Webinar: MACRA Quality Payment Program Update

April 20, 2017
Some general observations

• MACRA is complex
  • More than a “replacement for the SGR”

• Many of the “new” requirements are revisions to the current FFS program
  • Impacts of previous law not universally experienced, understood, or in full effect

• One goal of MACRA was to simplify administrative processes for physicians
  • Compared to recent past framework, there are significant improvements

• MACRA and ACA dynamics are often confused

• More work remains
MACRA: New vs. reorganized

New

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

<table>
<thead>
<tr>
<th>Prior Law</th>
<th>2019 adjustments</th>
</tr>
</thead>
<tbody>
<tr>
<td>PQRS</td>
<td>-2%</td>
</tr>
<tr>
<td>MU</td>
<td>-5%</td>
</tr>
<tr>
<td>VBM</td>
<td>-4% or more*</td>
</tr>
<tr>
<td>Total penalty risk</td>
<td>-11% or more*</td>
</tr>
<tr>
<td>Bonus potential (VBM only)</td>
<td>Unknown (budget neutral)*</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>MIPS factors</th>
<th>2019 scoring</th>
</tr>
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<tbody>
<tr>
<td>Quality measurement</td>
<td>60% of score</td>
</tr>
<tr>
<td>Advancing Care Info.</td>
<td>25% of score</td>
</tr>
<tr>
<td>Resource use</td>
<td>0% of score</td>
</tr>
<tr>
<td>Improvement Activities</td>
<td>15% of score</td>
</tr>
<tr>
<td>Total penalty risk</td>
<td>Max of -4%</td>
</tr>
<tr>
<td>Bonus potential</td>
<td>Max of 4%, plus potential 10% for high performers</td>
</tr>
</tbody>
</table>

*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.
AMA advocacy

- **Overarching aims in shaping regulations**: Choice, flexibility, simplicity, feasibility

- **Six internal measures for judging success**:
  1. Start date → “Pick Your Pace” program offers flexibility
  2. Reporting period → Full MIPS reporting period of 90 days for 2017
  3. Simplify the MIPS program
     - Cost component weight reduced to 0
     - Quality measure reporting requirements reduced to 50% of patients instead of 80-90%
     - Eliminated cross-cutting & domain quality measure requirements, removed acute & chronic composite measures, limited readmission measure to groups > 16
     - Reduced Improvement Activity requirements to 2 high-weight or 4 medium-weight activities from proposed 4 high or 6 medium
     - Reduced number of required Advancing Care Information measures
AMA advocacy

4. Increase the low volume threshold for MIPS reporting
   • Final rule exempts 45% of clinicians in practices of 1-9

5. More relief for small and rural practices
   • 90% of small practices to get neutral or positive MIPS adjustment in 2019

6. Expand opportunities for APMs
   • Minimum financial risk standards for APMs significantly reduced from proposed rule

   • **Cannot overstate contribution of constructive CMS approach**
MACRA Basics
MACRA established two Medicare paths for physicians

• MACRA was designed to offer physicians a choice between two payment pathways:
  • A modified fee-for-service model (MIPS)
  • New payment models that reduce costs of care and/or support high-value services not typically covered under the Medicare fee schedule (APMs)
• In the beginning, most are expected to participate in MIPS
• CMS named the physician payment system created by MACRA the Quality Payment Program (QPP)
MIPS Components for 2017

Quality Reporting (was PQRS) 60%
Cost (was Value-based Modifier) 0%
Advancing Care Information (was MU) 25%
Improvement Activities 15%

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
- Advanced APM participants
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.
Merit-based Incentive Payment System (MIPS)
# Quality reporting in MIPS vs. PQRS

<table>
<thead>
<tr>
<th>PQRS</th>
<th>MIPS Quality</th>
</tr>
</thead>
</table>
| • 9 measures  
• Pass/fail approach  
• 2% penalties, no bonuses  
• Measures must fall across specific domains  
• One cross cutting measure required | • 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 |
Quality category reporting

• 1 Administrative Claims measure
  • *All-cause Hospital Readmission* measure finalized for groups of 16 or more (vs. 10 in proposed rule) with 200 attributed cases
  • Will be calculated by CMS from administrative claims data

• 6 measures must be reported, or a specialty measure set
  • 1 must be an outcome measure
  • If no applicable outcome measure available, must report 1 other “high priority measure” instead
    • High priority areas include: appropriate use, patient safety, patient experience, care coordination
  • For maximum points, measure must be reported on 50% of eligible patients in 2017
    • Threshold increases to 60% of eligible patients in 2018
Quality category bonus point scoring

• Additional points awarded for:
  • Electronic reporting via clinical registry, EHR, qualified clinical data registry, or web-interface
  • Reporting on CG-CAHPS survey measure
  • Additional outcome or additional high priority measures outside the 1 required
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
### ACI performance category scoring: required measures (50% score)

<table>
<thead>
<tr>
<th>Objective</th>
<th>ACI Measure</th>
<th>Reporting Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Protect patient health information</td>
<td>Security risk analysis</td>
<td>Yes/No statement</td>
</tr>
<tr>
<td>Electronic prescribing</td>
<td>E-prescribing</td>
<td>Numerator/Denominator Eligible Patients</td>
</tr>
<tr>
<td>Patient electronic access</td>
<td>Provide patient access</td>
<td>Numerator/Denominator Eligible Patients</td>
</tr>
<tr>
<td>Health information exchange</td>
<td>Send summary of care</td>
<td>Numerator/Denominator Eligible Patients</td>
</tr>
<tr>
<td>Health information exchange (2015 CERHT only)</td>
<td>Request/ accept summary of care</td>
<td>Numerator/Denominator Eligible Patients</td>
</tr>
</tbody>
</table>
## 2017 ACI performance category scoring: optional measures (to reach full score)

<table>
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<tr>
<th>Objective</th>
<th>ACI Measure</th>
<th>Reporting requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient electronic access</td>
<td>Patient-specific education</td>
<td>Numerator/Denominator Eligible Patients</td>
</tr>
<tr>
<td>Coordination of care/patient engagement</td>
<td>View, download or transmit</td>
<td>Numerator/Denominator Eligible Patients</td>
</tr>
<tr>
<td>Coordination of care/patient engagement</td>
<td>Secure messaging</td>
<td>Numerator/Denominator Eligible Patient</td>
</tr>
<tr>
<td>Coordination of care/patient engagement</td>
<td>Patient-generated health data</td>
<td>Numerator/Denominator Eligible Patients</td>
</tr>
<tr>
<td>Health information exchange</td>
<td>Clinical information reconciliation</td>
<td>Numerator/Denominator Eligible Patients</td>
</tr>
<tr>
<td>Public health/ data registry reporting</td>
<td>Immunization registry reporting</td>
<td>Numerator/Denominator Eligible Patients</td>
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</table>
ACI bonus point scoring

• 5% bonus potential for reporting (via Yes/No statement) to one or more additional public health and clinical data registries:
  • Syndromic surveillance
  • Electronic case (in 2018)
  • Public health registry
  • Clinical data registry

• 10% bonus potential for reporting certain Improvement Activities (IAs) using CEHRT
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

• 40 points required for medium and large practices (2-4 activities)

• Only 1-2 activities required for groups ≤ 15, rural and HPSA practices, non-patient facing specialists
  • Most physicians fall into this category

• 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
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; will include total costs per capita and Medicare spending per beneficiary

No physician reporting required for this component; calculated by CMS based on claims submitted
Small practice accommodations: Low-volume threshold exemption

- Physicians with Medicare allowed charges of $30,000 or less or 100 or fewer Medicare patients (triple proposed threshold of $10,000)

- Eligibility calculated by CMS
  - Notification occurring this month
  - Based on 12-month historical data (September-August)
  - Includes Part B drug costs, but not Part D

- Exempted physicians receive annual fee schedule updates, but no bonuses or penalties

- Impact: Exempts 45% of clinicians in groups <10 from QPP
More small practice accommodations

• “Pick your pace” transition for 2017: CMS estimates 90% of eligible clinicians in groups < 10 will get zero or positive adjustments

• Fewer Improvement Activities required: 1 high or 2 medium = full credit
  • Example: Rural health clinic participation sufficient for full credit

• $100 million in grants for technical assistance to small practices via QIOs and regional health improvement collaboratives (see 2/17/17 announcement)

• Future rulemaking to address virtual groups, allowing solo and small practices to combine resources to jointly participate in QPP
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 will be 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)
2017 Advanced APMs

- **Comprehensive ESRD Care Model**
  (A portion of 37 ESCOs will qualify)

- **Comprehensive Primary Care Plus**
  (2,893 practices)

- **Medicare Shared Savings Track 2**
  (6 ACOs, 1% of total)

- **Medicare Shared Savings Track 3**
  (36 ACOs, 8% of total)

- **Next Generation ACO Model**
  (currently 45)

- **Oncology Care Model Track 2**
  (A portion of 190 practices qualify)

- **Comprehensive Joint Replacement**
  (A portion of participants in 67 MSAs qualify)
New Advanced APMs for 2018

<table>
<thead>
<tr>
<th>ACO Track 1+</th>
<th>New participants in 2017 APMs (ie, CPC+ Round 2)</th>
<th>Comprehensive Care for Joint Replacement Payment Model (CEHRT Track)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advancing care coordination through episode payment models Track 1 (CEHRT)</td>
<td>Vermont Medicare ACO Initiative (all payer ACO model)</td>
<td>New APMs TBD</td>
</tr>
</tbody>
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Timeline for determining eligibility and bonuses

- APM participants identified by CMS via 3 “snapshots”: March 31, June 30, August 31
  - Physicians listed as participants on one of those dates will be considered participants for that performance year
  - Performance of all participants in an APM entity to be judged as a whole
- Performance year ends August 31
  - Provides time for MIPS reporting for those not meeting thresholds
- 5% bonus will be calculated on Medicare revenues for second calendar year
  - Lump sum payment provided in third calendar year
- Example:
  - 2017 performance year determines eligibility (as of August 31)
  - 2018 year-end revenues provide base for calculating bonus
  - Lump sum bonus payment mid-2019 after all 2018 claims are submitted
MIPS APMs: All Advanced APMs below threshold PLUS

- ACO Track 1
  (438, 91% of total)

- Oncology Care Model Track 1

- Comprehensive ESRD Care Model
  1-sided risk

- Medical Homes
# APM improvements from proposed to final rule

<table>
<thead>
<tr>
<th>PROPOSED</th>
<th>FINAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimum financial risk set at 4% of total costs for APM patients, which can impose steep losses on practices</td>
<td>APMs financial risk can be 8% of Medicare revenues or 3% of total costs</td>
</tr>
<tr>
<td>Medical home participation leads to full credit for MIPS Improvement Activities; other APMs get 50% credit</td>
<td>Allows participation in MIPS APMs besides medical homes to provide full credit in Improvement Activities</td>
</tr>
<tr>
<td>Few APMs count as Advanced APMs</td>
<td>More APMs count as Advanced APMs</td>
</tr>
<tr>
<td>Plan to increase required use of CEHRT from 50% to 75% in 2018</td>
<td>Maintained required use of CEHRT at 50% of APM physicians</td>
</tr>
</tbody>
</table>
Physician-focused payment model proposals

• 11-member Physician-Focused Payment Model advisory committee created to review stakeholder APM proposals, make recommendations to HHS Secretary

• 7 proposals submitted to PTAC, of which 3 were reviewed at April meeting:
  1. **Project Sonar** submitted by the Illinois Gastroenterology Group and SonarMD, LLC ★
  2. **The COPD and Asthma Monitoring Project** submitted by Pulmonary Medicine, Infectious Disease and Critical Care Consultants Medical Group Inc. of Sacramento, CA
  3. **The ACS-Brandeis Advanced APM** submitted by the American College of Surgeons ★

• 17 additional Letters of Intent submitted with future proposals expected
### Examples of physician-focused APM pilots

<table>
<thead>
<tr>
<th>Project, MD leader, Payer</th>
<th>Care Improvement Opportunity</th>
<th>Barriers in Current Payment System</th>
<th>Results from Payment Model</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Frequent Emergency visits, Jennifer Wiler, MD, Univ. of Colorado, CMS Innovation Award</strong></td>
<td></td>
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</tr>
</tbody>
</table>
| • Many patients with 3+ ED visits per year: are uninsured; have behavioral health problems; do not have a PCP | • No pay for pt education and care coordination in ED  
• No pay for home visits post-ED  
• No coverage for non-medical needs such as transportation | • 41% fewer ED visits  
• 49% fewer admissions  
• 80% now have PCP  
• 50% lower total spending |
| **Crohn’s disease, Lawrence Kosinski, MD, Illinois Gastroenterology Group and SonarMD, Illinois BCBS** | | | |
| • Payer spends $11,000/yr for each Crohn’s patient  
• >50% of $ for hospitals, mostly for complications  
• <33% patients seen by MD w/i 30 days before admit | • No payment to support:  
  o Nurse care managers  
  o Clinical decision support tools  
  o Proactive outreach to high-risk patients | • Hospitalization rate cut >50%  
• Health plan spending cut 10%  
• Improved patient satisfaction due to fewer complications, lower out-of-pocket costs |
| **Total joint replacement, Stephen Zabinski, MD Shore Medical Center, Horizon BCBS of NJ** | | | |
| • Reduce risk factors for complications preoperatively  
• Obtain lower implant prices  
• Use lower-cost settings for surgery & rehab | • No support for pre- or post-op care coordination & risk reduction, ie, BMI, smoking, diabetes control, deconditioning  
• Lack of data on facility costs to support better decision making | • Avg LOS reduced 1.5 days for knees, 1.3 days for hips  
• Avg device cost cut 33%  
• Discharge to home: 34%→78%  
• Readmit rate: 3.2%→2.7% |
### Examples of physician-focused APMs being developed

<table>
<thead>
<tr>
<th>Condition</th>
<th>Specialties Involved</th>
<th>Opportunities to Improve Care and Reduce Spending</th>
</tr>
</thead>
<tbody>
<tr>
<td>Epilepsy Headache</td>
<td>• Neurology</td>
<td>• Improve accuracy of diagnosis and appropriateness of diagnostic tests&lt;br&gt;     • Reduce frequency and severity of seizures and headaches, achieve better control&lt;br&gt;     • Reduce injuries and complications requiring emergency visits and hospitalizations&lt;br&gt;     • Prevent progression from episodic to chronic migraine and reduce opioid use</td>
</tr>
<tr>
<td>Cancer</td>
<td>• Medical Oncology&lt;br&gt;</td>
<td>• Improve cancer outcomes through accurate diagnosis and staging, more focus on appropriate use of treatments&lt;br&gt;    • Coordinate treatment planning for each stage of cancer and type of treatment&lt;br&gt;    • Help patients manage psychological, physical, financial challenges of their disease&lt;br&gt;    • Reduce nausea, vomiting, pain, dehydration, other complications of cancer&lt;br&gt;    • Treat complications quickly without need for ED visits or hospital admissions&lt;br&gt;    • Prevent repeat operations and avoid unnecessary use of expensive radiation therapy modalities, imaging, lab tests and drugs</td>
</tr>
<tr>
<td>Asthma</td>
<td>• Allergy and Immunology</td>
<td>• Improve diagnostic accuracy, treatment planning, and medication adherence&lt;br&gt;     • Reduce work and school absenteeism and increase productivity&lt;br&gt;     • Reduce emergency visits and hospitalizations due to asthma exacerbations&lt;br&gt;     • Avoid unnecessary use of expensive tests and drugs</td>
</tr>
</tbody>
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AMA Recommendations for Future QPP Improvements

1. Maintain Pick-Your-Pace transitional approach for 2018 with modest increase in minimum requirements to avoid penalty and to achieve positive incentive in 2020

2. Simplify MIPS scoring and provide timely, actionable feedback reports

3. Maintain policy improvements like 50% quality reporting threshold, 90-day reporting period, point for quality reporting regardless of measure performance

4. Reduce required quality measures to 3, allow QCDRs flexibility, increase points for “topped out” measures, make outcome and high-priority measures optional

5. Keep 2018 cost category weight at 0

6. Remove mandate to update EHRs to new certification standard in 2018
AMA Recommendations for Future QPP Improvements

7. Provide more flexibility in ACI scoring with partial credit for each base measure

8. Avoid imposing complex Improvement Activity reporting and documentation rules

9. Maintain APM financial risk threshold at 8% of revenues instead of increasing it

10. Improve opportunities for physicians to participate in both Advanced APMs and MIPS APMs, including implementation of physician-focused APMs
AMA Resources on Quality Payment Program

www.ama-assn.org/MACRA

Medicare Payment & Delivery Changes
Increase understanding of the new quality payment program created by MACRA.

Links and tabs to:
- AMA comments and recommendations
- Detailed info on MIPS and APMs
- STEPSForward modules
- AMA Payment Model Evaluator
- Checklist to prepare
- Podcasts from ReachMD
- MACRA Action Kit and slides
- Links to specialty and state society MACRA resources
- Link to qpp.cms.gov
- Other MACRA resources, links, and news stories
Your MISSION is Our MISSION