

MACRA and What It Means For Palliative Care

Joe Rotella, MD, MBA, AAHPM

Phillip E. Rodgers, MD, FAAHPM, AAHPM/University of Michigan

Rev. George Handzo, BCC, CSSBB, HealthCare Chaplaincy Network

Stacie Sinclair, MPP, CAPC

Amy Melnick, MPA, NCHPC

Wednesday, June 8, 2016

Housekeeping

- All phone lines will be on mute throughout the duration of the call.
- Please submit questions and comments using the chat box, there will be Q & A at the end of the webinar.
- Webinar slides and recording will be available following the call.

Presenters



Amy Melnick
NCHPC



Joseph Rotella
AAHPM



Phillip E. Rodgers
AAHPM/University of Michigan



George Handzo
HealthCare Chaplaincy Network



Stacie Sinclair
CAPC

Welcome

Amy Melnick, MPA
Executive Director, NCHPC



National Coalition for Hospice and Palliative Care



National Hospice and Palliative Care
Organization



Introduction

**Stacie Sinclair, MPP LSWA
Policy Manager, CAPC**



Objectives

1. Introduce MACRA, with a specific focus on MIPS and APMs;
2. Clarify the relevance to and potential opportunities for palliative care;
3. Provide additional resources for providers; and
4. Learn from YOU about potential challenges.

Polling Question #1

- Who is in the audience (select your primary role)?
 - Physician
 - Nurse
 - Chaplain
 - Social Worker
 - Other (please share in chat box!)

Polling Question #2

- Do you know how MACRA will affect you as a palliative care provider?
 - Yes
 - No
 - Unsure

HHS Goals

In January 2015, the Department of Health and Human Services announced **new goals** for **value-based payments** and **APMs in Medicare**

Medicare Fee-for-Service

GOAL 1: **30%** 

Medicare payments are tied to quality or value through **alternative payment models** (categories 3-4) by the end of 2016, and 50% by the end of 2018

GOAL 2: **85%** 

Medicare fee-for-service payments are **tied to quality or value** (categories 2-4) by the end of 2016, and 90% by the end of 2018



STAKEHOLDERS:

Consumers | Businesses
Payers | Providers
State Partners



Set **internal goals** for HHS



Invite **private sector payers** to match or exceed HHS goals

Introduction to MACRA

- Medicare Access and Children's Health Insurance Program (CHIP) Reauthorization Act
- Repealed the Sustainable Growth Rate (SGR)
- Created the “Quality Payment Program” with two payment options: MIPS or APMs

Merit-based Incentive Payment System (MIPS)

Joe Rotella, MD MBA HMDC FAAHPM
Chief Medical Officer, AAHPM
CatalystHPM

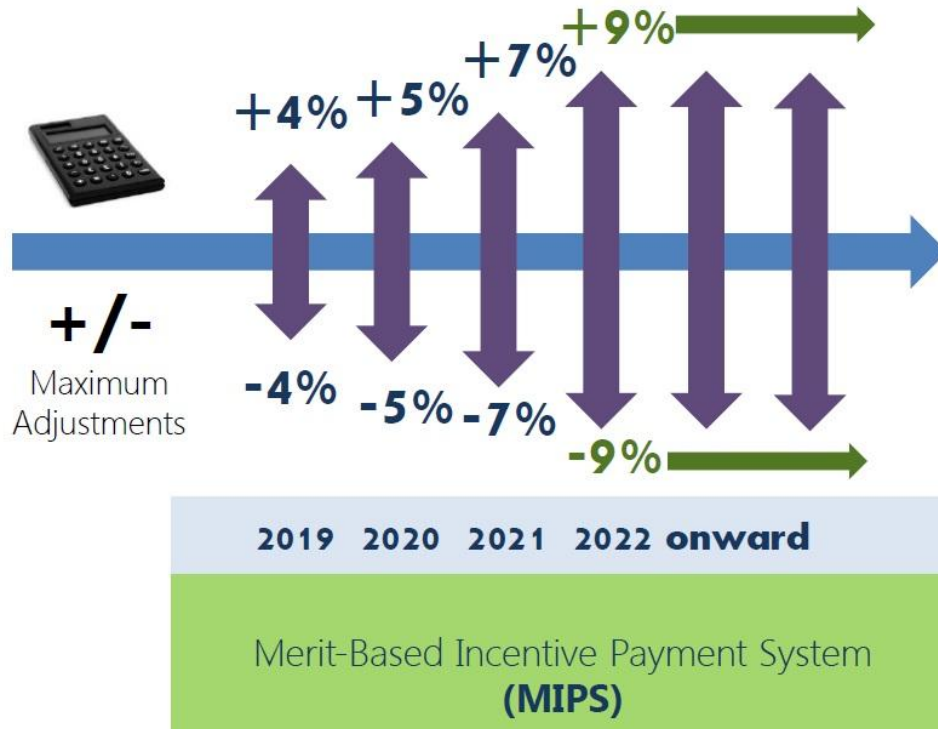


Introduction to MIPS

- Merit-based Incentive Payment System (MIPS)
- Fee-for-Service (FFS) architecture
- Combines PQRS, VM, and EHR Incentive programs
- Adjusts payment up or down based on quality reporting and claims data

MIPS Payment Adjustments

Based on a MIPS
Composite Performance Score, clinicians will receive **+/- or neutral** adjustments up to
the percentages below.



Adjusted
Medicare Part
B **payment** to
clinician

The potential maximum
adjustment % will
increase each year from
2019 to 2022

Why does MIPS Matter for Palliative Care?

- Roughly 700,000 eligible clinicians across all specialties, HPM included, will enter MIPS in 2017 and receive payment adjustments in 2019.
- Need to understand what and how you will be reporting and make MIPS work in your practice setting.
- CMS offers technical assistance for small practices.
 - <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/Small-Practices-Fact-Sheet.pdf>

MIPS Eligibility

Affected clinicians are called “**MIPS eligible clinicians**” and will participate in MIPS. The types of **Medicare Part B** eligible clinicians affected by MIPS may expand in future years.

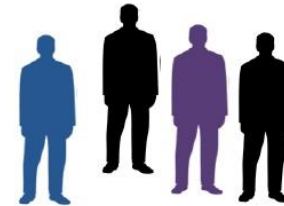
Years 1 and 2



Physicians (MD/DO and DMD/DDS),
PAs, NPs, Clinical nurse specialists,
Certified registered nurse
anesthetists

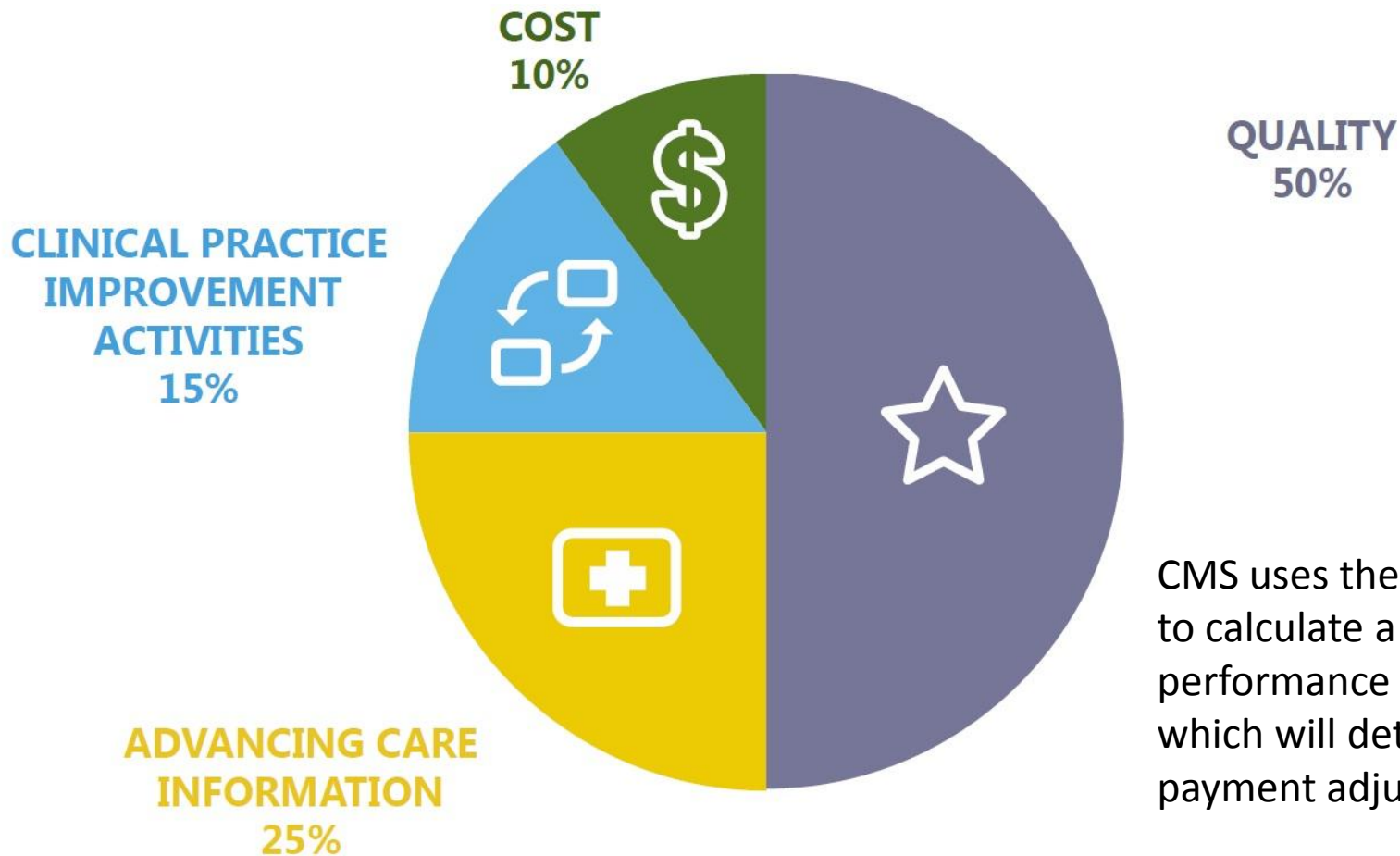
Years 3+

Secretary may
broaden Eligible
Clinicians group to
include others
such as



Physical or occupational therapists,
Speech-language pathologists,
Audiologists, Nurse midwives,
Clinical social workers, Clinical
psychologists, Dietitians /
Nutritional professionals

MIPS Structure



CMS uses these categories to calculate a composite performance score (CPS) which will determine payment adjustment.

MIPS Category 1 – Quality

- Selection of 6 measures (↓ from 9 in PQRS)
- 1 cross-cutting measure and 1 outcome measure, or another high priority measure if outcome is unavailable
- Select from individual measures or a specialty measure set
- Population measures automatically calculated

MIPS Category 1 – Quality

New MIPS Measures (NQF #), (*limited to cancer patients)

- #0210 – Proportion receiving chemotherapy in the last 14 days of life
- #2011 – Proportion w/ >1 ED visit in last 30 days of life **(O)**
- #0213 – Proportion admitted to ICU in last 30 days of life **(O)**
- #0215 – Proportion not admitted to hospice
- #0216 – Proportion admitted to hospice for <3 days **(O)**

Carryover PQRS Measures

- #046 – Medication reconciliation
- #047 – Advance care plan **(CC)**
- #130 – Documentation of current medications in medical record **(CC)**
- #131 – Pain assessment and follow-up
- #134 – Depression screening follow-up
- #143 – Oncology: Pain intensity quantified
- #144 – Oncology: Plan of care for pain
- #154 – Falls: Risk assessment
- #155 – Falls: Plan of care
- #282 – Dementia: Functional status assessment
- #283 – Dementia: Neurological/psychological assessment
- #288 – Dementia: Caregiver education and support
- #318 – Falls: Screening for fall risk
- #321 – CAHPS **(CC)**
- #342 – Pain brought under control within 48 hours **(O)**

MIPS Category 2 – Resource Use

- Calculated using claims data (total per capita costs, episode groups and Medicare Spending Per Beneficiary)
- No reporting requirements for clinicians
- Will compare resources used to treat similar care episodes and clinical condition groups across practices
- Can be risk-adjusted to reflect external factors

MIPS Category 3 – Clinical Performance Improvement Activities

- Full credit for PCMH, minimum of half credit for APM participation
- Other activities weighted as high or medium
- List of 91 activities to choose from; no minimum hours, but must perform for at least 90 days

Subcategories

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

MIPS Category 3 – CPIA

- Provide 24/7 access **(H)**
- Use of telehealth services & analysis of data for QI
- Collection of PT experience & satisfaction data **(H)**
- Use of a QCDR that promotes PT engagement tools, adherence to treatment plan, etc.
- Participation in research*
- Participation in registries*
- Regular reviews of targeted patient population
- Provide episodic care management
- Implementation of regular care coordination training
- Implementation of practices/ processes that document care coordination activities
- Develop regularly updated individual care plans shared with beneficiary or caregiver
- Develop pathways to neighborhood/ community-based resources to support PT health goals
- Use evidence-based decision aids to support shared decision-making

MIPS Category 4 – Advancing Care Information

- Replacement for MU EHR Incentive program
- Continued goals of promoting certified EHR adoption, health information exchange and interoperability, and patient engagement
- Based on mix of reporting and performance
- Promises more flexibility, but some flawed and all-or-none metrics carry over from MU

MIPS Reporting

	Individual Reporting	Group Reporting
Quality	<ul style="list-style-type: none"> •QCDR •Qualified Registry •EHR •Administrative Claims (No submission required) •Claims 	<ul style="list-style-type: none"> •QCDR •Qualified Registry •EHR •Administrative Claims (No submission required) •CMS Web Interface (groups of 25 or more) •CAHPS for MIPS Survey
Resource Use	<ul style="list-style-type: none"> •Administrative Claims (No submission required) 	<ul style="list-style-type: none"> •Administrative Claims (No submission required)
Advancing Care Information	<ul style="list-style-type: none"> •Attestation •QCDR •Qualified Registry •EHR 	<ul style="list-style-type: none"> •Attestation •QCDR •Qualified Registry •EHR •CMS Web Interface(groups of 25 or more)
CPIA	<ul style="list-style-type: none"> •Attestation •QCDR •Qualified Registry •EHR •Administrative Claims (No submission required) 	<ul style="list-style-type: none"> •Attestation •QCDR •Qualified Registry •EHR •CMS Web Interface (groups of 25 or more)

Alternative Payment Models (APMs) –

Phillip E. Rodgers, MD FAAHPM

Co-Chair, AAHPM Public Policy Committee

Co-Chair, AAHPM Quality/Payment Working Group

University of Michigan, Ann Arbor



What is an Alternative Payment Model (APM)?

APMs are **new approaches to paying** for medical care through Medicare that **incentivize quality and value**.

As defined by
MACRA,
APMs:

- ✓ Hold providers **accountable** for both **quality and cost** of care
- ✓ Are **incentivized by MACRA**, but development is **led by providers**
- ✓ Include **CMS Innovation Center Models, MSSPs**, and certain **Demonstrations** either in development or required by federal law

What is an **Advanced APM**?



As defined by MACRA, Advanced APMs **must meet the following criteria:**

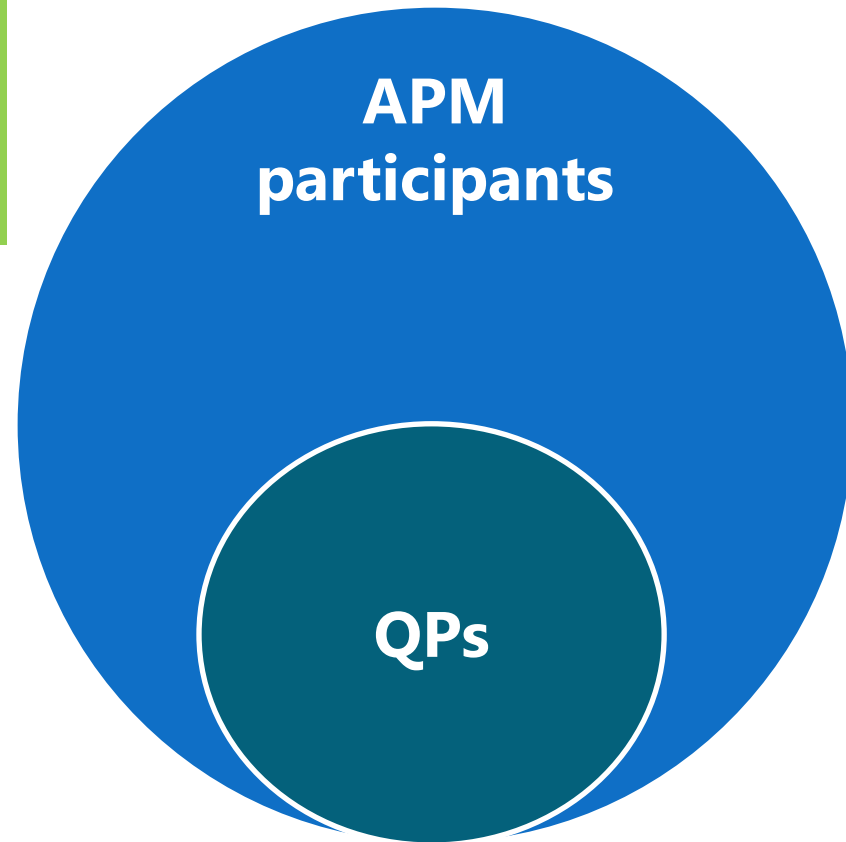
- ✓ The APM requires participants to use **certified EHR technology**.
- ✓ The APM **bases payment on quality** measures comparable to those in the MIPS quality performance category.
- ✓ The APM either: **(1)** requires APM Entities to bear more than nominal **financial risk** for monetary losses; **OR (2)** is a **Medical Home Model expanded** under CMMI authority.

How does MACRA provide additional rewards for participation in Advanced APMs?

Most physicians and practitioners who participate in APMs will be subject to MIPS and will receive **favorable scoring** under the MIPS clinical practice improvement activities performance category.

Those who participate in **Advanced** APMs and are determined to be **qualifying APM participants ("QPs")**:

1. Are **not subject** to MIPS
2. Receive 5% lump sum **bonus payments** for years 2019-2024.
3. Receive a **higher fee schedule update** for 2026 and beyond



Current Advanced APMs include:

- ☐ Medicare Shared Savings Program (Tracks 2 and 3)
- ☐ Next Generation ACO Model
- ☐ Comprehensive ESRD Care (CEC) (large dialysis organization arrangement)
- ☐ Comprehensive Primary Care Plus (CPC+)
- ☐ Oncology Care Model (OCM) (two-sided risk track available in 2018)

Currently excluded: Medicare Shared Savings Track 1; Independence at Home demo; Medicare Care Choices Model; Bundled Payment for Care Improvement

How do I become a Qualifying Provider (QP)?



QPs are physicians and practitioners who have at least **20% of their patients or 25% of payments** through an **Advanced APM**.

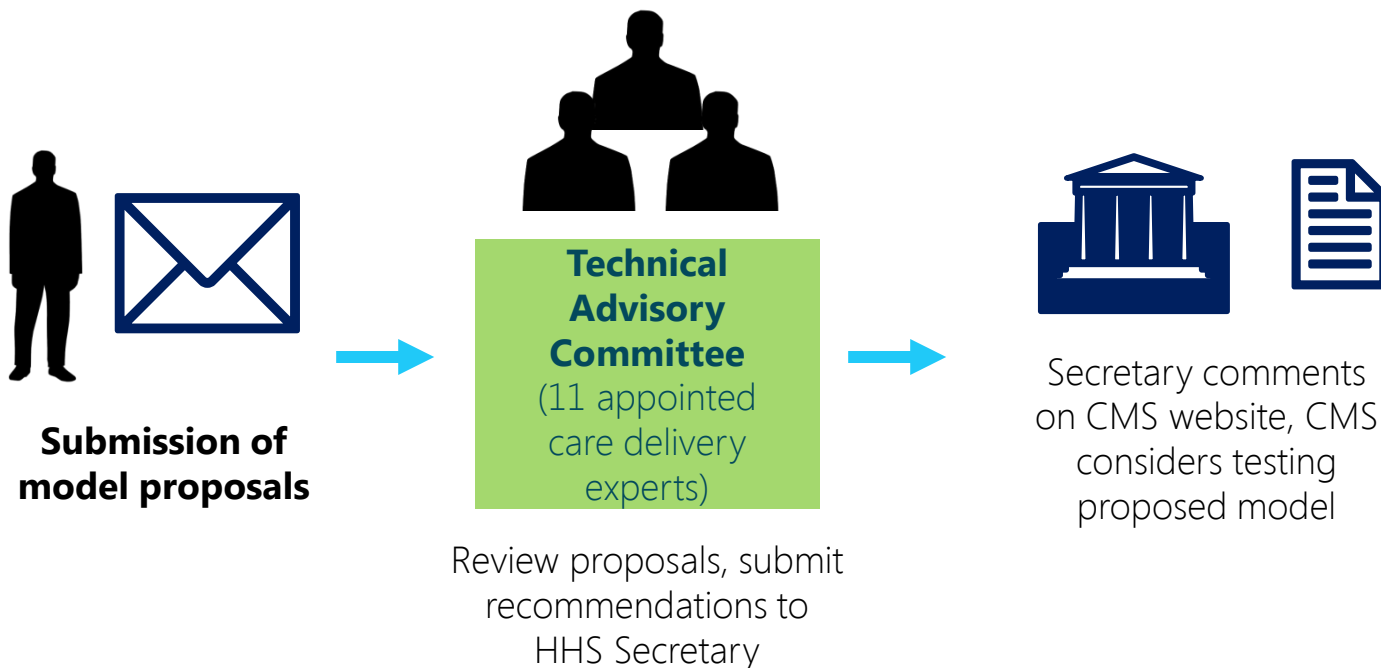
The QP thresholds for will rise steadily through 2024, to **50% of patients or 75% of payments** through an **Advanced APM**

Beginning in 2021, this threshold % may be reached through a **combination** of Medicare and other **non-Medicare payer arrangements**, such as private payers and Medicaid.

Physician Focused Payment Models

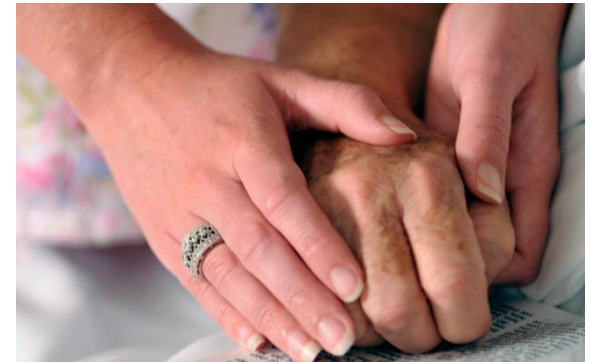
PFPM = Physician-Focused Payment Model

Encourage new **APM options** for Medicare physicians and practitioners.



What do Advanced APMs mean for Palliative Care Providers?

- Palliative care delivers benefits to AAPMs for their high-cost, seriously-ill patients:
 - minimize ED visits, avoid low-value care (cost)
 - improve satisfaction (quality)
- Can you handle some accountability for cost, with negotiated boundaries?
- If so, APM participation might mean:
 - Funding for the full IDT
 - Funding for social supports
 - Avoiding the potential penalties in MIPS



Connection to Psychosocial-Spiritual

**The Rev. George Handzo, BCC CSSBB
Director, Health Services and Quality
HealthCare Chaplaincy Network**



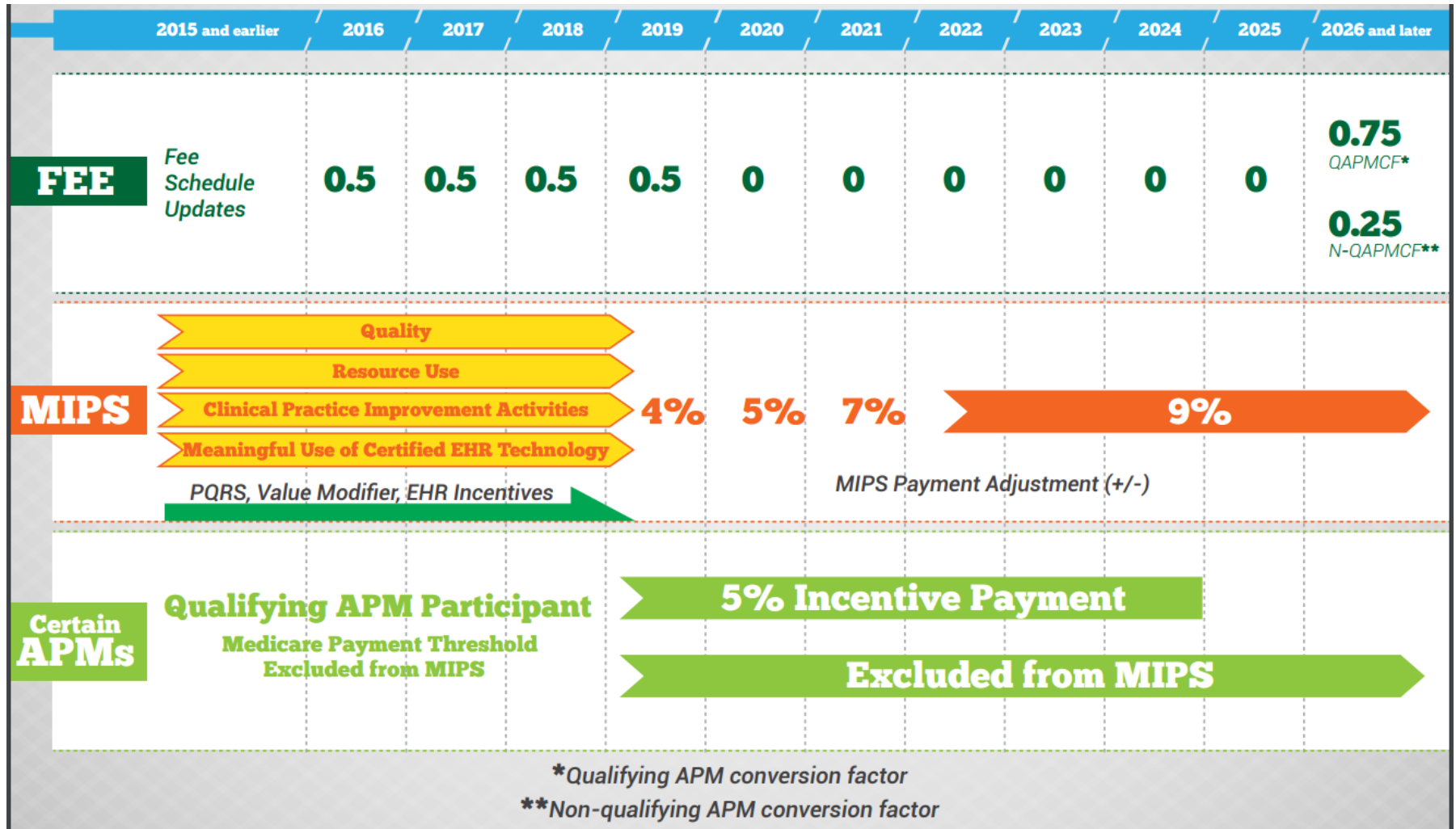
Opportunities for Psychosocial-Spiritual Care

- New Payment Models Reward Value = Quality/Cost (Resource Use)
- Payment is Based on Outcome of Provider or Group Not Just on the Service Provided by An Individual
- Social Work & Chaplaincy Can Make Contributions to both Quality and Resource Use

Potential Contributions of Psychosocial-Spiritual Providers

Contribution	Connection to MACRA
Increasing Patient & Family Satisfaction	Quality (CAHPS), CPIA
Reducing Aggressive Care at EOL Though Meeting Spiritual & Emotional Needs	Resource Use, Quality
Improving Physician-Patient Communication & Compliance Through Reducing Emotional & Spiritual Distress	Quality, CPIA
Reducing Symptoms Including Pain and Dyspnea Through Use of Complimentary Therapies Such as Relaxation and Prayer	Quality, CPIA, Resource Use (indirect)
Facilitating Culturally/Ethnically/ Religiously Appropriate Communication and Decision Making	Quality, CPIA

Implementation Timeline

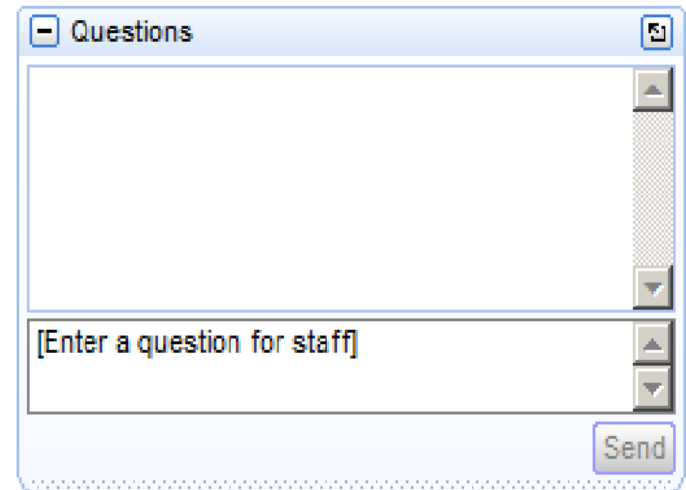


Resources

- **CMS Quality Payment Program** page ([link](#))
- Proposed Rule in the Federal Register ([link](#))
- Bull J, Kamal A, et al., Top 10 Tips About the PQRS for Palliative Care Professionals ([link](#))
- Advisory Board on MACRA ([link](#))
- American Medical Association on MACRA ([link](#))
- ACP Article – 10 Things You Need to Do for MACRA ([link](#))
- Health Affairs Policy Brief ([link](#))

Q & A

- To participate in the Q & A, please type your questions and comments into the chat box.
- Guiding questions:
 - What questions do you have on the material provided?
 - What information would you like us to share with CMS?
 - Where do you suggest modifications that could account for the high value palliative care provides?
 - What are the potential unintended consequences for palliative care providers?



A screenshot of a web-based chat interface titled "Questions". It features a large text input area with a placeholder text "[Enter a question for staff]". To the right of the input area are vertical scrollbars. At the bottom right of the chat box is a "Send" button.

Closing

- Webinar slides and recording will be available following the call.
- Comments on the MACRA proposed rule are due June 27, 2016.
- Please complete the follow-up survey!

THANK YOU!

For follow-up questions/comments:

Stacie Sinclair

(stacie.sinclair@mssm.edu)