Medical Coding & Billing

National Regulatory Changes

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Value-Based Payments

$$V_{(VALUE)} = \frac{Q_{(QUALITY)} + S_{(SERVICE)}}{\$_{(COST)}}$$

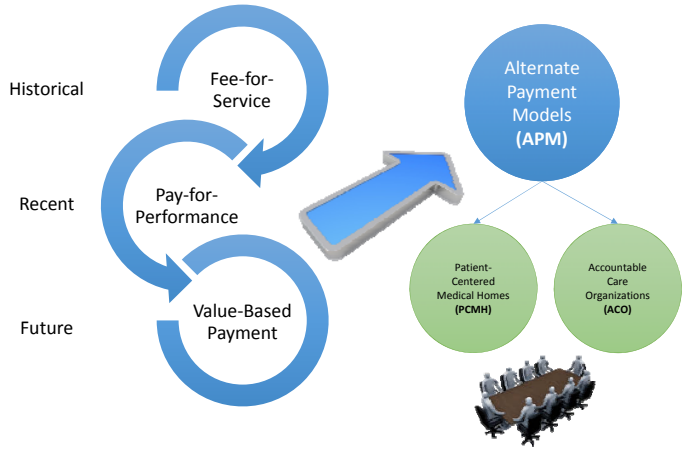
CMMI

CMS

HHS, CMS, & CMMI

Center for Medicare & Medicaid Innovation
CMMI

Transition in Payment Models



Framework for Progression of Payment to Clinicians and Organizations in Payment Reform

	Category 1: Fee for Service – No Link to Quality	Category 2: Fee for Service – Link to Quality	Category 3: Alternative Payment Models on Fee-for Service Architecture	Category 4: Population-Based Payment
Description	Payments are based on volume of services and not linked to quality or efficiency	At least a portion of payments vary based on the quality or efficiency of health care delivery	• Some payment is linked to the effective management of a population or an episode of care • Payments still triggered by delivery of services, but, opportunities for shared savings or 2-sided risk	• Payment is not directly triggered by service delivery so volume is not linked to payment • Clinicians and organizations are paid and responsible for the care of a beneficiary for a long period (eg, >1 yr)
Examples				
Medicare	• Limited in Medicare fee-for-service • Majority of Medicare payments now are linked to quality	• Hospital value-based purchasing • Physician Value-Based Modifier • Readmissions/Hospital Acquired Condition Reduction Program	• Accountable Care Organizations • Medical Homes • Bundled Payments	• Eligible Pioneer accountable care organizations in years 3 – 5 • Some Medicare Advantage plan payments to clinicians and organizations • Some Medicare-Medicaid (duals) plan payments to clinicians and organizations
Medicaid	Varies by state	• Primary Care Case Management • Some managed care models	• Integrated care models under fee for service • Managed fee-for-service models for Medicare-Medicaid beneficiaries • Medicaid Health Homes • Medicaid shared savings models	• Some Medicaid managed care plan payments to clinicians and organizations • Some Medicare-Medicaid (duals) plan payments to clinicians and organizations

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Rajkumar R, Conway PH, Tavenner M. The CMS—Engaging Multiple Payers in Risk-Sharing Models. JAMA. Doi:10.1001/jama.2014.3703

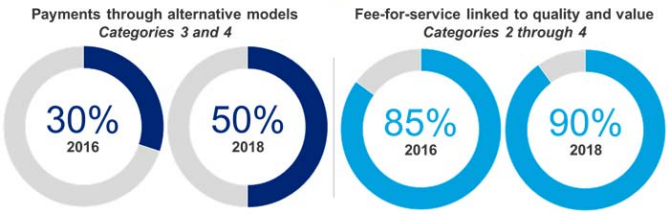
Alternate Payment Model Journey



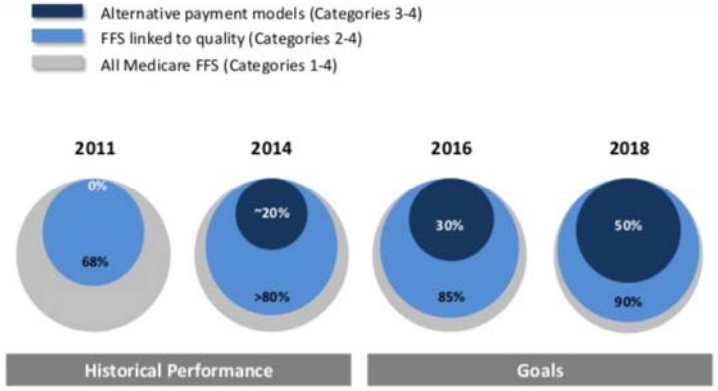
Coding	Valuation	Payment Models	MIPS & MACRA
AMA CPT Current Procedural Terminology	**AMA RUC** Relative Value Scale (RVS) Update Committee	**CMS / CMMI** Healthcare Payment Modeling & Improvement	**Future Alternate Payment Models (APM)** Value-Based Payment FFS & APM
Product or Service	RUC Valuation Analysis or Market Valued	Healthcare Reform a) Market & Exchange b) Payment Models c) Quality & Safety Improvement	Physician-Focused Technical Advisory Committee

HHS Goals

Alternate Payment Models (APM) & Fee-For-Service (FFS)



Target percentage of payments in 'FFS linked to quality' and 'alternative payment models' by 2016 and 2018



Potential value-based financial rewards

- APMs—and eligible APMs in particular—offer greater **potential risks and rewards** than MIPS.
- **In addition** to those potential rewards, MACRA provides a bonus payment to providers committed to operating under the most advanced APMs.

MIPS only	APMs	eligible APMs
MIPS adjustments	APM-specific rewards + MIPS adjustments	eligible APM-specific rewards + 5% lump sum bonus

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MACRA is part of a broader push towards value and quality

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

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Independent PFPM Technical Advisory Committee

PFPM = Physician-Focused Payment Model

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

Submission of model proposals

Technical Advisory Committee (11 appointed care delivery experts)

Secretary comments on CMS website, CMS considers testing proposed model

Review proposals, submit recommendations to HHS Secretary

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Opportunities for Integration Into CMS & CMMI Initiatives

CPC Comprehensive Primary Care

HEN 2.0

TCPi

A GUIDE TO PHYSICIAN-FOCUSED ALTERNATIVE PAYMENT MODELS

Hospital Engagement Networks (HEN)

Transforming Clinical Practice Initiative (TCPI)

Alternate Payment Models (APM)