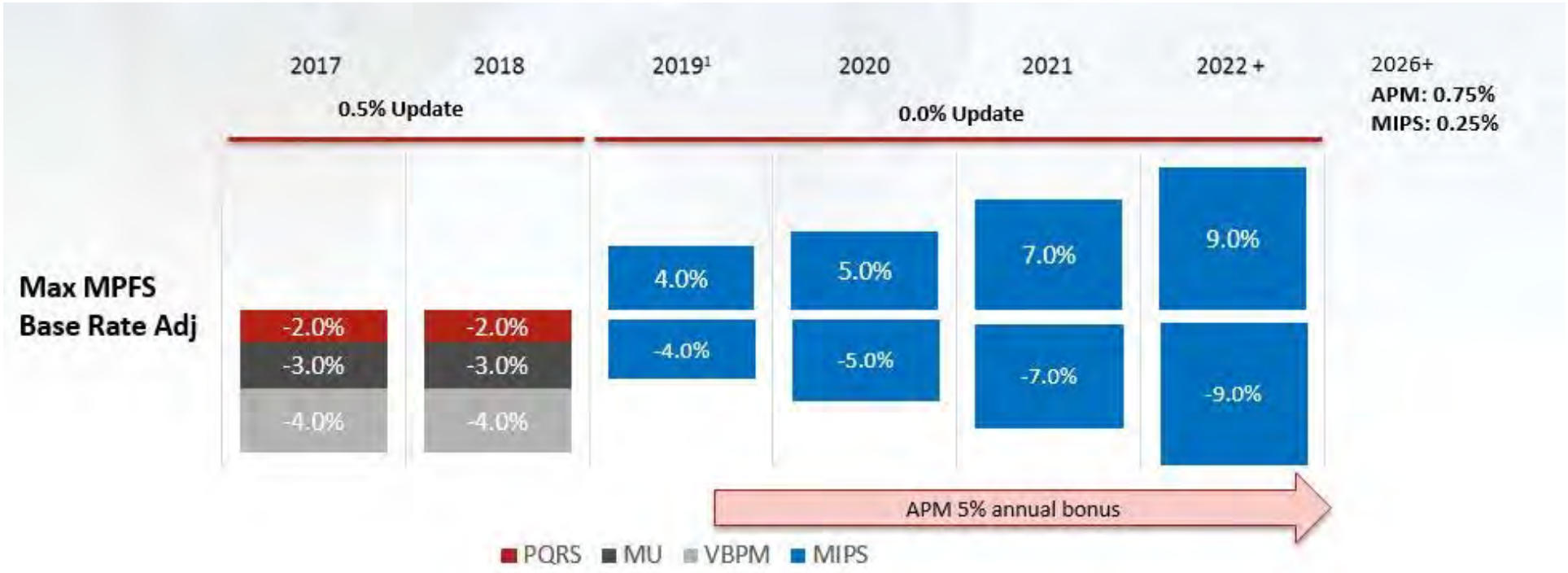
EXISTING PAYMENT REFORM MODELS: QUALITY PAYMENT PROGRAM (QPP)

- Single MIPS Composite Performance Score (100 points) across four categories
- CMS establishes performance threshold which determines upward or downward adjustment
- Budget neutral with potential scaling factor
- Exempt - ECs in year 1 of Medicare, or below “low” threshold or an Advanced APM QP/partial-QP
- CMS to evaluate historical claims data to determine, low-volume, hospital-based & non-patient facing clinicians

MIPS Overview

EXISTING PAYMENT REFORM MODELS: QUALITY PAYMENT PROGRAM (QPP)



EXISTING PAYMENT REFORM MODELS: QUALITY PAYMENT PROGRAM (QPP)

- Considerations for participation in model
  - Meet minimum standards or report full data?
  - Which measures to report?
  - Report as group or individual providers?
  - Keep existing NPI/Tax ID set up or change?
  - Does practice meet low volume threshold?
  - Do APMs exist that fit our practice model?
  - Take part in virtual reporting group?

EXISTING PAYMENT REFORM MODELS: COMPREHENSIVE PRIMARY CARE PLUS (CPC+)

- Voluntary model for primary care practices began in 2017 (round 2 began in 2018)
  - Only selected states eligible for participation
- Model includes commercial payers in addition to Medicare
  - Also limited number of practices accepted in model
- Practices required to forecasts CPC+ spending as well as payments
- Practices required to enhance comprehensiveness of care in primary care setting

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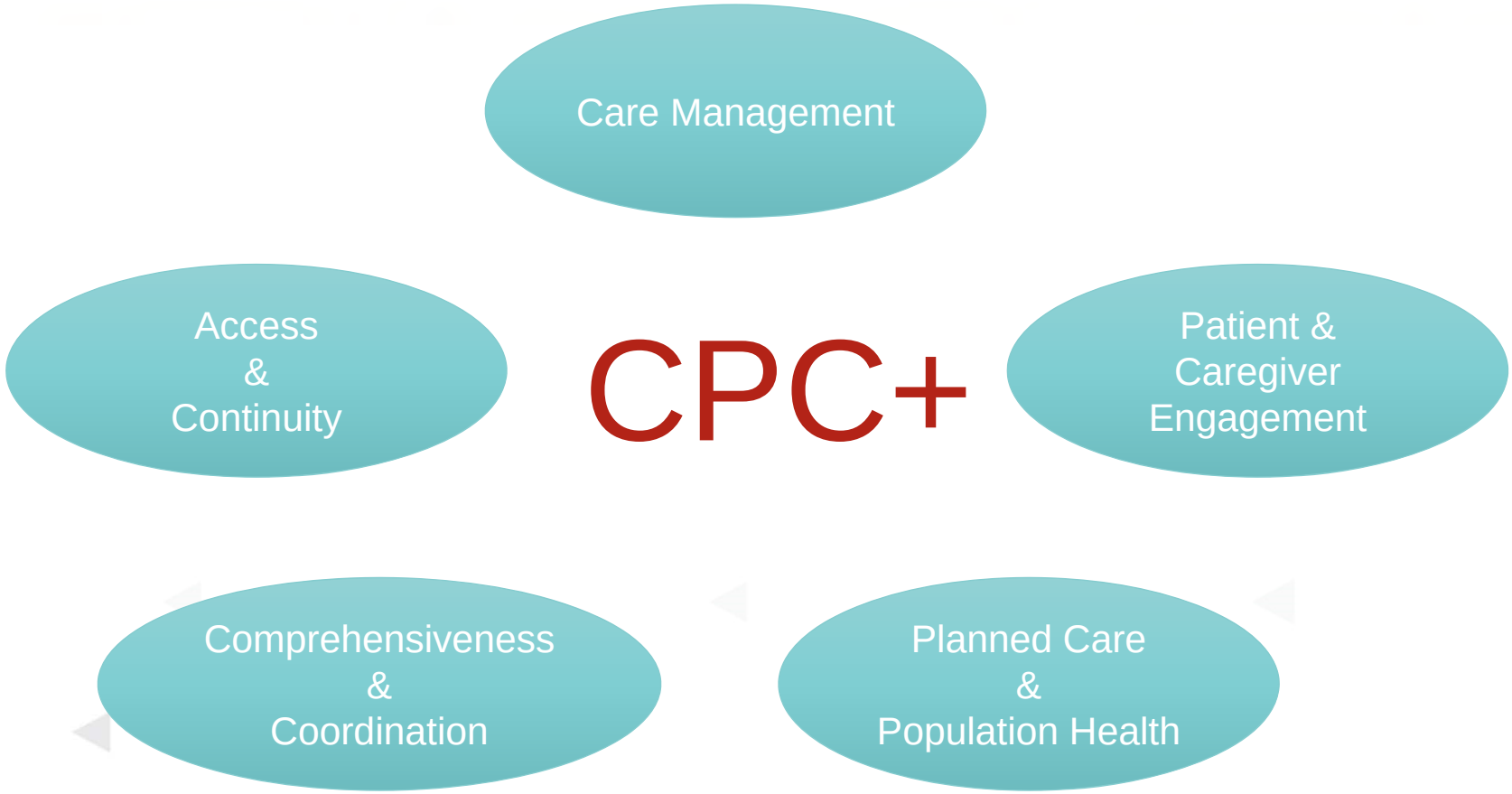
EXISTING PAYMENT REFORM MODELS: COMPREHENSIVE PRIMARY CARE PLUS (CPC+)



EXISTING PAYMENT REFORM MODELS: COMPREHENSIVE PRIMARY CARE PLUS (CPC+)

- Three payment elements:
  1. Care Management Fee (CMF)
     - Per Beneficiary Per Month (PBPM) payment paid quarterly
     - Risk adjusted for each practice to account for intensity of care management
  2. Performance-Based Incentive Payment
     - Prospective & retrospective payments based on patient experience, clinical quality measures & utilization measures
  3. Physician Fee Schedule Payments
     - Track 1 – continue to bill FFS as usual
     - Track 2 – continue to bill FFS, but FFS payments reduced as portion of payments shifted to lump sum quarterly payments

EXISTING PAYMENT REFORM MODELS: COMPREHENSIVE PRIMARY CARE PLUS (CPC+)

Both tracks provide risk-adjusted, prospective, monthly CMF for attributed CPC+ Medicare beneficiaries. Payments to be utilized to augment staffing & training in support of population health management & coordination.

Risk Tier	Attribution Criteria	Track 1	Track 2
Tier 1	1st quartile HCC	$6	$9
Tier 2	2nd quartile HCC	$8	$11
Tier 3	3rd quartile HCC	$16	$19
Tier 4	4th quartile HCC for Track 1; 75-89% HCC for Track 2	$30	$33
Complex (Track 2 only)	Top 10% HCC or Dementia	N/A	$100
Average PBPM		$15	$28

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EXISTING PAYMENT REFORM MODELS: QUALITY PAYMENT PROGRAM (QPP)

- Considerations for participation in model
  - How will our practice need to be modified?
  - What additional expenses will we have?
  - Can we track those expenses?
  - Can we implement behavioral health into primary care?
  - What is the acuity of our patient population?
  - Are our providers willing to engage in this model?
  - What commercial carriers are participating in our area?

EXISTING PAYMENT REFORM MODELS: COMMON THEMES & KEY ELEMENTS

- Quality
  - What are our existing quality scores?
  - Can we improve?
- Cost
  - What is our current cost per Medicare beneficiary?
  - Can we partner with other providers?
- Coding
  - Is our coding accurate & what is our acuity level?
- Access to Data
  - What do we (or don't) know about our practice/patients

FUTURE PAYMENT REFORM MODELS: STRATEGIES FOR SUCCESS

- Evaluate the model itself
  - Mandatory or voluntary
  - Specific procedures/codes of all inclusive
  - How long does model run & is early exit possible?
  - What are the upside & downside risks?
- Evaluate the practice
  - Are we open to change?
  - Will our providers, patients or partners engage?
  - How have we performed in the past?
  - Do we have the ability to improve?

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FUTURE PAYMENT REFORM MODELS: STRATEGIES FOR SUCCESS

- Coding Evaluation
  - Are we accurately capturing the acuity of our patients?
    - HCC scores
  - Are/can continual coding audits be performed?
  - When was last time our coding was reviewed by an external party? What were the results?
  - What training do we provide our coding staff?
    - ICD-11 is in beta form

FUTURE PAYMENT REFORM MODELS: STRATEGIES FOR SUCCESS

- Professional organization involvement
  - Excellent resource for regional & national information

Feedback Requested: KY Core Measures Set

The Kentuckiana Health Collaborative and Kentucky Department for Medicaid Services invites you to provide feedback on the Kentucky Core Healthcare Measures Set (KCHMS), a core measures set for primary care and pediatric care in Kentucky. **The comment period ends May 24, 2018.**

This is an opportunity to weigh in on the 38 proposed measures for the KCHMS, created by the Kentucky Performance Measurement Alignment Committee (PMAC), a private-public partnership between the Kentuckiana Health Collaborative and Kentucky Department for Medicaid Services. Five domains of primary care are represented in the draft measures set: Preventive Care, Pediatric Care, Chronic Care, Acute Care, and Behavioral Health Care.

You can find a copy of the draft KCHMS on the KHC website here, along with an online form to submit your comments.

Thank you,

Stephanie Clouser

Kentuckiana Health Collaborative

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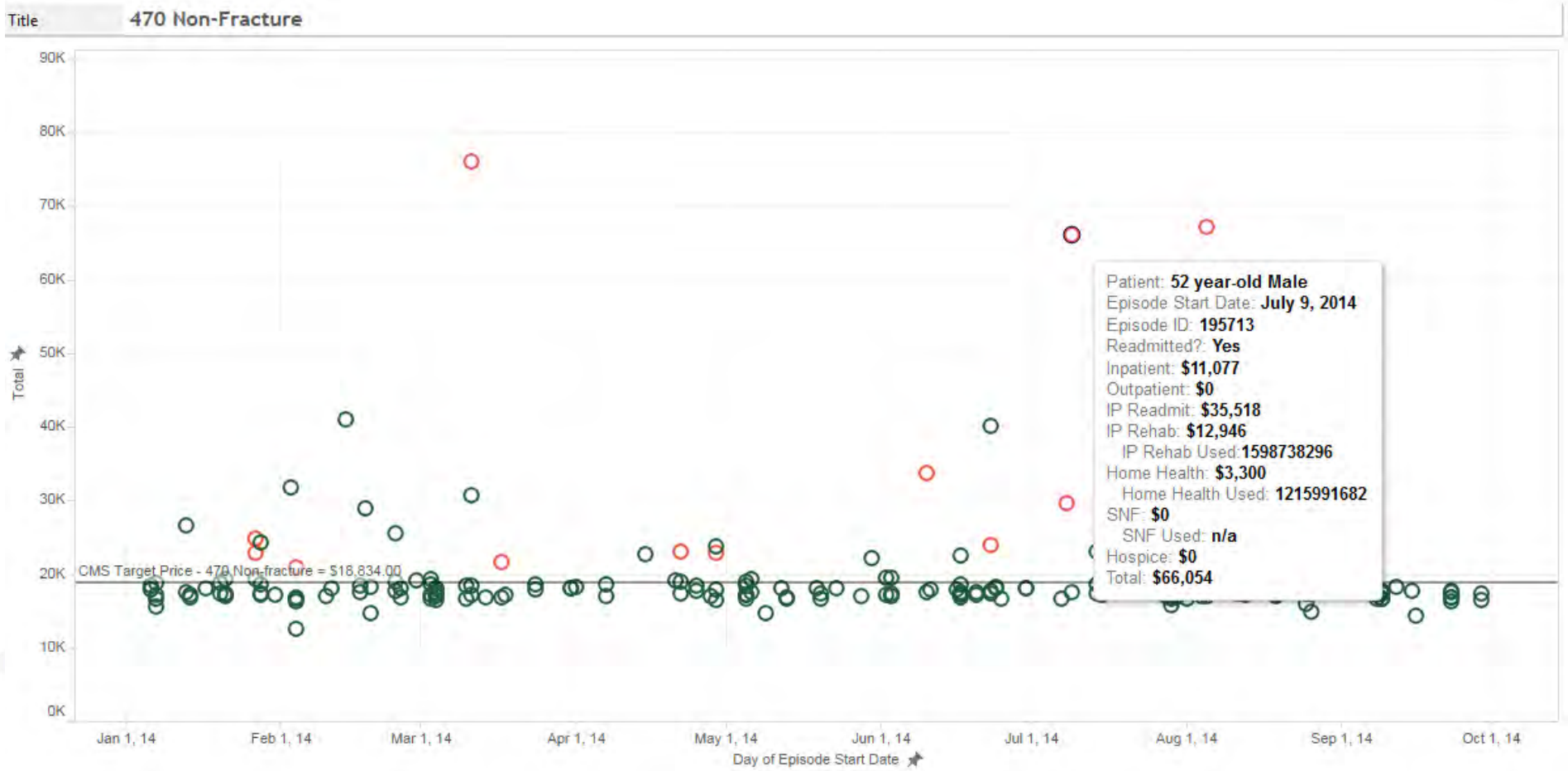
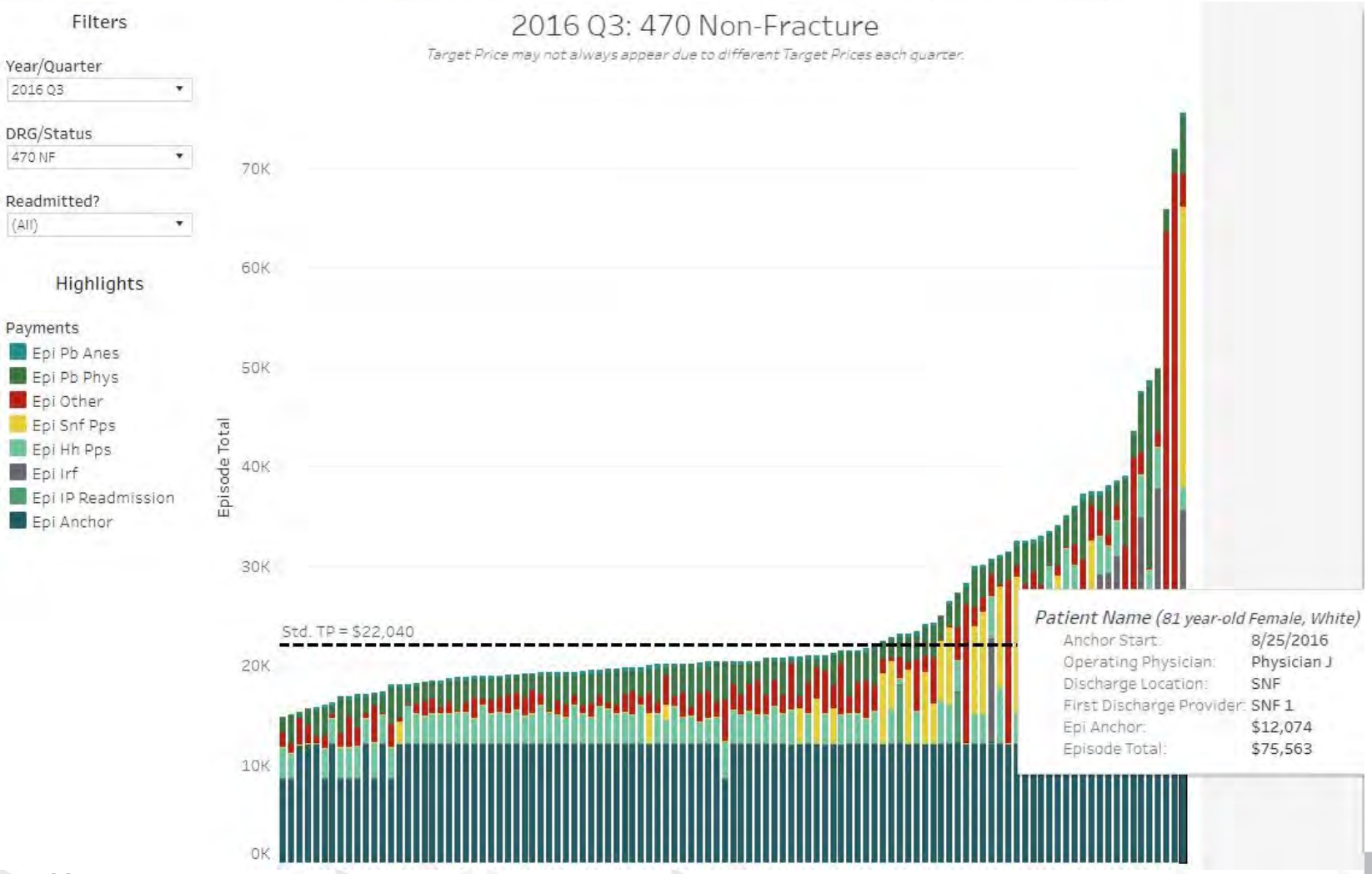
FUTURE PAYMENT REFORM MODELS: STRATEGIES FOR SUCCESS – DATA



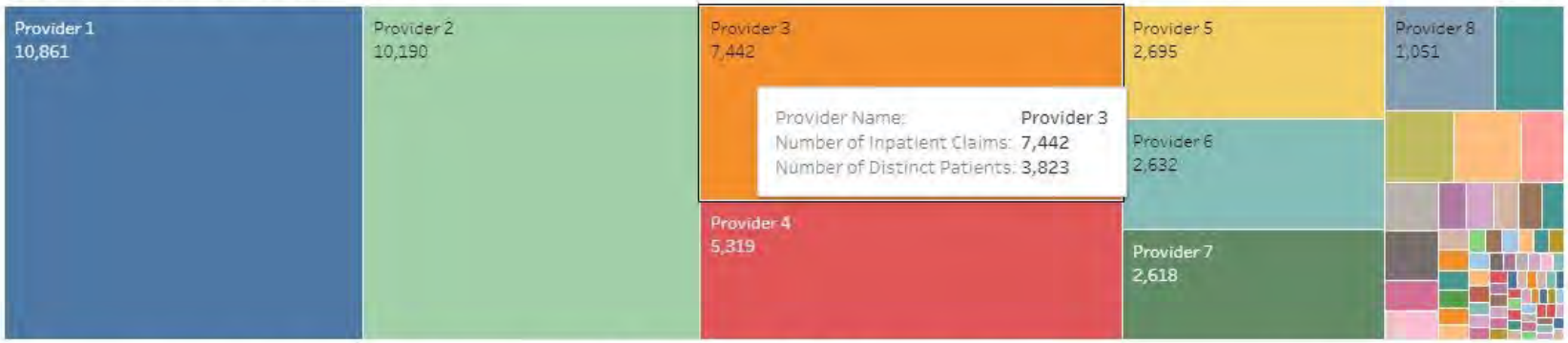
FUTURE PAYMENT REFORM MODELS: STRATEGIES FOR SUCCESS – DATA



FUTURE PAYMENT REFORM MODELS: STRATEGIES FOR SUCCESS – DATA

FUTURE PAYMENT REFORM MODELS: STRATEGIES FOR SUCCESS – DATA

Hospital Name and Inpatient Volume



Outpatient Referring Organization and Volume of PCP Visits

Organization 1	39,047
Organization 2	33,672
Organization 3	21,476
Organization 4	19,997
Organization 5	18,254
Organization 6	17,196
Organization 7	16,293
Organization 8	11,204
Organization 9	9,257
Organization 10	5,983
Organization 11	5,758
Organization 12	4,538
Organization 13	4,194
Organization 14	3,106
Organization 15	3,103
Organization 16	1,353
Organization 17	883
Organization 18	841

Referring Physician and Volume of PCP Visits

PCP Name	Taxonomy Description	
Physician 1	Physician/Internal Medicine	8,494
Physician 2	Physician/Internal Medicine	4,352
Physician 3	Physician/Internal Medicine	4,248
Physician 4	Physician/Internal Medicine	4,184
Physician 5	Physician/Family Practice	3,833
Physician 6	Physician/Family Practice	3,693
Physician 7	Physician/Family Practice	3,294
Physician 8	Physician/Internal Medicine	3,165
Physician 9	Physician/Family Practice	2,797
Physician 10	Physician/Family Practice	2,795
Physician 11	Podiatry	2,760
Physician 12	General Practice — Dental Providers	2,743
Physician 13	Physician/Internal Medicine	2,589
Physician 14	Podiatry	2,564
Physician 15	Physician/Family Practice	2,437
Physician 16	Physician/Family Practice	2,389
Physician 17	Physician/Internal Medicine	2,389

HELPFUL PAYMENT REFORM RESOURCES

- Coding Evaluation
  - https://innovation.cms.gov/
- BPCI Advanced
  - https://innovation.cms.gov/initiatives/bpci-advanced
- Quality Payment Program
  - https://qpp.cms.gov/
- Comprehensive Primary Care Plus
  - https://innovation.cms.gov/initiatives/comprehensive-primary-care-plus

Questions?

THANK YOU!

FOR MORE INFORMATION

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