MACRA[1]: The Law That Repealed The SGR

Refresher: MACRA[1] in Brief

- Legislation passed in April 2016 that repealed the Sustainable Growth Rate (SGR)
- CMS released proposed rule on MACRA implementation in April 2016, which is available for public comment until June 27, 2016
- Drastically changes the way CMS pays clinicians[2] for Medicare Part B services
- Locks provider reimbursement rates at near zero growth
  - 2016 – 2019: 0.5% increase
  - 2020 – 2025: 0% increase
  - 2026 and on: 0.25% increase
- Stipulates development of two new Medicare Part B payment tracks: Merit-Based Incentive Payment System (MIPS) and Alternative Payment Models (APMs)

Two New Payment Tracks Created by MACRA

1 Merit-Based Incentive Payment System (MIPS)

- Rolls existing quality programs[3] into one budget-neutral pay-for-performance program, in which providers will be scored on quality, resource use, clinical practice improvement, and EHR[4] use, and assigned payment adjustment accordingly

2 Advanced Alternative Payment Models (APM)

- Requires significant share of revenue in contracts with two-sided risk, quality measurement and EHR requirements
- APM track participants would be exempt from MIPS payment adjustments and would qualify for a 5 percent Medicare Part B incentive payment in 2019-2024

1. Medicare Access and CHIP Reauthorization Act.
2. Eligible clinicians include physicians, physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, and groups that include such clinicians.
3. Meaningful Use, Value-Based Payment Modifier, and Physician Quality Reporting System.
4. Electronic Health Record.

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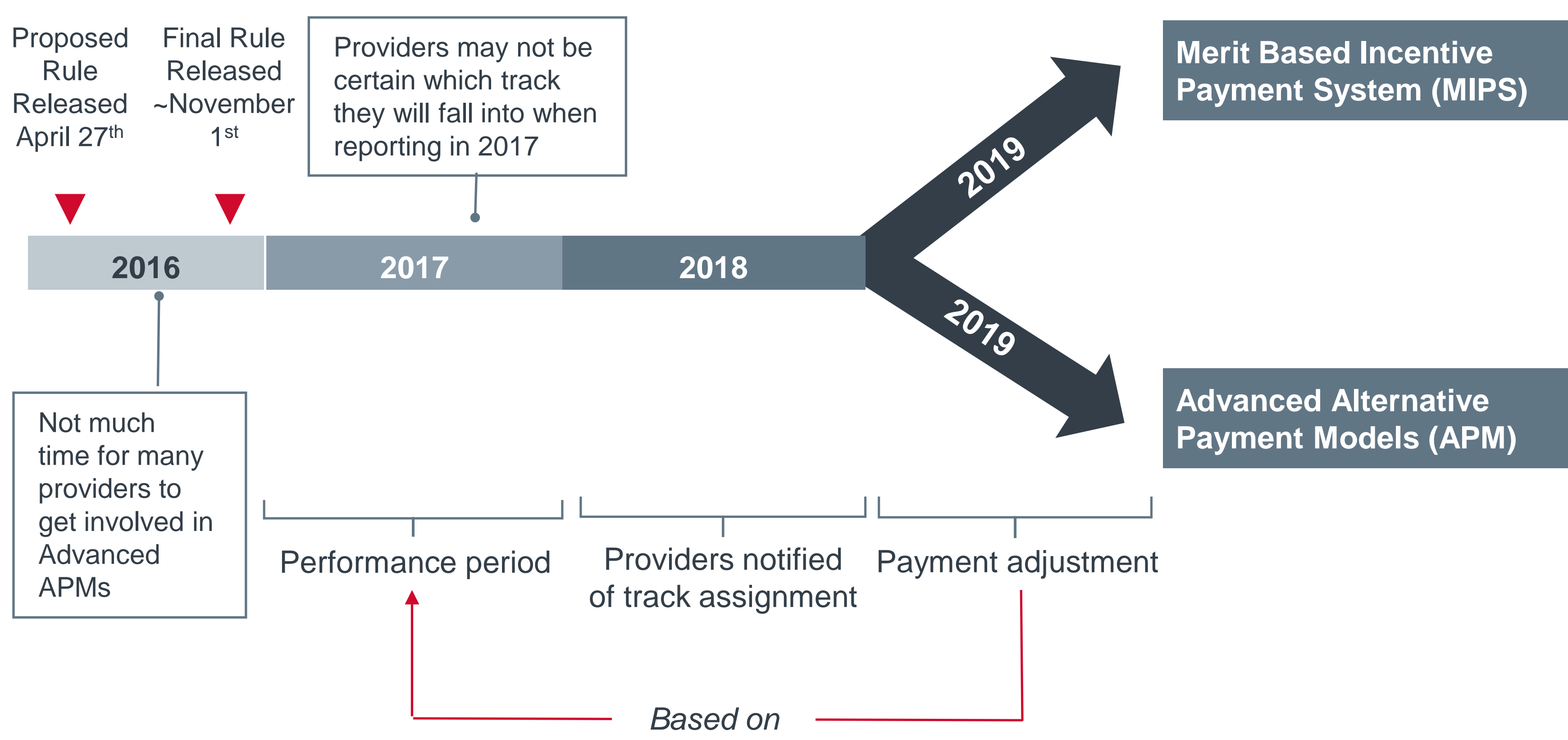
Not Much Time to Prepare

Not Enough Time for Most Providers to Ensure APM Eligibility in 2019

MACRA Implementation Timeline



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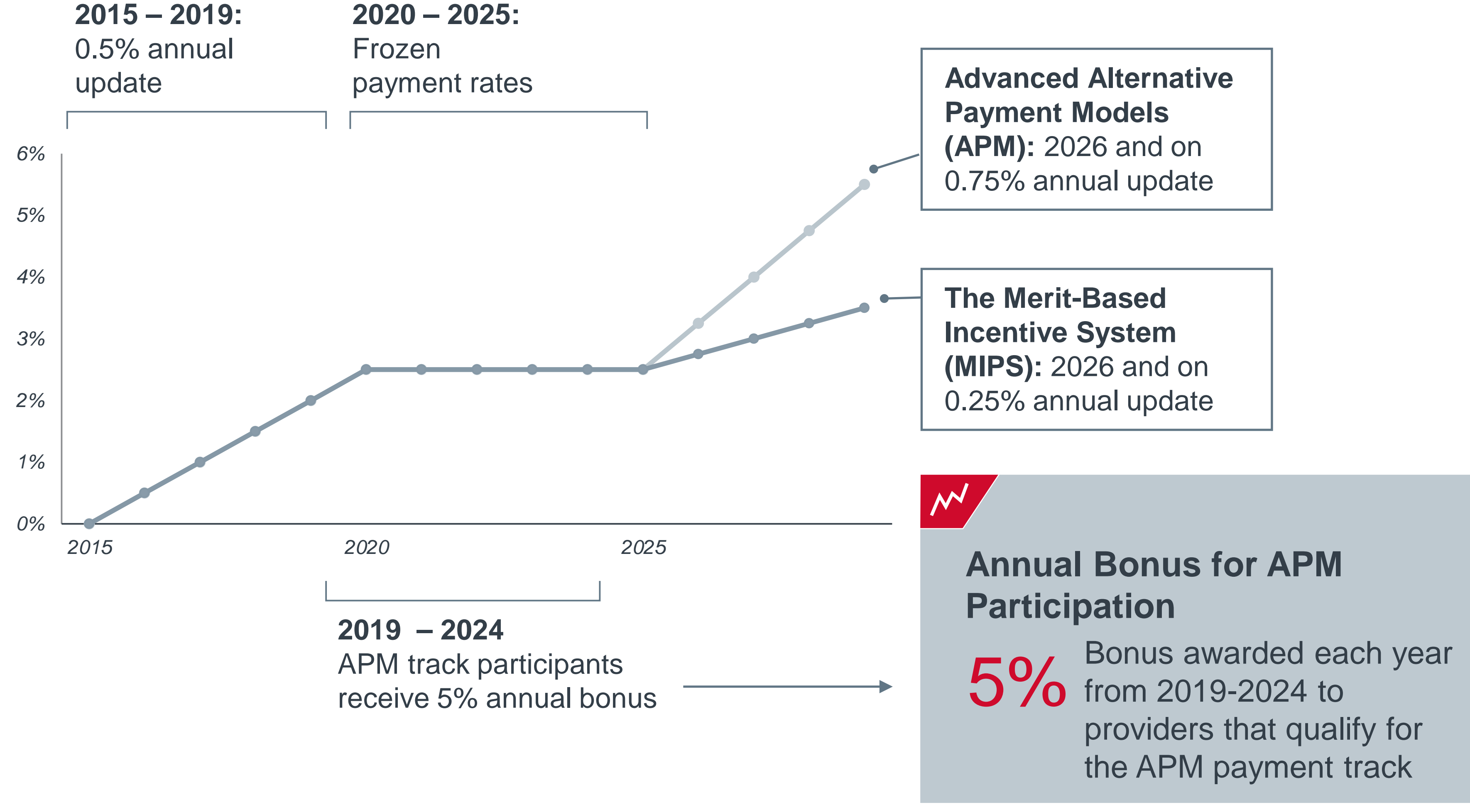
Regardless of Track, Baseline Payment Holding Steady



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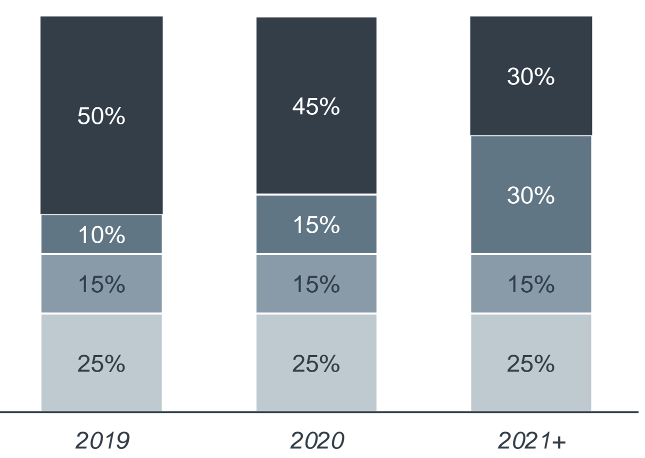
Much Yet to Be Determined Within Four MIPS Categories

Four Categories That Determine MIPS Score Relative Weight Over Time



Category	Outlined in the law	Yet to be determined
Quality	• CMS will use some quality measures from PQRS, VBPM programs to assess provider quality	• How will providers be required to report quality data? • How many and what types of measures are providers required to report?
Resource Use	• CMS will use cost measures from the VBPM program[2] to assess provider resource use • Part D drug costs will be included	• Are there other cost measures CMS will include in their assessment of a provider's Resource Use beyond those used in the VBPM program? • Will CMS compare our group's resource use to groups in similar specialties?
CPI	• CMS proposed five subcategories[3] under this category • Those participating in non-eligible APM models will automatically score well in this category	• What information must providers report and what mechanisms should providers use to report data related to clinical practice improvement? • How will CMS weigh each subcategory?
MU	• CMS plans to use meaningful use measures to score providers in this category	• Can providers receive some points for achieving partial credit of meaningful use measures?

1) Practices may demonstrate clinical practice improvement through expanded practice access, population management, care coordination, beneficiary engagement or improving patient safety.
2) VBPM assessment of provider costs include: 1. Total per capita costs for all attributed beneficiaries, 2. Total per capita costs for beneficiaries with specific conditions, and 3. Medicare spending per beneficiary.
3) Five subcategories include: promoting health equity and continuity, social and community involvement, achieving health equity, emergency preparedness and response, integrating primary care and behavioral health

Source: H.R. 2: Medicare Access and CHIP Reauthorization Act of 2015; "Request for Information Regarding Implementation of the Merit-Based Incentive Payments System, Promotion of Alternative Payment Models, and Incentive Payments for Participation in Eligible Alternative Payment Models", October 1, 2015, available at: www.federalregister.gov; Advisory Board Company interviews and analysis.

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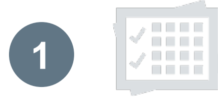
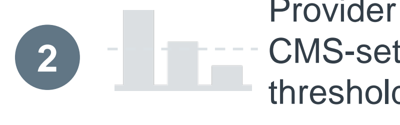
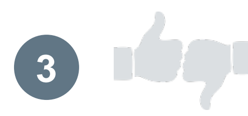
Calculating MIPS Participant Rewards, Penalties

Stronger Performers Benefit at Expense of Those with Low Scoring/No Data

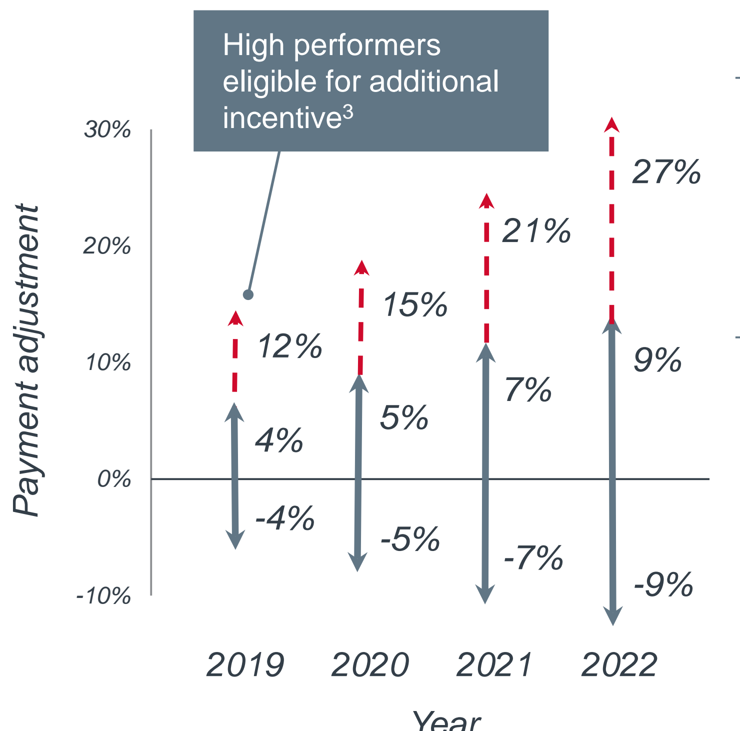
Payment Adjustment Determination

1  Providers assigned score of 0-100 based on performance across four categories

2  Provider score compared to CMS-set performance threshold[1] (PT); non-reporting groups given lowest score

3  Providers scoring above PT receive bonus; providers scoring below PT subject to penalty[2]

Maximum Provider Penalties and Bonuses



Budget neutrality adjustment: Scaling factor up to 3x may be applied to upward adjustment to ensure payout pool equals penalty pool

The mean or median (as selected by CMS) of the composite performance scores for all MIPS eligible professionals with respect to a prior period specified by the Secretary.
Bonus, penalty size correspond with how far providers deviate from the PT.
High performers eligible for additional incentive of up to 10% for MIPS eligible providers that exceed the 25th percentile.

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Two Categories of CMS Payment Models Emerging

Programs That Likely Do and Do Not Qualify Providers for APM Track

Ineligible Alternative Payment Models

- Bundled Payments for Care Improvement Initiative (BPCI)
- Comprehensive Care for Joint Replacement (CJR) Model
- Medicare Shared Savings Program (MSSP) Track 1 (50% sharing; upside only)

But participation in these models may positively affect MIPS payments[1]

Eligible Payment Models (“Advanced”)

- Medicare Shared Savings Program Tracks 2 and 3
- Next Generation ACO Model
- The Oncology Care Model Two-Sided Risk Arrangement[2]
- Comprehensive ESRD[3] Care Model (Large Dialysis Organization Arrangement)
- Comprehensive Primary Care Plus (CPC+)
- Certain commercial contracts with sufficient risk, including Medicare Advantage (starting in 2021)

1) Under Clinical Practice Improvement Activities category.
2) Available in 2018.
3) End stage renal disease.

Source: CMS, “Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models,” May 9, 2016, available at: https://s3.amazonaws.com/public-inspection.federalregister.gov/2016-10032.pdf; Advisory Board Company interviews and analysis.

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What Can I Do Now?

CMS on 10/14/16, released a final rule to implement new value-based payment programs under the Medicare Access and CHIP Reauthorization Act (MACRA). https://qpp.cms.gov/

The first payment adjustments under the programs will take effect Jan. 1, 2019, and will incorporate 2017 data. Providers who are not yet prepared to participate have until Oct. 2, 2017, to begin collecting performance data. Participating providers must submit all data, regardless of when collection began, to CMS by March 31, 2018.

Eligible providers include those who annually bill Medicare for more than $30,000 or care for more than 100 Medicare beneficiaries. CMS increased the thresholds from those included in its proposed rule as a way to exempt more small practices from the requirements. CMS estimates this represents 32.5 percent of clinicians, but accounts for only 5 percent of Medicare spending.

CMS estimated that between 70,000 and 120,000 clinicians in 2017 will participate in and qualify for incentive payments under the APM path and about 500,000 clinicians will be eligible to participate in MIPS in its first year.

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What Can I Do Now?

Providers who choose to participate in MIPS also can select the pace at which they transition to the program. Under the final rule, providers will be able to:

•Test the program by submitting a minimum amount of data, such as one quality measure or one improvement activity, to avoid a negative payment adjustment;
•Submit 90 days' worth of data to earn a neutral or small positive payment adjustment; or
•Submit data for all of 2017 to receive a "moderate" positive payment adjustment.
•Or, providers who qualify for the program but do not participate in the APM or MIPS paths will receive a 4 percent negative payment adjustment.

•To be eligible for the Advanced APM track and receive a 5 percent incentive payment annually from 2019 through 2024, eligible professionals will need to receive 25 percent of their Medicare-covered services through Advanced APMs or see 20 percent of their Medicare patients through Advanced APM in 2017.
• To qualify, advanced APMs must meet three requirements: Use certified EHR technology, base payments on quality measures comparable to MIPS and require providers to bear more than nominal risk.

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