MACRA and Delivery System Reform

The Health IT Policy Committee

Kate Goodrich, MD MHS
Director, Center for Clinical Standards & Quality
May 17th, 2016
Agenda

- 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)**
- 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.
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.
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.

- 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.

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.

✓ MIPS provides clinicians the flexibility to choose the activities and measures that are most meaningful to their practice to demonstrate performance.
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**
  - Medicare billing charges less than or equal to $10,000 and provides care for 100 or fewer Medicare patients in one year
- **Certain participants in ELIGIBLE Alternative Payment Models**

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

<table>
<thead>
<tr>
<th>Past Requirements for the Medicare EHR Incentive Program</th>
<th>New Proposal for Advancing Care Information Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>One-size-fits-all – every objective reported and weighed equally</td>
<td>Customizable – clinicians can choose which categories to emphasize in their scoring</td>
</tr>
<tr>
<td>Requires across-the-board levels of achievement or “thresholds,” regardless of practice or experience</td>
<td>Flexible. Allows for diverse reporting that matches clinician’s practice and experience.</td>
</tr>
<tr>
<td>Measurement emphasizing process</td>
<td>Measurement emphasizing patient engagement and interoperability</td>
</tr>
<tr>
<td>Disjointed and redundant with other Medicare reporting programs</td>
<td>Aligned with other Medicare reporting programs. No need to report redundant quality measures.</td>
</tr>
</tbody>
</table>
| No exemptions for reporting | Exemptions for reporting for clinicians in:  
  • Advanced alternative payment models  
  • First year with Medicare  
  • Have low Medicare volumes |
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:

- Quality
- Resource use
- Clinical practice improvement activities
- Advancing care information

* % weight of this may decrease as more users adopt EHR
PROPOSED RULE
MIPS: Advancing Care Information Performance Category

Who can participate?

- All MIPS Eligible Clinicians
- Participating as an Individual
  - or
  - Group
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

<table>
<thead>
<tr>
<th>Category</th>
<th>Weight</th>
<th>Scoring</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality</td>
<td>50%</td>
<td>• Each measure 1-10 points compared to historical benchmark (if avail.) &lt;br&gt;• 0 points for a measure that is not reported &lt;br&gt;• Bonus for reporting outcomes, patient experience, appropriate use, patient safety and EHR reporting &lt;br&gt;• Measures are averaged to get a score for the category</td>
</tr>
<tr>
<td>Resource Use</td>
<td>10%</td>
<td>• Similar to quality</td>
</tr>
<tr>
<td>CPIA</td>
<td>15%</td>
<td>• Each activity worth 10 points; double weight for “high” value activities; sum of activity points compared to a target</td>
</tr>
<tr>
<td>Advancing care information</td>
<td>25%</td>
<td>• Base score of 50 points is achieved by reporting at least one use case for each available measure &lt;br&gt;• Up to 10 additional performance points available per measure &lt;br&gt;• Total cap of 100 percentage points available</td>
</tr>
</tbody>
</table>

- 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**

<table>
<thead>
<tr>
<th>Individual Reporting</th>
<th>Group Reporting</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓ QCDR</td>
<td>✓ QCDR</td>
</tr>
<tr>
<td>✓ Qualified Registry</td>
<td>✓ Qualified Registry</td>
</tr>
<tr>
<td>✓ Health IT developer</td>
<td>✓ Health IT developer</td>
</tr>
<tr>
<td>✓ Administrative Claims (No submission required)</td>
<td>✓ CMS Web Interface (groups of 25 or more)</td>
</tr>
<tr>
<td>✓ CAHPS for MIPS Survey</td>
<td>✓ CAHPS for MIPS Survey</td>
</tr>
<tr>
<td>✓ Administrative Claims (No submission required)</td>
<td>✓ Administrative Claims (No submission required)</td>
</tr>
</tbody>
</table>

**Quality**

- QCDR
- Qualified Registry
- Health IT developer
- Administrative Claims (No submission required)

**Resource use**

- Administrative Claims (No submission required)
PROPOSED RULE
MIPS Data Submission Options
Advancing Care Information and CPIA

**Individual Reporting**
- Attestation
- QCDR
- Qualified Registry
- Health IT developer
- CMS Web Interface (groups of 25 or more)

**Group Reporting**
- Attestation
- QCDR
- Qualified Registry
- Health IT developer
- Administrative Claims (No submission required)
- CMS Web Interface (groups of 25 or more)
PROPOSED RULE
MIPS Performance Period

- 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).
Putting it all together:

<table>
<thead>
<tr>
<th>Year</th>
<th>Fee Schedule</th>
<th>MIPS</th>
<th>QP in Advanced APM</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016</td>
<td>+0.5% each year</td>
<td>Max Adjustment (+/-)</td>
<td>+5% bonus (excluded from MIPS)</td>
</tr>
<tr>
<td>2017</td>
<td>No change</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>2018</td>
<td>No change</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>2019</td>
<td>No change</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>2020</td>
<td>No change</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>2021</td>
<td>No change</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>2022</td>
<td>No change</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>2023</td>
<td>No change</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>2024</td>
<td>No change</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>2025</td>
<td>No change</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>2026 &amp; on</td>
<td>+0.25% or 0.75%</td>
<td>+5% bonus (excluded from MIPS)</td>
<td></td>
</tr>
</tbody>
</table>
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](http://go.cms.gov/QualityPaymentProgram)
Contact Information

Kate Goodrich, M.D., MHS
Director, Center for Clinical Standards & Quality
kate.goodrich@cms.hhs.gov