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

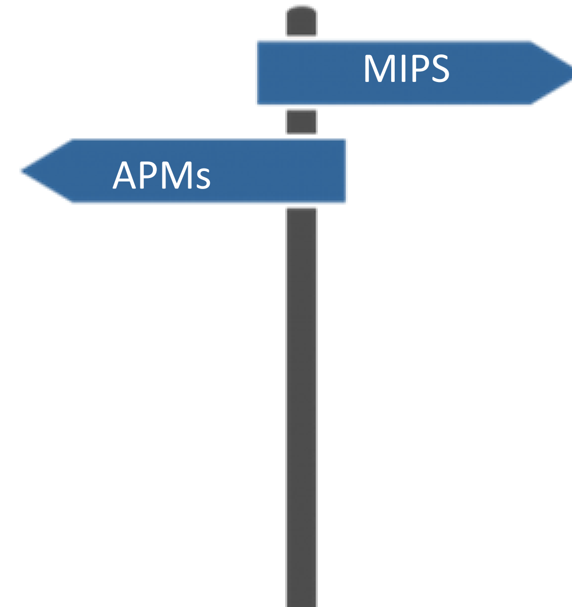
© 2018 American Medical Association. All rights reserved.
AMA

MACRA/QPP

© 2018 American Medical Association. All rights reserved.

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)

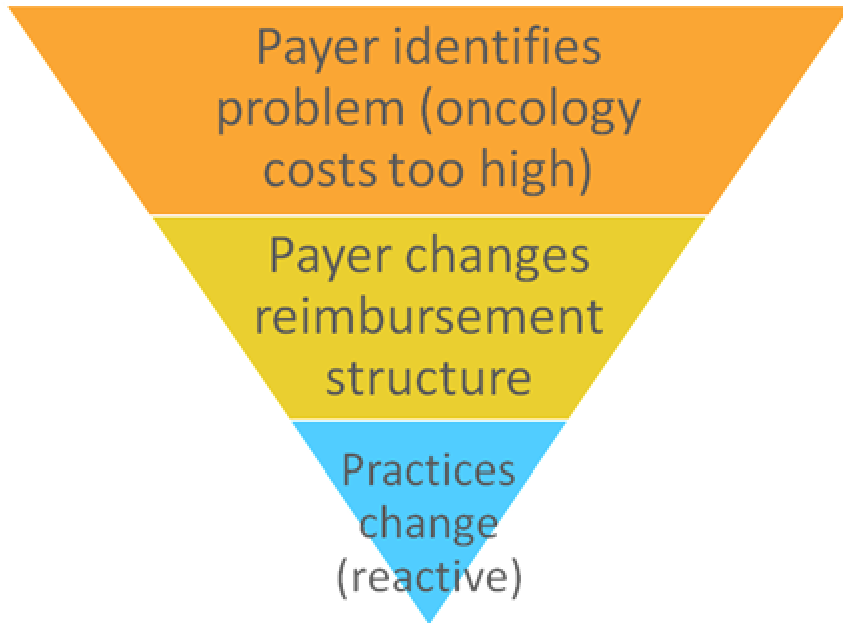


© 2018 American Medical Association. All rights reserved.

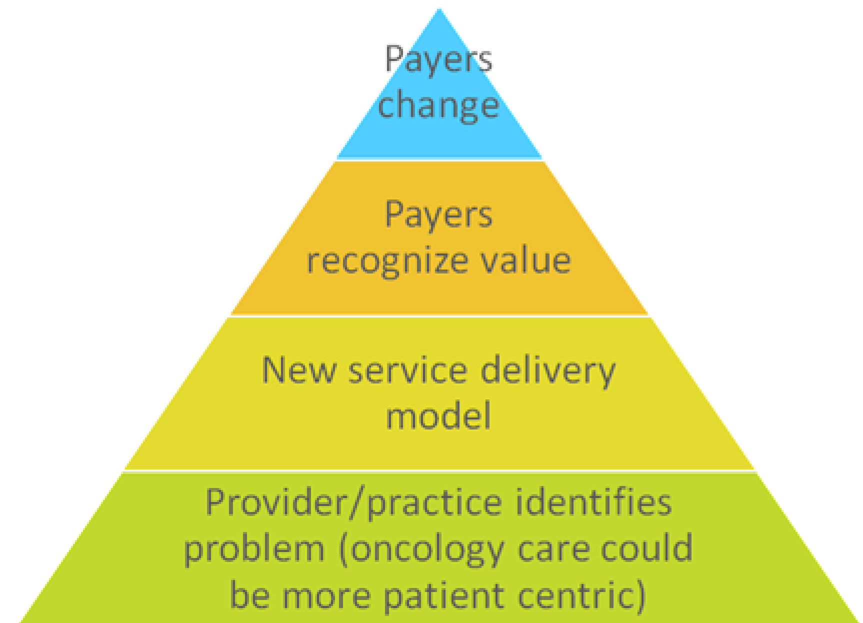
AMA

Top Down vs. Bottom Up: A Tale of Two Models

Payer-Driven



Provider-Driven



© 2018 American Medical Association. All rights reserved.

AMA

© 2018 American Medical Association. All rights reserved.

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

© 2018 American Medical Association. All rights reserved.

2019 and 2020 penalty risks compared

Legacy programs	Potential adjustments
PQRS	-2%
MU	-5%
VBM	-4% or more*
Total penalty risk	-11% or more*
Bonus potential (VBM only)	Unknown (budget neutral)*

*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.

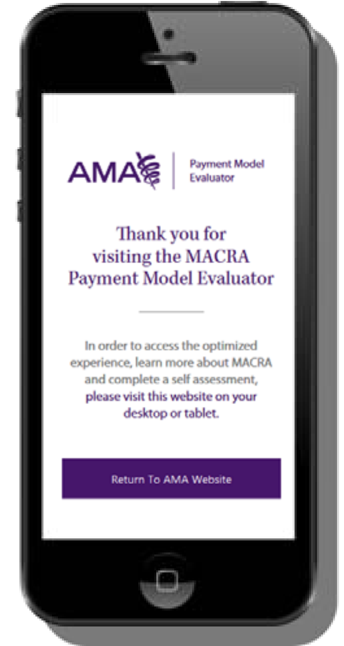
MIPS factors	2019 scoring	2020 scoring
Quality measurement	60% of score	50% of score
Advancing Care Info.	25% of score	No change
Cost	0% of score	10% of score
Improvement Activities	15% of score	No change
Total penalty risk	Max of -4%	Max of -5%
Bonus potential	Max of 4%, plus potential 10% for high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

© 2018 American Medical Association. All rights reserved.

AMA

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



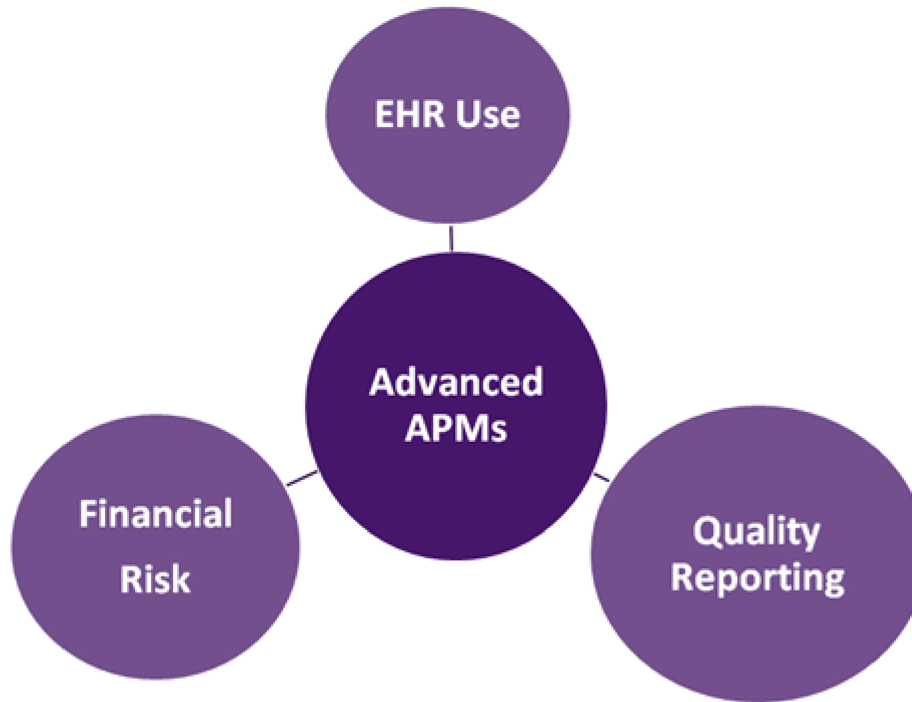
© 2018 American Medical Association. All rights reserved.
AMA

Alternative Payment Models

© 2018 American Medical Association. All rights reserved.

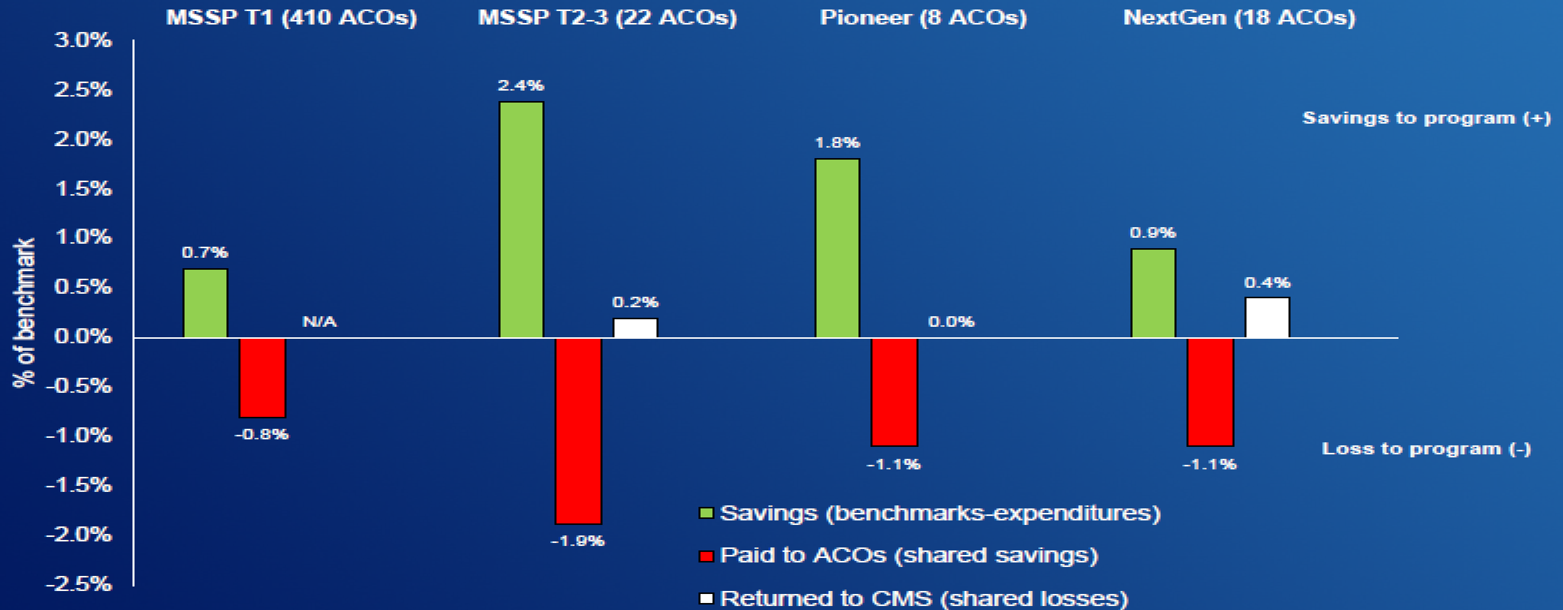
AMA

QPP criteria for "Advanced APMs"



© 2018 American Medical Association. All rights reserved.

AMA



© 2018 American Medical Association. All rights reserved.

AMA

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

MEDPAC

© 2018 American Medical Association. All rights reserved.

AMA

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)

© 2018 American Medical Association. All rights reserved.

AMA

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

© 2018 American Medical Association. All rights reserved.

AMA

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

© 2018 American Medical Association. All rights reserved.

AMA

Physician-focused APMs under MACRA

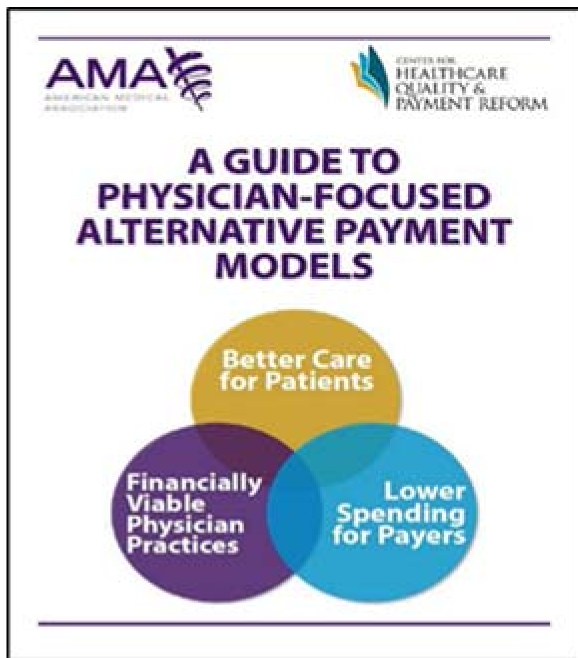
Definition:

- 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

© 2018 American Medical Association. All rights reserved.

AMA

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

© 2018 American Medical Association. All rights reserved.

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

© 2018 American Medical Association. All rights reserved.

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

© 2018 American Medical Association. All rights reserved.

AMA

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

© 2018 American Medical Association. All rights reserved.

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

© 2018 American Medical Association. All rights reserved.

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

© 2018 American Medical Association. All rights reserved.

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

© 2018 American Medical Association. All rights reserved.

AMA

Pilot Program "Bridges to Care" (B2C)

- Funded by CMS Innovation Award
- Care coordination targeted patients with ≥ 3 ED visits in 6-month period:
  - Community health workers
  - Primary care physicians
  - Care coordinators
  - Community organizers
  - Behavioral health referrals
  - Health coaches

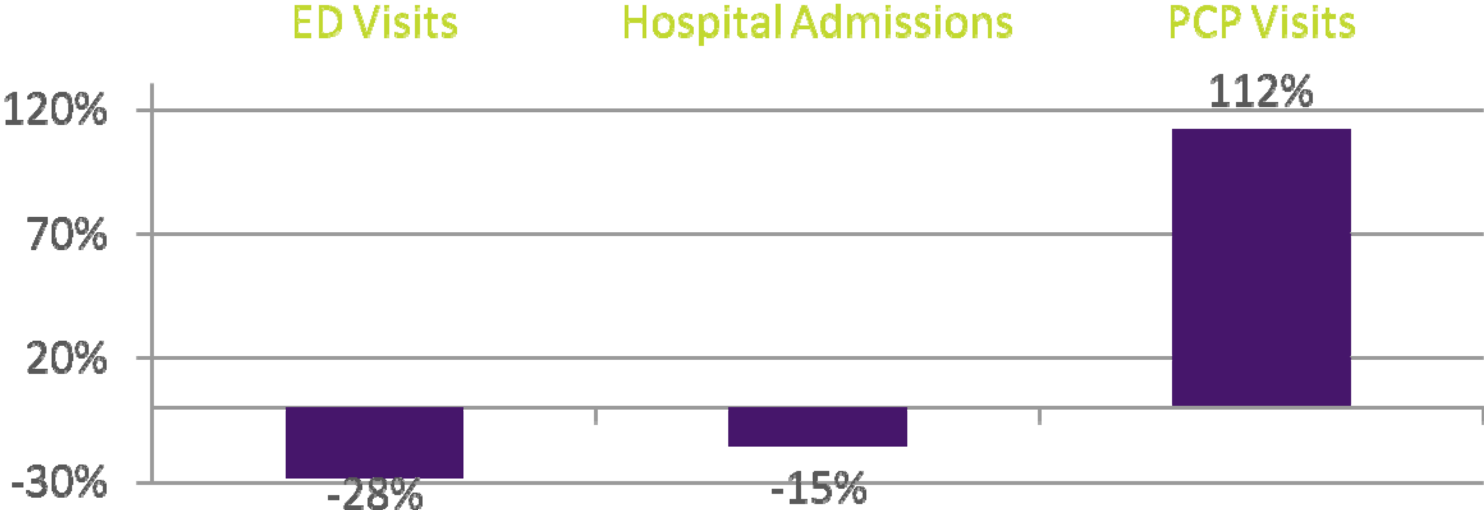
Coordination Program Reduced Acute Care Use And Increased Primary Care Visits Among Frequent Emergency Care Users

ABSTRACT Many high utilizers of the emergency department (ED) have public insurance, especially through Medicaid. We evaluated how participation in Bridges to Care (B2C)—an ED-initiated, multidisciplinary, community-based program—affected subsequent ED use, hospital admissions, and primary care use among publicly insured or Medicaid-eligible high ED utilizers. During the six months after the B2C intervention was completed, participants had significantly fewer ED visits (a reduction of 27.9 percent) and significantly more primary care visits (an increase of 114.0 percent), compared to patients in the control group. In a subanalysis of patients with mental health comorbidities, we found that recipients of B2C services had significantly fewer ED visits (a reduction of 29.7 percent) and hospitalizations (30.0 percent), and significantly more primary care visits (an increase of 123.2 percent), again compared to patients in the control group. The B2C program reduced acute care use and increased the number of primary care visits among high ED utilizers, including those with mental health comorbidities.

© 2018 American Medical Association. All rights reserved.

AMA

B2C Pilot Program Results

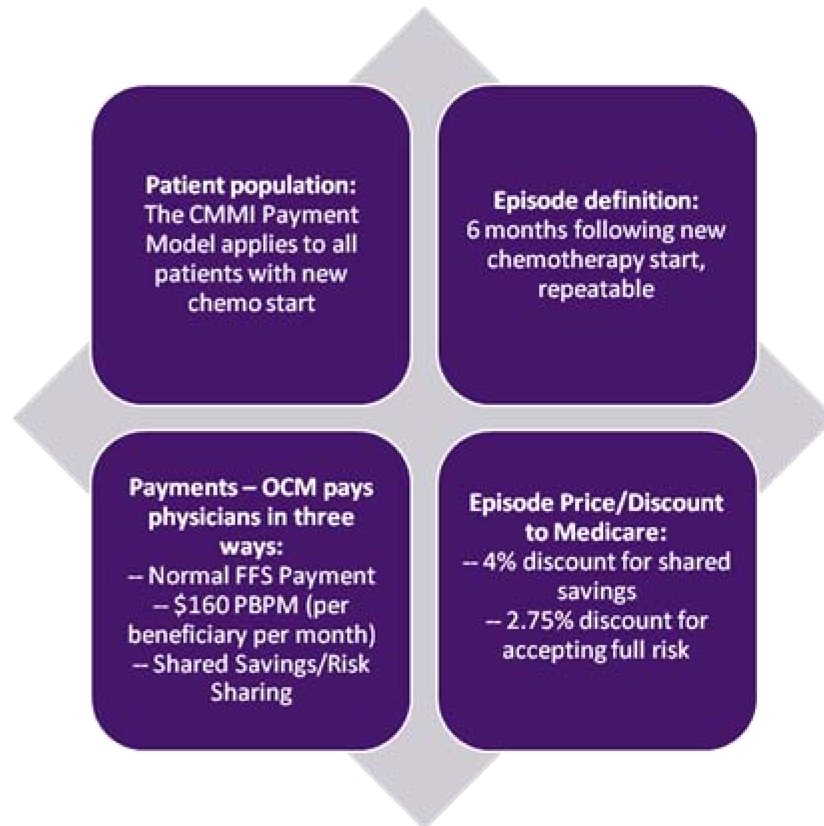


See *Health Affairs* 36, NO. 10 (2017): 1705–1711

© 2018 American Medical Association. All rights reserved.

© 2018 American Medical Association. All rights reserved.
AMA

The Oncology Care Model (OCM)



© 2018 American Medical Association. All rights reserved.
AMA

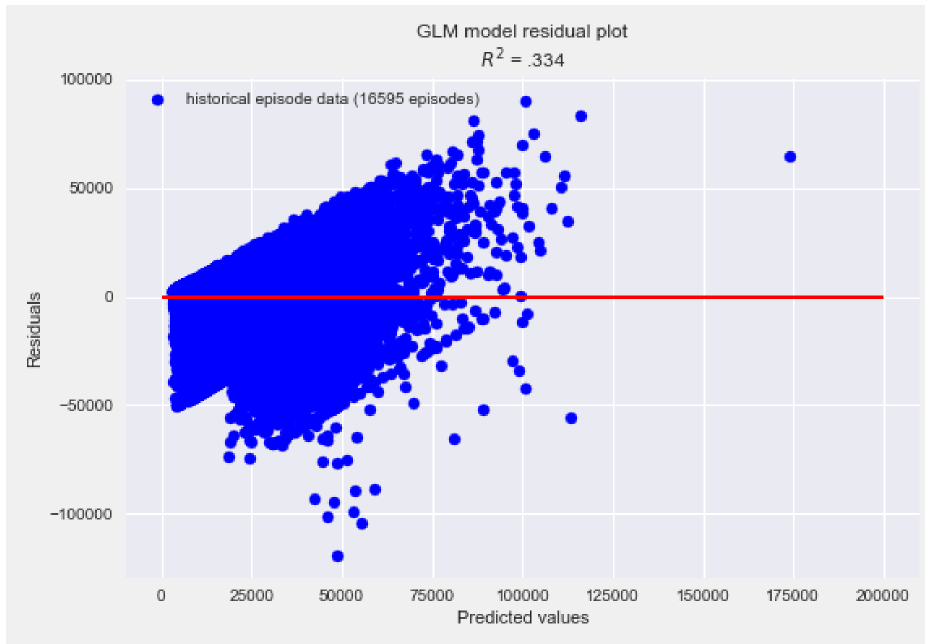
What’s Good About the OCM

© 2018 American Medical Association. All rights reserved.

© 2018 American Medical Association. All rights reserved.

AMA

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.

© 2018 American Medical Association. All rights reserved.
AMA

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

© 2018 American Medical Association. All rights reserved.
AMA

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

Actual Expense	Baseline Price	Age	Gender	Episode Start	Episode End	Zip
$9688.51	$22598.69	80	Male	10-01-2014	03-31-2015	45365
$49278.57	$22598.69	82	Male	10-06-2014	04-05-2015	45318

© 2018 American Medical Association. All rights reserved.

OCM risk arrangements

One-Sided Risk Arrangement	Two-Sided Risk Arrangement
• 4% OCM Discount • Practices not responsible for repaying Medicare for expenditures exceeding Target Amount • All practices are currently in one-sided risk	• 2.75% OCM Discount • Practices must repay Medicare expenditures exceeding Target Amount (up to 20% of Benchmark)

© 2018 American Medical Association. All rights reserved.

Simulated PBPs – OCM Full Risk

$1,000,000.00
$500,000.00
$0.00
-$500,000.00
-$1,000,000.00
-$1,500,000.00
-$2,000,000.00

© 2018 American Medical Association. All rights reserved.

Recommendations

© 2018 American Medical Association. All rights reserved.

AMA

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)

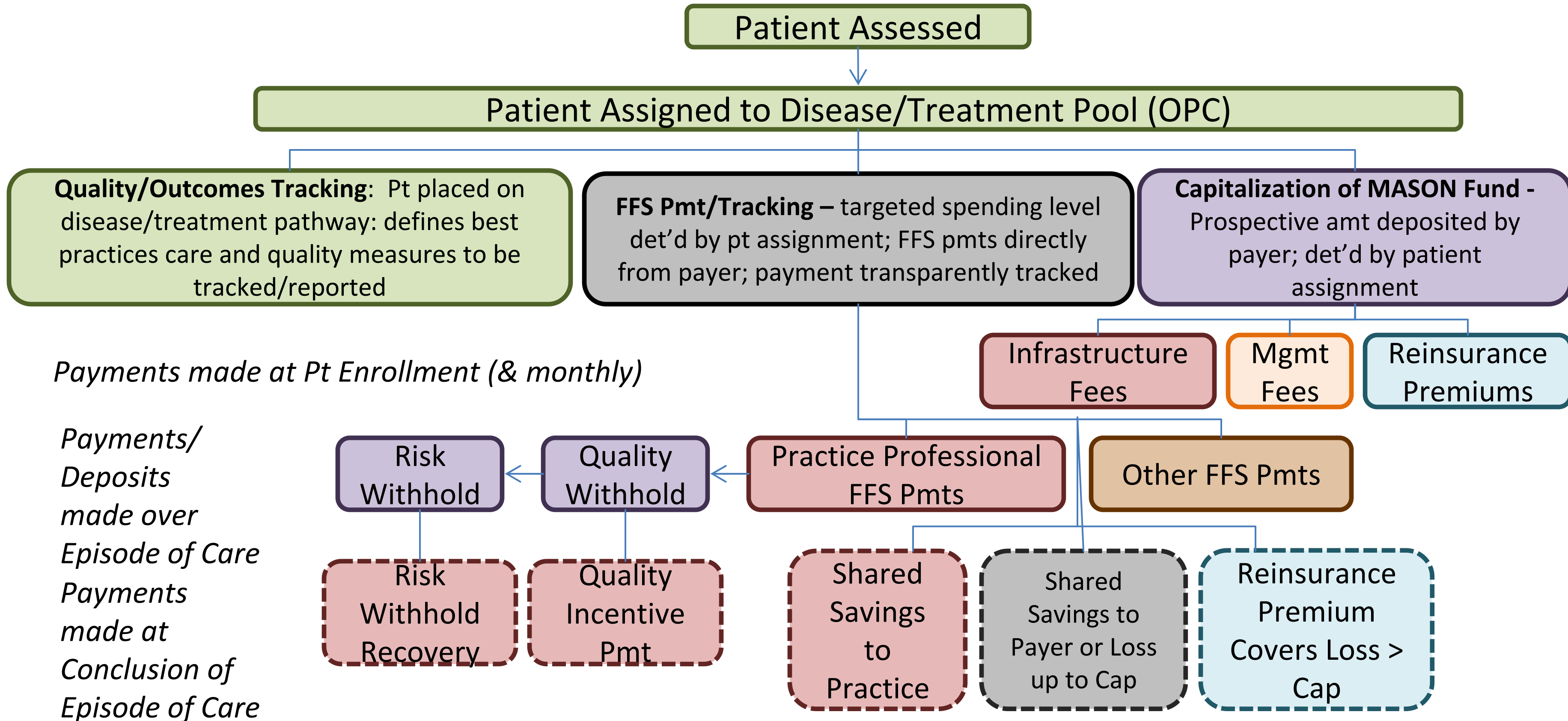
Accountability for spending should be tied to specific types of utilization that the physician can control, not to total spending and not to prices of drugs

© 2018 American Medical Association. All rights reserved.

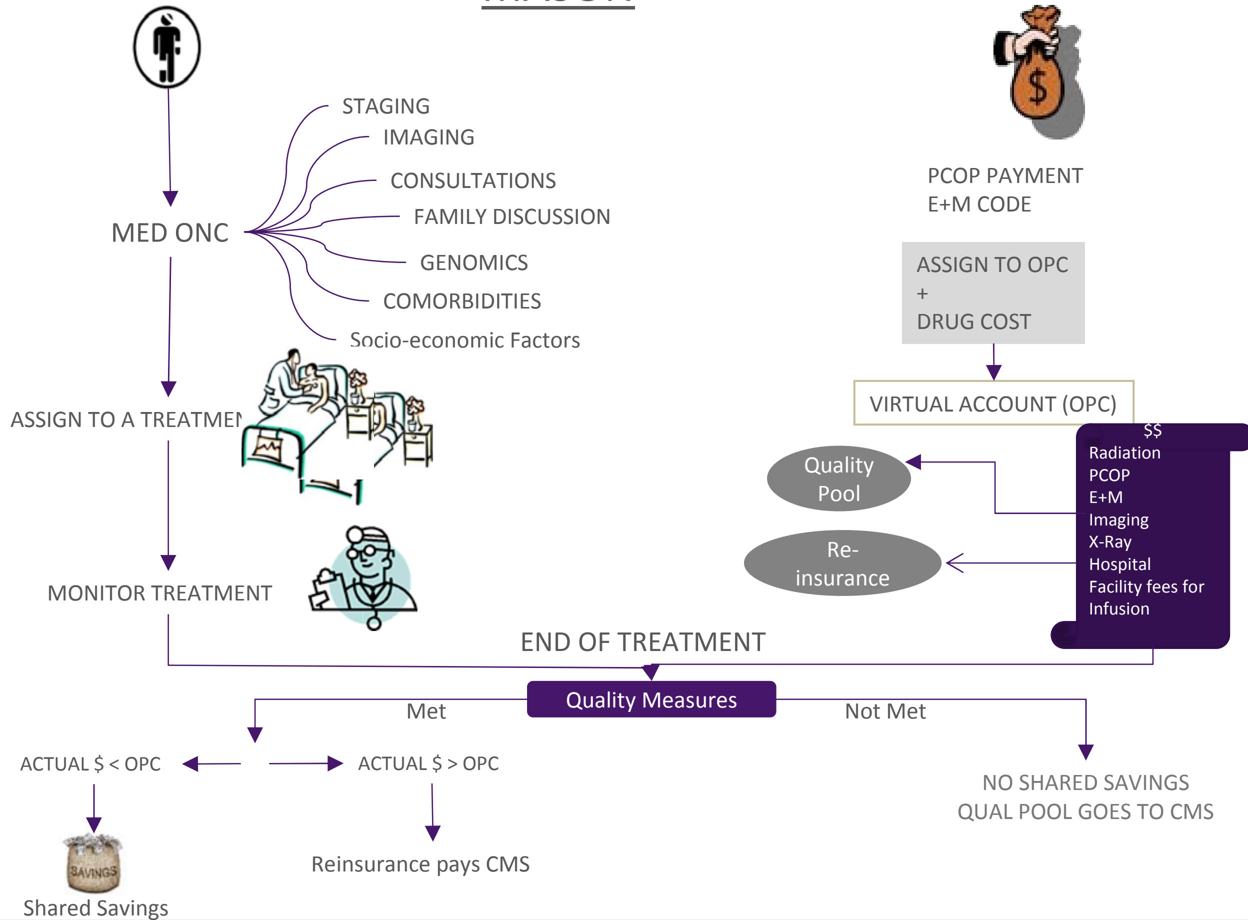
MASON

- 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



MASON



© 2018 American Medical Association. All rights reserved.

AMA

AMA
AMERICAN MEDICAL
ASSOCIATION