MACRA:

The Changing Nature of Medicare Reimbursement

Jim Price, Bob Cameron, and Rachel Gillis

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Purpose of Document

CMS has been steadily implementing new payment models. Individually, these models can seem immaterial. However, the newest models, driven by the new MACRA law, will dramatically accelerate the drive towards “value-based reimbursement.” This document provides an overview of the existing and planned models that will drive important changes in the delivery of healthcare.

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I. Overview of MACRA

- On April 26, 2015, the Medicare Access and CHIP Authorization Act (MACRA) was signed into law.
- **MACRA replaces the Sustainable Growth Rate** (SGR) formula in favor of a new system publicized as "promoting quality over quantity". In the past, the SGR tied Medicare physician spending to GDP growth. This approach had little to do with quality and was unsustainable.
- MACRA forces physician practices to travel one **of two tracks**:
  - **Alternative Payment Models (APMs)**

    -OR-
  - **Merit-Based Incentive Payment System (MIPS)**
- Physicians who do not qualify for the APM track will be automatically assigned into the MIPS track.
  - APMs are generally "safer" in that there is no risk of rate declines
  - MIPS is designed to be budget neutral; significant reimbursement variance across providers likely. Some will gain large increases while others will see significant rate declines.
- **Fee-for-service reimbursement rates will increase 0.5% annually for 2016-19.**
- APMs and MIPS govern 2019 physician reimbursement based on 2018 APM qualification and MIPS score (respectively). There will be **no annual rate increases from 2020 through 2025**.
- This timeline drives the need to make key strategic decisions quickly:
  - APM or MIPS track?
  - Employed physician compensation?
  - Independent physician strategy?
  - Infrastructure needs & development options?

Sources: http://www.healthlawpolicymatters.com/2015/04/20/with-sgr-repealed-replacement-policy-creates-new-priorities/
https://www.cms.gov/newsroom/mediareleasedatabase/fact-sheets/2015-fact-sheets-items/2015-07-08.html

II. Merit-Based Incentive Payment System (MIPS)

- MIPS will assess providers and score them out of 100 possible points based on:
  - Quality: PQRS measures (30%)
  - Resource Use: cost measures (30%)
  - EHR Use: meaningful use measures (25%)
  - Clinical Improvement: care coordination, patient satisfaction, access measures (15%)

- MIPS will draw data from 3 legacy programs:
  - 1. Physician Quality Reporting System (PQRS)
  - 2. Value-Based Modifier (VBM)
  - 3. Meaningful Use for EHRs

- Details on clinical improvement data are not yet available.

Sources: http://www.healthlawpolicymatters.com/2015/04/20/with-sgr-repealed-replacement-policy-creates-new-priorities/
https://www.cms.gov/newsroom/mediareleasedatabase/fact-sheets/2015-fact-sheets-items/2015-07-08.html

II. MIPS' Potential Impact on Physician Reimbursement

	2019	2020	2021	2022-2025
Above Performance Threshold: **Maximum Bonus***	**4%**	**5%**	**7%**	**9%**
At Performance Threshold	**0%**	**0%**	**0%**	**0%**
Below Performance Threshold: **Maximum Penalty**	**-4%**	**-5%**	**-7%**	**-9%**

**There is a possibilty for the very top performers to receive a bonus up to 3 times the stated amount for each year; however the math is unclear.*

Note: All bonuses and penalties are distributed on a linear sliding scale based on a physician's score in relation to the performance threshold

Sources: http://www.healthlawpolicymatters.com/2015/04/20/with-sgr-repealed-replacement-policy-creates-new-priorities/
http://www.aafp.org/practice-management/payment/medicare-payment/faq.html
http://www.saignite.com/resources/faq-about-merit-based-incentive-payment-mips
http://www.ahqa.org/sites/default/files/images/Understanding%20MACRA.pdf

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III. Alternative Payment Methods (APMs)

- Physicians have the opportunity to pursue APMs instead of MIPS.
  - Note: Participating in APMs may exempt physicians from having to meet most meaningful use requirements.
- Currently 3 APMs have been identified:
  - Accountable Care Organization / Medicare Shared Savings Program *
  - Medical Home Models, including Comprehensive Primary Care ("CPC").**
  - Bundled Payment Models.
- CMS Innovation Center is developing new APMs relevant for specialists, smaller practices, and practices that have similar type payment arrangements with private and / or state-based payers.
- For each qualified professional participating in APMs, there will be an annual **5% bonus** (based on total prior year Medicare reimbursement)
  - Bonus is in addition to any payment rate updates or any extra revenue the physician may realize from the APM's results.

*** In its draft ruling on May 9, 2016, CMS excluded Track 1 MSSPs from being counted as an APM**

**** The draft ruling adds Comprehensive Primary Care Plus (CPC+) to this list**

Sources: http://www.healthlawpolicymatters.com/2015/04/20/with-sgr-repealed-replacement-policy-creates-new-priorities/
http://www.aafp.org/practice-management/payment/medicare-payment/faq.html

III. APM Bonus Eligibility

- Physician practices must pass threshold requirements to qualify for APM participation:
  - In 2019 & 2020 at least **25%** of Medicare patients or revenues must have been covered by an APM (in 2018 & 2019 respectively)
  - This increases to **50%** for 2021 - 2022 and **75%** for 2023+
  - Thresholds are based on previous year (2019 payment is based on 2018 performance)
- In 2021 & 2022, a second "all payer" option is available to qualify for APM participation. 25% of Medicare patients or revenues must come from APMs and at least 50% of the practice's total patients or revenue (including Medicare) must come from models similar to an APM.
  - The overall practice threshold increases to **75%** in 2023 & 2024.
- A physician is also required to use a certified EHR, have quality measures in place and "bear more than nominal financial risk."

Sources: http://www.aao.org/Assets/19299be0-4a11-4f8a-810c-5f930fa91a40/635743054912800000/macra-apm-overview-pdf?inline=1

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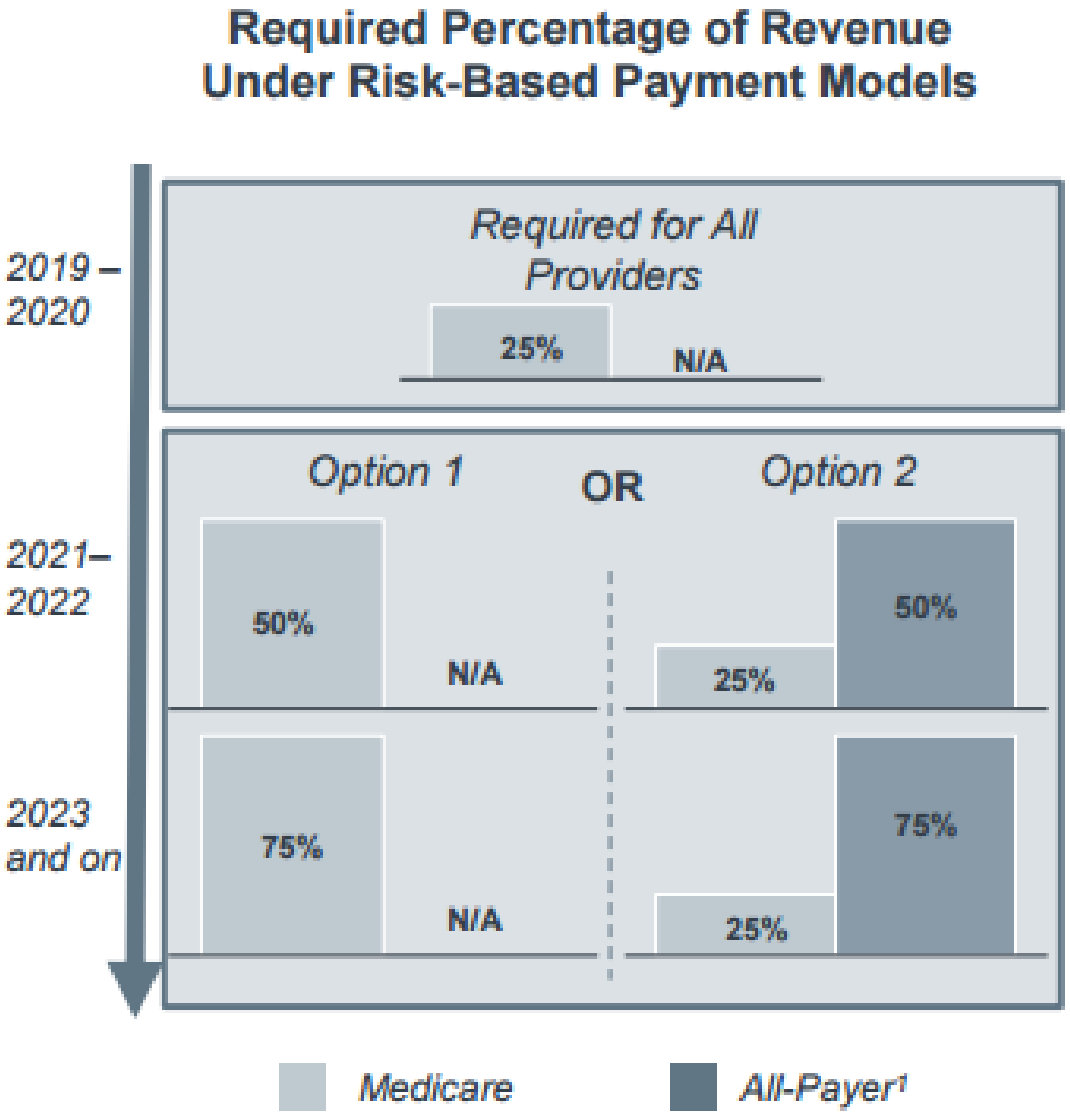
III. APM Bonus Qualification Chart



Sources: http://www.gpo.gov/fdsys/pkg/BILLS-114hr2enr/pdf/BILLS-114hr2enr.pdf

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III.A ACO (MSSP)

- 20 Pioneer ACOs ("PACO") combined for $120 million in total savings:
  - 11 of 20 PACOs earned $82 million in shared saving bonuses.
  - 6 PACOs generated savings insufficient to trigger bonus.
  - 3 PACOs owe CMS $9 million in shared loss reimbursement.

- 333 Medicare Shared Savings Plans ("MSSP") covered 7.3 million beneficiaries in 2014 and combined for $291 million in total savings:
  - 92 MSSPs saved $806 million and earned $341 in shared savings bonuses.
  - 89 MSSPs generated savings insufficient to trigger bonus.
  - 152 MSSPs had expenditures above their benchmark.

- April 2016: 433 MSSPs with 7.7 million enrollees

Source: CMS Report August 25, 2015
https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/All-Starts-MSSP-ACO.pdf

Observations

- Though hard, success begets success. ACOs earning a payout in year 1 all earned a bonus in year 2.
- Size need not be a limiting factor. The top 11 highest per beneficiary savings accrued to ACOS with less than 10,000 members.
- Quality matters and gets harder. Sub-perfect / unreported quality scores cost ACOs $54 million. Year 2 gains in quality scores slowed from year 1 results.
- While savings are debatable, ACOs are not going away any time soon:
  - CMS introducing “Next Generation ACO” & “Track 3 MSSP”.
  - CMS stated goal is to “have 50% of payments covered by an alternative payment model such as ACO or bundled payments.”
- Upfront and ongoing costs can be considerable and will offset bonuses; cost-effective approaches to population health management are available.

III.B Bundled Payments for Care Improvements (BPCI)

Old Model

- Traditionally, Medicare makes separate payments to providers for each service they perform for beneficiaries during a course of treatment
- This approach can lead to "fragmented care with minimal coordination across providers and health care settings"
- The old model rewards a provider for the quantity of services they provide, but not always the quality of care furnished

New Model

- Medicare is moving towards linking payments for the multiple services beneficiaries receive during an episode of care.
- Organizations enter into payment arrangements that include financial and performance accountability.
- This model may lead to higher quality and more coordinated care at a lower cost to Medicare
- Research has shown that "bundled payments can align incentives for providers… allowing them to work closely together across all specialties and settings"

CMS' Goal: "By focusing on outcomes, rather than separate procedures in care delivery, we are incentivizing providers to work together to provide high quality, coordinated care for patients."

Source: https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-08-13-2.html

III.B BPCI Today

- 3 models were made available for voluntary participation beginning in 2013:
  - Year 1 focused on gathering data and establishing performance baseline.
  - Year 2 (October 2013) began “at risk” payment period.
  - Payment model guarantees CMS a 3% savings over baseline FFS expenditures. Providers keep any additional savings.
  - Orthopedics (non-spine) represented 40% of clinical episodes.
- First evaluation done by Lewin Group focused on orthopedic clinical episodes in February 2015; for Model 2 it showed:
  - Decline in the surgical inpatient length of stay from 4.6 days to 4.3 days.
  - 29% decrease in use of institutional post acute care providers.
  - Increase in use of home health days.
  - Total average costs decreased from $37,275 to $32,369.
  - No change in mortality rates.
  - Readmission rate declined from 8.6% to 6.7%.
  - ER visit rate (without inpatient admission) increased from 6.9% to 8.7%.
- The Comprehensive Join Replacement (CJR) program was made mandatory for many metropolitan areas in July, 2015 (year 1 effective date April 1, 2016 with downside risk starting on January 1, 2017).

Sources: http://www.forbes.com/sites/brucejapsen/2015/08/21/even-when-voluntary-medicare-bundled-payment-gains-provider-favor/
https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2015-Press-releases-items/2015-08-13.html

Potential BCPI Expansion

BPCI Conditions by Specialty

	Medical	Surgical	Total
Cardiovascular	**7**	**8**	**15**
Musculoskeletal	**4**	**14**	**18**
Neuro	3	5	8
Orthopedic	1	9	10
Medical specialties (other))	**12**		**12**
Endocrinology	2		2
Gastroenterology	3		3
Hematology	1		1
Infectious Disease	2		2
Nephrology	1		1
Pulmonology	3		3
Surgical specialties	**1**	**2**	**3**
General surgery		2	2
Urology (for UTI?)	1		1
Total	24	24	48

III.B Bundled Payments

Source: Centers for Medicare and Medicaid Services. (2011). Contracting for Bundled Payment. Washington, DC.

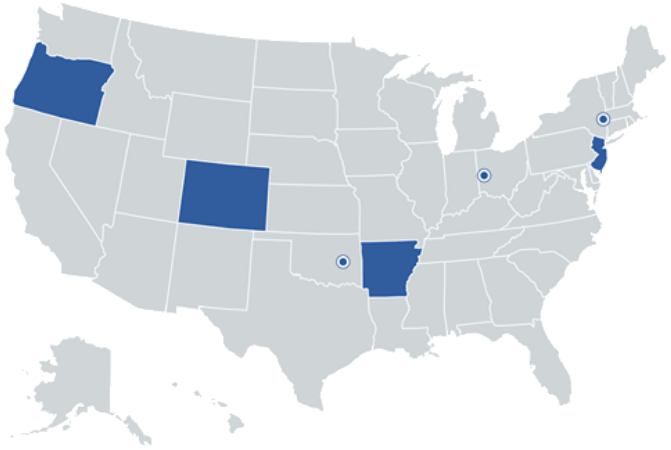
Management & Operations – Key Considerations

- **Clinical**: Who is leading care process redesign?
- **Partners**: Will all SNFs participate? What about home health?
- **Financial**: What is the proper financial model for physicians?
  Accounting: Who/how will key data be collected?
- **Performance:** How will results be tracked by the hospital?

III.C Comprehensive Primary Care (CPC)

- Details of Medical Home criteria for APM are being developed.
- Will likely draw from the Comprehensive Primary Care ("CPC") pilot program.

500 CPC Practices Cover 313,000 Beneficiaries in 7 Regions



$20 PMPM Covers 5 Core CPC Functions

1. Risk Stratified Care Management
2. Access & Continuity
3. Planned Chronic & Preventative Care
4. Patient / Provider Engagement
5. Coordination of Care Across the Medical Neighborhood

Source: https://innovation.cms.gov/initiatives/comprehensive-primary-care-initiative/

III.C CPC+ Details

CMS.gov
Centers for Medicare & Medicaid Services

2016-04-11

CMS launches largest-ever multi-payer initiative to improve primary care in America: Comprehensive Primary Care Plus (CPC+)

1. Alternative Payment Model "CPC +" details released
2. Expansion & modification of "comprehensive primary care" pilot:
   - Begins 1/1/17 and ends 12/31/21
   - Up to 20 regions, 5,000 practices, 20,000 providers & 25 million people
3. Multi-payer model, not just Medicare
4. Two step qualifying process:
   - Payers submit application by June 15th and awards issued in July
   - Providers apply from July 15th through September 1st
5. Two "tracks" available:
   - Both tracks include case management fees, FFS visits and bonus
   - Track 2 includes upfront partial payment for projected E&M revenue
6. Precludes ACO participation & billing for Chronic Care Management ("CCM")

Source: https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2016-Press-releases-items/2016-04-11.html

III.C CPC+ Objectives

The CPC+ model will benefit patients by helping primary care practices:

- Support patients with serious or chronic diseases to achieve their health goals
- Give patients 24-hour access to care and health information
- Deliver preventive care
- Engage patients and their families in their own care
- Work together with hospitals and other clinicians, including specialists, to provide better coordinated care

Source: https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2016-Press-releases-items/2016-04-11.html

While slightly re-worded, the goals are essentially the same as those in the original CPC pilot. Some of the goals also overlap with the functional requirements of Chronic Care Management (CCM; CPT 99490).

Who is not eligible for CPC+?:

- Providers in Medical Shared Savings Plan
- Providers billing for CCM.

IV. Key Conclusions

- The time to make decisions is now:
  - Best Case: 2016 and the 2nd half of 2017 can be used to "fine tune" your performance and allow you to establish a solid performance baseline in 2018.
  - Worst case: If CMS follows PQRS roadmap, 2017 data will be analyzed in 2018 and used to set MIPS reimbursement rates for 2019… This makes 2016 a critical year to preserve rates.
- Bundled payments work, aren't going away and will likely expand rapidly.
- Production-driven physician compensation models will soon be outdated.
- A large majority of physicians are (and want to remain) independent, but may not survive payment reforms:
  - What is your approach going to entail?
- Advanced infrastructure is needed, but does not have to be expensive and can even pay for itself.