MACRA and Standards-based Interoperability: The Road Ahead

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- **Sustainable Growth Rate (SGR): Gone!**
  - Small annual updates through 2019

- **Medicare Eligible Professional (EP) value-based payment: two paths**
  - CMS regulations – Proposed (April 2016) and Final (October 2016)
  - Aligned quality and performance measures, to cover more specialties

- **Merit-Based Incentive Payment System (MIPS)**
  - Integrates/replaces Medicare MU, PQRS, VM physician penalties – composite score
  - Start: 2019 payments (per 2017)
  - Increasing penalties/rewards per Final Score compared to threshold
  - Depends on eCQMs
  - Emphasis on qualified clinical data registries

- **Alternative Payment Models (APMs)**
MACRA Final Rule: CMS

Initial release October 14, 2016

Effective 1/1/2017

Final Rule with Comment Period (60-days from formal publication)

Builds on MACRA provisions and Proposed Rule

Quality Payment Program: MIPS and (Advanced) APMs

Staged approach – 2017 is “Transition Year” & 2018 likely transition year

New website – qpp.cms.gov
The new Merit-based Incentive Payment System helps to link fee-for-service payments to quality and value.

The law also provides incentives for participation in Alternative Payment Models in general and bonus payments to those in the most highly advanced 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**

Source: CMS 2/2016
Merit-Based Incentive Payment System (MIPS) and Transformation of Medicare Fee-for-service
MIPS and Eligible Clinicians (ECs)

Individual ECs, groups of ECs, “virtual groups”

2019-20

• Physicians, Physician Assistants, Certified Registered Nurse Anesthetists, Nurse Practitioners, Clinical Nurse Specialists, Certified Registered Nurse Anesthetists, Groups including such ECs by unique NPI/TIN combination for individual and TIN for groups

2021+

• Secretary can add other ECs (described in 1848(k)(3)(B)) to MIPS
• Other EC can also voluntarily report with no adjustments

Excluded ECs

• Qualifying APM Participants (QPs)
• Partial (specific %) Qualifying APM Participants (Partial QPs)
• Newly enrolled (first year) ECs

Low volume exclusions: Medicare allowed billing < or = $30K or fewer than 100 Part B beneficiaries – CMS revised to use historical and performance data to allow advance notice of low volume status: 32.5% of pre-exclusion ECs

Most in MIPS (592 - 642,000) ECs initially vs. Advanced APMs (70–120,000 in 2017 and 125-250,000 in 2018) - with new Advanced APMs expected to be available in 2017 and 2018
MIPS Performance Categories

Quality measures: 30%
- 60% 2019 and 50% 2020

Cost measures: 30%
- No more than 10% in 2019 and 15% in 2020 so additional weights of 30% and 20% added to Quality in 2019-20 – 0% for 2019 and 10% for 2020

Improvement Activities: 15%
- Sub-categories (e.g., Better Off-Hours Access, Care Coordination, Patient Safety, Beneficiary Engagement, others per HHS)

Advancing Care Information: 25%
- Could drop to 15% if “MU” levels >75% (CMS defines “MU” as 75% ACI score)
MIPS Reporting Year

2017 reporting affects 2019 payments and so on (APMs also)

Full year reporting for MIPS (other than 2017)

• CMS rejects 90-days for default MIPS reporting
• No 90-day for new Medicare ECs in 2017 (MIPS exempt)
• Partial year in limited cases (e.g., new EC or off for part of year)

2017: Transition year – consecutive 90-day minimum

• Can receive full incentive with 90 days but performance for some measures (e.g., some outcomes-based CQMs) may be enhanced by full year reporting (per CMS)

2018: Full year for quality and cost and minimum of 90-days for ACI (given shift to 2015 CEHRT) and IA (already 90-days)
Quality

Quality measures selected annually per call for measures and CMS criteria

- Final list in Federal Register by November 1 each year - initial list in proposed rule
- 2017 final list: Maintains most PQRS measures (Table A, with comments responses and Table D and G measures), revised VM claims measures, Table B), new measures (Table D), final specialty sets (Table E), final measures removed (Table F), substantive changes (Table G)

Report as individual or group

All-payer unless claims-based (some measures)

Data completeness criterion reduced to 50% for 2017

Some data can be submitted via third parties

- Clinical data registries (QCDRs), which can have separate measures
  - CMS to finalize QCDR list Spring 2017 for first year
- HIT vendors
- Qualified registries
- CMS-approved survey vendors
Quality (continued)

Select six measures

• No longer must span multiple National Quality Strategy domains
• Select from individual or specialty measure set (selection scenarios, many registry-only)
  – May be less than 6 and that is OK and no penalty for reporting beyond measure set
• Outcome measure if available (if not, use other high-priority* measure)
• CAHPS for MIPS optional, counts as one measure
• Fewer if not six applicable (Quality weight reduced if only 1-2 measures applicable)
  – CMS “clinical relation test” to validate fewer than 6 measures

CMS would also score up to 1 population measure from claims

Detailed measure specifications on QPP website

*Outcome, appropriate use, patient safety, efficiency, patient experience, or care coordination quality measures
Quality: Scoring (continued)

Bonus points

• High priority measures (outcome, appropriate use, efficiency, care coordination, patient safety, patient experience) – cap of 10% of denominator (first two years)

• CEHRT role & CEHRT/registry submission – cap of 10% of denominator (first two years)

*Quality performance category score* = sum of points for scored measures + bonus (capped) divided by sum of possible points

Total possible points generally 70 (6 + up to 1 population-based) & adjustments if CMS web portal (+) or small group/solo (-)

Will consider *improvement* and achievement after 2017
Quality: Scoring (continued)

Closing the Referral Loop: Receipt of Specialist Report

Percentage of patients with referrals, regardless of age, for which the referring provider receives a report from the provider to whom the patient was referred

<table>
<thead>
<tr>
<th>Measure Number</th>
<th>NQS Domain</th>
<th>Measure Type</th>
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<tbody>
<tr>
<td>eMeasure ID: CM550vS</td>
<td>Communication and Care Coordination</td>
<td>Process</td>
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<tr>
<td>eMeasure NQF: N/A</td>
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<tr>
<td>NQF: N/A</td>
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<td>Quality ID: 374</td>
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<table>
<thead>
<tr>
<th>High Priority Measure</th>
<th>Data Submission Method</th>
<th>Specialty Measure Set</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>EHR</td>
<td>Allergy/Immunology</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Cardiology</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Dermatology</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Emergency Medicine</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Gastroenterology</td>
</tr>
</tbody>
</table>
Improvement Activities

**IA Inventory**: 93 in Table H
- Medium (10 points)
- High (20 points)

*Many are HIT dependent*

At least 90 days

Multiple submission paths

2017: report yes/no on **IA Inventory**

40 (was 60) point target for 2017

Searchable filtered table: QPP website
Advancing Care Information: “Replaces” MU for Medicare ECs

Emphasizes interoperability and information exchange

Scoring revised from proposed rule

No “all or nothing,” measure choice flexibility, multiple paths

But, need high performance (above Stage 3) to do well

CPOE & Clinical Decision Support removed

Quality reporting moved to MIPS Quality

Multiple submission paths and group option

• CMS will permit EHR and registry reporting

Provisions for hospital-based, hardship, & non-patient-facing ECs
ACI: Overall Scoring

<table>
<thead>
<tr>
<th>Quality</th>
<th>Cost</th>
<th>IA</th>
<th>ACI</th>
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</thead>
</table>

Base Score
50 Points

+ Performance Score
90 Points

+ Bonus (PH) 5%

Bonuses (IA) 10%

= Final Score
Up to 155 points capped at 100 points for Full 25 Points for Advancing Care Information

Source: CMS, May and October 2016
Advancing Care Information: Objectives & Measures (“Stage 3”)

Base measures cut from 11 to 5

Some measure names changes

Performance rate of 1-10% = 1 percentage point, performance rate of 11-20% = 2 percentage points and so on

Specifications from CMS 10/2015 Final Rule as adjusted by MACRA Final Rule - Review discussion of comments for CMS interpretations

Exclusions eliminated, including immunization (no longer in Base)

Source: CMS, October 2016, Table 9

<table>
<thead>
<tr>
<th>Advancing Care Information Objective</th>
<th>Advancing Care Information Measure*</th>
<th>Required/Not Required for Base Score (50%)</th>
<th>Performance Score (up to 90%)</th>
<th>Reporting Requirement</th>
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<tbody>
<tr>
<td>Protect Patient Health Information</td>
<td>Security Risk Analysis</td>
<td>Required</td>
<td>0</td>
<td>Yes/No Statement</td>
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<tr>
<td>Electronic Prescribing</td>
<td>e-Prescribing</td>
<td>Required</td>
<td>0</td>
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<td>Patient Electronic Access</td>
<td>Provide Patient Access</td>
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<td>Patient-Specific Education</td>
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<td>Not Required</td>
<td>Up to 10%</td>
<td>Numerator/Denominator</td>
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<tr>
<td>Coordination of Care Through Patient Engagement</td>
<td>View, Download, or Transmit (VDT)</td>
<td>Not Required</td>
<td>Up to 10%</td>
<td>Numerator/Denominator</td>
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<td></td>
<td>Secure Messaging</td>
<td>Not Required</td>
<td>Up to 10%</td>
<td>Numerator/Denominator</td>
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<tr>
<td></td>
<td>Patient-Generated Health Data</td>
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<td>Up to 10%</td>
<td>Numerator/Denominator</td>
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<td>Send a Summary of Care</td>
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<td>Numerator/Denominator</td>
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<tr>
<td></td>
<td>Request/Accept Summary of Care</td>
<td>Required</td>
<td>Up to 10%</td>
<td>Numerator/Denominator</td>
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<tr>
<td></td>
<td>Clinical Information Reconciliation</td>
<td>Not Required</td>
<td>Up to 10%</td>
<td>Numerator/Denominator</td>
</tr>
<tr>
<td>Public Health and Clinical Data Registry Reporting</td>
<td>Immunization Registry Reporting</td>
<td>Not Required</td>
<td>0 or 10%</td>
<td>Yes/No Statement</td>
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<td></td>
<td>Syndromic Surveillance Reporting</td>
<td>Not Required</td>
<td>Bonus</td>
<td>Yes/No Statement</td>
</tr>
<tr>
<td></td>
<td>Electronic Case Reporting</td>
<td>Not Required</td>
<td>Bonus</td>
<td>Yes/No Statement</td>
</tr>
<tr>
<td></td>
<td>Public Health Registry Reporting</td>
<td>Not Required</td>
<td>Bonus</td>
<td>Yes/No Statement</td>
</tr>
<tr>
<td></td>
<td>Clinical Data Registry Reporting</td>
<td>Not Required</td>
<td>Bonus</td>
<td>Yes/No Statement</td>
</tr>
</tbody>
</table>

Bonus (up to 15%)

Report to one or more additional public health and clinical data registries beyond the Immunization Registry Reporting measure: 5% bonus

Report improvement activities using CEHRT: 10% bonus

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17 Source: CMS, October 2016, Table 9
Selected Stage 3 ACI Measures
ACI Objectives and Measures

- **Objective:** The MIPS EC provides patients (or patient authorized representative) with timely electronic access to their health information and patient-specific education.

- **Measure 1:** For at least one unique patient seen by the MIPS eligible clinician:
  1. The patient (or the patient authorized representative) is provided timely access to view online, download, and transmit his or her health information; and
  2. The MIPS EC ensures the patient’s health information is available for the patient (or patient—authorized representative) to access using any application of their choice that is configured to meet the technical specifications of the Application Programming Interface (API) in the MIPS eligible clinician’s certified EHR technology. (was 80%)

- **Measure 2:** The MIPS EC must use clinically relevant information from certified EHR technology to identify patient-specific educational resources and provide electronic access to those materials to at least one unique patient seen by the MIPS eligible clinician (was 35%)

- **Note:** Base reporting must include numerators and denominators
- **Note:** Various standards, including HL7 standards apply. API certification part of Measures 1 and 2.
ACI Objectives and Measures

Objective: Use CEHRT to engage with patients or their authorized representatives about the patient’s care

Measure 1: During the performance period, at least one unique patient (or patient-authorized representatives) seen by the MIPS eligible clinician actively engages with the EHR made accessible by the MIPS EC. A MIPS EC may meet the measure by either—(1) view, download or transmit to a third party their health information; or (2) access their health information through the use of an API that can be used by applications chosen by the patient and configured to the API in the MIPS EC’s CEHRT; or (3) a combination of (1) and (2). (was 10% and 5% for 2017)

Measure 2: For at least one unique patient seen by the MIPS EC during the performance period, a secure message was sent using the electronic messaging function of CEHRT to the patient (or the patient-authorized representative), or in response to a secure message sent by the patient (or the patient-authorized representative. (was 25% and 5% in 2017)

Measure 3: Patient-generated health data or data from a non-clinical setting is incorporated into the CEHRT for at least one unique patient seen by the MIPS EC during performance period (was 5%)

Note: Various standards, including HL7 standards apply. API certification part of Measures 1.
ACI Objectives and Measures

• **Objective:** The MIPS EC provides a summary of care record when transitioning or referring their patient to another setting of care, receives or retrieves a summary of care record upon the receipt of a transition or referral or upon the first patient encounter with a new patient, and incorporates summary of care information from other health care providers into their EHR using the functions of CEHRT

• **Measure 1:** For at least one transition of care or referral, the MIPS EC that transitions or refers their patient to another setting of care or health care provider—(1) creates a summary of care record using certified EHR technology; and (2) electronically exchanges the summary of care record (was 50%)

• **Measure 2:** For at least one transition of care or referral received or patient encounter in which the MIPS EC has never before encountered the patient, the MIPS EC receives or retrieves and incorporates into the patient’s record an electronic summary of care document (was 40%)
  • Note: Base reporting must include numerators and denominators.
  • Note: Various standards, including HL7 standards apply.
ACI Objectives and Measures

- **Measure 3**: For at least one transition of care or referral received or patient encounter in which the MIPS EC has never before encountered the patient, the MIPS EC performs clinical information reconciliation. The clinician must implement clinical information reconciliation for the following three clinical information sets: (1) Medication. Review of the patient’s medication, including the name, dosage, frequency, and route of each medication. (2) Medication allergy. Review of the patient’s known medication allergies. (3) Current Problem list. Review of the patient’s current and active diagnoses (was 80%)
HIE changes (from 10/2015 Final Rule)

- Retains one measure, electronic transmission
- No change in required C-CDA content except can limit lab data for “relevance” but must provide full data on request
- Eliminates specification of modes of transport (e.g., Direct)
  - Intended to provide more flexibility for finding exchange partners
  - Transport must still comply with HIPAA security and privacy
  - Need to “count” broader set of transmission options
  - Limited use of FAX when third party used to transmit summary of care and they must convert transmission to fax as only way receiving provider can accept transmission and is not default
Starting in 2019, a single MIPS Final score (0-100) will factor in performance in 4 weighted performance categories:

Quality, Cost, Improvement Activities, Advancing Care Information

Source: CMS, February, May, October 2016 (Resource Use weighted at zero in 2017)
Final Score and Payment

Upward and downward adjustments must be budget neutral.

Additional payment for exceptional performance (2019-24)

Source: CMS 8/2016 with annotations added
MIPS Payment Adjustments

- Per comparison of MIPS Final Score to threshold, ECs have positive, negative, or neutral adjustments up to percentages below.
- First (2019) threshold set at 3 (vs. proposal to look at historical data and budget neutrality goal).
- MIPS adjustments linear and budget neutral. Scaling factor* to upward adjustments to equalize total +/-.
- Final Score of 0 - ¼ of = maximum negative adjustment.

MAXIMUM Adjustments

2017 threshold = 3

-4%  -5%  -7%  -9%

Adjustment to provider’s base Medicare Part B payment

Additional + adjustment factor up to 10% for exceptional performance = >25th percentile of + scores (2019-24)

MACRA allows up to 3x upward adjustment
$500M Exceptional Performance payments in 2017

Source: CMS 2/2016 – updated to 10/2016 Final Rule
Attestations (MU & ACI) - Information blocking & connectivity per MACRA 106(b)(2)

1. Did not knowingly and willfully take action (e.g., disable functionality) to limit or restrict compatibility or interoperability of CEHRT

2. Implemented technologies, standards, policies, practices, and agreements reasonably calculated to ensure, to greatest extent practicable and permitted by law, that CEHRT was, at all relevant times: connected in accordance with applicable law; compliant with all standards applicable to exchange of information, including ONC standards, implementation specifications, and certification criteria; implemented in a manner that allowed for timely access by patients to their electronic health information (VDT); and implemented in a manner that allowed for timely, secure, and trusted bi-directional exchange of structured electronic health information with other providers including unaffiliated providers, and with disparate CEHRT and vendors

3. Responded in good faith and in a timely manner to requests to retrieve or exchange electronic health information, including from patients, health care providers and other persons, regardless of requestor’s affiliation or technology vendor

Finalized as proposed, with CMS indicating overall “good faith” standard and extensive responses to comments that appear to provide some flexibility
Alternative Payment Models (APMs)
Alternative Payment Models (APMs)

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

MACRA APMs include:

- CMS Innovation Center model (under section 1115A, other than Health Care Innovation Award)
- MSSP (Medicare Shared Savings Program)
- Demonstration under Health Care Quality Demonstration Program
- Demonstration required by Federal Law
- Adopted Physician-Focused Payment Models proposed to Physician-Focused Payment Model Technical Advisory Committee

- Only some APMs to be Advanced APMs (i.e., APMs that may qualify as an alternative to MIPS) & only some participants - Track 1 Shared Savings ACOs would not be Advanced APMs
- Qualifying Participants (QPs) - based on Medicare patients in A-APM
- Other Payer APMs - arrangements in which ECs participate through other payers.
- APM Entity participates in an APM through a contract with a payer
- MACRA does not change how APMs reward value
- APM participants who are not QPs still have favorable MIPS IA and other scoring

Source: CMS 2, 4, 10/2016
How does MACRA reward participation in APMs?

Most ECs in APMs subject to MIPS and receive favorable scoring for Improvement Activities and other special scoring – CMS expects greater APM and QP participation over time.

Those in most advanced (“eligible”) APMs may be determined to be qualifying APM participants (“QPs”) – year by year:
- Not subject to MIPS
- 5% lump sum bonus payments for 2019-2024
- Higher fee schedule update for 2026 and onward

Eligible APMs are most advanced APMs that:
- Base payment on quality measures comparable to those in MIPS
- Require use of “certified EHR technology”
- Either (1) bear more than nominal financial risk for monetary losses or (2) are medical home model expanded by CMMI

CMS announces which APMs are Advanced APMs by 1/1 of reporting year.
Advanced Payment Models in 2017

- Medicare Shared Savings Program (Tracks 2 & 3)
- CMS made aligning changes to SS ACOs in 2017 Physician Fee Schedule Final Rule (11/2016)
- Next Generation ACO Model
- Comprehensive ESRD Care (CEC - large dialysis organizations – two-sided risk)
- Comprehensive Primary Care Plus (CPC+, both tracks) – only smaller CPC+ after 2017 (<50 clinicians in parent organization)
- Oncology Care Model (OCM - two-sided risk)
- Comprehensive Care for Joint Replacement (CJR) Payment Model (Track 1- CEHRT)
- Vermont Medicare ACO Initiative (as part of the Vermont All-Payer ACO Model)

*Initial final list issued by 1/1/2017 and ad hoc updates as new APM models come online*

Medicare Shared Savings ACO Track 1+ (2018 launch, limited downside risk, details TBD)

*In July 2016, CMS proposed new Advanced APM tracks (related to risk and use of CEHRT) for existing and proposed bundling models, applying to collaborating ECs, some starting in 2017 and others 2018*

*CMS reopening applications for some A-APMs*
Key Take-aways
MACRA and Standards-based Interoperability

- Care coordination and collection and exchange of standards-based data are critical to success in both APMs and MIPs
- Care coordination and data exchange are woven into the fabric of MIPS measures – Quality, IA, ACI
- ACI simplifies approach with a strong focus on standards-based interoperability, with incentives for high performance
- APIs will be ubiquitous in certified HIT and provider capabilities – FHIR certain to be the backbone
- MACRA creates strong disincentive for provider “information blocking,” but also likelihood of significant confusion and uncertainty
- Growth of APMs will drive organic and non-prescriptive demands for value-based interoperability
THANK YOU FOR YOUR TIME

QUESTIONS?

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