MIPS AND MACRA: MAKING SENSE OF THE NEW REGULATIONS AND PAYMENT SYSTEMS

- No Disclosures
To Better Understand the Future…..

We must remember the past regarding physician payment.

THE SGR

- SGR=Sustainable Growth Rate
- Was a result of the Balanced Budget Act of 1997
- Sought to link (limit) growth in Physician spending to the US Real GDP
- Set a Medicare Physician spending target, almost always exceeded
- Led to “kicking the can” x 10 years, finally repealed SGR
Quality Reporting

- Existing Quality Programs Started in 2008
  - PQRS - 2008
  - Value-based Modifier – started as part of ACA
  - Meaningful Use of EMR – started as part of 2008 Stimulus Package

Quality Reporting Adjustments

- PQRS – Continues as is
  - 2% penalty for 2016 – 2018 per year
  - All Penalties based on two year data lag (e.g. 2015 reporting for 2017 penalty)

- VBM – Continues as is
  - 2016 Groups of 10 or more - +/-2%
  - 2017 Groups of 10 or more - +/-4%
  - Groups of 9 or less - +/- 2%
  - 2016 Final Rule – Same as 2015

- Meaningful Use – Continues as is
  - Stage 3 is not delayed
  - Penalties: 2016 – 2%, 2017 – 3%, 2018 – 4%, 2019 – 5%
The End of the Annual Cliff in Medicare Physician Payment

On April 16, 2015, President Obama signed into law, H.R. 2 the Medicare Access and Chip reauthorization act of 2015 (MACRA) – A new era in MD Medicare Payments Begins...

Baseline Medicare Payments

- Repeals the SGR
- Positive Updates for 4.5 Years
  - 0.5 percent for July 2015 – 2019
  - 2016 Conversion factor is $35.8279
- Flat for 2020 through 2025
- For 2026 and beyond...
  - 0.75 percent per year, if participating in APM
  - 0.25 percent for all others
CMS Renames MACRA to the "Quality Payment Program"

Proposed Rule Overview

- CMS released proposed rule to implement the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 on April 27th. Renamed it the "Quality Payment Program."

- Proposed rule establishes framework for transitioning to the Merit-based Incentive Payment System (MIPS), which consolidates the existing PQRS, Electronic Health Record Meaningful Use, and Value-Based Payment Modifier programs under the current Medicare Physician Fee Schedule.

- Proposed rule also provides technical specifics on how CMS will determine whether payment models meet the "Advanced Alternative Payment Model" (APM) criteria needed for receiving bonus payments and exemption from MIPS.

- Public comments on the proposed rule are due June 27th.
MACRA/Quality Payment Program

- Physicians choose one of two payment options, starting with 2017 as the reporting year to avoid penalties and achieve bonuses:
  - Merit-based Incentive Payment System (MIPS) or
  - Participation in an Advanced Alternative Payment Model (APM)

- Physicians can switch from year to year
Merit Incentive Payment System (MIPS)

- Replaces Existing Quality Programs
  - PQRS
  - Value-based Modifier
  - Meaningful Use of EMR

MIPS

- **Combined Index**
  - PQRS, VBM, EHR, Clinical Improvement Activities
  - Sliding Scale
  - Flexible Weighting
  - Risk Adjustment
  - Reset each year
  - Special extra bonus for high performers (2019 – 2024)
  - Measures Direct to CMS
  - Adding Group Practice Reporting to QCDR
  - Grandfathering Existing QCDR Measures
  - 2019 - +/- 4%, 2020 - +/-5%, 2021 - +/-7%, 2022 and beyond - +/-9%
MIPS Major Provisions

- Eligibility
- Performance Categories and Scoring
- Data Submission
- Performance Period and Payment Adjustments

MIPS Reporting

- First MIPS reporting period begins on January 1, 2017 and runs through December 31, 2017.
- MIPS Eligible Clinicians: Physicians, PAs, NPs, CMS, CRNA
- For applicable clinicians, 2017 MIPS performance will determine payment increases/penalties for the 2019 Payment Year.
- Maximum MIPS negative payment adjustment will be -4% for 2019.
- Three major categories of exempted physicians:
MIPS Reporting

- Eligible Clinician Identifier
  - Must elect the same MIPS identifier for all categories
  - Reporting as an “Individual,” - combination of TIN/NPI
  - Reporting as a “Group,” – Group’s billing TIN as identifier
    - Group = 2 or more Eligible Clinicians (EC) that have assigned billing rights to the same TIN
    - No “virtual groups,” till 2018 reporting year

MIPS Composite Score Categories

<table>
<thead>
<tr>
<th>MIPS Category</th>
<th>Maximum Scoring Weight During First Two Years</th>
<th>Scoring Weight When Fully-Implemented (Year Three)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality of Care</td>
<td>50% (Year One) 45% (Year Two)</td>
<td>30%</td>
</tr>
<tr>
<td>Resource Use</td>
<td>10% (Year One) 15% (Year Two)</td>
<td>30%</td>
</tr>
<tr>
<td>EHR Meaningful Use</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>Clinical Improvement Activities</td>
<td>15%</td>
<td>15%</td>
</tr>
</tbody>
</table>
MIPS: Quality Performance Category

- Selection of 6 measures
- 1 cross-cutting measure and 1 outcome measure, or another high priority measure
- Select from individual measures or a specialty measure set
- Key changes from current PQRS program
  - Reduced from 9 to 6 measures with no domain requirement
  - Emphasis on outcome measurement
  - Year 1 Weight: 50%

MIPS: Advancing Care Information Performance Category

- Six objectives with Yes or No Reporting for Base Score:
  - Protect Patient Health Information (Yes required)
  - Electronic Prescribing
  - Patient Electronic Access
  - Coordination of Care through Patient Engagement
  - Health Information Exchange
  - Public Health and Clinical Data Registry Reporting (Yes required)
MIPS: Advancing Care Information Performance Category

- **Performance Score**: Reporting on Measures that best fit the practice from the following objectives:
  - Patient Electronic Access
  - Coordination of Care through Patient Engagement
  - Health Information Exchange

MIPS: Clinical Practice Improvement Activities Performance Category

- Minimum selection of one CPIA activity (CMS proposed 90+)
- Would need three CPIAs with a “high rating” to gain points needed
- Full Credit if designated as a patient-centered medical home
- Minimum of half credit for APM participation in non-Advanced APM
MIPS: Resource Use Performance Category

- Assessment under all available resource use measures
- CMS calculates based on claims – no reporting by MDs
- Adding 40+ episode specific measures to address specialty concerns
- Year 1 weight is 10%

Resource Use Measures

- **Total Per Capita Cost Measure (All Attributed Bene)** — Per capita Medicare Part A and Part B costs that are payment standardized, risk adjusted, and specialty adjusted for beneficiaries for which the clinician provided a plurality of primary care services, as measured by allowed charges for primary care.

- **Medicare Spending Per Beneficiary (MSPB)** — Measures all Part A and Part B claims paid during 3 days prior to inpatient admission through 30 days after discharge. Each risk-adjusted MSPB episode is attributed to the one TIN responsible for the plurality of carrier services, as measured by Medicare allowed amounts, performed by EPs during the episode's index hospitalization.

- **Episode Groups** — CMS also proposes 41 clinical condition and treatment episode-based measures for the 2017 MIPS Performance Period.

  - Episode groups develop detailed, claims-based attribution rules (based largely on billing at least 30% of inpatient E&M services during initial treatment or “trigger” event that opened the episode, as well as billing for the trigger code for procedural episode).
    - One for Osteoporosis Care

  - Clinician must have at least 20 cases attributed for a particular episode group to have that episode group measured as part of clinician’s resource use performance score.
MIPS Composite Scoring Scales

Table 1: Summary of MIPS Performance Categories

<table>
<thead>
<tr>
<th>Performance Category</th>
<th>Points Need to Get a Full Value for Performance Category</th>
<th>Maximum Possible Points for Performance Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality</td>
<td>80 to 90 points depending on group size</td>
<td>50 percent</td>
</tr>
<tr>
<td>Advancing Care</td>
<td>100 points</td>
<td>25 percent</td>
</tr>
<tr>
<td>Clinical Practice</td>
<td>90 points</td>
<td>15 percent</td>
</tr>
<tr>
<td>Cost</td>
<td>Average scores of all resource measures that can be attributed.</td>
<td>10 percent</td>
</tr>
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</table>

MIPS Reporting Submission Options

<table>
<thead>
<tr>
<th>MIPS Category</th>
<th>Available Reporting Mechanisms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality of Care</td>
<td>Qualified Clinical Data Registry (QCDR)</td>
</tr>
<tr>
<td></td>
<td>Electronic Health Record</td>
</tr>
<tr>
<td></td>
<td>Claims Data</td>
</tr>
<tr>
<td></td>
<td>GPRO</td>
</tr>
<tr>
<td>Resource Use</td>
<td>Claims Data</td>
</tr>
<tr>
<td>EHR Meaningful Use</td>
<td>Attestations</td>
</tr>
<tr>
<td></td>
<td>QCDR</td>
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<tr>
<td></td>
<td>EHR</td>
</tr>
<tr>
<td>Clinical Improvement Activities</td>
<td>Attestation</td>
</tr>
<tr>
<td></td>
<td>QCDR</td>
</tr>
<tr>
<td></td>
<td>“Qualified Registry”</td>
</tr>
<tr>
<td></td>
<td>EHR</td>
</tr>
<tr>
<td></td>
<td>Claims Data</td>
</tr>
</tbody>
</table>
MIPS-Exceptional Performers

- Physicians in the MIPS model are compared either to their peers in the same specialty or against themselves.

- Physicians who score in the top 25th percentile are eligible for additional incentive payments from a Congressional set-aside of $500 million available through 2024.

- This can equal as much as 10% more in fee-for-service CMS payments annually, provided the physician or practice remains in the top 25%.
MIPS-Public Reporting

- For Each Eligible Clinician:
  - MIPS Composite Scores will be publicly reported on the CMS Physician Compare consumer website
  - Score for Each MIPS Category will be published on the consumer-facing Physician Compare website
  - Participation level will be published
- Eligible Clinician will get an opportunity to review scores 30 days prior to upload on the Physician Compare website.

MIPS Timeline

- **1/2016**
  - Group reporting under QCDR
- **1/2016**
  - CMS Measure Development Plan due for new measures for MIPS
- **7/2016**
  - MIPS quality measures and other elements in proposed rule for 2017 Reporting Period
- **7/2016**
  - Medicare claims data available to QCDRs and Qualified Entities
- **7/2016**
  - Physician Feedback Reports under MIPS
- **12/2017**
  - Providers must be informed of 2019 MIPS Adjustment
- **7/2018**
  - Information on patient services under MIPS
- **7/2019**
  - MEDIAC Report Due on Future Updates

FY 2015
- $15 million per year for measure development

2026
- MIPS Providers get .25% Updates
Alternative Payment Models (APMs)

- Beginning in 2019, based on 2017 reporting year, incentive payments of 5% in 2019-2024 for successful participation in an APM entity, which is voluntary.

- The entity must have applicable quality measures, use certified EHRs and bear “nominal” financial risk or is a Medical Home.

- For 2019-2020, the payment threshold requires that at least 25% of all Medicare payments are attributable to services furnished in an APM entity. This increases to 50% for 2021-2022 and 75% for 2023 and later.
Refresher on APM Requirements

- **Alternative Payment Model (APM)**—(1) a CMMI model (other than innovation award), (2) the Shared Savings Program for ACOs, (3) the Health Care Quality Demonstration, or (4) other demonstration required by federal law.

- **Advanced APM Entity**—An entity that
  - (A) Participates in an APM that requires use of certified EHR technology and provides payment based on quality measures comparable to MIPS quality measures; AND
  - (B) Either **bears financial risk** for monetary losses under the APM that are in excess of nominal amount, **OR is a medical home** that is expanded under CMMI’s expansion authority (i.e. due to finding of either improved quality w/o greater cost or reduced cost w/o reduced quality)

- **Qualifying APM Participant (“QP”)**—Eligible professional for whom certain percentages of Medicare payments and/or all-payer payments are attributable to services furnished through the Advanced APM Entity. These professionals are exempt from MIPS and eligible for APM bonuses.

- **Partial Qualifying APM Participant (“Partial QP”)**—Eligible professional for whom a certain lower percentage of Medicare payments and/or all-payer payments are attributable to services furnished through the Advanced APM Entity. These professionals are exempt from MIPS, but NOT eligible for APM bonuses.

APM Incentive Payment Requirements:

Requirements:
1. Participate in a **defined APM** and meet additional criteria of an **eligible alternative payment entity**.
2. Meet established thresholds.

Definition of APM
- A Centers for Medicare and Medicaid Innovation (CMMI) Model
- Medicare Shared Savings Program Accountable Care Organizations
- A CMS demonstration under section 1866C of the SSA; or required by Federal law
Additional Criteria - Eligible Alternative Payment Entity:

1. APM that requires participants to use certified EHR technology and provides for payment for covered professional services based on quality measures “comparable to” quality measures used in the MIPS, and

2. (a) APM bears financial risk for monetary losses that are in excess of a nominal amount or
(b) APM is a medical home expanded under section 1115A(c) of the SSA.

APM Risk Requirement

- **Marginal Risk**—CMS proposes to define Marginal Risk as the ratio of financial risk to the amount that actual expenditures exceed expected expenditures.  
  *(Minimum Marginal Risk: 30%)*

- **Minimum Loss Rate**—CMS proposes to define MLR as the percentage by which actual expenditures may exceed expected expenditures under the APM without triggering financial risk.  
  *(Minimum Loss Rate Must Be 4% or Less)*

- **Total Potential Risk**—CMS proposes to define Total Potential Risk as the maximum potential payment for which the APM Entity could be liable under the APM.  
  *(Total Potential Risk Must Be At Least 4% of Expected Spending)*
### Example of Statutory QP Thresholds: 2019 Reporting for 2021 Payment Adjustment

#### Thresholds for 2021 Payment Year

<table>
<thead>
<tr>
<th>APM Bonus?</th>
<th>QP</th>
<th>Partial QP</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>50% of Medicare Payments Attributable to Services Furnished through Advanced APM Entity</td>
<td>40-49% of Medicare Payments Attributable to Services Furnished through Advanced APM Entity</td>
<td>Less Than 40% of Medicare Payments Attributable to Services Furnished through Advanced APM Entity</td>
</tr>
<tr>
<td>No</td>
<td>OR</td>
<td>OR</td>
<td>AND</td>
</tr>
<tr>
<td>No</td>
<td>25% of Medicare Payments And 50% of All-Payer Payments Attributable to Services Furnished through Advanced APM Entity</td>
<td>20-24% of Medicare Payments And 40-49% of All-Payer Payments Attributable to Services Furnished through Advanced APM Entity</td>
<td>Less Than 20% of Medicare Payments Or Less Than 40% of All-Payer Payments Attributable to Services Furnished through Advanced APM Entity</td>
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#### Current List of Advanced APMs

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<tr>
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<td>Bundled Payment for Care Improvement Model 2</td>
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<td>Bundled Payment for Care Improvement Model 3</td>
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<td>Bundled Payment for Care Improvement Model 4</td>
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<td>Comprehensive Care for Joint Replacement</td>
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<td>Comprehensive DURD Care (LDS)</td>
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<td>Comprehensive Primary Care Plan</td>
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<td>Mature Community Health Integration Program</td>
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<td>Health Plan Innovation – Risk Value-Based Model</td>
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<td>Health Plan Innovation – Part D Enhanced Medication Therapy Management Model</td>
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<td>Home Health Value-Based Purchasing Model</td>
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<td>Independence at Home Demonstration</td>
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Current List of Advanced APMs

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<tr>
<td>Initiative to Reduce Preventable Hospitalizations Among Nursing Facility Residents - Phase 2</td>
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<td>Integrated Emergency Care Demonstration</td>
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<td>Maryland All-Payer Hospital Model</td>
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<td>Medicare Part B Drug Payment Model</td>
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<td>Medicare Care Choices Model</td>
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<td>Medicare Shared Savings Program - Track 1</td>
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<td>Medicare Shared Savings Program - Track 2</td>
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<td>Medicaid Shared Savings Program - Track 3</td>
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<td>Million Hearts - Cardiovascular Risk Reduction Program</td>
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<td>Next Generation ACO Model</td>
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<td>Oncology Care Model, Oncology Risk Adjustment</td>
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<td>Oncology Care Model, Traditional Risk Adjustment</td>
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APM Timeline

- **10/2015**: Physician-Focused Payment Model (FPPMs) Technical Advisory Committee Named
- **FY 2016**: $20 million in TA starts for small practices
- **2/2016**: New care episode comments dues
- **7/2016**: Report due to Congress on APMS in Medicare Advantage
- **11/2016**: Rules due on criteria for Physician Payment Models, proposals accepted on an ongoing basis
- **1/2017**: GAO report on small practices and APMs and others assuming risk in APMs
- **2019**: APM 5 percent bonus starts to "qualifying APM participants, goes until 2024.
- **2026**: Higher update – i.e. .75% for qualifying APM participants
Questions
Thank You!