WHAT IS MACRA?

TUESDAY, JANUARY 10:
WHAT IS MACRA?
Kate Gainer, PharmD
Executive Vice President and CEO
Iowa Pharmacy Association
WELCOME

Anthony Pudlo, PharmD, MBA, BCACP
Vice President of Professional Affairs
Iowa Pharmacy Association
TODAY’S PRESENTERS

Paul Mulhausen, MD
Chief Medical Officer
Telligen

Sandy Swallow
Program Specialist
Telligen
Transformation to Value-Based Healthcare at a Glance

Dr. Paul Mulhausen and Sandy Swallow

January 10, 2017
Today’s Objectives

- Describe the rationale for transformation to value-based care
- Understand incentives that drive the transformation
- Identify the basic requirements of the Quality Payment Program under MACRA
- Recognize how this will impact clinicians working in your environment
- Consider ways pharmacists can prepare for this transformation
Rationale for Transformation

**Medicare Trust Fund is Unsustainable Growth**

Projection: Health reform legislation will extend the life of the Medicare Part A Trust Fund from 2017 to 2029

Assets as a share of annual spending:

- **Pre-health reform:** 2017 projected insolvency date
- **Post-health reform:** 2029 projected insolvency date
Rationale for Transformation

Unsustainable growth in cost

Figure 4. Historical Growth Trajectory of National Health Expenditures, 1970-2011

JAMA. 2013;310(18):1947-1963
Better, Smarter, Healthier

Goals, Timelines and Reward Value

“Our goal is to have 85% of all Medicare fee-for-service payments tied to quality or value by 2016, and 90% by 2018. Perhaps even more important, our target is to have 30% of Medicare payments tied to quality or value through alternative payment models by the end of 2016, and 50% of payments by the end of 2018. Alternative payment models include accountable care organizations (ACOs) and bundled-payment arrangements........”

Sylvia M. Burwell, January 26, 2015
A health system that provides better care, spends dollars more wisely, and has healthier people

<table>
<thead>
<tr>
<th>Focus Areas</th>
<th>Description</th>
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<tr>
<td>INCENTIVES</td>
<td>- Promote value-based payment systems</td>
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<td>- Test new alternative payment models</td>
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<td>- Increase linkage of Medicaid, Medicare FFS, and other payments to value</td>
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<td>- Bring proven payment models to scale</td>
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<td>- Align quality measures</td>
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<td>CARE DELIVERY</td>
<td>- Encourage the integration and coordination of clinical care services</td>
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<td>- Improve individual and population health</td>
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<td>- Support innovation including for access</td>
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<td>INFORMATION</td>
<td>- Bring electronic health information to the point of care for meaningful use</td>
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<td>- Create transparency on cost and quality information</td>
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<td>- Support consumer and clinician decision making</td>
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Source: Burwell SM. Setting Value-Based Payment Goals – HHS Efforts to Improve U.S. Health Care. NEJM 2015 Jan 26; published online first.
Linking Medicare Fee For Service Payments to Quality and Alternative Payment Models

**Historical Performance (Pre-Announcement)**

- **2011**: 68%
  - 0%
  - 68%

- **2014**: >80%
  - ~20%
  - >80%

- **2016**: 85%
  - 30%
  - 85%

- **2018**: 90%
  - 50%
  - 90%

**Goals**

- **2011**: 0%
- **2014**: ~20%
- **2016**: 30%
- **2018**: 50%

Source: Burwell SM. Setting Value-Based Payment Goals ─ HHS Efforts to Improve U.S. Health Care. NEJM 2015 Jan 26; published online first.
Federal Transformation Drivers

**Comprehensive list of CMS quality and performance programs**

<table>
<thead>
<tr>
<th>Hospital Quality</th>
<th>Physician Quality Reporting</th>
<th>PACE and Other Setting Quality Reporting</th>
<th>Payment Model Reporting</th>
<th>“Population” Quality Reporting</th>
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<td>Medicare Shared Savings Program</td>
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<td>PPS-Exempt Cancer Hospital</td>
<td>PQRS</td>
<td>Nursing Home Compare Measures</td>
<td>Hospital Value-based Purchasing</td>
<td>CHIPRA Quality Reporting</td>
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<td>Inpatient Psychiatric Facilities</td>
<td>Value-based Modifier (VM)</td>
<td>LTCH Quality Reporting</td>
<td>Physician Feedback</td>
<td>Health Insurance Exchange Quality Reporting</td>
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<td>HAC Payment Reduction Program</td>
<td>Maintenance of Certification</td>
<td>Hospice Quality Reporting</td>
<td>ESRD QIP</td>
<td>Medicare Advantage</td>
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<td>Readmission Reduction Program</td>
<td>MACRA-QPP</td>
<td>Home Health Quality Reporting</td>
<td>Innovations Pilots</td>
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<td>Outpatient Quality Reporting</td>
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<td>Post Acute Value Based Purchasing</td>
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<td>Ambulatory Surgical Center</td>
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What is MACRA?

**A New Transformation Driver**

- **Medicare Access and CHIP Reauthorization Act of 2015**
  - Signed into law April 16, 2015
  - Begins in 2017 with first penalties and incentives in 2019

- **Modernizes the Medicare payment policy for physician services**
  - Repeals the Sustainable Growth Rate – “fixed the SGR”
  - Updates MC Part B payment rates 0.5 percent annually from 2016-2019
  - Streamlines multiple quality reporting programs (PQRS, MU & VM); introduces the Quality Payment Program (QPP)
  - Reimbursement based on value (quality and cost) rather than volume
What is MACRA?

Three most important need to know about MACRA:

- Passed with bipartisan Congressional support in 2015
- Introduces the Quality Payment Program (QPP)
- Pays clinicians for delivering best care and overall work with patients
What Impact Does MACRA Have on Clinicians?

• Without MACRA there would have been a 21% cut in Medicare payment under SGR in 2015
• Provides more certainty of payments over the next 10 years
• Alleviates the annual risk of payment cuts
• Combines existing quality reporting programs into a single structure that streamlines reporting
• Reporting burden, increases staffing, and additional expenses
A New Transformation Driver

• Creates Medicare payment incentives that promote quality over volume by:
  • Choice of 2 paths –
    • Alternative Payment Models (APMs) or
    • Merit-Based Incentive System (MIPS)

• 2017 Transition Year with options to avoid a penalty through “Pick Your Pace”
  • Test – minimal submission
  • Partial – 90 days of data submission
  • Full – full calendar year of data submission
The New Quality Payment Program (QPP)

Three Most Important Program Goals:

- Promote adoption of APMs that align with incentives across healthcare stakeholders
- Transition to a new payment system that promotes high-quality efficient care
- Support care improvements with better outcomes, decreases burden and preserves independent practices
Who’s in the Quality Payment Program?

✓ **MIPS Eligible Clinicians …**
  - Bill Medicare Part B more than $30,000 a year and bill for care to more than 100 Medicare patients
  - 2017 - 2018 Physician, Physician assistant, Nurse practitioner, Clinical nurse specialist or Certified registered nurse anesthetist
  - 2019 and Beyond — Additional clinicians will be added

✓ **Qualifying Advanced APM Participant (QP) who have….**
  - A certain % of Medicare Part B payments for professional services or patients served through an Advanced APM Entity
Alternative Payment Model (APMs)

Which Path is Right for You?

- New approach designed to incentivize quality and value
- Create the adoption of payment models that move away from FFS
- Tie payment to value and focus on better care, smarter spending and healthier people
- Must meet specific requirements
- Does not change how any particular APM rewards value
- Must be in an Advanced APM to participate
What are Advanced APMs?

Requirements to be Considered an Advanced APM

- Uses certified EHR technology
- Collects quality measures data comparable to MIPS
- Either:(1) is a Medical Home Model expanded under CMS Innovation Center authority OR (2) requires participants to bear more than a nominal amount of financial risk
What are Advanced APMs?

Impact on Eligible Clinicians

• May be determined as qualifying APM participants (QPs) if they meet proposed thresholds

• QPs:
  – Are not subject to MIPS
  – Receive 5 percent lump sum bonus payments for years 2019-2024
  – Receive a higher fee schedule update for 2026 and beyond

Eligible Advanced APMs Include:

- Comprehensive ESRD Care Model
- Comprehensive Primary Care Plus (CPC+)
- Medicare Shared Savings Program Track 2 and 3
- Next Generation ACO Model
- Oncology Care Model Two-Sided Risk Arrangement
Which Path is Right for You?

- ECs earn a performance-based payment adjustment on the Medicare Part B PFS
  - Adjusted either up, down, or neutral
- Payment adjustment is based on evidence-based and practice-specific quality data in 4 performance categories
- First Performance
  - Most ECs will report through MIPS the first year
  - Can report as an individual or group
MIPS: Performance Categories for 2017

**How will ECs be Scored?**

- **Quality**
  - ECs report on quality measures best reflecting their practice

- **Advancing Care Information**
  - ECs report customizable measures reflecting their EHR use

- **Improvement Activities**
  - ECs select practice improvement activities that match their practice’s goals; full credit if PCMH recognized

- **Cost**
  - Beginning in 2018 CMS will calculate measures based on claims; no reporting requirements from ECs

**MIPS Performance Category Weights for 2017**

- Quality: 60%
- ACI: 25%
- IA: 15%
- Cost: 5%
How Are Payments Adjusted Under MIPS?

• Calculate the final score by sum of performance categories

• Positive, negative, neutral adjustments based on CMS-established threshold
  – Budget neutral program

• Clinicians at or above performance threshold will receive a neutral or positive adjustment factor based on a linear sliding scale

• Adjustments applied to a clinician’s Medicare Part B claims
MIPS Performance Category: Cost

Basic Category Requirements for 2017

- Represents 0% of final score in 2017; 10% in 2018
- No reporting requirements
- Clinicians assessed on Medicare claims data based on services delivered
- Uses measures previously used in Value-based Modifier program or reported in the Quality and Resource Use Report (QRUR); but scoring is different
- Cost Measures from VM
  - Medicare Spending Per Beneficiary (MSPB)
  - Total Per-Capita Cost for All Attributed Beneficiaries
MIPS Performance Category: Improvement Activities (IA)

Basic Category Requirements for 2017

• Assesses participation in activities that improve clinical practice
  – Examples: Increasing access, patient safety, coordinating care
• Represents 15% of final score
• Choose from 90+ weighted activities under 9 subcategories
• Most participants attest that completed up to 4 improvement activities for a minimum of 90 days
• Special considerations for small, rural or HPSA, participant in certified PCMH, or certain APMs
• Activities help clinicians improve health outcomes and prepare for transition toward Advanced APM
Basic Category Requirements for 2017

- Replaces the Medicare EHR Incentive Program
- Represents 25% of final score
- In 2017, there are 2 measure sets for reporting based on EHR edition:
  - 1. Advancing Care Information Objectives and Measures
  - 2. 2017 Advancing Care Information Transition Objectives and Measures
- Promotes patient engagement and interoperability using certified EHR technology
- Score includes sum of 3 parts:
  - Base score
  - Performance score
  - Bonus score
Basic Category Requirements for 2017

• Replaces PQRS and quality portion of VM
• Represents 60% of final score
• Select 6 quality measures (minimum of 90 days); 1 must be:
  – Outcome measure or
  – High-priority measure
• Report as individual or group
• Special rules for web interface
• Measures submitted by providers
• Measures are compared to national benchmarks and scored
We Are All Part of the Quality Payment Program

Creating an Identity Toward a Common Goal

- CMS
- Clinicians
- Patients
- Our Support Teams

We all share a similar goal to improve patient outcomes!
How Can Pharmacists Prepare for Value-Based Transformation?

Pharmacist-Physician Collaboration

- Work effectively in collaborative arrangements and inter-professional teams
- Capitalize on new models of care and new models of payment to more fully engage patients and get paid for it
How Can Pharmacists Prepare for Value-Based Transformation?

- Assume the role of engaged team member
- Reach out to prescribers with concerns
- Physicians find value in pharmacists’ potential to find interactions and catch errors
- Build trust

1.5 million preventable ADE

$177 billion
How Can Pharmacists Prepare for Value-Based Transformation?

• Bring the skills and knowledge the team needs
• Define areas of contribution
• Know what’s relevant and when to assert your expertise
How Can Pharmacists Prepare for Value-Based Transformation?

Link to MIPS through Medication Management

• Advancing Care Information
  – Formulary management
  – Medication reconciliation
  – CDTM

• Cost and Care Coordination
  – Elderly/multi-morbidity
  – Serious mental illness
  – Multi-morbidity
  – Transitions
How Can Pharmacists Prepare for Value-Based Transformation?

Link to MIPS through Quality Measures

• Use of Appropriate Medications for People with Asthma
• Diabetes: Hemoglobin A1c Poor Control
• Controlling High Blood Pressure
• Anti-depressant Medication Management
• ADE Prevention and Monitoring: Warfarin Time in Therapeutic Range
• Use of High Risk Medications in Elderly
How Can Pharmacists Prepare for Value-Based Transformation?

(*Find a Home*)

- Nursing Home
- Patient-Centered Medical Home (PCMH)
- PCMH Neighbors
- Population Health Management Services
- Integrated Health Service Providers
How Can Pharmacists Prepare for Value-Based Transformation?

**Get Paid**

- Shared savings models
  - Accountable care organizations
  - Comprehensive primary care
  - Advanced Alternative Payment Models
- Chronic care management fees
- Health reform and the movement from volume-based reimbursement to value-based reimbursement creates new opportunity for pharmacists as part of an integrated workforce
THANK YOU!

Contact Information

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JOIN US TUESDAY, FEBRUARY 14:
CMS ENHANCED MTM PILOT PROGRAM

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