MACRA Basics
CMOG-GFP Meeting
Charleston, SC
February 25, 2016

Ivy Baer
ibaer@aamc.org

Gayle Lee
galee@aamc.org
The Changing World of Medicare Physician Payment
Drilling Down: Understanding MACRA
January 2015--HHS Goes BIG on Quality & Value

Centers for Medicare & Medicaid Services

Fact sheets
Return to Newsroom

Better Care. Smarter Spending. Healthier People: Why It Matters

Date: 2015-01-26
Title: Better Care. Smarter Spending. Healthier People: Why It Matters
Contact: press@cms.hhs.gov

Better Care. Smarter Spending. Healthier People: Why It Matters
HHS’s Ambitious Goals:

Moving to alternative payment models:

• **By end of 2016**: tie 30 % of fee-for-service, Medicare payments to quality or value through alternative payment models, such as Accountable Care Organizations (ACOs) or bundled payment arrangements

• **By end of 2018**: 50 % percent of payments to these models

Moving traditional fee for service payment too:

• **2016**: tie 85% of payment to quality or value (HVBP, HRRP, e.g.)

• **2018**: move to 90%
### April 2015: MACRA Is Enacted; MIPS/APMs Will Rule

<table>
<thead>
<tr>
<th>The Current System: Volume Based</th>
<th>The Future State: Value Based</th>
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</thead>
<tbody>
<tr>
<td>Provide a service, get paid.</td>
<td>Provide a service and your payment will vary depending on such factors as:</td>
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<tr>
<td></td>
<td>• Meeting quality measures</td>
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<td></td>
<td>• Participating in alternative payment models</td>
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<td></td>
<td>• Being in a primary care medical home that meets the standards set out by the Center for Medicare and Medicaid Innovation (CMMI)</td>
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<tr>
<td>The more services you provide, the more revenue you get</td>
<td>Starting in 2019 (based on performance in 2017) payments will be linked to quality and value under a Merit-based Incentive Payment System or Eligible Alternative Payment Model. Payment can be increased or decreased based on performance.</td>
</tr>
</tbody>
</table>
What to say about MACRA?

Sterling Haring (@SterlingHaring)
2/12/16, 12:32 AM
Our relationship is like MACRA - I don't fully understand it, but it's better than the alternative. #HealthPolicyValentines
Acronyms

MACRA: Medicare And CHIP Reauthorization Act of 2015

MIPS: Medicare-Based Incentive Payment System

APM: Alternative Payment Model, but only as defined by the legislation
MACRA

Repeals the Sustainable Growth Rate (SGR) Formula and sets up 2 payment programs: MIPS and APMs

Streamlines multiple quality programs (Meaningful Use, PQRS, Value-based Modifier) under MIPs

APM: Bonus payments for participation in eligible models.
MIPS: Additional payment for exceptional performance possible
### Timeline: How Much Payment Is At Risk?

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</tr>
</thead>
<tbody>
<tr>
<td>Medicare EHR Incentive</td>
<td>-1.0% or -2.0%&lt;sup&gt;c&lt;/sup&gt;</td>
<td>-2.0%</td>
<td>-3.0%</td>
<td>Up to -4.0%&lt;sup&gt;d&lt;/sup&gt;</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>PQRS</td>
<td>-1.5%</td>
<td>-2.0%</td>
<td>-2.0%</td>
<td>-2.0%</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Value-modifier (Max reduction)&lt;sup&gt;b&lt;/sup&gt;</td>
<td>-1.0%</td>
<td>-2.0%</td>
<td>-4.0%</td>
<td>-4.0%</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>MIPS</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>-4.0%</td>
<td>-5.0%</td>
<td>-7.0%</td>
<td>-9.0%</td>
</tr>
<tr>
<td><strong>Total Possible Reduction</strong></td>
<td>-4.5%</td>
<td>-6%</td>
<td>-9%</td>
<td>-10%</td>
<td>-4%</td>
<td>-5%</td>
<td>-7%</td>
<td>-9%</td>
</tr>
</tbody>
</table>

<sup>c</sup> Penalty increases to 2% if EP is subject to 2014 eRx penalty and Medicare EHR Incentive.

<sup>d</sup> After 2017, the penalty increases by 1 percent per year (to a max of 5%) if min 75% of EPs are not participating; otherwise max is 3%.

<sup>b</sup> MIPS reduction only applies if value modifier is negative.
Who Is Affected By MIPS?

Eligible Professionals (EPs):

- Starting in 2019
  - Physician
  - Physician assistant (PA)
  - Nurse practitioner (NP)
  - Clinical nurse specialist
  - CRNA
- Starting 2021, this category can be expanded

- **REMEMBER**: 2017 or 2018 WILL BE THE PERFORMANCE YEAR
Overview of MIPS

New Consolidated Pay-for-Performance Program

- PQRS
- Meaningful Use
- Value Modifier

Merit-Based Incentive Payment System (MIPS)

Does not apply to low-volume providers, qualifying APM participants, and partial qualifying APM participants (that did not report the necessary information).
MIPS Performance Categories

**Performance Categories (with some flexibility)**

- Quality measures (30%)
- Resource Use measures (30%)
  - 2019: Counts for not more than 10%
  - 2020: Counts for not more than 15%
  - NOTE: Additional weight of at least 20% and 15%, respectively, are added to the quality score in those years
- Clinical Practice Improvement Activities (15%)
  - Sub-categories include:
    - Expanded Practice Access
    - Population Management
    - Care Coordination
    - Patient Safety/Practice Assessment
    - Beneficiary Engagement
    - Others as Determined by Secretary
- Meaningful Use of EHRs (25%)
The Secretary is required to specify clinical practice improvement activities. Subcategories of activities are also specified in the statute, which are:

<table>
<thead>
<tr>
<th>Expanded Practice Access</th>
<th>Population Management</th>
<th>Care Coordination</th>
<th>Beneficiary Engagement</th>
<th>Patient Safety &amp; Practice Assessment</th>
<th>Participation in an APM</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Same day appointments for urgent needs</td>
<td>• Monitoring health conditions &amp; providing timely intervention</td>
<td>• Timely communication of test results</td>
<td>• Establishing care for complex patients</td>
<td>• Use of clinical or surgical checklists</td>
<td>• As defined in prior slide</td>
</tr>
<tr>
<td>• After hours clinician advice</td>
<td>• Participation in a QCDR</td>
<td>• Timely exchange of clinical information with patients AND providers</td>
<td>• Patient self management &amp; training</td>
<td>• Practice assessments related to maintain certification</td>
<td>• At a minimum receive ½ CPIA score for APM participation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Use of remote monitoring and Telehealth</td>
<td>• Employing shared decision making</td>
<td></td>
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</tr>
</tbody>
</table>

EP in a practice certified as a patient-centered medical home, or comparable specialty practice, will receive the highest CPIA score
MIPS Composite Performance Score (scoring scale 0-100)

Performance threshold will be established based on the mean or median of the composite performance scores during a prior period.

<table>
<thead>
<tr>
<th>Performance Categories*</th>
<th>Year 1 (2019)</th>
<th>Year 2 (2020)</th>
<th>2021-forward</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality</td>
<td>50%</td>
<td>45%</td>
<td>30%</td>
</tr>
<tr>
<td>Resource Use</td>
<td>10%</td>
<td>15%</td>
<td>30%</td>
</tr>
<tr>
<td>Clinical Practice Improvement Activities</td>
<td>15%</td>
<td>15%</td>
<td>15%</td>
</tr>
<tr>
<td>Meaningful Use of EHR*</td>
<td>25%</td>
<td>25%</td>
<td>25%</td>
</tr>
</tbody>
</table>

- Meaningful use weight can decrease to 15% and be redistributed if EHR adoption reaches 75%. If Secretary determines an EP does not have enough measures, then CMS may change weight distribution.
- As a Medical Home participant, you can receive the highest score in CPIA.
MIPS Payment Adjustment

Based on the MIPS composite performance score, providers receive positive, negative, or neutral payment adjustments

- 2019: +/- 4%
- 2020: +/- 5%
- 2021: +/- 7%
- 2022 and beyond: +/- 9%

Exceptional performers may be eligible for additional payments
MIPS PAYMENT ADJUSTMENT

Maximum Negative Adjustment

Sliding Scale Negative Adjustment

Performance Threshold (mean or median - TBD by CMS)

25% of performance threshold

Composite Score

0

100

Sliding Scale Positive Adjustment
Additional Payments for Exceptional Performers

- EPs with scores above performance threshold, can have adjustment increased or decreased by a scaling factor of up to 3, BUT must maintain budget neutrality
  - EX: for 2019 could be $3 \times 4\% = 12\%$
- 2019-2024 additional incentive payment: up to $500$m pool each year for exceptional performance
  - Maximum adjustment cannot be more than 10% of EP’s Medicare payments
New Scoring Methods Could Change the Look of Performance

- Value modifier scores for outliers
  - Most in “neutral zone”
  - No adjustment as long as reporting requirements are met

- MIPS
  - Measures on achievement and improvement
  - Establishes thresholds
  - Payment depends on whether threshold is based on mean or median

Source: FPSC Q&E 2013 Benchmarking Analysis
MIPS Public Reporting

• Information about the performance of MIPS EPs must be made available on Physician Compare:
  • Composite score for each EP and performance in each category
  • Names of EPs in APMs
    ▪ May include performance regarding each measure or activity in resource use
MIPS: Quality Measures

Nov 1\textsuperscript{st} each year, CMS to publish measure list for MIPS

- Update, add, revise list for coming performance period
- MACRA explicitly states must emphasize outcome measures
- CMS may use:
  - Facility based measures for MIPS EPs
  - Outpatient hospital measures may be used for emergency physicians, radiologists, & anesthesiologists.
- Population based measures are allowed for MIPS
- In selecting MIPS measures and applying the MIPS formula, Secretary shall give consideration to “non-patient facing” specialties
Late Breaking News: Core Quality Measures

- Effort by CMS, commercial plans, AHIP
- Alignment and harmonization of measure use and collection
- 7 sets:
  - ACOs, PCMHs, primary care
  - Cardiology
  - Gastroenterology
  - HIV and Hepatitis C
  - Medical Oncology
  - Obstetrics and Gynecology
  - Orthopedics
MACRA and Qualifying Alternative Payment Models”
Not Every APM Is A “Qualifying APM”

• Most physicians participating in APMs will receive favorable scoring under MIPS clinical performance improvement category

• Physicians participating in certain eligible APMs, qualify to receive 5% bonus payments begin January 1, 2019

• EPs can participate in MIPS or meet requirements to be a qualifying APM participant

• Qualifying APM Participant
  • If criteria are met, can receive 5 percent bonus payments for 2019-2024
  • Payment is in a lump sum on an annual basis

• Different thresholds qualify for either an APM or a Partial APM
Starting 2021: Thresholds Based on Medicare Or Medicare/All Payer

- To be classified as “qualifying APM participant” or “partial qualifying APM participant,” EPs have to meet or exceed certain thresholds related to eligible APM entities.
- Thresholds determined by payments for services in APM but **MA revenue does not count in 2019-2020.**
- Threshold can also be set using patients in lieu of services.

<table>
<thead>
<tr>
<th>Years</th>
<th>Min Thresholds for Qualifying APM Participant (In payments or patients)</th>
<th>Min Thresholds for Partial Qualifying APM Participant (in payments or patients)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Medicare</td>
<td>Combination Medicare &amp; All-Payer</td>
</tr>
<tr>
<td>2019-2020</td>
<td>25% <strong>Medicare FFS</strong></td>
<td>Medicare FFS Only</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Combination Medicare &amp; All-Payer</td>
</tr>
<tr>
<td>2021-2022</td>
<td>50% Medicare</td>
<td><strong>OR</strong> 50% Total/ 25% Medicare</td>
</tr>
<tr>
<td></td>
<td></td>
<td>40% Medicare <strong>OR</strong> 40% Total/ 20% Medicare</td>
</tr>
<tr>
<td>2023 and beyond</td>
<td>75% Medicare</td>
<td><strong>OR</strong> 75% Total / 25% Medicare</td>
</tr>
<tr>
<td></td>
<td></td>
<td>50% Medicare <strong>OR</strong> 50% Total/ 20% Medicare</td>
</tr>
</tbody>
</table>

**Qualifying APM Participants are eligible for 5% bonus from 2019-2024**
## Not All APMS Qualify Under MACRA

<table>
<thead>
<tr>
<th>Term</th>
<th>Description</th>
</tr>
</thead>
</table>
| Alternative Payment Model (APM)  | • Model under CMMI (except innovation awards)  
• MSSP ACO  
• CMS demonstration projects  
• Demonstration required under law |
| Eligible APM Entity              | Entity that meets the following requirements:  
• Use of CEHRT AND  
• Payment is based on quality measures comparable to MIPS  
And  
• Entity bears risk in excess of a nominal amount OR  
• Is a medical home expanded under section 1115A(c) or comparable medical home under Medicaid program |
| Qualifying APM Participant       | Eligible professional who has a certain % of their patients or payments through an eligible APM. Beginning in 2021, payment may be Medicare or all-payer. |
| Partial Qualifying APM Participant| Eligible professional who participates in an eligible APM, but meets a lower threshold                                                  |
## How Do MACRA Requirements Align with Existing APMs?

<table>
<thead>
<tr>
<th>Entity</th>
<th>Quality Measures Used?</th>
<th>Financial Risk for Physicians or CMMI Medical Home?</th>
<th>Use of CEHRT Required?</th>
</tr>
</thead>
<tbody>
<tr>
<td>MSSP ACO</td>
<td>Yes</td>
<td>Group practice can be main participant. Gainsharing of Medicare savings permitted.</td>
<td>No. However, there is a quality measure regarding meaningful use</td>
</tr>
<tr>
<td>Pioneer ACO</td>
<td>Yes</td>
<td>Group practice can be main participant. Gainsharing of Medicare savings permitted.</td>
<td>Yes; 50% of PCPs</td>
</tr>
<tr>
<td>BPCI</td>
<td>Not for receiving Medicare savings. Yes for gainsharing plan and reporting to Lewin.</td>
<td>Group Practice can be episode initiators; physicians can also gainshare Medicare savings and internal cost savings.</td>
<td>No</td>
</tr>
<tr>
<td>CJR</td>
<td>Yes</td>
<td>Yes, with gainsharing.</td>
<td>No</td>
</tr>
</tbody>
</table>
Clinicians who participate in the most advanced APMs may be determined to be qualifying APM participants (“QPs”). The QPs:

- Are **not subject** to MIPS
- Receive 5% lump sum **bonus payments** for years 2019-2024
- Receive a **higher fee schedule update** for 2026 and onward
Physician Options for 2019

Qualifying APM Participant
- Significant participation in APM (25% Medicare payments/patients)
- Eligible for 5% bonuses (2019-2024) paid in a lump sum
- Higher update starting 2026 (.75%)
- Avoid MIPS

Partial Qualifying APM
- Slightly lower threshold for participation (20% Medicare payments/patients)
- No APM incentive payments
- Lower annual updates
- Can avoid MIPS or choose to participate in MIPs; if participate in MIPs are considered to be a MIPS EP and may be subject to payment adjustment
- Starting 2026: 25% update

MIPS
- EPs for first 2 years: physician, PA, NP, CNS, and CRNA
- 3rd year onwards: additional EPs may qualify as per the Secretary discretion
- If exceptional performance, eligible for bonus from $500M pool (2019-2024)
- Starting 2026: .25% update
- Potential payment adjustment
New Coding Systems: MACRA

Claims Submitted after Jan. 1, 2018 must include:

• **Patient Condition Groups**: Based on a patient’s chronic conditions, current health status, and recent significant history (e.g. hospitalization or surgery) (better risk adjustment)

• **Care Episode Groups**: Create to define the types of procedures or services furnished for particular clinical conditions or diagnoses (kinds of services physicians can control)

• **Patient Relationship categories**: Distinguish the relationship and responsibility of a physician with a patient at the time of furnishing the item/service. (accountability)
Fraud and Abuse: Positive MACRA Change

• Gainsharing refers to arrangement where hospital agrees to share with physicians defined reductions in costs

• MACRA Revised the Gainsharing Civil Monetary Penalty Law to allow beneficial gainsharing relationships
  • Not subject to civil monetary penalties unless reduce or limit medically necessary services

• OIG report (expected Spring 2016) on options for amending existing fraud and abuse laws to allow for gainsharing arrangements between physicians and hospitals that improve care while reducing waste and increasing efficiency
MACRA Regulatory Timeline

- RFI: October 1, 2015
  Comments due 11/17/15
- Proposed Rule: Spring 2016
- Final Rule: November 2016
- APM/MIPS Implementation: January 2019 (based on performance in 2017)

MIPS/APM participation will begin 2019 and existing quality programs will sunset on December 31st, 2018.
Update: Activities Related to MACRA Implementation

- CMS Issued RFI regarding Implementation of MIPS and APMs (comment deadline November 2015)
- MedPAC meeting discussion of Potential Principles and Implementation Issues for APMs (January 15, 2016)
- NQF MAP Clinician Group Support Quality Measures for MIPS (February 2016)
- Physician Focused Payment Model Panel (February 2016)
- CMS Issued Episode Grouper Draft Document (comment deadline March 1, 2016)
- CMS released Draft Quality Measure Devp Plan for supporting transition to MIPS and APMs (comment deadline March 2016)
Physician-Focused Payment Models

MACRA established the “Physician Focused Payment Model Technical Advisory Committee (11 members)

- Assist in establishing criteria for “physician focused payment models
- Review proposals for models, and make recommendations to CMS.
- First meeting February 1, 2016
CMS should allow maximum flexibility for meeting requirements

Streamline program requirements so that measures are consistent, reflect standards of care, and are minimally burdensome to report.

As appropriate, risk adjust outcome and resource measures for socioeconomic and demographic status factors

Recognize much of work routinely done by teaching physicians fulfills clinical improvement activities

Ensure little separation between measure performance year and payment year

Allow providers to select whether they want to be identified by distinct MIPS identifier, NPI or TIN
AAMC Comments on “Qualifying APMs”

- Implement flexible requirements around classification of APM participants
- Recognize “risk in excess of a nominal amount” can be demonstrated in a variety of ways.
- Give credit for APM participation to physicians working in partner with teaching hospital
- Enable providers to know in sufficient time whether the APM is a “qualifying APM.”
To do now:

- Understand how your physicians, NPs, etc. perform on: Meaningful use, PQRS, VM
- If everyone is in MIPS in 2019, what will the financial impact be?
- If attribution for APMs is by primary care visits, how will your physicians do?
- Look at your specialists—what are their options? Are their specialty societies developing APM models?
- Are you participating in any APMs that might qualify?
- Are you participating in any medical homes that meet CMMI definition or might be Medicaid equivalent?
- Monitor what CMS is doing; provide feedback; work with AAMC