CALL FOR CALM

Hard truths on the road to value-based care

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WASHINGTON – Now that the move to value-based care is in full swing, it's time for physicians – especially those in small or solo practice – to get ready to change.

"This must be a completely overwhelming time for you. We get that," Dr. Hoangmai Pham, director of Seamless Care Models Group at the Centers for Medicare & Medicaid Services' Innovation Center, said at the annual meeting of the American College of Physicians. "We are trying to help you understand the landscape as much as possible."

Merit Based Incentive Payments (MIPS) are one way the federal government is transitioning physician payments from volume-based to value-based medicine. The proposed rule to implement the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) indicates how Medicare officials intend for MIPS to streamline the three main quality metrics reporting systems currently in use – Meaningful Use, the Patient Quality Reporting System, and Value-Based Payment Modifier Program – along with clinical practice improvement activities, into one quality metrics reporting system to be used for reimbursements.

The CMS currently bases pay incentives on at least 90 different clinical practice improvement activities, Dr. Pham said in an interview. Practices that already incorporate these activities will find it easy to comply with MIPS, according to several analysts. Under the proposed rule, physician's

Medicare fees would be adjusted based on MIPS starting in 2019; adjustments are slated to range from a 3.5% cut to as much as a 4.5% increase. By 2024, Medicare pay may be cut – or increased – by as much as 9%.

Because Congress set up MIPS to be budget neutral, it is not intended to help physicians grow their bottom line but to provide a bridge to the Brave New World of value-based care.

"MIPS helps to link fee-for-service payments with quality and value," Dr. Pham said.

The ultimate goal of the Quality Performance Program – the name CMS has selected for the MACRA-mandated reforms – is for physicians to deliver higher quality care over volume of care. Carrots (potential rewards for high quality) and sticks (financial risk for low quality) will be employed.

APMs, ACOs, CPC+, oh my!

Once physicians get over the bridge to value-based medicine, alternative payment models (APMs) are one way to start reaping the rewards.

APMs offer an avenue to increased revenue (shared savings) but also require physicians to share risk with the government.

Another option is the recently announced Comprehensive Primary Care Plus (CPC+) accountable care organization (ACO), under which physicians will be paid prospectively for meeting a variety of criteria.

The CMS is now soliciting bids from other insurers to participate in CPC+. Once the CMS knows which third-party payers are willing to participate, and at what level and in which regions, practices will be able to apply. The CMS expects selected practices to begin participating by January 2017, Dr. Pham said in the interview.

These and other forms of patient-centered medical home–type ACOs, offered by the CMS or by private insurers, are intended to help practices develop payment structures that can be tailored to fit the unique characteristics of a given practice, including the specific types of populations served.

The proposed rule also notes that the CMS would like to offer what is known as Physician Focused Payment Models. These organizations might be included in the final rule if they meet three criteria: a clear plan for setting and meeting quality goals; an enumeration of the type of population that will be served; and what resources will be necessary at what cost.

After the final rule is posted, all physician-focused proposals will be reviewed by an advisory committee to the CMS, known as the Physician Focused Payment Model Technical Advisory Committee (PTAC).

Practice managers interested in developing this kind of model should pay close attention to pages 562 and 624 of the proposed rule document for more specific instructions, according to Dr. Kavita Patel, a fellow and managing director of the Engelberg Center for Health Care Reform at the Brookings Institute in Washington.

When asked about the likelihood of such a plan being approved – particularly since the final rule is expected in November 2016, with metrics from 2017 to be collected for the first round of quality performance payments in 2019 – Dr. Patel emphasized that, while she was not speaking on behalf of the CMS, "the phrase they use is that they 'want to keep the door open.' I think that as long as you honor these criteria, the desire is to move these proposals through." Still, she acknowledged, "The timing is extremely tight."

The problem, she added, is that the criteria still need to be defined by the law, so it is hard to know if and when such proposals will be evaluated and approved. Meanwhile, all practices have the option of switching back to MIPS annually, but since the goal is to push physicians away from that model, as evidenced by the steeper penalties each year the law is in effect, this becomes less attractive an option.

Calls for calm

In some ways, according to Dr. Patel, this evolution in health care delivery should be seen as a good thing since "the fee-for-service model is not viable."

And yet, an impact analysis from the CMS Office of the Actuary that was included with the proposed rule predicts that, based on measurements

to be taken in 2017, 87% of all solo practices will be negatively adjusted in 2019, the year MACRA goes into full effect. Nearly 70% of practices with between 2 and 9 physicians are predicted to be penalized, while about 60% of those with between 10 and 24 physicians will be hit. Larger practices also are expected to be severely affected. For those with between 25 and 99 member physicians, nearly 45% will face negative adjustments and groups with 100 or more physicians will face a nearly 20% negative incursion, according to the analysis.

But before you sell your practice to the local hospital system or drop out of Medicare altogether, some analysts and officials advise against panic.

Robert B. Doherty, ACP senior vice president for governmental affairs and public policy, disputed the notion that the analysis is proof of the coming death of small practices. "I disagree with that. Essentially, the actuary was projecting using relatively low rates of participation [in the new value-based programs]," he said.

To that end, on May 11, acting CMS Administrator Andy Slavitt testified before the House Ways and Means Committee's Subcommittee on Health that, because those actuarial projections were based on data collected in 2014, they were not reflective of what he said was an uptick in quality measure reporting for 2015. Before the rule is finalized later this year, the actuarial tables would be updated to reflect the new data, he said.

That leaves plenty of time to advocate for feasible payment structures for practices of all sizes, Mr. Doherty said. "If we succeed in doing that, and I think there is some progress ... then I think there will be opportunities for smaller practices to get positive updates."

Advocacy is not enough

Dr. Patel, a practicing internist in Washington, said that she agrees with this approach.

In addition to making constructive, written comments on the proposed rule, which closes on June 27, 2016, at 5 p.m. EDT, Dr. Patel said that taking steps to optimize available resources now, such as reporting quality measures, or using the chronic care management fee, are ways to ensure higher revenues in the future. "Think about ways to leverage your practice now in order to actually get on one of the advanced payment care models so you avoid being in that track that gets all that downward pressure," she added.

Still, she said that advocacy may not be enough for some practices to stay solvent. "If the actuaries and CMS really believe that small practices are going to face these steep penalties and not be able to survive, then how we address that, such as through how we define alternative models that are broader [in scope] for practices to follow, has to actually be written by CMS into the final rule."

No matter the type of ark you choose to build, particularly if yours is a small practice, you'll have to create some kind of watertight vessel or else, said Dr. Patel, it is "going to be extremely hard to participate in the Medicare program."

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