MACRA-Impacts on Primary Care Providers and Practices

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MACRA 101

PCPCC Fall Conference 2015

November 12, 2015
Medicare Access and CHIP Reauthorization Act

- 18th time is a charm: MACRA repeals the 1997 sustainable growth rate for Part B payments
- Replaces the SGR with a new payment method that is meant to move physicians towards alternative payment models (APMs).
  - 2016-2019: Annual update of 0.5%
  - 2019-2025: 0% update + bonus payments under two available tracks
  - 2026 and beyond: Positive updates resume
Physicians Have a Choice

- Remain in fee-for-service and participate in the **Merit-Based Incentive Payment System (MIPS)**
  - Physician Quality Reporting System (PQRS)
  - Value-Based Payment Modifier
  - Meaningful Use Electronic Health Record (EHR) Incentive Program
Other Choice: APMs

- If providers don’t want to remain in FFS, they can participate in the second track called **Alternative Payment Models (APMs)**
  - New payment models that focus on quality and value
    - Requires provider risk and quality measurement
  - Provides financial incentives (5% annual bonus in 2019-2024) and exemption from MIPS requirements
MIPS Applies To...

- Physicians
- Nurse Practitioners
- Clinical Nurse Specialists
- Physician Assistants
- Certified RN Anesthetists
MIPS – Starting 2019

- Performance based on 4 categories:
  - Quality – PQRS measures
  - Resource use – Cost measures
  - Clinical practice improvement activities – Care coordination, pt. satisfaction, access
  - EHRs – Meaningful use measures
MIPS Weighting

- Quality: 30%
- Resource Use: 25%
- Clinical Improvement: 30%
- EHR Use: 15%
How Much Can MIPS Adjust Payment?

- Based on the MIPS composite performance score, providers receive +, -, or neutral payment adjustments
  - 2019: +/- 4%
  - 2020: +/- 5%
  - 2021: +/- 7%
  - 2022 and beyond: +/- 9%
What’s the MIPS Score?

- Composite performance score based on achievement and improvement
- Composite performance score ranges 0-100 and threshold based on the mean/median scores of all professionals from the prior period
What is an APM?

- A CMMI model under section 1115A
- Medicare Shared Savings Program
- Demonstration under the Health Care Quality Demonstration Program
- A demonstration required by Federal law
Not Every Alternative Model is an APM

To qualify as an eligible APM, the APM must:

- Require participants to use certified EHRs
- Base payment on quality measures “comparable to” MIPS quality measures
- Require participants to bear more than nominal financial risk for monetary losses or operate as a medical home model under CMMI
A Tale of Two APMs

- Most providers APMs will be subject to MIPS (clinical practice improvement activities)

- Those who participate in the most advanced APMs may be determined to be qualifying APM participants ("QPs")
  - Are not subject to MIPS
  - Receive 5% lump sum bonuses for years 2019-2024
  - Receive a higher fee schedule update for 2026 and beyond
Bonus Payments for Advanced APMs

• 5% bonus payments for Qualifying Professionals who bear risk
  – 2019-2020: 25% of Medicare revenue
  – 2021-2022: Either 50% of Medicare revenue OR 25% of Medicare revenue and 50% of all-payer revenue
  – 2023 and on: Either 75% of Medicare revenue OR 25% of Medicare revenue and 75% of all-payer revenue
Partial Credit Qualifying Providers

- CMS will also provide relief for partial qualifying APM participants
  - Professionals who meet slightly reduced APM thresholds and can choose whether to participate in MIPS.
CMS RFI – Wow

CMS seeks public comment on:

- MIPS EP Identifier and Exclusions
- Virtual Groups
- Quality Performance Category
- Resource Use Performance Category
- Clinical Practice Improvement Activities Performance Category
- Meaningful Use of Certified EHR Technology Performance Category
- Other Measures
- Development of Performance Standards
- Flexibility in Weighting Performance Categories
- MIPS Composite Performance Score and Performance Threshold
- Public Reporting
- Feedback Reports
## Timeline

<table>
<thead>
<tr>
<th>Year</th>
<th>Fee</th>
<th>MIPS Quality</th>
<th>MIPS Resource Use</th>
<th>MIPS Clinical Practice Improvement Activities</th>
<th>MIPS Meaningful Use of Certified EHR Technology</th>
<th>APM Qualifying APM Participant</th>
<th>APM Medicare Payment Threshold</th>
<th>APM Excluded from MIPS</th>
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*Qualifying APM conversion factor
**Non-qualifying APM conversion factor

Source: Centers for Medicare and Medicaid Services
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MACRA: Physician Group Perspectives

Presented to PCPCC
November 12, 2015
CAPG: Who We Are

- CAPG represents over 190 physician groups in 39 states, Puerto Rico, and Washington, DC

- The model – financial and clinical accountability
  - Payment is capitated to the multi-specialty physician group (usually per-member, per-month)
  - Physician group is clinically responsible for defined patient population
  - Robust internal and external quality reporting programs
MACRA: The Future of Physician Payments in Medicare

• MACRA creates two paths:
  – MIPS: “fee-for-service plus quality link” path
  – APM: accountable care organization or other risk-bearing organization path

• Which path will be more attractive for multi-specialty physician groups?

• Between now and 2019 when incentives begin:
  – Assessing existing options
  – Building and testing new options
  – It’s all about the regs!
Qualifying Alternative Payment Models

APMs

- Bigger Universe of all APMs

Bonus-Eligible APMs

- Narrower universe of “eligible” APMs
Narrower Set of Bonus-Eligible APMs Must Meet Criteria

Qualifying Model
- Innovation Center Model
- Shared Savings Program
- Demo required by federal law

Quality Measures
- Quality measures comparable to MIPS; and
- Uses certified EHR technology

Financial Model
- Bears financial risk for monetary losses in excess of a nominal amount; OR
- Certain primary care medical homes
## Eligible APM Thresholds

| Percentage of revenue that must be earned through APM to be considered an “Eligible APM” |
|---|---|---|
| **2019-2020** | **2021-2022** | **2023 and beyond** |
| 25% Medicare Part B payments attributable to APM entity | Option 1: 50% Medicare Part B Revenue | Option 2: 50% of all-payer revenue including 25% of Medicare Part B Revenue |
| | Option 1: 75% of Medicare Part B Revenue | Option 2: 75% all-payer Revenue, including 25% Medicare Part B Revenue |
What are Qualifying APMs?

• To hit the revenue threshold and meet risk-bearing requirements in Medicare Part B, do you have to be in an ACO?
  – Views on ACO program to-date are mixed
  – Time to make improvements to Medicare ACOs
  – New Next Generation ACO program holds promise for CAPG members

• Potential for development of new APMs
Developing New APMs

- MACRA anticipates the need for new APM options
- Establishes a Physician Focused Payment Model Technical Advisory Committee (TAC)

Notice and Comment rulemaking to develop criteria for evaluation of new models

- Stakeholders submit models for review
- TAC will review and make recommendation to Secretary of HHS
- Secretary of HHS will respond
APM Path Summary

- Potential for more certainty in eligible APM path – but a lot of pieces still need to be defined

- Bonus “cliff” in 2024

- Time to improve existing APMs and develop new APMs
What about Medicare Advantage?
Medicare Advantage on a Trajectory Parallel to FFS but More Advanced

Traditional (FFS) Medicare
- Fee-for-service

Fee-for-service plus quality link

Medical home

Fee-for-service plus quality link

Medical home

Fee-for-service

Shared Savings Track 1, 2 and 3

Next Gen ACO (2017)

Capitation

ACO

Medicare Advantage

RISK
Medicare Advantage APMs

• Q: How do Medicare Advantage (MA) APMs (contract between physician and MA plan) fit into MACRA bonus eligibility?
• A: MA counts in the all-payer category, but MA risk-bearing arrangements alone are not enough to qualify for APM bonus
  – A hypothetical physician group could have 90% of their Medicare in a MA capitated contracts; but if they don’t have 25% of their Part B in an APM, they will be in MIPS

• MACRA requires an MA APM study
  – By July 1, 2016, HHS is required to report to Congress on the feasibility of integrating the APM concept in Medicare Advantage

• CMS has released surveys and requests for information to MA plans about how those plans pay physicians
MA Summary Points

• Medicare Advantage payments to physicians on a similar trajectory in terms of APM development

• CAPG continues to work to advance APMs in MA

• How does CMS collect information about relationships between physician groups and “all-payers” for threshold purposes?
Conclusion

• Educate! Time for physicians and physician groups to learn about MACRA and implementation

• Engage! Submit comments and feedback to CMS in response to the RFI and the proposed rule

• Assess! Look at your options in your market, understand the opportunities that are available
Questions?

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MACRA: Impact on Primary Care

Patient Centered Primary Care Collaborative (PCPCC)
Fall Conference 2015

November 11, 2015
Key Areas of Importance about MACRA for Primary Care Clinicians/Practices to Know...

- **MIPS**:  
  - Clinical practice improvement activities  
  - Current FFS barriers and opportunities

- **APMs**:  
  - PCMH qualifies without taking on risk  
  - But not all PCMHs will “count” yet

- **Crosscutting Issues**:  
  - Technical Assistance Opportunities  
  - Private Payer and other Stakeholder Engagement - HCPLAN
Clinical Practice Improvement Activities

- The subcategories shall include at least the following:
  - Expanded practice access
  - Population management
  - Care coordination
  - Beneficiary engagement
  - Patient safety and practice assessment
  - Participation in an APM

- Must be established in collaboration with professionals

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

- How will these need to be reported/tracked? Need to ensure minimal burden but still push toward value.
Clinical Practice Improvement Activities – MACRA RFI

- CMS seeks comment on other potential clinical practice improvement activities (and subcategories of activities), and on the criteria that should be applicable for all clinical practice improvement activities.

- Seeking comment on subcategories of:
  - Promoting Health Equity and Continuity
  - Social and Community Involvement
  - Achieving Health Equity
  - Emergency preparedness and response
Clinical Practice Improvement Activities – PCMH and PCMH Specialty Practices

- “Certified” PCMH and PCMH specialty practices receive highest potential score
- 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.?
- PCPCC is developing recommendations related to PCMH accreditation programs.
It is important to briefly note what is also happening now in FFS that impacts PC...

Significant Barriers:
- Loss of Medicaid Pay Parity
- Likely loss of Primary Care Incentive Payment
- PAMA & ABLE Act RVU target impact on FFS payment

Opportunities:
- Transitional Care Management (TCM) – can now bill it on the day of the visit
- Chronic Care Management (CCM)
- Advance Care Planning
- Welcome to Medicare and Annual Wellness Visits
- CMS’ interest in other “add-on” codes more focused on value
PCMH as an Alternative Payment Model in MACRA

Strict definition:

- PCMH as expanded under the CMS Innovation Center can be an eligible APM without taking on financial risk
  - i.e., the Comprehensive Primary Care (CPC) Initiative

But...

- There are lots of other PCMH programs across the country
  - Initially, they will fall under MIPS
  - However, over time this will hopefully change
PCMH as an APM in the future

- Beginning in 2021, the threshold % (of payments or patients) to be an eligible APM may be reached through a combination of Medicare and other non-Medicare payer arrangements, such as private payers and Medicaid.

- The physician-focused payment model pathway is intended to allow for more APMs to be counted.

It is important to note that PCMH is a delivery model, not a payment model by itself (HCPLAN workgroup draft paper) – it can be supported by different payment approaches – and we need CMS to recognize and “count” those different approaches in the APM pathway.
Technical Assistance Opportunities

- The Secretary is required to enter into contracts or agreements with entities (such as QIOs, RECs) to offer guidance and assistance to MIPS EPs in practices of 15 or fewer professionals with respect to the MIPS performance categories or in transitioning to the implementation of, and participation in, an APM.
- $20 million annually from 2016-2020
- CMS and ONC are working on better organizing their technical assistance tools into one place.
New Acronyms!

- TCPI - Transforming Clinical Practices Initiative
- Practice Transformation Networks: PTN
  - Peer-based learning networks designed to coach, mentor and assist clinicians in developing core competencies specific to practice transformation
- Support and Alignment Networks: SAN
  - Provide a system for workforce development utilizing national and regional professional associations and public-private partnerships that are currently working in practice transformation efforts.
  - Utilizing existing and emerging tools, these networks will help ensure sustainability of these efforts.
  - Support the recruitment of clinician practices serving small, rural and medically underserved communities and play an active role in the alignment of new learning.
PTN Recipients: 29

- Arizona Health-e Connection
- Baptist Health System, Inc.
- Children's Hospital of Orange County
- Colorado Department of Health Care Policy & Financing, Community Care of North Carolina, Inc.
- Community Health Center Association of Connecticut, Inc.
- Consortium for Southeastern Hypertension Control
- Health Partners Delmarva, LLC
- Iowa Healthcare Collaborative
- Local Initiative Health Authority of Los Angeles County
- Maine Quality Counts
- Mayo Clinic
- National Council for Behavioral Health
- National Rural Accountable Care Consortium
- New Jersey Innovation Institute
- New Jersey Medical & Health Associates dba CarePoint Health
- New York eHealth Collaborative
- New York University School of Medicine
- Pacific Business Group on Health
- PeaceHealth Ketchikan Medical Center
- Rhode Island Quality Institute
- The Trustees of Indiana University
- VHA/UHC Alliance Newco, Inc.
- University of Massachusetts Medical School
- University of Washington
- Vanderbilt University Medical Center
- VHQC
- VHS Valley Health Systems, LLC
- Washington State Department of Health
SAN Recipients: 10

- American College of Emergency Physicians
- American College of Physicians, Inc.
- HCD International, Inc.
- **Patient Centered Primary Care Foundation**
- The American Board of Family Medicine, Inc.
- Network for Regional Healthcare Improvement
- American College of Radiology
- American Psychiatric Association
- American Medical Association
- National Nursing Centers Consortium
MACRA is part of a broader push towards value and quality

In January 2015, the Department of Health and Human Services announced new goals for value-based payments and APMs in Medicare

**Medicare Fee-for-Service**

**GOAL 1:**
- 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:**
- 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

**Stakeholders:**
- Consumers
- Businesses
- Payers
- Providers
- State Partners

**Source:** https://www.lansummit.org/wp-content/uploads/2015/09/4G-00Total.pdf
Health Care Payment Learning and Action Network (HCP LAN)

- Kicked off on March 25, 2015
- The MITRE Corporation is convening and independently managing the HCP LAN Guiding Committee and Work Groups on behalf of CMS.
- The goal of the LAN is to align private payers and the CMS in moving payment from traditional FFS methods to FFS-linked to quality and APMs.
- Guiding Committee, Workgroups, and Affinity groups – you can sign up to be a LAN Partner
Draft APM Framework

Note how PCMH/primary care can fit into a number of different categories below...

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<thead>
<tr>
<th>Category 1</th>
<th>Fee-for-Service – No Link to Quality</th>
<th>Category 2</th>
<th>Fee-for-Service – Link to Quality</th>
<th>Category 3</th>
<th>APMs Built on Fee-for-Service Architecture</th>
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<td>Research and Sensitivity for Performance</td>
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<td>APMs with Specialized/Patient Interaction</td>
<td><strong>D</strong></td>
<td>APMs with Specialized/Patient Interaction</td>
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- **Traditional FFS**
- **Data Not Linked to Quality**
- **Price Data**
- **Payment Data**

The government wants private payers, providers, consumers and employer groups who pay for care “to move in the same direction.”

Patrick Conway, Acting Principal Deputy Administrator, CMS, at Capitol Hill Briefing: Transforming Health Care to Drive Value November 6, 2015
Questions?

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