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· MACRA VALUE BASED CARE MODELS WEBINAR·

· January 17th · Wednesday ·12-2 pm · 2 CME Offered

12:00 - 12:15 p.m.	**MACRA in 5 Steps** Niharika Khanna, MBBS, MD, DGO Director Maryland GPTN Associate Professor Family and Community Medicine University of Maryland School of Medicine
12:15 - 12:40 p.m.	**How to Use the MIPS Calculator** Russ Montgomery, PhD GPTN in MD Quality Improvement Advisor Discern Health
12:40- 1:00 p.m.	**How to Select MIPS Metrics to Report** Marsha Davenport, MD, MPH GPTN in MD Practice Transformation Coach
1:00 – 1:30 p.m.	**Maryland Value Based Payment Models** Melanie Cavaliere, MS Chief Innovative Care Delivery, MHCC
1:30 – 2:00 p.m.	**Maryland Primary Care Program** Howard Haft , MD Deputy Secretary for Public Health Services, MDH

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ANNOUCEMENTS

- **Questions will be answered after each presenter has completed their topic. Please submit all questions in the chat box, they will be answered in the order they are received.**
- **2 CME Credits Available**

The evaluation form can be found here:
https://drive.google.com/file/d/1P0JROaQQ_et_MXnQtF-IxF1YBywzGA3p/view?usp=sharing

This link to the evaluation can be found in the reminder email sent out 1 hour ago in the reminder email with the WebEx Login information

- **Submit all evaluations and additional questions to: Lauren Gritzer at lgritzer@som.umaryland.edu**

*The Maryland Learning Collaborative at the Department of Family and Community Medicine, University of Maryland School of Medicine is accredited by the American Academy of Family Physicians to provide continuing medical education for physicians and healthcare personnel. This educational activity is accredited for a maxi-mum of two (2) Prescribed Credits. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

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MACRA

How to Avoid the Penalty in 2019

Niharika Khanna, MBBS, MD, DGO
Associate Professor, Family and Community Medicine
Director, Maryland Learning Collaborative

University of Maryland School of Medicine

MACRA

- **What is MACRA?**
  - Medicare Access and CHIP Reauthorization Act (Replaces SGR)
- **What is at Stake?**
  - 4 % penalty in CMS 2019 payments
  - 5% penalty in CMS 2020 payments

MACRA

- **Based on Two New Reimbursement Structures:**
  - Merit-Based Incentive Payment (MIPS)
  - Alternative Payment Models
    - Advanced Alternative Payment Model

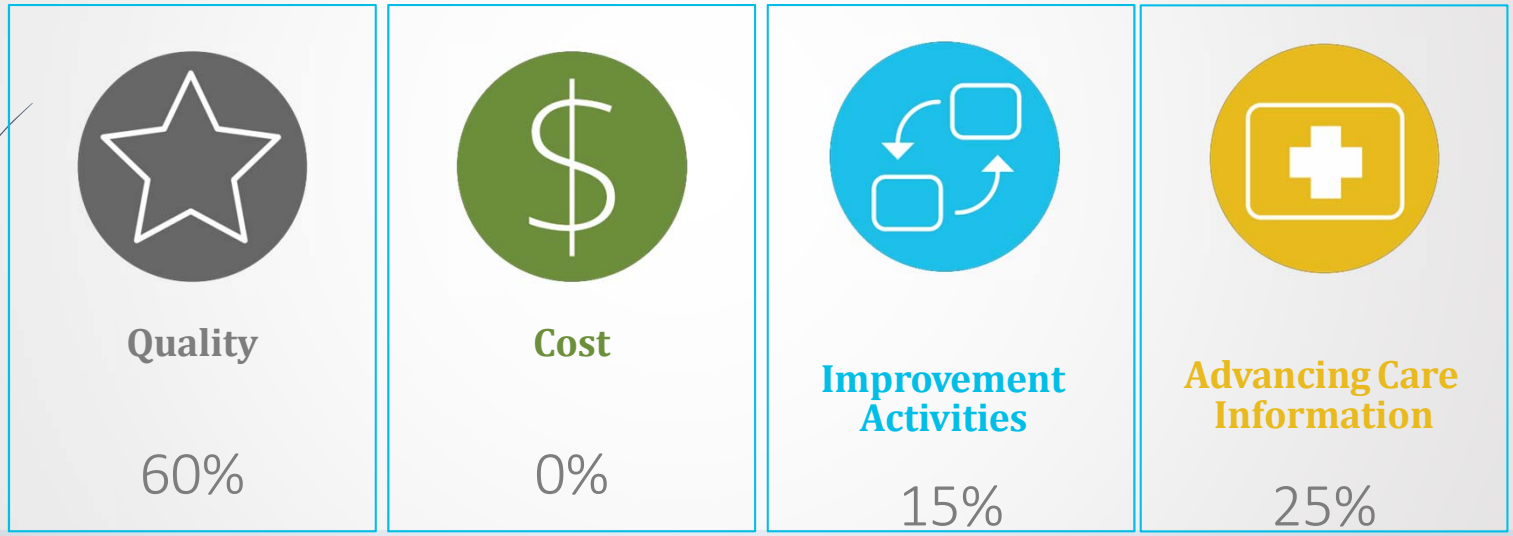
What is the Merit-Based Incentive Payment System (MIPS)?

- **What is the Merit Based Incentive Payment System (MIPS)?**
- **Eligible Professionals Will be Measured On:**
  - Quality reporting
  - Improvement Activities
  - Advancing Care Information

What are the Performance Category Weights?

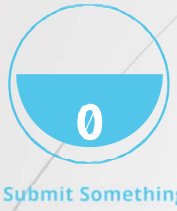
Weights assigned to each category based on a 1 to 100 point scale

Transition Year Weights



Note: These are default weights; the weights can be adjusted in certain circumstances

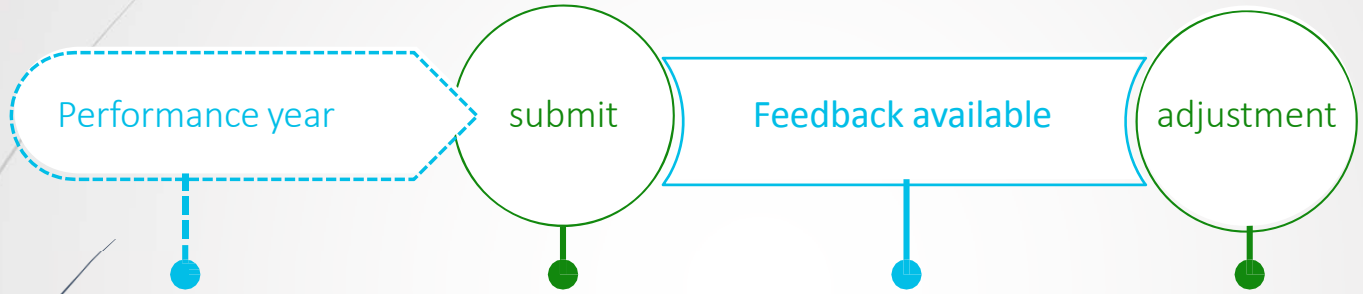
MIPS: Choosing to Test for 2017



- Submit minimum amount of 2017 data to Medicare
- Avoid a downward adjustment

You Have Asked: *"What is a minimum amount of data?"*

When Does the Merit-based Incentive Payment System (MIPS) Officially Begin?



2017
Performance Year

Performance: The first performance period opens January 1, 2017 and closes December 31, 2017. During 2017, you will 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.

March 31, 2018
Data Submission

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

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

January 1, 2019
Payment Adjustment

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 could earn 5% incentive payment in 2019.

MIPS Scoring for Quality
(60% of Final Score in Transition Year)

Select 6 of the approximately 300 available quality measures (minimum of 90 days)

- Or a specialty set
- Or CMS Web Interface measures
- Readmission measure is included for group reporting with groups with at least 16 clinicians and sufficient cases

Clinicians receive 3 to 10 points on each quality measure based on performance against benchmarks

Failure to submit performance data for a measure = 0 points

Quick Tip:
Easier for a clinician that participates longer to meet case volume criteria needed to receive more than 3 points

Bonus points are available

MIPS Performance Category: Advancing Care Information

Advancing Care Information Objectives and Measures:

Base Score Required Measures

Objective	*Measure*
Protect Patient Health Information	Security Risk Analysis
Electronic Prescribing	e-Prescribing
Patient Electronic Access	Provide Patient Access
Health Information Exchange	Send a Summary of Care
Health Information Exchange	Request/Accept a Summary of Care

2017 Advancing Care Information Transition Objectives and Measures:

Base Score Required Measures

Objective	*Measure*
Protect Patient Health Information	Security Risk Analysis
Electronic Prescribing	e-Prescribing
Patient Electronic Access	Provide Patient Access
Health Information Exchange	Health Information Exchange

MIPS Performance Category: Advancing Care Information

Advancing Care Information Objectives and Measures:

Performance Score* Measures

Objective	*Measure*
Patient Electronic Access	Provide Patient Access*
Patient Electronic Access	Patient-Specific Education
Coordination of Care through Patient Engagement	View, Download and Transmit (VDT)
Coordination of Care through Patient Engagement	Secure Messaging
Coordination of Care through Patient Engagement	Patient-Generated Health Data
Health Information Exchange	Send a Summary of Care*
Health Information Exchange	Request/Accept a Summary of Care*
Health Information Exchange	Clinical Information Reconciliation
Public Health and Clinical Data Registry Reporting	Immunization Registry Reporting

2017 Advancing Care Information Transition Objectives and Measures

Performance Score Measures

Objective	*Measure*
Patient Electronic Access	Provide Patient Access*
Patient Electronic Access	View, Download and Transmit (VDT)
Patient-Specific Education	Patient-Specific Education
Secure Messaging	Secure Messaging
Health Information Exchange	Health Information Exchange*
Medication Reconciliation	Medication Reconciliation
Public Health Reporting	Immunization Registry Reporting

***Performance Score:** Additional achievement on measures above the base score requirements

MIPS Performance Category: Improvement Activities

- Attest to participation in activities that improve clinical practice
  - Examples: Shared decision making, patient safety, coordinating care, increasing access
- *Clinicians choose* from 90+ activities under 9 subcategories:

1. Expanded Practice Access	2. Population Management	3. Care Coordination
4. Beneficiary Engagement	5. Patient Safety and Practice Assessment	6. Participation in an APM
7. Achieving Health Equity	8. Integrating Behavioral and Mental Health	9. Emergency Preparedness and Response

Improvement Activities: Flexibilities

Groups with 15 or fewer participants, non-patient facing clinicians, or if you are in a rural or health professional shortage area: Attest that you completed 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: You will automatically earn full credit.

Shared Savings Program Track 1 or the Oncology Care Model: You will automatically receive points based on the requirements of participating in the APM. For all current APMs under the APM scoring standard, this assigned score will be full credit. For all future APMs under the APM scoring standard, the assigned score will be at least half credit.

How to Select the Merit-Based Incentive Payment Program (MIPS) Metrics to Report

Marsha Davenport, MD, MPH
GPTN in MD Practice Transformation Coach
January 17, 2018

Selecting MIPS Quality Measures: Challenges

- Knowing where to start
- Appropriate 90 day period
- Selecting the entire year
- Electronic Health Record (EHR) limitations
  - Does not allow reporting by quarters or other time periods
  - Only can report for the entire year
  - EHR only supports pre-selected measures on MIPS Dashboard

https://qpp.cms.gov/mips/quality-measures

Selecting MIPS Quality Measures

- Select measures that represent the best side of your practice
  - Look for themes across patients with specific health conditions
    - Diabetes
    - Heart disease
    - Pulmonary disease
  - Look for themes by clinical or age categories
    - Preventive services
    - Adults
    - Children

https://qpp.cms.gov/mips/quality-measures

Selecting MIPS Quality Measures

- Identify at least 6 measures
  - Look for some of the common measures
  - Examples
    - Smoking screening and counseling (NQF 0028; Quality ID 226)
    - Influenza immunization (NQF 0041; Quality ID 110)
- Determine the appropriate outcome or high priority measures for r primary care practices (examples)
  - Hemoglobin A1C (NQF 0059; Quality ID 001)
  - Controlling High Blood Pressure (NQF 0018; Quality ID 236)

https://qpp.cms.gov/mips/quality-measures

Selecting MIPS Quality Measures (Cont'd)

- Determine the appropriate outcome or high priority measures for specialty practices
  - Controlling High Blood Pressure (NQF 0018; Quality ID 236)
  - Care Plan (NQF 0236; Quality ID 047)
  - Documentation of current medications in the chart (NQF 0419; Quality ID 130)

https://qpp.cms.gov/mips/quality-measures

Selecting MIPS Quality Measures (Cont'd)

- Other sources for metrics
  - Practices participating in the Transformation PTN review the key performance indicators (KPIs)
  - Review your 2016 Quality Resource and Use Report (QRUR)
    - Identify the measures where you have done well in the past
    - Compare to 2017
    - Make a special request to your EHR vendor for the 2017 data, if you do not have it as part of your MIPS dashboard
    - Vendors may charge for this "special" request
- Before making final selection use the MIPS Calculator to check potential points

https://qpp.cms.gov/mips/quality-measures

Resources

Centers for Medicare & Medicaid Services (CMS) Quality Payment Program (QPP) Website

https://qpp.cms.gov/mips/quality-measures

Ambulatory Practice Transformation Landscape in Maryland

MACRA Briefing
Maryland Health Care Commission
January 17, 2018

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Value-Based Payment Strategies

- Practice Transformation Network (PTN)
- Maryland Primary Care Program (MDPCP)
- Hospital Care Improvement Program (HCIP) and the Complex and Chronic Care Improvement Program (CCIP)
- MACRA Awareness and Support Program (MAS)

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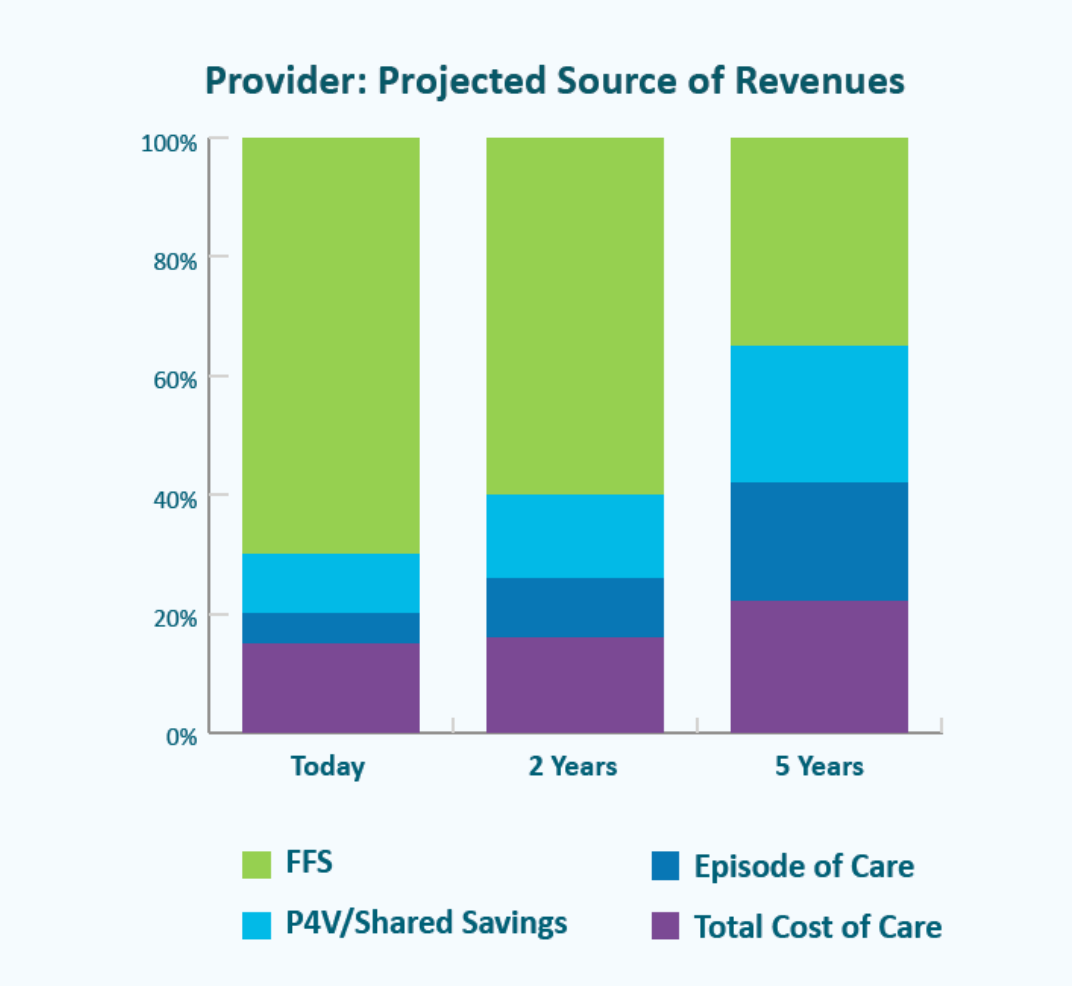
Physician Revenue



Source : ©2014 The Advisory Board Company, "Results from the 2013 Accountable Payment Survey."
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Environment Post ACA

- Accept more value-based care arrangements
- Invest in more evolved care-management models
- Establish new partnerships
- Reduce operating costs
- Integrate physicians and hospitals
- Use population health management data to support clinical improvements

Total Cost of Care Model

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Total Cost of Care Model (2019-2029)

Improving health, enhancing patient experience, and reducing

2017

2029

HSCRC Models
All Payer – 2014-18
Total Cost of Care – 2019-29
2014 - 2029

- Reduce unnecessary readmissions/ utilization
- Reduce hospital-based infections
- Increase appropriate care outside of hospital

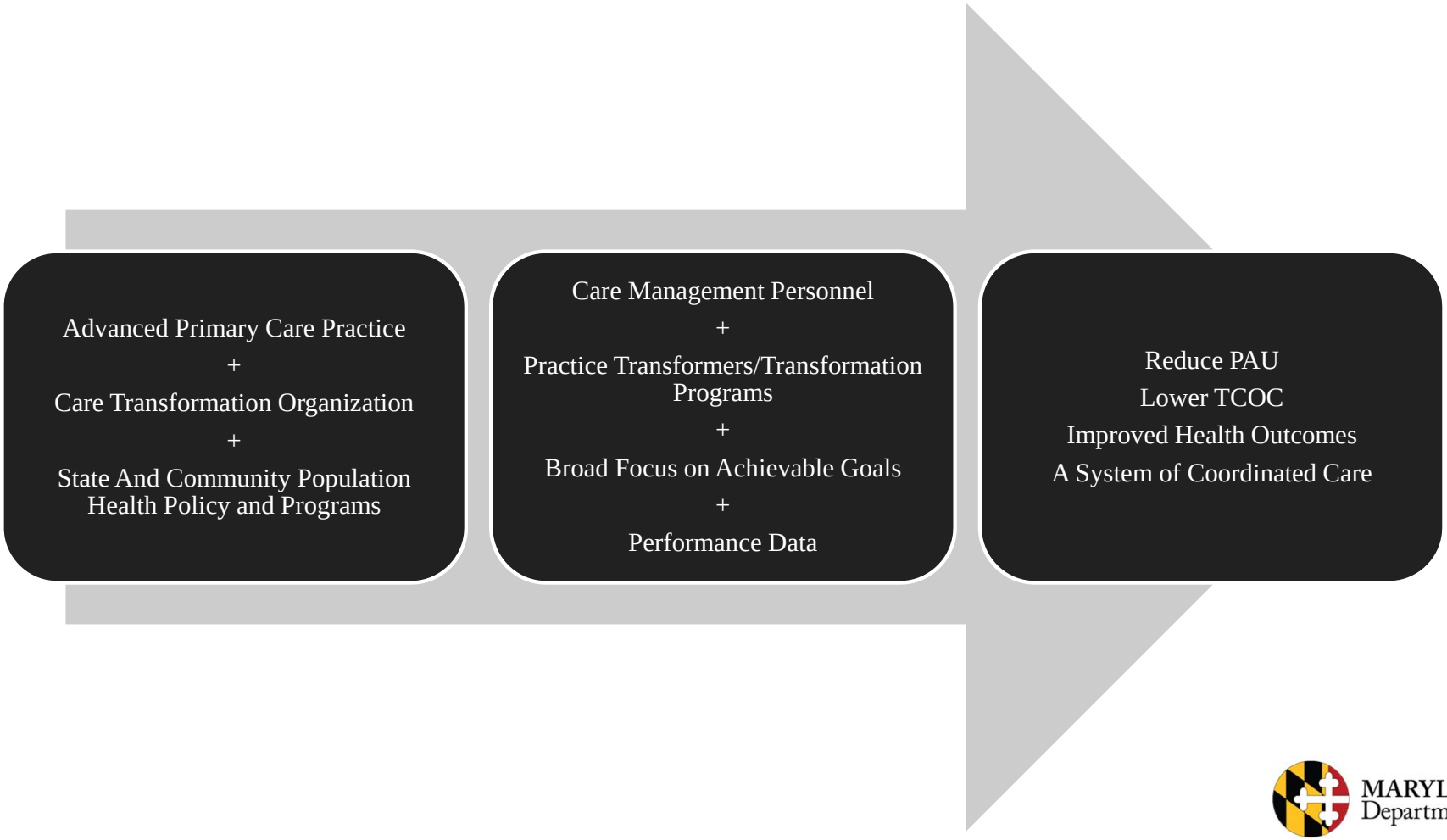
HSCRC Care Redesign Programs
2017 - TBD

- Reduce unnecessary lab tests
- Increase communication between hospital and community providers
- Increase complex care coordination for high and rising risk
- Improve efficiency of care in hospital

Maryland Primary Care Program
2018-2026

- Increase preventive care to lower the Total Cost of Care
- Decrease avoidable hospitalizations
- Decrease unnecessary ED visits
- Increase care coordination
- Increase community supports

Population Health Transformation



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Total Cost of Care Model

Total Cost of Care Model is the umbrella

Maryland Primary Care Program (MDPCP) is a distinct contract element

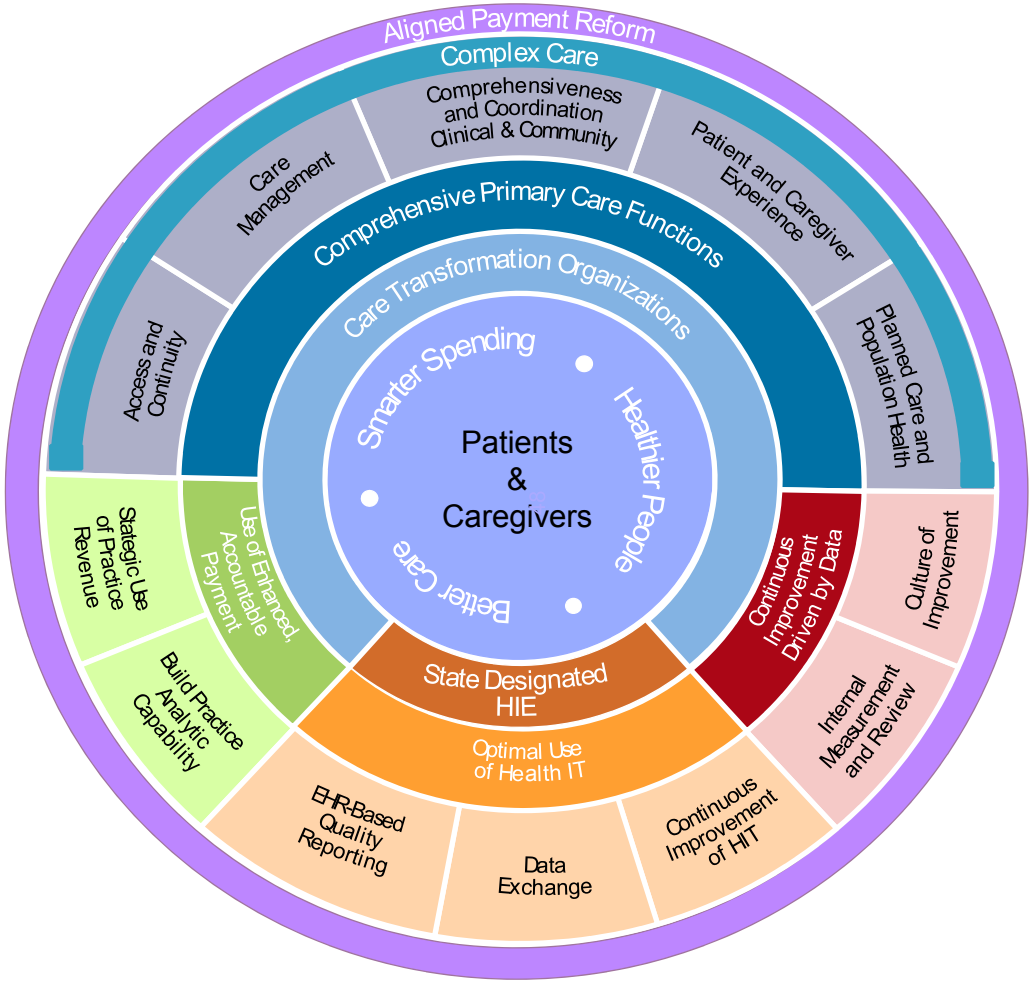
- Separate contract element of the Maryland Total Cost of Care Model contract between State and CMMI
- CMS will issue Requests For Applications (RFA) for practices and care transformation organizations (CTOs); CMS selects participants
- Require Participation Agreements for practices and CTOs

How is MDPCP Different from CPC+?

	CPC+	MDPCP
Integration with other State efforts	Independent model	Component of MD TCOC Model
Enrollment Limit	Cap of 5,000 practices nationally	No limit – practices must meet program qualifications
Enrollment Period	One-time application period for 5-year program	Annual application period starting in 2018
Track 1 v Track 2	Designated upon program entry	Migration to track 2 by end of Year 3
Supports to transform primary care	Payment redesign	Payment redesign and CTOs
Payers	61 payers are partnering with CMS including BCBS plans; Commercial payers including Aetna and UHC; FFS Medicaid, Medicaid MCOs such as Amerigroup and Molina; and Medicare Advantage Plans	Medicare FFS, Duals, (Other payers encouraged for future years)

Program Components

MDPCP Driver Diagram



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1. Access and Continuity

Track One

- Achieve and maintain > 95% empanelment to care teams
- Ensure patients have 24/7 access to a care team practitioner with real-time access to the EHR
- Build a care team responsible for a specific, identifiable panel of patients to optimize continuity

Track Two (all of the above, plus)

- Regularly offer at least one alternative to traditional office visits such as e-visits, phone visits, group visits, home visits, alternate location visits (e.g., senior centers and assisted living centers), and/or expanded hours in early mornings, evenings, and weekends

2. Care Management

Track One

- Risk-stratify all empaneled patients
- Provide targeted, proactive, relationship-based (longitudinal) care management to all patients identified as at increased risk, based on a defined risk stratification process and who are likely to benefit from intensive care management
- Provide episodic care management along with medication reconciliation to a high and increasing percentage of empanelled patients who have an ED visit or hospital admission/discharge/transfer and who are likely to benefit from care management
- Ensure patients with ED visits receive a follow up interaction within one week of discharge.
- Contact at least 75% of patients who were hospitalized in target hospital(s), within 2 business days

2. Care Management

Track Two (Track 1, plus)

- Use a two-step risk stratification process for all empanelled patients:
  - Step 1 - based on defined diagnoses, claims, or another algorithm (i.e., not care team intuition);
  - Step 2 - adds the care team's perception of risk to adjust the risk-stratification of patients, as needed
- Use a plan of care centered on patient's actions and support needs in management of chronic conditions for patients receiving longitudinal care management

3. Comprehensiveness and Coordination

Track One

- Systematically identify high-volume and/or high-cost specialists serving the patient population using CMS/other payer's data
- Identify hospitals and EDs responsible for the majority of patients' hospitalizations and ED visits, and assess and improve timeliness of notification and information transfer using CMS/other payer's data

3. Comprehensiveness and Coordination

Track Two (Track 1, plus)

- Enact collaborative care agreements with at least two groups of specialists identified based on analysis of CMS/other payer reports
- Choose and implement at least one option from a menu of options for integrating behavioral health into care
- Systematically assess patients' psychosocial needs using evidence-based tools
- Conduct an inventory of resources and supports to meet patients' psychosocial needs
- Characterize important needs of sub-populations of high-risk patients and identify a practice capability to develop that will meet those needs, and can be tracked over time

4. Patient and Caregiver Engagement

Track One

- Convene Patient Family Advisory Council (PFAC) at least annually and incorporate recommendations into care, as appropriate
- Assess practice capability + plan for patients' self-management

Track Two (the above, plus)

- Convene a PFAC in at least two quarters in PY2018 and integrate recommendations into care, as appropriate
- Implement self-management support for 3 or more high risk conditions

5. Planned Care and Population Health

Track One

- Use quarterly feedback reports to assess utilization and quality performance, identify practice strategies to address, and identify individual candidates to receive outreach, care management

Track Two (the above, plus)

- Regular care team meetings to review practice and panel-level data, refine tactics to improve outcomes and achieve practice goals

Quality Metrics

electronic Clinical Quality Measures (eCQM) (75%)

- Group 1: Outcome Measures (2) – Report both outcome measures
- Group 2: Other Measures (7) – Report at least 7 of 16 process Measures
- Measures overlap closely with MSSP ACO measures

Patient Satisfaction (25%)

- Consumer Assessment of Healthcare Providers and Systems (CAHPS) Clinician and Group Patient-Centered Medical Home Survey
- CMS will survey a representative population of each practice's patients, including non-Medicare FFS patients

Quality Metrics

eCQM (75%)

- Group 1: Outcome Measures – Report both outcome measures
- Group 2: Other Measures – Report at least 7 of 18 process Measures

Patient Satisfaction (25%)

- Consumer Assessment of Healthcare Providers and Systems (CAHPS) Clinician and Group Patient-Centered Medical Home Survey
- CMS will survey a representative population of each practice's patients, including non-Medicare FFS patients

Payment Incentives for Better Primary Care

Practices – Track 1

Care Management Fee (PBPM)

- $15 average payment
- $6-$50 PBPM
  - Tiered payments based on acuity/risk tier of patients in practice including $50 to support patients with complex needs
- Timing: Paid prospectively on a quarterly basis, not subject to "clawback"

Performance-Based Incentive Payment (PBPM)

- Up to a $2.50 PBPM payment opportunity
- Must meet quality and utilization metrics to keep incentive payment
- Timing: Paid prospectively on an annual basis, subject to "clawback" if measures are not met

Underlying Payment Structure

- Standard FFS
- Timing: Regular Medicare FFS claims payment

AAPM Status under MACRA Law to be determined – potential for additional bonuses

Payment Incentives for Better Primary Care

Practices – Track 2

Care Management Fee (PBPM)

- $28 average payment
- $9-$100 PBPM
  - Tiered payments based on acuity/risk tier of patients in practice including $100 to support patients with complex needs
- Timing: Paid prospectively on a quarterly basis, not subject to "clawback"

Performance-Based Incentive Payment (PBPM)

- Up to a $4.00 PBPM payment opportunity
- Must meet quality and utilization metrics to keep incentive payment
- Timing: Paid prospectively on an annual basis, subject to "clawback"

Underlying Payment Structure

- "Comprehensive Primary Care Payment" (CPCP)
- Partial pre-payment of historical E&M volume
- 10% bonus on CPCP
- Timing: CPCP paid prospectively on a quarterly basis, Medicare FFS claim submitted normally but paid at reduced rate

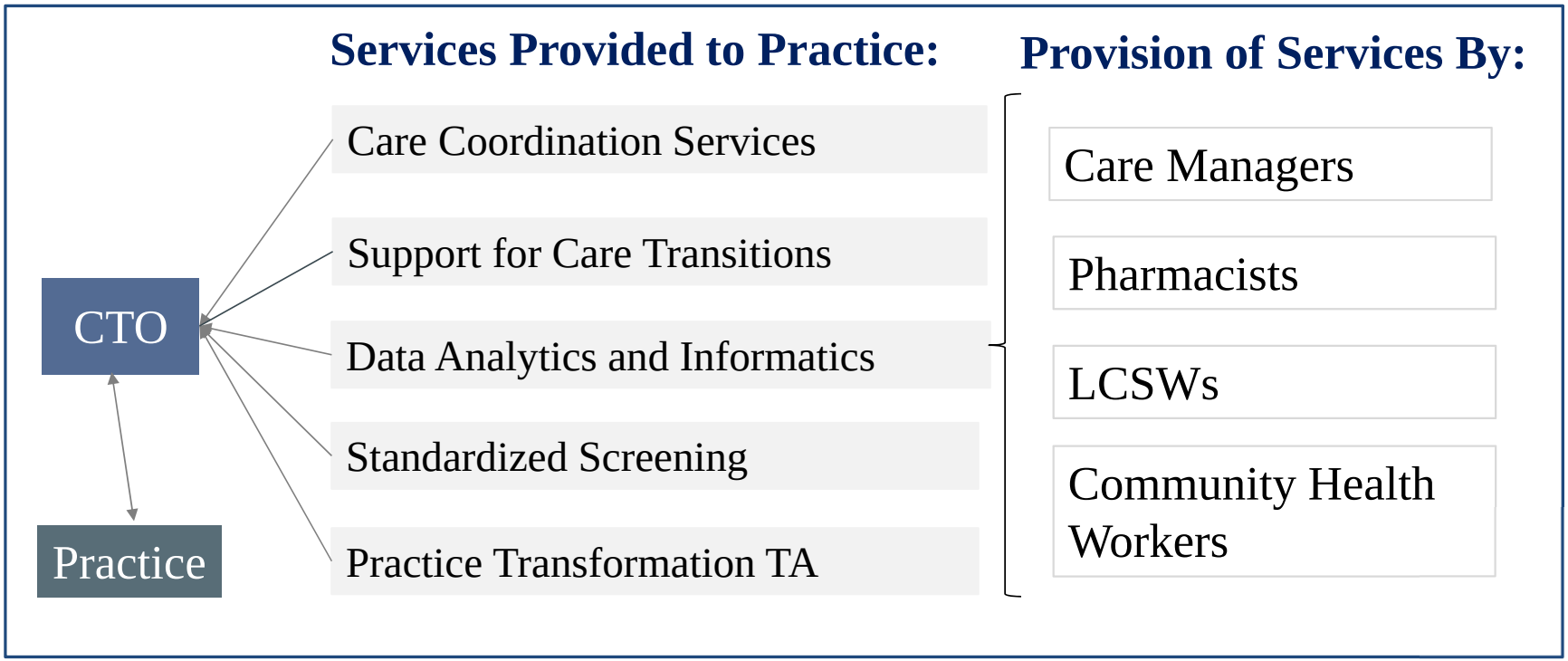
AAPM Status under MACRA Law to be determined – potential for additional bonuses

Application and Track Progression

- Annual application process, practices enroll when they are ready to succeed
- Practices may enter in Track 1 or Track 2
- Practices will progress from Track 1 to Track 2
- Track 1 Practices have three years to reach Track 2

Care Transformation Organization

Designed to assist the practice in meeting care transformation requirements



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Next Steps

Preview RFA Components

Practices

- Apply after CTO selection
- Electronic application
- Detail on practice
  - Ownership
  - Demographics
  - Capabilities
  - Connectivity
- Letters of support/commitment

Care Transformation Organizations

- Apply before practices
- Electronic Application
- Detail on proposed CTO
  - Ownership
  - Legal structure
  - Capabilities
  - Experience
- Letters of support/commitment

Sample RFA questions distributed for your review

See CPC+ RFA for more information:
https://innovation.cms.gov/Files/x/cpcplus-rfa.pdf

Practice Eligibility

- Meet program integrity standards
- Provide services to a minimum of 150 attributed Medicare FFS beneficiaries
- Letters of Support and commitments from
  - Clinical Leadership
  - Ownership of practice
  - CRISP letter of support for practice

Practice Eligibility *(continued)*

- Experience with specified practice transformation activities for Track 1 must include:
  - Assigning patients to practice panel
  - Providing 24/7 access to patients
  - Supporting quality improvement activities
- All practices must meet care delivery requirements for Track 2 by no later than end of Year 3 participation including:
  - Demonstrated ability to perform two-step risk stratification
  - Accept hybrid payment
- Commitments to submit complete care delivery practice reports, annual budget reporting, and other program requirements laid out in the Participation Agreement

Health Information Technology

- Utilize a certified electronic health record
- CRISP connectivity in year one with transition to Tier 3 in year two
- Use the latest eCQM specifications for all measures (including all annual updates)
- Connect to CRISP's CALIPHR quality measures system

Restrictions on Participation

- Not charge any concierge fees to Medicare beneficiaries
- Not be a participant in certain other CMMI initiatives including Accountable Care Organization [ACO] Investment Model, Next Generation ACO Model, and Comprehensive ESRD Care Model
- Not participating at a Rural Health Clinic or a Federally Qualified Health Center

Support You Can Expect

- Information Technology from CRISP and access to CMMI Practice Portal
- CMMI Learning System Vendors – educate practices on how to transform
- Additional State supports on practice transformation

Considerations for Participation

Winter/Spring 2018

Assess financial opportunity
Assess practice capabilities
Assess organizational priorities
Review CPC Plus RFA
Review CPC Plus FAQs
Attend meetings on MDPCP

Spring 2018

Review MDPCP RFA
Assess CTO Option
Attend meetings on MDPCP

Spring/Summer 2018

Apply for MDPCP

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Updates at

https://pophealth.health.maryland.gov/Pages/MarylandComprehensivePrimaryCareModel.aspx

Melanie Cavaliere

Maryland Health Care Commission

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Useful Videos on CPC+

- Part 1: (Attribution) https://www.youtube.com/watch?v=re7XBlJ9j-A&feature=youtu.be
- Part 2: (Care management fees) https://www.youtube.com/watch?v=NBVNQyNeKJ8&feature=youtu.be
- Part 3: (Performance Based Incentive Payment) https://www.youtube.com/watch?v=qU4hF1d9XjI&feature=youtu.be
- Part 4: (Hybrid Payment) https://www.youtube.com/watch?v=xPeyjE8couk&feature=youtu.be

Quality Metrics

Link to proposed measures for 2018

https://innovation.cms.gov/Files/x/cpcplus-qualrptpy2018.pdf