An Overview of MACRA, Quality Payment Program and New Payment Models

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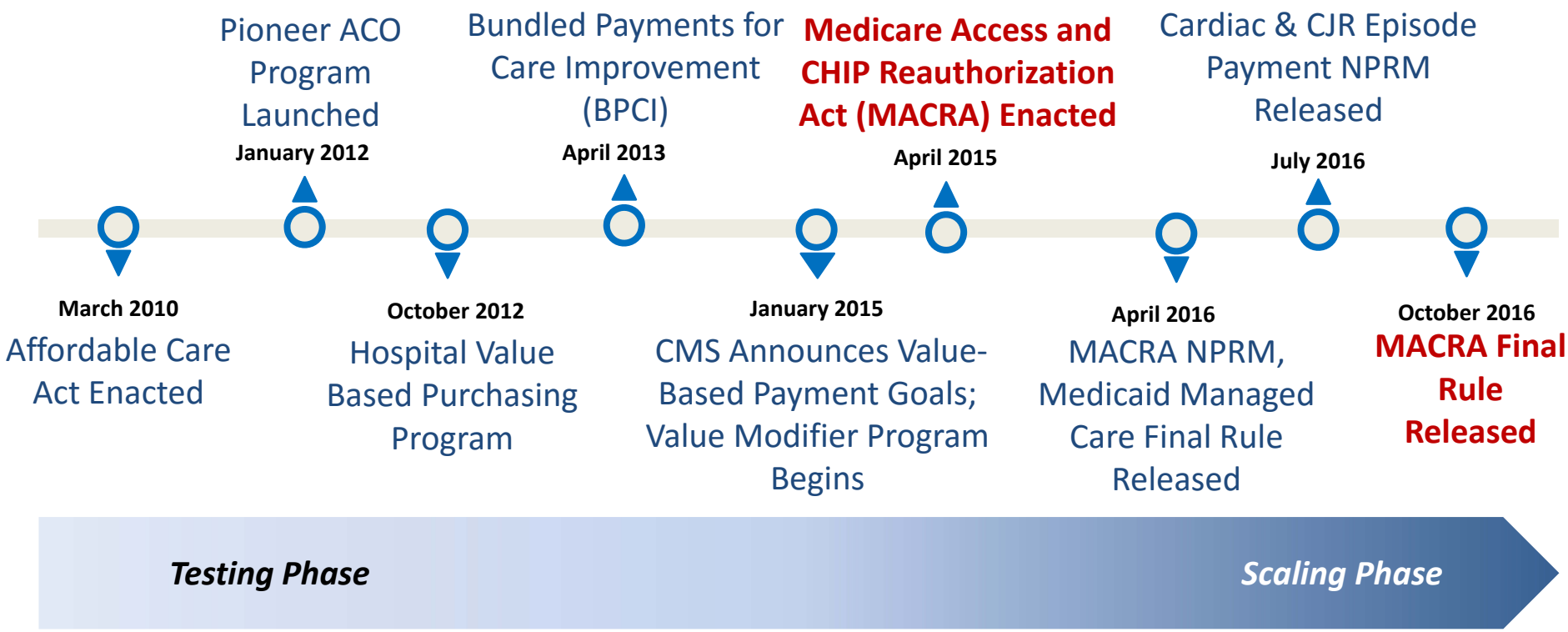
Tell me a little about yourself.

- How many are cardiologists? Staff?
- How many come from independent practices versus health systems?
- Is anyone participating in an ACO or a Bundle?

Overview of MACRA & the Quality Payment Program (QPP)

Volume to Value Based Shift

Recent legislative, regulatory and marketplace developments suggest that the transition from volume to value-based payment is accelerating from a “testing” phase to a “scaling” phase



MACRA Passed with Bipartisan Support

MACRA was passed on April 14, 2015 by both houses of a Republican-controlled Congress, had substantial Democratic support and was signed by a Democratic president. It is highly unlikely it will be repealed under the Trump administration.

MACRA Vote in Congress

Senate Vote: 92-8 **House Vote: 392-37**

MACRA Glossary of New Terms

Quality Payment Program (QPP)	• New program name for MACRA's change in Medicare Part B payments
Merit-Based Incentive Payment System (MIPS)	• New pay for performance approach under Medicare
Alternative Payment Models (APMs)	• New payment models (e.g., ACOs) that move away from fee-for-service reimbursement
Final Score	• Overall clinician score from 0-100 calculated based on four weighted performance categories
Quality	• Category that replaces PQRS; worth 60% of final score in Yr 1
Cost	• New name for resource use category; replaces value modifier program; not assessed in Yr 1
Advancing Care Information (ACI)	Category that replaces the Medicare EHR Incentive Program for meaningful use; worth 25% in Yr 1
Improvement Activities	• New category; worth 15% of final score; includes activities aimed at improving care

MACRA Created New Medicare Quality Payment Program

> 80% participating in MIPS

MIPS

Merit-based Incentive Payment System

APM

Alternative Payment Models

MACRA Timeline

October 14, 2016:

Release of Final Rule

Jan – Dec 2017:

1st Performance Period for MACRA

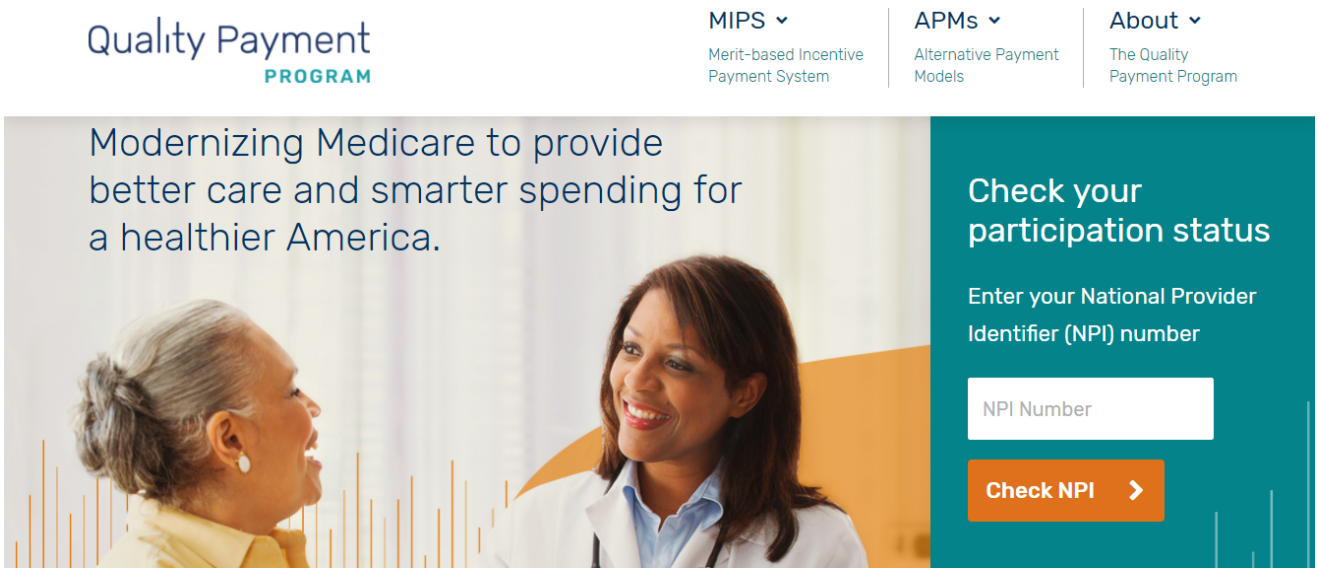
March 31, 2018:
Reporting Deadline for First Year

Jan – Dec 2019:

1st Payment Year = +/- up to 4%

Who is eligible? See the QPP NPI Lookup Tool

Want to know who is eligible for MACRA/QPP?
Go to http://qpp.cms.gov and click on the "Check NPI " button



MACRA Eligible Clinicians (ECs)

5 Types of Eligible Clinicians (ECs)

- **Physicians, PAs, NPs, CNS, CRNA**
- After 2020, CMS may expand to other clinicians in Medicare FFS: PT, OT, NMW, CSW, Clinical Psychologists, Dieticians and Nutrition professionals

Not covered by MACRA:

- Hospitals/Medicare Part A payments (Medicare Physician Fee Schedule only)
- FQHCs/RHCs and Medicaid Providers (non dual-eligible)

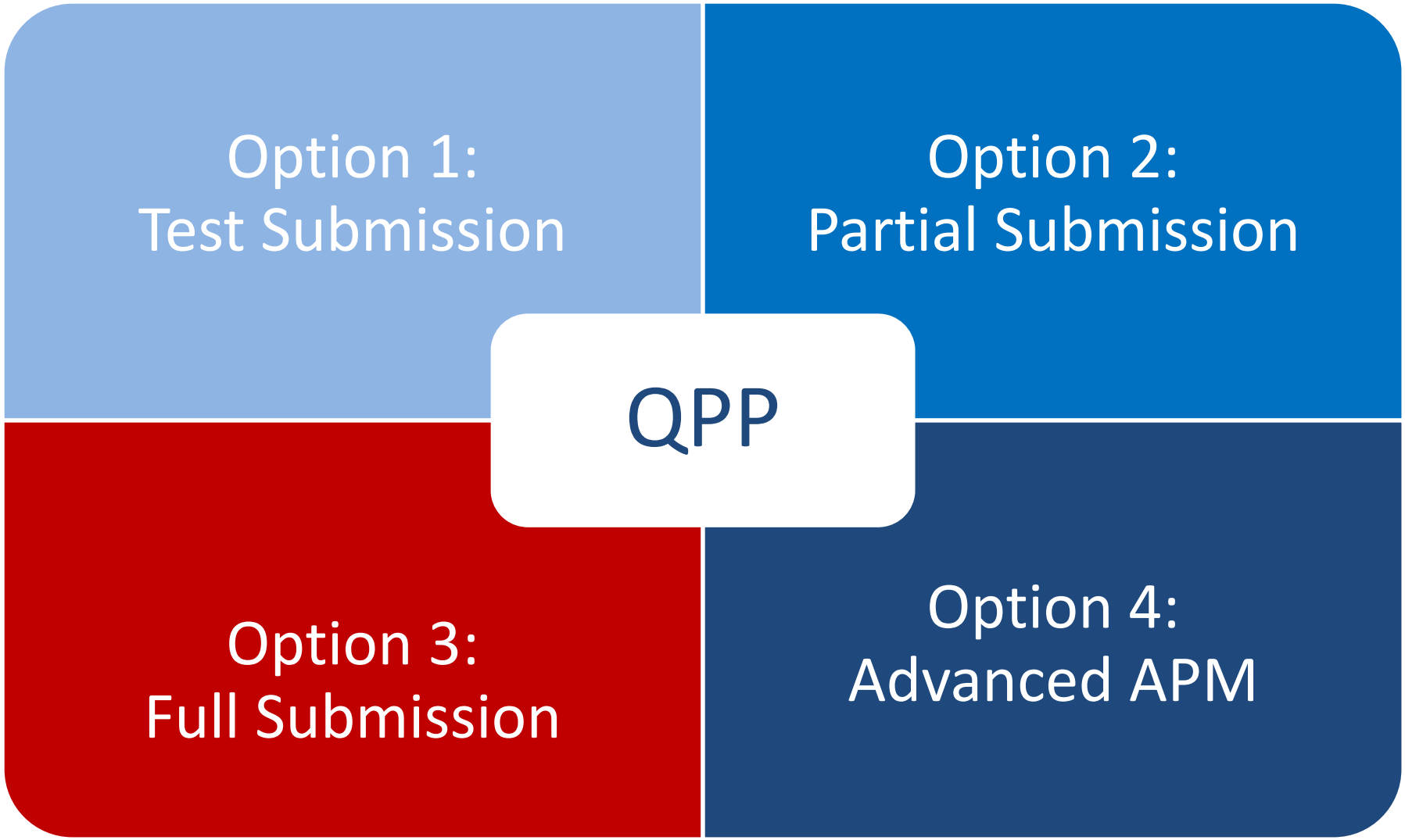
Exclusions:

- 1st year ECs
- Low Volume: Less than $30K and/or 100 Medicare patients
- Advanced APM Qualifying Provider

Different Scoring & Reporting Requirements:

- "Non-patient facing" clinicians
- MIPS APMs

2017 Participation Options

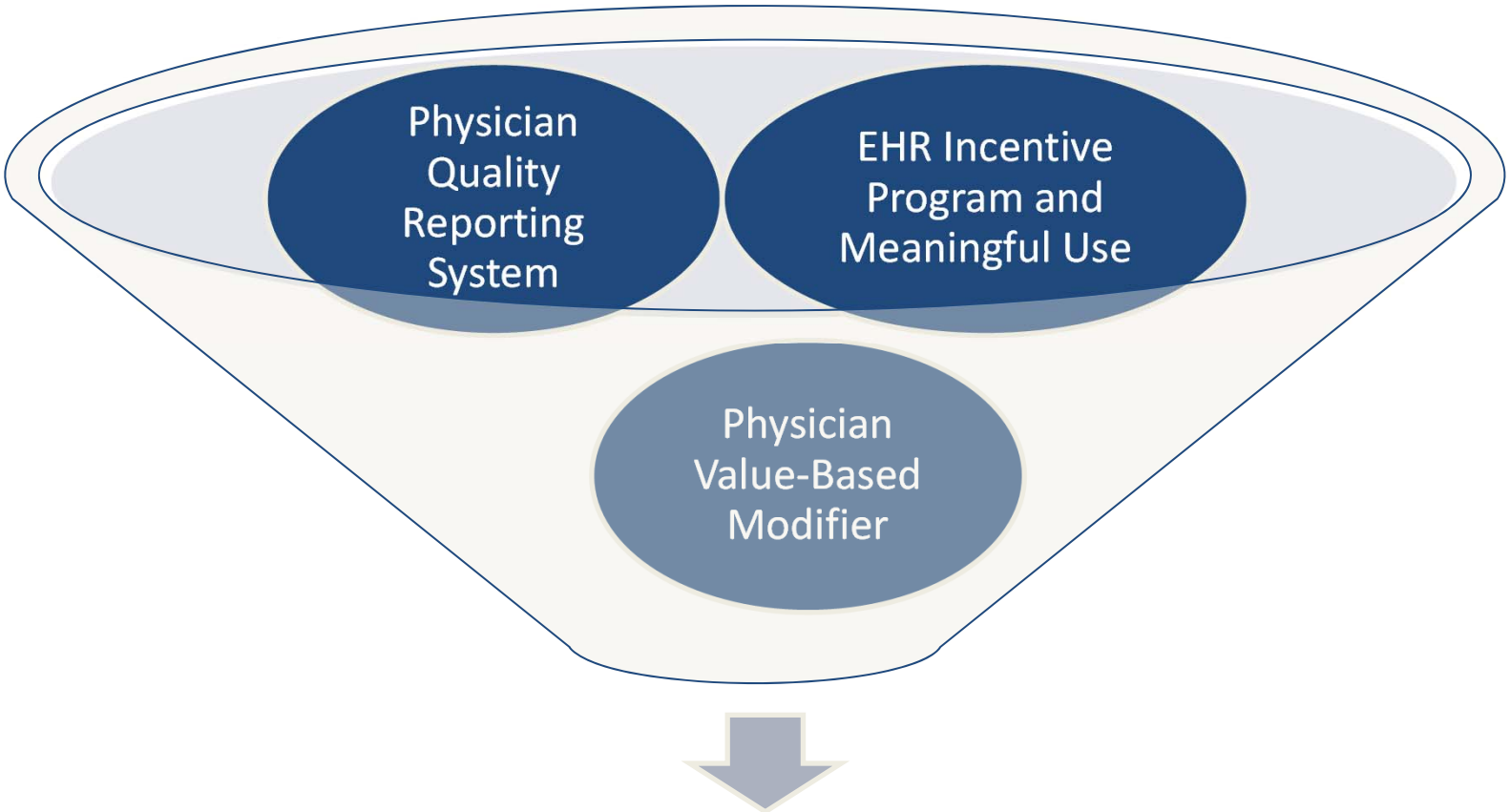


New Medicare
Quality Payment Program

MIPS

Merit-based Incentive Payment System

MIPS: A Consolidation of 3 Programs



MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS)

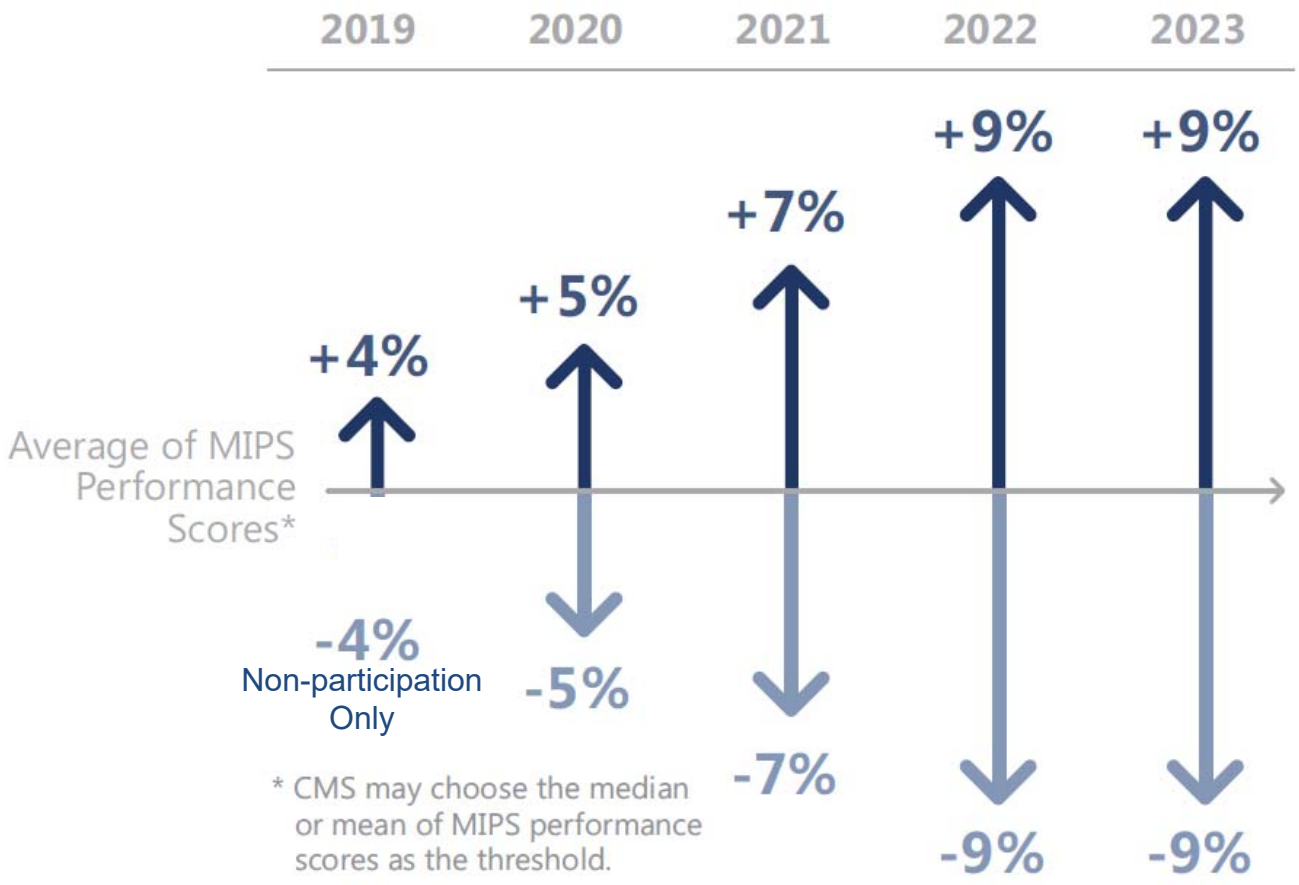
MIPS Performance Measurement

Providers will receive a **MIPS final score** based on 4 weighted performance categories:

	Quality	Cost	Improvement activities	Advancing Care Information
CY19	**60%**	**0%**	**15%**	**25%**
CY20	50%	10%	15%	25%
CY21	30%	30%	15%	25%

→ **MIPS Final Score 0-100**

Maximum MIPS Payment Adjustments



Notes:
Losers fund winners

Top performers:
- Up to 3X more with scaling factor

- Additional bonus up to 10% from $500 M funded separately

Source: Leavitt Partners - MACRA: Quality Incentives, Provider Considerations, and the Path Forward

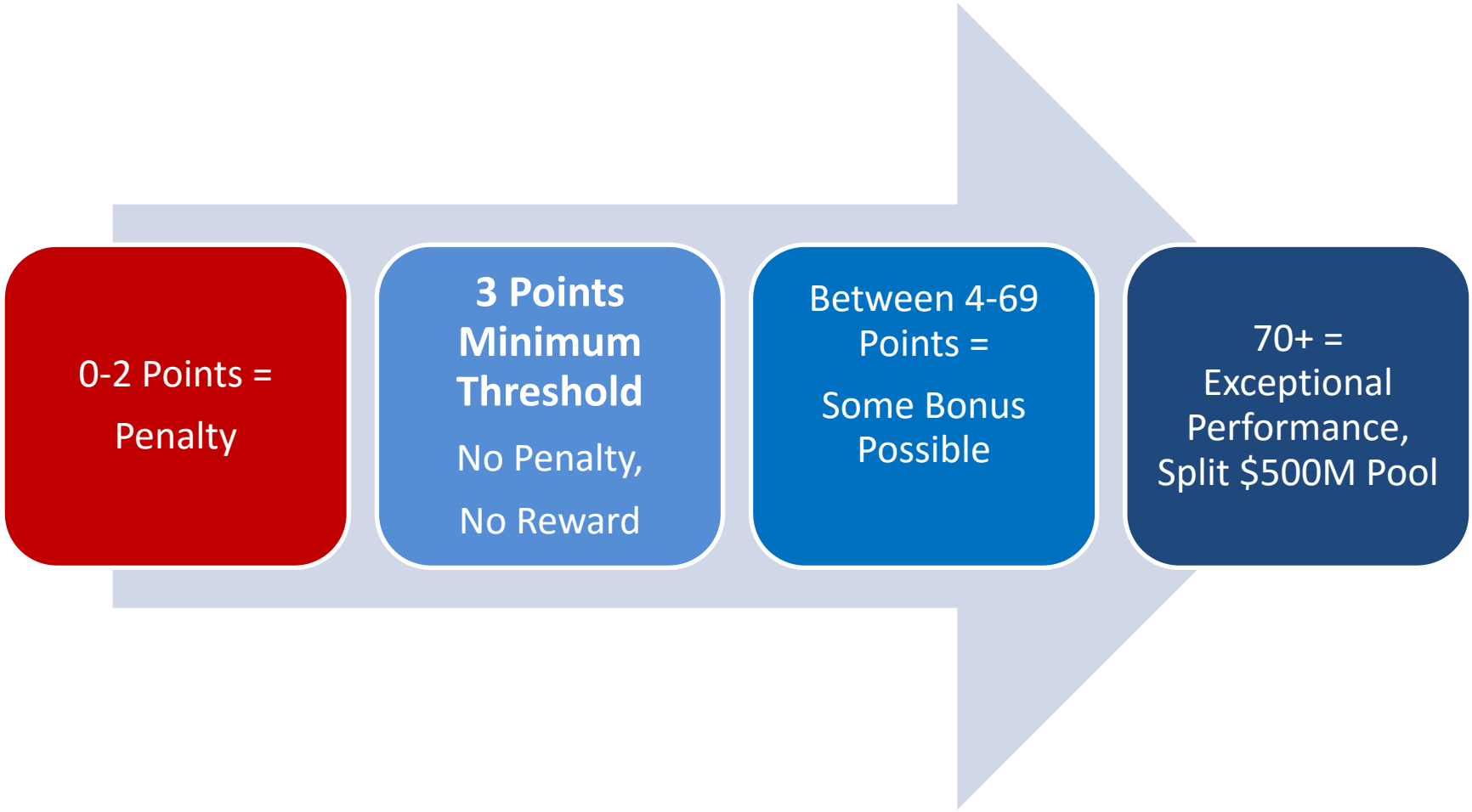
MIPS Reporting Timeframe

For 2017 / Transition Year

Quality	**Cost**	**Improvement activities**	**Advancing Care Information**
90 day-full year optional	No reporting required	90 days	90 days-full year optional

Reporting Deadline:

Year 1 Thresholds Already Set



How You Submit Data: Levels & Methods

Category	Individual	Group/TIN
Quality	Qualified Data Registry (QCDR) Qualified Registry EHR Claims	QCDR Qualified Registry EHR Administrative Claims CMS Web Interface CAHPS for MIPS Survey
IA	QCDR Qualified Registry EHR Attestation	QCDR Qualified Registry EHR CMS Web Interface Attestation
ACI	QCDR Qualified Registry EHR Attestation	QCDR Qualified Registry EHR CMS Web Interface Attestation

MACRA Created New Medicare Quality Payment Program

APM

Alternative Payment Models

What's the big deal about APMs?

CMS intention states more and more of its $ will be spent in APMs over time

5% Annual Participation Bonus for *Advanced* APM participants from 2019-2025

Favorable scoring under MIPS for all APM participants

Annual update after 2025 is 0.75% for APM entities versus 0.25% for MIPS entities

Advanced Alternative Payment Models

Advanced APM participants are eligible for 5% bonus payment.

But, only some APMs are risk-bearing Medicare payment models that qualify for this bonus payment.

In new MACRA Final Rule, Advanced APMs include:

- ✓ **Next Generation ACO Model**
- ✓ **Medicare Shared Savings Program – Tracks 2 & 3**
- ✓ **Comprehensive Primary Care Plus (CPC+)**
- ✓ **Comprehensive ESRD Care Model**
- ✓ **Oncology Care Model Two-Sided Risk Arrangement (in 2018)**
- ✓ **CJR Episode Model (in 2018)**

MACRA does not change how any particular APM rewards value.

APM participants who are not "Qualifying Providers" (QPs) will receive favorable scoring under MIPS.

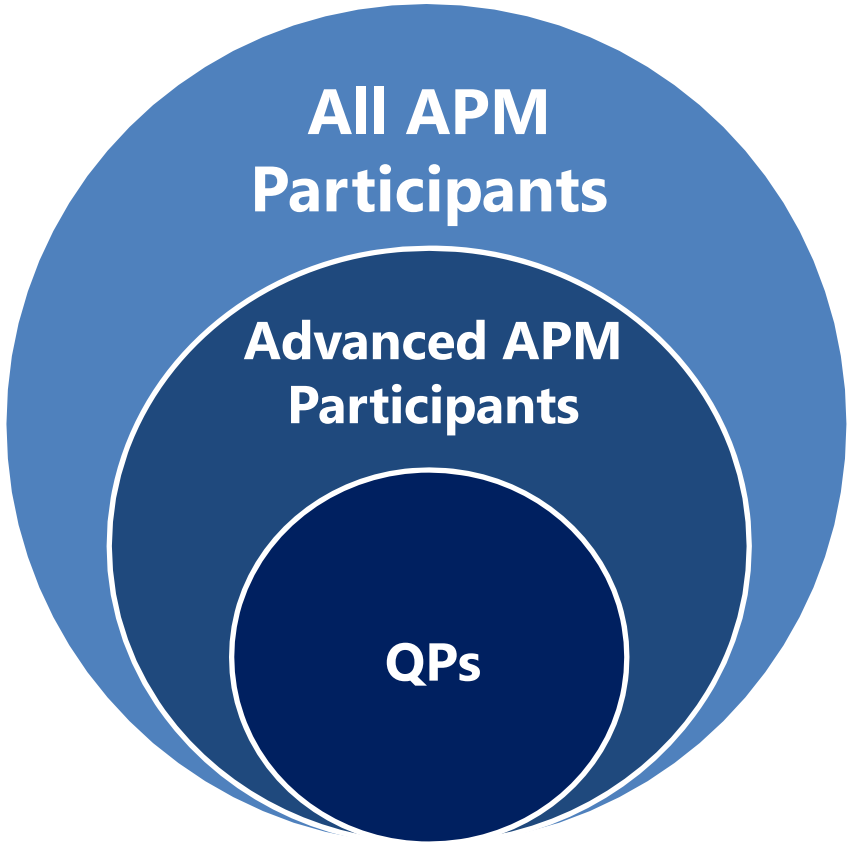
Catch: Not Every APM Participant May Qualify for the 5% APM Bonus

Most physicians and practitioners who participate in APMs will be subject to MIPS and will receive *favorable scoring* under MIPS.

Clinicians in Advanced APMs will be deemed **Qualifying APM Participants ("QPs") if they**:

1. Report APM quality measures comparable to MIPS
2. Use of Certified EHR
3. Meet Advanced APM criteria (risk-bearing or medical home model)
4. Must meet APM thresholds for payment and patient volumes

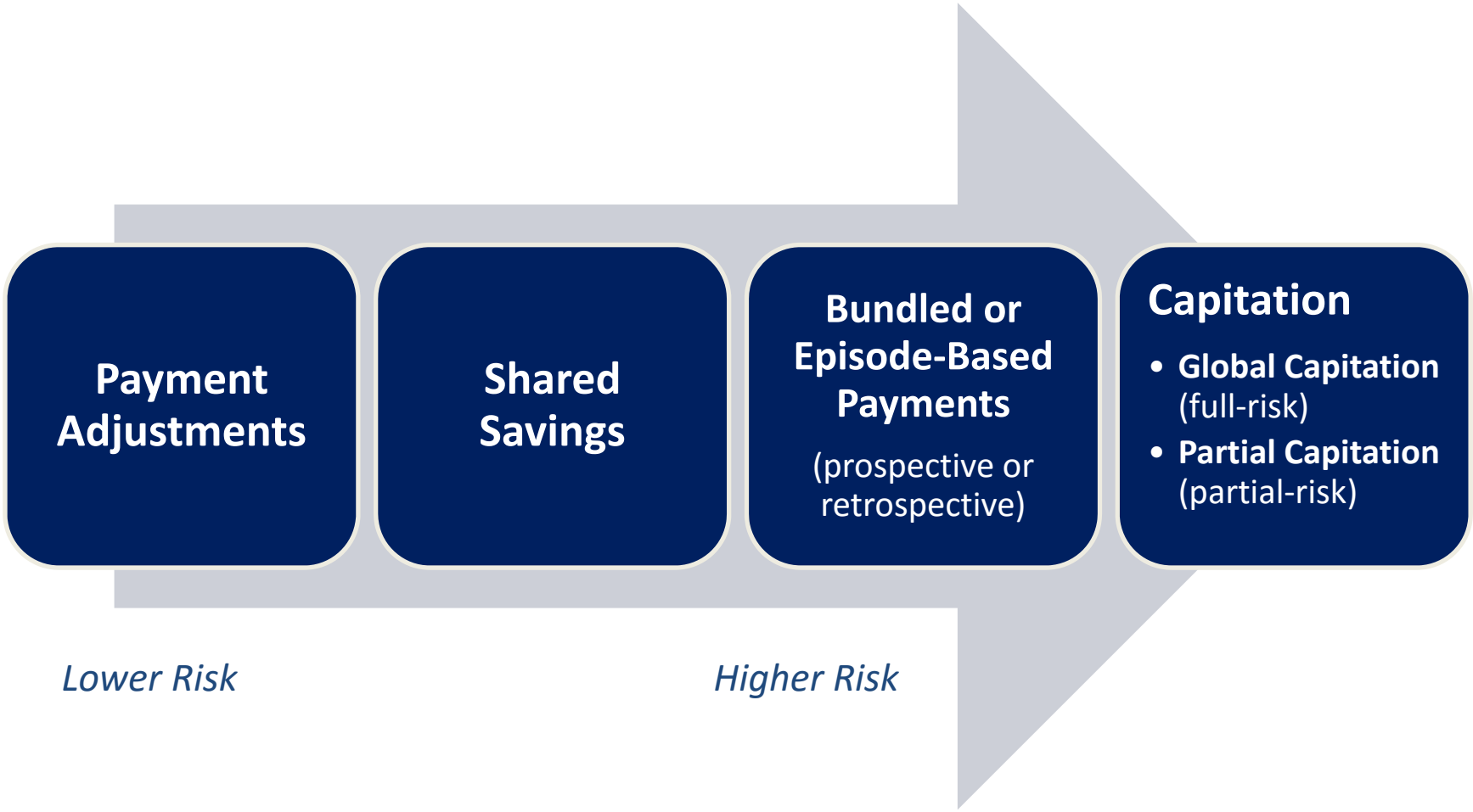
Only QPs receive the 5% bonus from Medicare.



New Care Delivery Models

Medical Home / Advanced Primary Care	Accountable Care Organization	Episode-Based Care
• Emphasis on primary care • Does not include hospitals or specialists • Lower risk model • Attribution - often assigned based on most recent visit	• Emphasis on primary care • May or may not include hospitals, specialists • Risk-based payment • Attribution – patients assigned on plurality of care	• Emphasis on acute and post-acute care teams working together • Usually includes hospitals • Can be prospective or retrospective

New Payment Models



Strategies & Recommendations to Prepare

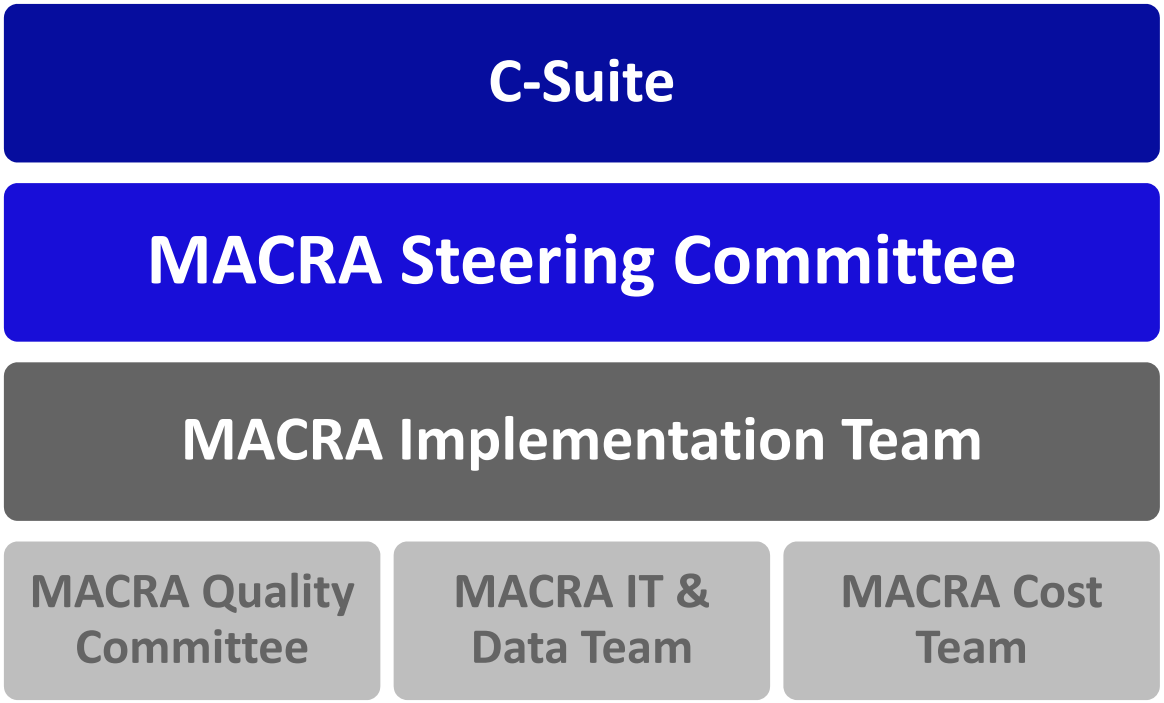
Next Steps

1. Team
2. Assessment
3. Action Plan

Example: UKHC Enterprise-wide MACRA Steering Committee

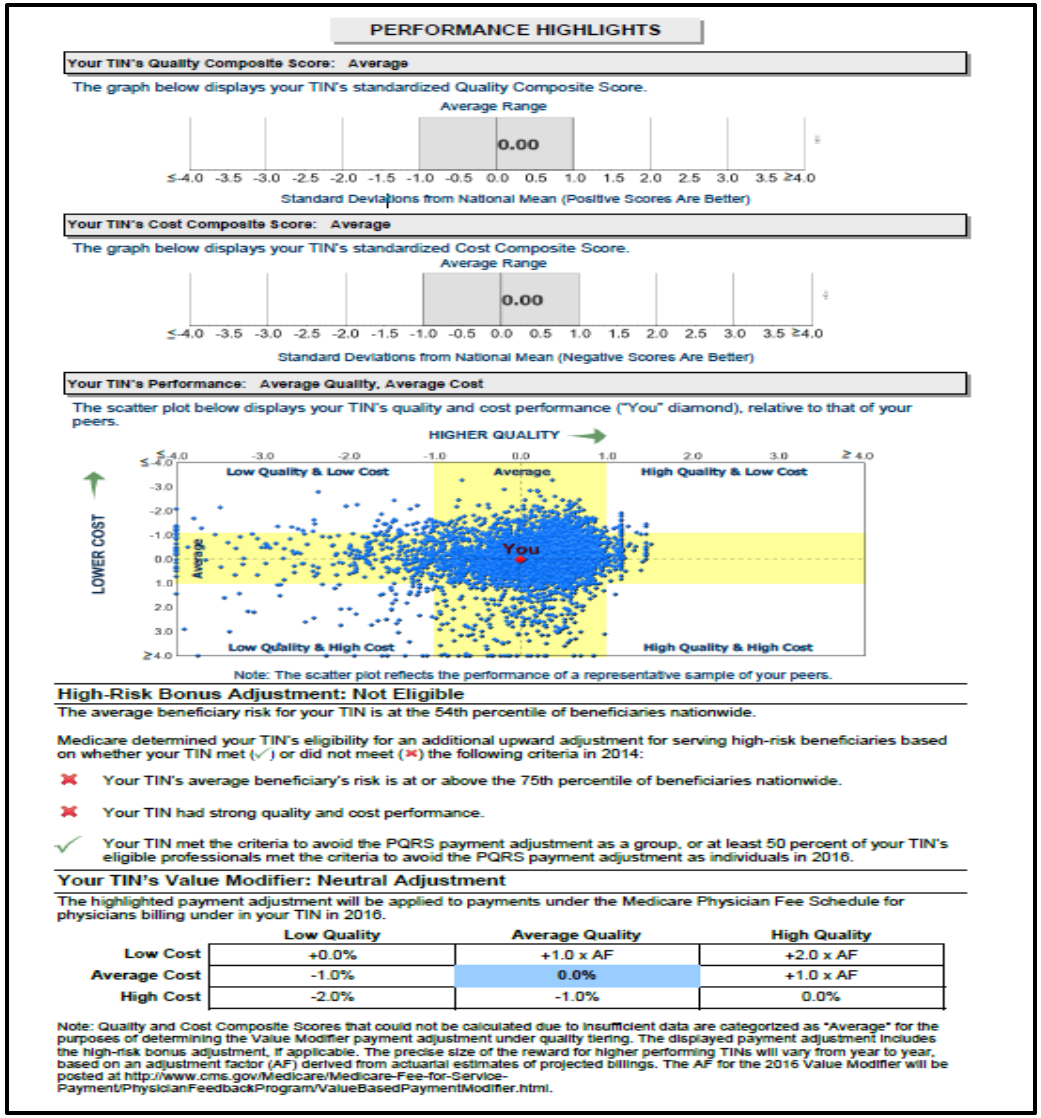
Committees & teams include:

- Physicians & Nursing representatives
- Clinical Operations
- Chief Medical Office
- Finance
- IT
- OVIHD
- Government & Regulatory Affairs



- Steering Committee responsible for alignment across enterprise
- Reports to C-Suite quarterly

Know Your Quality & Resource Use Report



PERFORMANCE HIGHLIGHTS

Your TIN's Quality Composite Score: Average

The graph below displays your TIN's standardized Quality Composite Score.

Average Range

0.00

≤-4.0 -3.5 -3.0 -2.5 -2.0 -1.5 -1.0 -0.5 0.0 0.5 1.0 1.5 2.0 2.5 3.0 3.5 ≥4.0

Standard Deviations from National Mean (Positive Scores Are Better)

Your TIN's Cost Composite Score: Average

The graph below displays your TIN's standardized Cost Composite Score.

Average Range

0.00

≤-4.0 -3.5 -3.0 -2.5 -2.0 -1.5 -1.0 -0.5 0.0 0.5 1.0 1.5 2.0 2.5 3.0 3.5 ≥4.0

Standard Deviations from National Mean (Negative Scores Are Better)

Your TIN's Performance: Average Quality, Average Cost

The scatter plot below displays your TIN's quality and cost performance ("You" diamond), relative to that of your peers.

HIGHER QUALITY

LOWER COST

Low Quality & Low Cost

Average

High Quality & Low Cost

Average

You

Low Quality & High Cost

High Quality & High Cost

Note: The scatter plot reflects the performance of a representative sample of your peers.

High-Risk Bonus Adjustment: Not Eligible

The average beneficiary risk for your TIN is at the 54th percentile of beneficiaries nationwide.

Medicare determined your TIN's eligibility for an additional upward adjustment for serving high-risk beneficiaries based on whether your TIN met (✓) or did not meet (✖) the following criteria in 2014:

✖ Your TIN's average beneficiary's risk is at or above the 75th percentile of beneficiaries nationwide.

✖ Your TIN had strong quality and cost performance.

✓ Your TIN met the criteria to avoid the PQRS payment adjustment as a group, or at least 50 percent of your TIN's eligible professionals met the criteria to avoid the PQRS payment adjustment as individuals in 2016.

Your TIN's Value Modifier: Neutral Adjustment

The highlighted payment adjustment will be applied to payments under the Medicare Physician Fee Schedule for physicians billing under in your TIN in 2016.

	Low Quality	Average Quality	High Quality
Low Cost	+0.0%	+1.0 x AF	+2.0 x AF
Average Cost	-1.0%	0.0%	+1.0 x AF
High Cost	-2.0%	-1.0%	0.0%

Note: Quality and Cost Composite Scores that could not be calculated due to insufficient data are categorized as "Average" for the purposes of determining the Value Modifier payment adjustment under quality tiering. The displayed payment adjustment includes the high-risk bonus adjustment, if applicable. The precise size of the reward for higher performing TINs will vary from year to year, based on an adjustment factor (AF) derived from actuarial estimates of projected billings. The AF for the 2016 Value Modifier will be posted at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/ValueBasedPaymentModifier.html.

Some Questions to Ask

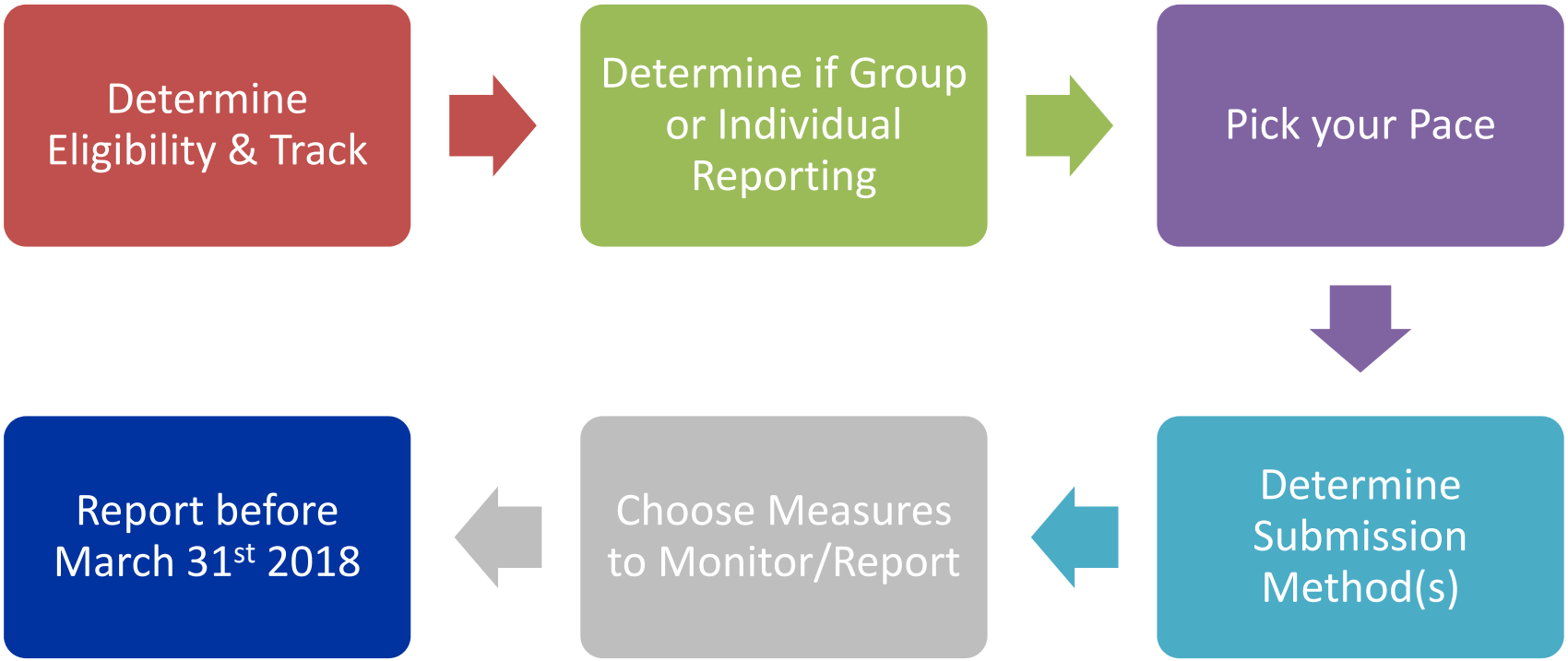
- **Organizational**: Are you independent?

  Or are clinicians employed?
- **Legal:** How many TINs & NPIs do you practice under?
- **Billing**: What percentage of your revenue is Medicare? Are your ECs eligible or low volume?
- **Special Status**: Are you small (15 or under) or in a rural area?

Some Additional Things to Ask

- **History**: What did you do last year? (Nothing, PQRS only, MU only or both?)
- **Performance**: Analyze QRUR – Do you need to change your quality measures?
- **Technology**: How good is your EHR? Do you need a registry to help with quality reporting? How has your MU participation been?
- **Interest in Exceptional Performance Bonus or an APM?**: Consider patient-centered specialty recognition to accelerate culture change

Action Plan for MACRA/QPP Participation



Choosing Your Metrics

Requirements:

- Report 6 quality measures, including one outcome measure (or high priority measure if no outcome measure available)
- Specialist measure sets available
- Each quality measure submitted is worth 3-10 points

Strategies to Score Well:

- Choose benchmarked measures
- Report additional outcome, patient experience, or high priority
- Submit electronically end-to-end
- Have Sufficient case volume within your practice
- Perform in the 70th or higher scoring percentile
- Avoid topped out measures (more on this later)

The Challenge: Analyzing Cost

% Final Score	Measures	Requirement	Method
Makes up 0% of your final score for PY 2017 ✓ In later years scored higher ✓ ECs will get feedback on this category in Quality and Resource Use Report (QRUR)	Score based off of Medicare claims <u>Measure 1:</u> Spending per Beneficiary (MSPB) <u>Measure 2:</u> Total costs per capita for all attributed beneficiaries	When clinician bills Medicare for diagnosis code or admission gets included in measure Minimum # of patients sample. Typically 20 or > 35 for MSPB	No data submission required Validation of data is important!

Some clinicians think MACRA means…

- Stop seeing sick, non-compliant patients
- Start accepting only patients who are healthy

But successful VBP/APM leaders understand

the 5-50 Rule/80-20 Rule:

5% of patients are responsible for 50% of costs

20% of patients are responsible for 80% of costs

The ACO program has a greater chance of success…where you have sicker patients who are overutilizing health services *and you can make corrections by applying outpatient care management. Your patients will get better, and you'll be able to improve quality and save money. There's not too much to fix when you have a population where everyone is eating their vegetables and going to the gym.*

Jose F. Pena, MD, chief executive officer and chief medical director of Rio Grande Health, *Managed Healthcare Executive*, "CEO of ACO shares how it saved nearly $12 million in year 1," June 15, 2016

A National Support Network

PRIMARY CARE & SPECIALIST PHYSICIANS

Transforming Clinical Practice Initiative

- Supports more than 140,000 clinician practices through active, collaborative and peer-based learning networks over 4 years.
- **Practice Transformation Networks (PTNs) and Support Alignment Networks (SANs)** are located in all 50 states to provide comprehensive technical assistance, as well as tools, data, and resources to improve quality of care and reduce costs.
- The goal is to help practices transform over time and move toward Advanced Alternative Payment Models.
- Contact TCPI.ISC@TruvenHealth.com for extra assistance.

Locate the PTN(s) and SAN(s) in your state

SMALL & SOLO PRACTICES

Small, Underserved, and Rural Support (SURS)

- Provides outreach, guidance, and direct technical assistance to clinicians in **solo or small practices (15 or fewer), particularly those in rural and underserved areas**, to promote successful health IT adoption, optimization, and delivery system reform activities.
  - Assistance will be tailored to the needs of the clinicians.
  - There are 11 SURS organizations providing assistance to small practices in all 50 states, the District of Columbia, Puerto Rico, and the Virgin Islands.

LARGE PRACTICES

Quality Innovation Networks-Quality Improvement Organizations (QIN-QIO)

- Supports clinicians in **large practices (more than 15 clinicians)** in meeting Merit- Based Incentive Payment System requirements through customized technical assistance.
- Includes one-on-one assistance when needed.
- There are 14 QIN-QIOs that serve all 50 states, the District of Columbia, Guam, Puerto Rico, and Virgin Islands.

Locate the QIN-QIO that serves your state

Quality Innovation Network (QIN) Directory

TECHNICAL SUPPORT

All Eligible Clinicians Are Supported By:

Quality Payment Program Website: qpp.cms.gov
Serves as a starting point for information on the Quality Payment Program.

Quality Payment Program Service Center
Assists with all Quality Payment Program questions.
1-866-288-8292 TTY: 1-877-715-6222 QPP@cms.hhs.gov

Center for Medicare & Medicaid Innovation (CMMI) Learning Systems
Helps clinicians share best practices for success, and move through stages of transformation to successful participation in APMs.

Thank you! Questions?

UK's Kentucky Regional Extension Center

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