MACRA, MIPS, QPP, and APMs.  

*The acronym soup of moving from volume to value.*

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Professor, Colleges of Medicine and Public Health  
Chief Quality Officer – OU Physicians  
Medical Director – Clinical Skills Education and Testing Center

Oklahoma University Health Sciences Center

October 30, 2016
I have no relevant financial relationships or affiliations to disclose.

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Objectives

• Explain the drivers promoting change in payment methods

• Summarize current programs designed to move to value-based payment for healthcare

• Describe the role of internal medicine as systems become accountable for costs and quality of patient outcomes
Payment Reform

• We have a payment system that has rewarded more care, regardless of the value (or quality) of that care.

• Payment models have not promoted coordination of care across settings
$3.0 trillion in 2014
$9,523 per person

Exhibit 1. Health Care Spending as a Percentage of GDP, 1980–2013

* 2012.
Notes: GDP refers to gross domestic product. Dutch and Swiss data are for current spending only, and exclude spending on capital formation of health care providers.
Source: OECD Health Data 2015.

Where do we spend the money?

- Hospitals - $971 billion in 2014 (a 4.1% increase)
- Physicians and clinical services - $604 billion in 2014 (a 4.6% increase)

<table>
<thead>
<tr>
<th>Service</th>
<th>Spending*</th>
<th>Increase</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other professional services</td>
<td>$84.4</td>
<td>5.2%</td>
</tr>
<tr>
<td>Dental services</td>
<td>$113.5</td>
<td>2.8%</td>
</tr>
<tr>
<td>Home health services</td>
<td>$83.2</td>
<td>4.8%</td>
</tr>
<tr>
<td>Nursing care facilities</td>
<td>$155.6</td>
<td>3.6%</td>
</tr>
<tr>
<td>Prescription drugs</td>
<td>$297.7</td>
<td>12.2%</td>
</tr>
</tbody>
</table>

*in billions
## EXHIBIT ES-1. OVERALL RANKING

### Country Rankings

- **Top 2**
- **Middle**
- **Bottom 2**

### Overall Ranking (2013)

<table>
<thead>
<tr>
<th></th>
<th>AUS</th>
<th>CAN</th>
<th>FRA</th>
<th>GER</th>
<th>NETH</th>
<th>NZ</th>
<th>NOR</th>
<th>SWE</th>
<th>SWIZ</th>
<th>UK</th>
<th>US</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Quality Care</strong></td>
<td>4</td>
<td>10</td>
<td>9</td>
<td>5</td>
<td>5</td>
<td>7</td>
<td>7</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>11</td>
</tr>
<tr>
<td><strong>Effective Care</strong></td>
<td>2</td>
<td>9</td>
<td>8</td>
<td>7</td>
<td>5</td>
<td>4</td>
<td>11</td>
<td>10</td>
<td>3</td>
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<td>5</td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>7</td>
<td>9</td>
<td>6</td>
<td>5</td>
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<td>11</td>
<td>10</td>
<td>8</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td><strong>Safe Care</strong></td>
<td>3</td>
<td>10</td>
<td>2</td>
<td>6</td>
<td>7</td>
<td>9</td>
<td>11</td>
<td>5</td>
<td>4</td>
<td>1</td>
<td>7</td>
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<tr>
<td><strong>Coordinated Care</strong></td>
<td>4</td>
<td>8</td>
<td>9</td>
<td>10</td>
<td>2</td>
<td>7</td>
<td>11</td>
<td>3</td>
<td>1</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td><strong>Patient-Centered Care</strong></td>
<td>5</td>
<td>8</td>
<td>10</td>
<td>7</td>
<td>3</td>
<td>6</td>
<td>11</td>
<td>9</td>
<td>2</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td><strong>Access</strong></td>
<td>8</td>
<td>9</td>
<td>11</td>
<td>2</td>
<td>4</td>
<td>7</td>
<td>6</td>
<td>4</td>
<td>2</td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td><strong>Cost-Related Problem</strong></td>
<td>9</td>
<td>5</td>
<td>11</td>
<td>10</td>
<td>2</td>
<td>4</td>
<td>7</td>
<td>11</td>
<td>1</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td><strong>Timeliness of Care</strong></td>
<td>6</td>
<td>11</td>
<td>10</td>
<td>4</td>
<td>2</td>
<td>7</td>
<td>8</td>
<td>1</td>
<td>3</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td><strong>Efficiency</strong></td>
<td>4</td>
<td>10</td>
<td>8</td>
<td>9</td>
<td>7</td>
<td>3</td>
<td>4</td>
<td>2</td>
<td>6</td>
<td>1</td>
<td>11</td>
</tr>
<tr>
<td><strong>Equity</strong></td>
<td>5</td>
<td>9</td>
<td>7</td>
<td>4</td>
<td>8</td>
<td>10</td>
<td>6</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>11</td>
</tr>
<tr>
<td><strong>Healthy Lives</strong></td>
<td>4</td>
<td>8</td>
<td>1</td>
<td>7</td>
<td>5</td>
<td>9</td>
<td>6</td>
<td>2</td>
<td>3</td>
<td>10</td>
<td>11</td>
</tr>
</tbody>
</table>

### Health Expenditures/ Capita, 2011**

- **USA**: $3,800
- **Canada**: $4,522
- **France**: $4,118
- **Germany**: $4,495
- **Netherlands**: $5,099
- **New Zealand**: $3,182
- **Norway**: $5,669
- **Sweden**: $3,925
- **Switzerland**: $5,643
- **UK**: $3,405
- **USA**: $8,508

**Notes:** *Includes ties.** Expenditures shown in US$ PPP (purchasing power parity); Australian $ data are from 2010.

Consumers are demanding transparency!

- Consumer groups are demanding transparency – particularly about quality and costs of care
Healthcare quality is in the public domain for most settings of care!
“In 2014, we make purchasing decisions for every other commodity based on transparent price and quality information. Why not healthcare, too?”

Dr. Neel Shah, Costs of Care
Congress Reacts

• When consumer groups have a consistent message, legislators respond...
  – The Medicare Program and other agencies then are required to adopt standardized measures that reflect the quality of medical practice

• Multiple laws passed since 2003 require the Secretary of HHS to measure, publicly report, and to adjust payment based on quality of care

Three events that have accelerated the move to value............
REPORT TO CONGRESS:
Plan to Implement a Medicare Hospital
Value-Based Purchasing Program

November 21, 2007

Forwarded to Congress by the Bush Administration
(Secretary Leavitt)

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/downloads/HospitalVBPPlanRTCFINALSUBMITTED2007.pdf
Affordable Care Act (2010) Accelerates the Move

Move to “Value”

Value = Quality (and Service)/Costs

Goal: We want the highest quality of care (and service) at the lowest costs.
Range of Models in Existence or Development

Increasing assumed risk by provider

Increasing coordination/integration required

Current State: Payments for Reporting

Incremental FFS payments for value

Bundled payments for acute episode

Bundled payments for chronic care/disease carve-outs

Accountability for Population Health

From... get paid more for doing more

To... profiting by keeping your population of patients healthy, delivering high-quality care, and doing so at less cost
Comprehensive Care for Joint Replacement Model

The Comprehensive Care for Joint Replacement (CJR) model aims to support better and more efficient care for beneficiaries.

The proposed rule for the CJR model was published on July 9, 2015, with the comment period ending September 8, 2015. After reviewing nearly 400 comments from the public on the proposed rule, several major changes were made from the proposed rule, including changing the model start date to April 1, 2016. The final rule was placed on display on November 16, 2015 and can be viewed at the Federal Register.

Background

Hip and knee replacements are the most common inpatient surgery for Medicare beneficiaries and can require lengthy recovery and rehabilitation periods. In 2014, there were more than 400,000 procedures, costing more than $7 billion for the hospitalizations alone. Despite the high volume of these surgeries, quality and costs of care for these hip and knee replacement surgeries still vary greatly among providers.
“This model aims to provide higher quality, more coordinated oncology care at a lower cost to Medicare.”

Medicare and Medicaid Services (CMS) is also seeking the participation of other payers in the model. This model aims to provide higher quality, more highly coordinated oncology care at a lower cost to Medicare.

Background

Cancer diagnoses comprise some of the most common and devastating diseases in the United States, with 1.6 million new cases diagnosed each year and 600,000 deaths annually. The goal...
Bundled payment for cardiac bypass surgery and heart attack care....

A new mandatory program the CMS proposed Monday would make hospitals in 98 markets financially accountable for the cost and quality of all care associated with bypass surgery and heart attacks. “We think it’s important to keep pushing forward on delivery system reform,” Dr. Patrick Conway, acting principal deputy administrator and chief medical officer for the CMS, told reporters in a call. “We think this is a huge opportunity.” In 2014, hospitalizations for heart attacks for more than 200,000 beneficiaries cost Medicare over $6 billion, the CMS said. Yet for every treatment, the cost could vary by as much as 50%, the agency said. The CMS is seeking comment on the five-year demonstration, which would take effect July 1, 2017, in 98 randomly selected metropolitan areas.
Target percentage of payments in ‘FFS linked to quality’ and ‘alternative payment models’ by 2016 and 2018

- Alternative payment models (Categories 3-4)
- FFS linked to quality (Categories 2-4)
- All Medicare FFS (Categories 1-4)

2011: 0% (Alternative), 68% (FFS), 32% (All Medicare)
2014: 22% (Alternative), 85% (FFS), 5% (All Medicare)
2016: 30% (Alternative), 85% (FFS), 5% (All Medicare)
2018: 50% (Alternative), 90% (FFS), 10% (All Medicare)

Goal achieved
The new alphabet soup.......
Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)

One Hundred Fourteenth Congress of the United States of America

AT THE FIRST SESSION
Begun and held at the City of Washington on Tuesday, the sixth day of January, two thousand and fifteen

An Act
To amend title XVIII of the Social Security Act to repeal the Medicare sustainable growth rate and strengthen Medicare access by improving physician payments and making other improvements, to reauthorize the Children’s Health Insurance Program, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.
(a) SHORT TITLE.—This Act may be cited as the “Medicare Access and CHIP Reauthorization Act of 2015”.
(b) TABLE OF CONTENTS.—The table of contents of this Act is as follows:
Sec. 1. Short title; table of contents.
TITLE I—SGR REPEAL AND MEDICARE PROVIDER PAYMENT MODERNIZATION

Republican controlled
Senate and House:
• Senate vote: 92 yea; 8 nay
• House vote: 392 yea; 37 nay
House sponsor: Michael C. Burgess, MD [R - Texas]

Repealed the SGR!
Very bipartisan!

http://www.gpo.gov/fdsys/pkg/BILLS-114hr2enr/pdf/BILLS-114hr2enr.pdf
MACRA Final Rule released on October 14, 2016

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 414 and 495

[CMS-5517-FC]

RIN 0938-AS69

Medicare Program; Merit-based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Final rule with comment period.

SUMMARY: The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) repeals
Who’s in or out?

Who’s in?
• Physicians
• Physician assistants
• Nurse practitioners
• Clinical nurse specialists
• Certified registered nurse anesthetists

Who’s excluded?
• If 2017 is your first year of participation in Medicare
• You have less than or equal to $30,000 in Medicare Part B allowed charges for the year
• You care for less than or equal to 100 Medicare patients during the year
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, 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

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**Note:** Physician means doctor of medicine, doctor of osteopathy (including osteopathic practitioner), doctor of dental surgery, doctor of dental medicine, doctor of podiatric medicine, or doctor of optometry, and, with respect to certain specified treatment, a doctor of chiropractic legally authorized to practice by a State in which he/she performs this function.
Who Will Participate in MIPS?

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.

practitioner), doctor of dental surgery, doctor of dental medicine, doctor of podiatric medicine, or doctor of optometry, and, with respect to certain specified treatment, a doctor of chiropractic legally authorized to practice by a State in which he/she performs this function.
What happens in 2017?

Eligible Professional

Advanced Alternate Payment Mechanisms (APM)
- “Substantial portion” of revenues from “approved” alternate payment models
  - 5% bonus each year from 2019-2024
  - 0.75% increase per year beginning in 2026

Merit-based Incentive Payment System (MIPS)†
- Providers receive a score of 0-100
- Each year, CMS will establish a threshold score based on the median or mean composite performance scores of all providers
  - Providers scoring above the threshold will receive bonus payments (up to three times the annual penalty cap).

†Performance scores will be posted to Physician Compare website.
You can choose to start anytime between January 1 and October 2, 2017. Whenever you choose to start, you'll need to send in your performance data by March 31, 2018.

Failure to submit any data for 2017 will result in an automatic 4% reduction in Medicare payment for 2019.
Merit-based Incentive Payment System (MIPS)*

- **Quality Performance**
  - Replaces the Physician Quality Reporting System (PQRS) and some components of the Value-Based Modifier

- **Resource Use**
  - Replaces the cost component of the VBM

- **Clinical Practice Improvement Activities (CPIA) - new**

- **Advancing Care Information**
  - Replaces the Meaningful Use (MU) program
  - a particular emphasis on interoperability and information exchange

*Does include the Group Practice Reporting Option. Performance in 2017 will impact 2019 payment.*
Merit-based Incentive Payment System (MIPS)

First performance year is CY 2017 to adjust payment in CY 2019.

*Reduced to 0% for the 2017 “transition year” only. By statute, must go up to 30% for payment year CY 2021.
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**. A **scaling factor** may be applied to upward adjustments to make total upward and downward adjustments equal.

<table>
<thead>
<tr>
<th>Year</th>
<th>Maximum Adjustments</th>
</tr>
</thead>
<tbody>
<tr>
<td>2019</td>
<td>4%</td>
</tr>
<tr>
<td>2020</td>
<td>5%</td>
</tr>
<tr>
<td>2021</td>
<td>7%</td>
</tr>
<tr>
<td>2022 onward</td>
<td>9%</td>
</tr>
</tbody>
</table>

**Adjustment to provider’s base rate of Medicare Part B payment**

**Merit-Based Incentive Payment System (MIPS)**
Quality Performance – 60% of Score for CY 2017

• Most participants: Report up to 6 quality measures, including an outcome measure, for a minimum of 90 days.

• Groups using the web interface: Report 15 quality measures for a full year.
Resource Use – 0% of Score for 2017*

• CMS will calculate from claims over 40 episode-specific measures to account for differences among specialties.
  – For cost measures, clinicians that deliver more efficient care achieve better performance and score the highest points (the most efficient resource use).

“Episodes of care” roll up all costs of inpatient and outpatient care (including imaging, laboratory, drugs, rehabilitation, etc).

*By statute must make up 30% of the MIPS score for payment year 2021.
Over time, resource use is more heavily weighted

### MIPS Performance Categories/Weights

<table>
<thead>
<tr>
<th>Performance Category</th>
<th>MIPS General*</th>
<th>MIPS APM</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Year 1 (2019)</td>
<td>Year 2 (2020)</td>
</tr>
<tr>
<td>Quality</td>
<td>50%</td>
<td>60%</td>
</tr>
<tr>
<td>Resource Use</td>
<td>10%</td>
<td>0%</td>
</tr>
<tr>
<td>CPIA</td>
<td>15%</td>
<td>15%</td>
</tr>
<tr>
<td>ACI</td>
<td>25%</td>
<td>25%</td>
</tr>
</tbody>
</table>

*For MIPS General weights will be adjusted for certain factors, such as non-patient facing clinicians.

Details not known for 2018 and beyond.
Clinical Performance Improvement Activities – 15% of Score

- CMS proposes to allow physicians to select from a list of more than 90 activities.

<table>
<thead>
<tr>
<th>Expanded Practice Access</th>
<th>Beneficiary Engagement</th>
<th>Achieving Health Equity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care Coordination</td>
<td>Participation in an APM, including a medical home model</td>
<td>Integrated Behavioral and Mental Health</td>
</tr>
</tbody>
</table>
Clinical Performance Improvement Activities

• **Most participants:** Attest that you completed up to 4 improvement activities for a minimum of 90 days.

• **Groups with fewer than 15 participants or if you are in a rural or health professional shortage area:** Attest that you completed up to 2 activities for a minimum of 90 days.
Advancing Care Information – 25% of MIPS score

Fulfill the required measures for a minimum of 90 days:

• Security Risk Analysis
• e-Prescribing
• Provide Patient Access
• Send Summary of Care
• Request/Accept Summary of Care

• Choose to submit up to 9 measures for a minimum of 90 days for additional credit.

For bonus credit, you can:

• Report Public Health and Clinical Data Registry Reporting measures
• Use certified EHR technology to complete certain improvement activities in the improvement activities performance category
Reporting MIPS Data

• **Reporting as an individual.**
  – An individual is defined as a single National Provider Identifier (NPI) tied to a single Tax Identification Number.

• **Reporting as a group.**
  – A group is defined as a set of clinicians (identified by their NPIs) sharing a common Tax Identification Number, no matter the specialty or practice site.
Scoring under MIPS

Top performance - Additional “Bonus” Incentive

Threshold* (No Payment Adjustment)

Maximum Penalty
4% in 2018, 5% in 2019, 7% in 2020, and 9% in 2021 to 2023

Sliding scale positive adjustment

Sliding scale negative adjustment
Scoring under MIPS

By law, the program must be budget neutral. There have to be losers to have incentive payments!...

....with one caveat. Congress appropriated $500 million (2019-2024) to bonus top performers under MIPS

Maximum Penalty
4% in 2018, 5% in 2019, 7% in 2020, and 9% in 2021 to 2023
Alternate Payment Models (APMs)

- “Substantial portion” of revenues* from “approved” alternate payment models
  - For now, very few “approved” APMs
  - Not subject to MIPS
- Receive 5% lump sum bonus payments for years 2019-2024
- Receive a higher fee schedule update from 2026 onward
Alternate Payment Models

- Advanced APMs defined as those that meet criteria for linking payments to quality measures, using EHRs, and nominal risk.
- Only participants in Advanced APMs at MACRA thresholds qualify for 5% lump sum payments.

- Current models that meet Advanced APM criteria are Track 2 & 3 ACOs, Next Generation ACOs, Comprehensive Primary Care Plus (CPC+), some Comprehensive ESRD Care organizations (ESCOs).

- 6 (1%) MSSP ACOs are in Track 2 and 16 (4%) are in Track 3
- There are 13 ESCOs and 18 Next Gen ACOs
- CPC+ just announced three weeks ago

The practice must bear more than nominal financial risk!

- 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 Advanced APMs

For the 2017 performance year, we anticipate that the following models will be Advanced APMs:

- Comprehensive End Stage Renal Disease Care Model (Two-Sided Risk Arrangements)
- Comprehensive Primary Care Plus (CPC+)
- Medicare Shared Savings Program Track 2
- Medicare Shared Savings Program Track 3
- Next Generation ACO Model
- Oncology Care Model (two sided risk)

This list may change before January 1, 2017.
# Advanced APM – to avoid MIPS

<table>
<thead>
<tr>
<th>Performance Year</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
<th>2020</th>
<th>2021</th>
<th>2022 and later</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of Medicare Payments through an Advanced APM</td>
<td>25%</td>
<td>25%</td>
<td>50%</td>
<td>50%</td>
<td>75%</td>
<td>75%</td>
</tr>
<tr>
<td>Percentage of Medicare Patients through an Advanced APM</td>
<td>20%</td>
<td>20%</td>
<td>35%</td>
<td>35%</td>
<td>50%</td>
<td>50%</td>
</tr>
</tbody>
</table>

Table 1: Requirements for APM Incentive Payments for Participation in Advanced APMs  
(Clinicians must meet payment or patient requirements)
“Pick Your Pace”

• **First option**: Report something to avoid penalties (no incentives)

• **Second option**: Submit data for part of the calendar year (small incentives and avoid penalties)

• **Third option**: Submit data for the entire calendar year (“modest” payment incentive and avoid penalties)

• **Fourth option**: Participate in an Alternate Payment Model
Comprehensive Primary Care Plus (CPC+)

A new model for primary care in America

CPC+ Participating Regions & Provisional Payer Partners

- North Hudson-Capitol Region
- Greater Philadelphia Region
- Ohio & Northern Kentucky Region
- Greater Kansas City Region

= Region spans the entire state
= Region comprises contiguous counties

https://innovation.cms.gov/initiatives/comprehensive-primary-care-plus
CMS Required Other Payers to Participate to Select a Region

<table>
<thead>
<tr>
<th>REGION</th>
<th>PARTICIPATING COUNTIES</th>
<th>PROVISIONAL PAYER PARTNERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>OKLAHOMA</td>
<td>Statewide</td>
<td>Advantage Medicare Plan (AMP)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CommunityCare</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Blue Cross and Blue Shield of Oklahoma</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Medicaid</td>
</tr>
<tr>
<td></td>
<td></td>
<td>UnitedHealthcare</td>
</tr>
</tbody>
</table>

It is not just Medicare!
CPC+ Regions Selected Based on Multi-Payer Support

Partner Payers Aligned With But Not Identical to Medicare

Payers Invited to Partner

- Commercial insurance plans
- Medicare Advantage plans
- Medicaid/CHIP state agencies
- Health Insurance Marketplace plans
- Public employee plans
- Self-insured business and admins
- Medicaid/CHIP managed care plans
- Medicare FFS

Required Payer Alignment

- Enhanced, non-FFS support
- Change in cash flow mechanism from fee-for-service to at least a partial alternative payment methodology for Track 2 practices
- Performance-based incentive
- Aligned quality and patient experience measures with Medicare FFS and other payers in the region
- Practice- and member-level cost and utilization data at regular intervals
Substantially changes payment for primary care.

<table>
<thead>
<tr>
<th>Objective</th>
<th>Care Management Fee (PBPM)</th>
<th>Performance-Based Incentive Payment (PBPM)</th>
<th>Payment Structure Redesign</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Track 1</strong></td>
<td>Support augmented staffing and training for delivering comprehensive primary care</td>
<td>Reward practice performance on utilization and quality of care</td>
<td>Reduce dependence on visit-based fee-for-service to offer flexibility in care setting</td>
</tr>
<tr>
<td></td>
<td>$15 average</td>
<td>$2.50 opportunity</td>
<td>N/A (Standard FFS)</td>
</tr>
<tr>
<td><strong>Track 2</strong></td>
<td>$28 average; including $100 to support patients with complex needs</td>
<td>$4.00 opportunity</td>
<td>Reduced FFS with prospective “Comprehensive Primary Care Payment” (CPCP)</td>
</tr>
</tbody>
</table>
Track 2 Payment Redesign

Designed to promote population health beyond office visits!

Hybrid of FFS and Upfront “Comprehensive Primary Care Payment” (CPCP) for Evaluation & Management

- Practices receive enhanced fees with roughly half of expected FFS payments upfront and subsequent FFS billings reduced by the prepaid amount
- CPCP reduces incentive to bring patients into the office for a visit but maintenance of some FFS allows for flexibility to treat patients in accordance with their preferences
- Practices select the pace at which they will progress towards one of two hybrid payment options (both roughly 50/50) by 2019

Total CPCP/FFS is ~10% larger than historical FFS to compensate for more comprehensive services
Track 2 Payment Redesign

<table>
<thead>
<tr>
<th>CPCP%/FFS% options available to practices, by year</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
<th>2020</th>
<th>2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>10%/90%</td>
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<tr>
<td>25%/75%</td>
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<td>40%/60%</td>
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</tbody>
</table>

Track 2 practices will receive a percentage of their expected Medicare E&M payment upfront in the form of a CPCP and a reduced fee-for-service payment for face-to-face E&M claims.

This is designed to incentivize the practice to keep patients healthy rather than promoting additional delivery of healthcare services.
Docs face stark choices under new Medicare pay proposal

By Beth Kutscher | April 30, 2016

The new draft regulations designed to change the payment system for Medicare represent the most sweeping overhaul that the profession has had to deal with in decades, and the business of running a physician practice changes.

The goal is to have the vast majority of GPs and specialists develop models that reward doctors for the quality of care they provide to their patients.

“You can no longer afford to ignore quality reporting”

With MACRA, 2017 will be 'year of reckoning' for physician payment

2:56 PM on May 2, 2016 by Rivka Friedman

Last Wednesday, CMS released its proposed rule for MACRA, the Medicare Access and CHIP Reauthorization Act, which replaced SGR and redefined parameters for Medicare physician reimbursement.
• 558,885 EPs are currently subject to the 2016 PQRS negative payment adjustment.*

• Of those professionals subject to the adjustment
  • 466,351 were non-participants (those EPs who did not attempt to participate)
  • 92,534 were participants who were unsuccessful in meeting the reporting requirements

*Based on 2014 PQRS reporting.
The Role of Internal Medicine

- Access and Continuity
- Care Management
- Comprehensiveness and Coordination
- Patient and Caregiver Engagement
- Planned Care and Population Health
The additional challenge for a group practice…….

……...provider compensation models will have to change to match incentives under payment reform.
Quality Payment Program

Modernizing Medicare to provide better care and smarter spending for a healthier America.

https://qpp.cms.gov/
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