Medicare Access and CHIP Reauthorization Act of 2015
Merit-Based Incentive Payment System and
Alternative Payment Model Provisions

Department of Health &
Human Services
Centers for Medicare &
Medicaid Services
Center for Clinical
Standards and Quality

Lemeneh Tefera MD MSc
Medical Officer- Value Based Purchasing

The Annual Meeting
of the American Health Quality Association

September 9th, 2015
Baltimore, MD
Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) Overview:

• Passed House 3/26/2015 - Senate 4/14/2015
• Signed into Law 4/16/2015
• Repeals 1997 Sustainable Growth Rate Physician Fee Schedule (PFS) Update
• Changes Medicare PFS Payment
  – Merit-Based Incentive Payment System (MIPS)
  – Incentives for participation in Alternate Payment Model (APM)
Physician Fee Schedule Updates:

- PFS 0.5% update 7/1/15-12/31/15
- PFS 0.5% update CY2016 - CY2019
- PFS 0.0% update CY 2020-2025
- MIPS & APMs will drive payment 2019 onward
- Beginning with CY 2026 - 0.75% APM update
- Beginning with CY 2026 - 0.25% update for other PFS services
MIPS & APM Incentives:

• Separate application of payment adjustments under PQRS, VM, and EHR-MU will sunset Dec. 31, 2018
• January 1, 2019 – MIPS and APM incentive payments begin
• EPs can participate in MIPS or meet requirements to be qualifying APM participant
• MIPS – Can receive positive, negative or zero payment adjustment
• APM Participant – If criteria are met, can receive 5 percent incentive payment for 6 years
Merit-Based Incentive Payment System (MIPS):

• Jan 1, 2019- MIPS payment adjustment begins
• Under MIPS the Secretary must develop a methodology to assess EP performance and determine a composite performance score
• Features of PQRS, the Value Modifier and the EHR Meaningful Use program are included in MIPS
• The score is used to determine and apply a MIPS payment adjustment factor for 2019 onward
• Adjustment Can Be Positive, Negative, or Zero
MIPS Eligible Professionals (EPs):

- Applies to individual EPs, groups of EPs or virtual groups
- 2019 & 2020 (First two years)
  - Physicians, PAs
  - Certified Registered Nurse Anesthetists
  - NPs, Clinical Nurse Specialists
  - Groups that include such professionals
- 2021 onward
  - Secretary can add EPs (described in 1848(k)(3)(B)) to MIPS
- Excluded EPs
  - Qualifying APM participants
  - Partial Qualifying APM Participants
  - Low volume threshold exclusions
More on MIPS:

• Beginning **Jan 1, 2019**
  – CMS must assess performance based on performance standards during a performance period for measures and activities in the following 4 performance categories.
  – A composite or total performance score will be developed using a scoring scale of 0 to 100.
  – The weights for each category are indicated below.

**Performance Categories**

– Quality measures (**30% of Score**)
– Resource Use measures (**30% of Score**)
  • Counts for not more than 10% in 2019 and 15% in 2020; additional weight of at least 20% and 15%, respectively, are added to the Quality score in those years
– Clinical Improvement Activities (**15% of Score**)
  • *Sub-Categories* - Includes Better Off-Hours Access, Care Coordination
  • Patient Safety, Beneficiary Engagement
  • Others as Determined by Secretary
– Meaningful Use of EHRs (**25% of Score**)
More on MIPS:

• CMS will propose the initial policies for the MIPS in CY2017 PFS Rule Making - proposed rule published around June 2016

• CMS must make available timely ("such as quarterly") confidential feedback reports to each MIPS EP starting July 1, 2017

• Beginning July 1, 2018, CMS must make available to each MIPS EP information about items and services furnished to the EP’s patients by other providers and suppliers for which payment is made under Medicare

• Information about the performance of MIPS EPs must be made available on Physician Compare
MIPS- Clinical Practice Improvement Activities:

The Secretary is required to specify clinical practice improvement activities. Subcategories of activities are also specified in the statute, some of which are:

**Expanded Practice Access**
- Same day appointments for urgent needs
- After hours clinician advice

**Population Management**
- Monitoring health conditions & providing timely intervention
- Participation in a qualified clinical data registry

**Care Coordination**
- Timely communication of test results
- Timely exchange of clinical information with patients AND providers
- Use of remote monitoring
- Use of telehealth

**Beneficiary Engagement**
- Establishing care plans for complex patients
- Beneficiary self-management assessment & training
- Employing shared decision making

Secretary shall solicit suggestions from stakeholders to identify activities. Sec. retains discretion. Secretary shall give consideration to practices <15 EPs, rural practices, & EPs in under served areas.
MIPS Composite Performance Score:

- Performance assessment in four categories using weights established in the statute.
- Weights may be adjusted if there are not sufficient measures and activities applicable for each type of EP, including assigning a scoring weight of 0 for a performance category.
- EHR weighting can be decreased and shifted to other categories if Secretary estimates the proportion of physicians who are meaningful EHR users is 75% or greater (statutory floor for EHR weight is 15%).
- **Performance threshold** will be established based on the mean or median of the composite performance scores during a prior period.
- The composite performance score will range from 0 – 100.
- The score will assess achievement & improvement (when data available).
MIPS Incentive Payment Formula

• Statute establishes formula for calculating payment adjustment factors relative to performance threshold and established “applicable percent” amounts.

• EPs receive a positive adjustment factor if score is above the performance threshold and a negative adjustment factor if score is below threshold.

• MIPS applicable percent defined: (positive or negative)
  – 2019 4%
  – 2020 5%
  – 2021 7%
  – 2022 & onward 9%

  (Application of applicable percent is described on next 2 slides)

• Scaling Factor applied to positive adjustment factors assures budget neutrality.

• Adjustment factor is applied to payments for all Physician Fee Schedule items and services furnished in a year"
MIPS Incentive Payment Formula:

• MIPS Adjustment for Performance _Below_ Threshold
  – EPs with performance score below performance threshold receive **negative** payment adjustment factor between 0 and negative of the applicable percent.
  – Scores determined based on linear sliding scale relative to threshold
  – Exception: EPs with scores below a number equivalent to one-quarter (25%) of the performance threshold receive maximum reduction
MIPS Incentive Payment Formula:

• **MIPS Adjustment for Performance Above Threshold**
  – EPs with performance score above performance threshold receive *positive* payment adjustment factor.
  – Scores determined based on linear sliding scale relative to threshold and the applicable percent.
    • Scaling for budget neutrality – All positive adjustment factors are increased or decreased by a scaling factor to achieve budget neutrality with respect to aggregate application of negative adjustment factors. (Scaling factor cannot be greater than 3.)
  – **Additional Adjustment for Exceptional Performance:**
    • For 6 years beginning in 2019, EPs with scores above additional performance threshold (defined in statute) receive additional positive adjustment factor ($500 million is available each year for 6 years for these payments.)
Alternative Payment Model (APM)  
Incentive Payments:

Beginning in 2019 and for 6 years 5% incentive payment for:

– EPs or groups of EPs who participate in certain types of APMs and who meet specified payment thresholds.

– Payment is made in a lump sum on an annual basis.

– EPs or groups of EPs meeting criteria to receive APM incentive payment are excluded from the requirements of MIPS.
APM Incentive Payment Requirements:

Requirements:
1) Participate in a *defined* APM and meet additional criteria of an *eligible alternative payment entity*.
2) Meet established thresholds.

**Definition of APM**
- A Centers for Medicare and Medicaid Innovation (CMMI) model
- Medicare Shared Savings Program Accountable Care Organizations
- A CMS demonstration under section 1866C of the SSA; or required by Federal law
Additional criteria - 

**Eligible Alternative Payment Entity:**

1. APM that requires participants to use certified EHR technology and provides for payment for covered professional services based on quality measures “comparable to” quality measures used in the MIPS, and

2. (a) APM bears financial risk for monetary losses that are in excess of a nominal amount or

   (b) APM is a medical home expanded under section 1115A(c) of the SSA.
Thresholds for Receiving APM Incentive Payments:

**Thresholds based on Medicare payments**

- **2019 and 2020**, EPs must have 25% of Part B payments for covered professional services furnished by APM that meets criteria of eligible alternative payment entity.
- **2021/2022**: 50% of Part B payments
- **2023 onward**: 75% of Part B payments

**Alternative: Combination Medicare/All-Payer Thresholds**

- Beginning in 2021, a second option is established based on thresholds for combined payments from Medicare and other payers.

*Secretary has flexibility to use patients counts instead of payments in applying the above thresholds.*
Partial Qualifying APM Participants:

• A partial qualifying APM participant is defined as an EP who does not meet the thresholds established but meets slightly reduced thresholds.

• Partial qualifying APM participants do not receive the 5% APM incentive payment.

• They can participate in MIPS but are held harmless if they do not participate in MIPs.
MIPS & Measures:

- Nov 1st each year, CMS to publish measure list for MIPS
  - Update, add, revise list for coming performance period
- MACRA explicitly states to emphasize outcome measures
- CMS may use:
  - Inpatient hospital measures for MIPS EPs
  - Outpatient hospital measures may be used for emergency physicians, radiologists, & anesthesiologists.
- Population based measures are allowed for MIPS
- In selecting MIPS measures and applying the MIPS formula, Secretary shall give consideration to “non-patient facing” specialties
Measure Development Plan (Sec. 102):

- Jan 1st 2016- CMS will post “Draft Plan” for development of quality measures for MIPS and APMs
  - Comment period thru March 1st 2016
  - May 1st, 2016 Final Plan Posted on CMS Website
  - Annual report shall include any updates to the plan.

- The plan shall:
  - address how measures used by private payers & integrated delivery systems could be incorporated
  - Take into account how clinical best practices & guidelines should be used in measure development
The Measure Development plan shall identify gaps where no or few quality measures exist.

Priorities for measure development:
1. Clinical outcome and patient reported outcome and functional status measures
2. Patient and Caregiver Experience
3. Care coordination
4. Appropriate use of services including measures of overuse

Based on priorities in plan, Secretary shall enter into contracts and other arrangements to develop quality measures for MIPS and APMs ($15 million per year for 5 years provided).

Annual report beginning May 1st 2017 - CMS will post on its website a report on progress made in developing measures:
- Report will publically enumerate ALL measures developed and being developed & their cost to develop
- Very detailed: Steward, Timeline for completion
Other MIPS/APM Provisions:

• Requires the Secretary to engage the physician and eligible professional community to develop care episode groups, patient condition groups, and patient relationship categories. When developed, the information will assist in evaluating resources used to treat patients.

• Technical assistance is provided to small practices in rural areas, health professional shortage areas, and medically underserved areas with respect to the MIPS performance categories and to help practices transition to APMs.
This presentation was prepared as a tool to assist providers and is not intended to grant rights or impose obligations. Although every reasonable effort has been made to assure the accuracy of the information within these pages, the ultimate responsibility for the correct submission of claims and response to any remittance advice lies with the provider of services.

This publication is a general summary that explains certain aspects of the Medicare Program, but is not a legal document. The official Medicare Program provisions are contained in the relevant laws, regulations, and rulings. Medicare policy changes frequently, and links to the source documents have been provided within the document for your reference.

The Centers for Medicare & Medicaid Services (CMS) employees, agents, and staff make no representation, warranty, or guarantee that this compilation of Medicare information is error-free and will bear no responsibility or liability for the results or consequences of the use of this guide.
References:

• HR 2- Medicare Access and CHIP Reauthorization Act of 2015
  – https://www.govtrack.us/congress/bills/114/hr2

• CRS Review of HR2
The Big Picture - Results Matter.

What do we have to show for our work in Value Based Purchasing programs and implementing the Affordable Care Act?
Major Reductions in Harm
AHRQ 2010 Baseline & Results to Date

<table>
<thead>
<tr>
<th>Year</th>
<th>Harm Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>145 Harms/1,000 Discharges*</td>
</tr>
<tr>
<td>2011</td>
<td>142 Harms/1,000 Discharges</td>
</tr>
<tr>
<td>2012</td>
<td>132 Harms/1,000 Discharges</td>
</tr>
<tr>
<td>2013</td>
<td>121 Harms/1,000 Discharges</td>
</tr>
<tr>
<td>2014</td>
<td>TBD</td>
</tr>
</tbody>
</table>

*In 2010, the Agency for Healthcare Research on Quality (AHRQ) established a national baseline of **145 harms per 1000 discharges** in their National Scorecard.

*Source: Secretary Burwell announces results of patient safety improvement efforts, HHS News Release, December 2, 2014*
Preliminary 2013 AHQR National Scorecard on HACs - Compared to 2010 Baseline

- **17% Reduction in HACs, 2010-2013**
  - from 4,757,000 to 3,960,000
  - from 145 per 1,000 discharges to 121 per 1,000 discharges

- **$12B in Estimated Associated Cost Savings, 2010-2013**
  - $4B for 2011 and 2012 combined
  - $8B for 2013

- **50,000 Lives Saved, 2010-2013**
  - ~15,000 lives saved for 2011 and 2012 combined
  - ~35,000 lives saved for 2013

*Final MPSMS-based 2013 HACs, Preliminary 2013 NHSN-based HACs, and extrapolation of 2012 Data for 2013 PSI-based HACs; Partnership for Patients 12/1/14 press release*
The Pinocchio Test

The president’s statement could have been a bit more precisely worded to reflect some of the uncertainty in the estimate: “likely a major reason why we’ve seen an estimated 50,000 fewer preventable patient deaths in hospitals.”

But that’s a relatively minor quibble. The numbers might seem large, but the research seems solid, according to experts we consulted, and it is based on a review of an extensive database. The results likely reflect work that predated the ACA but at the same time the ACA has spurred even greater cooperation among hospitals. Since the president is using a figure more than a year old, it is likely understated — unless, of course, the interim number for 2013 turns out to be overstated. We will keep a watch on that.

But in the meantime, the president’s claim appears worthy of the elusive Geppetto Checkmark.

The Geppetto Checkmark
ACA Enrollment - Tell Your Patients!

2015 Open Enrollment
- Nov 1st, 2015
- thru Jan 31st, 2016

Special Enrollment Period
- Marriage
- Having a baby
- Adoption

Special Enrollment Period
- Moving to new residence
- Gaining citizenship or lawful residence
- Native American/Alaskan tribe member
- Leaving incarceration
- Change in income that affects premium tax credits or cost sharing

https://www.healthcare.gov/coverage-outside-open-enrollment/special-enrollment-period/
Google “open enrollment”
Google “special enrollment”