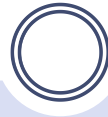
NEW HEALTH ANALYTICS

Summary of Final Rule for MACRA, MIPS, and APMs

FINAL RULE PUBLISHED NOVEMBER 4, 2016
REPORTING BEGINS JANUARY 1, 2017
EFFECTIVE JANUARY 1, 2019

Overview of MACRA



Implement changes through unified framework called the "Quality Payment Program"

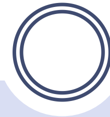
Merit-based Incentive Payment System (MIPS)

or

Advanced Alternative Payment Method (APMs)

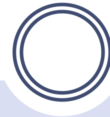
Reporting starts January 2017
Payments adjustments begin 2019, based on performance period of 2017

Changes to Existing Programs



- Sun setting of current programs
  - PQRS, Value-based Payment Modifier, and EHR Incentive Program for EPs (Meaningful Use)
- IT Measurement
  - Prevention of Information Blocking
  - Remove pass-fail nature of reporting
  - Reduces number of measures from 18 to 11
  - Eliminated reporting on clinical decision support and computerized physician ordering

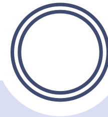
MIPS: Participants



Applies to Medicare Part B clinicians

- Physicians, physician assistants, nurse practitioners, clinical nurse specialists, and certified registered nurse anesthetists
- Special measurement considerations for non-patient facing clinicians

MIPS: Exemptions



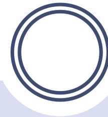
Exemption for clinicians who:

Are newly enrolled in Medicare;

Have less than or equal to $30,000 in Medicare charges and less than or equal to 100 Medicare patients; or

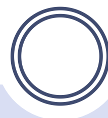
Are significantly participating in an APM

MACRA: Participation for Small Practices



Virtual Groups	Option for small practices and solo physicians to join together in virtual groups and **submit combined MIPS data**
Training and Education	Allots **$20 million a year for five years** for training and education of physicians in practices of 15 or fewer and those in underserved areas
Adjusted exemption requirements	In final rule, those who fall below **$30,000 in Medicare Part B charges** are exempt from 2017 participation. Proposed rule had exemption at $10,000 in Medicare Part B charges.
Simplified "all or nothing" EHR requirements	Total number of required certified EHR technology measures **from 11 in the Proposed rule to five**. Clinicians have the option of reporting on the other measures and would allow them to **receive a bonus during the transition year.**

MIPS: Performance Categories

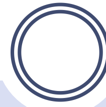


Adjustments made using composite score based on four categories

Category	CY 2019	CY 2020	CY 2021 and beyond
Quality	60%	50%	30%
Resource Use (Cost)	N/A	10%	30%
Clinical practice improvement activities (CPIA)	15%	15%	15%
Advancing Care Information (i.e., Meaningful Use) (ACI)	25%	25%	25%

CMS is invoking statutory flexibility to not score the cost category in CY 2019

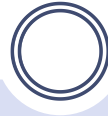
MACRA: Pick Your Pace



CMS has introduced a gradual ramp to full participation, allowing physicians to pick their pace between the following four options in 2017

- No participation and an automatic 4% negative payment adjustment
- Submission of a minimum amount of data and a neutral payment adjustment
- Submission of 90 days of data for a potential small positive payment adjustment or a neutral adjustment
- Submission of a full year of data for the potential to earn a moderate positive payment adjustment

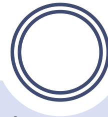
MIPS: Quality Category



Clinicians choose 6 measures to report

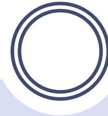
- Must choose one crosscutting measure and an outcome measure or another high quality measure (e.g., patient safety)
- 200 Measures to choose from
- Alternatively, clinicians can choose to report specialty measure set

MIPS: Advancing Care Information Category



- Continuous 90-day reporting period for 2017 and 2018
- Finalized a Base Score, Performance Score, and Bonus Score Structures
- Offers the 2017 ACI Transition objectives and measures with fewer reporting requirements
- Reporting public health and clinical data registry reporting measures available for bonus points

MIPS: Clinical Practice Improvement Activities Category



Clinicians choose from list of 93 activities

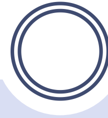
- Each activity assigned weight of “medium” or “high”
- Full credit requires participation in up to 4 activities

Participation in certified PCMH automatically receives highest score

Participation in MIPS APM automatically receives at least half of the highest score

- MSSP Track 1 and Next Generation ACO would receive full credit

MIPS: Cost Category

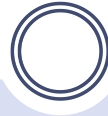


CMS will use:

- Total costs per capita
- Medicare spending per beneficiary for physicians
- Clinical condition and procedure episode cost measures from a list of 10 measures

Cost score is the average of all the measures that can be attributed to the clinician/group

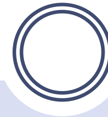
MIPS Reporting



Rule proposes to allow third parties to act as intermediaries on behalf of clinicians and submit data for performance categories

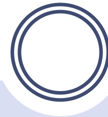
- Registries
- Qualified Clinical Data Registries
- Health information technology developers
- Certified survey vendors

Reporting Mechanisms



Performance Category Submission Combinations Accepted	Individual Reporting Data Submission Mechanisms	Group Practice Reporting Data Submission Mechanisms
Quality	Claims QCDR Qualified registry EHR Administrative Claims (no submission required)	QCDR Qualified registry EHR CMS Web Interface (groups of 25 or more CMS-approved survey vendor for CAHPS for MIPS and Administrative claims (no submission required)
Resource Use	Administrative Claims (no submission required)	Administrative Claims (no submission required)
Advancing Care Information	Attestation QCDR Qualified registry EHR	Attestation QCDR Qualified registry EHR CMS Web Interface (groups of 25 or more)
CPIA	Attestation QCDR Qualified registry EHR Administrative claims (if technically feasible, no submission required)	Attestation QCDR Qualified registry EHR Administrative claims (if technically feasible, no submission required)

MIPS: Payment Adjustments

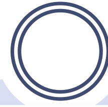


- Budget Neutral
- $500 million in additional performance bonuses exempt from budget neutrality
- Negative adjustments to increase every year, positive adjustments would correspond

Maximum Negative Adjustments Per Year:

2019	2020	2021	2022 and after
4%	**5%**	**7%**	**9%**

MIPS APMs

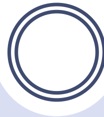


Mechanism to recognize participation in APMs in the context of MIPS and to limit inconsistency between performance assessment on the MIPS and AMPs

Defined as APM with:

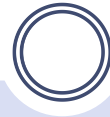
- Participation agreement with CMS
- One or more MIPS-eligible clinicians
- Payment incentives based on quality and cost

MIPS APMs



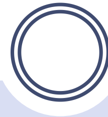
MIPS Category	Weight for MSSP and Next Gen ACO	Weight for Other MIPS APMs
Quality	50%	0%
Resource Use	0%	0%
CPIA	20%	25%
ACI	30%	75%

Advanced Alternative Payment Models (APMS)



- Does not change how any APM rewards value
- Creates extra incentives to participate
- 2019-2024: 5% incentive payment through Part B
- 2026 and later: higher fee schedule update

Standards for Advanced APMs

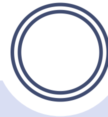


Require Participants to bear a certain amount of financial risk

Base Payments on quality measures comparable to those used in the MIPS quality performance category

Require participants to use certified EHR technology

Qualifying APMs

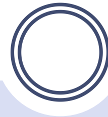


- Comprehensive ESRD Care Model (LDO and non-LDO two-sided risk arrangements)
- Comprehensive Primary Care Plus Model
- Medicare Shared Savings Program Tracks 2 and 3
- Next Generation ACO Model
- Oncology Care Model (two-sided track)

CMS would update list annually to add new qualifying payment models.

APMs that no not qualify or partially qualify are subject to MIPS.

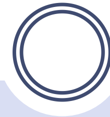
APM: Additional Future Pathways



CMS plans to add additional APM programs in 2017 or 2018

- Accountable Care organization Track 1+ Model
- Comprehensive Care for Joint Replacement
- Medicare Diabetes Prevention Program

APMs: Qualifying for Incentive Payments

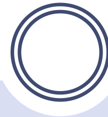


- Clinicians must see sufficient number of patients or receive sufficient payments through APM
- Participation Requirements:
  - 2019 & 2020: Medicare patients only
  - 2021 and on: Medicare and non-Medicare patients

Clinicians must meet payment or patient requirements

Payment Year	2019	2020	2021	2022	2023	2024 and later
Percentage of Payments through and Advanced APM	25%	25%	50%	50%	75%	75%
Percentage of Patients through an Advanced APM	20%	20%	35%	35%	50%	50%

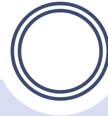
All-Payer Combination Option



Starting in 2019:

- Incentive payments APMs developed by non-Medicare payers
  - E.g., private insurers or state Medicaid programs
- Payments and patients under non-Medicare payers can be counted toward APM participation

Public Reporting and Transparency



Law requires public reporting for the following:

- Names of clinicians in Advanced APMs
- As feasible, the names and performance of Advanced APMs
- MIPS scores for clinicians, including aggregate and individual scores for each performance category

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