Accelerating Movement via MACRA

- MACRA is formally known as the H.R.2 Medicare Access and CHIP Reauthorization Act of 2015
  - Signed into law 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
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:** 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

**30%**

**GOAL 2:** 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

**85%**

**STAKEHOLDERS:**
Consumers | Businesses
Payers | Providers
State Partners

- Set internal goals for HHS
- Invite private sector payers to match or exceed HHS goals

MACRA reform timeline
(Medicare Access and CHIP Reauthorization Act of 2015)

Permanent repeal of SGR
Updates in physician payments
0.5% (7/2015-2019) 0% (2020-2025)
PQRS pay for reporting
Meaningful Use Penalty (up to %)
Value-based Payment Modifier

Merit-Based Incentive Payment System (MIPS) adjustments
+/- 4% +/− 5% +/− 7% +/− 9%
MIPS exceptional performance adjustment; ≤ 10%
Medicare payment (2019-2024)

Advanced APM participating providers exempt from MIPS; receive annual 5% bonus (2019-2024)

Source: MACRA Summit
**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**
     - 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

  2. **AAPMs: Advanced Alternative Payment Models**
     - Medicare providers can opt out of MIPS and receive **+5% bonus** in rates if a substantial portion of their revenue is through AAPMs

- **2026+:** All Medicare providers receive **0.25% update**
  - AAPM 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: Merit-Based Incentive Payment System (MIPS)

- MIPS is based on traditional Medicare FFS payments
- Performance Areas
  - Streamlines 3 currently independent programs to work as one and to ease clinician burden.
  - Adds a fourth component to promote ongoing improvement and innovation to clinical activities.

<table>
<thead>
<tr>
<th>Performance Area</th>
<th>Description</th>
<th>Previous Program</th>
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</thead>
<tbody>
<tr>
<td>Quality</td>
<td>Preventive care, safety, etc</td>
<td>PQRS and Quality Portion of the VBM</td>
</tr>
<tr>
<td>Cost</td>
<td>Medicare spending per beneficiary, etc</td>
<td>Physician VBM</td>
</tr>
<tr>
<td>Advancing Care information</td>
<td>certified EHR technology</td>
<td>Meaningful Use</td>
</tr>
<tr>
<td>Improvement Activities</td>
<td>Shared decision making, APM participation, patient safety, coordinating care, increasing access, etc</td>
<td>None</td>
</tr>
</tbody>
</table>

Track 2: Advanced Alternative Payment Models (AAPMs)

- Advanced Alternative Payment Models (Advanced APMs) enable clinicians and practices to earn greater rewards for taking on some risk related to their patients’ outcomes
  - Advanced APMs are a Subset of Alternative Payment Models.
  - Alternative Payment Models on their own do not take on “nominal risk,” as defined by CMS, but can qualify providers for additional credit in MIPS

- Advanced Alternative Payment Models (AAPM) Entities Must:
  - Use certified EHR technology,
  - Pay based on MIPS comparable quality measures, and
  - Bear more than “nominal” financial risk for losses
    - 8% of the average estimated total Medicare Parts A and B revenues of participating APM Entities; OR
    - 3% of the expected expenditures for which an APM Entity is responsible under the APM.

- Providers will receive **+5% bonus incentive payment in 2019** for Advanced APM Participation in 2017 if
  - They receive 25% of their Medicare Part B payments through an Advanced APM;
  - OR See 20% of their Medicare patients through an Advanced APM

Track 2: Advanced Alternative Payment Models (AAPMs)

- Eligible for 2017 Performance Year

- CMMI anticipates the following models will be Advanced APMS in the future:

  - Comprehensive End Stage Renal Disease Care Model (Two-Sided Risk Arrangements)
  - Comprehensive Primary Care Plus (CPC+)
  - Shared Savings Program Track 3
  - Shared Savings Program Track 2
  - Next Generation ACO Model
  - Oncology Care Model (Two-Sided Risk Arrangement)
  - Advancing Care Coordination through Episode Payment Models Track 1 (CEHRT)
  - Comprehensive Care for Joint Replacement (CJR) Payment Model
  - New Voluntary Bundled Payment Model
  - Vermont Medicare ACO Initiative (as part of the Vermont All-Payer ACO Model)
  - ACO Track 1+

Language Referencing Maryland in the MACRA final rule

- Final Rule on MACRA was released in October 2016
- There was a specific clause in the final rule referencing the Maryland All-Payer Model and eligibility for MACRA in 2018:

  “With new Advanced APMs expected to become available for participation in 2017 and 2018, including the Medicare ACO Track 1 Plus (1+), and anticipated amendments to reopen applications to modify current APMs, such as the Maryland All-Payer Model and Comprehensive Care for Joint Replacement (CJR) model, we anticipate higher numbers of QPs—approximately 70,000 to 120,000 in 2017 and 125,000 to 250,000 in 2018.”

MACRA-tizing the Maryland Model

- Progression
  - Engaged physicians and other providers in aligned efforts

- Key Strategies to have the All-Payer Model qualify as Advanced APM:
  - CMS approved Care Redesign Programs to link physicians to the All-Payer Model
  - Hospital global revenues incorporate non-hospital Part B costs through incentives

- Other Key approaches to have Advanced APMS in Maryland:
  - Statewide Comprehensive Primary Care Model (CPC+ design)
  - ACOs with downside risk, new Dual Eligible ACOs