A Survival Guide to MACRA
What You Need to Know in 2016

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A New Era of Healthcare Payment

The Past – Fee for Service
• Payment for *quantity* of services

The Future – Alternative Payment Models
• Payment for *quality* of care and accountability for cost of care
Payment System Changing from Volume (Curve 1) to Value (Curve 2)

Curve #1: FEE-FOR-SERVICE

Curve #2: ALTERNATIVE PAYMENT MODELS

Natural Trajectory
Basics of Alternative Payment Models

1. Pay for Performance
   • Physician Quality Reporting System (PQRS)
   • Care Management Programs (Blue Cross, Humana)

2. Shared Savings
   • Medicare Shared Savings Program (MSSP)

3. Bundled Payments
   • Comprehensive Care for Joint Replacement

4. Capitation
What is Driving Payment Reform?

1. President Bush’s Executive Order
2. Affordable Care Act
3. HHS Announcement in New England Journal of Medicine
4. MACRA
Part IV

The President

Executive Order 13410—Promoting Quality and Efficient Health Care in Federal Government Administered or Sponsored Health Care Programs

Notice of August 24, 2006—Intention To Enter Into a Free Trade Agreement With Colombia
Directs Federal Agencies to:

1. Encourage adoption of health information technology standards for interoperability
2. Increase transparency in healthcare quality measurements
3. Increase transparency in healthcare pricing information
4. Promote quality and efficiency of care, which may include pay for performance
CMS Quality Agenda:

Transform Medicare from a *passive payer* to an *active purchaser* of higher quality, more efficient health care

Value-Based Purchasing
(payment based on quality)

Tools and initiatives for promoting better *quality*, while avoiding unnecessary *costs*

**Triple Aim:** Better Care, Better Health, Lower Cost
The Affordable Care Act of 2010
Affordable Care Act of 2010

• Hospital-level P4P Programs
  – Hospital Value-based Purchasing Program
  – Readmissions Reduction program
  – Hospital Acquired Conditions Reduction Program

• Physician-level P4P Programs
  – Continuation of PQRS
  – Value-based Modifier

• Medicare Shared Savings Program (MSSP)

• Center for Medicare/Medicaid Innovation (CMMI)
  – Bundled Payments for Care Improvement (BPCI)
THE EMERGING ROLE OF “HOSPITALISTS” IN THE AMERICAN HEALTH CARE SYSTEM

The explosive growth of managed care has led to an increased role for general internists and other primary care physicians in the American health care system. This change is welcome in many respects, since generalists have perennially been undervalued by health care institutions, payers, and even patients. The greater prominence of generalists has led to an increase in the number of medical students who choose careers in primary care, expanded job opportunities for generalists, and a modest increase in the incomes of primary care physicians.

Two of the principles underlying generalism, whether in the form of internal medicine, pediatrics, or family medicine, have been comprehensiveness and continuity. Ideally, the primary care physician would provide all aspects of care, ranging from preventive care to the care of critically ill hospitalized patients. This approach argues the patient, would result in medical care that was more holistic, less fragmented, and less expensive. To its proponents, the notion was so attractive the general internist admits the patient to the hospital, directs the inpatient workup, and arranges for a seamless transition back to the outpatient setting. The question was it would have seemed sacrilegious merely a few years ago.

Unfortunately, this approach collides with the realities of managed care and its emphasis on efficiency. As a result, we anticipate the rapid growth of a new breed of physicians we call “hospitalists” — specialists in inpatient medicine — who will be responsible for managing the care of hospitalized patients in the same way that primary care physicians are responsible for managing the care of outpatients. Specialists in inpatient care have long had a central role in urban hospitals in Canada and Great Britain, but until recently such specialists have been scarce in the United States. However, a role for this specialty is now being developed both in and outside academia, especially in areas where managed care predominates, such as San Francisco, and we expect this growth to accelerate soon.

We believe the hospitalist specialty will burgeon for several reasons. First, because of cost pressures, managed care organizations will reward professionals who can provide efficient care. In the outpatient setting, the premium on efficiency requires that the physician provide care for a large panel of patients and be available in the office to see them promptly as required. There is no greater barrier to efficiency in outpatient care than the need to go across the street (or even worse, across town) to the hospital to see an unpredictable number of inpatients, sometimes several times a day. There are parallel pressures for efficiency in the hospital. Since the inpatient setting involves the most intensive use of resources, it is the place where the ability to respond quickly to changes in a patient’s condition and to use resources judiciously will be most highly valued. This should prove to be the hospitalist’s forte.

Equally pressing is the question of value, defined as the quality of care divided by its cost. The survival of all health care systems is becoming increasingly dependent on the delivery of high-value care. (For academic health centers, this means that more expensive care must be justified by better outcomes.) Many physicians, though primarily serving outpatients, have exceptional skills in providing inpatient care. It seems unlikely, however, that high-value care can be delivered in the hospital by physicians who spend only a small fraction of their time in this setting. As hospital stays become shorter and inpatient care becomes more intense, a greater premium will be placed on the skill, experience, and availability of physicians caring for inpatients.

The debate over the role of hospitalists is taking place against the backdrop of the larger controversy over whether generalists or specialists should provide care for relatively ill patients. The first decade of managed care has been dominated by a gatekeeper model, in which care is managed by a primary care physician. There is some evidence that this model saves money, and for common diseases, the quality of care provided by generalists and specialists appears to be similar. Building on a considerable body of data demonstrating a positive relation between procedural experience and outcomes, a number of recent studies have examined whether a similar relation exists for nonprocedural care of patients with complex medical diseases. Those who favor the use of inpatient specialists for hospital care point to the strong correlation of experience with the quality of care provided for patients in an intensive care unit, as well as for those with AIDS, asthma, rheumatoid arthritis, or acute coronary syndromes.

If our prediction of an increased role for hospitalists is borne out, the effects on academic medical centers will be profound. The “triple threat” leader — skilled clinician, researcher, and educator — was the paradigm of exceptional faculty achievement (or failure) for more than a generation. Balancing a productive research career with teaching and clinical care was easier when academic health centers were less accountable for the quality and cost of clinical care than they are now. Given the parallel pressure for funding research, one can envision fewer triple threats in the future, with researchers concentrating...
Perspective

Setting Value-Based Payment Goals — HHS Efforts to Improve U.S. Health Care

Sylvia M. Burwell
January 26, 2015 | DOI: 10.1056/NEJMp1500445

Now that the Affordable Care Act (ACA) has expanded health care coverage and made it affordable to many more Americans, we have the opportunity to shape the way care is delivered and improve the quality of care systemwide, while helping to reduce the growth of health care costs. Many efforts have already been initiated on these fronts, leveraging the ACA’s new tools. The Department of Health and Human Services (HHS) now intends to focus its energies on augmenting reform in three important and interdependent ways: using incentives to motivate higher-value care, by increasingly tying payment to value through alternative payment models; changing the way care is delivered through greater teamwork and integration, more effective coordination of providers across settings, and greater attention by providers to population health; and harnessing the power of information to improve care for patients.
HHS Payment Goals for Medicare

Medicare Fee-for-Service

GOAL 1: 
Government 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: 
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.

NEXT STEPS:
Testing of new models and expansion of existing models will be critical to reaching incentive goals.

Creation of a Health Care Payment Learning and Action Network to align incentives for payers.

STAKEHOLDERS:
Consumers | Businesses | Payers | Providers | State Partners

Set internal goals for HHS
Invite private sector payers to match or exceed HHS goals
Target % of Medicare Payments Linked to Quality and Alternative Payment Models by 2016 and 2018

Historical Performance

- 2011: ~70%
- 2014: >80%

Goals

- 2016: 30%
- 2018: 50%
# Medicare APM’s

<table>
<thead>
<tr>
<th>Major APM Categories</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
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<tbody>
<tr>
<td><strong>Accountable Care Organizations</strong></td>
<td>Medicare Shared Savings Program ACO*</td>
<td>Pioneer ACO*</td>
<td>Comprehensive ESRD Care Model</td>
<td>Next Generation ACO</td>
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<tr>
<td><strong>Bundled Payments</strong></td>
<td>Bundled Payment for Care Improvement*</td>
<td></td>
<td>Comprehensive Care for Joint Replacement</td>
<td>Oncology Care</td>
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<tr>
<td><strong>Advanced Primary Care</strong></td>
<td>Comprehensive Primary Care*</td>
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<tr>
<td><strong>Other Models</strong></td>
<td>Maryland All-Payer Hospital Payments*</td>
<td>ESRD Prospective Payment System*</td>
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</table>

- CMS will continue to test new models and will identify opportunities to expand existing models.
Future of FFS in Medicare

NOW

FFS

2016

Alternative Payment Models “Built on FFS Architecture” & Population-Based Payment
30%

Fee for Service – “Link to Quality”
55%

FFS - No Link to Quality
15%

2018

Alternative Payment Models “Built on FFS Architecture” & Population-Based Payment
50%

Fee for Service – “Link to Quality”
40%

FFS - No Link to Quality
10%
Medicare Access and *CHIP Reauthorization Act of 2015 (MACRA)

- Significant changes to **physician** payment under Medicare Physician Fee Schedule (PFS)
- Bipartisan Support:
  - Congress: 392 to 37
  - Senate: 92 to 8
- 962 Page Proposed Rule released April 27, 2016

*Children’s Health Insurance Program*
MACRA Overview

**Designed to disrupt physician payment:**

1. Repeals and Replaces Sustainable Growth Rate Formula (SGR)
   1. Part of 1997 Balanced Budget Act linking physician payment to GDP
   2. 19 “doc fixes” to prevent payment cuts

2. Align physician reimbursement with quality

3. Drive physicians to APM’s
MACRA Overview

• 2016 to 2018:
  o 0.5% annual increase
  o Preserves PQRS, Value Modifier, MU
• 2019 - 2 options for physicians:
  1. Merit-Based Incentive Program (MIPS)
  2. Alternative Payment Model Track (APM Track)
• January 1, 2017 begins performance period for 2019 payment adjustments!
Merit-Based Incentive Program

- Combines PQRS, VM, MU into a single program
- Individual physician Performance Score (0 to 100) in 4 categories:
  1. Quality: requires 6 measures, replaces PQRS
  2. Resource Use/Cost – based on claims data
  3. Advancing Care Information – replaces MU
  4. Clinical Practice Improvement Activities
- Significant reporting obligations
- Budget neutral annual payment adjustments of +/- 4 to 9%
Advanced APM Track

- 5% lump sum increases beginning 2019
- Requires > 25% Medicare payments through Advanced APM
  - Next Generation ACO (21 current participants)
  - MSSP Track 2 (6 current participants)
  - MSSP Track 3 (16 current participants)
- **MSSP Track 1 and CJR do not qualify as Advanced APM**
Advanced APM Requirements

• Quality measurements comparable to MIPS
• Requires use of Certified Electronic Health Record
• Bear financial risk for “more than nominal losses”
  o Marginal Risk: % of amount actual expenditures exceed expected – must be at least 30%
  o Minimum Loss Rate: % expenditures may exceed expected without triggering financial loss – maximum 4%
  o Total Potential Risk: at least 4% of expected expenditures
• All Payer Model coming in 2021 includes Medicare Advantage, Medicaid and Commercial Insurance
MIPS vs. APM Track

**MIPS**
- Annual adjustments based on Performance Score
- Significant reporting burden
- 687,000 to 746,000 eligible clinicians
- $833 million positive/negative distribution

**APM Track**
- 5% lump sum annual increases
- 30,658 to 90,000 eligible clinicians
- $146 to $429 million upward payment adjustments
Payments, Updates and Bonuses Under MACRA

Although MACRA creates separate paths for payments under the Medicare PFS, these paths are in addition to, not in replacement of the PFS.

- **PFS Updates**:
  - 2016: 0.5%
  - 2017: 0.5%
  - 2018: 0.5%
  - 2019: 0.5%
  - 2020: 0%
  - 2021: 0%
  - 2022: 0%
  - 2023: 0%
  - 2024: 0%
  - 2025: 0%
  - 2026+: 0.75%

- **APM Temporary Bonuses**:
  - 2019: 5%
  - 2020: 5%
  - 2021: 5%
  - 2022: 5%
  - 2023: 5%
  - 2024: 5%
  - 2026+: 0.25%

- **MIPS Payment Adjustments**:
  - MIPS Performance Range:
    - 2019: +/- 4%
    - 2020: +/- 5%
    - 2021: +/- 7%
  - 2022 and subsequent years: +/- 9%

*For 2019 through 2024, the highest performing MIPS professionals who receive a positive payment adjustment will be eligible to share up to $500 million each year for "exceptional performance" payments. This upside is limited by the statute to +10% of Medicare charges.
## MACRA Impact on Physician Reimbursement

### Estimated Annual Financial Impact by Physician Type:

<table>
<thead>
<tr>
<th>Physician Practice Area</th>
<th>Revenue &amp; Payor Mix</th>
<th>Annual Financial Impact (2019)</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Total FFS Rev.</td>
<td>% Medicare</td>
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<tr>
<td>Primary Care</td>
<td>$545,573.00</td>
<td>24.37%</td>
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<tr>
<td>Non-Surgical Specialist</td>
<td>$534,131.00</td>
<td>40.44%</td>
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<tr>
<td>Surgical Specialist</td>
<td>$664,596.00</td>
<td>35.39%</td>
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</tbody>
</table>

### Potential APM Incentive Payments vs. Potential MIPS Payment Adjustments (2019-2024)

<table>
<thead>
<tr>
<th>Physician Practice Area</th>
<th>2019</th>
<th>2020</th>
<th>2021</th>
<th>2022</th>
<th>2023</th>
<th>2024</th>
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<tbody>
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<td></td>
<td>APMs</td>
<td>MIPS</td>
<td>APMs</td>
<td>MIPS</td>
<td>APMs</td>
<td>MIPS</td>
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<tr>
<td>Primary Care Physician</td>
<td>$6,648</td>
<td>$5,318</td>
<td>$6,648</td>
<td>$6,648</td>
<td>$9,307</td>
<td>$6,648</td>
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<tr>
<td>Non-Surgical Specialist</td>
<td>$10,800</td>
<td>$8,640</td>
<td>$10,800</td>
<td>$10,800</td>
<td>$15,120</td>
<td>$10,800</td>
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<tr>
<td>Surgical Specialist</td>
<td>$12,114</td>
<td>$9,691</td>
<td>$12,114</td>
<td>$12,114</td>
<td>$16,960</td>
<td>$12,114</td>
</tr>
</tbody>
</table>

SHM

HOSPITALISTS. TRANSFORMING HEALTHCARE. REVOLUTIONIZING PATIENT CARE.
MIPS or APM Track – You Decide?

MIPS

APM Track

- 5% Lump Sum Payment Increases
- No MIPS Reporting

- Annual Payment Adjustments Based on Performance Score
Timeline for MACRA implementation

- May 1, 2016: Deadline for CMS to post a final Quality Measure Development Plan. To be updated annually.
- Jul 1, 2016: Date for the HHS Secretary to establish and publish in the Federal Register an annual list of quality measures to serve as the basis for the MIPS payment adjustment.
- Nov 1, 2016: Deadline for HHS to submit report to Congress on including APMs in Medicare Advantage.
- Nov 9, 2016: Deadline for HHS Secretary directed to establish metrics to assess EHR interoperability.
- Jan 1, 2017: Deadline for HHS to publish final rule on MIPS. Start of first performance period.
- Apr 10, 2017: The HHS Secretary is directed to draft a list of the care episode and patient condition codes and post them on the CMS website. Secretary seeks comments from physician specialty societies, applicable practitioner organizations and other stakeholders for 120 days (March 9, 2017).
- Jul 1, 2017: The HHS Secretary will post an operational list of patient relationship categories and codes on the CMS website.
- Nov 1, 2017: Date for HHS to begin providing confidential performance reports to MIPS-eligible professionals on the individual's performance on quality and resource use.
- Dec 14, 2017: The HHS Secretary will post an operational list of care episodes and patient condition codes on the CMS website.
- Jan 1, 2018: Date for HHS to begin providing to each MIPS-eligible professional information about items and services provided to the professional's patients by other suppliers and providers of services.
- Dec 2, 2018: Statutory deadline for achieving national priority of widespread interoperability of EHRs.

Extraordinary measures under the act:
- Deadline to begin including on all Medicare claims the new codes and the national provider number of the ordering physician or applicable practitioner.
- Codes established for care episode groups, patient condition groups, and patient relationship categories required on all Medicare claims going forward.
Implications of MACRA for Physician Practices

The new MACRA law significantly impacts a number of key areas across health care provider organizations:

- **Financial**
  - Affects future Medicare reimbursement for all paid on Physician Fee Schedule

- **Clinical**
  - Will require clinicians to change/add incremental workflow and assess and improve clinical quality outcomes

- **Operational**
  - Will require organization-wide collaboration and coordination of eligibility, multiple moving parts and regulatory requirements

- **Technological**
  - Will require robust clinical data capabilities (data governance, capture, collection, validation and reporting)

- **Strategic/Competitive**
  - Prioritizes strategic Physician Acquisition/Growth decisions related to who (PCPs/Specialties, etc.), where, when, how (types of arrangements)

- **Reputational**
  - MIPS program performance results will be made public and transparency will expose the good and the bad

- **Physician Engagement**
  - Relationships/Partnerships/Arrangements will need to evolve in order to attract, retain, evaluate and optimize

- **Patient Engagement**
  - Greater coordination of care and two-sided risk for health care providers will raise the stakes for health care providers to foster closer ties with patients and help them actively manage their health
What You Can Do to Prepare for MACRA

1. Know who bills under your Tax ID Number (TIN)
2. Know your Medicare practice revenue
3. PQRS Participation: Claims, Registry, GPRO
4. Meaningful use of an EHR
5. Clinical Practice Improvement Activities: 90 Options
6. Advanced APM Participation: ACO, CIN
7. Recognize we are in rule-making stage and changes to are likely
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Questions/Comments?