

Perspectives on Primary Care Transformation: Measurement, MACRA, Medical Homes, and Payment Reform

Robert A. Berenson, MD

Institute Fellow, the Urban Institute

rberenson@urban.org

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“If you can’t measure it, you can’t manage it”

- And its derivative cousin, “If something... cannot be measured, it cannot be improved.”
 - Called a “truism” by well respected health policy experts David Blumenthal and Michael McGinnis
 - JAMA 2015; 313:1901-2
- The original quote is usually attributed to W. Edwards Deming, one of the revered experts on management practices (and father of PDCA cycles for total quality management)

Not Just Out of Context, but an Egregious Misquote

- “It is wrong to suppose that *if you can’t measure it, you can’t manage it* – a costly myth.”
 - *The New Economics*, 1994, page 35.
- Other consistent Deming quotes (of many available):
 - “The most important figures one needs for management are unknown or unknowable, but successful management must nevertheless take account of them.” *Out of the Crisis*, 1982, p 121
 - “Management by numerical goal is an attempt to manage without knowledge of what to do, and in fact is usually management by fear.” *Out of the Crisis*, p. 76

Dueling aphorisms

- *“If you can’t measure it, you can’t manage it”*
 - Commonly attributed to Deming (sometimes, Peter Drucker, another management scholar, who also did not believe it)
- *“Not everything that can be counted counts, and not everything that counts can be counted.”*
 - Who said this?

No, Not Albert Einstein

(although if you google the saying, you will find dozens of images of the learned professor writing it on his blackboard)

but rather a sociologist named William Bruce Cameron, writing in the 1960s, after Einstein had died

The Medicare Access and
CHIP Reauthorization Act of
2015
(MACRA)

“Stabilizes” Fee Updates

- Repeals SGR, averting a nearly 25% cut in fees
- July 2015-2019: Annual fee update 0.5%, 2020-2025 0%
 - Payment increases (and decreases) otherwise take place through MIPS
- After 2025: 0.25% update, but 0.75% if APM participation
- Before 2025, 5 percent bonuses for six years for physicians that qualify as participating in APMs with more than “nominal risk”

The Merit Based Incentive Payment System (MIPS)

- Combines the 3 current incentive programs:
 - Physician Quality Reporting System (PQRS) – quality
 - Value-Based Modifier (VBM) – quality & resource use
 - Meaningful Use (EHR)
- Applies to payments after January 1, 2019 – the current programs are in use till then and sun-setted – but data from 2017 may be used as baseline for MIPS
- Applies to all “eligible” health professionals getting fee schedule \$’s
- Excludes new EPs, those with too few Medicare patients and those who qualify for getting alternative payment methods (although the APMs have to meet comparable quality measures)
- May participate through EHR use, qualified clinical data registries and/or through group, “virtual” group or affiliation with a facility

MIPS Assessment Categories

- Quality (30%)
 - Current measures
 - Solicitation of new measures
 - Qualified clinical data registries
- Resource Use (30%)
 - Current VBM measures
 - Develop new measures
 - Link cost of services to a professional: Allow for reporting of role in treatment & type of treatment
 - Research on risk adjustment

MIPS Assessment Categories (cont.)

- Meaningful Use (MU) (25%, although some variation)
 - Current system use (note CMS is liberalizing expectations)
 - Reporting through certified EHR systems for MIPS are deemed to meet MU component
- Clinical Practice Improvement Activities (15%)
 - Credit for engaging in clinical practice improvement activities (expanded practice areas, population management, care coordination, beneficiary engagement, patient safety)
 - Activities must be applicable to all specialties & attainable for small practices and underserved areas
 - Credit if already doing
 - Encourages activities that facilitate future APM participation

MIPS Payment Adjustment

- Negative adjustments capped
 - Those at 0-25% of threshold get maximum negative adjustment
 - 2019: 4%
 - 2020: 5%
 - 2021: 7%
 - 2022: 9%
- Positive
 - Maximum: 3 X annual cap for negative adjustment – so theoretically as much as 27% more (I am not kidding)
 - Eligible for additional payment if 25% above performance threshold
 - But total is capped at \$500 million / year (2019-2024)

*The food here is terrible --
and such small portions*

-- old Catskill's joke

Alternative Payment Models

- 5% bonus (2019-2024) if physician has significant APM participation – based on increasing percent of revenues or patients *through an entity* that participates in an eligible APM [emphasis added]
- There is an alternative track for multi-payer APM percentages
- From 2026, update of 0.75%, compared to the default of 0.25%
 - APM must involve more than “nominal” risk and have a quality measure component
 - Part of a PCMH exempt from risk if CMMI finds it works in Medicare
- Eligible Providers in APMs are excluded from MIPS & most EHR requirements (but the APM must meet MIPS-like and EHR requirements)
- Special emphasis on testing APMs with specialists & small practices and that align with private and state-based payer initiatives
- A Technical Advisory Committee (PTAC) established to consider physician-focused payment models – issue – are these qualifying APMs or not?

HHS Framework for the Evolution of Payment Models

- Category 1—fee-for-service with no link of payment to quality
- Category 2—fee-for-service with a link of payment to quality
- Category 3—alternative payment models built on fee-for-service architecture
- Category 4—population-based payment

“Value-based purchasing includes payments made in categories 2 through 4.”

HHS Jan 26, 2015 “Historic Announcement” of Goals and Timeline for Value Payments

- 30% of traditional Medicare payments tied to value thru APMs (categories 3,4) by the end of 2016, and 50% by 2018 – CMS has already achieved >30%
- 85% tied to value (categories 2-4) by 2016 and 90% by 2018
- CMS says “the majority of Medicare payments now are linked to quality” – that is true only by crediting any use of P4P in a payment system as a link to quality -- even something trivial affecting few services

Berenson Dissent on MACRA Formulation of Value Improving on a Continuum

You can find more or less value in any payment method. While trying to figure out – with appropriate testing and evaluation – the proper roles for P4P (MIPS), and Alternative Payment Models, there is a ripe opportunity to consider value and to correct cost-based mis-valuations in relative value units, which are the basis for the Medicare Physician Fee Schedule, and introduce new E&M codes to foster greater collaboration among clinicians and with patients (note- a care management payment is a new code)

Concerns About the HHS Classification and the Learning Action Network Framework

- Assumes that category 1 is not part of the policy action, even while acknowledging that most payment reform methods for physicians are layered on top of the MPFS architecture
- Wrongly assumes that value can only come from 1) quality measurement and 2) risk-bearing
- Over-emphasizes theoretical incentives in payment methods, ignoring the design and operational issues that largely determine their influence on provider behavior
- In short, the typology is useful in presenting a continuum of payment method elements (measures and risk) but incorrectly implies that value increases along the same continuum

Alternatives to Reliance on Measurement and Financial Incentives

- We might be better off with “incentive neutral” payments, relying more on intrinsic motivation
 - Would involve, first, fixing the mis-valued fees in the MPFS and, second, reducing the financial impact of fee schedule payments, using hybrid payment approaches, at least for primary care clinicians
- Lucian Leape, M.D., on the success of the Michigan Keystone Project at eliminating central line-associated blood stream infections in MI hospitals
 - “The most powerful methods for reducing medical harm are: feedback, learning from the best, and working in collaboration, i.e., improve without measuring

Non-Financial Incentive-Based Initiatives

- Promote local responsibility for quality improvement activities
 - Partnership for Patients
 - Conditions of Participation
 - Accountable care organizations
 - Health Care Innovation Awards
- QI Collaboratives
- Develop partnerships among payers and providers
- Follow-Up and Feedback (for diagnosis errors – memorable, if not measurable)

Hot Off the Ticker from CMMI

- CMS's Proposed MACRA Regs distinguish APMs from Advanced APMs – only the latter qualify for the 5% extra
- Advanced APMs are Innovation Center models, MSSP tracks or other demos involving risk and which also involve MIPS-level measurement and prescribed use
- So only some models now qualify as advanced APMs:
 - Comprehensive ESRD care model
 - Comprehensive Primary Care Plus (CPC+)
 - MSSP – Tracks 2 and 3
 - Next-Gen ACO
 - Oncology Care Model Two-Sided Risk (in 2018)

How Solid Is The Primary Care Foundation Of The Medical Home? (Health Affairs Blog, Mar. 25, 2016)

- Based on interviews with primary care physicians in and not in ACOs:
 - Expectations for Medical Homes in assessment tools mostly ignore 3 of the 4 core tenets of primary care: first contact care, continuity, and comprehensiveness
 - Which in turn results in avoidable hospital admissions, lack of patient-centered care in hospital and post-acute facilities, over-reliance on referrals and specialists, despite the important PCMH commitment to population health and team-based care
 - There are “work arounds” to accomplish classic primary care even with younger docs’ lifestyle expectations

Some suggestions

- Primary care “transformation” may be too ambitious and somewhat off-putting an aspiration for many
- Bodenheimer et al., 10 Building Blocks may be the right foundation for primary care redesign because it includes the core primary care tenets and has less focus on infrastructure
- Primary care suffers from the wrong payment approach (pure FFS) and insufficient payment levels – CPC(+) is a potentially important payment method innovation
- Use measurement not as an end in itself but to guard against untoward effects of payment incentives, but only if important and statistically valid ones, e.g., screening and prevention measures with capitation

Suggestions (cont.)

- MIPS's "clinical practice improvement" is an opportunity to challenge the dominance of measurement for quality
- Pick off "low hanging fruit" rather than seeking transformation:
 - medical neighborhood activity, starting with primary care physician-ER/hospitalist communication
 - improve comprehensiveness with new supports -- e-consults
 - support behavioral health/primary care collaboration in the primary care office for affective disorders like depression and anxiety
- Comment on Medicare policy, which also affects private patients: documentation guidelines, fee distortions in the MPFS, the site-of-service differential between OPDs and physician practices