Getting Ready For MACRA

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I have nothing to disclose

Objectives

- Describe the proposed payment adjustments under MACRA
- Describe the proposed new payment rules for MACRA:
  - → Alternative Payment Model (APM)
  - → Merit-Based Incentive Payment System (MIPS)
- Describing Resources for support

Significant changes in Medicare payments are coming in 2019 based on your performance in 2017

Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)

- Repeals 1997 SGR and PFS Updates
- *Bipartisan law signed 4/16/15*
  - 392 to 37 House
  - 92 to 8 Senate

It will not be repealed. The time to act is now!

- MACRA = Quality Payment Program
- Reforms payment for Medicare reimbursement to more than 600,000 Eligible Clinicians (EC)
- Serving 55 million Americans on Medicare
- A major step moving health care to pay for value rather than volume
- Will continue to evolve over time

MACRA

- Exclusions
  - First year participant in Medicare
  - Low volume threshold:
    - < 100 Medicare patients seen in a year

      ~ OR ~

    - < $30,000 in Medicare claims for the year (NEW)

- Inclusions - in year 1 and 2:

Physician	Physician Assistant	Nurse Practitioner	Clinical Nurse Specialist	Certified Registered Nurse Anesthetist

MACRA aka Quality Payment Program

Advanced Alternative Payment Models (APMs)

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

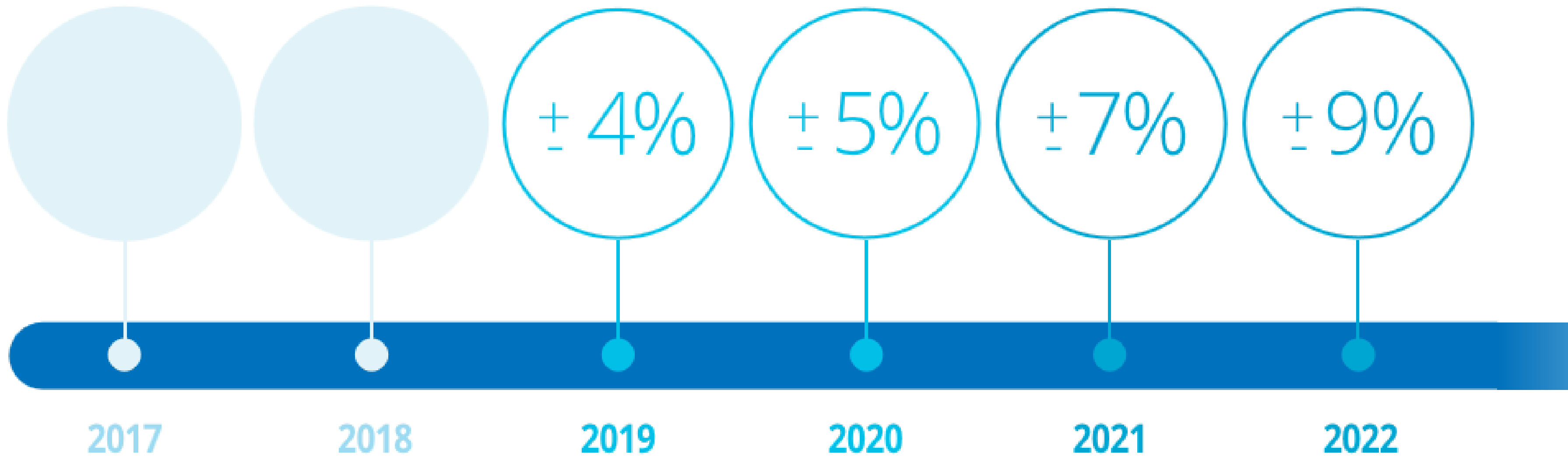
OR

The Merit-based Incentive Payment System (MIPS)

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

https://qpp.cms.gov/docs/Quality_Payment_Program_Overview_Fact_Sheet.pdf

MIPS Payment Adjustments



OR

Participate in the Advanced APM path:

If you receive 25% of Medicare payments or see 20% of your Medicare patients through an Advanced APM in 2017, then you earn a 5% incentive payment in 2019.

Advanced Alternative Payment Model A-APM

Alternative Payment Models - APMs

MACRA definition for Alternative Payment Model

- ✓ **CMS Innovation Center model** (under section 1115A, other than a Health Care Innovation Award)
- ✓ **MSSP** (Medicare Shared Savings Program)
- ✓ **Demonstration** under the Health Care Quality Demonstration Program
- ✓ **Demonstration** required by federal law

MACRA - Advanced Alternative Payment Model (APM) Criteria

- ✓ The APM requires participants to use **certified EHR technology**.
- ✓ The APM **bases payment on quality** measures comparable to those in the MIPS quality performance category.
- ✓ The APM either: **(1)** requires APM Entities to bear more than nominal **financial risk** for monetary losses; **OR (2)** is a **Medical Home Model expanded** under CMMI authority.

Advanced Alternative Payment Models for 2017

- Comprehensive End Stage Renal Disease Care Model (Two-Sided Risk Arrangements)
- Comprehensive Primary Care Plus (CPC+)
- Medicare Shared Savings Program Track 2
- Medicare Shared Savings Program Track 3
- Next Generation ACO Model

- Accounts for 70,000 to 120,000 clinicians
- Will qualify for the 5% incentive payment

Requirements for APM Incentive Payments for Participation in Advanced APMs

Performance Year	2017	2018	2019	2020	2021	2022 and later
Percentage of Medicare Payments through an Advanced APM	25%	25%	50%	50%	75%	75%
Percentage of Medicare Patients through an Advanced APM	20%	20%	35%	35%	50%	50%

Clinicians must meet payment or patient requirements or will be scored under MIPS APM

Merit-Based Incentive Payment System (MIPS)

Merit-Based Incentive Payment System (MIPS)

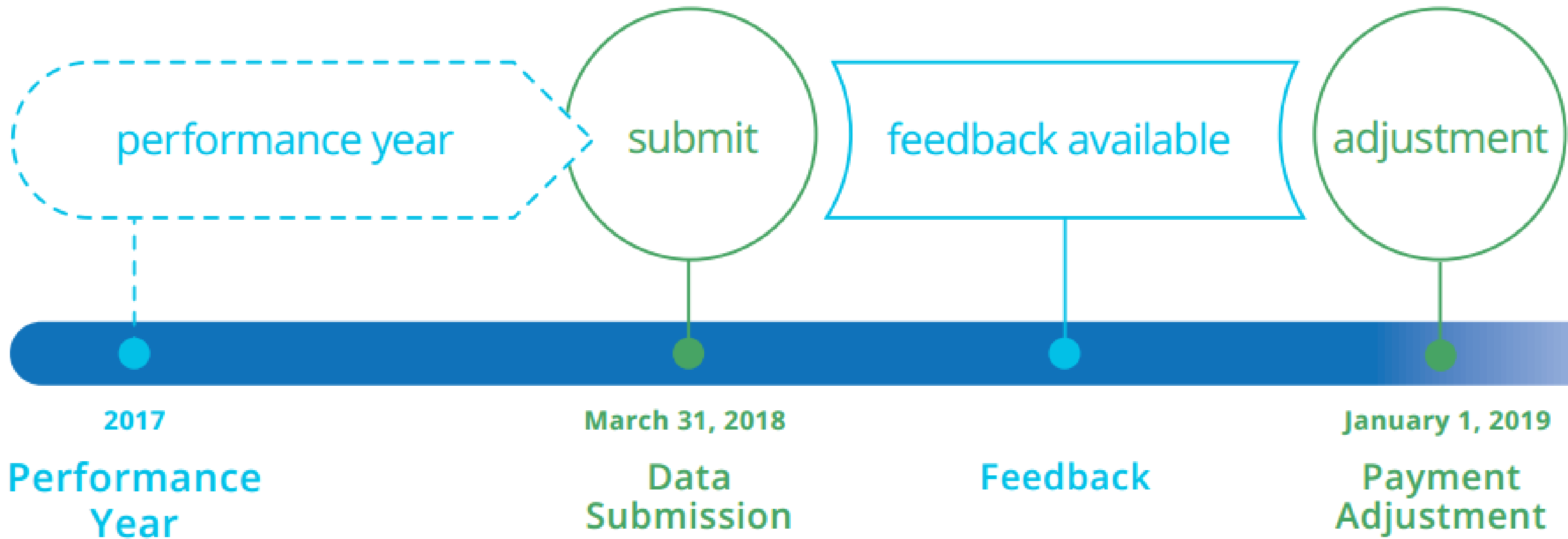
- 500,000 clinicians will be eligible to participate in MIPS in the first year of the program
- In 2017 there is a positive, neutral, or negative adjustment of up to 4% (grows to 9% in 2022)
- Replaces the up to 9% penalties of legacy programs:
  - Medicare Meaningful Use
  - Physician Quality Reporting System
  - Value-Based Payment Modifier

Quality Payment Program Participation

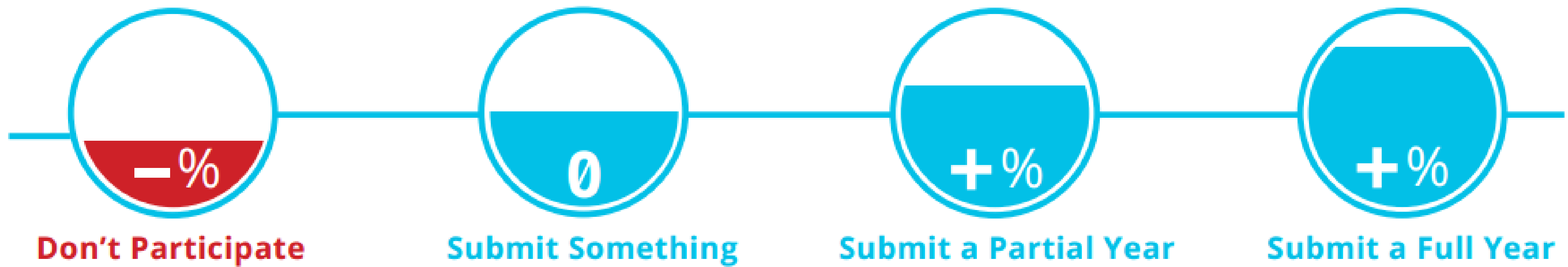
- Program begins January 1, 2017
- Flexible start date for data collection

- Final submission of performance data by March 31, 2018

MIPS Program Cycle

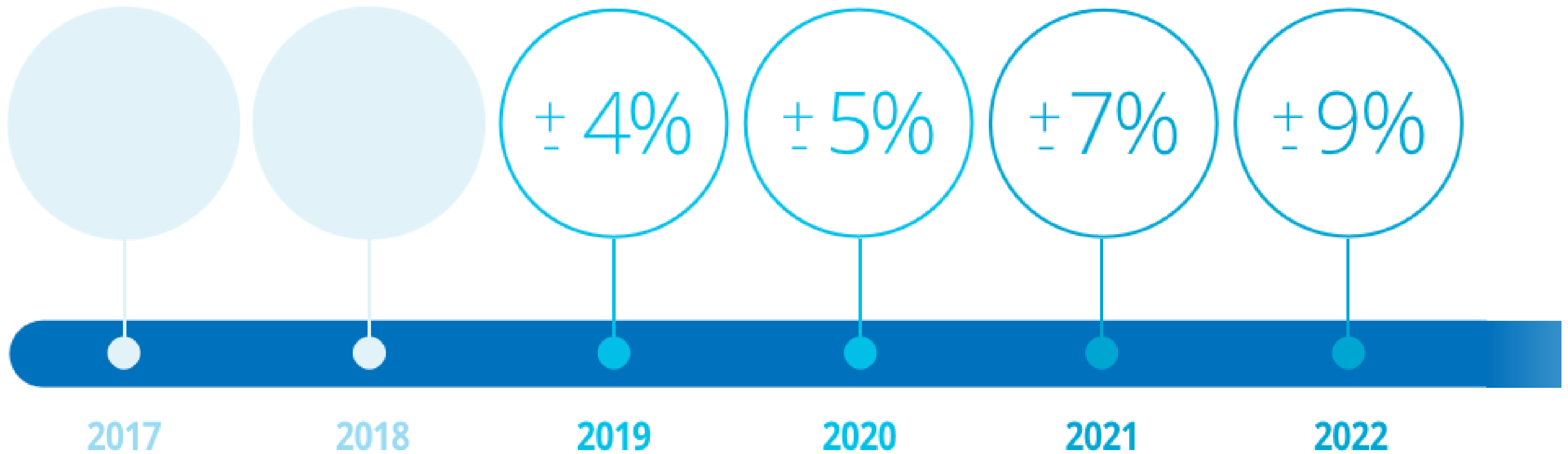


Pick your pace in MIPS



- Don't participate – receive a (- 4%) payment adjustment
- Submit one quality measure or one improvement activity – avoids the negative adjustment
- Submit 90 days of data – you may earn a neutral or small positive payment adjustment
- Submit a full year of data – you may earn a moderate positive payment adjustment

MIPS Payment Adjustments



When Will Clinicians Learn If They Are Eligible for MIPS?

December 2016

CMS contacts clinicians

January 2017

NPI Lookup Tool available on Quality Payment Program Online Portal

MIPS Four Performance Categories

Quality

Replaces the Physician Quality Reporting System (PQRS).

Advancing Care Information

Replaces the Medicare EHR Incentive Program also known as Meaningful Use.

Improvement Activities

New category.

Cost

Replaces Value-Based Modifier.

2017 MIPS Performance Weights

Quality (60%)

Advancing Care Information (25%)

Improvement Activities (15%)

*

*No Cost Category for 2017 **(NEW)**

Quality – 60% in 2017

Quality – 60% in 2017

(NEW)

Most participants: Report up to 6 quality measures,* including an outcome measure, for a minimum of 90 days.

Groups using the web interface: Report 15 quality measures for a full year.

Groups in APMs qualifying for special scoring under MIPS, such as Shared Savings Program Track 1 or the Oncology Care Model: Report quality measures through your APM. You do not need to do anything additional for MIPS quality.

*271 measures available

Selected Specialty Measure Set Categories

- Allergy/Immunology
- Anesthesiology
- Cardiology
- Dermatology
- Diagnostic Radiology
- Electrophysiology Cardiac Specialist
- Emergency Medicine
- Gastroenterology
- General Oncology
- General Practice/Family Medicine
- General Surgery
- Hospitalists
- Internal Medicine
- Interventional Radiology
- Mental/Behavioral Health
- Neurology
- Obstetrics/Gynecology
- Ophthalmology
- Orthopedic Surgery
- Otolaryngology
- Pathology
- Pediatrics
- Physical Medicine
- Plastic Surgery
- Preventive Medicine
- Radiation Oncology
- Rheumatology
- Thoracic Surgery
- Urology
- Vascular Surgery

Quality – 60% in 2017

Individual clinicians may report through:

- Qualified Registry
- Electronic Health Record (EHR)
- Qualified Clinical Data Registry (QCDR)
- Claims

Groups may report measures through:

- Qualified Registry
- EHR
- QCDR
- CMS Web Interface (groups of 25 or more)
- CAHPS for MIPS Survey
  - Counts as 1patient experience measure
  - Must submit 5 other measures through a different mechanism above

Quality – 60% in 2017

- Clinicians receive 3 to 10 points on each quality measure based on performance against benchmarks
  - Benchmarks based on historical data (if available); or performance period if historical benchmark is not available
  - Failure to submit performance data for a measure = 0 points

Year 1 participants automatically receive 3 points for completing and submitting a measure

Quality Performance: Assessment Tools Available Now

- PQRS Feedback report
- Health Plan HEDIS Report
- Clinical Registry Data

PQRS Report - Example

2015 PHYSICIAN QUALITY REPORTING SYSTEM (PQRS) FEEDBACK REPORT*

PQRS Payment Adjustment Measure Performance Detail

(TIN-NPI LEVEL REPORT)

Tax ID Name: XXXXX 7226

Tax ID Number: XXXXX 7226

NPI Name: ABCD, MD

NPI Number: 1111111111

GPRO TIN? No

GPRO Registered Method: N/A

GPRO Size: N/A

Registry Performance Information for 20 Patients Measures Groups Method

Vendor Name	Measure Group	PQRS Measure #	NQF Measure #	Measure Title	Measures Group Satisfactorily Reported? (6,7)	MG Reporting Denominato	MG Reporting Numerator (1)	Reporting Rate	Performance Rate	Medicare FFS Patient Count (6)
Covisint Corporation, ReqSelfNom	Chronic Obstructive Pulmonary Disease (COPD) Measures Group	47	326	Advance Care Plan	Yes	20	20	100.00%	70.00%	20
Covisint Corporation, ReqSelfNom	Chronic Obstructive Pulmonary Disease (COPD) Measures Group	51	91	Chronic Obstructive Pulmonary Disease (COPD): Spirometry	Yes	20	20	100.00%	95.00%	20
Covisint Corporation, ReqSelfNom	Chronic Obstructive Pulmonary Disease (COPD) Measures Group	52	102	Chronic Obstructive Pulmonary Disease (COPD): Inhaled	Yes	20	20	100.00%	100.00%	20
Covisint Corporation, ReqSelfNom	Chronic Obstructive Pulmonary Disease (COPD) Measures Group	111	43	Pneumonia Vaccination Status for Older Adults	Yes	20	20	100.00%	100.00%	20
Covisint Corporation, ReqSelfNom	Chronic Obstructive Pulmonary Disease (COPD) Measures Group	130	419	Documentation of Current Medications in the Medical Record	Yes	20	20	100.00%	100.00%	20
Covisint Corporation, ReqSelfNom	Chronic Obstructive Pulmonary Disease (COPD) Measures Group	110	41	Preventive Care and Screening: Influenza Immunization	Yes	20	20	100.00%	100.00%	20
Covisint Corporation, ReqSelfNom	Chronic Obstructive Pulmonary Disease (COPD) Measures Group	226	28	Preventive Care and Screening: Tobacco Use: Screening and Cessation	Yes	20	20	100.00%	100.00%	20

*Redacted report, some columns are hidden

HEDIS Report Card - Example

XYZ Insurer

XYZ Practice - PARTS C & D REPORT CARD

Part C - HEDIS Measures	Wt.	Eligible	Total Compliant	Rate	Star	Gaps to 3 Stars	Gaps to 4 Stars	Gaps to 5 Stars	*Additional Compliant Members 12/31/15
Adult BMI Assessment	1	7	3	43%	1	4	4	4	0
Breast Cancer Screening	1	0	0	N/A	N/A				0
Care Older Adults - Func Status	1	8	0	0%	1	6	7	8	1
Care Older Adults - Med Review	1	8	1	13%	1	5	6	7	1
Care Older Adults - Pain Screen	1	8	2	25%	1	4	6	6	1
Colorectal Cancer Screening	1	9	0	0%	1	7	7	8	2
CDC - Eye Exam	1	19	8	42%	1	6	8	9	1
CDC - HbA1C <= 9	3	19	7	37%	1	5	8	10	0
CDC - Kidney Disease	1	19	18	95%	3		1	1	0
Controlling Blood Pressure	3	25	0	0%	1	17	20	21	2
Osteoporosis Fracture Management	1	0	0	N/A	N/A				0
Rheumatoid Arthritis Management	1	2	1	50%	1	1	1	1	0
Part C Weighted Score					1.1				
Part D - HEDIS Measures	**Wt.**	**Eligible**	**Total Compliant**	**Rate**	**Star**	**Gaps to 3 Stars**	**Gaps to 4 Stars**	**Gaps to 5 Stars**	**Per Claims**
High Risk Medication	3	72.2	0	0%	5				
Medication Adherence - Cholesterol	3	33.5	25.2	75%	3		1	3	
Medication Adherence - Hypertension	3	41.2	30.7	74%	2	1	3	5	
Medication Adherence - Oral Diabetes	3	13.2	11.7	89%	5				
Part D Weighted Score					3.8				
Combined Weighted Score					2.3				

Cost – Not included in 2017

Will Be Included in 2018

Cost – Not included in 2017

- Clinicians do not select Cost measures
- Measure based on services delivered
- For a measure to be applied, a clinician must either:
  1. Bill for certain attributable services - *Example:* Aortic valve replacement
  2. Provide services a minimum number of times

     ≥ 35 times for MSPB *

     ≥ 20 times for all other measures

*MSPB – Medicare Spending Per Beneficiary

Cost – Not included in 2017

Cost Measures from VM*

1. Medicare Spending Per Beneficiary (MSPB)
2. Total Per-Capita Cost for All Attributed Beneficiaries

*VM – Value Modifier or Value Based Payment Modifier data available On Quality Resource Use Report (QRUR)

QRUR Cost Performance Measures

- **The Medicare Spending Per Beneficiary:**
  - This measure assesses resource use surrounding a Medicare Beneficiary's hospital stay, from 3 days prior to admission through 30 days post-discharge.
- **Per Capita Costs for All Attributed Beneficiaries:**
  - This measure represents the average (mean) of all Medicare Part A and B payments to all providers for beneficiaries attributed to a Medicare-enrolled TAXPAYER IDENTIFICATION NUMBER (TIN) during calendar year 2015

Sample QRUR Report

2015 ANNUAL QUALITY AND RESOURCE USE REPORT

AND THE 2017 VALUE-BASED PAYMENT MODIFIER

.TH CARE CENTER

LAST FOUR DIGITS OF YOUR MEDICARE-ENROLLED TAXPAYER IDENTIFICATION NUMBI 0886

PERFORMANCE PERIOD: 01/01/2015 – 12/31/2015

ABOUT THIS REPORT FROM MEDICARE

The 2015 Annual Quality and Resource Use Report (QRUR) shows how your group or solo practice, as identified by its Medicare-enrolled Taxpayer Identification Number (TIN), performed in calendar year 2015 on the quality and cost measures used to calculate the Value-Based Payment Modifier (Value Modifier) for 2017.

In 2017, the Value Modifier will apply to all physicians in groups with two or more eligible professionals and to physicians who are solo practitioners who bill under the Medicare Physician Fee Schedule. It will not apply to eligible professionals who are not physicians.

As a participant in a Medicare Shared Savings Program Accountable Care Organization (ACO) in 2015, your TIN's 2017 Value Modifier is based on the ACO's quality performance in 2015.

The information contained in this report is believed to be accurate at the time of production. The information may be subject to change at the discretion of the Centers for Medicare & Medicaid Services (CMS), including, but not limited to, circumstances in which an error is discovered.

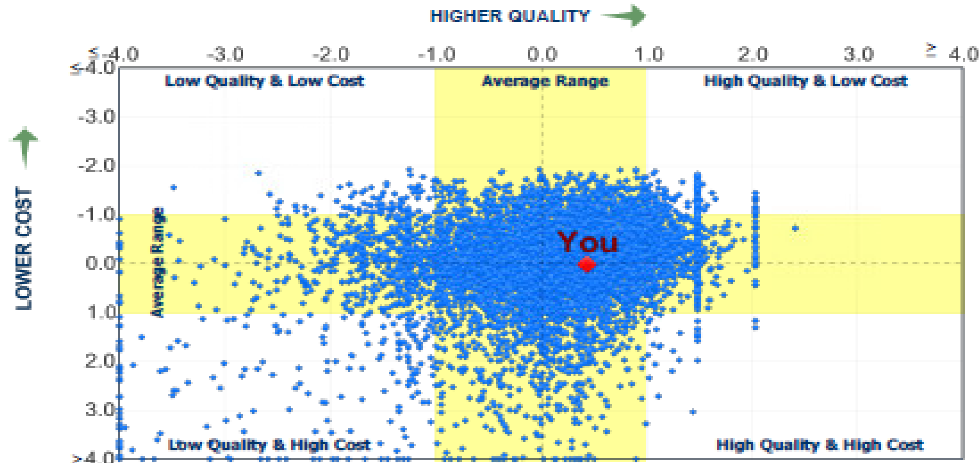
YOUR TIN'S 2017 VALUE MODIFIER

Average Quality, Average Cost = Neutral Adjustment (0.0%)

Your ACO's performance was determined to be average on quality measures. As a participant in a Shared Savings Program ACO in 2015, your TIN's cost composite is classified as Average Cost.

This means that the Value Modifier applied to payments for items and services under the Medicare Physician Fee Schedule for physicians billing under your TIN in 2017 will result in a neutral adjustment, meaning no adjustment (0.0%).

The scatter plot below shows how your TIN ("You" diamond) compares to a representative sample of other TINs on the Quality Composite scores used to calculate the 2017 Value Modifier.



Note: The scatter plot shows performance among a representative sample of all TINs with Quality and Cost Composite Scores reflecting standard deviations from the mean for each Composite Score.

Overall Quality and Cost Scores Example from QRUR

Exhibit 2. Your TIN's Quality Composite Score

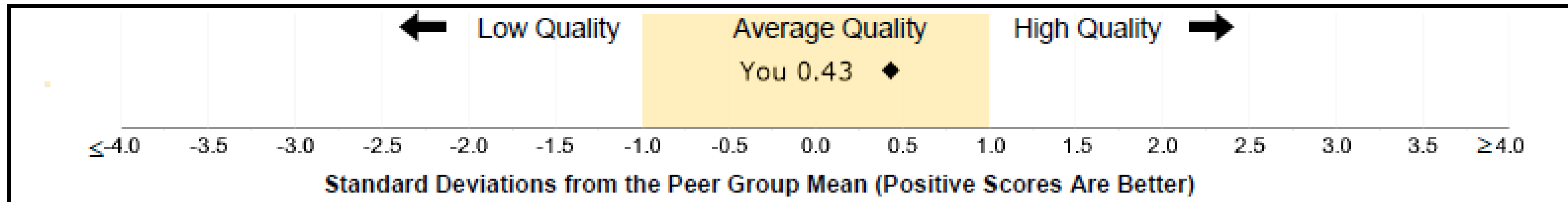


Exhibit 4. Your TIN's Cost Composite Score

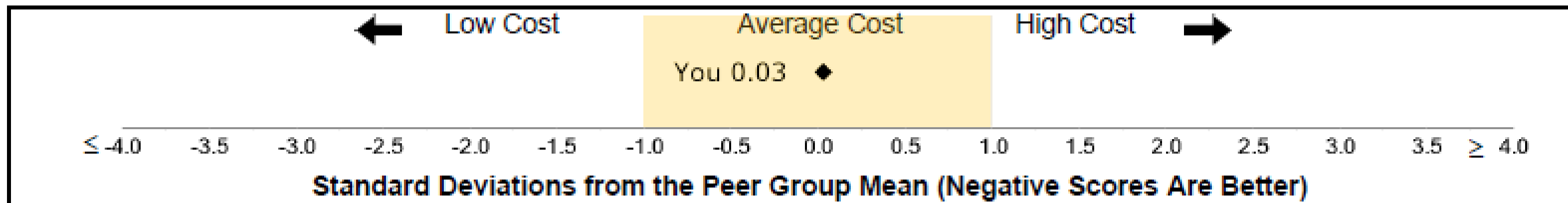


Exhibit 1. 2017 Value Modifier Payment Adjustments under Quality-Tiering (Shared Savings Program Participant TINs with Fewer Than 10 Eligible Professionals)

	Low Quality	Average Quality	High Quality
Low Cost	*Does not apply*	*Does not apply*	*Does not apply*
Average Cost	0.0%	**0.0%**	+1.0 x AF
High Cost	*Does not apply*	*Does not apply*	*Does not apply*

Per Capita Costs for All Attributed Beneficiaries (example)

Exhibit 5-AAB. Costs for All Attributed Beneficiaries Domain

Domain Score

You -0.11

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	618	**$11,910**	-0.11	Yes	**$12,326**	$3,665
Medicare Spending per Beneficiary	0	**—**	—	No	**$20,599**	$1,254

Improvement Activities

Clinical Practice Improvement Activities (CPIA)

Clinical Practice Improvement Activities

- Must perform selected activities for 90 consecutive days
- Must attest each activity performed for 90-day period by selecting "Yes" during reporting
- May report activities through:
  - Qualified Registry
  - Electronic Health Record (EHR)
  - Qualified Clinical Data Registry (QCDR)
  - CMS Web Interface (for groups of 25 clinicians or more)

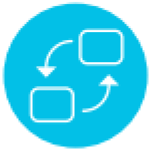
Select from 93 possible CPIAs

Improvement Activities

- Additional improvements in access as a result of QIN/QIO TA
- Annual registration in the Prescription Drug Monitoring Program
- Chronic care and preventative care management for empaneled patients
- Completion of training and receipt of approved waiver for provision opioid medication-assisted treatments
- Depression screening
- Diabetes screening
- Engagement with QIN-QIO to implement self-management training programs
- Implementation of antibiotic stewardship program
- Integration of patient coaching practices between visits
- Measurement and improvement at the practice and panel level
- Participation in AAFP MOC Part IV
- Population empanelment
- TCPI participation
- Unhealthy alcohol use
- Tobacco use
- Use of telehealth services that expand practice access

Free assistance from QIN/QIO

Clinical Practice Improvement Activities



Clinicians will receive a 0 as their improvement activity score if they do not participate in an APM, a certified patient-centered medical home, or a Medical Home Model, and they do not report any activities

"Certified" means that a patient-centered medical home is nationally accredited by the Accreditation Association for Ambulatory Health Care, the National Committee for Quality Assurance, The Joint Commission Designation, or the Utilization Review Accreditation Commission or they meet the two criteria (certified a large number of medical organizations and meet national guidelines).

Clinical Practice Improvement Activities

A "certified" Medical Home Model generally includes:

- Participants are primary care practices or multispecialty practices
- Patients are empaneled to a primary clinician
- The model must meet 4 of following 7 requirements:
    1. Planned coordination of chronic and preventative care
    2. Patient access and continuity of care
    3. Risk-stratified care management
    4. Coordination of care across the medical neighborhood
    5. Patient and caregiver engagement
    6. Shared decision-making
    7. Payment arrangements in addition to, or substitute for, fee-for-service payments

Advancing Care
Information

Advancing Care Information (ACI)

Advancing Care Information 25%

Clinicians must use certified EHR technology to report

For those using EHR Certified to the 2015 Edition:	For those using 2014 Certified EHR Technology:
Option 1: Advancing Care Information Objectives and Measures	Option 1: 2017 Advancing Care Information Transition Objectives and Measures
Option 2: Combination of the two measure sets	Option 2: Combination of the two measure sets

Advancing Care Information 25%

Fulfill the required measures for a minimum of 90 days:

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

(NEW)

Choose to submit up to 9 measures for a minimum of 90 days for additional credit.

For bonus credit, you can:

- Report Public Health and Clinical Data Registry Reporting measures
- Use certified EHR technology to complete certain improvement activities in the improvement activities performance category

Advancing Care Information 25%

Advancing Care Information

Advancing Care Information Objectives and Measures:

Base Score Required Measures

Objective	Measure
Protect Patient Health Information	Security Risk Analysis
Electronic Prescribing	e-Prescribing
Patient Electronic Access	Provide Patient Access
Health Information Exchange	Send a Summary of Care
Health Information Exchange	Request/Accept a Summary of Care

2017 Advancing Care Information Transition Objectives and Measures:

Base Score Required Measures

Objective	Measure
Protect Patient Health Information	Security Risk Analysis
Electronic Prescribing	e-Prescribing
Patient Electronic Access	Provide Patient Access
Health Information Exchange	Health Information Exchange

Base score

- Clinicians must submit a numerator/denominator OR Yes/No

Failure to meet reporting requirements will result in base score of 0

Advancing Care Information 25%

Advancing Care Information Objectives and Measures

Objective	Measure
Patient Electronic Access	Provide Patient Access*
Patient Electronic Access	Patient-Specific Education
Coordination of Care through Patient Engagement	View, Download and Transmit (VDT)
Coordination of Care through Patient Engagement	Secure Messaging
Coordination of Care through Patient Engagement	Patient-Generated Health Data
Health Information Exchange	Send a Summary of Care*
Health Information Exchange	Request/Accept a Summary of Care*
Health Information Exchange	Clinical Information Reconciliation
Public Health and Clinical Data Registry Reporting	Immunization Registry Reporting

2017 Advancing Care Information Transition Objectives and Measures

Objective	Measure
Patient Electronic Access	Provide Patient Access*
Patient Electronic Access	View, Download and Transmit (VDT)
Patient-Specific Education	Patient-Specific Education
Secure Messaging	Secure Messaging
Health Information Exchange	Health Information Exchange*
Medication Reconciliation	Medication Reconciliation
Public Health Reporting	Immunization Registry Reporting

Getting Ready for 2017

- Check that your electronic health record is certified by the Office of the National Coordinator for Health Information Technology. If it is, it should be ready to capture information for the MIPS advancing care information category and certain measures for the quality category.
- Consider using a qualified clinical data registry or a registry to extract and submit your quality data.

Resources

- Quality Performance Program
  https://qpp.cms.gov/
- Transforming Clinical Practice Initiative
  https://innovation.cms.gov/initiatives/Transforming-Clinical-Practices/
- Quality Innovation Network-Quality Improvement Organizations (QIN-QIO)
  http://qioprogram.org/contact-zones?map=qin

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Making Health Care Better

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