

Governor's Council on Healthcare Innovation and Reform

The Medicare Access and CHIP Reauthorization Act of 2015

May 10, 2016

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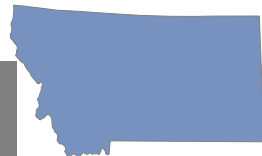
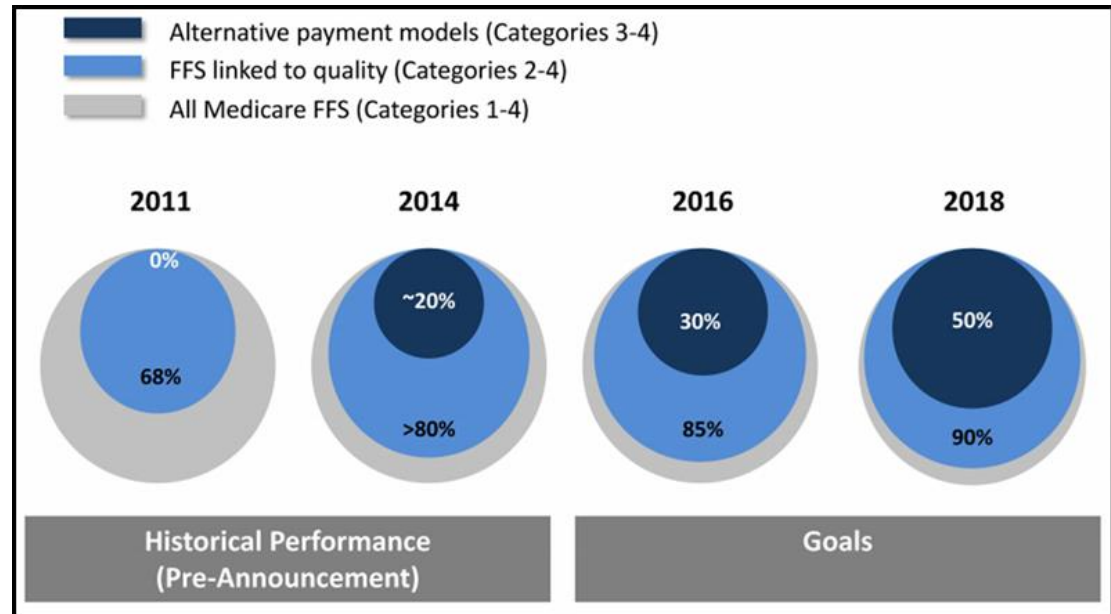
MACRA – What is it?



MACRA, passed in April 2015 repealed the flawed Medicare Sustainable Growth Rate (SGR). There had been bipartisan understanding for many years that the SGR needed to be replaced.

Just before MACRA, in January 2015, HHS announced bold goals for the growth of payments linked to value over volume in Medicare.

MACRA combined the goals of repealing the SGR and promoting widespread payment reform in Medicare



MACRA – Overview

On April 27, 2016, CMS issued 962 pages of detailed implementation proposals

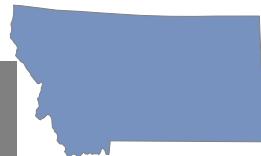
Every year, every practitioner will be assessed in one of two tracks.

Merit-Based Incentive Payment System (MIPS)

Adjusts traditional fee-for service payments up or down based on new reporting program, integrating PQRS, Meaningful Use and Value-Based Modifier.

“Advanced Alternative Payment Models” (A-APMs)

Providers who participate in **risk-bearing** payment models will be MIPS-exempt and will receive an annual 5% bonus.



MACRA Timeline

The 2019 calendar year (CY) is the first year of payment adjustments under MACRA, based on performance in CY 2017.

2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026-
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Universal annual payment updates (was SGR)

0.5% annual payment update

0% annual payment update

MIPS (most providers)

- PQRS P4R
- MU penalties
- Value Modifier

Merit- Based Incentive Payment System (MIPS) adjustments

+/- 4%

+/- 5%

+/- 7%

+/- 9%

MIPS exceptional performance adjustment (\$500m/year fund)

0.25% update

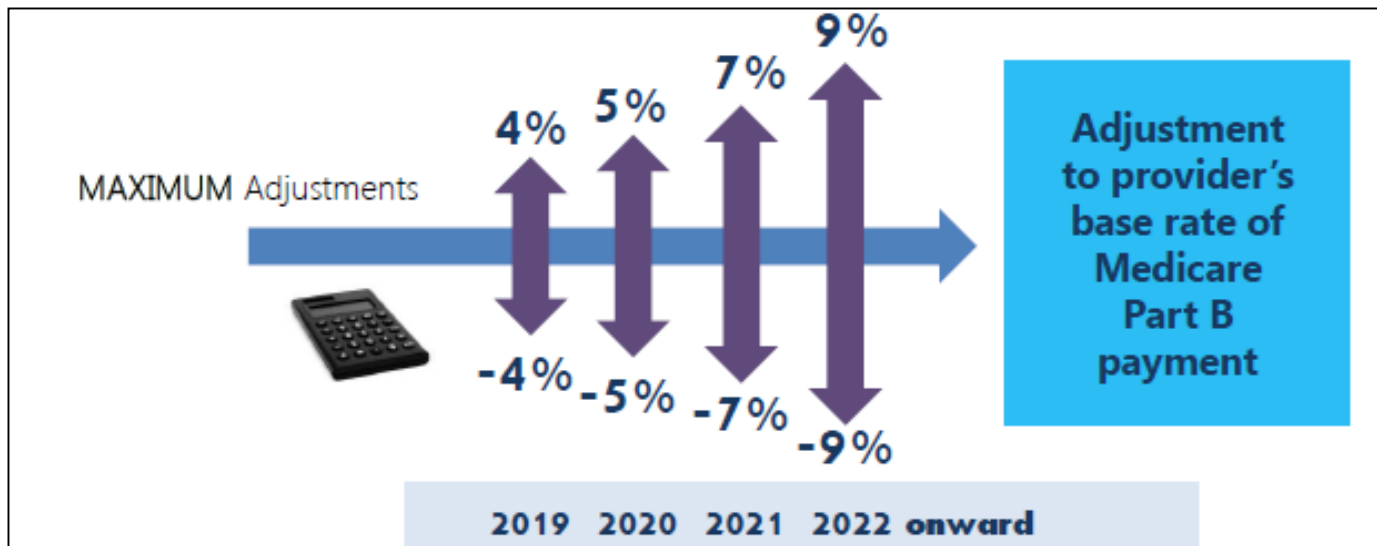
Advanced Alternative Payment Models track

Advanced APM Participants exempt from MIPS and receive annual 5% bonus.

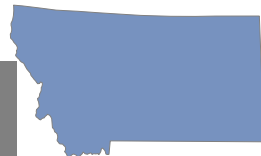
0.75% update



The Adjustment Range under MIPS Increases Each Year

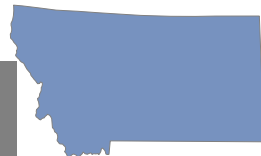
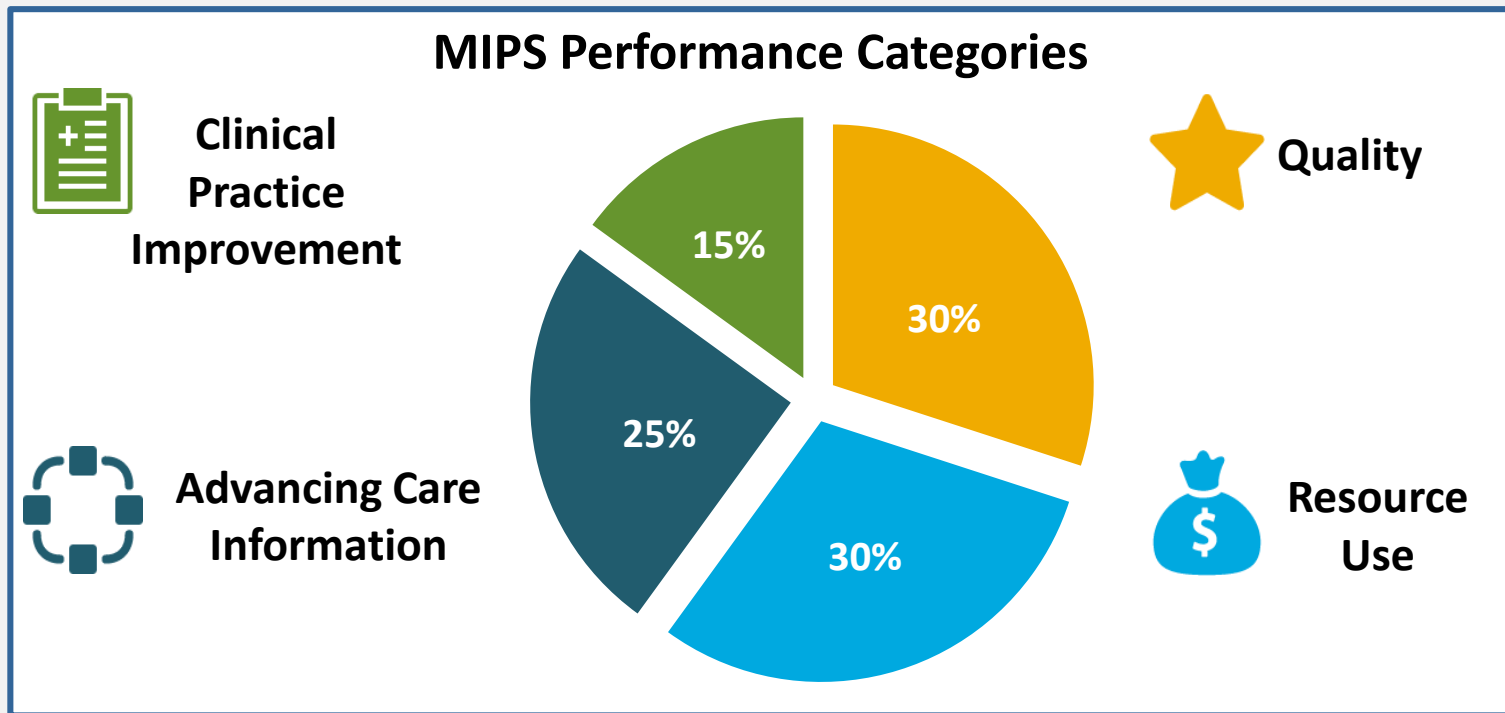


- Based on composite MIPS score, each “Eligible Clinician” (“EC” - physician or practitioner) will receive an upward, downward or neutral payment adjustment each year.
- Adjustments are **budget neutral**.



Clinicians Will be Measured on Four Performance Categories

The proposed rule provides further details on how performance will be measured across each category, to create a composite score of 100.



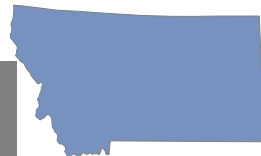
Quality Performance Category



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Modest Reduction Compared to PQRS

- MIPS reduces the number of measures physicians are required to report from **nine** to **six**.
- For the first year of MIPS, CMS proposes to retain a majority of PQRS measures, though there are fewer cross-cutting measures in MIPS than under PQRS.
- CMS is proposing 18 new measures, 16 of which were recommended by the Core Measures Collaborative.
- Participation in the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey will not be required. Clinicians reporting CAHPS data will instead receive bonus points.

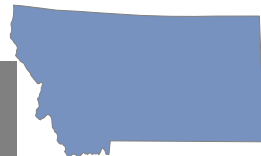


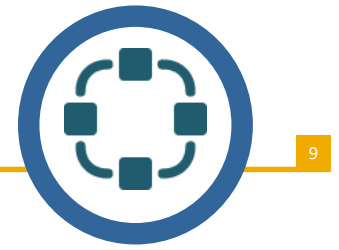
Resource Use Performance Category



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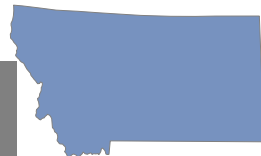
- CMS proposes to use two measures from the Value-Based Modifier Program:
 - ① **Total per capita costs for all attributed beneficiaries** (Part A & B spending during performance period)
 - ② **Medicare spending per beneficiary** (Part A & B spending during episode that spans from three days prior to an inpatient hospital admission through 30 days after discharge)
- MIPS ECs will be assessed on resource use for attributed Medicare patients only.
- CMS intends to consider how to incorporate Part D spending per statutory requirements.





MACRA sunsets the EHR Incentive Program (“Meaningful Use”) and incorporates measures from Meaningful Use

- **ACI adopts the same Objectives and Measures framework as Meaningful Use Modified Stage 2 and Stage 3.** CMS proposes to remove two Objectives that many providers have already reached.
- **CMS proposes to modify the all-or-nothing structure** and minimum threshold requirements of Meaningful Use.
- **All providers must use 2015 Edition CEHRT**, as defined by the Office of the National Coordinator’s certification criteria beginning in 2018.
- In 2017 only, a MIPS EC can report on the Meaningful Use Modified Stage 2 Measures.



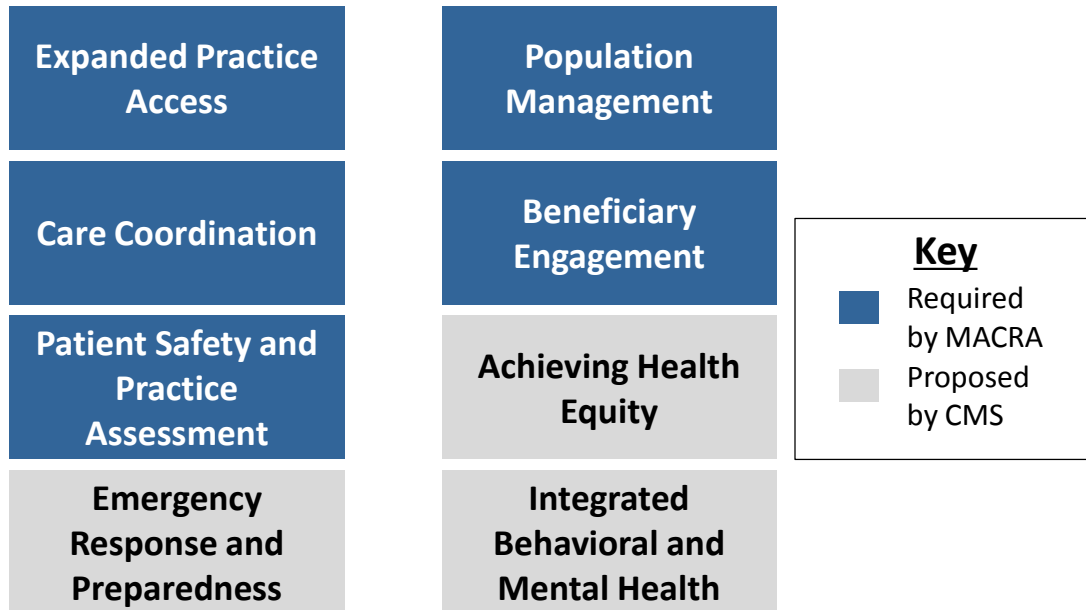
Clinical Practice Improvement Activity (CPIA) Performance Category



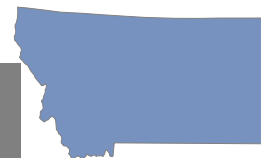
MACRA Definition

“An activity that relevant eligible clinician organizations and other relevant stakeholders identify as **improving clinical practice or care delivery**, and that the Secretary determines, when effectively executed, is likely to result in improved outcomes.”

CMS proposes 92 CPIA activities across eight categories:



MIPS ECs certified as a patient-centered medical home (PCMH) or comparable specialty practice will receive the highest possible CPIA score.



CMS proposes to score MIPS ECs according to a two-step process:

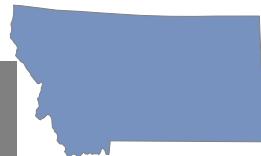
1 EC scores from each category are aggregated into one Composite Performance Score



2 EC's CPS is compared against a threshold CPS to determine the payment adjustment

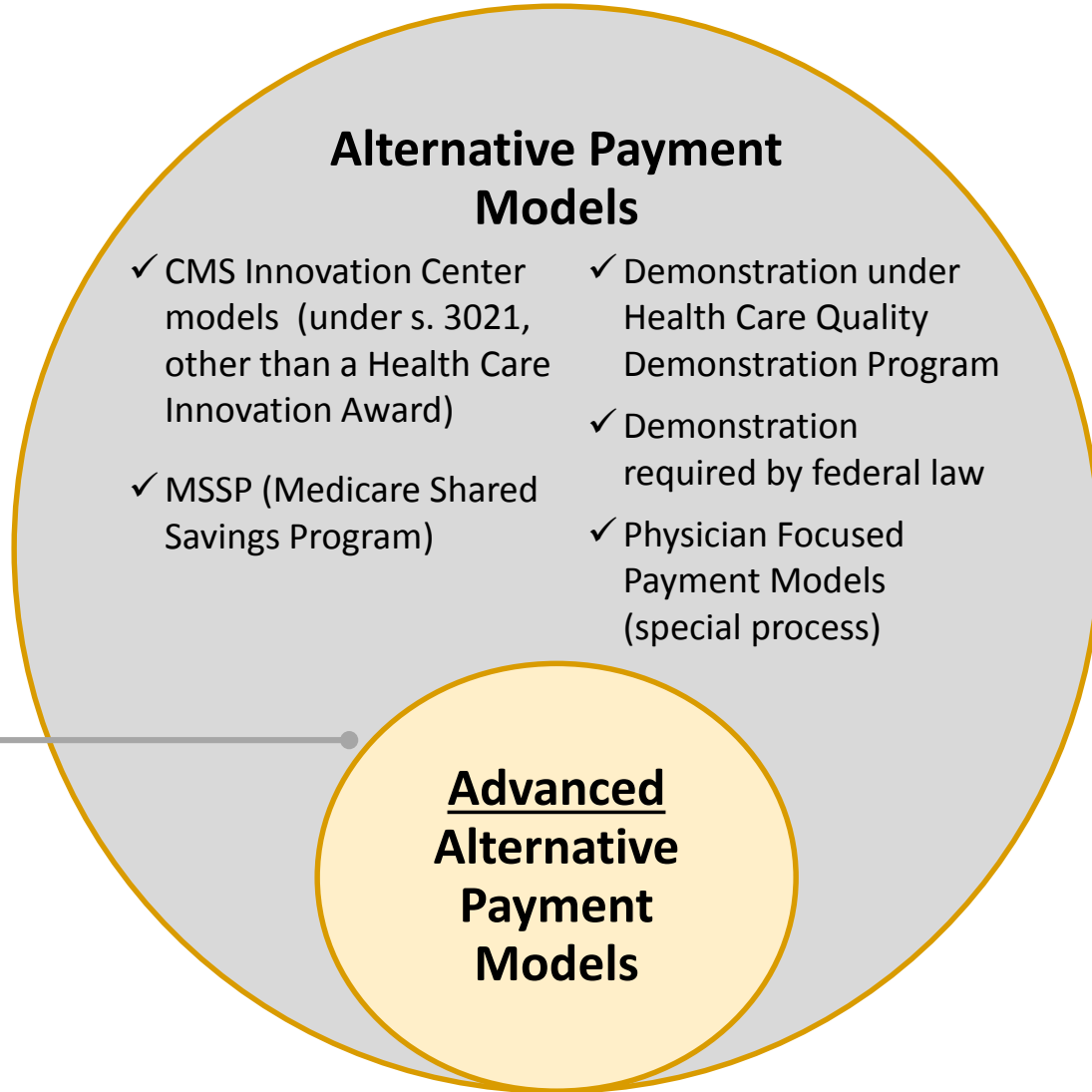


“Exceptional Performance”
MIPS ECs who score in the top quartile would be eligible for an additional 10% adjustment factor for each of the years 2019-2024.



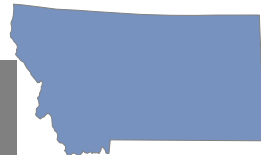
“Advanced Alternative Payment Models” Track

- ✓ Require use of CEHRT
- ✓ Quality requirements “comparable to MIPS”
- ✓ “Financial risk for monetary losses, of a more than nominal amount,” OR medical home model expanded under Innovation Center authority.

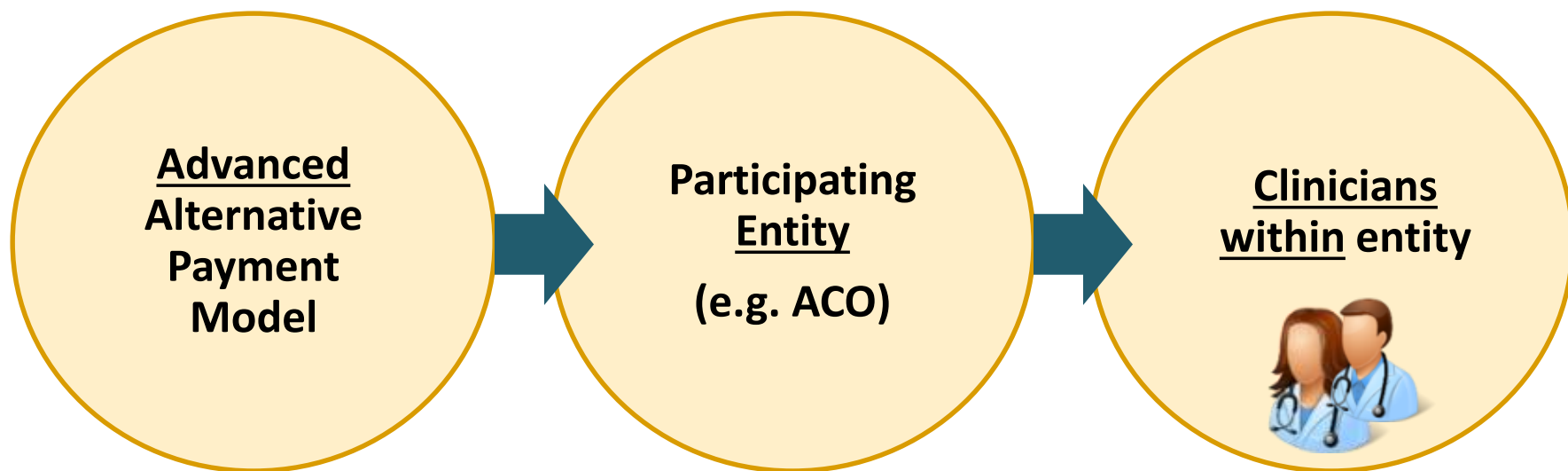


Participants in “regular” APMs are assessed under MIPS, but receive credit under MIPS for participating in an APM.

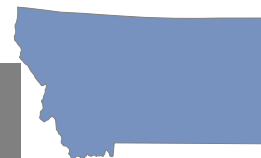
2017 Advanced APMs will likely be MSSP Tracks 2 & 3; CPC+, CEC (LDOs), Next Gen ACO and Oncology Care Model (2 sided).



Qualifying for MIPS exemption and 5% Bonus Payment

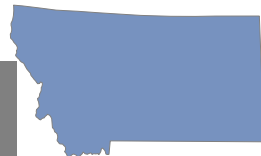


Physicians and other clinicians must meet CMS' thresholds for % of patients, and/or % of payments through the Advanced APM entity, in order to become "**Qualifying Advanced APM Participants**" (QPs) and receive the MIPS exemption and bonus.

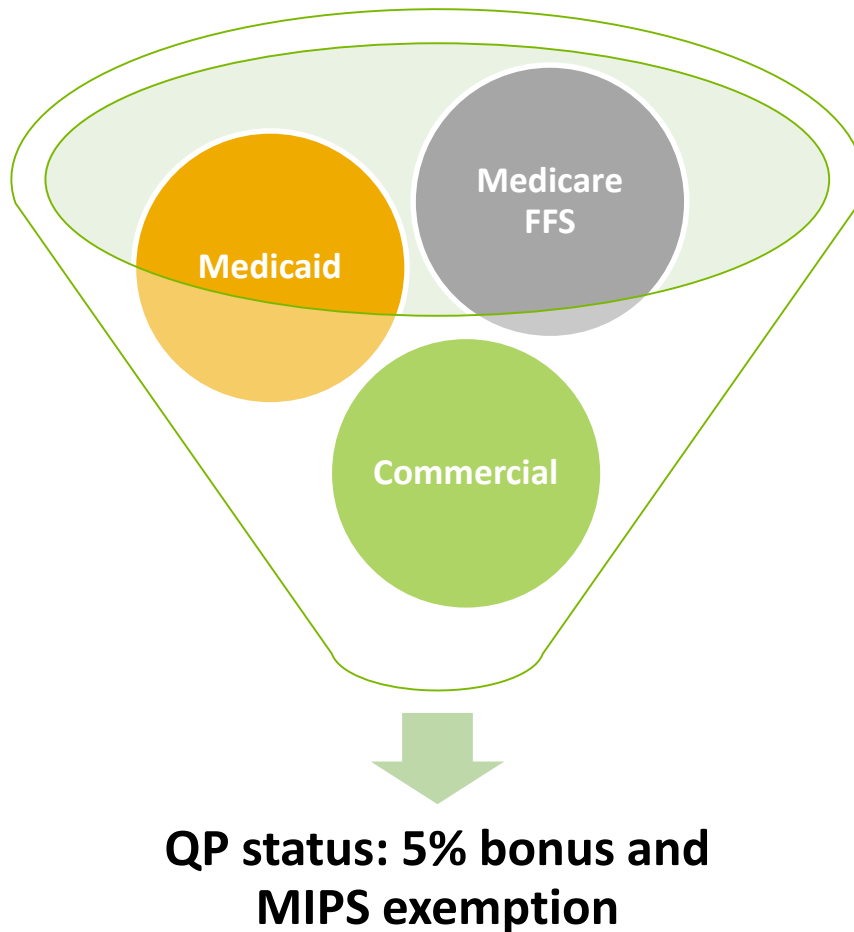


Special rules for Medical Homes

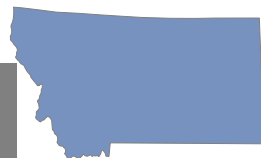
- CMS recognizes the importance of medical homes, but notes that it is more challenging for smaller entities to accept financial risk.
- Under the proposals, clinicians in groups with 50 or fewer, participating in CMS' Comprehensive Primary Care Plus initiative (starting 2017) will qualify as QPs.



The “All-Payer Combination Option” starting in 2019



Starting in 2019, participants in Medicare Advanced APMs who would otherwise not meet CMS’s thresholds for “QP” status will be able to **combine their participation in Medicare and non-Medicare Advanced APMs.**



Independent Committee on “Physician Focused Payment Models”

- The MACRA statute sets out a process by which the industry/public could suggest new models for CMS to test.
- The public may submit ideas for models to the **Physician Focused Payment Model Technical Advisory Committee**, which has already begun to meet. This Committee reviews proposals and submits them to the Secretary and CMS for consideration.
- If accepted, the models will be APMs, but not necessarily Advanced APMs. The Committee will likely focus on **specialist-centered** APMs.

