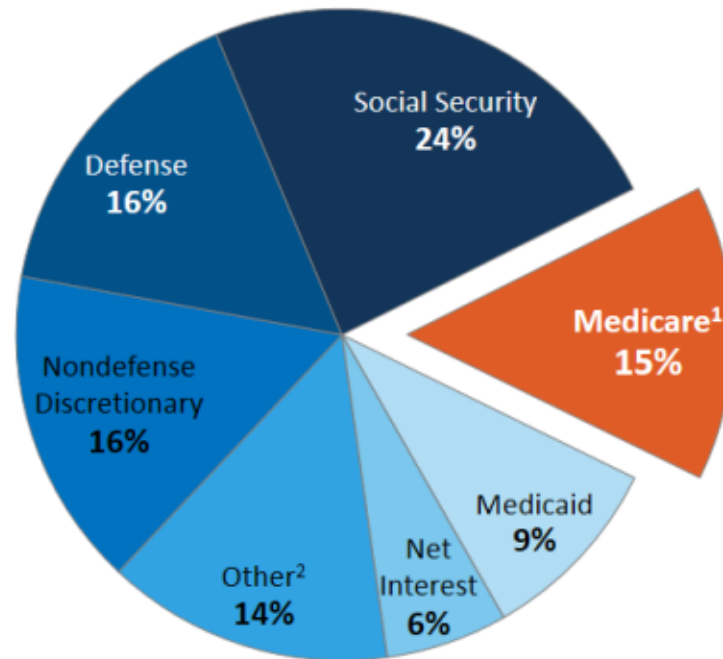


# MACRA, the End of Fee-for-Service, and the Future of Medicine

Jay Bhattacharya, MD, PhD  
Stanford University

A Quick History of the  
Medicare Access and CHIP  
Reauthorization Act (MACRA)

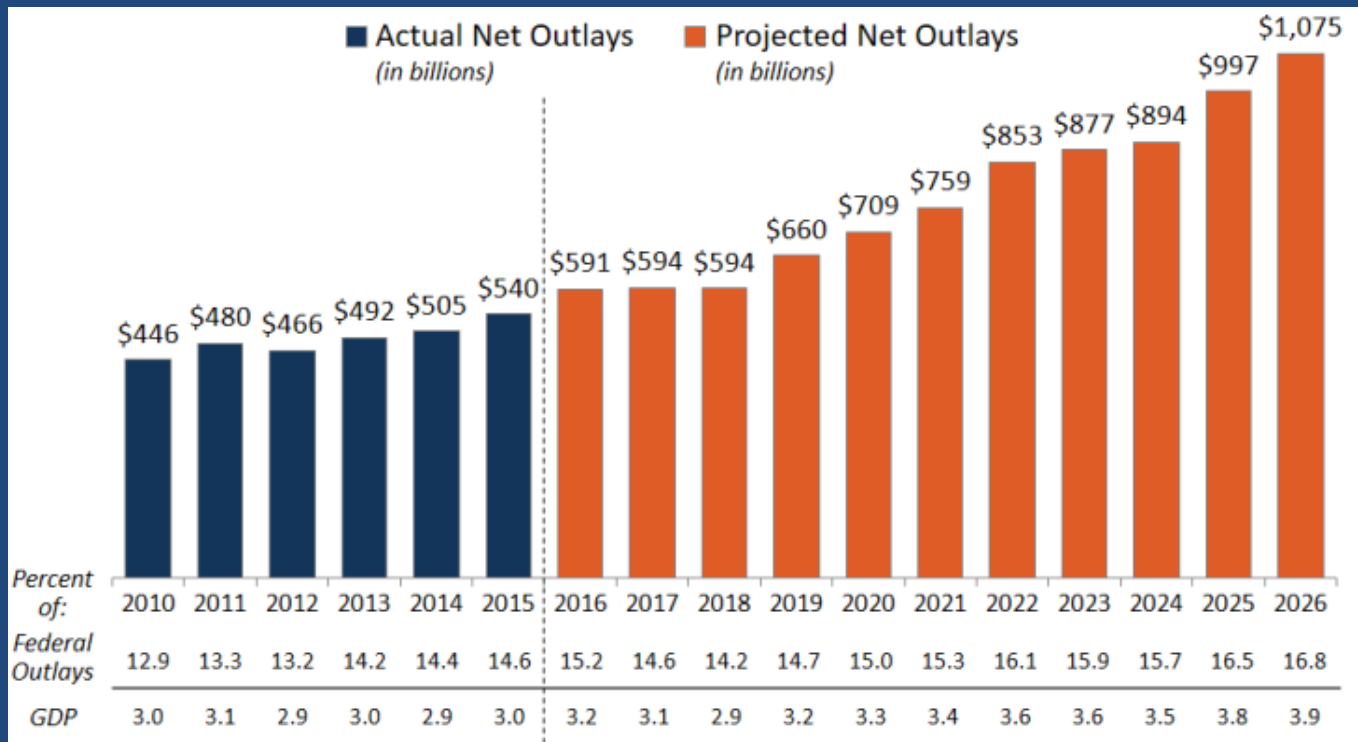
# Medicare as a Share of the Federal Budget, 2015



**Total Federal Outlays, 2015: \$3.7 trillion**  
**Net Federal Medicare Outlays, 2015: \$540 billion**

NOTE: All amounts are for federal fiscal year 2015. <sup>1</sup>Consists of mandatory Medicare spending minus income from premiums and other offsetting receipts. <sup>2</sup>Includes spending on other mandatory outlays minus income from offsetting receipts.  
SOURCE: Congressional Budget Office, Updated Budget Projections: 2016 to 2026 (March 2016).

# Actual and Projected Net Medicare Spending, 2010-2026

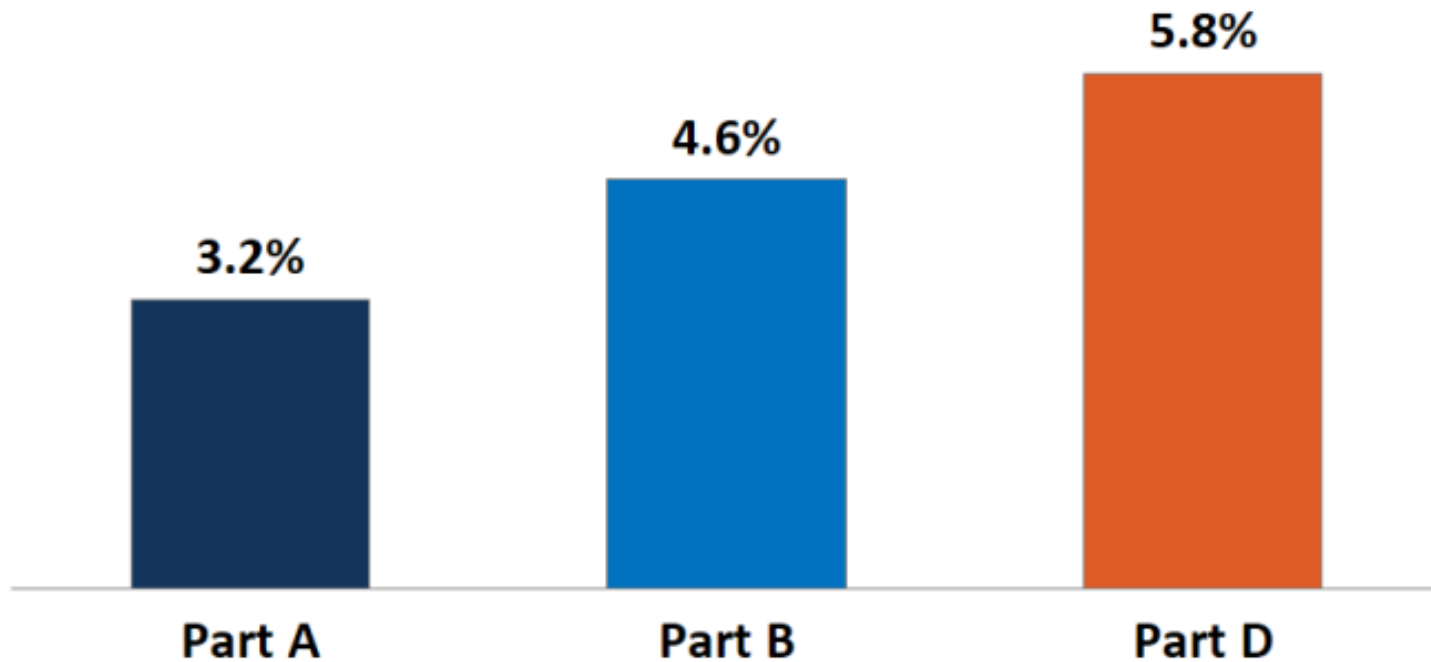


NOTE: All amounts are for federal fiscal years; amounts are in billions and consist of mandatory Medicare spending minus income from premiums and other offsetting receipts.

SOURCE: Congressional Budget Office, Updated Budget Projections: 2016 to 2026 (March 2016); March 2016 Medicare Baseline.



# Average Annual Growth in Medicare Beneficiary Costs for Part A, Part B and Part D Between 2015 and 2025



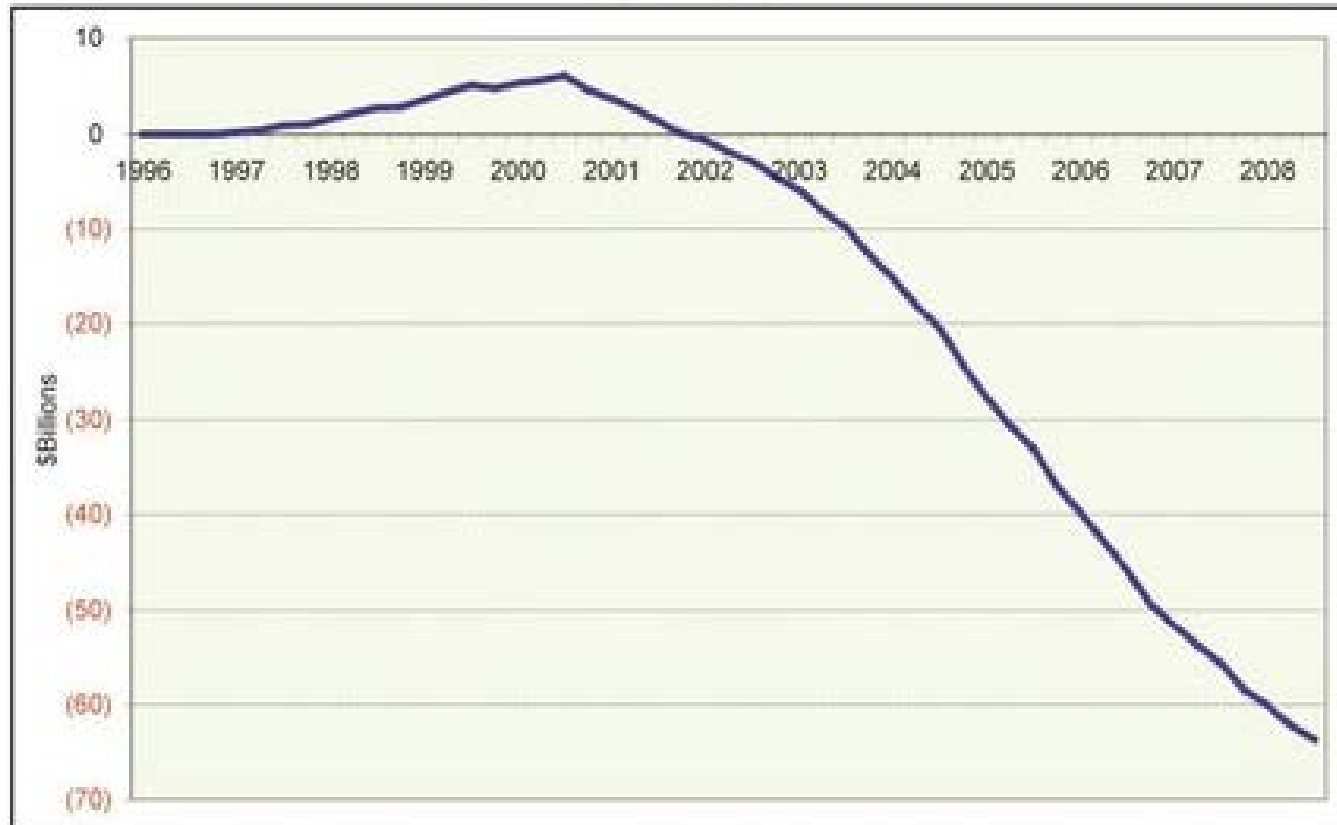
*Per beneficiary spending:*

	Part A	Part B	Part D
<b>2015</b>	<b>\$5,019</b>	<b>\$5,522</b>	<b>\$2,203</b>
<b>2025</b>	<b>\$6,901</b>	<b>\$8,642</b>	<b>\$3,861</b>

SOURCE: Kaiser Family Foundation analysis of Medicare spending data from the 2016 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds (Table V.D1)

**Figure 1. Difference Between Cumulative Allowed and Actual Expenditures for Physician Services Under the SGR System**

1996-2008



**Source:** CRS figure from CMS data contained in "Estimated Sustainable Growth Rate and Conversion Factor, for Medicare Payments to Physicians in 2010." Available at <http://www.cms.hhs.gov/SustainableGRatesConFact/Downloads/sgr2010p.pdf>

CBS/AP / April 16, 2015, 5:50 PM

# Obama signs "doc fix" bill, changing Medicare payments to doctors



President Obama signs the Medicare Access CHIP Reauthorization Act 2015 on April 16, 2015 in Washington, DC.

/ POOL, GETTY IMAGES

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President Obama signed legislation Thursday that will permanently change how Medicare pays doctors, a rare bipartisan achievement by Democrats and Republicans that will end years of short-term fixes.





# The MACRA Choice

# The Quality Payment Program

- Clinicians can choose how they want to participate in the Quality Payment Program based on their practice size, specialty, location, or patient population.

## Two tracks to choose from:

### Advanced Alternative Payment Models (APMs)

If you decide to take part in an Advanced APM, you may earn a Medicare incentive payment for participating in an innovative payment model.

or

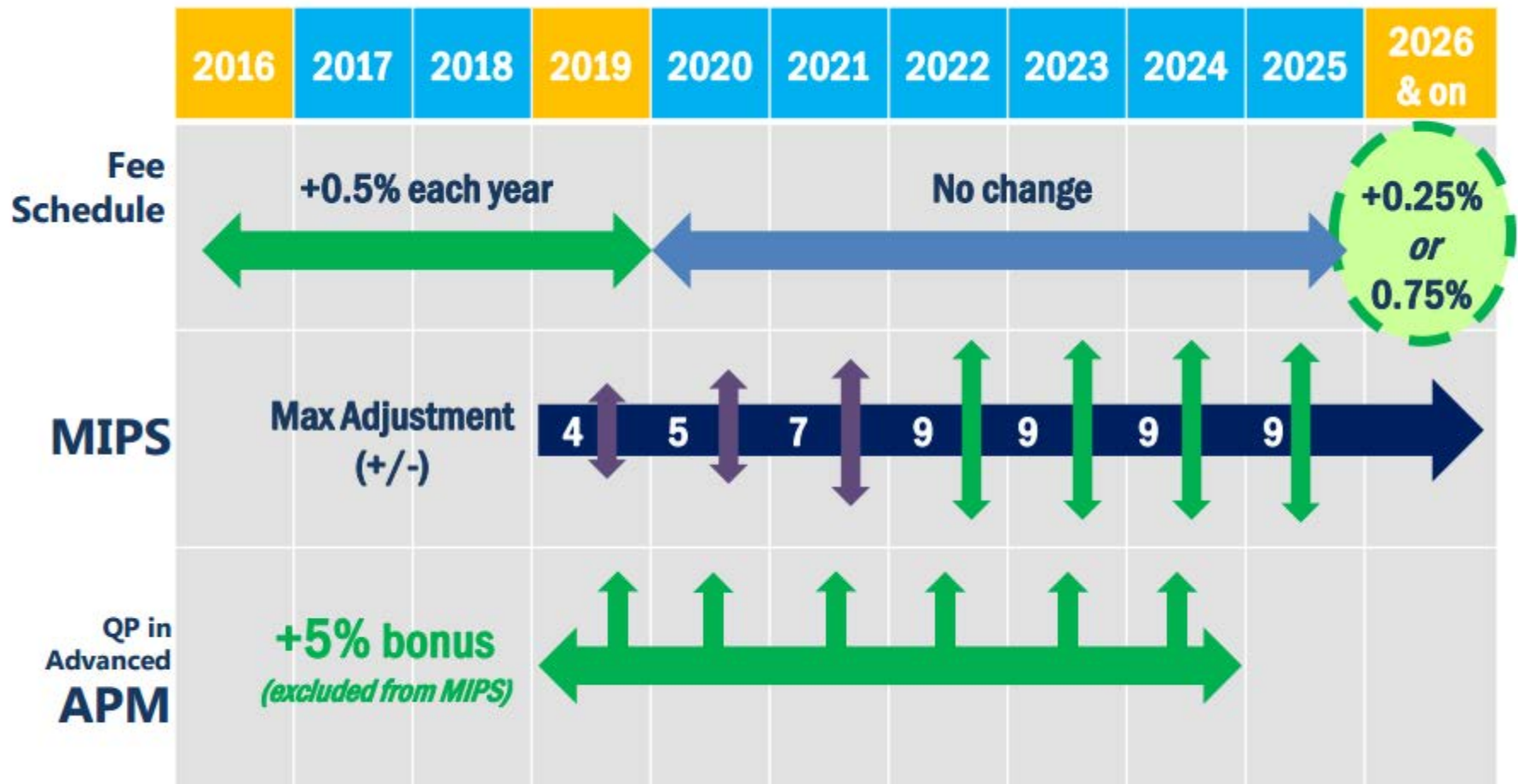
### The Merit-based Incentive Payment System (MIPS)

If you decide to participate in traditional Medicare, you may earn a performance-based payment adjustment through MIPS.

# Eligible Clinicians

- Must bill at least \$30k to Medicare Part B
- Must provide care for at least 100 Medicare patients
- ECs include:
  - Physicians
  - PAs
  - Nurse Practitioners
  - Clinical Nurse Specialists
  - CRNAs
- The Quality Payment Program policy will reform Medicare Part B payments for more than 600,000 clinicians (out of 800k) across the country.

# Physician Payment Adjustment



Source: CMS website

# Merit-Based Incentive Payment System (MIPS)

**Note: Most clinicians will be subject to MIPS.**

Subject to MIPS

Not in APM



In non-advanced APM



In advanced APM, but not a QP

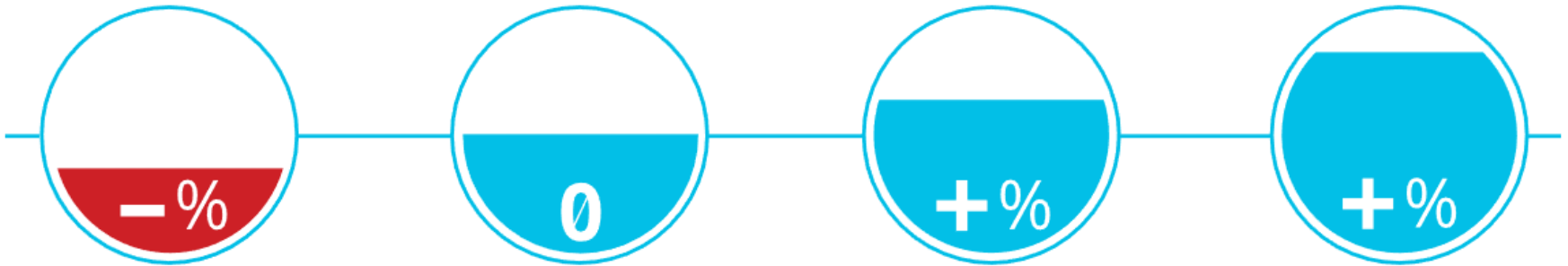


QP in advanced APM



Some people may be in advanced APMs but not have enough payments or patients through the advanced APM to be a QP.

# MIPS Choices



## Don't Participate

### Not participating in the Quality Payment Program:

If you don't send in any 2017 data, then you receive a negative 4% payment adjustment.

## Submit Something

### Test:

If you submit a minimum amount of 2017 data to Medicare (for example, one quality measure or one improvement activity for any point in 2017), you can avoid a downward payment adjustment.

## Submit a Partial Year

### Partial:

If you submit 90 days of 2017 data to Medicare, you may earn a neutral or positive payment adjustment and may even earn the max adjustment.

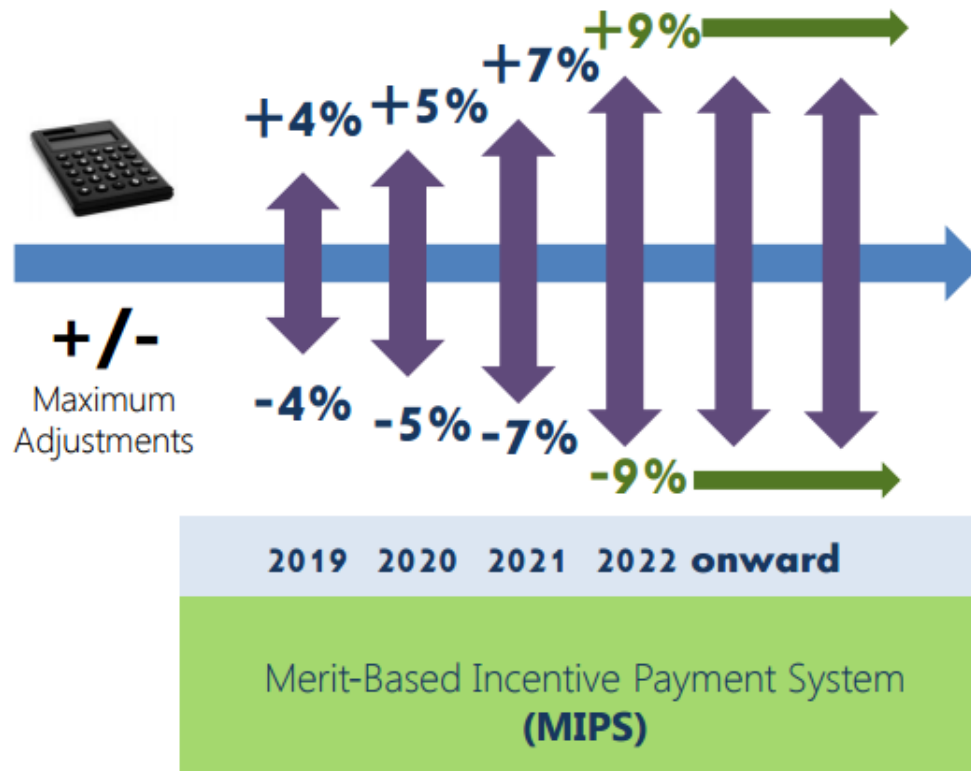
## Submit a Full Year

### Full:

If you submit a full year of 2017 data to Medicare, you may earn a positive payment adjustment.

# How much can MIPS adjust payments?

Based on a MIPS Composite Performance Score, clinicians will receive +/- or neutral adjustments up to the percentages below.

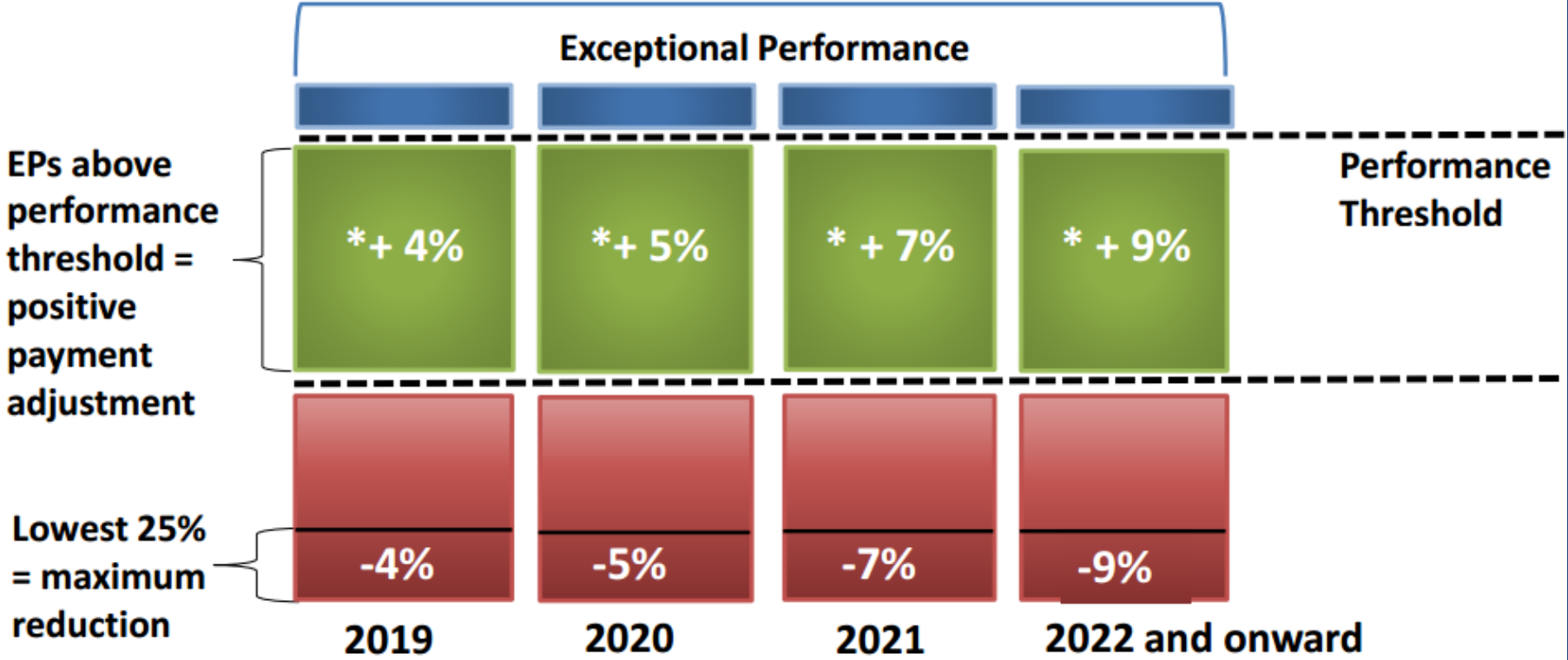


The potential maximum adjustment % will increase each year from 2019 to 2022



# MIPS Incentive Payment Formula

Exceptional performers receive additional positive adjustment factor – up to \$500M available each year from 2019 to 2024



Source: CMS website

# What is the Merit-based Incentive Payment System?

## Performance Categories



- Moves Medicare Part B clinicians to a performance-based payment system
- Provides clinicians with flexibility to choose the activities and measures that are most meaningful to their practice
- Reporting standards align with Advanced APMs wherever possible

# What are the Performance Category Weights?

- Weights assigned to each category based on a



Up to 30% in the long run

Will shrink to 0% as EHRs become universal

# MIPS Cost Component

# Three Types of Episode Groups

- Procedural episodes
  - Typically triggered by a Part B claim with a relevant CPT code
  - e.g. Colonoscopy
- Acute condition episodes
  - Typically triggered by Part B claim associated with an inpatient stay
  - e.g. Admission for simple pneumonia
- Chronic condition episodes
  - Will be developed for future revisions of MIPS cost component
  - e.g. Outpatient chronic disease management

# Desired Characteristics of Cost Measures

- Provide incentives for high quality and cost-efficient care by balancing costs of initial treatment against costs of downstream services
  - Measures must respect each clinician's distinct role in patient care
- Must be aligned with quality measures
- Clear *ex ante* attribution of episodes
- Reports should suggest actions by clinicians that could improve future scores

# Cost Measures Have Five Essential Components

*Component 1:* Defining an episode group

*Component 2:* Assigning services and their respective costs to the episode group

*Component 3:* Attributing episode groups to clinicians

*Component 4:* Risk adjusting episode groups

*Component 5:* Aligning cost with quality

# MIPS Cost Component Will Consider Only Costs Associated With Care Provided

- Assignment of items and services determines what is included in episode costs and depends on role of attributed clinician
- Episode window determines the period of time during which claims are eligible to be assigned to the episode

## Items and Services that **Are** Assigned to the Episode Group

### ***Direct Services***

Provided or ordered to treat the clinical condition, plus ancillary care

### ***Indirect Services***

Provided or ordered by other clinicians in the same clinical context

- Post-operative care
- Ancillary care
- Consequences of care (e.g., complications)

## Items and Services that **Are Not** Assigned to the Episode Group

### ***Unrelated Services***

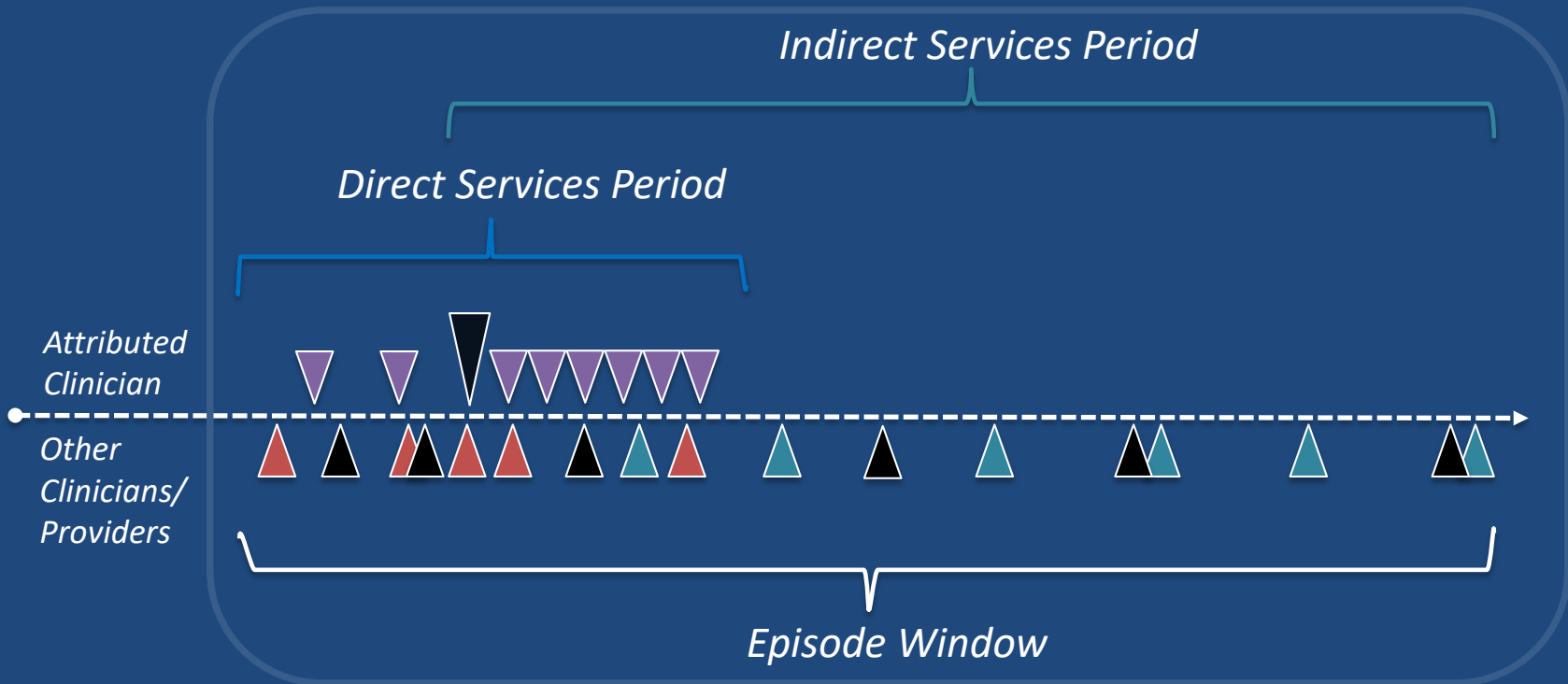
Unrelated to the clinical management of the patient's condition



# Measures that Respect Each Clinician's Role in Patient Care

- Different clinicians often play distinct roles in patient care
- Cost measures need to only include costs that are associated with the role a clinician plays
- Building cost measures around episode groups permits this feature
  - Define different, overlapping episode groups for each clinician
  - e.g. One episode group for the surgeon, another for the anesthesiologist for a procedural episode group

# Elements of an Episode of Care



# Elements of an Episode of Care

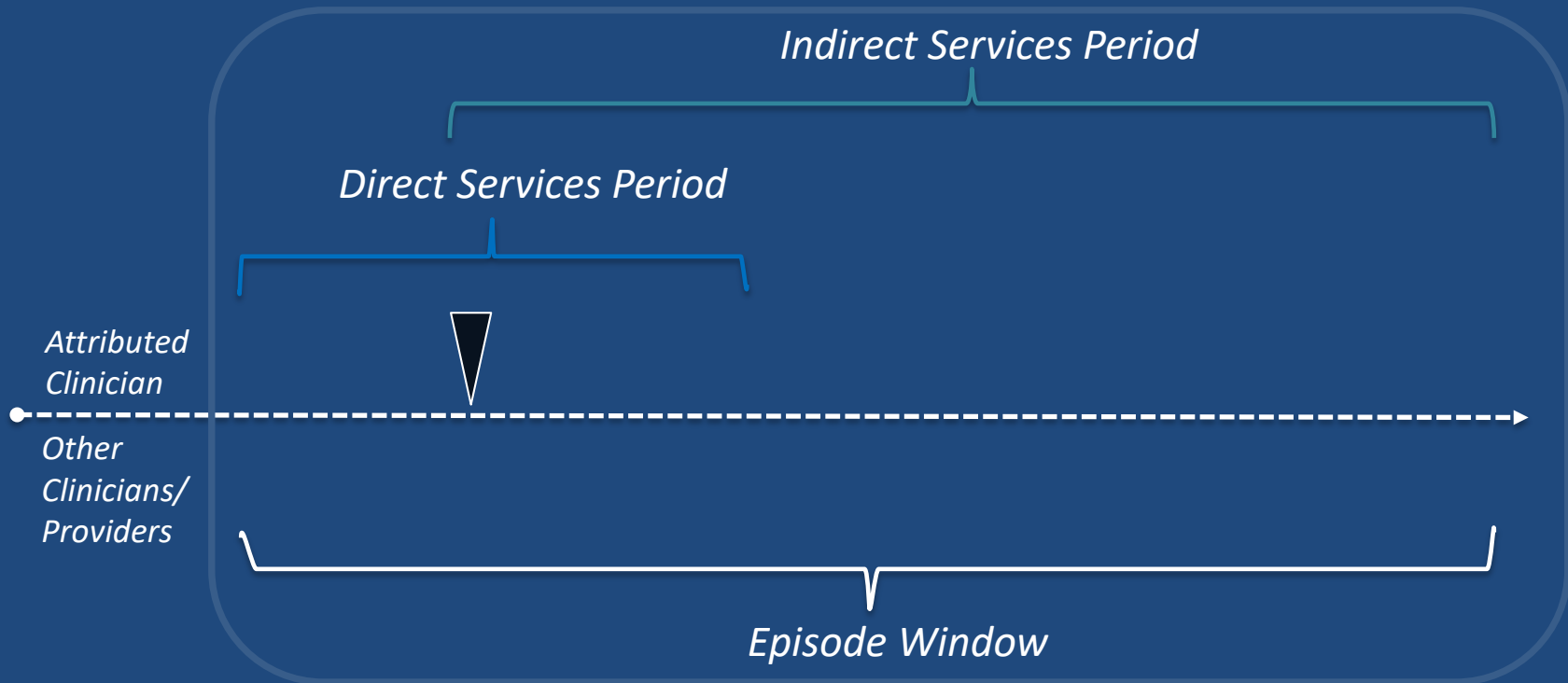
▼ Trigger Service

▼ Attributed Clinician Direct Service

▲ Other Clinicians/Providers Direct Service

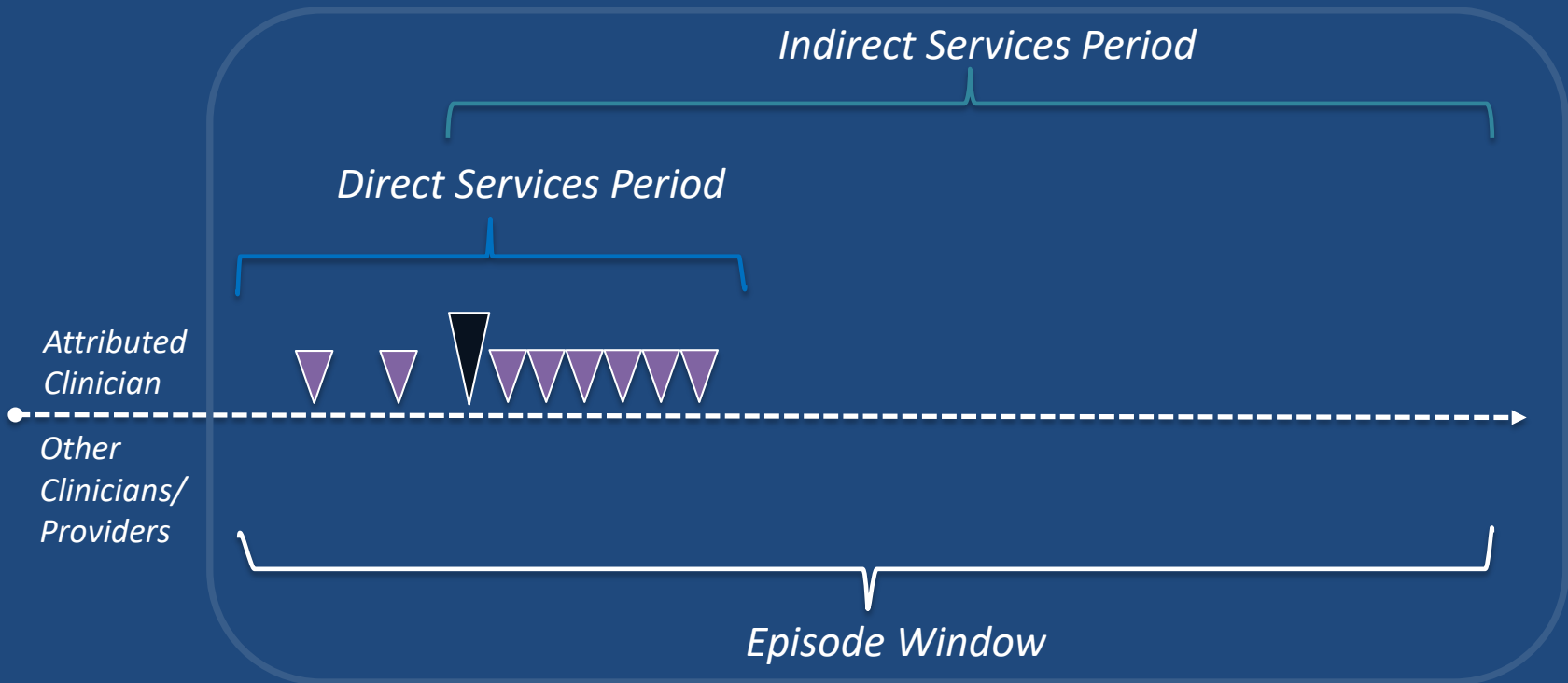
▲ Indirect Service

▲ Service Not Assigned to Episode



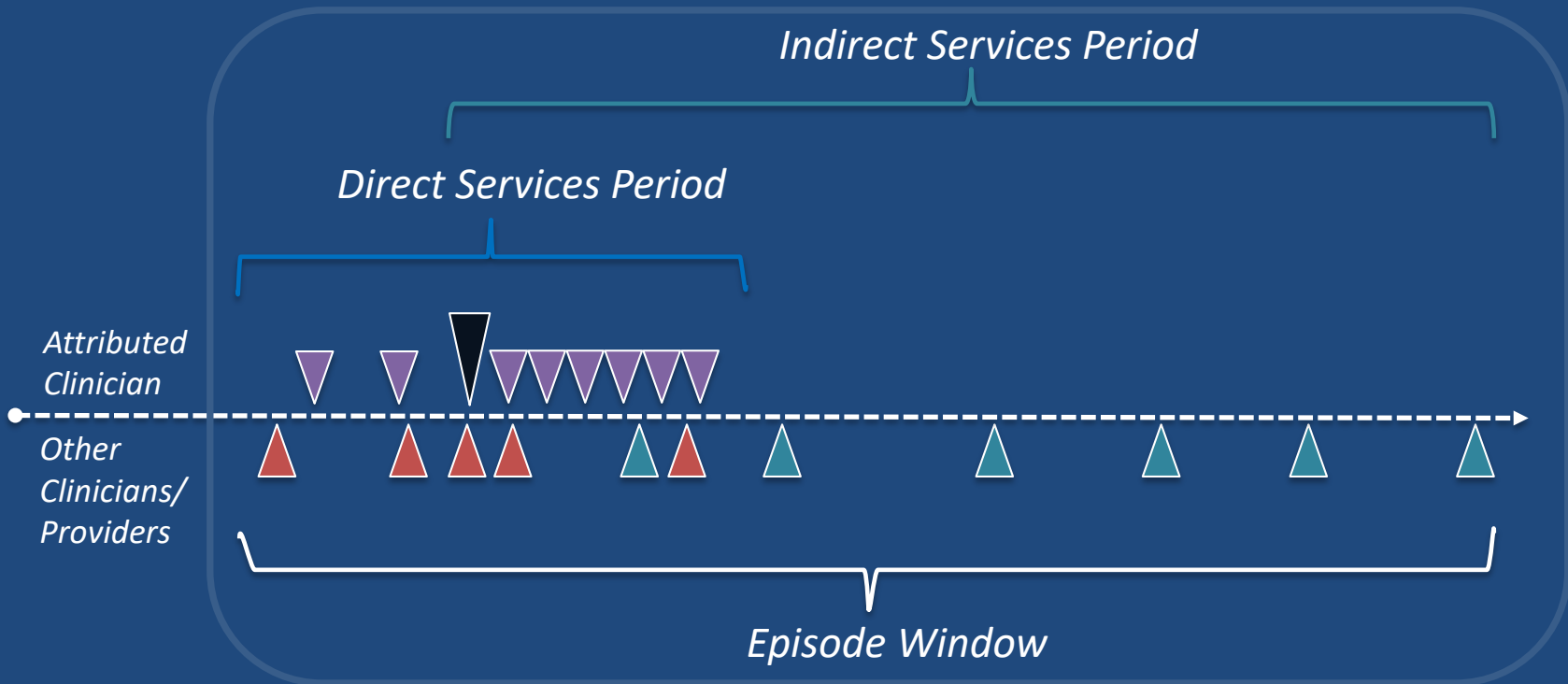
# Elements of an Episode of Care

- ▼ Trigger Service
- ▼ Attributed Clinician Direct Service
- ▲ Other Clinicians/Providers Direct Service
- ▲ Indirect Service
- ▲ Service Not Assigned to Episode

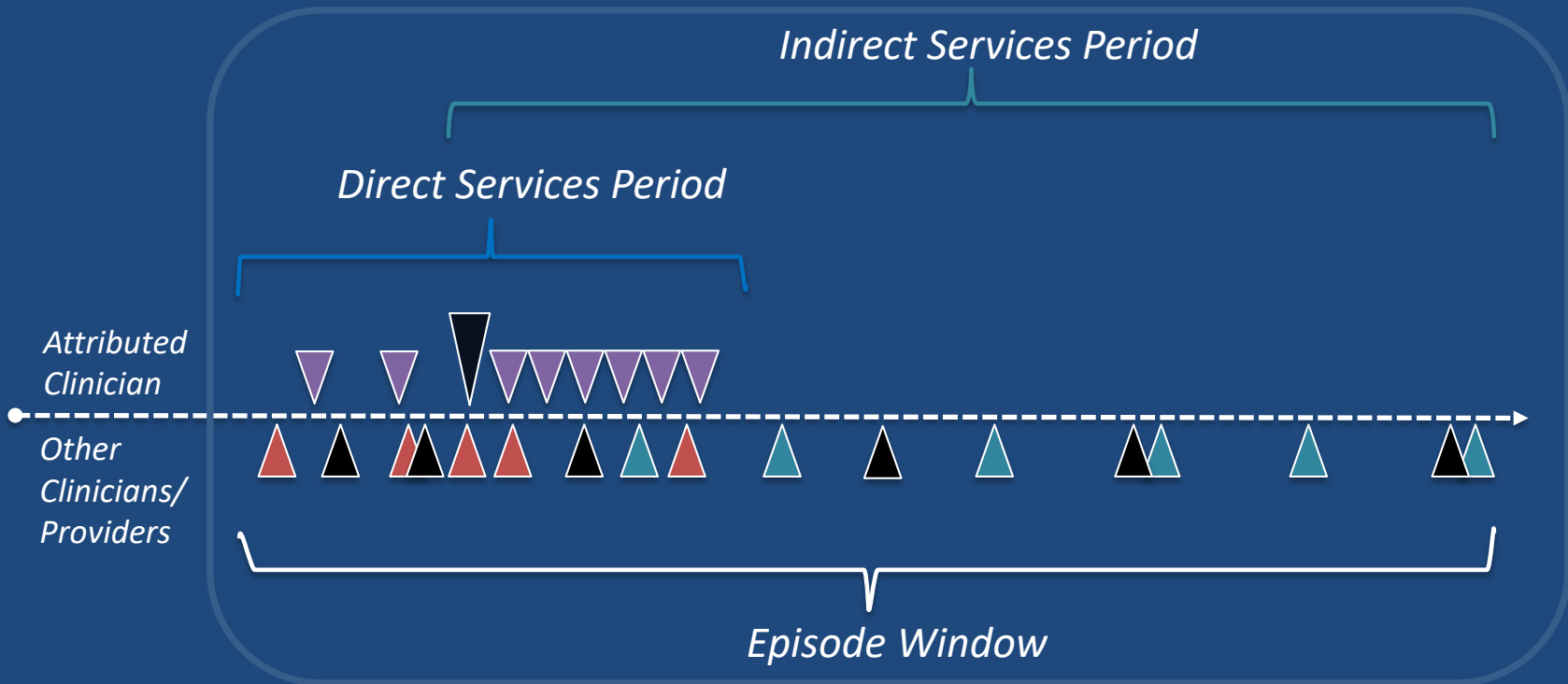


# Elements of an Episode of Care

- ▼ Trigger Service
- ▲ Other Clinicians/Providers Direct Service
- ▼ Attributed Clinician Direct Service
- ▲ Indirect Service
- ▲ Service Not Assigned to Episode



# Elements of an Episode of Care



# Alternative Payment Models

## What is an Alternative Payment Model (APM)?

APMs are **new approaches to paying** for medical care through Medicare that **incentivize quality and value.**

As defined by  
MACRA,  
**APMs**  
**include:**

- ✓ **CMS Innovation Center model** (under section 1115A, other than a Health Care Innovation Award)
- ✓ **MSSP** (Medicare Shared Savings Program)
- ✓ **Demonstration** under the Health Care Quality Demonstration Program
- ✓ **Demonstration** required by federal law



## Advanced APMs meet certain criteria.



As defined by MACRA, Advanced APMs **must meet the following criteria:**

- ✓ The APM requires participants to use **certified EHR technology**.
- ✓ The APM **bases payment on quality** measures comparable to those in the MIPS quality performance category.
- ✓ The APM either: **(1)** requires APM Entities to bear more than nominal **financial risk** for monetary losses; **OR (2)** is a **Medical Home Model expanded** under CMMI authority.

# PROPOSED RULE

## Medical Home Models

### Medical Home Models:





- ✓ Have a **unique financial risk criterion** for becoming an Advanced APM.
- ✓ Enable participants (who are not excluded from MIPS) to receive the **maximum score in the MIPS CPIA category.**



A **Medical Home Model is an APM** that has the following features:

- ✓ Participants include **primary care practices** or multispecialty practices that include primary care physicians and practitioners and offer primary care services.
- ✓ **Empanelment of each patient** to a primary clinician; and
- ✓ **At least four** of the following:
  - Planned coordination of chronic and preventive care.
  - Patient access and continuity of care.
  - Risk-stratified care management.
  - Coordination of care across the medical neighborhood.
  - Patient and caregiver engagement.
  - Shared decision-making.
  - Payment arrangements in addition to, or substituting for, fee-for-service payments.

# Advanced APMs Assume Increasing Risk for Patient Expenditures

 <p><b>Category 1</b> Fee for Service – No Link to Quality &amp; Value</p>	 <p><b>Category 2</b> Fee for Service – Link to Quality &amp; Value</p>	 <p><b>Category 3</b> APMs Built on Fee-for-Service Architecture</p>	 <p><b>Category 4</b> Population-Based Payment</p>
	<p><b>A</b> Foundational Payments for Infrastructure &amp; Operations</p> <p><b>B</b> Pay for Reporting</p> <p><b>C</b> Rewards for Performance</p> <p><b>D</b> Rewards and Penalties for Performance</p>	<p><b>A</b> APMs with Upside Gainsharing</p> <p><b>B</b> APMs with Upside Gainsharing/Downside Risk</p>	<p><b>A</b> Condition-Specific Population-Based Payment</p> <p><b>B</b> Comprehensive Population-Based Payment</p>

Source: Nussbaum, McClellan, Smith, and Conway (2016)

## PROPOSED RULE

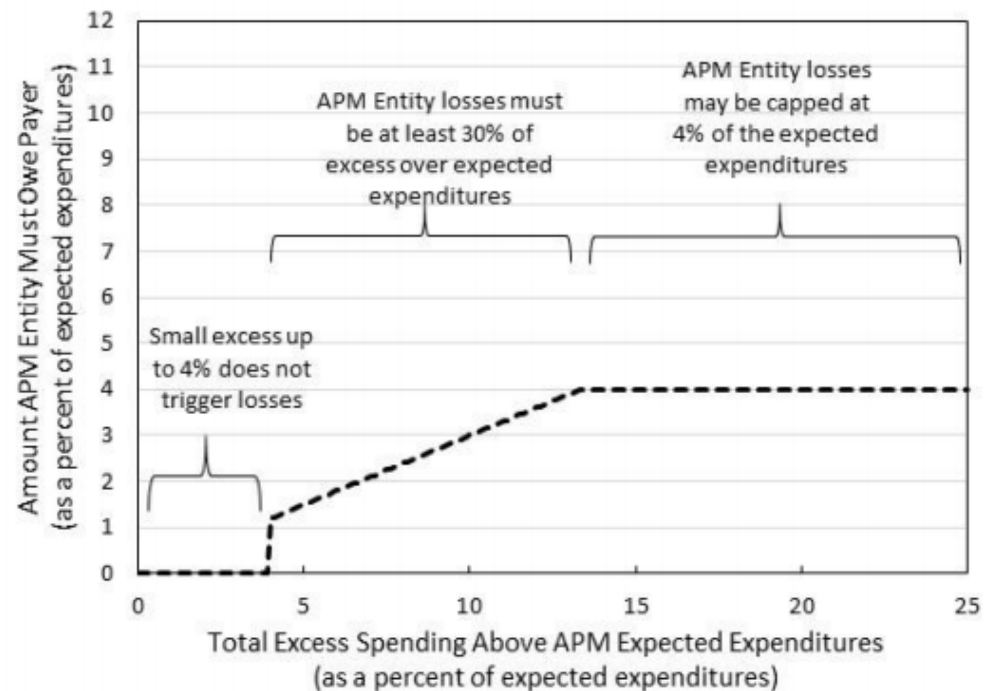
# Advanced APM Criterion 3: Financial Risk Criterion

### Nominal Amount Standard

The **amount of risk** under an Advanced APM must at least meet the following components:

- ✓ **Total risk** of at least 4% of expected expenditures
- ✓ **Marginal risk** of at least 30%
- ✓ **Minimum loss ratio (MLR)** of no more than 4%.

### Illustration of the amount of risk an APM Entity must bear in an Advanced APM:



# Advanced APMs

- Comprehensive ESRD Care (CEC) - Two-Sided Risk
- Comprehensive Primary Care Plus (CPC+)
- Next Generation ACO Model
- Shared Savings Program - Track 2
- Shared Savings Program - Track 3
- Oncology Care Model (OCM) - Two-Sided Risk
- Comprehensive Care for Joint Replacement (CJR) Payment Model (Track 1- CEHRT)

# The End of Fee-for-Service Medicine

# Administered Prices

- Administered price schedules like Medicare's seek to align the marginal costs of care provision with the marginal benefits of the care provided
  - This is impossible given the large number of pricing decisions made by CMS
- Reimbursement above marginal costs → over use of services (above social optimum)
- Reimbursement below marginal costs → under provision of services

# FFS and Care Coordination

- FFS payment systems provide a reimbursement for each service provided
- Such systems typically do not pay directly for care coordination activities
- Clinician reimbursement is not directly affected by the decisions of other clinicians participating in the care of the patient





By HikingArtist.com

# MACRA and Medicare FFS Prices

- The architecture of episode groups in the MIPS cost component guarantees that a clinician's reimbursement for a services will depend on the care provided by all the clinicians providing care to the patient
- APMs explicitly bundle payments
- **MACRA fosters interdependence among clinicians in patient care**

# Penalty for Overuse of Services

- MACRA penalizes physicians for *overuse* of services
  - That is, services that provide no measurable benefit for the patient
- *Underuse* of services is penalized via worse quality scores

# The Future of Medicine

# Some Speculation

- MACRA payment adjustment formulas are likely to be used (in the long run) by many private payers
  - Similar to the spread of DRG payment for hospitals
- MACRA will lead to significant changes in the organization of care
  - Changes in referral patterns away from expensive, inefficient providers
  - Strong incentive to consolidate practices into multi-specialty group practices