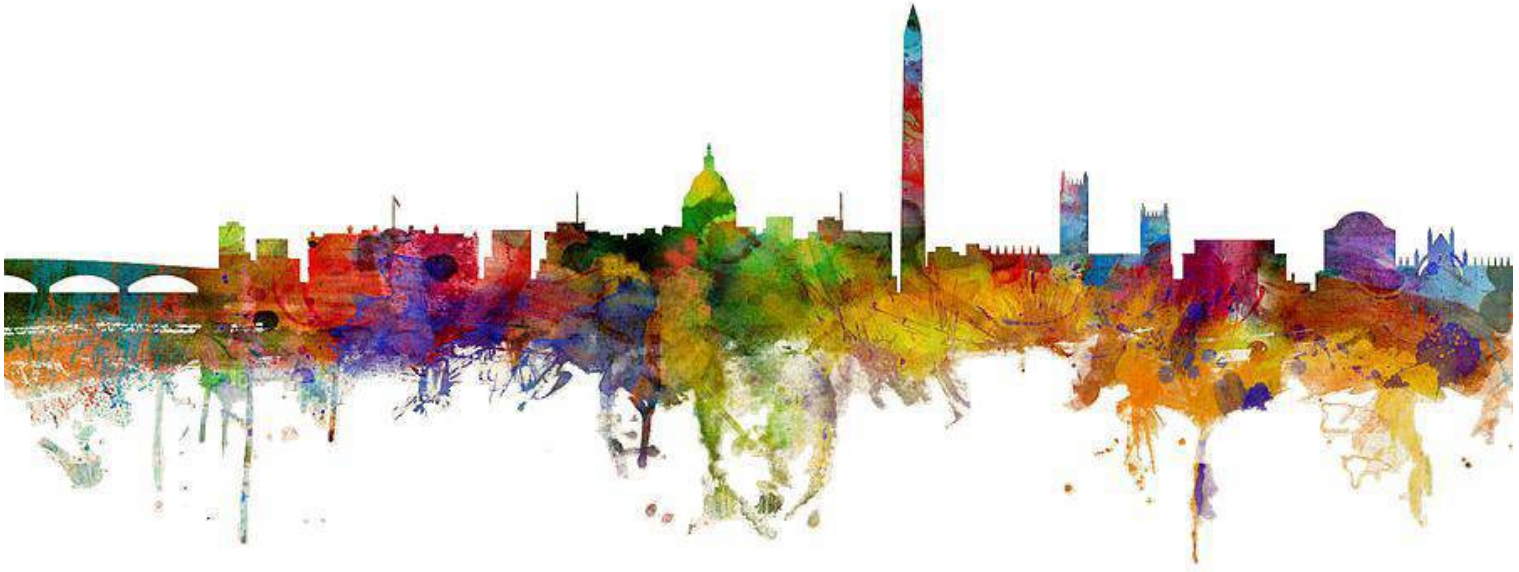
# MACRA: Initial Parameters and Future Direction



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# Overview

- **Background and History**
- **Merit-based Incentive Payment System (MIPS)**
  - Physician Quality Reporting System
  - Meaningful Use
  - Value-Based Modifier
  - Clinical Practice Improvement Activities
- **Alternative Payment Models**
  - Status of Models
  - Key Concerns
- **Outlook**

# History: The Notorious S.G.R.

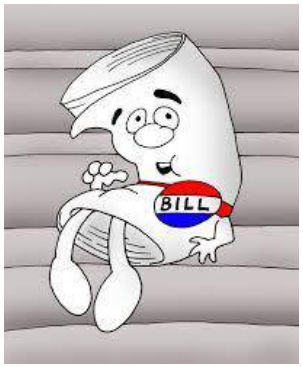
- Enacted as part of the Balanced Budget Act of 1997, the Sustainable Growth Rate formula adjusted physician payments based on service utilization rates
  - Utilization below benchmarks, payments increased
  - Utilization above benchmarks, utilization decreased
- Among other issues, SGR presented a classic collective action problem
- First payment cut arrived in 2002 and first "doc fix" in 2003
- 17 doc fixes later, MACRA repealed the SGR in 2015

# Enactment of MACRA


- Then-Speaker Boehner and Minority Leader Pelosi cut a backroom deal to dispose of the SGR
- Eliminating the 10-years of cuts projected from 2015 cost $210 billion, about a third of which was offset
- MACRA included two years of CHIP funding and extended several ancillary Medicare provisions
  - Funds development of quality measures
  - Congress must revisit the package in 2017

# MACRA in a Nutshell

- All physicians receive automatic 0.5% increases to their base rates from 2015-2019
- For 2020-2025, each physician's respective rate will be adjusted based on MIPS performance
  - Zero some game + $500m for high performances over 5 years
  - 5% bonus for docs participating in APMs
- Starting in 2026, payment adjusted based on performance in APMs
  - APM participants get 0.75% increase
  - Non-participants get 0.25% increase



# MIPS: Overview

- MIPS reflects aggregation of three existing performance measurement programs + one new one
  - Physician Quality Reporting System
  - Meaningful Use standards for EHRs
  - Value-Based Modifier for resource use
  - Clinical improvement activities
- Four performance categories yield a single composite score
  - Payment at risk increases from +/-4% in 2019 to +/- 9% in 2022
  - Participants referred to as "eligible professionals"
- Measure set updated every year
- Performance can be reported at individual or group practice level
- Three existing quality programs sunset 12/31/18
- MIPS launches 1/1/19

# MIPS: 4 Elements

| Element | Weight | Reporting Method | Additional Notes |
|---|---|---|---|
| Quality | 50% | Registry, EHR, group, claims | In Year 1, MDs select six measures |
| EHRs | 25% | Attestation | Must be certified |
| Resource Use | 10% | Automated from claims | 40 episode-specific measures |
| Clinical Practice Improvement | 15% | Attestation | Care coordination, patient engagement, etc. |

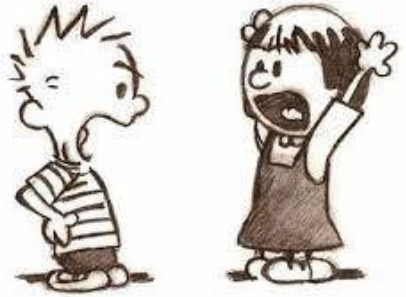
# APMs: Overview

- APM "qualifying participants" are exempt from MIPS
- In short, APMs reflect converse of historical fee-for-service scheme
  - Incentive to decrease utilization
  - But must maintain quality
- Some cross-cutting requirements
  - Certified EHR
  - Quality metrics
  - Bear "more than nominal risk"
- Bonus payments from 2019-2024 are lump sum based on share of payments derived from APMs (evaluated as portion of Medicare or all-payer)
  - 2019-2020: 25%
  - 2021-2022: 50%
  - 2023->: 75%

# APMs: Status of Models

- In January 2015, HHS set goal of having 30% of Medicare payments under APMs by 12/31/16 and 50% by 12/31/18
  - So far, on track
- Existing options are ACOs, bundled (or episode-based) payments, the "duals demo," and advanced PCMH programs
  - Payments still triggered by delivery of service, but include opportunities for shared savings or two-sided risk
  - "Category Four" = population-based management with no linkage between service delivery and payment (e.g., Pioneer ACOs)
- New models to be generated via the Physician Technical Advisory Committee (P-TAC)

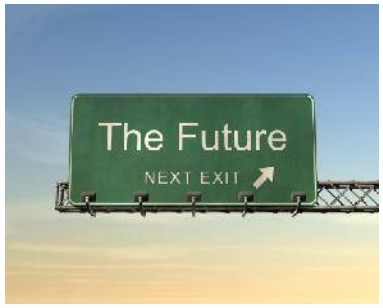
# APMs: Key Concerns I



- Has the focus on patient care been lost?
  - Models are in their infancy
  - Quality of data questionable
  - Does care (and measurement) match patient?
    - Socioeconomic factors
- Administrative burden real and growing
  - Policymaker concern about hospital acquisition of physician practices
  - Exemptions for small N
  - Alternative reporting mechanisms

# APMs: Key Concerns II

- Heightened criteria may shut many providers out
  - Degree of financial risk favors most advanced/largest systems
  - Is the risk worth it?
- Small, rural practitioners
- Viability of timeline
  - Feedback loop
  - Opportunity to learn and improve



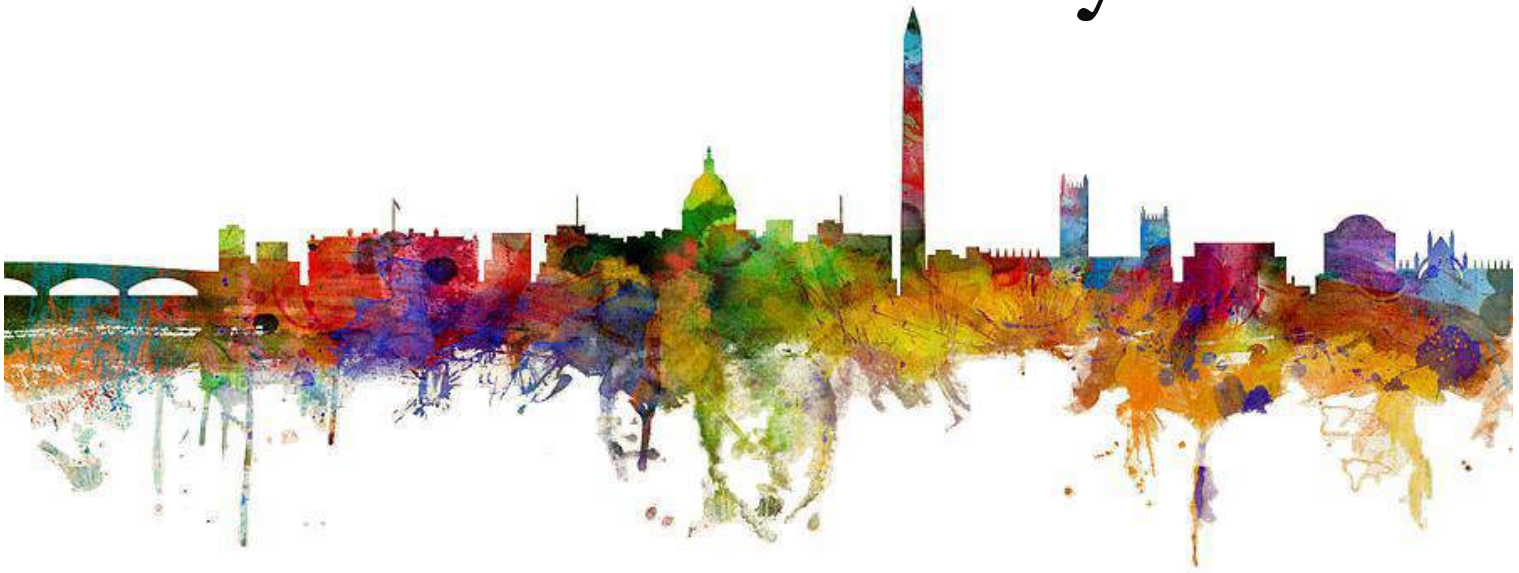

# Outlook

- Final MACRA rule anticipated by early November
- 2017 must be baseline reporting period
  - Need not necessarily be entire calendar year
  - Acting CMS Administrator expressed openness to delaying some components
- Must-pass Medicare bill due next year by 9/30/17
  - Could be avenue for statutory changes or delays
- PQRS and other quality programs operate through 12/31/18, including reporting in 2017

# So, what do I do?

- Start with MIPS
  - Up to 9% at risk by 2022
- Review measures for appropriateness to your practice
  - Quality metrics 50% of MIPS calculation
- Optimize tracking and reporting of measures
  - Other MIPS components are automated or attested
- Consider financial trade-offs of implementing a certified EHR system under the MACRA regime
- Get an APM plan: specialty-specific, potential partners, delay…
  - Forego 5% bonus starting 2020
  - Forego 0.5% (accruing) differential for APM participants starting 2026

# To Influence Policy, You have to *Know* Policy



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