MACRA, MIPS, QPP, and APMs.

The acronym soup of moving from volume to value.

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October 11, 2017

OU Medicine

Speaker Disclosure

I have no relevant financial relationships or affiliations to disclose.

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OU Medicine

Speaker Disclosure

- Current appointment as a "Quality Payment Program Clinical Champion" for the Centers for Medicare & Medicaid Services
- Recently appointed member of the Technical Expert Panel (TEP) for the project entitled "Development of Inpatient Outcome Measures for the Merit-based Incentive Payment System"
- Rural Quality Advisory Panel for the Rural Quality Improvement Technical Assistance (RQITA) Program (funded by the Federal Office of Rural Health Policy)

All are volunteer (unpaid) positions.

OU Medicine

Objectives

- Discuss the quality payment program that was authorized under MACRA
- Outline the requirements for MIPS and APMs
- Introduce possible changes to the Quality Payment Program for 2018

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BUSINESS REAL ESTATE AIRLINES RETAIL HEALTH CARE TECHNOLOGY ENERGY TOP 100 WORKPLACES

HEALTH CARE 4 DAYS AGO

Spending on health care reached $3.4 trillion in 2016 and is expected to rise, report says

Health spending grew 4.8 percent in 2016, slightly less than the year before when it rose 5.8 percent. **However, don't expect the expenditures to stall for long, the report found. They could account for nearly 20 percent of U.S. spending by 2025.**

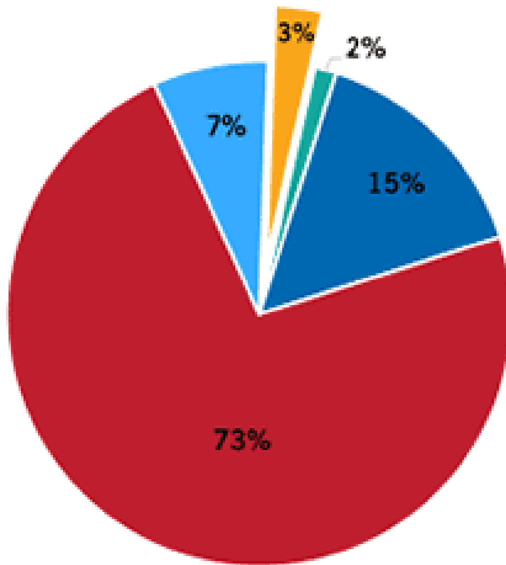
OU Medicine

Keehan SP, et al. National Health Expenditure Projections, 2016-25: Price Increases, Aging Push Sector To 20 Percent Of Economy. *Health Aff*. 2017; 36:553-563.

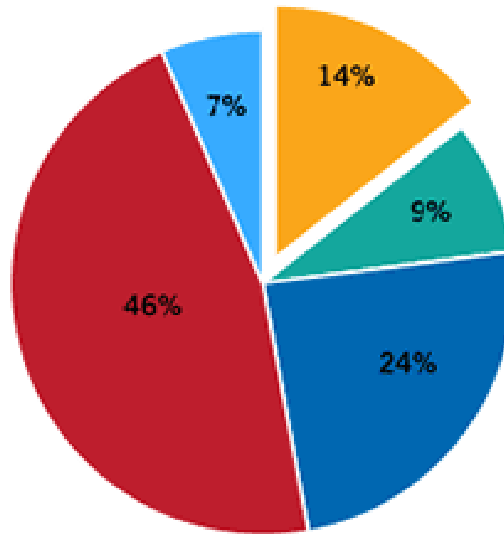
PETER G. PETERSON FOUNDATION

Medicare spending is a growing share of the federal budget

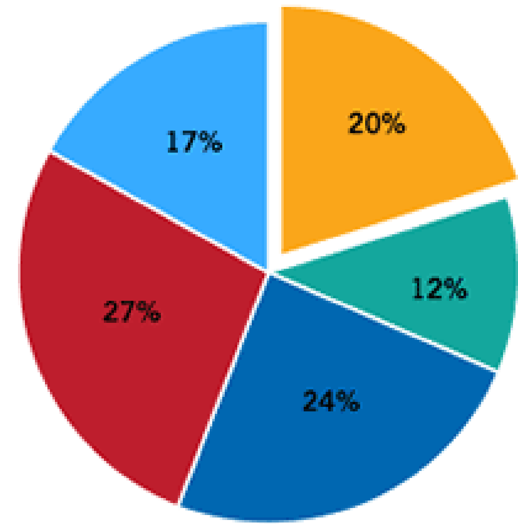
■ Medicare ■ Medicaid ■ Social Security ■ Other Programs ■ Net Interest



1970



2014



2040

SOURCE: Office of Management and Budget, *Budget of the United States Government*, Fiscal Year 2015, February 2015 and Congressional Budget Office, *The 2015 Long-Term Budget Outlook*, June 2015. Compiled by PGPF.

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PGPF.ORG

Medicine

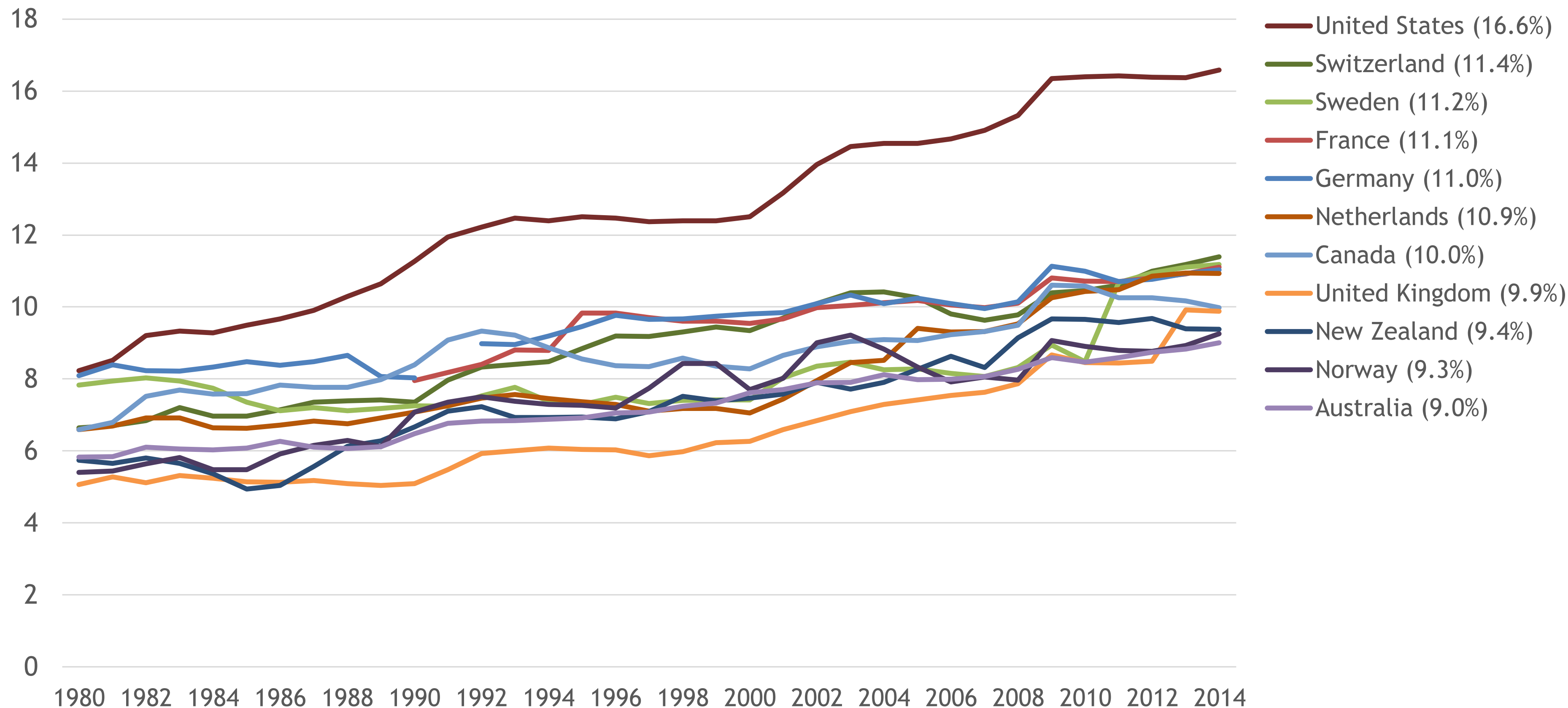
Defense, education, infrastructure, public safety, etc…

Publications > Fund Reports > Mirror, Mirror 2017: Inte...

Mirror, Mirror 2017: International Comparison Reflects Flaws and Opportunities for Better U.S. Health Care

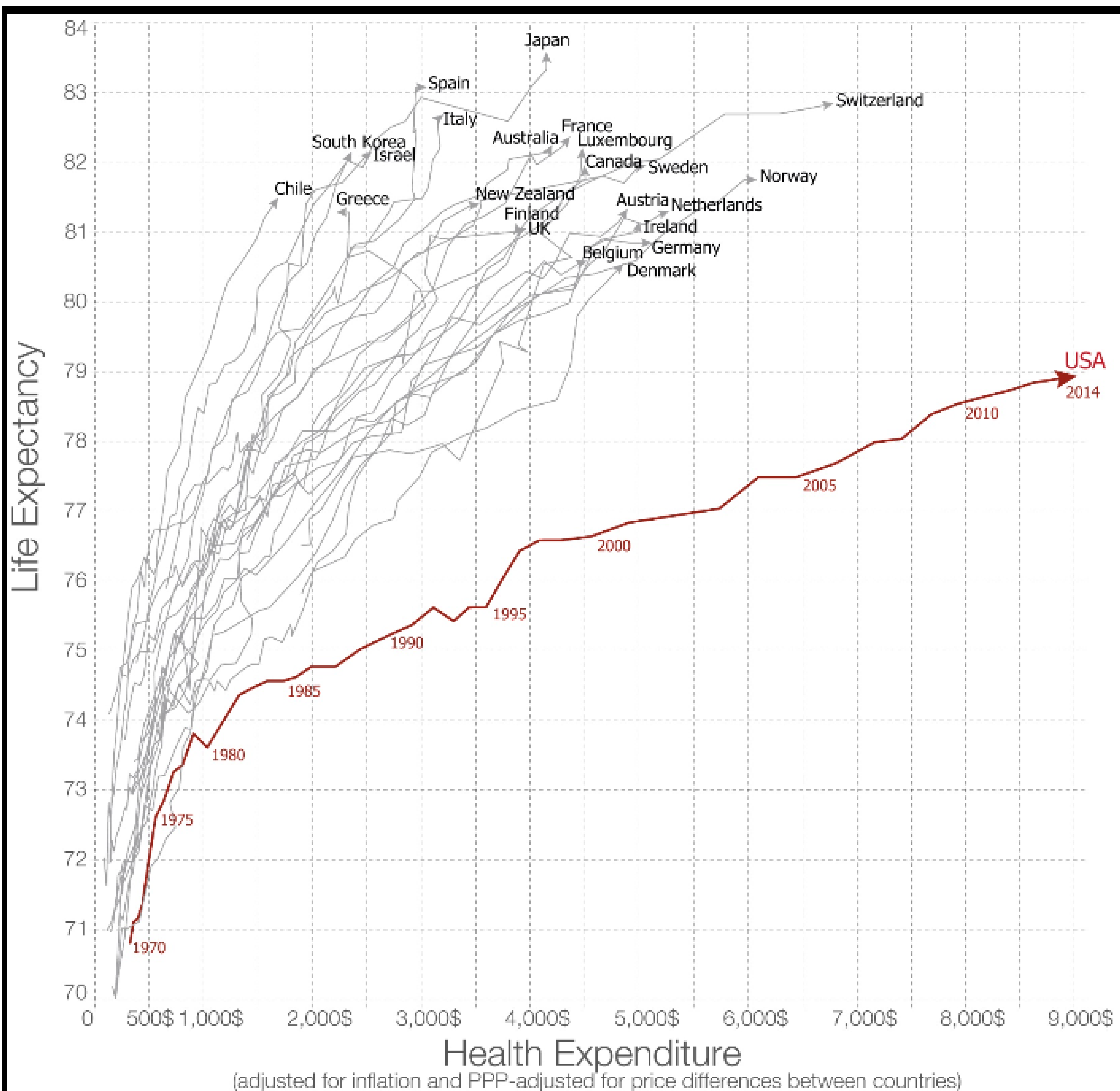
http://www.commonwealthfund.org/Publications/Fund-Reports/2017/Jul/Mirror-Mirror-International-Comparisons-2017

Health Care Spending as a Percentage of GDP, 1980–2014



GDP refers to gross domestic product. Data in legend are for 2014.
Source: OECD Health Data 2016. Data are for current spending only, and exclude spending on capital formation of health care providers.

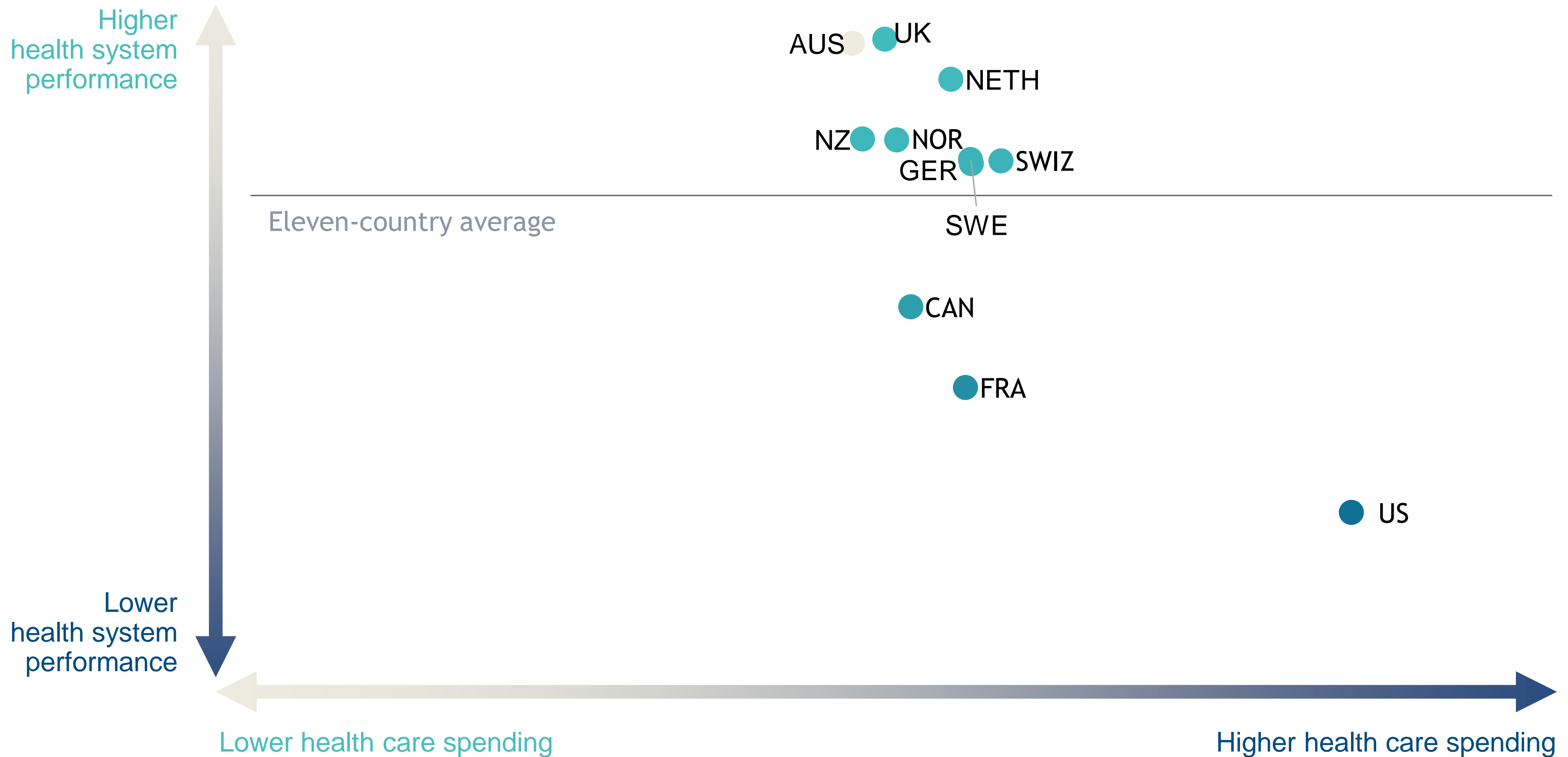
Despite the amount of money the US spends on health care…



Per capita health expenditures and life expectancy

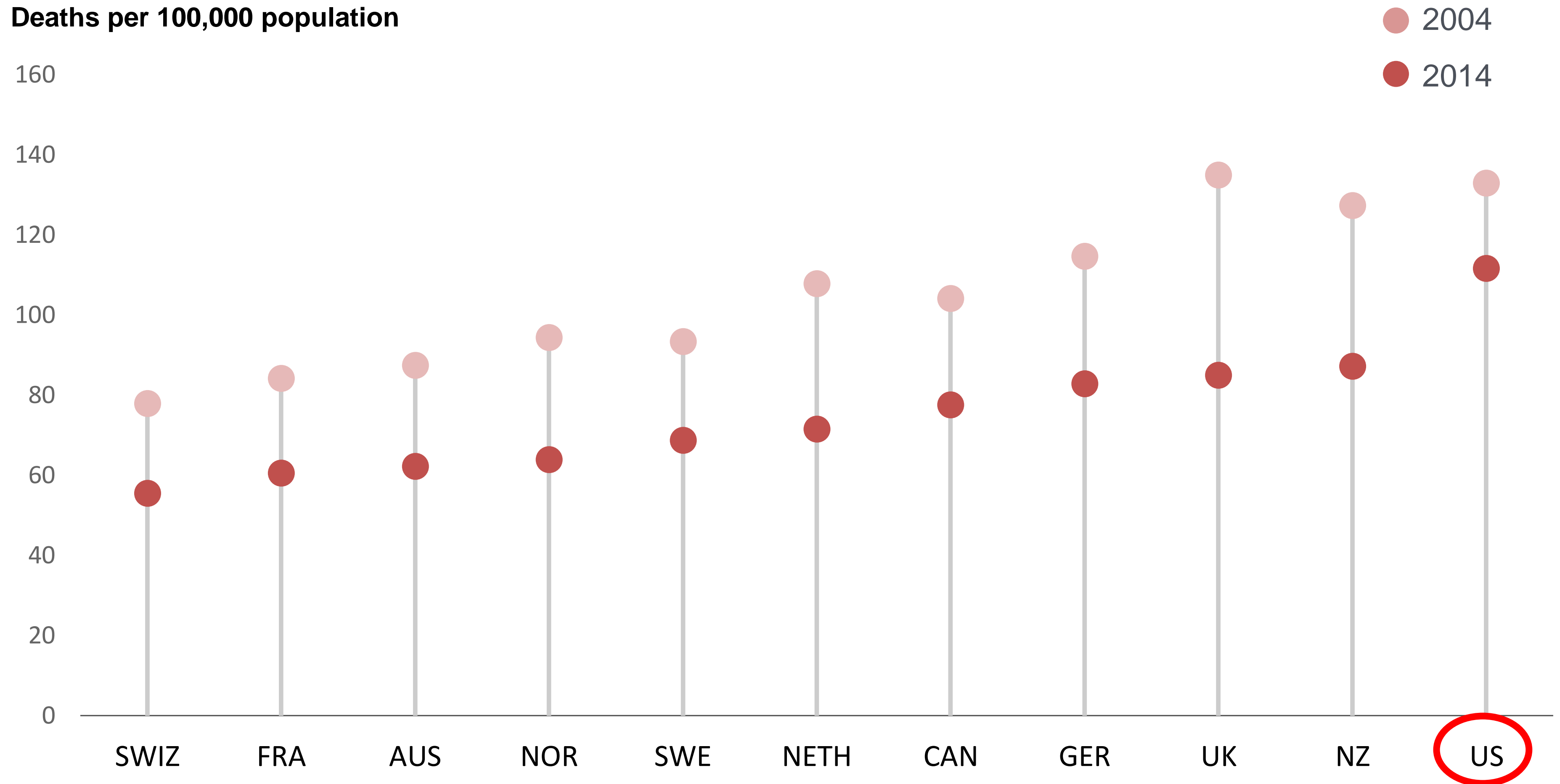
1970-2014

Health Care System Performance Compared to Spending



Note: Health care spending as a percent of GDP.
Source: Spending data are from OECD for the year 2014, and exclude spending on capital formation of health care providers.

Mortality Amenable to Health Care, 2004 and 2014



Source: European Observatory on Health Systems and Policies (2017). Trends in amenable mortality for selected countries, 2004 and 2014. Data for 2014 in all countries except Canada (2011), France (2013), the Netherlands (2013), New Zealand (2012), Switzerland (2013), and the U.K. (2013). Amenable mortality causes based on Nolte and McKee (2004). Mortality and population data derived from WHO mortality files (Sept. 2016); population data for Canada and the U.S. derived from the Human Mortality Database. Age-specific rates standardized to the European Standard Population (2013).

Payment Reform

- We have a payment system that has rewarded more care, regardless of the value (or quality) of that care.

- Payment models have not promoted coordination of care across settings

The new alphabet soup…….

Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)

One Hundred Fourteenth Congress
of the
United States of America

AT THE FIRST SESSION

Begun and held at the City of Washington on Tuesday, the sixth day of January, two thousand and fifteen

An Act

To amend title XVIII of the Social Security Act to repeal the Medicare sustainable growth rate and strengthen Medicare access by improving physician payments and making other improvements, to reauthorize the Children's Health Insurance Program, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the "Medicare Access and CHIP Reauthorization Act of 2015".

(b) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

Sec. 1. Short title; table of contents.

TITLE I—SGR REPEAL AND MEDICARE PROVIDER PAYMENT MODERNIZATION

Republican controlled Senate and House:

- **Senate vote: 92 yea; 8 nay**
- **House vote: 392 yea; 37 nay**

House sponsor: Michael C. Burgess, MD [R - Texas]

Repealed the SGR!

Very bipartisan!

http://www.gpo.gov/fdsys/pkg/BILLS-114hr2enr/pdf/BILLS-114hr2enr.pdf

Quality Payment Program Website

Quality Payment
PROGRAM

MIPS
Merit-based Incentive Payment System

APMs
Alternative Payment Models

About
The Quality Payment Program

Modernizing Medicare to provide better care and smarter spending a healthier America.

THE TRACK

MIPS Overview

Individual or Group Participation

What To Report

EXPLORE MEASURES

Quality Measures

Improvement Activities

Advancing Care Information

Check Your Participation Status

Check your participation status

Enter your National Provider Identifier (NPI) number

NPI Number

Check NPI

TITLE I—SGR Repeal and Medicare Provider Payment Modernization – What happens in 2017?

Eligible Professional

Quality Payment Program (QPP)

Advanced Alternate Payment Mechanisms (APM)

- "Substantial portion" of revenues from "approved" alternate payment models
  - 5% bonus each year from 2019-2024
  - 0.75% increase per year beginning in 2026

Merit-based Incentive Payment System (MIPS)†

- Providers receive a score of 0-100
- Each year, CMS will establish a threshold score based on the median or mean composite performance scores of all providers
  - Providers scoring above the threshold will receive bonus payments (up to three times the annual penalty cap).

Medicine

†Performance scores will be posted to Physician Compare website.

Who Will Participate in MIPS?

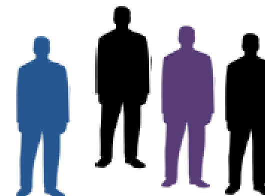
Affected clinicians are called "**MIPS eligible clinicians**" and will participate in MIPS. The types of **Medicare Part B** eligible clinicians affected by MIPS may expand in future years.

Years 1 and 2

Physicians, PAs, NPs, Clinical nurse specialists, Certified registered nurse anesthetists

Years 3+

Secretary may broaden Eligible Clinicians group to include others such as



Physical or occupational therapists, Speech-language pathologists, Audiologists, Nurse midwives, Clinical social workers, Clinical psychologists, Dietitians / Nutritional professionals

Note: Physician means doctor of medicine, doctor of osteopathy (including osteopathic practitioner), doctor of dental surgery, doctor of dental medicine, doctor of podiatric medicine, or doctor of optometry, and, with respect to certain specified treatment, a doctor of chiropractic legally authorized to practice by a State in which he/she performs this function.

How much can MIPS adjust payments?

- Based on the MIPS **composite performance score**, physicians and practitioners will receive positive, negative, or neutral adjustments up to the percentages below.
- MIPS adjustments are **budget neutral**. A **scaling factor** may be applied to upward adjustments to make total upward and downward adjustments equal.

MAXIMUM Adjustments

	2019	2020	2021	2022 onward
Maximum positive	4%	5%	7%	9%
Maximum negative	-4%	-5%	-7%	-9%

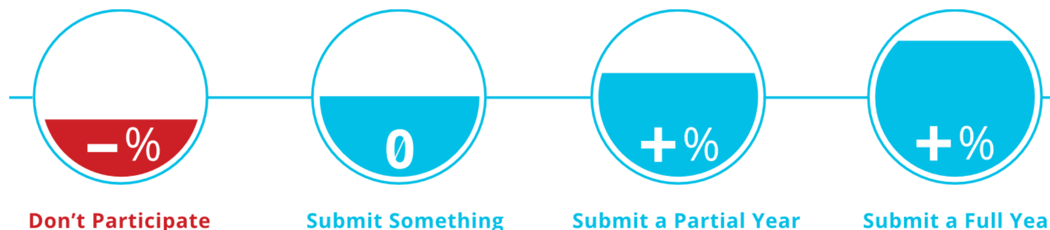
Adjustment to provider's base rate of Medicare Part B payment

Merit-Based Incentive Payment System **(MIPS)**

2017 is a Transition Year

"Pick Your Pace"

- **First option**: Report something to avoid penalties (no incentives)
- **Second option**: Submit data for part of the calendar year (small incentives and avoid penalties)
- **Third option**: Submit data for the entire calendar year ("modest" payment incentive and avoid penalties)
- **Fourth option**: Participate in an Alternate Payment Model



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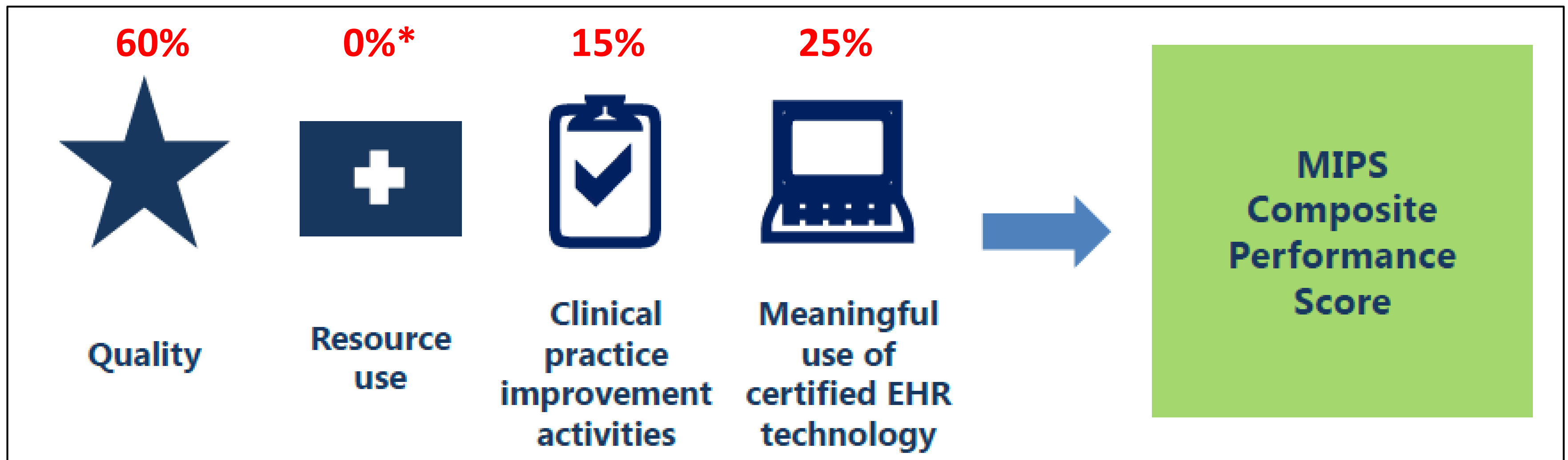
https://blog.cms.gov/2016/09/08/QualityPaymentProgram-PickYourPace/

Merit-based Incentive Payment System (MIPS) - 2017



First performance year is CY 2017 to adjust payment in CY 2019.

***Reduced to 0% for the 2017 "transition year". By statute, must go up to 30% for payment year CY 2021.**

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Quality Performance – 60% of Score for CY 2017

- For most participants: Report up to 6 quality measures, including an outcome measure, for a minimum of 90 days.
  - Remember – submitting one measure for one patient during 2017 avoids the 2019 payment penalty (Pick Your Pace).
  - Submitting a quality measure nets a minimum of 3 points

MIPS Quality Performance Category

- Clinicians receive 3 to 10 points on each quality measure based on performance against benchmarks
  - Year 1 participants automatically receive 3 points for completing and submitting a measure
- Failure to submit performance data for a measure = 0 points

Submit something…!

MIPS Quality Performance Category

Benchmarks

- Each submitted measure is assessed against its benchmarks to determine how many points the measure earns.
  - Benchmarks are specific to the type of submission mechanism

- These historic benchmarks are based on actual performance data submitted to PQRS in 2015, except for CAHPS
  - For CAHPS, the benchmarks are based on two sets of surveys: 2015 CAHPS for PQRS and CAHPS for Accountable Care Organizations (ACOs)

Points based on Benchmarks

Decile	Number of Points Assigned for the 2017 MIPS Performance Period
Below Decile 3	3 points
Decile 3	3-3.9 points
Decile 4	4-4.9 points
Decile 5	5-5.9 points
Decile 6	6-6.9 points
Decile 7	7-7.9 points
Decile 8	8-8.9 points
Decile 9	9-9.9 points
Decile 10	10 points

**For inverse measures, the order would be reversed. Where Decile 1 starts with the highest value and decile 10 has the lowest value.*

Benchmark example: Diabetes: Hemoglobin A1c Poor Control*

Measure_Name	Submission_Method	Measure_Type	Decile 3	Decile 4	Decile 5	Decile 6	Decile 7	Decile 8	Decile 9	Decile 10
Diabetes: Hemoglobin A1c Poor Control	Claims	Outcome	35.00 - 25.72	25.71 - 20.32	20.31 - 16.23	16.22 - 13.05	13.04 - 10.01	10.00 - 7.42	7.41 - 4.01	<= 4.00
Diabetes: Hemoglobin A1c Poor Control	EHR	Outcome	54.67 - 35.91	35.90 - 25.63	25.62 - 19.34	19.33 - 14.15	14.14 - 9.10	9.09 - 3.34	3.33 - 0.01	0
Diabetes: Hemoglobin A1c Poor Control	Registry/QCDR	Outcome	83.10 - 68.19	68.18 - 53.14	53.13 - 40.66	40.65 - 30.20	30.19 - 22.74	22.73 - 16.82	16.81 - 10.33	<= 10.32

To be 10th decile performance for HbA1c Poor Control:

- Reporting by claims: <= 4% of your diabetics can have a HbA1c > 9.0%
- Reporting by EHR: none (zero) of your diabetics can have a HbA1c > 9.0%
- Reporting by Registry/QCDR: <= 10.32% of your diabetics can have a HbA1c > 9.0%

***A case fails the measure if no HbA1c was documented in the past year.**

Benchmark example: Diabetes: Eye Exam

Measure_Name	Submission_Method	Measure_Type	Decile 3	Decile 4	Decile 5	Decile 6	Decile 7	Decile 8	Decile 9	Decile 10
Diabetes: Eye Exam	Claims	Process	86.36 - 97.77	97.78 - 99.99	--	--	--	--	--	100
Diabetes: Eye Exam	EHR	Process	50.57 - 80.68	80.69 - 90.05	90.06 - 94.11	94.12 - 96.66	96.67 - 98.57	98.58 - 99.99	--	100
Diabetes: Eye Exam	Registry/QCDR	Process	69.39 - 89.68	89.69 - 95.95	95.96 - 98.72	98.73 - 99.99	--	--	--	100

If you have documentation that 99.99% of your diabetic patients have had a dilated retinal exam, out of 10 possible points:

- Reporting by claims: You will be Decile 4 performance (4 points)
- Reporting by EHR: You will be Decile 8 performance (8 points)
- Reporting by Registry/QCDR: You will be Decile 6 performance (6 points)

MIPS Quality Performance Category

*Bonus Points**

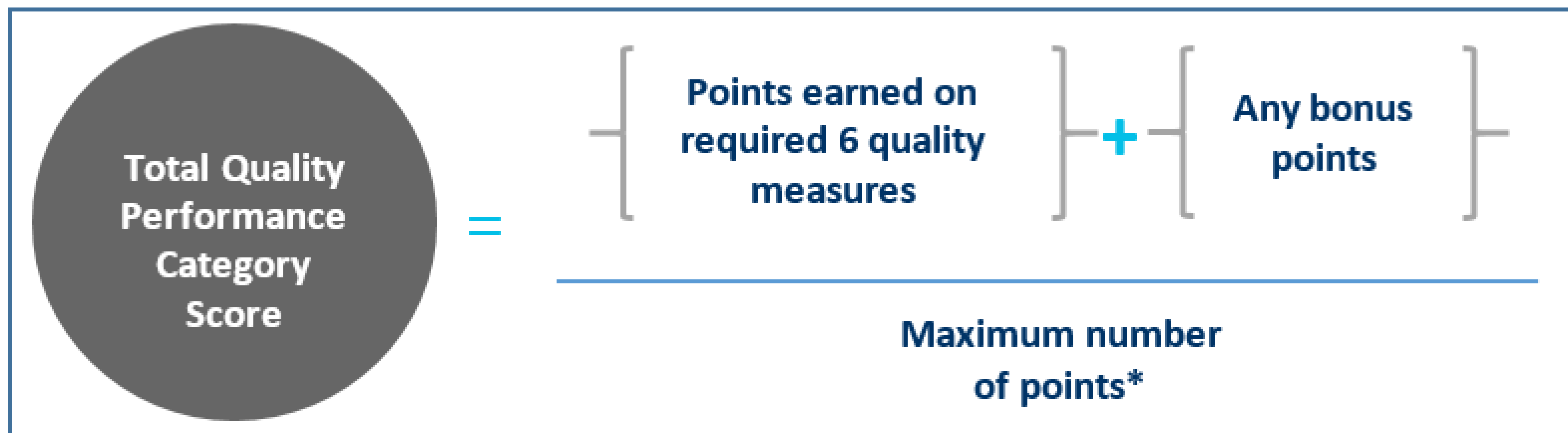
- **Submitting an additional high-priority measure**
  - **2 bonus points** for each additional outcome or patient experience measure
  - **1 bonus point** for each additional high-priority measure

- **Using Certified Electronic Health Record Technology (CEHRT) to submit measures to registries or CMS**
  - **1 bonus point** for each measure submitted with end-to-end electronic reporting

*Capped at 10% of the denominator.

MIPS Quality Performance Category

Points



The Quality performance category score is then multiplied by the 60% Quality performance category weight with the result adding to the overall MIPS final score.

Total Quality Performance Category Score is capped at 100%.

Resource Use – 0% of Score for 2017*

- CMS will calculate from claims episode-specific measures to account for differences among specialties.
  - For cost measures, clinicians that deliver more efficient care achieve better performance and score the highest points (the most efficient resource use).
  - Expert group currently developing cost measures

"Episodes of care" roll up all costs of inpatient and outpatient care (including imaging, laboratory, drugs, rehabilitation, etc).

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***By statute must make up 30% of the MIPS score for payment year 2021 (practice year 2019).**

Cost Measures are not New

You 0.12

Standard deviations from the mean domain score (negative scores are better)

	Your TIN				All TINs in Peer Group	
Cost Measure	Number of Eligible Cases or Episodes	**Per Capita or Per Episode Costs**	Standardized Cost Score	Included in Domain Score?	**Benchmark (National Mean)**	Standard Deviation
Per Capita Costs for All Attributed Beneficiaries	8,414	**$11,790**	-0.15	Yes	**$12,326**	$3,665
Medicare Spending per Beneficiary	2,473	**$21,088**	0.39	Yes	**$20,599**	$1,254

Example from the Medicare Quality and Resource Use Report (QRUR) for 2015 care.

Clinical Performance Improvement Activities – 15% of Score

- CMS allows physicians to select from a list of more than 90 activities.

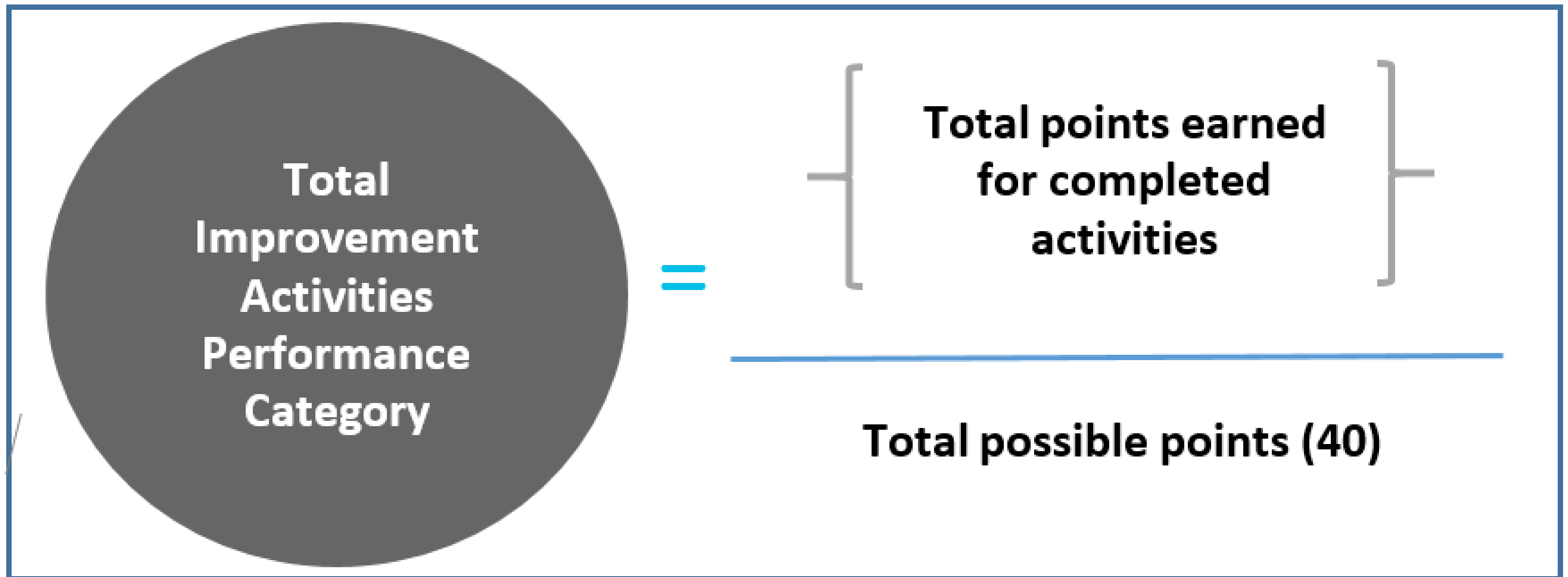
Clinical Performance Improvement Activities

- **Most participants:** Attest that you completed up to 4 improvement activities for a minimum of 90 days.
  - Having one of your clinic sites "certified" as a patient-centered medical home (PCMH) nets all 40 points for this category

- **Groups with fewer than 15 participants or if you are in a rural or health professional shortage area:** Attest that you completed up to 2 activities for a minimum of 90 days.

MIPS Improvement Activities Category

Points



The Improvement Activities performance category score is then multiplied by the 15% Improvement Activities performance category weight with the result adding to the overall MIPS final score.

MIPS Scoring - Advancing Care Information *(25% of Final Score): Base Score*

50% Base score (worth 50%)

Clinicians must submit a numerator/denominator or Yes/No response for each of the following required measures:

Advancing Care Information Measures

- Security Risk Analysis
- e-Prescribing
- Provide Patient Access
- Send a Summary of Care
- Request/Accept a Summary of Care

2017 Advancing Care Information Transition Measures

- Security Risk Analysis
- e-Prescribing
- Provide Patient Access
- Health Information Exchange

0% Failure to meet reporting requirements will result in base score of zero, and an advancing care information performance score of zero.

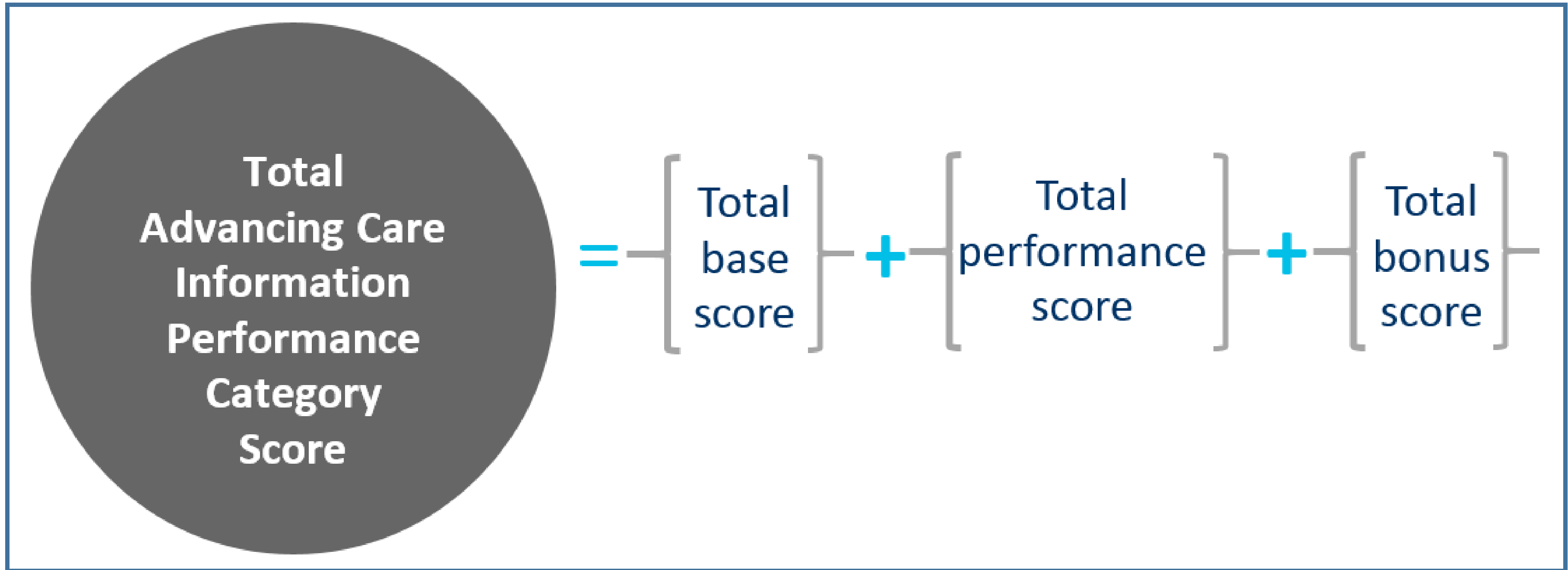
ACI Performance Score

Measure	Performance Score
Provide Patient Access	Up to 10%
Patient-Specific Education	Up to 10%
View, Download and Transmit (VDT)	Up to 10%
Secure Messaging*	Up to 10%
Patient-Generated Health Data	Up to 10%
Send a Summary of Care	Up to 10%
Request/Accept Summary of Care	Up to 10%
Clinical Information Reconciliation	Up to 10%
Immunization Registry Reporting	0 or 10%

***Scoring example for ACI:**

- **Secure message 10% of your patients – get 1% towards the performanc score.**
- **Secure message 71% of your patients – get 7% towards the performance score.**

MIPS Advancing Care Information Category
Points



The Advancing Care Information performance category score is then multiplied by the 25% Advancing Care Information performance category weight with the result adding to the overall MIPS final score.

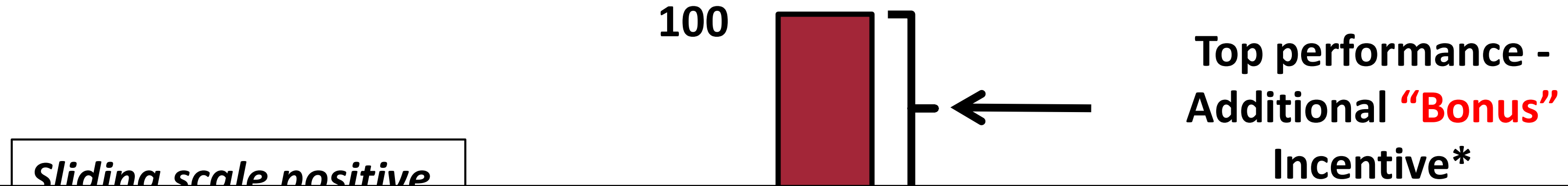
Final MIPS Score (0 – 100)

Calculating the Final Score Under MIPS

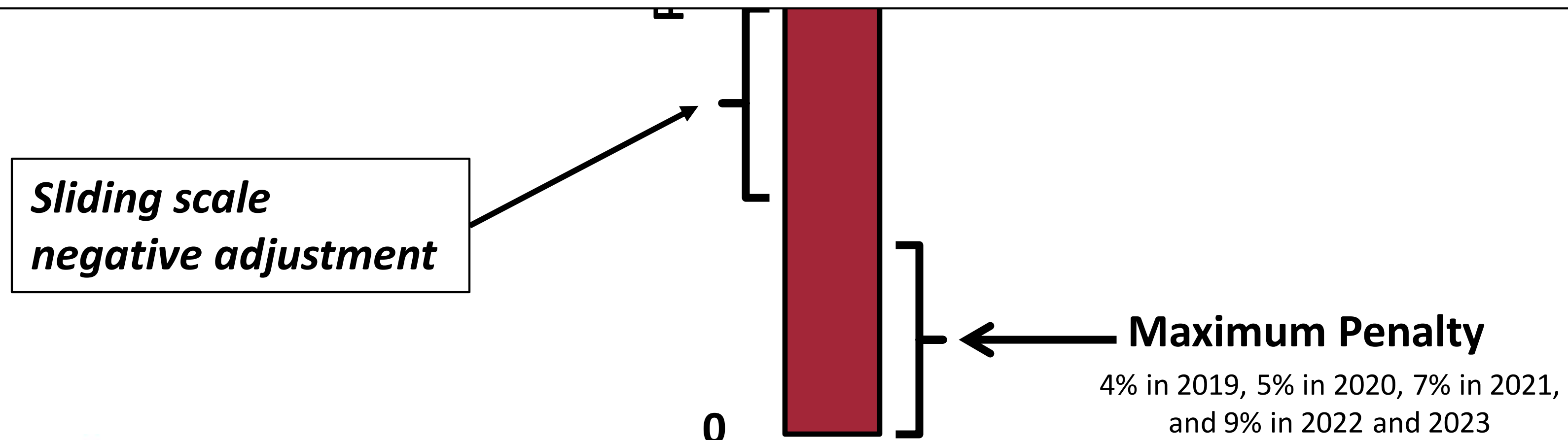
Final Score =

[Clinician Quality performance category score x actual Quality performance category weight] + [Clinician Cost performance category score x actual Cost performance category weight] + [Clinician Improvement Activities performance category score x actual Improvement Activities performance category weight] + [Clinician Advancing Care Information performance category score x actual Advancing Care Information performance category weight] × 100

Scoring under MIPS



By law the program must be budget neutral. There have to be losers to have incentive payments! *(except for the exceptional performance bonus)*

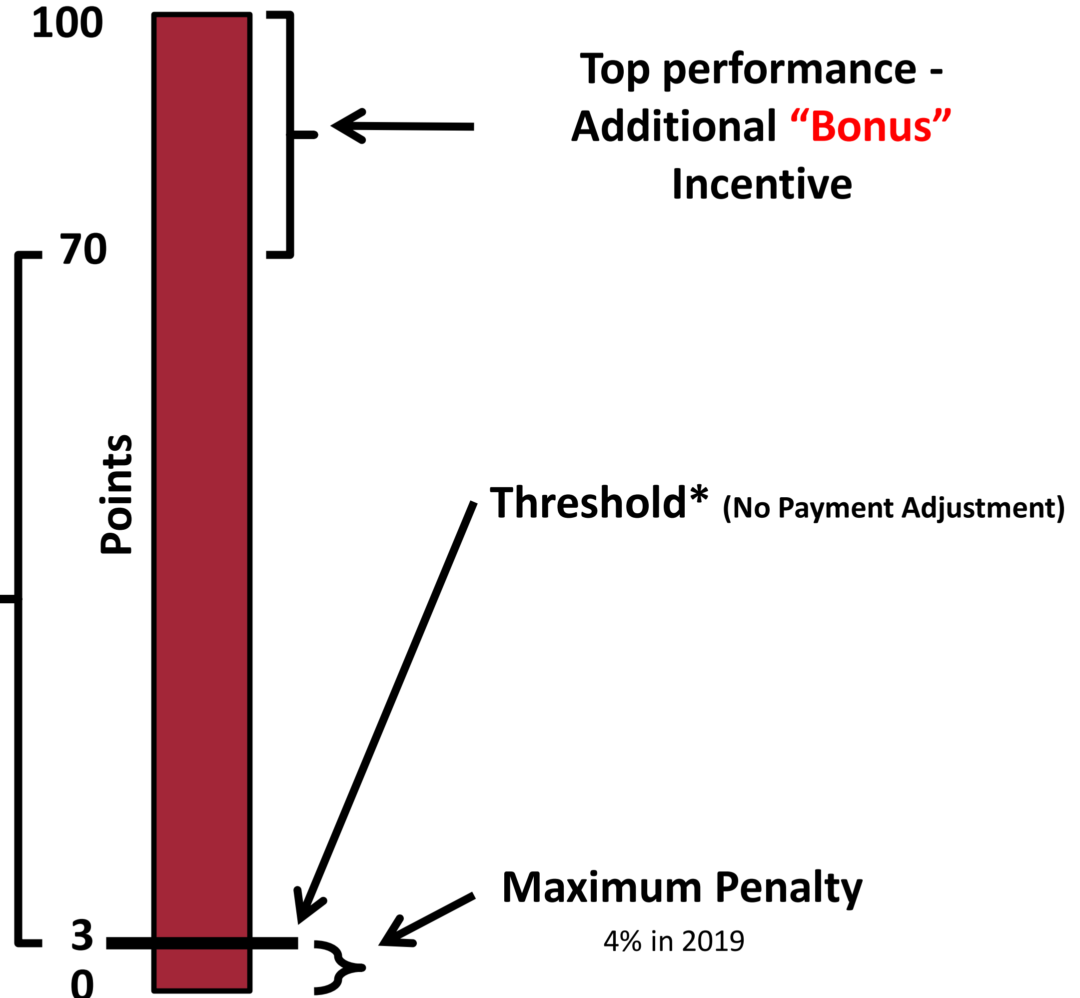


***Congress set aside $500 million per year for five years to reward exceptional performance.**

Scoring under MIPS 2017

Because the threshold is set so low for CY 2017, there will likely be very few incentive dollars to distribute (except for the exceptional performance bonus dollars).

Sliding scale positive adjustment



Medicine

So you'd rather be in an advanced APM….

The Merit-based Incentive Payment System (MIPS)

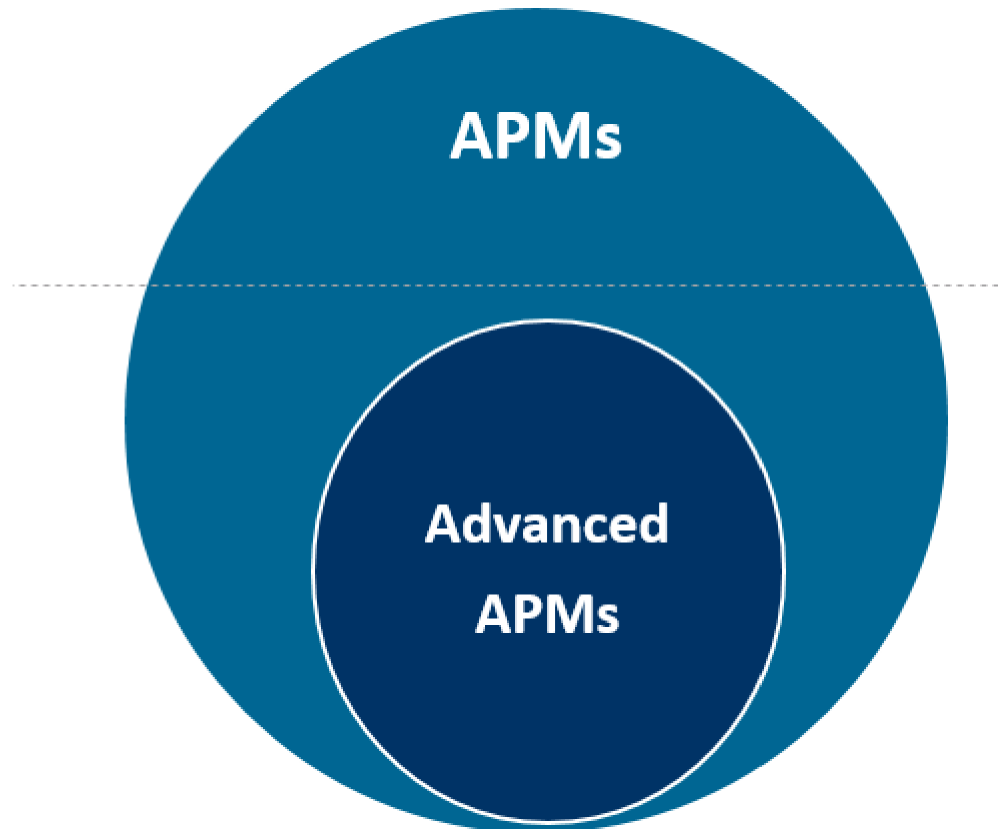
If you decide to participate in MIPS, you may earn a performance-based payment adjustment through MIPS.

OR

Advanced Alternative Payment Models (Advanced APMs)

If you decide to take part in an Advanced APM, you may earn a Medicare incentive payment for sufficiently participating in an innovative payment model.

Advanced APMs are a Subset of APMs



Alternate Payment Models (APMs)

- "Substantial portion" of revenues* from "approved" alternate payment models
  - For now, very few "approved" APMs
  - Not subject to MIPS
    - Receive 5% lump sum bonus payments for years 2019-2024
    - Receive a higher fee schedule update from 2026 onward

What is an eligible APM?

Eligible APMs are the **most**

The practice must bear more than nominal financial risk!

- ✓ **Base payment on quality** measures comparable to those in MIPS
- ✓ Require use of certified **EHR** technology
- ✓ Either (1) bear more than nominal **financial risk** for monetary losses **OR** (2) be a **medical home model expanded** under CMMI authority

Qualifying Advanced APMs - 2017

- Comprehensive ESRD Care (CEC) - Two-Sided Risk
- Comprehensive Primary Care Plus (CPC+)
- Next Generation ACO Model
- Shared Savings Program - Track 2
- Shared Savings Program - Track 3
- Oncology Care Model (OCM) - Two-Sided Risk
- Comprehensive Care for Joint Replacement (CJR) Payment Model (Track 1- CEHRT)

0 Sign in Sign up

FEDERAL REGISTER

The Daily Journal of the United States Government

PR Proposed Rule

Medicare Program; CY 2018 Updates to the Quality Payment Program

A Proposed Rule by the Centers for Medicare & Medicaid Services on 06/30/2017

Comments on this document are being accepted at Regulations.gov.

SUBMIT A FORMAL COMMENT

PUBLISHED DOCUMENT

Start Printed Page 30010

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Centers for Medicare & Medicaid Services (CMS), HHS.

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06/30/2017

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https://www.federalregister.gov/documents/2017/06/30/2017-13010/medicare-program-cy-2018-updates-to-the-quality-payment-program

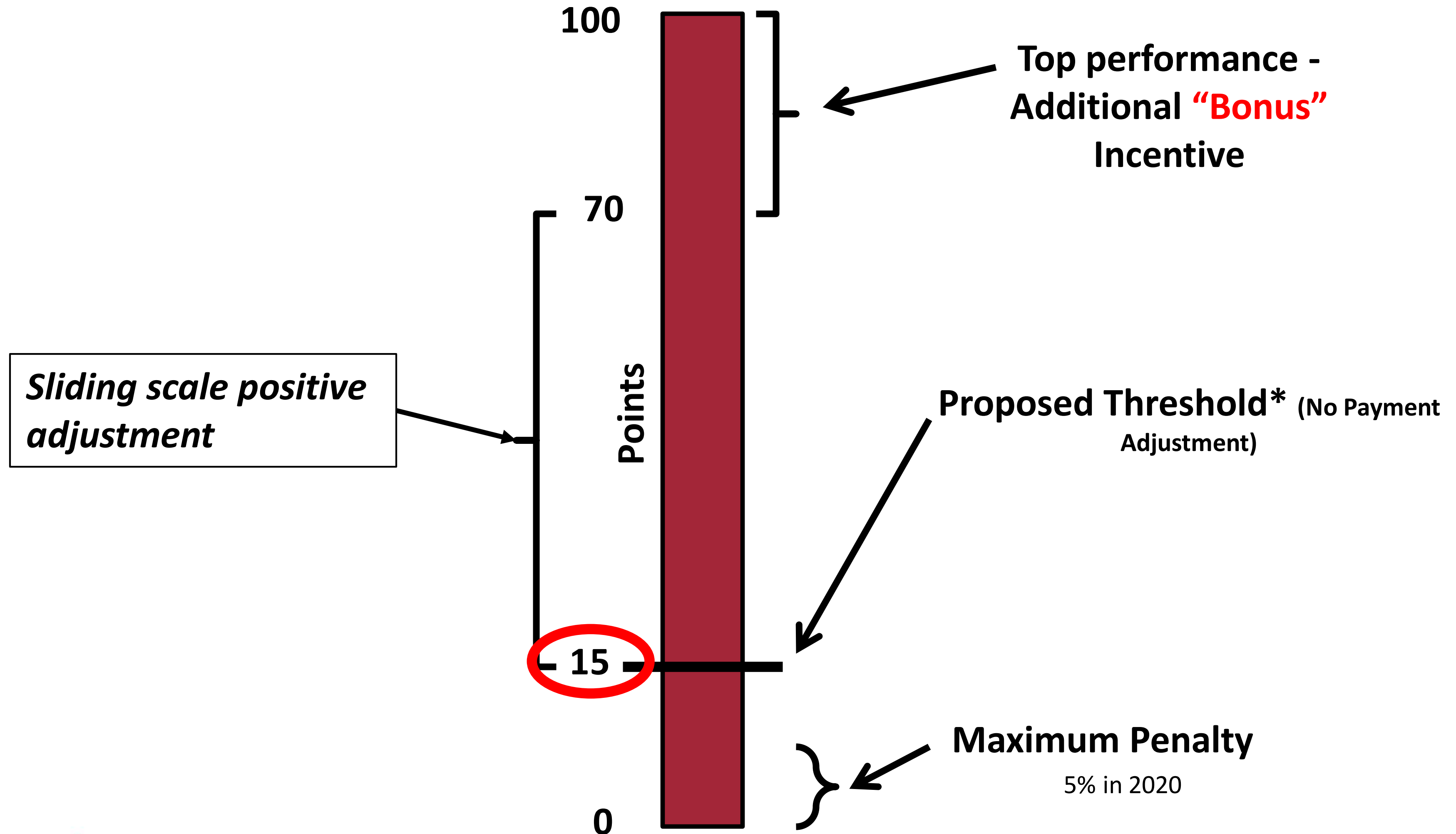
Major Changes (Proposed)

- Exclude MIPS eligible clinicians or groups who bill <$90,000 in Part B allowed charges OR provide care for < 200 Part B enrolled beneficiaries during the performance period or a prior period.

Major Changes (Proposed)

- Virtual Groups
  - Definition: A combination of two or more Taxpayer Identification Numbers (TINs) composed of a solo practitioner (individual MIPS eligible clinician who bills under a TIN with no other NPIs billing under such TIN), or a group with 10 or fewer eligible clinicians under the TIN that elects to form a virtual group with at least one other such solo practitioner or group for a performance period for a year.
    - All MIPS eligible clinicians within a TIN must participate in the virtual group

Proposed for MIPS 2018



Major Changes (Proposed)

- For the number of practice sites within a TIN that need to be recognized as patient-centered medical homes for the TIN to receive the full credit for improvement activities, we propose a threshold of 50% for 2018.

Major Changes (Proposed)

- Complex Patient Bonus
  - Apply an adjustment of 1 to 3 bonus points to the final score by adding the average Hierarchical Conditions Category (HCC) risk score to the final score.
    - Generally, this will award between 1 to 3 points to clinicians based on the medical complexity for the patients treated.

Major Changes (Proposed)

- Small Practice Bonus
  - Adjust the final score of any MIPS eligible clinician or group who is in a small practice (15 or fewer clinicians) by adding 5 points, so long as the MIPS eligible clinician or group submits data on at least 1 performance category in an applicable performance period.

What do you need to do now?

- Determine if you are MIPS eligible (CMS should have already notified you)
- Assuming you are MIPS eligible, determine your pace of participation for 2017
  - If you don’t participate, you will see a 4% reduction in your Medicare Part B payment in 2019
- Visit www.qpp.cms.gov to learn more about the program and use the tools to pick measures

What do you need to do now?

- Decide how you are going to report
  - Individually or as a part of a group practice
  - Claims, Qualified Registry, Qualified Clinical Data Registry, eCQMs

- Start thinking about 2018 when the bar will likely be higher

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