MIPS AND MACRA: MAKING SENSE OF THE NEW REGULATIONS AND PAYMENT SYSTEMS
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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- Led to “kicking the can” x 10 years, finally repealed SGR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

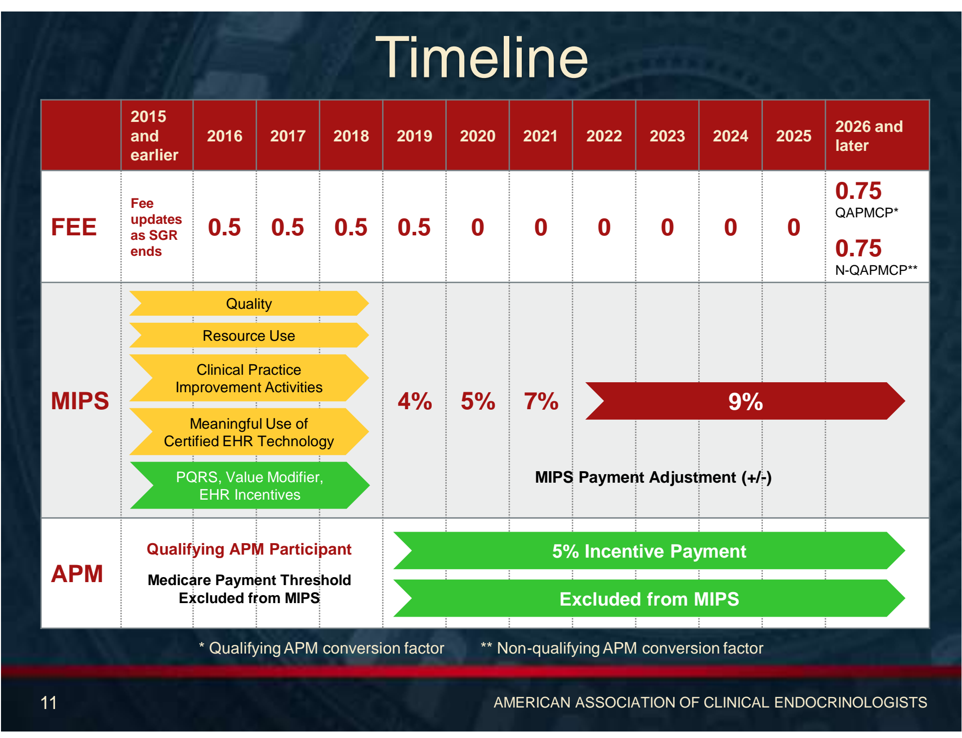
- Repeals the SGR
- Positive Updates for 4.5 Years
  - 0.5 percent for July 2015 – 2019
  - 2016 Conversion factor is $35.8279
- Flat for 2020 through 2025
- For 2026 and beyond…
  - 0.75 percent per year, if participating in APM
  - 0.25 percent for all others

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.**



Timeline

	2015 and earlier	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026 and later
FEE	Fee updates as SGR ends	0.5	0.5	0.5	0.5	0	0	0	0	0	0	0.75 QAPMCP* 0.75 N-QAPMCP**
MIPS	Quality Resource Use Clinical Practice Improvement Activities Meaningful Use of Certified EHR Technology PQRS, Value Modifier, EHR Incentives				4%	5%	7%	9% MIPS Payment Adjustment (+/-)				
APM	Qualifying APM Participant Medicare Payment Threshold Excluded from MIPS				5% Incentive Payment Excluded from MIPS							

* Qualifying APM conversion factor ** Non-qualifying APM conversion factor

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 <u>Advanced Alternative Payment Model (APM)</u>**
- 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

Allocation of Scoring Weights for MIPS Categories		
MIPS Category	**Maximum Scoring Weight During First Two Years**	**Scoring Weight When Fully-Implemented (Year Three)**
Quality of Care	50% (Year One) 45% (Year Two)	30%
Resource Use	10% (Year One) 15% (Year Two)	30%
EHR Meaningful Use	25%	25%
Clinical Improvement Activities	15%	15%

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

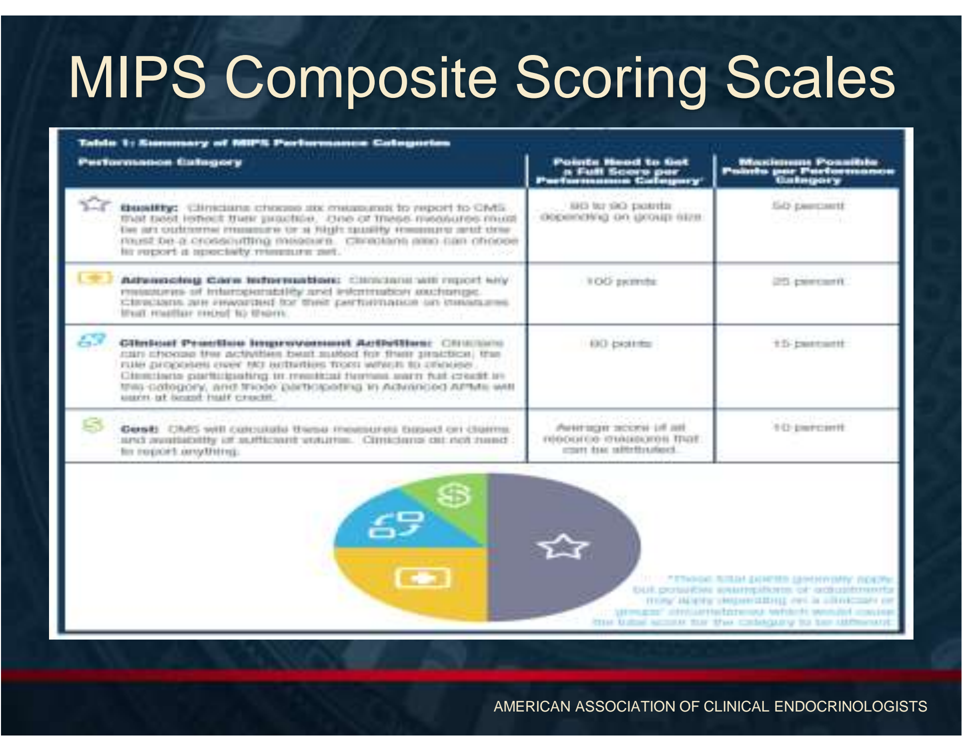
- Minimum selection of one CPIA activity (CMS proposed 90+)
- Would need three CPIAs with a “high rating” to gain points needed
- Full Credit if designated as a patient-centered medical home
- Minimum of half credit for APM participation in non-Advanced APM

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%

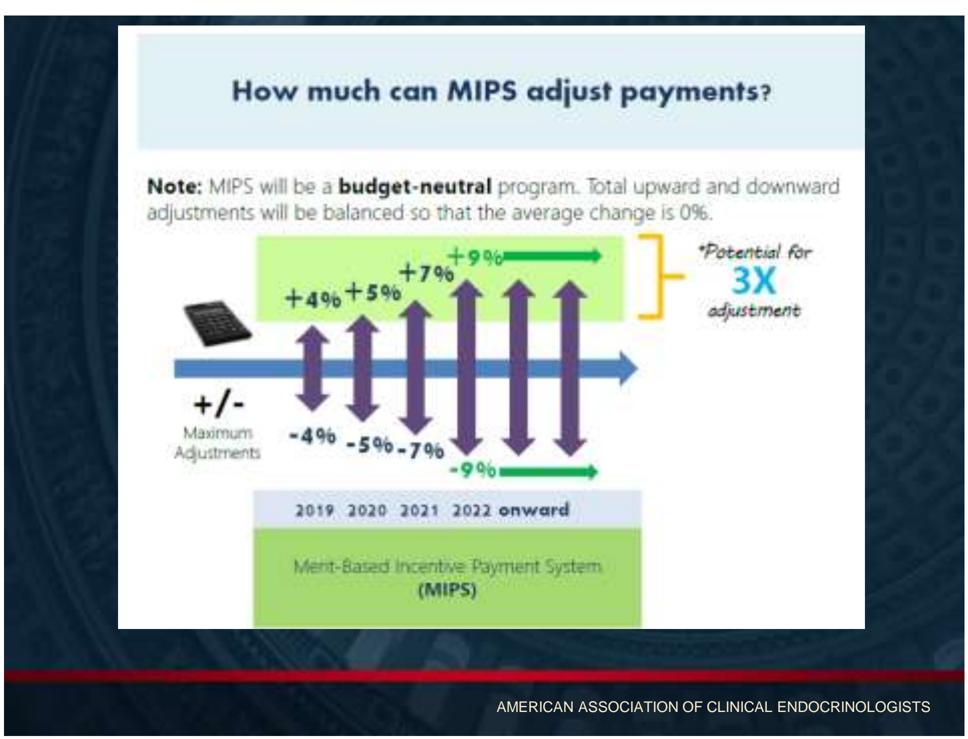
Resource Use Measures

- Total Per Capita Cost Measure (All Attributed Benes)—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 Reporting Submission Options

MIPS Category	Available Reporting Mechanisms
Quality of Care	Qualified Clinical Data Registry (QCDR) Electronic Health Record Claims Data GPRO
Resource Use	Claims Data
EHR Meaningful Use	Attestations QCDR EHR
Clinical Improvement Activities	Attestation QCDR "Qualified Registry" EHR Claims Data



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.

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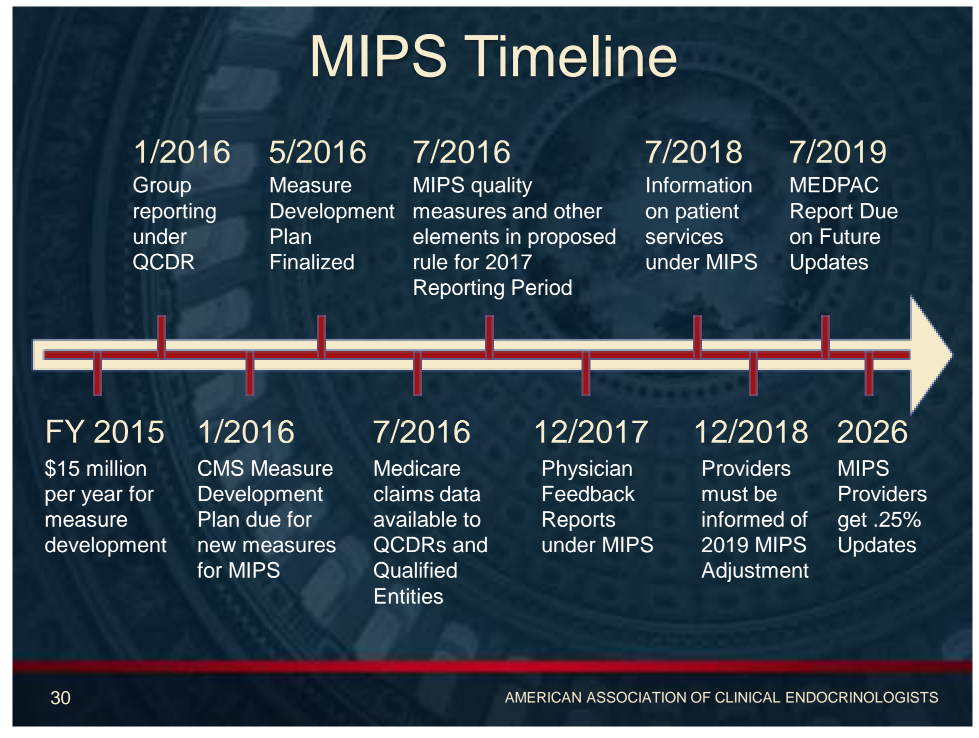

Alternative Payment Models (APMs)

- 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.

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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.

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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

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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			
	QP	**Partial QP**	**Other**
Medicare-Only Threshold	**50% of Medicare Payments** Attributable to Services Furnished through Advanced APM Entity	**40-49% of Medicare Payments** Attributable to Services Furnished through Advanced APM Entity	**Less Than 40% of Medicare Payments** Attributable to Services Furnished through Advanced APM Entity
	OR	**OR**	**AND**
Combination All-Payer Threshold	**25% of Medicare Payments** And **50% of All-Payer Payment** Attributable to Services Furnished through Advanced APM Entity	**20-24% of Medicare Payments** And **40-49% of All-Payer Payment** Attributable to Services Furnished through Advanced APM Entity	**Less Than 20% of Medicare Payments** Or **Less Than 40% of All-Payer Payment** Attributable to Services Furnished through Advanced APM Entity
APM Bonus?	**Yes**	**No**	**No**
MIPS Participation Required?	**No**	**No**	**Yes**

Current List of Advanced APMs

CMS PRELIMINARY APM QUALIFICATION FINDINGS

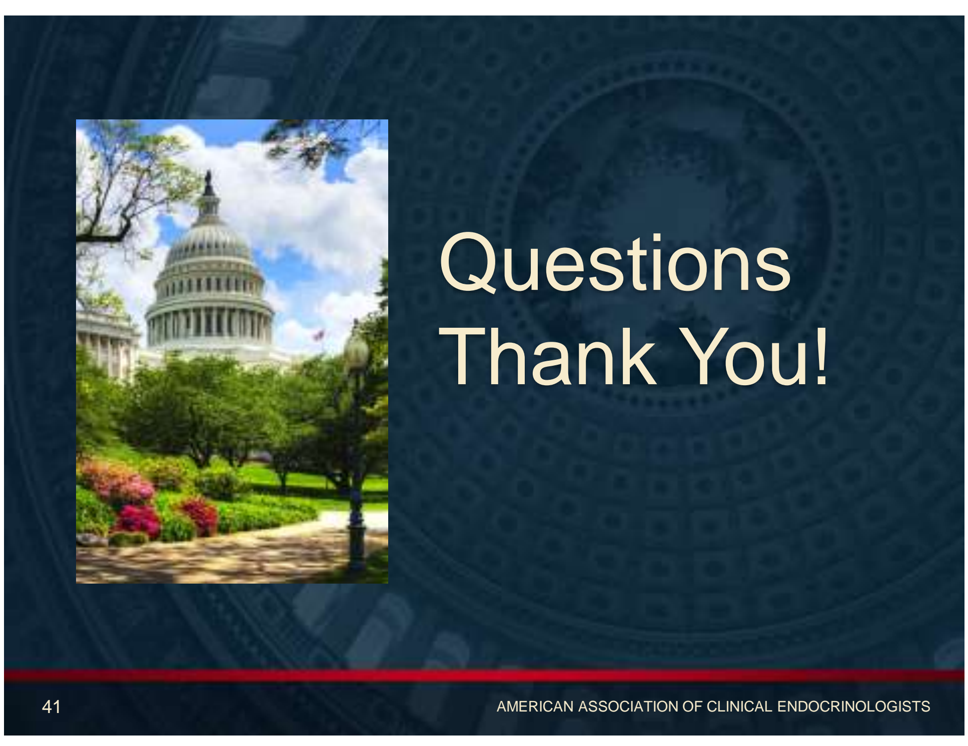
APM and Abbreviation	Qualifies as a MIPS APM for APM Scoring Standard?	Medical Home Model?	Use of CEHRT Criterion?	Quality Measures Criterion?	Financial Risk Criterion?	Advanced APM?
Bundled Payment for Care Improvement Model 2	No	No	No	No	Yes	No
Bundled Payment for Care Improvement Model 3	No	No	No	No	Yes	No
Bundled Payment for Care Improvement Model 4	No	No	No	No	Yes	No
Comprehensive Care for Joint Replacement	No	No	No	Yes	Yes	No
Comprehensive ESRD Care (LDO arrangement)	Yes	No	Yes	Yes	Yes	Yes
Comprehensive ESRD Care (non-LDO)	Yes	No	Yes	Yes	No	No
Comprehensive Primary Care Plus	Yes	Yes	Yes	Yes	Yes	Yes
Frontier Community Health Integration Program	No	No	No	No	No	No
Health Plan Innovation – MA Value-Based Insurance Design Model	No	No	No	No	No	No
Health Plan Innovation – Part D Enhanced Medication Therapy Management Model	No	No	No	No	No	No
Home Health Value-Based Purchasing Model	No	No	No	No	No	No
Independence at Home Demonstration	No	Yes	No	Yes	No	No

Current List of Advanced APMs

APM and Abbreviation	Qualifies as a MIPS APM for APM Scoring Standard?	Medical Home Model?	Use of CEHRT Criterion?	Quality Measures Criterion?	Financial Risk Criterion?	Advanced APM?
Initiative to Reduce Preventable Hospitalizations Among Nursing Facility Residents – Phase 2	No	No	No	No	No	No
Intravenous Immune Globulin Demonstration	No	No	No	No	No	No
Maryland All-Payer Hospital Model	No	No	No	No	No	No
Medicare Part B Drugs Payment Model	No	No	No	No	No	No
Medicare Care Choices Model	No	No	No	No	No	No
Medicare Shared Savings Program – Track 1	Yes	No	Yes	Yes	No	No
Medicare Shared Savings Program – Track 2	Yes	No	Yes	Yes	Yes	Yes
Medicare Shared Savings Program – Track 3	Yes	No	Yes	Yes	Yes	Yes
Million Hearts – Cardiovascular Risk Reduction Model	No	No	No	No	No	No
Next Generation ACO Model	Yes	No	Yes	Yes	Yes	Yes
Oncology Care Model, One-Sided Risk Arrangement	Yes	No	Yes	Yes	No	No
Oncology Care Model, Two-sided Risk Arrangement	Yes	No	Yes	Yes	Yes	Yes

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!
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