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

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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
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

Meaningful Use

Certified Technology Infrastructure

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 1-888-MICH-EHR www.qppresourcecenter.com

MACRA:

Paying for Quality and Value
MACRA: What is it?

▲ Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)

▲ Bipartisan legislation (yes, really) that replaced the flawed Sustainable Growth Rate (SGR) formula by paying clinicians for the value and quality of care they provide

▲ MACRA is more predictable than SGR. It will increase the number of physicians participating in alternative payment models (APMs), with those in high quality, efficient practices benefiting financially

▲ Extends funding for Children’s Health Insurance Program (CHIP) for two years

▲ And introduces us to... (imagine a drumroll here)
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

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

Path 1 of the QPP: Merit-based Incentive Payment System (MIPS)
What is MIPS?
- The Merit-based Incentive Payment System

▲ Combines multiple Medicare Part B programs into a single program

▲ MIPS Composite Score Categories:
- Quality (PQRS/Value Modifier-Quality Program)
- Cost (Value Modifier-Cost Program)
- Advancing Care Information (Medicare MU*)
- Clinical Practice Improvement (new category)

*MACRA does not alter or end the Medicaid EHR Incentive Program

Who is Eligible?

<table>
<thead>
<tr>
<th>Years 1 and 2 (2017 &amp; 2018)</th>
<th>Years 3+ (2019 and beyond)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Limited list which may exclude some previously participating in PQRS:</td>
<td>CMS may broaden eligible clinicians group to include others such as:</td>
</tr>
<tr>
<td>MDs</td>
<td>PTs</td>
</tr>
<tr>
<td>DOs</td>
<td>OTs</td>
</tr>
<tr>
<td>PAs</td>
<td>SLPs</td>
</tr>
<tr>
<td>NPs</td>
<td>AuDs</td>
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<tr>
<td>CNSs</td>
<td>CMNs</td>
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<td>CRNAs</td>
<td>LCSWs</td>
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<td>CRNAs</td>
<td>LCPs</td>
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<td>CRNAs</td>
<td>RDNs</td>
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<td>LCSWs</td>
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<tr>
<td>CRNAs</td>
<td>LNs</td>
</tr>
</tbody>
</table>

*Note: The term Eligible Professional or "EP" is being replaced with Eligible Clinician or "EC"*

Who is exempt from MIPS participation?

- First Year of Medicare Part B participation
- Below low patient volume threshold
- Certain participants in ADVANCED Alternative Payment Models

Medicare ALLOWABLE billing charges less than or equal to $30,000 and provide care for 100 or fewer Medicare patients in one year

Dates used for 2017
- Phase 1: 9/1/15 to 8/31/16
- Phase 2: 9/1/16 to 8/31/17

NOTE: MIPS also does not apply to hospitals or facilities
Individual vs. Group Reporting

**OPTIONS**

1. Individual—under an
   National Provider
   Identifier (NPI) number
   and Taxpayer
   Identification Number
   (TIN) where they reassign
   benefits

2. As a Group
   a) 2 or more clinicians
      (NPIs) who have
      reassigned their
      billing rights to a
      single TIN*
   b) As an APM Entity

*If clinicians participate as a group, they are assessed
as a group across all 4 MIPS performance categories

MIPS Performance Categories

**MIPS Composite Performance Score (CPS)**

A single MIPS composite performance score will factor performance in 4 weighted categories on a 0-100 point scale:

<table>
<thead>
<tr>
<th>Performance Categories</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality</td>
</tr>
<tr>
<td>Cost</td>
</tr>
<tr>
<td>Improvement Activities</td>
</tr>
<tr>
<td>Advancing Care Information</td>
</tr>
</tbody>
</table>

2017 MIPS Components & Scoring

(a transition year)

<table>
<thead>
<tr>
<th>Scoring Model</th>
</tr>
</thead>
<tbody>
<tr>
<td>Creates a 100pt system to increase and consolidate financial impacts</td>
</tr>
<tr>
<td>0 POINTS</td>
</tr>
</tbody>
</table>
"Pick Your Pace" in 2017

- Don't Participate
- Submit Something
- Submit a Partial Year
- Submit a Full Year

Not participating in the Quality Payment Program: If you don’t want to use 2017 data, you receive a negative 5% payment adjustment.

Data Submission Options

How does CMS get the data?

Total financial impact will depend on how much data you submit and your performance results.
MIPS - Incentives and Penalties

+/– 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!

MIPS Incentive Payment Formula

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

Alternative Payment Models

Advanced APM

The other fork in the path to Quality Payments
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.

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.

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).
Current Advanced APM Options

- **Comprehensive ESRD Care Model** (13 ESCOs)
- **Comprehensive Primary Care Plus (CPC+)** (14 states)
- **Medicare Shared Savings Track 2** (6 ACOs, 1% of total)
- **Medicare Shared Savings Track 3** (16 ACOs, 4% of total)
- **Next Generation ACO Model** (Currently 18)
- **Oncology Care Model Track 2** (A portion of 196 practices will qualify)

▲ More options available soon. Access up-to-date listing at QPP.CMS.GOV

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Preparation for 2017 MIPS Participation

- MIPS Payment Adjustment
- 5% Incentive Payment
- Excluded from MIPS

*Qualifying APM incentive factor
**Non-qualifying APM incentive factor
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.qpp.cms.gov and www.qppresourcecenter.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

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.qpp.cms.gov will soon offer the ability to check EC eligibility

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.
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 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/#/](https://chpl.healthit.gov/#/)

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)

Choose Your Measures and Activities

**How Do I Do This?**

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

- **▲ Click on the** [Measures](http://www.qpp.cms.gov) **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**
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.

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

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.
Concluding Thoughts

▲ We are in the beginning stages of long overdue payment reform
▲ We will continue to see the QPP evolve over time
▲ Long term goal is to push ECs into Advanced APMs
▲ MIPS bonuses are potentially significant for high performers (37%)
▲ There is a risk for significant financial penalty (-9% → 46% gap!)
▲ Don’t forget about the current rules that are still in place as we work our way to 2019

Until Dec 2018 providers still subject to penalties/bonuses of Value Based Modifier (VBM), Meaningful Use (MU) and Physician Quality Reporting System (PQRS) assessed from the 2016 performance year

Resources

▲ QPP Resource Center for the Midwest:
https://www.qppresourcecenter.com/
▲ CMS Quality Payment Program Website:
https://qpp.cms.gov/
▲ QPP Executive Summary:
▲ QPP Final Rule:
▲ QPP Fact Sheet:
▲ Comprehensive List of APMs:
▲ Additional Webinars and Educational Programs:

Questions?

www.mceita.org

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