Medicare Quality Payment Program Overview (MACRA=QPP)

IPPS

November 2016

AMA
AMERICAN MEDICAL ASSOCIATION

Rev. 10/25/16

MACRA: New vs. Reorganized

New

- Bonus opportunities (APMs & MIPS)
- Greater support for physicians that want to pursue new models
- CPIA requirement

Re-organized

- PQRS, MU and VBM
  Penalties reduced in absolute terms & through partial credit
- Reduce net administrative burdens
- Greater flexibility for physicians
- Low score in one area can be made up by high score in other components
- No more double jeopardy for failing PQRS (trigger VBM failure)

2019 (first year) penalty risks compared

Prior Law	2019 adjustments
PQRS	-2%
MU	-5%
VBM	-4% or more*
Total penalty risk	-11% or more*
Bonus potential (VBM only)	Unknown (budget neutral)*

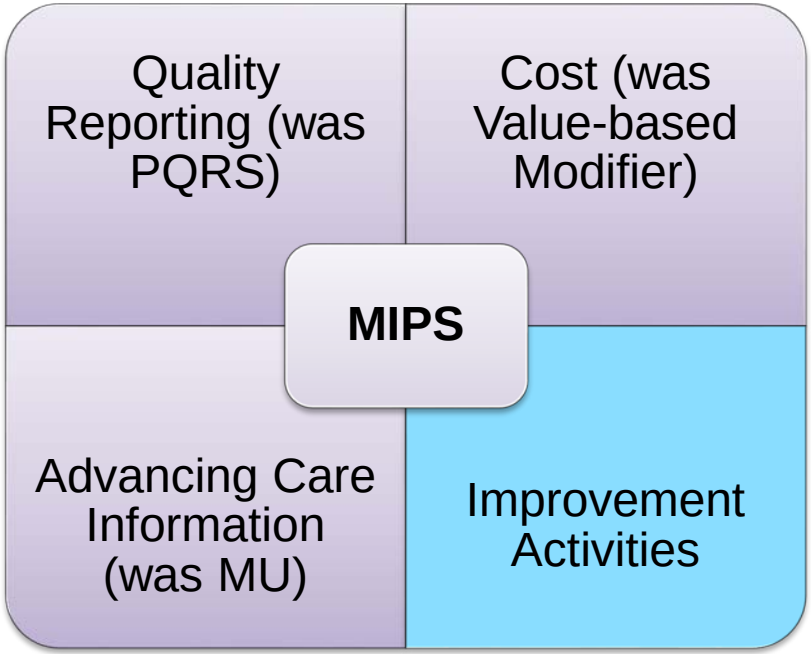
*VBM was in effect for 3 years before MACRA passed, and penalty risk was increased in each of these years; there were no ceilings or floors on penalties and bonuses, only a budget neutrality requirement.

MIPS factors	2019 scoring
Quality measurement	60% of score
Advancing Care Info.	25% of score
Resource use	0% of score
Improvement Activities	15% of score
Total penalty risk	Max of -4%
Bonus potential	Max of 4%, plus potential 10% for high performers

6 of 6 Markers for Success

- Moving proposed start date of Jan. 1
- Simplify MIPS program
- Increase low volume threshold
- More relief for small rural/practices
- Modify MIPS performance threshold formula
- Expand opportunities for APMs

MIPS components



MIPS aims:

- Align 3 current independent programs
- Add 4th component to promote improvement and innovation
- Provide more flexibility and choice of measures
- Retain a fee-for-service payment option

Clinicians exempt from MIPS:

- First year of Part B participation
- Medicare allowed charges ≤ $30K or ≤ 100 patients
- Non-patient facing with ≤ 100 patients
- Advanced APM participants

Low-volume exclusion: AMA proposal adopted

- Eligibility for low-volume exclusion to be calculated by CMS
  - Notification should occur in December
  - Based on 12-month historical data (September-August)
  - Includes Part B drug costs, but not Part D
- Info provided by TIN/NPI for clinicians and by TIN for groups
  - Something to factor in when group members decide whether to report as individuals or as a group
- Qualifying individuals may volunteer to report, but they will not be eligible for pay adjustments

Pick Your Pace: 2017 transitional performance reporting options

MIPS Testing	• Report some data at any point in CY 2017 to demonstrate capability • 1 quality measure, or 1 improvement activity, or 4 required ACI measures • No minimum reporting period • No negative adjustment in 2019
Partial MIPS reporting	• Submit partial MIPS data for at least 90 consecutive days • 1+ quality measure, or 1+ improvement activities, or 4 required ACI measures • No negative adjustment in 2019 • Potential for some positive adjustment (< 4%) in 2019
Full MIPS reporting	• Meet all reporting requirements for at least 90 consecutive days • No negative adjustment in 2019 • Maximum opportunity for positive 2019 adjustment (≤ 4%) • Exceptional performers eligible for additional positive adjustment (up to 10%)
Advanced APM participation	• No MIPS reporting requirements (APMs have their own reporting requirements) • Eligible for 5% advanced APM participation incentive in 2019

The only physicians who will experience negative payment adjustments (-4%) in 2019 are those who report no data in 2017

Other transition elements

2017

- 90-day reporting for all MIPS elements
- Quality reporting threshold maintained at 50%
- ACI required measures reduced to 4/5 (depending on whether using 2014 or 2015 certified technology)
- Cost component of MIPS weighted 0%; quality component raised to 60% (for 2019 adjustments)

2018 (subject to rulemaking)

- 90-day reporting likely maintained for ACI and Improvement Activities only
- Quality threshold likely increased to 60%
- ACI required measures is 5 (must use 2015 certified technology)
- Cost component weight increased to 10%; quality component reduced to 50% (for 2020 adjustments)

Future years

- Full-year reporting for ACI?
- Quality threshold anticipated to increase over time
- Cost component weight will increase to 30% (for 2021 adjustments and beyond)
- Quality component weight will decrease to 30% (for 2021 adjustments and beyond)

2019 payment adjustments (based on 2017 transition)

Quality score weighted (60%)

+

Cost score weighted (0%)

+

ACI score weighted (25%)

+

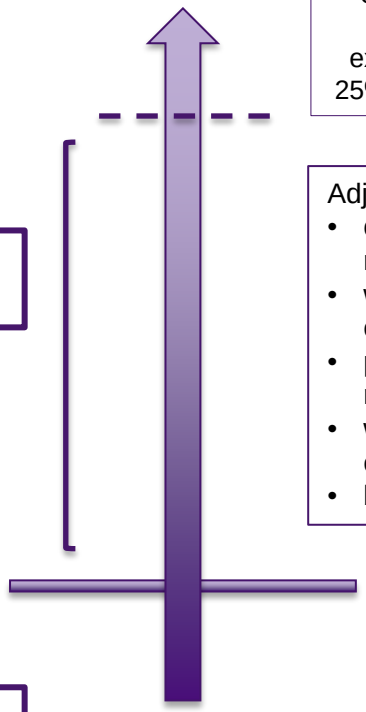
Improvement Activity score weighted (15%)

Composite Performance Score (CPS)

CPS above threshold (up to 70 points) = up to 0 to +4%

CPS at 2017 threshold of 3 points (one data element reported) = 0%

No data reported = - 4%



Up to $500 million available to provide 10% extra bonus for exceptional performance (≥ top 25% of those above the threshold)

Adjustment amounts depend on:

- choice of 90-day or full-year reporting
- whether some or all data elements are reported
- performance under each reported measure
- whether bonus points are earned
- budget neutrality calculations

Quality reporting in MIPS vs. PQRS

PQRS

- 9 measures
- Pass/ fail approach
- 2% penalties, no bonuses
- Measures must fall across specific domains
- One cross cutting measure required

MIPS Quality

- 6 measures (or 1 specialty set)
- Partial credit allowed toward positive payment adjustments
- Flexibility in measure choice
- No domains, no cross cutting measures
- Bonuses available for reporting through EHR, qualified registry, QCDR, or web interface

ACI reporting in MIPS vs. meaningful use

MU

- 100% score required on all measures to avoid penalty
- Included redundant measures and problematic CPOE, CDS, and clinical quality measures
- Full-year reporting (although twice reduced in Q4)

MIPS ACI

- Pass-fail program replaced with base and performance scoring
  - 4/ 5 base measures required
  - Partial credit allowed for performance measures
- Fewer measures: CPOE, CDS, and clinical quality measures eliminated
  - Public health registry reporting optional
- Performance score thresholds eliminated
- 90-day reporting periods for 2017 and 2018
- Bonuses available for registry reporting and use of CEHRT in IA

Improvement Activities (formerly CPIA)

- New component, intended to provide credit for practice innovations that improve access and quality
  - Over 90 activities that cross 8 categories
  - No required categories
  - Includes Steps Forward modules
- Reduced burden for small practices
- Participation in 2017 MIPS APMs and non-advanced medical homes worth 40 points
  - PCMH definition expanded to include national, regional, state, private payer, and other certifications

Improvement Activities categories

- Expanded Practice Access
- Population Management
- Care Coordination
- Beneficiary Engagement
- Patient Safety & Practice Assessment
- Achieving Health Equity
- Emergency Response and Preparedness
- Integrated Behavioral & Mental Health

Cost in MIPS vs. VBM

VBM

- Included both quality reporting and resource-use measures
- PQRS failure counted twice in penalty calculations
- Poor risk adjustment produced penalties for treating sickest patients
- No statutory limits on penalty risk

MIPS Cost

- Focuses solely on cost; no duplicative quality reporting, no duplicative penalties
- 10 episode groups finalized; others being tested and refined
- Plans to improve attribution methods in 2018 (for 2020 payments)
- Part D drug costs will not be included in calculation
- During 2017 transition, category weight will be zero
  - Reports provided to physicians in transition for review only

No physician reporting required for this component; calculated by CMS based on claims submitted

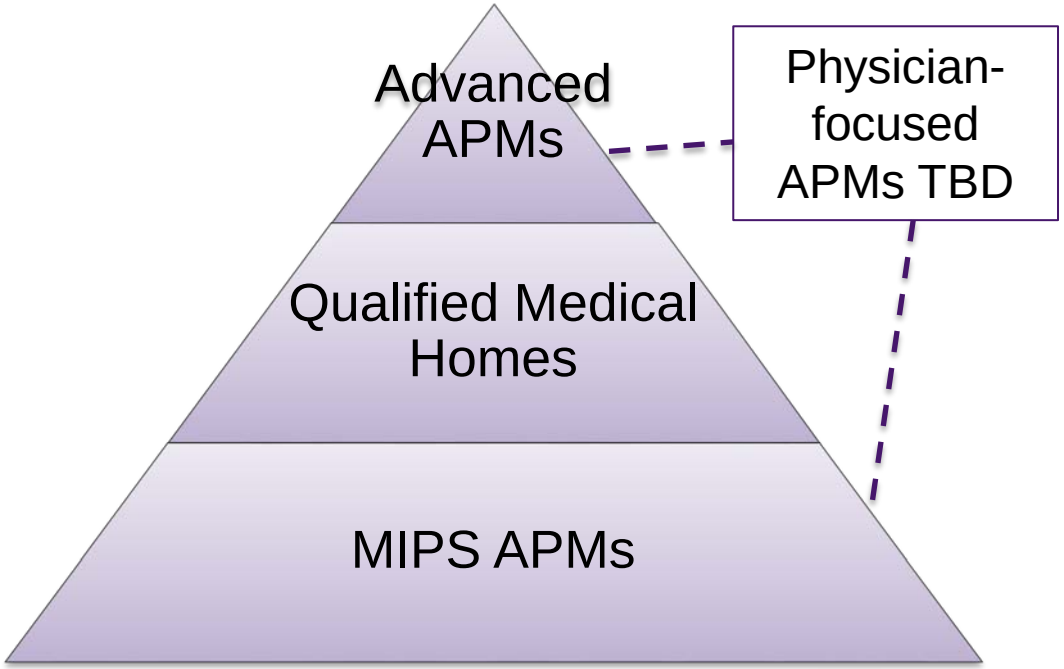
Small practice accommodations and impacts

- Low volume exclusion
- “Pick your pace” transition for 2017
  - CMS estimates 90% of eligible clinicians will get zero or positive adjustments
  - CMS estimates 80% of those will be in groups ≤ 10
- Eased requirements for Improvement Activities component
- $100 million in grants for technical assistance to small practices via QIOs, regional health cooperatives, etc.
- Participation in rural health clinics sufficient for full Improvement Activities score for rural and small practices
- Future rulemaking to address virtual groups, pooled financial risk arrangements

Alternative Payment Models (APMs)

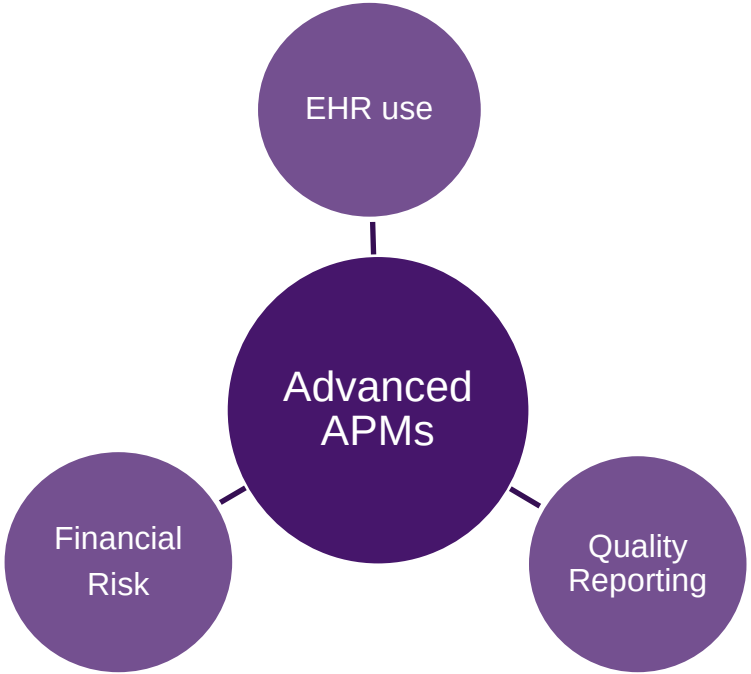
APMs participation options as outlined by CMS

- **“Advanced” APMs**--term established by CMS; these have greatest risks and offer potential for greatest rewards
- **Qualified Medical Homes** have different risk structure but otherwise treated as Advanced APMs
- **MIPS APMs** receive favorable MIPS scoring
- **Physician-focused APMs** are under development



CMS criteria for Advanced APMs

- 50% of participants must use certified EHR technology
- 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)
- Physicians may be Qualified Participants (QPs) or Partially Qualified Participants (PQPs) based on revenue and patient thresholds, with differential rewards



MACRA incentives for Advanced APM participation

Model design

- APMs have shared savings, flexible payment bundles and other desirable features

Bonuses

- In 2019-2024, 5% bonus payments made to physicians participating in Advanced APMs

Higher updates

- Annual baseline payment updates will be higher (0.75%) for Advanced APM participants than for MIPS participants (0.25%) starting 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 APMs

Comprehensive ESRD Care Model (13 ESCOs)	Comprehensive Primary Care Plus (14 states, practice applications closed 9/15/16)	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 APMs for 2018 (subject to rulemaking)

- ACO Track 1+
- Voluntary bundled payment models
- Comprehensive Care for Joint Replacement Payment Model (CEHRT Track)
- Advancing care coordination through episode payment models Track 1 (CEHRT)

MIPS APMs

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 (either on entity or individual clinician level)

2017 qualified models

- MSSP Tracks 1, 2, 3
- Next Generation ACOs
- Comprehensive ESRD Care Model
- Oncology Care Model
- CPC+ Model

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

Other benefits

- 2017 MIPS APMs receive full Improvement Activities credit
- ACOs: must report quality (50%), IA (20%) and ACI (30%)
- Non-ACO MIPS: quality score reweighted to zero and IA/ ACI reweighted to 25%/ 75%
- APM-specific rewards (e.g., shared savings)
- Eligible for annual MIPS bonuses, which continue indefinitely (vs. 6 years for 5% APM bonuses)

Moving Forward

Milestones

2017	Jan 1: First transitional performance period begins
	Spring: PQRS, VBM, MU pay adjustments (2015 performance)
	Oct 1: Last chance to start 90-day reporting period
	Nov 1: 2018 performance threshold announced
	Dec: Notification of LVT exception (9/1/16-8/31/17)
2018	Jan 1: Second transitional performance period begins
	Jan 2-Mar 31: Submission period for 2017 performance data
	Spring: Final PQRS, VBM, MU pay adjustments (2016 performance)
	Nov 1: 2019 performance threshold announced
	Dec: Notification of LVT exception (9/1/17-8/31/18)
2019	Jan 1: QPP transitional reporting completed
	Spring: First QPP pay adjustments implemented (2017 performance)

AMA advocacy

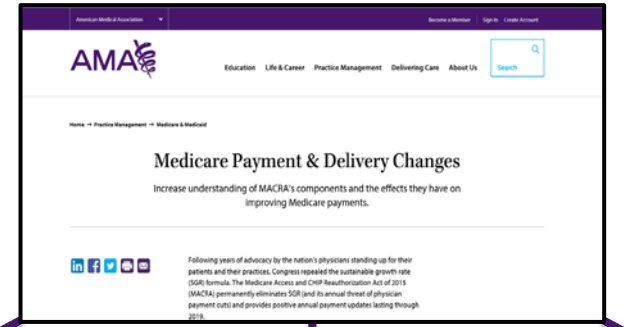
- Our overarching aims in shaping regulations:
  - Choice, flexibility, simplicity, feasibility
- Opportunities for further improvements in 2017 rulemaking and via Congressional oversight
- Developing tool chest of practical resources to help physicians

What Physicians Can Do to Prepare

Learn, Assess, Prepare

www.ama-assn.org/go/medicarepayment

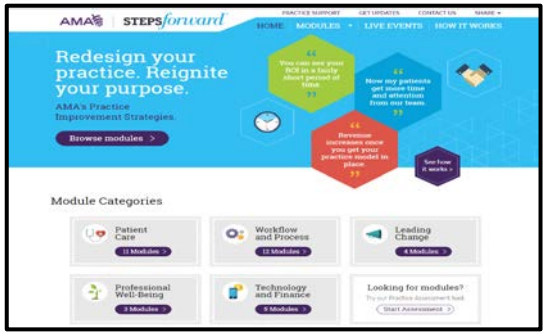
Offering an Iterative and Comprehensive Set of Resources



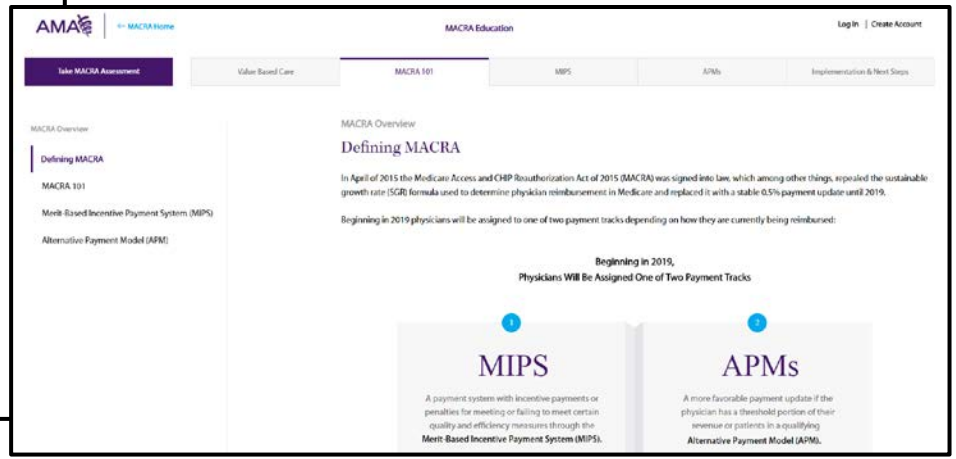
Dedicated AMA website pages
www.ama-assn.org/go/medicarepayment

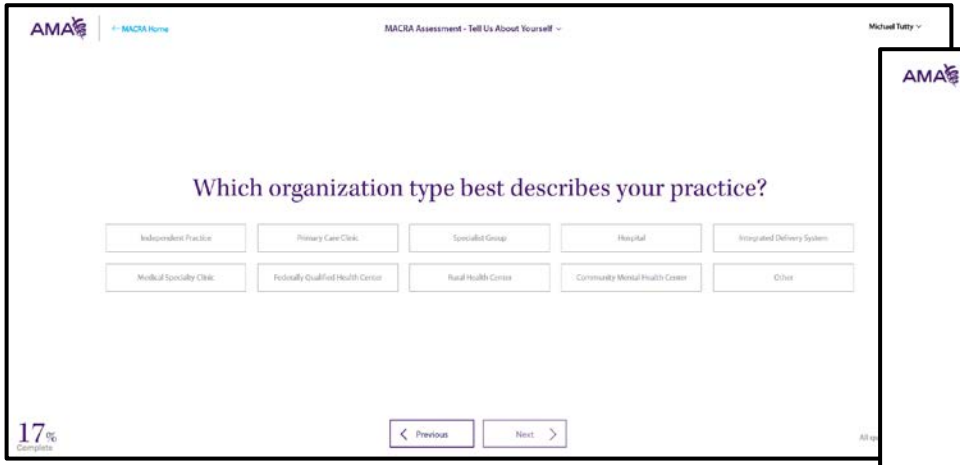
Background/How to Prepare

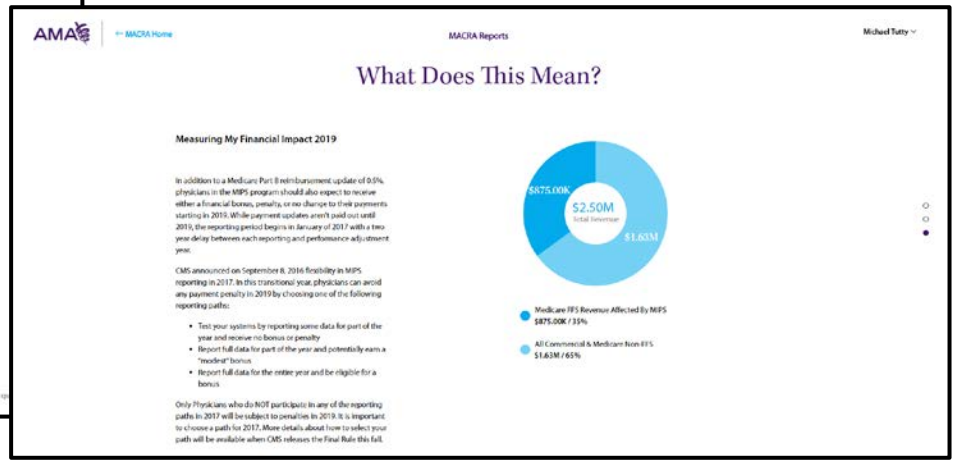
Payment Model Evaluator



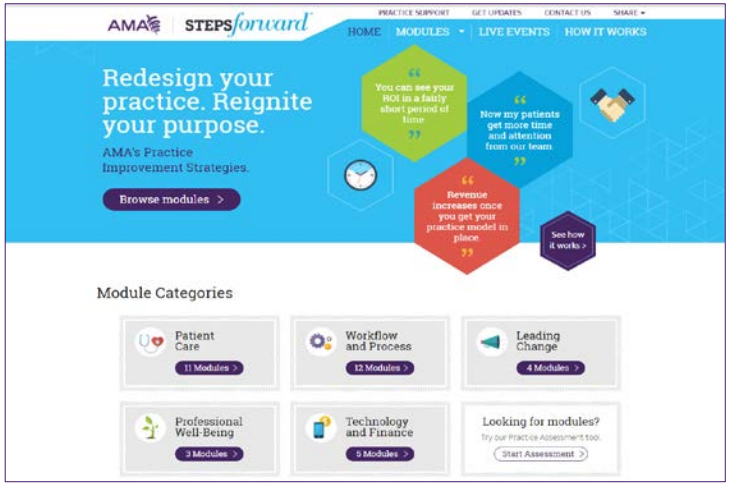
Steps Forward



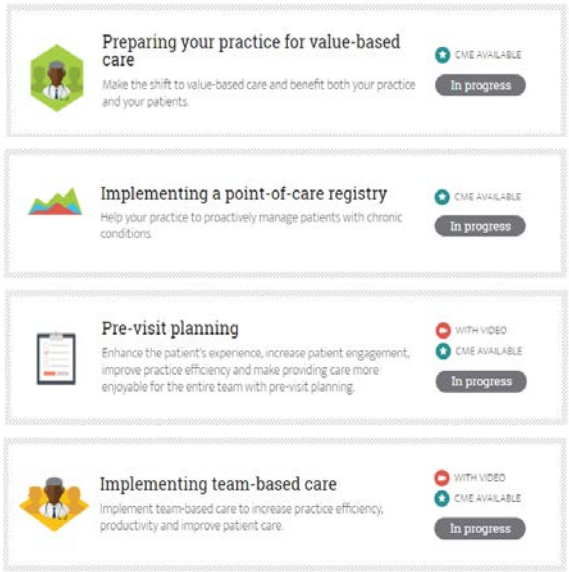




Take Advantage of Educational Opportunities



www.stepsforward.org



Completion of select STEPS Forward™ modules meets eligibility criteria for Improvement Activity category credit

Learn From Those Who Do

ReachMD™
Be part of the knowledge

Plans underway to share information from experienced physicians

- Podcast Interviews
- Instructional videos
- Demos
- Webinars (Nov. 21 and Dec. 6)
- Seminars (Dec. 1 in Atlanta; Dec. 10 in San Francisco)

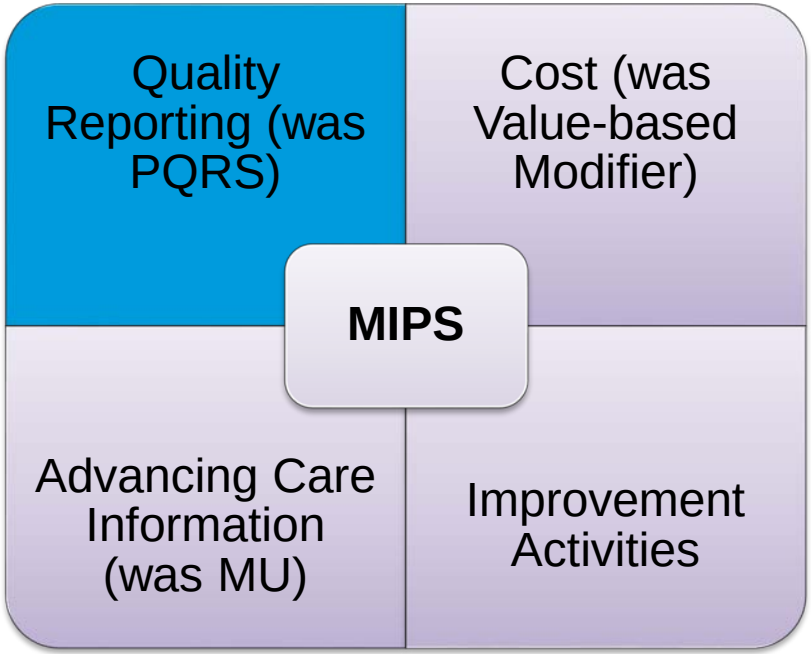
Also:

- Paid media
- Social media
- Federation outreach

Prepare for MACRA/QPP

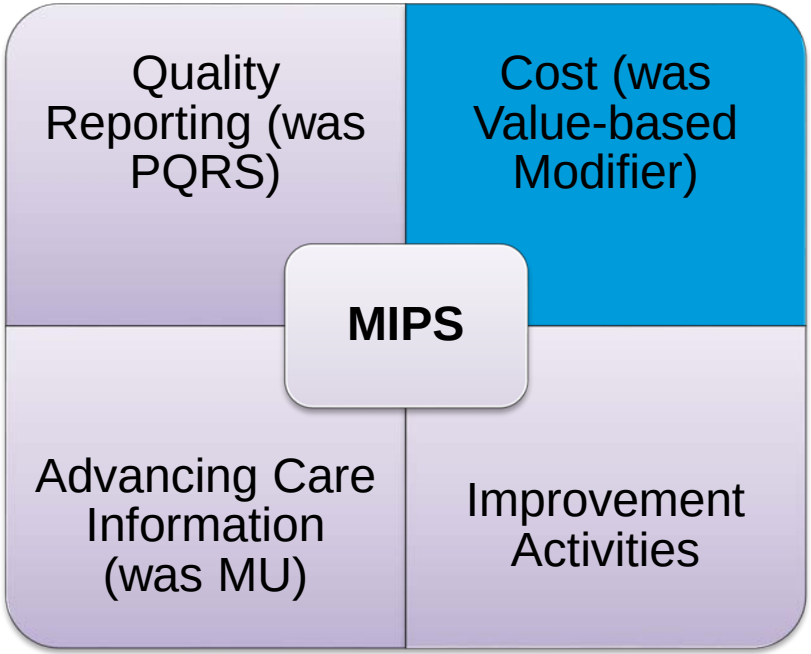
- ✓ Will you likely be in MIPS or APMS?
- ✓ Are you exempt from MIPS?
  - ✓ Low volume provider?
  - ✓ Qualified participant in an advanced APM?
- ✓ Do you meet requirements for small, rural, non-patient-facing accommodations?
- ✓ Would you be reporting as a group or an individual?

Prepare for MIPS: Quality



- ✓ Are you reporting quality metrics?
- ✓ Do you plan to report through claims, EHR, clinical registry, qualified clinical data registry, or group practice reporting option
  - ✓ If you are not already participating in a patient clinical data registry, contact your specialty society about participating in theirs
- ✓ Check your PQRS feedback reports
  - ✓ Authorized representatives can access the Annual PQRS Feedback Reports on the CMS Enterprise Portal

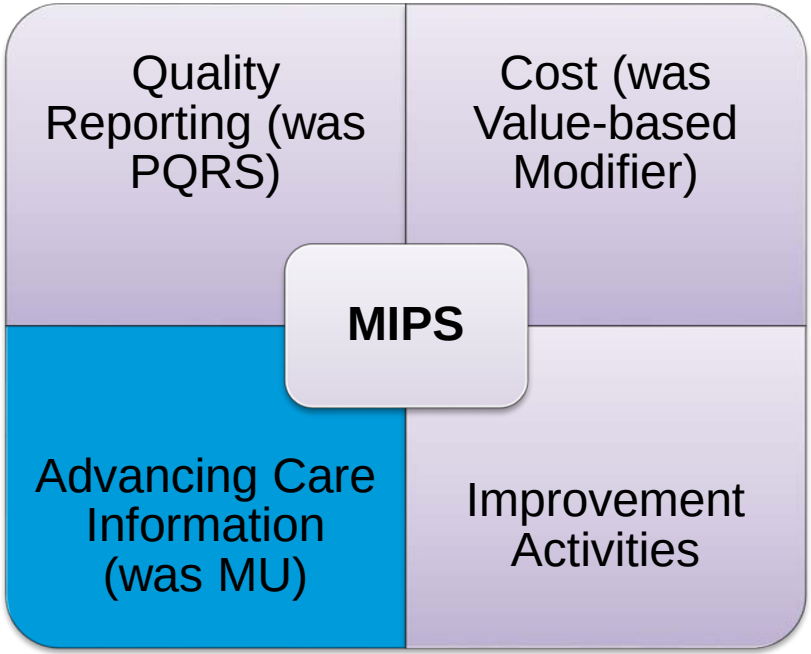
Prepare for MIPS: Cost



Although the cost component of MIPS is weighted 0% for 2019; opportunities to prepare:

- ✓ Access and review your Medicare Quality and Resource Use Reports (QRURs) to see where improvements can be made
  - ✓ Authorized representatives can access the QRURs on the CMS Enterprise Portal
- ✓ Review your most costly patient population conditions and diagnoses and seek improvement opportunities

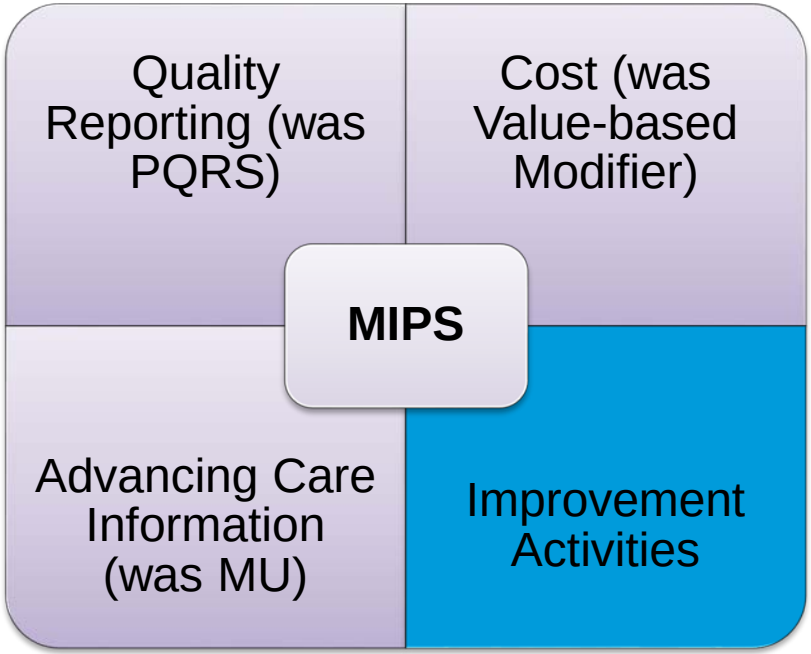
Prepare for MIPS: Advancing Care Information



If you have an EHR, speak with your vendor about how their product supports the new payment models:

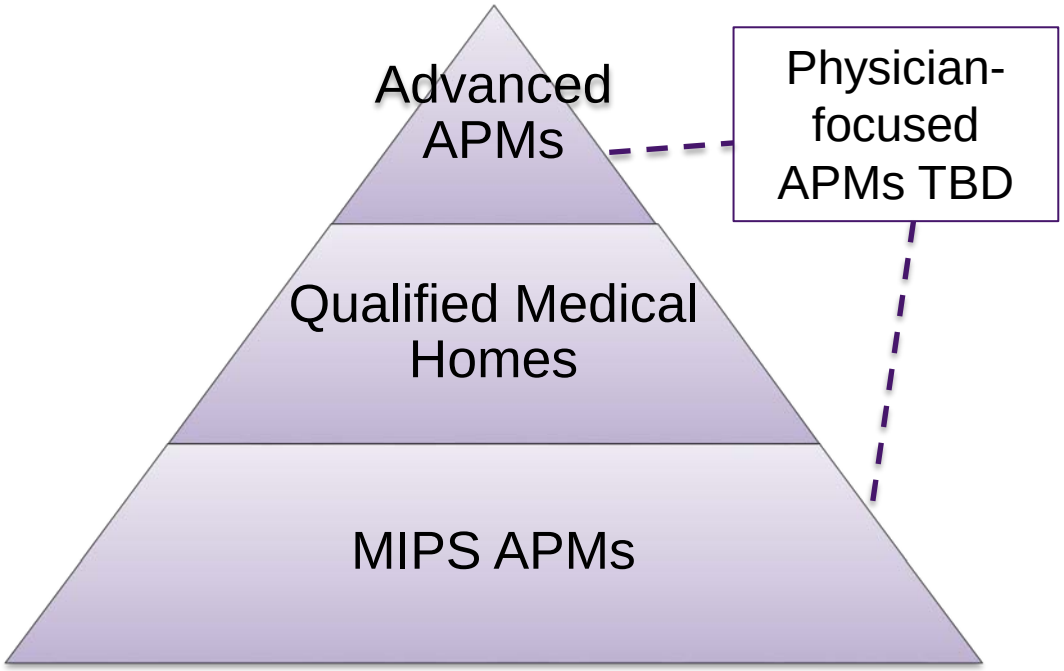
- ✓ Is your EHR certified?
- ✓ If so, is it the 2014 or 2015 edition?
- ✓ Does your vendor support Medicare quality reporting?
- ✓ Does your vendor offer patient tracking and clinical decision support tools?

Prepare for MIPS: Improvement Activities



- ✓ Review the more than 90 plus approved Improvement Activities?
- ✓ Which Improvement Activities are you engaged in now?
- ✓ What are you interested in doing?
- ✓ Consider which 90 days in 2017 would work best for your practice's selected Improvement Activities
- ✓ Review the AMA's Steps Forward program

Prepare for APMS



- ✓ Confirm whether you are a participant in any of the advanced APMs
  - ✓ If not, contact your specialty society or state medical society to find out if there are APM opportunities for your area
- ✓ Evaluate whether you are likely to meet the threshold for significant participation in an advanced APM, which would qualify you for incentive payments

Stay Informed with Updates, New Tools and Resources

Leverage resources from the AMA and other Federation groups