MACRA:
An Overview

CAOM January Seminar
21 JANUARY 2017

Medicare
Access and
Chip
Reauthorization
Act

What it is….

CMS/Medicare Provider Payment Reform:

Repeals SGR

Rewards Quality

- Creates Quality Payment Program (QPP)
  - MIPS
  - APM

Combines Our Current Quality Reporting Programs

- Into One Program

Zero Sum/Competitive

What it is not….

ACA

MACRA

Enjoys Strong Bipartisan Support

Senate Vote: 92-8

House Vote: 392-37

Medicare Access and CHIP Reauthorization Act of 2015

Replaces the 1997 SGR formula, which capped Medicare physician per beneficiary spending growth at GDP growth rate

- Overwhelming bipartisan support.
- Provides new tools in implementing the payment reforms.
- Applies to expanded group of clinicians
- Creates clear timetable and benchmarks.

On 3/26, the House passed H.R. 2 by 392-37 vote.

On 4/14, the Senate passed the House bill by a vote of 92-8, and the President signed the bill.

Who is Affected….

Medicare Part B Providers (for now)

- Not Medicaid
- Not Medicare Advantage (part C)

Providers (600,000)

- Physicians, PA's, NP's, CNS's, CRNA's who bill:
  - >$30,000 Medicare Part B charges or
  - >100 Medicare patients and
  - >1 year enrolled in Medicare billing

MACRA Timeline

- April 16, 2015 — Signed into Law
- April 27, 2016 — Released Proposed Rule Opened for Comment (OFC)
- June 27, 2016 — Closed to Comment
- October 14, 2016 — Final Rule Issued-OFC
- December, 2016 — Closed to Comment
- January 1, 2017 — Measurement Period Begins
- August, 2017 — Provider Track Notification
- January 1, 2019 — Fee adjustments begin

Final Rule: October 14, 2016

- Slowed the Transition for MIPS Providers
  - "Pick Your Pace"
- Increased the Threshold for Required Participation
  - More physicians Exempted
- Virtual Groups Not Addressed in 2017
- Hints at Continuing Transition in 2018
- Cost/Resource Use Parameter Not Scored in 2017

2017 becomes a kinder, gentler transitional year

MACRA Summary

Legislation in Brief

- Medicare Access and CHIP Reauthorization Act (MACRA) passed in April 2015
- Proposed rule issued April 27, 2016; final rule issued October 14, 2016
- Repeals the Sustainable Growth Rate (SGR)
- Locks Medicare Physician Fee Schedule reimbursement rates at near-zero growth:
  - 2016-2019: 0.5% annual increase
  - 2020-2025: 0% annual increase
  - 2026 and on: 0.25% annual increase or 0.75% increase, depending on payment track
- Stipulates development of two new Medicare Part B payment tracks: Merit-Based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (APMs)
- Programs to be implemented on Jan. 1, 2019 based on annual performance period starting Jan. 1, 2017

The Quality Payment Program: Two New Medicare Part B Payment Tracks Created by MACRA

1 Merit-Based Incentive Payment System (MIPS)

- Rolls existing Medicare Physician Fee Schedule payment programs[1] into one budget-neutral pay-for-performance program
- Clinicians will be scored on quality, resource use, clinical practice improvement, and EHR[2] use—and assigned a positive or negative payment adjustment accordingly

2 Advanced Alternative Payment Models (APM)

- Requires significant share of patients and/or revenue in payment contracts with two-sided risk, quality measurement, and EHR requirements
- APM track participants will be exempt from MIPS payment adjustments and qualify for a 5 percent incentive payment in 2019-2024

MACRA Consolidation Timeline

MACRA Consolidates Previous Quality Reporting Programs for Medicare Clinicians

MACRA Legislation Received Strong Bipartisan Support

92-8 Senate vote in favor of MACRA

392-37 House vote in favor of MACRA

MACRA Reduced Total Maximum Penalties for Near-Term

-4%

Under MACRA, 2019 maximum penalty rate based on 2017 MIPS performance

-9%

Prior to MACRA, maximum penalty rate among separate quality programs[1]

1) Based on -2% PQRS, -4% VBPM, -3% MU.

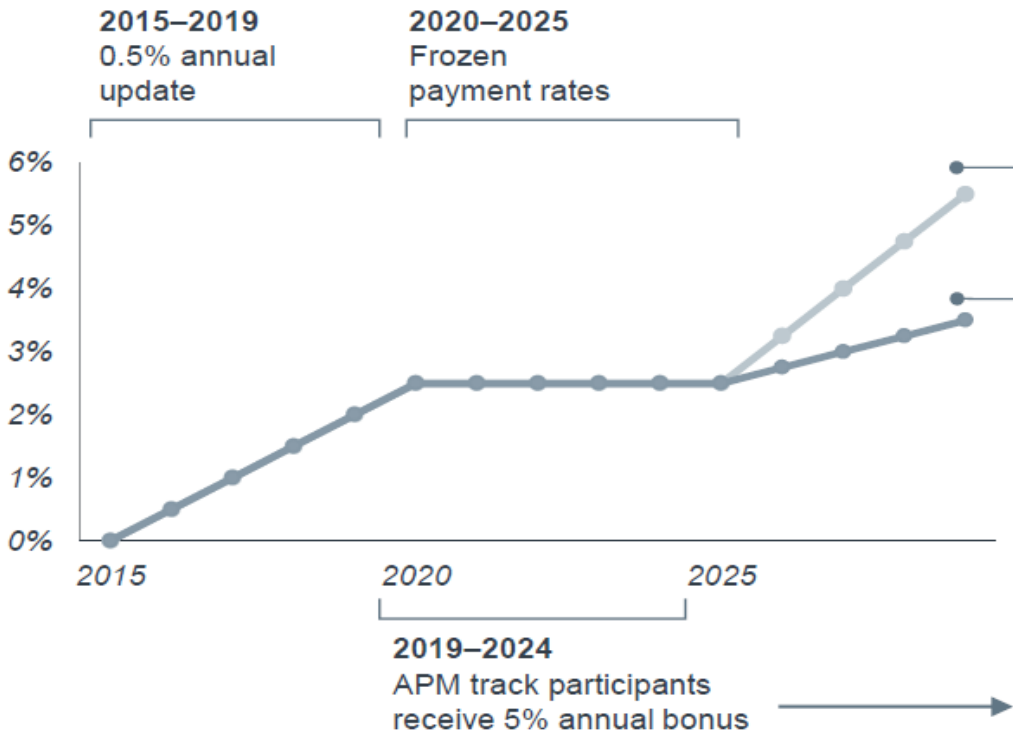
Source: Advisory Board research and analysis.

Quality Payment Program (QPP)

- Two Pathways:
  - Merit-Based Incentive Payment System (MIPS)
    - Most Physicians Will Participate Here
    - The “Default” Pathway
    - Data Reporting Requirements Start January 1, 2017
  - Advanced Alternative Payment Model (APM)
    - Providers More at Risk
    - Must Be a CMS Approved Model

Payment: APM vs MIPS

Baseline Payment Adjustments Under Each Track



Alternative Payment Model Track: 2026 and on 0.75% annual update

The Merit-Based Incentive System: 2026 and on 0.25% annual update

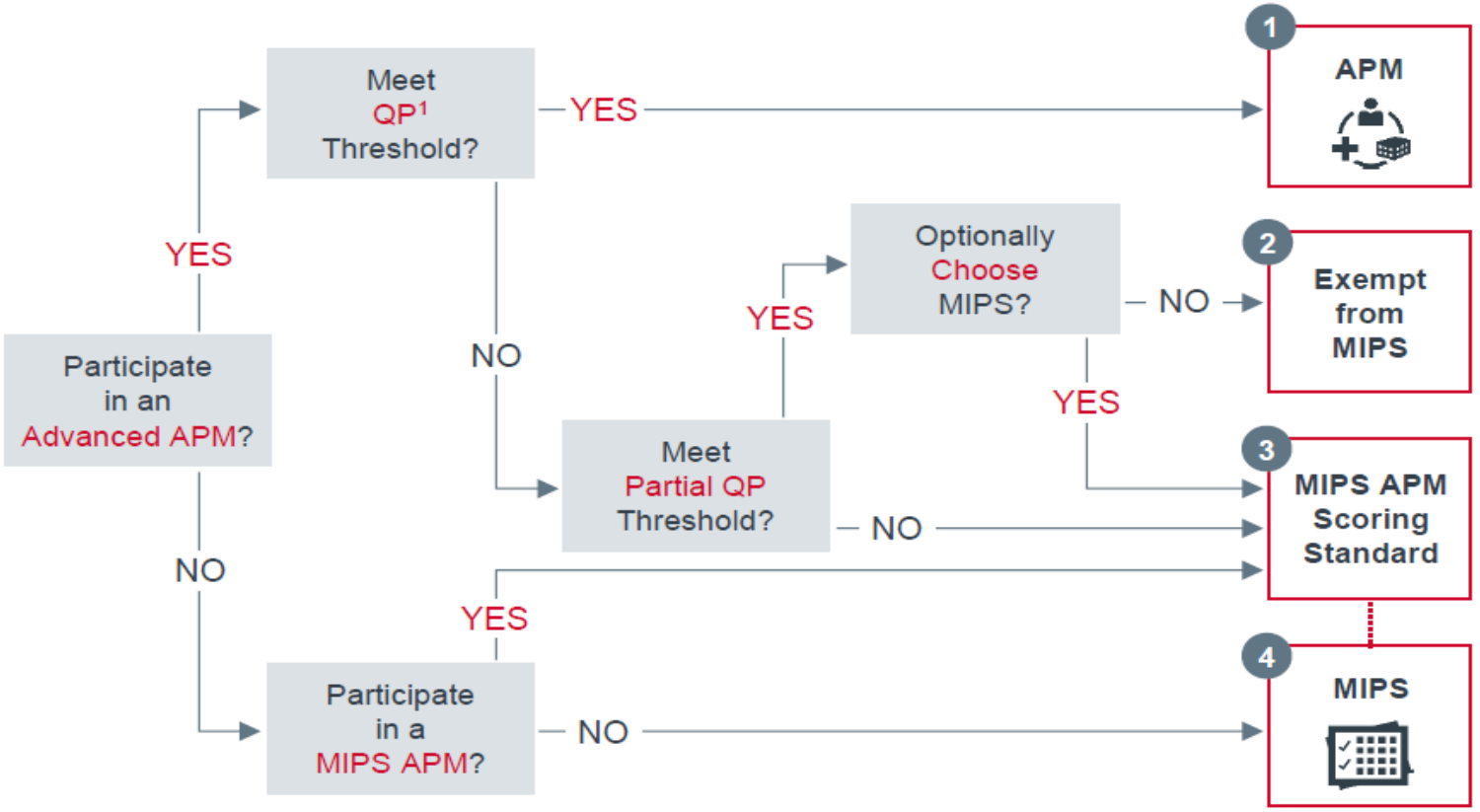
Annual Bonus for APM Participation

5% Bonus awarded each year from 2019–2024 to clinicians who qualify for the APM track

Sources: CMS; Advisory Board research and analysis.

Which Track?

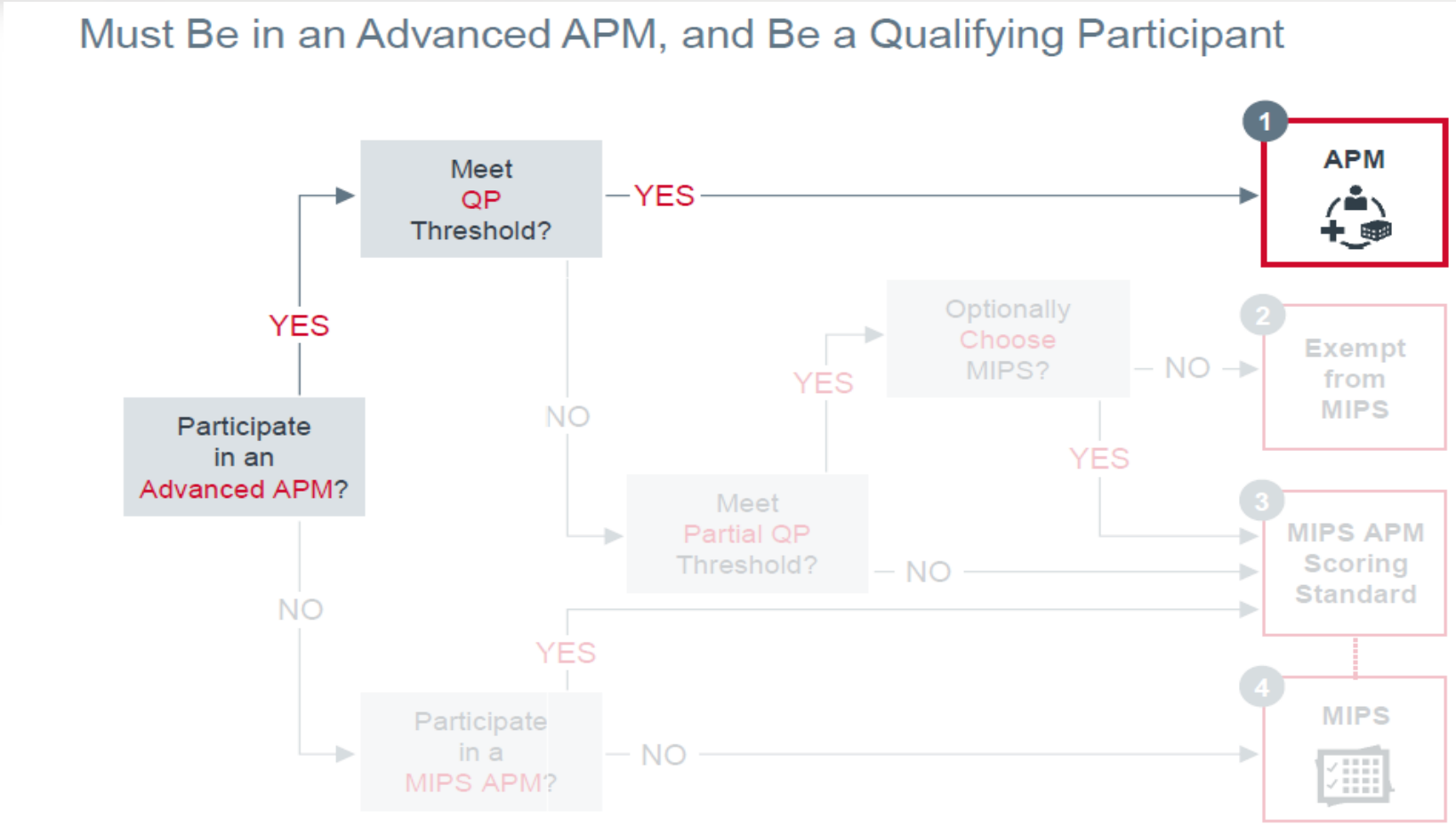
Must Know First Whether Payment Model Is an Advanced APM



1) QP = Qualifying participant.

Source: Advisory Board research and analysis.

APM Track Criteria



Source: Advisory Board research and analysis.

APM Eligibility Requirements

Advanced APMs Confirmed for 2017

Advanced APM Criteria

Financial Risk Criteria

- ☑ Meet revenue-based standard (average of at least 8% of revenues at risk for participating APMs) or
- ☑ Meet benchmark-based standard (maximum possible loss must be at least 3% of spending target)

- ☑ Certified EHR use
- ☑ Quality requirements comparable to MIPS

2017 Medicare Advanced APMs

Comprehensive ESRD[1] Care LDO[2] Arrangement
Comprehensive ESRD Care non-LDO Arrangement (two-sided risk)
CPC+[3]
MSSP[4] Track 2 and Track 3
Next Generation ACO[5]
Oncology Care Model (OCM, two-sided risk arrangement)

1) ESRD = End-stage renal disease.
2) LDO = Large dialysis organization.
3) CPC+ = Comprehensive Primary Care Plus.
4) MSSP = Medicare Shared Savings Program.
5) ACO = Accountable care organization.

Sources: CMS, "Alternative Payment Models in the Quality Payment Program," https://qpp.cms.gov/docs/QPP_Advanced_APMs_in_2017.pdf, October 14, 2016; Advisory Board research and analysis.

Anticipated Advanced APM Additions

CMS to Expand List of Qualifying Programs in 2018 and Beyond

Anticipated Additions to Advanced APM List for 2018 Program Year

Creation of Qualifying New Models

MSSP Track 1+

Two-sided risk track with less upside reward but also less downside risk than Track 2 and Track 3; expected to begin in 2018

Voluntary Bundled Payment Model

CMMI[1] considering a new voluntary bundled payment model for 2018; would build on BPCI[2]

Inclusion of Existing Models

CJR[3] Payment Model (CEHRT[4] Track)

Proposed rule allows for qualification as an Advanced APM if participating hospitals are using CEHRT

EPM[5] Track 1 (CEHRT Track)

Proposed rule creates two tracks; participants required to use CEHRT in Track 1 of each EPM to qualify as Advanced APM

Vermont Medicare ACO Initiative

CMS expects the Vermont Medicare ACO program (part of Vermont's new All-Payer ACO Model) to be an Advanced APM

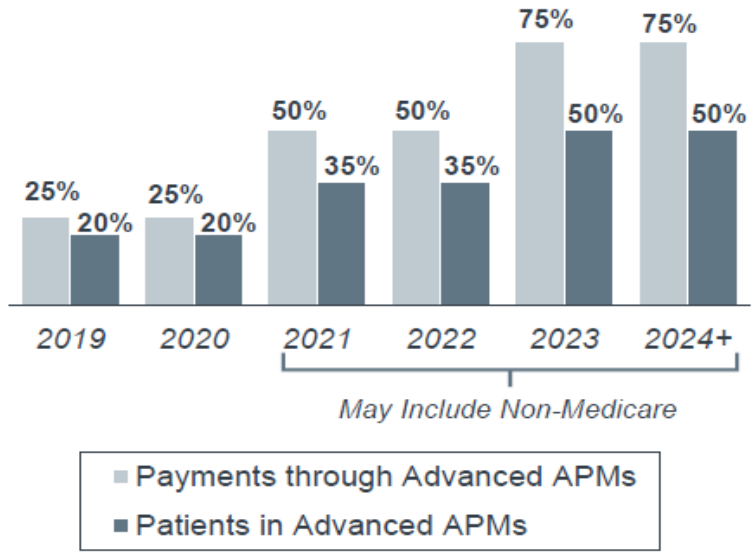
1) CMMI = Center for Medicare and Medicaid Innovation.
2) BPCI = Bundled Payments for Care Improvement.
3) CJR = Comprehensive Care for Joint Replacement.
4) CEHRT = Certified electronic health record technology.
5) EPM = Episode Payment Model.

Sources: CMS; Advisory Board research and analysis.

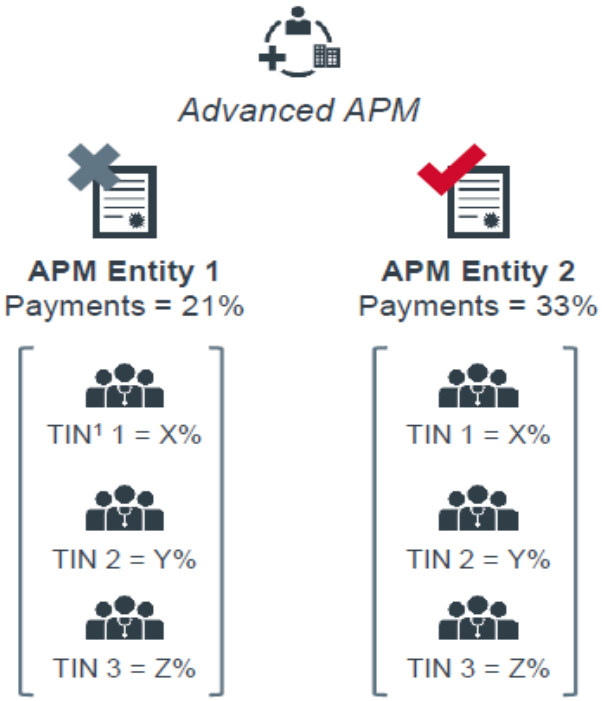
APM must meet Qualifying Participant (QP) Status

Variation in Volume Can Make or Break APM Track Determination

APM Entities Must Meet Percent of Payments or Patient Counts



Example of 2019 Payment Qualification



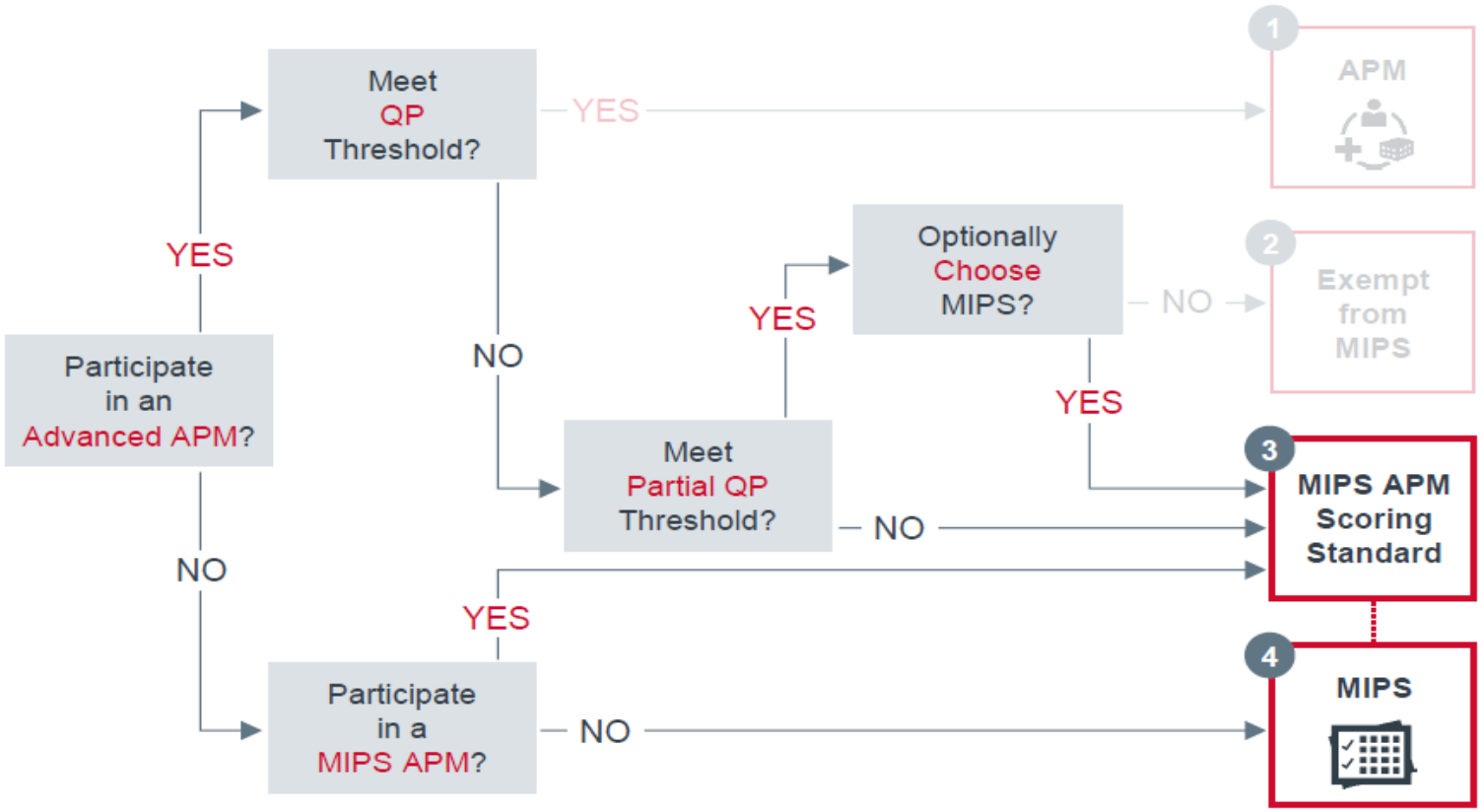
10%–16% Clinicians currently projected by CMS to qualify for APM track in 2019 payment year

1) TIN = Tax identification number.

Sources: CMS; Advisory Board research and analysis.

MIPS

Majority Will Participate in MIPS; Some Receive Preferential Scoring



Source: Advisory Board research and analysis.

MIPS

MIPS Performance Categories

A single MIPS composite performance **score** will factor in performance in **4 weighted performance categories on a 0-100 point scale**:

MIPS 2017 Performance Categories

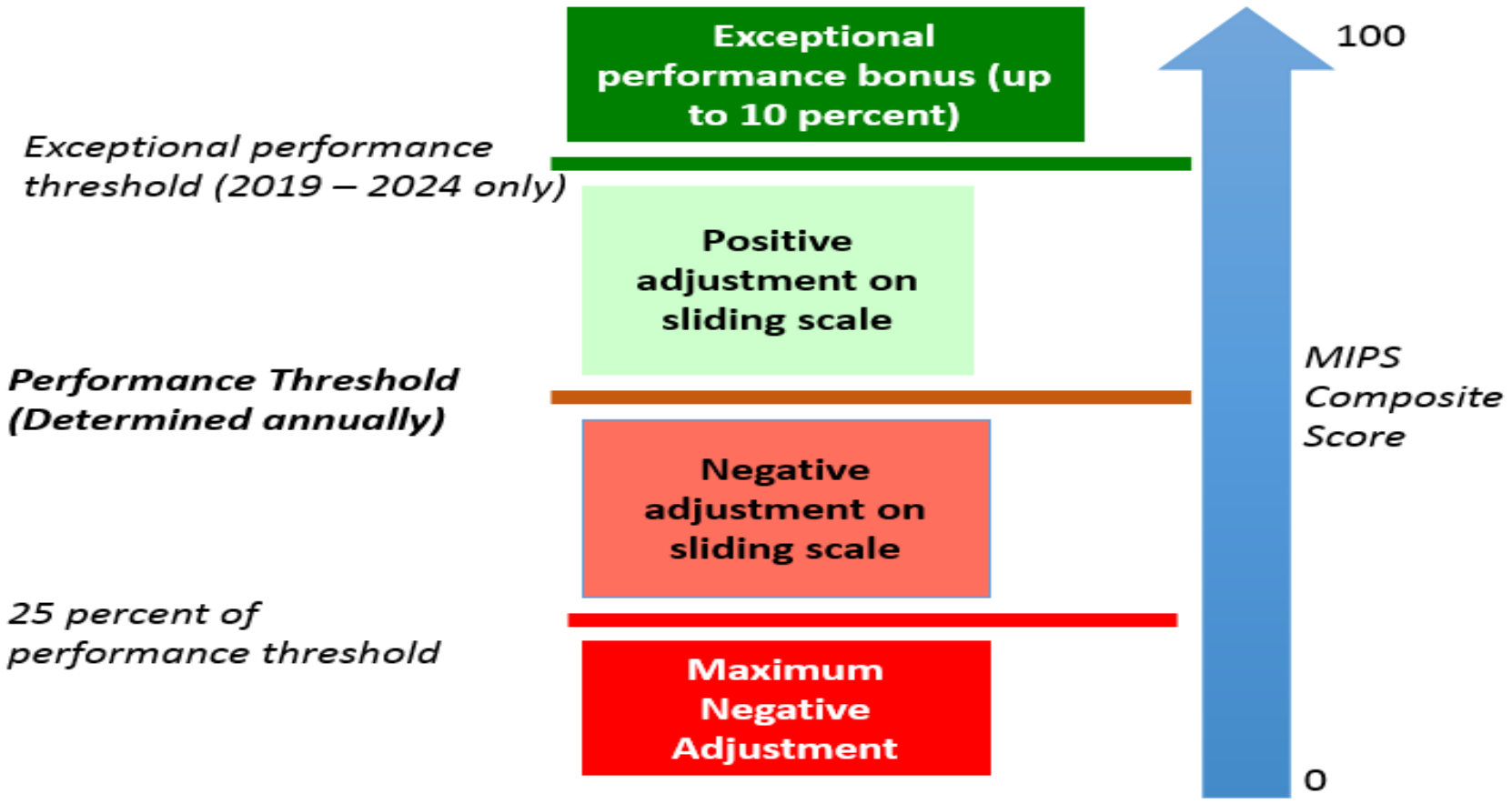
Category	Key Components	Scoring & Weight[1]
Quality (Previously PQRS)	• Over 200 measures to choose from, 80% of which are tailored to specialists • Providers required to report six measures, including one outcome measure; in addition, all-cause readmissions will be calculated based on claims for certain providers	Based on peer benchmarks **60%**
Cost (Previously VBPM cost component)	• Not a component of MIPS performance in program year 2017 • CMS will include this category beginning 2018	**0%**
Improvement Activities (New category)	• Over 90 activities to choose from; offers flexibility for many provider types • Preferential scoring for small practices, MIPS APM participants, and PCMH[2]	Based on EC's own performance **15%**
Advancing Care Information (Previously MU)	• Applies to additional clinicians,[3] unlike previous Medicare Eligible Professional MU requirements (which applied only to physicians) • No longer requires "all-or-nothing" measure threshold reporting; clinicians scored on participation and performance	Based on EC's own performance **25%**

621K Clinicians currently projected by CMS subject to the MIPS track for the 2019 payment year

1) Different weights apply to MIPS APM scoring standard.
2) PCMH = Patient-Centered Medical Homes.
3) MIPS eligible clinicians include physicians, physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, and groups that include such clinicians. In 2017, Advancing Care Information (ACI) category may be reweighted to zero for non-physician clinicians.

Sources: CMS; Advisory Board research and analysis.

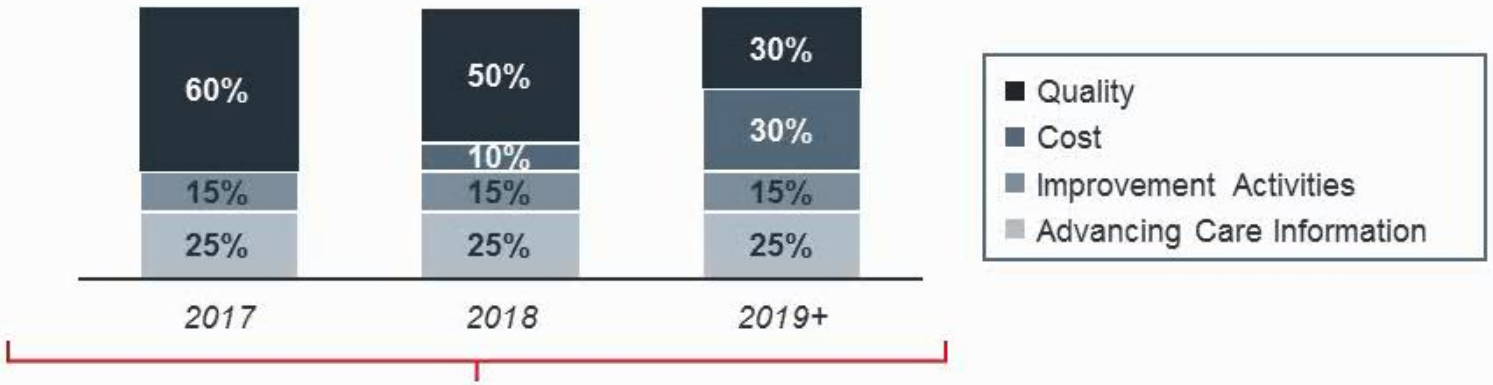
MIPS Composite Score: Bonus and Penalty



MIPS Going Forward

Full-Year Reporting, Weighting for Cost Category, Outcomes Metrics Loom

Weights of MIPS Score Components in Final Rule



Key MACRA Reporting Trends Looking Forward

Resource Use Measurement Intensifies Post-Transition Year

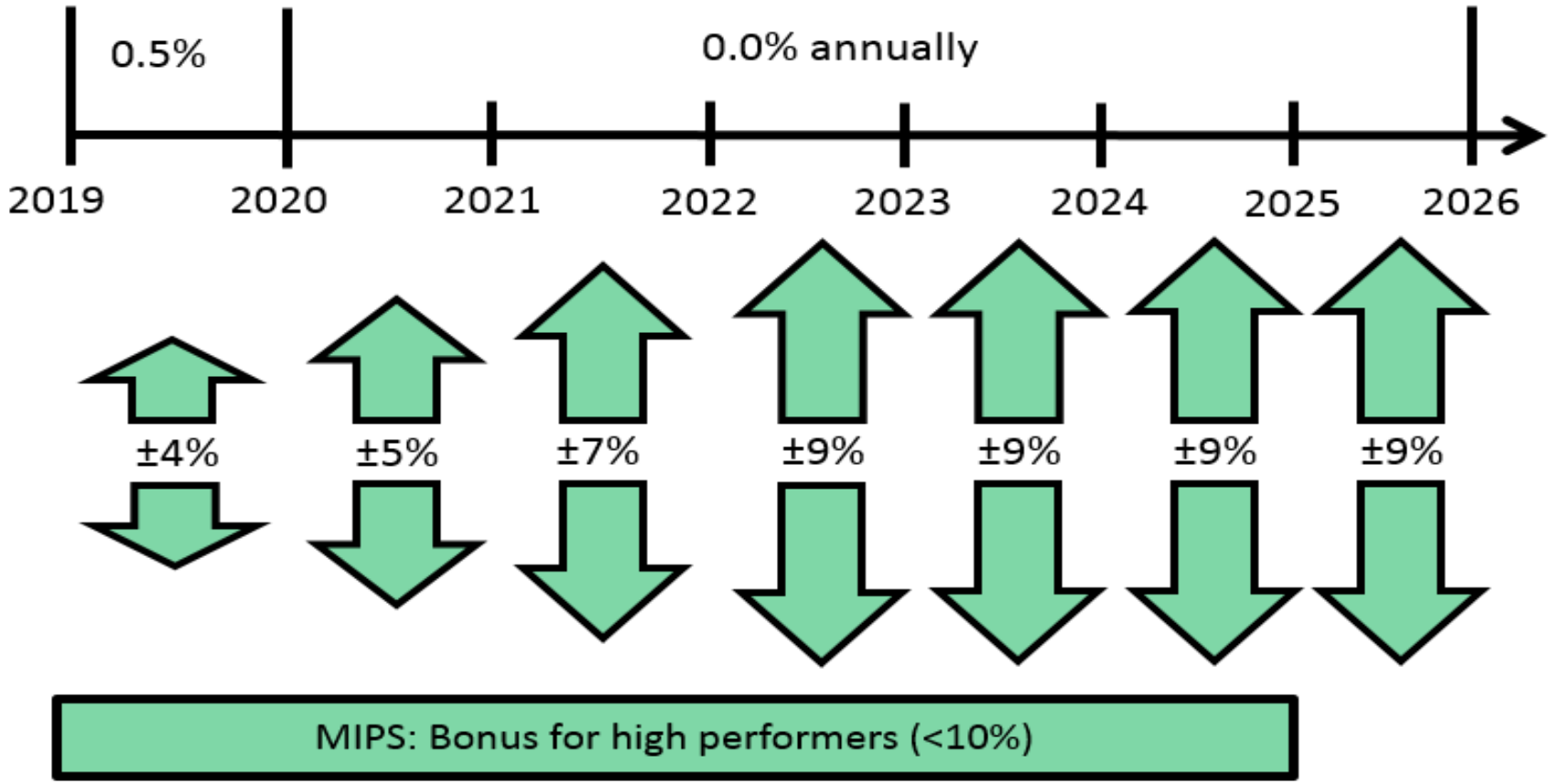
Resource use reporting not considered for 2017 performance year, but still increased to 30% by 2019; CMS expects to add more episode-based measures over time

Quality Scoring to Center on Outcomes Metrics

"To keep the emphasis on such measures in the statute, **we plan to increase the requirements for reporting outcome measures** over the next several years through future rulemaking, as more outcome measures become available."

Centers for Medicare and Medicaid Services

Annual MIPS Adjustments



Reporting Under MIPS/2017 Transition

Reporting Requirements and Financial Implications

Pick Your Pace Options	Reporting Period	Performance Category	Minimum Reporting Requirements	Financial Implications in 2019
"Crawl" 	• No required reporting period • Less than 90 days permitted	**Any**: • Quality, or • IA, or • ACI	**Any**: • One Quality measure • One IA • "Base" ACI measures	• Avoid penalty
"Walk" 	• Minimum 90 continuous days	**Any**: • Quality, or • IA, or • ACI	**Any**: • ≥ 2 Quality measures • ≥ 2 IAs • "Base" and ≥ 1 "performance" ACI measure(s)	• Avoid penalty • Possible nominal incentives
"Run" 	• Minimum 90 continuous days • A full year is **NOT** required	**All Three Categories:** • Quality, and • IA, and • ACI	**Achieve Highest Points Possible:** • 6 Quality measures, • IAs sufficient for full credit • "Base" and "performance" ACI measures for full credit	• Avoid penalty • Possible modest incentives • Possible exceptional performance[1] incentives

"A full year gives you the most measures to pick from. But if you report for 90 days, you could still earn the max adjustment."

CMS

1) Additional pool of $500M available for exceptional performers that have a Composite Performance Score (CPS) of 70 or higher in 2017.

Sources: CMS; CMS, "Quality Payment Program Overview," https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/MACRA-Quality-Payment-Program-webinar-slides-10-26-16.pdf; Advisory Board research and analysis.

MIPS Reporting

Qualified Registry

Meets specific CMS qualifications and scope of registry is limited to MIPS measures

For more: MIPS Qualified Registry Self-Nomination Fact Sheet

Qualified Clinical Data Registry (QCDR)

Meets specific CMS qualifications but scope of registry is *not* limited to MIPS measures

For more: MIPS QCDR Self-Nomination Fact Sheet

EHR

Office of the National Coordinator-certified EHR submits data directly to CMS

For more: certified EHRs available

CMS Web Interface

Group practice reporting option via CMS' QualityNet web site

For more: see QualityNet

Attestation or Claims

Attestation: TBD; CMS may utilize existing MU attestation portal

Claims: Coded data inputted through claims

CAHPS[1] Vendor

CMS-certified vendor used for combined CAHPS and MIPS reporting

For more: see currently approved vendors

1) CAHPS = Consumer Assessment of Health Providers and Systems.

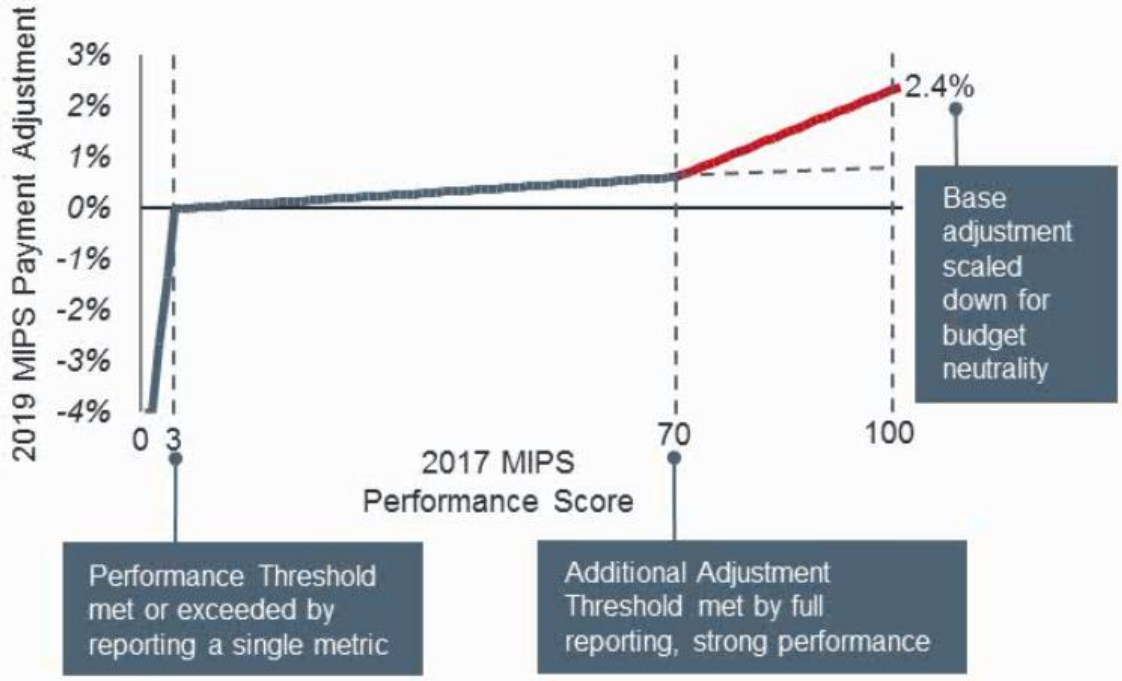
Sources: CMS; Advisory Board research and analysis.

Ease of Avoiding Penalties Mean Light Bonuses

But Low Bar Rises Quickly After 2017

Hypothetical 2019 Payment Adjustments

Based on CMS Example of 2017 Provider Score Distribution



$199M

Penalties anticipated from non-reporting ECs in 2017

$336

Estimated net upward base adjustment per clinician subject to MIPS

$500M

Additional funds to be distributed to ECs above Additional Adjustment Threshold

MIPS Zero-Sum

Annual Evaluation Likely to Create Volatility

Payment Adjustment Determination

1. Clinicians assigned score of 0-100 based on performance across four categories
2. Score compared to CMS-set performance threshold; non-reporting groups given lowest score
3. A score above performance threshold results in upward payment adjustment; a score below results in a downward adjustment[2]

Maximum Clinician Penalties and Bonuses