New Reimbursement Models in a Value Based Delivery System
About the Speaker

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Founder *SmartCloud* Software and ChiroTouch Chief Market Strategy Officer

- Practicing in Iowa since 1988 (27 years)
- Expert in Health IT, EHR, and HIPAA compliance and regulations affecting DC’s.
- CEO Future Health Software 2004-2014
- Past President of the Iowa Chiropractic Society 1995 (Board member 9 years)
- Past Chairman of the Iowa Board of Chiropractic, Serving 10 years
- Developed, managed, & sold 18 practices
- Strategic consultant nationwide to more than 400 chiropractic clinics in buying & selling those practices with a successful transition.
- Served on numerous state and national committees and boards including current member of the Chiropractic Summit.
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Prepare Your Practice

Patient Expectations Grow

Will The Patient Of The Future™ Choose You?

There are now more mobile devices on Earth than people.
(Source: Pew Internet & American Life Project)

CHIROTTOUCH
FUTURE HEALTH
TOUCH THE FUTURE
Patient Adoption of Technology Leads to New Expectations for the Modern Doctor of Chiropractic

National surveys show an increase in patients responses that said they would use a patient portal to retrieve their health information, communicate with their doctor, and pay bills online and schedule appointments.
The New Empowered Consumer

1900
Age of Manufacturing
Mass manufacturing makes industrial powerhouses successful

1960
Age of Distribution
Global connections and transportation systems make distribution key

1990
Age of Information
Connected PCs and supply chains mean that those who control information flow dominate

2010
Age of the Consumer
Empowered buyers demand a new level of expectations

TOUCH THE FUTURE
Where Do We Go From Here

– Collaboration
– Referrals
– ACO’s
– Medical Homes
– Value Based Reimbursement Models
– Report Cards
– Patient’s Choosing Providers based on Data...Outcomes
The Future of Big Data is Here...Today!

- Big Data will drive healthcare decision makers
- Participation will be dependent upon data
- Payment Models will be shaped by Big Data
- Providers will be rated by the data
- Consumers make choices partly based on data
- Delivery Models and Practices will market themselves based on outcomes and cost data
Will DC’s Rise to the Data Capture Challenge?
24 July 2014 Michigan Blues’ patient-centered medical home program shows statewide transformation of care YEAR 6

- 9.9 percent lower rate of adult ER visits
- 27.5 percent lower rate of adult ambulatory care sensitive inpatient stays
- 11.8 percent lower rate of adult primary care sensitive ER visits
- 8.7 percent lower rate of adult high-tech radiology usage
- 14.9 percent lower rate of pediatric ER visits
- 21.3 percent lower rate of pediatric primary-care sensitive ER visits

4,022 primary care doctors at 1,422 practices around the state in its sixth year of operation. These practices care for more than 1.2 million BCBSM members.
Data is Driving Health Care Decisions
Proof is in the Data

17 found improvements in cost
24 improvements in quality
10 found improvements in access
8 found improvements in satisfaction
24 found improvements in utilization

14 Peer-Reviewed Studies
- 10 reported on cost, 6 found improvements
- 13 reported on utilization, 12 found improvements
- 3 reported on quality, 2 found improvements
- 4 reported on access, 4 found improvements
- 4 reported on satisfaction, 4 found improvements

7 State Government Evaluations
- 7 reported cost savings
- 6 reported reductions in utilization
- 6 reported improvements in population health/preventive services
- 5 reported improvements in access
- 3 reported improvements in patient or clinician satisfaction

7 Industry Reports
- 4 reported cost savings
- 6 reported reductions in utilization
- 3 reported improvements in population health/preventive services
- 1 reported improvement in access
- 1 reported improvement in patient or clinician satisfaction

"Reported on" indicates that a peer-reviewed study either evaluated that measure as an outcome variable, or the article reported additional information on that measure outside the scope of the study.
Sources of waste in American health care

Institute of Medicine

- Unnecessary Services: $210b
- Excessive administrative costs: $190b
- Inefficiently-delivered services: $130b
- Prices that are too high: $105b
- Fraud: $75b
- Missed prevention opportunities: $55b
Cognitive Computing will Transform Healthcare

Engage Patients

We measure our quality with analytics and make rapid changes to improve it

Care is standardized according to evidence based guidelines and advance cognitive systems

Care is determined by a proactive plan to meet health needs, with or without visits

Improve Outcomes

Control Costs
Driven By Actionable Personalized Data

Healthcare Will Transform --- Family Medicine for America’s Health

Data Driven

Every person has a plan

Team based

Managing a population down to the person
Patient Portal Access to Data and Mobility

- On line test results
- Bill Pay
- Direct Messaging to Doctor
- Appointment management
- Contextual Health Education
- Interface with Biometric Devices for Data capture and monitoring
- Easy Access to Clinic for a Connected relationship
Patients Accessing Test Results On-Line Increase Each Year (Kaiser)

Online test results are the most popular feature at KP.org, and also have consistent growth in usage.
TOUCH THE FUTURE

New Payment Reimbursement Models
## Transformation of Healthcare by 2020

<table>
<thead>
<tr>
<th><strong>Today's Care</strong></th>
<th><strong>PCMH Care</strong></th>
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<tbody>
<tr>
<td>My patients are those who make appointments to see me</td>
<td>Our patients are the population community</td>
</tr>
<tr>
<td>Care is determined by today's problem and time available today</td>
<td>Care is determined by a proactive plan to meet patient needs with or without visits</td>
</tr>
<tr>
<td>Care varies by scheduled time and memory or skill of the doctor</td>
<td>Care is standardized according to evidence-based guidelines</td>
</tr>
<tr>
<td>I know I deliver high quality care because I'm well trained</td>
<td>We measure our quality and make rapid changes to improve it</td>
</tr>
<tr>
<td>Patients are responsible for coordinating their own care</td>
<td>A prepared team of professionals coordinates all patients' care</td>
</tr>
<tr>
<td>It's up to the patient to tell us what happened to them</td>
<td>We track tests &amp; consultations, and follow-up after ED &amp; hospital</td>
</tr>
<tr>
<td>Clinic operations center on meeting the doctor's needs</td>
<td>A multidisciplinary team works at the top of our licenses to serve patients</td>
</tr>
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</table>
Nearly 1/3 traditional Medicare tied to alternative reimbursement models—such as Patient Centered Medical home (PCMH)/ accountable care organizations (ACOs) or bundled payments—by the end of 2016 50% by end 2018

And end of 2018 90% of traditional Medicare payments to quality or value through programs such as the Partnership for Patients Hospital, Value Based Purchasing and the Hospital Readmissions

https://www.youtube.com/watch?v=UY088YyQ6uA
HHS Secretary Sylvia M. Burwell holds a panel presentation on Delivery System Reform and makes an historic Medicare announcement.

1) Delivery of Care—More responsive to patients
2) Pay providers
3) The way CMS distributes information

(ACO, PCMH, Bundle Payments (total care)
CMS announced for the first time they will set clear timelines and goals to move from volume to value for alternative payment models.

**CMS Goals:**
Alternative: 30% of all payments by 2016; 50% by 2018.
Value Based payments: 90% by 2018.
Trajectory to Value Based Purchasing:
Achieving Real Care Coordination and Outcome Measurement

- Value-Based Purchasing: Reimbursement Tied to Performance on Value (quality, appropriate utilization and patient satisfaction)
- Operational Care Coordination: Reporting of Quality, Utilization and Patient Satisfaction Measures
- HIT Infrastructure: EHRs and Connectivity
- Primary Care Capacity: Patient Centered Medical Home
- Value/Outcome Measurement: Embedded RN Coordinator and Health Plan Care Coordination $
Defining the Care Centered on Patient

- Superb Access to Care
- Patient Engagement in Care
- Clinical Information Systems, Registry
- Care Coordination
- Team Care
- Communication
- Patient Feedback
- Mobile easy to use and Available Information
Payment reform requires more than one method, you have dials, adjust them!!!

“fee for health”
“fee for value”
“fee for outcome”
“fee for process”
“fee for belonging”
“fee for service”
“fee for satisfaction”
Cultural Shift

Current
Clinical & Passive Patient-Generated Health Data

Future
Engaged Patient and Active Patient-Generated Health Data

= BEST CARE

Patient-Provider Partnership
Patient-Centered Access

Empowering Caregivers
- Online Access
- Download Record
- Secure Messaging
- Two-Way Communication
- Schedule Appointments

Empowering Patients

Patient-Facing Tools

GP

Mary

John

GP

Laptop

Tablet

Phone
Government Strategy

Pay for Structures & Systems
Electronic Health Records  Incentives

Pay for Care Collaboration
Shared Savings  Bundled Pay

FFS Plus Payment
Medical Home  Case Rate

Pay for Quality
PQRS  Value-based Modifiers
### Value-Based Payment Modifier

**CY 2017 Payment Based on CY 2015 Performance**

<table>
<thead>
<tr>
<th>Group Size</th>
<th>Quality Tiering Adjustment</th>
<th>PLUS Penalty for Not Reporting PQRS</th>
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<tbody>
<tr>
<td>10+ EPs</td>
<td>-4.0% to +4.0x of MPFS</td>
<td></td>
</tr>
<tr>
<td>2 to 9 EPs</td>
<td>0.0% to +2.0x of MPFS</td>
<td></td>
</tr>
<tr>
<td>Solo practitioners</td>
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**EP**: Eligible provider  
**MPFS**: Medicare Physician Fee Schedule  
**X**: Payment adjustment factor (to be determined; budget neutral)
Learn How Merit Based Incentive Payments Will Impact Your Practice’s Bottom Line

Based on the proposed CY 2016 Physician Fee Schedule rule issued in July, CMS is planning on the implementation of certain provisions of the MACRA, including the new Merit-based Incentive Payment System (MIPS). This is part of a broader effort of HHS to move the Medicare program to a health care system focused on the delivery of quality care and value based reimbursement.

Learn how the impact of MIPS will impact your practice including:

- How the MIPS program rolls together Meaningful Use, PQRS, and Value-Based Modifier to result in a +/-9% or more Medicare Part B reimbursement impact.

- Understand MIPS eligibility requirements and exceptions with financial implications.

- Learn through numerical examples how MIPS dollars can play out.
The Merit-Based Incentive Payment System (MIPS) & Alternative Payment Models (APMs):

Delivery System Reform, Medicare Payment Reform, & the MACRA

How does the Medicare Access & CHIP Reauthorization Act of 2015 (MACRA) reform Medicare payment?

The MACRA makes three important changes to how Medicare pays those who give care to Medicare beneficiaries. These changes include:

- Ending the Sustainable Growth Rate (SGR) formula for determining Medicare payments for health care providers’ services.
- Making a new framework for rewarding health care providers for giving better care not more just more care.
- Combining our existing quality reporting programs into one new system.

How do the MACRA payment reforms work?

The MACRA will help us to move more quickly toward our goal of paying for value and better care. It also makes it easier for more health care providers to successfully take part in our quality programs in one of two streamlined ways:

1. Merit-Based Incentive Payment System (MIPS)
2. Alternative Payment Models (APMs)

MIPS and APMs will go into effect over a timeline from 2015 through 2021 and beyond.
How do the MACRA payment reforms work?

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The MACRA: A New Opportunity

On April 14, 2015, a large bipartisan majority in Congress passed the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). President Obama signed the MACRA into law on April 16, 2015. The MACRA permanently repeals the flawed Sustainable Growth Rate formula for determining Medicare payments for clinicians’ services, establishes a new framework for rewarding clinicians for value over volume, and streamlines other existing quality reporting programs into one new system.

The MACRA was passed with bi-partisan support and will help accelerate paying for and rewarding value. Implementation of the MACRA is a major opportunity to put a broad range of health care providers on the path to value through the new Merit-Based Incentive Payment System (MIPS) and incentive payments for participation in certain Alternative Payment Models (APMs).

Path #1: MIPS

The MACRA sunsets the payment adjustments associated with the Physician Quality Reporting System, the Value-based Payment Modifier, and the Medicare Electronic Health Record (EHR) incentive program for Eligible Professionals. The MIPS combines those efforts into a single consolidated program with four weighted performance categories upon which eligible professionals (EPs) will be assessed: Quality; Resource Use; Clinical Practice Improvement Activities; and Meaningful Use of Certified EHR Technology.

MIPS requires the Secretary to develop and provide clinicians with a Composite Performance Score that incorporates MIPS EP performance on each of these categories. Based on this Composite Performance Score, EPs may receive an upward, downward, or no payment adjustment. MIPS offers an opportunity for EPs to achieve significant financial incentives for providing health care that advances the goals of a better, smarter, and healthier system.

Path #2: APMs

The MACRA also provides incentives for participation in certain APMs. “Qualifying APM participants” will not be subject to MIPS adjustments and will receive a lump sum incentive payment equal to 5 percent of the prior year’s estimated aggregate expenditures under the fee schedule. The 5 percent incentive payment is available from 2019 to 2024, but beginning in 2026, the fee schedule growth rate will be higher for qualifying APM participants than for other practitioners.

The MACRA also encourages expansion of the APM options available to physicians, especially specialists, through physician focused payment models (PFPMs). The law requires the establishment of a Technical Advisory Committee that will assess PFPM proposals submitted by stakeholders and make recommendations to the Secretary about which models to consider testing. This is a valuable opportunity for stakeholders to participate in delivery system reform by developing and submitting their ideas for APMs.
The Shift to and Challenges of Value Based Care

ACO: Population Health

Medical Home

Bundles
Appropriate Financial Incentives and Reimbursement Models
Many Varied Pay for Performance Models

- Simple and Complex Structures
- Metrics (Utilization, Quality, Cost)
- Defined populations and/or defined procedures
- No risk, shared risk, full risk
- Gainsharing – upside only on specific areas of savings opportunities
- Revenue enhancement (without cost savings) opportunities shared with health plans
Pay for Performance Models – Vary by Payor and Product

- Commercial, Medicare and Medicaid
- Legal restrictions on Government products/dollars
- State restrictions on capacity for taking on ‘risk’
- Payor obligations to share savings with consumers/government below target Medical Loss Ratio
- Receipt of shared savings/enhanced revenues – Commercial more timely than Medicare
Patient Center Medical Home

Enhanced Payments that appropriately recognize added value to patients

• Whole-person care – Comprehensive, preventative, self management support, routine and urgent, mental health, health habits, etc.
• Systematic tracking of tests and follow up on test results
• Streamlined referral processes and care coordination
• Continuous quality improvement and performance reporting
• Enhanced access and communication
• Patient tracking and registry functions
• Electronic prescribing, communication, etc.
• Adoption and implementation of evidence based guidelines for three chronic or important conditions
Basic Framework of A Gainsharing Program

- Physicians rewarded for reaching benchmarks and/or making significant improvement in performance and quality.
- All cases severity adjusted to 4 levels using APR DRGs to account for ‘sicker’ patients.
- Benchmarks established using physicians’ actual experience in their region - the top 25th percentile (lowest cost) performers (by APR DRG).
- Monies to pay bonus come from hospital savings generated by improvements in efficiency. If hospital achieves no savings - no bonuses paid out.
- Payments withheld from physicians who do not meet quality standards.
Movement Toward Reduced Variation in Practice and Higher Quality

- Shrink variation in cost between bottom 75th and the top 25th percentile
- Physicians begin to ask – ‘What is the top 25th percentile doctor doing that I’m not doing?’
- Greater acceptance/easier transition to clinical guidelines/care maps
- Greater collaboration, improved communication and documentation - alignment achieved
- Halo effect on other ‘payor’ populations, including those that hospital will not be able to share savings, if they occur (i.e. Medicare fee for service – without a waiver)
- Side benefit of enhanced revenue from improved coding
Connecting All Patient Encounters

Addressing Social, Economic, Behavioral, Mental Needs

- Safety and Quality
- Whole Person Orientation
- Care is coordinated and integrated
- Personal Physician
- Enhanced Access
- Physician Directed Practice
- Payment for Added Value
Value to the Rural Region

- Enhanced patient satisfaction and continuity of care for the citizens.
- Enhanced financial stability of local health care providers.
- Enhanced bargaining and negotiating power with payers through the coalition.
- Enhanced awareness of healthcare issues and challenges with elected officials and community leaders.
What is Clinical Decision Support?

• “A process for enhancing health-related decisions and actions with pertinent, organized clinical knowledge and patient information to improve health and healthcare delivery.” - Jerry Osheroff, et al.

• “HIT functionality that provides...general and person-specific information, intelligently filtered and organized, at appropriate times, to enhance health and health care.” - CMS
CDS Design for the Triple Aim of Quality

Better Care for Individuals

Better Health for Populations

Lower Per Capita Costs
Broadening the Potential & Impact of CDS

1. The right information
2. To the right person
3. In the right CDS intervention format
4. Through the right channel
5. At the right time in the patient workflow

- What is the “right” information when you are designing for multiple Care Team members?
- The “right” person may be more than one person in light of emerging Care Team models and workflows.
- What are the highest priorities for a given condition / screening / patient situation, shared across the Care Team?
- Is the EHR necessarily the “right” format for a CDS intervention? Are there other health IT solutions that can provide CDS?
- What data needs to be known at certain points of the workflow, across interdisciplinary Care Team members?
Financial incentives effect how they access/receive care.

Everyone agrees to help reduce health care costs!

I can’t afford that diagnosis. Do you have a cheaper one?
Better Patient Care

- Alerts and reminders in case management
- Outcomes driven tools for case improvement
- Clinical protocols to help choose reliable care
- Quality measures to guide doctors
- Advanced Care Plans customized by you
- Data analysis for managing progress
- Knowing your own practice profile by DX
Thank you!
PQRS Additional Resources

ACA webpage dedicated to PQRS:  www.acatoday.org/PQRS
CMS webpage dedicated to PQRS:  www.cms.gov/PQRS
ACA’s Government Relations Department:  Phone 703-812-0242 | Email: Medicare@acatoday.org
CMS PQRS Helpdesk: Phone: 1-866-288-8912 | Email: Qnetsupport@hcqis.org

In addition, CMS regularly holds calls dedicated to PQRS and allows for open question and answer sessions. Look for announcements of these calls on the www.cms.gov/PQRS website under “CMS Sponsored Calls” and in ACA publications.
PQRS Reporting

2 measures for DC’s:
1) Pain Assessment Measure #131: Pain Assessment and Follow-Up

2) OAT Tool Measure #182: Functional Outcome Assessment

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