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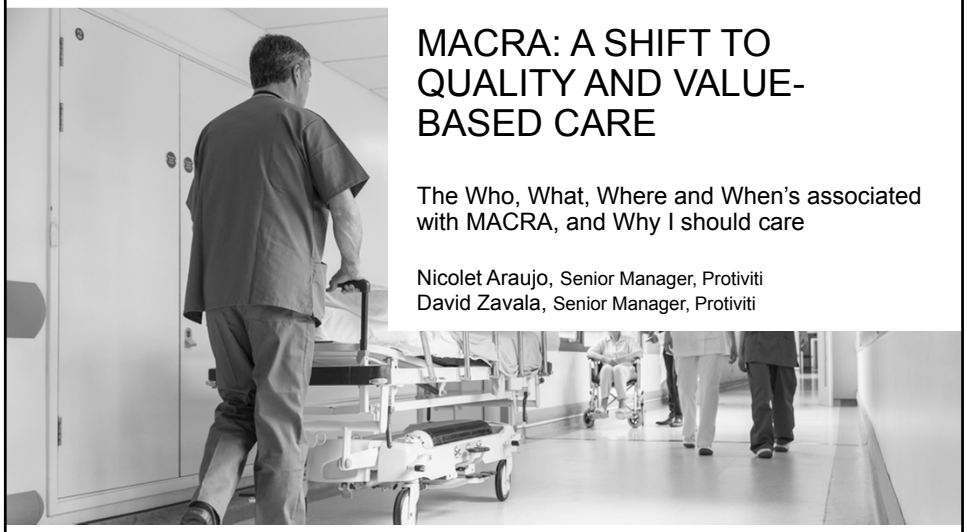

MACRA: A SHIFT TO QUALITY AND VALUE-BASED CARE

The Who, What, Where and When's associated with MACRA, and Why I should care

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Internal Audit, Risk, Business & Technology Consulting

AGENDA

- **Why Should I Care?**
- **What Is It?**
  - **The Quality Payment Program (QPP)**
- **Who Does It Apply To?**
  - **Merit-based Incentive Payment System (MIPS)**
  - **Advanced Alternative Payment Models (APMs)**
- **When Does It Start?**
- **What Do We Do?**
- **What's Next?**
  - **2018 QPP Updates**
- **Who's Doing What?**
  - **Case Studies**
- **What Should I Do Now?**
- **What Should I Remember?**
- **Q&A**

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WHY SHOULD I CARE?

WHY SHOULD I CARE?

Value Proposition

Who in your organization is accountable or even aware of the reporting requirements?

Financial Impact

Reputational Impact (Info made public by CMS – HealthGrades, etc.)

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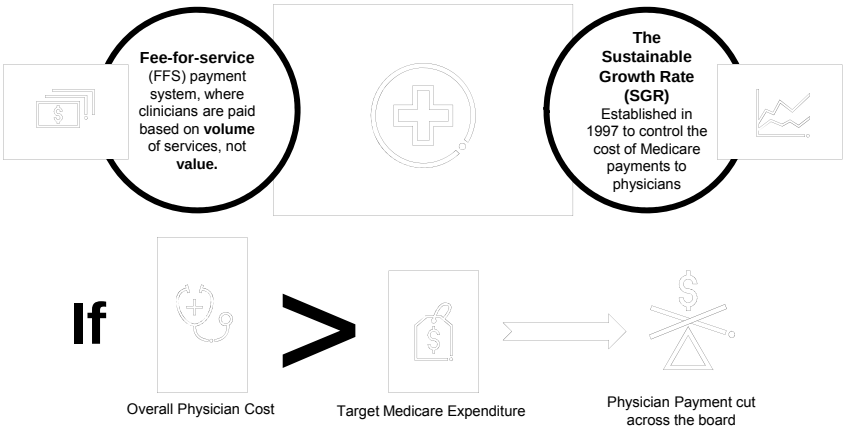
WHAT IS IT?

Quality Payment Program: Background and Beyond

MEDICARE PAYMENT PRIOR TO MACRA



Each year, Congress passed temporary **"doc fixes"** to avert cuts (no fix in 2015 would have resulted in a **21%** cut in Medicare payments to clinicians)

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MACRA

In January, 2015, the U.S. Department of Health and Human Services (HHS) outlined goals to, in the coming years, fundamentally reform how providers will be paid for treating Medicare patients.

In line with these goals, on April 16, 2015, President Obama signed into law the Medicare Access and CHIP (Children's Health Insurance Program) Reauthorization Act of 2015 **(MACRA)**, with strong bipartisan support.

MACRA repealed the flawed Sustainable Growth Rate (SGR) formula, and replaced it with a payment method that incentivizes value and quality of care over volume. **This signals a shift away from fee-for-service toward value-based care.**

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THE QUALITY PAYMENT PROGRAM

The Quality Payment Program (QPP) was implemented as a provision of MACRA with strategic objectives aimed at improving health outcomes, promoting smarter spending, minimizing burden of participation, and providing fairness and transparency in operations.

Strategic objectives include the following:

1. Improve beneficiary outcomes and engage patients through patient-centered Advanced APM and Merit-based Incentive Payment System (MIPS) policies.
2. Enhance clinician experience through flexible and transparent program design and interactions with easy-to-use program tools.
3. Increase the availability and adoption of robust Advanced APMs.
4. Promote program understanding and maximize participation through customized communication, education, outreach, and support that meet the needs of the diversity of physician practices and patients, especially the unique needs of small practices.
5. Improve data and information sharing to provide accurate, timely, and actionable feedback to clinicians and other stakeholders.
6. Promote IT systems capabilities that meet the needs of users, and are seamless, efficient, and valuable on the front and back-end.
7. Ensure operational excellence in program implementation and ongoing development.

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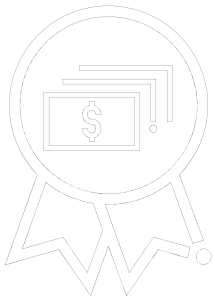
THE QUALITY PAYMENT PROGRAM (CONTD.)

The Quality Payment Program (QPP) consists of two tracks for Medicare reimbursement:



Merit-based Incentive Payment System (MIPS), for the majority of providers (who are reimbursed largely through fee-for-service). Centered around performance-based payment adjustments.

Advanced Alternative Payment Models (APMs) track for physicians who participate in Eligible APMs (i.e., as it states in the law, an Eligible APM must include "more than nominal financial risk"), e.g., ACOs, Patient Centered Medical Homes, etc. Includes 5% lump-sum incentive payment.

CMS has defined 2017 as the "transition year". Physician Medicare reimbursement payment adjustments will begin in 2019, however, they will be based on 2017 performance data!

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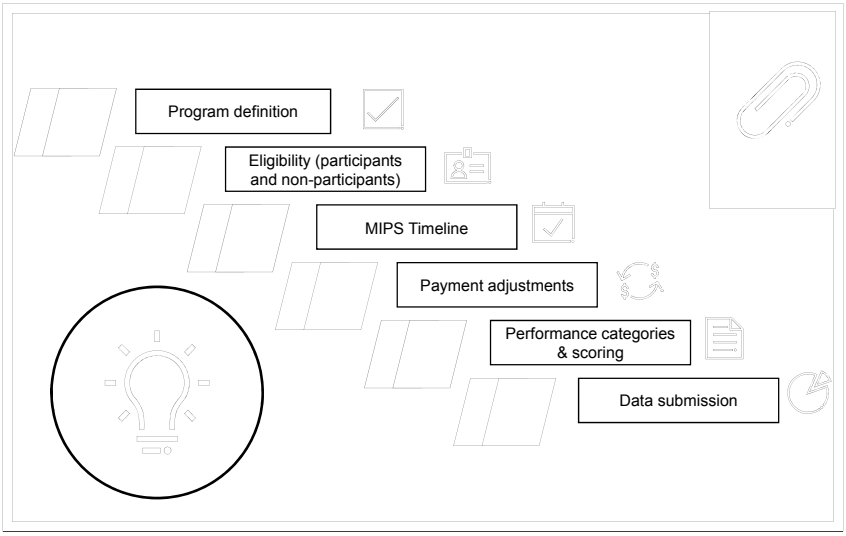
WHO DOES IT APPLY TO?

The Merit-based Incentive Payment System (MIPS)

Alternative Payment Model (APM)

MIPS: KEY KNOWLEDGE POINTS



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MIPS DEFINED

Quality

Resource Use

Clinical Practice Improvement Activities

Advancing Care Information

The **M**erit-based **I**ncentive **P**ayment **S**ystem (**MIPS**) streamlines the **Physician Quality Reporting System (PQRS),** the **Physician Value-based Payment Modifier (VM),** and the **Medicare Electronic Health Record (EHR) Incentive Program (aka "Meaningful Use")** into one single program to measure provider performance. A fourth component is also added to promote ongoing improvement and innovation to clinical activities.

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WHO PARTICIPATES IN MIPS?

The following clinician types can participate in MIPS, and are referred to as "Eligible Clinicians".

2017 & 2018

- Physicians: Doctors of Medicine, Osteopathy, Dental Surgery/Medicine, Podiatry, Optometry, and Chiropractors
- Physician assistants (PAs)
- Nurse practitioners (NPs)
- Clinical nurse specialists
- Certified registered nurse anesthetists
- Non-patient-facing MIPS eligible clinicians (e.g., radiologists)

Beyond 2018: Same as Y1/Y2, plus

- Physical or occupational therapists
- Speech-language pathologists
- Audiologists
- Nurse midwives
- Clinical social workers
- Clinical psychologists
- Dietitians / Nutritional professionals

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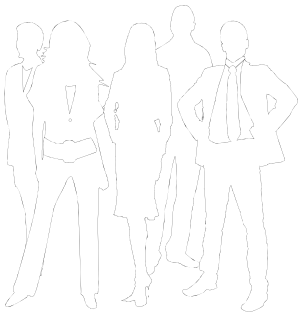
MOST CLINICIANS WILL BE SUBJECT TO MIPS

Eligible Clinicians can participate in MIPS as an:

Individual OR **Group**



A group, as defined by taxpayer identification number (TIN), would be assessed as a group practice across all four MIPS performance categories.

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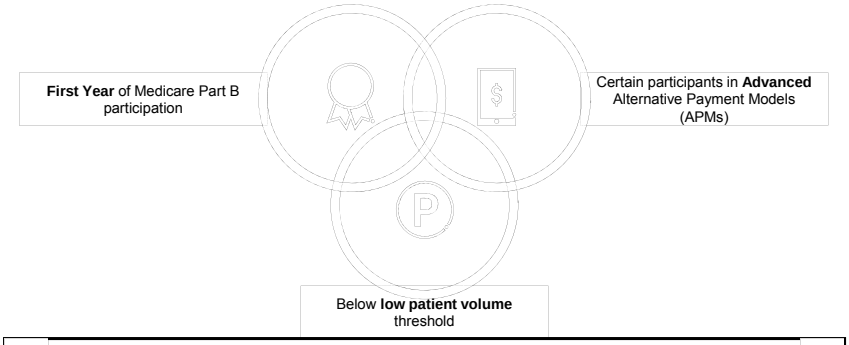
WHO IS EXCLUDED FROM MIPS?

There are 3 groups of clinicians who are NOT subject to MIPS:



Medicare billing charges less than or equal to $30,000 **($90,000 in 2018)**

OR

Provides care to 100 or fewer Medicare patients in the year **(200 in 2018)**

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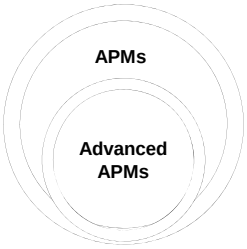
APM OVERVIEW

An Alternative Payment Model (APM) is a payment approach, developed in partnership with the clinician community, that provides added incentives to clinicians to provide high-quality and cost-efficient care. APMs can apply to a specific clinical condition, a care episode, or a population.

Advanced Alternative Payment Models (Advanced APMs) enable clinicians and practices to earn greater rewards for taking on some financial risk related to their patients' outcomes. **Participants of Advanced APMs receive a 5% lump sum incentive under the QPP**.

Advanced APMs are a subset of APMs…



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ADVANCED APMS

For the 2017 performance year, the following models are Advanced APMs:

- Comprehensive End Stage Renal Disease Care Model (Two-Sided Risk Arrangement)
- MSSP Track 2 ACOs
- Next Generation ACOs
- Comprehensive Primary Care Plus (CPC+)
- MSSP Track 3 ACOs
- Oncology Care Model (Two-Sided Risk Arrangement)

MSSP Track 1+ ACOs are proposed to be included as an Advanced APM in 2018.

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MIPS-APMS

- "MIPS-APMs" are a type of APM that includes MIPS eligible clinicians as participants, and hold their participants accountable for the cost and quality of care provided to Medicare beneficiaries. There are special reporting requirements for MIPS-APMs in addition to special scoring standards.
- Most Advanced APMs are also MIPS-APMs, so that if an eligible clinician participating in the Advanced APM does not meet the threshold of having sufficient payments or patients through an Advanced APM in order to become a Qualifying APM Participant (QP), the eligible clinician will be scored under MIPS according to the MIPS-APM scoring standard.

MIPS-APMs include the following

- Comprehensive ESRD Care (CED) Model (non-LDO arrangement one sided risk arrangement)
- MSSP Track 1 ACOs
- MSSP Track 1+ ACOs (Proposed Advanced APM for 2018)
- Oncology Care Models (OCM) (one-sided risk arrangement)

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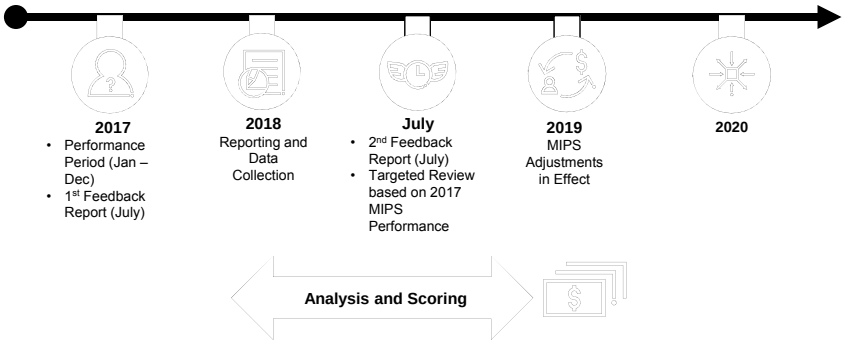
WHEN DOES IT START?

MIPS TIMELINE



Providers must have begun collecting performance data by October 2nd, 2017!

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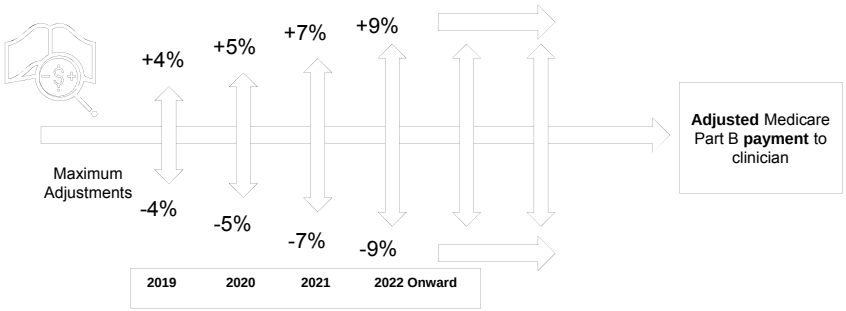
MIPS PAYMENT ADJUSTMENTS

Based on a MIPS Composite Performance Score, clinicians will receive **positive, negative, or neutral** adjustments **up to** the percentages below.



An additional bonus (not to exceed 10%) will be applied to payments to Eligible Clinicians with exceptional performance.

MIPS is a budget-neutral program. Total upward and downward adjustments will be balanced so that the average change is 0%.

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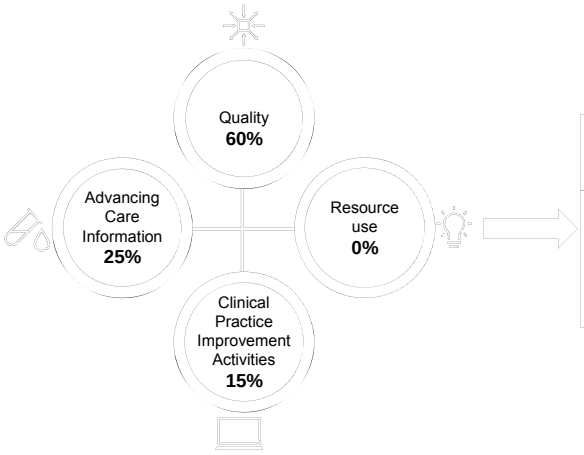
MIPS PERFORMANCE CATEGORIES AND SCORING

The MIPS Composite Performance Score will factor in performance across 4 weighted categories on a 0-100 point scale. For the **2017** performance year, the weighting of each category is as follows:



MIPS Composite Performance Score (CPS)

The CPS will be compared to the MIPS performance threshold to determine the adjustment percentage the Eligible Clinician will receive.

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POTENTIAL IMPACT TO PRACTICES

Larger practices are expected to do better under MIPS

CMS estimate of percentage of Eligible Clinicians receiving MIPS penalties or bonuses, by practice size:

Practice Size	Percentage Eligible Clinicians Receiving MIPS Penalty	Percentage Eligible Clinicians Receiving MIPS Bonus
Solo	87.0%	12.9%
2-9	69.9%	29.8%
10-24	59.4%	40.3%
25-99	44.9%	54.5%
100+	18.3%	81.3%

MACRA establishes an allotment of $20 million per year to provide assistance to practices of 15 or less providers to help transition them to APMs or improve MIPS scores!

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MIPS 2017 REQUIREMENTS

CMS has defined 2017 as the "Transitional Year", where providers can pick their pace to ease transition into the program. There are varying levels for participation:

No participation: Sending in no performance data for 2017 results in a **negative** 4% payment adjustment in Medicare reimbursement payments in 2019 .

"Test Pace": Submitting the **minimum** amount of 2017 data to Medicare (for example, one quality measure or one improvement activity **for any point in 2017**), a negative payment adjustment can be avoided (i.e., neutral payment adjustment).

Partial year participation: Submitting 90 days of 2017 data may earn a neutral or small positive payment adjustment. The max positive adjustment can be earned using this level of participation.

Full year: Submitting a full year of 2017 data may earn a positive payment adjustment. This is the best way to earn the largest positive adjustment.

Advanced APM participation: Practices that participate in an Advanced APM earn a 5% lump-sum bonus and are exempt from MIPS.

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"TEST PACE": WATCH OUT!

While a negative payment adjustment can be avoided using the Test Pace, other risks should be considered:

Financial

- Money left on the table
  - E.g., A provider practice with 25 eligible clinicians with $2M avg./yr in annual Part B payments:
    - Neutral ($0) adjustment for minimal reporting in 2017 = $22K in missed revenue for the practice in 2019
    - Maximum scoring over the first three years of the program = ~$350K in revenue!
- Forecasting
- M&A Activity

Reputational

- Performance scores will be made public!
  - Healthgrades, Yelp, Payer websites, etc.
- Provider comparison/selection by patients – competitive advantage!
- Litigation

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WHAT DO WE DO?

MIPS DATA SUBMISSION OPTIONS

	Individual Reporting	Group Reporting
Quality	• Claims • QCDR • Qualified Registry • EHR Vendors • Administrative Claims (No submission required)	• QCDR • Qualified Registry • EHR Vendors • CMS Web Interface (groups of 25 or more) • CAHPS for MIPS Survey • Administrative Claims (No submission required)
Advancing Care Information	• Attestation • QCDR • Qualified Registry • EHR Vendor	• Attestation • QCDR • Qualified Registry • EHR Vendor • CMS Web Interface (groups of 25 or more)
Clinical Practice Improvement Activities	• Attestation • QCDR • Qualified Registry • EHR Vendor • Administrative Claims (No submission required)	• Attestation • QCDR • Qualified Registry • EHR Vendor • CMS Web Interface (groups of 25 or more)
Resource Use	• Administrative Claims (No submission required)	• Administrative Claims (No submission required)

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WHAT'S NEXT: 2018 QPP UPDATES (PROPOSED RULE)

THE 2018 PROPOSED RULE

On June 20, 2017, the Centers for Medicare & Medicaid Services (CMS) released the 2018 Updates to the Quality Payment Program NPRM (Notice of Proposed Rulemaking). Final rule is expected by November 1, 2017.

Key takeaways from the NPRM include:

Enhanced focus on small practices. Provide greater flexibility by increasing the low-volume threshold from $30k in Part B charges or 100 Part B patients to $90k and 200 patients, respectively. Small practices also get 5 add'l points added to final score.

Allow for continued use of 2014 Edition Certified EHR Technology (10 bonus points available for those on 2015 Edition during the 2018 performance year).

Continue 2017 MIPS performance category weighting into 2018 (60% Quality, 25% Advancing Care Information, 15% Clinical Improvement Activities, and 0% Cost).

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THE 2018 PROPOSED RULE (CONTD.)

Introduction of "Virtual Groups":
- 10 or less EC per TIN
- Must elect by 12/1/17
- MIPS policies generally
- Model agreement

Facility Measurement Options
- Definition: EC must provide 75% of services in an inpatient or emergency room setting
- Aligns hospital-based providers with Value-Based Purchasing scores
- Voluntary – opt in or out

MSSP Track 1+ ACOs included as an Advanced APM

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THE 2018 PROPOSED RULE (CONTD.)

Increased Performance Thresholds & Scoring Requirements

Thresholds	2017 Points	2018 Points
Neutral – No Adjustments	3	15
Penalty	0-2 Pts (-4% Max)	0 – 14Pts (-5% Max)
Positive Adjustment (Budget Neutral)	4-69	16-69
Positive Adjustment for exceptional performers (0.5% - 10%) + $500 Million	70	70

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WHO'S DOING WHAT? CASE STUDIES

CLIENT CASE STUDY #1

- Large multi-hospital healthcare system
- 8 hospitals
- 150+ multi-specialty provider clinics
- ~400 employed physicians

Profile

Challenge

- Newly acquired clinics and providers were not aware of QPP
- No governance structure in place
- Various EHRs in use
- Healthcare system is responsible for provider reporting and attestation for all clinics

Action

- Education
- Establish governance structure
- Assess CEHRT

- Evaluate provider performance
- Implement optimization activities (repeat performance evaluation)
- Begin performance data collection

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CLIENT CASE STUDY #2

- Large non-profit multi-hospital healthcare system spanning 6 states
- 25+ hospitals
- 300+ multi-specialty provider clinics

Profile

Challenge

- Heavy ACO involvement (MSSP Track 1 ACO), operated by the healthcare system
- New hospitals & practices being actively acquired
- Disparate providers and systems
- Decentralized governance
- Data integrity issues

Action

- Enhance communication and data sharing between entities
- Centralize QPP governance/reporting structure
- Assess data governance program

- Identify root cause and resolve data integrity issues
- Formulate reporting strategy
- Educate regions
- Begin performance data collection

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WHAT SHOULD I DO NOW? PREPARATION CONSIDERATIONS

WHAT SHOULD ORGANIZATIONS BE DOING TODAY?

1. Ensure clinicians know about the Quality Payment Program (surveys show < 50% are aware)
2. Ensure data collection has begun (should've started no later than October 2, 2017)
3. Understand which track (MIPS vs APM) your organization is in, and if this may change in 2018
4. Understand current provider performance (including QRUR reports), and the related financial impact of reimbursement adjustments in 2019 and beyond – include a detailed mock scoring assessment – address gaps, and optimize performance
5. Understand reporting options – mechanisms for reporting, and individual vs. group, etc.
6. For 2017, plan to submit data for **at least** the minimum requirement to avoid the penalty
7. Retain all relevant documentation for potential audit purposes (similar to Meaningful Use)
8. Stay current on forthcoming final rule for 2018 QPP, expected this fall
9. Assess and align your organization's MACRA program goals to the governance of quality and value programs impacted by MACRA (i.e., PQRS, Value-Based Payment Modifier, and Meaningful Use)
10. Hospitals should continue adhering to Meaningful Use requirements

    (remember the QPP does not *directly* impact EHs!)

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WHAT IS A QRUR REPORT?

2016 Quality and Resource Use Reports (QRUR) were released 9/18/17. These can be a good tool to understand your organization's MIPS readiness. Benefits of the QRUR reports include:

- **Reveal Comparative Performance**: QRURs can provide a good sense of how your organization (TIN) is doing as compared to other TINs on the measures compared. 2016 performance can also be compared to 2015 performance to see if your organization made improvements on in various areas.
- **Determine Baseline Performance:** Performance percentages of the quality measures included in the QRUR can serve as a baseline and provide an estimate of potential MIPS performance in those areas.
- **Identify Quality Measures:** As the quality measures included in the QRUR also used the minimum case volume of 20, some of the same quality measures can be used for 2017 MIPS reporting (i.e., the ones in which your organization excels).
- **Identify Improvement Activities:** Utilize the report by diagnosis to identify the gaps that may need to be worked on. Look for MIPS improvement activities related to those areas. Reporting on these improvement activities will help your organization get credit for the effort you are already putting in.
- **Get a Heads-up on Cost:** Cost is risk adjusted based on the mix of beneficiaries attributed to the TIN. Paying attention to cost and understanding where your organization stands as compared to others in terms of quality of care delivered and the cost at which it was delivered will have your organization better prepared when the cost performance category weight jumps directly to **30% in 2019** (up from 0% in 2017 and 2018).

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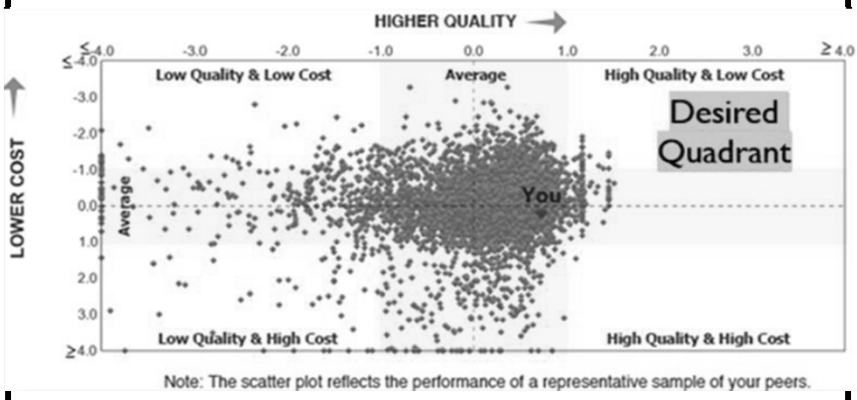
QRUR- WHERE IS YOUR DOT?



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

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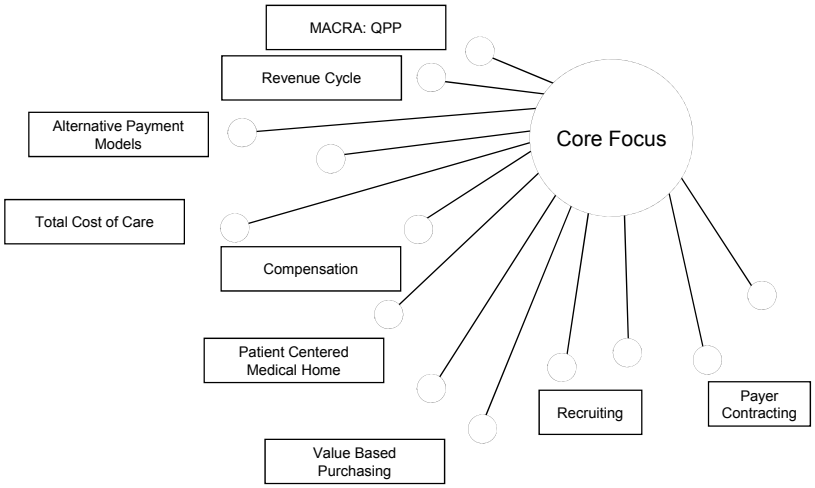
QRUR – CONNECTING THE DOTS



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WHAT SHOULD I REMEMBER – KEY TAKEAWAYS

RECAP

What is it?

The **Quality Payment Program (QPP)** was established by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), which changed how clinicians are reimbursed for treating Medicare patients. The QPP represents a shift from what has traditionally been a fee-for-service industry to more of a focus on quality and value-based care.

Who participates?

Physicians, Physician Assistants, Nurse Practitioners, Clinical Nurse Specialists, Certified Registered Nurse Anesthetists, and participants of Advanced APMs (ACOs, CPC+, etc.).

Who doesn't?

Clinicians who bill less than $30k in Part B charges/year, who provide care for less than 100 Medicare patients/year, or who are in their first year of participating in Medicare (these thresholds proposed to increase in 2018).

How do they participate?

Eligible Clinicians choose from either the APM track, or the MIPS track. Most will fall under the MIPS track, but over time APM participation is expected to increase.

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RECAP (CONTD.)

2017 is the Quality Payment Program "transition year". Physician Medicare reimbursement payment increases/decreases will begin in 2019, but are based on 2017 performance.

Advanced APM participants receive an automatic 5% incentive payment in 2019 (must receive 25% of Medicare payments or see 20% of Medicare patients through the APM).

MIPS participants can pick their pace in 2017 to determine +/- 4% adjustment for 2019 Medicare reimbursement. Submitting one quality measure or one improvement activity avoids a negative adjustment, but there are other risks to consider (reputational and financial).

Performance data collection must begin no later than Oct. 2nd (90-day reporting period), and must be submitted by March 31st , 2018.

Hospitals are not included within MACRA/QPP legislation, but they are still indirectly impacted (e.g., employed physicians, physician groups, performance analysis, EHR workflow config, etc.).

Understand the things your organization can be doing today to prepare!

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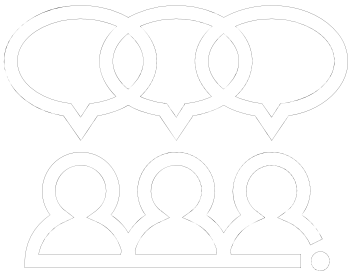
Q&A



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David is a Senior Manager in Protiviti's Dallas office and has 14 years professional experience providing IT, operational, and regulatory consulting services to the healthcare industry. David serves as Protiviti's Quality and Value-Based Care PMO Leader and brings expertise working with provider organizations undergoing initiatives in strategic planning, implementation, and compliance around MACRA legislation, Meaningful Use, Electronic Health Records, and Digital Transformation. David has shared expertise and best practices on a variety of topics through speaking engagements at national conferences, webinars, and industry publications.

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