MACRA, MIPS, QPP, and APMs.

The acronym soup of moving from volume to value.

Dale W. Bratzler, DO, MPH, MACOI, FIDSA
Edith Kinney Gaylord Presidential Professor
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

OU Medicine

Speaker Disclosure

I have no relevant financial relationships or affiliations to disclose.

Dale W. Bratzler, DO, MPH

dale-bratzler@ouhsc.edu

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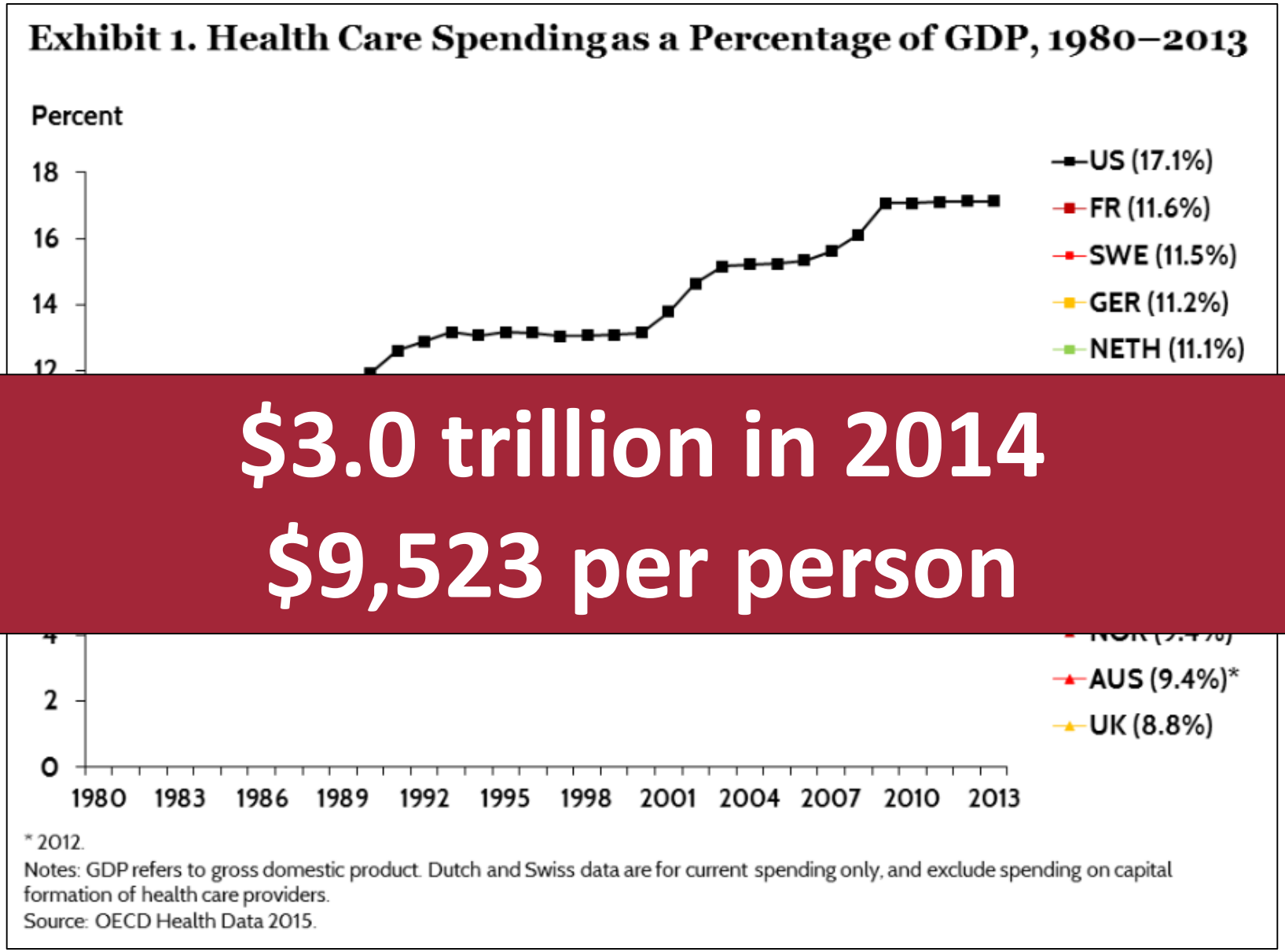
Objectives

- 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

http://www.commonwealthfund.org/publications/issue-briefs/2015/oct/us-health-care-from-a-global-perspective

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)

	Spending*	Increase
Other professional services	$84.4	5.2%
Dental services	$113.5	2.8%
Home health services	$83.2	4.8%
Nursing care facilities	$155.6	3.6%
Prescription drugs	$297.7	12.2%

*in billions

EXHIBIT ES-1. OVERALL RANKING

COUNTRY RANKINGS

- Top 2*
- Middle
- Bottom 2*

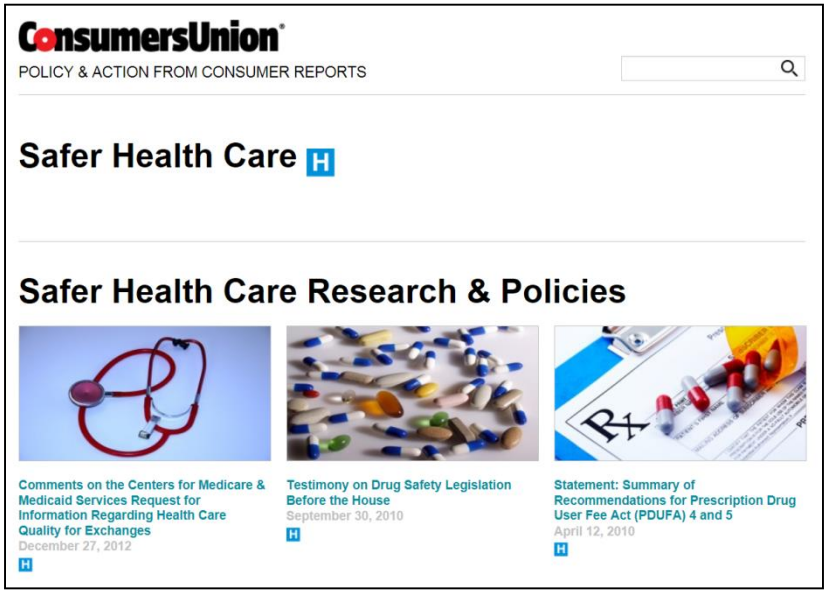
	AUS	CAN	FRA	GER	NETH	NZ	NOR	SWE	SWIZ	UK	US
OVERALL RANKING (2013)	4	10	9	5	5	7	7	3	2	1	11
Quality Care	2	9	8	7	5	4	11	10	3	1	5
Effective Care	4	7	9	6	5	2	11	10	8	1	3
Safe Care	3	10	2	6	7	9	11	5	4	1	7
Coordinated Care	4	8	9	10	5	2	7	11	3	1	6
Patient-Centered Care	5	8	10	7	3	6	11	9	2	1	4
Access	8	9	11	2	4	7	6	4	2	1	9
Cost-Related Problem	9	5	10	4	8	6	3	1	7	1	11
Timeliness of Care	6	11	10	4	2	7	8	9	1	3	5
Efficiency	4	10	8	9	7	3	4	2	6	1	11
Equity	5	9	7	4	8	10	6	1	2	2	11
Healthy Lives	4	8	1	7	5	9	6	2	3	10	11
Health Expenditures/Capita, 2011**	$3,800	$4,522	$4,118	$4,495	$5,099	$3,182	$5,669	$3,925	$5,643	$3,405	$8,508

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

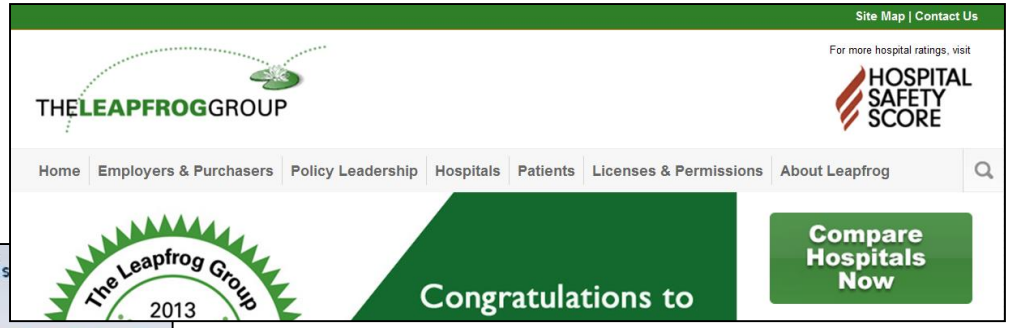
Source: Calculated by The Commonwealth Fund based on 2011 International Health Policy Survey of Sicker Adults; 2012 International Health Policy Survey of Primary Care Physicians; 2013 International Health Policy Survey; Commonwealth Fund *National Scorecard 2011;* World Health Organization; and Organization for Economic Cooperation and Development, *OECD Health Data, 2013* (Paris: OECD, Nov. 2013).

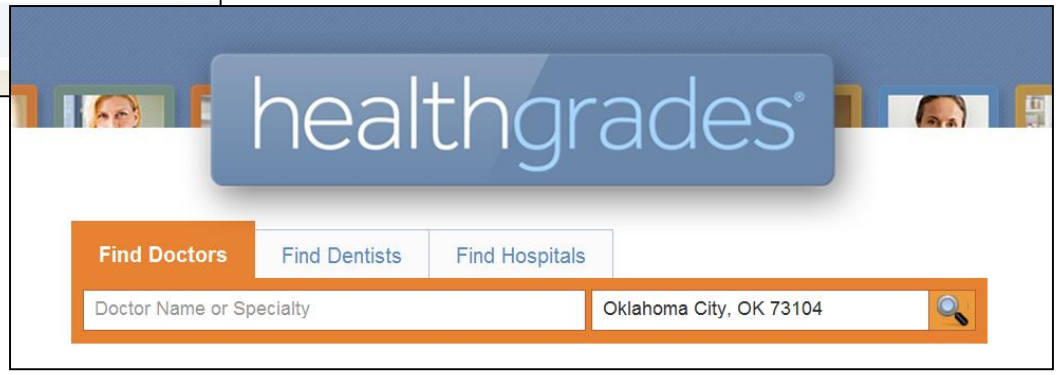
Consumers are demanding transparency!

- Consumer groups are demanding transparency – particularly about quality and costs of care



Transparency!





Healthcare quality is in the public domain for most settings of care!

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"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

https://publichealthonline.gwu.edu/healthcare-price-cost-transparency/#CoC

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……

U.S. Department of Health and Human Services

REPORT TO CONGRESS:

Plan to Implement a Medicare Hospital Value-Based Purchasing Program

November 21, 2007

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

#1

Forwarded to Congress by the Bush Administration (Secretary Leavitt)

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https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/downloads/HospitalVBPPlanRTCFINALSUBMITTED2007.pdf

#2 Affordable Care Act (2010) Accelerates the Move

Move to "Value"

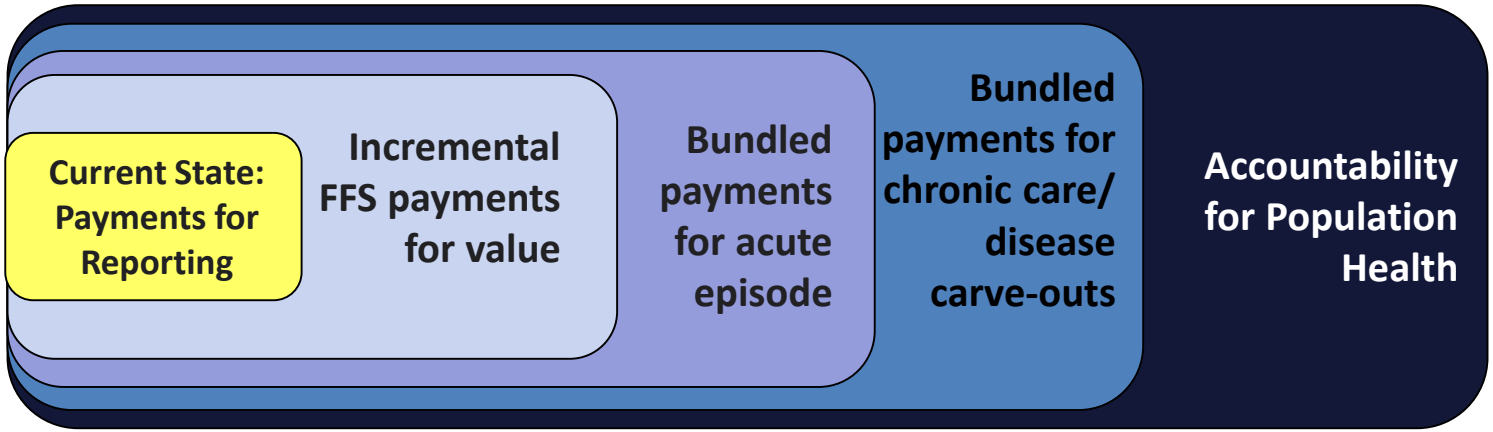
Value = Quality (and Service)/Costs

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



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

"…..aims to support better and more efficient care for beneficiaries……."

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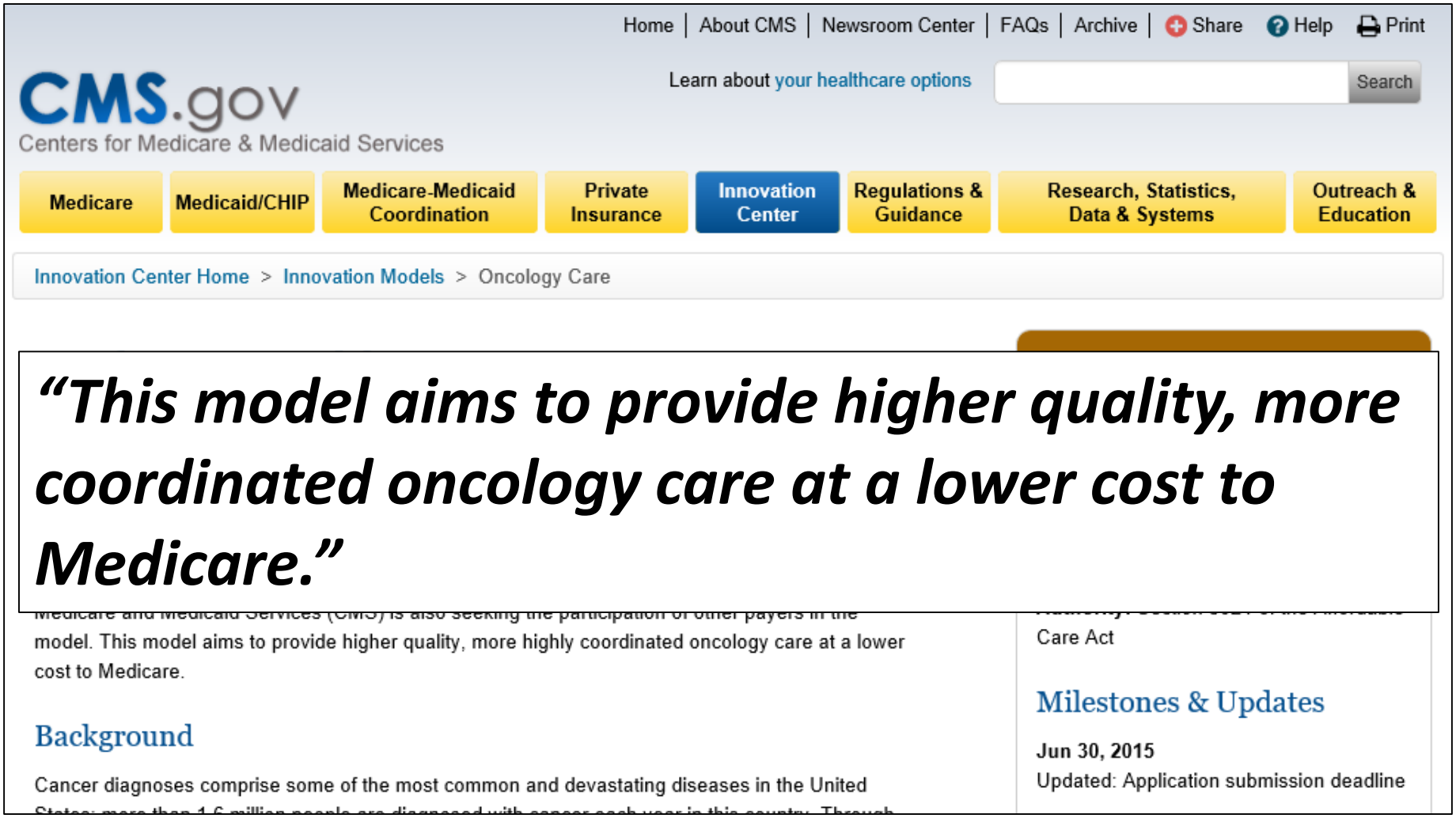
https://innovation.cms.gov/initiatives/cjr



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https://innovation.cms.gov/initiatives/Oncology-Care/

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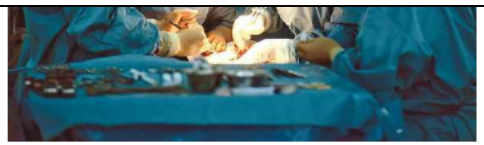
Bundled payment for cardiac bypass surgery and heart attack care….



RELATED CONTENT

Knee and hip bundled-payment challenge is about to start

Bundling risk: New demo program shows CMS' eagerness to ditch fee for service

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.

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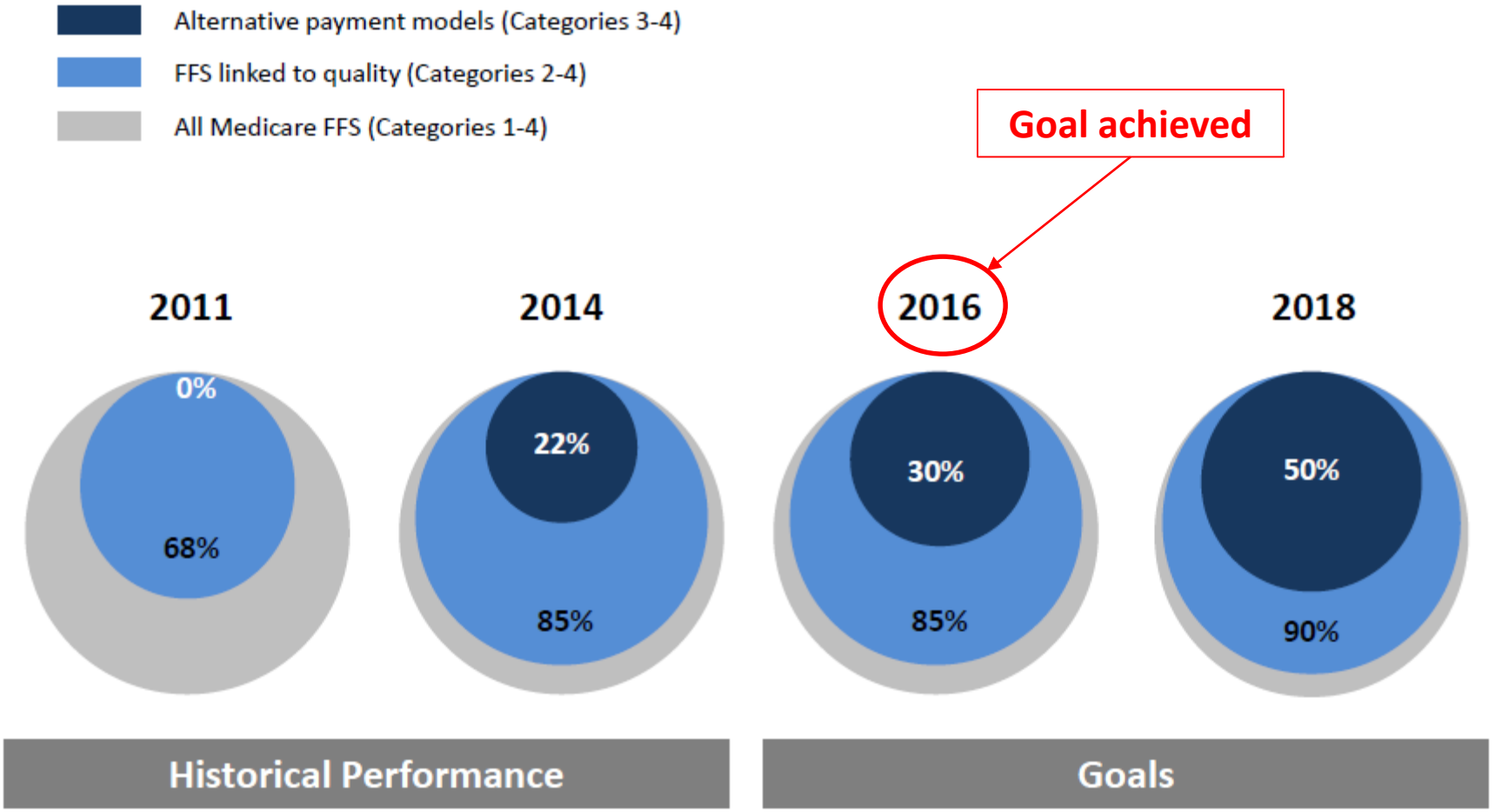
Target percentage of payments in 'FFS linked to quality' and 'alternative payment models' by 2016 and 2018



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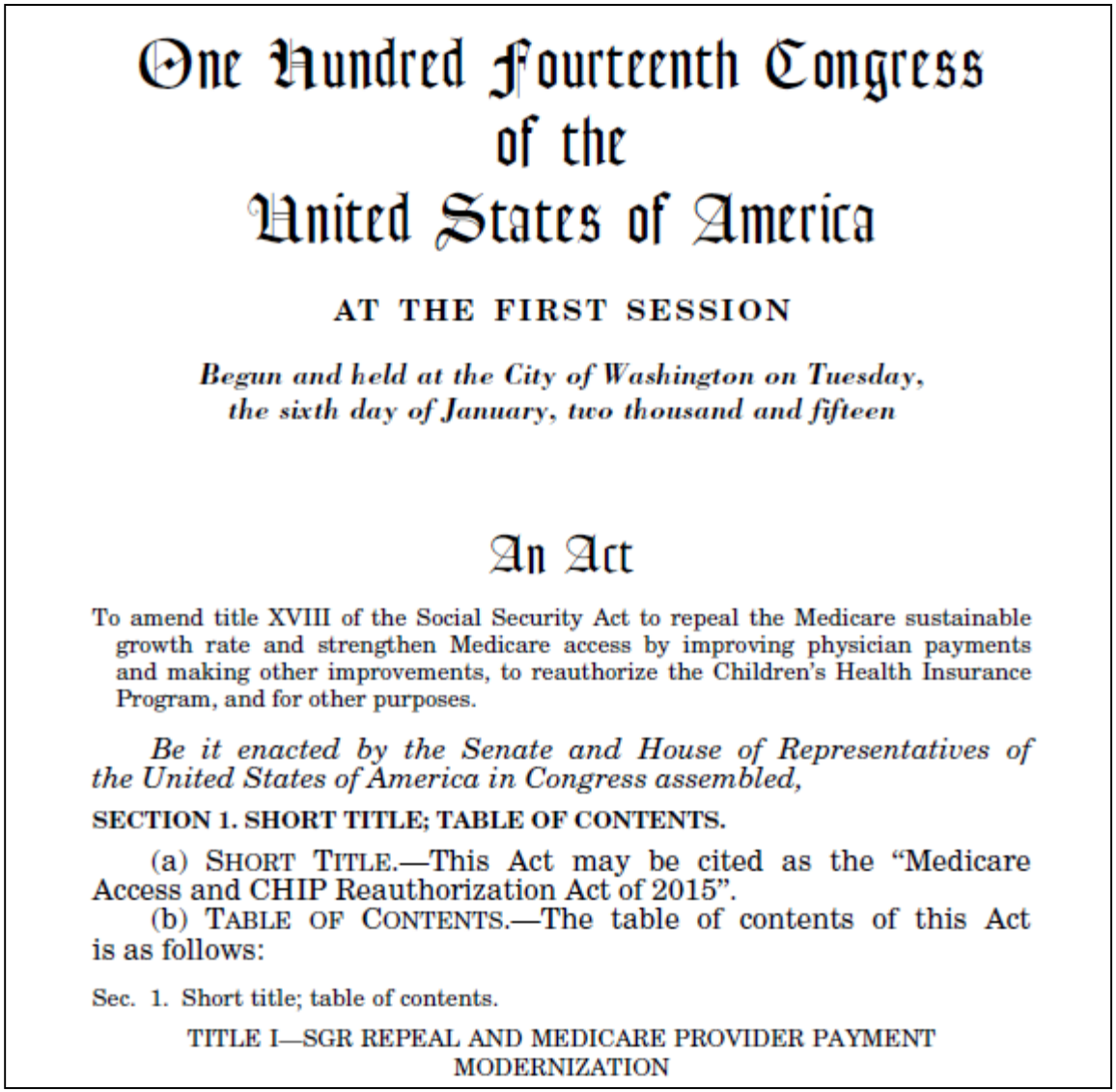
The new alphabet soup…….

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

#3

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!

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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

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Available at: https://qpp.cms.gov/docs/CMS-5517-FC.pdf

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

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?

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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?

Quality Payment Program (QPP)

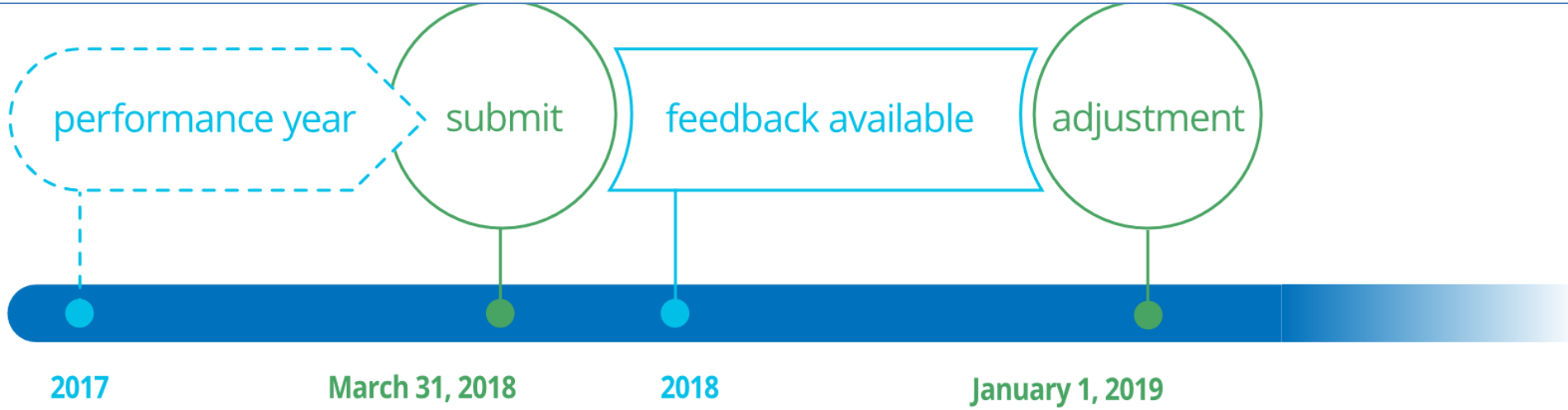
Advanced Alternate Payment Mechanisms (APM)

- "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

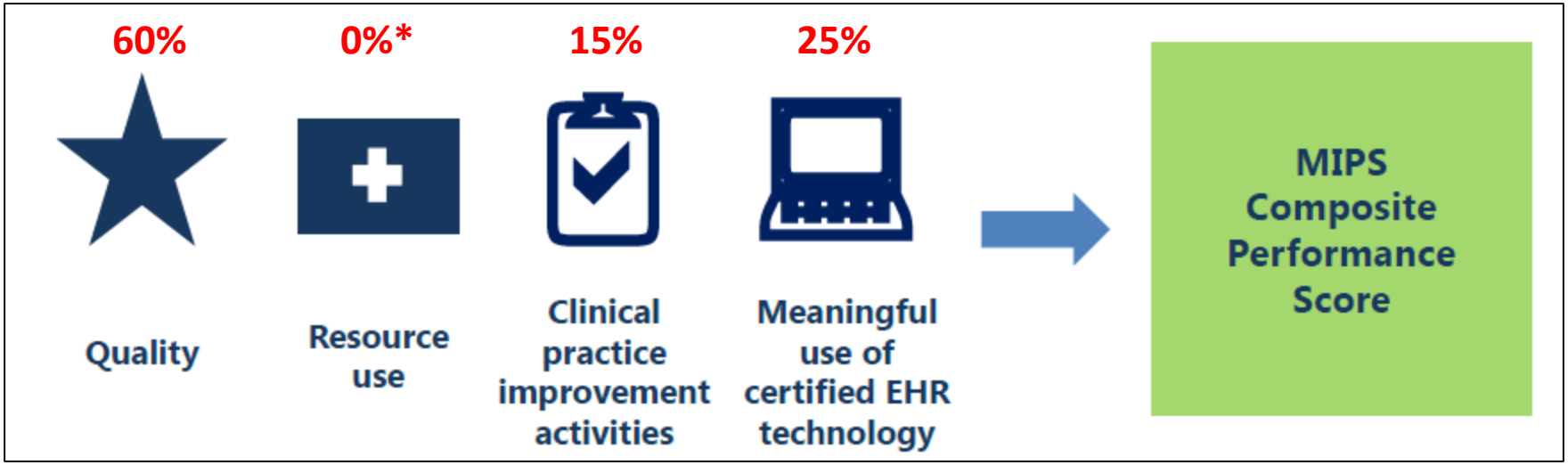
- **Resource Use**
  - Replaces the cost component of the VBM

- **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.

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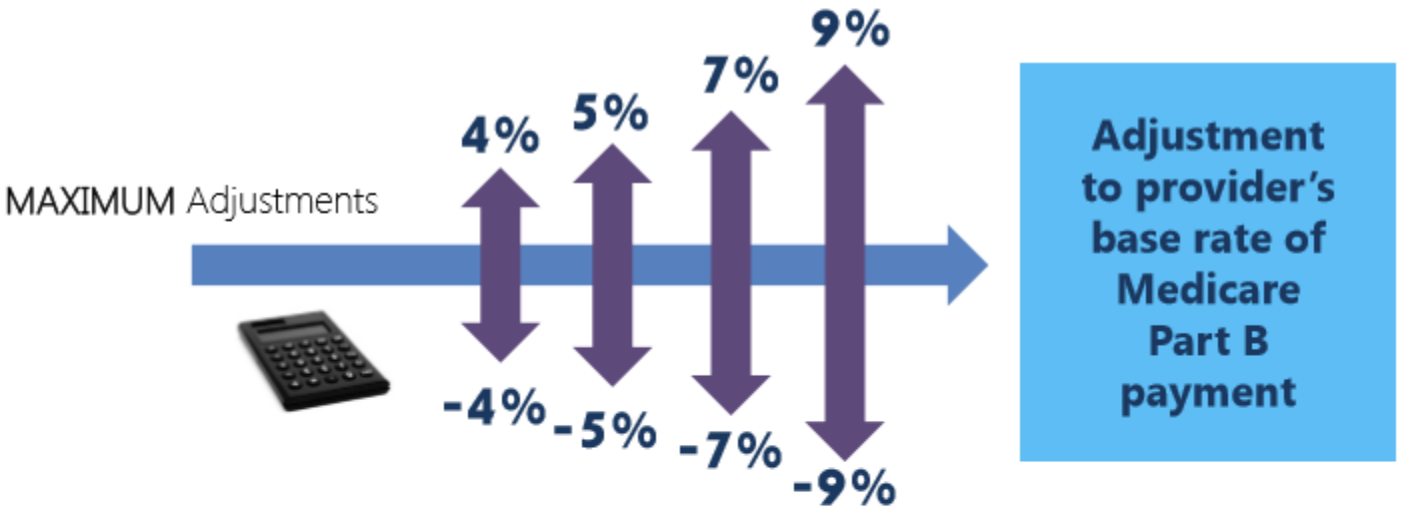
*Reduced to 0% for the 2017 "transition year" only. By statute, must go up to 30% for payment year CY 2021.

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.



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

Performance Category	MIPS General*			MIPS APM
	Year 1 (2019)	Year 2 (2020)	Year 3 (2021)	
Quality	~~50%~~ 60%	45%	30%	Varies depending on APM
Resource Use	~~10%~~ 0%	15%	30%	
CPIA	15%	15%	15%	
ACI	25%	25%	25%	

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

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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.

Expanded Practice Access	Beneficiary Engagement	Achieving Health Equity
Population Management	Patient Safety and Practice Assessment	Emergency Preparedness and Response
Care Coordination	Participation in an APM, including a medical home model	Integrated Behavioral and Mental Health

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

Required

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

For bonus credit, you can:

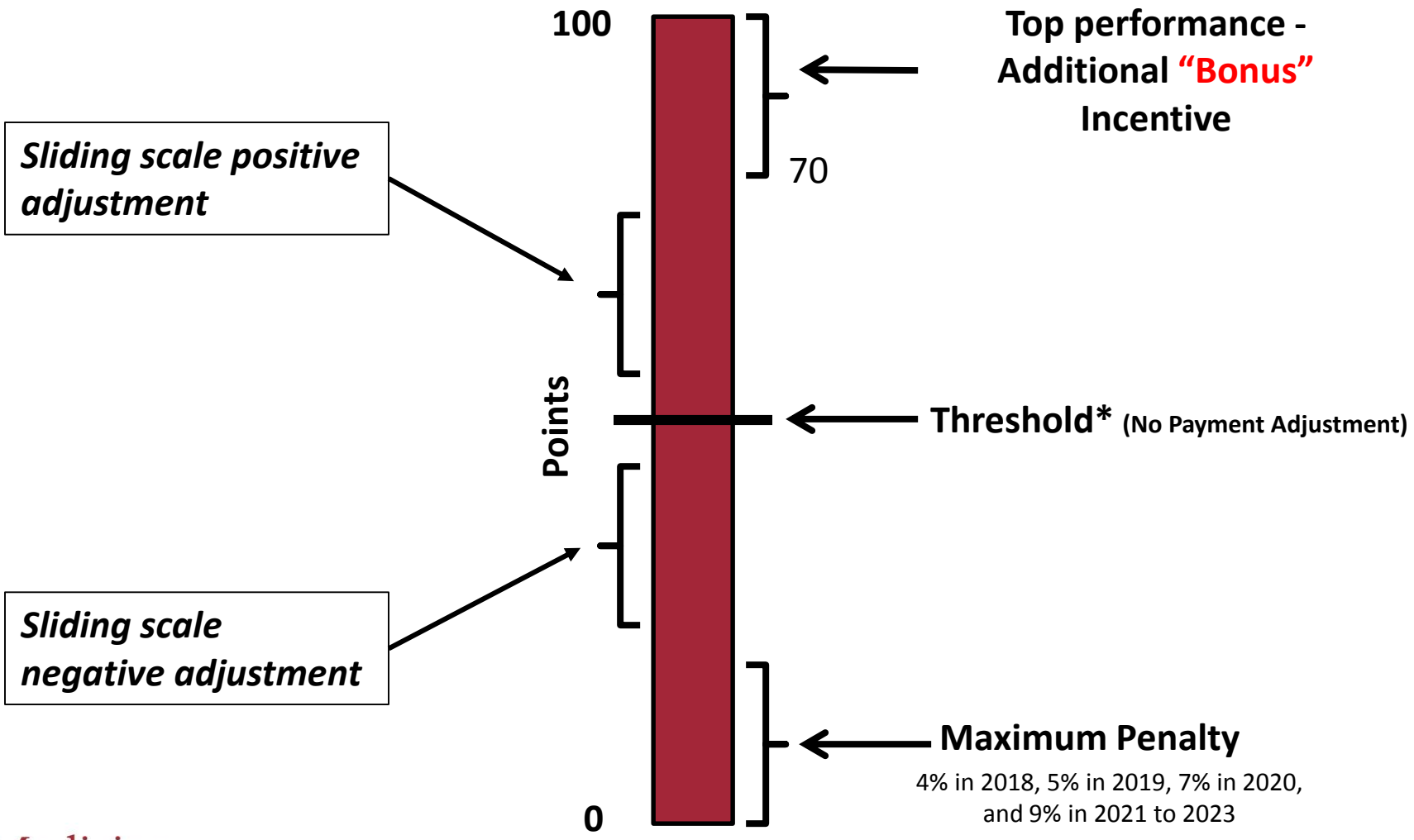
- Report Public Health and Clinical Data Registry Reporting measures
- Use certified EHR technology to complete certain improvement activities in the improvement activities performance category

Reporting MIPS Data

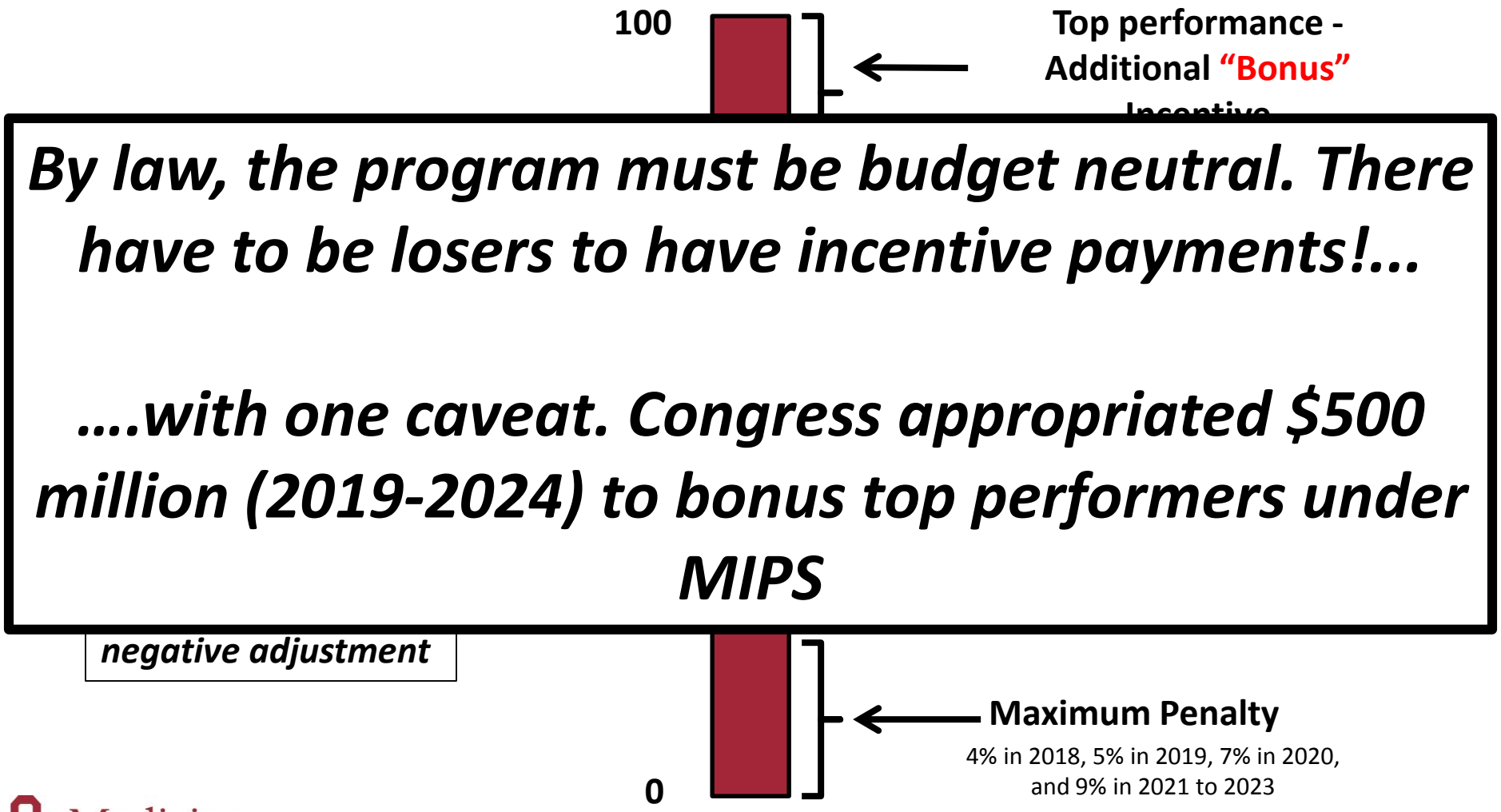
- **Reporting as an individual.**
  - An individual is defined as a single National Provider Identifier (NPI) tied to a single Tax Identification Number.

- **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



Scoring under MIPS



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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

What is an eligible APM?

Eligible APMs are the **most**

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)

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This list may change before January 1, 2017.

Advanced APM – to avoid MIPS

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

Performance Year	2017	2018	2019	2020	2021	2022 and later
Percentage of Medicare Payments through an Advanced APM	25%	25%	50%	50%	75%	75%
Percentage of Medicare Patients through an Advanced APM	20%	20%	35%	35%	50%	50%

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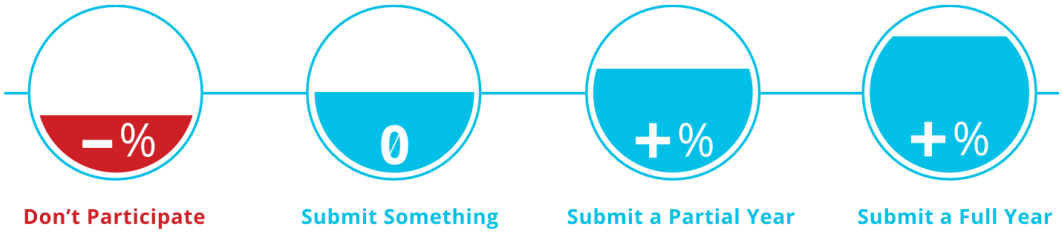
"Pick Your Pace"

- **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

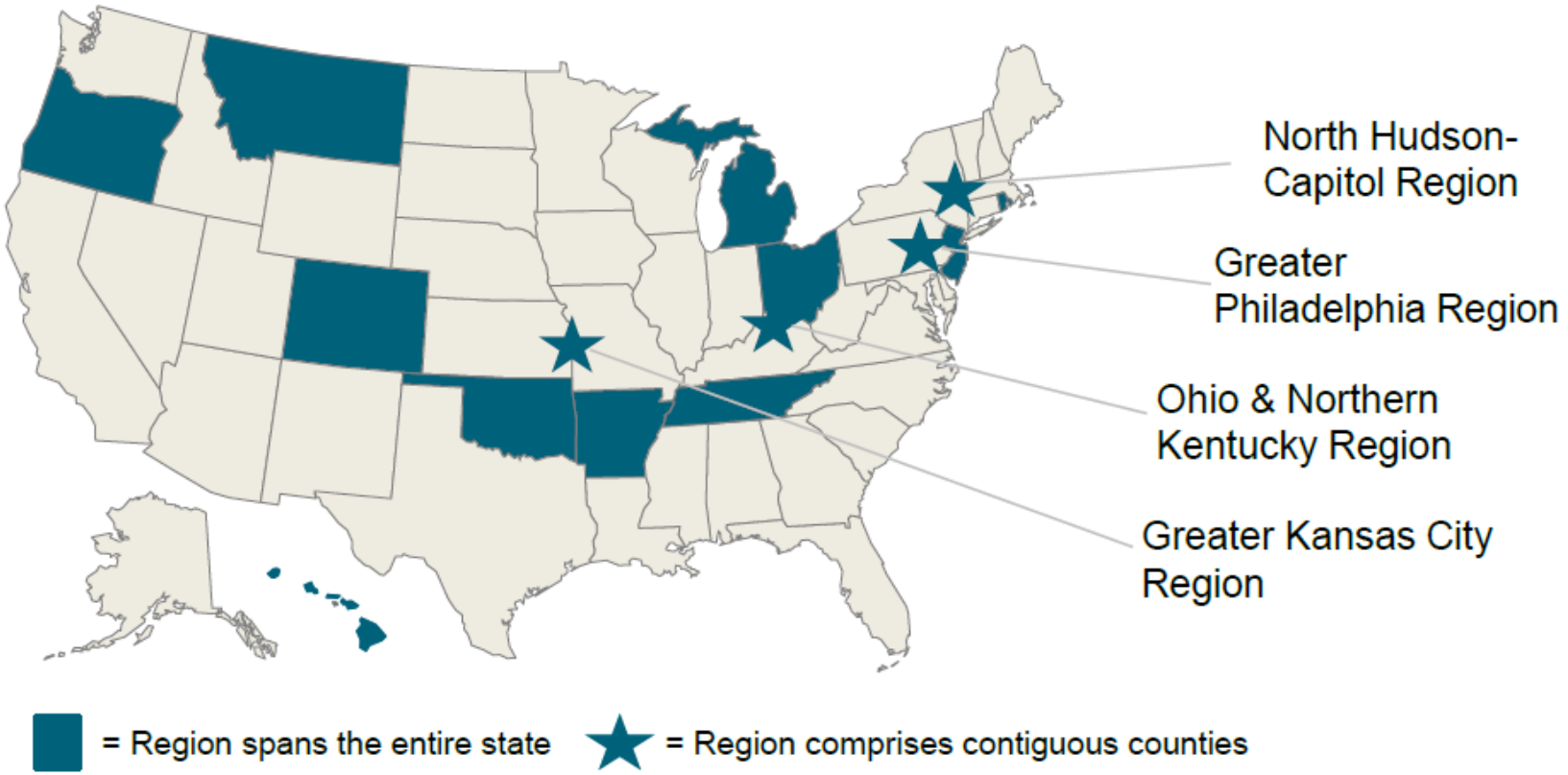


https://blog.cms.gov/2016/09/08/QualityPaymentProgram-PickYourPace/

Comprehensive Primary Care Plus (CPC+)

A new model for primary care in America

CPC+ Participating Regions & Provisional Payer Partners



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https://innovation.cms.gov/initiatives/comprehensive-primary-care-plus

CMS Required Other Payers to Participate to Select a Region

REGION	PARTICIPATING COUNTIES	PROVISIONAL PAYER PARTNERS
OKLAHOMA	Statewide	Advantage Medicare Plan (AMP) CommunityCare Blue Cross and Blue Shield of Oklahoma Medicaid UnitedHealthcare

It is not just Medicare!

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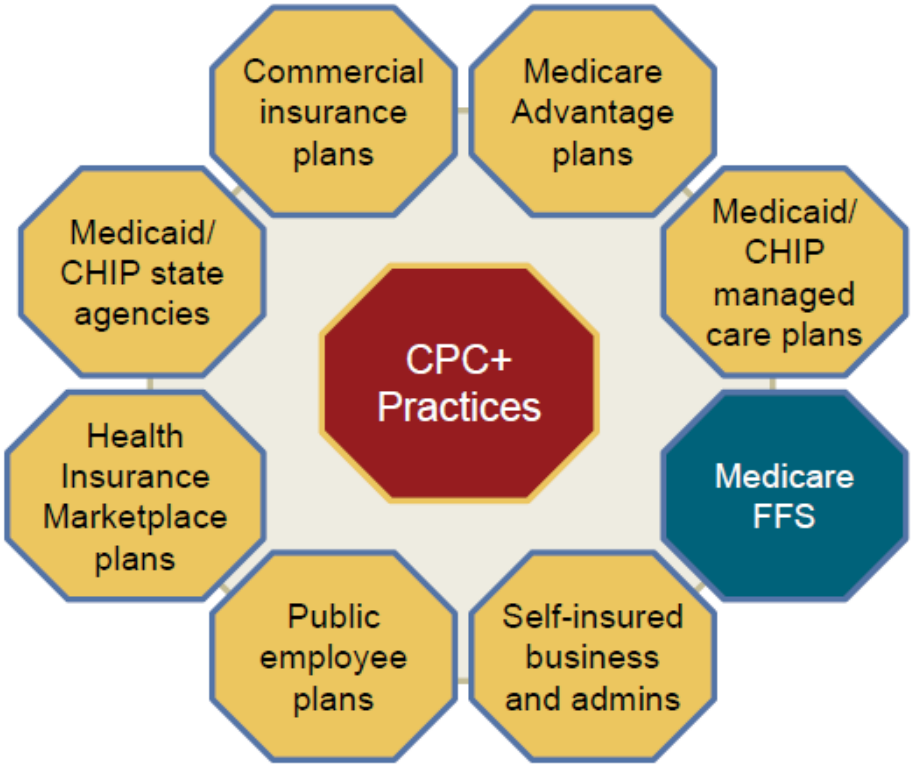
CPC+ Regions Selected Based on Multi-Payer Support

Partner Payers Aligned With But Not Identical to Medicare

Payers Invited to Partner



Required Payer Alignment

- Enhanced, non-FFS support
- Change in cash flow mechanism from fee-for-service to at a 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

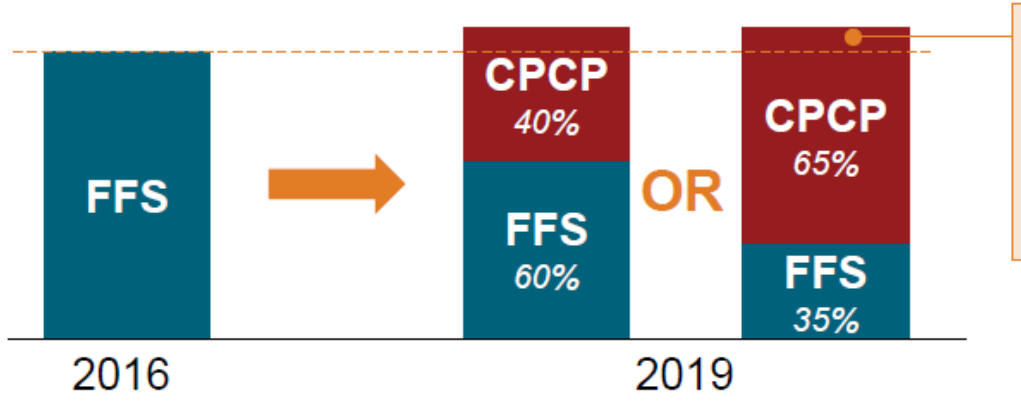
Substantially changes payment for primary care.

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

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



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

?

- 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

Track 2 Payment Redesign

CPCP and FFS Options

	2017	2018	2019	2020	2021
CPCP%/FFS% options available to practices, by year	10%/90%				
	25%/75%	25%/75%			
	40%/60%	40%/60%	40%/60%	40%/60%	40%/60%
	65%/35%	65%/35%	65%/35%	65%/35%	65%/35%

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.

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Docs face stark choices under new Medicare pay proposal

By Beth Kutscher | April 30, 2016

The new draft regulations designed to ch
represent the most sweeping overhaul th
business of running a physician practice

The goal is to have the vast majority of C
models that reward doctors for the qualit
patients they see.

"You can no longer afford to ignore quality reporting"

The Advisory Board Company

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Practice Notes

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.

http://www.modernhealthcare.com/article/20160430/MAGAZINE/304309988

https://www.advisory.com/research/medical-group-strategy-council/practice-notes/2016/05/macra-proposed-rule

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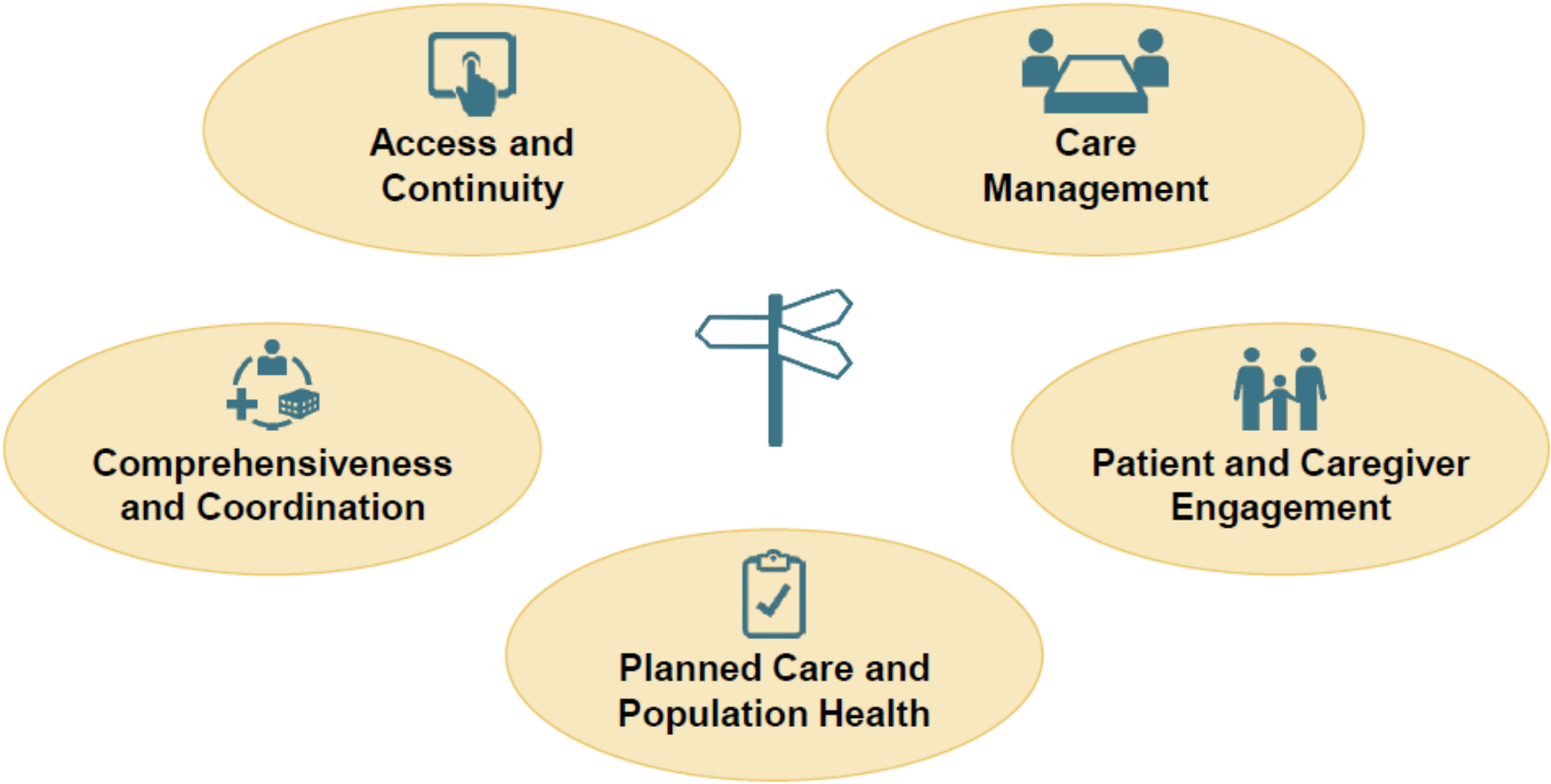
- **558,885 EPs are currently subject to the 2016 PQRS negative payment adjustment.***
- **Of those professionals subject to the adjustment**
  - 466,351 were non-participants (those EPs who did not attempt to participate)
  - 92,534 were participants who were unsuccessful in meeting the reporting requirements

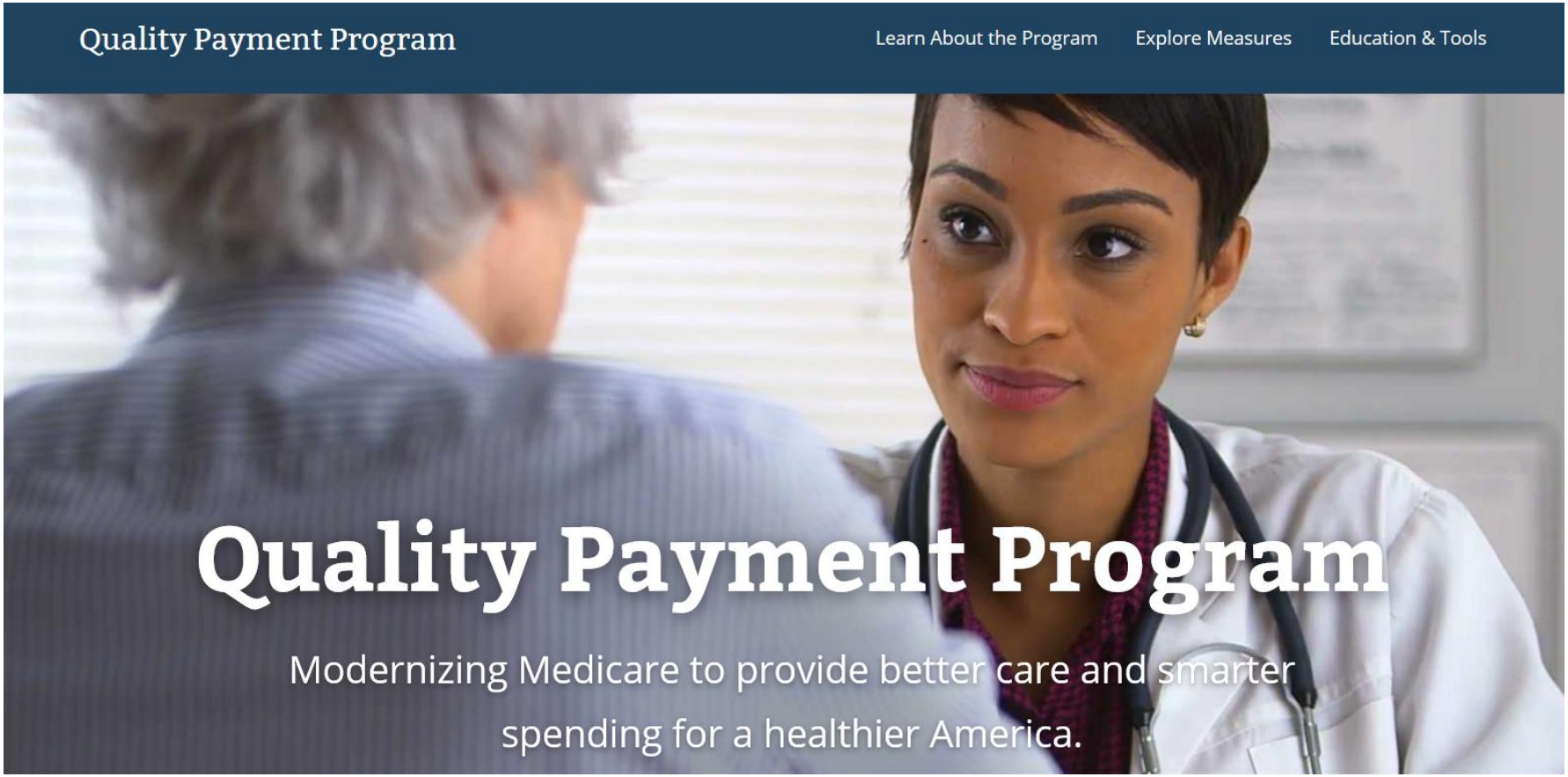
*Based on 2014 PQRS reporting.

The Role of Internal Medicine



The additional challenge for a group practice…….

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



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dale-bratzler@ouhsc.edu