Are you ready for MACRA?
Transformative law final rule published
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Orlando, FL

Do you know what MACRA stands for??
What we'll cover today

- Summary of MACRA
- Updates from the just-released Final Rule
- Strategic impact of MACRA
- How to prepare
- Q&A
CMS overall quality strategy

**Better Care** + **Smarter Spending** + **Healthier People**

**Bold moves**

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:** 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:** Medicare fee-for-service payments are tied to quality or value (categories 2-4) by the end of 2015, and 99% by the end of 2018.
Permanent replacement of SGR

- 17 “fixes” to Sustainable Growth Rate by Congress
- Affordable Care Act mandates introduction of “value” to reimbursement
- Two tracks: MIPS & AAPMs
- 2,398 pages in the Final Rule!!!
- Just beginning to sift through the jungle
Integrates three formerly separate programs

- Physician Quality Reporting System (PQRS)
- Physician Value-based Payment Modifier (VM)
- Medicare Electronic Health Record (EHR) Incentive Programs

Four pillars of MIPS

- Quality: Clinical practice improvement (now called “Improvement Activities”)
- Merit: Meaningful use of certified electronic health records (now called “Advancing Care Information”)
- Resource use (aka “Cost”):
CY 2017 is the “transition year”; CY 2019 starts the performance period

**Pick your pace of participation**

- Simply report a minimum number of measures (1 from each of the 3 categories)
  - No penalty, but no upside available

- Report more than one measure from each category for a continuous 90 days
  - No penalty, small upside

- Submit data for all of 2017, 90-day period
  - Moderate positive payment adjustment

Or and one more . . . Do nothing and take a -4.0% hit

**Transition Year**

- Cost (value modifier) will have zero weight

- **“Full participation”**
  - Quality = report 6 quality measures or 1 specialty-specific measure set
  - Advancing Care = 5 required measures
    - Security, e-prescribe, patient access, summary of care
  - Improvement Activities = 4 activities, down from 6 in proposed (40 points)
Exclusions to MIPS

- CMS estimates nearly half of physicians will be excluded
  - Those excluded from MACRA via its exclusion criteria
  - Small practices with less than $30,000 in Medicare revenue, 100 patients
- Collectively excluded providers represent ~25% of total Part B charges

During the transition

<table>
<thead>
<tr>
<th>Year</th>
<th>Value Modifier</th>
<th>Meaningful Use</th>
<th>PQRS</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015</td>
<td>1%</td>
<td>1%</td>
<td>1.50%</td>
</tr>
<tr>
<td>2016</td>
<td>3.5%</td>
<td>6%</td>
<td>2%</td>
</tr>
<tr>
<td>2017</td>
<td>4%</td>
<td>9%</td>
<td>2%</td>
</tr>
</tbody>
</table>
## How Much Payment Is At Risk?

### Potential Reductions

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare EHR Incentives</td>
<td>-1.0% or -2.0%</td>
<td>-2.0%</td>
<td>-3.0%</td>
<td>Up to 4.0%</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>PQRS</td>
<td>-1.5%</td>
<td>-2.0%</td>
<td>-2.0%</td>
<td>-2.0%</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Value-Modifier (Max reduction)⁹</td>
<td>-1.0%</td>
<td>-2.0%</td>
<td>-4.0%</td>
<td>-4.0%</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>MIPS</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>4.0%</td>
<td>-5.0%</td>
<td>-7.0%</td>
</tr>
<tr>
<td><strong>Total Possible Reduction</strong></td>
<td><strong>-4.5%</strong></td>
<td><strong>-6%</strong></td>
<td><strong>-9%</strong></td>
<td><strong>-10%</strong></td>
<td><strong>-4%</strong></td>
<td><strong>-5%</strong></td>
<td><strong>-7%</strong></td>
<td><strong>-9%</strong></td>
</tr>
</tbody>
</table>

Considering inflation, these could be a 30% reduction over 10 yrs.

## Transition to MACRA

### Changing quality / cost mix

<table>
<thead>
<tr>
<th>Year</th>
<th>Quality</th>
<th>Cost</th>
<th>Advancing Care</th>
<th>Improvement Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>2019</td>
<td>25%</td>
<td>60%</td>
<td>15%</td>
<td>15%</td>
</tr>
<tr>
<td>2020</td>
<td>25%</td>
<td>45%</td>
<td>15%</td>
<td>15%</td>
</tr>
<tr>
<td>2021</td>
<td>30%</td>
<td>30%</td>
<td>-4%</td>
<td>-5%</td>
</tr>
<tr>
<td>2022+</td>
<td>30%</td>
<td>30%</td>
<td>-4%</td>
<td>-5%</td>
</tr>
</tbody>
</table>

*Reward Potential* | *Penalty Risk*

$500 million in “exceptional performance” bonus available for 2019 – 2024. Can earn 3 x upside reward.
Scoring
Aggregate of 4 (3 in year one) categories will create a score up to 100 points

Risk
Payment adjustment will be relative to peer scoring

Zero Sum Game
Budget neutrality

Performance Threshold
Physicians placed in one of three categories based on performance relative to peer threshold; threshold established prospectively based on the mean or median of the composite performance scores during prior period

Quality, 60%
Cost, 0%
Advancing Care, 25%
Improvement Activities, 15%

Year 1 MIPS Composite

Core measures in the following sets
- Cardiology
- Gastroenterology
- HIV and Hepatitis C
- Medical Oncology
- Obstetrics and Gynecology
- Orthopedics
Year 1 MIPS Composite

Improvement Activities
- Expanded practice access
- Population management
- Care Coordination
- Engagement and practice assessment
- APM participation

Patient Centered Specialty Practice (max score)

MACRA

MIPS

AAPMs
Advanced Alternative Payment Models (APMs)

1. 5% “bonus” incentive beginning in 2019
   - Continued positive payment updates
   - Compared to 0% for MIPS with downside risk

2. Participation provides “get out jail” from MIPS
   - 20% of revenue; 25% of patients

3. Ability to create new models in the future

Qualifying AAPMs

- Limited to those created by CMMI
- Require use of certified EHR
- Link payment to quality
- Bear more than “nominal risk”
- AMI & CABG Bundles qualify!!

In the Final Rule, CMS is trying to make participation in an Advanced APM more attainable
- Medicare ACO Track 1+
- Reopening APM participation
- Loosening “qualified providers”
“So with all the unknowns and choices, what do you do now??”

1. Align Your Resources
Asking the alignment questions

- Do we have an effective governance structure?
  - Authority, responsibility, accountability
- Does it include physicians & administrators?
  - Dyad leadership
  - Front line constituents
- Is there broad constituent participation?
- Is it aligned around the patient or departments?
- Is there a governance link between ambulatory & hospital?

Sample governance structure
Economic alignment

- Does physician compensation include value (non-production) measures?
- Is it meaningful?
- Do the measures drive organizational objectives?
- Is there accountability amongst physicians?

2. Know your numbers

QRUR
- Panel size
- Cost per beneficiary
- Physician Compare
- Hospital Compare
- MedAxcess
**Cost Per Capita**

**Exhibit 4. Total Per Capita Costs for All Your Medicare Patients, 2011**

<table>
<thead>
<tr>
<th>Total for Whom Physician Filed Any Claim</th>
<th>Total Per Capita Costs for Your Patients</th>
<th>Per Capita Costs for Medicare Patients of Physicians in Your Specialty in the Nine States</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total for Whom Physician Filed Any Claim</td>
<td>$21,256</td>
<td>$19,086</td>
</tr>
<tr>
<td>Patients Whose Care Physician Directed</td>
<td>$11,789</td>
<td>$10,159</td>
</tr>
<tr>
<td>Patients Whose Care Physician Influenced</td>
<td>$10,399</td>
<td>$9,359</td>
</tr>
<tr>
<td>Patients To Whose Care Physician Contributed</td>
<td>$21,835</td>
<td>$20,338</td>
</tr>
</tbody>
</table>
Internal Data

- Can you identify the actual cost to provide services?
  - Practice
  - Hospital
- Are you able to measure differences at the provider level?
- How have you performed on today's value measures?
  - VBP, RRP
  - PQRS, MU, VM
- Is your classification correct?
- Understand gaps in your longitudinal care (SNF, home, etc)

Someone needs to own this!!

When hiring new docs, check their numbers!
(They become your numbers)

Quick status check

- Run the average number of diagnosis codes per office encounter in your practice
- If it's just one, that's not good!
  - Should be around 4
- See what DX codes are being used most often
  - Unspecified codes aren't helping you
3. Standardize

ORDER

CHAOS

This can’t happen anymore!

ED
Admit Hospitalist
Discharge Primary Care

PCP
Refer to EP
AF Ablation

PCP
Retain patient medical management

Cardiologist
Retain patient medical management

Cardiologist
Consult, no procedure – no follow up

Cardiologist
Refer to EP
No AF Ablation
4. Start Now!

This transition takes time

Uncomfortable Truth:
Volume was an easy game.
Value is a lot harder
Q&A

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