Patient-Centered Primary Care COLLABORATIVE

Payment Reform, Medicare, & Primary Care – Why We Have to Care About MACRA & the Proposed Rule

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@Marci_PCPCC

Thursday
June 22, 2016

Objectives

- What IS MACRA?
- Why is it such a hot topic in health policy and advanced primary care?
- How did the PCPCC respond to the 962-page proposed rule that outlines its details?

WHAT IS MACRA?

MEDICARE ACCESS & CHIP REAUTHORIZATION ACT

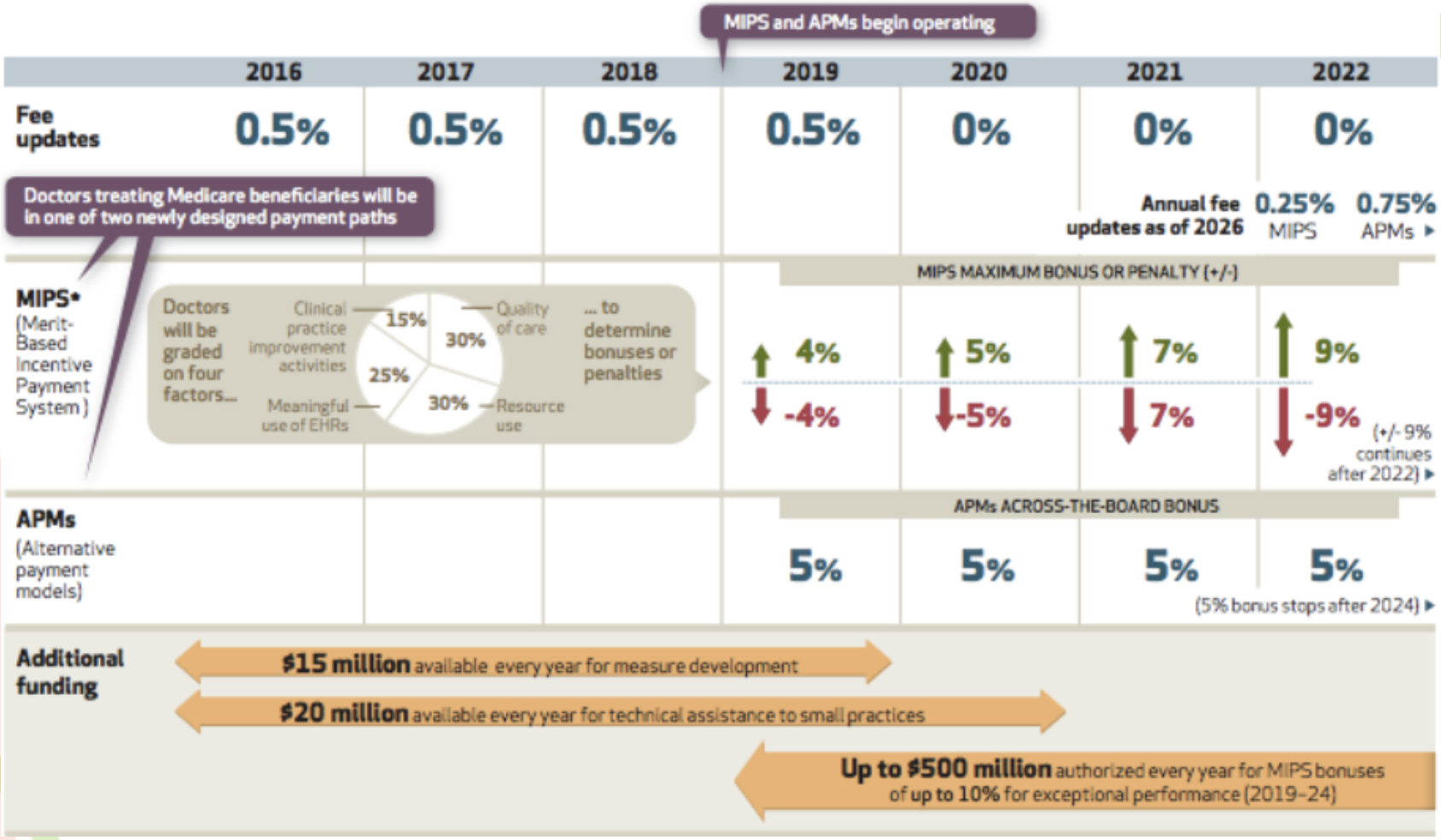
Quality Payment Program

- ✓ **Repeals** the Sustainable Growth Rate (SGR) Formula
- ✓ **Streamlines** multiple quality reporting programs into the new Merit-based Incentive Payment System (MIPS)
- ✓ **Provides incentive payments** for participation in **Advanced Alternative Payment Models (APMs)**

The Merit-based Incentive Payment System (MIPS) **or** **Advanced Alternative Payment Models (APMs)**

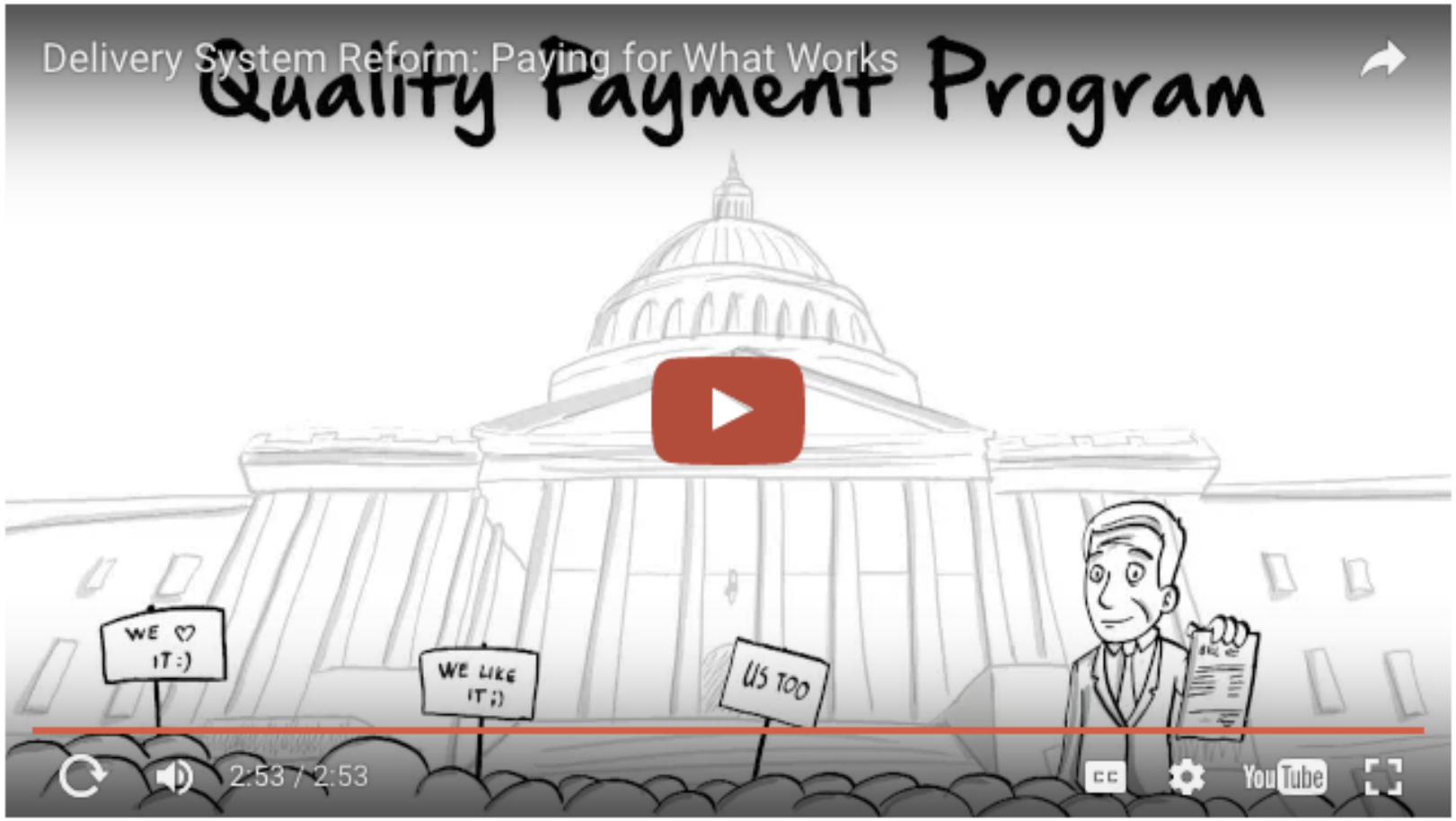
- ✓ **First step to a fresh start**
- ✓ **We're listening and help is available**
- ✓ **A better, smarter Medicare for healthier people**
- ✓ **Pay for what works to create a Medicare that is enduring**
- ✓ **Health information needs to be open, flexible, and user-centric**

MACRA IN ONE EASY SLIDE



SOURCE Author's analysis. NOTES EHR is electronic health record. CMS is Centers for Medicare and Medicaid Services. HHS is Department of Health and Human Services. GAO is Government Accountability Office. MedPAC is Medicare Payment Advisory Commission.

EXPLAINING MACRA TO REAL PEOPLE



http://www.hhs.gov/blog/2016/04/27/paying-what-works.html

CMS RESOURCES

- https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/Quality-Payment-Program.html
- Fantastic resource – descriptions, press releases, multiple slides, fact sheets, even widgets!

WHY IS IT SO IMPORTANT TO PRIMARY CARE?

"EACH SYSTEM PERFECTLY DESIGNED TO ACHIEVE RESULTS IT GETS"

Confronting a Changing Paradigm: The Evolution of Incentives for Providers

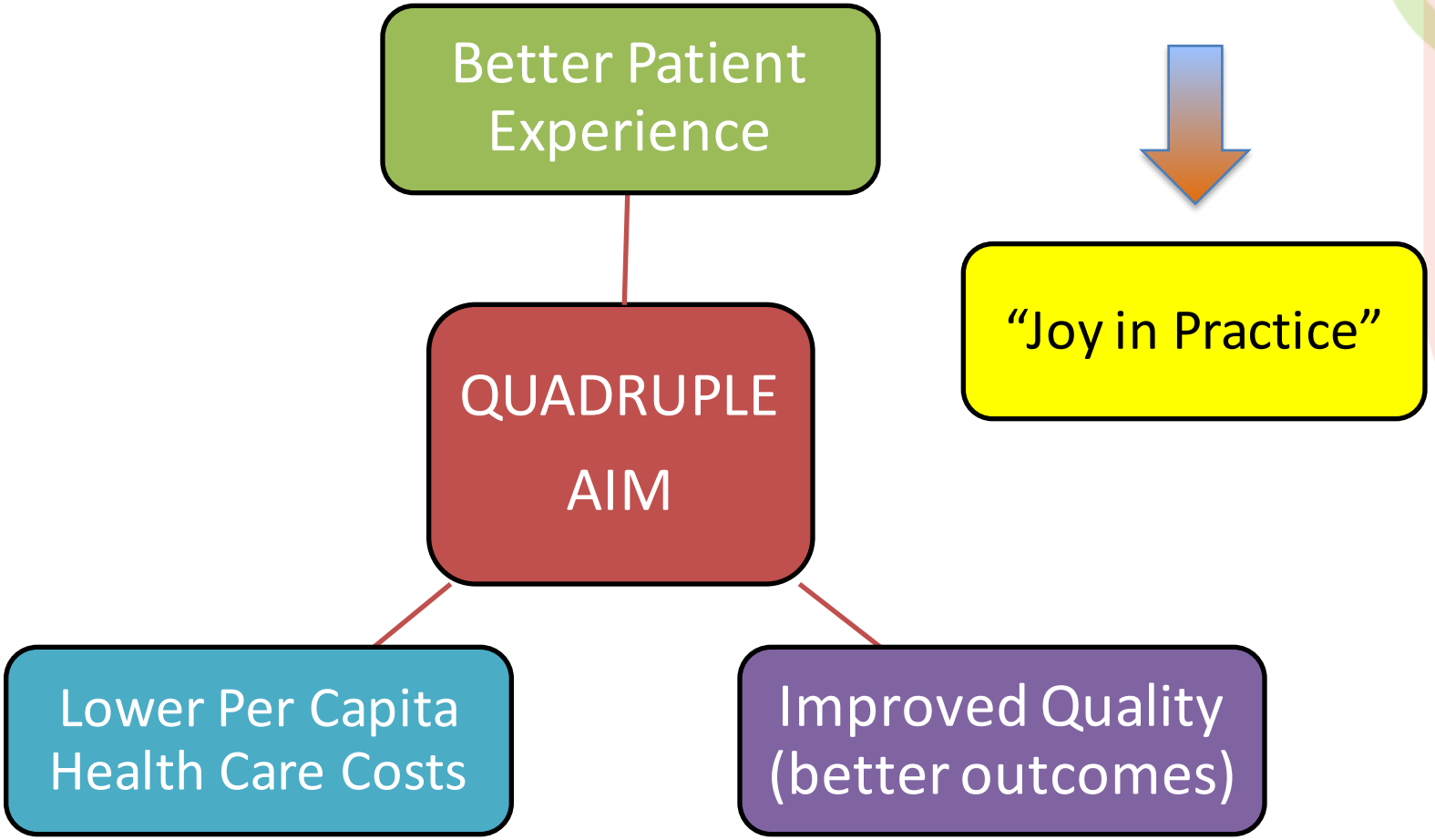
	Fee for Service	DRG/Quality Cost Incentives	Accountable Care
Patient Volume	▲	▲	▼
Length of Stay	▲	▼	▼
Ancillary Testing	▲	▼	▼
Health Care Environmental Paradigm	• System formation and expansion, market consolidation • Volume driven primary and specialty care	• Continued expansion • Emergence of quality and safety processes and metrics • Increased transparency on pricing and outcomes	The "Triple Aim" (Value) • Improve the experience of care • Improve the health of populations • Reduce the per capita costs of health care • Accept "integrator" role • Two-way risk sharing • Appropriate utilization

▲ UP
▼ DOWN

http://www.dartmouth-hitchcock.org/about_dh/new_reimbursement_models.html

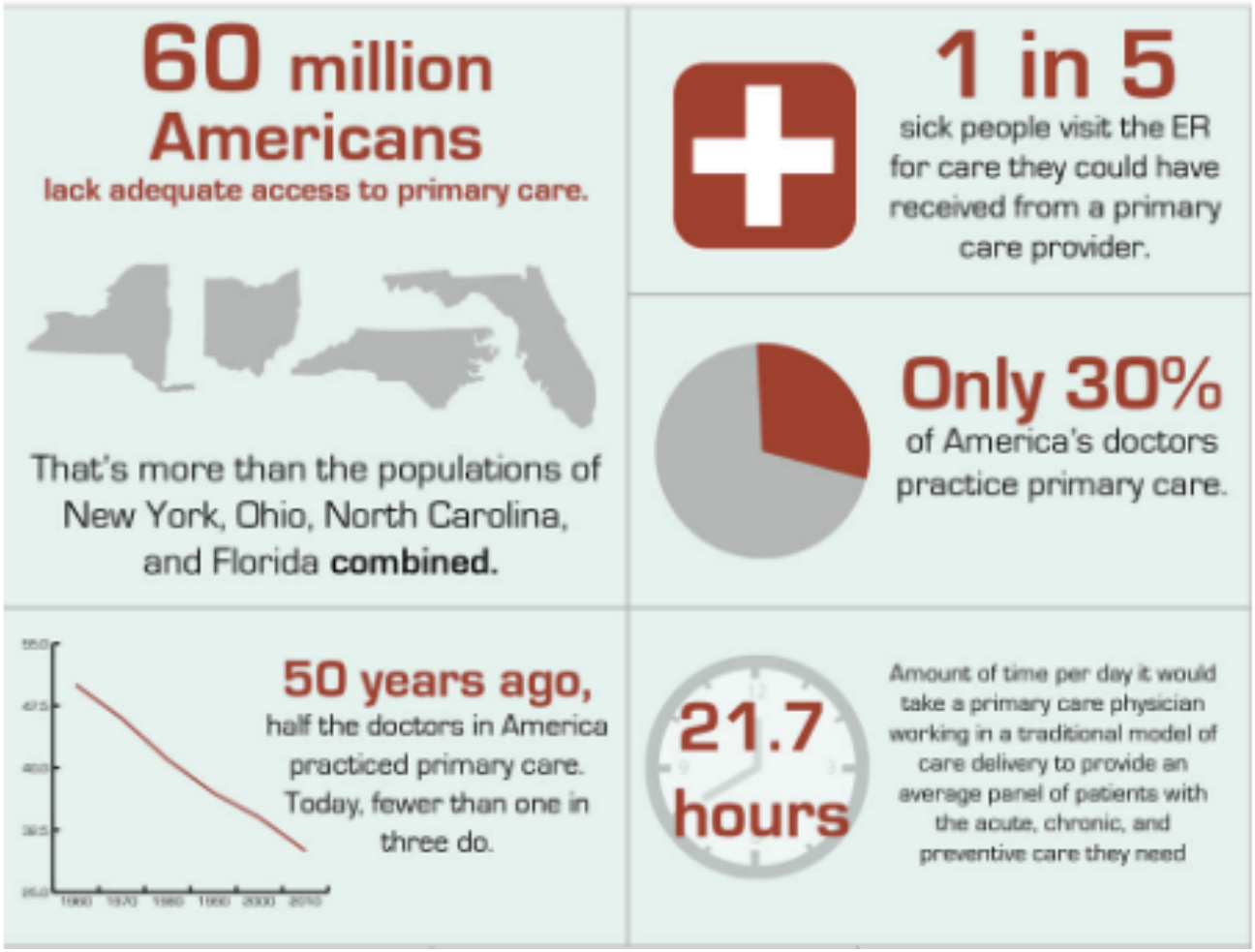
PRIMARY CARE LEADING THE WAY … BUT CAN WE?

"~~TRIPLE~~ AIM" "QUADRUPLE AIM"



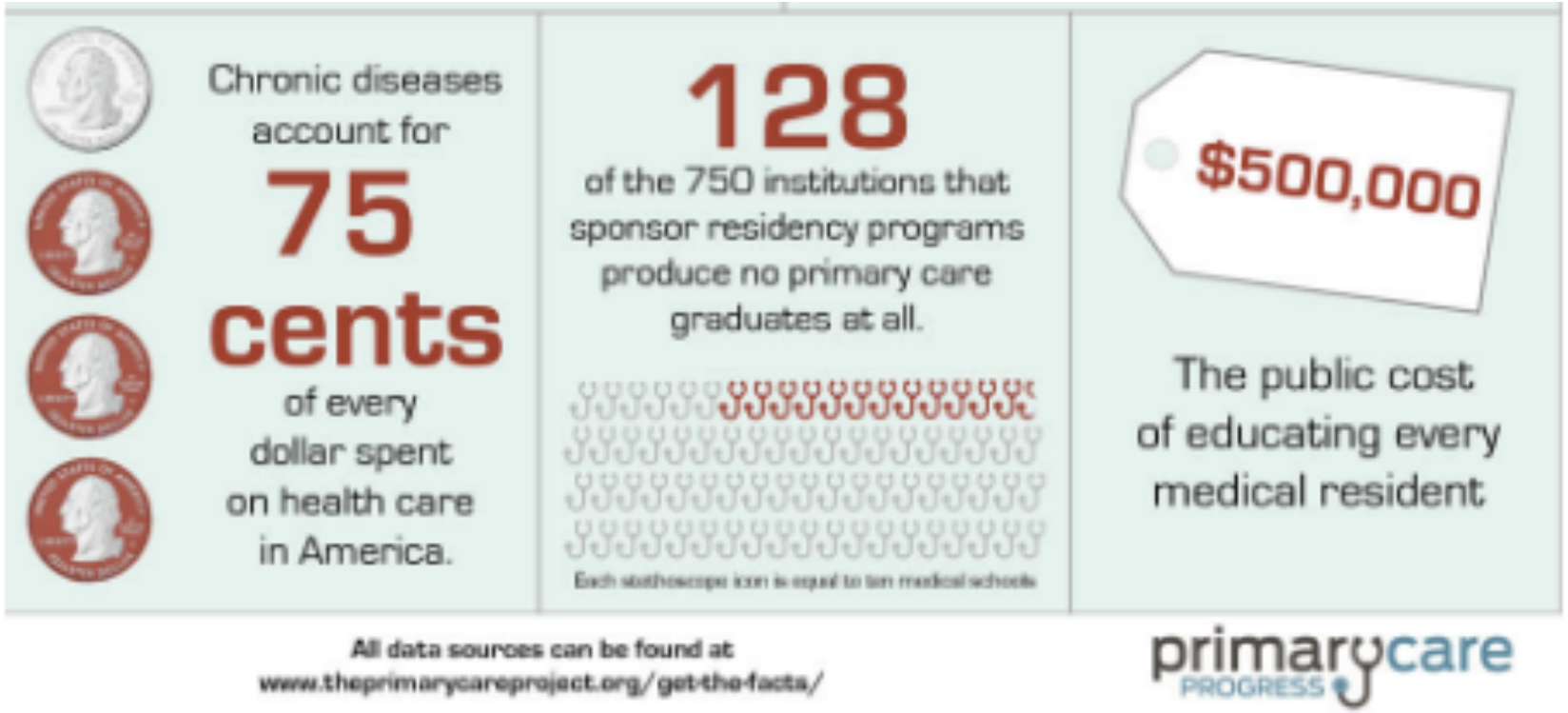
Source : Berwick, Donald M., Thomas W. Nolan, and John Whittington. "The triple aim: care, health, and cost." *Health Affairs* 27.3 (2008): 759-769.

PRIMARY CARE CHALLENGES



http://theprimarycareproject.org/get-the-facts/

AND MORE …



http://theprimarycareproject.org/get-the-facts/

IS HIGH-PERFORMING PRIMARY CARE THE SAME AS PCMH?

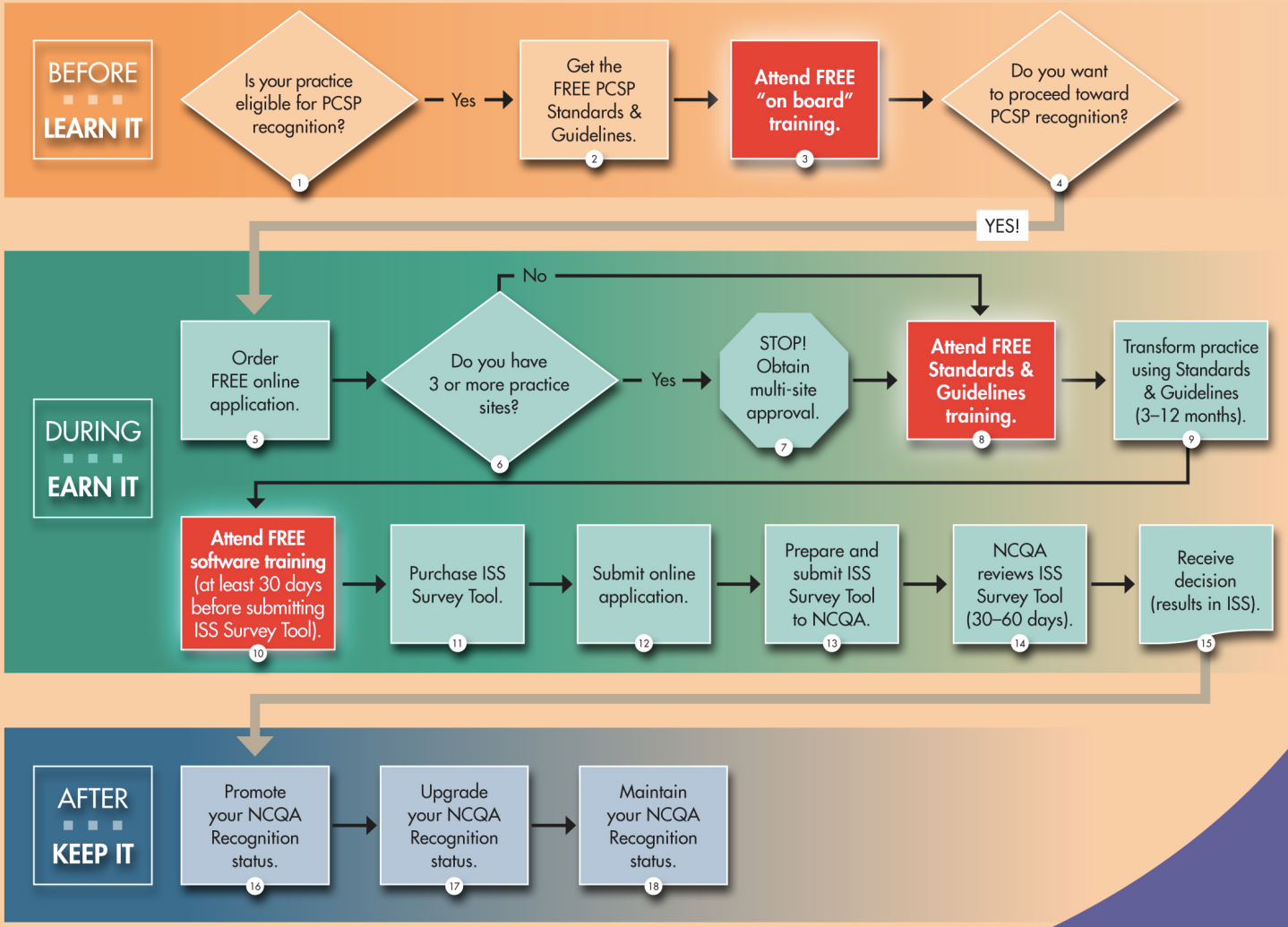
Is it a "Good Housekeeping" Seal of Approval for the Public?

Is it a quality improvement process for practices?

Is it a recognition or certification process for payers and purchasers?

Is it a payment model for government and/or commercial plans?

HOW MANY PROCESSES?

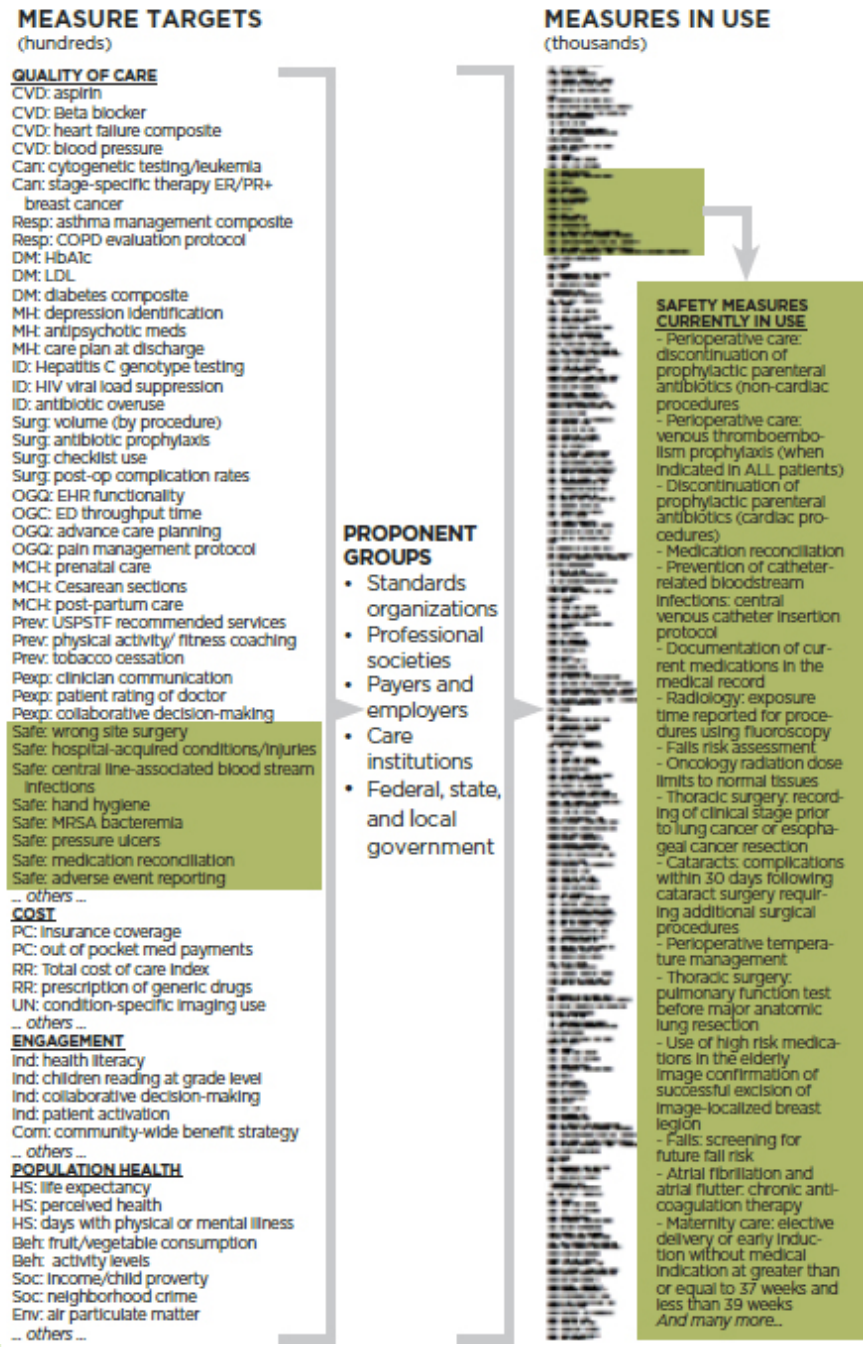


PCMH as a "certification"

- External validation
- "Short term" view of model
- Focused more on process measures
- Role in practice transformation & increased reimbursement
- Role in assessing value by payers

PCMH as ideal of practice transformation

- "North star" – aspirational guide
- "Long term" view of model
- Focused more on outcomes
- What's most important to patients, families, caregivers & consumers?



HOW MANY MEASURES?

Vital Signs:
Core Metrics
For Health and
Health Care
(2015)
Institute of Medicine

AND NOW …

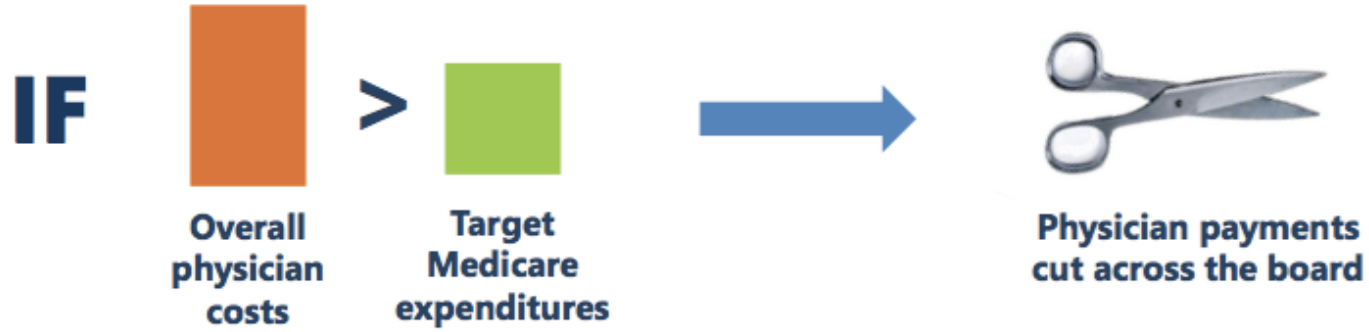
REMEMBER WHERE WE STARTED…

Medicare Payment Prior to MACRA

Fee-for-service (FFS) payment system, where clinicians are paid based on **volume** of services, not **value.**

The Sustainable Growth Rate (SGR)

- Established in 1997 to **control the cost of Medicare payments** to physicians



Each year, Congress passed temporary **"doc fixes"** to avert cuts (no fix in 2015 would have meant a **21% cut** in Medicare payments to clinicians)

…AND HOW WE GOT HERE

Medicare Payment Prior to MACRA

Fee-for-service (FFS) payment system, where clinicians are paid based on **volume** of services, not **value.**

The Sustainable Growth Rate (SGR)

Each year, Congress passed temporary **"doc fixes"** to avert cuts (no fix in 2015 would have meant a **21% cut** in Medicare payments to clinicians)

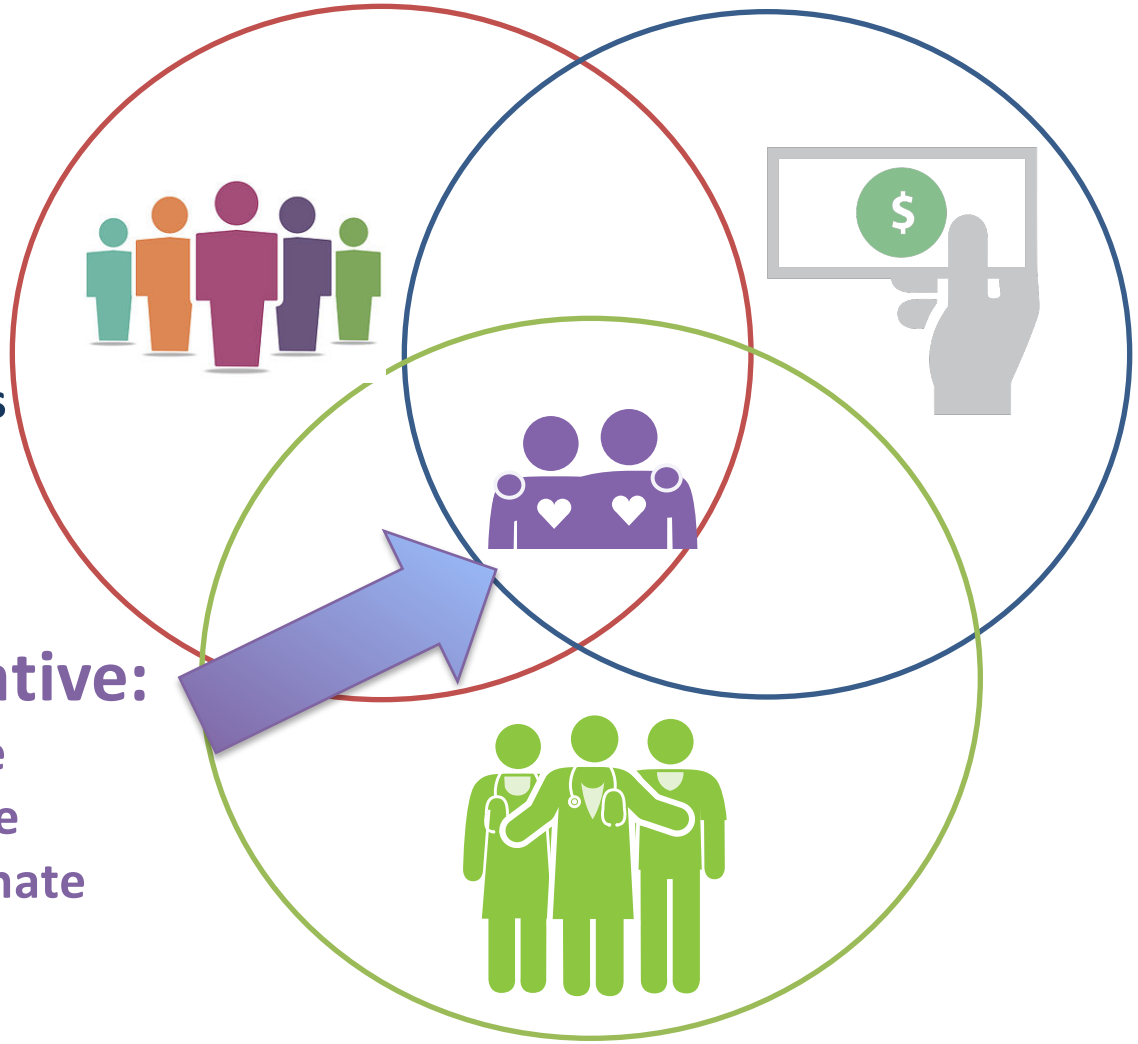
MACRA **replaces the SGR** with a **more predictable** payment method that **incentivizes value**.

HOW DID THE PCPCC RESPOND TO THE PROPOSED REG?

PATIENT-CENTERED PRIMARY CARE COLLABORATIVE

Unifying **for a better health system - by better investing in** ***team-based*** **patient-centered primary care**

PUBLIC:
Patients,
Families,
Caregivers,
Communities



PAYERS:
Employers,
Government,
Health plans,
Consumers

Collaborative:

- Convene
- Advocate
- Disseminate

HEALTH CARE PROVIDERS: People who take care of patients/families

PCPCC SUPPORTS PROVISIONS THAT:

- Acknowledge the key role of Patient-Centered Medical Homes in health system delivery reform
- Improve Quality Measurement and Reporting, to include Patient Reported Outcome Measures
- Advance the Comprehensive Primary Care Plus (CPC+) program as an Advanced Alternative Payment Model
- Promote New Categories within the Clinical Practice Improvement Activities (CPIA), including Achieving Health Equity and Integration of Behavioral and Mental Health
- Elevate the Physician-Focused Payment Model Technical Advisory Committee (PTAC) – *PCPCC requests PTAC work with CMS to track primary care spend*

PCPCC RECOMMENDS NEEDED IMPROVEMENTS TO:

- Revise the implementation timeline
- Expand recognition of patient-centered medical homes
- Streamline quality measurement by including a parsimonious unified set of quality measures from the Core Quality Measures Collaborative
- Acknowledge the challenges of solo and small practices and provide greater support for them
- Strengthen beneficiary engagement
- Provide multiple pathways for medical homes to qualify as advanced alternative payment models

MACRA: MIPS + APMS

Quality Payment Program

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The Merit-based Incentive Payment System (MIPS) **or** **Advanced Alternative Payment Models (APMs)**

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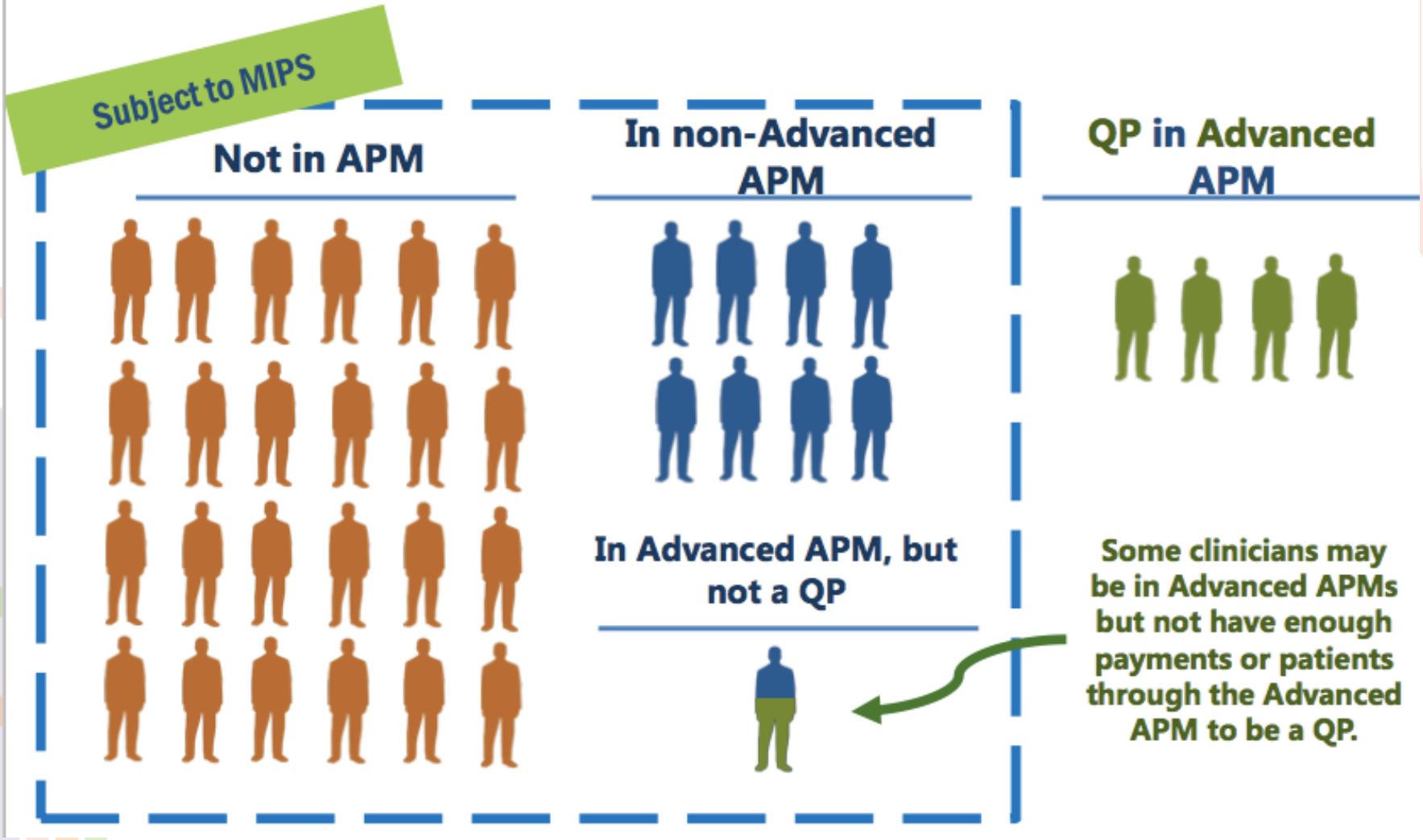
BACKGROUND ON MIPS:

Note: Most practitioners will be subject to MIPS.



MIPS: First Step to a Fresh Start

- ✓ **MIPS is a new program**
  - **Streamlines 3 currently independent programs to work as one and to ease clinician burden.**
  - **Adds a fourth component to promote ongoing improvement and innovation to clinical activities.**

Quality

Resource use

Clinical practice improvement activities

Advancing care information

- ✓ **MIPS provides clinicians the flexibility to choose the activities and measures that are most meaningful to their practice to demonstrate performance.**

Who Will Participate in MIPS?

Affected clinicians are called **"MIPS eligible clinicians"** and will participate in MIPS. The types of **Medicare Part B** eligible clinicians affected by MIPS may expand in future years.

Years 1 and 2

Physicians (MD/DO and DMD/DDS), PAs, NPs, Clinical nurse specialists, Certified registered nurse anesthetists

Years 3+

Secretary may broaden Eligible Clinicians group to include others such as

Physical or occupational therapists, Speech-language pathologists, Audiologists, Nurse midwives, Clinical social workers, Clinical psychologists, Dietitians / Nutritional professionals

Who will NOT Participate in MIPS?

There are 3 groups of clinicians who will NOT be subject to MIPS:

FIRST year of Medicare Part B participation

Below low patient volume threshold

Certain participants in ADVANCED Alternative Payment Models

↓

Medicare billing charges less than or equal to $10,000 and provides care for 100 or fewer Medicare patients in one year

Note: MIPS **does not** apply to hospitals or facilities

MIPS Performance Categories

A single MIPS composite performance **score** will factor in performance in **4 weighted performance categories on a 0-100 point scale**:

Quality

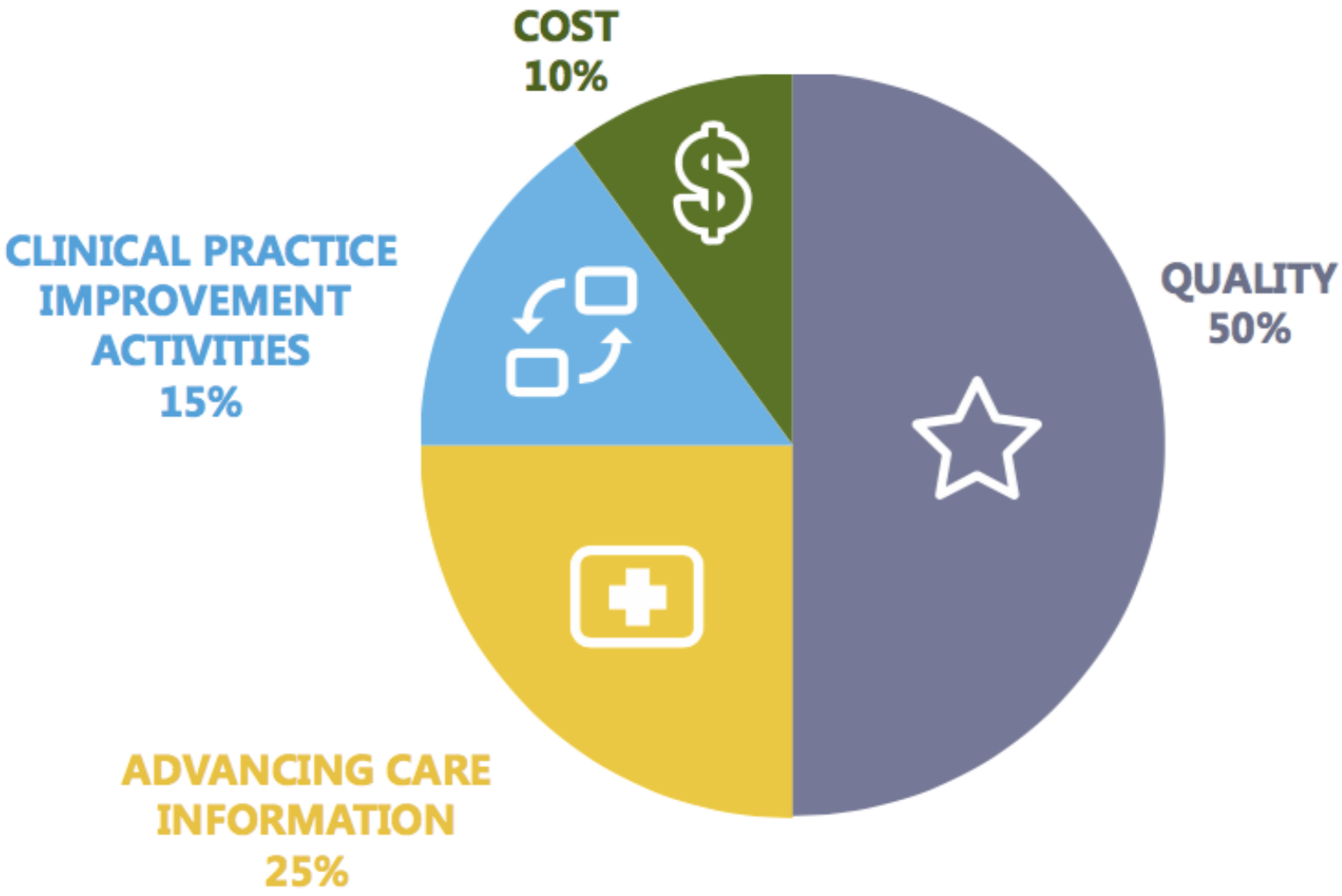
Resource use

Clinical practice improvement activities

Advancing care information

MIPS Composite Performance Score (CPS)

Year 1 Performance Category Weights for MIPS



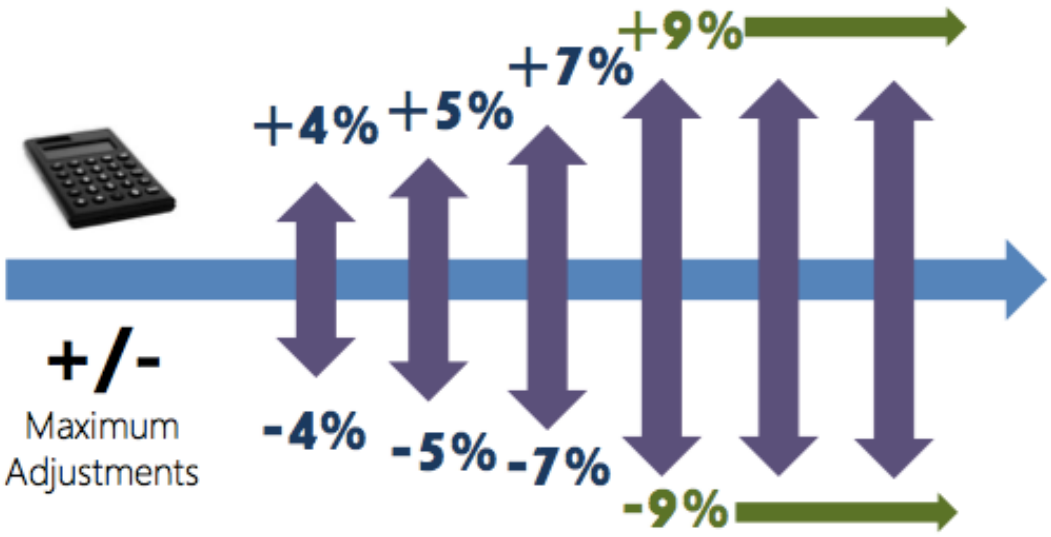
PROPOSED RULE

MIPS: Performance Category Scoring

Summary of MIPS Performance Categories			
	Performance Category	**Maximum Possible Points per Performance Category**	**Percentage of Overall MIPS Score (Performance Year 1 - 2017)**
	**Quality:** Clinicians choose six measures to report to CMS that best reflect their practice. One of these measures must be an outcome measure or a high-value measure and one must be a crosscutting measure. Clinicians also can choose to report a specialty measure set.	80 to 90 points depending on group size	50 percent
	**Advancing Care Information:** Clinicians will report key measures of patient engagement and information exchange. Clinicians are rewarded for their performance on measures that matter most to them.	100 points	25 percent
	**Clinical Practice Improvement Activities:** Clinicians can choose the activities best suited for their practice; the rule proposes over 90 activities from which to choose. Clinicians participating in medical homes earn "full credit" in this category, and those participating in Advanced APMs will earn at least half credit.	60 points	15 percent
	**Cost:** CMS will calculate these measures based on claims and availability of sufficient volume. Clinicians do not need to report anything.	Average score of all cost measures that can be attributed	10 percent

How much can MIPS adjust payments?

Based on a MIPS Composite Performance Score , clinicians will receive **+/- or neutral** adjustments **up to** the percentages below.



Adjusted Medicare Part B **payment** to clinician

2019 2020 2021 2022 onward

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

The potential maximum adjustment % will increase each year from 2019 to 2022

PROPOSED RULE
MIPS Timeline

2017	2018	July		2019	2020
Performance Period (Jan-Dec) 1st Feedback Report (July)	Reporting and Data Collection	2nd Feedback Report (July)	Targeted Review Based on 2017 MIPS Performance	MIPS Adjustments in Effect	

Analysis and Scoring

PROPOSED RULE

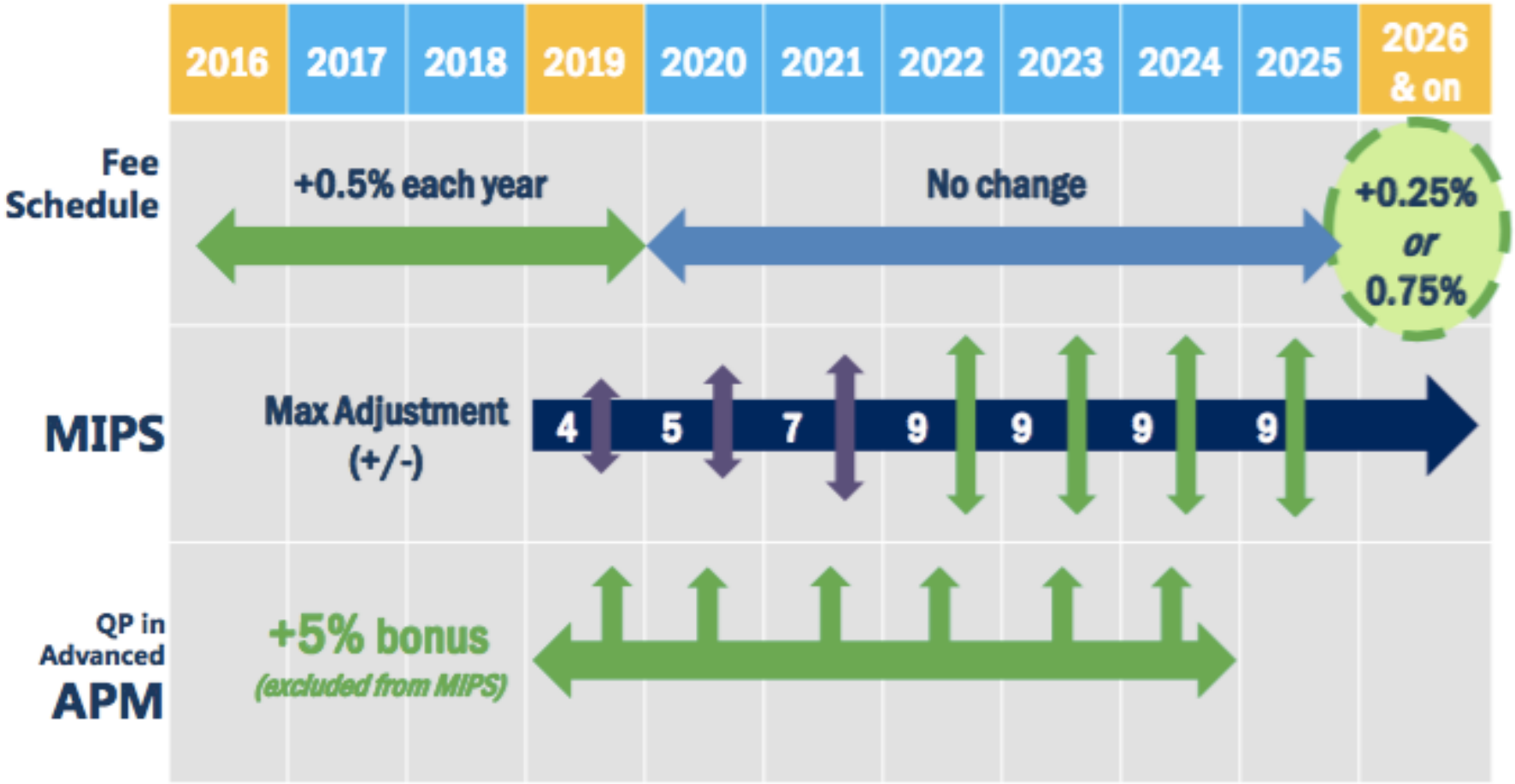
MIPS Performance Period

MIPS Performance Period (Begins 2017)

- ✓ **All MIPS performance categories are aligned to a performance period of one full calendar year.**
- ✓ **Goes into effect in first year (2017 performance period, 2019 payment year).**

2017	2018	2019	2020	2021	2022	2023	2024	2025
								
Performance Period		Payment Year						

Putting it all together:



REVISE THE IMPLEMENTATION TIMELINE

- The PCPCC is concerned that the proposed rule outlines an implementation timeframe that is too aggressive for many clinicians, especially solo and small practices.
- We urge CMS to start the initial period of assessment no earlier than July 1, 2017. While setting the performance period in 2018 is preferable, delaying it until at least July 1, 2017, will provide additional, much needed time for practices to prepare.

EXPAND RECOGNITION OF PATIENT-CENTERED MEDICAL HOMES

- We strongly recommend expansion beyond the four nationally recognized medical home programs outlined in the regulation, and we recommend that CMS broaden the definition of patient-centered medical home specifically to include programs that have a demonstrated track record of support by non-Medicare payers, state Medicaid programs, employers, or others in a region or state.
- The PCPCC also recommends that CMS closely review and adopt the recommendations of the PCPCC Accreditation Workgroup– a broad stakeholder group convened to assess the purpose of and improvements to current PCMH accreditation – to inform CMS criteria for certification (or recognition) of the patient-centered medical home.

PARSIMONIOUS UNIFIED SET OF QUALITY MEASURES FROM THE CORE QUALITY MEASURES COLLABORATIVE

- The PCPCC recommends that the proposed rule identify and adopt measures that encourage all providers to report on a parsimonious unified set of quality measures.
- CMS should consider adoption of the recommendations from the Core Quality Measures Collaborative, developed through a multi-stakeholder process intent on reducing administrative burden and clinician burnout. Creating core sets of measures for primary care and subspecialists is essential for comparing clinicians across payment models.
- The proposed rule for the Advancing Care Information (ACI) performance category, based on the legacy meaningful use (MU) program, appears to have missed the mark on streamlining and simplifying performance reporting, and appears to be another complex and burdensome program, representing only marginal improvements, if any, on the original program.

ACKNOWLEDGE THE CHALLENGES OF SOLO AND SMALL PRACTICES

- Given the requisite investment in infrastructure, the cost of practice transformation, the lack of ability to spread risk throughout a larger patient panel, and a patient population that is disproportionately medically underserved, solo and small group practices warrant special consideration in the proposed rule.
- The PCPCC strongly encourages CMS to better support solo and small group practices by revisiting the proposed creation of virtual groups, which are essential to begin building networks that would encourage small practices to progress toward more sophisticated delivery models such as medical homes and accountable care organizations.
- The PCPCC recommends a "safe harbor exemption" for any solo clinician or small group that participates in the MIPS program, making them eligible for positive payment updates if their performance yields such payments, but exempt from any negative payment update until such time that the virtual group option is available.

STRENGTHEN BENEFICIARY ENGAGEMENT

- The PCPCC echoes the comments of the National Partnership of Women and Families, Community Catalyst, and other patient and consumer organizations to encourage CMS to move beyond the current definition of beneficiary engagement that too often limits patient engagement to the point of care.
- We recommend that the regulation include measures that encourage partnership with beneficiaries across all six CPIA subcategories.
- Many of the promising activities and measures link to the work we are doing through our Support and Alignment Network grant, including:
  - community-based supports that integrate social determinants of health and promote social and community involvement by linking electronic health records to community and social services,
  - the creation of Patient and Family Advisory Councils (PFACs),
  - and the inclusion of beneficiary/family caregiver representatives on key governance and decision-making bodies.

BACKGROUND ON APMS

What is an Alternative Payment Model (APM)?

APMs are **new approaches to paying** for medical care through Medicare that **incentivize quality and value.**

As defined by MACRA, **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

Advanced APMs meet certain criteria.

As defined by MACRA, Advanced APMs **must meet the following criteria**:

- ✓ The APM requires participants to use **certified EHR technology**.
- ✓ The APM **bases payment on quality** measures comparable to those in the MIPS quality performance category.
- ✓ The APM either: **(1)** requires APM Entities to bear more than nominal **financial risk** for monetary losses; **OR (2)** is a **Medical Home Model expanded** under CMMI authority.

NOTE: MACRA **does NOT** change how any particular APM functions or rewards value. Instead, it **creates extra incentives** for APM participation.

How do I become a Qualifying APM Participant (QP)?

Advanced APM QP

You must have a **certain %** of your patients or payments through an **Advanced APM.**

QPs will:

- **Be excluded from MIPS**
- **Receive a 5% lump sum bonus**

Bonus applies in 2019-2024; then QPs receive higher fee schedule updates starting in 2026

What about Medicaid or private payers APMs? Can they help me qualify to be a QP?

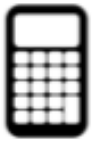
Starting in **2021**, **some** arrangements with other non-Medicare payers can **count toward** becoming a QP.

"All-Payer Combination Option"

IF the "Other Payer APMs" meet criteria similar to those for Advanced APMs, CMS will consider them "Other Payer Advanced APMs":

Certified EHR use

Quality Measures



Financial Risk

PROPOSED RULE

Medicaid Medical Home Models

Medicaid Medical Home Models:

- ✓ Have a **unique financial risk criterion** for becoming an Other Payer Advanced APM.
- ✓ Enable participants (who are not excluded from MIPS) to receive the **maximum score in the MIPS CPIA category.**

A **Medicaid Medical Home Model is an Other Payer APM** that has the following features:

- ✓ Participants include **primary care practices** or multispecialty practices that include primary care physicians and practitioners and offer primary care services.
- ✓ **Empanelment of each patient** to a primary clinician; and
- ✓ **At least four** of the following:
  - Planned coordination of chronic and preventive care.
  - Patient access and continuity of care.
  - Risk-stratified care management.
  - Coordination of care across the medical neighborhood.
  - Patient and caregiver engagement.
  - Shared decision-making.
  - Payment arrangements in addition to, or substituting for, fee-for-service payments.

PROPOSED RULE

Other Payer Advanced APM Criterion 3: Medicaid Medical Home Model Nominal Amount Standard

Medicaid Medical Home Model Nominal Amount Standard:

Subject to Size Limit

The Medicaid Medical Home Model standards **only apply to APM Entities with ≤ 50 eligible clinicians** in the APM Entity's **parent organization**

To be an Other Payer Advanced APM, the **amount of risk** under a Medicaid Medical Home Model must be at least the following amounts:

- ✓ **4% of payer revenue (2019)**
- ✓ **5% of payer revenue (2020 and later)**

How will the Quality Payment Program affect me?

Am I in an **APM**?

- **Yes** → Am I in an **Advanced** APM?
  - **Yes** → Do I have **enough payments or patients** through my Advanced APM?
    - **Yes** → **Qualifying APM Participant (QP)**
    - **No** → **Favorable** MIPS scoring & APM-specific **rewards**
  - **No** → **Favorable** MIPS scoring & APM-specific **rewards**
- **No** → Is this my **first year** in Medicare OR am I below the **low-volume threshold**?
  - **Yes** → **Not** subject to **MIPS**
  - **No** → Subject to **MIPS**

Qualifying APM Participant (QP)

- **Excluded** from MIPS
- 5% lump sum **bonus payment** (2019-2024), higher **fee schedule updates** (2026+)
- APM-specific **rewards**

Bottom line: There will be **financial incentives for participating in an APM**, even if you don't become a **QP.**

PROVIDE MULTIPLE PATHWAYS FOR MEDICAL HOMES TO QUALIFY AS ADVANCED ALTERNATIVE PAYMENT MODELS

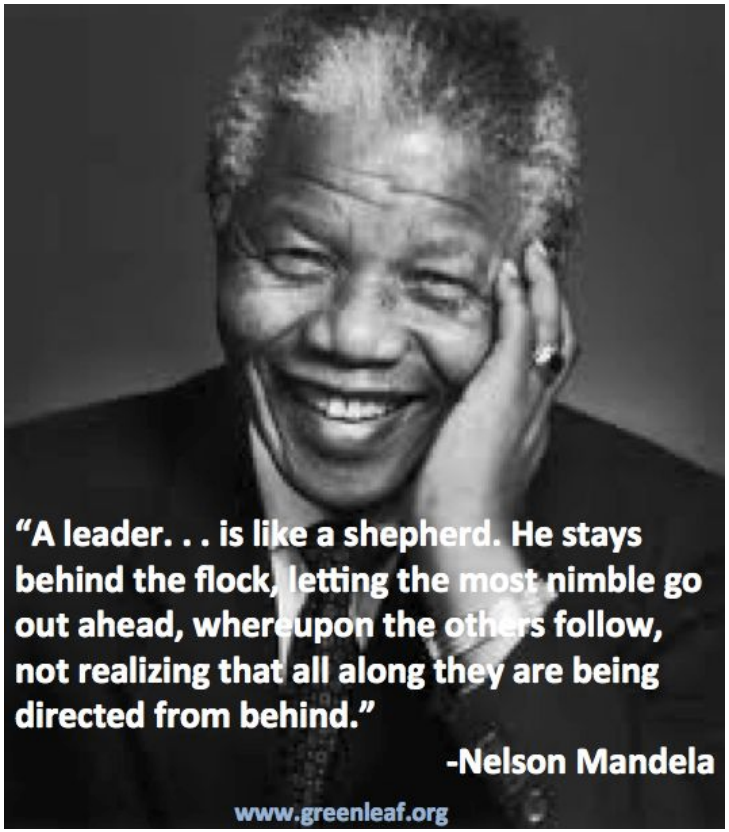
- The PCPCC firmly supports multiple pathways by which high-performing primary care practices can be recognized and rewarded as medical homes, specifically as (advanced) APMs.
- Together with the American Academy of Family Physicians (AAFP), the American College of Physicians (ACP), and the American Osteopathic Association (AOA), the PCPCC strongly recommends:
  - that CMS undertake an expedited analysis of the Comprehensive Primary Care initiative (CPC) to determine whether CPC meets statutory requirements for expansion (and thus qualify as an advanced APM).
  - We also recommend establishing and implementing a new medical home deeming program that enables high-performing practices enrolled in medical home programs run by states (including state Medicaid programs), other non-Medicare payers, and employers to be deemed as having met the criteria.
- Finally, while the PCPCC appreciates CMS' acknowledgement that medical homes have limited ability to assume significant financial risk in comparison to larger health care organizations, we question whether Congress intended any financial risk requirement for the Medical Home Model based on the statute, and thus encourage CMS to revisit this.

PCPCC RESOURCES

- PRESS RELEASE:
  - https://pcpcc.org/2016/06/28/pcpcc-letter-cms-calls-simplified-macra-regulations-offers-recommendations-more-strongly
- COMMENTS:
  - https://pcpcc.org/2016/06/28/pcpcc-responds-proposed-macra-regulations

PRECONDITION: LEADERSHIP

"It takes leadership, and leadership of a particular kind. The creation of integrated, comprehensive primary care is not a technical proposition. **Clinicians are not line workers who produce bits of health care, and clinics are not factories where health care is made**. … Health is personal …"



DeGruy, F (2015) Integrated Care: Tools, Maps, and Leadership
J Am Board Fam Med September-October 2015 vol. 28no. Supplement 1 S107-S110

SAVE THE DATE

–Celebrate the PCPCC'S 10 year Anniversary

–Annual Meeting &

Awards Dinner

- November 9th and 10th, Grand Hyatt, Washington DC

Patient-Centered Primary Care COLLABORATIVE

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THANK YOU!

WWW.PCPCC.ORG

@Marci_PCPCC