MACRA Implementation Update
13th National Value-Based Payment and Pay for Performance Summit
March 2, 2018

Barbara L. McAneny, MD
Incoming President of the AMA
AMA – Who we are

• **Membership**
  Largest physician organization in the U.S.

• **House of Delegates**
  186 state and specialty societies
  >1000 representatives

• **Board of Trustees**
  21 members
MACRA/QPP
MACRA established two Medicare paths for physicians

- MACRA was designed to offer physicians a choice between two payment pathways:
  - A modified fee-for-service model (MIPS)
  - New payment models that reduce costs of care and/or support high-value services not typically covered under the Medicare fee schedule (APMs)

- In short-term, most are expected to participate in MIPS

- CMS named the physician payment system created by the Medicare Access and CHIP Reauthorization Act (MACRA) law the Quality Payment Program (QPP)
Top Down vs. Bottom Up: A Tale of Two Models

**Payer-Driven**
- Payer identifies problem (oncology costs too high)
- Payer changes reimbursement structure
- Practices change (reactive)

**Provider-Driven**
- Payers recognize value
- New service delivery model
- Provider/practice identifies problem (oncology care could be more patient centric)
Merit-based Incentive Payment System
Some general observations

• QPP created by MACRA is complex

• Most of the “new” requirements are really revisions to the legacy FFS programs
  • Perceptions/ understanding shaped by participation in legacy programs
  • Those who chose to accept penalties before may still decline to participate
    • Penalties less severe than combined legacy programs

• One goal of MACRA was to simplify administrative processes for physicians
  • Many improvements in effect now

• There is more work to do
  • Improving the practice environment is a high priority for the AMA
## 2019 and 2020 penalty risks compared

<table>
<thead>
<tr>
<th>Legacy programs</th>
<th>Potential adjustments</th>
</tr>
</thead>
<tbody>
<tr>
<td>PQRS</td>
<td>-2%</td>
</tr>
<tr>
<td>MU</td>
<td>-5%</td>
</tr>
<tr>
<td>VBM</td>
<td>-4% or more*</td>
</tr>
<tr>
<td><strong>Total penalty risk</strong></td>
<td><strong>-11% or more</strong>*</td>
</tr>
<tr>
<td>Bonus potential (VBM only)</td>
<td>Unknown (budget neutral)*</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MIPS factors</th>
<th>2019 scoring</th>
<th>2020 scoring</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality measurement</td>
<td>60% of score</td>
<td>50% of score</td>
</tr>
<tr>
<td>Advancing Care Info.</td>
<td>25% of score</td>
<td>No change</td>
</tr>
<tr>
<td>Cost</td>
<td>0% of score</td>
<td>10% of score</td>
</tr>
<tr>
<td>Improvement Activities</td>
<td>15% of score</td>
<td>No change</td>
</tr>
<tr>
<td><strong>Total penalty risk</strong></td>
<td><strong>Max of -4%</strong></td>
<td><strong>Max of -5%</strong></td>
</tr>
<tr>
<td>Bonus potential</td>
<td>Max of 4%, plus potential 10% for high performers</td>
<td>Max of 5%, plus potential 10% for high performers; bonus points available for complex patients, small practices</td>
</tr>
</tbody>
</table>

*VBM was in effect for 3 years before MACRA passed, and penalty risk was increased in each of these years; there were no ceilings or floors on penalties and bonuses, only a budget neutrality requirement.*
MACRA-Quality Payment Program (QPP)

• Remains a high priority for the AMA
• AMA advocacy successes mean:
  • A more workable transition
  • More practices are exempt
  • Special provisions to benefit small practices
• Visit: ama-assn.org/navigating-payment for information, tools and resources
Alternative Payment Models
QPP criteria for “Advanced APMs”
ACO financial performance by ACO model, 2016

- MSSP T1 (419 ACOs): Savings: 0.7%, Loss: -0.8%
- MSSP T2-3 (22 ACOs): Savings: 2.4%, Loss: -1.0%
- Pioneer (8 ACOs): Savings: 1.8%, Loss: -1.1%
- NextGen (18 ACOs): Savings: 0.0%, Loss: -1.1%

Source: CMS data. Results preliminary and subject to change.
ACO quality assessed predominantly on process measures

- ACOs have consistently high overall quality scores
- But in all ACO models, more than half of measures are process measures
- On population-based outcome and patient experience measures, ACOs maintain at least average results
  - MSSP ACOs: Slightly higher performance on readmissions measure compared to FFS
  - ESCOs: Patient experience similar to national average
CMS models qualified as Advanced APMs

- Comprehensive ESRD Care Model
  (Subset of 37 ESCOs qualify)

- Comprehensive Primary Care Plus
  (2,816 Round 1 practices + 165 Round 2)

- ACOs: Tracks 1+, 2, 3 NextGen, Vermont
  (159 ACOs + VT)

- Bundled Payments for Care Improvement Advanced
  (starts 10/1/2018)

- Oncology Care Model Track 2
  (Subset of 192 practices qualify)

- Comprehensive Joint Replacement
  (Subset of participants in 67 MSAs qualify)
Pros & cons of CMS-developed APMs

Pros:

• Extra $$ for non-face-to-face services and support staff

• 5% annual bonus to Advanced APMs in 2019-24 with higher update after 2026

• Ease of MIPS participation for MIPS APMs and MIPS exemption for Advanced APMs

• Waivers improve patient access to telehealth and post-acute care

• Opportunities to share savings can lead to better treatment planning
Pros & cons of CMS-developed APMs

Cons:

- Financial risk rules force physicians to be accountable for costs outside their control
- Lack of risk adjustment hurts practices with more complex patients, worse functional status, poor support at home
- No incentive for HIT innovation
- Added documentation burdens
- Attribution methods limit patient access to APMs’ benefits and keep physicians guessing which of their patients are in APMs
- No recognition of ACO start-up costs and ACO benchmarks hurt efficient practices
- Difficult to get timely data and feedback from CMS
- Years-long waits for shared savings payments
Physician-focused APMs under MACRA

Definition:

- Medicare is a payer
- MACRA-eligible clinicians are participants and play core role in implementing APM’s payment methodology
- Targets quality and costs of services that clinicians participating in the APM provide, order, or can significantly influence

PFPM = Physician-Focused Payment Model
Goal: to encourage new APM options for Medicare clinicians

Submission of model proposals by stakeholders → Technical Advisory Committee
11 GAO appointed care delivery experts that review proposals, submit recommendations to the HHS Secretary → Secretary comments on CMS website, CMS considers testing proposed models
AMA promotes physician-focused APMs

Medicare payments will be increasingly tied to APMs

See examples of physician-focused APMs at: ama-assn.org/MACRA

Clips from AMA’s APM Workshop:

https://youtu.be/DdsVIS-dEMo
Physician-focused APM Technical Advisory Committee (PTAC)

- 11-members (7 MDs) created to review stakeholder APM proposals, make recommendations to HHS Secy
- 21 proposals submitted in 2017
- 14 additional Letters of Intent with future proposals expected
- In 3 public meetings to review proposals, PTAC recommended 6 models be tested or implemented:
  1. Project Sonar (Crohn’s Disease)
  2. American College of Surgeons-Brandeis Episodes
  3. Hospital at Home Plus
  4. Oncology Bundled Payment Using CNA-Guided Care
  5. Advanced Primary Care
  6. Incident End Stage Renal Disease Clinical Episode
Physician-focused APM for Crohn’s Disease

• “Patients are like submarines…out there submerged. We can’t see them; we don’t know how they are [because] they only come in when they’re in trouble. Which means that, number one, they have to recognize that they’re in trouble and, number two, realize that they can’t fix it themselves…So we need a sonar system to ping them.”

  Larry Kosinski, MD, Sonar Founder

• **Opportunities for Improvement:**
  - Payer was spending $22,000 per patient per year for Crohn’s
  - >50% of spending went to hospital costs
  - 2/3 of patients had 0 physician visits 30 days before admission
Barriers to improving patient care

- No process, staff, or payment for outreach to patients between visits to find out how they are doing and adjust treatment plan
- No data to show how often complications of Crohn’s Disease led to emergency visits and hospitalizations
- No process for engaging patients as partners in their care
- No IT platform to share information with other team members, patients’ other physicians, or patients themselves
- Financial penalties incurred by gastroenterologist for practicing more efficiently
Project Sonar design

- Payer attributes patients based on diagnosis
- Once enrolled in Sonar, patient has enrollment visit, care management plan is developed, patient signs off
- Nurse care managers ping patients with disease specific questions
- “Sonar score” calculated based on patient’s response to ping
- Patients get immediate feedback
- Care manager uses algorithm to interpret Sonar score, contacts physician if necessary so treatment can be adjusted
- Sonar provides performance reports to practices including claims data
Sonar APM yields results

• Monthly payments support:
  • Nurse care managers
  • Clinical decision support tools
  • Proactive outreach to high-risk patients

• Hospitalization rate and emergency visits cut > 50%
• Payer spending significantly reduced
• Patient satisfaction improved
• Following PTAC recommendation to HHS Secy, Medicare now studying use of Sonar APM for other chronic conditions
Physician-focused APM for emergency care

- Many emergency department (ED) patients do not have a regular source of primary care or mental/behavioral health care.
- Current system does not support providing primary or mental health care services in the ED; patient education and care coordination in ED; post-ED home visits; non-medical needs.
- Common post-ED events: repeat ED visits, inpatient admissions, observation stays, repeat opioid overdose, death.
- Opportunity to improve care by providing support for discharge planning, appropriate care transitions and post-ED care coordination.
Pilot Program “Bridges to Care” (B2C)

- Funded by CMS Innovation Award
- Care coordination targeted patients with \( \geq 3 \) ED visits in 6-month period:
  - Community health workers
  - Primary care physicians
  - Care coordinators
  - Community organizers
  - Behavioral health referrals
  - Health coaches
B2C Pilot Program Results

See *Health Affairs* 36, NO. 10 (2017): 1705–1711
The Oncology Care Model
The Oncology Care Model (OCM)

Patient population: The CMMI Payment Model applies to all patients with new chemo start

Episode definition: 6 months following new chemotherapy start, repeatable

Payments – OCM pays physicians in three ways:
- Normal FFS Payment
- $160 PBPM (per beneficiary per month)
- Shared Savings/Risk Sharing

Episode Price/Discount to Medicare:
- 4% discount for shared savings
- 2.75% discount for accepting full risk
What’s Good About the OCM
What’s Problematic About the OCM
What’s Problematic About the OCM: Target Calculation

- 16K historical episode data (2012-2015) from CMS
- Residual Value: OCM model predicted value - actual values for each historical episode
- Residual Plot: Scatter Plot of Residual vs Predicted Value
- If the points are not randomly dispersed across the red line, than a linear regression model is inappropriate. R-squared =0.334
- Time and Clinical data are not included in the model -> Residual plot not randomly dispersed around the red line.
Current CMS Model- Generalized Linear Model (GLM)

- Only Claims data

- Variables
  - Age/Sex/Cancer type
  - Part D Chemotherapy drugs taken/administered during the episode
  - Receipt of cancer-related surgery
  - Part D eligibility and dual eligibility for Medicare and Medicaid
  - Receipt of radiation therapy
  - Receipt of bone marrow transplant
  - Clinical trial participation
  - Comorbidities (HCC)

- Variables (continued)
  - History of prior chemotherapy use
  - Institutional status
  - Episode length
  - Geographic location/Hospital Referral Region

- Model was built without explicit consideration of Time

- Cost increase with time- Trend Factor may be needed

- Novel Therapies and Expensive Drugs may require corrections and adjustments to the model
Pancreatic Cancer

- Below are 2 patients which show huge actual price differences but with identical baseline prices with the following similarities
  - Same Cancer Type, Same HCC group
  - Age, Gender
  - No Surgery, No Radiation
  - No Clinical Trial

<table>
<thead>
<tr>
<th>Actual Expense</th>
<th>Baseline Price</th>
<th>Age</th>
<th>Gender</th>
<th>Episode Start</th>
<th>Episode End</th>
<th>Zip</th>
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<tbody>
<tr>
<td>$9688.51</td>
<td>$22598.69</td>
<td>80</td>
<td>Male</td>
<td>10-01-2014</td>
<td>03-31-2015</td>
<td>45365</td>
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<tr>
<td>$49278.57</td>
<td>$22598.69</td>
<td>82</td>
<td>Male</td>
<td>10-06-2014</td>
<td>04-05-2015</td>
<td>45318</td>
</tr>
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</table>
### OCM risk arrangements

<table>
<thead>
<tr>
<th>One-Sided Risk Arrangement</th>
<th>Two-Sided Risk Arrangement</th>
</tr>
</thead>
<tbody>
<tr>
<td>• 4% OCM Discount</td>
<td>• 2.75% OCM Discount</td>
</tr>
<tr>
<td>• Practices not responsible for repaying Medicare for expenditures exceeding Target Amount</td>
<td>• Practices must repay Medicare expenditures exceeding Target Amount (up to 20% of Benchmark)</td>
</tr>
<tr>
<td>• All practices are currently in one-sided risk</td>
<td></td>
</tr>
</tbody>
</table>
Simulated PBPs – OCM Full Risk
Recommendations
Recommendations for Physician-Designed APMs

Payments are needed to support good diagnosis and treatment planning as well as care management; tying payments solely to treatments increases the incentive to give treatments.

Payment amounts must be adequate to cover costs and losses:

- Costs of delivering new services to patients not covered by FFS
- Losses of revenues from delivering fewer or lower-cost FFS services
- Administrative costs associated with evaluation requirements, etc.

Payment amounts and accountability measures should be stratified based on differences in patient needs (which involves more than just how many diagnoses they have).

Accountability for spending should be tied to specific types of utilization that the physician can control, not to total spending and not to prices of drugs.
MASON

- Transition from volume to value
- Builds on COME HOME, OCM, FFS, APC, and DRGs
- Oncology Payment Category (OPC)-Accurate Cost Target modeled on above methodology
- Tight-knit relationship between Patient, Care team- (physicians, caregivers and family)
- Personalized care plan based on multiple factors
- Uses Cognitive computing Platform (CCP) for best Diagnostic and Therapeutic Pathways (DTP)
- 2% of OPC is reserved for a quality pool
- Practices bear Risk from the purchase of Reinsurance which covers
  - expenses over the target if the patient is an outlier above a designated amount OR
  - if the practice incurs expenses in aggregate for patients over the designated amount
  - CMS would be repaid from the reinsurance money, if payments exceed OPC
- Shared Savings for practice
  - If all quality parameters are met AND
  - Actual episode cost less than OPC
Proposed Payment Model: MASON

Patient Assessed

Patient Assigned to Disease/Treatment Pool (OPC)

Quality/Outcomes Tracking: Pt placed on disease/treatment pathway: defines best practices care and quality measures to be tracked/reported

FFS Pmt/Tracking – targeted spending level det’d by pt assignment; FFS pmts directly from payer; payment transparently tracked

Capitalization of MASON Fund - Prospective amt deposited by payer; det’d by patient assignment

Payments made at Pt Enrollment (& monthly)

Payments/Deposits made over Episode of Care Payments made at Conclusion of Episode of Care

Risk Withhold

Quality Withhold

Practice Professional FFS Pmts

Other FFS Pmts

Risk Withhold

Quality Incentive Pmt

Shared Savings to Practice

Shared Savings to Payer or Loss up to Cap

Reinsurance Premium Covers Loss > Cap

Infrastructure Fees

Mgmt Fees

Reinsurance Premiums
MED ONC

ASSIGN TO A TREATMENT

MONITOR TREATMENT

ASSIGN TO OPC

VIRTUAL ACCOUNT (OPC)

PCOP PAYMENT E+M CODE

ASSIGN TO OPC + DRUG COST

Reinsurance

Quality Pool

END OF TREATMENT

Quality Measures

Met

ACTUAL $ < OPC

Shared Savings

ACTUAL $ > OPC

Reinsurance pays CMS

Not Met

NO SHARED SAVINGS
QUAL POOL GOES TO CMS

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