MACRA Overview

December 2016

HSCRC
Health Services Cost Review Commission

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:

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

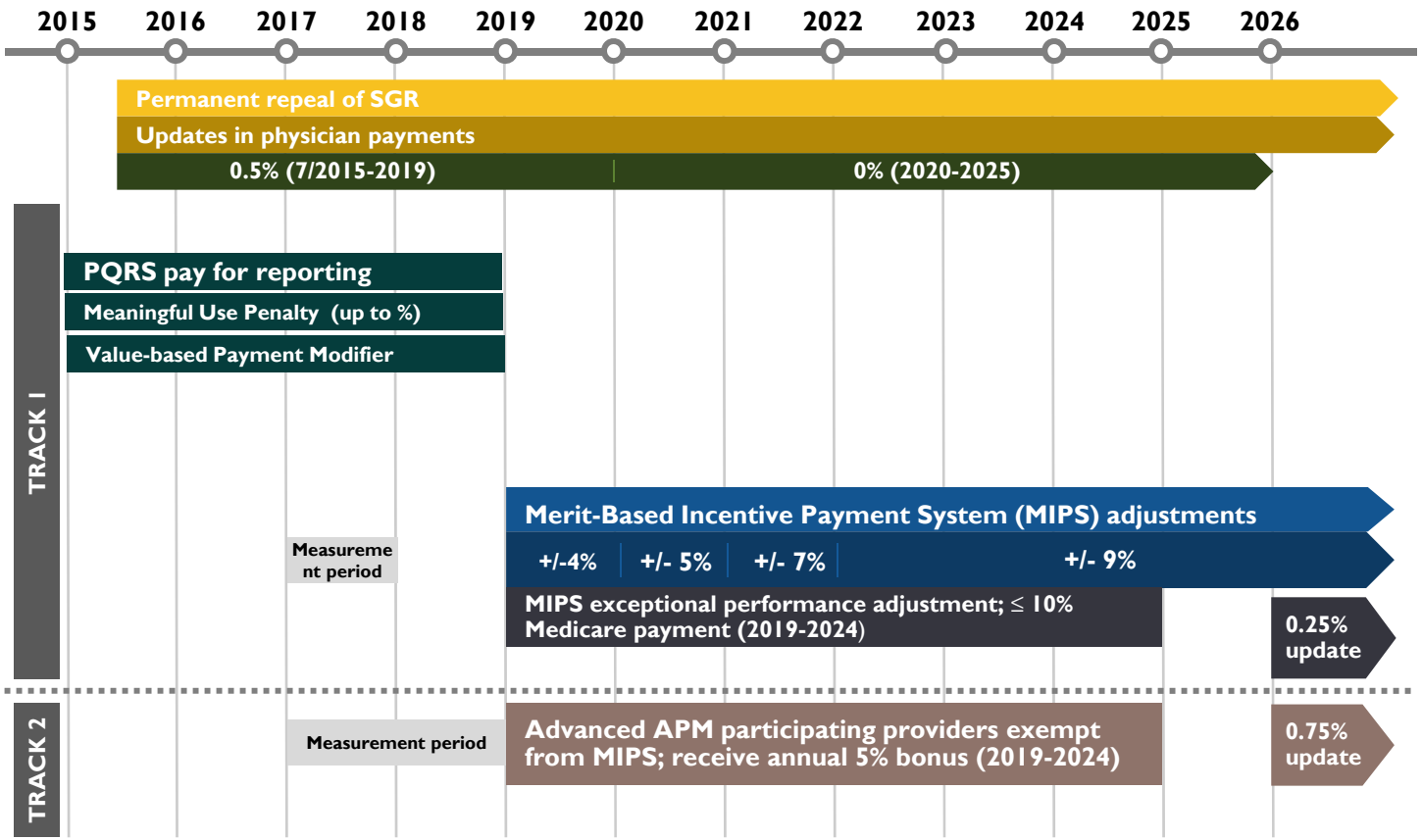
Set **internal goals** for HHS

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

MACRA reform timeline

(Medicare Access and CHIP Reauthorization Act of 2015)



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	2) AAPMs: Advanced 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 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.

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

Source: Summarized from 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

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

Source: Summarized from 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

Track 2: Advanced Alternative Payment Models (AAPMs)

- Eligible for 2017 Performance Year

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)

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

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+

Source: Summarized from 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

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****."*

Source: MACRA Final Rule p. 77013: https://www.gpo.gov/fdsys/pkg/FR-2016-11-04/pdf/2016-25240.pdf

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