McDermott + CONSULTING | HEALTH LOBBYING ANALYTICS POLICY

MACRA Update: What to Expect Next

March 2016

+ Agenda

- MACRA overview
- Milestones: April 2015 - March 2016
- What to expect next

MACRA overview

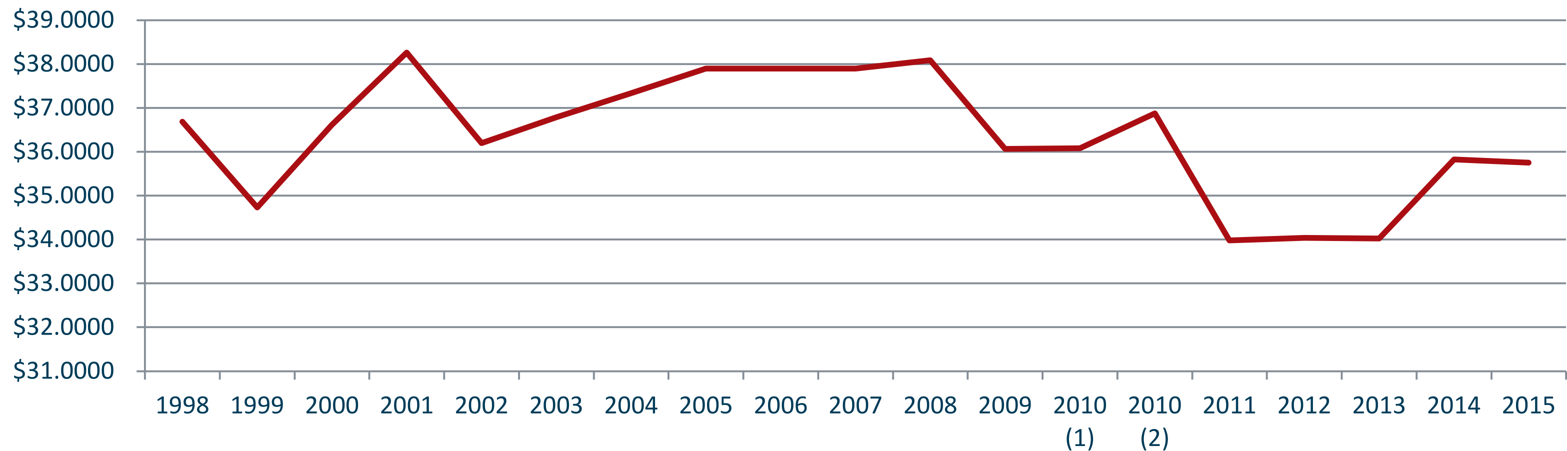
Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 (PL-114-10)

- Passed House of Representatives – March 26, 2015 (392-37)
- Passed Senate – April 14, 2015 (92-8)
- Signed into law by President Obama – April 16, 2015

Historic Bipartisan Legislation
484 members of Congress or 91% voted for MACRA

+ SGR Repeal is Centerpiece of Legislation

- Sustainable growth rate (SGR)
  - Established by the Balanced Budget Act of 1997
  - SGR sets a target rate for Medicare physician spending based on spending growth in the economy
  - If overall spending, exceeds target expenditures, triggers a cut
    - Result is the CF is reduced
    - Even with numerous short-term legislative fixes from Congress, great instability in the CF
  - The 2015 CF **is less than** the 1998 CF!!



+ MACRA Seeks to Bring Stability to Medicare Doc Pay

- After 13 years…
- 17 short term fixes…
- And a cost of nearly $170 billion…
- MACRA fundamentally changes Medicare physician payment by…
  - Eliminating the Sustainable Growth Rate (SGR) mechanism for updating payments
  - Stabilizing annual payment updates
  - Incentivizing the transition from a volume-based (fee for service) to a value-based system

Why Now? How Did MACRA Pass in 2015?

Reduction in Cost

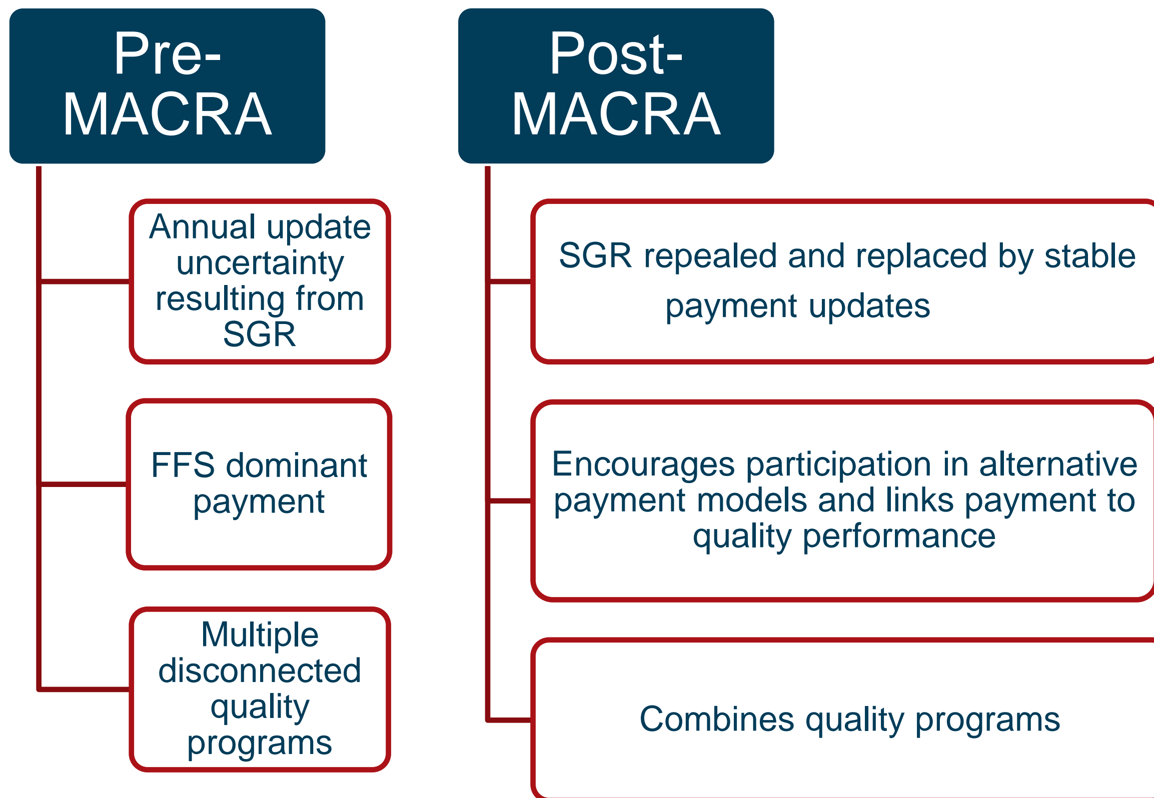
- Reduction in cost to permanently repeal SGR
- 2013 - $300 billion
- 2015 - $175 billion (confluence of events)

Bipartisan Negotiation

- As the March 31, 2015, expiration of the most recent one-year patch approached, most observers expected Congress to rally around another short-term patch
- Bipartisan House leadership began a series of negotiations that resulted in MACRA
- Key to their success this time was a bipartisan agreement to only *partially offset* the cost of eliminating the SGR

Why is MACRA Important?

MACRA Transforms Medicare Physician Payment



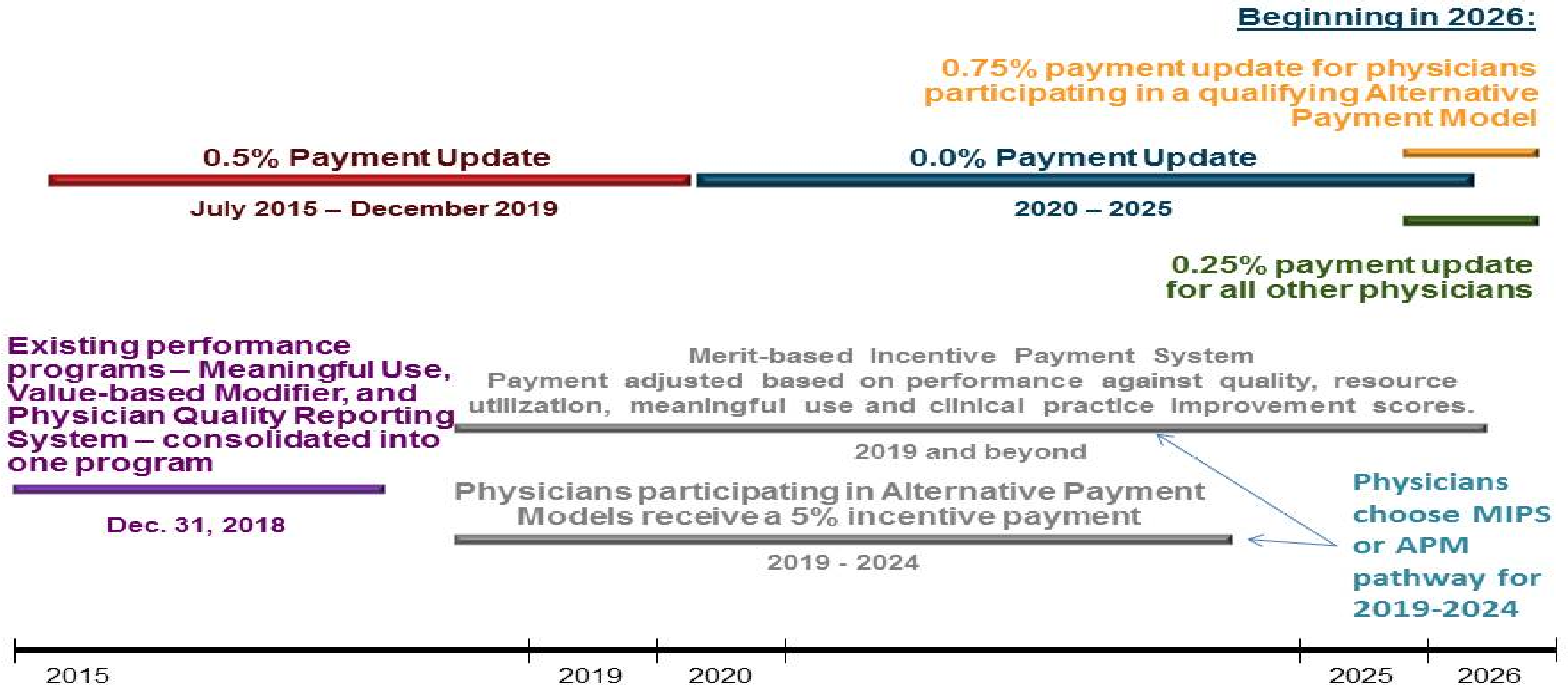
Who Does MACRA Impact?

- Title I. SGR Repeal and Medicare Provider Payment Modernization
  - Physicians
    - Directly impacts their Medicare reimbursement
  - Hospitals and health systems who employ physicians or have professional agreements with physicians
    - Should review their relationships (compensation and performance evaluation)

Major Provisions

- Major provisions
  - Repealed SGR and established a period of stable payment updates
    - +0.5% from July 2015 – 2019
    - +0% 2020-2024
  - Collapsed existing physician performance programs (Physician Quality Reporting System (PQRS), EHR Incentive Program, Value Based Payment Modifier (VBM)) into a single program called Merit-based Incentive System (MIPS)
  - Established incentive payments from 2019-2024 encouraging certain eligible professionals (EPs) to participate in Alternative Payment Models (APMs)
    - Created a higher annual update for providers who meet certain thresholds for APM participation beginning in 2025

+ Medicare Physician Payment MACRA Timeline



+ Providers Must Choose a Participation Option

MACRA adjustments are scheduled to begin in 2019 but are based on a ***2017 reporting/performance year.***

<table>
<tr><th colspan="2"></th><th>MIPS</th><th>Qualifying APM</th><th>Partially Qualifying APM</th></tr>
<tr><td colspan="2"></td><td>Participate in MIPS incentive programs</td><td>Meet the Qualifying APM participation threshold</td><td>Meet the Partially Qualifying APM participation threshold (lower than Qualifying APM)</td></tr>
<tr><td rowspan="3">CF Update</td><td>July 2015-Dec. 2019</td><td colspan="3">.5%</td></tr>
<tr><td>2020-2025</td><td colspan="3">0%</td></tr>
<tr><td>2026 & Beyond</td><td>.25%</td><td>.75%</td><td>.25%</td></tr>
<tr><td rowspan="6">Bonuses and Penalties</td><td>2019</td><td>+4/-4 %</td><td rowspan="6">5% lump sum
(2024 last year of bonus)</td><td rowspan="6">Not subject to any penalties and not eligible for any bonus payments</td></tr>
<tr><td>2020</td><td>+5/-5%</td></tr>
<tr><td>2021</td><td>+7/-7%</td></tr>
<tr><td>2022</td><td rowspan="3">+9/-9%
(2022 and beyond)</td></tr>
<tr><td>2023</td></tr>
<tr><td>2024</td></tr>
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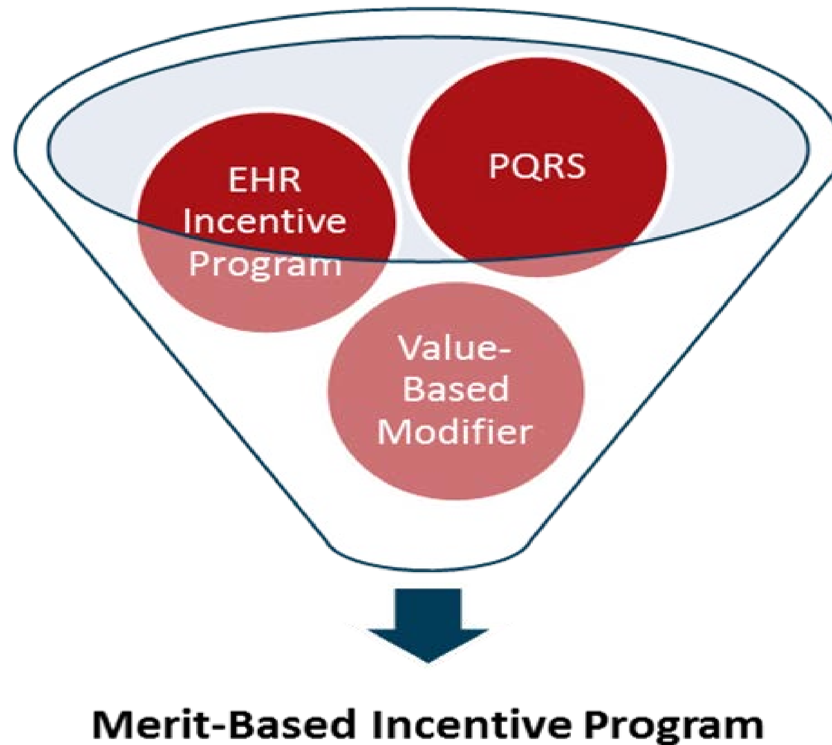
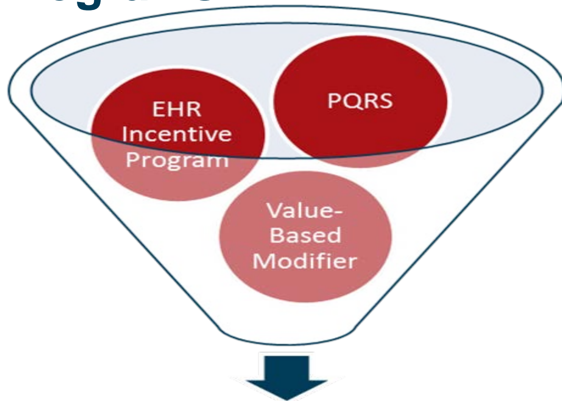
+ MIPS: Consolidation of Existing Incentive Initiatives



+ MIPS: How it Works

Consolidation of Existing Programs



MIPS Performance Areas

Under MIPS, eligible professionals will be measured in 4 performance areas:

- Meaningful use
- Quality
- Resource use
- Clinical practice improvement

A composite score calculated based on a weighted score in the 4 performance areas

Weighting of MIPS Performance Areas

Category	2019	2020	2021 and beyond
Quality	50%	45%	30%
Resource Use	10%	15%	30%
Clinical Practice Improvement Activities	15%	15%	15%
EHR*	25%	25%	25%

* May go as low as 15% if EHR adoption reaches 75%, other weights will be appropriately adjusted

+ MIPS: Analyzing Performance

Composite Score Between 0-100

Payment increased if composite score above threshold

Annual Threshold
Median or mean of composite score from previous performance period

Payment reduced if composite score below threshold

MIPS Payment Adjustments

CMS can increase positive adjustments by 3X to maintain budget neutrality

	Positive Adjustment	Negative Adjustment
CY 2019	4%	-4%
CY 2020	5%	-5%
CY 2021	7%	-7%
CY 2022 and beyond	9%	-9%

+ Eligible APMs: Overview

<table>
<tr><td rowspan="1">APM Definition</td><td colspan="2">To be considered to be participating in an eligible APM, the APM must meet the following criteria according to MACRA law:
• Base payment on quality measures comparable to those in MIPS
• Require use of certified EHR technology
• Either (1) bear more than nominal financial risk for monetary losses OR (2) be a medical home model expanded under Center for Medicare and Medicaid Innovation (CMMI) authority

It is anticipated that the definition of an eligible APM will be clarified through the regulatory process.</td></tr>
<tr><td rowspan="3">Participation Threshold</td><td>Qualifying APM</td><td>Partially Qualifying** APM</td></tr>
<tr><td colspan="2">Gradually increasing percent of Medicare or total payments* by 2023</td></tr>
<tr><td>75%</td><td>50%</td></tr>
<tr><td>Payment Update</td><td>Higher payment update beginning in 2026</td><td>N/A</td></tr>
<tr><td>Bonus</td><td>5% payment bonus 2019-2024</td><td>N/A</td></tr>
</table>

* Total payments exclude payments made by the Defense/Veterans Affairs and Medicaid payments in states without medical homes or Medicaid APMs.
**Partially qualifying APM participants are not subject to MIPS but also do not qualify for the bonus payments provided to qualifying APM participants.

+ Eligible APMs: Types of Participation

Category	Description (Eligible professionals who…)
Qualifying APM participant	meet or exceed the following thresholds: • 2019-2020: 25% of Medicare payments (during the most recent period for which data are available) • 2021-2022: 50% of Medicare payments or 50% of total payments* (and at least 25% of Medicare payments) • 2023 and beyond: 75% of Medicare payments or 75% of total payments (and at least 25% of Medicare payments)
Partial qualifying APM participant**	meet somewhat lower payment thresholds: • 2019-2020: 20% of Medicare payments • 2021-2022: 40% of Medicare payments or 40% of total payments (and at least 20% of Medicare payments) • 2023 and beyond: 50% of Medicare payments or 50% of total payments (and at least 20% of Medicare payments)

* Total payments exclude payments made by the Defense/Veterans Affairs and Medicaid payments in states without medical homes or Medicaid APMs.

**Partial qualifying APM participants are not subject to MIPS but also do not qualify for the bonus payments provided to qualifying APM participants.

Other MACRA Provisions by Category

These provisions support the implementation of the MACRA MIPS and APM programs.

CATEGORY	DESCRIPTION
MIPS MEASURE DEVELOPMENT *Enhances the coordination of performance measurement programs and encourages greater participation in such programs and an increased focus generally on performance*	• Annual publication of list of quality measures • Measure development and maintenance plan • Enhance methodology to develop episode groups (resource use measures) • Creation of episode group list • Creation of clinical practice activity measures • Report on alignment of quality measures from the Government Accountability Office (GAO)
APMs *Accelerates participation in APMs*	• Creation of the Physician-Focused Payment Model Technical Advisory Committee (TAC) • Solicitation of physician-focused payment models • Reports on MIPS and APMs from GAO • APM-related reports issued from the Secretary of Health and Human Services (HHS)
FFS REVISION *Examines relationship between payment rates and inputs used to provide service*	• Reports from the Medicare Payment Advisory Commission (MedPAC) on utilization and the impact of payment updates • Collection of data on 10 and 90 day global period codes and the implementation of data
INCREASES DISCLOSURE OF PROVIDER DATA *Contributes to efforts to expand access to publicly available physician data*	• Expansion of physician data and the rules around its use by CMS-approved qualified entities • Expansion of physician data available on Physician Compare

Milestones: April 2015 - March 2016

Intent of MACRA Legislation Consistent with HHS goals

News

FOR IMMEDIATE RELEASE
January 26, 2015

Contact: HHS Press Office
202-690-6343

Better, Smarter, Healthier: In historic announcement, HHS sets clear goals and timeline for shifting Medicare reimbursements from volume to value

In a meeting with nearly two dozen leaders representing consumers, insurers, providers, and business leaders, Health and Human Services Secretary Sylvia M. Burwell today announced measurable goals and a timeline to move the Medicare program, and the health care system at large, toward paying providers based on the quality, rather than the quantity of care they give patients.

HHS has set a goal of tying 30 percent of traditional, or fee-for-service, Medicare payments to quality or value through alternative payment models, such as Accountable Care Organizations (ACOs) or bundled payment arrangements by the end of 2016, and tying 50 percent of payments to these models by the end of 2018. HHS also set a goal of tying 85 percent of all traditional Medicare payments to quality or value by 2016 and 90 percent by 2018 through programs such as the Hospital Value Based Purchasing and the Hospital Readmissions Reduction Programs. This is the first time in the history of the Medicare program that HHS has set explicit goals for alternative payment models and value-based payments.

CMS Meets Target

On March 3, 2016 CMS announced they met their first target of 30 percent Medicare payments tied to APMs.

+ Checkup on MACRA Implementation

- Hearing sponsored by House Energy and Commerce Committee: *Medicare Access and CHIP Reauthorization Act of 2015: Examining Implementation of Medicare Payment Reforms*
  - March 17, 2016

"MACRA will help move Medicare towards rewarding the value and quality of physician services, not just the quantity of such services. As a practicing physician who has also led quality improvement efforts in health systems, I know the importance of quality measurement and improvement. We intend to use a patient-centered approach that leads to better care, smarter spending, improved patient outcomes, and program development that is meaningful, understandable, and flexible for participating clinicians. It is our role and responsibility to continue leading this change and to continue partnering with lawmakers, physicians, and other providers, consumers, and other stakeholders across the nation to make a transformed system a reality for all Americans. We look forward to working with this Committee, members of Congress, and other stakeholders as we continue to implement this seminal piece of legislation."

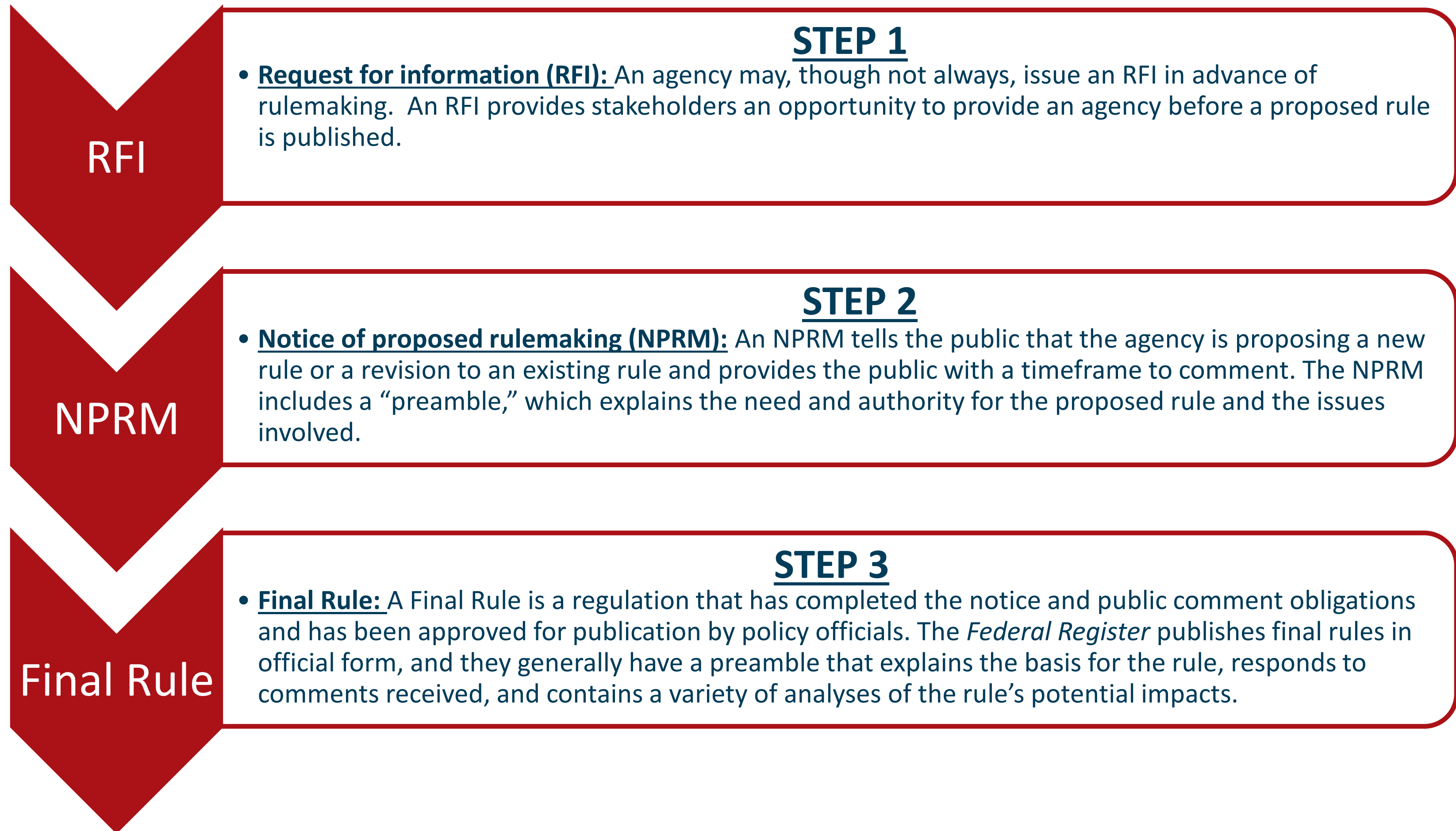
Patrick Conway, MD, MSc
Acting Principal Deputy Administrator, Deputy Administrator for Innovation and Quality, and Chief Medical Officer, CMS

From Passage of Legislation to Implementation

- CMS in collaboration with related agencies is now responsible for implementing MACRA
- Some guidance on implementation provided in the statute
- Significant leeway provided to Secretary of HHS
- Provisions fall into four categories
  - MIPS implementation and measure development
  - APM implementation
  - FFS revision
  - Increased disclosure of provider data

Rulemaking Process Overview

Agencies issue Federal Regulations (rules) through the rulemaking process to implement legislation.



+ MACRA RFI Released on Sept. 28, 2015

Medicare Program: Request for Information Regarding Implementation of the Merit Based Incentive Payment System, Promotion of Alternative Payment Models, and Incentive Payments for Participation in Eligible Alternative Payment Models

(*Federal Register*, October 1, 2015; Vol 80, No. 190; pages 59102-59113)

+ Overview
  - Included more than 100 questions
  - Organized questions into three main sections:
    - MIPS
    - Promotion of APMs
    - Technical assistance to small practices in health professional shortage areas
  - CMS received 463 comments (comment period was extended to November 17, 2015)
+ Questions posed in the RFI addressed the following general areas:
  - Implementation, logistical, and administrative issues
  - Methodological issues
  - Alignment and integration with other Medicare programs
  - Participation of providers from specialties that do not have appropriate quality measures, providers who practice in underserved areas, and providers in small practice groups

CMS Sought Input from Stakeholders, April 2015 - March 2016

Date	Description	Background
1/29/2016	Expanding Uses of Medicare Data by Qualified Entities [CMS-5061-P]	Proposed rule to allow organizations approved as qualified entities to confidentially share or sell analyses of Medicare and private sector claims data to providers, employers, and other groups who can use the data to support improved care. In addition, qualified entities will be allowed to provide or sell claims data to providers. Comments due March 29, 2016.
12/30/2015	Certification Frequency and Requirements for the Reporting of Quality Measures under CMS Programs [CMS-3323-NC]	RFI regarding several items related to the certification of health information technology (IT), including electronic health records (EHR) products used for reporting to certain CMS quality reporting programs such as, but not limited to, the Hospital Inpatient Quality Reporting (IQR) Program and the Physician Quality Reporting System (PQRS). Comments due February 1, 2016.
12/18/2015	Awarding and the Administration of Medicare Administrative Contractor Contracts [CMS-1653-NC]	RFI on the processes and procedures that CMS could use to leverage new legal authorities to-- incentivize and reward exceptional Medicare Administrative Contractor (MAC) contract performance; publish performance information on each MAC, to the extent permitted by law; and make MAC jurisdictional changes. Comments due February 19, 2016.
12/18/2015	CMS Quality Measure Development Plan: Supporting the Transition to the Merit-based Incentive Payment System (MIPS) and Alternative Payment Models (APMs) (DRAFT)	CMS seeks comments on this draft plan that provides a strategic framework for the future of clinical quality measure development to support MIPS and APMs. It also meets the requirements of the MACRA to develop and publically post a plan for measure development. Comments due March 1, 2016.
11/10/2015	MACRA Episode Groups	CMS requested comments on episode groups, and clinical criteria and patient characteristics to classify patients into care episode and patient condition groups. MACRA requires CMS to establish care episode groups and patient condition groups, and related classification codes, to measure resource use for purposes including MIPS and APMs. Comments due February 1, 2016.

Other MACRA Activities, April 2015 – March 2016

Date	Description	Background
2/1/2016	Physician Focused Payment Model Technical Advisory Committee Conducts First Public Meeting	This committee, established by MACRA, is tasked with providing comments and recommendations to the Secretary of Health and Human Services on physician payment models. During this first meeting, the committee presented a proposed framework for the proposal submission process, there was an opportunity for members of the public to make comments, and representatives from the Center for Medicare & Medicaid Innovation (CMMI) made a presentation on the process for model development within CMMI.
1/20/2016	Listening Session: Collecting Data on Global Surgery as Required by MACRA	MACRA requires that CMS collect information about the number and level of medical visits and other items and services related to the surgery and furnished during the global period. CMS is developing a proposal for implementing these new data collection requirements, including the definition of global periods, sampling approach, mechanisms for data collection, and definition of services furnished within the global period. The purpose of the listening session was to provide stakeholders with an opportunity to provide input early on in the process as the agency develops proposals for the CY 2017 PFS proposed rule.
10/9/2015	GAO Makes Appointments to New HHS Advisory Committee on Physician Payment Models	The Government Accountability Office (GAO) announced the first appointments to the Physician-Focused Payment Model Technical Advisory Committee. The Comptroller General is responsible for appointing the committee's 11 members.
10/15/2015 & 10/8/2015	Webinar on MACRA RFI on MIPS/APMs	CMMI hosted a webinar providing an overview of the MACRA RFI on MIPS/APMs. An archive of the webinar is available here: https://innovation.cms.gov/resources/macra-intro2.html
10/8/2015	MedPAC MACRA Discussion	The Medicare Payment Advisory Commission (MedPAC) discussed MIPS and APMs during their October 2015 meeting. MedPAC notes that since it is likely that not all APMs would be considered "eligible" APMs under MACRA, that at least initially, there might be limited APM options for physicians.

What to expect next

Anticipated MACRA Rulemaking Timeline

- Spring 2016
  - Release of MACRA proposed rule
- Fall 2016
  - Release of MACRA final rule
- January 1, 2017
  - MACRA adjustments are scheduled to begin in 2019 but are based on a 2017 reporting/performance year
- Proposed rule on Physician Focused Payment Models is also expected in 2016

Medicare Physician Fee Schedule

- While CMS will be issuing a separate rule for MACRA, it is possible that the CY 2017 Medicare Physician Fee Schedule (MPFS) rule may also contain provisions that could impact implementation of MIPS or eligible APMs
  - Timeline for the CY 2017 MPFS
    - July 1, 2016 – release of the proposed rule
    - November 1, 2016 – release of the final rule
    - January 1, 2017 – effective date of the CY 2017 MPFS

Quality Measure Development Activities

- Final Quality Measure Development Plan
  - Draft plan released in December 2015
  - Final plan scheduled to be released by May 1, 2016
  - Plan will be updated annually
- Annual publication of measure list
  - CMS will publish list annually through rulemaking
  - List open for public comments (July 2016 est.)
  - Final list must be posted by November 1 of each year

+ Collection of Global Surgery Data

- MACRA requires that CMS collect information about the number and level of medical visits and other items and services related to the surgery and furnished during the global period
- CMS is developing a proposal for implementing these new data collection requirements, including the definition of global periods, sampling approach, mechanisms for data collection, and definition of services furnished within the global period
  - 2017
    - Data collection on global surgical packages begins on representative sample of physicians
    - Data must be reassessed every 4 years
  - 2019
    - Implementation of data collected on global surgical packages

MACRA-mandated Reports

Date (expected)	Author	Description
July 2016	CMS	Report examines the feasibility of integrating APMs into Medicare Advantage; the study shall include the feasibility of including a value-based modifier and whether such modifier should be budget neutral
October 2016	GAO	Report to examine the alignment of quality measures in public and private programs.
January 2017	GAO	Report on whether entities that pool financial risk for physician practices, such as independent risk managers, can play a role in supporting physician practices, particularly small physician practices, in assuming financial risk for the treatment of patients.
April 2017	CMS and Office of the Inspector General (OIG)	APM-related report on the applicability of Federal fraud prevention laws under APMs and the vulnerability of APMs to fraudulent activity
July 2017	MedPAC	Report (initial) on physician and other health professional utilization and expenditures (and the rate of increase of such utilization and expenditures) and total utilization and expenditures (and the rate of increase of such utilization and expenditures) under Medicare Parts A, B, and D
July 2019	MedPAC	Report on effect of 2015-2019 Medicare physician updates
July 2021	MedPAC	Report (final version) on utilization and expenditures
October 2021	GAO	Report evaluating the MIPS program
October 2021	GAO	Report on the transition of physicians in rural health professional shortage and medically underserved areas

Increased Disclosure of Provider Data

- MACRA also includes provisions related to efforts to expand access to publicly available physician data
  - Qualified Entities: Expansion of physician data and the rules around its use
    - CMS released a proposed rule on this issue in January 2016 (previously noted in presentation)
    - CMS is mandated to expand use of the data by July 1, 2016
  - Physician Compare: Expansion of physician data available on the website
    - Physician Compare is a website that provides information to assist Medicare beneficiaries in selecting a physician or other healthcare provider
    - On December 10, 2015, CMS expanded the number of quality measures publicly reported on Physician Compare
    - Beginning in CY 2016 CMS will expand and integrate from other sources the information available on Physician Compare
    - MIPS performance information, including a provider's composite score, will be posted on Physician Compare

+ Is an Implementation Delay Possible?

- The American Medical Association (AMA) and other physician specialty societies supported MACRA
- As the implementation deadlines looms, concern about readiness grows and calls for delay are increasing

"Sure, the docs lobbied like crazy for the legislation as a replacement for the much-maligned SGR. But Pro's Erin Mershon tells us the docs have a new concern: MACRA's implementation is approaching, and quickly. CMS is set to finalize its rules for the program before the end of this year, and the performance period for docs likely starts in January. Is AMA president Steven Stack worried? "Yes," he told reporters, adding that he's waiting until April to see a proposal before calling for a delay."

Source: Politico.com, accessed 2/24/2016; http://www.politico.com/tipsheets/politico-pulse/2016/02/califf-poised-for-confirmation-who-and-white-house-both-ask-for-zika-dollars-212864#ixzz416JPB5ST

Further Information

- McDermottPlus MACRA Resource Center
  - http://www.mcdermottplus.com/news/macra-resource-center
- CMS MACRA Information page
  - https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/MACRA-MIPS-and-APMs.html