

Overview of MACRA

CHA Assembly
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Five things to know about MACRA

- Short for the Medicare Access and CHIP Reauthorization Act, enacted April 16, 2015; passed Congress with bipartisan support
- Ended the Sustainable Growth Rate (SGR) element of Medicare physician payment that generated the annual “doc fix”
- Creates a new pay-for-performance adjustment to the Physician Fee Schedule called the “MIPS” (Merit-based Incentive Payment System)
- Promotes physician participation in Alternative Payment Models
- On April 27, 2016 CMS issued a proposed rule to implement the MIPS adjustment in 2019 based on 2017 clinician performance; expect the final rule around November 1, 2016.



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The Medicare Access & Chip Reauthorization Act of 2015

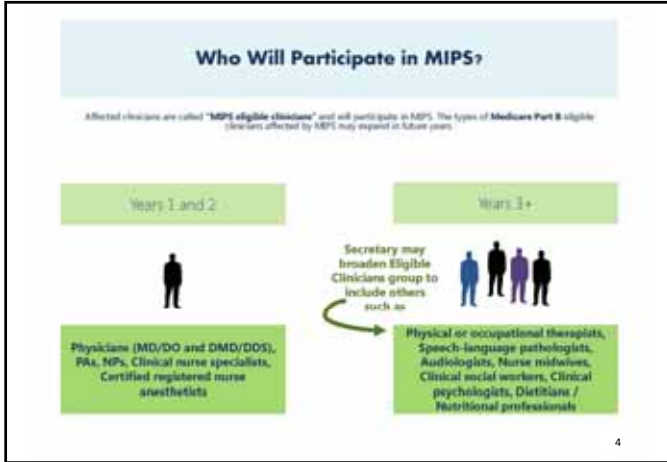
QUALITY PAYMENT PROGRAM

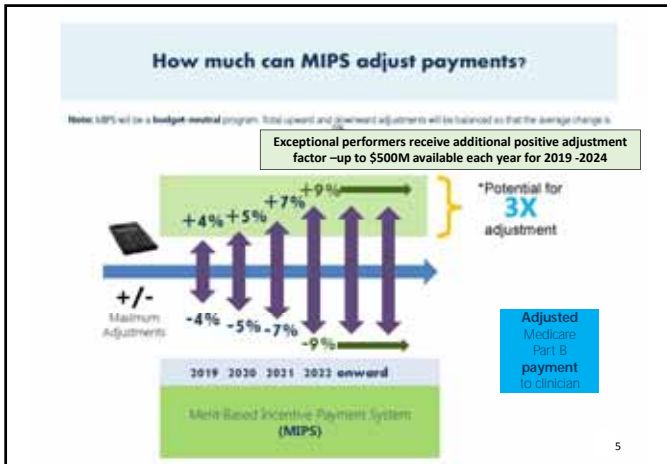
Most of the following slides come directly from CMS training materials. (Your tax dollars at work!)

Find the full set at:
<https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPs-and-APMs/Quality-Payment-Program-MACRA-NPRM-Slides.pdf>







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PROPOSED RULE MIPS: Performance Category Scoring

Performance Category	Maximum Possible Points per Performance Category	Percentage of Overall MIPS Score (Performance Year 1 - 2020)
 Quality: Clinicians choose six measures to report to CMS that best reflect their practice. One of these measures must be an outcome measure or a high-value measure and one must be a cross-cutting measure. Clinicians also can choose to report a specialty measure set. Using claims data, CMS will also calculate scores for 3 population-based measures.	80 to 90 points, depending on group size	50 percent ↓ 30% in 2021
 Advancing Care Information: Clinicians will report key measures of patient engagement and information exchange. Clinicians are rewarded for their performance on measures that matter most to them.	100 points	25 percent
 Clinical Practice Improvement Activities: Clinicians can choose the activities best suited for their practice; the rule promotes over 90 activities from which to choose. Clinicians participating in medical homes earn "full credit" in this category, and those participating in Advanced APNs will earn at least half credit.	40 points	15 percent
 Cost: CMS will calculate these measures based on claims and availability of sufficient volume. Clinicians do not need to report anything.	Average score of all cost measures that can be attributed	10 percent ↑ 30% in 2021



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PROPOSED RULE
MIPS Data Submission Options
Quality and Resource Use

	Individual Reporting 	Group Reporting 
 Quality	<ul style="list-style-type: none"> ✓ QCDR ✓ Qualified Registry ✓ EHR ✓ Administrative Claims (No submission required) ✓ Claims 	<ul style="list-style-type: none"> ✓ QCDR ✓ Qualified Registry ✓ EHR ✓ Administrative Claims (No submission required) ✓ CMS Web Interface (groups of 25 or more) ✓ CAHPS for MIPS Survey
 Resource use	<ul style="list-style-type: none"> ✓ Administrative Claims (No submission required) 	<ul style="list-style-type: none"> ✓ Administrative Claims (No submission required)

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PROPOSED RULE
MIPS Timeline

2017	2018	July		2019	2020
Performance Period (Jan-Dec) 1 st Feedback Report (July)	Reporting and Data Collection	2 nd Feedback Report (July)	Targeted Review Based on 2017 MIPS Performance	MIPS Adjustments in Effect	
					

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INCENTIVES FOR ADVANCED APM PARTICIPATION

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What is an Alternative Payment Model (APM)?

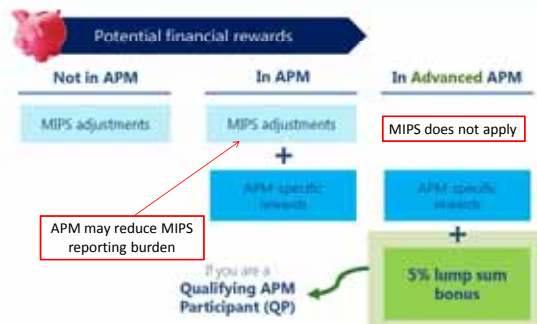
APMs are **new approaches to paying** for medical care through Medicare that **incentivize quality and value**.

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

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The Quality Payment Program provides additional rewards for participating in APMs.




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



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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

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**Proposed Rule
Advanced APMs**

Based on the proposed criteria, which current APMs will be Advanced APMs in 2017?

- ✓ Shared Savings Program (Tracks 2 and 3)
- ✓ Next Generation ACO Model
- ✓ Comprehensive ESRD Care (CEC) (large dialysis organization arrangement)
- ✓ Comprehensive Primary Care Plus (CPC+)
- ✓ Oncology Care Model (OCM) (two-sided risk track available in 2018)




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**What about private payer or Medicaid APMs?
Can they help me qualify to be a QP?**

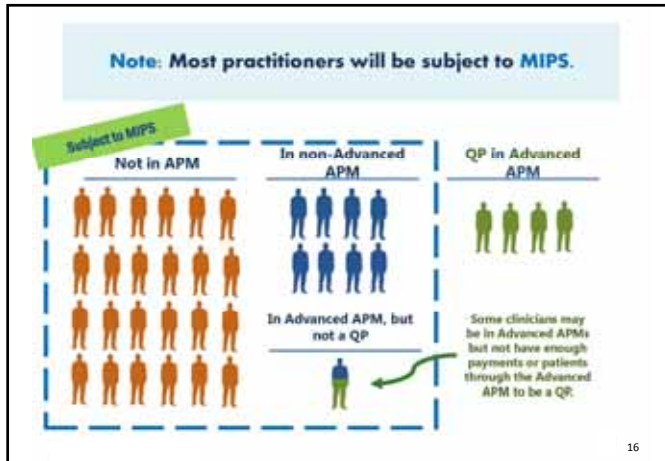
Starting in **2021**, some arrangements with other non-Medicare payers can **count toward** becoming a QP

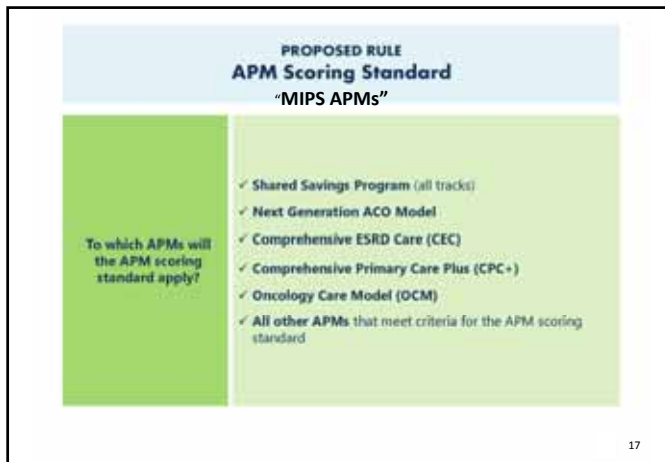
“All-Payer Combination Option”

If the “Other Payer APMs” meet criteria similar to those for Advanced APMs, CMS will consider them “Other Payer Advanced APMs”:

 Certified EHR use
  Quality Measures
  Financial Risk

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Implications for Hospitals and Health Systems

- Direct effect if you bill for Medicare Part B services paid under the Physician Fee Schedule
 - Special treatment of non patient-facing clinicians
 - Possible future opportunities for facility-based physician reporting
- Some currently independent physicians and groups may seek to join systems to avoid MIPS reporting burden
- Physicians and other MIPS-eligible clinician partners who are not employees may newly look to hospitals for assistance with MIPS reporting
- Clinicians are incentivized to participate in APMs – yours or another one
 - MIPS APM reporting alternative (if clinician is participant)
 - Greatest incentives as QPs in Advanced APMs – can your APM get there?
