NATIONAL QUALITY FORUM

MACRA: Legislative Overview and Proposed Regulations

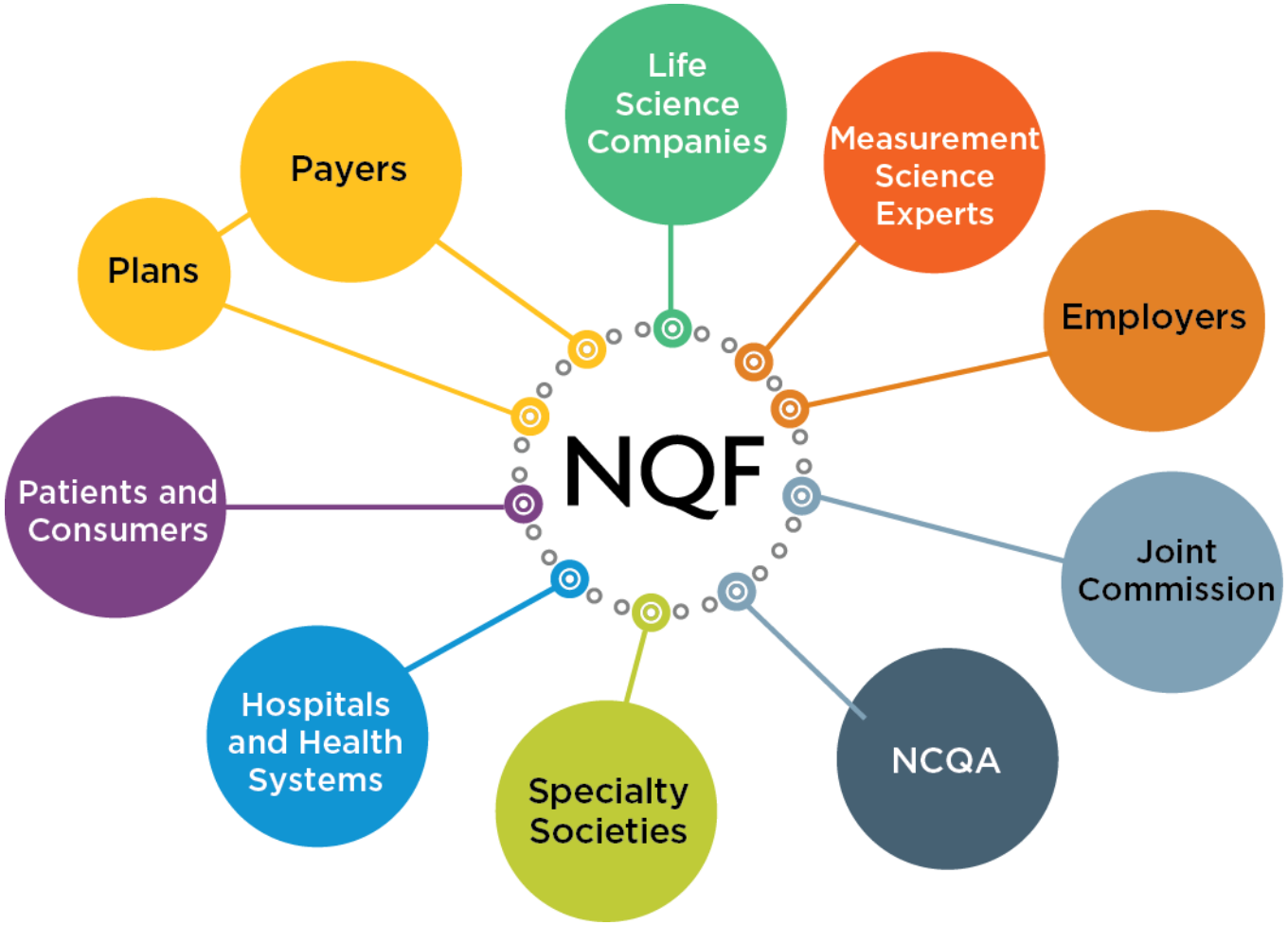
Measurement and Review Committee of the Board of Directors, Minnesota Community Measurement

June 8, 2016

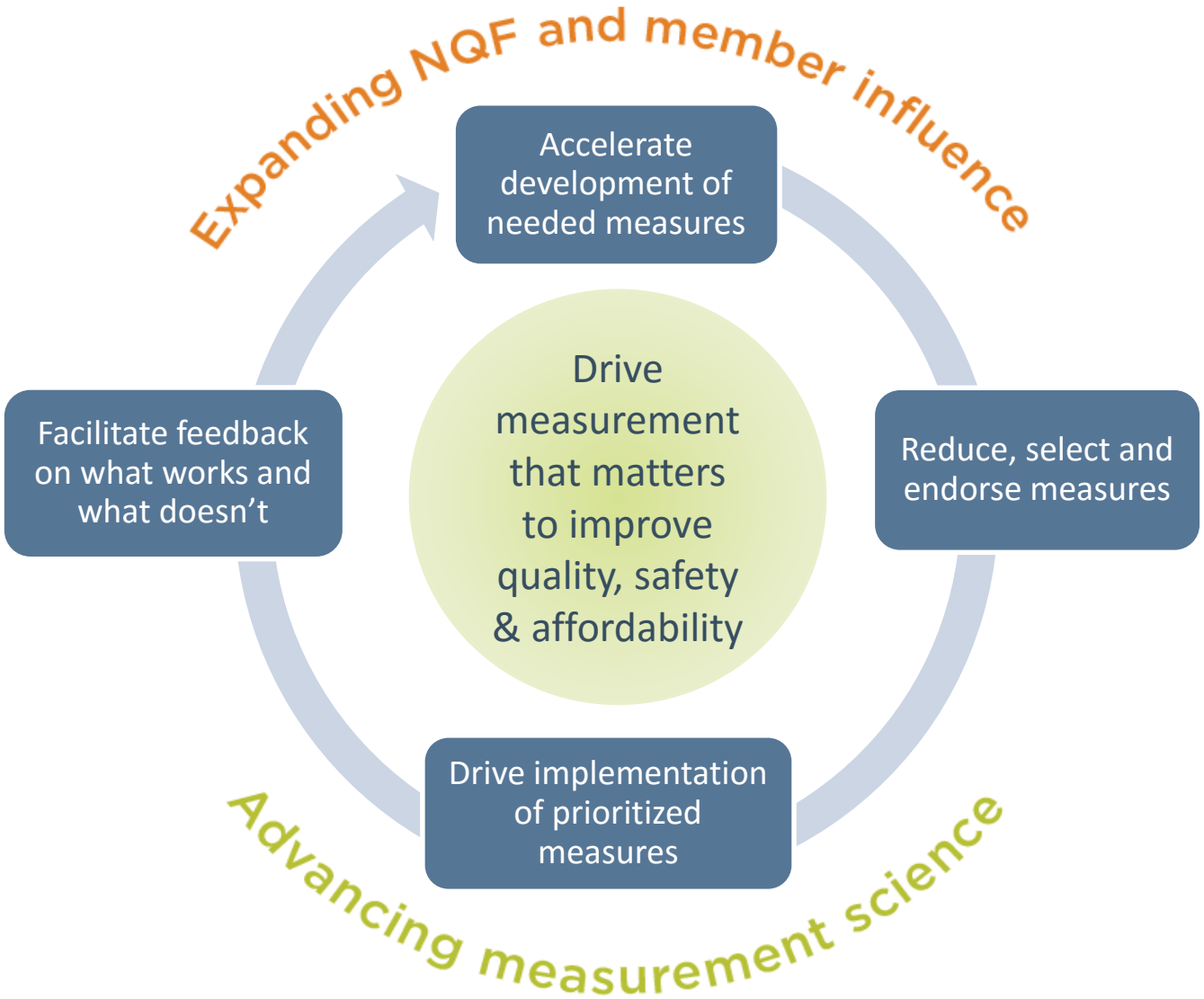
What is the National Quality Forum (NQF)?

An independent, non-profit, membership organization that brings together all stakeholders to improve health and healthcare through quality measurement.

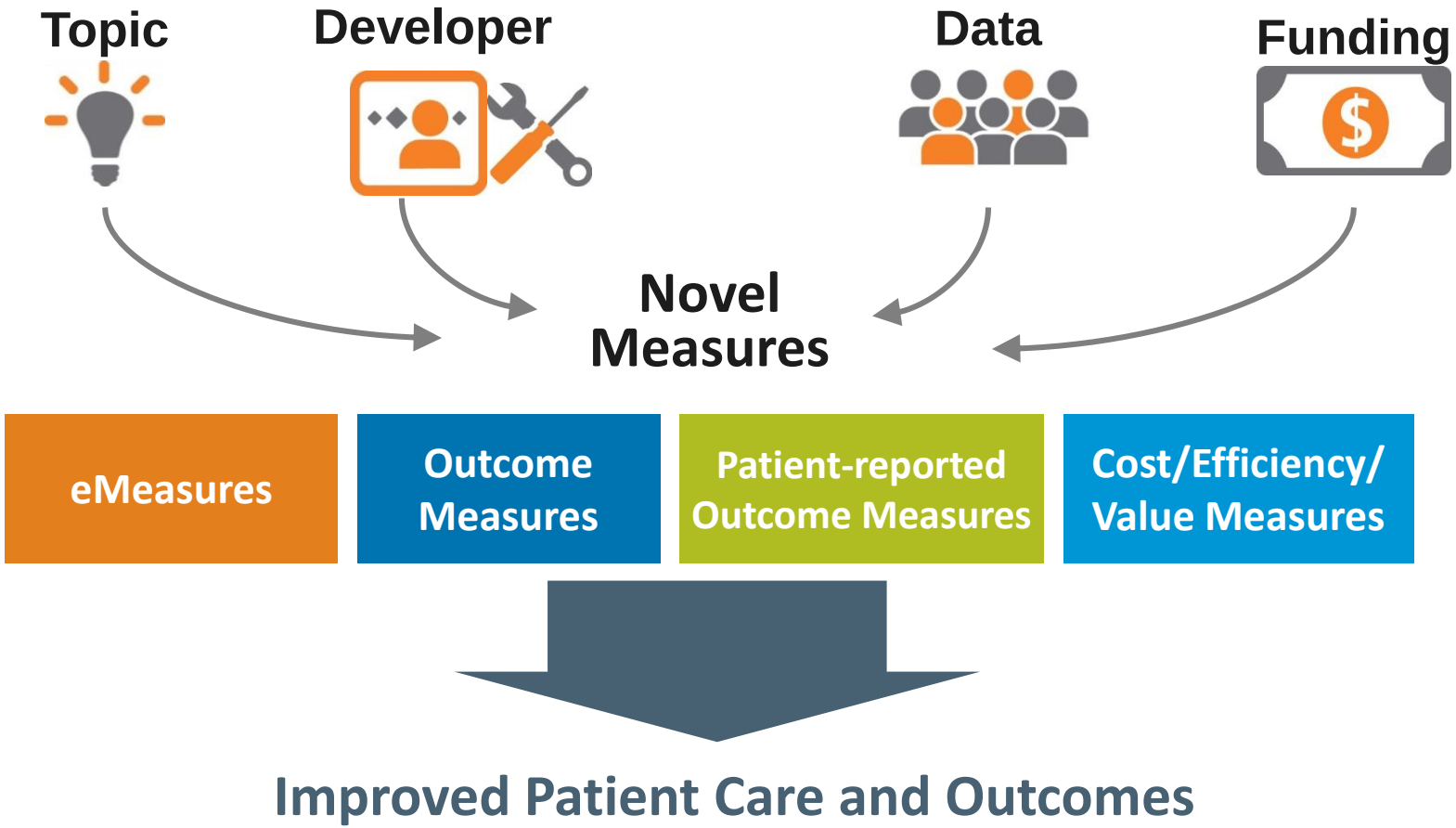
NQF Works with Diverse Stakeholders



NQF's 2016-2019 Strategic Priorities



NQF Measure Incubator: Getting to quality measures that matter



MACRA Overview

Or Holy MACRA !!!!

"CMS lost doctors hearts and minds and MACRA is going to get them back"

Andy Slavitt, Acting Administrator at CMS

Motivation for MACRA Legislation

- **Widespread agreement that SGR payment was broken** – it was patched 15 times
- **Perfect storm of opportunities** – SGR was on "sale;" consensus on the policy; agreement about how to pay for it; and the political stars aligned
- **Passed with overwhelming bi-partisan support in April 2015** – transformative policy

Congressional Goals for MACRA

- **Replace SGR with payment system based on value;** incents advanced APMS
- **Reduce burden:** streamline 3 quality reporting programs and align measures
- **Engage physicians in developing measures & advanced APMs, and using measures for QI** – gives clinicians/specialty societies a cat bird seat
- **Provide more flexibility/choice**

Key Features of MACRA

- **Establishes the Quality Payment Program (QPP)**
- **Two pathways – shift clinicians to A-APMs**
  - MIPS (merit based incentive payment system): PFP on fee for service infrastructure
  - Advanced APMs
- **Builds upon existing programs** – with more flexibility, < requirements in some cases
- **Performance year begins in 2017** – payment in 2019
- **Budget neutrality in MIPs creates winners/losers**
- **Extra support:** for measure development, technical assistance – particularly for small, rural practices

Overview of MIPS

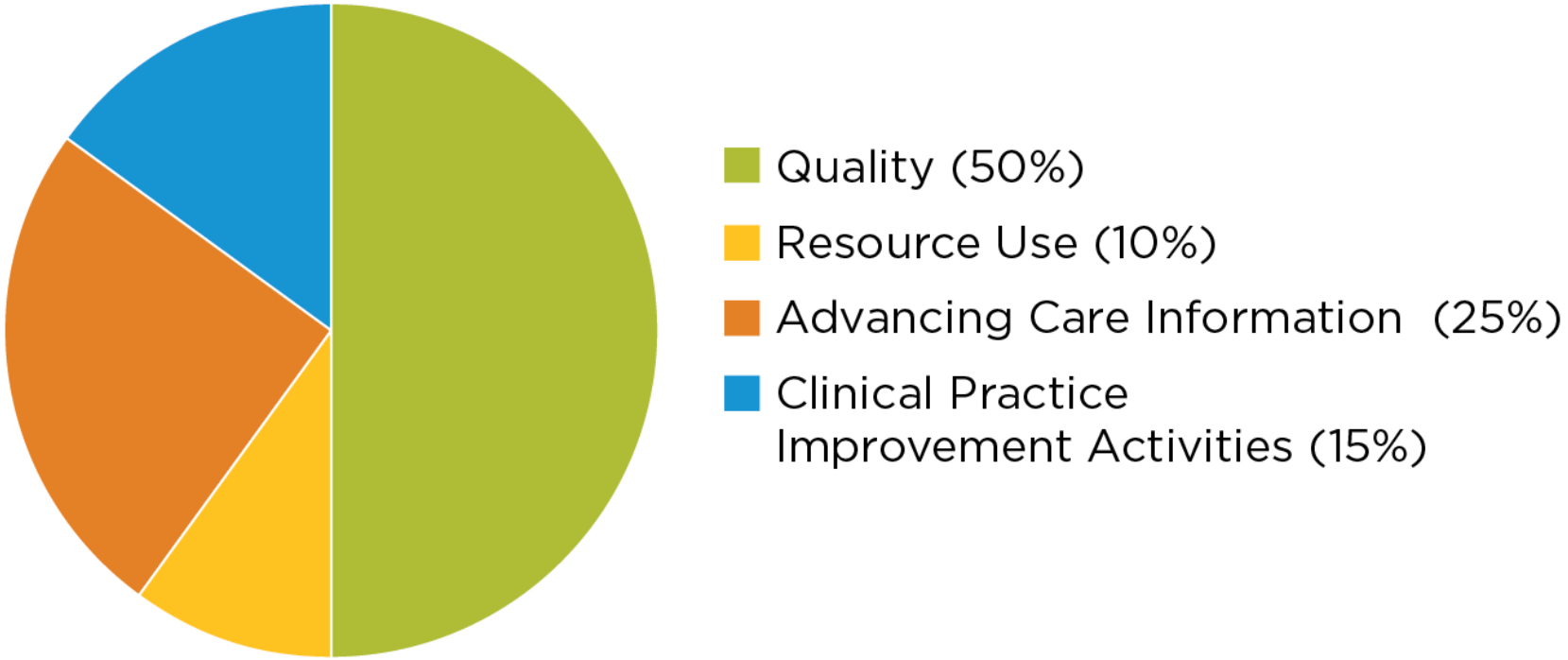
- **Most clinicians will be in MIPS initially**
  - CMS estimates that in 2017 only 30,000 clinicians or 4 % will be in A-APMS
- **Three plus one inputs determines performance score**
  - Quality (PQRS)
  - Resource Use (Value-Based Modifier)
  - Advancing Care Information (Meaningful Use)
  - **New:** Clinical Practice Improvement Activities

Eligibility for MIPS

- **Years 1 & 2:** physicians (MD/DO; DMD/DDS); PAs, NPs and other advanced practice nurses
- **Year 3:** HHS Secretary can broaden eligibility, e.g., social workers, therapists, dieticians etc.
- Clinicians who will **not** participate in MIPS:
  - 1st year of Medicare Part B participation
  - Below low patient volume: < or = to $10 K in billings or < 100 patients in Medicare
  - Certain participants in Advanced–APMs

MIPS Payment System: Year One

Four components contribute to a MIPS score from 1- 100:



MIPs: Payment Adjustments

- **Fee schedule:** -0.5 between 2016-2019; no change between 2020-2024
- MIPs performance adjustment **based on a clinician's CPS and the CPS performance threshold**
- **Budget neutral adjustments by year:**
  - 2019 +/- 4 percent
  - 2020 +/- 5 percent
  - 2021 +/- 7 percent
  - 2022 +/- 9 percent -- extends into the out years
- Additional $ available for high performers

Proposed Rule: Quality

- Move from 9 to **6 required quality measures**
- **One outcome measure OR other high priority measure and one cross-cutting measure**, e.g., blood pressure
  - OR report a specialty specific measure set
- **Approximately 200 measures available:**
  - Removed 29 measures – "low bar," documentation measures but not "topped out" measures
  - Added 17 measures – 13 are NQF endorsed
  - AHIP-CMS alignment work influenced measures proposed
- Bonus for reporting outcomes, patient experience, appropriate use, patient safety and via EHRs

Proposed Rule: Resource Use

- Clinicians assessed under all available resource use measures
- **No reporting requirements for clinicians –** measures are calculated off of claims
- **CMS added 40 + episode specific measures**

Proposed Rule: Advancing Care Information

- **Receive 50% credit** for attesting to the numerator/denominator or yes/no for each objective and measure
- **Remaining 50% based on 11 measures selected by clinicians** related to:
  - Patient electronic access
  - Coordination of care
  - Health information exchange
- **Scratches CPOE and CDS objectives**

Proposed Rule:
Clinical Practice Improvement Activities

- **Attest or submit data on performance related to 90+ CPIAs, including:**
  - Expanded access
  - Population management
  - Care coordination
  - Patient engagement
  - And the list goes on…
- **Full automatic credit for accredited PCMHs** – patient centered medical homes
- **Half credit for participating in non-Advanced APMs**

Deep Breath …

Advanced – APMs

- A-APM Qualifications
  - Certain % of payments/patients via A-APMs
  - Quality measures comparable to MIPS
  - "More than nominal" two-sided risk
  - Certain % of clinicians using certified EHRs
- MACRA does not change how A-APMs function or reward value
- MACRA creates extra incentives for participation in A-APMs

Extra Incentives to Participate

- **Between 2019 – 2024** A-APM clinicians receive an automatic 5% annual incentive payment – on top of any incentive they may receive (or not) for participating in the A-APM
- **Beyond 2025**, clinicians in A-APMs receive an .75 annual update versus .25 for those in MIPS

Payment & Patient Requirements

Requirements for Participation in A-APMs						
Payment Year	2019	2020	2021	2022	2023	2024 +
Percentage of Payments through an Advanced	25%	25%	50%	50%	75%	75%
Percentage of Patients through an Advanced APM	20%	20%	35%	35%	50%	50%

Clinicians must meet payment or patient requirements

Starting in 2021, non-Medicare payments can count towards required totals.

6 Qualified A-APMs

- Next generation ACOs
- Medicare Share Savings ACOs (track 2, 3)
- Comprehensive Primary Care Plus
- Oncology Care Model – 2 sided risk available in 2018
- Comprehensive ESRD Care
- **Not qualified:** track 1 ACOs (95%), bundled payment models, garden variety PCMHs, many APMs proposed by SS

Considerations

- Quick turn before final rule and reporting year for a very complex payment program
- Long term desire for clinicians to be in A-APMs and short term reality that almost all will be in MIPS
- Budget neutrality of MIPS – those below par fund those above. Will that affect collaboration?
- Precision of the CPS – how will that work?
- Congressional interest: hearings focus on implementation
- What affect might a change in Administration have on implementation?