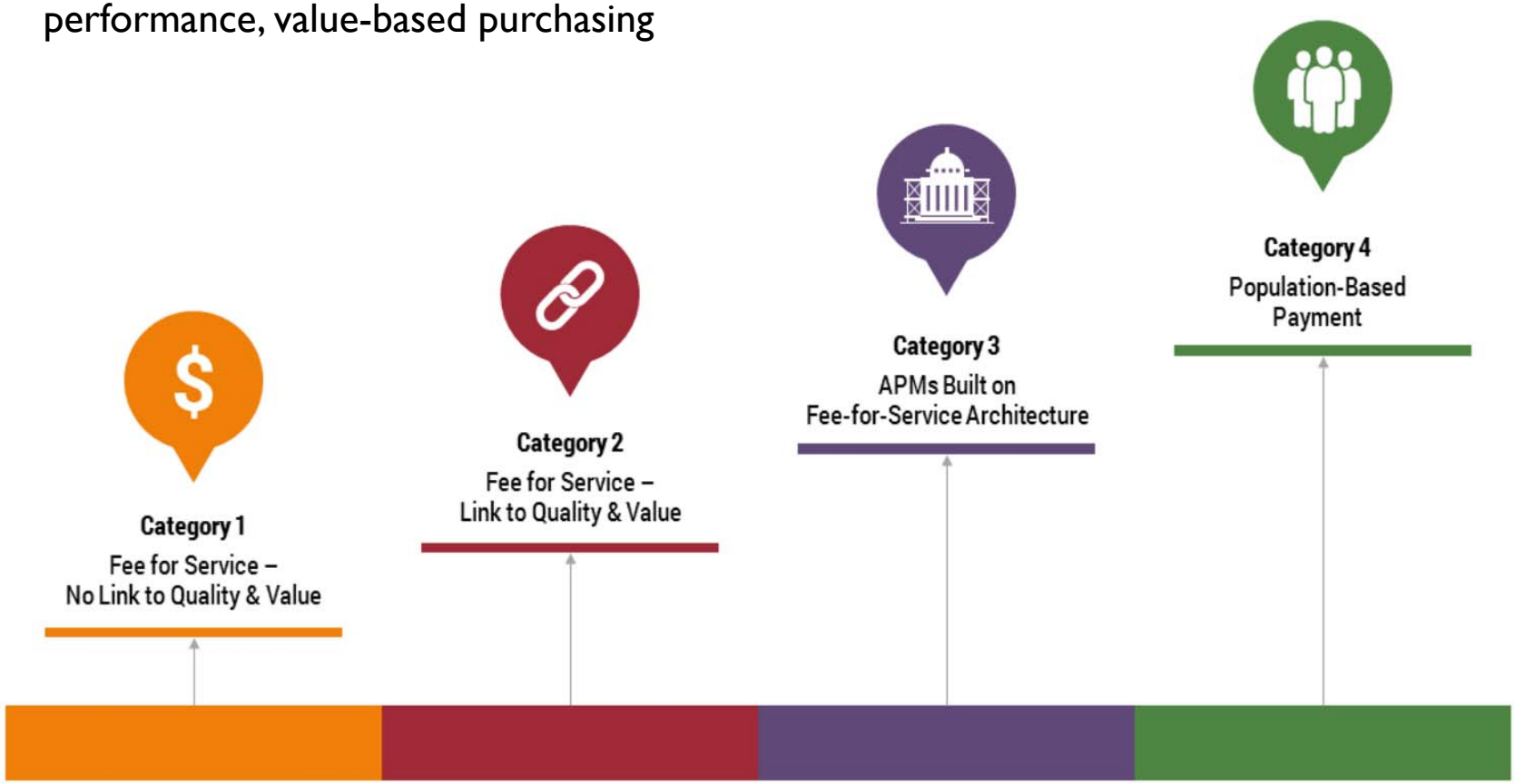
MACRA Overview

April 2016

HSCRC
Health Services Cost Review Commission

CMS is Focused on Progression from Volume-Based to Value-Based Payments

- Hospitals have some value-based payment via Hospital VBP, readmissions, and HAC programs
- Other provider groups (e.g. physicians, post-acute care) are moving to pay-for-performance, value-based purchasing



Source: Health Care Payment Learning & Action Network Alternative Payment Model (APM) Framework Final White Paper, 2016

MACRA is part of a broader push towards value and quality

In January 2015, the Department of Health and Human Services announced **new goals** for **value-based payments** and **APMs in Medicare**

Medicare Fee-for-Service

GOAL 1:

30%

Medicare payments are tied to quality or value through **alternative payment models** (categories 3-4) by the end of 2016, and 50% by the end of 2018

GOAL 2:

85%

Medicare fee-for-service payments are **tied to quality or value** (categories 2-4) by the end of 2016, and 90% by the end of 2018

STAKEHOLDERS:

Consumers | Businesses
Payers | Providers
State Partners

Set **internal goals** for HHS

Invite **private sector payers** to match or exceeed HHS goals

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/MACRA-LAN-PPT.pdf

Accelerating Movement via MACRA

- MACRA is formally known as the H.R.2 Medicare Access and CHIP Reauthorization Act of 2015
  - Signed into law by Obama in April 2015

- MACRA Highlights
  - Repeals use of the Sustainable Growth Rate (SGR) Formula
    - Cut Medicare physician fees for all services if total physician spending exceeded a target, penalizing individuals who did control their costs
    - Was volume-based- did not reward improvements in quality
  - Replaces SGR with new quality-driven payment systems for providers

- ***Still many unknowns- Regs coming out this summer

MACRA: Provider Reimbursement Changes

- 2019-2025: Move to value-based payments via involvement in either of two tracks:

1) MIPS: Merit-Based Incentive Payment System	2) APMs: Alternative Payment Models
• Continues traditional FFS track • BUT a portion of Medicare provider payment at risk will gradually increase up to **-9% to +9%** based on their performance on quality and outcomes measures	• Medicare providers can opt out of MIPS and **receive +5% bonus** in rates if a substantial portion of their revenue is through APMs • Qualifying APMs definition TBD based on rulemaking.

- 2026+: All Medicare providers receive 0.25% update
  - APM providers will receive an additional 0.5% update, thereby receiving a 0.75% update overall for Medicare services

Source: Summarized from Premier Medicare Payment Reform: Implications and Options for Physicians and Hospitals, 2015

Track 1: MIPS

- Performance Areas
  - Quality (e.g. preventive care, safety, etc.)
  - Resource use (e.g. Medicare spending per beneficiary)
  - Meaningful use of EHRs
  - Clinical practice improvement activities
    - Care coordination
    - Expanded access (e.g. same day appointments)
    - Patient safety and practice assessment (e..g surgical checklists)
    - Beneficiary engagement (e.g. use of shared decision-making)
    - Population management
    - APM participation
- Each category will have an underlying set of activities or measures
  - Measures used for the evaluation of provider performance can be based on all payer data (not only Medicare)

Source: Summarized from Premier Medicare Payment Reform: Implications and Options for Physicians and Hospitals, 2015

Track 2: Alternative Payment Models (APMs)

- Poviders will receive **+5% bonus**, in addition to payments otherwise made under the APM, if they have a minimum amount of revenue at risk through an APM
  - To qualify for the bonus in 2019, providers may need to be in an APM in 2017
  - See Appendix

- To qualify as an eligible APM, providers must:
  - Use certified EHR technology
  - Meet quality measures (comparable to MIPS measures)
  - Assume more than "nominal" financial risk
    - Not yet sure what this means– definition TBD based on rulemaking

Source: Summarized from Premier Medicare Payment Reform: Implications and Options for Physicians and Hospitals, 2015

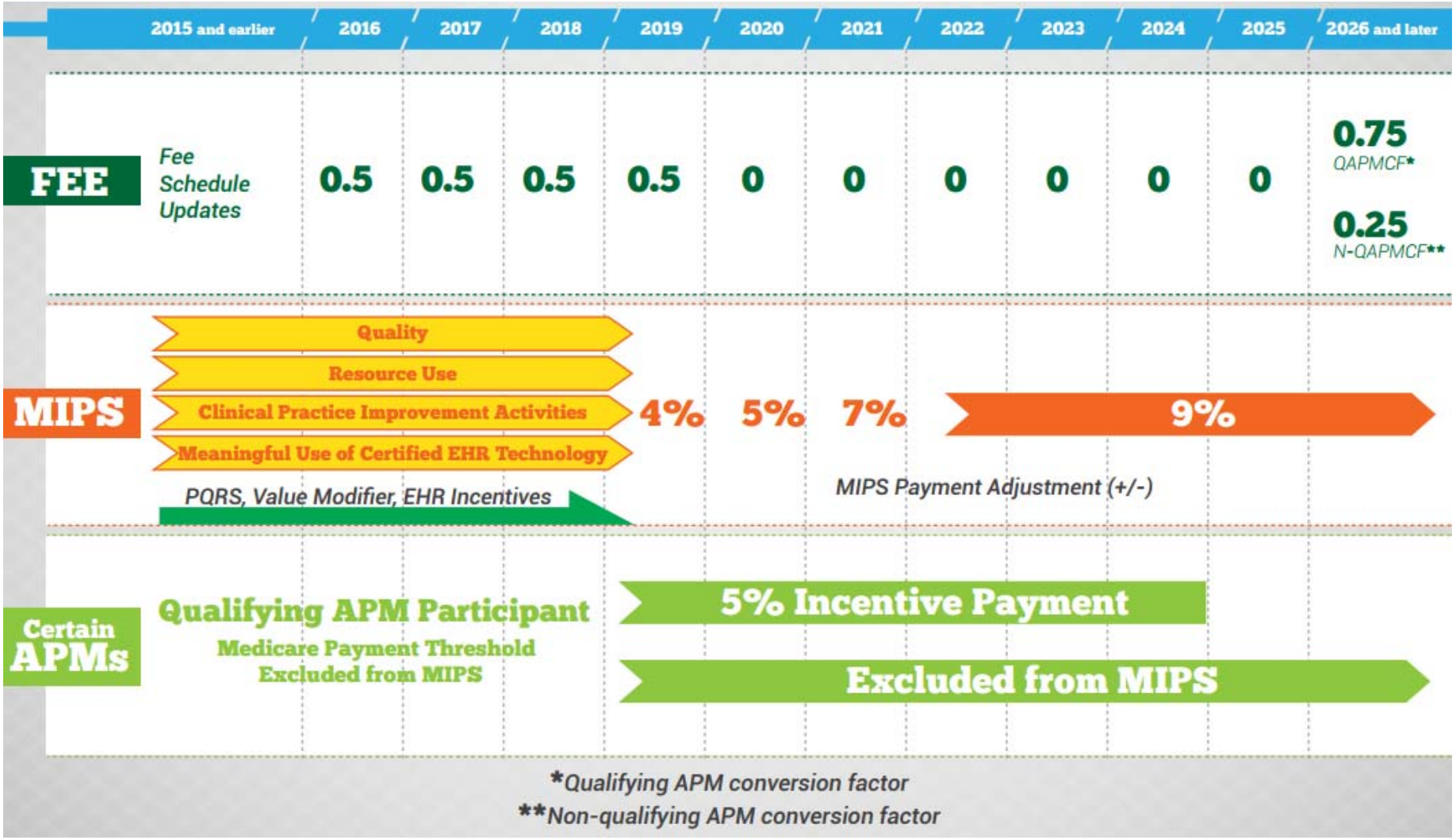
Strategic Implications for Maryland

- MACRA demonstrates the federal movement to two-sided risk and alternative payment models (e.g. ACO, PCMH, bundled payment, etc.) and focus on efficiency, outcomes, and financial responsibility
- Maryland's next steps may include:
  - Assess current state, identify gaps, analyze opportunities and develop roadmap
  - Develop and implement physician partnership strategy

Source: Summarized from Premier Medicare Payment Reform: Implications and Options for Physicians and Hospitals, 2015

Appendix

MACRA: MIPS & APM Timeline Overview



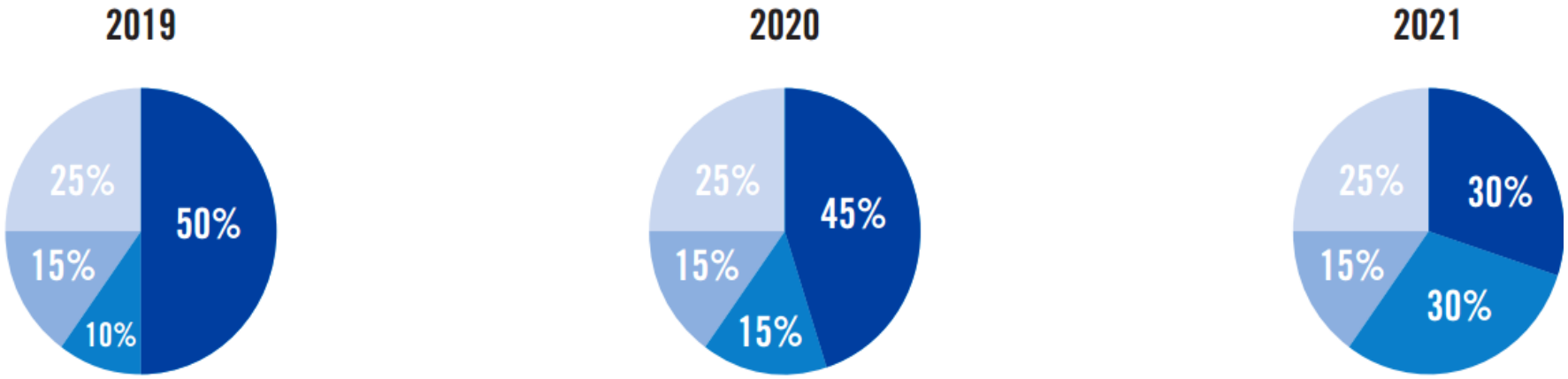
Source: CMS.gov Merit-Based Incentive Payment System (MIPS) & Alternative Payment Models (APMs) website, 2015

MIPS & MACRA Eligibility

TYPES OF ELIGIBLE PROFESSIONALS	TRACK 1		TRACK 2
	Value-Modifier	MIPS	APM
Medicare Physicians: Doctor of Medicine, Doctor of Osteopathy, Doctor of Podiatric Medicine, Doctor of Optometry, Doctor of Oral Surgery, Doctor of Dental Medicine, Doctor of Chiropractic	2017 (2015 performance)	2019	2019
Practitioners: Physician Assistant, Nurse Practitioner, Clinical Nurse Specialist, Certified Registered Nurse Anesthetist	2018 (2016 performance)	2019	2019
Practitioners: Certified Nurse Midwife, Clinical Social Worker, Clinical Psychologist, Registered Dietician, Nutrition Professional, Audiologists	N/A	2021	2019
Therapists: Physical Therapist, Occupational Therapist, Qualified Speech-Language Therapist	N/A	2021	2019

Source: Premier Medicare Payment Reform: Implications and Options for Physicians and Hospitals, 2015

MIPS Performance Measures



QUALITY	Physician Quality Reporting System measures
RESOURCE USE	Value-based Payment Modifier measures
MEANINGFUL USE OF EHR	EHR incentive payment measures
CLINICAL PRACTICE IMPROVEMENT ACTIVITIES	Expanded access, population management, care coordination, beneficiary engagement, patient safety, and alternative payment models

Source: Premier Medicare Payment Reform: Implications and Options for Physicians and Hospitals, 2015

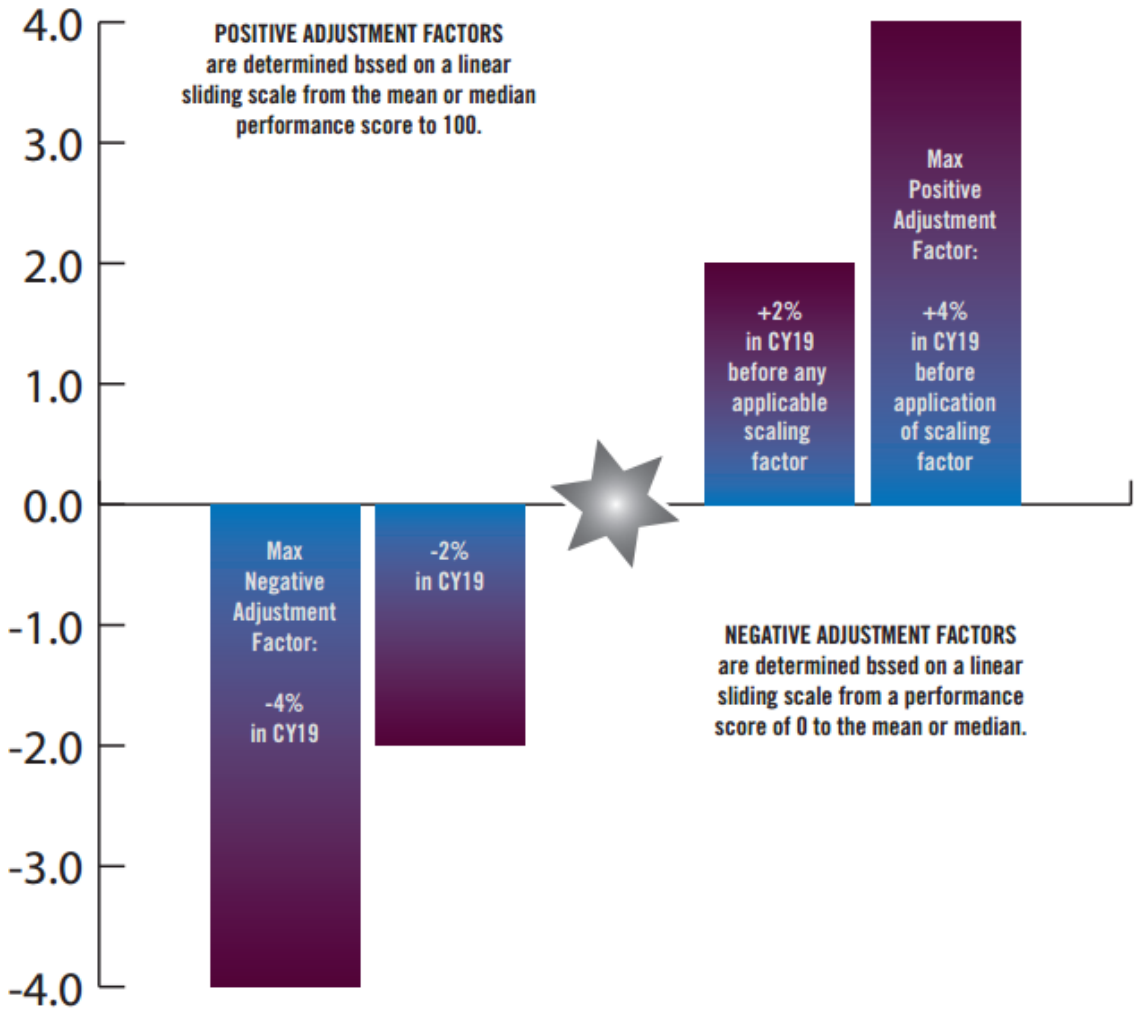
MIPS Payment Adjustment Factors

Figure 6 – MIPS payment adjustment factors

	Maximum positive adjustment before budget neutrality scaling factor	Maximum negative adjustment factor	Maximum positive adjustment after budget neutrality scaling factor
CY 2019	4%	-4%	12%
CY 2020	5%	-5%	15%
CY 2021	7%	-7%	21%
CY 2022	9%	-9%	27%

Source: Premier Medicare Payment Reform: Implications and Options for Physicians and Hospitals, 2015

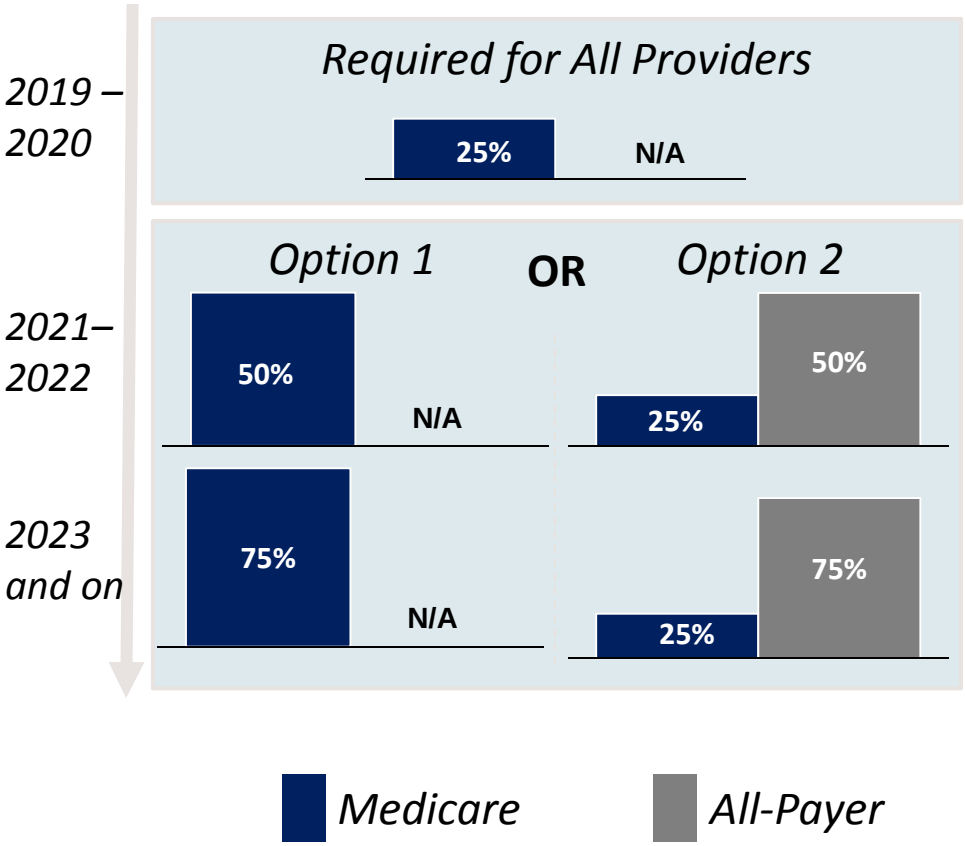
MIPS Payment Adjustment Factors



Source: Premier Medicare Payment Reform: Implications and Options for Physicians and Hospitals, 2015

APM: Provider Eligibility

Required Percentage of Provider's Revenue Under Risk-Based Payment Models



Source: The Medicare Access and CHIP Reauthorization Act of 2015; Advisory Board analysis.