Understanding the Medicare Access and CHIP Reauthorization Act of 2015

(MACRA)

AMERICAN COLLEGE of CARDIOLOGY

ACC ADVOCACY AMBASSADOR

M. Eugene Sherman, MD FACC

Past Chair, ACC Advocacy Steering Committee
Past Chair, ACCPAC
Past Governor, Colorado ACC

AMERICAN COLLEGE of CARDIOLOGY

ACC by the Numbers

52,000+ members across the entire cardiovascular care team

More than 85 percent of U.S. cardiologists are ACC members

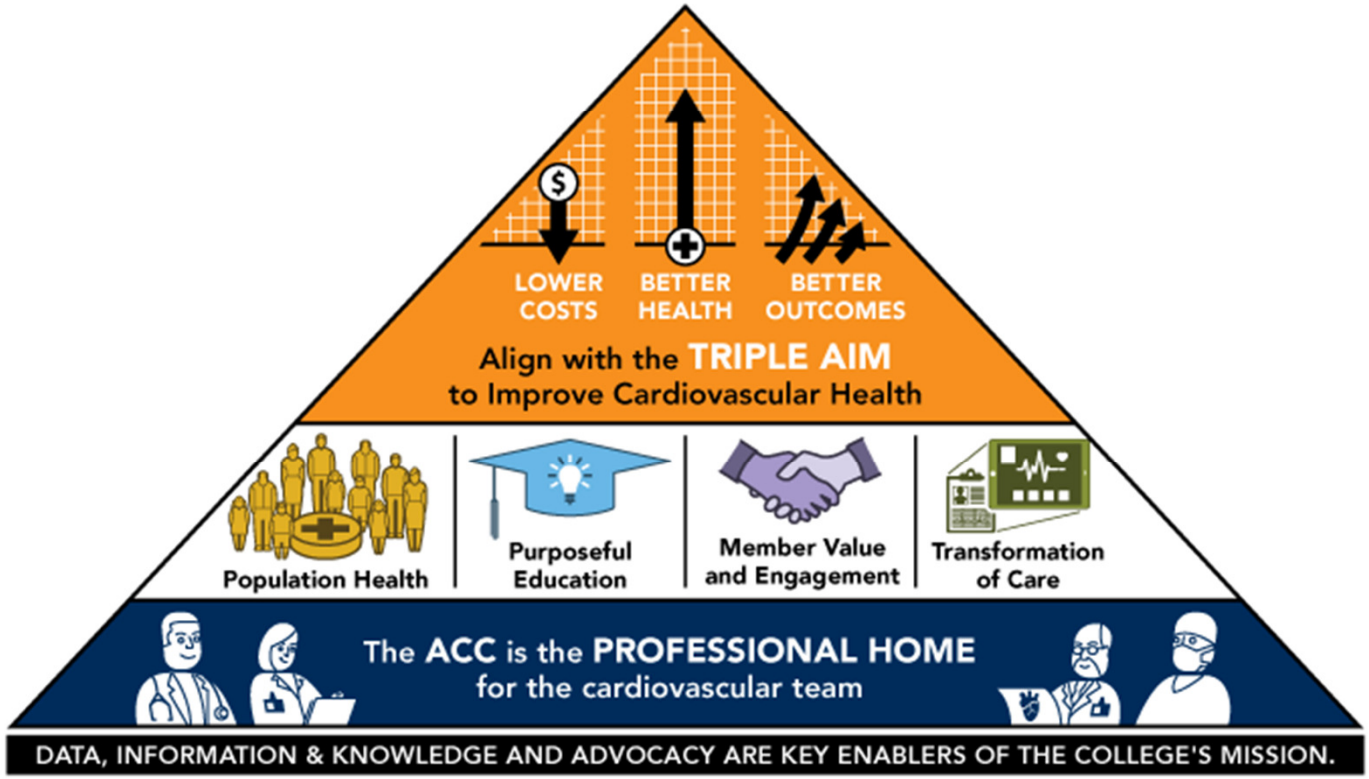
48 Domestic Chapters

36 International Chapters

10 NCDR Registries

AMERICAN COLLEGE *of* CARDIOLOGY

The Strategic Plan positions the College and its members for success in meeting the Triple Aim of improving cardiovascular health through lower costs, better health and better outcomes



AMERICAN COLLEGE *of* CARDIOLOGY

Fiscal and Staff Growth in the Last Quarter Century (1990 – 2015)

1990 Highlights

Members: 18,700

FTEs: 80+

Operations Revenue: $18.3M

Investments: $19.4M

Total Net Assets: $28.8M

Debt: $0

2015 Highlights

Members: 52,000+

FTEs: 400+

Operations Revenue: $123.3M

Investments: $102.4M

Total Net Assets: $87.3M

Debt: $60.9M

Current HOT Topics

Governance

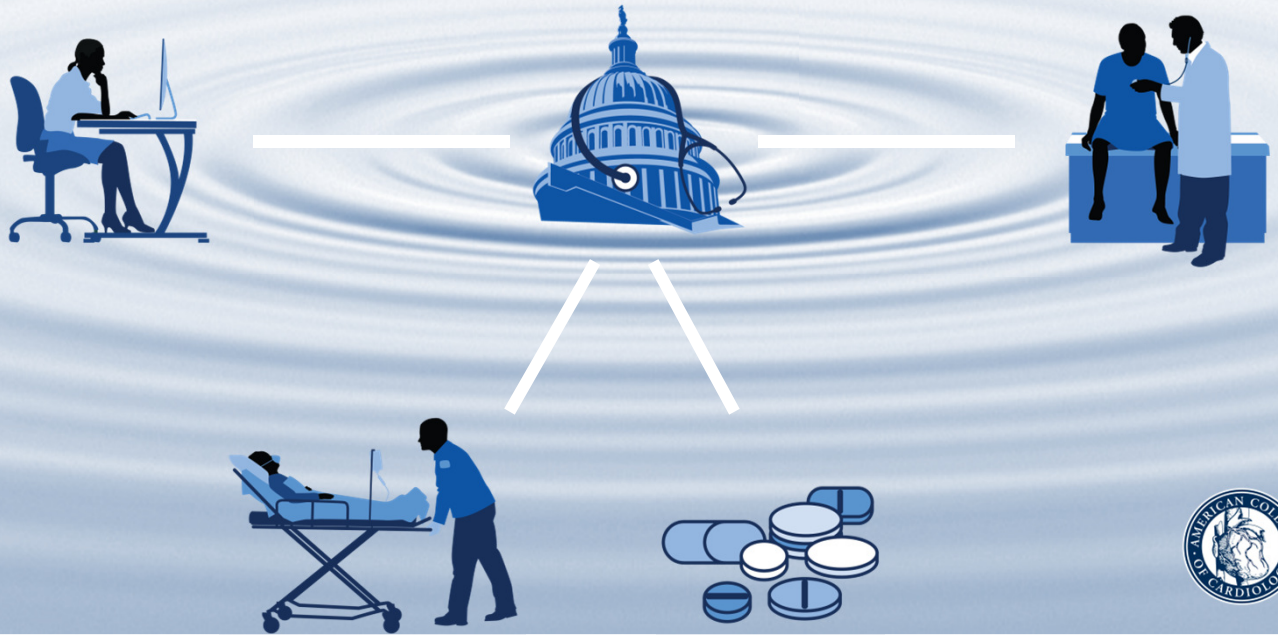
MACRA

MOC

Accreditation

AMERICAN COLLEGE *of* CARDIOLOGY

MACRA Impact on Health Care Delivery Will be Profound



AMERICAN COLLEGE of CARDIOLOGY

What Did MACRA Do?

- Repealed the flawed

  Sustainable Growth Rate (SGR)

- Established framework for moving Medicare from a **VOLUME** to a **VALUE-BASED** system

AMERICAN COLLEGE *of* CARDIOLOGY

Background: Creation of the SGR

- The sustainable growth rate (SGR) was created by the *Balanced Budget Act of 1997* as a means to control Medicare spending by tying Medicare clinician payments to increases in the gross domestic product (GDP).
- When health spending outpaced GDP, negative payment updates were threatened as a result.
- Due to the inability to find sufficient offsets, the SGR was unable to be repealed for nearly two decades.

Congress passed 17 patches to avoid cuts
(implementing cuts twice)

AMERICAN COLLEGE *of* CARDIOLOGY

Elimination of the SGR

- **Early 2014**: Congressional leaders from the House and Senate, in close collaboration with the physician community, drafted legislation which would repeal the SGR and reward physicians for the value of the services they provided.
- **Spring 2015**: Speaker of the House John Boehner and Minority Leader Pelosi struck a deal on the offsets and the *Medicare and CHIP Reauthorization Act of 2015* (MACRA) was born.

Virtually the entire House of Representatives united to pass MACRA, followed by the Senate.
President Obama signed the now-law on **April 16, 2015.**

AMERICAN COLLEGE *of* CARDIOLOGY

Historic agreement

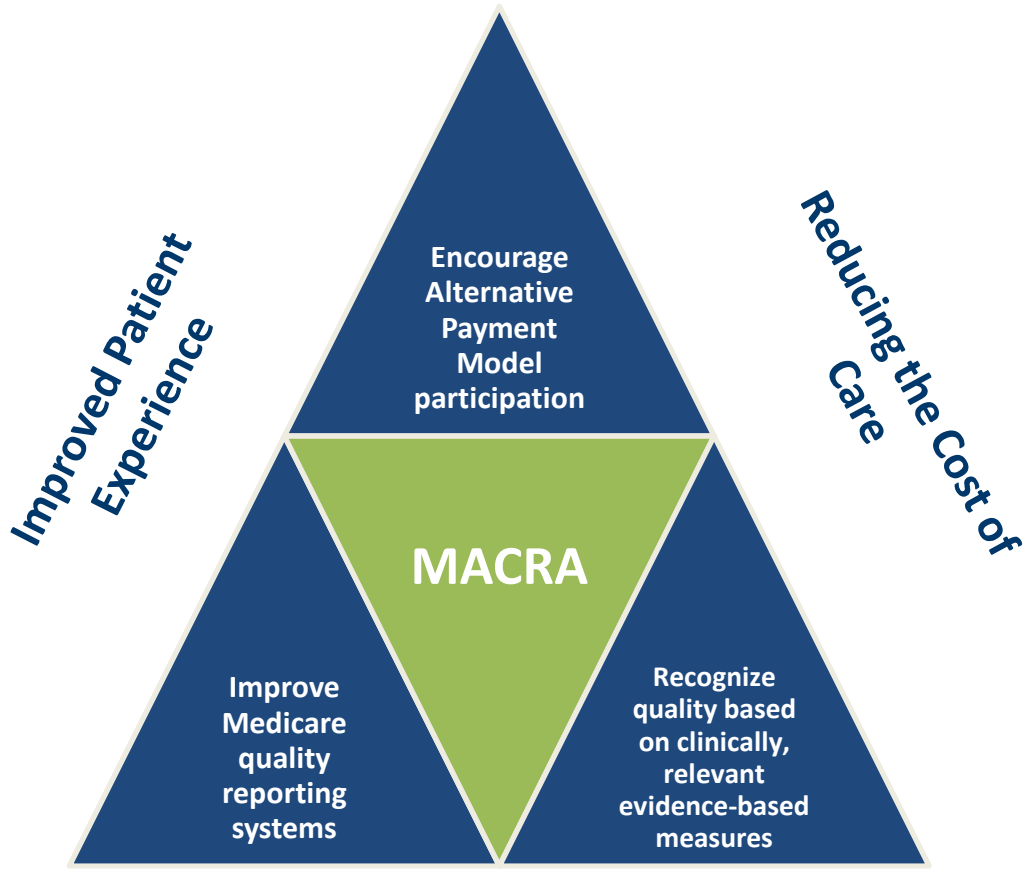
Dr. Rick Synder and Rep. Burgess (R-Tx)

Rep. Bera (D-CA) and FITs (Drs. Jeff Geske and Michael Cullen)

Rep. Steven Palazzo (R-MS),Dr. Thad Waites, and Rep. Price (R-GA)

Speaker Boehner receiving award from ACC

Sen. Michael Bennet (D-CO) with Drs. Fullerton and Sherman



AMERICAN COLLEGE *of* CARDIOLOGY

What About the Details of the Law?

- Broadly Written Directions, Implementation Details Open for Comment
- Proposed Rule Released in April 2016

AMERICAN COLLEGE of CARDIOLOGY

Medicare and CHIP Reauthorization Act of 2015

- Delayed enforcement of the "two-midnight" rule until October 1, 2015
- Extends the Children's Health Insurance Program (CHIP) for two years (until 2017)
- Extends the Teaching Health Center Graduate Medical Education Program (THCGME) for two years (until 2017)
- Declares a national objective to achieve interoperable electronic health records by December 31, 2018
- Prevents quality program standards and measures (such as PQRS/MIPS) from being used as a standard or duty of care in medical liability cases

AMERICAN COLLEGE *of* CARDIOLOGY

Changing the Payment Landscape

Pre-MACRA

- 21% payment cut in 2015, continued uncertainty
- Separate quality reporting programs
- Incentives for alternative payment model participation mainly from savings

Post-MACRA

- Eliminates SGR; implements stable payment increases
- Streamlined quality reporting program
- Incentives for alternative payment model participation built into payment system

AMERICAN COLLEGE *of* CARDIOLOGY

Proposed Rule

- 962-page rule released **April 27, 2016**
- Proposed policies implementing the **Merit-Based Incentive Payment System (MIPS**) and **Advanced Alternative Payment Model (APM)** participation
- Includes **CMS responses to RFI comments** and proposed **policies and measures for the 2017 performance period**

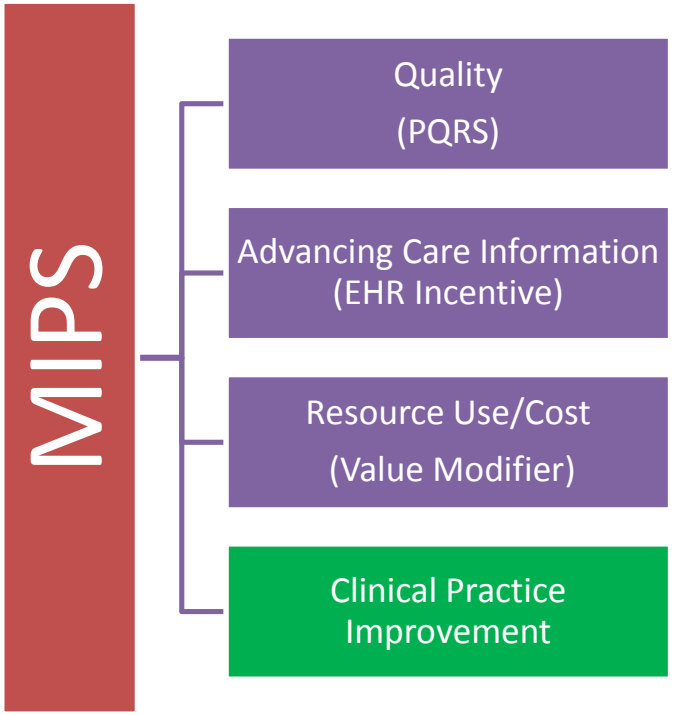
AMERICAN COLLEGE *of* CARDIOLOGY

New Terminology

- Meaningful Use → Advancing Care Information
- MIPS Composite Performance Score
- Eligible APMS → Advanced APMs
  - Qualifying Participants
  - Partial Qualifying Participants
  - Advanced APM Incentive
  - Physician Focused Payment Models

AMERICAN COLLEGE *of* CARDIOLOGY

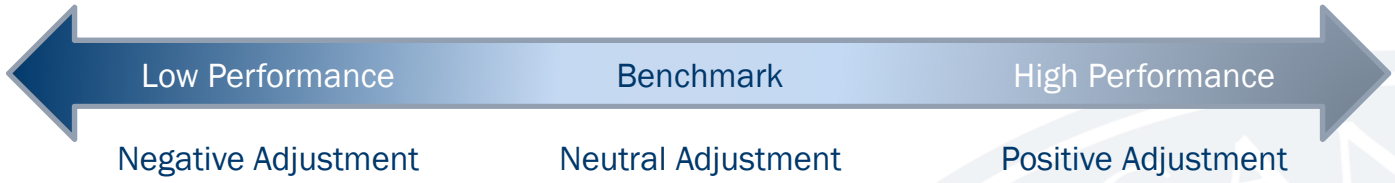
Merit-Based Incentive Payment System



- Individual programs continue through 2018
- MIPS begins in 2019 for physicians and most mid-level clinicians
  - 2017 performance
- Eligible professionals scored against benchmark based on prior year's performance
- Low-volume providers and some APM participants may be exempt from MIPS requirements

AMERICAN COLLEGE *of* CARDIOLOGY

MIPS Payment Adjustments



	2015	2016	2017	2018	2019	2020	2021	2022+
PQRS+VM+EHR Incentive Penalties (combined)	-4.5%	-6.0%	-9.0%	-10% or more	-11% or more	-11% or more	-11% or more	-11% or more
MIPS Bonus/Penalty (max)	-4.5%	-6.0%	-9.0%	-10% or more	+4%* -4%	+5%* -5%	+7%* -7%	+9%* -9%

* May be increased by up to 3 times to incentivize performance
$500 mil funding for bonuses allocated through 2024

AMERICAN COLLEGE of CARDIOLOGY

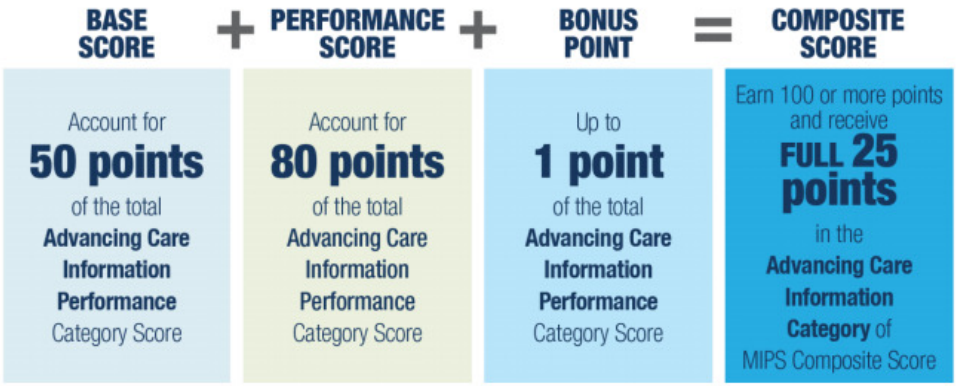
MIPS Composite Performance Score

Performance Category	Points Need to Get a Full Score per Performance Category[1]	Maximum Possible Points per Performance Category
Quality: Clinicians choose six measures to report to CMS that best reflect their practice. One of these measures must be an outcome measure or a high quality measure and one must be a crosscutting measure. Clinicians also can choose to report a specialty measure set.	80 to 90 points depending on group size	50 percent
Advancing Care Information: Clinicians will report key measures of interoperability and information exchange. Clinicians are rewarded for their performance on measures that matter most to them.	100 points	25 percent
Clinical Practice Improvement Activities: Clinicians can choose the activities best suited for their practice; the rule proposes over 90 activities from which to choose. Clinicians participating in medical homes earn full credit in this category, and those participating in Advanced APMs will earn at least half credit.	60 points	15 percent
Cost: CMS will calculate these measures based on claims and availability of sufficient volume. Clinicians do not need to report anything.	Average score of all resource measures that can be attributed.	10 percent

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/NPRM-QPP-Fact-Sheet.pdf

Advancing Care Information: The "New MU"

- 25% of the MIPS score for most clinicians in 2019
- Scored at the group level (TIN), regardless of reporting level
- Registry participants may be eligible for the bonus point
- Advanced practice professionals are optional for 2017 reporting



The overall Advancing Care Information score would be made up of a base score and a performance score for a maximum score of 100 percentage points

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/Advancing-Care-Information-Presentation.pdf

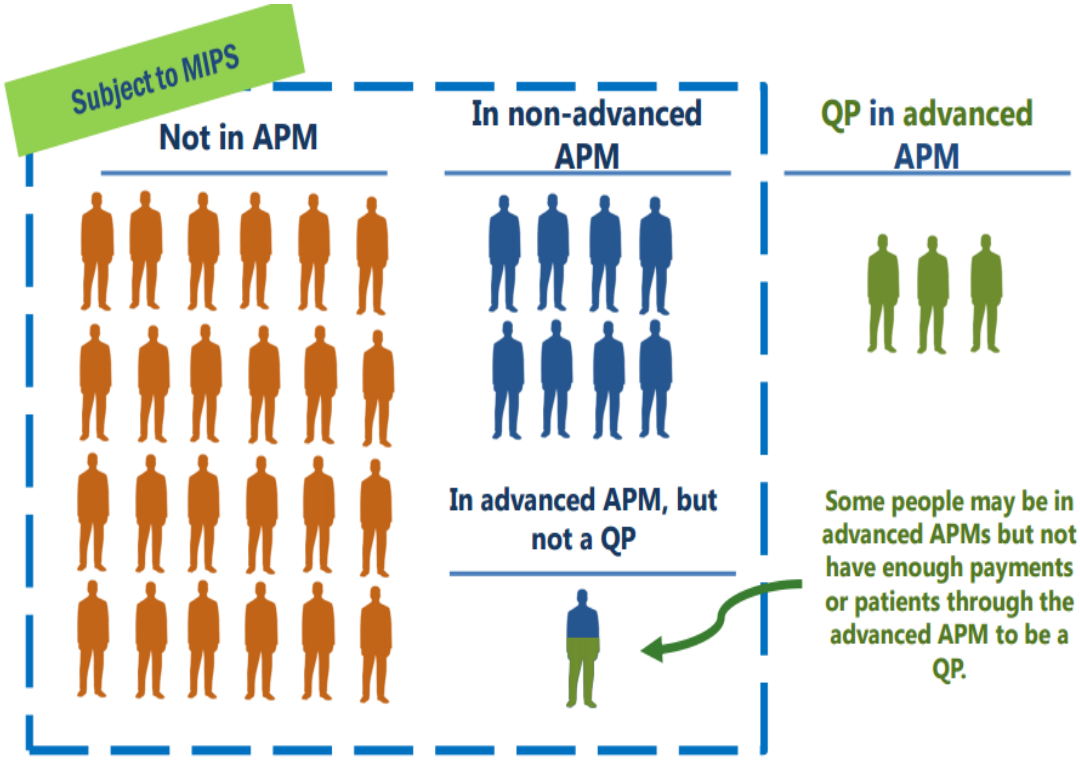
Clinical Practice Improvement

- 15% of MIPS score for most clinicians in 2019
- 90+ proposed activities eligible
  - Assigned 10, 20, 30 points
- Participate in any number of activities to reach a score of 60 points
- APM participation awards half credit (only 30 points needed)

Population Management	Use of a QCDR to generate regular feedback reports that summarize local practice patterns and treatment outcomes, including for vulnerable populations.
Population Management	Participation in CMMI models such as Million Hearts Campaign.

Population Management	Participation in a QCDR, clinical data registries, or other registries run by other government agencies such as FDA, or private entities such as a hospital or medical or surgical society. Activity must include use of QCDR data for quality improvement (e.g., comparative analysis across specific patient populations for adverse outcomes after an outpatient surgical procedure and corrective steps to address adverse outcome).

Most clinicians will be subject to MIPS

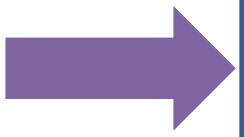


- 29,176 cardiology clinicians
- 5,488 exempt from MIPS
  - First year, low-volume, Advanced APM
- MIPS APM participants may have different scoring thresholds

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/Quality-Payment-Program-MACRA-NPRM-Slides.pdf

Advanced APMs

- Require use of CEHRT
- Pay based on quality measures comparable to MIPS
- Entity must bear more than nominal financial risk or be a Medical Home Model



- Comprehensive ESRD Care Model
- Comprehensive Primary Care Plus
- Medicare Shared Savings Program – Track 2
- Medicare Shared Savings Program – Track 3
- Next Generation ACO Model
- Oncology Care Model Two-Sided Risk Arrangement (2018)
- More to be identified…

AMERICAN COLLEGE *of* CARDIOLOGY

Advanced APM Incentive

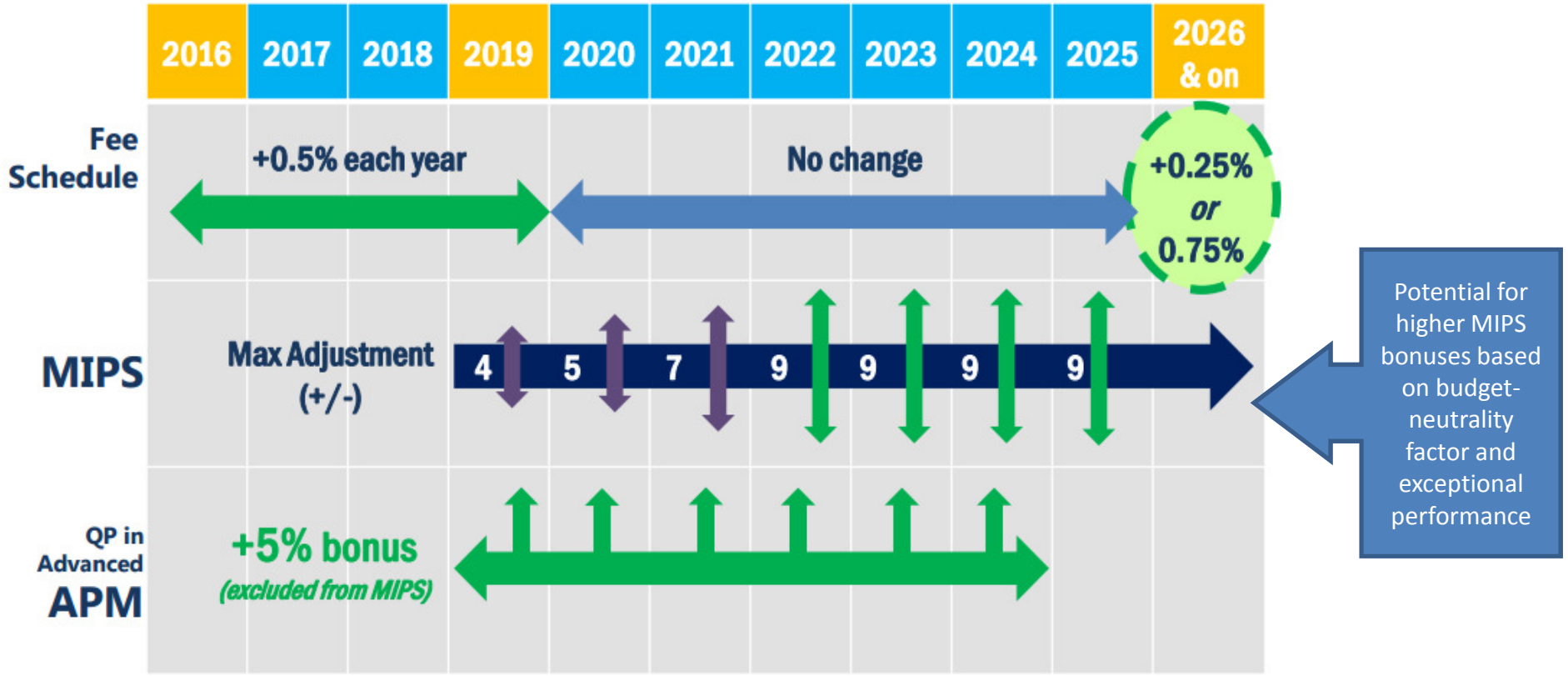
2017	2018	2019
QP Performance Period	**Incentive Payment Base Period**	**Payment Year**
QP status based on Advanced APM participation here.	Add up payments for a QP's services here.	+5% lump sum payment made here. (and excluded from MIPS adjustments)

- 2019-2024: 5% lump sum bonus
  - Starts with 2017 performance
  - Based on professional service payments furnished the year prior to the payment year (e.g., 2019 bonus based on 2018 payments)
- 2026 and beyond: higher fee schedule updates (0.75% versus 0.25% for all other clinicians)
- APM participants meeting threshold are MIPS-exempt

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/Quality-Payment-Program-MACRA-NPRM-Slides.pdf

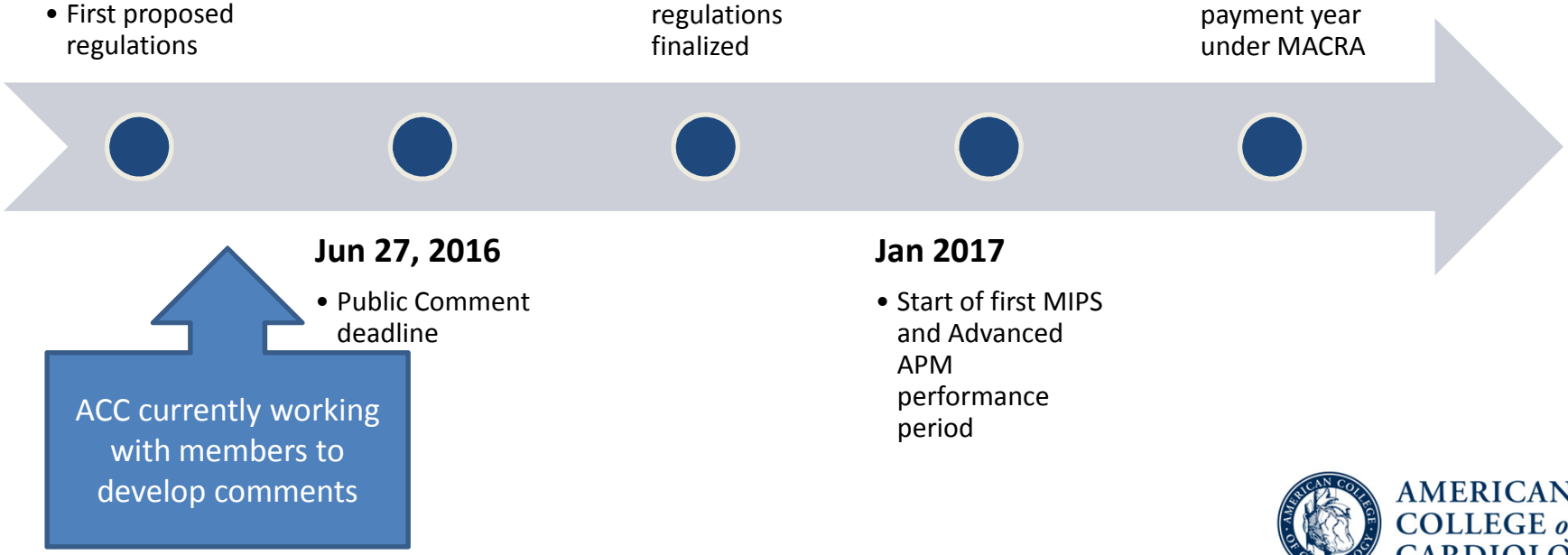
AMERICAN COLLEGE *of* CARDIOLOGY

Summary: MACRA Payment



https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/Quality-Payment-Program-MACRA-NPRM-Slides.pdf

Timeline



AMERICAN COLLEGE of CARDIOLOGY

ACTING CMS ADMINISTRATOR SLAVITT SPEAKING BEFORE AMA, JUNE 2016

- "I am convinced that adding new regulations to an already busy health care system without improving how the pieces fit together just will not work."

Pick Your Pace in 2017

Test the Quality Payment Program

- Submit some MIPS data to the Quality Payment Program, including data from after January 1, 2017
- Avoid a negative payment adjustment in 2019

Participate for part of the calendar year

- Submit information for a reduced number of days, which could begin after Jan 1, 2017
- Potential for a small positive payment adjustment in 2019

Participate for the full calendar year

- Submit information covering the full year reporting period, starting Jan 1, 2017
- Potential for a modest positive payment adjustment in 2019

Participate in an Advanced Alternative Payment Model

- Participate in an recognized Advanced APM and meet the patient or payment threshold in 2017
- 5 percent incentive payment in 2019

The CMS Blog, Sep 8 2016: https://blog.cms.gov/2016/09/08/qualitypaymentprogram-pickyourpace/

Positives

- Intent to move away from “all or nothing” and “one size fits all” scoring on EHR use
- Reduction in required quality measure reporting
- Recognition of all national medical specialty registries, not just Qualified Clinical Data Registries, for Clinical Practice Improvement
- Menu approach to Clinical Practice Improvement Activities
- Incentives for APM participation, even under MIPS

AMERICAN COLLEGE *of* CARDIOLOGY

CMS Bundled Payments
Proposed Model7/25/16

- **Bundled payment models for cardiac care** and an extension of the existing bundled payment model for hip replacements to other hip surgeries.
- A new model **to increase cardiac rehabilitation utilization**.
- A **proposed pathway for physicians** with significant participation in bundled payment models **to qualify for payment incentives under the proposed Quality Payment Program.**

From CMS Website

Bundled Payment Model:
Key Elements

- Quality-adjusted target episode price for each facility based on historic costs.
  - Performance based on average episode costs for reporting period.
  - **Costs in excess of quality-adjusted target price must be paid back. Savings will be shared**. [may have 1.5-3% inc]
- All Medicare costs included (e.g., post-acute facilities, physician payments, etc.); hospital assumes risk.
  - **Hospital can enter into risk/gain sharing agreements with other providers. What is this going to mean for private practice?**
  - Physicians may get advanced APM credit under MACRA.
  - Downside risk begins in Q2 2018

Bundled Payment Model: Opportunities

- Represents **continued movement towards a value-based payment system** that focuses on improved quality and value – key elements of ACC's strategic plan.
- Reflects CMS' continued efforts to find new ways for specialists to be rewarded for delivering quality care
- **May qualify as Advanced Alternative Payment Models (APMs) under MACRA.**
  - HHS goal to have 50% of Medicare payments tied to APMS by end of 2018.
- Cost-saving opportunities lie in lowering readmissions, home health and SNF utilization

Bundled Payment Model: Challenges

- Different from previous CMS bundles payment models:
  - Higher-risk patients
  - Surgeries are not elective (Physicians have less control over timing/planning)
- Some hospitals have had experience with APM models, while others have not. Those without experience will have little time to adapt or plan in advance.
- Changes in payment structures in health care can pose significant challenges to clinicians and must be driven by clinical practices that improve patient outcomes.

Bundled Payment Model: Challenges

- AMI model combines medical management and revascularization procedures in one condition-based bundle
- AMI model includes heterogeneous population, patients discharged under relevant PCI MS-DRGs with a principal and secondary diagnosis of AMI
- Full benefits of participation in Advanced APM may not be achievable unless threshold to meet QP status under MACRA is lowered
- Quality Performance Weighting for Risk-Standardized Mortality Rate is high and may not be achievable

Bundled Payment Model:
Next Steps

- **ACC will review and provide recommendations to CMS** in comment period (due October 3)
  - Health Affairs/Partners in Quality have the lead on comments, with input from other committees.
  - Consultation with CV subspecialties and other important stakeholders (e.g., hospitals) in progress.
- **Opportunity to extend value of NCDR (ACTION, Cath-PCI) and ACC quality programs.**

Areas for Further Analysis

- Group level performance scoring under MIPS
- Advancing Care Information performance scoring
- Resource Use/Cost measurement
  - Condition and treatment-specific episode groups
- Exemption thresholds and processes for low-volume, non-patient facing, and other clinicians
- Understanding requirements for MIPS eligible, MIPS APM, and Advanced APM clinicians
- Impact on solo practitioners and small and private practices

AMERICAN COLLEGE *of* CARDIOLOGY

What can you do now to prepare?

- ✓ Ensure that you are currently successful in the existing programs – PQRS, Meaningful Use, Value Modifier
- ✓ Find out if you are participating in an alternative payment model
- ✓ Work with your administrator to find and understand your cost and quality data
- ✓ Understand cost and episodes of care
- ✓ Make care coordination an organizational priority
- ✓ Focus on proper documentation
- ✓ Watch acc.org/macra for updates

Challenges Ahead, Engagement Necessary

- To be flexible, the MACRA regulations are written with a degree of complexity – there will be growing pains
- ACC working with HHS and CMS to minimize these challenges to support **evidence-based, cost-effective, high quality care.**
- ACC continues to work with Congress on **appropriate implementation** of MACRA that supports clinicians.

AMERICAN COLLEGE *of* CARDIOLOGY

There Will Be Opportunities for ACC to *Provide Input* Into *How* the Law Will Function

We ARE and will continue to be at the table!

AMERICAN COLLEGE *of* CARDIOLOGY

More information is available on the ACC's online MACRA hub at *ACC.org/MACRA*

Updates are provided via the hub and through the ACC's *Advocate* newsletter.

E-mail macra@acc.org with questions.

AMERICAN COLLEGE *of* CARDIOLOGY

A New Dawn

I hope this is the sun rising and **not** setting on the practice of cardiology in the US.

More to follow!

AMERICAN
COLLEGE *of*
CARDIOLOGY