# MACRA

## MEDICARE ACCESS & CHIP REAUTHORIZATION ACT

# We will be covering the following information today……

- MACRA legislation
- MIPS basics
- APM basics
- VM, PQRS & MU participation implications
- QRUR basics
- Physician compare basics

# MACRA FACTS



- Medicare Access & CHIP Reauthorization Act
- Law was signed April 16, 2015  (final rule July 2016)
- Legislation that created MIPS
- Shifting payment models from "volume based" to "value based"
- Introduces a ***budget neutral*** payment system
- Combines our existing quality reporting programs into one new system

# TRANSFORMING OUR HEALTH CARE SYSTEM

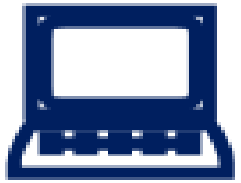
**3 goals for our health care system:**

**BETTER care**
**SMARTER spending**
**HEALTHIER people**

Via a focus on **3 areas**

**Incentives**

**Care Delivery**



**Information Sharing**

# MACRA is part of a broader push toward value & 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:

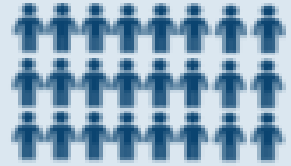
**30%**

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

# ELIGIBLE PROFESSIONALS BY YEAR



**2017 – 2018 Performance years**

- Physicians, physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists

**2019 and thereafter**

- Physical & occupational therapists, speech-language pathologists, audiologists, nurse midwives, clinical social workers, clinical psychologists & dieticians or nutrition specialists

# MACRA CREATES 2 PAYMENT TRACKS



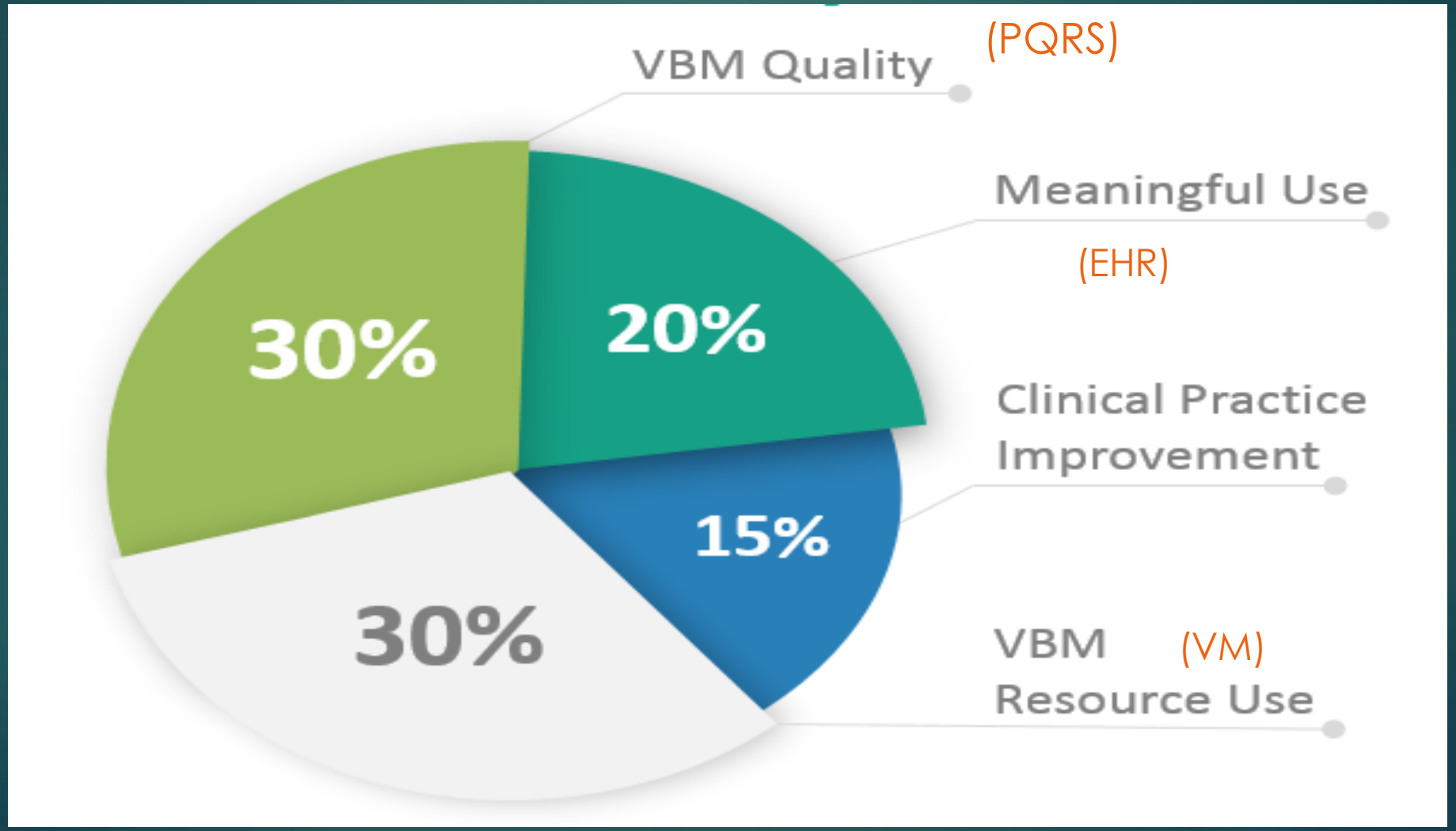
**APM** = advanced payment model
AND
**MIPS** = merit based incentive payment system

Combines MU + PQRS + VBM + Clinical Practice Improvement Measurements to create one program based on:

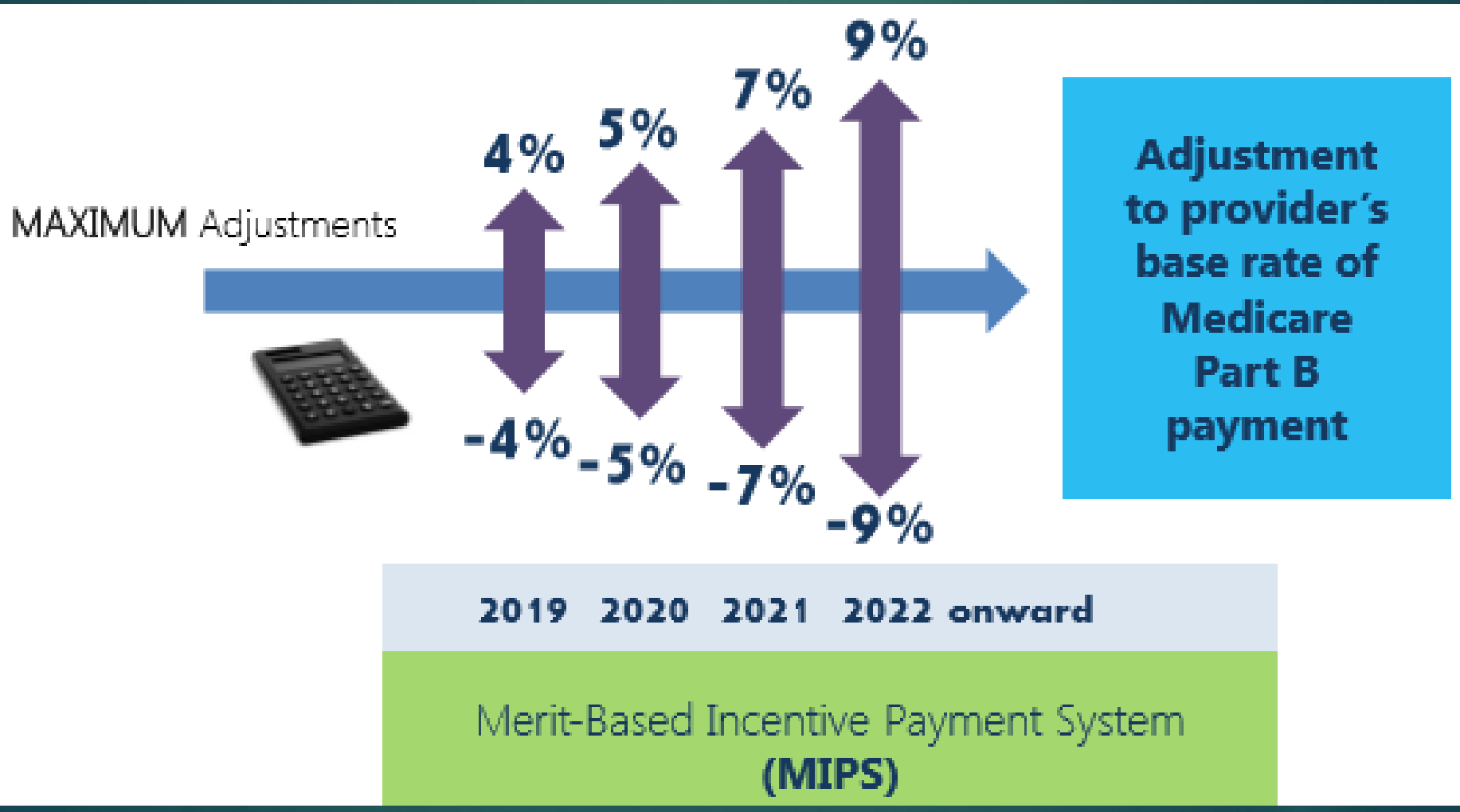
- Quality
- Resource use
- Clinical practice improvement
- Meaningful use of certified EHR technology

# MIPS SCORING





# MIPS BASE PAYMENT ADJUSTMENTS



# MIPS INCENTIVE PAYMENT FORMULA



| Year | Penalty Cap | Value-Based Bonus Opportunity (subject to scaling factor) |
|---|---|---|
| 2019 | -4% | Up to +12% |
| 2020 | -5% | Up to +15% |
| 2021 | -7% | Up to +21% |
| 2022 | -9% | Up to +27% |

UP TO 27% IN 2022 FOR TOP PERFOMERS

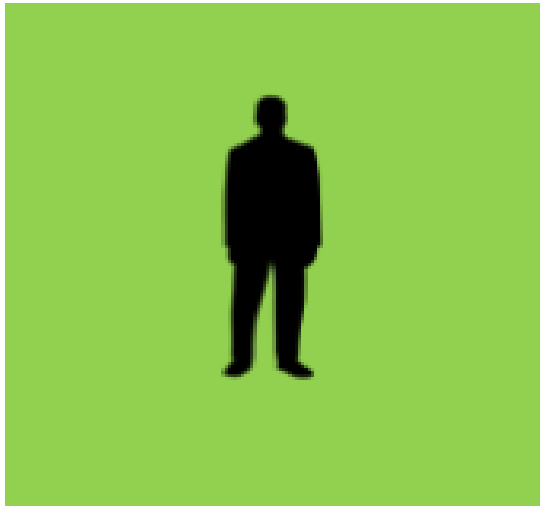
# EXCEPTIONS TO MIPS ADJUSTMENTS



There are **3 groups** of physicians and practitioners who will NOT be subject to MIPS:


**FIRST year of Medicare participation**

**Participants in eligible Alternative Payment Models who qualify for the bonus payment**



**Below low volume threshold**

Note: MIPS **does not** apply to hospitals or facilities

**Minimum threshold of patients or encounters during the reporting period is 15**

**2016 reporting period is 1 year**

# APM

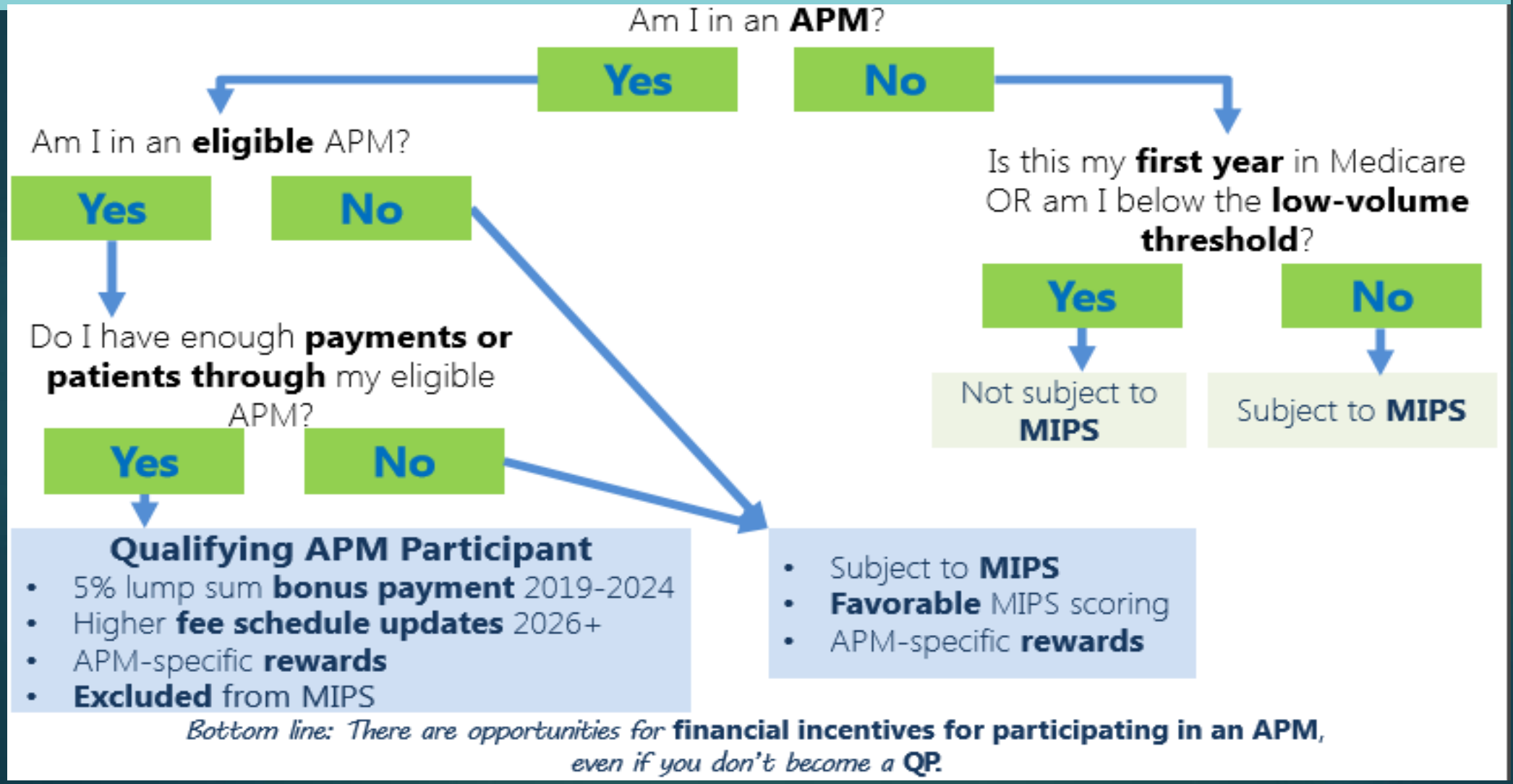
APMs give us new ways to pay providers for the care they give Medicare beneficiaries.

- From 2019-2024, pay some participating health care providers a lump-sum incentive payment.
- Increases transparency of physician-focused payments.
- In 2026, some participating health care providers higher annual payments.

Examples: ACO's, MSSP Medicare Shared Savings Programs, Programs created by Center for Medicare & Medicaid Innovation (CMMI), Health Care Quality Demonstration Programs, PCMH Patient centered medical homes

***QUALIFYING & PARTIALLY QUALIFYING APM PARTICIPANTS ARE EXEMPT FROM MIPS***

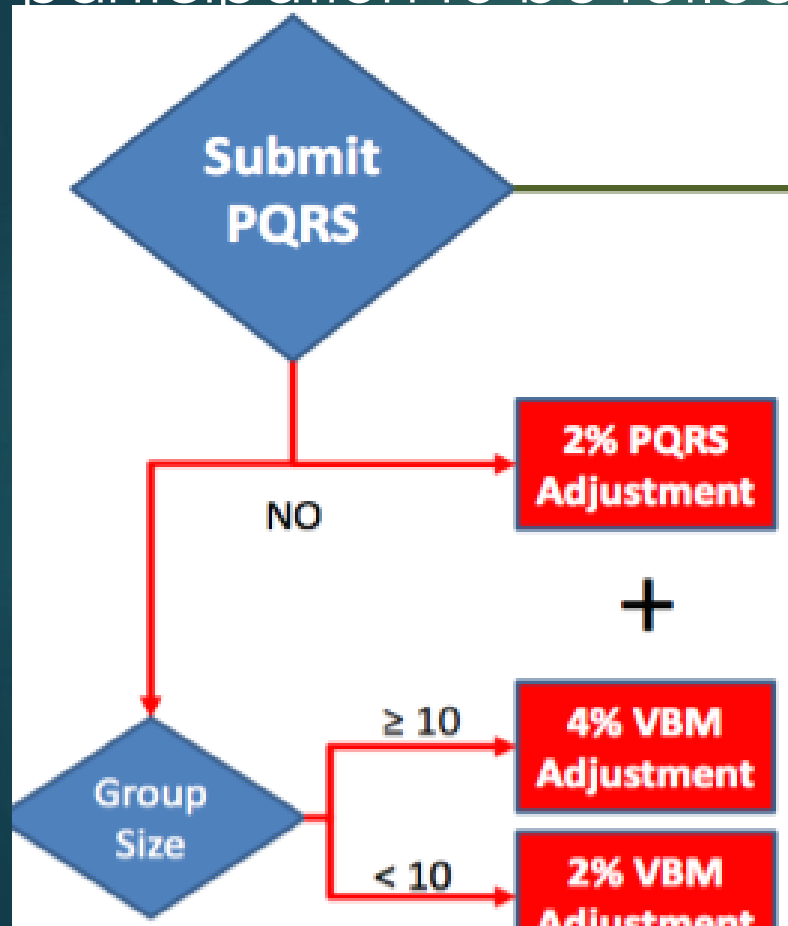
# MACRA IMPACT



# VBM (Value Based Modifier)



Implementation of VM is based on participation in PQRS. Below is 2016 participation to be reflected in 2018 payments.




VBM Quality Tiering

| Groups of 1 - 9 | | | |
|---|---|---|---|
| Low Quality | Avg Quality | High Quality | |
| 0 | +1% | +2% | Low Cost |
| 0 | 0 | +1% | Avg Cost |
| 0 | 0 | 0 | High Cost |

| Groups of 10 or More | | | |
|---|---|---|---|
| Low Quality | Avg Quality | High Quality | |
| 0 | +2% | +4% | Low Cost |
| -2% | 0 | +2% | Avg Cost |
| -4% | -2% | 0 | High Cost |

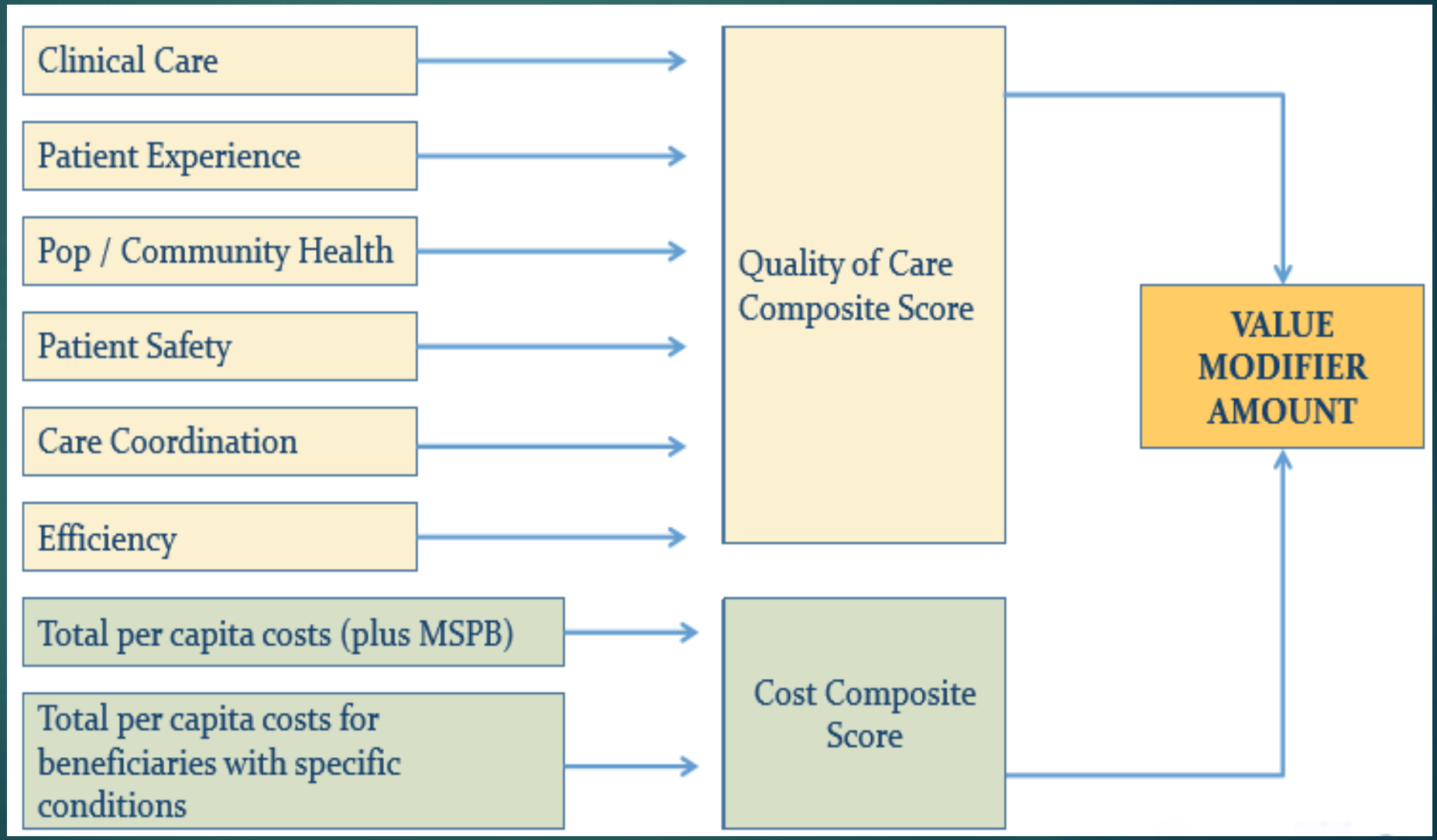
# Quality - Tiering Methodology



Align EHR CQM's with PQRS measures when possible

Total per capita costs calculated using claims data from MCR Part A & B

Specified conditions (COPD, Congestive heart failure, Coronary artery disease & diabetes)



# Quality - Tiering



*Adjustment factor will change from year to year.

***2014 to be paid in 2016 is 15.92%**, this is paid in one lump sum to providers.

*This is due to the fact that many providers did not participate in 2014. As more provider participate the amount will decrease.

| Quality/Cost | Low Cost | Avg. Cost | High Cost |
|---|---|---|---|
| High Quality | +4.0x* | +2.0x* | +0.0% |
| Medium Quality | +2.0x* | +0.0% | -2.0% |
| Low Quality | +0.0% | -2.0% | -4.0% |

# 2018 Penalty Information (based on 2016)



**-2 - 4% VM**

- Groups of 10+ EPS who do not satisfactorily report PQRS will receive an automatic -2% or -4% downward adjustment for 2018 (depends on group size)

**-2% PQRS**

- Automatic -2% payment adjustment for non-reporting of PQRS

**-4% MU**

- An additional -4% payment adjustment for Meaningful Use if individual EPs do not submit CQMs through attestation module

# QRUR Report

Every provider should view their QRUR at least two times per year. QRURs can be retrieved from the CMS Enterprise Portal (PV-PQRS) and will show the following information.

- Cost performance per capita
- Quality performance by domain
- Specialty adjusted benchmarks
- PQRS measure performance
- Episode Costs

***Annual QRUR (1/1/14–12/31/14) reports and Mid-year QRUR (7/1/13–6/30/14) reports are available for ALL Medicare providers***

# QRUR Snapshot

https://portal.cms.gov/wps/portal/unauthportal/home

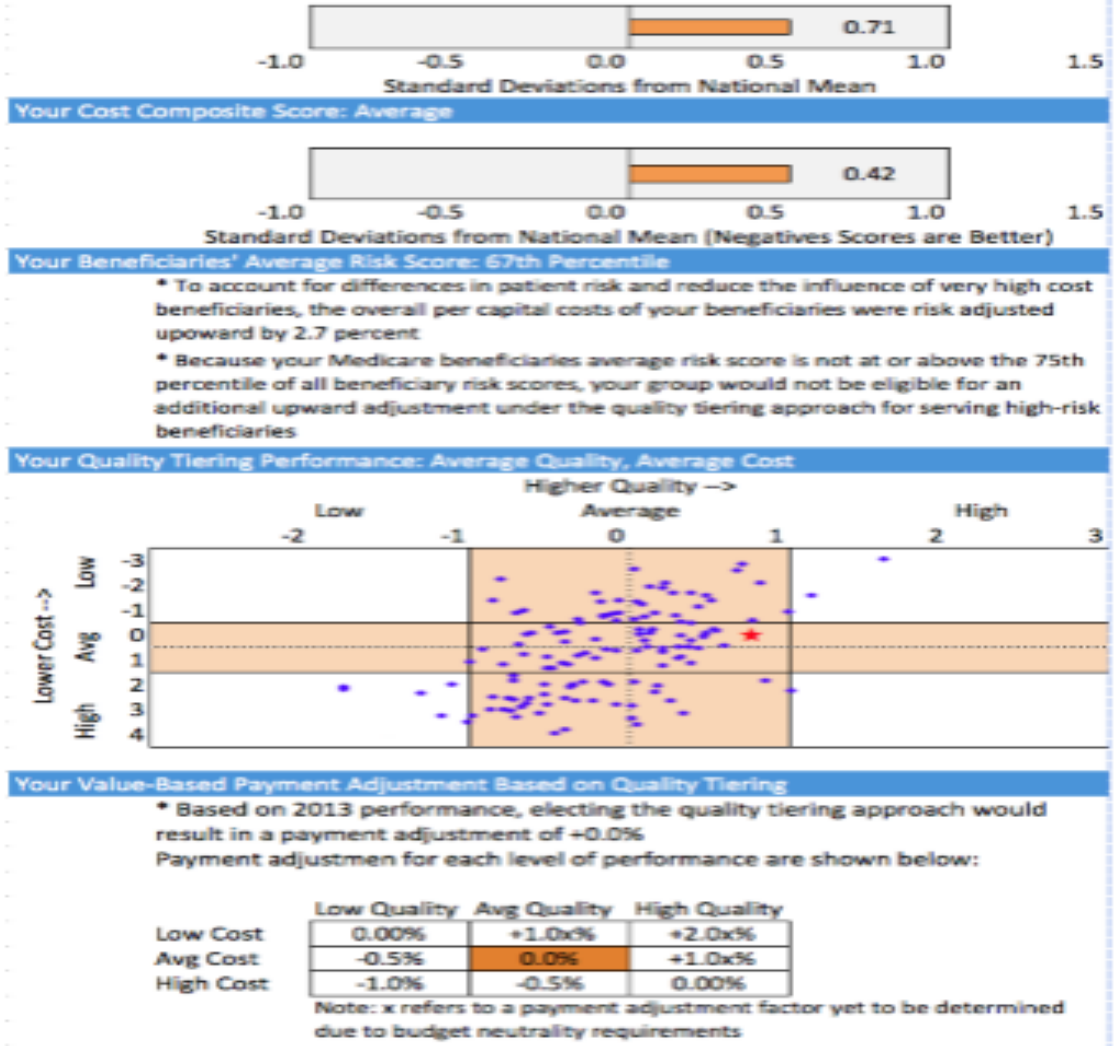
Your Quality Composite Score

Your cost composite score

Your beneficiaries' average risk score

Your Quality Tiering Performance Graph

Your payment adjustment based on quality tiering



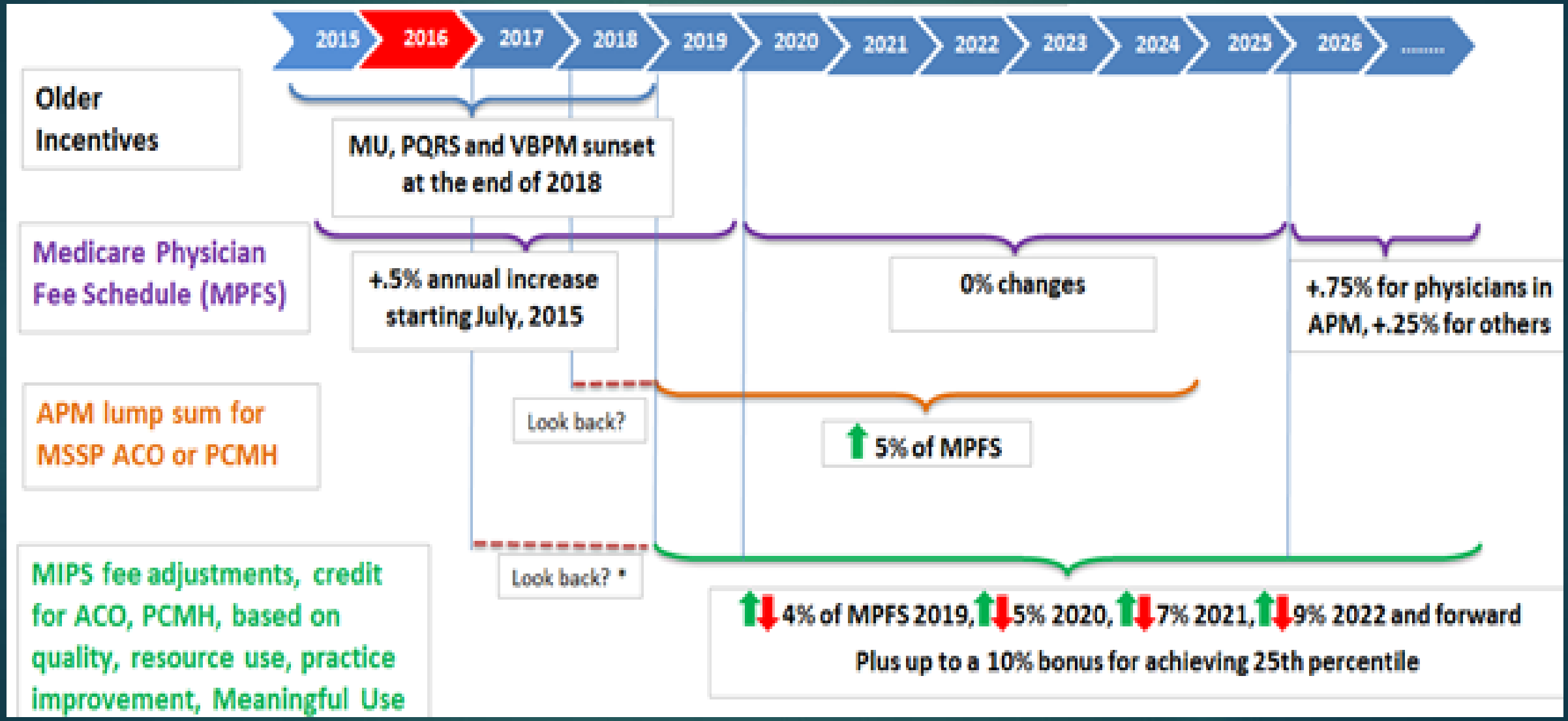
# Fairness of QRUR reports



Many physicians who are specialists, have noted that they should only be held accountable for patients whose care they directed. They do want to be penalized for costs incurred by patients to whose care they neither influenced or contributed. The services tracked through these reports are largely preventive care, many specialists, have little or no impact on the care. CMS has acknowledged this complaint, but the system will continue nonetheless. CMS wants every provider to see the entire spectrum of care patients receive and to monitor (possibly influence) the care patients receive.

# TIMELINE




2015
2016
2017
2018
2019
2020
2021
2022
2023
2024
2025
2026
.....
Older Incentives
MU, PQRS and VBPM sunset at the end of 2018
Medicare Physician Fee Schedule (MPFS)
+.5% annual increase starting July, 2015
0% changes
+.75% for physicians in APM, +.25% for others
APM lump sum for MSSP ACO or PCMH
Look back?
5% of MPFS
MIPS fee adjustments, credit for ACO, PCMH, based on quality, resource use, practice improvement, Meaningful Use
Look back? *
4% of MPFS 2019, 5% 2020, 7% 2021, 9% 2022 and forward
Plus up to a 10% bonus for achieving 25th percentile

# What is the purpose and where are we going?



**Lowering cost** of care for patients by having every provider's contribution taken into consideration. They don't say the practice cost must be reduced per patient, they say avoid unnecessary care. Examples: duplicate tests, more care than needed

Larger idea is to have transparency in healthcare. **Physician Compare** is the CMS site that lists physician information. This is a website that anyone can access to see a providers rating for Quality of Care, general practice information, etc. (sort of like an "Angie's list" for providers created and maintained by CMS)

# Physician Compare Website



https://www.medicare.gov/physiciancompare/search.html

# Physician Compare Website



*Will show which programs the provider successfully participated with and programs the provider did not successfully participate with.

*It is downloadable file.

*In order for information to make it to the website a 20 patient minimum sample is required.

*Measure needs to be >1 year

*Measures must be comparable, specifically reliable, valuable and easily understood by consumers

*CAHPS surveys will also be included (patient satisfaction surveys).

# Review Information



MACRA is the parent program for MIPS and APM.

The plurality of patient care is being taken into consideration

Physician compare will make provider program participation, quality scores and location information accessible to anyone with internet access.

PQRS, MU, VBM sunset at the end of 2018. The programs are being rolled into MIPS and APM's, they are not going away!!!!

Every provider needs to review their QRUR as if they were reviewing a bank statement.

Medicare has invited private sector payers to meet or exceed the MACRA goals.

Information sharing is at the forefront of every program moving forward.