Refining MIPS and A-APMs and encouraging primary care

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Feedback from January meeting and path for today

- MIPS unlikely to succeed at identifying or paying for clinicians delivering value to the program, at great administrative burden
  - Eliminate clinician measure reporting
  - Use a uniform set of CMS-calculated outcome and patient experience measures to assess clinicians at an aggregate level (either self-defined group or referral area)
- Design should help move clinicians from MIPS to A-APMs
  - Limit potential upside in MIPS
  - Move MIPS exceptional performance bonus to A-APMs

Feedback from January meeting and path for today, continued

- Make A-APMs more attractive
  - Address ability of practices with small share of total A&B spending to take risk
    - For small, clinician-only or primary-care focused entities, limit risk to a share of practice revenue through A-APM
  - Create additional upside for two-sided ACOs
    - Redirect $500m from MIPS to fund asymmetric risk corridor in two-sided ACOs
    - (Two-sided ACOs and models like them are the A-APMs most consistent with Commission principles)
- Better support primary care
  - Upfront payment for PCPs in two-sided ACOs
  - Per beneficiary payments for all PCPs; would redistribute fee schedule spending from non-primary care services to PCPs

Issues with current MIPS framework

- Uses hundreds of quality measures, many of which are topped out and narrowly targeted to specific specialties and cases
- Data elements for meaningful use and practice improvement activities are attestation-only, and have not been proven to correspond to high-value care
- Relatively small number of patients for an individual clinician contribute to noisy performance scores
- Individual measures chosen by the clinician used to assess clinicians' performance, so results not comparable across clinicians
- Overall, MIPS will fail to identify high- or low-value clinicians and will not be useful for
  - Beneficiaries (in selecting high-value clinicians)
  - Clinicians (in understanding their performance and what to do to improve)
  - The Medicare program (in adjusting payments based on value)

Illustrative MIPS proposal: Overview

- All clinicians contribute to quality pool (e.g., 1% withhold)
- Clinicians receive withhold back if they join an A-APM
- Clinicians could be eligible for a positive or negative quality adjustment if
  - They elect a clinician-defined virtual group
  - They elect to be measured in a CMS-defined referral area
- Virtual group or referral area must be sufficiently large to detect performance on population measures
- Clinicians who choose to do none of the above lose withhold

Illustrative MIPS proposal: Measurement and adjustment

- Performance assessed at virtual group or referral area
- Uses a set of population-based outcome measures
  - Potentially preventable admissions and ED visits
  - Mortality and readmission rates
  - Patient experience
  - Healthy days at home
  - Rates of low-value care
  - Relative resource use
- Resulting uniform payment adjustment applied to all clinicians in virtual group or referral area

Illustrative MIPS proposal: Key differences from current policy

- Reminder: Current MIPS program is a redistributive budget-neutral payment adjustment
- Illustrative proposal is also a redistributive payment adjustment but limits downside (-1%, e.g.) and upside (can set parameter so less attractive than A-APM participation)
- Less burden: Clinicians no longer report any quality measures, meaningful use, or practice improvement activities to Medicare
- Same set of claims-calculated and patient-reported population measures to assess all clinicians
- Clinicians only measured as a group or area, no individual measurement
- Resulting payment adjustments are for entire clinician group or referral area, do not vary by clinician within group/area

Rebalancing program from MIPS toward A-APMs

- Under our illustrative MIPS proposal; MIPS quality withhold automatically returned to clinicians in A-APMs, incentive for clinicians to join A-APMs
- Move MIPS “exceptional performance” fund to A-APMs to fund asymmetric risk corridors; $500 million each year (2019-2024)

Revised approach to A-APMs
Result of January meeting

- Remove 5% incentive payment cliff: Make payment proportional to practice revenue through A-APM rather than threshold approach
- Make accepting risk more feasible for practices: Revenue-based standard instead of benchmark-based standard, define risk corridor in revenue terms (savings/losses based on A&B performance)
- Stays consistent with Commission principles
  - Small entities would need to aggregate to detect cost and quality performance
  - Payment for performance not participation (e.g., 5% incentive)

Use $500 million from MIPS to encourage 2-sided ACOs

- Build on revised model by making risk corridor asymmetric (i.e., higher upside than downside)
- Rebalances from MIPS and encourages practices to accept risk by increasing expected value
- Requires funding to offset higher program spending due to random variation and asymmetry
- Indirectly promotes primary care to the extent that:
  - Attribution rules are built on primary care services
  - Practices that emphasize primary care case management are successful
  - Successful entities reward PCPs

Asymmetric risk corridor: illustrative example

	Risk corridor	
	Symmetric + 20% / – 20%	Asymmetric + 100% / – 20%
Upper limit	$100,000	$500,000
Lower limit	– $100,000	– $100,000

Assumptions:

---Beneficiaries	1,000
---Benchmark per capita	$10,000
---Total A&B benchmark	$10,000,000
---Total practice revenue (assumed to be 5% of A&B)	$500,000

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Upfront payment for PCPs in 2-sided ACOs

- Allow PCPs to take upfront payment (not required)
- Upfront payment would be financed by reducing FFS payment for each primary care visit (no new money)
- Would give practitioners more flexibility to invest in care coordination
- No change in beneficiary cost sharing

Issues with primary care in fee schedule

- Primary care services underpriced in fee schedule
- Fee schedule not well-designed to support primary care (oriented towards discrete services)
- Income disparities may encourage medical students to choose specialty care over primary care
- Primary Care Incentive Payment program (PCIP) expired at end of 2015
- Commission recommended a per beneficiary payment for primary care to replace PCIP (2015)

Per beneficiary payment for all PCPs

- $700 million/year (2015 recommendation)
  - Per beneficiary payment: ~$28/year (~$3,600 per clinician, on average)
  - Funded by reducing fees by 1.3% for all services other than primary care visits
- $1.5 billion/year
  - Per beneficiary payment: ~$60/year (~$7,800 per clinician, on average)
  - Funded by reducing fees by 2.8% for all services other than primary care visits
- No beneficiary cost sharing

Plan to discuss broader fee schedule issues at future meeting

- Need greater focus on overpriced services
- Process for pricing services should be improved
- Data used to maintain the fee schedule are inadequate
- Revisit prior Commission recommendations
  - Establish expert panel to help CMS set payment rates
  - Collect data from cohort of selected practices
- Explore combining CPT codes into families of codes

Discussion

- Comments on MIPS redesign
- Comments on rebalancing from MIPS to A-APMs
- Comments on two-sided ACO risk model with an asymmetric risk corridor
- Comments on how to better support primary care
  - Upfront payment for PCPs in two-sided ACOs
  - Level of per beneficiary payments for all PCPs