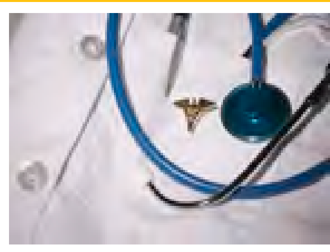
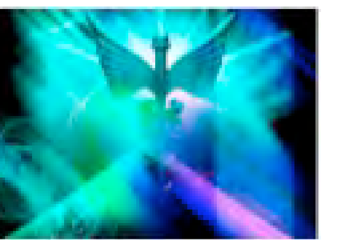
Centers for Medicare & Medicaid Services

LAN and MACRA: Understanding the Connection





LAN SUMMIT April 26th

Presenters :
Jean D. Moody-Williams, RN, MPP
and
JP Sharp, JD, MPH

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"What if we don't change at all ...
and something magical just happens?"

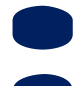
Three goals for our health care system

BETTER care
SMARTER spending
HEALTHIER people

Via a focus on **3 areas**

Incentives

Care Delivery



Information Sharing

Better Care, Smarter Spending, Healthier People

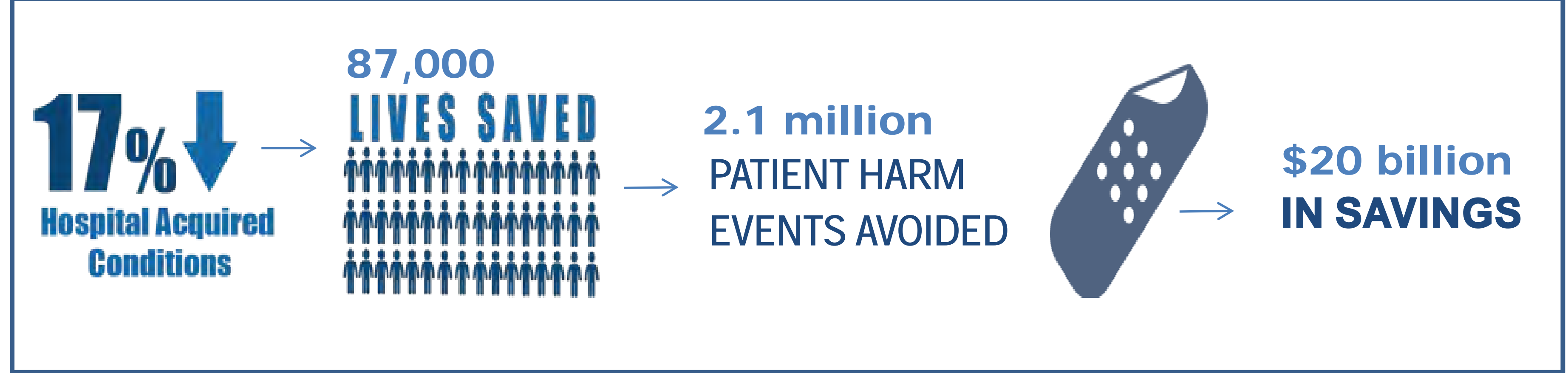
Focus Areas	Description
Incentives	§ Promote value-based payment systems – Test new alternative payment models – Increase linkage of Medicaid, Medicare FFS, and other payments to value § Bring proven payment models to scale
Care Delivery	§ Encourage the integration and coordination of services § Improve population health § Promote patient engagement through shared decision making
Information	§ Create transparency on cost and quality information § Bring electronic health information to the point of care for meaningful use

Source: Burwell SM. Setting Value-Based Payment Goals – HHS Efforts to Improve U.S. Health Care. NEJM 2015 Jan 26; published online first.

Care Delivery

Partnership for Patients contributes to quality improvements

Data shows from 2010 to 2014…



Leading Indicators, change from 2010 to 2013

Ventilator-Associated Pneumonia	Early Elective Delivery	Central Line-Associated Blood Stream Infections	Venous thromboembolic complications	Re-admissions
62.4% ↓	70.4% ↓	12.3% ↓	14.2% ↓	7.3% ↓

The Innovation Center portfolio aligns with delivery system reform focus areas

Focus Areas	CMS Innovation Center Portfolio*
Pay Providers	**Test and expand alternative payment models** § Accountable Care – Pioneer ACO Model – Medicare Shared Savings Program (housed in Center for Medicare) – Advance Payment ACO Model – Comprehensive ERSD Care Initiative – Next Generation ACO § Primary Care Transformation – Comprehensive Primary Care Initiative (CPC) – Multi-Payer Advanced Primary Care Practice (MAPCP) Demonstration – Independence at Home Demonstration – Graduate Nurse Education Demonstration – Home Health Value Based Purchasing – Medicare Care Choices § Bundled payment models – Bundled Payment for Care Improvement Models 1-4 – Oncology Care Model – Comprehensive Care for Joint Replacement § Initiatives Focused on the Medicaid – Medicaid Incentives for Prevention of Chronic Diseases – Strong Start Initiative – Medicaid Innovation Accelerator Program § Dual Eligible (Medicare-Medicaid Enrollees) – Financial Alignment Initiative – Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents § Medicare Advantage (Part C) and Part D – Medicare Advantage Value-Based Insurance Design model – Part D Enhanced Medication Therapy Management
Deliver Care	**Support providers and states to improve the delivery of care** § Learning and Diffusion – Partnership for Patients – Transforming Clinical Practice – Community-Based Care Transitions § Health Care Innovation Awards § Accountable Health Communities § State Innovation Models Initiative – SIM Round 1 – SIM Round 2 – Maryland All-Payer Model § Million Hearts Cardiovascular Risk Reduction Model
Distribute Information	**Increase information available for effective informed decision-making by consumers and providers** § Health Care Payment Learning and Action Network § Information to providers in CMMI models § Shared decision-making required by many models

* Many CMMI programs test innovations across multiple focus areas

Information

Improving the State of Information for EHRs

- Recognizing providers for the **outcomes** technology helps them achieve with their patients.
- Allowing providers the **flexibility to customize** health IT to their individual practice needs. Technology must be user-centered and support physicians.
- **Leveling the technology playing field** to promote innovation including opportunities for new entrants to the field so that new apps, analytic tools and plug-ins can be connected to easily and securely access data and direct it where and when it is needed to support patient care.
- **Prioritizing interoperability** by integrating federally recognized, national interoperability standards and planning in the future for real-world use cases of technology by patients and physicians.

Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014

- Bi-partisan bill introduced in March, U.S. House & Senate, passed on September 18, 2014, and signed into law by President Obama October 6, 2014.

- **The Act requires the submission of standardized data by:**
  - Long-Term Care Hospitals (LTCHs): LCDS
  - Skilled Nursing Facilities (SNFs): MDS
  - Home Health Agencies (HHAs): OASIS
  - Inpatient Rehabilitation Facilities (IRFs): IRF-PAI

- **The Act requires patient assessment data be standardized and interoperable** to allow for the exchange of data among PAC and other providers to facilitate coordinated care and improved outcomes.

Quality Measures Collaborative

- Measure requirements are often not aligned among payers, which has resulted in confusion and complexity for reporting providers.
- CMS, AHIP, commercial plans, Medicare and Medicaid managed care plans, purchasers, physician and other care provider organizations, and consumers worked together through the Core Quality Measures Collaborative to identify core sets of quality measures.
- The guiding principles used by the Collaborative in developing the core measure sets are that they be meaningful to patients, consumers, and physicians, while reducing variability in measure selection, collection burden, and cost.
- The goal is to establish broadly agreed upon core measure sets that could be harmonized across both commercial and government payers.

Incentives

A Broader Push Towards Value and Quality

In January 2015, the Department of Health and Human Services (HHS) announced new goals for value-based payments and APMs in Medicare.

Medicare Fee-for-Service

GOAL 1: **30%**

Medicare payments are tied to quality or value through **alternative payment models** (categories 3-4) by the end of 2016, and 50% by the end of 2018

GOAL 2: **85%**

Medicare fee-for-service payments are **tied to quality or value** (categories 2-4) by the end of 2016, and 90% by the end of 2018

Consumers | Businesses
Payers | Providers
State Partners

Set **internal** goals for HHS

APM FRAMEWORK

At-a-Glance

The Framework is a critical first step toward the goal of better care, smarter spending, and healthier people.

- **Serves as the foundation** for generating evidence about what works and lessons learned
- **Provides a road map** for payment reform capable of supporting the delivery of person-centered care
- **Acts as a "gauge" for measuring progress** toward adoption of alternative payment models
- **Establishes a common nomenclature and a set of conventions** that will facilitate discussions within and across stakeholder communities

Population-Based Payment (Categories 3 and 4)

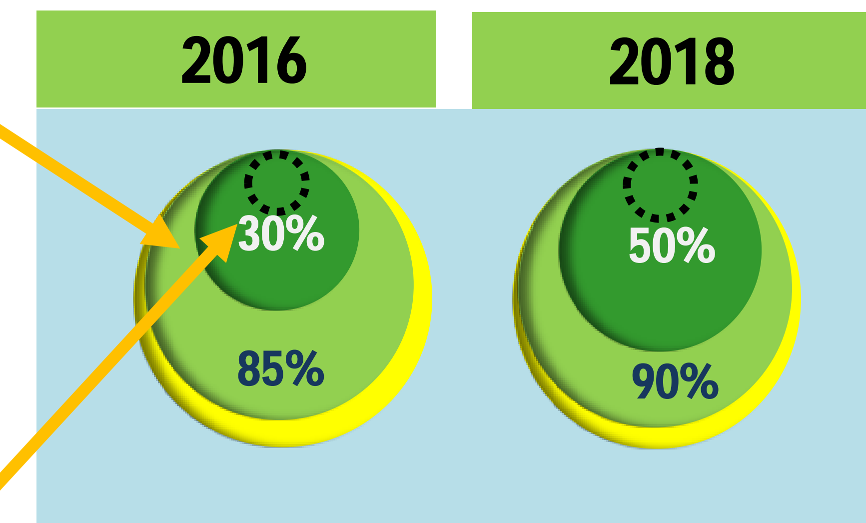
Category 1	Category 2	Category 3	Category 4
Fee for Service – No Link to Quality & Value	Fee for Service – Link to Quality & Value	APMs Built on Fee-for-Service Architecture	Population-Based Payment
	A Foundational Payments for Infrastructure & Operations	A APMs with Upside Gainsharing	A Condition-Specific Population-Based Payment
	B Pay for Reporting	B APMs with Upside Gainsharing/Downside Risk	B Comprehensive Population-Based Payment
	C Rewards for Performance		
	D Rewards and Penalties for Performance		

The framework situates existing and potential APMs into a series of categories.

MACRA moves us closer to meeting these goals…

MIPS helps to link **fee-for-service payments** to quality and value.

The law also **incentivizes participation in APMs**.



All Medicare fee-for-service (FFS) payments (Categories 1-4)

Medicare **FFS** payments **linked to quality and value** (Categories 2-4)

Medicare payments linked to quality and value **via APMs** (Categories 3-4)

Medicare payments to those in the **most highly advanced APMs under MACRA** ("eligible APMs")

Images not drawn to scale

What is “MACRA”?

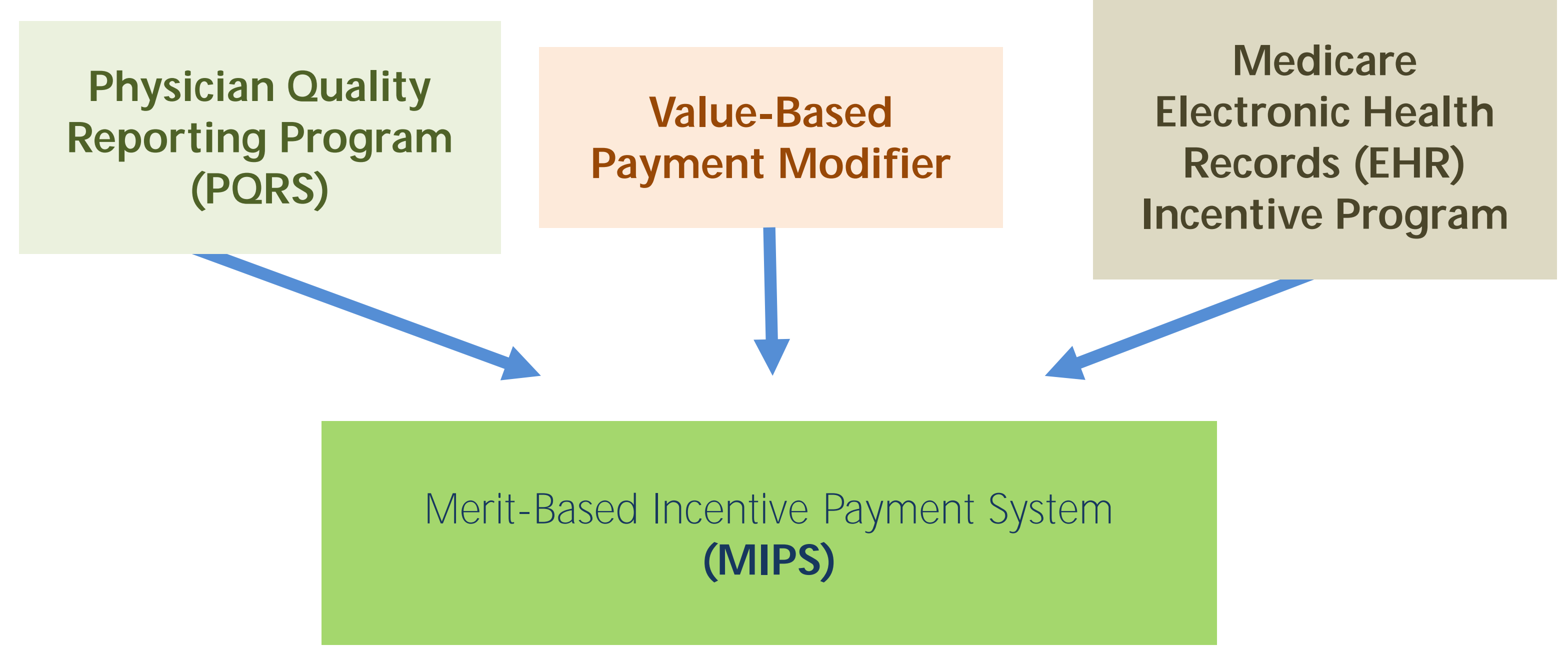
MACRA stands for the **Medicare Access and CHIP Reauthorization Act of 2015**, bipartisan legislation signed into law on April 16, 2015.

What does it do?

- **Repeals** the Sustainable Growth Rate (SGR) Formula
- **Changes the way that Medicare pays clinicians** and establishes a new framework to reward clinicians for **value** over volume
- **Streamlines** multiple quality reporting programs into 1 new system (MIPS)
- **Provides bonus payments** for participation in ***eligible* alternative payment models (APMs)**

Medicare Reporting Prior to MACRA

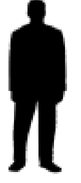
MACRA streamlines these programs into **MIPS.**



MACRA affects Medicare Part B clinicians.

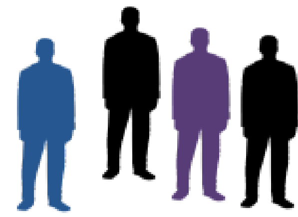
Affected clinicians are called **"eligible clinician" (EPs)** and will participate in MIPS. The types of **Medicare Part B** health care clinicians affected by MIPS may expand in the first 3 years of implementation.

Years 1 and 2



Physicians, PAs, NPs, Clinical nurse specialists, Nurse anesthetists

Years 3+



Secretary may broaden EP group to include others such as

Physical or occupational therapists, Speech-language pathologists, Audiologists, Nurse midwives, Clinical social workers, Clinical psychologists, Dietitians / Nutritional professionals

Are there any exceptions to participation in MIPS?

There are **3 groups** of clinicians who will NOT be subject to MIPS:

FIRST year of Medicare Part B participation

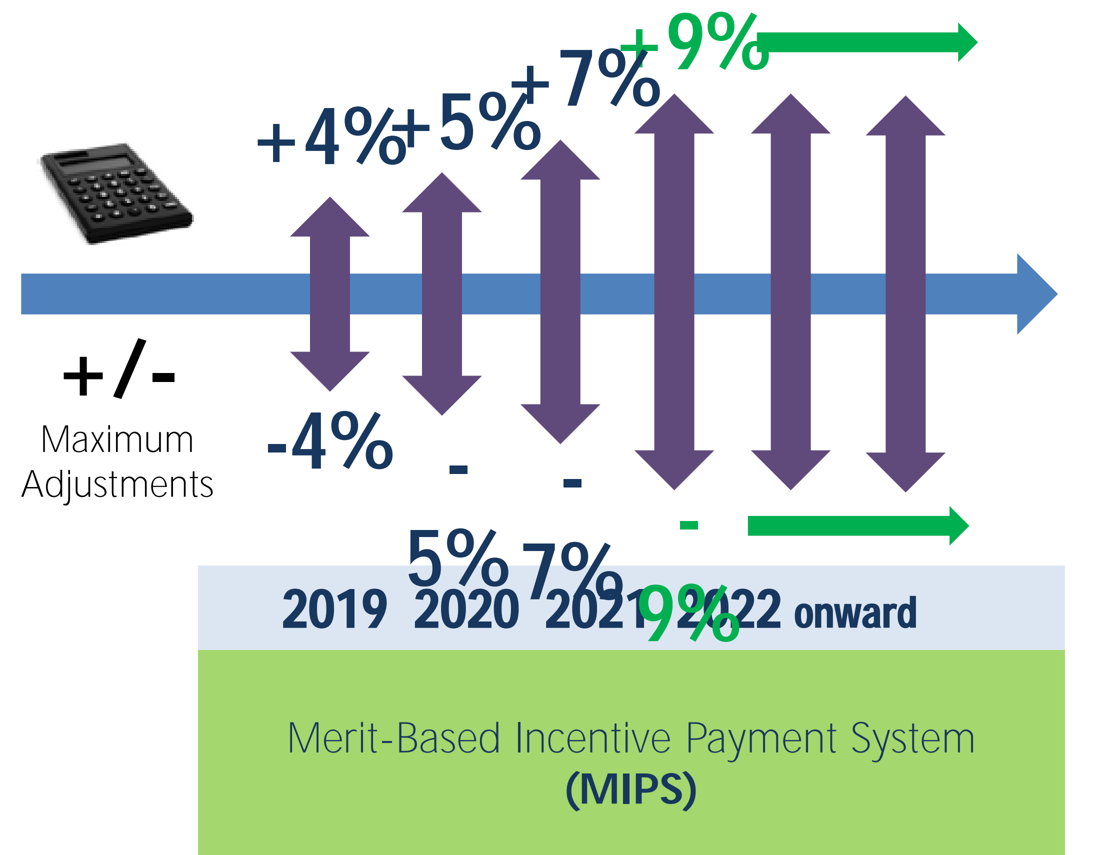
Below low patient volume threshold

Certain participants in ELIGIBLE Alternative Payment Models

Note: MIPS **does not** apply to hospitals or facilities

How much can MIPS adjust payments?

Based on a composite performance score, clinicians will receive **+/- or neutral** adjustments **up to** the percentages below.

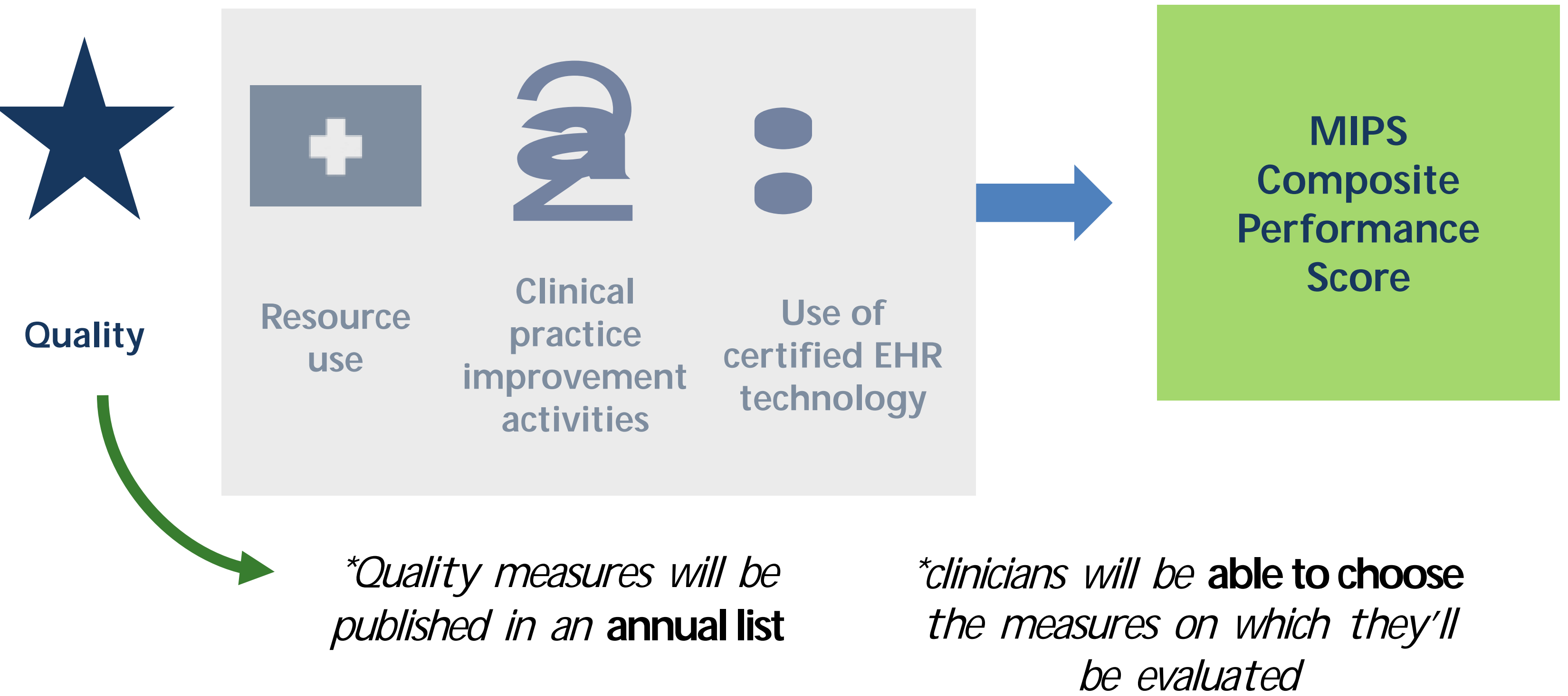


Adjusted Medicare Part B **payment** to clinician

The potential ***maximum*** *adjustment % will* ***increase*** *each year from* ***2019 to 2022***

What will determine my MIPS score?

The MIPS composite performance **score** will factor in performance in **4 weighted categories**:



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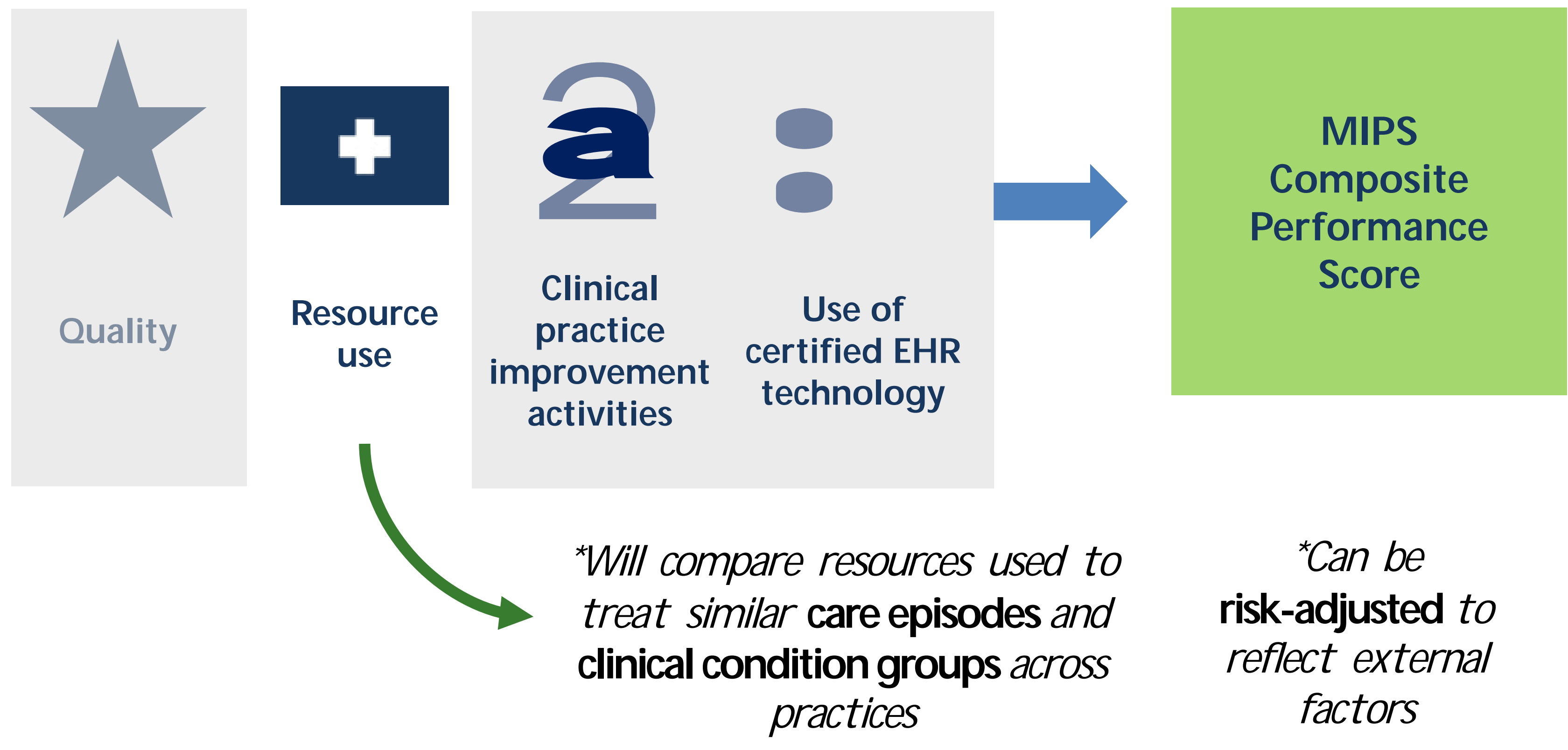

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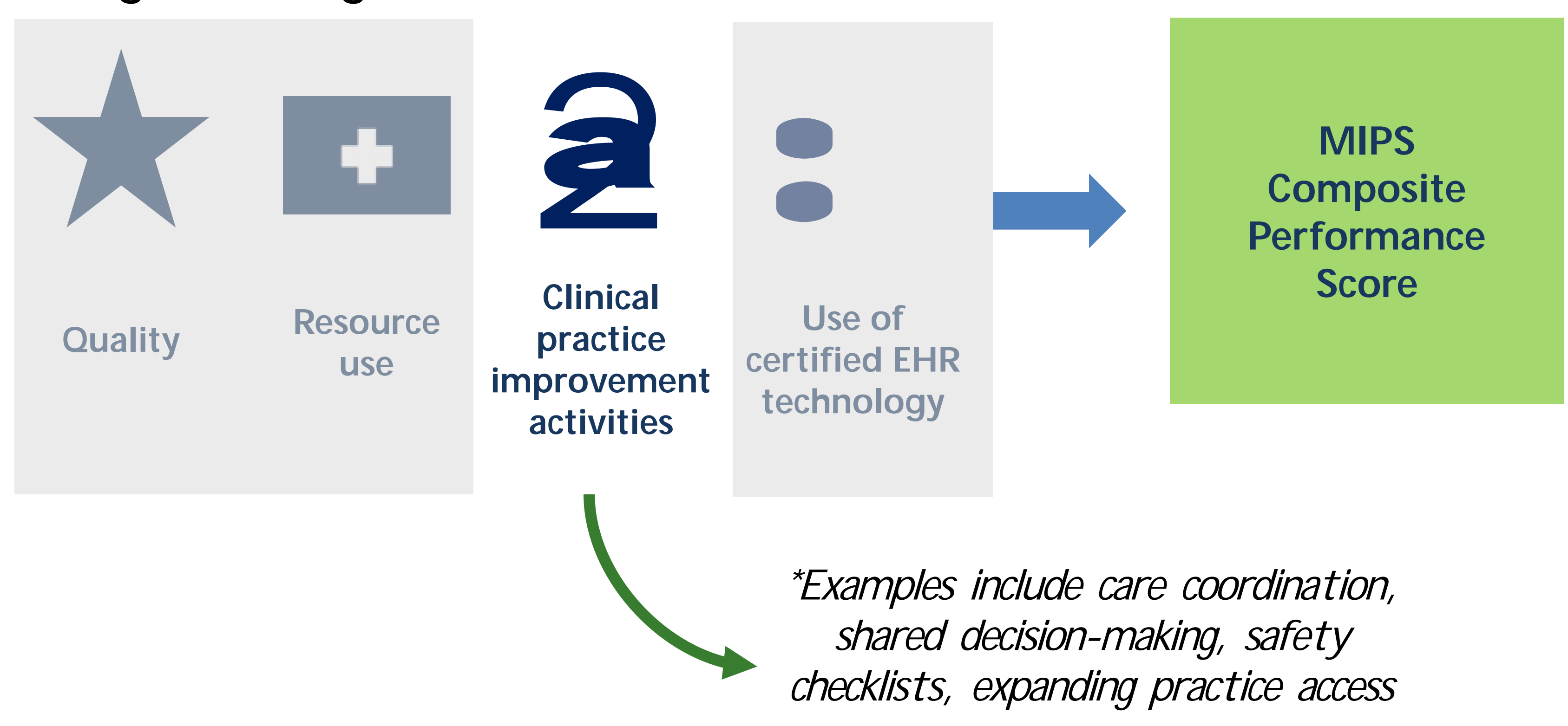

MIPS: Clinical Practice Improvement Activities

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	Population Management	Care Coordination	Beneficiary Engagement	Patient Safety Practice Assessment	Alternative Payment Models
•Same day appointments for urgent needs •After hours clinician advice	•Monitoring health conditions & providing timely intervention •Participation in a qualified clinical data registry	•Timely communication of test results •Timely exchange of clinical information with patients AND providers •Use of remote monitoring •Use of telehealth	•Establishing care plans for complex patients •Beneficiary self-management assessment & training •Employing shared decision making	•Use of clinical checklists •Use of surgical checklists •Assessments related to maintaining of certification	•Participation in an APM will also count for CPIA

- Secretary shall solicit suggestions from stakeholders to identify activities.
- Secretary shall give consideration to practices <15 EPs, rural practices, and EPs in underserved areas.

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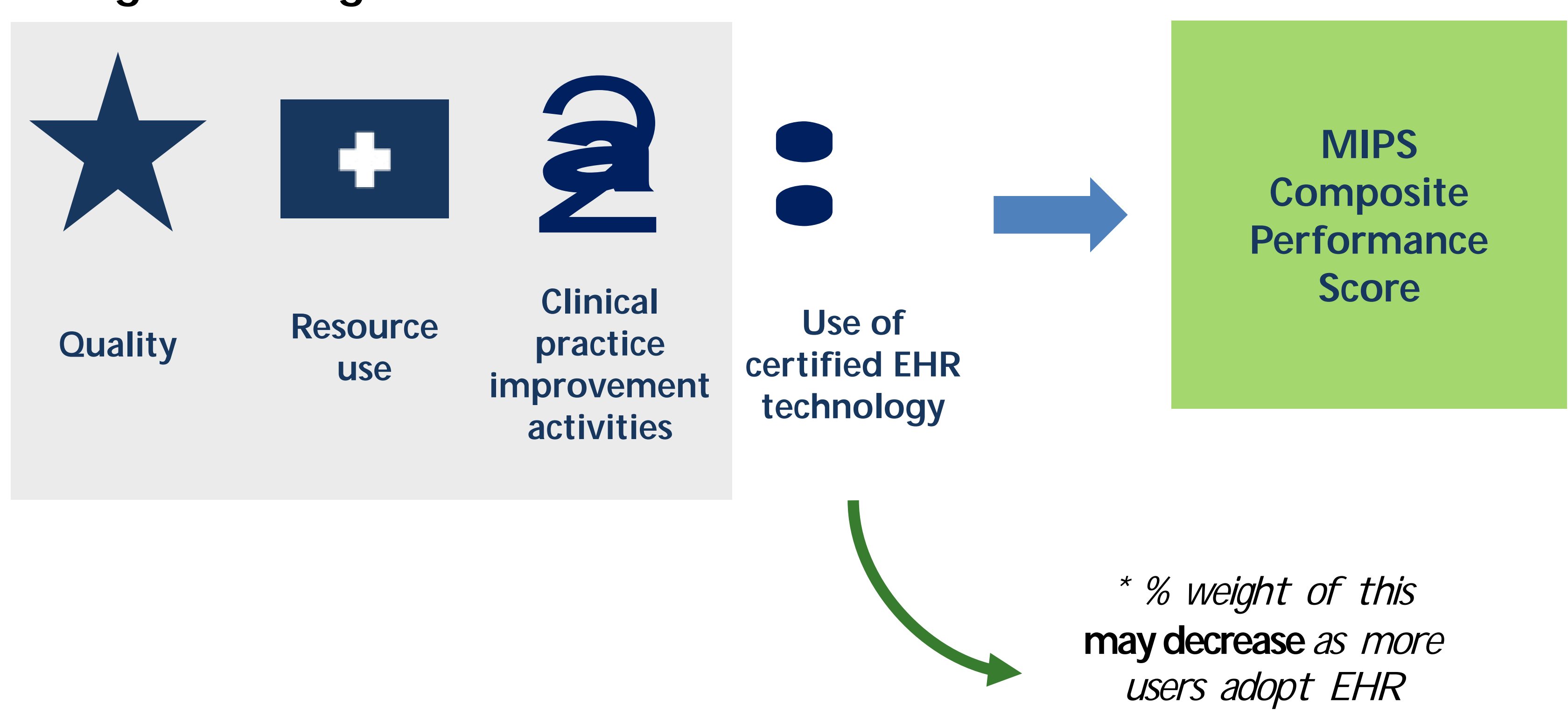
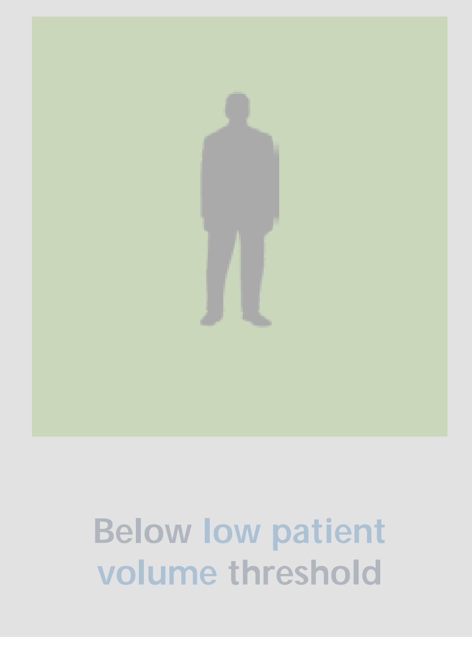
The MIPS composite performance **score** will factor in performance in **4 weighted categories**:



RECALL: Exceptions to Participation in MIPS

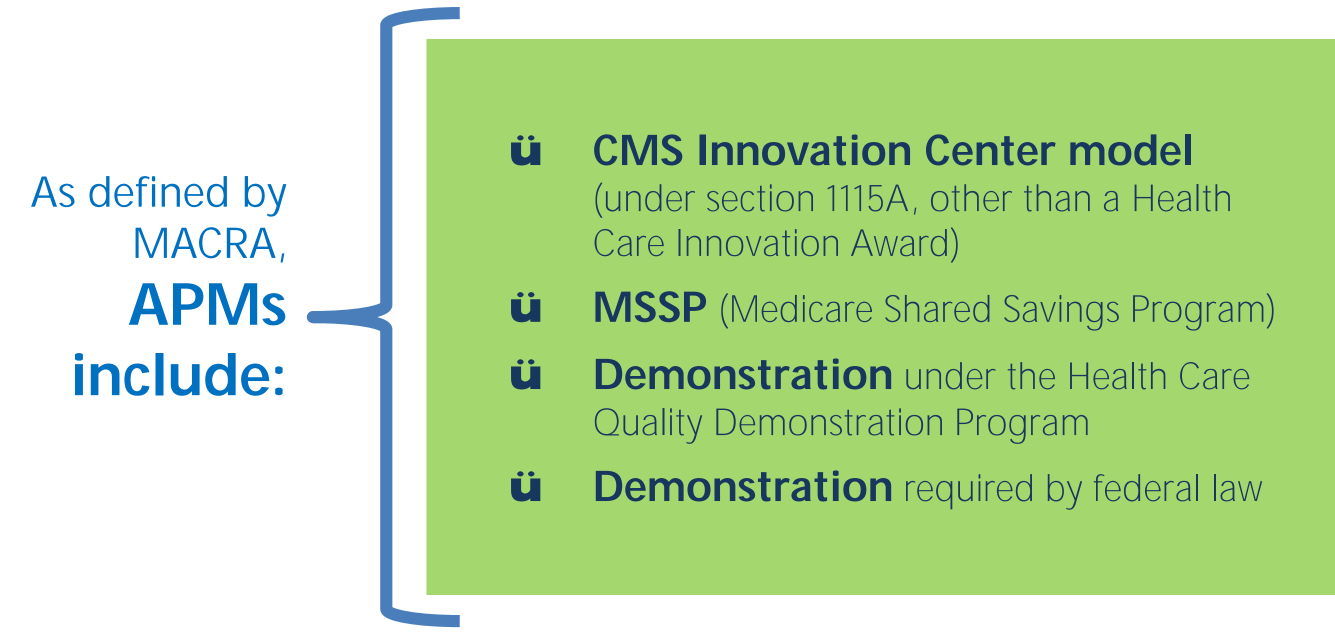
There are **3 groups** of clinicians who will NOT be subject to MIPS:



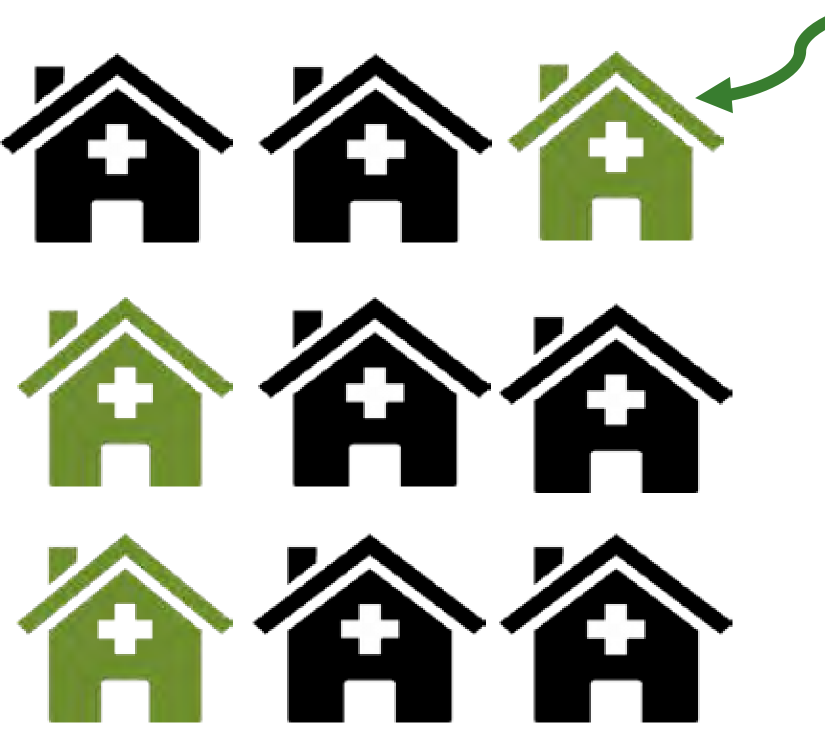
Certain participants in ELIGIBLE Alternative Payment Models

What is a Medicare Alternative Payment Model (APM)?

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



"Eligible" APMs are the most advanced APMs.



As defined by MACRA, eligible APMs **must meet the following criteria**:

- ü **Base payment on quality** measures comparable to those in MIPS
- ü Require use of certified **EHR** technology
- ü Either **(1)** bear more than nominal **financial risk** for monetary losses **OR (2)**be a **medical home model** expanded under CMMI authority

Note: **MACRA does NOT change how any particular APM rewards value. Instead, it creates extra incentives for APM participation.**

MACRA provides additional rewards for participating in APMs.

Potential financial **rewards**

Not in APM	In APM	In eligible APM

MACRA provides additional rewards for participating in APMs.

Potential financial rewards

Not in APM	In APM	In eligible APM
MIPS adjustments		

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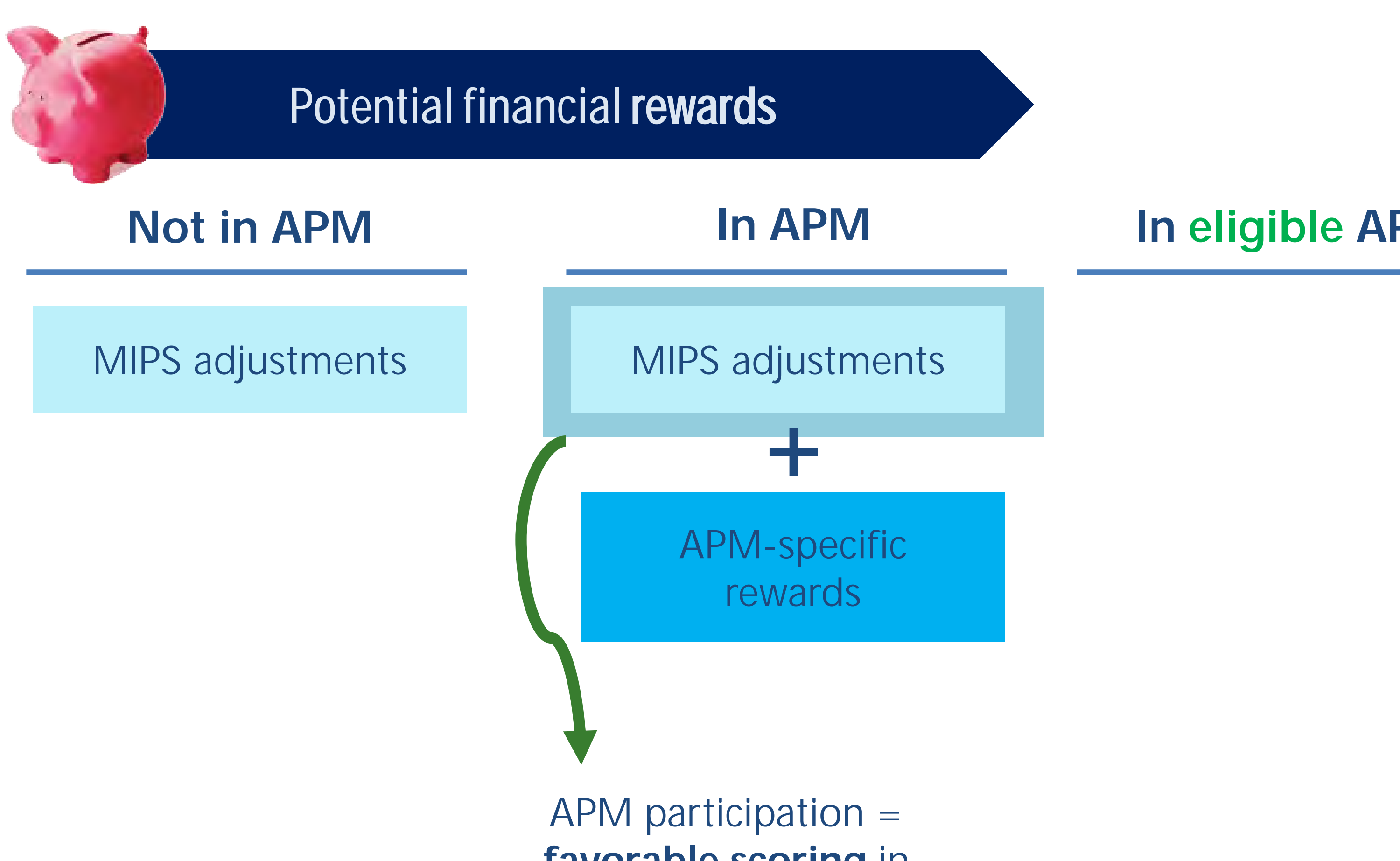

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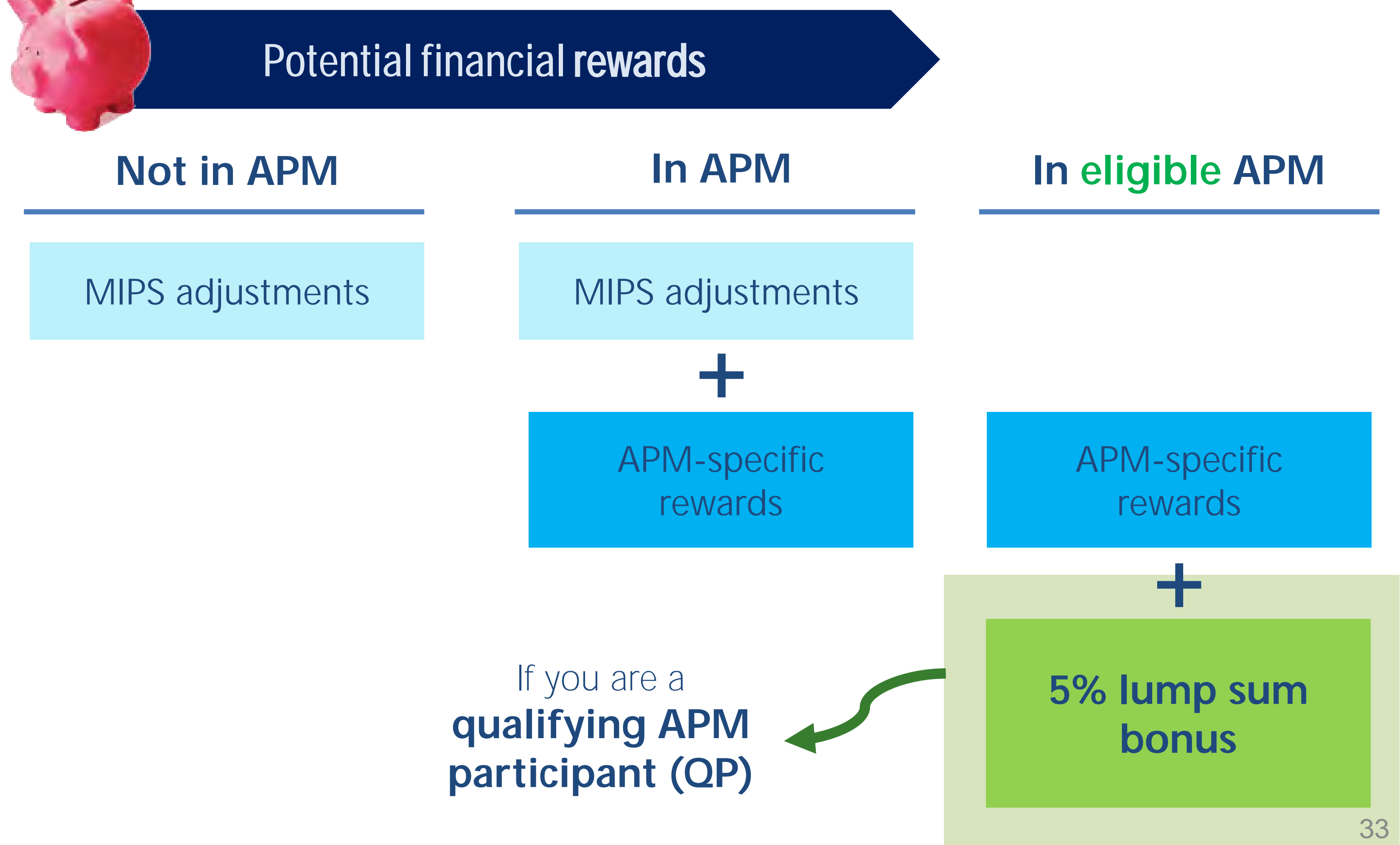
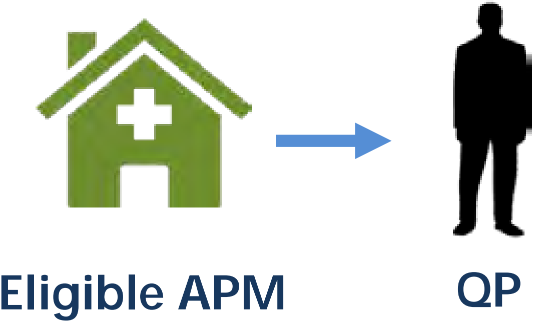


How do I become a qualifying APM participant (QP)?

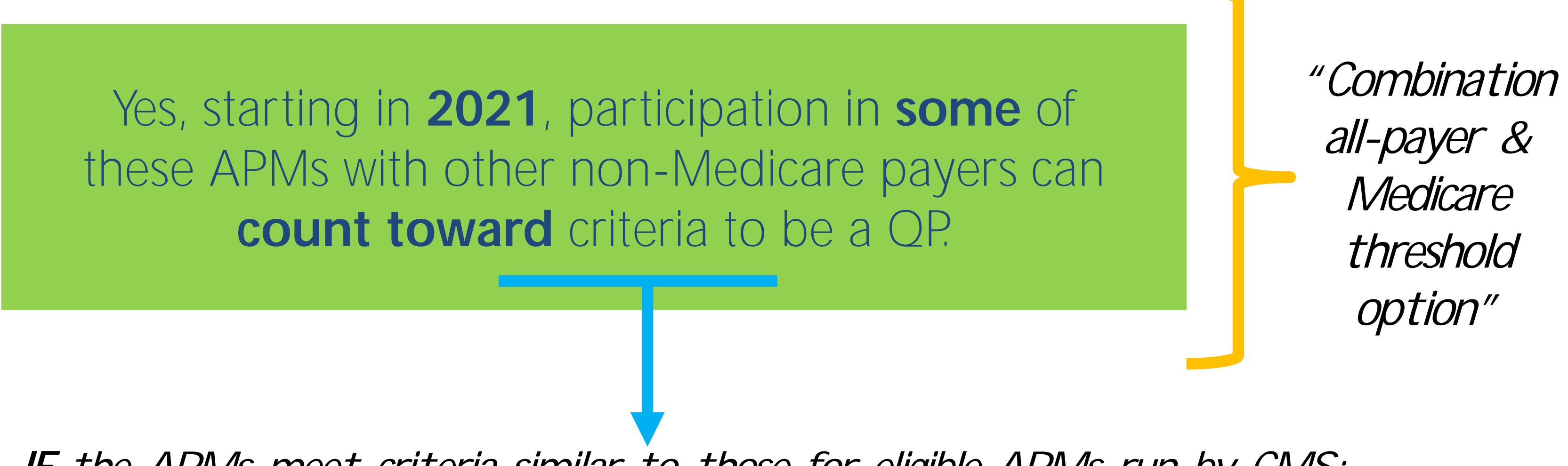


25% in 2019 and 2020

You must have a **certain %** of your patients or payments through an **eligible APM**.

Bonus applies in 2019-2024; then will receive higher fee schedule update starting in 2026

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

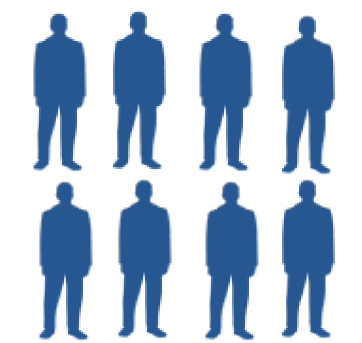


Note: Most practitioners will be subject to MIPS.

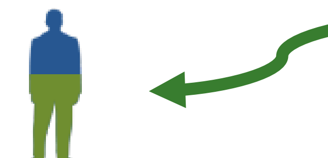
Subject to MIPS

Not in APM

In non-eligible APM



In eligible APM, but not a QP

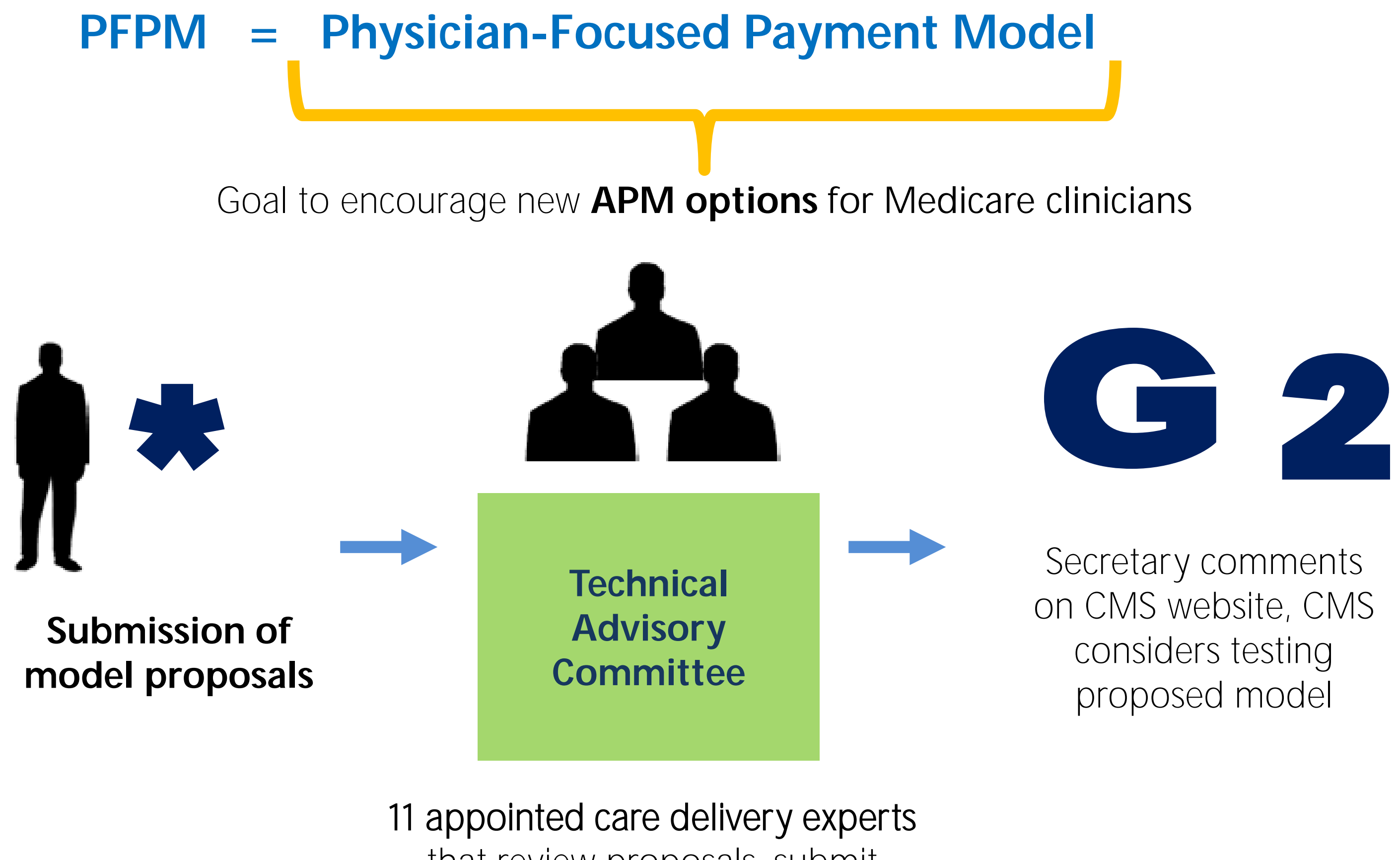


QP in eligible APM

Some people may be in eligible APMs and but not have enough payments or patients through the eligible APM to be a QP.

Note: Figure not to scale.

Independent PFPM Technical Advisory Committee



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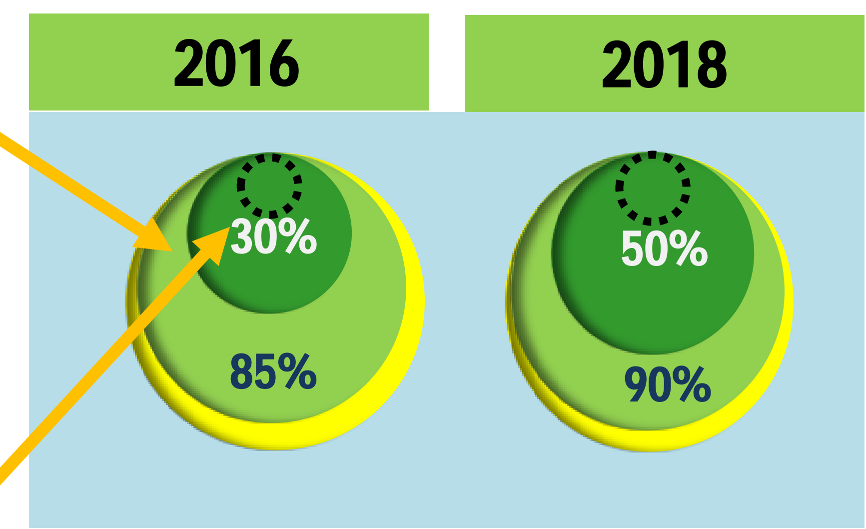

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Supporting Clinicians for Success

Specific MIPS/APM Focused TA

MACRA Quality Improvement Direct Technical Assistance (MQIDTA)

(15,000 providers)

-Small Practices(<=15 Eps)

-Practices in rural & HPSA Areas/medically underserved populations

-Support maximizing existing REC/QIO /RHC network infrastructure

Quality Innovation Network- Quality Improvement Organizations (QIN-QIO) TA

-Larger practices (>15 EPs)

- Non-rural

- LAN events with CME credits

- Direct TA when warranted

Transforming Clinical Practice Initiative (TCPI)

(140,000+ Practices)

- Four year model test

-Large Scale Practice Transformation Improvement Efforts

-Leveraging existing collaboration to create comprehensive Community of Practice

Open Door Forums

Background

The Department of Health and Human Services (HHS), Centers for Medicare and Medicaid Services (CMS) intends to solicit and award multiple contracts to qualified contractors for Medicare Access and CHIP Reauthorization Act (MACRA) Quality Improvement Direct Technical Assistance (MQIDTA). Direct technical assistance through this program will target:

- Eligible clinicians in individual or small group practices of 15 or fewer
- Health professional shortage areas (HPSA)
- Focus on those clinicians practicing in historically under resourced areas including rural areas
- Medically underserved areas (MUA)

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MACRA Technical Assistance

The purpose of this contract is to provide a ***flexible*** and ***agile*** approach to **customized direct technical assistance** and support services tailored to provider needs to ensure success for participating Merit-based Incentive Payment System (MIPS) eligible clinicians in easing the transition of Medicare payments from a fee-for-service system to one based on performance and patient outcomes.

CMS on behalf of the Secretary shall enter into contracts or agreements with appropriate entities (such as quality improvement organizations, regional extension centers …or regional health collaboratives) to offer guidance and assistance to MIPS eligible professionals in practices of 15 or fewer professionals

Priority given to such practices located in rural areas, health professional shortage areas and medically underserved areas, and practices with low composite scores) …or… with transition to the implementation of and participation in an alternative payment model as described in section

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Technical Assistance

What is Technical Assistance

- Provider Outreach and Education
- Practice Readiness
- Practice Facilitation

- Health Information (HIT) optimization
- Practice workflow redesign

- Change Management
- Strategic Planning
- Provider Satisfaction

- Assisting clinicians in fully transitioning to Alternative Payment Models (APM)
- Enabling partnerships

The contractor must ***identify, assess, and enroll*** clinicians into the program, ***assist*** with the implementation of a quality improvement program, provide a flexible and agile approach to customized direct technical assistance tailored to provider needs in order to heighten customer satisfaction.

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Solicitation Information

MQIDTA Solicitation

- Will comply with all applicable statute and regulations associated with the criteria contractors must meet in order to win MIQDTA contract awards
- In accordance with Federal Acquisition Regulation (FAR) 5.203, CMS hereby notifies industry of its intent solicit for this requirement under full and open competition under NAICS code 541618 (Other Management Consulting Services) with a size standard of $15 million
- CMS anticipates a full and open national competition to implement TA provision of MACRA statute.

Pre-Proposal Conference

- Tentatively planned on or about **May 18, 2016** that will include information about this new requirement. CMS anticipates that this conference will take place via webinar only. More details about this conference, including the final date and time, and registration instructions, will be made available in the proposal solicitation notice.

Additional Information

- Quality Improvement Organizations, Regional Extension Centers, Regional Health Collaboratives and others will be eligible to compete. Eligible entities are encouraged to partner.
- CMS anticipates that multiple contracts to be awarded for the MQIDTA will be cost-reimbursement.
- In accordance with FAR 16.301-3, Offerors must have an accounting system that has been deemed adequate for determining applicable costs prior to contract award.
- This requirement flows down to any proposed subcontractor for cost-reimbursement services

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Overall Aims of the TCPI Model

1.Transform Practice. Support more than 140,000 clinicians in work to achieve practice transformation

2. High Performance. Improve health outcomes for 5M Medicare, Medicaid & CHIP beneficiaries.

3. Reduce Utilization. Reduce unnec-essary hospital-izations & over utilization of other services for 5M Medicare, Medicaid & CHIP beneficiaries

4. Scale. Build the evidence base on practice transformation so that effective solutions can be scaled, if successful

5. Savings. $1B– $4B in savings to federal government over… 4 years through reduced Medicare, Medicaid & CHIP expenditures

6. Value Based. Move >75% of clinicians that complete the TCPI… to participate in incentive programs & practice models that reward value

→ Logic Flow

Clinicians

Beneficiaries

System Impact

Getting Ready

- Comment on the proposed rule
- Participate in Listening Sessions
- Begin to determine your measurement strategies
- Begin to analyze your practice data
- Share best practices in quality improvement and practice management
- Know the terms of your risk sharing arrangements if you are in an APM or planning to join one
- Make sure your peers are aware of the change

What Are Your Thoughts?

- What are the opportunities for MACRA to help achieve the goals of DSR in collaboration with the HCPLAN?
- How can the HCPLAN help to engage clinicians in transformation to meet the goals of MACRA and the HCPLAN?
- What are the most important considerations for CMS in program design?