Washington Update

Congressman Andy Harris, M.D. (MD-1)
Anesthesiologist
Disclosures

• I have no pertinent disclosures.
Appropriations Committee

- Only physician on the entire committee
- Serve on subcommittee that deals with all health funding issues (Labor/HHS)
  - HHS: CMS, CDC, NIH
- Serve on Agriculture Subcommittee, which funds FDA
- Can influence other subcommittee appropriation bills that involve health
- Appropriations controls the purse strings
Topics

• Medicare Access and CHIP Reauthorization Act (MACRA)

• Meaningful Use

• The CCJR *Mandatory* Model

• NIH, research reform
US Health Spending by Source - 2014 CMS NHE Account

Total=$2.87 trillion

- Out of pocket: 3.87%
- Private Health Insurance: 11.49%
- Medicare: 11.46%
- Medicaid: 17.23%
- Other Health Insurance Programs: 21.50%
- Other Third Party Payers and Programs and Public Health Activity: 34.44%
Sustainable Growth Rate (SGR) Repeal

• After 17 different “Doc Fixes” dating back to 2003 and facing a 21% SGR cut last year, finally repealed SGR!

[Image of MLN Connects Provider eNews - Special Edition]

Attention Health Professionals: Information Regarding the 2015 Medicare Physician Fee Schedule

The negative update of 21% under current law for the Medicare Physician Fee Schedule is scheduled to take effect on April 1, 2015. Medicare Physician Fee Schedule claims for services rendered on or before March 31, 2015, are not subject by the payment cut and will be processed and paid as normal procedures and time frames. The Administration urges Congress to take action to ensure these cuts do not take effect. However, until that happens, CMS must take steps to implement the negative update. Under current law, electronic claims are not paid sooner than 14 calendar days (29 days for paper claims) after the date of receipt. CMS will notify you on or before April 11, 2015, with more information about the status of Congressional action to avert the negative update and next steps.
Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)

- Reauthorizes CHIP & significant changes to Medicare physician payment:
  1) Merit-Based Incentive Payment System (MIPS)
  2) Alternative Payment Models (APMs)
Overarching MACRA Impact

- Repeals the Medicare SGR

- Annual update July 1, 2015 through 2019 is set at 0.5%

- 2020-2025 the annual update is set at 0.0%

- For years 2026 forward the annual update is set at 0.75% for qualifying APM participants and 0.25% for all other physicians
How will physicians and practitioners be scored under MIPS?

A single MIPS **composite performance score** will factor in performance in **4 weighted performance categories**:

- Quality
- Resource use
- Clinical practice improvement activities
- Meaningful use of certified EHR technology

Source: CMS
Physicians Choose MIPS or APMs

**MIPS**

- **2018**: Last year of separate MU, PQRS, and VBM penalties
- **2019**: Combine PQRS, MU, & VBM programs and add CPIA: -4% to +12%
- **2021**: -7% to +21%
- **2022 and on**: -9% to +27%

**APMs**

- **2019 - 2020**: 25% Medicare revenue requirement
- **2019 - 2024**: 5% annual participation bonus and additional 0.5% annual update
- **2021 and on**: Ramped up Medicare or allpayer Revenue requirements

*Medicare Fee-for-Service remains an eligible payment model, but will be heavily influenced by MIPS.*
## MACRA Payment Timeline

### Timeline

<table>
<thead>
<tr>
<th>Year</th>
<th>Fee Schedule Updates</th>
<th>Quality</th>
<th>Resource Use</th>
<th>Clinical Practice Improvement Activities</th>
<th>Meaningful Use of Certified EHR Technology</th>
<th>PQRS, Value Modifier, EHR Incentives</th>
<th>MIPS Payment Adjustment (+/-)</th>
<th>5% Incentive Payment</th>
<th>Excluded from MIPS</th>
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<td>2026 and later</td>
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<td>0.25 (N-QAPMCF**)</td>
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*Qualifying APM conversion factor

**Non-qualifying APM conversion factor
How CMS Envisions MACRA Payment Shifts

Target percentage of Medicare FFS payments linked to quality and alternative payment models in 2016 and 2018

- All Medicare FFS (Categories 1-4)
- FFS linked to quality (Categories 2-4)
- Alternative payment models (Categories 3-4)

2016:
- 85%
- 30%

2018:
- 90%
- 50%

CMS Newsroom:
Next Steps for MACRA

• CMS celebrated 1 year anniversary of MACRA passage

• MACRA implementation rule expected soon

• Energy & Commerce Health Subcommittee to host second MACRA implementation hearing focused on physician efforts to prepare for implementation
Unresolved questions

• MACRA is not perfect:
  – Will likely need updates in coming years
  – Many big questions remain on how new system will be implemented
    • Where will MIPS thresholds be set?
    • How will physicians measure Clinical Practice Improvement Activities?
    • Or when it comes to the resource use component to the composite score, who and what will be measured?
    • In APMs, how will levels of risk be established and shared?
    • Etc
Electronic Health Records
Meaningful Use Program

• Host of issues:
  – Interoperability of systems
  – Flexibility of systems to incorporate physician and patient choice
  – Physicians spending more time entering data unrelated to patient needs
  – Low successful compliance despite high EHR usage
  – Etc
The end of Meaningful Use as we currently know it?

• Blanket hardship exemption passed Congress in Dec. 2015 (S.2425)
  - Also streamlined process to allow group exemptions rather than requiring each physician to apply individually

• Change on the way?
  – CMS Acting Administrator Andy Slavitt stated “The Meaningful Use program as it has existed, will now be effectively over and replaced with something better”
Meaningful Use

- 21st Century Cures Bill and interoperability:
  - Require HHS and ONC set standards on what makes a technology interoperable based on:
    - Allow for secure transfer of all patient data
    - Access to all patient data
    - Not configured to block information
Comprehensive Care for Joint Replacement Model

- This impacting about 800 hospitals over 67 regions, this is CMS’ first **mandatory** bundled-payment initiative and will apply to hip and knee replacements.

- Ultimately, the “episode of care” makes providers responsible for the cost of the joint replacement care from the time of surgery through 90 days post-discharge.
  - All medical services delivered including physician inpatient services, outpatient follow-up, home health services, skilled nursing facility services, and hospital readmissions are included.

- If costs exceed CMS’s target price then the hospitals will pay a penalty.
Delaying CJR implementation

- Co-signed House letter with 60 colleagues to CMS calling for a delay to examine the implications of this new mandatory model
- This mandatory model went into affect 4/1 and there was less than 150 days to prepare
- Impact on future payment will begin at the end of the year
- Co-sponsored H.R. 4848 the “Health Inpatient Procedures Act of 2016” to delay this until January 1, 2018
Figure 1: An Age Distribution for Scientific Genius. The Ages at which Individuals Produced Nobel-Prize Winning Insights and Great Technological Contributions over the 20th Century
Age Distribution of RO1 PIs

1980

Source: AAMC
Age Distribution of RO1 PIs 2013

Source: AAMC
‘21st Century Cures’ Bill – Set aside money to fund emerging scientists

American Health Care Reform Act – section on Young Investigators, X-prize

Appropriations Language requiring a workforce study and a greater focus on young investigators
Summary

- Big changes to Medicare payment that the physician community should continue to spearhead
- Meaningful Use appears primed for significant changes
- CCJR may be first step
- Research reform is advancing
- Remain vigilant in addressing the future of medicine