MACRA and Delivery System Reform
American Academy of Orthopedic Surgeons

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THE

MEDICARE ACCESS &
CHIP REAUTHORIZATION ACT

OF 2015

Quality Payment Program
What is “MACRA”? 


What does it do?

- **Repeals** the Sustainable Growth Rate (SGR) Formula
- **Changes the way that Medicare pays clinicians** and establishes a new framework to reward clinicians for **value** over **volume**
- **Streamlines** multiple quality reporting programs into 1 new system (MIPS)
- **Provides bonus payments** for participation in **eligible alternative payment models (APMs)**
Quality Payment Program

- 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

The Merit-based Incentive Payment System or Advanced Alternative Payment Models (APMs)
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.
Note: MACRA does NOT change how any particular APM functions or rewards value. Instead, it creates extra incentives for APM participation.
PROPOSED RULE
Advanced APM Criterion 1: Requires use of CEHRT

Certified EHR use

Example: An Advanced APM has a provision in its participation agreement that at least 50% of an APM Entity’s eligible clinicians must use CEHRT.

✓ An Advanced APM must require at least 50% of the eligible clinicians in each APM Entity to use CEHRT to document and communicate clinical care. The threshold will increase to 75% after the first year.

✓ For the Shared Savings Program only, the APM may apply a penalty or reward to APM entities based on the degree of CEHRT use among its eligible clinicians.
An Advanced APM must base payment on quality measures comparable to those under the proposed annual list of MIPS quality performance measures;

No minimum number of measures or domain requirements, except that an Advanced APM must have at least one outcome measure unless there is not an appropriate outcome measure available under MIPS.

Comparable means any actual MIPS measures or other measures that are evidence-based, reliable, and valid. For example:

• Quality measures that are endorsed by a consensus-based entity; or
• Quality measures submitted in response to the MIPS Call for Quality Measures; or
• Any other quality measures that CMS determines to have an evidence-based focus to be reliable and valid.
PROPOSED RULE
Advanced APM Criterion 3: Requires APM Entities to Bear More than Nominal Financial Risk

An Advanced APM must meet two standards:

Financial Risk Standard
APM Entities must bear risk for monetary losses.

Nominal Amount Standard
The risk APM Entities bear must be of a certain magnitude.

- The Advanced APM financial risk criterion is completely met if the APM is a Medical Home Model that is expanded under CMS Innovation Center Authority.
- Medical Home Models that have not been expanded will have different financial risk and nominal amount standards than those for other APMs.
MACRA provides additional rewards for participating in APMs.

Potential financial rewards

<table>
<thead>
<tr>
<th>Not in APM</th>
<th>In APM</th>
<th>In advanced APM</th>
</tr>
</thead>
<tbody>
<tr>
<td>MIPS adjustments</td>
<td>MIPS adjustments</td>
<td>APM-specific rewards</td>
</tr>
<tr>
<td>5% lump sum bonus</td>
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</tbody>
</table>

If you are a qualifying APM participant (QP)
How do I become a **Qualifying APM Participant (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.

Not in APM

In non-Advanced APM

In Advanced APM, but not a QP

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.

✓ MIPS provides clinicians the flexibility to choose the activities and measures that are most meaningful to their practice to demonstrate performance.
Currently there are multiple quality and value reporting programs for Medicare clinicians:

- **Physician Quality Reporting Program (PQRS)**
- **Value-Based Payment Modifier (VM)**
- **Medicare Electronic Health Records (EHR) Incentive Program**
PROPOSED RULE
MIPS: Major Provisions

✓ Eligibility (participants and non-participants)
✓ Performance categories & scoring
✓ Data submission
✓ Performance period & payment adjustments
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:

1. **FIRST year of Medicare Part B participation**
2. Below low patient volume threshold
3. 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: Performance Categories & Scoring
A single MIPS composite performance score will factor in performance in 4 weighted performance categories:
Year 1 Performance Category Weights for MIPS

- Quality: 50%
- Advancing Care Information: 25%
- CPIA: 15%
- Resource Use: 10%
A single MIPS composite performance score will factor in performance in 4 weighted performance categories:

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

\[\text{MIPS Composite Performance Score (CPS)}\]
Proposed Rule
MIPS: Quality Performance Category

Summary:
✓ Selection of 6 measures
✓ 1 outcome measure and 1 cross-cutting measure, or other high priority measure, OR
✓ Selection of a specialty-specific measure set
✓ Key Changes from Current Program (PQRS):
  • Reduced from 9 measures to 6 measures with no domain requirement
  • Measure Applicability Validation (MAV) process is retired
  • Year 1 Weight: 50%
Summary:
✓ Assessment under all available resource use measures, as applicable to the clinician
✓ CMS calculates based on claims so there are no reporting requirements for clinicians
✓ Key Changes from Current Program (Value Modifier):
  • Adding 40+ episode specific measures to address specialty concerns
  • Year 1 Weight: 10%
PROPOSED RULE
MIPS: Clinical Practice Improvement Activity Performance Category

Summary:
✓ Minimum selection of one CPIA activity (from 90+ proposed activities) with additional scoring for more activities
✓ Full credit for patient-centered medical home
✓ Minimum of half credit for APM participation
✓ Key Changes from Current Program:
  • Not applicable (new category)
  • Year 1 Weight: 15%
Summary:

- Scoring based on key measures of health IT interoperability and information exchange.
- Flexible scoring for all measures to promote care coordination for better patient outcomes.
- Key Changes from Current Program (EHR Incentive):
  - Dropped “all or nothing” threshold for measurement.
  - Removed redundant measures to alleviate reporting burden.
  - Eliminated Clinical Provider Order Entry and Clinical Decision Support objectives.
  - Reduced the number of required public health registries to which clinicians must report.
  - Year 1 Weight: 25%
## 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>
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<th>Group Reporting</th>
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<tr>
<td>✓ QCDR</td>
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<tr>
<td>✓ Qualified Registry</td>
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</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>
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<tr>
<td></td>
<td>✓ CAHPS for MIPS Survey</td>
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<tr>
<td></td>
<td>✓ Administrative Claims (No submission required)</td>
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**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

<table>
<thead>
<tr>
<th>Individual Reporting</th>
<th>Group Reporting</th>
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<tbody>
<tr>
<td>✓ Attestation</td>
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- Attestation
- QCDR
- Qualified Registry
- Health IT developer
- Administrative Claims (No submission required)
Proposed Rule
MIPS Performance Period & Payment Adjustment
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).

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<tr>
<td><strong>Performance Year</strong></td>
<td><strong>Payment Year</strong></td>
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A MIPS eligible clinician’s payment adjustment rate is based on the relationship between their CPS and the CPS performance threshold.

A CPS below the performance threshold will yield negative payment adjustment; a CPS above the performance threshold will yield neutral or positive payment adjustment.

A CPS less than or equal to 25% of the threshold will yield the maximum negative adjustment of -4%.

MIPS Composite Performance Score (CPS)
A CPS that falls above the threshold will yield payment adjustment of 0 to +12%, based on the degree to which the CPS exceeds the threshold and the overall CPS distribution.

An additional bonus (not to exceed 10%) will be applied to payments to eligible clinicians where CPS is equal to or greater than an “exceptional performance threshold,” defined as the 25th quartile of possible values above the CPS performance threshold.
When will these Quality Payment Program provisions take effect?
Putting it all together:

<table>
<thead>
<tr>
<th>Year</th>
<th>Fee Schedule</th>
<th>MIPS</th>
<th>QP in Advanced APM</th>
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<tbody>
<tr>
<td>2016</td>
<td>+0.5% each year</td>
<td></td>
<td></td>
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<tr>
<td>2017</td>
<td>+0.5% each year</td>
<td></td>
<td></td>
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<tr>
<td>2018</td>
<td>No change</td>
<td></td>
<td></td>
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<tr>
<td>2019</td>
<td>No change</td>
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<td>2020</td>
<td>No change</td>
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<td>2021</td>
<td>No change</td>
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<td>2022</td>
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<td>2023</td>
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<td>2024</td>
<td>No change</td>
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<tr>
<td>2025</td>
<td>No change</td>
<td></td>
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</tr>
<tr>
<td>2026 &amp; on</td>
<td>+0.25% or 0.75%</td>
<td></td>
<td>+5% bonus (excluded from MIPS)</td>
</tr>
</tbody>
</table>
Contact Information

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