Note: This information can be found at www.SaginawCountyMS.com under the "Members Only" tab

Centers for Medicare and Medicaid Services (CMS.gov)

MACRA - Delivery System Reform, Medicare Payment Reform

How does the Medicare Access & CHIP Reauthorization Act of 2015 (MACRA) reform Medicare payment?

The MACRA makes three important changes to how Medicare pays those who give care to Medicare beneficiaries. These changes create a Quality Payment Program (QPP):

- Ending the Sustainable Growth Rate (SGR) formula for determining Medicare payments for health care providers' services.
- Making a new framework for rewarding health care providers for giving better care not just more care.
- Combining our existing quality reporting programs into one new system.

These proposed changes replace a patchwork system of Medicare reporting programs with a flexible system that allows you to choose from two paths that link quality to payments: The Merit-Based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (APMs).

MACRA also required CMS to develop and post a Quality Measure Development Plan that gives a framework for making clinician quality measures to support the MIPS and APMs.

What's the MACRA Quality Payment Program?
The MACRA QPP will help us to move more quickly toward our goal of paying for value and better care. The Quality Payment Program has two paths:

1. Merit-Based Incentive Payment System (MIPS)
2. Alternative Payment Models (APMs)

MIPS and APMs will go into effect over a timeline from 2015 through 2021 and beyond.

What's the Merit-Based Incentive Payment System (MIPS)?
The MIPS is a new program that combines parts of the Physician Quality Reporting System (PQRS), the Value Modifier (VM or Value-based Payment Modifier), and the Medicare Electronic Health Record (EHR) incentive program into one single program in which Eligible Professionals (EPs) will be measured on:

- Quality
- Resource use
- Clinical practice improvement
- Meaningful use of certified EHR technology

What are Alternative Payment Models (APMs)?
APMs give us new ways to pay health care providers for the care they give Medicare beneficiaries. For example:

- From 2019-2024, pay some participating health care providers a lump-sum incentive payment.
- Increased transparency of physician-focused payment models.
- Starting in 2026, offers some participating health care providers higher annual payments.

Accountable Care Organizations (ACOs), Patient Centered Medical Homes, and bundled payment models are some examples of APMs.

What's the CMS Quality Measure Development Plan (MDP)?
Our Quality Measure Development Plan (MDP), required by MACRA section 102, is a focused framework to help us build and improve quality measures for clinicians. These quality measures will support MIPS and advanced APMs. We posted the draft MDP on December 18, 2015, and asked for the public's comments through March 1, 2016. We received and carefully considered comments and feedback from 60 individuals and 150 institutions.

On May 2, 2016, we posted the final Quality Measure Development Plan (MDP) that includes the main themes and specific recommendations from the public comments. We'll post updates in the MDP Annual Report each year by May 1, or as needed.

Social Security Number Removal Initiative
What's the Social Security Number Removal Initiative?
MACRA requires us to remove Social Security Numbers (SSNs) from all Medicare cards. When we replace the SSN on all Medicare cards, we can better protect:

- Private health care and financial information
- Federal health care benefit and service payments

Where can I find more information about MACRA?

- Get more in-depth information on the MACRA Quality Payment Program.
- Attend webinars
- Read or find answers to many questions about the MACRA Request for Information (RFI).
- Learn more about Physician Focused Payment Models (PFPMs) Technical Committee.
- Read and comment on the patient relationship categories and codes.
- Find the episode groups summary and make comments on the Supplemental Episode Groups, Episode Workbooks and Design Report.

Plans for the Quality Payment Program in 2017: Pick Your Pace
By Andy Slavitt, Acting Administrator of CMS

As the baby boom generation ages, 10,000 people enter the Medicare program each day. Facing that demand, it is essential that Medicare continues to support physicians in delivering high-quality patient care. This includes increasing its focus on patient outcomes and reducing the obstacles that make it harder for physicians to practice good care.

The bipartisan Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) offers the opportunity to advance these goals and put Medicare on surer footing. Among other policies, it repeals the Sustainable Growth Rate formula and its annual payment cliffs, streamlines the existing patchwork of Medicare reporting programs, and provides opportunities for physicians and other clinicians to earn more by focusing on quality patient care. We are referring to these provisions of MACRA collectively as the Quality Payment Program.

We received feedback on our April proposal for implementing the Quality Payment Program, both in writing and as we talked to thousands of physicians and other clinicians across the country. Universally, the clinician community wants a system that begins and ends with what's right for the patient. We heard from physicians and other clinicians on how technology can help with patient care and how excessive reporting can distract from patient care; how new programs like medical homes can be encouraged; and the unique issues facing small and rural non-hospital-based physicians. We will address these areas and the many other comments we received when we release the final rule by November 1, 2016.

But, with the Quality Payment Program set to begin on January 1, 2017, we wanted to share our plans for the timing of reporting for the first year of the program. In recognition of the wide diversity of physician practices, we intend for the Quality Payment Program to allow physicians to pick their pace of participation for the first performance period that begins January 1, 2017. During 2017, eligible physicians and other clinicians will have multiple options for participation. Choosing one of these options would ensure you do not receive a negative payment adjustment in 2019. These options and other supporting details will be described fully in the final rule.

First Option: Test the Quality Payment Program.
With this option, as long as you submit some data to the Quality Payment Program, including data from after January 1, 2017, you will avoid a negative payment adjustment. This first option is designed to ensure that your system is working and that you are prepared for broader participation in 2018 and 2019 as you learn more.

Second Option: Participate for part of the calendar year.
You may choose to submit Quality Payment Program information for a reduced number of days. This means your first performance period could begin later than January 1, 2017, and your practice could still qualify for a small positive payment adjustment. For example, if you submit information for part of the calendar year for quality measures, how your practice uses technology, and what improvement activities your practice is undertaking, you could qualify for a small positive payment adjustment. You could select from the list of quality measures and improvement activities available under the Quality Payment Program.

Third Option: Participate for the full calendar year.
For practices that are ready to go on January 1, 2017, you may choose to submit Quality Payment Program information for a full calendar year. This means your first performance period would begin on January 1, 2017. For example, if you submit information for the entire year on quality measures, how your practice uses technology, and what improvement activities your practice is undertaking, you could qualify for a modest positive payment adjustment. We've seen physician practices of all sizes successfully submit a full year's quality data, and expect many will be ready to do so.

Fourth Option: Participate in an Advanced Alternative Payment Model in 2017.
Instead of reporting quality data and other information, the law allows you to participate in the Quality Payment Program by joining an Advanced Alternative Payment Model, such as Medicare Shared Savings Track 2 or 3 in 2017. If you receive enough of your Medicare payments or see enough of your Medicare patients through the Advanced Alternative Payment Model in 2017, then you would qualify for a five percent incentive payment in 2019.

However you choose to participate in 2017, we will have resources available to assist you and walk you through what needs to be done. And however you choose to participate, your feedback will be invaluable to building this program for the long term to achieve outcomes that matter to your patients.

We appreciate the sincere and constructive participation in the feedback process to date and look forward to advancing step-by-step in that same spirit. We look forward to releasing the final details about the program this fall. Most importantly, we look forward to further engagement with physicians and other clinicians toward our shared goal of the highest quality of care and best outcomes for patients.

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