

AMCP Webinar

Emerging Physician Payment Models: What Does it Mean for AMCP Members and Medication Management?

April 19, 2017

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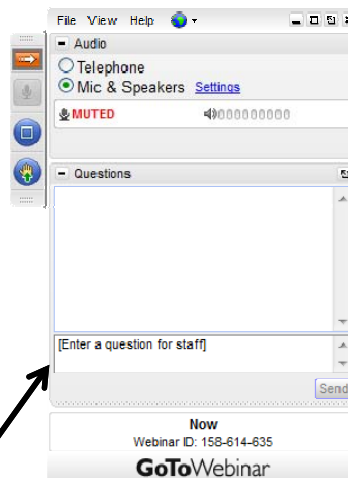
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How to Ask A Question

Type your question in the 'Questions' area



Speakers



Darryl Drevna
Director, Regulatory and Public Relations Policy
AMGA



Daniel Buffington, PharmD, MBA
President
American Institute of
Pharmaceutical Sciences (AIPS)

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MACRA and the Physicians' Perspective

Darryl Drevna, MA
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Presentation Outline

- **MACRA Basics**
- **Merit-Based Incentive Payment System (MIPS)**
 - Eligible Clinicians (ECs) and Exemptions
- **MIPS Alternative Payment Modes**
- **Advanced Alternative Payment Models (APMs)**
- **Medical Group Response**
- **Pharmacy Spend**



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Medicare Access and CHIP Reauthorization Act (MACRA)

- MACRA became law April 16, 2015 (the bill passed with overwhelming Congressional support, i.e., received over 90% of Senate and House vote)
- MACRA Title 1 sunsets and replaces the SGR annual physician (and other eligible professionals) fee update methodology
- MACRA creates what CMS terms the “Quality Payment Program”
- The law establishes a 0.5% annual physician fee update in the short-term, from 2015 and through 2019



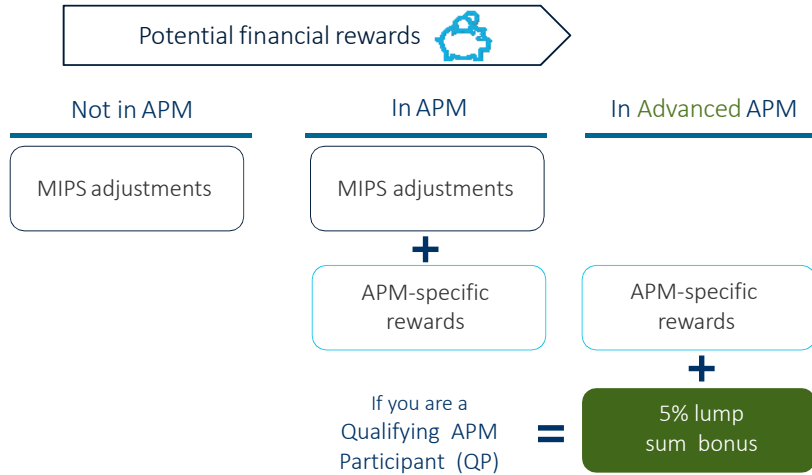
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Three Pathways: MIPS, APM, Advanced APM

Quality Payment Program

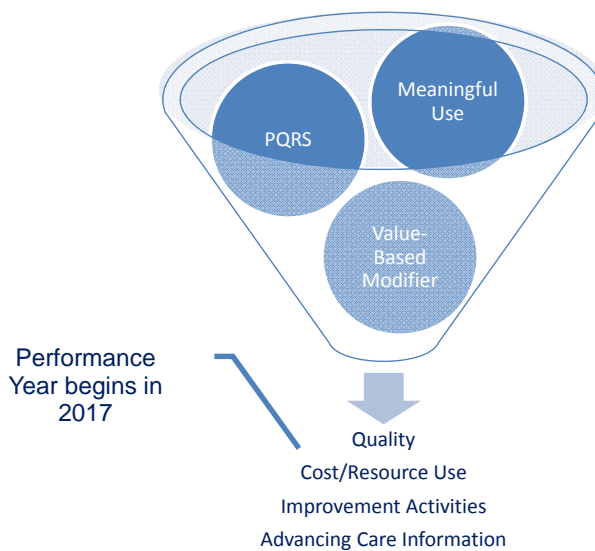


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MACRA: Merit-Based Incentive Payment System



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MIPS: Who's In

Years 1 – 2
(2017-
2018)

- Physicians
- Physician Assistants
- Nurse Practitioners
- Clinical Nurse Specialists
- Certified Registered Nurse Anesthetists

Potential
additions
(2019+)

- Physical or Occupational Therapists
- Speech Language Pathologists
- Audiologists
- Nurse Midwives
- Clinical Social Workers
- Clinical Pathologists
- Clinical Psychologists
- Dietitians/Nutritional Professionals



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MIPS: Who's Out

- Providers below the Medicare low-volume threshold
 - \$30,000 **OR** 100 or fewer beneficiaries annually
- First year Medicare providers
- Providers in an Advanced Alternative Payment Model



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MIPS: Four Components



Add each weighted category to earn MIPS Composite Performance Score

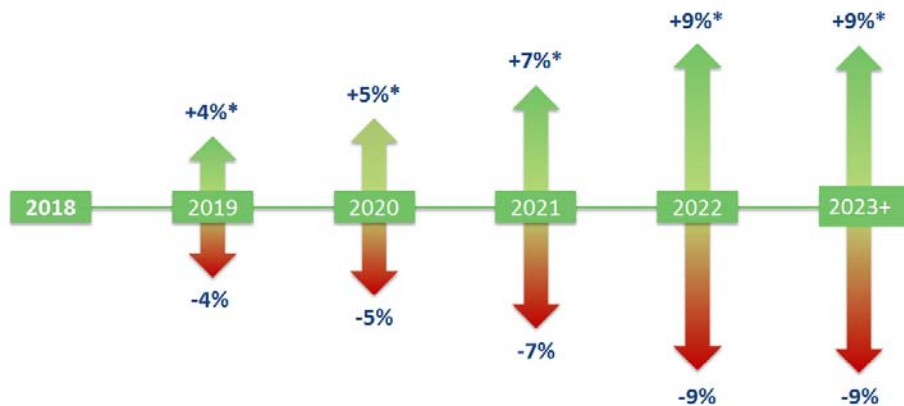


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MIPS Payments



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MIPS: “Pick Your Pace” Payment Adjustment

2017 performance determines 2019 payment adjustment



1. Submit no data = -4% update
2. One quality measure OR one improvement activity OR the required advancing care information measures: neutral or positive MIPS update
 - 1) If reporting via GPRO must meet case minimum requirements
3. More than one quality measure, OR more than one improvement activity, OR advancing care information base measures: positive update possible, avoid negative update

(Medicare physician fee schedule updated 0.5% from 2015-2019)

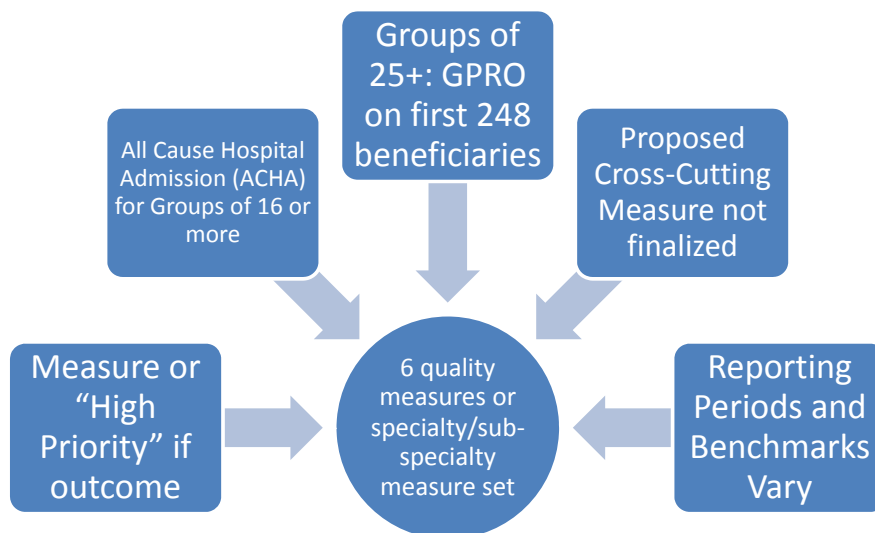


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MIPS: Quality Measures Reporting Full Participation

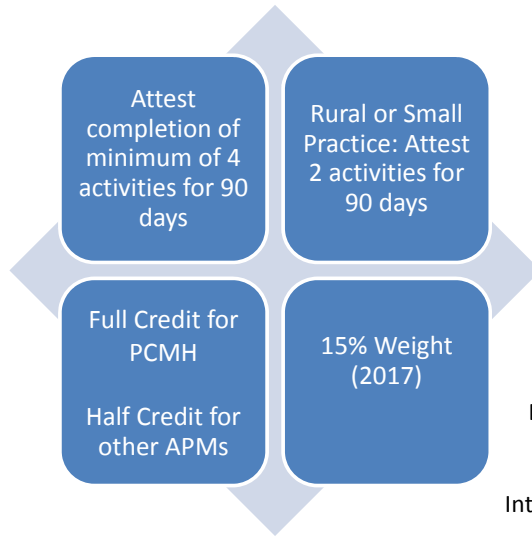


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MIPS: Improvement Activities Reporting



- Expanded Care Access
- Care Coordination
- Population Management
- Beneficiary Engagement
- Patient Safety and Practice Assessment
- Achieving Health Equity
- Emergency Preparedness and Response
- Integrated Behavior and Mental Health

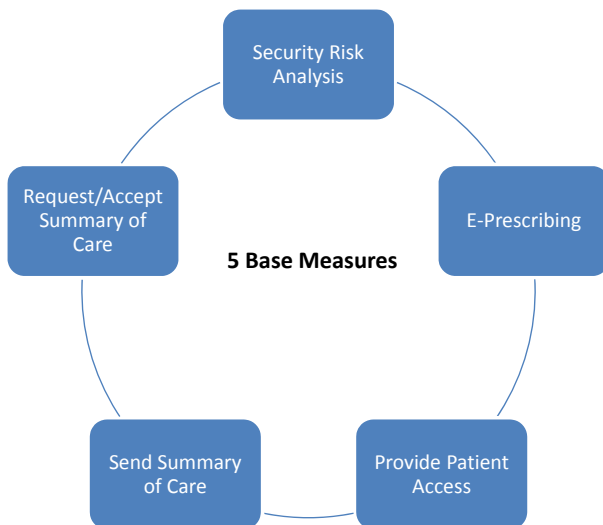


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MIPS: Advancing Care Information Reporting



- Has base and performance reporting components
- Final rule reduced required "base" measures from 11 to 5
- 9 performance measures
- 2015 CEHRT required to report in the ACI category in 2018
- 90-day performance period (reduction from full year)



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MIPS: Cost

0% in
2017

10% in
2018

30% in
2019

CMS will consider how to include Part D into the cost category

Rejected requests to remove Part B drugs



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MIPS: Cost Scoring

- Cost scoring replaces Value-Based Modifier
- Reporting is claims based – no reporting requirement
- The benchmark is the performance period
- The benchmark is national not regional
- CMS will forward for informational purposes per capita costs (minimum 20 cases) and Medicare spending per beneficiary (MSPP) (minimum 35 cases)
- **For 2018 look to Proposed Rule?**
 - Resource Use: Continuation of two measures from the VM: Total per costs capita for all attributed beneficiaries and Medicare Spending per Beneficiaries (MSPB)
 - In VM all cost measures attributed to TIN



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MIPS: Data Submission Benchmarks Differ by Method

Individual Clinician	Group (One TIN)
<ul style="list-style-type: none"> • Quality <ul style="list-style-type: none"> • Qualified Clinical Data Registry (QCDR) • Qualified Registry • EHR Vendors • Claims (No submission needed) • Resource Use <ul style="list-style-type: none"> • Claims (No submission needed) • Advanced Care Information <ul style="list-style-type: none"> • Attestation • QCDR • Qualified Registry • EHR Vendor • Clinical Practice Improvement Activities <ul style="list-style-type: none"> • Attestation • QCDR • EHR Vendor • Claims (No submission needed) 	<ul style="list-style-type: none"> • Quality <ul style="list-style-type: none"> • QCDR • Qualified Registry • EHR Vendors • CMS Web Interface (GPRO) • CAHPS • Resource Use <ul style="list-style-type: none"> • Claims (No submission needed) • Advanced Care Information <ul style="list-style-type: none"> • Attestation • QCDR • Qualified Registry • EHR Vendor • CMS Web Interface (Group of 25+) (GPRO) • Clinical Practice Improvement Activities <ul style="list-style-type: none"> • Attestation • QCDR • Qualified Registry • EHR Vendor • CMS Web Interface (Group of 25+) (GPRO)

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MIPS: Exceptional Performance Bonus

- \$500 million available each year from 2019 – 2024 for those with exceptional performance
- Exceptional performance threshold is 70 points for performance year 2017
- Limited to stop-gain restrictions



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Alternative Payment Models (APMs)

MIPS APMs
(No 5% Bonus)

Partially-Qualifying
APMs
(No 5% Bonus &
MIPS Choice)

Advanced APMs
(5% Bonus)



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Quality Payment Program

What are MIPS APMs?

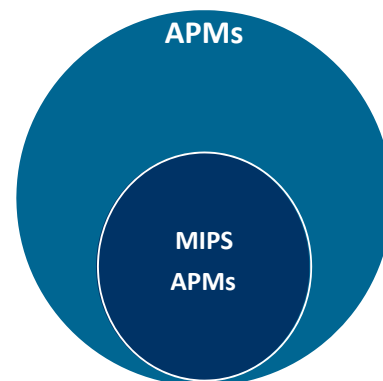
Goals

- Reduce eligible clinician reporting burden.
- Maintain focus on the goals and objectives of APMs.

How does it work?

- Streamlined MIPS reporting and scoring for eligible clinicians in certain APMs.
- Aggregates eligible clinician MIPS scores to the APM Entity level.
- All eligible clinicians in an APM Entity receive the same MIPS final score.
- Uses APM-related performance to the extent practicable.

MIPS APMs are a Subset of APMs



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Shared Savings Program under the APM Scoring Standard



Quality



Cost



Improvement Activities



Advancing Care



REPORTING REQUIREMENT	PERFORMANCE SCORE	WEIGHT
<ul style="list-style-type: none"> ✓ No additional reporting necessary. ACOs submit quality measures to the CMS Web Interface on behalf of their participating MIPS eligible clinicians. 	<ul style="list-style-type: none"> ✓ The MIPS quality performance category requirements and benchmarks will be used to score quality at the ACO level. 	50%
<ul style="list-style-type: none"> ✓ MIPS eligible clinicians will not be assessed on cost. 	<ul style="list-style-type: none"> ✓ N/A 	0%
<ul style="list-style-type: none"> ✓ No additional reporting necessary. 	<ul style="list-style-type: none"> ✓ CMS will assign a 100% score to each APM Entity group based on the activities required of participants in the Shared Savings Program. 	20%
<ul style="list-style-type: none"> ✓ Each ACO participant TIN in the ACO submits under this category according to MIPS reporting requirements. 	<ul style="list-style-type: none"> ✓ All of the ACO participant TIN scores will be aggregated as a weighted average based on the number of MIPS eligible clinicians in each TIN to yield one APM Entity group score. 	30%

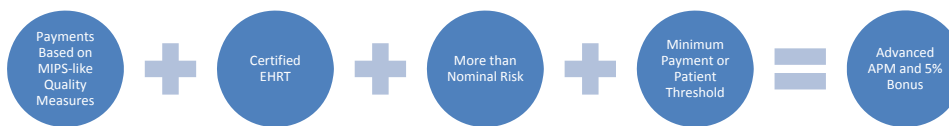


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Advanced APMs: Bonus Payment



- 5% of aggregate amounts paid for Medicare Part B professional services from preceding year across all billing TINs associated with the QPs NPI
- CMS estimates \$333 million to \$571 million in Advanced APM bonus payments in 2019



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CMS “Pre-Approved” Advanced APMs

2017 Performance Year

- Comprehensive ESRD Care (CEC) - Two-Sided Risk
- Comprehensive Primary Care Plus (CPC+)
- Next Generation ACO Model
- Shared Savings Program - Track 2
- Shared Savings Program - Track 3
- Oncology Care Model (OCM) - Two-Sided Risk
- Comprehensive Care for Joint Replacement (CJR) Payment Model (Track 1-CEHRT)
- Vermont Medicare ACO Initiative (as part of the Vermont All-Payer ACO Model)

Updated on an ad hoc basis – will not go through formal rulemaking process

2018 Performance Year and beyond

- ACO Track 1+
- Episode (bundled) payment models to be determined



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Medical Group Response

- Strong incentives to address the overall cost of care
- Strong incentives to form APMs
- Improve Quality and Outcomes
 - Device or Drug must be statistically significantly better than the competition
- Systems and groups will look for one solution
 - Physician preference not a factor anymore
- **Reduce pharmacy spend**
 - Drugs among most costly items
 - Practice formulary
 - Monitor adherence and tie to physician compensation



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MACRA and Pharmacists' Perspective



Daniel E. Buffington, PharmD, MBA

President
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Dan Buffington, PharmD, MBA



Practice Director
Associate Professor, USF Colleges of Medicine & Pharmacy

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Practice Settings

Clinical Specialty Practice / Tampa, FL

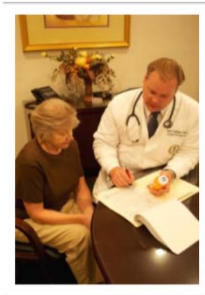
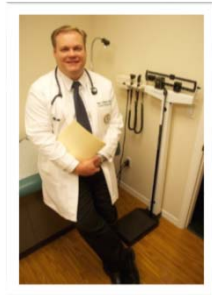


Clinical Pharmacology Services, Inc.



Practice Settings

Clinical Specialty Practice / Tampa, FL



Current Professional Activities

“Academia” University of South Florida

Faculty at the University of South Florida Colleges of Medicine and Pharmacy.
Experiential Preceptor for numerous Colleges of Pharmacy



“Clinical Practice” Clinical Pharmacology Services, Inc.

Private Specialty MTM Practice Model located in Tampa, FL. MTM, clinical research trials, drug information services, forensic expert.

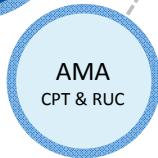


“Professional Activities”

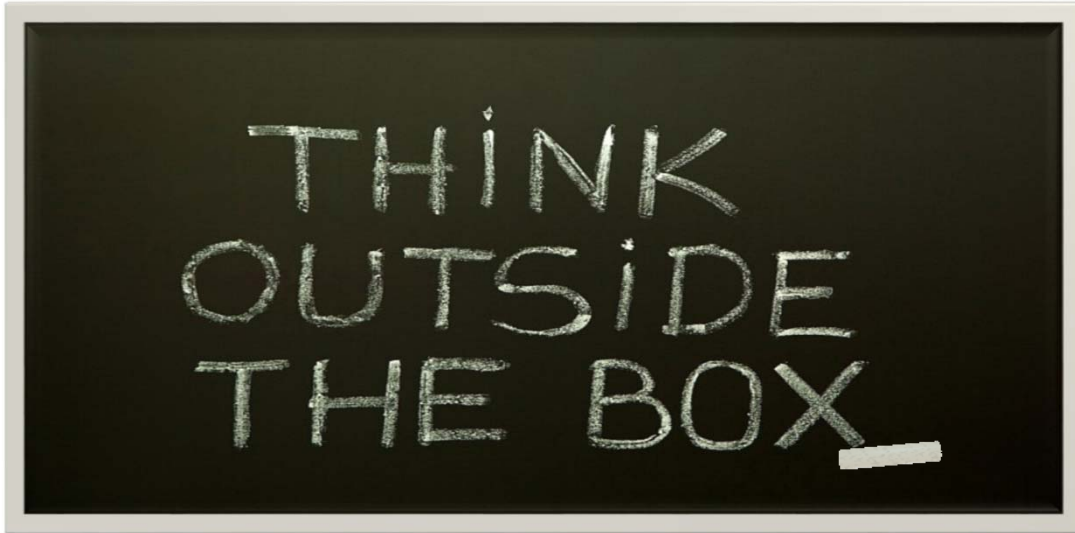
National Associations Pharmacy and Medical
AMA
CPT Editorial Panel Advisory
CMS & CMMI
Medication Safety Expert



APhA
AMCP AACCP
NCPA ASHP
ACCP ASCP



Medication Therapy Management



Emerging Payment Models for Physicians: What Does it Mean for AMCP Members and Medication Management?

Pharmacists' Billing Models

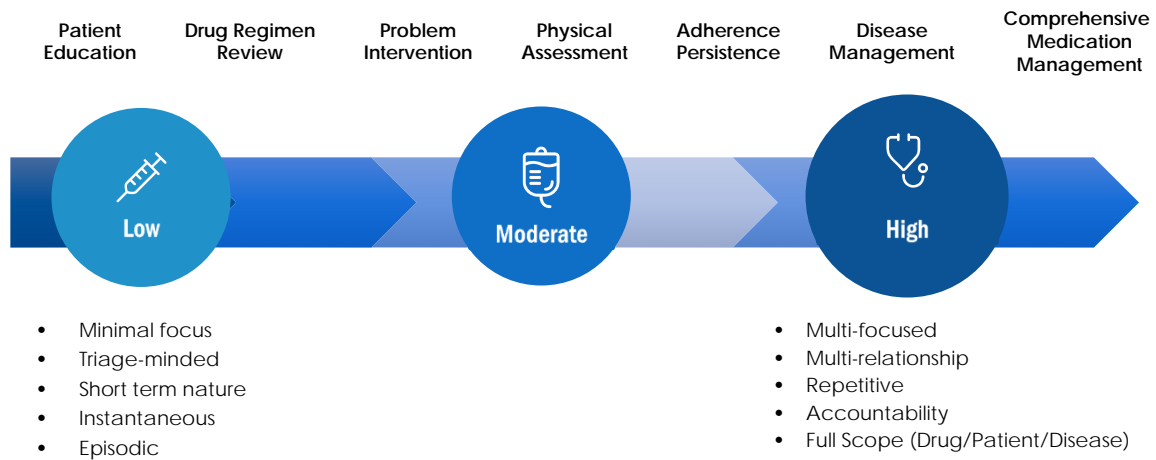


Product-Based



Clinical Service-Based

Progression of MTM Service Intensity



Medication Therapy Management Services (MTMS)

AMA / Current Procedural Terminology (CPT), 2017

Medication Therapy Management Service(s) (MTMS) describe face-to-face patient assessment and intervention as appropriate, by a pharmacist. MTMS is provided to optimize the response to medications or to manage treatment-related medication interactions or complications.

MTMS includes the following documented elements: review of the pertinent patient history, medication profile (prescription and non-prescription), and recommendations for improving health outcomes and treatment compliance. These codes are not to be used to describe the provision of product-specific information at the point of dispensing or any other routine dispensing-related activities.

99605 Medication therapy management service(s) provided by a pharmacist, individual, face-to-face with patient, initial 15 minutes, with assessment, and intervention if provided; initial 15 minutes, new patient

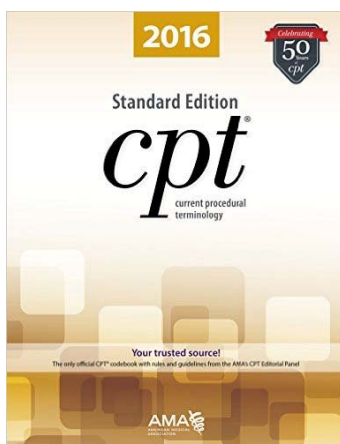
99606 Initial 15 minutes, established patient

99607 each additional 15 minutes (List separately in addition to code for the primary service)

(Use 99607 in conjunction with 99605, 99606)



Expanding CPT Coding for Pharmacist Services



Initial CPT Coding

Medication Therapy Management Services (MTMS)

99605, 99606, 99607

Chapters:

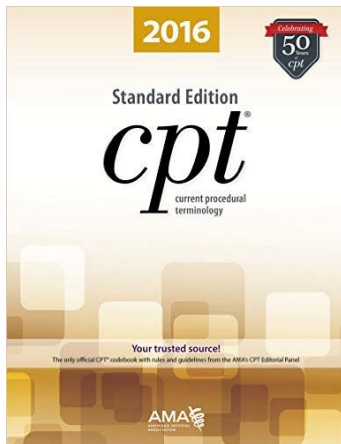
- Evaluation & Management (E&M)
- Medicine
- Laboratory

Expanded Code Access

- Incident-To Services
- Discharge counseling
- Device training
- Pharmacokinetic Monitoring
- Evaluation & Management (E&M)
- Chronic Care Management
- Transitional Care Management

Broader Payer Adoption

Expanding CPT Coding for Pharmacist Services



Initial CPT Coding

Medication Therapy Management Services (MTMS)

99605, 99060, 99607

Chapters:

- Evaluation & Management (E&M)
- Medicine
- Laboratory

Expanded Code Access

- Incident-To Services
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- Chronic Care Management
- Transitional Care Management

Broader Payer Adoption

DHHS / CMS / CMMI



Tom Price, MD
DHHS Secretary



Seema Verma, MD
Administrator

Center for Medicare & Medicaid Innovation



Patrick Conway, MD



Paul McGann, MD

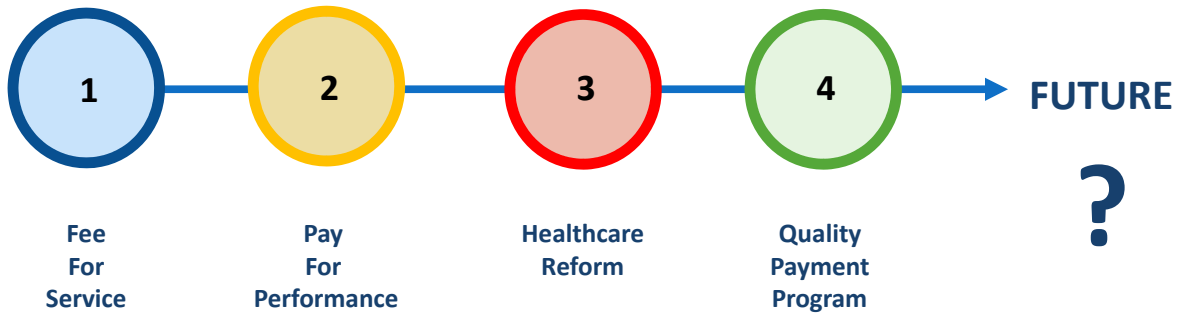


Dennis Wagner



Darren Dewalt, MD

Healthcare Payment Reform



Current Procedural Terminology (CPT)



CPT Editorial Panel
"CPT Advisor – Pharmacists"



Relative-Value System Update Committee (RUC)



RVS Update Committee
Code Valuation Panel



Center for Medicare & Medicaid Innovation (CMMI)



Health Care Reform Team
CMMI & CCSQ
"Health Policy & Medication Safety Fellow"



Center for Medicare & Medicaid Innovation (CMMI)



Health Care Reform Team
CMMI & CCSQ

"Health Policy & Medication Safety Fellow"



Healthcare Innovation Goals



Physician Technical Advisory Coalition (PTAC)



Alternate Payment Models (APM)

Alternate Payment Model Journey



AMA CPT
Current Procedural Terminology

Product
or
Service

AMA RUC
Relative Value Scale (RVS)
Update Committee

RUC Valuation Analysis
or
Market Valued

CMS / CMMI
Healthcare Payment
Modeling & Improvement

Healthcare Reform

- a) Market & Exchange
- b) Payment Models
- c) Quality & Safety Improvement

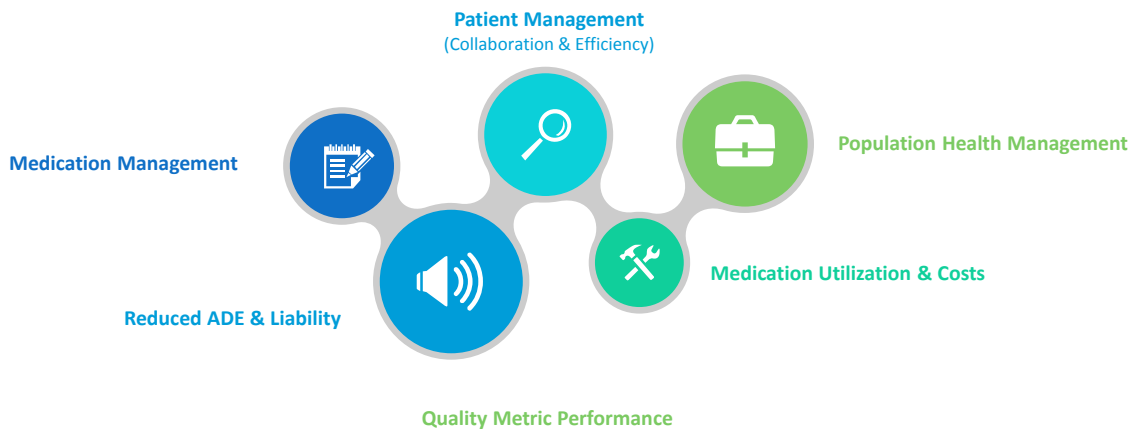
**Future Alternate
Payment Models (APM)**
Value-Based Payment
FFS & APM

Physician-Focused
Technical Advisory Committee



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APM INTEGRATION



Practice-Based Testimonials

Clinical Efficiency



Improved Quality Metrics



Enhanced Practice Revenue



Patient Education & Safety



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APM INTEGRATION



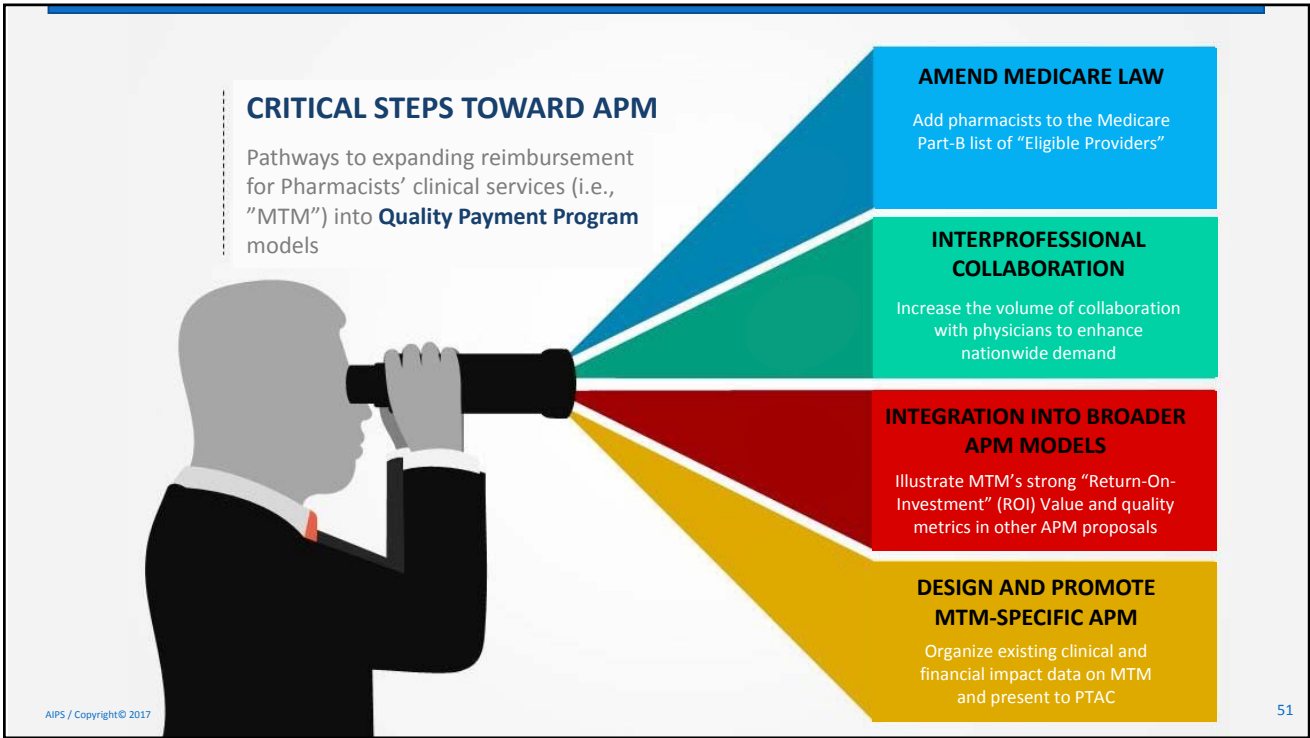
PTAC Meeting / April 10 - 11, 2017

1. ACS-Brandeis Advanced APM (Surgeons)
2. Project Sonar (Chronic GI Conditions) APM (Gastroenterologists)
3. COPD & Asthma Monitoring (Pulmonologists)



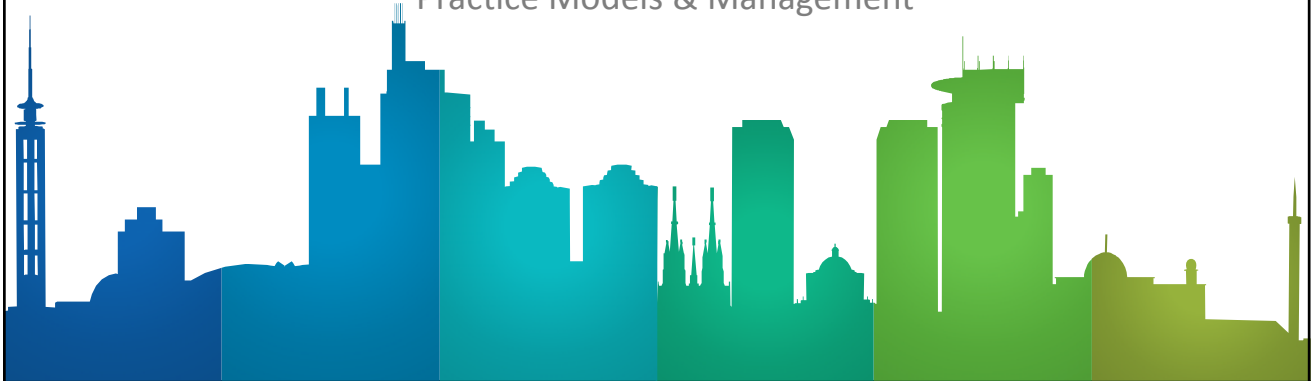
Race to Be In Place...

Costs are not included in the core until 2020, but starting with data tracking from 2018 and 2019 as a baseline.



Medication Therapy Management

Practice Models & Management




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Question & Answer



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