MACRA, MIPS and APMs: Participating in the new Quality Payment Program

Bruce Maki, MA
M-CEITA / Altarum
Regulatory & Incentive Program Analyst

November 10, 2017

Disclaimer

▲ This presentation was current at the time it was published or uploaded onto the web. Medicare and Medicaid policies change frequently, so links to source documents have been provided for your reference.

▲ This presentation was prepared as a service to the public and is not intended to grant rights or impose obligations. This presentation may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage participants to review the specific statutes, regulations, and other interpretive materials for a full and accurate statement of their contents.

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
- 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 MU
- Funded by ARRA of 2009 (Stimulus Plan)
- Purpose: support the Triple Aim by achieving 5 overall performance goals

THE TRIPLE AIM

- Improve patient experience
- Improve population health
- Reduce costs

M-CEITA Services

- Meaningful Use Support
- Audit Preparation
- Consulting Services
- Great Lakes Practice Transformation Network (GLPTN)
- Chronic Care Management (CCM)
- Quality Payment Program Resource Center™

MACRA:

Paying for Quality and Value
<table>
<thead>
<tr>
<th>Acronym</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACI</td>
<td>Advancing Care Information</td>
</tr>
<tr>
<td>HIT/HEALTH IT</td>
<td>Health Information Technology for EHRs and Clinical Health Act</td>
</tr>
<tr>
<td>APM</td>
<td>Alternative Payment Model</td>
</tr>
<tr>
<td>IIA</td>
<td>Improvement Activities Performance Category (aka CPIA)</td>
</tr>
<tr>
<td>EDT</td>
<td>ED Improving Activities Performance Category (aka CPIA)</td>
</tr>
<tr>
<td>MHI</td>
<td>Medicaid Access and CHIP Reauthorization Act</td>
</tr>
<tr>
<td>CEITA</td>
<td>Michigan Center for Effective IT Adoption</td>
</tr>
<tr>
<td>CIP</td>
<td>Children's Health Insurance Program</td>
</tr>
<tr>
<td>MHI</td>
<td>Medicaid Care Improvement Regency</td>
</tr>
<tr>
<td>CNS</td>
<td>Clinical Nurse Specialist</td>
</tr>
<tr>
<td>CPIA</td>
<td>Clinical Performance Improvement Category</td>
</tr>
<tr>
<td>CMS</td>
<td>Center for Medicare &amp; Medicaid Services</td>
</tr>
<tr>
<td>MIPS</td>
<td>Merit-based Incentive Payment System</td>
</tr>
<tr>
<td>CNS</td>
<td>Clinical Nurse Specialist</td>
</tr>
<tr>
<td>MHI</td>
<td>Medicaid Access and CHIP Reauthorization Act</td>
</tr>
<tr>
<td>CEITA</td>
<td>Michigan Center for Effective IT Adoption</td>
</tr>
<tr>
<td>CIP</td>
<td>Children's Health Insurance Program</td>
</tr>
<tr>
<td>MHI</td>
<td>Medicaid Access and CHIP Reauthorization Act</td>
</tr>
<tr>
<td>CEITA</td>
<td>Michigan Center for Effective IT Adoption</td>
</tr>
<tr>
<td>CIP</td>
<td>Children's Health Insurance Program</td>
</tr>
<tr>
<td>MHI</td>
<td>Medicaid Access and CHIP Reauthorization Act</td>
</tr>
<tr>
<td>CEITA</td>
<td>Michigan Center for Effective IT Adoption</td>
</tr>
<tr>
<td>CIP</td>
<td>Children's Health Insurance Program</td>
</tr>
<tr>
<td>MHI</td>
<td>Medicaid Access and CHIP Reauthorization Act</td>
</tr>
<tr>
<td>CEITA</td>
<td>Michigan Center for Effective IT Adoption</td>
</tr>
<tr>
<td>CIP</td>
<td>Children's Health Insurance Program</td>
</tr>
<tr>
<td>MHI</td>
<td>Medicaid Access and CHIP Reauthorization Act</td>
</tr>
</tbody>
</table>

**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)

**The Quality Payment Program**

Part of a broader push towards paying for **VALUE** and **QUALITY**

- **GOAL 1:** 30% Medicare Fee-For-Service
- **GOAL 2:** 85% Medicare Fee-For-Service
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

▲ (4) MIPS Performance Categories:
   - Quality (PQRS/Value Modifier-Quality Program)
   - Cost (Value Modifier-Cost Program)
   - Advancing Care Information (ACI) (Medicare MU*)
   - Improvement Activities (IA) (new category)

*MIPS also does not alter or end the Medicaid EMR Incentive Program

Who is Eligible*?

Years 1 and 2
(2017 & 2018)

Limited list which may exclude some previously participating in PQRS:

- MDs
- DOs
- NPs
- CNAs
- CRNAs

Years 3+
(2019 and beyond)

CMS may broaden eligible clinicians group to include others such as:

- PTs
- OTs
- SLPs
- AuDs
- CMs
- LCSWs
- RDNs
- LNs

*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 Volume Threshold

Certain participants in ADVANCED Alternative Payment Models

Medicare ALLOWABLE billing charges less than or equal to $30,000 or provides 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

*MACRA does not alter or end the Medicaid EMR Incentive Program
**Individual vs. Group Reporting**

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**

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

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

---

**2017 MIPS Components & Scoring**

*(a transition year)*

<table>
<thead>
<tr>
<th>Scoring Model</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Create a 100pt system to increase and consolidate financial impact</strong></td>
</tr>
<tr>
<td><strong>Ranks peers nationally and reports scores publicly (CMS Physician Compare website)</strong></td>
</tr>
<tr>
<td><strong>In 2017, weighting puts 85% in Quality and ACI but will be increased in future years</strong></td>
</tr>
</tbody>
</table>

0 POINTS  
15 POINTS  
25 POINTS  
60 POINTS
**“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 submit any 2017 data, you receive a negative 4% payment adjustment.

**Partial:** If you submit 100% of 2017 data to Medicare, you may earn a neutral or positive payment adjustment.

**Total financial impact will depend on how much data you submit and your performance results.**

---

**How does CMS get the data?**

**Data Submission Options**

**Qualified Clinical Data Registry (QCDR)**
A QCDR is a CMS-approved entity that collects, analyses, and distributes data on the part of patients and clinicians to foster improvement in the quality of care provided to patients. Each QCDR typically provides tailored instructions on data submission for eligible clinicians.

**Qualified Registry (QR)**
A Qualified Registry collects clinical data from eligible clinicians or group of eligible clinicians and submits it to CMS on their behalf.

**Electronic Health Record (EHR)**
Eligible clinicians submit data directly through the use of certified EHR technology (CEHRT). Alternatively, clinicians may work with a qualified EHR data submission vendor (DSV) who submits on behalf of the clinician or group.

**Attestation**
Using the CMS attestation website (not yet available), eligible clinicians prove (attest) that they have completed measures or activities.

**CMS Web Interface**
A secure internet-based application available to pre-registered groups of 25 or more clinicians. CMS loads the Web Interface with a sample of the group's patients. The group then reports requested data for the pre-populated list. (ACOs use this submission method for Quality reporting).

**Claims**
Eligible clinicians select measures and begin reporting through the routine billing processes.
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 MIPS Final Score, as compared to the set performance threshold for that year (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 +50% for ECs in the top 25%
  ▲ ECs may receive a 37% increase on Medicare reimbursements by 2024!

**MIPS Incentive Payment Formula**

The program is budget neutral, so ECs receiving negative adjustments pay for those receiving positive adjustments.

**Alternative Payment Models**

Advanced APM

The other fork in the path to Quality-based Reimbursement
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; program adds incentives to existing model.

▲ APM participants also participating in MIPS may receive favorable scoring under certain MIPS performance categories.

▲ Only some APMs are “Advanced” APMs.

“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; these are not affected by the QPP

▲ Bonuses
  – In 2019-2024, 5% lump sum bonus payments made to ECs significantly participating in Advanced APMs (all APM 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

<table>
<thead>
<tr>
<th>Option</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comprehensive ESRD Care Model</td>
<td>(13 ESCOs)</td>
</tr>
<tr>
<td>Comprehensive Primary Care Plus (CPC+)</td>
<td>(14 states)</td>
</tr>
<tr>
<td>Medicare Shared Savings Track 2</td>
<td>(6 ACOs, 1% of total)</td>
</tr>
<tr>
<td>Medicare Shared Savings Track 3</td>
<td>(16 ACOs, 4% of total)</td>
</tr>
<tr>
<td>Next Generation ACO Model</td>
<td>(Currently 18)</td>
</tr>
<tr>
<td>Oncology Care Model Track 2</td>
<td>(A portion of 196 practices will qualify)</td>
</tr>
</tbody>
</table>

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

### TIMELINE

<table>
<thead>
<tr>
<th>Year</th>
<th>APM Participation</th>
<th>MIPS Incentive Payment</th>
<th>MIPS Payment Adjustment</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015</td>
<td>0.5</td>
<td>5%</td>
<td>0.75</td>
</tr>
<tr>
<td>2016</td>
<td>0.5</td>
<td>5%</td>
<td>0.75</td>
</tr>
<tr>
<td>2017</td>
<td>0.5</td>
<td>7%</td>
<td>0.75</td>
</tr>
<tr>
<td>2018</td>
<td>0.5</td>
<td>9%</td>
<td>0.75</td>
</tr>
</tbody>
</table>

### Preparing for 2017 MIPS Participation

- Qualifying APM Participant
- Excluded from MIPS

*Qualifying APM conversion factor
**Non-qualifying APM conversion 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(s) and verify capabilities
- Verify your EHR vendor or registry’s capabilities before your chosen reporting period(s)
- 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 to CMS 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 to Medicare Part B AND provide care for more than 100 Medicare patients between 9/1/15 – 8/31/16?
    ▶ Yes: You’re eligible and must participate to protect your reimbursement rate
    ▶ No: You’re exempt and do not have to participate in 2017

▲ Between April – May, CMS sent letters to each practice which detailed participation options for each associated EC
  - Additionally, www.qpp.cms.gov offers the ability to check EC eligibility, with the addition of important "special status" information

Choose to Submit Data as an Individual or as a Group

How Do I Do This?

▲ Perform a detailed analysis to determine which option is best
  - Many factors should be considered to make this determination.
    ▶ TIN structure
    ▶ Technology available
    ▶ Are you a multi-specialty group or a member of an ACO?
    ▶ 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 Your Submission Method(s) and Verify 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 (TCP, QIN-QIOs, QPP-SURs) for decision support. [https://www.appresourcercenter.com/]
  – Visit qpp.cms.gov for information on submission and support options.

▲ Choose data submission option(s)
  – 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/]

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(s)?
  – 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 to avoid 4% penalty)
  – Partial (Submit under 1-3 performance categories for a minimum of 90 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 and https://www.appresourcercenter.com/
▲ Click on the [Explore Measures] tab at the top of the CMS website.
▲ Select the performance category of interest

Quality Measures, Advancing Care Information, Improvement Activities

▲ Review the individual Quality and Advancing Care Information measures and specifications 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’ve participated in one of the legacy quality programs, consider your current billing codes and Quality Resource Use Report (QRUR) to help identify suitable measures
  ▶ Past PQRS Feedback Reports and QRURs can be accessed at [https://portal.cms.gov](https://portal.cms.gov) using your 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(s)
  - 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%) and 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 are 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: 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-Events.html
▲ Questions?
  www.qppresourcecenter.com
  Bruce Maki
  bruce.maki@altarum.org
  734-302-4744