The Medicare Access & CHIP Reauthorization Act (MACRA) and Models for Containing Costs

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Goals for Health Care System Improvement

↑ Access
↑ Quality
↓ Costs

TRIPLE AIM

↑ Experience of Care

↑ Population Health
↓ Per-capita costs

Timeline

1997 – Sustainable Growth Rate (SGR) Formula
2007 – Physician Quality Reporting System (PQRS)
2009 – Medicare EHR Incentive Program
2013 – Value-based Payment Modifier (VM)
2015 (Jan.) – Goals for Value-based Payment →
2015 (Apr.) – Medicare Access & CHIP Reauthorization Act
2016 (Apr.) – MACRA Prop. Rule: Quality Payment Program
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Medicare Fee-for-Service

GOAL 1: 30%
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: 85%
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
Timeline

1997 – Sustainable Growth Rate (SGR) Formula
2007 – Physician Quality Reporting System (PQRS)
2009 – Medicare EHR Incentive Program (EHRIP)
2013 – Value-based Payment Modifier (VM)
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MACRA

- Repeals the Sustainable Growth Rate Formula
- Changes the way that Medicare rewards clinicians for value over volume
- Streamlines multiple quality programs under the new Merit-Based Incentive Payment System (MIPS)
- Provides bonus payments for participation in eligible alternative payment models (APMs)

Merit-Based Incentive Payment System (MIPS)

- **Single composite score** for adjusting payments (streamlining PQRS, EHRIP, VM)
  - Quality
  - Cost
  - Clinical Practice Improvement Activities
  - Advancing Care Information (meaningful use of EHRs)

- **Large adjustments:**
  - 2019: ±4%
  - 2020: ±5%
  - 2021: ±7%
  - 2022: ±9%
MIPS: Cost

Average resource use score across 40+ episode-specific measures

Medicare claims-based

10% of composite score

- Practices will use tools for monitoring resource use within episodes
  - Benchmarking
  - Incentives
MIPS: Clinical Practice Improvement Activities

Implement and report on CPIA activities from a list of 90+ (choose 5-6 for 100%)

Examples:

• Pop. needs assessments, IDing vulnerable pts
• Glycemic treatment goal documentation
• Timely communication of abn. test results
• Condition-specific self-management support
Advanced Alternative Payment Models (APMs)

Stringent reqs. for moving beyond MIPS:

- Financial risk-bearing (4%+ of benchmarks)
- Payment tied to quality measures
- Certified EHR technology use

OR: ACOs, Comprehensive Primary Care (CPC+), Oncology Care Model, etc.

➤ Likely relatively few will qualify
Summary

MACRA marks how cost containment now means emphasizing population health, quality and value

- Value-based payment becoming the new normal
- Identifying and meeting needs of vulnerable patients
- Innovative, inexpensive clinical and non-clinical interventions
Questions / Comments?

“See the [MACRA] proposed rule for information on submitting ...comments by the close of the 60-day comment period on June 27, 2016. When commenting refer to file code CMS-5517-P.”

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Resources

The Medicare Access & Chip Reauthorization Act of 2015 Quality Payment Program

MACRA text