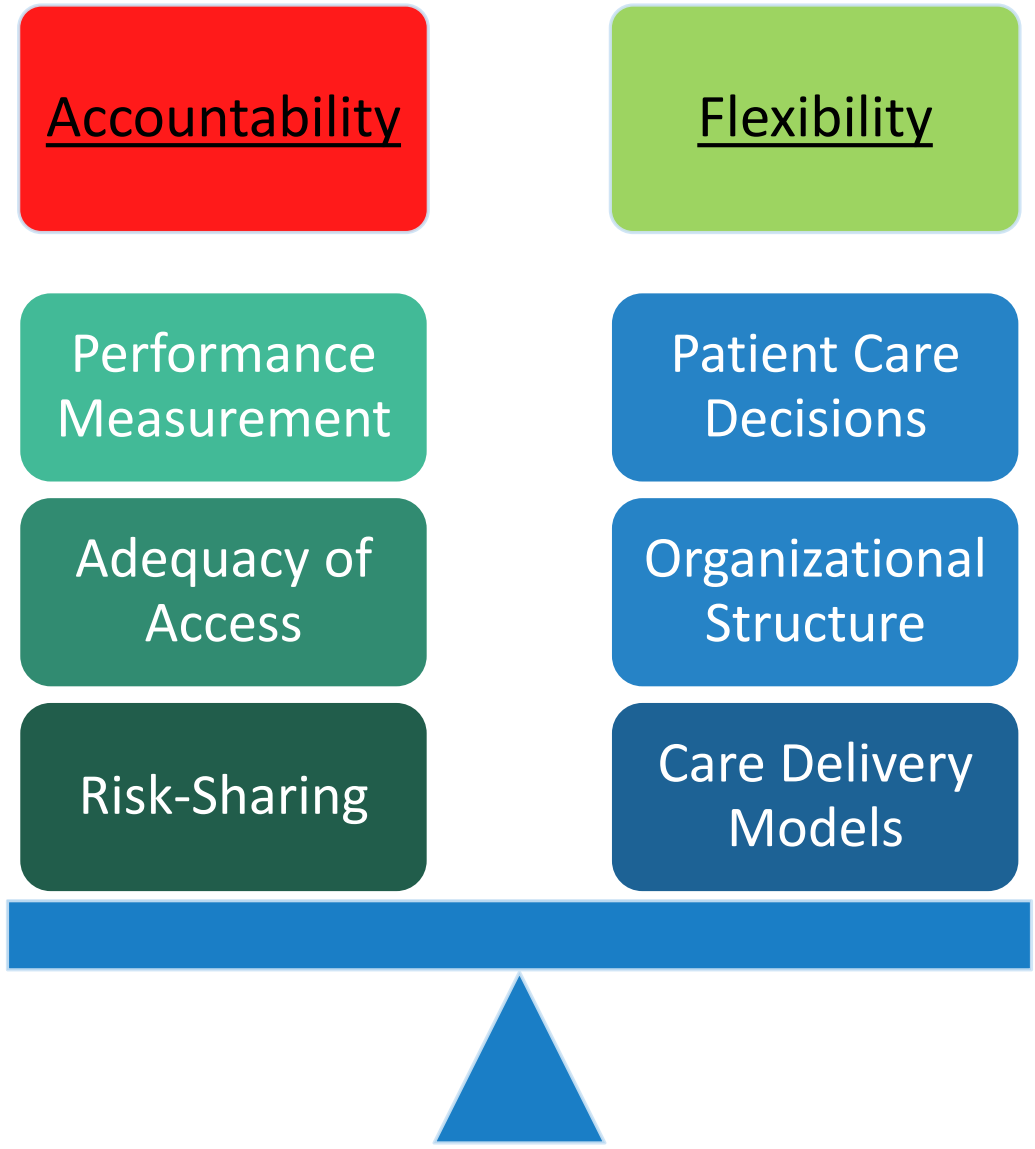
Provider-Carrier Workgroup – Study on Self-Referral

JULY 22, 2015

MARYLAND HEALTH CARE COMMISSION

Core Principle

Providers who take on greater accountability should have greater flexibility in managing their practices and patients.



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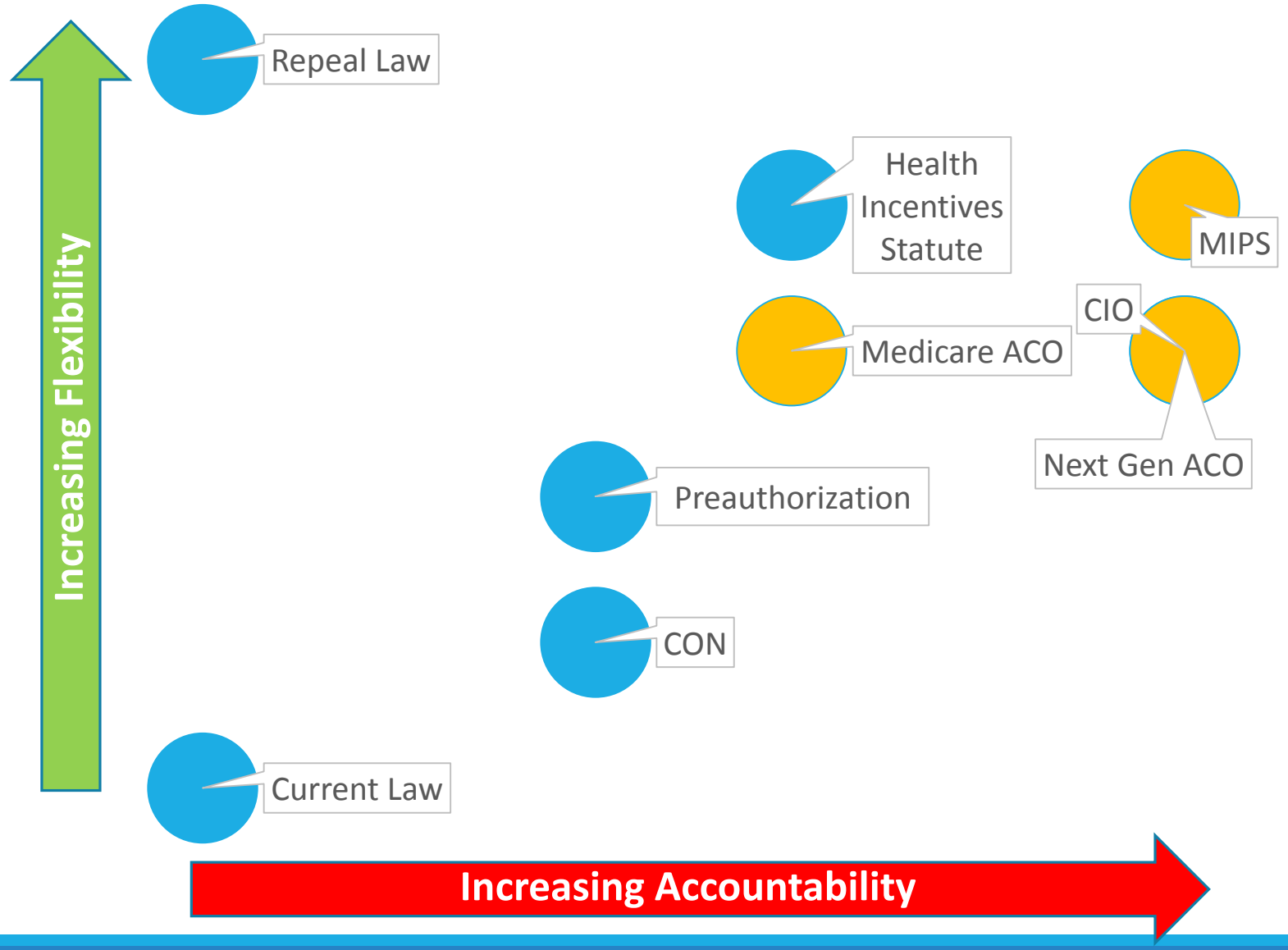
Accountable Programs

Continuum of Options: Making Trade-Offs



MARYLAND HEALTH CARE COMMISSION

Medicare

DISCERN HEALTH

Medicare Incentive Programs that promote Accountability: Current and Future

Presentation to MHCC
Provider/Carrier Workgroup -
Study on Physician Self-Referral

July 22, 2015

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Presentation Overview

- Current Medicare Incentive Programs to Promote Accountability in Payment
  - Physician Quality Reporting System
  - Value-Based Payment Modifier
  - Meaningful Use
- Forthcoming Changes
  - Medicare Sustainable Growth Rate (SGR)
  - Medicare Access and CHIP Reauthorization Act (MACRA)
  - Merit-based incentive payment system (MIPS)
- Medicare Accountable Care Organizations (ACOs)

Current Medicare Incentive Programs

Physician Quality Reporting System (PQRS)

- **Overview**: PQRS uses incentive payments to encourage eligible health care professionals (EPs) to report on specific quality measures applied to Medicare Part B claims.
- Each year, providers receive feedback reports on whether they satisfactorily reported required measures, making them eligible for an **incentive payment** equal to a percentage of the provider's estimated total allowed charges for covered services
- Beginning in 2015, CMS introduced a **negative payment** for providers failing to meet satisfactory quality measure standards
- Providers receiving a negative payment will be paid 1.5% less than the Medicare Physician Fee Schedule (MPFS) amount for those services rendered January 1 to December 31, 2015.

Value-Based Payment Modifier (VBPM)

- Provides for **differential payment** to a provider based on a comparison of quality measures and cost of care measures.
- Currently VBPM applies to groups of 100 or more eligible physicians. Beginning in 2017, the VBPM will also be implemented for individual providers.
- If a group fails to achieve satisfactory quality/cost benchmarks, the Value Modifier is set at -1%
- Payments made under the Value Modifier must be budget neutral - upward payment adjustments for high performance must balance the downward payment adjustments applied for poor performance.

Meaningful Use

- The Medicare and Medicaid Electronic Health Care Record (EHR) Incentive Programs provide incentive payments to eligible professionals, eligible hospitals, and critical access hospitals (CAHs) as they adopt, implement, upgrade or demonstrate meaningful use of certified EHR technology.

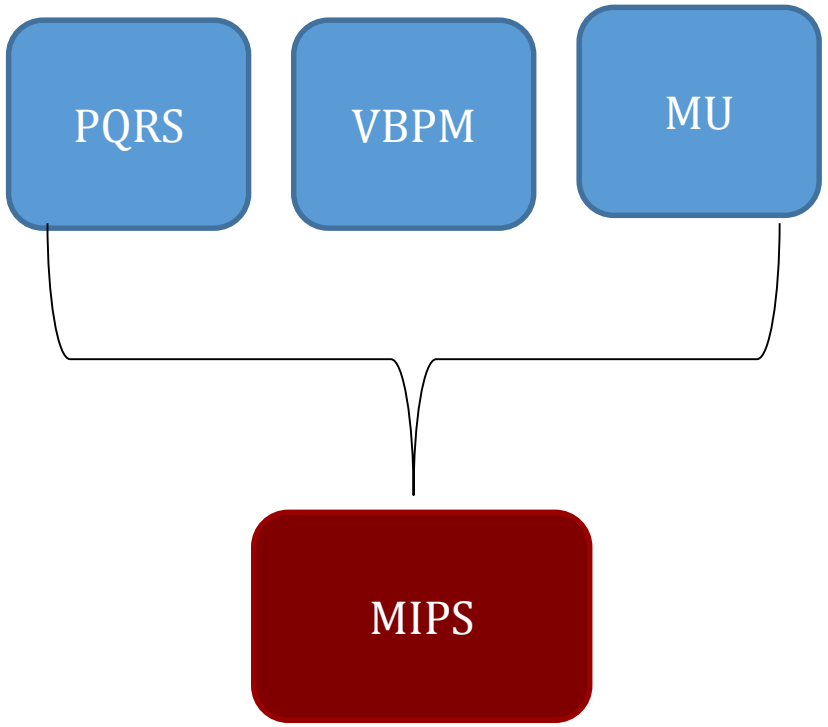
Forthcoming Changes to Medicare Incentive Programs

SGR and MACRA

- Medicare Sustainable Growth Rate (SGR) permanently repealed and replaced with Medicare Access and CHIP Reauthorization Act (MACRA) April 2015
- Medicare rates were frozen at pre-April levels through June, then raised 0.5% in the second half of 2015
- Will continue to increase 0.5% each year from 2016 through 2019.
- **MACRA will shift Medicare compensation from fee-for-service to pay-for-performance.**

Merit-Based Incentive Payment System (MIPS)

- Under MACRA, consolidation of MU, PQRS and VBM incentives and penalties while continuing to measure performance as specified by those programs
- MIPS will annually measure Medicare Part B providers in categories below to determine Medicare reimbursement:
  - VBM-measured quality
  - VBM-measured resource use
  - MU
  - clinical practice improvement
- Providers participating in an alternative payment model (APM) are rewarded with an additional financial incentive of 5% of their Medicare reimbursements received in the prior year



Medicare ACOs

Medicare Shared Savings Program (MSSP)

- CMS program that helps a Medicare fee-for-service program providers become an ACO to improve the quality of care for Medicare Fee-For-Service (FFS) beneficiaries and reduce unnecessary costs.
- Preceded by Pioneer ACO program
- MSSP has various payment models across the country:
  - One sided risk (vast majority)
  - Two sided risk
  - Advanced payment

Advance Payment ACO Model

- Supplementary incentive program for selected participants (physician-based and rural providers) in the MSSP ACOs.
- Participants receive upfront and monthly payments, which they can use to make important investments in their care coordination infrastructure.
  - An upfront, fixed payment: Each ACO receives a fixed payment.
  - An upfront, variable payment: Each ACO receives a payment based on the number of its historically-assigned beneficiaries.
  - A monthly payment of varying amount depending on the size of the ACO: Each ACO receives a monthly payment based on the number of its historically-assigned beneficiaries.

Summary

Medicare – Parameters of Accountability

- Quality
  - Clinical performance
    - Process
    - Outcomes
    - Utilization
  - Patient experience
- Financial
  - Adjustments to fee-for-service
  - Bundled payment
  - Risk for overall costs (one-tailed or two-tailed)

Medicare – Parameters of Flexibility

- MedPAC 2011 Report addresses challenges in Stark Law and states that value-based payment arrangements could mitigate them.
  - "….under an alternative payment structure in which providers are rewarded for constraining volume growth while improving the quality of care, the volume-increasing effects of self-referral would be mitigated. Therefore, the preferred long-term approach to address self-referral is to develop new payment systems."
- In the 2016 Physician Fee Schedule Proposed Rule, CMS suggests two exceptions to Federal Stark Law:
  - Assistance to physicians to employ non-physician practitioners, and
  - Clarification for FQHCs and rural health clinics to determine the geographic areas that they serve.
- The 2016 Proposed rule also solicits comments on impacts of Stark on financial relationships in light of alternative payment/delivery models, indicating that CMS will address this issue in the near future.

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Private Payer Programs

MHA Gain Sharing Approach

Gainsharing: Foundation for Physician Alignment & Engagement

Nicole Stallings

Vice President, Policy & Data Analytics

Maryland Hospital Association

Background

- New All-Payer Model Agreement effective January 2014
- Aggressive financial and quality requirements
- Extensive monitoring from CMS, HSCRC
- Success under new spending caps requires volume control and cost reduction
- Several new HSCRC payment policies in place
- All hospitals operating under global budget

Opening Perspectives

- Effective hospital/physician collaboration is essential to meet the aggressive quality and financial requirements under the five-year waiver demonstration and to succeed under global budgets.
- Gainsharing is the direct payment by hospitals to physicians, based on quality and efficiency. Unlike "Shared Savings," it is based on hospital costs, not Medicare payments.
- HSCRC's Physician Alignment & Engagement Workgroup agreed gainsharing should be explored as a *first step* for interested providers, while working to pursue initiatives that will move the state toward the longer term goal of population-based models.

MHA's Gainsharing Program

- Comprehensive (all costs, all DRGs) inpatient only program modeled after demonstrations in New York and New Jersey
- Based on methodology approved by CMS three times
- Voluntary physician participation
- No change in physician reimbursement; incentive only
- Hospital/Physician Steering Committee conditions incentive payments based on specific quality and care redesign initiatives
- Utilizes severity adjusted, physician specific data to identify clinical and non-clinical savings opportunities, determine incentive payments

Design Principles

- Purpose: Recognize the important role of physicians in contributing to efficient hospital operations
  - Rewards achieved levels of performance, incent improved performance
  - Safeguards to ensure patient protections, maintain quality of care
- Measurement: Performance is rewarded based on regionally derived Best Practice Norms
  - 25th percentile of lowest patient costs in MD hospitals
  - Responsible Physician/Physician of Record eligible for incentive
  - Ability to add specialists, consultants and ancillary physicians

Patient Protection

Regulatory Concerns	Characteristics of Approach
Cherry picking, quicker-sicker, stinting and steering	Severity of illness adjustment
Phantom savings	Uniform methodology
New and untried practices	Limit on incentive payments
Compensation to induce referrals	Volume requirements
Patient participation	Requires patient notice

Quality Components

- Integral part of determining incentive payment
- Standard measures: mortality, readmissions (within 7 and 30 days)
- Other measures determined by Hospital/Physician Steering Committee

Sample Quality Measures			
Efficiency	**Outcomes**	**Patient Experience**	**Other**
• Delinquent medical records • Timely operative report dictation • Calling consultants in a timely manner • First case start times in OR	• Hospital-acquired complications • Medication errors • Returns to the OR • Readmission	• HCAHPS – Physician Domain • Validated patient complaints	• Compliance with hospital policies • Attendance at Grand Rounds

Demonstration Experience

- Increased physician engagement
- Initial savings offset initial physician payment
- Additional physician participation after initial payments
- Hospital/Physician Steering Committee critical to focus opportunities for improvement/identification of processes that need to be put in place
- Quality scores improve on targeted initiatives
- Communication with physicians is key – one-on-one, departmental meetings, routine reports

Physician Dashboard

Current - July 2013 through June 2014; All Payor Claims

Provider: 01 - General Medical Center

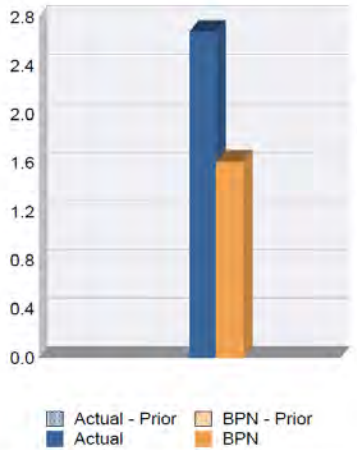
Analytics

Responsible Physician	10000	**Specialty**	
Physician's First Name		**Physician's Last Name**	

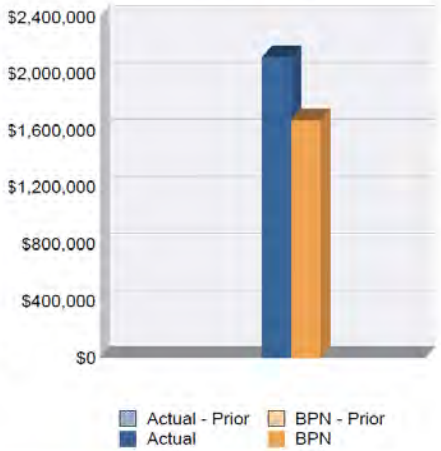
QUICK STATISTICS	Cost		Average LOS		INCENTIVE	Performance		Improvement		Total	
	Prior	Current	Prior	Current		Prior	Current	Prior	Current	Prior	Current
Your Information		$2,120,483		2.7	Maximum Incentive		$21,906		$0		$21,906
Best Practice Norm (BPN)		$1,677,763		1.6	Your Incentive		$8,245		$0		$8,245
Variance		$442,719		1.1	Unearned Incentive		$13,661		$0		$13,661

Discharges by Complexity Level (SOI)										
	Current	SOI 1:	105	SOI 2:	111	SOI 3:	13	SOI 4 :	0	Total: 229
	Prior	SOI 1:		SOI 2:		SOI 3:		SOI 4 :		Total:

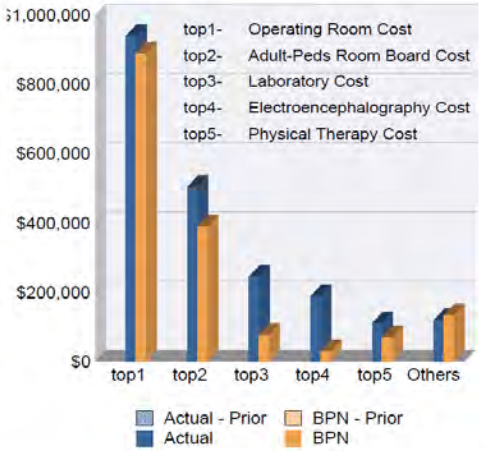
LOS Summary



Cost Summary

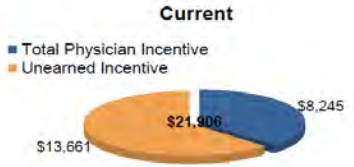


Top Cost Centers



No Prior Period Utilization.

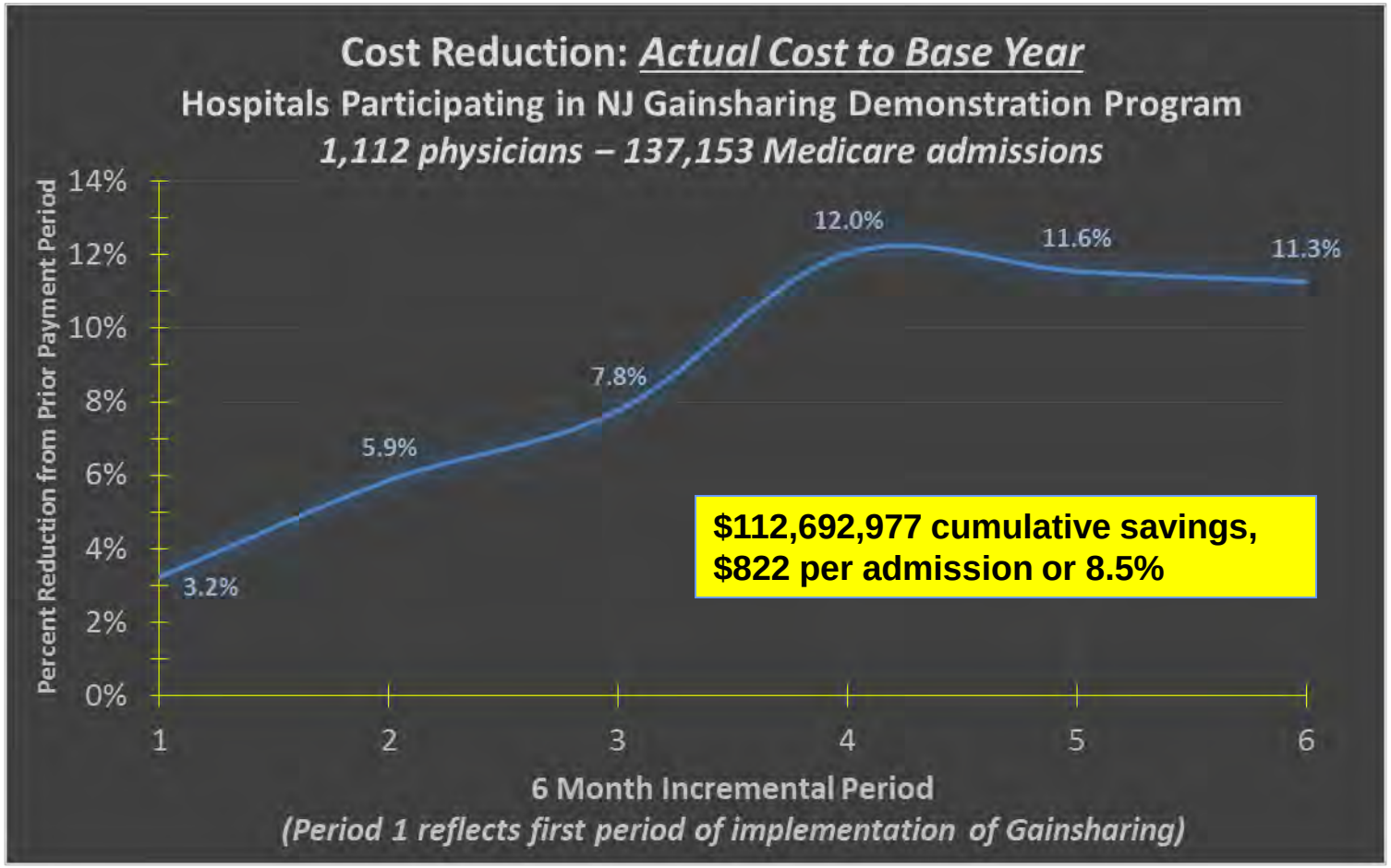
Current



Cost Center Summary		Your Cost		BPN		Variance	
		Prior	Current	Prior	Current	Prior	Current
Top1	Operating Room Cost		$941,846		$891,696		$50,150
Top2	Adult-Peds Room Board Cost		$505,028		$390,949		$114,079
Top3	Laboratory Cost		$245,652		$76,869		$168,783
Top4	Electroencephalography Cost		$188,838		$29,160		$159,678
Top5	Physical Therapy Cost		$110,455		$70,200		$40,255
Top6	Occupational Therapy Cost		$66,766		$41,173		$25,593
Top7	Radiology Cost		$36,139		$69,828		$-33,689
Top8	Respiratory Therapy Cost		$6,854		$17,104		$-10,249
Top9	Magnetic Resonance Technology Cost		$5,448		$1,192		$4,256
Top10	Emergency Room Cost		$4,598		$4,345		$253

AMS: Maryland (s2014c 10% Var) - Program: dashbrd6 11MAR2015 04:47

NJ Medicare Demo - 12 hospitals
6 Payment Period Results (36 months)



NOTE: *Savings analysis is a comparison of actual cost to base year cost adjusted for inflation, case-mix and SOI (i.e. expected cost). The statements contained in this document are solely those of NJHA/AMS and do not necessarily reflect the views or policies of CMS.*

Program Status

- Program Steering Committee convened to provide oversight, approve adjustments to methodology
- Over half of Maryland's hospitals have signed Letters of Intent to participate
- HSCRC, MedChi and MHA have initiated conversations with CMMI regarding waiver authority
- Exploring additional implementation mechanisms (existing ACOs, commercial program)

Gainsharing: Foundation for Physician Alignment & Engagement

Nicole Stallings

Vice President, Policy & Data Analytics

Maryland Hospital Association

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Implementing Accountability to Permit Self-Referral

Clinically Integrated Organizations

Established under HB 598 / SB 723 (2009)

Clinically Integrated Organizations are:

- A joint venture between a hospital and physicians that has:
  - Received an advisory opinion from the FTC; and
  - Has been established to evaluate and improve practice patterns and promote collaboration and efficiency; OR
- A joint venture between a hospital and physicians that:
  - Is accountable for total spending and quality; and
  - Is an Accountable Care Organization, as defined by CMS.

CIO's may enter into a contract with an insurance carrier

- Clinical integration, such as the ability to freely share medical records between CIO and carrier must a be a central feature
- May include performance incentives and payment for coordination of services
- Must include an evaluation of the program

Regulated by the Maryland Insurance Administration and monitored/evaluated by the Maryland Health Care Commission

Statute may be amended to permit self-referral within CIO's

Mandatory Preauthorization

Maryland law requires that all payers and pharmacy benefit managers implement an electronic preauthorization process.

- Requests for pharmaceuticals are approved in real-time or within one business day after receiving all pertinent information.
- Requests for non-urgent medical services are approved within two business days after receiving all pertinent information.

Amend Maryland statute to require preauthorization for services for which a self-referral exemption was issued.

Certificate of Need

Amend the Certificate of Need statue to include certain equipment regulated under the current self-referral statute.

Regulated Service	Number of States
Computed Tomography Services (CT)	12 + DC
Mobile Hi Technology (CT/MRI/PET, etc.)	15 + DC
Magnetic Resonance Imaging (MRI) Scanners	18 + DC
Positron Emission Tomography Scanners	19 + DC
Radiation Therapy	22 + DC

Retrieved from http://www.ncsl.org/research/health/con-certificate-of-need-state-laws.aspx

Steps in Bringing a Service under Health Planning and CON

1. Change Statute

2. Develop new state health plan chapter - define eligibility for offering service, need methodology, establish application schedule

3. CON process review standards
   a. The most cost-effective approach to meeting identified needs;
   b. Geographically and financially accessible;
   c. Financially viable; and
   d. Will not have a "MAJOR" significant negative impact on the cost, quality, or viability of other health care facilities and services.

Likely that MHCC would be reluctant to expand health planning/CON to technologies such as advanced imaging

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Other Suggestions

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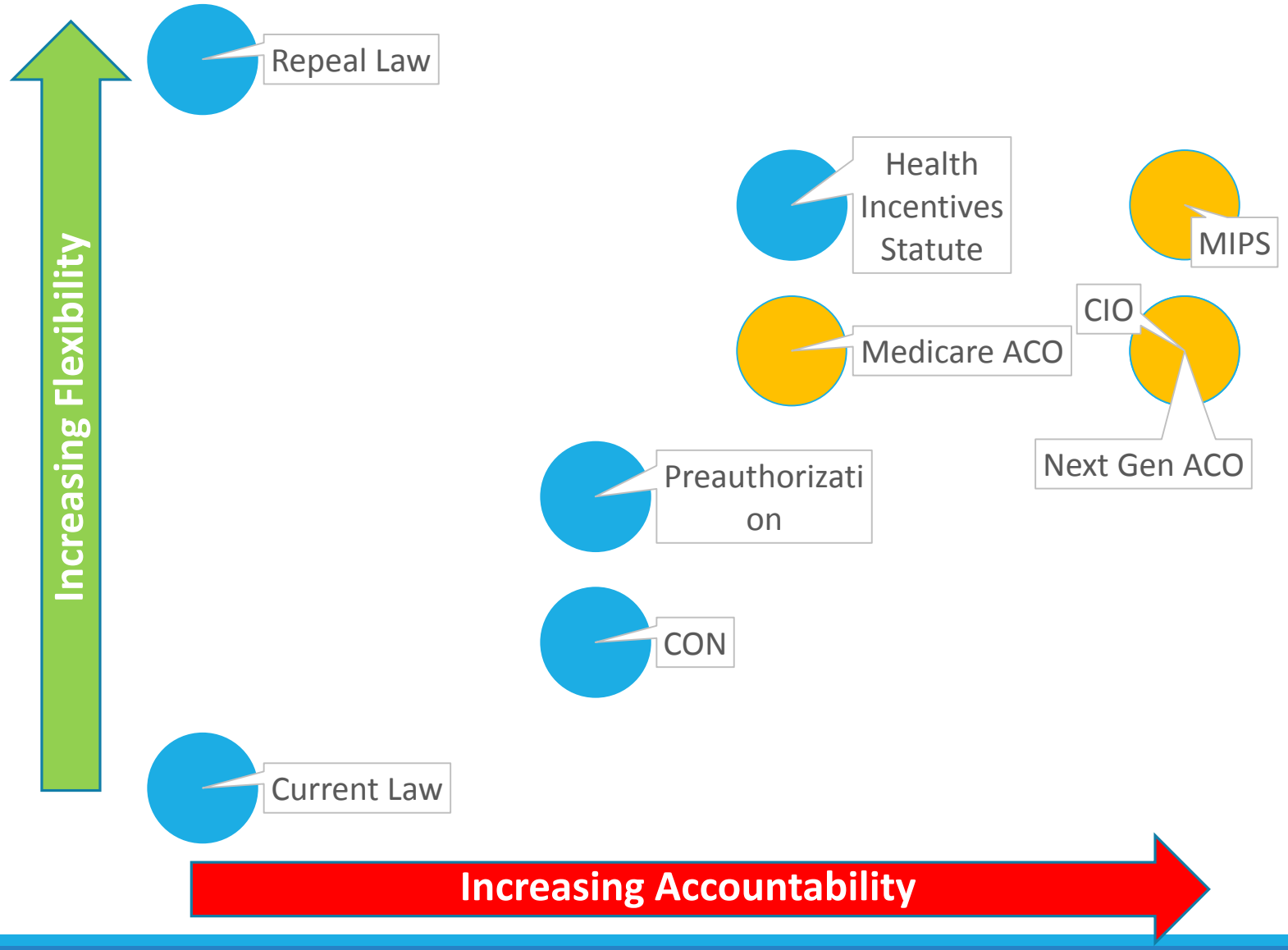
Discussion

Continuum of Options: Making Trade-Offs



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Wrap-up & Next Steps