



# MACRA, MIPS and APMs: Exploring the new Quality Payment Program

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## Disclaimer

- ▲ This presentation was current at the time it was performed, broadcast, published or uploaded to the web. Medicare and Medicaid policy changes frequently, so links to source documents and resources have been provided for your reference.
- ▲ This presentation was prepared as a service to the public and is not intended to grant rights or impose obligations. This presentation may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage participants to review the specific statutes, regulations, and other interpretive materials for a full and accurate statement of their contents.



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## Agenda

- ▲ Brief overview of M-CEITA
- ▲ High-level overview of MACRA
- ▲ Quality Payment Program
  - Merit-based Incentive Payment System (MIPS)
  - Alternative Payment Models (APMs)
  - Program Scoring / Incentives and Penalties
  - Timeline
- ▲ Preparing for 2017 MIPS Participation
- ▲ Questions & Answers

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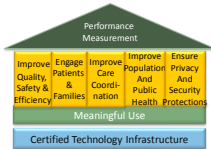
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## Who is M-CEITA?

- ▲ Michigan Center for Effective Information Technology Adoption (M-CEITA)
- ▲ One of 62 **ONC Regional Extension Centers (REC)** providing education & technical assistance to primary care providers across the country
- ▲ Funded by **ARRA of 2009** (Stimulus Plan)
- ▲ Founded as part of the **HITECH Act** to accelerate the adoption, implementation, and effective use of electronic health records (EHR), e.g. 90-days of Meaningful Use
- ▲ **Purpose:** support the Triple Aim by achieving 5 overall performance goals

### THE TRIPLE AIM

**3** Improve patient experience  
Improve population health  
Reduce costs



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## M-CEITA Services

-  **Meaningful Use Support**
-  **Security Risk Assessment**
-  **Program Audit Preparation**
-  **Targeted Process Optimization (Lean)**
-  **GLPTN - Great Lakes Practice Transformation Network**
-  **Chronic Care Management (CCM)**
-  **Quality Payment Program Resource Center™**

[www.mceita.org](http://www.mceita.org) 1-888-MICH-EHR [www.qppresourcecenter.com](http://www.qppresourcecenter.com)

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## MACRA:

### Paying for Quality and Value



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### Quality Payment Program Strategic Goals

- |                                      |   |
|--------------------------------------|---|
| Improve beneficiary outcomes         | Enhance clinician experience                            |
| Increase adoption of Advanced APMs   | Maximize participation                                  |
| Improve data and information sharing | Ensure operational excellence in program implementation |

**Quick Tip:**  
For additional information on the Quality Payment Program, please visit [QPP.CMS.GOV](http://QPP.CMS.GOV)

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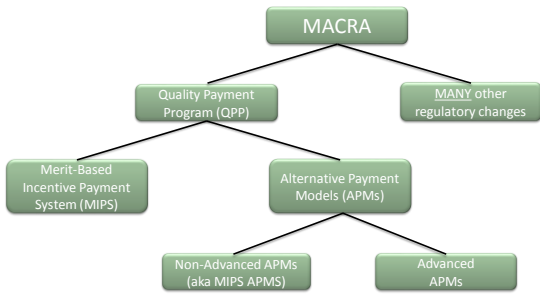
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### Conceptual MACRA Diagram



For CY 2017, out of 1.3M Part B Clinicians, CMS projects:  
- 600,000 MIPS Eligible Clinicians  
- 100,000 Advanced APM Clinicians

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### Path 1 of the QPP: Merit-based Incentive Payment System (MIPS)



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**+/- Payment Adjustments**

- ▲ Adjustments applied 2 years after performance year (e.g. 2019 reimbursement rate is based on 2017 performance year)
- ▲ The program is budget neutral, so ECs receiving negative adjustments pay for those receiving positive adjustments
- ▲ Linear adjustment based on composite score, as compared to performance threshold (positive, negative, or zero/neutral)
- ▲ Those scoring in the bottom 25% will automatically be adjusted down to the maximum penalty for that program/payment year (4% in Yr1)
- ▲ Higher scores receive proportionally larger incentive payments, up to **3x** the maximum positive adjustment for the year [4%(3x)=12%]
- ▲ Highest performers eligible for "Exceptional Performance Bonus"
  - Additional payment adjustment of up to +10% for ECs in the top 25%
  - ECs may receive a 37% increase on Medicare reimbursements by 2024!

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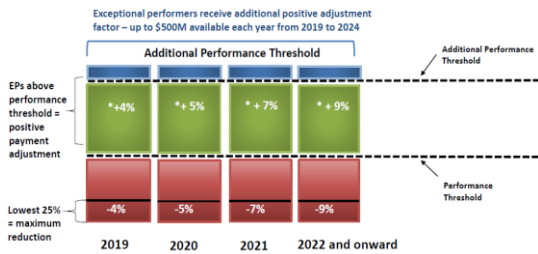
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**MIPS Incentive Payment Formula**



\*MACRA allows potential 3x **upward adjustment**, used to maintain budget neutrality

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**Advanced APM**



The other fork in the path to Quality Payments

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### Alternative Payment Models (APMs)

What are they?

- ▲ Alternative Payment Model or APM is a **generic term** describing a payment model in which providers take **responsibility for cost and quality performance** and **receive payments to support** the services and activities designed to achieve high value
- ▲ According to MACRA, APMs in general include:
  - Medicare Shared Savings Program (MSSP) ACOs
  - Demonstrations under the Health Care Quality Demonstration Program
  - CMS Innovation Center Models
  - Demonstrations required by Federal Law
- ▲ MACRA does not change how any particular APM pays for medical care and rewards value
- ▲ APM participants may receive favorable scoring under certain MIPS performance categories
- ▲ Only **some** APMs are “**Advanced**” APMs

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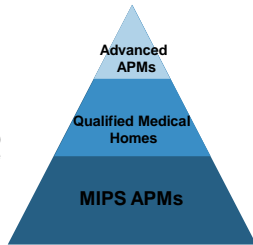
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### Alternative Payment Models

- ▲ “**Advanced**” APMs – Term established by CMS; these have the greatest risks and offer potential for greatest rewards
- ▲ **Qualified Medical Homes** (must be expanded under CMS authority) have different risk structure but are otherwise treated as Advanced APMs
- ▲ **MIPS APMs** receive favorable MIPS scoring



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### Incentives for Advanced APM Participation

- ▲ **Model design**
  - APMs have shared savings, flexible payment bundles and other desirable features
- ▲ **Bonuses**
  - In 2019-2024, 5% lump sum bonus payments made to ECs significantly participating in Advanced APMs [*all members must reach QP (Qualified Participant) status*]
- ▲ **Higher reimbursement updates**
  - Annual baseline payment updates will be higher (0.75%) for Advanced APM participants than for MIPS participants (0.25%) starting in 2026
- ▲ **MIPS exemption**
  - Advanced APM participants do not have to participate in MIPS (models include their own EHR use and quality reporting requirements)

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## Preparing for 2017 MIPS Participation

- Determine your eligibility and understand the requirements
- Choose whether you want to submit data as an individual or as a part of a group
- Choose your submission method and verify its capabilities
- Verify your EHR vendor or registry's capabilities before your chosen reporting period
- Prepare to participate by reviewing practice readiness, ability to report, and the Pick Your Pace options
- Choose your measures. Visit [www.gpp.cms.gov](http://www.gpp.cms.gov) and [www.gppresourcecenter.com](http://www.gppresourcecenter.com) for valuable measure selection resources
- Verify the information you need to report successfully
- Care for your patients and record the data
- Submit your data between 1/1/18 – 3/31/18

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## Determine Your Eligibility

### How Do I Do This?

- ▲ **Calculate your annual patient count and billing amount for the 2017 transition year**
  - Review your claims for services provided between September 1, 2015 and August 31, 2016, and where CMS processed the claim by November 4, 2016.
  - Did you bill more than \$30,000 **AND** provide care for more than 100 Medicare patients between 9/1/15-8/31/16?
    - Yes: You're eligible
    - No: You're exempt
- ▲ **Between April – May, CMS is sending letters to each practice which details participation options for each associated EC.**
  - Additionally, [www.gpp.cms.gov](http://www.gpp.cms.gov) will soon offer the ability to check EC eligibility

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## Choose to Submit Data as an Individual or as Part of a Group

### How Do I Do This?

- ▲ **Perform a detailed analysis to determine which option is best**
  - Many factors must be considered to make this determination.
    - TIN structure
    - Technology available
    - Are you a multi-specialty group?
    - Past performance in legacy programs
    - Others
- ▲ **Individual:**
  - Submit the data under each unique TIN/NPI combination using the chosen submission method(s).
- ▲ **Group:**
  - All eligible clinicians under a single TIN collectively submit performance data across all MIPS performance categories.

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## Choose a Submission Method and Verify its Capabilities

### How Do I Do This?

#### ▲ Review the available submission options for 2017

- Speak with your specialty society about your options.
- Consider using a Technical Assistance program (TCPI, QIN-QIOs, QPP-SURS) for decision support.
- Visit [qpp.cms.gov](http://qpp.cms.gov) for information on submission options.

#### ▲ Choose a data submission option

- For Qualified Registries, QCDRs, and CAHPS for MIPS Survey:
  - Check that each of the submission options are approved by CMS.
- For EHR reporting:
  - Check that your EHR is certified by the Office of the National Coordinator for Health Information Technology. <https://chpl.healthit.gov/#/search>

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## Prepare to Participate

### How Do I Do This?

#### ▲ Consider your practice readiness

- Have you previously participated in a quality reporting program?

#### ▲ Evaluate your ability to report

- What is your data submission method?
- Are you prepared to begin reporting data between January 1, 2018 and March 31, 2018?

#### ▲ Review the Pick-Your-Pace options for Transition Year 2017

- Test (send something)
- Partial Year (Submit under all 3 categories for 90-364 days)
- Full Year (Submit under all 3 categories for entire calendar year)

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## Choose Your Measures and Activities

### How Do I Do This?

#### ▲ Go to [www.qpp.cms.gov](http://www.qpp.cms.gov)

#### ▲ Click on the **Explore Measures** tab at the top of the page

#### ▲ Select the performance category of interest

Quality Measures   Advancing Care Information   Improvement Activities

#### ▲ Review the individual Quality and Advancing Care Information measures as well as Improvement Activities

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**Choose Your Measures and Activities**

*Tips for Reviewing and Selecting Measures/Activities*

**▲ Consider the following:**

- Your patient population and the clinical conditions that you treat
- Your practice improvement goals
- Quality data that you may submit to other payers
- If you're currently participating in one of the legacy quality programs, consider your current billing codes and Quality Resource Use Report (QRUR) to help identify suitable measures
  - PQRS Feedback Reports and QRURs can be accessed at <https://portal.cms.gov> using the same EIDM account.

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**Verify the Information You Need to Report Successfully**

*How Do I Do This?*

**▲ Review the specifications for any Quality measure you intend to report, including:**

- Measure number, NQF number (if applicable), Measure title and domain
- Submission method option
- Measure type
- Measure description
- Instructions on reporting including frequency, timeframes, and applicability
- Denominator statement, denominator criteria and coding
- Numerator statement and coding options
- Definition(s) of terms where applicable
- Rationale
- Clinical recommendations statement or clinical evidence supporting the measure intent

**Quick Tip:**  
Measure specifications can be downloaded at [app.cms.gov](http://app.cms.gov)

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**Submit Your Data**

*How Do I Do This?*

**▲ Care for your patients and record the data**

**▲ Submit your data to CMS prior to the March 31, 2018 deadline using your chosen submission method**

- CMS anticipates the data submission window to open January 1, 2018.
- You are encouraged to submit as early as possible following this date to ensure the timely receipt and accuracy of your data.

**▲ If relying on someone else to submit on your behalf (Staff, EHR Vendor, Qualified Registry, QCDR, etc.), seek confirmation of data submission.**

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