



# MACRA and Delivery System Reform



*The Health IT Policy  
Committee*

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*May 17<sup>th</sup>, 2016*

# Agenda

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- Quality Payment Program Overview
- Data Submission
- Timeline
- Public Comment

# **INTRODUCING THE QUALITY PAYMENT PROGRAM**

# Quality Payment Program

- ✓ **Repeals** the Sustainable Growth Rate (SGR) Formula
- ✓ **Streamlines** multiple quality reporting programs into the new Merit-based Incentive Payment System (MIPS)
- ✓ **Provides incentive payments** for participation in **Advanced Alternative Payment Models (APMs)**



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

**or**

**Advanced  
Alternative  
Payment Models  
(APMs)**

- ✓ **First step to a fresh start**
- ✓ **We're listening and help is available**
- ✓ **A better, smarter Medicare for healthier people**
- ✓ **Pay for what works to create a Medicare that is enduring**
- ✓ **Health information needs to be open, flexible, and user-centric**

# APMs

## 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

## APM Scoring Standard

### Goals:

- ✓ **Reduce** eligible clinician reporting burden.
- ✓ Maintain focus on the **goals and objectives of APMs**.

### How does it work?

- ✓ **Streamlined MIPS reporting and scoring** for eligible clinicians in certain APMs.
- ✓ Aggregates eligible clinician MIPS scores to the **APM Entity level**.
- ✓ All eligible clinicians in an APM Entity **receive the same MIPS composite performance score**.
- ✓ Uses **APM-related performance** to the extent practicable.



## PROPOSED RULE

# APM Scoring Standard



The APM scoring standard **applies to APMs that meet these criteria:**

- ✓ APM Entities participate in the APM under an **agreement with CMS;**
- ✓ APM Entities include one or more **MIPS eligible clinicians** on a Participation List; and
- ✓ APM bases payment incentives on performance (either at the APM Entity or eligible clinician level) on **cost/utilization and quality measures.**

- ✓ To be considered part of the APM Entity for the APM scoring standard, an eligible clinician **must be on an APM Participation List on December 31** of the MIPS performance year.
- ✓ Otherwise an eligible clinician must report to MIPS under the standard MIPS methods.

## PROPOSED RULE

# APM Scoring Standard

**To which APMs will the APM scoring standard apply?**

- ✓ **Shared Savings Program** (all tracks)
- ✓ **Next Generation ACO Model**
- ✓ **Comprehensive ESRD Care (CEC)** (large dialysis organization arrangement)
- ✓ **Comprehensive Primary Care Plus (CPC+)**
- ✓ **Oncology Care Model (OCM)**
- ✓ **All other APMs** that meet criteria for the APM scoring standard

**Note: MACRA does NOT change how any particular APM functions or rewards value. Instead, it creates extra incentives for APM participation.**

# MACRA provides **additional** rewards for participating in **APMs**.



## Potential financial rewards

Not in APM

MIPS adjustments

In APM

MIPS adjustments

+

APM-specific  
rewards

In **advanced** APM

APM-specific  
rewards

+

**5% lump sum  
bonus**

If you are a  
**qualifying APM  
participant (QP)**

# How do I become a **Qualifying APM Participant (QP)**?



Advanced APM

QP

You must have a **certain %** of your patients or payments through an **advanced APM.**

QPs will:

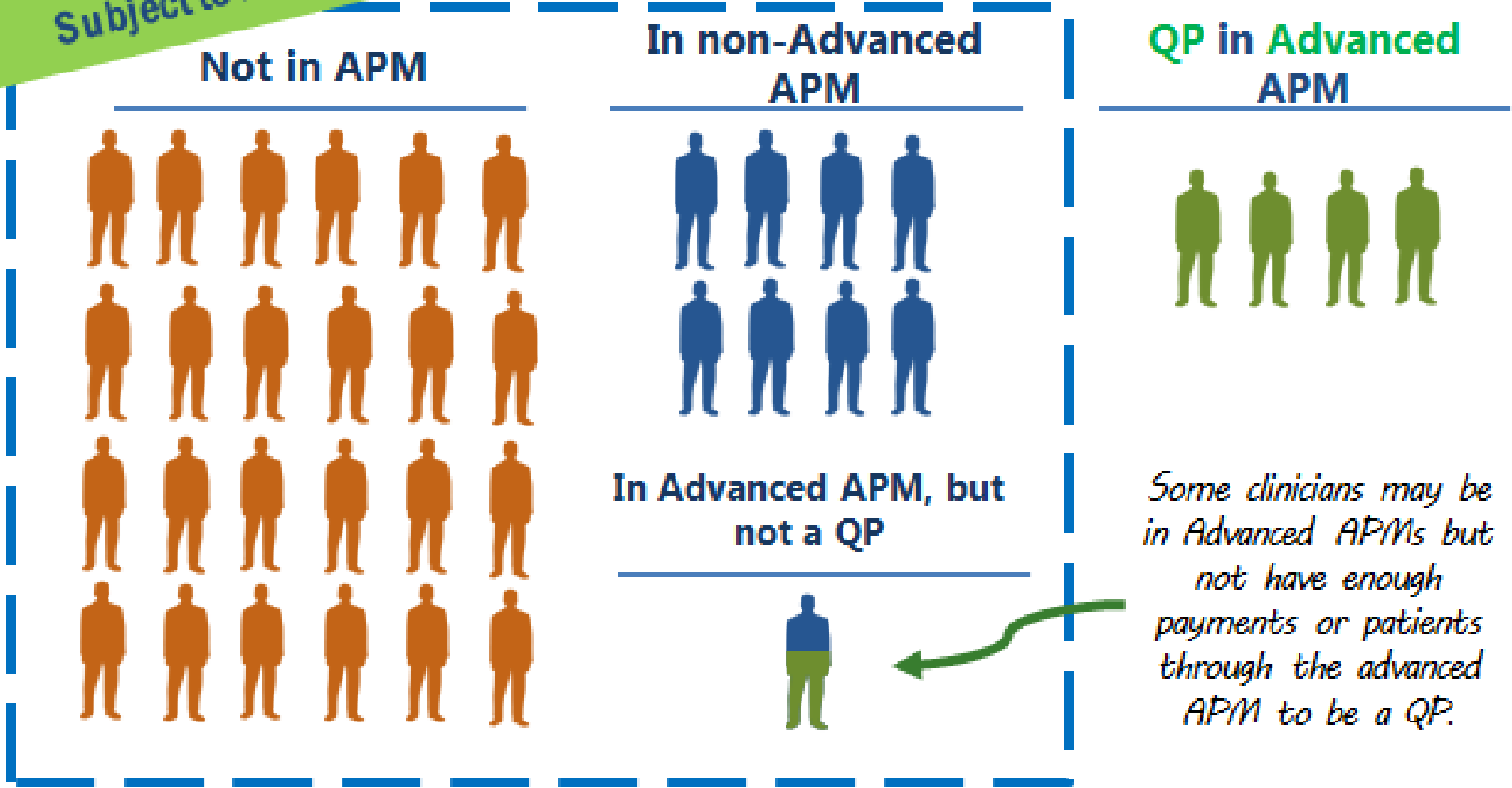
Be excluded from MIPS

Receive a 5% lump sum bonus

*Bonus applies in 2019-2024; then QPs receive higher fee schedule updates starting in 2026*

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

**Subject to MIPS**



**QP in Advanced APM**

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

*Note: Figure not to scale.*

# MIPS

# MIPS: First Step to a Fresh Start

- ✓ **MIPS is a new program**

**Streamlines 3 currently independent programs to work as one and to ease clinician burden.**

**Adds a fourth component to promote ongoing improvement and innovation to clinical activities.**



**Quality**



**Resource  
use**



**Clinical practice  
improvement  
activities**



**Advancing  
care  
information**

- ✓ **MIPS provides clinicians the flexibility to choose the activities and measures that are most meaningful to their practice to demonstrate performance.**



# Who Will Participate in MIPS?

Affected clinicians are called “**MIPS eligible clinicians**” and will participate in MIPS. The types of **Medicare Part B** health care clinicians affected by MIPS may expand in the first 3 years of implementation.

Years 1 and 2



**Physicians (MD/DO and DMD/DDS),  
PAs, NPs, Clinical nurse specialists,  
Nurse anesthetists**

Years 3+

*Secretary may  
broaden Eligible  
Clinicians group to  
include others such  
as*



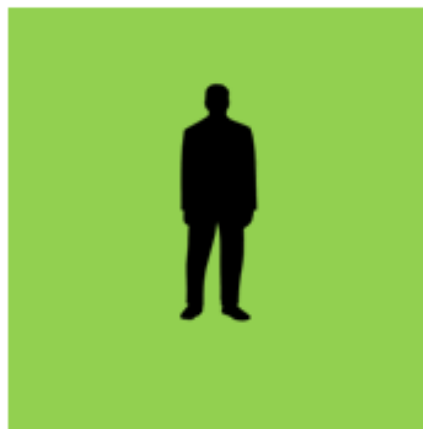
**Physical or occupational therapists,  
Speech-language pathologists,  
Audiologists, Nurse midwives, Clinical  
social workers, Clinical psychologists,  
Dietitians / Nutritional professionals**

## Who will NOT Participate in MIPS?

There are **3 groups** of clinicians who will NOT be subject to MIPS:



**FIRST** year of Medicare  
Part B participation



Below **low patient**  
**volume** threshold



Certain participants in  
**ELIGIBLE** Alternative  
Payment Models

Medicare billing charges less than or equal to \$10,000  
and provides care for 100 or fewer Medicare patients in  
one year

Note: MIPS **does not** apply to hospitals or facilities

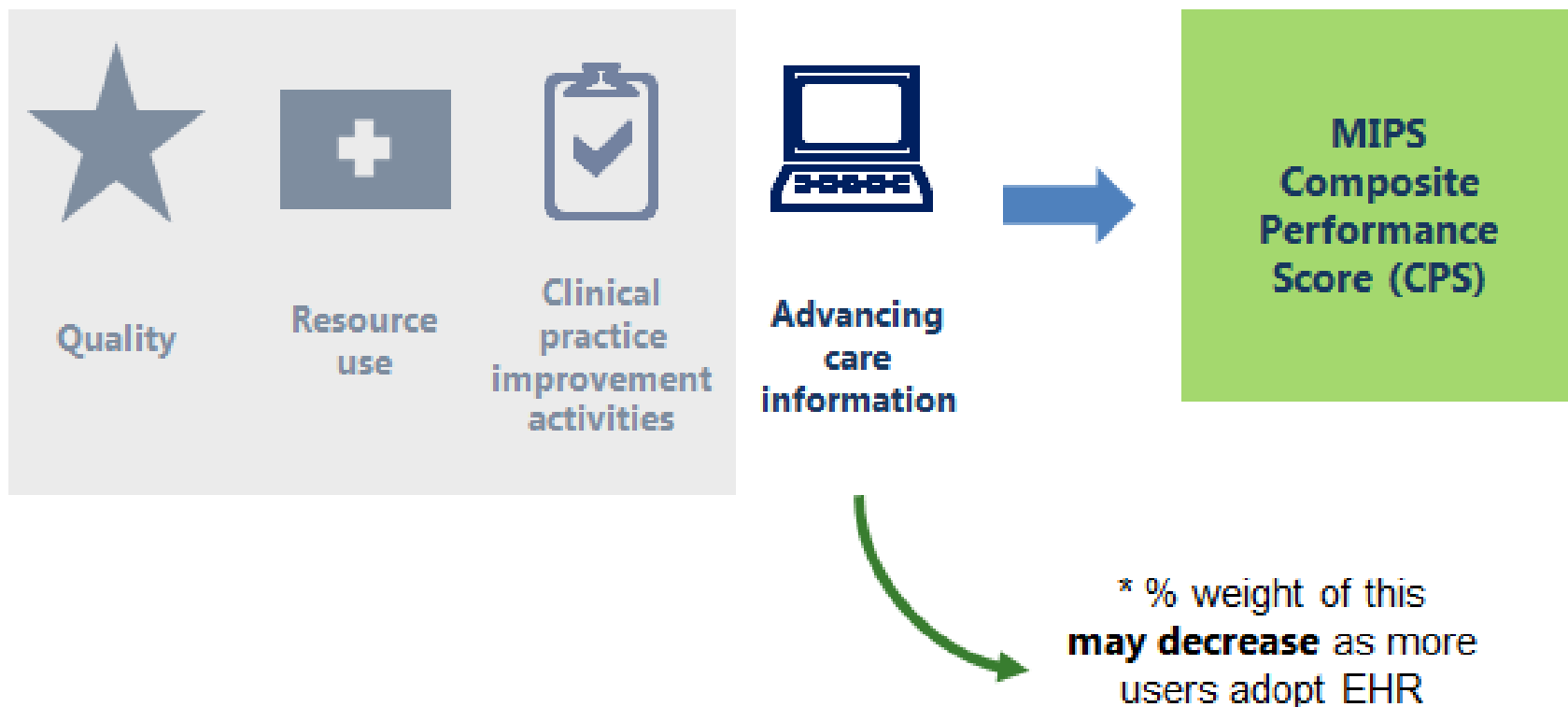
**PROPOSED RULE  
MIPS: ADVANCING CARE  
INFORMATION PERFORMANCE  
CATEGORY**

# Changes from EHR Incentive Program to Advancing Care Information

Past Requirements for the Medicare EHR Incentive Program	New Proposal for Advancing Care Information Category
One-size-fits-all – every objective reported and weighed equally	Customizable – clinicians can choose which categories to emphasize in their scoring
Requires across-the-board levels of achievement or “thresholds,” regardless of practice or experience	Flexible. Allows for diverse reporting that matches clinician’s practice and experience.
Measurement emphasizing process	Measurement emphasizing patient engagement and interoperability
Disjointed and redundant with other Medicare reporting programs	Aligned with other Medicare reporting programs. No need to report redundant quality measures.
No exemptions for reporting	Exemptions for reporting for clinicians in: <ul style="list-style-type: none"> <li>• Advanced alternative payment models</li> <li>• First year with Medicare</li> <li>• Have low Medicare volumes</li> </ul>

# What will determine my MIPS score?

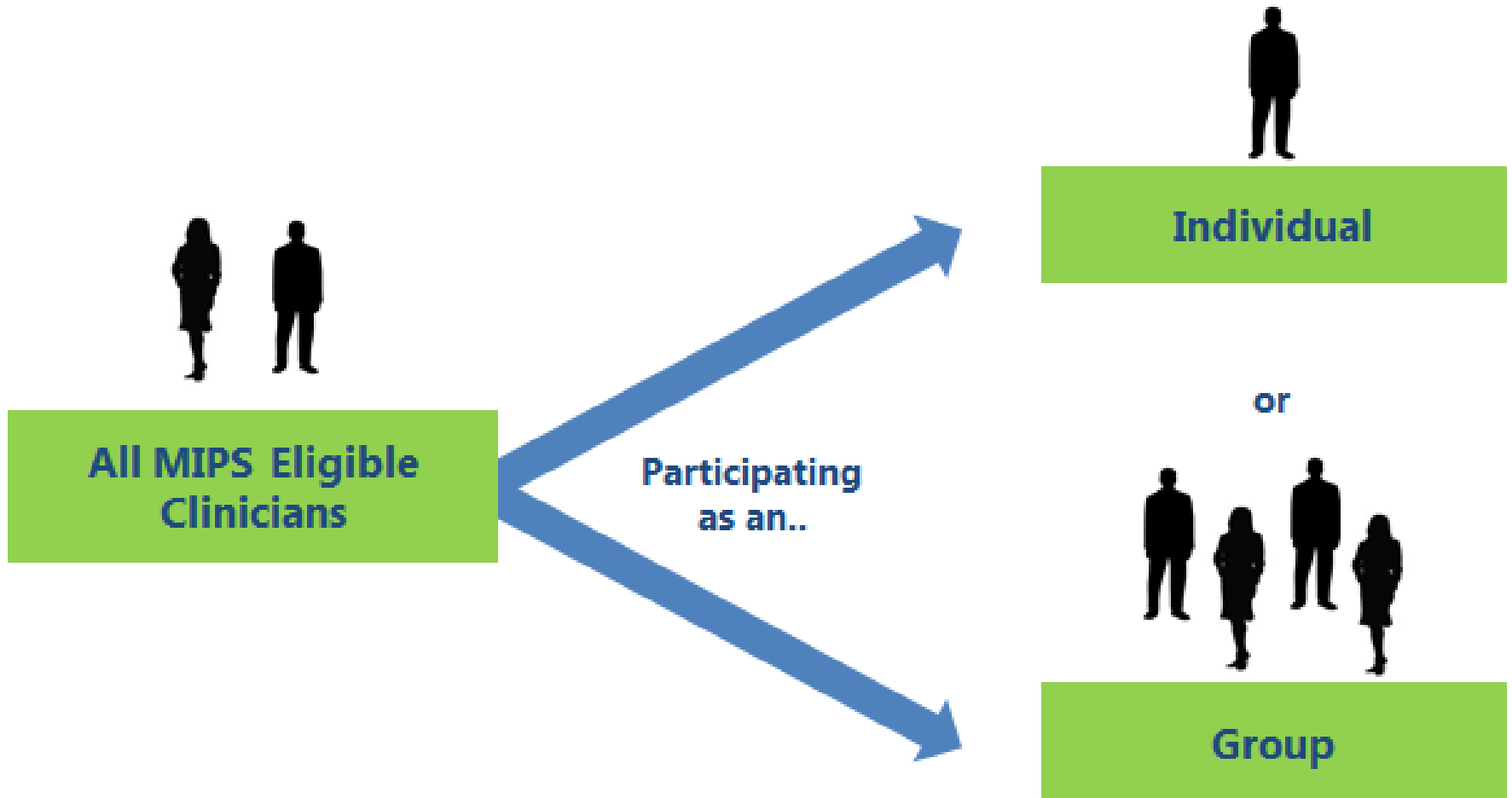
The MIPS composite performance **score** will factor in performance in **4 weighted performance categories** on a **0-100 point scale** :



# PROPOSED RULE

## MIPS: Advancing Care Information Performance Category

Who can participate?



# PROPOSED RULE

## MIPS: Advancing Care Information Performance Category

CMS proposes six objectives and their measures that would require reporting for the base score:



**Protect Patient Health  
Information**  
(yes required)



**Electronic  
Prescribing**  
(numerator/denominator)



**Patient Electronic  
Access**  
(numerator/denominator)



**Coordination of Care Through  
Patient Engagement**  
(numerator/denominator)



**Health Information  
Exchange**  
(numerator/denominator)



**Public Health and Clinical Data  
Registry Reporting**  
(yes required)

# Calculating the Composite Performance Score (CPS) for MIPS

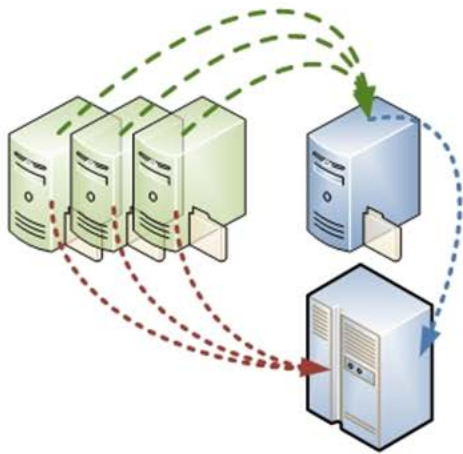
Category	Weight	Scoring
Quality	50%	<ul style="list-style-type: none"> <li>• Each measure 1-10 points compared to historical benchmark (if avail.)</li> <li>• 0 points for a measure that is not reported</li> <li>• Bonus for reporting outcomes, patient experience, appropriate use, patient safety and EHR reporting</li> <li>• Measures are averaged to get a score for the category</li> </ul>
Resource Use	10%	<ul style="list-style-type: none"> <li>• Similar to quality</li> </ul>
CPIA	15%	<ul style="list-style-type: none"> <li>• Each activity worth 10 points; double weight for "high" value activities; sum of activity points compared to a target</li> </ul>
Advancing care information	25%	<ul style="list-style-type: none"> <li>• Base score of 50 points is achieved by reporting at least one use case for each available measure</li> <li>• Up to 10 additional performance points available per measure</li> <li>• Total cap of 100 percentage points available</li> </ul>

- ✓ Unified scoring system:
  1. Converts measures/activities to points
  2. Eligible Clinicians will know in advance what they need to do to achieve top performance
  3. Partial credit available



# How do I get my data to CMS?

## *Data Submission for MIPS*



# PROPOSED RULE

## MIPS Data Submission Options

### Quality and Resource Use

*Individual Reporting*

*Group Reporting*



<ul style="list-style-type: none"> <li>✓ QCDR</li> <li>✓ Qualified Registry</li> <li>✓ Health IT developer</li> <li>✓ Administrative Claims (No submission required)</li> </ul>	<ul style="list-style-type: none"> <li>✓ QCDR</li> <li>✓ Qualified Registry</li> <li>✓ Health IT developer</li> <li>✓ CMS Web Interface (groups of 25 or more)</li> <li>✓ CAHPS for MIPS Survey</li> <li>✓ Administrative Claims (No submission required)</li> </ul>
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# PROPOSED RULE

## MIPS Data Submission Options

### Advancing Care Information and CPIA

*Individual Reporting*



*Group Reporting*



**Advancing care information**

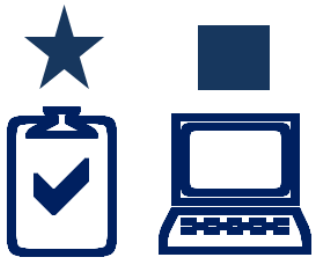


**CPIA**

<ul style="list-style-type: none"> <li>✓ Attestation</li> <li>✓ QCDR</li> <li>✓ Qualified Registry</li> <li>✓ Health IT developer</li> </ul>	<ul style="list-style-type: none"> <li>✓ Attestation</li> <li>✓ QCDR</li> <li>✓ Qualified Registry</li> <li>✓ Health IT developer</li> <li>✓ CMS Web Interface (groups of 25 or more)</li> </ul>
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# PROPOSED RULE

## MIPS Performance Period

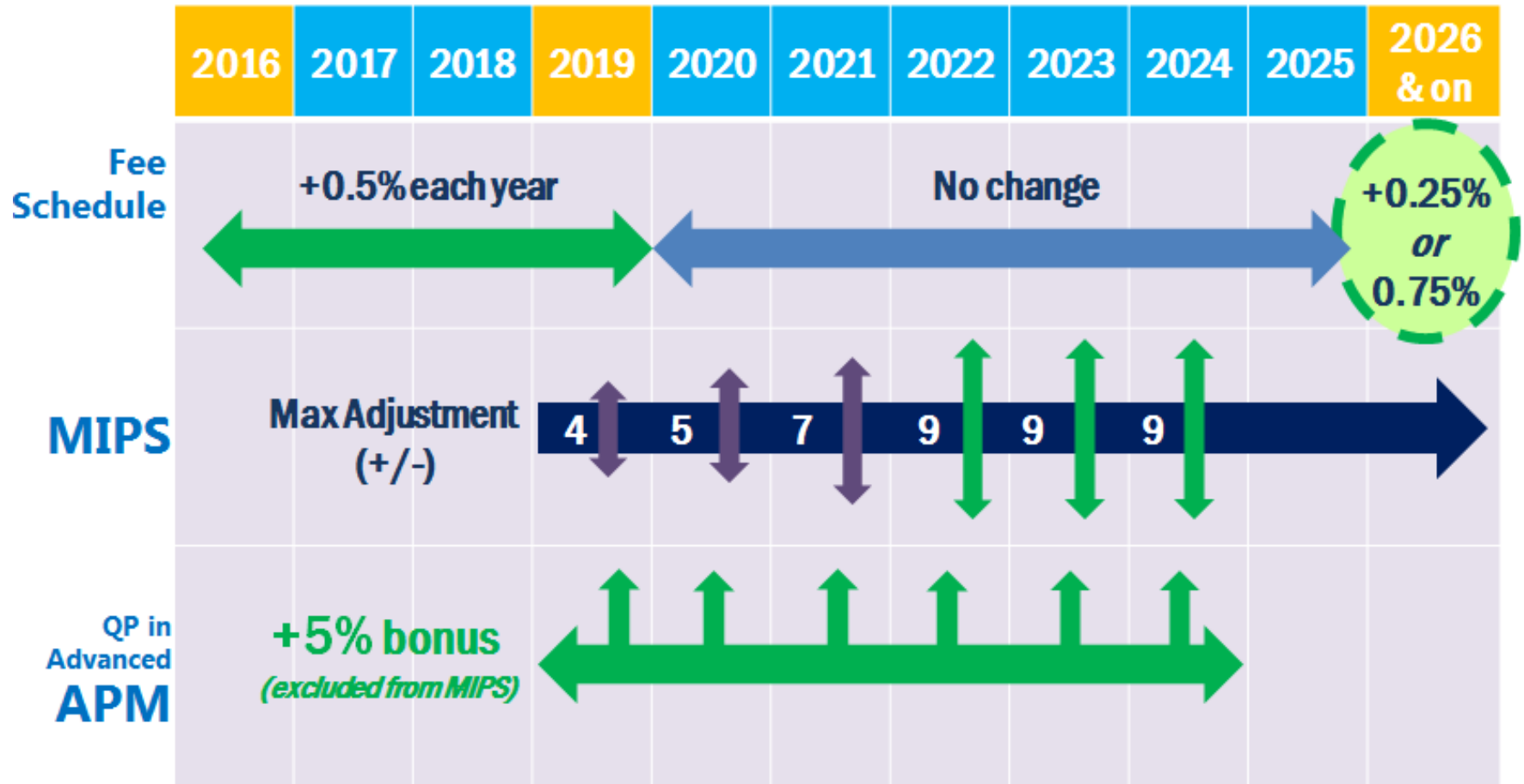


MIPS Performance  
Period  
(Begins 2017)

- ✓ All MIPS performance categories are aligned to a performance period of one full calendar year.
- ✓ Goes into effect in first year  
(2017 performance period, 2019 payment year).

2017	2018	2019	2020	2021	2022	2023	2024	2025
Performance Year		Payment Year						

# Putting it all together:



## When and where do I submit comments?

- The proposed rule includes proposed changes not reviewed in this presentation. We will not consider feedback during the call as formal comments on the rule. See the proposed rule for information on submitting these comments by the close of the 60-day comment period on June 27, 2016. When commenting, refer to file code CMS-5517-P.
- Instructions for submitting comments can be found in the proposed rule; FAX transmissions will not be accepted. You must officially submit your comments in one of the following ways: electronically through
  - Regulations.gov
  - by regular mail
  - by express or overnight mail
  - by hand or courier
- For additional information, please go to:  
<http://go.cms.gov/QualityPaymentProgram>

## Contact Information

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