The Influence of Health Policy on Clinical Practice

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Editor & Author: Integration of Palliative Care in Chronic Conditions: An interdisciplinary Approach
Objectives:

- Provide a brief overview on the new era of value and quality measures and provider transparency
- Describe how nursing advocacy can be used to inform and engage legislators to make practice change
- Review examples of nursing and legislative collaboration used to improve patient care outcomes
- Discuss current initiatives and opportunities for integrating policy into evidence based practice
Federal Health Policy

Health Policy Directs:

- **Clinical Practice**
- **Evidence Based Practice Guidelines**
- **Reimbursement Criteria**
- **Research Focus and Funding**
- **Optimal Patient Outcomes**
  - **Standard of Care**
  - **State Medicaid**
Test Your Knowledge

How Old is the Affordable Care Act?
Affordable Care Act

The Patient Protection and Affordable Care Act of 2010

111TH CONGRESS
2d Session

COMPILATION OF PATIENT PROTECTION AND AFFORDABLE CARE ACT HEALTH-RELATED PORTIONS OF THE HEALTH CARE AND EDUCATION RECONCILIATION ACT OF 2010

PREPARED BY THE Office of the Legislative Counsel FOR THE USE OF THE U.S. HOUSE OF REPRESENTATIVES

MAY 2010
Medicaid Expansion

A central goal of the Affordable Care Act (ACA) is to significantly reduce the number of uninsured by providing a continuum of affordable coverage options through Medicaid and the Health Insurance Marketplaces.

The ACA expands Medicaid coverage for most low-income adults to 138% of the federal poverty level – State specific criteria.
Test Your Knowledge

How many states aligned with the Federal Government in Medicaid Expansion?
Medicaid Expansion

- 32 states are participating
- 19 States are not currently adopting Medicaid Expansion

Following the June 2012 Supreme Court decision, states face a decision about whether to adopt the Medicaid expansion.

Under CMS guidance, there is no deadline for states to implement the Medicaid expansion.
Current Status of State Medicaid Expansion Decisions

NOTES: Current status for each state is based on KCMU tracking and analysis of state executive activity. *AR, IA, IN, MI, MT, and NH have approved Section 1115 waivers. WI covers adults up to 100% FPL in Medicaid, but did not adopt the ACA expansion.
Test Your Knowledge

HOW MANY AGENCIES ARE THERE UNDER THE US DEPARTMENT OF HEALTH AND HUMAN SERVICES?
US Department of Health & Human Services

Eleven Operating Divisions

Drive Health Care Practices in the US
Directly Influenced by the Affordable Care Act
US Department of Health & Human Services

• Administration for Children and Families (ACF)
• Administration for Community Living (ACL)
• Agency for Health, Research and Quality (AHRQ)
• Agency for Toxic Substances and Disease Registry (ATSDR)
• Centers for Disease Control and Prevention (CDC)
• Centers for Medicare and Medicaid Services (CMS)
US Department of Health & Human Services

• Food and Drug Administration (FDA)
• Health Resources and Services Administration (HRSA)
• Indian Health Service (HIS)
• National Institutes of Health (NIH)
• Substance Abuse and Mental Health Services Administration (SAMHSA)
US Department of Health & Human Services

11 operating divisions, that include 8 agencies in the US Public Health Services – and 3 human services agencies
These divisions administer a wide variety of health and human services and conduct life-saving research for the nation, protecting and serving all Americans.
Test Your Knowledge

Who is the Secretary of the US Department of HHS?
Test Your Knowledge

Who is the US Department of Health & Human Services Acting Deputy Secretary?
Test Your Knowledge

What are the Three Tenets or the Triple Aim of the Affordable Care Act?
Tenets of the Affordable Care Act

US Department of Health & Human Services

Triple Aim for Health Policy Changes

• **BETTER CARE**
• **BETTER HEALTH**
• **LOWER COSTS**
Test Your Knowledge

How Many Titles are there in the Affordable Care Act?
Affordable Care Act Titles

10 Specific Titles that Drive Change in US Health Care

1. Quality Affordable Health Care for all Americans
2. Role of Public Programs
3. Improving Quality and Efficiency of Health Care
4. Prevention of Chronic Disease and Improving Public Health
Affordable Care Act Titles

5. Health Care Work Force
6. Transparency and Program Integrity
7. Improving Access to Innovative Medical Therapies
8. Community Living Assistance Services and Supports Act (CLASS Act)
9. Revenue Provision
10. Re-authorization of the Indian Health Care Improvement Act
Test Your Knowledge

What Federal agencies have been developed through the Affordable Care Act?
Centers for Medicare & Medicaid Innovation

The Center for Medicare and Medicaid Innovation (CMMI) Center was established by section 1115A of the Social Security Act (as added by section 3021 of the Affordable Care Act).

Congress created the Innovation Center for the purpose of testing “innovative payment and service delivery models to reduce program expenditures ...while preserving or enhancing the quality of care” for those individuals who receive Medicare and Medicaid...

US Department of HHS, 2014
Centers for Medicare and Medicaid Innovation

**Priorities**

- Testing new payment and service delivery models
- Evaluating results and advancing best practices
- Engaging a broad range of stakeholders to develop additional models for testing

US Department of HHS, 2014
Centers for Medicare & Medicaid Innovation

- From 2010 through 2013, the Innovation Center obligated approximately $1.8 billion.
- Cumulative obligations increased to $3.5 billion by the end of 2014 and to nearly $5 billion by the end of 2015 as the portfolio of models being tested continued to expand.
- In 2014 and 2015, roughly 93 percent of spending is on specific models and initiatives.

US Department of Health and Human Services, 2016
Centers for Medicare & Medicaid Innovation

Categories for Funding Include:

• Accountable Care Organizations
• Episode Based Payment Initiatives
• Primary Care Transformation
• Initiatives Focused on Medicaid & CHIP Populations
• Initiatives Focused on the Medicare-Medicaid Enrollees
Centers for Medicare & Medicaid Innovation

- Initiatives to Accelerate the Development & testing of New Payment and Service Delivery Models
- Initiatives for Speed the Adoption of Best Practices
Patient Centered Outcomes Research Institute

Patient-Centered-Outcomes Research Institute (PCORI)

2010 ACA funded to generate patient-centered outcomes research through comparative effectiveness research
Real world, real time and where the rubber hits the road
Clinical Outcomes that are Important to the Patient and Caregiver
Patient Centered Outcomes Research Institute

Extending the concept of patient-centeredness from health care delivery to health care research

PCORI IS HOME TO COMPARATIVE EFFECTIVENESS RESEARCH
Comparative Effectiveness Research

U.S Health Economics and Outcomes Research

- National Institutes of Health
- Agency for Health Care Research and Quality
- Food and Drug Administration
- Centers for Medicare and Medicaid
- Veterans Affairs
- Academics
Comparative Effectiveness Research

CER is the generation and synthesis of evidence that compares the benefits and harms of alternative methods to prevent, diagnose, treat and monitor a clinical condition, or to improve the delivery of care.
Comparative Effectiveness Research

The purpose of CER is to assist consumers, clinicians, purchasers, and policy makers to make informed decisions that will improve health care at both the individual and population level.

Institutes of Medicine, 2009
Comparative Effectiveness Research

A analytical learning process to assist real world decision-making.

Lives on the boundary of evidence development and evidence synthesis.

It is not experimental or observational.
Comparative Effectiveness Research

Patient-centered outcomes research institute

Heterogeneity is a focus (individualized care)

Conduct real-time review of study relevance

IT IS HEADED YOUR WAY!!!! Faster than you think...
Evolution

• 1970’s – Today: Health Assessment Technology
• 1980’s – Effectiveness Research
• 1990’s – Outcomes Research
• 2000’s - Evidence Based Practice
• 2010’s - Comparative Effectiveness Research
• TODAY:

*Patient-Centered Outcomes Research*

*Incentive Payment for Outcomes*
Secretary Burwell - January 2015

• This is the first time in the history of the Medicare program when US Dept. of HHS set explicit goals for alternative payment models and value-based payments

• President Obama’s creation of the Health Care Payment Learning and Action Network

• Together with HHS working with private payers, employers, consumers, providers, states and state Medicaid programs, to expand alternative payment models into their programs
HEALTH CARE PAYMENT AND LEARNING ACTION NETWORK (HCPLAN)

ALTERNATIVE PAYMENT MODELS (APM) FRAMEWORK

Alternative Payment Model Framework and Progress Tracking (APM FPT) Work Group
VALUE VS. VOLUME

Incentive Health Outcomes and Value over Volume

30% of fee-for-service reimbursement in APMs end of 2016

50-80% APM reimbursement end of 2018
Value vs. Volume

Reward Providers who implement patient-centered care and patient responsive delivery systems
Patient - Centered Outcomes

Health Care Payment and Learning Action Network define patient-centered care as:

“High quality care that is delivered in an efficient manner where the patient’s or consumers informed choices, values, priorities and individual circumstances are paramount.”
Patient - Centered Outcomes

• Quality Care through the use of evidence-based practice guidelines
• Cost Effectiveness to include social determinants
• Patient Engagement and shared decision making
Transition to Practice Change

• Moving away from anecdotal practice and volume vs. value

• Moving away from fee-for-service to population based payments
Health Care Payment & Learning Action Network White Paper

- White paper serves as a framework – for value and quality metrics for reimbursement
- Four Priorities
- Self Management – patient engagement and accountability
1. Fee-for-service that is not linked to quality – phasing out
2. Fee-for-service that is linked to quality, portion of payment reimbursed vary based on quality and efficiency
3. Alternative Payment Models – in the form of: 
Accountable Care Organization (ACO), Medical Home Models, and Bundled Services

4. Population Based Payment – volume not linked to payment. Providers and organizations reimbursed on care provided a beneficiary longer than one year
Value - Based Incentives

• Value-based incentives will reach providers delivery quality patient-centered care

• Payment models that do not take quality and value into account will be classified in the “inappropriate” category – if not value based excluded from tracking purposes and not reimbursed
Value - Based Incentives

• Provider risk and reward – will risk a percentage of reimbursement to support the global population

• Centers of Excellence – ACOs and Medical Home Models of care will accommodate wide variety associated with risk-sharing payment models
Value - Based Incentives

HCPLAN believe the new reimbursement models of care will demonstrate sustainability, drive care coordination and delivery improvements – enabling advanced payment models.
Test Your Knowledge

What is meant by MACRA Legislation?
MACRA Legislation

• April 27th, 2016 executive notice by the US Department of Health and Human Services issued key provisions to the Medicare Access and Summary CHIP Reauthorization Act of 2015, (MACRA).

• MACRA replaced the 1997 Sustainable Growth Rate formula for determining Medicare reimbursement. MACRA provides a new approach in Medicare reimbursement based on value and quality care.
MACRA Legislation

- MACRA legislation is guided by the Quality Payment Program, directing two paths for Medicare reimbursement:
  - The Merit-based Incentive Payment System (MIPS), or the Advanced Alternative Payment Model (APM).
  - Nurse Practitioners, require knowledge and information to prepare for MIPS and APM to begin January 1, 2017.
MACRA Legislation

• The reimbursement tracks provide incentives when providers, practices, organizations or health systems demonstrate and meet or exceed the quality and value metrics uniquely determined by type of practice and patient care population served.

• MACRA, changes the manner in which Medicare will reward providers for value over volume.
MACRA Legislation

MACRA provides incentive payment for providers through MIPS and bonus payment for provider participation in eligible APMs
MACRA Legislation

MIPPS, will replace the current Medicare measures used to determine quality and value:

• The Physicians Quality Reporting System (PQRS),
• Value Modifier Program (VM) and the;
• Medicare Electronic Health Record (EHR) Incentive Program’s or Meaningful Use will be grouped together under MIPPS
MACRA Legislation

Congress streamlined and improved upon these individualized programs into one merit-based incentive payment.

CMS suggests most Medicare providers (physicians, nurse practitioners, physician assistants and certified registered nurse anesthetists) will participate in the quality payment program through MIPPS
MACRA Legislation

• Prior to this new incentive approach, providers have been required to embed a minimum of 9 quality measures into a CMS certified meaningful use EHR.

• MIPS requires 6 measures and allows providers flexibility by choosing measures and activities that are appropriated by the care they provide.
MACRA Legislation Quality Measures

• Providers will continue to utilize the core measures from the National Quality Forum (NQF) by selecting from over 300 NQF endorsed measures

• The NQF offers a portfolio of performance measures that provide the measures used to quantify health care processes, patient-centered outcomes, evaluate patient satisfaction and organizational or systems responsible for high-quality care
MACRA Legislation - MIPPS

MIPPS ensures Medicare providers care is incentivized for quality, efficient care:

*Quality Performance* – this category replaces PQRS and VM, and responsible for 50% weight in the first year. Emphasis is on outcome measurements (6 measures in the certified CMS meaningful use EHR);
MACRA Legislation - MIPPS

*Advancing Care Information* – this category supports the use of patient engagement, medication safety, patient access to EHR etc., and accounts for 25% of weight in the first year. The weight of this category may decrease as more providers and practices adopt EHR use.
MACRA Legislation - MIPPS

*Clinical Practice Improvement* – providers can select from over 90 proposed activities such as self-management, shared decision making, care coordination, patient safety checklists etc. This category accounts for 15% weight in the first year.
**Resource Use**, CMS calculates the weight of this category based upon claims data and accounts for 10% in the first year. This category replaces the VM
MACRA Legislation - MIPPS

• A composite total of MIPS performance categories is aligned to a performance period of one full calendar year beginning the first of 2017

• The composite MIPS score will be used from individual providers and practices to determine, 2019 payment year

• MIPS data will identify if the provider or practice meets the national threshold and, if above or below, will determine penalty or incentive payment in 2019
MACRA Legislation APMs

APMs primarily include innovation care models funded and awarded by the CMS Innovation Center (CMMI), Medicare Shared Savings Program and/or any demonstration under the Health Care Quality Demonstration Program, or federally funded demonstrations.
MACRA Legislation – APMs

Under MACRA legislation the APM requires providers and participants to:

• utilize a certified EHR (minimum requirement of 50% use of EHR between providers);

• payment is based on quality measures similar to MIPS quality performance category. There is no set number of measures, APMs are however, required to report at least one outcome measure;
MACRA Legislation - APMs

- Identify the ability to take on financial risk for monetary losses, if not meeting quality measures, or is identified as a Medical Home Model defined by CMMI
- Medical home models that have not expanded by CMMI criteria, will be responsible for alternate financial and risk benefit ratios
MACRA Legislation - APMs

CMS, has agreed to annually evaluate and partner with innovative APMs that meet criteria and undergo evaluation by the US Department of Health and Human Services, Technical Advisory Committee appointees (11 members).
MACRA Legislation - APMs

- Shared Savings Program
- Accountable Care Organization (ACO) Next Generation Model
- Comprehensive End Stage Renal Disease Care
- Comprehensive Primary Care
- Oncology Care Model
MIPPS Enactment: Nurse Practitioners!

• All Medicare Part B providers will report to MIPS beginning, January 1, 2017 through December 31, 2017.

• Calendar year 2018, will allow CMS to collect, correlate and develop incentive criteria based upon the generated 4 categories.

• Providers who are new to Medicare Part B, or, who have billed less than or equal to $10,000 will not be eligible for MIPS
CMS is considering a delay in Physician participation in MACRA beginning January, 2017.

US Department of HHS he will finalize this potential change in their November rule
The final MACRA regulation will exempt physicians from any risk of penalties if they choose one of three distinct MIPS reporting options in 2017, in addition to the option of participating in an advanced APM:

- Full-year reporting that begins on January 1;
- Partial year reporting for a reduced number of days; and
- A "test" option under which physicians can report minimal amounts of data.
What Does This All Mean?

- 7 years of massive spending and innovation
- MACRA legislation replaced the 1997 Sustainable Growth
- Better Care, Smarter Spending, and Healthier People
- Paying Providers for Value, Not Volume
- Reward value and care coordination – rather than volume and care duplication
- Reimbursed for patient-centered-outcomes through the use of evidence
Agency for Health Research and Quality

- Standard of Clinical Care
- Evidence Based Practice Guidelines
- Multiple Chronic Conditions Initiatives
- Shared Decision Making
- Self Management
- Literacy Tool Kit
- Team STEPPS for Patient Safety
- Patient Engagement
Self Reflection and Your Role in Health Policy

• WHO ARE YOU?
• Where have you been?
• What is important and timely?
• Where are you going?
• Are you an expert?
• How do you talk the language?
Self-Reflection

• How do you become a collaborative partner in the development and implementation of health policy?

• Are you informed on the issues?
Self-Reflection

• What is happening locally, state and national on important issues?

• Why is this important to know?
Local Health Policy

• Directed by the State and Federal Government
• Public Health Programs
• Medicare, Medicaid
• Adult and Family Services
• Unique and Individual
• Lots of Opportunities!!
State Health Policy

- State Department of Community Health
- Programs and Initiatives of the Governor and Director of DCH
- State Medical Associations
- State Nurses Association
- Regulated by Federal Financing
Who Are Your Leaders?

Identify the Key Leaders in your community that you believe have power and influence
Who Are Your Leaders

- Who is your State Representatives?
- Who is your State Senator?
- Who is your Congressman?
- Who is your Federal Senator?
- What Bills are they involved with?
- What Committees are they on?
Who Are Your Leaders

• How do you communicate with them?
• What is your message?
• Who should you contact first?
• Where do you begin, local, state or federal?
• Are you ready?
Staying Current

• List Serves (HHS, CDC, AHRQ, HRSA, FDA, CMS etc),
• American Academy of Medicine (formally IOM)
• Medical Societies, Organizations, Associations
• National Academies Press
• Physician and Politics
Are you prepared?

• Professionally
• Personally
• Academically
• Clinically