MACRA, MIPS & APMs: Countdown to Payment Reform
Goals

✓ Learn the language (jargon) behind MACRA/QPP
✓ Understand MACRA basics including:
  – MIPS and how it relates to providers
  – The APM framework
✓ Recognize CMS and provider challenges
✓ Learn how Telligen can help you succeed in the new program
MACRA Basics

**The Law That “Fixed” the SGR**

- Medicare Access and CHIP Reauthorization Act of 2015
  - Signed into law April 16, 2015
- Modernizes the Medicare payment policy for physician services
  - Repeals the Sustainable Growth Rate
  - Updates MC Part B payment rates 0.5 percent annually from 2016-2019
  - Streamlines multiple quality reporting programs (PQRS, MU & VM)

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*Our goal is to have 85% of all Medicare fee-for-service payments tied to quality or value by 2016 and **90% by 2018**. Perhaps even more important, our target is to have 30% of Medicare payments tied to quality or value through alternative payment models by the end of 2016, and **50% of payments by the end of 2018**.*

- Sylvia M. Burwell, January 26, 2015

*HHS Press Release January 26, 2015*
MACRA Basics

Impact on Medicare Physician Pay

MACRA Basics

Impact on Clinicians & Beneficiaries

- **Hospitals** — Restructures disproportionate share hospital funding
  - Delays cuts scheduled for 2017 by one year and extends them through 2025
  - Requires 2018 increase in payments to be phased in over six-years

- **Post-Acute Care Providers** — Reduces market basket updates
  - Limits the 2018 payment adjustment to 1.0 percent

- **Beneficiaries** — Imposes income-related adjustments
  - Bans first-dollar Medigap policies
  - Adjusts Part B and D premiums based on income
MACRA Basics
The New Quality Payment Program (QPP)

- Includes Two Paths:
  - Merit-Based Incentive Payment System (MIPS)
    - Receive +, - or neutral
  - Advanced Alternative Payment Model (APMs)
    - 5 percent incentive bonus

- First Performance
  - Most Eligible Clinicians (ECs) will report through MIPS the first year
  - Jan. 1, 2017 through Dec. 31, 2017
MACRA Basics

QPP = Future of Medicare Payments

Goals: MIPS vs. APMs

- Payments Linked to Quality
  - 2016: 85
  - 2018: 90
- Payments Linked to APMs
  - 2016: 30
  - 2018: 50

Linking Quality and Value
MACRA Basics

QPP Implementation Timeline

October 2015
- Two MU final rules
  - 60-day comment period on Stage 3
- MIPS & APM implementation RFIs

Spring 2016
- MU Stage 3 Final Rule
- MACRA Proposed Rule, Quality Payment Program (4/27/16)
- MACRA measure development plan

Fall 2016
- QPP Final Rule
  - Applies to 2017 performance period & 2019 MIPS payment adjustment period
- Annual list of MIPS quality measures (11/1/2017 performance period)

January 2017
- First performance year begins 1/1/2017 for EC’s
  - First payment adjustment year 2019
MIPS

PQRS
Physician Quality Reporting Program

VM
Value-Based Payment Modifier

MU
Medicare EHR Incentive Program (aka MU)

MIPS
Merit-Based Incentive Payment System
MIPS
Who is Affected by MIPS?

✓ Medicare Part B ECs:
  – 2019-2020 — Physicians, PAs, NPs, CRNA, CNS
  – 2021 and Beyond — Additional clinicians will be added

✓ ECs Assessed as an Individual or Group
  – Group is defined by tax identification number and assessed across all four categories

Who is Exempt?
- First Year of Medicare Part B
- Below Low Patient Volume
- Certain Participants in Eligible Alternative Payment Models
- Hospitals and Facilities
MIPS

Impact on Providers & Facilities

- Applies only to ECs, not facilities
  - Exception: Part B services performed by EC at hospital (similar to current PQRS and MU programs)

- Applies only to Medicare Part B; Part A services are not subject
MIPS Year One*
How will EC’s be Scored?

**Quality**
EC’s select 6 of 9 PQRS measures to report

**Advancing Care Information**
EC’s report customizable measures reflecting their EHR use

**Clinical Improvement Activities**
EC’s select practice improvement activities that match their practice’s goals

**Resource Use**
Based on Medicare claims; no reporting requirements from EC’s

**Composite Performance Score (CPS) Categories**

- Quality: 50%
- Advancing Care Information (MU): 25%
- Clinical Improvement Activities: 15%
- Resource Use: 10%

*Proposed only; subject to change
MIPS Year One*

**Quality**

- Replaces PQRS and quality component of VM program
- Choose six measures (verses nine) measures
- One cross-cutting and one outcomes measure
- Allows options to accommodate differences in specialty and practices
- Additional measures established from stakeholder comments
- Depending on group size, MIPS calculates measures with each worth 10 points for a total of 80 to 90

*MIPS: Quality 50%

*Proposed only; subject to change
MIPS Proposed Year One

Advancing Care Information (ACI)

- Replaces Medicare EHR Incentive Program (MU)
- Choose customizable measures that reflect EHR use (emphasis is on interoperability and information exchange)
- Report as individual or group
- Must choose Protect Health Information (security risk analysis)
- No longer all-or-nothing EHR measurement
- NP & PA do not have to report year one (2017)
- 2017 — Use 2014 or 2015 CEHRT
- 2018 — Use 2015 CEHRT
- Total score calculates base score (50), performance score (up to 80) and bonus points

*MIPS: Advancing Care Information 25%*

*Proposed only; subject to change*
**MIPS Year One***

*Clinical Practice Improvement (CPIA)*

- Rewards practice improvement activities (see below)
- Choose from over 90 activities that suit practice’s scope
- Full credit for PCMH accreditation; partial credit for APM participation
- Activities are weighted; can earn up to 60 points

**Sample Practice Improvement Activities**

- Implementing programs that improve quality & outcomes (e.g., telehealth, population health management)
- Collaborating with key partners to improve community health
- Participating in CMS’ TCPI initiative
- Engaging in a QIO self-management training program

*MIPS: Clinical Practice Improvement*

*Proposed only; subject to change*
MIPS Year One*

*Resource Use*

- Replaces cost component of VM Program
- Calculates the score based on MC claims
- No reporting requirement for clinicians
- Uses more than 40 episode-specific measures to account for differences among specialties
Alternative Payment Models (APMs)
**APMs**

**APM Framework**

1. **FFS**
   - Traditional Fee-for-service
   - No link to quality & value

2. **FFS**
   - Linked to Quality & Value
   - Foundational payments for infrastructure & operations
   - Pay-for-reporting
   - Rewards for performance

3. **APMs**
   - Built on FFS Architecture
   - APMs with upside gainsharing
   - APMs with upside gainsharing/downside risk

4. **Population-Based**
   - Condition-specific, population-based payment
   - Comprehensive population-based payment
APMs

The Basics

- APMs are new approach designed to incentivize the adoption of payment models that move away from FFS
- Examples:
  - Certain accountable care organizations (ACOs);
  - Bundled payments models; and
  - Patient-Centered Medical Homes

<table>
<thead>
<tr>
<th>Is my APM Eligible?</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓ ECs meets a threshold of associated Medicare payments(^1)</td>
</tr>
<tr>
<td>✓ Uses Certified EHR Technology</td>
</tr>
<tr>
<td>✓ Collects quality measures data comparable to MIPS</td>
</tr>
<tr>
<td>✓ Includes a nominal financial risk(^2) for losses or is a patient centered medical home.</td>
</tr>
</tbody>
</table>

Eligible APMs:
- Models under Medicare demonstration authority
- CMMI models
- Medicare shared savings program

\(^1\) In 2017 (proposed), partial QP threshold = at least 20% of Part B payments; \(^2\) The definition of this risk will be defined in rulemaking.
APMs

Proposed Thresholds

<table>
<thead>
<tr>
<th>Participation in Advanced APMs: Incentive Payment Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinicians must meet payment or payment requirements</td>
</tr>
<tr>
<td>Payment Year</td>
</tr>
<tr>
<td>----------------</td>
</tr>
<tr>
<td>% of Payments for Advanced APMs</td>
</tr>
<tr>
<td>% of Patients through an Advanced APMs</td>
</tr>
</tbody>
</table>

**Alternative:** Combination Medicare/All-Payer Thresholds

Beginning 2021, a second option is established based on thresholds for combined payments from Medicare and other payers.
APMs

**Eligible Advanced APMs (Proposed)**

- ECs participating in advanced APMs may be determined as qualifying APM participants (QPs)
- QPs:
  - Are not subject to MIPS
  - Receive 5 percent lump sum bonus payments for years 2019-2024
  - Receive a higher fee schedule update for 2026 and beyond

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**Eligible Advanced APMs Include:**

- Comprehensive ESRD Care Model
- Comprehensive Primary Care Plus (CPC+)
- Medicare Shared Savings Program Track 2
- MSSP Track 3
- Next Generation ACO Model
- Oncology Care Model Two-Sided Risk Arrangement *(available in 2018)*
Moving Forward with QPP
# Moving Forward with QPP

**MIPS-APM Adjustment Timeline**

<table>
<thead>
<tr>
<th>Year</th>
<th>Fee Schedule Updates</th>
<th>Quality</th>
<th>Resource Use</th>
<th>Clinical Practice Improvement Activities</th>
<th>MIPS Payment Adjustment (+/−)</th>
<th>5% Incentive Payment</th>
<th>Certain APMs</th>
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</thead>
<tbody>
<tr>
<td>2015 and earlier</td>
<td>0.5</td>
<td>4%</td>
<td>5%</td>
<td>7%</td>
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<tr>
<td>2016</td>
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<td>5%</td>
<td>5%</td>
<td>7%</td>
<td>9%</td>
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<tr>
<td>2017</td>
<td>0.5</td>
<td>5%</td>
<td>5%</td>
<td>7%</td>
<td>9%</td>
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<tr>
<td>2018</td>
<td>0.5</td>
<td>5%</td>
<td>5%</td>
<td>7%</td>
<td>9%</td>
<td>0</td>
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<tr>
<td>2019</td>
<td>0.5</td>
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<td>2025</td>
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<td>2026 and later</td>
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<td>0.25</td>
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</tr>
</tbody>
</table>

*Qualifying APM conversion factor
**Non-qualifying APM conversion factor

Moving Forward with QPP

Provider Challenges

- Providers:
  - Broadly unaware of program and program structure
  - Small practices may struggle with administrative requirements and implementation – CMS offers some support and flexibility
  - Menu of quality measures may not capture “quality” for some provider types
  - Quality measure reporting remains challenging

<table>
<thead>
<tr>
<th>CMS:</th>
</tr>
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<tbody>
<tr>
<td>▪ What is the benchmark for “nominal risk” in an APM?</td>
</tr>
<tr>
<td>▪ For what spending is an APM accountable? How is “value” measured for medical providers who do not directly work with beneficiaries?</td>
</tr>
<tr>
<td>▪ How is “value” measured for individual providers?</td>
</tr>
</tbody>
</table>
Moving Forward with QPP

*Conclusions*

- Value-based payments have arrived
- The APM framework will be used to categorize future APMs
- The language of MIPS and APMs will replace the language of PQRS, MU and VM
- Technology plays a key role in healthcare’s future
- Performance year 2017 will be basis for MIPS in payment year 2019
- Telligen has the technical assistance resources to help you achieve success
Thanks for Joining Us!

Paul Mulhausen, MD

- Chief Medical Officer, Telligen
- pmulhausen@telligen.com

Sandy Swallow

- Senior QI Advisor, Telligen
- 515.223.2105
- sswallow@telligen.com
Resources


- Telligen www.telligen.com