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

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Agenda

▲ 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

▲ 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

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**THE TRIPLE AIM**

3

- Improve patient experience
- Improve population health
- Reduce costs

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1. **Meaningful Use**
   - Improve Quality, Safety & Efficiency
   - Engage Patients & Families
   - Improve Care Coordination
   - Improve Population & Public Health
   - Ensure Privacy & Security Protections

2. **Certified Technology Infrastructure**

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3. **Performance Measurement**
M-CEITA Services

**Meaningful Use Support**
Technical assistance, including workflow redesign, security risk assessment and MU compliance. (e.g. patient portal and clinical quality measures)

**Security Risk Assessment**
Support meeting the requirements of MU Measure: Protect Electronic Health Information, including an assessment using our exclusive tool.

**Audit Preparation**
A review of Meaningful Use attestation documentation using our exclusive Audit File Checklist to correct any issues before completing the process.

**Targeted Process Optimization (Lean)**
A workflow analysis and redesign of core processes using Lean principles to increase efficiency and reduce duplication. (e.g. chart prep, document management, test tracking, revenue cycle, etc.)

**PQRS Support**
Technical Assistance for the Physician Quality Reporting System including measure selection as well as reporting method selection and assistance.

**GLPTN - Great Lakes Practice Transformation Network**
No cost Technical Assistance to eligible providers in support of quality improvement initiatives, PQRS support, and preparing for upcoming advanced payment model changes under MACRA/MIPS
MACRA:
Paying for Value and Quality
## Glossary of Acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Definition</th>
<th>Acronym</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACI</td>
<td>Advancing Care Information</td>
<td>HIE</td>
<td>Health Information Exchange</td>
</tr>
<tr>
<td>APM</td>
<td>Alternative Payment Model</td>
<td>HIT/HEALTH IT</td>
<td>Health Information Technology</td>
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<td>ARRA</td>
<td>American Recovery and Reinvestment Act of 2009</td>
<td>HITECH ACT</td>
<td>Health Information Technology for Economic and Clinical Health Act</td>
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<tr>
<td>CDS</td>
<td>Clinical Decision Support</td>
<td>MACRA</td>
<td>Medicare Access and CHIP Reauthorization Act</td>
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<tr>
<td>CEHRT</td>
<td>Certified Electronic Health Record Technology</td>
<td>M-CEITA</td>
<td>Michigan Center for Effective IT Adoption</td>
</tr>
<tr>
<td>CHIP</td>
<td>Children's Health Insurance Program</td>
<td>MCIR</td>
<td>Michigan Care Improvement Registry</td>
</tr>
<tr>
<td>CMS</td>
<td>Center for Medicare &amp; Medicaid Services</td>
<td>MIPS</td>
<td>Merit-based Incentive Payment System</td>
</tr>
<tr>
<td>CNS</td>
<td>Certified Nurse Specialist</td>
<td>MU</td>
<td>Meaningful Use</td>
</tr>
<tr>
<td>CPI/CPIA</td>
<td>Clinical Practice Improvement Activities</td>
<td>NP</td>
<td>Nurse Practitioner</td>
</tr>
<tr>
<td>CPOE</td>
<td>Computerized Provider Order Entry</td>
<td>ONC</td>
<td>Office of the National Coordinator for Health IT</td>
</tr>
<tr>
<td>CPS</td>
<td>Composite Performance Score</td>
<td>PA</td>
<td>Physicians Assistant</td>
</tr>
<tr>
<td>CRNA</td>
<td>Certified Registered Nurse Anesthetist</td>
<td>PQRS</td>
<td>Physician Quality Reporting System</td>
</tr>
<tr>
<td>EC</td>
<td>Eligible Clinician</td>
<td>QCDR</td>
<td>Qualified Clinical Data Registry</td>
</tr>
<tr>
<td>EHR</td>
<td>Electronic Health Record</td>
<td>QPP</td>
<td>Quality Payment Program</td>
</tr>
<tr>
<td>EP</td>
<td>Eligible Professional</td>
<td>SGR</td>
<td>Sustainable Growth Rate</td>
</tr>
<tr>
<td>ePHI</td>
<td>Electronic Protected Health Information</td>
<td>SRA</td>
<td>Security Risk Assessment</td>
</tr>
<tr>
<td>eRX</td>
<td>Electronic Prescribing</td>
<td>TIN</td>
<td>Tax Identification Number</td>
</tr>
<tr>
<td>GLPTN</td>
<td>Great Lakes Practice Transformation Network</td>
<td>VM/VBM</td>
<td>Value Modifier/Value Based Modifier</td>
</tr>
</tbody>
</table>
MACRA: What is it?

▲ Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) AKA “Doc Fix” bill

▲ 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)
Part of a broader push towards paying for VALUE and QUALITY

Medicare Fee-for-Service

GOAL 1: 
Medicare payments are tied to quality or value through alternative payment models (categories 3-4) by the end of 2016, and 50% by the end of 2018

GOAL 2: 
Medicare fee-for-service payments are tied to quality or value (categories 2-4) by the end of 2016, and 90% by the end of 2018

STAKEHOLDERS:
Consumers | Businesses | Payers | Providers | State Partners

Set internal goals for HHS

Invite private sector payers to match or exceed HHS goals
CMS Framework for Alternative Payment Models (APMs)

Category 1: Fee for Service – No Link to Value
- Pure FFS

Category 2: Fee for Service – Link to Quality
- Category 2a: Pay for Reporting
- Category 2b: Pay for Performance

Category 3: Alternative Payment Models Built on Fee-for-Service Architecture
- Category 3a: APMs w/ upside risk
- Category 3b: APMs w/ downside & upside risk

Category 4: Population-Based Payment
- Category 4: Population-Based Payment

MACRA’s Long-term Aim

Conceptual diagram of the desired shift in payment model application given the current state of the commercial market*

Note:
- Size of “bubble” indicates overall investment in each category of APM
- Over time, APMs will move up the Y-axis and there will be more investment in the higher categories

*Source: CPR 2014 National Scorecard on Payment Reform, based on the National commercial market using 2013 data.
### Quality Payment Program Strategic Goals

<table>
<thead>
<tr>
<th>Improve beneficiary outcomes</th>
<th>Enhance clinician experience</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase adoption of Advanced APMs</td>
<td>Maximize participation</td>
</tr>
<tr>
<td>Improve data and information sharing</td>
<td>Ensure operational excellence in program implementation</td>
</tr>
</tbody>
</table>

**Quick Tip:**
For additional information on the Quality Payment Program, please visit QPP.CMS.GOV
For CY 2017, out of 1.3M Part B Clinicians, CMS projects:
~ 600,000 MIPS Eligible Clinicians
~ 100,000 Advanced APM Clinicians
Path 1: Merit-based Incentive Payment System (MIPS)
What is MIPS?

▲ Combines multiple Medicare Part B programs into a single program

▲ This new, single program is based on:
  – Quality (PQRS/VM-Quality Program)
  – Resource Use (Cost) (VM-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*?

*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: Medicare billing charges less than or equal to $30,000 or provides care for 100 or fewer Medicare patients in one year
- Certain participants in ADVANCED Alternative Payment Models

NOTE: MIPS also does not apply to hospitals or facilities
Eligible Clinicians can participate in MIPS as an:

- **Individual**: NPI
- **Group**: A group, as defined by taxpayer identification number (TIN), would be assessed as a group practice across all four MIPS performance categories
- **APM Entity Group**: A collection of entities participating in an Alternative Payment Model
Group Reporting

▲ Providers can opt to be assessed as a group of ECs

▲ The “low volume threshold” for participation remains the same but is met by combining the charges and patient counts from all group members

▲ Performance is measured as a combined score of all the eligible clinicians in the group (across all 4 MIPS performance categories)

▲ Clinics with 10 or fewer ECs can join with others to form a “Virtual Group” (option beginning in year 2)

▲ Virtual groups can be based on geography or specialty

▲ “All or none”- Individual small practice providers within a clinic cannot “opt out” of virtual group participation (similar to group proxy calculations for Medicaid MU program eligibility)
A MIPS Composite Score (CPS) will be calculated based on the performance of 4 weighted categories:

- Resource Use (Cost) – 10%
- Clinical Practice Improvement Activities (CPIA) – 15%
- Advancing Care Information (ACI) – 25%
- Quality – 50%

\[ 75\% = ACI + PQRS/VBM \]
# 2017 MIPS Components & Scoring
(a transition year)

## Scoring Model

<table>
<thead>
<tr>
<th>Component</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resource Use (Cost)</td>
<td>0</td>
</tr>
<tr>
<td>Clinical Practice Improvement Activities</td>
<td>15</td>
</tr>
<tr>
<td>Advancing Care Information (Meaningful Use)</td>
<td>25</td>
</tr>
<tr>
<td>Quality (PQRS/VBM)</td>
<td>60</td>
</tr>
</tbody>
</table>

- Creates a 100pt system to increase and consolidate financial impacts
- Ranks peers nationally and reports scores publicly
- In 2017, weighing puts 85% in Quality and ACI
- Resource Use is 0% for 2017, but will be increased in 2018 and more in future years
“Pick Your Pace” in 2017

**Not participating in the Quality Payment Program:**
If you don’t send in any 2017 data, then you receive a negative 4% payment adjustment.

**Test:**
If you submit a minimum amount of 2017 data to Medicare (for example, one quality measure or one improvement activity for any point in 2017), you can avoid a downward payment adjustment.

**Partial:**
If you submit 90 days of 2017 data to Medicare, you may earn a neutral or positive payment adjustment.

**Full:**
If you submit a full year of 2017 data to Medicare, you may earn a positive payment adjustment.

Total financial impact will depend on how much data you submit and your performance results.
Avoid a penalty by reporting at least (1) quality measure or (1) clinical activity or (5) ACI base measures

Minimum 90-day performance period allowed which can earn max incentives

Max Base Incentive ~ 0.9%

Max Total Incentive ~ 2.4%

(CMS sample estimate from QPP Final Rule, p1179-1183)

Percentages may be +/- depending on actual scores.
MIPS Composite Performance Score (CPS)

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

▲ Weights may be adjusted if there are not sufficient measures and activities applicable for each type of EC, including assigning a scoring weight of 0 for a performance category
  ▪ Reweighting is automatic for some. Application process for others.

▲ Performance threshold will be established based on the mean or median of the composite performance scores during a prior period (Yrs 1 and 2 HHS Secretary will establish threshold; Year 1 = 3pts)

▲ Those who score below the threshold will see negative payment adjustments, those who score above it will see positive adjustments

▲ Any providers who score in the bottom quartile will have their payments immediately reduced to the maximum penalty for that year (4% in Year 1 and increasing to 9% in future years)
MIPS Performance Category: Quality

Performance Categories

- Quality
- Cost
- Improvement Activities
- Advancing Care Information
Quality

▲ Summary:

- Selection of 6 measures relevant to scope of practice
- 1 outcome measure, or another high priority measure if outcome is unavailable
- Select from individual measures or a specialty measure set
- Several data submission options which alter reporting requirements
- Patient Threshold: 50% in 2017, 60% in 2018
- Topped Out Measures: Scored the same as all measures
- Key changes from current program (PQRS):
  - Reduced from 9 measures to 6 measures with no domain requirement
  - Performance influences score
  - Emphasis on outcome measurement
<table>
<thead>
<tr>
<th>Measure Name</th>
<th>Measure Type</th>
<th>Submission Method</th>
<th>Benchmark</th>
<th>Decile 3</th>
<th>Decile 4</th>
<th>Decile 5</th>
<th>Decile 6</th>
<th>Decile 7</th>
<th>Decile 8</th>
<th>Decile 9</th>
<th>Topped Out</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes: Hemoglobin A1c Poor Control</td>
<td>Outcome</td>
<td>Claims</td>
<td>Y</td>
<td>35.00 - 25.72</td>
<td>25.71 - 20.32</td>
<td>20.31 - 16.23</td>
<td>16.22 - 13.05</td>
<td>13.04 - 10.01</td>
<td>10.00 - 7.42</td>
<td>7.41 - 4.01</td>
<td>&lt;= 4.00 No</td>
</tr>
<tr>
<td>Diabetes: Hemoglobin A1c Poor Control</td>
<td>Outcome</td>
<td>Registry/QCDR</td>
<td>Y</td>
<td>83.10 - 68.19</td>
<td>68.18 - 58.14</td>
<td>58.13 - 40.66</td>
<td>40.65 - 30.20</td>
<td>30.19 - 22.74</td>
<td>22.73 - 16.82</td>
<td>16.81 - 10.33</td>
<td>&lt;= 10.32 No</td>
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<tr>
<td>Colorectal Cancer Resection Pathology Reporting: pT Category (Primary Tumor) and pN Category (Regional Lymph Nodes) with Histologic Grade</td>
<td>Process</td>
<td>Claims</td>
<td>Y</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>100 Yes</td>
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</tr>
<tr>
<td>Colorectal Cancer Resection Pathology Reporting: pT Category (Primary Tumor) and pN Category (Regional Lymph Nodes) with Histologic Grade</td>
<td>Process</td>
<td>Registry/QCDR</td>
<td>Y</td>
<td>83.36 - 96.56</td>
<td>96.97 - 99.99</td>
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<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>100 Yes</td>
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<tr>
<td>Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients</td>
<td>Process</td>
<td>Registry/QCDR</td>
<td>Y</td>
<td>42.12 - 54.99</td>
<td>55.00 - 71.72</td>
<td>71.73 - 82.13</td>
<td>82.14 - 99.46</td>
<td>99.47 - 99.99</td>
<td>--</td>
<td>--</td>
<td>100 Yes</td>
</tr>
<tr>
<td>Prostate Cancer: Adjuvant Hormonal Therapy for High Risk Prostate Cancer Patients</td>
<td>Process</td>
<td>Registry/QCDR</td>
<td>Y</td>
<td>77.31 - 80.64</td>
<td>80.65 - 91.15</td>
<td>91.20 - 95.65</td>
<td>95.67 - 98.82</td>
<td>98.83 - 99.99</td>
<td>--</td>
<td>--</td>
<td>100 Yes</td>
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<tr>
<td>Adult Major Depressive Disorder (MDD): Suicide Risk Assessment</td>
<td>Process</td>
<td>Claims</td>
<td>Y</td>
<td>53.85 - 64.74</td>
<td>64.75 - 70.90</td>
<td>70.91 - 85.65</td>
<td>85.69 - 93.31</td>
<td>93.32 - 92.90</td>
<td>92.91 - 96.54</td>
<td>96.55 - 98.67</td>
<td>&gt;= 98.68 No</td>
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<tr>
<td>Osteoarthritis (OA): Function and Pain Assessment</td>
<td>Process</td>
<td>Claims</td>
<td>Y</td>
<td>80.92 - 94.14</td>
<td>94.15 - 98.67</td>
<td>98.68 - 99.99</td>
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<td>100 Yes</td>
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<tr>
<td>Osteoarthritis (OA): Function and Pain Assessment</td>
<td>Process</td>
<td>Registry/QCDR</td>
<td>Y</td>
<td>9.16 - 14.84</td>
<td>14.85 - 37.78</td>
<td>37.79 - 65.33</td>
<td>65.34 - 88.04</td>
<td>88.05 - 97.81</td>
<td>97.82 - 99.99</td>
<td>--</td>
<td>100 No</td>
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<td>Preventive Care and Screening: Influenza Immunization</td>
<td>Process</td>
<td>Claims</td>
<td>Y</td>
<td>22.84 - 31.75</td>
<td>31.76 - 48.13</td>
<td>43.14 - 50.68</td>
<td>50.69 - 67.38</td>
<td>66.39 - 77.47</td>
<td>77.48 - 92.03</td>
<td>92.04 - 99.99</td>
<td>100 No</td>
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<td>Pneumonia Vaccination Status for Older Adults</td>
<td>Process</td>
<td>Claims</td>
<td>Y</td>
<td>39.78 - 51.32</td>
<td>51.33 - 61.67</td>
<td>61.68 - 70.47</td>
<td>70.48 - 77.77</td>
<td>77.78 - 84.48</td>
<td>84.50 - 91.99</td>
<td>91.99 - 99.06</td>
<td>&gt;= 99.07 No</td>
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<tr>
<td>Pneumonia Vaccination Status for Older Adults</td>
<td>Process</td>
<td>EHR</td>
<td>Y</td>
<td>14.13 - 23.25</td>
<td>23.26 - 33.02</td>
<td>33.03 - 43.58</td>
<td>43.59 - 53.96</td>
<td>53.97 - 63.60</td>
<td>63.61 - 74.54</td>
<td>74.55 - 85.52</td>
<td>&gt;= 85.53 No</td>
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<tr>
<td>Pneumonia Vaccination Status for Older Adults</td>
<td>Process</td>
<td>Registry/QCDR</td>
<td>Y</td>
<td>12.24 - 24.02</td>
<td>24.03 - 36.34</td>
<td>36.35 - 48.51</td>
<td>48.52 - 58.95</td>
<td>58.95 - 68.05</td>
<td>68.06 - 77.77</td>
<td>77.78 - 90.19</td>
<td>&gt;= 90.20 No</td>
</tr>
<tr>
<td>Breast Cancer Screening</td>
<td>Process</td>
<td>Claims</td>
<td>Y</td>
<td>38.46 - 48.01</td>
<td>48.02 - 55.67</td>
<td>55.68 - 62.78</td>
<td>62.79 - 69.41</td>
<td>69.42 - 77.18</td>
<td>77.19 - 87.87</td>
<td>87.88 - 98.52</td>
<td>&gt;= 98.53 No</td>
</tr>
</tbody>
</table>
Example Scoring: Quality

Performance Score
Up to 60 Points
- Each measure scored relative to benchmark, e.g. 5th decile = 5 points
- 3 point minimum earned per measure

Bonus Points
Up to 10%
- End-to-end electronic reporting
- High priority measures
- CAHPS for MIPS

Composite Score
Earn 60-70 points and receive full 60 POINTS in the Quality Category of MIPS Composite Performance Score (CPS)
MIPS Performance Category: Resource Use (aka Cost)
Resource Use (Cost)

▲ Summary:

– Assessment under all available resource use measures, as applicable to the clinician

– CMS calculates based on claims so there are no reporting requirements for clinicians

– Key Changes from Current Program (Value Modifier):
  
  ▪ Adding up to 41 episode specific measures to address specialty concerns

  ▪ Year 1 Weight: 0%
MIPS Performance Category:
Clinical Practice Improvement Activities (CPIA)
Clinical Practice Improvement Activities (CPIA)

▲ Summary:

- 94 activities available across 8 categories
- Based on PCMH standards so familiar to those ECs
- Activities categorized as “high” or “medium” weight, earning 20 or 10 points each, respectively
- Activity must be implemented at least 90 days
- Full credit = achievement of 40 points
- Automatically receive full credit for being a Medical Home
- Minimum of half credit for APM participation; select additional activities for full credit. In 2017, MIPS APM participants receive full credit

- Year 1 Weight: 15%
When examining the list of activities, you will likely find several you are already doing in the interest of good patient care.
CPIA: Scoring Considerations

MIPS eligible clinician or group

40 pts = 15%

= 40

Small practices, practices located in rural areas or geographic HPSAs, or non-patient facing

20 pts = 15%

= 20

High - 20
High - 20

High - 20
Med - 10
Med - 10

High - 20
Med - 10
Med - 10
MIPS Performance Category:
Advancing Care Information (ACI)
(formerly Meaningful Use)
Advancing Care Information

▲ Summary:

– Scoring based on key measures of health IT interoperability promoting patient engagement and electronic information exchange

– Dropped “all or nothing” thresholds for measurement as well as exclusions

– Eliminated Computerized Provider Order Entry (CPOE) and Clinical Decision Support (CDS) objectives

– Reduced the number of required public health registries reported
  ▪ 5% bonus for registry reporting beyond immunization registry (MCIR)

– 10% bonus points for using CEHRT for CPIA activities
  ▪ Ex: Increasing access ~ if done via patient portal

– Two scores calculated
  ▪ Base Score and Performance Score
Advancing Care Information Structure

Base Score
Makes up to 50 POINTS of the total Advancing Care Information Performance Category Score

Performance Score
Makes up to 90 POINTS of the total Advancing Care Information Performance Category Score

Bonus Points
Earn up to an add’l 15 POINTS in the total Advancing Care Information Performance Category Score

Composite Score
Earn 100 or more points and receive the full 25 POINTS in the Advancing Care Information Category of the MIPS Composite Performance Score
## Advancing Care Information Structure

**Base Score**

Makes up to **50 POINTS** of the total Advancing Care Information Performance Category Score

<table>
<thead>
<tr>
<th>2017 ACI Transition Objectives</th>
<th>2018 + (2015 CEHRT/Stage 3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>eRx</td>
<td>eRx</td>
</tr>
<tr>
<td>Health Information Exchange</td>
<td>Send Summary of Care</td>
</tr>
<tr>
<td>(Create/Send Summary of Care)</td>
<td>(Patient Care Record Exchange)</td>
</tr>
<tr>
<td>Security Risk Analysis</td>
<td>Request Summary of Care</td>
</tr>
<tr>
<td>(Patient Access)</td>
<td>(Patient Care Record)</td>
</tr>
<tr>
<td>Provide Patient Access</td>
<td>Provide Patient Access</td>
</tr>
<tr>
<td>(Patient Access)</td>
<td>(Patient Access)</td>
</tr>
</tbody>
</table>
Advancing Care Information Structure

### Performance Score

Makes up to **90 POINTS** of the total Advancing Care Information Performance Category Score

<table>
<thead>
<tr>
<th>ACI Transition Objectives</th>
<th>2018 + (2015 CEHRT/Stage 3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provide Patient Access</td>
<td>Provide Patient Access</td>
</tr>
<tr>
<td>View Download Transmit</td>
<td>View Download Transmit</td>
</tr>
<tr>
<td>Patient-specific Information</td>
<td>Patient-specific Information</td>
</tr>
<tr>
<td>Secure Messaging</td>
<td>Secure Messaging</td>
</tr>
<tr>
<td>Health Information Exchange</td>
<td>Send a Summary of Care</td>
</tr>
<tr>
<td></td>
<td>Request/Accept a Summary of Care</td>
</tr>
<tr>
<td>Medication Reconciliation</td>
<td>Clinical Information Reconciliation</td>
</tr>
<tr>
<td>Immunization Registry Reporting</td>
<td>Immunization Registry Reporting</td>
</tr>
<tr>
<td></td>
<td>Patient-generated Health Data</td>
</tr>
</tbody>
</table>
How is the Performance Score Calculated?
The performance score is calculated by using the numerators and denominators submitted for measures included in the performance score, or for one measure, by the yes or no answer submitted.

The potential total performance score is 90%. For each measure with a numerator/denominator, the percentage score is determined by the performance rate. Most measures are worth a maximum of 10 percentage points, except for two measures reported under the 2017 Transition measures, which are worth up to 20 percentage points.

<table>
<thead>
<tr>
<th>Performance Rates for Each Measure Worth Up to 10%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Performance Rate 1-10 = 1%</td>
</tr>
<tr>
<td>Performance Rate 11-20 = 2%</td>
</tr>
<tr>
<td>Performance Rate 21-30 = 3%</td>
</tr>
<tr>
<td>Performance Rate 31-40 = 4%</td>
</tr>
<tr>
<td>Performance Rate 41-50 = 5%</td>
</tr>
<tr>
<td>Performance Rate 51-60 = 6%</td>
</tr>
<tr>
<td>Performance Rate 61-70 = 7%</td>
</tr>
<tr>
<td>Performance Rate 71-80 = 8%</td>
</tr>
<tr>
<td>Performance Rate 81-90 = 9%</td>
</tr>
<tr>
<td>Performance Rate 91-100 = 10%</td>
</tr>
</tbody>
</table>

*Example: If a MIPS eligible clinician submits a numerator and denominator of 85/100 for the Patient-Specific Education measure, their performance rate would be 85%, and they would earn 9 out of 10 percentage points for that measure.*
Example Scoring: Advancing Care Information

Base Score

Earn 50 Points

Attest for all 5 measures (all or nothing) (4 measures if still on 2014 CEHRT)

Performance Score

Up to 90 Points

Measure points accumulated by decile
1-10% = 1 point
11-20% = 2 points
Etc.

Bonus Points

Up to 15 Points

5% Additional Public Health Registry
10% CPIA Alignment

Composite Score

Earn 100-155 points and receive full 25 POINTS in the Advancing Care Information category of MIPS Composite Performance Score (CPS)

Example: If a MIPS eligible clinician receives the base score (50%) and a 40% performance score and no bonus score, they would earn a 90% Advancing Care Information performance category score. When weighted by 25%, this would contribute 22.5 points to their overall MIPS final score. (90 X .25 = 22.5).
When is the ACI Score Reweighted?

▲ A clinician’s ACI performance score may be reweighted to 0% for the following two reasons:

1. They apply for reweighting, citing one of the 3 specified reasons:
   – Insufficient Internet Connectivity
   – Extreme and Uncontrollable Circumstances
   – Lack of Control over the Availability of CEHRT

These ECs must submit an application for CMS to reweight ACI to 0%. Information regarding the application process is not yet available.
ACI Reweighting (Cont’d)

▲ A clinician’s ACI performance score may also be reweighted if:

2. They are one of the following provider types that qualify for automatic ACI performance category reweighting:
   - Hospital-based MIPS Clinicians
   - Physician Assistants (PA)
   - Nurse Practitioners (NP)
   - Clinical Nurse Specialists (CNS)
   - Certified Registered Nurse Anesthetists (CRNA)
   - Clinicians who lack face-to-face interactions with patients

These ECs can still choose to report ACI if they would like, and if reported, CMS will score performance and weight ACI performance accordingly (25% in 2017)
## 2017 Requirements and Scoring Summarized

<table>
<thead>
<tr>
<th>Category</th>
<th>Report Some Data</th>
<th>Report Partial/Full Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACI</td>
<td>5 required OR</td>
<td>5 required measures AND</td>
</tr>
<tr>
<td>Quality</td>
<td>1 measure OR</td>
<td>6 quality measures; or 1 specialty measure set AND</td>
</tr>
<tr>
<td>CPIA</td>
<td>1 measure</td>
<td>2 High or 4 Med activities</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Final Score Points</th>
<th>MIPS Adjustment</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-0.75</td>
<td>Negative 4 percent (Note: We anticipate that this range will comprise mostly of MIPS eligible clinicians with a final score of 0.)</td>
</tr>
<tr>
<td>0.76-2.9</td>
<td>Negative MIPS payment adjustment greater than negative 4 percent and less than 0 percent on a linear sliding scale. (Note: We do not anticipate many MIPS eligible clinicians to fall into this range.)</td>
</tr>
<tr>
<td>3.0</td>
<td>0 percent adjustment</td>
</tr>
<tr>
<td>3.1-69.9</td>
<td>Positive MIPS payment adjustment ranging from greater than 0 percent to 4 percent ( \times ) a scaling factor to preserve budget neutrality, on a linear sliding scale</td>
</tr>
<tr>
<td>70.0-100</td>
<td>Positive MIPS payment adjustment AND additional MIPS payment adjustment for exceptional performance. (Additional MIPS payment adjustment starting at 0.5 percent and increasing on a linear sliding scale to 10 percent multiplied by a scaling factor.)</td>
</tr>
</tbody>
</table>
How does CMS get the data?

Data Submission Options (Quality and Cost)

Individual Reporting
- Claims
- QCDR
- Qualified Registry
- EHR Vendors
- Administrative Claims (No submission required)

Group Reporting
- QCDR
- Qualified Registry
- EHR Vendors
- CMS Web Interface (groups of 25 or more)
- CAHPS for MIPS Survey
- Administrative Claims (No submission required)

Quality

Resource use

✓ Administrative Claims (No submission required)
✓ Administrative Claims (No submission required)
Data Submission Options (ACI and CPIA)

Individual Reporting
- Attestation
- QCDR
- Qualified Registry
- EHR Vendor

Group Reporting
- Attestation
- QCDR
- Qualified Registry
- EHR Vendor
- CMS Web Interface (groups of 25 or more)

- Attestation
- QCDR
- Qualified Registry
- EHR Vendor
- Administrative Claims (No submission required)

- Attestation
- QCDR
- Qualified Registry
- EHR Vendor
- CMS Web Interface (groups of 25 or more)
Feedback and Review

- **Performance feedback will be available at least annually, starting July 1, 2017**
  - Minimally, will address quality and cost performance categories

- **MIPS eligible clinicians or groups will have an opportunity to request a targeted review of the calculation of their payment adjustment.**
MIPS - Incentives and Penalties

Payment Adjustments

▲ Adjustments applied 2 years after performance year (e.g. 2019 adjustment 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

▲ Higher scores receive proportionally larger incentive payments, up to 3x the maximum positive adjustment for the year

▲ Highest performers eligible for “Exceptional Performance Bonus”

  – Additional payment adjustment of +10% for ECs in the top 25%

  – ECs have the potential to receive a 37% increase in 2024!
MIPS Incentive Payment Formula

Exceptional performers receive additional positive adjustment factor – up to $500M available each year from 2019 to 2024

- Additional Performance Threshold
  - EPs above performance threshold = positive payment adjustment
  - Lowest 25% = maximum reduction

- 2019: -4%
- 2020: -5%
- 2021: -7%
- 2022 and onward: -9%

*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 have different risk structure but are otherwise treated as Advanced APMs

▲ MIPS APMs receive favorable MIPS scoring
Criteria for Advanced APMs

▲ 50% of participants must use certified EHR Technology (CEHRT)

▲ Must report and at least partially base clinician payments on quality measures comparable to MIPS

▲ Bear “more than nominal risk” for monetary losses
  – Defined as the lesser of 8% of total Medicare revenues or 3% of total Medicare expenditures
  – Primary Care Medical Home models with < 50 clinicians have different standards (2.5%-5% total Medicare revenues)
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 participating in Advanced APMs

▲ 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)
Volume Thresholds for APMs

▲ A “Qualifying APM” is one that meets increasing thresholds for the percentage of charges that pass through the APMs methodology

▲ An individual Eligible Clinician (EC) in a qualifying APM is a “Qualified APM Participant” or “QP”

▲ QP status is awarded to all advanced APM participants collectively (or to none as the case may be)

What if the threshold for QP status is not met?

▲ If the advanced APM does not meet the volume threshold to qualify it’s members for QP status, members are considered “Partially Qualifying APM Participants” or “PQPs”

▲ If a PQP chooses to stay in the APM track, s/he will not receive the 5% bonus, but also will not be subject to MIPS

▲ If PQP chooses, s/he can report MIPS measures and participate in the MIPS incentive track
Current Advanced APM Options

- **Comprehensive ESRD Care Model**
  - (13 ESCOs)

- **Comprehensive Primary Care Plus (CPC+)**
  - (14 states, applications closed but reopening)

- **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)
### New Advanced APM Options in 2018

<table>
<thead>
<tr>
<th>ACO Track 1+</th>
<th>Advancing Care Coordination through Episode Payment Models Track 1 (CEHRT)</th>
<th>Comprehensive Care for Joint Replacement Payment Model (CEHRT Track)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Voluntary bundled payment models</td>
<td>Vermont Medicare ACO Initiative (all payer ACO model)</td>
<td>Others???(likely)</td>
</tr>
</tbody>
</table>
Qualified Medical Home Models
(for the model to qualify as an Advanced APM)

(1) Requires expansion under CMS authority (none today)
(2) Requires participants to bear a more than nominal amount of financial risk

Medical Home Model Financial Risk Standard
Bearing financial risk means that the Medical Home Model may do one or more of the following if actual expenditures exceed expected expenditures:
• Withhold payment for services to the APM Entity or the APM Entity’s eligible clinicians
• Reduce payment rates to the APM Entity or the APM Entity’s eligible clinicians
• Require direct payments by the APM Entity to CMS, or
• Cause the APM Entity to lose the right to all or part of an otherwise guaranteed payment or payments.

Medical Home Model Nominal Risk Standard
To be an Advanced APM, the amount of risk under a Medical Home Model must be at least the following amounts:
• 2.5% of estimated average total Medicare Parts A and B revenue (2017)
• 3% of estimated average total Medicare Parts A and B revenue (2018)
• 4% of estimated average total Medicare Parts A and B revenue (2019)
• 5% of estimated average total Medicare Parts A and B revenue (2020 and later)
MIPS Certified Medical Homes

▲ CMS expanded the definition from the proposed rule to include clinicians or groups that have received certification or accreditation as a Medical Home from a:

- National program
- Regional or state program**
- Private payer; or
- Other body that administers PCMH accreditation or comparable specialty practice certification

** Certifying or accrediting entities other than a national program must have 500 or more certified practices

▲ Advantages of being a Certified Medical Home

- Receive full credit for the Clinical Practice Improvement Activities (CPIA) category
- If at least one practice in a larger group is “certified”, then all ECs reporting under that tax identification number (TIN) receives full credit in the CPIA category
▲ Criteria

– APM entity participates in a model under an agreement with CMS
– Entity includes at least one MIPS eligible clinician on a participant list
– Payment incentives based on performance on cost and quality measures

▲ 2017 Qualified Models

– MSSP Track 1 is included (Majority of Medicare ACOs)

▲ Advanced APM benefits do not apply

– Must participate in MIPS to receive any favorable payment adjustments
– Do not qualify for 5% APM bonus payments 2019-2024
– Not eligible for higher baseline annual updates beginning 2026

▲ MIPS APM Benefits

– 2017 MIPS APMs receive full Clinical Practice Improvement Activities credit
– APM-specific rewards (e.g., shared savings)
– Eligible for annual MIPS bonuses, which continue indefinitely (vs. 6 years for 5% APM bonuses)
# Requirements and Payments for APM Participants

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Qualified Participant in Advanced APM</th>
<th>Partially Qualified Participant in Advanced APM</th>
<th>MIPS APM participant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient and revenue thresholds required</td>
<td>&gt;25% revenues or &gt;20% patients in 2019, rising to 75% or 50%, respectively by 2023</td>
<td>&gt;20% revenues or &gt;10% patients in 2019, rising to 50% and 35%, respectively, by 2023</td>
<td>None</td>
</tr>
<tr>
<td>Eligible for APM bonus, higher updates</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Must participate in MIPS</td>
<td>No</td>
<td>Optional (but no performance adjustments without MIPS)</td>
<td>Yes</td>
</tr>
<tr>
<td>MIPS scoring and adjustments</td>
<td>N/A</td>
<td>Favorable weighting and scoring</td>
<td>Favorable weighting and scoring</td>
</tr>
</tbody>
</table>
**How will the Quality Payment Program affect me?**

- **Am I in an Advanced APM?**
  - Yes
  - No

  - Do I have enough payments or patients through my Advanced APM?
    - Yes
    - No

  - **Qualifying APM Participant (QP)**
    - **Excluded** from MIPS
    - 5% lump sum **bonus payment** (2019-2024), higher **fee schedule updates** (2026+)
    - APM-specific **rewards**

- **Am I in an APM?**
  - Yes
  - No

  - Is this my **first year** in Medicare OR am I below the **low-volume threshold**?
    - Yes
    - No

  - **Favorable MIPS scoring & APM-specific rewards**
    - Not subject to MIPS
    - Subject to MIPS

Bottom line: There will be **financial incentives for participating in an APM**, even if you don’t become a QP.
QPP Odds and Ends

▲ Determining Hospital-based status
  – 75% of charges billed to POS 21, 22, or 23
  – 2 year look back period, starting Oct 1 of second year to Sept 30 of current program year
  – If hospital-based, ACI is 0% and weight shifts to Quality (85%) and CPIA (15%)

▲ If on 2014 CEHRT for part of year and 2015 CEHRT for part, EC can choose between “regular” ACI measures or the “transitional” measures

▲ Limited MIPS Eligibility info (Quality) is available now on QPP website

▲ Comparisons are done via each data submission method

▲ Group vs Individual data submission can be decided at the time of attestation

▲ Different 90 day periods can be chosen for each performance category
QPP Odds and Ends

▲ PAs and NPs must participate in MIPS, but ACI is optional (if no ACI, performance category weight shifts to Quality just like Hospital-based ECs)

▲ If EC works for multiple employers, each NPI/TIN generates a separate MIPS score, potentially affecting reimbursement rates differently at each TIN

▲ If EC is new to a TIN in a payment year, his/her MIPS score from 2 years ago follows EC to new employer (if multiple MIPS scores, best one is used)

▲ (3) Snapshots to determine A-APM & QP determination: 3/31, 6/30 and 8/31

▲ FQHCs and RHCs are exempt but can opt in to “practice”. No $ adjustments
  – If also billing Medicare Part B, EC may need to participate in MIPS (if low volume threshold of $30k/100pts is met) to avoid adjustments on Part B reimbursements

▲ Critical Access Hospitals (CAHs) must participate or receive penalties

▲ Medicare Advantage: Not Part B so not included
  – This could change in Program Year 3 (2019) as MA plans could be considered Advanced APMs
MACRA Timeline

2016
- Last performance year for PQRS, Medicare MU, and VBM
- Prepare for Quality Payment Program in 2017

2017
- First performance measurement year for MIPS
- APM criteria set, proposals accepted for review on an ongoing basis

2018
- First performance measurement year for APMs and second for MIPS
- Separate PQRS, Meaningful Use, and VBM programs / penalties sunset on Dec. 31

2019
- First MIPS payment adjustments applied, maximum $4\%$ (increases to $9\%$ in 2022)
- First APM performance assessed, 5% bonus payments made to qualifying participants (based off 2018 Medicare payments)
TIMELINE

**Fee**

- Fee updates as SGR ends
- 2015 and earlier: 0.5
- 2016: 0.5
- 2017: 0.5
- 2018: 0.5
- 2019: 0
- 2020: 0
- 2021: 0
- 2022: 0
- 2023: 0
- 2024: 0
- 2025: 0
- 2026 and later: 0.75 QAPMCF*
- 2026 and later: 0.25 N-QAPMCF**

**MIPS**

- Quality Resource Use
- Clinical Practice Improvement Activities
- Meaningful Use of Certified EHR Technology

- PQRS, Value Modifier, EHR Incentives
- 2015 and earlier: 4%
- 2016: 5%
- 2017: 7%
- 2018: 9%
- 2019: 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
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

▲ Quality Payment Program Website: https://qpp.cms.gov/

▲ QPP Executive Summary: https://qpp.cms.gov/docs/QPP_Executive_Summary_of_Final_Rule.pdf


▲ QPP Fact Sheet: https://qpp.cms.gov/docs/Quality_Payment_Program_Overview_Fact_Sheet.pdf

▲ Comprehensive List of APMs: https://qpp.cms.gov/docs/QPP_Advanced_APMs_in_2017.pdf

▲ Additional Webinars and Educational Programs: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/Quality-Payment-Program-Program-Events.html
Questions?

www.mceita.org

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