MACRA- Quality Payment Program

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Agenda

- MACRA and the Quality Payment Program
  - Payment Impact
  - MIPS track
  - APM track
- Other MACRA Provisions
- Planning and Strategic Implications

Quality Payment Program (QPP)

- MACRA created a QPP as part of repealing the Sustainable Growth Rate (SGR) problem with the MPFS
  - Two tracks/methods exist for physicians to participate in the QPP
    1) MIPS - Merit-based Incentive Payment System - Likely to have the most practitioners
    2) APMs - Alternative Payment Models - Only ”Advanced APMs” count for the QPP APM Bonus

- MACRA combines the Physician Quality Reporting System (PQRS), Value Modifier (VM) and Meaningful Use programs into the Merit Based Incentive Payment System (MIPS)

- MIPS and APMs are intended to be aligned

- Reporting or “performance measurement” begins in CY 2017; Payment impact occurs 2 years from performance period, beginning CY2019

Payment Impact - 2 Components - MPFS Updates & QPP Incentives/Penalties

MPFS Updates 2016=0.5%	0.5%	0.5%	0.5%	None	None	None	2026 QPPs=0.75% Others = 0.25%
Bonus for A-APM Participation - Based on 2019-2024 Pmts			5%	5%	5%	5%	Thru 2026- 5%
Potential High Performer MIPS Bonus	Existing PQRS, VM & EHR		Up to 10%	Up to 10%	Up to 10%	Up to 10%	Up to 10% to 2024
Potential Upside			+ 12%	+ 15%	+ 21%	+ 27%	+ 27%
How Much			+/- 4%	+/- 5%	+/- 7%	+/- 9%	+/- 9%
Who MIPS = ECs APM = QPs	MDs; DOs; NPs; PAs; CNSs; DMD/DDS Report/Enroll		MDs; DOs; NPs; PAs; CNSs; DMD/DDS; PTs; OTs; SLPs; LCSWs; Midwives; CPs; Nutritionists/Dietitians Report/Enroll				
When- CY Basis	2017	2018	2019	2020	2021	2022	Beyond

MIPS

- It is assumed the vast majority of Eligible Clinicians (ECs) will initially participate in MIPS because qualifying APMs are limited in number, scope & geographic location
- There are 4 categories to MIPS:
    - Quality Reporting - based off current PQRS reporting
    - Advancing Care Information -based off current EHR meaningful use
    - Clinical Practice Improvement Activities (CPIA) - new - over 90 measures loosely defined
    - Cost - based off current Value Modifier
- Each category has a weight and the weights will change over time (quality will be reduced and cost will be increased)
- There will be one composite score reflecting the category scores & weights

MIPS Categories & Weighting for 2017/2019

PROPOSED RULE

MIPS: Performance Category Scoring

Summary of MIPS Performance Categories		
Performance Category	Maximum Possible Points per Performance Category	Percentage of Overall MIPS Score (Performance Year 1 - 2017)
Quality: Clinicians choose six measures to report to CMS that best reflect their practice. One of these measures must be an outcome measure or a high-value measure and one must be a crosscutting measure. Clinicians also can choose to report a specialty measure set.	80 to 90 points depending on group size	50 percent
Advancing Care Information: Clinicians will report key measures of interoperability and information exchange. Clinicians are rewarded for their performance on measures that matter most to them.	100 points	25 percent
Clinical Practice Improvement Activities: Clinicians can choose the activities best suited for their practice; the rule proposes over 90 activities from which to choose. Clinicians participating in medical homes earn "full credit" in this category, and those participating in Advanced APMs will earn at least half credit.	60 points	15 percent
Cost: CMS will calculate these measures based on claims and availability of sufficient volume. Clinicians do not need to report anything.	Average score of all cost measures that can be attributed	10 percent

Where to Find More Info on the Measures

Category	Tables In Proposed Rule
Quality	Table A (w/NQF/PQRS #s); Table B (no reporting); Table C (Crosscutting); Table D (new measures); Table E (Specialty-specific measure sets); Table F (PQRS measures proposed for removal for 2017); Table G (Measures with substantial changes for 2017);
Advancing Care Information	Table 6 - Six Objectives & Measures for each objective; Table 7 - alternative proposal; Table 8 - Combined Primary and Alternative; Tables 9 & 10 - Example Scoring
Clinical Practice Improvement Activities (CPIA)	Table H - list of activities Note: Medical homes receive “full credit” for CPIA if certified
Cost	Tables 4 & 5 for Episodes

How ECs Participate in MIPS

- As an Individual EC - NPI/TIN combination
- As a Group - defined as 2 or more ECs under the same TIN. Measures averaged across all performance categories. ECs awarded mean MIPS score
- MACRA has a concept of a Virtual Group - CMS proposes to defer that to 2018
- CMS proposes to reweight a performance category to zero and reallocate the points to other categories or lower the weight of a category if there are not at least three scored measures for "non-patient facing" ECs defined as 25 or fewer visit-type codes in a year
- ECs who practice in Method I CAHs or Method II and have not assigned billing to the CAHs would have the MIPS adjustment apply to their MPFS payments. ECs in Method II CAHs who have assigned their billing, would not receive payment adjustments
- RHC & FQHCs adjustments depend on whether the ECs bill under MPFS
- As an EC through a non-advanced APM that reports on behalf of enrolled practitioners

Exceptions/Concessions to ECs for MIPS

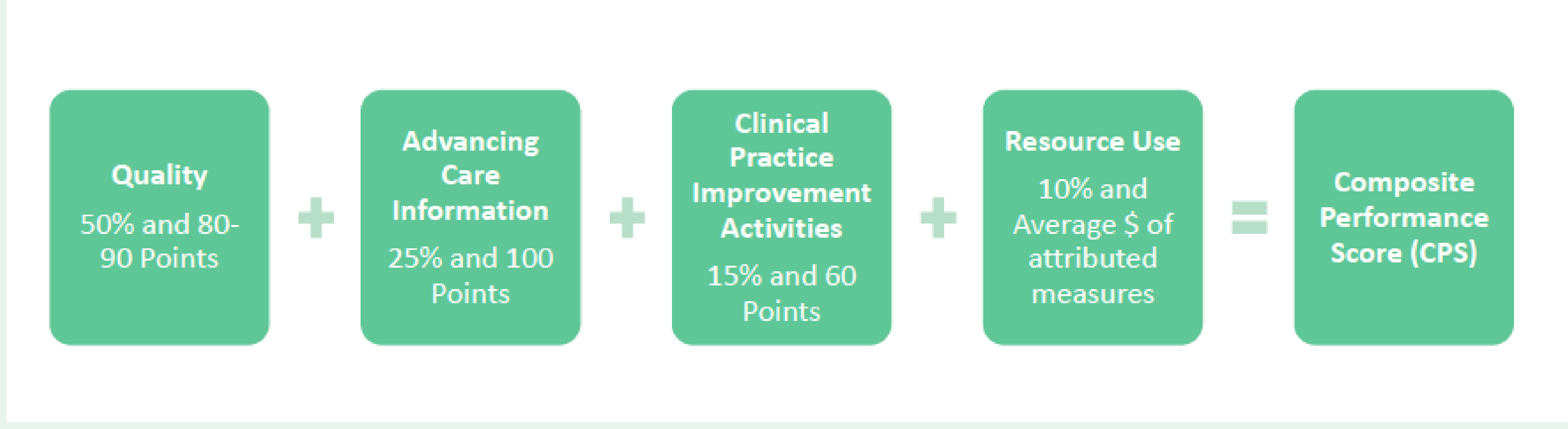
- New practitioners (for the first year only), low volume practitioners and those who enroll in Advanced APMs are exempt from MIPS
- Certain Partial Qualifying Practitioners enrolled in Advanced APMs can "fall back on" MIPS - PQPs are enrolled in Advanced APMs but do not have enough payments or patients through the Advanced APM to be a QP
- MIPS-APMs - EC that is enrolled in a CMS approved non-advanced APM. For the APM scoring standard, CMS proposes to generate a MIPS CPS by aggregating all scores for eligible clinicians in the APM Entity that is participating in the MIPS APM to the level of the APM Entity and the weights for the resource use and quality categories will be zero and scoring adjusted so the CPS is still 100.

Composite Scoring

Calculating the Composite Performance Score (CPS) for MIPS

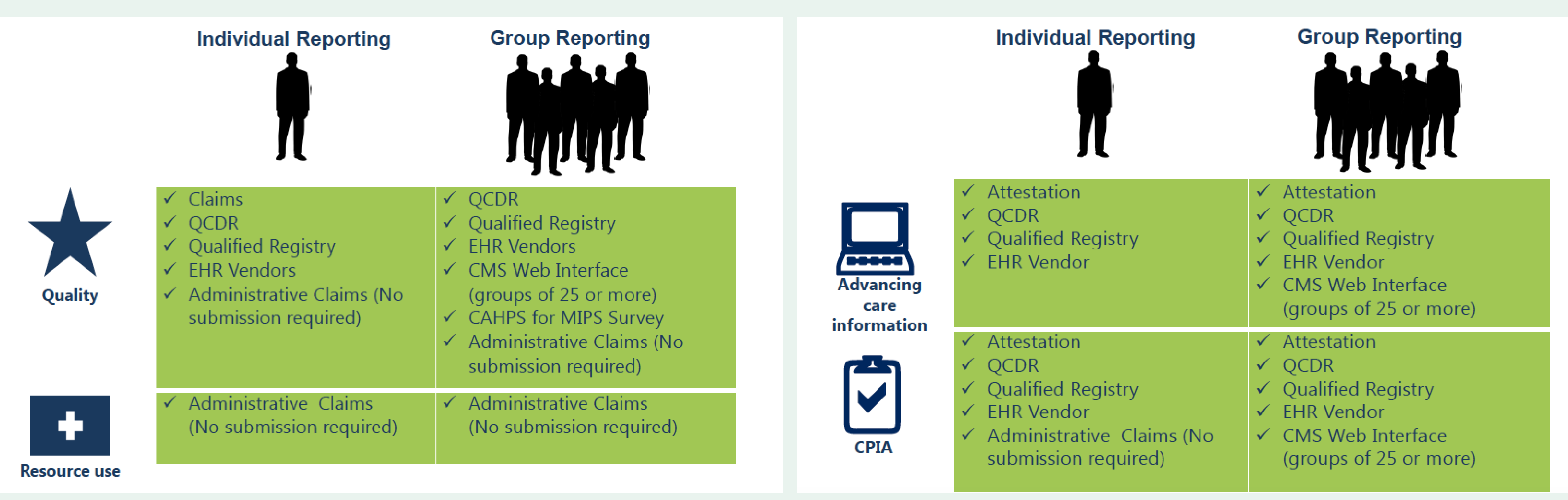
Category	Weight	Scoring
Quality	50%	• Each measure 1-10 points compared to historical benchmark (if avail.) • 0 points for a measure that is not reported • Bonus for reporting outcomes, patient experience, appropriate use, patient safety and EHR reporting • Measures are averaged to get a score for the category
Advancing care information	25%	• Base score of 60 points is achieved by reporting at least one use case for each available measure • Up to 10 additional performance points available per measure • Total cap of 100 percentage points available
CPIA	15%	• Each activity worth 10 points; double weight for "high" value activities; sum of activity points compared to a target
Resource Use	10%	• Similar to quality

MIPS Performance Measured via A Composite Score



Beginning 2020, CMS will also take into account year over year improvement with adjusted scoring and/or additional bonus payments.

How to Report Measures for MIPS



The same mechanism must be used to report within a category. CMS also proposes that a single mechanism should be able to be used for the the 3 categories that require reporting, such as EHR.

Performance Feedback

- As of July 1, 2017, CMS would provide information on the quality and resource use performance categories based on historical data because initial MIPS data will not be available until 2018
- Beginning July 1, 2018, CMS is required to make available to ECs information about the Medicare services provided to their patients by other providers
- Payment adjustment info must be made available by Dec. 1 prior to the adjustment period - example: Dec. 1 2018 for the CY2019 adjustment
- Providers can request review of their data by July 31 after the close of the reporting period (March 31 after the end of the CY is the close of the reporting period)
- MACRA also requires posting of scores for each clinician on CMS's Physician Compare website

APMs & Advanced APMs

- MACRA incentivizes APMs beyond the additional 0.5% MPFS update. Beginning in 2026, QPs will receive an additional 5% of their prior year's allowable Part B payments from 2019-2024 as a lump sum
- MACRA defines qualifying characteristics of APMs:
  - Certain CMMI Projects
  - MSSP
  - Health Care Quality Demonstration Projects
  - Require the use of CEHRT
  - Is a Medical Home Model that includes PCP & meets other criteria

CMS Will Determine Advanced APMs & QPs

- Based on the MACRA requirements and CMS' proposals, CMS announced that only the following currently meet the requirements for "Advanced APMs":
  - MSSP Tracks 2&3
  - Comprehensive ESRD Care Model
  - Comprehensive Primary Care Plus
  - Oncology Care Model
  - Next Generation ACO
  - Expanded medical homes
- CMS will post the APMs that meet the "Advanced APM" requirements
- A Qualifying APM Participant (QP) must have threshold levels of payment or percentage of patients flow through the APM which will increase over time
  - 2017 - payment is 25% for QP and 20% for a PQP
  - 2017 - patients is 20% for a QP and 10% for a PQP
- A QP must enroll in a APM by December 31 before a performance year

Risk Thresholds for Advanced APMs

- Total risk, or the maximum amount of losses possible under the advanced APM, must be at least 4% of the APM spending target
- Marginal risk, or the percentage of spending above the advanced APM benchmark (or target price for bundles) for which APM is responsible (i.e., the sharing rate), must be at least 30%
- Minimum loss rate, the amount by which spending can exceed the APM benchmark (or bundle target price) before the APM has responsibility for losses, must be no more than 4%

More Advanced APM Characteristics

- For 2019 performance period and beyond, ECs may continue to be QPs by participating solely in Medicare-only Advanced APMs or they will have an option of participating in a combination of Advanced APMs and APMs with other payers (Other Payer Advanced APMs).
- APMs must use CEHRT to document & communicate clinical care with patients and other clinicians (50% of the ECs in 2017 & 75% in 2018)
- APMs must provide payment based on quality measures comparable to those in MIPS

Medical Home Model Characteristics

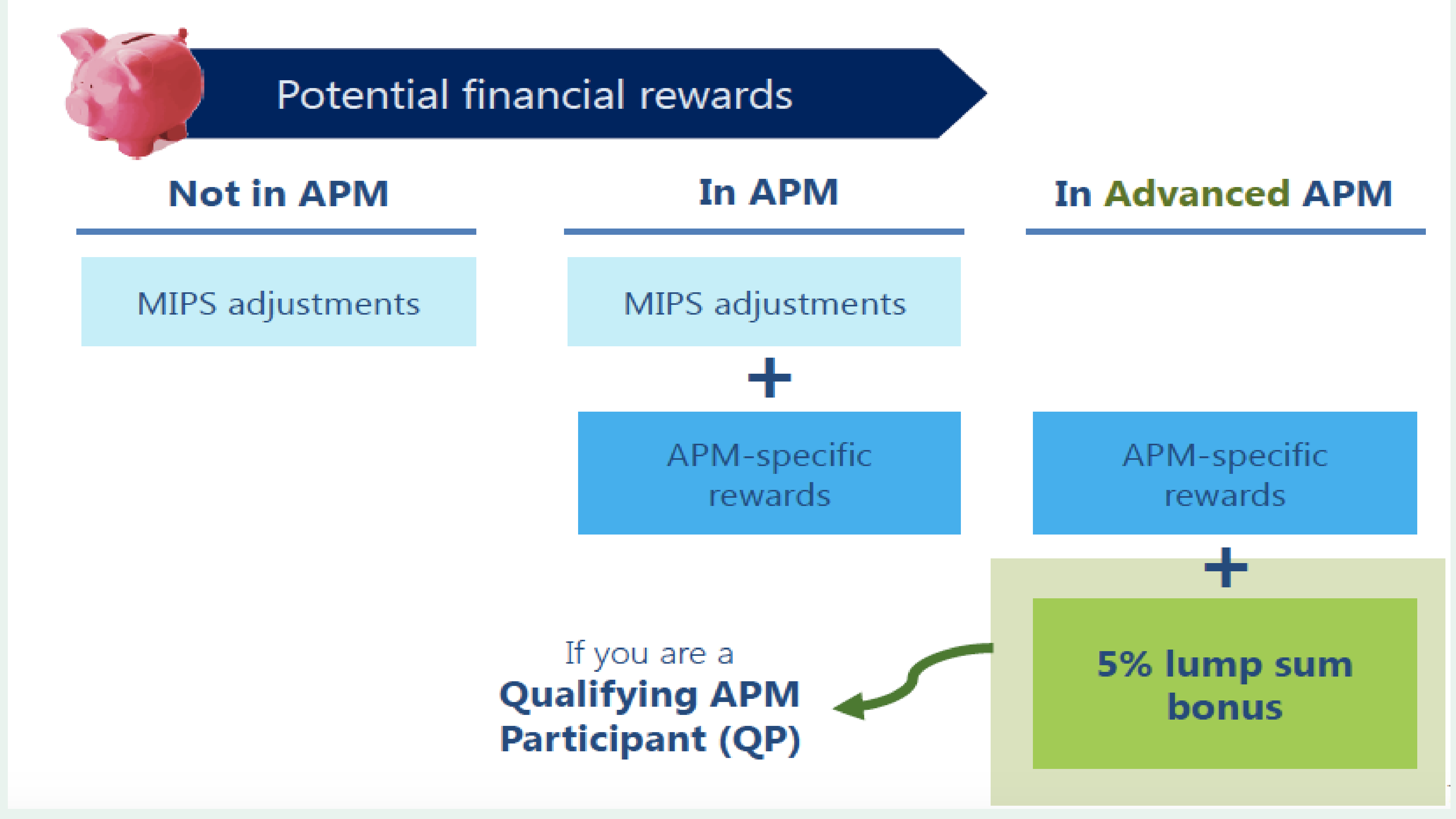
Proposed Medical Home Model Nominal Risk Standard Total Risk Amounts	
Performance (Calendar) Year	Amount (% of the APM Entity's total Parts A and B revenue)
2017	2.5%
2018	3.0%
2019	4.0%
2020 and beyond	5.0%

An APM Entity seeking to become an Advanced APM entity must either satisfy MACRA's financial risk criterion or must be deemed to be a medical home expanded under section 1115A(c). The expansion must occur under 1115A(c) to meet the expanded Medical Home criterion. Expansion criteria requires reduced expenditures or improved quality with no increase in expenditures and no limits to coverage or benefits.

Determining QP and PQPs in APMs

- CMS proposes to require that each Advanced APM Entity make an election annually on behalf of all of its ECs on whether to report to MIPS should the clinician group be determined to be Partial QPs for a given year.
- CMS notes that when an APM Entity elects not to report under MIPS, this decision signals CMS not to score the MIPS-related information submitted by the entity.
- Calculations will utilize claims data for MPFS payment-based calculations and use attributed patient counts for patient count-based thresholds. Each APM Entity defines its own attribution rules & CMS proposes ways to improve attribution in markets with more than one APM

Benefits to APM Participation



Beginning 2019- Other Payer APMs

- Other Payer APMs include payment arrangements under any payer other than traditional Medicare FFS. Medicare Advantage and other Medicare-funded private plans are categorized as a payer other than traditional Medicare for these purposes.
- An arrangement with an non-Medicare payer can become an Other Payer APMs if it meets the following criteria:
  - Use CEHRT
  - Use Quality Measures
  - Include Medicaid or be a Medicaid Medical Home Model that meets criteria similar to Section 1115A(c)
  - Bears more than a nominal amount of financial risk

Medicare Advantage-Part C

- Approximately 30% of Medicare beneficiaries are enrolled in MA or Part C plans
- Currently, MA does not qualify for APMs, but MACRA requires Sec. of HHS to submit a report to Congress
- CMS also wants MA plans to begin voluntarily reporting the proportion of their payments tied to quality and value

CMS' Regulatory Impact Analysis

- CMS estimates that for 2019, the proposed rule would distribute about $833 million in payment adjustments in a budget neutral fashion
- An additional $500 million is available for exceptional performance payments
- The APM QP incentive payment is estimated to range from $146 million to $429 million
- CMS estimates 54% of MIPS ECs would receive a positive adjustment, and 46%would receive a negative adjustment

Impact by Specialty & Practice Size

- The following specialties show a net negative adjustment even when the additional performance incentives are taken into account:
  - Podiatry, psychiatry, optometry, CRNAs, physiatry, infectious disease, plastic surgery, general practice, allergy/immunology, dentistry and chiropractic
- All practice sizes except solo practitioners have a positive impact estimate
- A Blackbook survey (non-CMS) of small practices (5 or fewer) indicated 89% plan to reduce Medicare share and 78% plan to join IDNs or larger group practices by 2019

Implications & Next Steps

- Final rule around November 1 with reporting beginning Jan 1, 2017 - plan now
- Do practitioners want to bear risk at practice (TIN) or organizational/enterprise (TIN) level?
- Estimate potential downside financial impact based on current PQRS, VM & EHR programs - who reports or not, what is their individual/collective performance? What are implications of not participating?
- Determine any ECs not reporting PQRS & steps to get them reporting under MIPS, if desired.
- Evaluate EHR vendor and compare to any other reporting mechanisms - Can all reporting for MIPS be achieved through the EHR if all physicians used CEHRT? What changes/adjustments are needed? Do new discrete fields need to be built to leverage EHR over other reporting methods?
- What are the advantages for registries and QCDRs vs EHR reporting mechanisms? Who provides the most/broadest support?

Implications Continued

- Evaluate physicians who re-assign billing to the hospital/organization - Is all MPFS billing under one hospital NPI/TIN consolidating all specialties? Evaluate contracts and compensation formulas.
- Is support for MIPS reporting or APMs an opportunity for expanded/improved affiliation?
- APMs - Is the organization participating in an APM that qualifies as an Advanced APM? If yes, can or should more ECs participate and enroll? If not an advanced APM, could the APM entity perform the MIPS reporting for the enrolled clinicians?
- Could and should the organization (i.e., enterprise, physician group) become a participant in an Advanced APM or move towards more risk based APM-like models?

Additional Strategic Planning Thoughts

- Evaluate how to optimize their measure performance particularly for outcome and crosscutting measures (e.g., strive to document that smoking cessation counseling was performed for 100 percent of patients under their care)
- How does this impact negotiations/contracts & plans with private payers?
- Review the CPIAs proposed by CMS and start planning for their implementation
- With Oregon’s CCOs, evaluate how and whether CCOs could participate as an Other Payer APM

Stakeholder Reactions to MACRA

- Risk-adjust measures to accommodate physicians who care for complex patients
- Align physician and hospital EHR Incentive Program - some proposals to do this in the 2017 Proposed OPPS Rule
- Permit physicians associated with hospitals to use their hospital's quality and performance data for MIPS
- Provide more of a transition period and/or reduce performance periods to any 90 day period in 2017 for all the measures
- Allow more APMs to qualify for bonuses
- Lower reporting burdens for small and rural practices

Additional Resources

- AMA
- AHA
- AMGA
- MGMA
- HFMA
- American Academy of Family Physicians website
  - http://www.aafp.org/practice-management/payment/macraready.html

Questions?