Medicare Access and CHIP Reauthorization Act (2015)

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Objectives

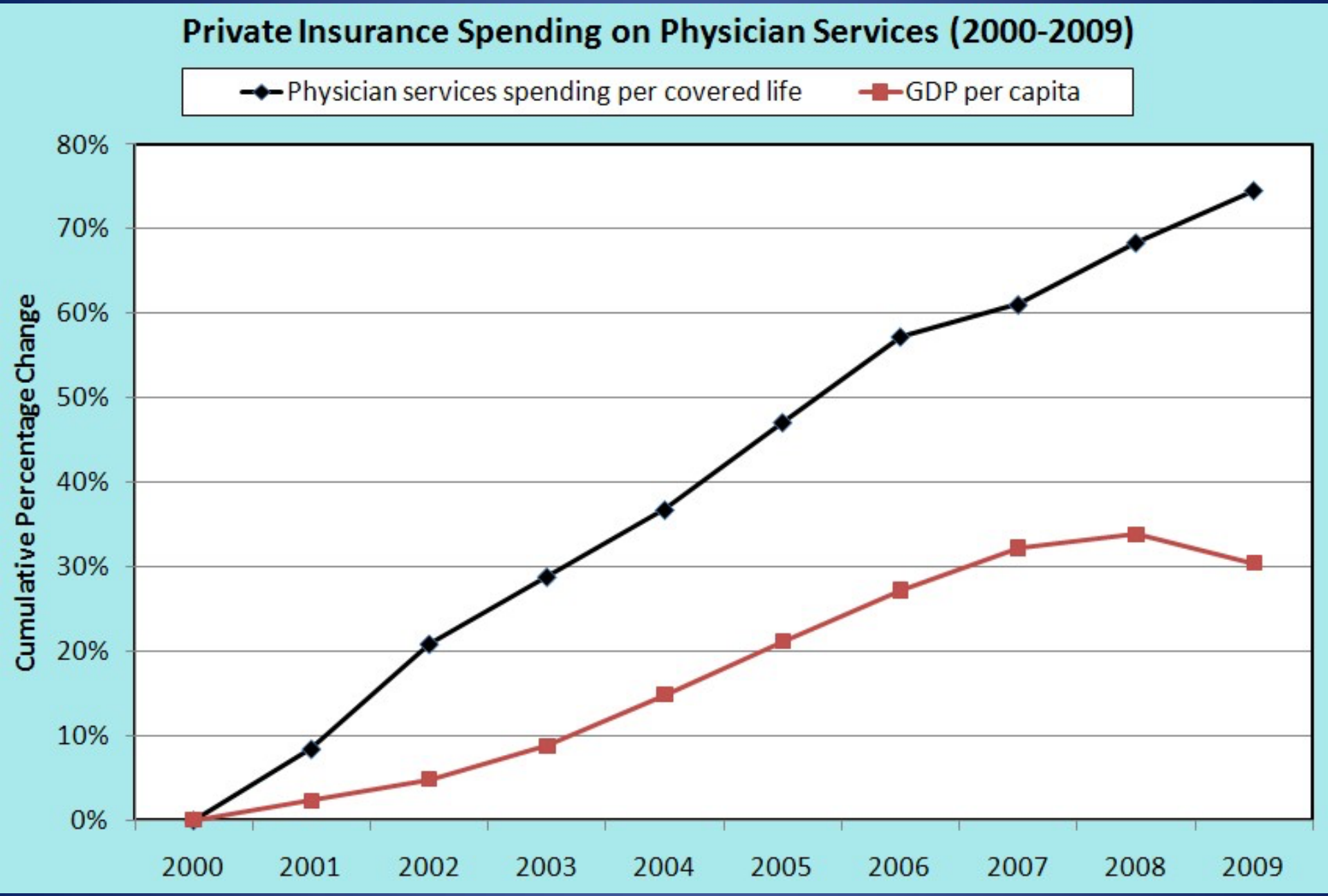
- Major Healthcare Changes
- Sustainable Growth Rate
- Why MACRA?
- What is MACRA?
- What is MIPS?
- What is APM?
- Potential problems

Major Healthcare Changes

- Affordable Care Act (2010)
  - Health Insurance Reform (Beneficiary/Patient)
    - Providing more people access to affordable and adequate health insurance
- MACRA (2015)
  - Healthcare payment and delivery system reform (provider/facility)
    - Improved quality with reduced costs to Medicare and Medicaid

Sustainable Growth Rate (SGR) Model

- Implemented in 1997
- Attempted to link physician reimbursement from Medicare and Medicaid services to the nation's economic growth rate via the gross domestic product (GDP) and inflation
- It sets a growth rate for target Medicare expenditures based on changes in enrollment, economic growth, and a measure of provider efficiency
- In 2001, healthcare spending outpaced GDP growth. First negative payment
- Congress has been "patching" the model to avoid cuts
- Repealed in 2015


Private Insurance Spending on Physician Services (2000-2009)
Physician services spending per covered life
GDP per capita
Cumulative Percentage Change
80%
70%
60%
50%
40%
30%
20%
10%
0%
2000
2001
2002
2003
2004
2005
2006
2007
2008
2009

Medicare Access and CHIP Reauthorization Act (2015)

- Repealed sustainable growth rate (SGR) formula
  - Avoided 21% physician Medicare pay cut
- Brings efficiency to healthcare
  - Contains costs through payment reform
  - Better care, not just more care
- Fee-for-service → Value-based reimbursement
- Combining all Medicare/Medicaid quality reporting programs into one new systems
- $70 Billion savings predicted

Ambitious Goals of U.S. Dept. of Health & Human Services Goals

- Moving to alternative payment models:
  - By 2016- Tying 30% of traditional, or fee-for-service, Medicare payments to quality or value through alternative payment models (APMs) (e.g. Accountable Care Organizations (ACOs) or bundled payment arrangements)
  - By 2018- Tying 85% of payments to these models
- Moving traditional fee for service payment too:
  - By 2016- Tying 50% of all traditional Medicare payments to quality or value through programs such as the Hospital Value Based Purchasing and the Hospital Readmissions Reduction Programs
  - By 2018- Tying 90% of these payments

8 Types of Payment Models

Current Models

1. Fee-for-Service
2. Pay-for-Coordination (Not used)
3. Pay-for-Performance (Value Based Reimbursement)
4. Bundled Payment or Episode-of-Care Payment
5. Upside Shared Savings Programs
   - Incentives to providers for specific patient population who provide care within a set "budget"
6. Downside Shared Savings Programs
   - Penalty for going over "budget" and higher reward for being below "budget".
7. Partial or Full Capitation
8. Global Budget
   - Ex. (Canadian Healthcare System)

New Models

1. Merit-Based Incentive Payment Systems (MIPS)
2. Alternative Payment Models (APMs)

MACRA

Repeals the Sustainable Growth Rate (SGR) Formula and sets up 2 payment programs: MIPS and APMs

Streamlines multiple quality programs (Meaningful Use, PQRS, Value-based Modifier) under MIPs

APM: Bonus payments for participation in eligible models.

MIPS: Additional payment for exceptional performance possible

Merit-Based Incentive Payment System (MIPS)

3 Models into 1

- Physician Quality Reporting System (PQRS)
- Value Modifier (VM or Value-based Payment Modifier)
- Medicare Electronic Health Record (EHR) incentive program
- Ends in 2018

+ 1 New Model

- Clinical Practice Incentive Activities (CPIA)
- Starts in 2019

Physician Quality Reporting System (PQRS)

- Encourages health care professionals and group practices to report information on health care practices
- 255 individual measures and 22 measure groups
- Penalties for not reporting
- 6 Domains:
  - Clinical Care Effectiveness
  - Patient Experience
  - Patient Safety
  - Care Coordination
  - Efficiency
  - Population Health

Qualified Clinical Data Registry (QCDR)

- A QCDR is a CMS-approved entity (such as a registry, certification board, collaborative, etc.) that collects medical and/or clinical data for the purpose of patient and disease tracking to foster improvement in the quality of care furnished to patients.
- Alternates to PQRS measures

Value-Based Modifier (VBM)

- Performance-year scorecard
- Adjusts physician reimbursement based on quality and cost of care provided to fee-for-service based patients
- Budget-neutral
  - Penalties off-set rewards
- Quality measure component includes:
  - acute conditions
  - chronic conditions
  - hospital readmission in 30 days
- Available in the fall of the year after that performance year
- Ends in 2016

Certified Electronic Health Record Technology (CEHRT)

- "All American should have access to an EHR by 2014" – Obama (2009)
- Incentives to adopt, implement, upgrade, or provide meaningful use of certified EHR technology.
- Objectives:
  - Protect PHI
  - Clinical Decision support
  - Computerized Provider Order Entry
  - Electronic Prescribing
  - Health Information Exchange
  - Patient Education
  - Medication Reconciliation
  - Patient Electronic Access
  - Secure Messaging
  - Public Health Reporting

Clinical Practice Improvement Activities (CPIA)

- Starts in 2019
- Criteria and sub-categories still being developed
  - Some sub-categories:
    - Expanded Practice Access
    - Population Management
    - Care Coordination
    - Patient Safety/Practice Assessment
    - Beneficiary Engagement

CPIA Subcategories Examples

Expanded Practice Access	Population Management	Care Coordination	Beneficiary Engagement	Patient Safety & Practice Assessment	Participation in an APM
• Same day appointments for urgent needs • After hours clinician advice	• Monitoring health conditions & providing timely intervention • Participation in a QCDR	• Timely communication of test results • Timely exchange of clinical information with patients AND providers • Use of remote monitoring and Telehealth	• Establishing care for complex patients • Patient self management & training • Employing shared decision making	• Use of clinical or surgical checklists • Practice assessments related to maintain certification	• As defined in prior slide • At a minimum receive ½ CPIA score for APM participation

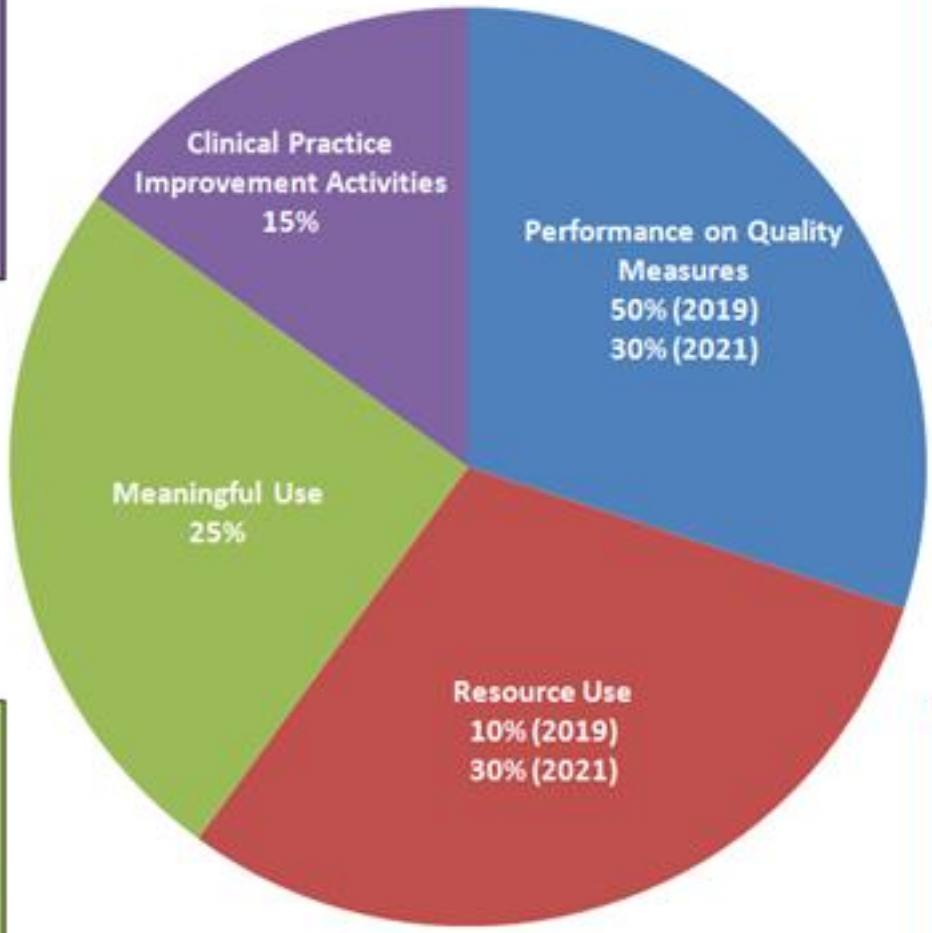
Implementation of MIPS

- 2019 incentives dependent on 2017 performance
- MIPS eligible EPs for 2019-2020
  - MD/DO, PA, CNP, CRNA, groups that include these EPs
- 2021 Onwards: More EP types can be added
- MIPS exempt:
  - Providers not meeting “low volume threshold”
  - First-year Medicare providers
  - Fully qualifying/partially qualifying APM participants

MIPS Adjustment Factor

- Dependent on EP's Composite Performance Score
  - Score Ranges from 0-100 and based on 4 factors
  - Annual Performance Threshold (CMS derived)
    - Above threshold: + incentives
    - At threshold: 0
    - Below threshold: - incentives

CMS is asking for significant input on criteria for subcategories and activities that could be considered CPIA, reporting mechanisms, and minimum activity thresholds.

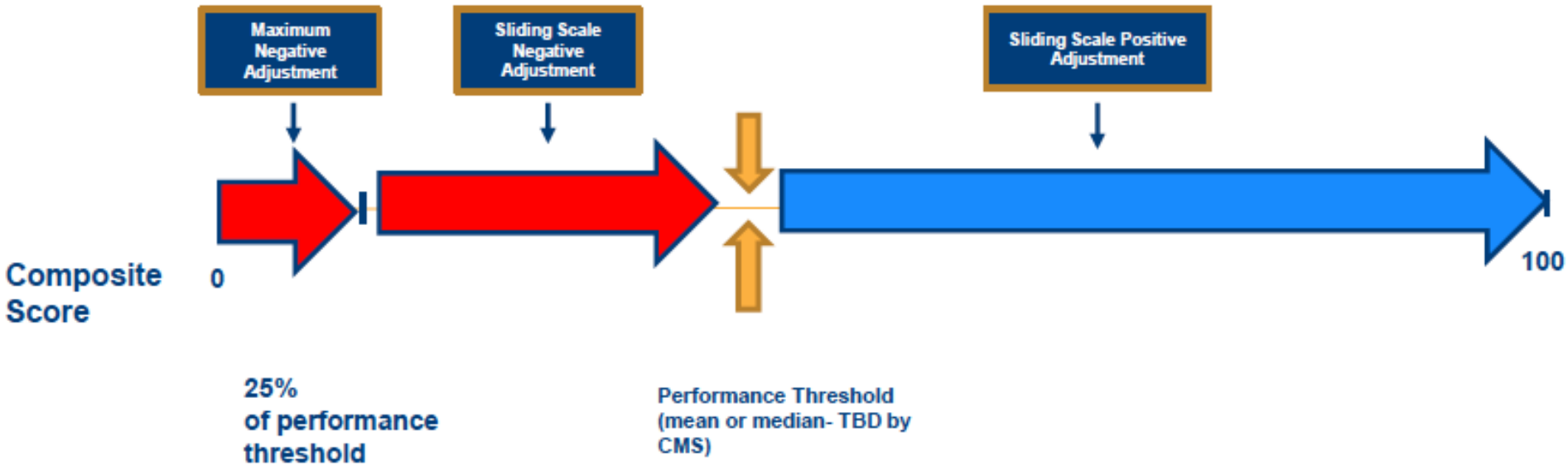


Initial quality measures for this category will come from the PQRS and existing QCDRs, although CMS is asking for input on topics such as reporting mechanisms, data accuracy, and the use of CEHRT.

Initial criteria for this category will come from the Medicare EHR Incentive Program, although CMS is asking for input on the methodology for assessing performance.

Initial cost measures for this category will come from the VM, although CMS is asking for input on additional resource use and cost measures, and other considerations.

MIPS Payment Adjustment



MIPS Base Payment Adjustment Schedule

Excludes the Exceptional Performance Bonus

MIPS Score	Payment Year (2 years after Performance Year)				
	2019	2020	2021	2022	
100	+4x%	+5x%	+7x%	+9x%	Max%
PT to 100	**Linear:** 0% to Max%				
PT ("Performance Threshold")	0%				
25%*PT to PT	**Linear:** 0.75*Min% to 0%				
0 to 25%*PT	-4%	-5%	-7%	-9%	Min%

"x" is a budget-neutrality factor to make the national incentive $ pool equal to the national penalty $ assessed, where x is capped at 3.0 (or 27% max base adjustment).

MIPS Exceptional Performers

- Special pool of up to $500 million per annum
- Scaling factors can significantly increase incentives
  - Ex. Scaling factor of 3
    - 3 x 4% = 12% rewards
- Maximum adjustment cannot be more than 10% of EPs Medicare Payment

Alternative Payment Models (APMs)

- Examples: Accountable Care Organizations, Patient centered medical homes, and bundled payment models.
- EPs can be "Partial APM" and "Full APM."
  - Different thresholds qualify for either an APM or a Partial APM
- Not every APM is a "Qualifying APM"
- Qualified EPs are exempt from MIPS
- APMs must meet the following criteria for EPs to be rewarded.
  - Must require EPs to use CEHRT
  - Provides payment for covered professional services based on quality measures "comparable to" MIPS quality measures

Who qualifies?

Eligible APM Entity	Entity that meets the following requirements: • Use of CEHRT AND • Payment is based on quality measures comparable to MIPS **And** • Entity bears risk in excess of a nominal amount **OR** • Is a medical home expanded under section 1115A(c) or comparable medical home under Medicaid program
Qualifying APM Participant	Eligible professional who has a certain % of their patients or payments through an eligible APM. Beginning in 2021, payment may be Medicare or all-payer.
Partial Qualifying APM Participant	Eligible professional who participates in an eligible APM, but meets a lower threshold

*Partially qualifying EPs get no incentive payments but are exempt from reporting MIPS

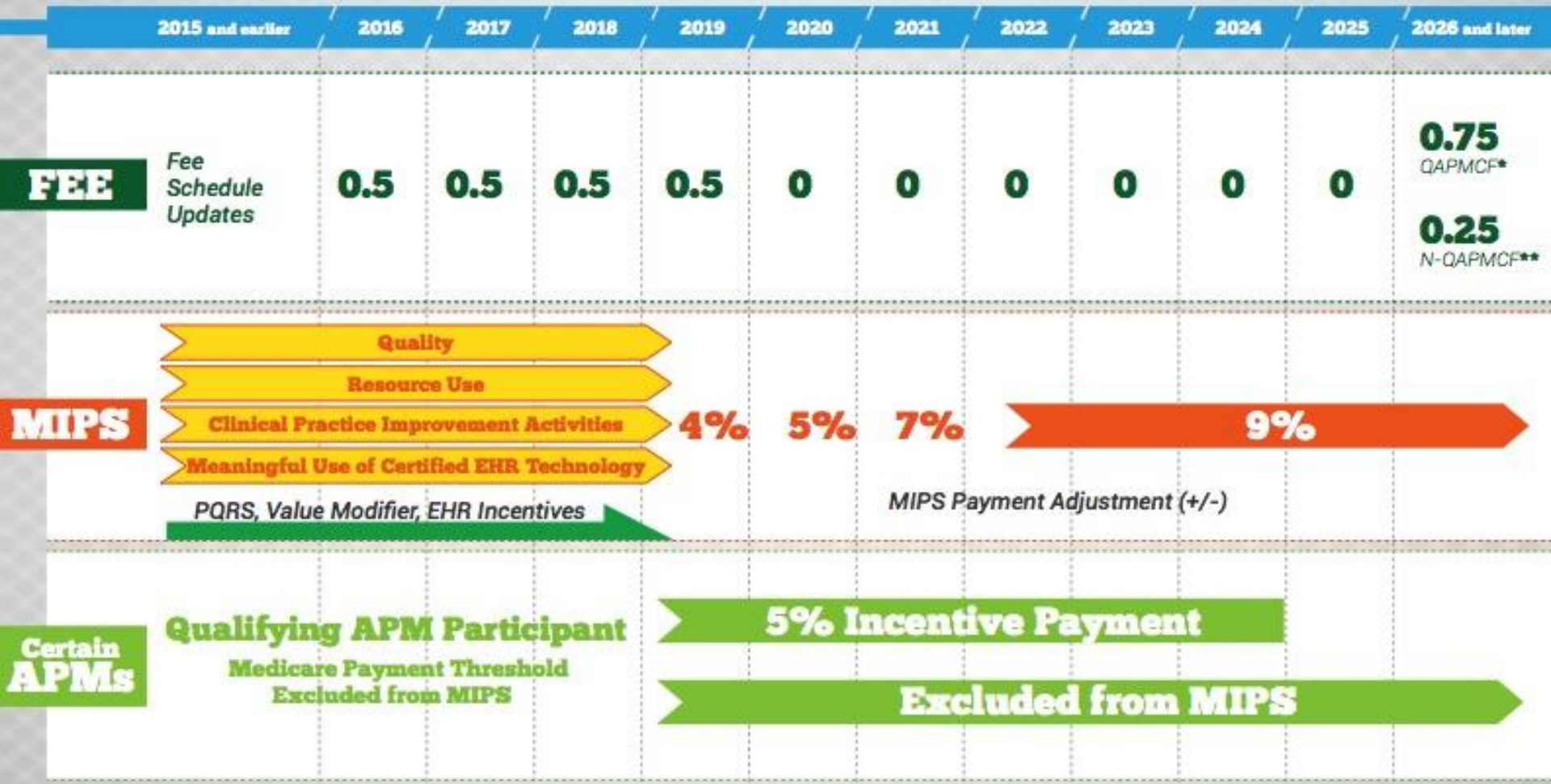
APM Thresholds

Years	Min Thresholds for Qualifying APM Participant (In payments or patients)			Min Thresholds for Partial Qualifying APM Participant (in payments or patients)		
	Medicare		Combination Medicare & All-Payer	Medicare FFS Only		Combination Medicare & All-Payer
2019-2020	25% **Medicare FFS**		n/a	20% Medicare		n/a
2021-2022	50% Medicare	**OR**	50% Total/ 25% Medicare	40% Medicare	**OR**	40% Total/ 20% Medicare
2023 and beyond	75% Medicare	**OR**	75% Total / 25% Medicare	50% Medicare	**OR**	50% Total/ 20% Medicare

Alternative Payment Model (APM)

- 2019 to 2024: 5% annual lump sum bonus
- Starting in 2026, offers some participating health care providers higher annual payments.

Timeline



*Qualifying APM conversion factor

**Non-qualifying APM conversion factor

Potential Problems

- How can Specialized EPs contribute to an ACO?
  - Maximum flexibility for meeting requirements?
- How will more than ”nominal” risk be identified?
- Too slow? (2017 performance for 2019 reimbursement)
- Teaching physicians who contribute to clinical improvement aren’t recognized
- Treatment of the terminally ill high risk
- Delay of Physician Payment Technical Advisory Committee
  - Review proposals for models and make recommendations to CMS

Questions

Thank you!

Extra Slides

Changing Payment Landscape

- Pre-MACRA
  - 21% payment cut 2015
  - PQRS, VBM, CEHRT
  - Some regulatory flexibility for alternative payment model participation
- Post –MACRA
  - Eliminates SGR
  - Streamlined quality reporting program (MIPS)
  - Incentives for alternative payment model (APM) participation

Qualified Clinical Data Registry (QCDR)

- A QCDR may submit measures from one or more of the following categories with a maximum of 30 non-PQRS measures allowed:

Composite Score Factors

Year	Quality Measurement	Resource Use	Clinical Improvement Activities	Meaningful Use of CEHRT	MIPS Adjustment Factor
2019	50%	10%	15%	25%	+/- 4%
2020	45%	15%	15%	25%	+/- 5%
2021	30%	30%	15%	25%	+/- 7%
2022 and Beyond	30%	30%	15%	25%	+/- 9%

2019 – 2024: Additional +10% adjust will be available for excellent performers
2026: Physicians participating in MIPS may be eligible for 0.25% annual payment increase