

MACRA – THE BASICS

Getting Ready for the Post-SGR World

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February 2016

To Ask a Question

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- Send to 'Host'
- Type your question in the text box and hit "send"
- Additional questions after the webinar can be sent to macra@asco.org

Presentation Overview:

- ✓ Review SGR/SGR Appeal
- ✓ MACRA Goals
- ✓ CMS Quality Improvement Goals
- ✓ General Timelines and Milestones
- ✓ MACRA Details
- ✓ MIPS
- ✓ APMs
- ✓ ASCO Member Readiness

A Wild Ride on the Sustainable Growth Rate Roller Coaster Comes to an End



How Repeal of the Sustainable Growth Rate Formula Happened

- **March 26, 2015:** House passes the Medicare Access and CHIP Reauthorization Act of 2015 to (392-37) which permanently repeals and replaces the SGR
- **April 14, 2015:** Senate passes the Medicare Access and CHIP Reauthorization Act of 2015 (92-8)
- **April 16, 2015:** President signs Medicare Access and CHIP Reauthorization Act of 2015 into law

WHY ASCO SUPPORTED REPEAL

Issues with SGR ...

- Unworkable formula
- Annual uncertainty
- Piecemeal approach to incentives

Promise of MACRA...

- Rewards quality and value-based care
- Allows practice organization as desired
- Consolidated incentive programs

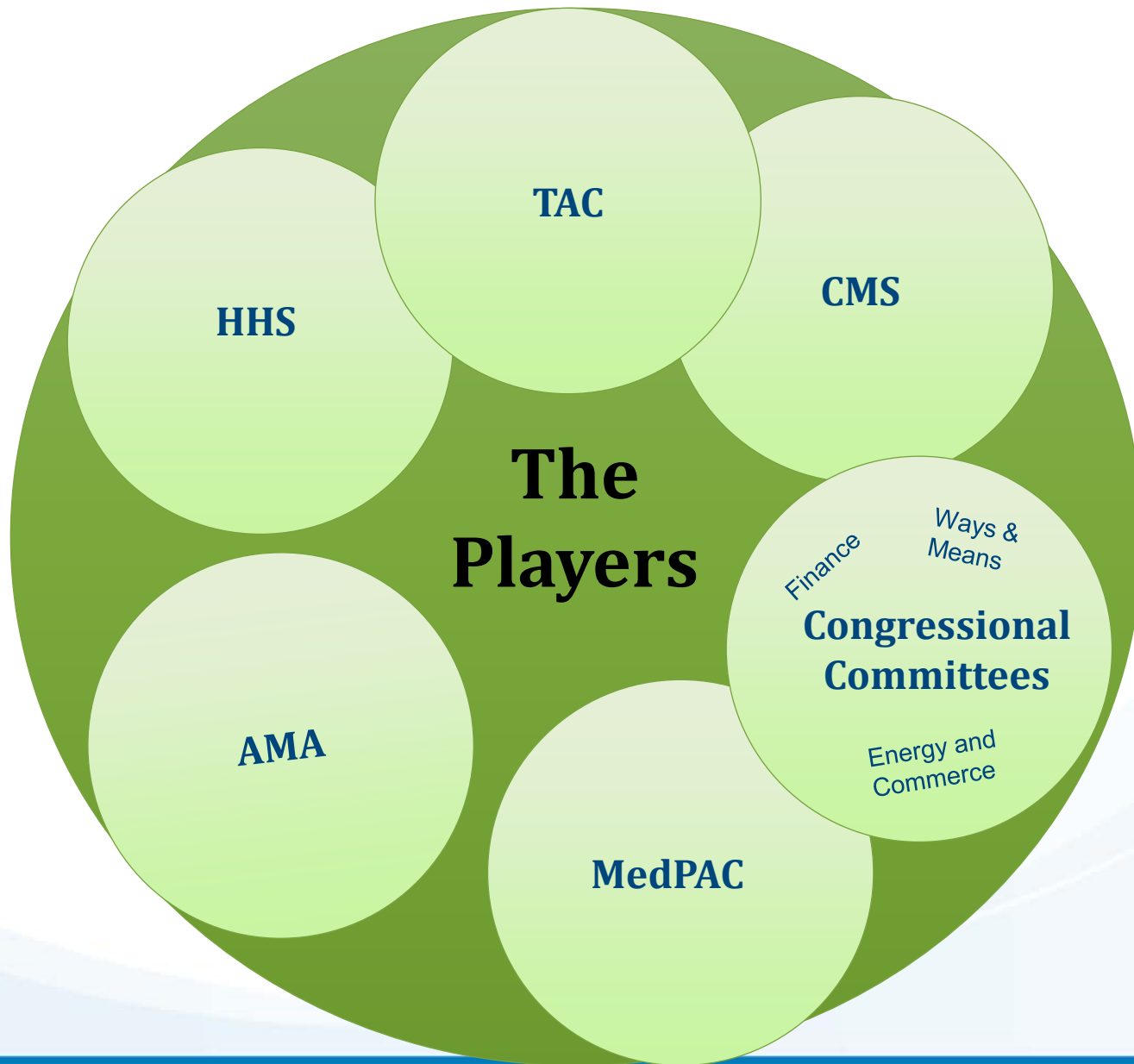
A NEW ACRONYM

Medicare Access and CHIP Reauthorization Act



MACRA - REALIZING THE PROMISE

- Built in period of stability
...but things are moving now
- Push to Alternative Payment Models
- Focus on Registries and QCDRs
- Streamlines current reporting requirements
- Provides some support for practice transformation



THERE ARE OPPORTUNITIES AND THREATS HERE

- **Specialty APMs**
- **Quality measure development**
- **Dialogue often with decision makers**
- **Advisory opportunities**
- **Path for QOPI/CancerLinQ, PCOP**
- **A lot has to happen very quickly**
- **Congress already looking to Medicare payments as “pay for”**
- **Unknowns e.g. resource use, composite score threshold**

We Caught the Car...SGR is Gone. *...Now What?*

THIS

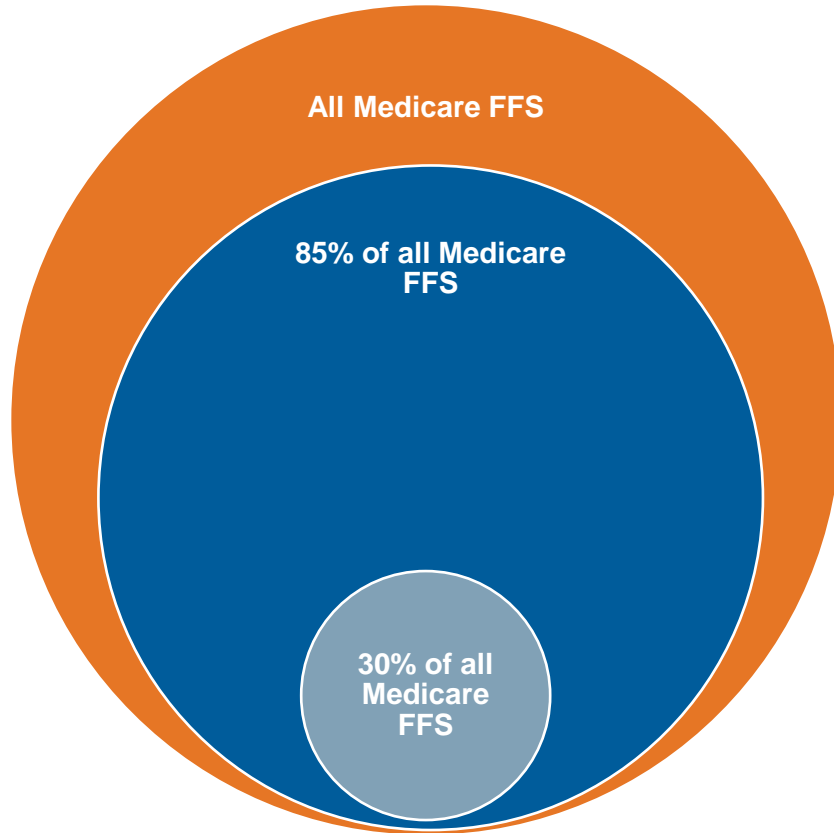


NOT THIS

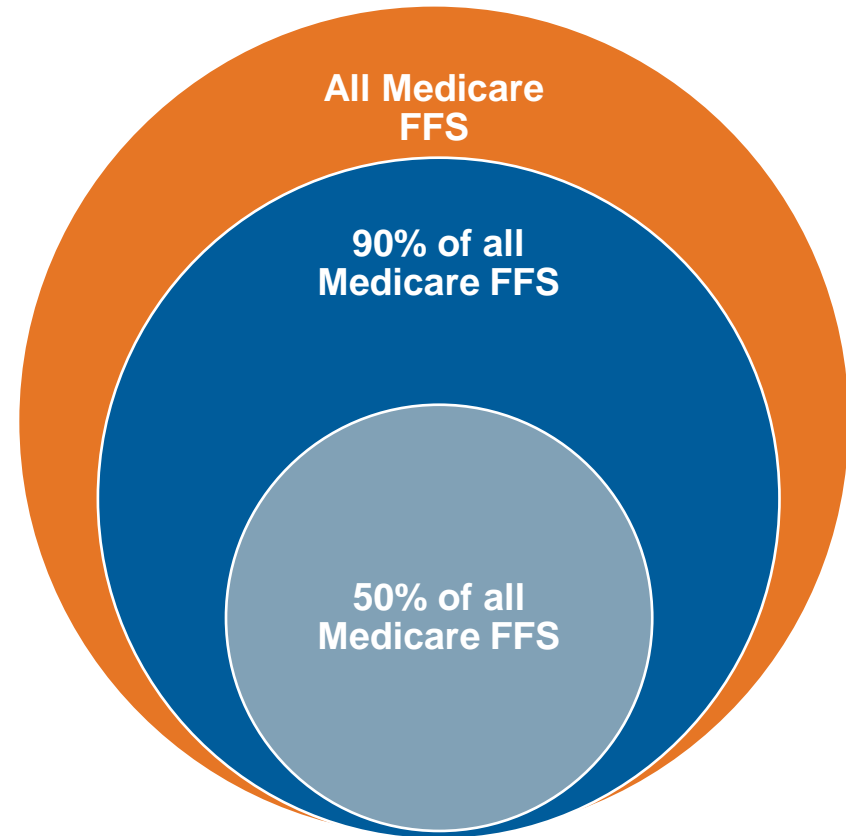


CMS QUALITY IMPROVEMENT GOALS

2016 Medicare FFS Payments



2018 Medicare FFS Payments

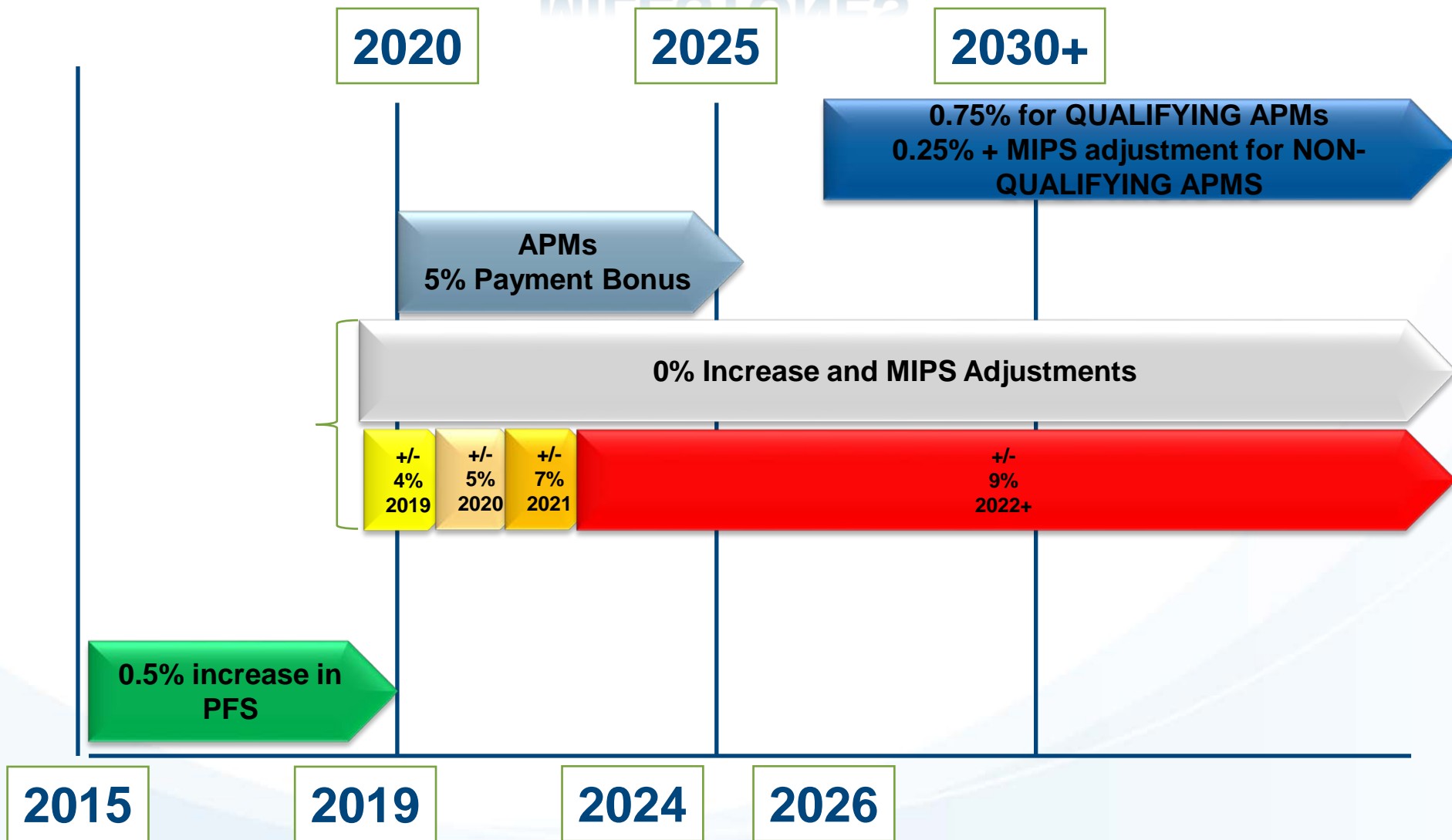


Alternative Payment Models

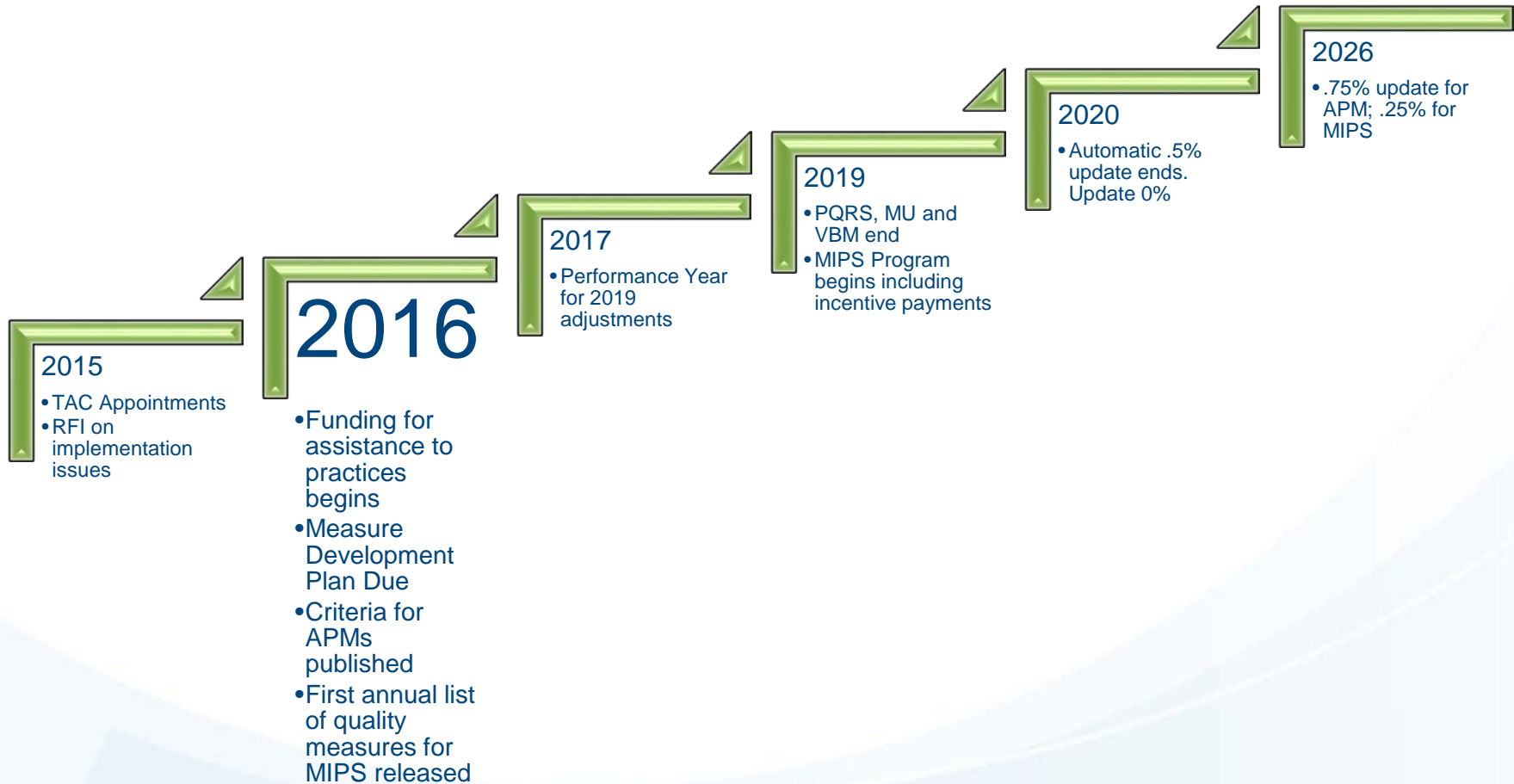
FFS Linked to Quality

All Medicare FFS 100%

MPFS/MACRA PAYMENT ADJUSTMENT MILESTONES



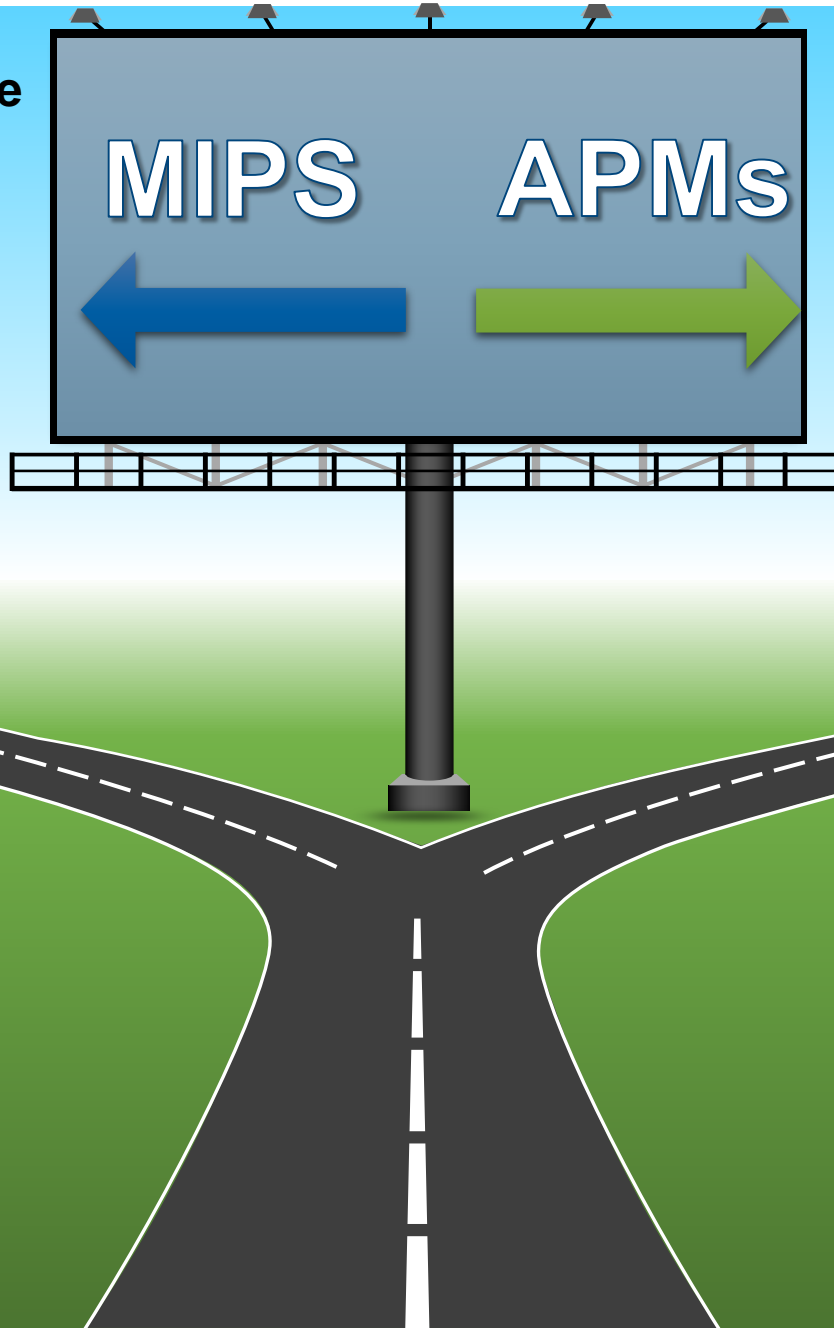
GENERAL TIMELINE



2019 MACRA PAYMENT OPTIONS

Merit Based Incentive Payment System

- Default
- 0-100 Composite Scoring
- PQRS, RU, CPIA, MU
- +/- 4-9% Adjustments



Alternative Payment Models

- New Delivery Models
- Physician Focused Payment Model
- 5% Payment Adjustment
- Quality & Value Measures

MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS)

MIPS: GENERAL STRUCTURE

- **Merit-Based Incentive Payment System**
- **MIPS Eligibility**
- **Scores will be publicly reported on the CMS Physician – Compare website**
- **MIPS consolidates and leverages the MU, PQRS, and VBM programs**
- **The MIPS payment adjustments can be significant**

MERIT-BASED INCENTIVE PAYMENT SYSTEM

- **Measures Medicare Part B providers in four performance categories:**
 - Quality
 - Value Based Modifier
 - Meaningful Use
 - Clinical Practice Improvement
- **Assigns a composite score of 0-100**
- **Score reimbursement impact ranges start at a minimum +/- 4 and increases to at least +/- 9**
- **For the 2015 and 2016 performance years, the VBM, PQRS, and MU programs will continue as separate payment adjustment programs.**

MIPS ELIGIBILITY - PROVIDERS

Years 1 and 2, Eligible Providers include:

- Physicians
- Physician Assistants
- Nurse Practitioners
- Clinical Nurse Specialists
- Nurse Anesthetists

Years 3 and beyond, Eligible Providers include:

- Occupational Therapists
- Speech-language Pathologists
- Audiologists
- Nurse Midwives
- Clinical Social Workers
- Clinical Psychologists
- Dietitians/nutrition professionals

MIPS ELIGIBILITY - EXCLUSIONS

Only three classes of Part B providers are exempt from MIPS:

- APM Participants
- Low patient volume
- First time Medicare providers

MIPS - PUBLIC REPORTING

Scores will be publicly reported on the CMS Physician –Compare website

- Composite score rating reported
- All providers
- Comparison to peers
- Available to consumers

MIPS - EXISTING PROGRAMS

MIPS consolidates and leverages the current MU, PQRS, and VBM programs

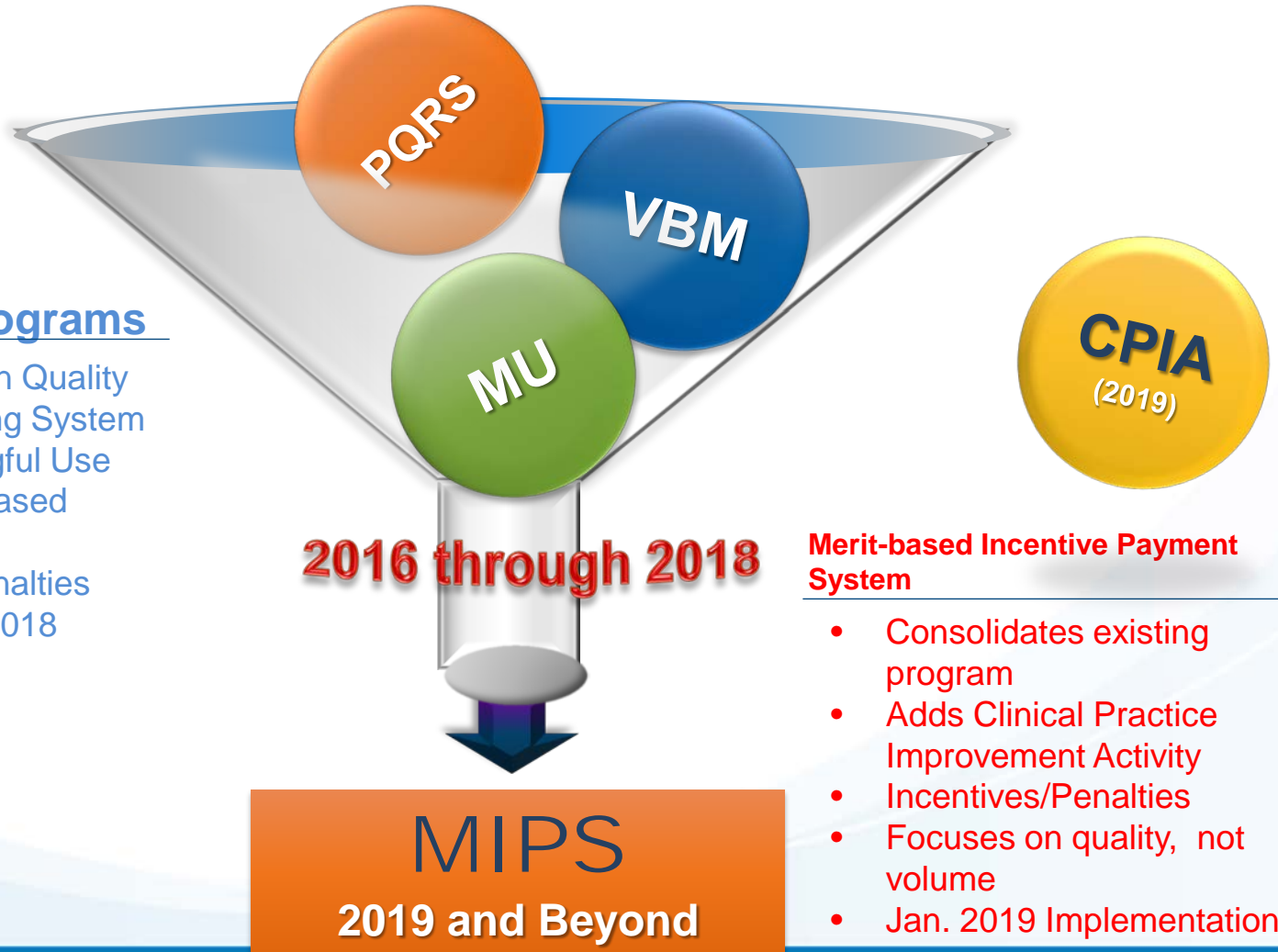
- Medicare MU and PQRS penalties, and
- VBM incentives and penalties
- Maximum of 25 points earned for MU Compliance
- The MIPS quality category score based on:
 - PQRS mandatory quality reporting requirement; and
 - VBM quality score.

MIPS – PAYMENT ADJUSTMENT

The MIPS payment adjustments can be significant

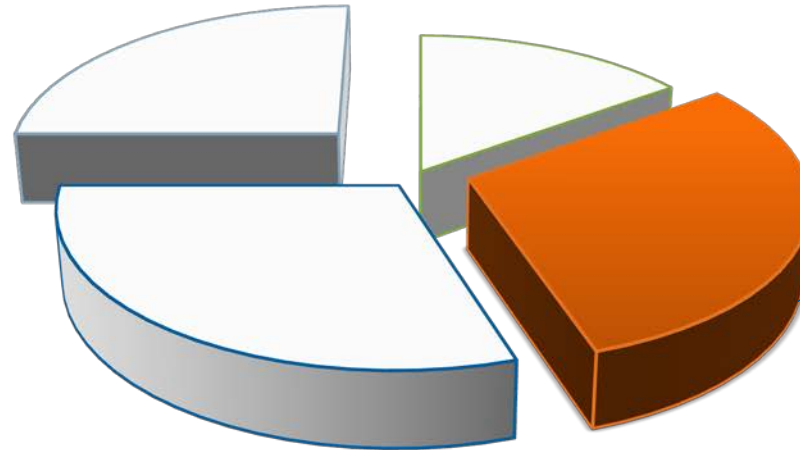
- Score reimbursement impact ranges start at a minimum
 - +/- 4 and increases to at least +/- 9
 - Exceptional performers can receive up to 3x the incentive
- Must be budget neutral
 - Winners and Losers
 - MIPS incentive pool equal to penalty pool

MACRA STREAMLINES CURRENT REPORTING PROCESS



MIPS Composite Score Components

QUALITY



**QUALITY
(PQRS)**
30% of total
score in 2021



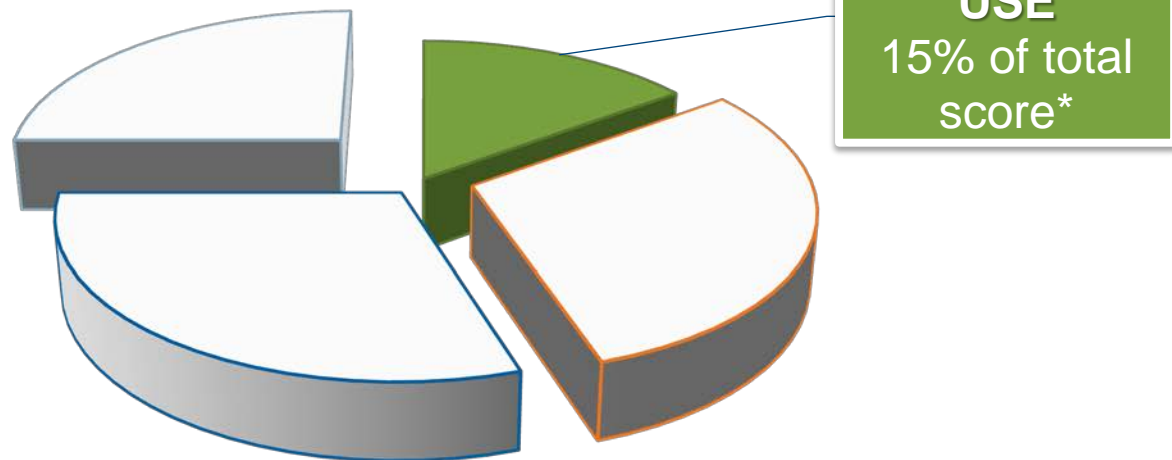
Incentivizes providers for reporting on specific quality measures

- Annual posting of measures every November
- Will be publicly available
- Measures pulled from PQRS, VBM, HER and MU
- Also considers: clinical care, safety, care coordination, patient experience, and population health and prevention
- 2017 PQRS performance assessed for 2019
- Common Rule/QCDR integration determined in 2016

- 2017 PQRS performance assessed for 2019
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MIPS Composite Score Components

MEANINGFUL USE



*Begins at 25% of composite score, will be reduced to 15% based on National Performance



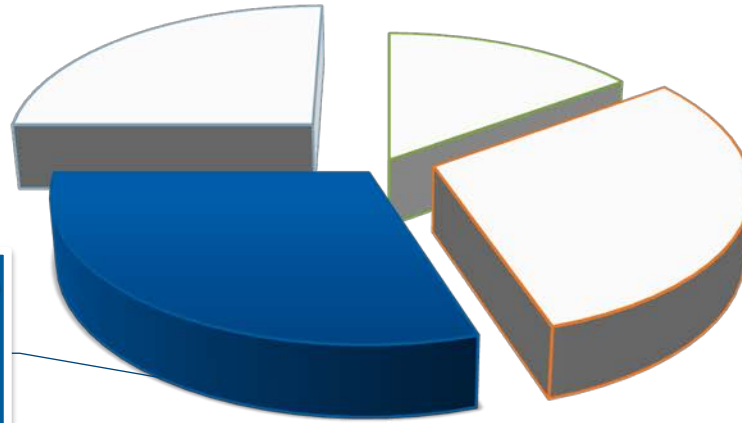
Using EHR to improve quality, safety, efficiency and reduce health disparities.

- Certification standards in 2016 MPFS
- Goal = Interoperability
- 15% credit for reporting quality measures through EHR
- *75% compliance or better will decrease composite weighting

- Jul 2016 goals/metrics for interoperability

MIPS Composite Score Components **RESOURCE USE**

**Resource Use
(VBM)**
30% of total
score in 2021



10% 2019
15% 2020



Measures cost, including Part D drugs.

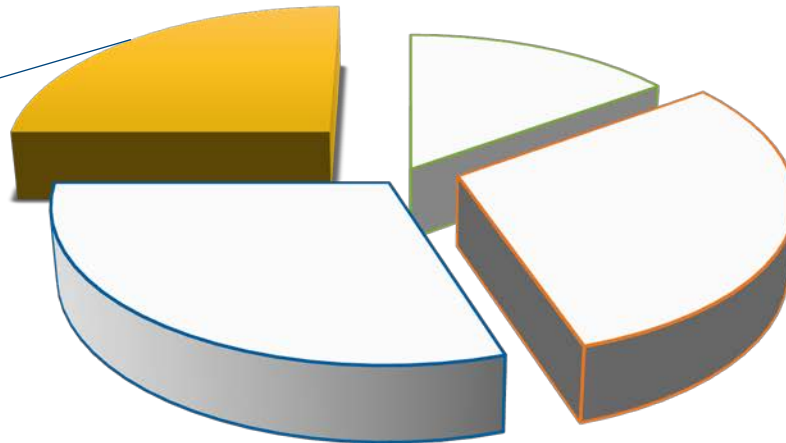
- Considers all Part A&B costs
- Part D drugs, as feasible
- Considers costs for specific care episodes and patient relationships

- Establishment of Care Episodes in 2016
- Establishment of Patient Relationship Categories in 2016
- May also apply to Medicare Advantage
- May consider resource use in other programs (as benchmark)

MIPS Composite Score Components

CLINICAL PRACTICE IMPROVEMENT ACTIVITY

**CLINICAL
PRACTICE
IMPROVEMENT**
25% of total
score

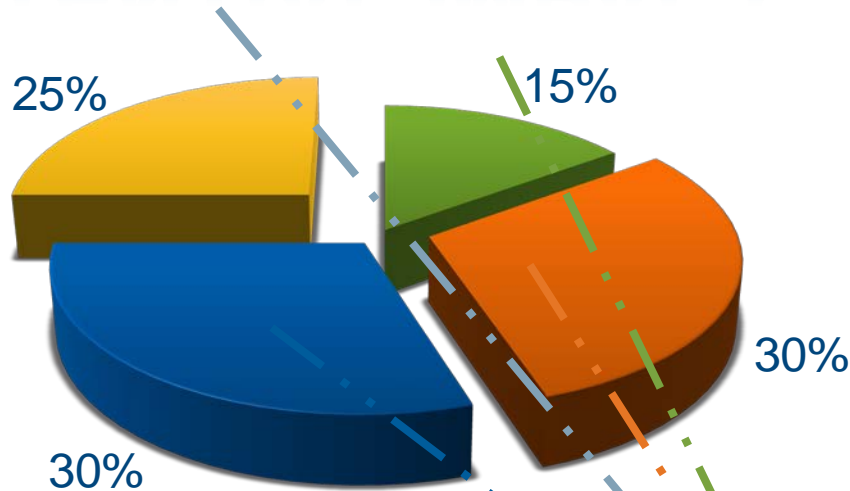


Recognizes activities that contribute to advancing patient care, safety and coordination.

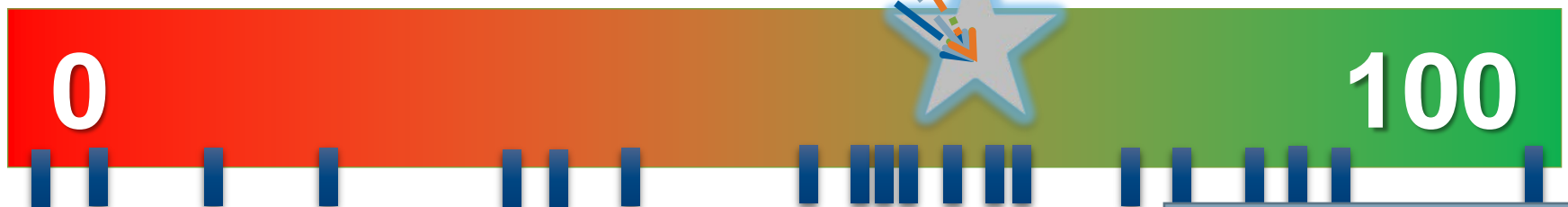
- Expanded practice access
- Population management
- Care coordination
- Beneficiary engagement
- Patient safety
- Participation in APMs
- Participation in QCDR

- Development of categories in 2016
- Stakeholder input includes specialty providers

MIPS COMPOSITE – POTENTIAL IMPACT



- Meaningful Use
- PQRs (Quality)
- Resource Use (Cost)
- Clinical Practice Improvement Activity



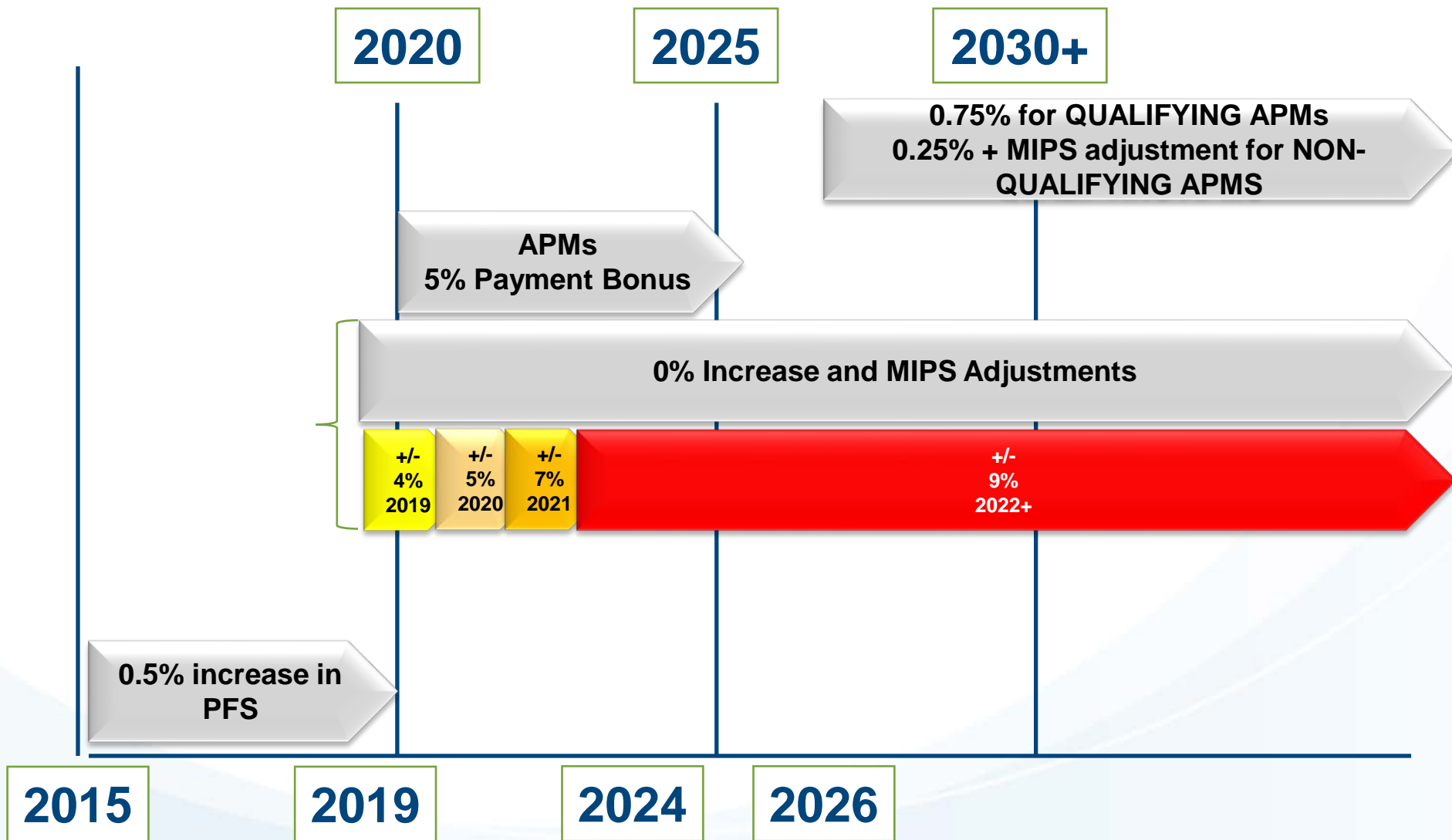
Low Performers -9%

High Performers +9%

Top Performers +27%

- ★ National Median Composite Score
- Medicare Provider Composite Score

MIPS PAYMENT ADJUSTMENT MILESTONES



ALTERNATIVE PAYMENT MODELS (APMS)

WHAT IS AN APM UNDER MACRA?

EXISTING MODELS

- New approaches to paying for care
- Incentivizes quality and value
- Some existing models will be eligible APMs
- Non-qualifying APM participants get favorable MIPS scoring

Accountable Care Organizations

Primary Care & Specialty Medical Home Models

Bundled Payment Initiatives

Integrated Care & Care Management

NEW PATHWAY AVAILABLE

Accountable Care Organizations

Primary Care & Medical Home Models

Bundled Payment Initiatives

Integrated Care & Care Management

**PHYSICIAN FOCUSED
PAYMENT MODELS (PFPM)**

NEW

PFPM - STATUTORY REQUIREMENTS

- Quality measures
- Certified EHR
- “more than nominal financial risk” *
- Includes financial incentives (e.g., shared savings)

**CMS designated patient centered medical homes qualify without risk*

PFPM - PROCESS

- By November 1, 2016: Secretary must release criteria for qualifying APM, including specialty APMs
- Stakeholders can submit proposals
- “Physician Focused Payment Model Technical Advisory Committee” reviews and advises Secretary (11 member committee, no more than 5 physicians)
- Secretary will respond publicly to requests

HOW TO QUALIFY

APMS – ELIGIBILITY QUALIFYING PARTICIPANTS

Qualifying APM Participant (QP): participation in most advanced APM

- Not subject to MIPS
- 2019 – 2014: 5% lump sum bonus payment
- 2026 – beyond: higher fee schedule updated

NOT ALL APM PARTICIPANTS
RECOGNIZED AS QPS, but most APM participants
will receive favorable MIPS scoring.

APMS – ELIGIBILITY ADVANCED MODELS

Eligible APMs are the most advanced APMs:

- 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) is a medical home model expanded under CMMI authority

APMS – ELIGIBILITY

QPS IN ELIGIBLE APMS

- Participation in an eligible APM
- APM must comprise a “significant” share of provider revenue or patients
 - 25% 2019-2020
 - 50% 2021-2022*
 - 75% 2023 and on
- * Beginning in 2021 may be Medicare revenue or revenue from Medicare and other payers (including Medicaid)
- Can partially qualify if close (specified in law)

QUALIFYING APMS - INCENTIVE PAYMENT

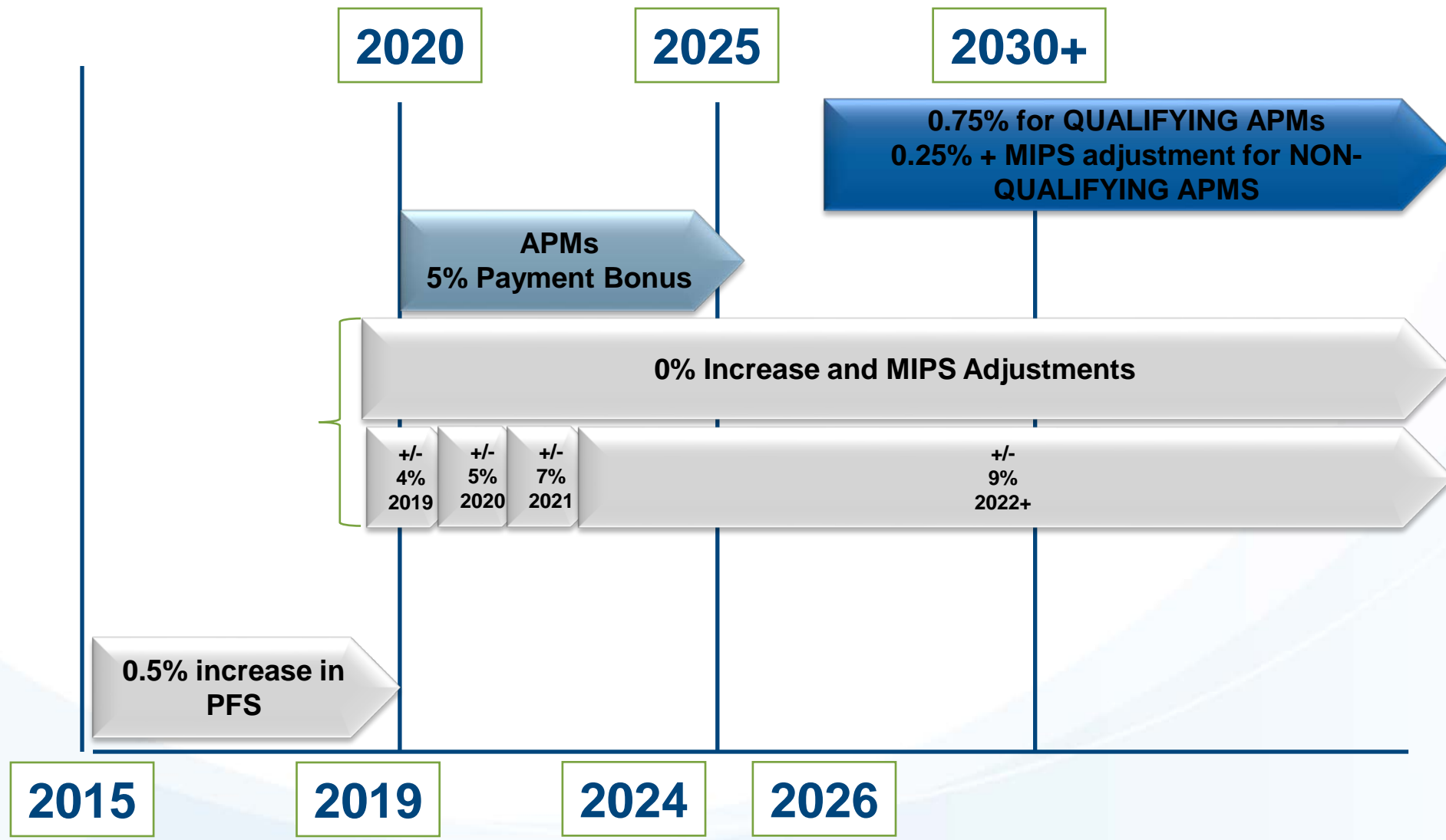
➤ 2019-2024: 5%

- Annual payment
- Based on estimate of aggregate Part B professional services
- Can extrapolate

➤ 2026 and beyond: 0.75%

** Participation in an APM can help with composite score for MIPS professional*

APM PAYMENT ADJUSTMENT MILESTONES



APMS - TECHNICAL ASSISTANCE

- Beginning 2016 contract with QIOs or similar organizations
- \$20 million/year from 2016-2020
- Practices of under 15 or less
- Focused on practices in rural or underserved areas or with low composite scores

POTENTIAL MACRA REWARDS

MIPS Only

- MIPS adjustment

APMs

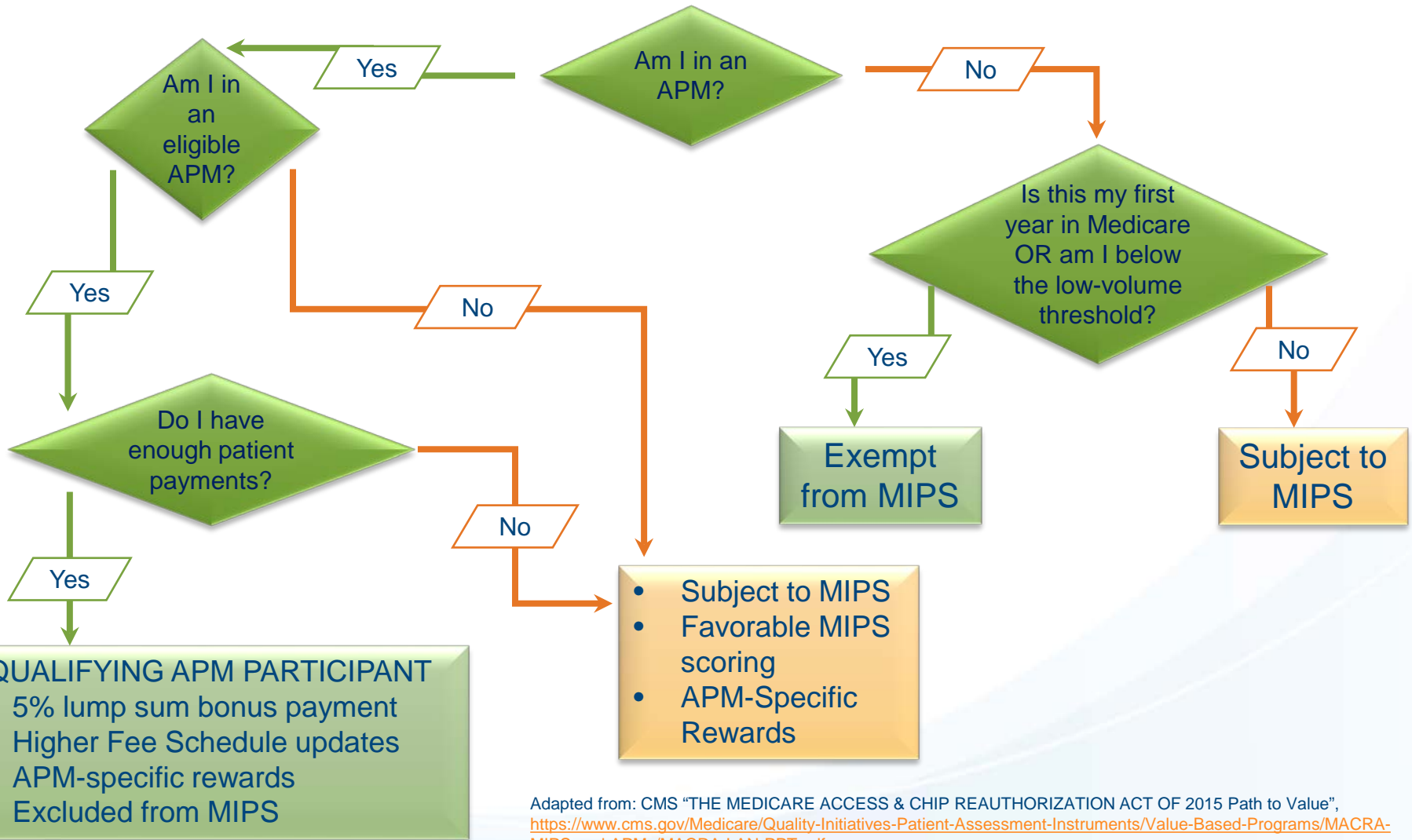
- APM- Specific Rewards
- MIPS Adjustment

Eligible APMs

- Eligible APM- Specific rewards
- 5% lump sum bonus

Adapted from: CMS "THE MEDICARE ACCESS & CHIP REAUTHORIZATION ACT OF 2015 Path to Value", <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/MACRA-LAN-PPT.pdf>

HOW WILL MACRA AFFECT ME?



Adapted from: CMS "THE MEDICARE ACCESS & CHIP REAUTHORIZATION ACT OF 2015 Path to Value", <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/MACRA-LAN-PPT.pdf>

IMPLEMENTING RULES:

CMS seeking Input:

- ✓ 2016 Medicare Physician Fee Schedule
- ✓ Request for Information
- Resource Use Methodology
- Physician Focused Payment Model Technical Advisory Committee
- ✓ HCPLAN APM Framework Whitepaper
- Quality Measure Development Plan
- Meaningful Use EHR Certification Standards
- 2016 – 2018 Rulemaking on various programmatic aspects

Stay Tuned...More Implementing Rules Still to be Written

MACRA SUMMARY:

MACRA makes three important changes to how Medicare pays healthcare providers who care for Medicare beneficiaries:

- **Repeals the Sustainable Growth Rate (SGR) formula as a mechanism for determining Medicare payments for physicians' services**
- **Establishes two payment options**
 - MIPS
 - APM
- **Incentivizes practice transformation**

2015

- **April 16, 2015:** *The Medicare Access and CHIP Reauthorization Act of 2015* (MACRA) signed into law, permanently repealing the flawed Sustainable Growth Rate (SGR)
- **July 2015-December 2019:** 0.5 percent annual adjustment for providers
- **2015:** Members will be appointed to the Physician-Focused Payment Model Technical Advisory Committee, which evaluates alternative payment Models (APMs) and makes recommendations to CMS
- **2015-2018:** Separate programs and penalties will continue under PQRS, MU and VBM
- **2015 and Beyond:** Annual public release on physician services, charges and payments. Starting in 2016 this will be integrated into 'Physician Compare'

2016

- **July 2016:** A list of MIPS Quality measures for the 2017 performance period will be proposed
- **November 1, 2016:** CMS to set criteria for physician-focused payment models
- **November 1, 2016 and Beyond:** APM proposals will be accepted on a rolling basis
- **November 1, 2016 and Beyond:** MIPS Quality measures due each November 1 for the next performance period

2017

- **January 1, 2017:** The beginning of the performance baseline period for MIPS reporting and scoring, which will determine 2019 payment adjustments. Physicians must begin MIPS reporting or be participating in a qualified Alternative Payment Model (APM)

2018

- **December 1, 2018:** Each eligible professional (EP) must be informed annually of the MIPS adjustment factor(s) at least 30 days in advance
- **December 31, 2018:** Sunset of PQRS, MU, and VBMs as separate penalties and incentives programs
- **December 31, 2018 :** Deadline for achieving interoperability

2019

- **January 1, 2019:** The MIPS program takes effect, consolidating PQRS, MU, and the VBM. MIPS bonuses and penalties begin to apply to payments for physician services and will be phased in
 - 2019-2024: a 5% bonus to “qualifying APM participants will be applied based on varying criteria throughout the years
- **2019 and Beyond:** composite MIPS scores fully phased in : quality 30%, resource use 30%, meaningful use 25% and clinical practice improvement activities 15%; though these weights may change over time

2020

- **2020:** Maximum penalties for MIPS will be 5% with the highest MIPS bonuses between 5-15%, with additional bonuses up to 10% for ‘exceptional performance’
- **2020-2025:** Annual 0.5% update ends and replaced with annual update of 0%

2021

- **2021:** Maximum penalties for MIPS will be 7% with the highest MIPS bonuses between 7-21%, additional bonuses up to 10% for ‘exceptional performance’

2022+

- **2022 and Beyond:** Maximum penalties for MIPS will be 9% with the highest MIPS bonuses between 9-27%, with additional bonuses up to 10% for ‘exceptional performance’

2026+

- **2026 and Beyond:** Updates for participation in qualifying APMs will be 0.75% and 0.25% for all other APMs

START PREPARING NOW

- MACRA will transform all oncology practices in two major ways:
 - how you conduct your Medicare reporting requirements, and
 - how you are paid for the services you provide to Medicare beneficiaries
- The ultimate goal of these changes is to move toward a value-based healthcare system that ensures high-quality, affordable health care.
- ASCO has long embraced this goal and has dedicated significant resources that will provide you with the foundation needed
 - Quality Oncology Practice Initiative (QOPI®); and
 - Patient-Centered Oncology Payment Reform model

ASCO STRATEGY FOR MACRA IMPLEMENTATION

QOPI, CancerLinQ and PCOP will be ASCO's best offering to ensure member success.

- Education and Awareness for ASCO Members
- Practice Transformation/Readiness
- Aggressive Pursuit of Interoperability and Robust Rapid Learning Environment for Oncology

THE BOTTOM LINE...

- ASCO is uniquely positioned compared to other specialty organizations
- Decisions and actions regarding MACRA must reflect ASCO's vision and current goals and policy priorities
- ASCO must be vigilant throughout and be involved at every level of implementation

RESOURCES

For the latest MACRA developments,
please visit:

www.asco.org/macra

WEBINAR FEEDBACK

A survey will be sent to registered attendees following the webinar today to obtain feedback

<https://www.surveymonkey.com/r/VZQ3MKR>

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