PAYING FOR VALUE: THE MEDICARE QUALITY PAYMENT PROGRAM

ACHI is a nonpartisan, independent, health policy center that serves as a catalyst to improve the health of Arkansans.

JUNE 2016

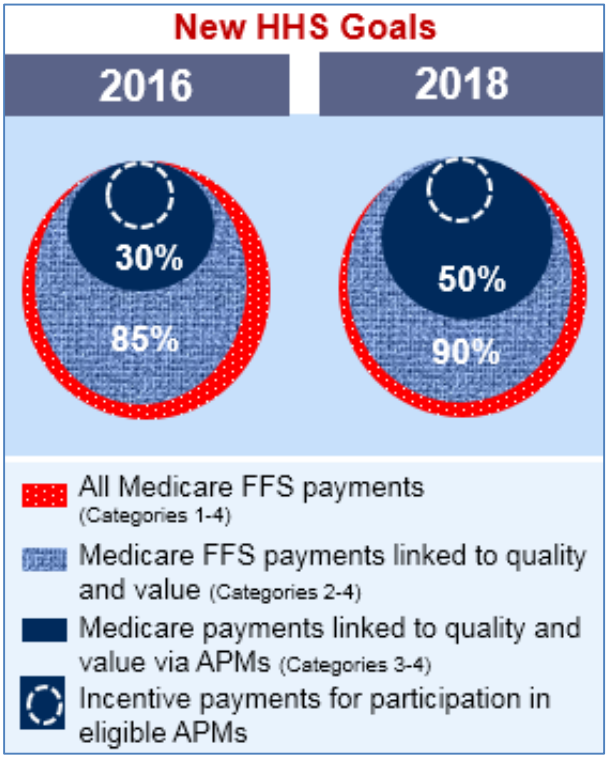
Arkansas has been a leader in the transition to value-based payment for healthcare services, with a majority of the state's providers now delivering care under the state's multi-payer PCMH program and episodes-of-care model. The state has been successful in this transition by optimizing innovation opportunities offered by the federal government and leading value-based payment efforts in both public and private sectors. After several years of testing various value-based payment models across the states, the federal government has established a goal of having a majority of Medicare payments tied to value and quality by 2018. Recent federal legislation, the Medicare Access and Chip Reauthorization Act (MACRA) of 2015, drastically changes the way that Medicare pays for healthcare services and authorizes initiatives to achieve value-based payment objectives. This brief provides background information on the MACRA legislation, describes the Medicare Quality Payment Program (QPP) initiative enabled by MACRA, and potential impacts for Arkansas.

Introduction and Background

In January 2015, the U.S. Department of Health and Human Services (HHS) announced aggressive goals designed to shift the healthcare system away from a fee-for service payment structure that has the potential to financially incentivize the volume of services delivered, rather than financially rewarding quality outcomes and efficiency. More specifically, HHS established a goal to 50 percent of Medicare payments made through Alternative Payment Models (APMs), and 90 percent of Medicare fee-for-service payments tied to quality or value by 2018.[1] (See Figure 1). The HHS announcement follows several years of value-based payment experiments launched by the federal Center for Medicare and Medicaid Innovation including shared savings approaches through the Comprehensive Primary Care Initiative and bundled payments for episodes of care. The announcement also follows nearly two decades of congressional actions – in the form of frequent passage of "doc fix" bills – to delay cuts to Medicare reimbursements under the Sustainable Growth Rate (SGR) Formula. Enacted as part of the Balanced Budget Act of 1997, The SGR sought to contain Medicare costs by adjusting payment rates for all providers depending on the rate of Medicare spending growth as compared to overall economic growth.

MACRA and the Medicare Quality Payment Program

A bi-partisan legislation signed into law in April 2015, MACRA is designed to help achieve HHS goals for value-based care delivery. Title I of MACRA repeals the SGR Formula, which only addressed costs and did not directly incentivize quality outcomes at the individual provider level[2]. MACRA seeks to do this by enabling the Medicare Quality Payment Program, which includes two complementary paths to align financial incentives with quality performance and efficient resource utilization. These paths are The Merit-based Incentive Program (MIPS) and participation in APMs.

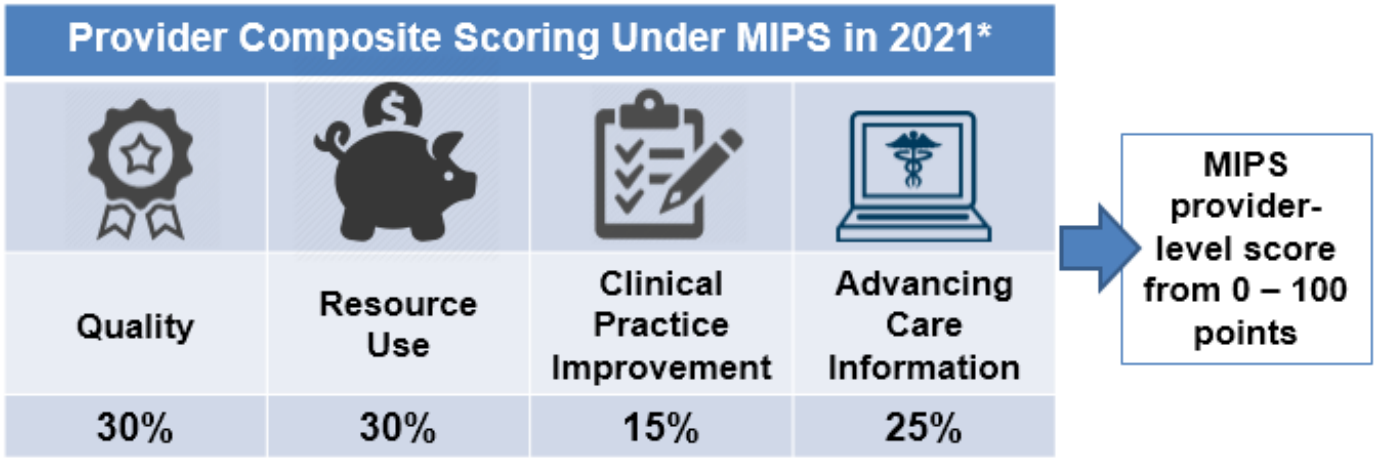


Merit-Based Incentive Payment System (MIPS)

Currently, there are multiple federally administered programs to incentivize and measure quality and value. These include the Physician Quality Reporting Program[3], the Value-Based Payment Modifier Program[4], and the Medicare EHR Incentive Program[5]. The MIPS streamlines these programs and gives physicians a composite score, which will determine the degree of MIPS payment adjustments to individual providers.

Provider Scoring Under MIPS

Beginning in 2019, most physicians and practitioners who provide care to Medicare beneficiaries will receive a MIPS composite score based on four weighted performance categories. These categories are quality, resource use, clinical practice improvement activities, and meaningful use of certified EHR technology. Although the first MIPS payment adjustments are not scheduled to occur until 2019, scoring within the performance categories will be based on performance beginning in 2017. The graphic below provides information about the weighting of each category.

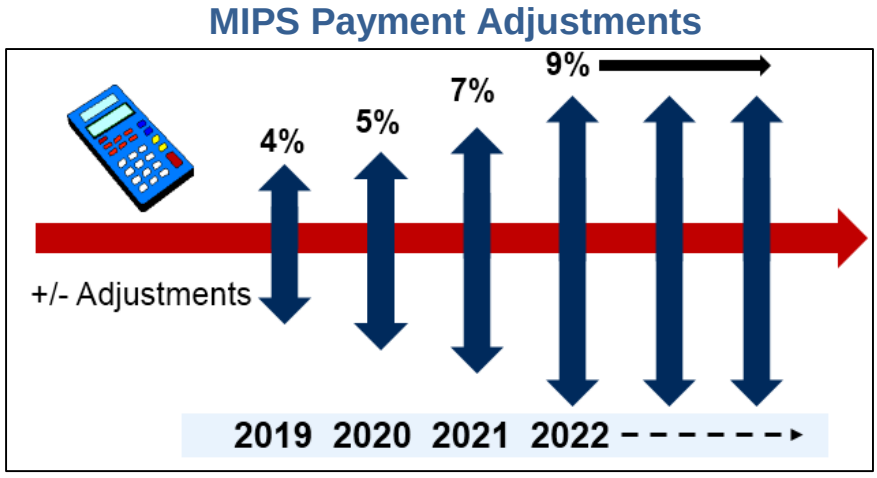


*Weighted values reflect those for 2021 and beyond. In 2019 Quality is 50% of score and Resource Use is 10%. In 2020, Quality is 45% of score and Resource Use is 15%.

Medicare Payment Adjustments under MIPS

Physicians and practitioners will receive positive, negative, or no adjustments. Beginning in 2019, providers may receive up to a maximum four percent positive or negative payment adjustment. This range will increase each year until 2022, when providers may receive up to a maximum nine percent positive or negative payment adjustment.

In years 2019 – 2024, providers whose MIPS score is in the top 25 percent will be eligible for a performance adjustment of up to 10 percent. With the exception of the potential 10 percent adjustment for providers whose MIPS score is in the top 25 percent, MIPS adjustment are designed to be budget neutral, so that across all providers, total positive adjustments will be equal to providers' negative adjustments. A scaling factor may be applied to upwards adjustments to ensure budget neutrality. Provider payment rate adjustments under MIPS will be made to provider's base rate of Medicare Part B payments.



While the majority of Medicare Part B providers will be subject to MIPS payment adjustments, MIPS does not apply to hospitals and facilities. Hospital or facility-based physicians who are Medicare Part B providers will be subject to MIPS if they do not participate in Advanced Alternative Payment Models (APMs). Additionally, there are three groups of physicians and practitioners who will not be subject to MIPS. These excluded groups include providers who are in their first year of Medicare participation, providers that are participating in an Advanced APM, and providers who do not deliver services to at least 100 Medicare Part B patients or that don't bill for at least $10,000 in Part B services in one year.

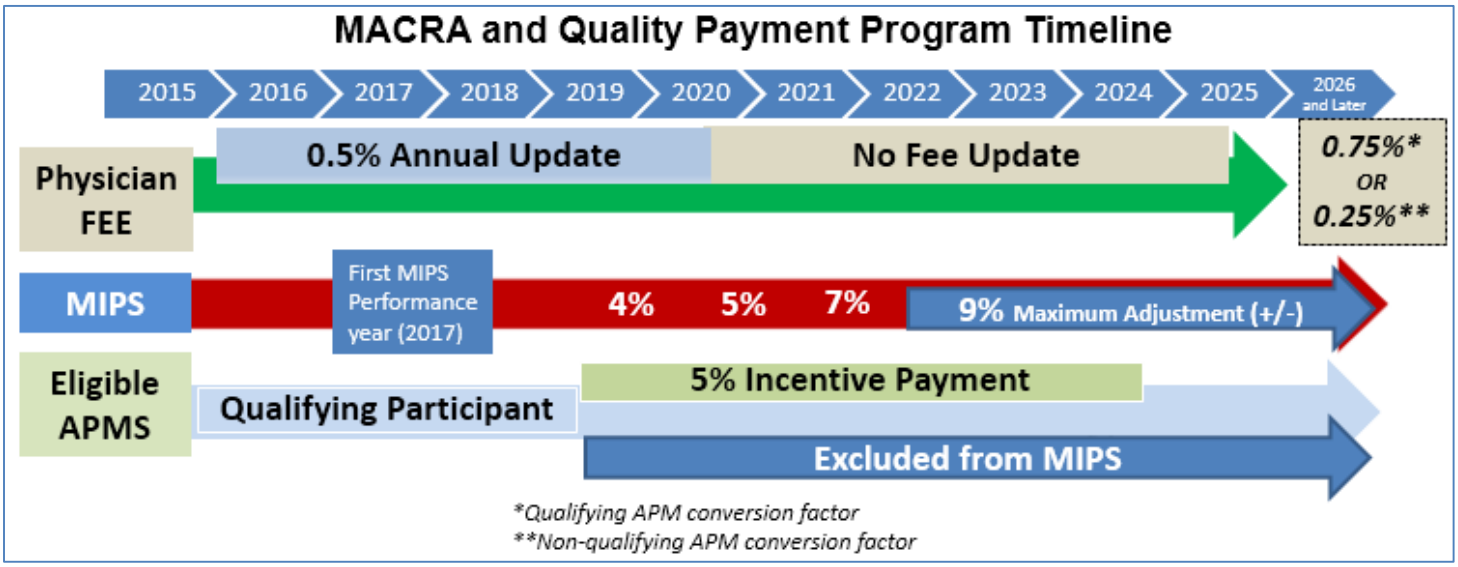
Alternative Payment Models (APMs)

Under MACRA, the Medicare QPP incentivizes participation in APMs, such as health homes for high-needs populations, patient centered medical homes (PCMH) and accountable care organizations (ACOs) for primary care population-based care management, and episodic or bundled payments for certain acute conditions. Under MACRA law, APMs include CMS Innovation Center models, the Medicare shared Savings Program (MSSP), a demonstration under the Health Care Quality Program, or a demonstration required by Federal Law. Most APM participants will receive a favorable MIPS score in the clinical practice improvement activities performance category. While the QPP generally incentivizes participation in APMs by way of a higher MIPS score, certain advanced models are deemed eligible APMs by HHS and have the potential for separate bonus payments. Qualifying Providers (QPs) who participate in Advanced APMs are not subject to MIPS, will receive a five percent lump sum bonus payment for 2019 through 2024, and will receive a higher fee schedule update for 2026 and onward.

Advanced Alternative Payment Models

Under MACRA, eligible or Advanced APMs are those that base payments on quality measures comparable to those in MIPS. In addition, Advanced APMS also require use of EHR technology, and they must either bear more than nominal financial risk for monetary losses or be a PCMH expanded under CMMI authority. Physicians and other clinicians who have a significant amount of patients or payments under an eligible APM are deemed QPs. Physicians who do not meet the minimum volume requirement will be ineligible for the separate APM bonus payment. To meet the minimum threshold in 2019 and become a QP, providers must receive at least 25 percent of payments or deliver service to 20 percent of their Medicare patients through an Advanced APM. These requirements increase in subsequent years, with QPs being required to have at least 75 percent of payments or 50 percent of patients seen under an Advanced APM.

The proposed rule includes Medicare-focused models that are already qualified as Advanced APMs. While the first wave of qualified APMs have been established in the rule, CMS will update the list annually to add new payment models that meet the qualifying criteria. Starting in 2021, CMS will consider Medicaid or private carrier APMs that can count towards a provider becoming a QP. Models that have already been deemed Advanced APMs include but are not limited to: The Comprehensive Primary Care Plus (CPC+) model, Medicare Shared Savings Program (track two and three), and Next Generation ACO Model[6]. Under MACRA, Medicare fee-for-service reimbursement for physician services will increase annually by 0.5 percent, starting July 1, 2015 and going through 2019. In 2019, the MIPS and Advanced APM incentives begin, and the physician fee schedule will remain at 2019 rates until 2025. After 2025, physicians fee schedule updates will be 0.75 percent for Advanced APM participants, or 0.25 percent for physicians not in an Advanced APM.



Testing New APMs: Physician–Focused Technical Advisory Committee

In order to encourage new APM options for Medicare providers, HHS has established an independent Physician-focused Payment Model Technical Advisory Committee. The purpose of the committee is to review APM model submissions with 11 appointed subject matter experts, and make recommendations to HHS about which models should be tested or considered eligible or Advanced APMS.

Arkansas's PCMH Program and the Comprehensive Primary Care Plus Program

In 2012, Arkansas was chosen as one of seven markets to participate in the Medicare-led Comprehensive Primary Care Initiative, with 69 practices participating throughout the state. In 2013, Arkansas was one of only six states awarded a State-Innovation Model (SIM) grant by the Centers for Medicare and Medicaid Services (CMS). Both of these initiatives supported the development of the state's Medicaid-led, multi-payer PCMH program. Through improved care coordination and communication, the goal of the Arkansas PCMH program is to help patients stay healthy, increase the quality of care, and control or reduce cost growth. The state's program now has nearly 200 participating practices, covering over 80 percent of eligible Medicaid beneficiaries and a large and increasing number of commercial and self-insured beneficiaries. After the first year of implementation, the vast majority of providers met practice transformation requirements and improvement was demonstrated in a majority of quality measures[7].

In April 2016, CMS announced the Comprehensive Primary Care Plus (CPC+) program. The goals of CPC+ are essentially the same as the CPC model before it, as well as Arkansas's PCMH program; to improve the quality of care, improve population health, and to use health care resources more efficiently. If Arkansas is selected as a participating region in CPC+, participating providers would be eligible for the Advanced APM incentive under the QPP. The CPC+ program offers two tracks for providers. Track one participants will be supported in delivering more comprehensive primary care with an average care management fee of $15 per Medicare beneficiary per month. Track two participants will be expected to care for more complex patient needs, while receiving an average fee of $28 per beneficiary per month, which includes a $100 care management fee for patients with the most complex needs[8].

Future Impacts for Arkansas Patients and Providers

The proposed rule for MACRA was released on April 27, 2016[6]. While the rule is not expected to be finalized until late 2016, providers who are participating in PCMH models will likely be better positioned to succeed within the QPP. Through MACRA, HHS aims to support multi-payer initiatives such as Arkansas's and the development of APMs within these initiatives. Increased Medicare incentives for providers will help reinforce practice transformation, improve clinical processes, and support developing infrastructure throughout the state, all leading to better health outcomes.

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