Society of Academic Anesthesiology Associations
MACRA Mambo #5: The Dance You Can't Avoid
11/12/2016
1:45pm – 2:05pm
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Background

In 1997 congress passed the Balanced Budget Act (BBA) of 1997, which replaced the Medicare Volume Performance Standard (MVPS), to rein in the growth in physician expenditure and healthcare costs. The BBA was designed to ensure that the annual increase in expense per Medicare beneficiary did not exceed the growth in Gross Domestic Product, and tied physician reimbursement to GDP. Each year CMS would send a report to the Medicare Payment Advisory Commission, and include a conversion factor that would either increase or decrease physician reimbursement based on whether targeted expenditures. Unfortunately, almost all the potential adjustments were downward and each Spring Congress would have to suspend or adjust the Sustained Growth Rate (SGR) formula ("doc fix"). This situation led to the passage of the Medicare Access and CHIP Reauthorization Act (MACRA)[1] of 2015, which President Obama signed into law on April 16, 2015 and went into effect in July of 2015.

Center for Medicare and Medicaid Services (CMS) Goals

In January of 2015, Secretary of Health and Human Services, Sylvia Burwell, stated that the goal of CMS was to have 85% of all Medicare fee-for-service payments tied to quality or value by 2016, and 90% by 2018. Even more striking was the goal to have 30% of all Medicare payments tied through either quality or value through an alternative payment model by 2016, and 50% of those payments by the end of 2018.

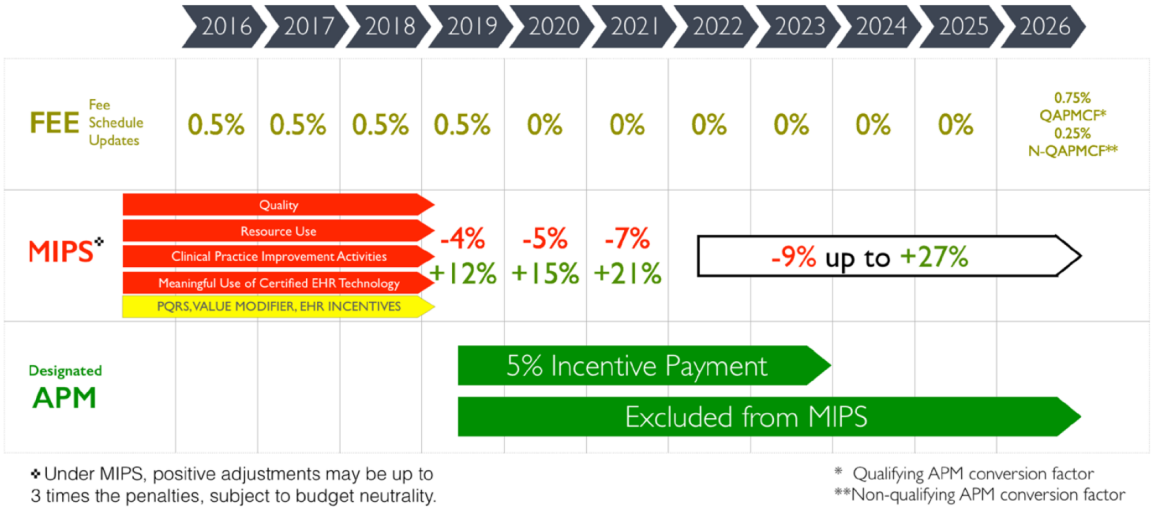
New Payment System Options (MIPS vs. APMs)

Physicians and other Eligible Providers (physician assistants, nurse practitioners, CRNAs, etc.) will now be paid through systems set up via MACRA. Payment will be through the Quality Payment Program, which will have two pathways for participation. These are the Merit-based Incentive Payment System (MIPS)[2] or the Advanced Payment Model (APM). About 5% of all physicians are initially expected to participate in the APM, which provides a 5% bonus for participation for the first six years of the program but also places some of those payments within a risk model. MIPS applies to all Eligible Providers except for those new to Medicare, have less than or equal to $10,000 in Medicare charges, and less than or equal to 100 Medicare patients.

Beginning in 2019, 4 percent of an Eligible Professional's revenue generated through Medicare fee-for-service payments will be distributed under MIPS and will grow to 9 percent by 2022 and remain at that level for an indeterminate time. Under the previous PQRS programs physicians in small practices were liable to penalties as

much as 6 percent or bonuses of up to 2 percent; practices with 8 or more physicians were subject to maximum penalties of 8 percent and a bonus of 4 percent.[3]

Payment Adjustment Under MACRA

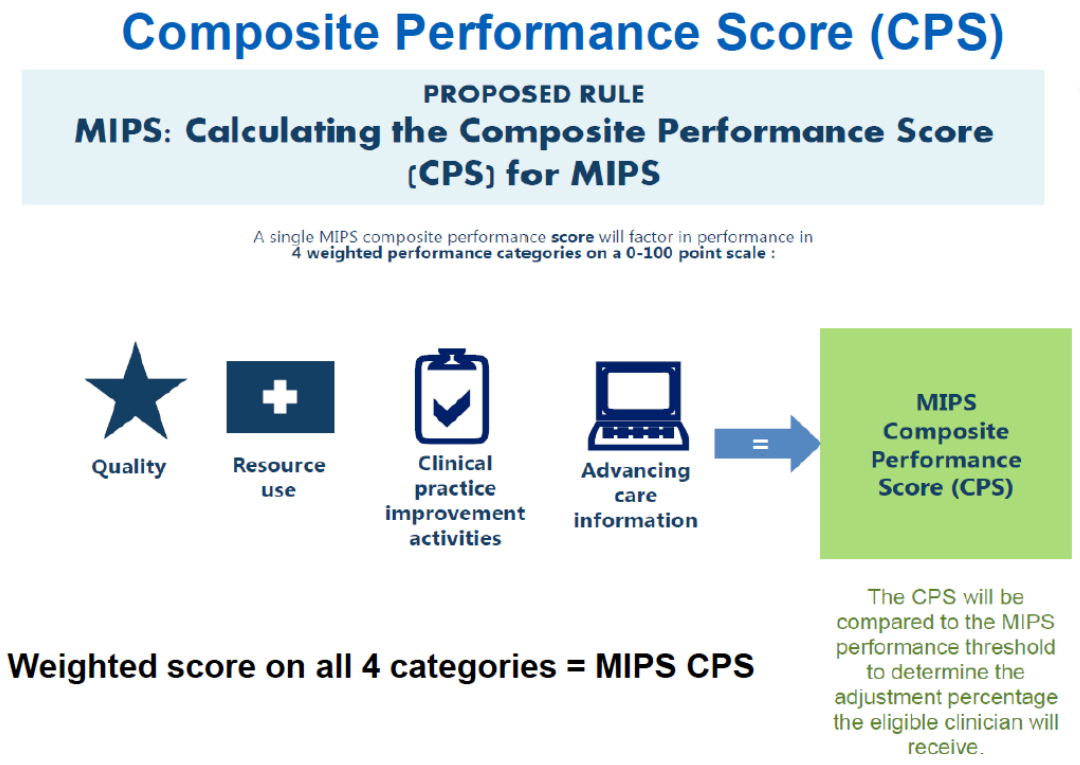


MACRA includes a 0.5% upward adjustment to the Medicare conversion factor for the first five years of the program, followed by no upward adjustment for the subsequent five years. From year 11 onward, Eligible Providers will receive either a 0.25% increase under the MIPS program or a 0.75% increase under the APM model. To be eligible for the APM providers must be part of current APMs that measure up to the "advanced" threshold." These include the Medicare Shared Savings Program (MSSP) ACOs, Tracks 2 and 3; Medicare Next Generation ACOs; Comprehensive Primary Care Plus (CPC+) Model; Oncology Care Model (two-sided risk); and, Comprehensive End-Stage Renal Disease Care Model. Absent from the proposed APM rules are Track 1 MSSP ACOs and other bundled payment models. There will also be rewards or penalties under the new Quality Payment Program, with incentives ranging from 4% to 9%, and penalties starting at 4% and increasing to 9% of Medicare reimbursement. Overall the program is budget neutral ("Hunger Games" strategy). However, the program does provide for an additional $500 million in funding that is separate from budget neutrality and can be awarded for those exceeding targets within the first five years. The bonuses would be awarded on a sliding scale with those bonuses reaching a maximum 10% additional amount above the base MIPS bonus. Bonuses within the APM model are not required to be budget neutral.

Composite Performance Score (CPS)

Under MACRA, the current separate programs of quality and cost (Value-based Modifier), Physician Quality Reporting System (PQRS), and Meaningful Use will all

be combined under MACRA. There will now be four components (quality, resource use, clinical practice improvement activities, and meaningful use of certified EHR technology) comprising payment and Eligible Providers will be scored, and those scores will be weighted and combined into a composite score. The weight of each of the four components will shift over time, with initial benchmark of quality at 50%, cost at 10%, Clinical Practice Improvement Activities (CPIA) at 15%, and advancing care information at 25%. Most anesthesiologists are exempt under the current standard of Meaningful Use and may continue to be exempt under the new Advancing Care Information program as a "non-patient facing" specialty, as long as the anesthesia provider reported 25 or fewer codes during the given reporting year. Under Clinical Practice Improvement Activities, Eligible Providers must report on three high-weighted activities or six medium-weighted activities (out of a total of 90 listed activities).



Current Quality Reporting System

Under the Physician Quality Reporting System (PQRS) over 70% of anesthesiologists reported on quality measures with over 30% receiving a payment adjustment in 2016. This rate of participation is much higher than other specialties such as cardiology (26.7%), emergency medicine (28.3%), and radiology (25.7%). MACRA will fundamentally alter how the Centers for Medicare & Medicaid Services (CMS) pays physicians and other medical professionals as the shift from quantity to

quality occurs and emphasis will be on pay-for-value rather than pay-for-reporting or pay-for-performance. The reporting period begins January 1, 2017.

Quality Under MACRA[4]

Under the new quality program, Eligible Providers only need to report on six measures versus the previous 9 measures under PQRS. One measure must be an outcome measure and one measure must be a cross-cutting measure. Clinicians may still continue to report quality measures via claims (80%) of Medicare patients, or 90% of all patients if reporting through a Qualified Clinical Data Registry (QCDR).

The trend by CMS to emphasize non-process measures will continue in the areas of patient outcomes, patient experience and satisfaction, and patient perception of coordination of care by multiple eligible professionals (EPs).
CMS in its release of the 2016 Measure Development Plan (MDP) and the MACRA proposed rule emphasized measures that follow the patient across the continuum of care including patient-reported outcome measures such as functional status, measures that accountability among multiple levels of care, etc.

Quality Measures for Anesthesiologists:

CMS has proposed an Anesthesiology Specialty-Specific Measure Set for eligible anesthesiologists. Those are:

- MIPS #44: CABG: Preoperative Beta-Blocker in Patients with Isolated CABG Surgery
- MIPS #76: Prevention of CVC-Related Bloodstream Infections*
- MIPS #404 Anesthesiology Smoking Abstinence*
- MIPS #424: Perioperative Temperature Management*
- MIPS #426: Post-Anesthetic Transfer of Care Measure: Procedure Room to PACU*
- MIPS #427" Post-Anesthetic Transfer of Care Measure: Procedure Room to ICU*
- MIPS #430: Prevention of PONV-Combination Therapy*

* Indicates a proposed "high priority measure"

Different Options for Inclusion in MACRA in 2017

On September 8, the Acting Administrator at CMS, Andy Slavitt, published a blog[5] post outlining different options that eligible clinicians might follow for inclusion in MACRA in 2017. This occurred after comments by many professional organizations over concern regarding the relative short timeline for implementation of quality reporting measures. The proposal was to allow up to four options to avoid negative payment adjustments under MACRA in 2019. The new plan allows eligible providers

to pick the pace of participation for the first performance period that begins January 1, 2017.

- Option #1: As long as eligible providers submit some data to the Quality Payment Program, the negative payment adjustment will be avoided.
- Option #2: Allows the eligible provider to submit date to the Quality Payment Program for a reduced number of days. In practicality this means that one's first performance period could begin after January 1, 2017. The EP could qualify for a small positive payment adjustment
- Option #3: Eligible Providers may opt to submit Quality Payment Program information for a full calendar year beginning on January 1, 2017. The Eligible Providers then could qualify for a modest positive payment adjustment
- Option #4: Instead of reporting quality data and other information, MACRA allows the EP to participate in the Quality Payment Program by joining an Advanced Alternative Payment Model (APM), such as Medicare Shared Savings Track 2 or 3 in 2017. The EP could then qualify for a 5 percent payment incentive in 2019.

Conclusion

MACRA will fundamentally change how physicians are judged on quality, cost, and practice improvement projects. Both CMS and the American Society of Anesthesiologists have excellent resources for understanding the nuances of this new program.

References

1. https://s3.amazonaws.com/public-inspection.federalregister.gov/2016-10032.pdf

2. http://www.asahq.org/quality-and-practice-management/macra/asa-macra-resources/MIPS-Information

3. https://www.brookings.edu/research/how-the-money-flows-under-macra/

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

5. https://blog.cms.gov/2016/09/08/qualitypaymentprogram-pickyourpace/