Making Sense of MACRA’s Alphabet Soup: What does it mean for Internal Medicine? How Can ACP Help?

September 2016
April 2015 – Congress Passed Landmark, Bipartisan Law – MACRA...

- Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) – focused on Part B Medicare
- Congressional Intent of MACRA:
  - Sustainable Growth Rate repeal
  - Improve care for Medicare beneficiaries
  - Change our physician payment system from one focused on volume to one focused on value

MACRA is now being recast as the Quality Payment Program - NPRM April 27, 2016
Quality Payment Program In a Nutshell

Law *intended* to align physician payment with *value*

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)
Or now the...

**Quality Payment Program**

- Merit-Based Incentive Payment System (MIPS)
- Advanced Alternative Payment Models (APMs)
However, it feels like CMS may be taking a secret code approach to implementation...

Merit-based Incentive Payment System (MIPS)
This new MIPS “report card” will replace current Medicare reporting programs

There are currently multiple individual **quality and value** programs for Medicare physicians and practitioners:

- Physician Quality Reporting Program (**PQRS**)  
- Value-Based Payment Modifier (quality and cost of care)  
- “Meaningful use” of EHRs

**MACRA** streamlines those programs into **MIPS**:  

- Merit-Based Incentive Payment System (**MIPS**)  

How will Clinicians Be Scored Under MIPS?

A single MIPS composite performance score will factor in performance in 4 weighted performance categories:

**Year 1:**
- **Quality** 50%
- **Advancing Care Information** 25%
- **Clinical practice improvement activities** 15%
- **Cost** 10%

MIPS Proposed Rule: Quality Performance Category

✓ Selection of 6 measures
✓ 1 cross-cutting measure and 1 outcome measure, or another high priority measure if outcome is unavailable
✓ Select from individual measures or a specialty measure set
✓ Population measures automatically calculated
✓ Key Changes from Current Program (PQRS):
  • Reduced from 9 measures to 6 measures with no domain requirement
  • Emphasis on outcome measurement
  • Year 1 Weight: 50%
What is ACP saying about measures?

- In the short term, ACP encourages CMS to consider adopting a **core set of measures** identified through the America’s Health Insurance Plans (AHIP) coalition.

- Over the longer term, CMS must continue to **improve the measures and reporting systems** to be used in MIPS to ensure that they:
  - measure the right things
  - move toward clinical outcomes and patient experience
  - do not create unintended adverse consequences, such as treating to the measure, increasing healthcare disparities, e.g. avoiding sicker and “less compliant” patients
What is ACP saying about measures?

- Fill critical gaps in quality measurement
- Obtain **stakeholder input** into the measure development process
- Focus on outcomes-based measures, patient and family experience measures, care coordination measures, and measures of population health and prevention – over time
- Critically important to **minimize the burden** related to data collection and reporting in the quality category (as with all of the MIPS categories)
- Ensure that performance measurement and reporting becomes increasingly **patient-focused**
ACP Recommendations* re: MIPS Quality Performance Category... CMS must:

- Take concrete actions to provide clear options for specialties that may be most impacted by too few appropriate measures;
- Remove the mandate for clinicians to report on at least 1 outcome measure (but give them bonus points if they do);
- Remove the 3 population health measures (and provide optional points for these as well);
- Make CAHPS for MIPS reporting voluntary;
- Improve risk adjustment methodology (including incorporating SES);
- Keep data completeness at 50%; and
- Hold physicians harmless from reporting on topped-out measures.

*Selected recommendations included here, complete list with detailed information can be found at: https://www.acponline.org/acp_policy/letters/comment_letter_macra_proposed_rule_2016.pdf
CMS Final Measure Development Plan - Released on May 2, 2016

Initial Priorities for Measure Development:

- Clinical Care
  - Incorporating patient preference and shared decision-making
  - Cross-cutting
  - Focused for specialities with clear gaps
  - Outcomes
- Safety
  - Diagnostic accuracy
  - Medication safety
- Care Coordination
  - Team-based care
  - Use of new technologies
- Patient and Caregiver Experience
  - PROMs and additional topics
- Population Health and Prevention
  - Outcomes at population level
  - IOM *Vital Signs* topics
  - Detection and prevention of chronic disease
- Affordable Care – overuse measures

From Meaningful Use to Advancing Care Information

What is final?
- Stage 2 modifications for 2015-2016

So, what about Stage 3?
- The MACRA NPRM proposes to replace MU with Advancing Care Information (ACI).
- 2017 MU (renamed ACI) is proposed to be the first reporting period for MIPS.

**New Proposal from CMS would shorten 2016 MU reporting to any continuous 90-day period**
The overall Advancing Care Information score would be made up of a base score and a performance score for a maximum score of 100 points
CMS proposes six objectives and their measures that would require reporting for the base score:
ACP Recommendations* re: MIPS ACI Category... CMS must:

- Simplify the reporting requirements and scoring!
  - ACP proposed a specific alternative scoring approach:
    - Removing all yes-required or threshold requirements except for the protecting patient health information attestation
    - Selecting from a longer list of health IT activities

- Focus on applying health IT to improve quality and value and not simply the use of the technology;

- Change the reporting period to 90-days;

- Not hold physicians accountable for information blocking factors that are beyond their control; and

- Reduce burden – including providing physicians with up-front estimates of the cost and time involved in submitting their attestations.

*Selected recommendations included here, complete list with detailed information can be found at: https://www.acponline.org/acp_policy/letters/comment_letter_macra_proposed_rule_2016.pdf
Clinical Practice Improvement Activities (CPIA)

- Minimum selection of one CPIA activity (from 90+ proposed activities) with additional credit for more activities -
  - High-weighted = 20 points; Medium-weighted = 10 points – max score of 100 points
  - Lower bar for small, rural, and/or HPSA area practices

- Full credit for patient-centered medical home & PCMH specialty practices (as defined in the rule)

- Minimum of half credit for other APM participation

- Key Changes from Current Program:
  - Not applicable (new category)
  - Year 1 Weight: 15%
ACP Recommendations* re: MIPS Clinical Practice Improvement Activities Category... CMS must:

- Weight all activities the same at 5 points per activity
  - Full scoring would be accomplished by attesting to 3 activities OR being a PCMH, PCMH Specialty Practice, or other APM);

- Include the following on the list of activities:
  - ACP Practice Advisor ®
  - ACP’s High-Value Care resources
  - Certain defined CME activities (i.e., that involve QI-related work)

- Establish a clear and transparent process for adding new items; and

- Permit practicing clinicians to submit alternative activities for credit and/or consideration for future credit.

*Selected recommendations included here, complete list with detailed information can be found at: https://www.acponline.org/acp_policy/letters/comment_letter_macra_proposed_rule_2016.pdf
Patient-Centered Medical Homes (PCMHs) & PCMH Specialty Practices in CPIA

- CMS definitions for full CPIA credit:
  - PCMH
    1. Nationally accredited PCMH;
    2. Medicaid Medical Home Model; or
    3. Medical Home Model.
  - PCMH Specialty Practice – Nationally accredited

- ACP Recommends:
  - Broaden their definitions – include other programs with a demonstrated track record of support by non-Medicare payers, state Medicaid programs, employers, and/or others
Cost (aka Resource Use)

- 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%

ACP Recommendation – CMS Must:
- Adjust resource use to zero for the first performance year – the measures are not yet proven to be reliable and validated in their application to physicians.
How Much Can MIPS Adjust Payments?

- Based on the MIPS composite performance score, physicians and practitioners will receive positive, negative, or neutral adjustments up to the percentages below.
- MIPS adjustments are budget neutral.

**MAXIMUM Adjustments**

<table>
<thead>
<tr>
<th>Year</th>
<th>Adjustment to provider’s base rate of Medicare Part B payment</th>
</tr>
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<tbody>
<tr>
<td>2019</td>
<td>4%</td>
</tr>
<tr>
<td>2020</td>
<td>5%</td>
</tr>
<tr>
<td>2021</td>
<td>7%</td>
</tr>
<tr>
<td>2022 onward</td>
<td>9%</td>
</tr>
</tbody>
</table>

Those who score in top 25% are eligible for an additional annual performance adjustment of up to 10%, 2019-24 (NOT budget neutral)

Merit-Based Incentive Payment System (MIPS)
**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).

<table>
<thead>
<tr>
<th>Performance Period</th>
<th>Payment Year</th>
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<tbody>
<tr>
<td>2017</td>
<td></td>
</tr>
<tr>
<td>2018</td>
<td></td>
</tr>
<tr>
<td>2019</td>
<td>2020</td>
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<td>2021</td>
<td>2022</td>
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<tr>
<td>2023</td>
<td>2024</td>
</tr>
<tr>
<td>2025</td>
<td></td>
</tr>
</tbody>
</table>

ACP Recommended that CMS must:
- Start the initial performance period July 1, 2017 (rather than January 1, 2017)
- Initial reporting period for quality would remain 12 months, but CPIA and ACI would be any continuous 90-day period
YOU KNOW, I DON'T THINK
MATH IS A SCIENCE. I
THINK IT'S A RELIGION.

A RELIGION?

YEAH. ALL THESE EQUATIONS
ARE LIKE MIRACLES. YOU
TAKE TWO NUMBERS AND WHEN
YOU ADD THEM, THEY MAGICALLY
BECOME ONE NEW NUMBER.
NO ONE CAN SAY HOW IT
HAPPENS. YOU EITHER BELIEVE
IT OR YOU DON'T.

THIS WHOLE BOOK IS FULL
OF THINGS THAT HAVE TO
BE ACCEPTED ON FAITH.
IT'S A RELIGION.

AND IN THE
PUBLIC SCHOOLS
NO LESS. CALL
A LAWYER.

AS A MATH
ATHEIST, I
SHOULD BE EXCUSED
FROM THIS.

HELP ME
WITH THIS
HOMEWORK,
OK? WHAT'S
6+3?

6+3. EH? WELL,
THIS ONE IS
A BIT TRICKY.

FIRST WE CALL THE ANSWER
"Y," AS IN "DO WE CARE?"
NOW Y MAY BE A SQUARE
NUMBER, SO WE'LL DRAW A
SQUARE AND MAKE THIS SIDE
6 AND THAT SIDE 3. THEN
WE'LL MEASURE THE DIAGONAL.

I DON'T REMEMBER
THE TEACHER
EXPLAINING IT LIKE
THIS.

SHE PROBABLY
DOESN'T KNOW
HIGHER MATH.
WHEN YOU DEAL
WITH HIGH
NUMBERS, YOU
NEED HIGHER
MATH.

BUT THIS
DIAGONAL
IS JUST A
LITTLE UNDER
TWO.

OK, HERE, I'LL
DRAW A BIGGER
SQUARE.
ACP’s Recommended Scoring Approach

- Total points for Quality = #/60
  - Not #/80 x 50% as proposed
- Total points for Resource Use = 0
  - Not an average of applicable measures x 10%
- Total points for CPIA = #/15
  - Not #/60 x 15%
- Total points for ACI = #/25
  - Not #/100 (which could actually be up to 131 points) x 25%
Advanced Alternative Payment Models (APMs)
Advanced Alternative Payment Models (APMs)

Initial definitions from MACRA law, 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

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.
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.

PROPOSED RULE
Advanced APM Criterion 2: Requires MIPS-Comparable Quality Measures

- 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:**

<table>
<thead>
<tr>
<th>Financial Risk Standard</th>
<th>Nominal Amount Standard</th>
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<tbody>
<tr>
<td>APM Entities must bear risk for monetary losses.</td>
<td>The risk APM Entities bear must be of a certain magnitude.</td>
</tr>
</tbody>
</table>

- 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.

Medical Home Models:
- Have a unique financial risk criterion for becoming an Advanced APM.
- Enable participants (who are not excluded from MIPS) to receive the maximum score in the MIPS CPIA category.

A Medical Home Model is an APM that has the following features:
- Participants include primary care practices or multispecialty practices that include primary care physicians and practitioners and offer primary care services.
- Empannelment of each patient to a primary clinician; and
- At least four of the following:
  - Planned coordination of chronic and preventive care.
  - Patient access and continuity of care.
  - Risk-stratified care management.
  - Coordination of care across the medical neighborhood.
  - Patient and caregiver engagement.
  - Shared decision-making.
  - Payment arrangements in addition to, or substituting for, fee-for-service payments.

Important Information to Note about APMs and Advanced APMs

- MACRA does not change how any particular APM rewards value.
- Only some APMs will be considered “advanced” APMs
  - Within an advanced APM, a clinician must meet payment or patient requirements to be a “qualified participant”
- APM participants who are not “Qualified Participants” will receive favorable scoring under MIPS.
- Over time, more advanced APM options will become available.
How does MACRA Provide Additional Rewards for Participation in Advanced APMs?

Most clinicians who participate in APMs will be subject to MIPS and will receive favorable scoring under the MIPS clinical practice improvement activities performance category.

Those who participate in the most Advanced APMs may be determined to be qualifying APM participants (“QPs”). As a result, QPs:

1. Are not subject to MIPS
2. Receive 5% lump sum bonus payments for years 2019-2024
3. Receive a higher fee schedule update for 2026 and onward
PROPOSED RULE
APM Incentive Payment

QPs will:

- Be excluded from MIPS
- Receive a 5% lump sum bonus

Bonus applies in payment years 2019-2024; then QPs receive higher fee schedule updates starting in 2026

- The “APM Incentive Payment” will be based on the estimated aggregate payments for professional services furnished the year prior to the payment year.
- E.g., the 2019 APM Incentive Payment will be based on 2018 services.

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)

MACRA provides additional rewards for participating in APMs.

Potential financial rewards

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<thead>
<tr>
<th>Not in APM</th>
<th>In APM</th>
<th>In Advanced APM</th>
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<td>MIPS adjustments</td>
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</tr>
<tr>
<td></td>
<td>APM-specific rewards</td>
<td></td>
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APM participation = favorable scoring in certain MIPS categories

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

Potential financial rewards

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If you are a **Qualifying APM Participant (QP)**

5% lump sum bonus

Independent PFPM Technical Advisory Committee

PFPM = Physician-Focused Payment Model

Goal to encourage new APM options for Medicare clinicians

Submission of model proposals by Stakeholders

Technical Advisory Committee

11 appointed care delivery experts that review proposals, submit recommendations to HHS Secretary

Secretary comments on CMS website, CMS considers testing proposed models

For more information on the PTAC, go to: https://aspe.hhs.gov/ptac-physician-focused-payment-model-technical-advisory-committee
**PROPOSED RULE**

**Physician-focused Payment Model (PFPM)**

Proposed definition: An Alternative Payment Model wherein Medicare is a payer, which includes physician group practices (PGPs) or individual physicians as APM Entities and targets the quality and costs of physician services.

Proposed criteria fall under 3 categories:

- Payment incentives for higher-value care
- Care delivery improvements
- Information availability and enhancements

Any PFPM that is selected for testing by CMS and meets the criteria for an Advanced APM would be an Advanced APM.
ACP Recommendations re: PCMHs as Advanced APMs:

- CMS should allow PCMH to qualify as advanced APMs without financial risk, if it meets the criteria laid out in the law

- CMS should allow multiple pathways for PCMHs:
  1. Expedited analysis if Comprehensive Primary Care Initiative and advance planning to expand CPCI
  2. Deeming Process for PCMH programs run by states (e.g., Medicaid programs), non-Medicare payers, and employers
  3. Inclusion of PCMH programs and practices that meet the Medical Home Model Standard for financial risk and nominal amount (beyond CPC+)
ACP Recommendations re: Advanced APMs

- Give priority via PTAC for CMMI testing of models involving specialty/subspecialty categories where there are current NO recognized APMs and advanced APM options available.
- Reduce the nominal risk amount for advanced APM models
- Create a platform to expedite testing for APM recognition of bundled payment and similar episodes of care models.
- MSSP/Medicare ACOs – Track One MSSP ACOs should qualify; also consider adding a new track within MSSP to help bridge the transition
Recent MACRA Advocacy from ACP

Recent MACRA Advocacy from ACP (cont.)

- Meaningful Use Stage 3 Comments:
  - healthaffairs.org/blog/2016/01/14/its-time-to-fix-meaningful-use/ (Jan. 14, 2016)


- CMS Measure Development Plan (3/1/16): www.acponline.org/acp_policy/letters/comments_cms_draft_quality_measures_development_plan_2016.pdf
Things You Can Do This Year to Prepare

Spring 2016
- Participate in PQRS
- Participate in EHR Incentive Program (Meaningful Use)

Summer 2016
- Review your Quality Resource Use Report (QRUR)
- Begin to implement the principles of patient-centered medical home (PCMH)

Fall 2016
- Begin to implement quality improvement activities to improve your quality measures for PQRS and MU

Winter 2016
- Use a CMS-certified vendor for collection of Consumer Assessment of Healthcare Providers and Systems (CAHPS) data
ACP Resources for MACRA – and Value-Based Payment Overall

ACP’s MACRA webpage:  http://www.acponline.org/macra

ACP’s Practice Transformation webpage:  https://www.acponline.org/practice-resources/business-resources/practice-transformation

- Physician & Practice Timeline (text alerts–acptimeline to 313131) - http://www.acponline.org/timeline
  - Will help you to know key deadlines and prepare for them!
- ACP Practice Advisor® - https://www.practiceadvisor.org/
  - Interactive web tool to assist with quality improvement, practice transformation, and more
  - Data from physicians for physicians on EHR selection and usability, including MU certification
  - Registry software option to assist with reporting to CMS on PQRS and/or MU.
  - Provides current, evidence-based clinical decision support
- Questions:  macra@acponline.org
Coming soon…

Electronic algorithm/ practice readiness assessment—practice characteristics, quality measurement experience, quality improvement activities, and readiness

Algorithm does NOT result in a single answer (of MIPS vs APMs)—but rather analyzes the challenges and opportunities with each option—and identifies gap areas (e.g., are you doing care coordination, population management, etc.)

The user identifies their pathway—and is then directed to tailored resources to help them succeed. ACP resources such as Practice Advisor®, Genesis Registry, AmericanEHR, etc.
Specific Support for IM Subspecialists

- Ongoing workgroup/advisory panel of IM subspecialists members to help ACP develop our strategy for supporting our subspecialty members
- Setting up an online special interest group discussion board for IM subspecialists regarding MACRA and APM development
- What else?
While this might be overwhelming, ACP does hope to make your day feel better... through our advocacy and support efforts.
Contact Information

e-mail: macra@acponline.org
webpage: acponline.org/macra

ACP can help you navigate upcoming payment changes