Patient-Centered Primary Care COLLABORATIVE

MACRA, MIPS, APMs & CPC+:

What to Expect from All These Acronyms?!

Monthly National Briefing

April 26, 2016

Patient-Centered Primary Care COLLABORATIVE

ACP American College of Physicians
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MACRA is part of a broader, rapid push toward value and quality

January 2015: The Department of Health and Human Services announced **new goals** for **value-based payments** and **APMs in Medicare**

Medicare Part B/Fee-for-Service

Goal 1: 30% → 50%

30% of Medicare payments are tied to quality or value through **alternative payment models** by the end of 2016, and 50% by the end of 2018

Goal 2: 85% → 90%

85% of Medicare **fee-for-service payments** are tied to quality or value by the end of 2016, and 90% by the end of 2018

May 2015: HHS formed **Health Care Payment Learning & Action Network (LAN)** network of public and private stakeholders (including private payers, clinicians, and consumers) to collaboratively work toward substantially reforming the U.S. health care payment structure to incentivize quality, health outcomes, and value over volume.

March 2016: HHS announced that it had met the "**goal of tying 30 percent of Medicare payments to quality ahead of schedule"**

Source: www.hhs.gov/about/news/2016/03/03/hhs-reaches-goal-tying-30-percent-medicare-payments-quality-ahead-schedule.html

MACRA In a Nutshell

The **Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)** is a *bipartisan* legislation signed into law on April 16, 2015

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

Two pathways: MIPS versus APMs (2019)

MIPS

- MIPS adjusts traditional fee-for-service payments upward or downward based on new reporting program, integrating PQRS, Meaningful Use, and Value-Based Modifier
- **Measurement categories (composite score of 0-100):**
  - **Clinical quality**
  - **Meaningful use**
  - **Resource Use**
  - **Practice improvement**

APMs

- **Supported by their own payment rules, plus**
- **5% annual bonus FFS payments for physicians who get substantial revenue from *alternative payment models*** that
  - Involve upside and downside financial risk, e.g. ACOs or bundled payments
  - OR
  - PCMHs, if ↑ quality with ↓ or ↔ cost; ↓ cost with ↑ or ↔ quality (e.g., CPCI)

MIPS changes how Medicare links performance to payment

There are currently multiple individual **quality and value** programs for Medicare physicians and practitioners:

- Physician Quality Reporting Program **(PQRS)**
- Value-Based Payment Modifier
- Medicare EHR Incentive Program

MACRA streamlines those programs into **MIPS**:

- Merit-Based Incentive Payment System **(MIPS)**

Source: www.lansummit.org/wp-content/uploads/2015/09/4G-00Total.pdf

How Eligible Providers Scored For MIPS

MIPS Composite Performance Score in 2021

Factors in performance score in **4 weighted categories**

Quality
30%

Resource use
30%

Clinical practice improvement activities
15%

Meaningful use of certified EHR technology
25%

MIPS Composite Performance Score On the individual provider level 0 – 100 points

2019 Quality 50% & Resource Use 10%
2020 Quality 45% & Resource Use 15%

Clinical Practice Improvement Activities (CPIA) – Yes, Another New Acronym!

Must be established in collaboration with professionals

The Secretary must consider if they are attainable for small practices those in rural and underserved areas.

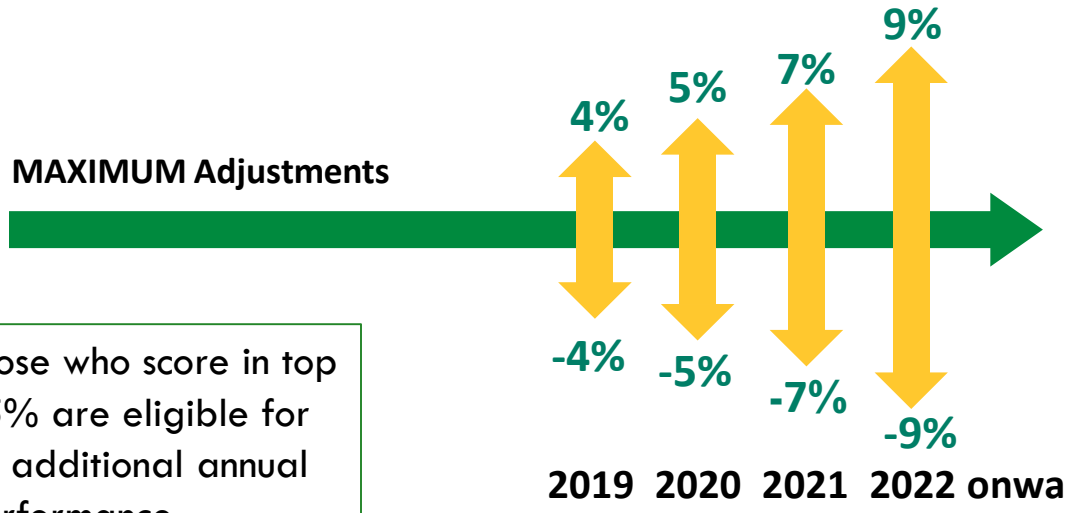
"Certified" PCMH and PCMH specialty practices receive highest potential score

Key questions (to be answered via rulemaking):

- How will these activities need to be reported/tracked? Need to ensure minimal burden but still push toward value.
- What will be the role of existing PCMH and PCMH specialty practice accreditation and recognition programs?
- Will CMS consider PCMH programs that are led by other payers, states, etc.?
- What about CPCi and CPC+ (for both CPIA in MIPS and for APMs)?

How Much Can MIPS Adjust Payments?

- Based on the MIPS **composite performance score**, physicians and practitioners will receive positive, negative, or neutral adjustments up to the percentages below.
- MIPS adjustments are **budget neutral**.



Adjustment to provider's base rate of Medicare Part B payment

Those who score in top 25% are eligible for an additional annual performance adjustment of up to 10%, 2019-24 (NOT budget neutral)

Merit-Based Incentive Payment System **(MIPS)**

Alternative Payment Models (APMs)

Initial definitions from MACRA law, APMs include:

- **CMS Innovation Center model** (under section 1115A, other than a Health Care Innovation Award)
- **MSSP** (Medicare Shared Savings Program)
- **Demonstration** under the Health Care Quality Demonstration Program
- **Demonstration** required by Federal Law

- MACRA **does not change how any particular APM rewards value**.
- **Base payment on quality** measures comparable to those in MIPS
- **Supported by their own payment rules "plus" a 5% annual bonus on FFS payments**
- Involve upside and downside financial risk OR be a ***PCMH*** (with some caveats)
- Over time, more APM options will become available (Physician-Focused Technical Advisory Committee).

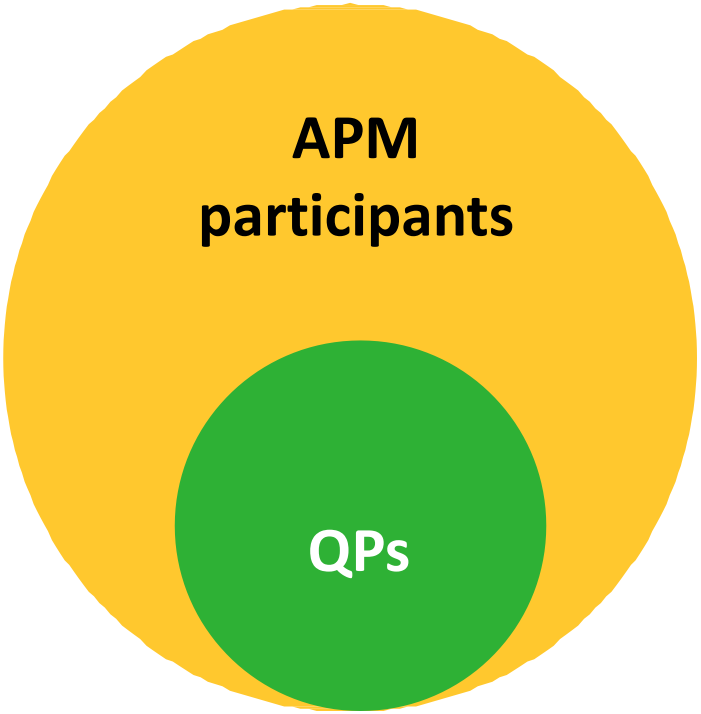
Two basic "screens" for APMs

Eligible APM:

- The **most advanced** APMs that meet the following criteria according to the MACRA law:
  - **Base payment on quality** measures comparable to those in MIPS
  - Require use of certified **EHR** technology
  - Either (1) bear more than nominal **financial risk** for monetary losses **OR** (2) be a **medical home model expanded** under CMMI authority

Qualifying APM participants (i.e., qualifying participants or QPs):

- Physicians and other clinicians who have a certain **% of their patients or payments** through an **eligible** APM



Independent PFPM Technical Advisory Committee

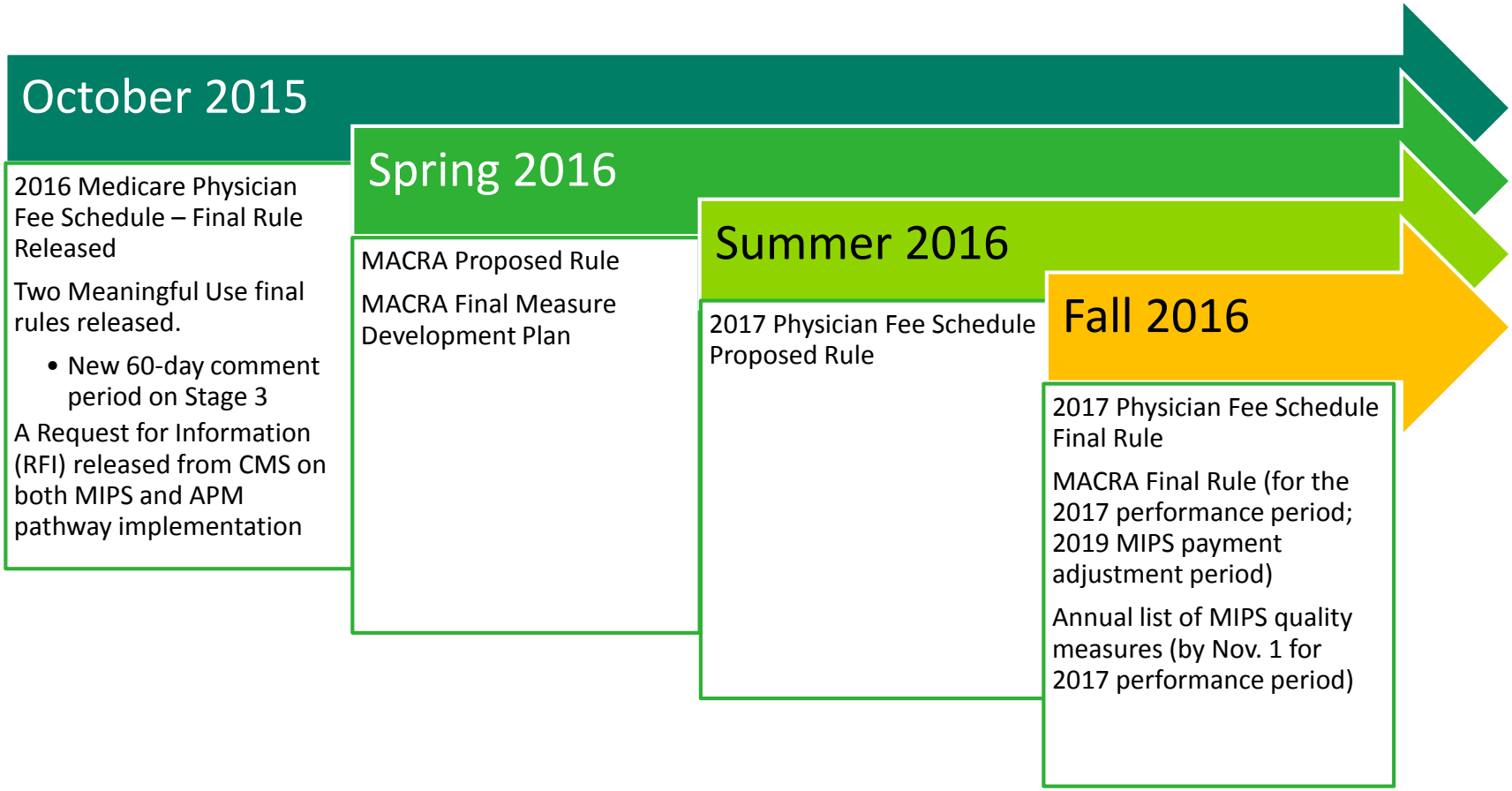
PFPM = Physician-Focused Payment Model

Encourage new **APM options** for Medicare physicians and other clinicians.

This group has been appointed by the GAO and held an introductory meeting on February 1, 2016 and second meeting will be May 4, 2016

(Source: www.gao.gov/press/appointments_hhs_advisory_committee_physician_payment_methods.htm)

MACRA Implementation Timeline



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Medicare's Transition to Value

Medicare Fee-for-Service

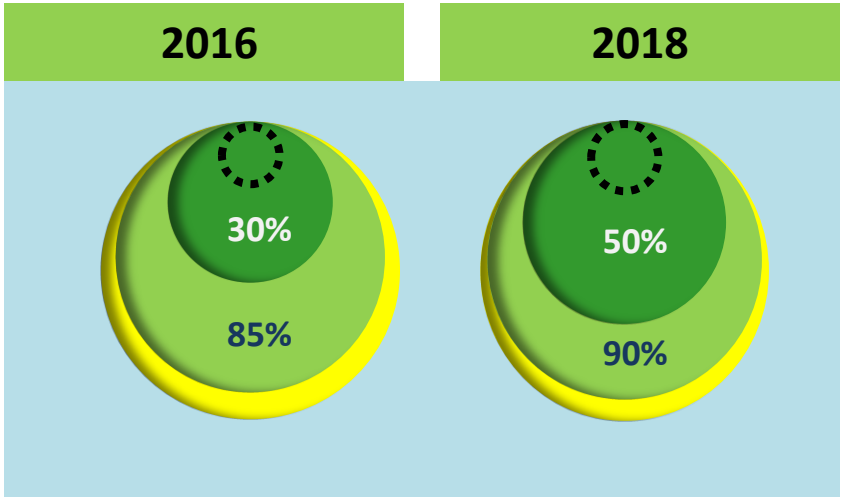
GOAL 1: 30%

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

Department of Health and Human Services Goals



All Medicare fee-for-service (FFS) payments (Categories 1-4)

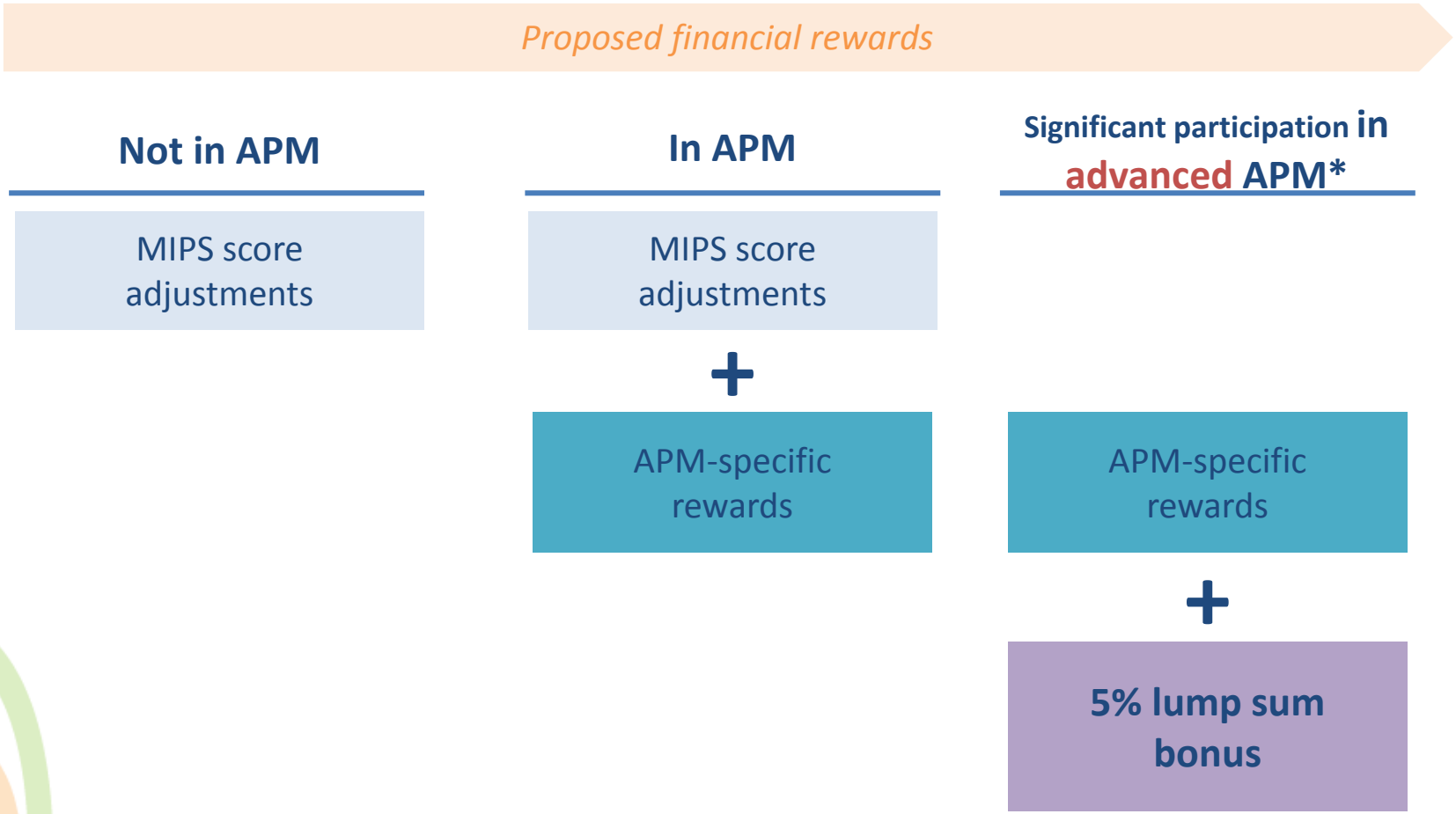
Medicare **FFS** payments **linked to quality and value** (Categories 2-4)

Medicare payments linked to quality and value via **APMs** (Categories 3-4)

Medicare payments to those in the most highly **"advanced APMs"**

Images not drawn to scale

Financial Rewards Under the Proposed Medicare Quality Payment Program



CPC+ a Proposed Advanced APM Under Special Rules for Medical Homes

Excerpts from Proposed Rule

TABLE 32: APM List Based on Proposed Criteria

APM and Abbreviation	Qualifies as a MIPS APM for APM Scoring Standard under II.E.3.h	Medical Home Model	Use of CEHRT Criterion	Quality Measures Criterion	Financial Risk Criterion	Advanced APM
Bundled Payment for Care Improvement Model 2 (BPCI)	NO	NO	NO	NO	YES	NO
Bundled Payment for Care Improvement Model 3 (BPCI)	NO	NO	NO	NO	YES	NO
Bundled Payment for Care Improvement Model 4 (BPCI)	NO	NO	NO	NO	YES	NO
Comprehensive Care for Joint Replacement (CJR)	NO	NO	NO	NO	YES	NO
Comprehensive ESRD Care (CEC) (LDO arrangement)	YES	NO	YES	YES	YES	YES
Comprehensive ESRD Care (CEC) (non- LDO arrangement)	YES	NO	YES	YES	NO	NO
Comprehensive Primary Care Plus (CPC Plus)	YES	YES	YES	YES	YES	YES
Frontier Community Health Integration Program (FCHIP)	NO	NO	NO	NO	NO	NO
Health Plan Innovation (HPI) - Medicare Advantage Value Based	NO	NO	NO	NO	NO	NO

Released 4/27/16; available at: https://s3.amazonaws.com/public-inspection.federalregister.gov/2016-10032.pdf

CPC+ a Proposed Advanced APM Under Special Rules for Medical Homes

Excerpts from Proposed Rule

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We believe that, given the unique financial risk and nominal amount standards we are proposing for Medical Home Models in this section below, it would be appropriate to impose size and composition limits for the Medical Home Models to which the unique standards would apply in order to ensure that the focus is on organizations with a limited capacity for bearing the same magnitude of financial risk as larger APM Entities do. We propose that beginning in the second QP Performance Period (proposed to be 2018), the Medical Home Model financial risk standard and nominal amount standard, described in section II.F.4.b.(4) of this preamble, would only apply to APM Entities that participate in Medical Home Models and that have 50 or fewer eligible clinicians in the organization through which the APM Entity is owned and operated. **Thus, in a Medical Home Model that is an Advanced APM, the proposed Medical Home Model financial risk and nominal amount standards would only apply to those APM Entities owned and operated by organizations with 50 or fewer eligible clinicians.** We believe it is appropriate to use eligible clinicians, rather than physicians, when setting this threshold as the number of eligible clinicians both reflects organizational resources and capacity and also may fluctuate widely around a specific number of physicians.

Released 4/27/16; available at: https://s3.amazonaws.com/public-inspection.federalregister.gov/2016-10032.pdf

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Questions?